# The Process and Outcome of Transactional Analysis Psychotherapy

# For the Treatment of Depression: An Adjudicated Case Series

## Thesis

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## By

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# The Process and Outcome of Transactional Analysis Psychotherapy for the Treatment of Depression: An Adjudicated Case Series

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**ABSTRACT:** Depression is a common mental health disorder which affects around one in ten people.  A range of psychotherapies have demonstrated efficacy for treating depression. Transactional Analysis (TA) is a relatively under-researched therapeutic approach which had hitherto not been tested for effectiveness for depression.  This study used systematic case study research which incorporated both quantitative and qualitative methods to investigate the process and outcome of TA psychotherapy for depression. A naturalistic design was used and five cases were examined to explore the application of up to sixteen sessions of TA therapy in community-based routine practice. Four of the cases were analysed using Elliott's (2001, 2002) Hermeneutic Single-Case Efficacy Design. This involved the recruitment of a number of independent psychotherapy researchers who adjudicated the cases and provided a verdict on the outcome of these cases. Case study method and cross-case analysis techniques were also developed during this investigation.  The findings show that TA therapy can be effective for the treatment of depression. A benchmarking strategy suggests that TA is likely to have comparable effectiveness to other therapies.  It is proposed that therapy is more effective when the type of therapy and therapist style is matched to client preferences and that pre-therapy preparation/ role induction is beneficial to overall outcome.  TA appears to be a coherent and integrative approach to psychotherapy, which can be used flexibly according to client need and preferences. The clients in this series all reported finding the use of TA theory to understand their own process and take charge of their own change process to be helpful. The use of TA concepts and language provides the therapist and client with a framework for a collaborative approach to therapy.  The integrative nature of TA and the use of shared language are two distinctive features of the approach that make a useful contribution to the wider psychotherapy literature. Further research is warranted to confirm and develop these findings.

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**Abbreviations**

| | |
|---|---|
| **APA** | American Psychological Association |
| **BACP** | British Association for Counselling and Psychotherapy |
| **BDI** | Beck Depression Inventory |
| **CBT** | Cognitive Behavioural Therapy |
| **CSC** | Clinically Significant Change |
| **CORE-OM** | Clinical Outcomes Routine Evaluation- Outcome Measure |
| **CTA** | Certified Transactional Analyst |
| **DALY** | Disability Adjusted Life Year |
| **DSM-IV** | Diagnostic and Statistical Manual- Fourth Edition |
| **EATA** | European Association for Transactional Analysis |
| **ED50** **change)** | Effective Dose (for 50% of sample to experience clinically significant |
| **EFT** | Emotion Focused Therapy |
| **HAT** | Helpful Aspects of Therapy |
| **HSCED** | Hermeneutic Single-Case Efficacy Design |
| **IAPT** | Increasing Access to Psychological Therapy |
| **ICP** | Integrative Counselling Psychology |
| **IIP** | Inventory of Interpersonal Problems |
| **IPA** | Interpretive Phenomenological Analysis |
| **IPT** | Interpersonal Psychotherapy |
| **MAOI** | Mono Amine Oxidase Inhibitor |
| **MDD** | Major Depressive Disorder |
| **MDE** | Major Depressive Episode |
| **MMPI** | Minnesota Multiphasic Personality Inventory |
| **NICE** | National Institute for Health and Clinical Excellence |

| | |
|---|---|
| **NIMH** | National Institute for Mental Health |
| **NHS** | The National Health Service |
| **OQ-45** | Outcome Questionnaire 45 |
| **PA** | Physically Abusive |
| **PDM** | Psychodynamic Diagnostic Manual |
| **PQ** | Personal Questionnaire |
| **RCI** | Reliable Change Index |
| **RCT** | Randomised Controlled Trial |
| **SCL-90-R** | Symptom Checklist 90 |
| **SN** | Seriously Neglectful |
| **SSRI** | Selective Serotonin Reuptake Inhibitor |
| **STPP** | Short Term Psychodynamic Psychotherapy |
| **TA** | Transactional Analysis |

**TDCRP** (National Institute of Mental Health) Treatment of Depression Collaborative Research Program

| | |
|---|---|
| **TRD** | Treatment Resistant Depression |
| **UK** | United Kingdom |
| **UKCP** | United Kingdom Council for Psychotherapy |
| **USA** | United States of America |
| **WAI** | Working Alliance Inventory |
| **YLD** | Years Lived with Disability |

# Chapter One: Introduction

*'In all its complexity, the question towards which all outcome research should ultimately be directed is the following: What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?' (Paul, 1967: 111)*

## 1.1. Research Rationale: Personal Context

The research presented in this thesis derives its inspiration from a number of personal and professional factors in my work as a psychotherapist. I started training in 1995, and started practise in 1996- originally within an integrative framework. By the end of the diploma in counselling course, I had started to become critical of the approach I had been taught which seemed to me to be eclectic and lacking in any cohesive meta-theory of integration. Around this time, I first encountered Transactional Analysis (TA) and was immediately inspired by its accessible and simple concepts. I experienced TA as rich in its capacity to help me conceptualise issues I had faced in my personal and professional life. TA also offered me a sense of clarity and guidance in how to work with clients. During this early stage in my career I was working in a research project which provided support and community-based rehabilitation for people with severe and enduring mental health problems. Although I did not realise it at the time, this grounding in researching practice would be an influence throughout my entire career as a therapist. After my diploma in counselling I continued training in TA

psychotherapy, gaining certification as a transactional analyst in 2002. In 2003 I gained accreditation as a TA trainer and supervisor and began to complement my clinical work with the teaching and supervision of TA therapists.

Throughout my career as a TA therapist and more latterly as a trainer I have been frustrated with the relative paucity of TA research. This frustration continued to grow over time, and an informal conversation provided the spark of inspiration that I needed to engage in doctoral research. Whilst having this conversation, I became aware of my internal dialogue in which I remembered a confrontation which is sometimes used in TA. The confrontation can be paraphrased as; 'don't complain about something if you are not going to do anything about it'. My complaints and frustration were then positively channelled into energy for conducting research.

Choosing to investigate depression was partly a strategic choice- I wanted to conduct research which would have the biggest possible impact, but which was both grounded in and reflected my clinical practice. Depression had been the single most common disorder which my clients presented with, ever since the start of my practice. It was also the most frequent complaint which the clients of my supervisees and trainees encountered. Frustratingly, TA theory had surprisingly little to say about depression, with just two articles exclusively focusing on treatment of depression from the entire TA literature. Students often wanted clear guidance and articles to help them work with their depressed clients and I felt that this was an area where I could make a real contribution.

Although I wanted to investigate the effectiveness of TA therapy, I was less interested in a large-scale quantitative study. I was seeking something which would stimulate me

and be both based on and enhance my practice more than a study which was about numbers and statistics and controlling variables. I wanted to know more about TA as it is practiced routinely with the type of clients I work with on a daily basis. I was also interested in the process of TA therapy, and in using a method which was both congruent with the philosophy, theory and practice of TA and which drew upon my existing skills base. Case study research emerged as the best possible option which would integrate each of these aspects.

## 1.2. Statement of the Problem

Epidemiological studies repeatedly demonstrate that depression is a common mental health problem. Estimates vary with regards its prevalence, although it is believed that between 10 and 20% of the population will experience depression during their life (American Psychiatric Association, 1994; Kessler et al., 2003; Office of National Statistics, 2000). During 2011, a staggering 46.7 million prescriptions for antidepressants were issued in England alone (The Health and Social Care Information Centre, 2011). Clearly, depression is a major public health problem.

The United Kingdom (UK) government Improving Access to Psychological Therapies (IAPT) initiative is underway in England, with services providing psychological therapies (mostly cognitive-behavioural therapy) to patients with depression and anxiety disorders. The UK's National Institute for health and Clinical Excellence (NICE) have produced guidelines for the treatment of depression (National Collaborating Centre for Mental Health, 2009) which indicate psychological therapies as the treatment of choice for mild to moderate depression. The guidelines recommend combined antidepressant medication and psychological therapy for severe depression.

The political climate within the UK at the present time is such that despite meta analytic studies which demonstrate there is little significant difference of efficacy between different types of therapy (Lambert & Bergin, 1994; Wampold, 2001), each type of therapy is required to have evidence of efficacy to meet criteria for inclusion in NICE guidelines, and as such, be available for patients to access for treatment of their psychological distress.

Transactional Analysis (TA) was developed during the early 1960s. It is a popular method of psychotherapy within the UK and Europe, with around 1500 practitioners in the UK alone. TA is not recognised within the NICE guidelines due to the absence of any substantive research evidence regarding its effectiveness.  In light of research which suggests different therapies produce equivalent outcomes, it seems reasonable to expect that TA psychotherapy will also demonstrate some effectiveness for depression.

## 1.3. Study Aims

The primary aim of this study was therefore to examine the effectiveness of TA psychotherapy for the treatment of depression in an adjudicated clinical study. The study focused on the gathering of rich data from a series of naturally-occurring cases within community-based routine practice. A secondary aim was to explore the factors associated with good and poor outcomes in this form of therapy. It was also intended that the study would generate practice-friendly findings which can be used for the training of TA psychotherapists.

Case study research which incorporates both quantitative and qualitative methods was selected to gather the rich data sets relating to the process and outcome of therapy.

**1.4. Outline Structure of this Thesis**

The literature review in chapter two is divided into seven sections. The first section presents an overview of the theory and practice of TA psychotherapy. This has been provided to enable the reader to contextualise both TA therapy and this study, and to become familiar with concepts which may be new or conceptualised in ways similar to their own theoretical approach to therapy. The review then continues with an outline of the existing TA research literature. This is then followed by a review of some key aspects of the process and outcome research literature on depression. Finally, the research questions which are the basis of the rest of the thesis will be identified.

Chapter three begins with examining the philosophical and methodological issues and the research design which are the basis of this thesis and also discusses the role of the researcher's subjectivity in design selection and data interpretation.

Chapter four provides a detailed outline of the methods used in this research. This is then followed by Chapter five, which is in five sections each of which is one of the case studies which form the data of this research. Chapter six is a cross-case analysis where the cases are compared and contrasted and both unique and common features are identified. This is followed by chapter seven which is a critical discussion of the findings of this research and the thesis is then brought to a close by chapter eight, which summarises the conclusions, key findings and implications for future research.

# Chapter Two: Literature Review

# Section One: The Theory and Practice of Transactional Analysis Psychotherapy

*'TA is probably the most comprehensive theoretical framework currently available in the field of counselling and psychotherapy' (McLeod, 1998)*

## 2.1.1. A Brief History and Context of Transactional Analysis

The founder of Transactional Analysis (TA) was Eric Berne, a Jewish Canadian neurologist who emigrated to the USA in 1935 in order to train as a psychiatrist. Between 1941 and 1943 Berne commenced training in psychoanalysis in New York. His training was interrupted for a few years whilst he served as an army psychiatrist during World War II. After the war, he moved to the San Francisco area and resumed his psychoanalytic training.

Berne was particularly interested in social psychiatry and ran weekly seminars on the subject from his home. By 1956 he had developed the basic elements of his theory which he had named Transactional Analysis. In 1959, his application to join the San Francisco Psychoanalytic Institute as a full member was rejected. This event acted as a catalyst and inspired Berne to develop his theories in conjunction with the colleagues who had joined him in his seminars. Culturally, San Francisco is well-known as being a hub of subversion and counter-culture and this spirit of rebellion no doubt influenced Berne. By 1961 his first book on TA was published and his theories started to gain popularity.

Transactional Analysis has grown and flourished over the years into an international community of practitioners. The European Association for Transactional Analysis currently has over 7500 members, of which, around 1500 are based in the UK

**2.1.2. The Theory of Transactional Analysis Psychotherapy**

Berne was passionate about demystifying the psychotherapy process and the importance of engaging the client as a collaborative partner in the therapy. This passion was evident early in his career as a psychiatrist. Berne was one of the first psychiatrists to invite patients into case conferences in hospitals and he actively invited them to participate in choices about their treatment (Berne, 1966). One aspect of the demystifying process Berne emphasised was his insistence on using colloquial, everyday language for the theoretical concepts of Transactional Analysis (TA). While the use of accessible language and concepts have likely contributed to TA's popularity, some TA professionals have speculated that the colloquial labels typically used in TA theory might give an impression of lack of academic substance or even amateurishness.  Despite this, some authors argue that the use of accessible language and the diagramming of internal and interpersonal processes is one of TA's strengths (McLeod, 2009; Stewart & Joines, 1987).

*2.1.2.1. The Theory of Personality- Structural Analysis*

*'Parent, Adult and Child ego states were first systematically studied by transactional analysis, and they are its foundation stones and its mark. Whatever deals with ego states is transactional analysis and whatever overlooks them is not' (Berne 1972: 223)*

Berne's theory of ego states developed from the theories of his analyst, Paul Federn (1952) and those of Eduardo Weiss (1950) and Ronald Fairbairn (1952). Federn was particularly interested in understanding one part of Freud's tripartite structure of the personality- the ego. Federn's definition of an ego state was of the entirety of an individual's internal subjective experience at any given moment (Federn, 1952).

Berne developed this definition of an ego state to include the element of observability (Berne, 1961) that posited that an internal shift of an individual's ego states might be directly observed (or inferred from observations of shifts in an individual's behaviour) by an external observer (in this context, the therapist). Berne developed Federn's theory that an ego state could be a direct response to the here-and-now situation the individual was presently experiencing, or one re-experienced as a regression to a childhood state to include an ego state which the individual had 'taken in' or introjected from external sources (generally, parents or parent figures). Thus he developed his theory of a tripartite structure to the ego which was both internally experienced and directly observable (Berne, 1961).

Within TA theory, the personality (ego) can be manifested in three ways, known as *ego states.* An ego state is defined as a '*consistent pattern of feeling and experience directly related to a corresponding consistent pattern of behaviour*' (Berne, 1966: 364). Ego states are divided into three categories which are called Parent, Adult and Child. The Parent ego state is a repository of *introjected* 'others' - usually primary caregivers but also influences from the social and cultural environment which were internalised by the infant during personality development (Stewart & Joines, 1987). This internalisation process is shaped by the quality of the relationship with caregivers,

which is 'recorded' in the infant's psyche.  The Parent ego state is believed to have a powerful influence on an individual's behaviour and internal process. Berne defined the Parent ego state as '*a set of feelings, attitudes and behaviour patterns which resemble those of a parental figure*' (Berne, 1961: 66) - a definition he later extended to include aspects of the individual's personality which were 'borrowed' from others (Berne, 1966: 366).

The Adult ego state stems from here-and-now reality and was described by Berne as '*an autonomous set of feelings, attitudes and behaviour patterns which are adapted to the current reality*' (Berne, 1961: 67).

The Child ego state is comprised of an individual's historical experiences and acts as a source of regression from a repository of subjective memory systems, including the affective components of experiences. Berne defined the Child ego state as '*a set of feelings, attitudes and behaviours which are relics of an individual's own childhood*' (Berne, 1961: 69).

Fairbairn's theory of the ego proposed a tripartite structure (Fairbairn, 1952) which Berne described as being '*one of the best heuristic bridges between transactional analysis and psychoanalysis*' (Berne, 1972: 134). Fairbairn argued that the ego is composed of an observing 'central ego', an object-seeking 'libidinal ego' and an 'antilibidinal ego' which he described as the internalised persecutory aspect (Fairbairn, 1952). A key difference between Fairbairn's theory and Berne's was that Berne's theory included nurturing and caring functions within the Parent ego state (Clarkson, 1992). Also, Berne's asserted that ego states are directly observable phenomena rather than abstract theoretical constructs (Stewart, 2010).

TA therapists pay considerable attention to analysis of the content of the different ego states *and* to the internal interaction between ego states, such as internal dialogue (which is often presumed to be pre-conscious or unconscious) (Berne, 1972).
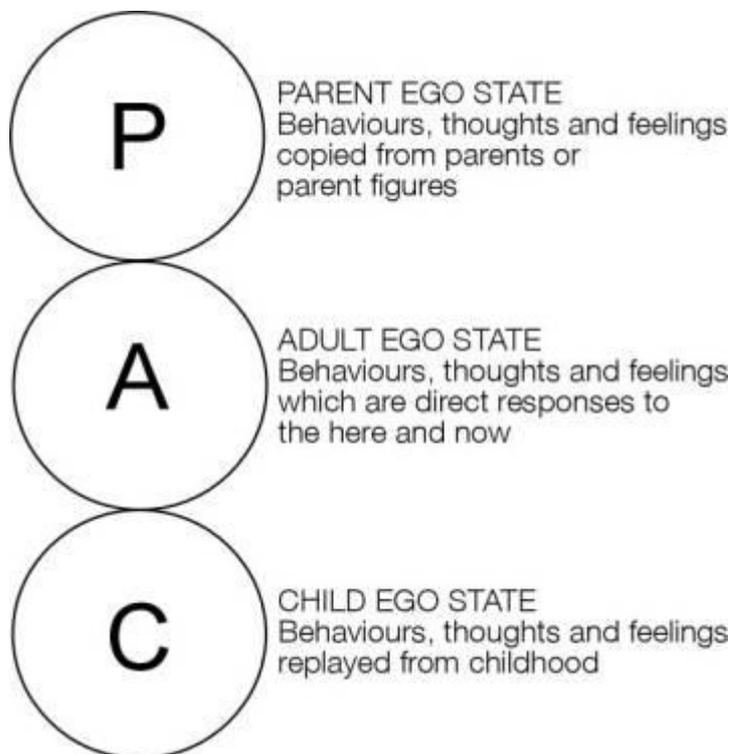


**Figure 2.1. The First Order Structural Model of Ego States (Berne, 1961; Stewart and Joines, 1987)**

*2.1.2.2. The Theory of Communication- Analysis of Transactions*

Berne's interest in social psychology led him to explore group therapy as an adjunct or alternative to individual therapy. It is from his experiences as a group therapist that he developed many of TA's theories relating to communication and interpersonal processes.  In TA theory, individuals are said to be communicating from a particular ego state at any given moment and these interpersonal communications are referred

to as *transactions* (Berne, 1961). The nature of the transactions between individuals and groups is then analysed. Using the ego state diagram as the basis for analysing transactions, communication between individuals can be diagrammatically represented in terms of the source and recipient of each particular communicative transaction and the subsequent communicative response. Berne's model of analysis of transactions can also be used for the analysis of transference and countertransference reactions and responses (Berne, 1972; Erskine, 1991).
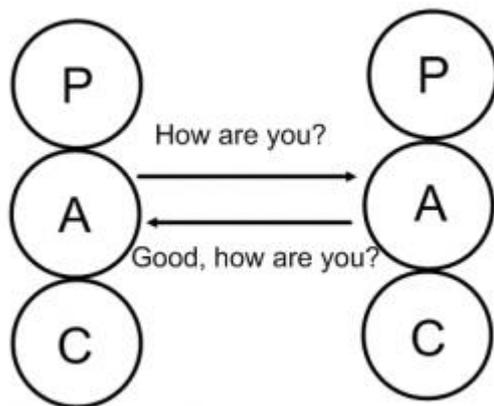


**Figure 2.2. Analysis of Transactions (Berne, 1961; Stewart & Joines, 1987)**

*2.1.2.3. The Life Script Theory of the Genesis of Psychopathology*

The *life script* is an '*unconscious life plan*' (Berne, 1966: 368), or '*a life plan made in childhood, reinforced by parents, justified by subsequent events and culminating in a chosen alternative*' (Berne, 1972: 445). Erskine describes the script as '*A life plan based on a decision made at any developmental stage which inhibits spontaneity and limits flexibility in problem solving and in relating to people*' (Erskine, 1980: 102). The script determines how an individual experiences and interprets the world, and interacts with others and the environment. Berne's theory of life script was influenced by Adler's

(1956) theory of 'style of life' which Adler described as an unconscious and repetitious pattern of living. Berne was also influenced by Erik Erikson (with whom Berne was in analysis with for several years), and Erikson's theories of psychological development through the life-span (Erikson, 1950, 1959). The theory of life script also has clear parallels with the cognitive-behavioural therapy theory of *schemas,* which are underlying structures that determine how an individual experiences self, others and the world (Beck, Rush, Emery & Shaw, 1979; Young, Klosko & Weishaar, 2003).

TA theory assumes that an individual adopts a *life position* which is a fundamental orientation the infant develops usually in response to very early interactions with his or her caregivers. It establishes the sense of relative worth and value of the self and others. In characteristic TA style, the life position is described using everyday language. The ideal, healthy position is one where an individual develops an 'I'm OK- You're OK' life position. Unfortunately, (often in response to interactions in these early relationships) individuals develop either an 'I'm OK- You're Not OK', 'I'm Not OK- You're OK' or an 'I'm Not OK- You're Not OK' life position (Berne, 1972). These link to Klein's (1975) concept of the Paranoid, Depressive and Schizoid positions, respectively. This life position is to some extent malleable, but it is largely consistent and 'reinforced' throughout life. Life positions have similarity to attachment patterns (Bowlby 1979, 1988; Ainsworth & Bowlby, 1965; Hobbes 1996, 1997; Holmes, 2001).

The *protocol* (Berne, 1972) refers to the very earliest relational (unconscious/preconscious) 'blueprint', which sets out the 'rules of engagement' that an individual determines from their early interpersonal experiences about how self and others interact.  There are clear parallels here with Stern's (1985) concept of

representations of interactions that are generalised, and to Luborsky's (1984) core conflictual relational themes.

Early TA (during the late 1960's) was particularly concerned with the script and script analysis, and the conscious elaboration of script. However more recently TA therapists have turned their attention towards understanding and working with the protocol. This shift in focus has been shaped by an increasing interest in implicit memory and early child development theory (Stern, 1985) that has influenced recent psychotherapy theory.

Life positions, protocol and script can be considered to be satisfying structure hunger (see below), and as part of an inherent tendency amongst people to organise the world psychologically, and make meaning. The theory of life script (as well as life positions and protocol, which are sub-divisions of script theory) serves to describe how human survival is preserved by the development and maintenance of relationships. The infant is entirely dependent on his caregiver[s] and will adapt very early to the needs of the caregivers to ensure he gains the optimal care. '*Script decisions represent the infant's best strategy for surviving in a world which often seems hostile, even life threatening*' (Stewart & Joines, 1987: 101-102).

Life script decisions are however often deeply irrational and overgeneralised, which is a direct result of them being developed with a child's cognitive skills. It is postulated that the child's relative lack of power, lack of options and lack of information together with immature thinking capacity and a neurological inability to handle stress make him particularly vulnerable to extreme conclusions and sweeping generalisations about self, others and the world (Woollams & Brown, 1979). These script decisions are then

stored in the Child ego state and profoundly influence how s/he lives their life and interacts with others. Experiences which conflict with script beliefs (generating cognitive dissonance) are frequently discounted (Schiff et. al., 1975) in order to preserve the script, and so preserve the internal sense of attachment with caregivers.

### *2.1.2.4. Racket Analysis: The Intrapsychic Process of the Script*

Transactional analysts believe that an individual's script beliefs will be linked intrapsychically to their affective experience and behaviour and their memories in a self-reinforcing cognitive-affective system known as a *racket* (Erskine & Zalcman, 1979). Each racket will have its own emotional content, such as sadness, or anger, or anxiety, which will in some way link to the emotions that an individual was 'permitted' to feel in their childhood. It is believed that a racket feeling will cover some repressed emotional content, often related to particular experiences (usually those from childhood). The concept of working with repressed emotions is similar to psychoanalytic theory regarding repression. In both TA and psychoanalysis, the treatment aim is for the client to access and express the repressed affect. In TA, the process of contacting and expressing repressed affect is also known as *deconfusion* (Berne, 1961, 1966; Hargaden & Sills, 2002). Berne described deconfusion as being a psychoanalytic process in his early work (Berne, 1961) in that it requires the discovery and expression of repressed affect. The racket feeling will be connected to a series of beliefs about self, others and the world, and a range of internal experiences (or symptoms) and observable behaviours. It will also have a number of associated memories. All this is interlinked in an associative network known as the 'racket system' (Erskine and Zalcman, 1979) (or more recently, the 'Script System'; Erskine, 2010). A

parallel can be drawn between the cognitive-behavioural theory of schemas (Young et

al., 2003) and the racket system.

**SCRIPT SYSTEM**

| SCRIPT BELIEFS/FEELINGS | SCRIPT DISPLAYS | REINFORCING EXPERIENCES |
|---|---|---|
| **Beliefs About:** Self Others Quality of Life | **Observable Behaviors** (stylized, repetitive) | **Current Events** |
| | Reported Internal Experiences (somatic ailments, physical sensations) | Old Emotional Memories |
| (Intrapsychic process) | Fantasies | Result of Fantasies |
| | | (Provide Evidence and Justification) |
| Needs and Feelings Repressed at the Time of Script Decision | | |

**Figure 2.3. The Racket (script) System (Erskine & Zalcman, 1979; Erskine, 2010)**

### 2.1.2.5. TA Theory of 'Games': How the Script is Enacted

TA theory states that people 'play games' to further their life script (Berne, 1964).

'Games', in this context, are repetitive, predictable and maladaptive interpersonal

patterns, which result in one or both parties feeling bad (Stewart & Joines, 1987). The

negative thoughts and emotions at the conclusion of a game serve to reinforce the

script and 'confirm' the individual's script beliefs. These unhelpful relationship patterns

are thought to be linked to the early experience of the individual, and might be seen as

a symbolic re-enactment of some primary scene from the individual's early life history.

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This theory accounts for patterns that might ordinarily be thought of as problems of the individual (such as alcoholism) which usually have some interpersonal element to their aetiology wherein the individual's interactions with others and his or her environment provide reinforcement (strokes) for the problematic behaviour.

Berne's psychoanalytic background and the influence of Freud's (1914) theory of 'repetition compulsion' is evident in the theory of games. From this, Berne created a model for direct observation and analysis of the repetition compulsion (Berne, 1972; Stewart, 1992).

### 2.1.2.6. Motivational Theory

Berne was inspired by some of the psychology experiments of the late 1950's into sensory deprivation, and also the work of Rene Spitz regarding 'failure to thrive' amongst children looked after in impersonal orphanages (Spitz, 1946). From this, he developed his theory of *the psychological hungers* (Berne, 1964). The hungers provide a motivational theory to TA which links biology and the social world with psychology (Erskine, 1998). Noting that the human senses are designed to absorb stimuli and that prolonged sensory deprivation leads to extreme psychological distress and even psychotic experiences, Berne posited that humans have an innate need for stimulus, and therefore have a *stimulus hunger*. With his theory of *recognition hunger,* Berne emphasised the fact that human beings are inherently relationship seeking. Recognition hunger leads a person to interact with others, which in turn, meets some of his or her stimulus needs, particularly those to do with physical contact and affection. Berne also noted that humans seem to have an inherent need to organise (or make psychological sense) of their world. This extends to the need to organise time

and the environment through to the creation of social hierarchies. Berne referred to this need as *structure hunger.* In adult life, relationship hunger (and to some extent, stimulus hunger) are met through the acquisition of strokes. A stroke is defined as 'a unit of recognition' (Berne 1972:447), thus highlighting the interpersonal nature of the concept. Stroke theory has similarities with the behaviourist concept of operant conditioning (Skinner, 1937) in that strokes are considered by transactional analysts to reinforce behaviour. TA practitioners consider that negative strokes can also be used as reinforcement, working on the principle that 'any stroke is better than no stroke at all' (Stewart & Joines, 1987). The view that humans are inherently relationship seeking also links TA theory to the object relations approach within psychoanalysis and in particular the theories of Fairbairn (1952). Thus, the core motivational theory of TA has similarities with both psychoanalytic and cognitive approaches.

These core aspects of theory provide TA therapists with tools for understanding intrapsychic process (structural analysis and racket analysis), and interpersonal process (analysis of transactions and game analysis), as well as presenting a unifying theory which accounts for both intrapsychic and interpersonal processes (script analysis).

**2.1.3: The Practice of Transactional Analysis Psychotherapy**

*2.1.3.1: Contractual Method*

Berne's belief in client-therapist collaboration was reflected in his theory of contractual method (Berne, 1966), in which clients are invited to set their own goals for therapy, rather than coming to therapy to 'work on' some indeterminate goals arbitrarily and unilaterally decided by the analyst. This acknowledgement that the client does indeed have some insight into his or her needs is congruent with the

humanistic values of TA. The client's goals are usually defined by some observable

means so that the therapist and client can readily identify whether the goals have

been reached or not (Berne, 1966; Goulding & Goulding, 1979; Steiner, 1974; Stewart,

2007). Attainment of the client's stated therapy goals is used to determine when

therapy should be terminated. The whole process of TA therapy is contractual. The

therapist and client negotiate and seek agreement at each step of the way; agreeing

on the focus of each session, agreeing on (and establishing informed consent for) the

use of specific techniques, and collaborating towards the on-going facilitation of the

client's goals (Stewart, 2007; Woollams & Brown, 1979). The therapy contract is not a

'static' phenomenon in that it can be, and often is, re-negotiated regularly throughout

the therapy.

### 2.1.3.2: The Practice of TA Psychotherapy

Traditionally, TA therapy eschews formal treatment manuals and favours a more

individualised approach to therapy. However, several key texts do influence the ways

in which TA therapists approach therapy and select their interventions (Hargaden &

Sills, 2002; Lister-Ford, 2002; Stewart, 2007; Woollams & Brown, 1979; and

Widdowson, 2010).  The influence of Berne's medical training is embedded throughout

TA. Traditional medical terms are frequently used in TA - 'diagnosis', 'treatment plan',

'cure'  - are medical in nature and suggest a medical model approach to the person

and to psychological therapy (Tudor & Widdowson, 2008).

Berne developed the concept of *stages of cure* (Berne, 1961; 1966). Berne's theory

was that the first stage of the change process is *social control,* whereby an individual

develops control over their behaviour in interactions with others. The next stage,

*symptomatic relief* involves the individual obtaining some subjective relief from their symptoms, such as anxiety. The next stage in Berne's framework is *transference cure,* whereby the individual maintains health by keeping the therapist 'in their head' as an introject (Clarkson, 1992; Stewart, 2007). It is considered that the 'cure' will be maintained for as long as the client can sustain the introject as a significant intrapsychic presence. Berne's final stage of cure was *script cure,* which involved the individual completely 'throwing off' their script, redeciding their limiting script decisions and becoming autonomous.

The concept of 'cure' is particularly problematic for many TA therapists, as it is often viewed as being philosophically incongruent with a humanistic approach to the person (Tudor & Widdowson, 2008). Also, the concept of cure suggests that one can be completely script-free and also maintains a disease model- a view that many modern TA therapists are challenging. Recent views consider that rather than becoming script free, an individual develops a more flexible script (English, 2010; Newton, 2006).

### 2.1.3.3: The Goals of TA Therapy

Berne (1972) advanced two primary goals of TA therapy: 1. The attainment of autonomy, and: 2. The attainment of an 'I'm OK- You're OK' life position.  Berne (1964) defined autonomy as being characterised by the release of three capacities; *awareness, spontaneity* and *intimacy*. It is a state in which the individual is adaptive and relates to the self, others and the environment in ways which are not restricted by the negative or limiting aspects of their life script (English, 2010).

### 2.1.3.4: Preconditions for Therapeutic Change in TA

The TA therapist seeks to develop a relationship in which the client experiences the therapist's warmth and acceptance towards them.  This subjective feeling contributes towards being part of an 'I'm OK- You're OK' relationship in which both parties are valued and in which there is a sense of mutuality (Berne, 1966; Stewart, 2007; Woollams & Brown, 1979). The development of the 'I'm OK- You're OK' relationship has clear parallels to the person-centred concept of 'unconditional positive regard' (Mearns & Thorne, 2007; Rogers, 1951):  a therapeutic model which is widely recognised and empirically supported (Norcross, 2002). The development of an accepting therapeutic relationship is augmented by the contract to foster the formation of the client's sense of self-determination and to help form an egalitarian therapeutic relationship with a greater degree of mutuality than approaches to therapy that require the therapist to adopt an authoritarian stance (Sills, 2006). The therapist also seeks to create a therapeutic atmosphere of *protection* and *permission* whereby the client can safely experiment with relaxing their script (Crossman, 1966). This is combined with a stance of therapeutic *potency* which requires the therapist to be a robust and resilient figure who can construct appropriate therapeutic interventions (Steiner, 1968).

### 2.1.3.5: Core Change Processes in TA Psychotherapy

The process of TA therapy can be seen as comprising three core change processes, each of which the therapist is seeking to facilitate. These processes are *decontamination, deconfusion and redecision.*

*Decontamination* is a process which is focused on working with the Adult ego state (Berne, 1961, 1966; Stewart & Joines, 1987; Woollams & Brown, 1979). It can involve procedures that are designed to challenge irrational beliefs, similar to the CBT method of disputing negative automatic thoughts (Beck & Beck, 1995), as well as procedures designed to enhance an individual's capacity to be in the here-and-now. In practice, this tends to be a largely cognitive process.

*Deconfusion* is often a cathartic process, whereby previously 'hidden' feelings or unmet needs held within the Child ego state are expressed and the individual makes meaning of (and peace with) their past. This also involves developing an internal sense of safety (Clarkson, 1992; Woollams & Brown, 1979). As a process, deconfusion relies on empathic transactions and analysis of the transference/ countertransference matrix (Hargaden & Sills, 2002) and is primarily an affective process.

*Redecision* engages both Child and Adult ego states (Goulding & Goulding, 1979; Stewart, 2007); an individual is encouraged to let go of limiting script beliefs and make a new personal decision and commitment regarding how they will conduct their life from now on. The process of redecision combines cognitive and affective processes.

The majority of TA therapy practice is designed to promote or facilitate one of the three core change processes. Decontamination, deconfusion and redecision have often been considered to take place in a roughly linear fashion, with therapy beginning with decontamination and moving through deconfusion to the final stages of redecision, then followed by a period of consolidation and termination (Pulleyblank & McCormick, 1985; Woollams & Brown, 1979). Recent TA authors (Hargaden & Sills, 2002) have challenged the view that decontamination comes before deconfusion. They argue that

deconfusion can often be seen from session one, since the establishment of a

therapeutic relationship in which the therapist responds empathically to the client

frequently results in the client contacting and expressing some repressed emotion in

their Child ego state. Clarkson (1992) and Hargaden and Sills (2002) also argue that it is

probable that some deconfusion (as part of the process of forging the therapeutic

relationship) *needs* to take place before decontamination can proceed effectively.

They claim that once the client has sufficiently decontaminated the Adult ego state to

enable the client to function effectively (and has experienced sufficient deconfusion of

the Child ego state to release repressed affect) the individual will often experience a

'loosening' of the script. This will enable them to evaluate their script decisions and,

where relevant, engage in redecision, which increasingly replaces dysfunctional script

beliefs with more healthy and adaptive beliefs. This in turn brings the client a sense of

an expansion of options in living and relating to others, therefore he or she thus

becomes increasingly free to live a relatively autonomous life, unshackled by the out-

dated constraints of the negative script.

# Section Two: Review of the Transactional Analysis
# Psychotherapy Outcome Research Literature

## 2.2.1. Introduction

Despite a fifty-year history as a therapeutic model, TA is relatively under-researched. As such, it is possible to summarise most of the evidence-base for TA in this literature review.

An early meta-analysis of the effectiveness of different types of psychotherapy was conducted by Smith, Glass and Miller (1980). They analysed data from 18 therapeutic interventions including TA therapy. Their meta-analysis concluded that TA had a medium effect size of 0.68 which was comparable to other therapies included within the study.  This team was the first to conduct wide meta-analyses of psychotherapy. As such, at the time of publication, this was considered to be a ground-breaking study, although its conclusions are somewhat dated now. The research studies of TA that were included in the meta-analysis included some which did not report findings relating to the outcome of TA psychotherapy (but related to the application of TA in non-therapy settings). In light of this, the conclusions Smith *et al*. (1980) came to regarding TA need to be interpreted with caution.

Two more recent reviews of the TA evidence base conducted by Khalil (2007) and Ohlsson (2010) concluded that there is valid evidence that TA is an effective approach. However, these reviews are somewhat limited since many of the articles included were not studies of psychotherapeutic efficacy or effectiveness. In fact, a number of articles referred to related to non-psychotherapy applications of TA (for example, use of TA in

educational settings). Due to this problem with the source data, the conclusions of these two reviews cannot be considered as strong support for the effectiveness of TA therapy.

For this section of the literature review, the focus will be a summary and evaluation of efficacy and effectiveness studies of TA psychotherapy as conducted within routine practice. Although they were included within the search, this review will not discuss findings relating to in-patient settings but will focus on both individual and group therapy. The rationale behind this is that these are the therapy formats in which TA is traditionally conducted in and therefore represent 'routine practice'. Furthermore, these are the formats in which TA therapists seeking certification must demonstrate competence in delivery (European Association for Transactional Analysis, 2008).

### 2.2.2. Search Method

Five key electronic databases were searched using the term 'transactional analysis psychotherapy'. These were; PsychInfo, PsychArticles, Scopus, Web of Science, and PsychExtra. The *Transactional Analysis Journal* (CD-ROM) disc was searched as a target journal using the term 'research' and hand searching was used for editions of this journal not included on the database disc. All editions of the *International Journal of Transactional Analysis Research* were manually searched for articles relating to psychotherapy and outcome research. Additional articles were identified by manually checking the references list from the two previously published reviews by Khalil (2007) and Ohlsson (2010).

### 2.2.3. Criteria for Inclusion and Exclusion

The scope of articles included in this review covered empirical work on transactional analysis psychotherapy with adults (over 18 years old) which were published in English in a peer-reviewed journal or book. Studies which referred to something other than transactional analysis counselling or psychotherapy (for example communications, business or economics articles) were excluded as were studies which measured or evaluated validity of specific theoretical constructs, such as ego states. Articles which were included in meta-analytic studies were not included separately. Studies that investigated the effect of training in TA psychotherapy on trainees were also excluded as they were not considered to be relevant to the present search.

### 2.2.4. Search Selection

The search identified 278 articles with some duplication across databases. The abstracts of articles identified in the search were examined using the above inclusion-exclusion criteria and 32 relevant articles were identified. These 32 articles were then retrieved for analysis.

### 2.2.5. Results

Of the 32 papers retrieved, 3 were rejected due to not satisfying inclusion-exclusion criteria. Of the remaining 29 articles, 21 studies demonstrated a positive effect from TA psychotherapy and 8 studies had inconclusive results. No studies were identified which demonstrated a negative effect from TA psychotherapy. The research topics of these articles were considered from a thematic perspective, and grouped according to format of delivery of the therapy. Ten articles investigated group therapy, nine articles

investigated in-patient therapy and seven articles investigated individual therapy, two articles investigated couples therapy and one article investigated family therapy. Due to space restrictions, this review will focus on the findings of articles relating to both group and individual TA therapy. These will be summarised, and this section will conclude with an overall summary of the existing TA research evidence relating to these therapy formats.

## 2.2.6. Summary of Published Research into the Effectiveness and Efficacy of TA Group Therapy

Ten articles addressing the outcomes of TA group therapy were identified, making this the TA therapy format with the largest amount of research evidence.  All ten studies conducted on TA group therapy demonstrated positive outcomes.

The two studies by Shaskan, Moran and Moran (1981) and Shaskan and Moran (1986) provide a perspective which is historically interesting to Transactional Analysts, although limited from a research perspective. These two studies involved tracing and contacting members of one of Eric Berne's therapy groups for a thirty-year and then a thirty-eight-year follow-up. Empirically speaking, the quality of these studies was poor. Both involved the investigators conducting a retrospective satisfaction study whereby they asked the former group members about their experiences of Berne's therapy group. This introduces the potential for recall bias and issues connected to remembering, the effects of time and so on which affect the study quality. Despite the methodological problems in these studies, 16 out of the 17 members contacted in the first study reported that the group had been a helpful experience and of the 9 contacted in the second study, all reported the group to have been an 'interesting and

important' experience. Obviously such findings need to be treated with extreme caution, but it does suggest that for whatever reason, group members have positive memories of their experiences of a TA therapy group long after the group had finished.

Several studies have investigated the outcome of TA redecision therapy groups and TA therapy marathons (intensive residential therapy groups conducted over several days). All of these report positive findings. McNeel (1982) investigated the outcomes of a weekend redecision therapy marathon group attended by fifteen people and found that participants experienced the group as 'a positive experience' which had led to 'greater personal growth'. This growth was sustained at a three month follow-up. Unfortunately, the study lacked standardised outcome measures so it is difficult to quantify the specific psychological or behavioural effects of the marathon.

A study conducted by Boholst (2003) also reported positive outcomes from a five-day TA therapy marathon group. Of the 28 participants, 15 attended the marathon while 13 did not have any intervention and acted as a control group. As with McNeel, Boholst did not use standardised outcome measures, however participants were both self and peer-rated as having improved their communication and interpersonal style in the general direction proposed by the functional model of TA theory- namely, a reduction in 'Controlling Parent and Adapted Child' responses and an increase in 'Nurturing Parent, Free Child and Adult' responses.

Sinclair-Brown (1982) conducted a study whereby nine physically abusive (PA), and nine seriously neglectful (SN) mothers (*n*=18) participated in a twelve-week TA redecision therapy group. The participants were referred either by social services or by a court order requiring their participation in a treatment programme. Participants

joined one of four on-going weekly TA therapy groups for PA/SN mothers which met for two hours per week. For ethical reasons there was no control group. The Minnesota Multiphasic Personality Inventory (MMPI) was used as a pre-post intervention measure of psychopathology. Other measurements of therapeutic effect included; making and completing behavioural change contracts, therapists' and social workers' reports of behavioural change (using a standardised evaluation form), children returned to participant's homes from local authority care and demonstrations of increased coping skills (as assessed by social workers). Statistically significant change occurred on an individual level for all participants on several of the indices, although no uniform pattern of improvement across *all* participants within the study was identified. The findings suggest that TA redecision group therapy may be a useful method for the treatment and rehabilitation of physically abusive and neglectful mothers.

Steere, Tucker and Worth (1981) conducted a study (*n*=22) comparing the outcomes of a twelve-session weekly TA therapy group to those of an 18-hour TA therapy marathon group. The Cattell Sixteen Factor Personality Questionnaire (16PF) was administered pre and post-therapy to measure change in personality, and a pre-post Goal Attainment Scale was used to measure behavioural changes. Significant personal change occurred at both the level of behaviour (goal attainment) and underlying personality structure with the two groups. The therapy marathon group participants demonstrated a rapid response to treatment, with the weekly therapy group participants making slower, more gradual change. Overall, both groups produced similar levels of change which were maintained during follow-up.  The authors concluded that both formats of TA group therapy were effective at producing positive

change and suggested that therapists provide both types of therapy groups and offer them to clients at different stages in their therapy.

A meta-analysis which examined the outcomes of therapy for post-partum depression included some reference to TA therapy (Bledsoe & Grote, 2006). This meta-analysis investigated a range of intervention approaches and formats, and concluded that the treatment based on a combined TA, CBT and psychoeducational approach was the most effective of all the non-medication based approaches, demonstrating an impressive effect size of 2.046. Unfortunately, the paper does not provide more details about the nature or content of the group, so it is difficult to tell how substantial the TA component was, what the TA component involved, or how it was delivered. Nevertheless, this does indicate that TA may be a useful method- singly or in combination with another approach- for treatment of post-partum depression and in relation to the present study does suggest that TA may have some use in the treatment of depression and that further research is warranted.

The only investigation specifically examining the outcome of TA psychotherapy for depression was a controlled trial conducted by Fetsch and Sprinkle (1982). Their study recruited 21 men who were screened and identified as having 'reactive depression'. Twelve members of the sample were randomised into a four week physical exercise (running) group, and eight were recruited into a TA 'stroke theory' based therapy group. The therapy arm of the study involved four, weekly, two-hour group therapy sessions. These therapy groups included psychoeducational aspects relating to stroke theory and behavioural contracting (homework) to practise what was learnt in the sessions. The group mean score on the pre-test Beck Depression Inventory (BDI) was

19, indicating mild depression. This changed to a statistically significant group mean score of 11.63 post-test. Although the participants were still within the clinical range of scores, it is important to note that this improvement meets criteria for reliable change and occurred within a relatively short time scale of four weeks. However, these findings seem less impressive when compared with the physical exercise group, who demonstrated equivalent improvement in BDI scores within the same time frame. In light of this, it is possible that the passage of time may have been a factor in improvements. Alternatively (or perhaps, in addition to), the experience of being part of a group specifically to overcome depression may have been a factor. The lack of a no-intervention control group means that conclusions relating to these potential factors cannot be drawn. Nevertheless, the findings do suggest that a short-term TA-based intervention may be an effective treatment for mild depression.

Self-esteem is a concept which is often linked to depression and two studies have addressed the impact of TA therapy groups on the self-esteem of participants. In the first study, Wissink (1994) recruited 22 participants to a six-week 'enhance your self-esteem' group of two and a half hours duration each time, based on transactional analysis psychotherapy self-reparenting procedures. Ten participants joined the treatment group and twelve joined a waiting list control group. Both groups completed pre and post-test measures of self-esteem. The treatment group demonstrated statistically significant increases in self-esteem in comparison with controls. Scores in the control group remained stable during the investigation period with no increase in self-esteem.  This study suggests that TA based group therapy may be useful for improving self-esteem, and therefore may be of benefit to people with depression or sub-threshold depressive symptoms.

These findings were supported in a study conducted by Noriega Gayol (1997) who investigated the outcomes of a one-week intensive TA psychotherapy group. Her study recruited 21 participants into a single group which was based on the TA principles of contracting, self-reparenting and redecision therapy. A TA-specific tool (measuring ego state boundary problems, used to determine individualised treatment goals for participants) and a quality of life instrument were developed and tested for validity prior to the study. These were administered to participants both prior to and post the group intervention. Participants also completed the Coopersmith Self-Esteem Inventory pre and post intervention. An analysis of results demonstrated statistically significant improvement in self-esteem ($p$= 0.01) which was maintained at three month follow-up. Noriega Gayol identified limitations of the quality of life instrument relating to lack of sensitivity to cultural differences in group participants from the participants in the study which validated the tool. Nevertheless, her findings are supportive of those of Wissink (1994) and suggest that TA psychotherapy groups which include a component of self-reparenting are a promising intervention for improving self-esteem.

### 2.2.7. Individual TA Therapy

Moving on to the TA literature regarding the outcome of individual TA therapy, there are only seven published articles which address this issue. Of these, one study had inconclusive results, but suggested that TA is a consistent and coherent approach to individual therapy (Grunewald-Zemsch, 2000). The first published study of outcomes of brief individual TA therapy was conducted with university students (Jensen, Baker & Koeep, 1980). Whilst the Jensen *et al*. (1980) study reported positive results of using brief TA therapy in a university setting, their study has significant methodological

problems (for example, using retrospective client self-report, no data regarding number of completed questionnaires, or information relating to the statistical procedures used) such that it is impossible to draw valid conclusions from the findings.

Two studies of TA used an identical method to that employed by Seligman's (1995) retrospective study of the effectiveness of psychotherapy which was published in *Consumer Reports.* In these two TA studies, clients who had received TA psychotherapy in the previous five years were contacted and asked to respond to a comparable questionnaire about their experiences of this form of therapy. The first of these studies (Novey, 1999)  (*n*=240) found that TA therapy compared highly favourably against the categories of therapist (psychiatrist, psychologist, marital therapist etc.) in the *Consumer Reports* study, with a significantly higher mean retrospective effectiveness rating of self-reported patient improvement and general functioning. This was an important study, and the largest and most detailed into TA therapy at the time. Of course, the findings need to be interpreted cautiously as results were based on retrospective self-report only. A further limitation of Novey's study was that completed questionnaires were returned to the therapist who had conducted the treatment, which may have biased the responses. Also, it is possible that the client sample would be biased towards the participation of those who felt their therapy was beneficial (over those who did not).

Novey (2002) conducted a partial replication of his first paper in a second research study, which analysed responses from 932 clients treated by an international cohort of 27 certified transactional analysis psychotherapists. In this second study a change to the procedure was that questionnaires were posted back to a third-party address and

were not seen by the former client's therapist. The data was compared to the original Consumer Reports study by Seligman and a similar study by Freedman, Hoffenburg, Vorus and Frosch (1999) which had investigated retrospective effectiveness of psychoanalytic psychotherapy. In his second study, Novey conducted a Chi-squared comparison of his data and the published findings of the Seligman (1995) and Freedman *et al*. (1999) papers. His paper reported results indicating a statistically significant superiority of Transactional Analysis to comparative therapies on measures of specific improvements, client satisfaction and global improvement.  Despite these impressive results, the findings must again be interpreted with caution. Although the study reported notable improvements in resolution of specific problems and overall functioning, the design of the study relies on a degree of accuracy in an individual's retrospective assessment of problem severity. Furthermore, the retrospective, subjective reporting of current symptoms and global functioning used a non-standardised tool and did not include any pre-post therapy measurement. Consequently the reliability of the findings may be compromised by recall bias. Given these methodological problems, it is not possible to state that on the basis of these two studies alone that TA is an effective psychotherapy.

Nathan, Stuart and Dolan (2000) criticised Seligman's (1995) study for *Consumer Reports*, arguing that it is insufficiently robust to draw conclusions about effectiveness of psychotherapy. They do however suggest that it might validly reflect high levels of client satisfaction with psychotherapy. In light of this critique, Novey's studies are perhaps more appropriately interpreted as evidence of high levels of satisfaction with TA (as opposed to evidence of effectiveness of TA). Although these studies by Novey

are important and represent the largest studies of TA psychotherapy to date, high rates of client satisfaction do not necessarily equate to client improvement.

The only Randomised Controlled Trial (RCT) involving TA to date was conducted by Cross, Sheehan and Khan (1982). Their small-scale RCT compared outcomes for 30 clients who each received 12 individual sessions of either TA-based insight-oriented therapy ($n$=15) or behavioural therapy ($n$=15) over a three month period. Twenty-six clients participated in a four-month and twelve-month follow-up process. Treatment manuals were not used in this study and therapists were permitted to implement the therapy based on their clinical judgment and in line with the general approach used in their theoretical orientation. Change was measured using a personalised measure of change in presenting problems, an outcome measure and a structured interview which measured social and interpersonal adjustment, and a measure of self-actualisation. Both treatment conditions resulted in statistically significant and comparable positive change on all measures which was stable during the follow-up period. Unfortunately the study did not report treatment adherence and was also of a relatively small sample of clients. Nevertheless, this does provide some initial evidence that TA-based therapy may produce equivalent effects to behaviourally oriented therapy.

A recent effectiveness study by van Rijn, Wild and Moran, (2011) compared TA therapy with Integrative Counselling Psychology (ICP). Both therapy programmes were short-term, up to a maximum of twelve sessions. The therapy was delivered by trainee therapists working in primary care settings within a single borough of London. Adherence scales were used to measure treatment fidelity and were scored by the supervisors of the participating therapists. This study used a battery of outcome

measures measuring psychological distress and depression and anxiety symptoms to determine effectiveness of the two different treatment conditions. The outcome measures were selected to provide a direct comparison with Cognitive Behavioural Therapy (CBT) as delivered in the UK's Improving Access to Psychological Therapies (IAPT) initiative. The Working Alliance Inventory (WAI) was also used to investigate if the strength of the working alliance would predict outcome. Seventy-eight patients participated in the study (38 allocated to TA therapy, 40 to ICP), with 21.8% attending fewer than six sessions and 78.2% attending more than six sessions. At point of entry into the study, 77.25% of patients had scores above clinical cut-off points for depression and anxiety. Although working alliance as measured using WAI improved over the course of therapy, strength of working alliance was not predictive of outcome, however initial severity of symptoms was predictive of outcome. Both treatments were found to be equally effective, with an average of 57.7% of patients overall demonstrating improvement for anxiety, depression and overall functioning. This result indicated that both TA therapy and ICP were comparable in outcome to CBT as delivered in the IAPT initiative which showed improvement in 55% of patients (Clark et al., 2009).

The final paper which has investigated the outcome of individual TA therapy was a hermeneutic, qualitative case-series conducted by McLeod (2013a). This study investigated the process and outcome of pluralistic TA counselling for three people with a range of long-term health conditions and found that TA therapy had been effective and helpful for all three clients in the study. The study sought to investigate the reasons for this. McLeod noted that the use of a TA framework enabled the

therapy to be delivered in a flexible manner which was easily adapted to the needs of each client and adapted for each client as their particular circumstances changed.

These last two studies provide a promising initial indication of effectiveness of individual TA therapy, suggesting that further research is warranted.

**2.2.8. Summary**

There is some preliminary evidence that TA therapy can be effective in both group and individual settings, however, to date there has been insufficient research to draw firm conclusions about its efficacy or effectiveness with clearly defined client groups. Where studies have reported positive findings, there has not been adequate replication of findings to support or refine their conclusions. Furthermore, there are significant gaps in the existing TA research literature. This is perhaps not surprising, given the relatively small amount of research conducted on TA therapy to date. Nevertheless, TA psychotherapy does appear to be a promising approach and one which is worthy of further investigation.

# Section Three: Overview of Theory and Research on Depression: Prevalence, Symptoms, Course and Pattern of Recovery[1]

### 2.3.1. Prevalence

Figures in the fourth edition of the American Psychiatric Association's (1994) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) estimate that between 10% and 25% of American women and between 5% and 10% of American men will experience major depressive disorder (MDD) during their lifetime. The Office of National Statistics (2000) in the United Kingdom reported that 9.2% of the British general population experienced mixed anxiety and depression in the year 2000, with 2.8% experiencing a depressive episode (without anxiety symptoms). They estimate that one in ten adults in Britain experience depression at some point during their life, with one in six experiencing mental health problems at any one time.

Epidemiological studies in the United States suggest that 9% of all adults will experience a major depressive disorder (MDD) in any given year, and approximately 16% will experience MDD during their lifetime (Kessler et al., 2003). Depression accounted for 4.46% of total worldwide Disability Adjusted Life Years (DALYs) in the year 2000, and globally depression accounted for 12% of the total number of Years Lived with Disability (YLD). It is estimated that globally, depression is the fourth most common cause of disease burden in women and the seventh most common cause in men (Moussavi, Chatterji, Verdes, Tandon, Patel & Ustun, 2007; Ustun, Ayuso-Mateos, Chatterji, Mathers & Murray, 2004).

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[1] Parts of this section have previously been published in an article: Widdowson, M. (2011a). 'Depression: A Literature Review on Diagnosis, Subtypes, Patterns of Recovery, and Psychotherapeutic Models', *Transactional Analysis Journal,* 41(4): 351-364.

Although there are mixed findings regarding the incidence and prevalence of depression by demographic factors such as class and race, there is some research which suggests that people with lower socioeconomic status are more likely to become depressed and to endure more persistent depression than people with higher socioeconomic status (e.g. Lorant, Deliege, Eaton, Philippot & Ansseau, 2003).

Major depressive disorder has a high mortality rate, with up to 15% of people with MDD committing suicide (American Psychiatric Association, 1994). Considering the prevalence of depression, the figures relating to suicide risk for those with depression are alarming. Anecdotal evidence drawn from informal conversations between author and psychotherapist colleagues, strongly suggests that depression is the single most common disorder for which people seek therapy. Clearly, depression is a significant mental health problem; one that all psychotherapists encounter regularly in clinical practice. However, despite this, the treatment of depression is not a major focus of literature pertaining to TA.

### 2.3.2. Depression: Diagnostic Features and Symptoms

*'Depression is not just a form of extreme sadness. It is a disorder that affects both brain and body, including cognition, behaviour, the immune system and peripheral nervous system. Unlike a passing sad mood, depression is considered a disorder because it interferes with ordinary functioning in work, school, or relationships. Unlike normal grief, which comes in waves, it is constant and oppressive. Depression also differs from ordinary mourning in that the mourner experiences the world as empty or bad, whereas clinically depressed individuals locate their sense of emptiness or badness in the self'* (PDM Task Force,2006:  109).

Depression varies in intensity, from mild to extremely severe, and its symptoms can range from subtle to profoundly disabling. The American Psychiatric Association's (APA) Diagnostic and Statistical Manual (4<sup>th</sup> Edition) provides the following diagnostic criteria for Major Depressive Episode. These are summarised below.

'Major Depressive Disorder is characterised by one or more Major Depressive Episodes (i.e., at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression)' (APA, 1994:  DSM-IV, p.317)

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

(4) Insomnia or hypersomnia nearly every day.

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(6) Fatigue or loss of energy nearly every day.

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

*Criteria summarized from: American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders, fourth edition, page 327.*

### 2.3.2.1. Types of Symptoms

Affective symptoms include loss of pleasure and interest in life or activities the individual previously enjoyed (anhedonia); feelings of worthlessness, guilt, inferiority, inadequacy, helplessness, and weakness; and an overwhelming sense of sadness, despair, loss of hope, and self-hatred.

Cognitive symptoms include impaired concentration and memory, indecisiveness, rationalisation of guilt, and sustained and intense self-criticism. Suicidal ideation of varying intensity is common in depressed individuals.

Somatic symptoms are common among people with depression and can include fatigue, lethargy, sleep disruption (hypersomnia or insomnia), restlessness and agitation, headache, muscular pain, back pain, weight loss or gain (and associated appetite changes), and loss of sexual desire. A greater number and severity of somatic

symptoms has been associated with Treatment-Resistant Depression (TRD) (Papakostas et al., 2003).

### 2.3.3. Depression: Patterns of Natural Course, Relapse, and Recovery

#### 2.3.3.1. Natural Course of Depression

It is difficult to generalise about the natural course of depression because it is quite possible that many people experience depression that - due to factors such as felt stigma and reluctance to seek advice and treatment - are not identified in epidemiological studies. The course of depression and prognostic indicators vary considerably according to type and number of previous episodes.

Symptoms of MDD typically develop over a period of between several days and a number of weeks, although early indicators of an impending depressive episode (prodromal symptoms) can occur several months before the onset of a depressive episode that meets DSM criteria. The duration of a major depressive episode (MDE) is variable, although in most cases it is between six months and two years. Between five and ten percent of all individuals continue to meet criteria for MDD for 2 or more years. Despite not meeting diagnostic criteria for MDD, it is probable that many people continue to experience depressive symptoms for a prolonged period of time (American Psychiatric Association, 1994). Forty percent of people will continue to meet diagnostic criteria one year after diagnosis of MDD, twenty percent will continue to have some symptoms without meeting full diagnostic criteria (partial remission), and forty percent will have no mood disorder. Initial severity of the episode appears to be predictive of its persistence, with more severe episodes lasting longer.

DSM-IV criteria for recovery from MDD are that the individual must not have met diagnostic criteria (i.e., depressed mood or loss of interest or pleasure plus four additional symptoms) for a period of 2 consecutive months. Throughout this time, an individual may still exhibit a number of depressive symptoms, in which case the individual is considered to be in partial remission.

### 2.3.3.2. Relapse Rates

A review of follow-up studies by Piccinelli and Wilkinson (1994) found that 75% of people with MDD would have at least one further episode of depression within ten years. Ten percent of patients in their study had experienced chronic and persistent depression for a period of ten years. The DSM-IV states that approximately 50%-60% of individuals who experience a single MDE will go on to have a second episode. Individuals who have had two episodes have a 70% chance of having a third, and individuals who have had three episodes have a 90% chance of having a fourth. Clearly, the number of episodes is a predictor of the likelihood of recurring episodes of major depression. There is a greater likelihood of an individual experiencing another episode of depression when there is only partial remission (i.e., some symptoms remain). While psychosocial stressors (such as relationship problems or bereavement) are often associated with the first or second episode, they are less often associated with subsequent episodes.

People with dysthymia (persistent low-grade depression) have a high probability of eventually having an MDE, with estimates as high as 79% of people diagnosed with dysthymia going on to develop an MDD during their lifetime. People who have had an MDD and who have an underlying dysthymic disorder will also have a much higher rate

of relapse for an MDD, with 62% experiencing an MDE within two years (Keller, Lavori,

Endicott, Coryell & Klerman, 1983).

### 2.3.3.3. Patterns of Symptomatic Recovery and Relapse in Psychotherapy

In their study of patterns of symptomatic recovery in time-limited (cognitive-

behavioural or interpersonal) psychotherapy conducted with a sample of 212

depressed patients, Barkham *et al.* (1996) found that percentages of patients meeting

criteria for clinically significant change as measured using the Beck Depression

Inventory (Beck, Ward, Mendelssohn, and Erbaugh, 1961) ranged from 34% to 89%

within 16 sessions of therapy . Kopta, Howard, Lowry, and Beutler (1994) examined

patterns of symptomatic recovery among a sample of 854 patients in ongoing (not

time-limited) outpatient psychotherapy measured using the Symptom Checklist-90

(SCL- 90-R) (Derogatis, 1983). The study identified three categories of symptoms:

acute, chronic, and characterological. As might be expected, acute symptoms

demonstrated the fastest average rate of response to treatment, followed by chronic

symptoms, then characterological symptoms. The mean ED50 ("effective dose" or

number of sessions needed for 50% of the sample to achieve clinically significant

change) for acute distress symptoms was five sessions. The ED50 for chronic distress

symptoms was 14 sessions, and the ED50 for characterological symptoms was over

104 sessions. Within the acute distress category, which listed 20 symptoms, the

symptom dimension showing the largest number of ED50 changes was 'Depression'

(five symptoms), followed by 'Somatization' (four symptoms) and 'Obsessive-

Compulsive' (four symptoms). Within the 'Chronic Distress' symptoms category, which

listed 27 symptoms, Depression was again the symptom dimension showing the largest

number of ED50 changes (seven symptoms), followed by 'Interpersonal Sensitivity' (five symptoms).

These two studies suggest that around 50% of patients will achieve clinically significant symptomatic relief of between 12 and 21 depressive symptoms within 16 sessions of psychotherapy—an encouraging result for those who practise shorter-term psychotherapy. Nevertheless, this still leaves 50% of patients who will require a greater number of sessions to achieve symptomatic relief, and characterological symptoms (which, from a transactional analysis perspective would require script change) may require therapy of at least two years duration. Between 78-88% of clients who took part in the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program and who had short-term manualised therapy had either relapsed or sought further treatment by the 18-month follow-up (Morrison, Bradley, & Westen, 2003; Shea, Widiger, & Klein, 1992). Westen and Morrison (2001) also identified that by two-year follow-up after short-term manualised therapy, only 27% of patients with depression had maintained their improvement. One possible explanation for such low levels of maintained recovery is that manualised therapies used in research tend to focus on a limited area of the client's presentation, do not necessarily work with the client's other presenting problems (comorbidity), do not account for characterological problems, and/ or do not provide therapy of a sufficient length to remedy such issues (Morrison et al., 2003).

### 2.3.3.4. Comorbidity, Recovery, and Standard Length of Therapy for the Treatment of Depression

Morrison *et al.* (2003) conducted a study on a sample of 242 therapists in the United States regarding cases in which both therapist and client were satisfied with the outcome. They set out to test the validity of the widely accepted belief among therapists that a significant proportion of clients present with comorbidity of more than one Axis I disorder and that a significant proportion of clients present with a comorbid Axis II disorder. It is also widely accepted that the presence of comorbidity complicates the therapy and will require extension of the usual expected course of treatment a therapist might deliver for single-disorder depression (to achieve clinically significant change (i.e., change in which the client is considered to have recovered from the disorder). They found that 47.9% of patients in their sample presenting with depression had comorbidity with another Axis I disorder and 46.3% had comorbidity with an Axis II disorder. Comorbidity with characterological issues (non-Axis II diagnosable) was as high at 76.9% of all clients, a finding concordant with many therapists' anecdotal clinical experience.

# Section Four: A Review of Studies of the Efficacy of Psychotherapy for the Treatment of Depression.

## 2.4.1. Introduction

The psychotherapy research literature investigating outcomes of treatment for depression spans many thousands of articles. It is not possible to encompass this vast body of literature within the available space in this thesis. Consequently, this present review is limited to studies of short-term individual psychotherapy (i.e. fewer than 30 sessions) for the treatment of depression amongst adult clients (over 18 years) and is primarily focused on the findings of meta-analytic studies and key randomised controlled trials (RCTs). Many different therapeutic approaches to treatment of depression have been investigated. Again, due to limitations of space, this review must take a focused approach in selection of therapies. The therapies in this review are those recommended by the National Institute for Health and Clinical Excellence (NICE) for the treatment of depression (National Collaborating Centre for Mental Health, 2009) and those recognised by the American Psychological Association's division 12 (clinical psychology) as constituting an empirically supported form of therapy.

## 2.4.2. Cognitive-Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is a manualised system of therapy which involves the identification, evaluation and challenging of various thoughts and thought processes that cause distress, and the replacement of these with more adaptive thoughts. CBT also involves the use of various behavioural strategies to promote behavioural change, reinforce positive changes in thinking and to interrupt

problematic behaviours which maintain psychological problems. (Beck, Rush, Emery & Shaw, 1979; Hollon, Shelton & David, 1993)[2].

The first major trial of CBT for the treatment of depression was conducted by Rush, Beck, Kovacs, and Hollon (1977). Methodologically, the study did not yield findings that allowed a direct comparison between the outcomes of CBT and pharmacotherapy, however CBT did perform well and the study demonstrated that it could be an effective treatment for depression. Another RCT trial of CBT was conducted by Hollon *et al*. (1992). This study, involving 107 subjects, investigated the relative efficacy of CBT compared to both antidepressant medication alone and in combination with medication. It concluded that all three treatment approaches demonstrated equivalent efficacy for the treatment of depression (this evidence must however be interpreted with caution due to a high drop-out rate).

CBT has traditionally performed well in meta-analysis studies. Three notable meta-analyses identify CBT as a superior approach to other therapies (Dobson, 1989; Gloaguen, Cottraux , Cucherata & Blackburn, 1998; Tolin, 2010) whereas others (Cuijpers, Smit, Bohlmeijer, Hollon & Andersson, 2010, for example) claim it is equivalent to other therapies.

Dobson (1989) conducted a meta-analysis of 28 studies using a range of therapies (mostly cognitive, behavioural or a CBT combination) and concluded that therapy based on the cognitive therapy manual developed by Beck *et al.* (1979) was a superior form of treatment.  This finding was supported by a meta-analysis by Tolin (2010) who

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[2] *Studies of 'Behavioural Activation' (a recognised, empirically-supported intervention) have not been included in this review since the process of  behavioural activation is included as a component of the original CBT treatment manual for depression (Beck, Rush, Shaw, & Emery,1979)*

concluded that CBT was superior to a range of 'other therapies' (with the exception of Interpersonal Therapy and 'Supportive' therapy) and had a small effect size of $d$=0.21 in favour of its superiority against other 'bona fide' therapies.

Gloaguen, Cottraux, Cucherata and Blackburn (1998) concluded from their meta-analysis of 48 studies involving a total of 2765 subjects that cognitive therapy was equal in effect to behaviour therapy and superior to psychodynamic therapy, interpersonal therapy, non-directive therapy, supportive therapy, relaxation, bibliotherapy and antidepressant treatment. These findings have been disputed by Wampold *et al.* (2002) (see below), but despite this critique, the findings of the Gloaguen *et al.* (1998) meta-analysis strongly support the contention that cognitive therapy is an effective treatment for mild or moderate depression.

These findings of superiority of CBT have however proven to be controversial and there are several meta-analysis studies that challenge their claims. Cuijpers, Smit, Bohlmeijer,Hollon and Andersson (2010) conducted a meta-analysis of 117 trials and used a range of procedures to examine publication bias in the studies. Their paper concluded that '*the main analyses pointed at a considerable and significant risk of publication bias among studies examining cognitive–behavioural therapy, and this remained high in all sensitivity analyses*' (Cuijpers et. al., 2010: 175-176) and that the effects of psychotherapy (in general) for the treatment of adult depression tended to have been overstated in the literature due to publication bias. Despite this second conclusion, it is nevertheless significant that in their study, Cuijpers *et al.* (2010) specifically identified CBT as being at risk of overstating effect but did not discuss why this might be the case. Their conclusion is relevant in considering studies which

suggest that CBT is a superior therapy for the treatment of depression. Despite the debate surrounding the issue of whether CBT is indeed a superior treatment for depression, this does not detract from the fact that there is substantial research evidence relating to the considerable efficacy of CBT.

### 2.4.3. Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT) is a manualised form of psychotherapy which focuses on the resolution of interpersonal problems to relieve psychological distress. The IPT approach to depression is based on a process whereby the therapist and client work together to address four main problem areas; grief and loss, role transition, interpersonal conflict and interpersonal sensitivity (Klerman, Weissman, Rounsaville and Chevron, 1984; Stuart & Robertson, 2003).

The first form of solid evidence of the efficacy of IPT came from the trial conducted by Weissman, Prusoff and DiMascio (1979), which compared the outcome of treatment programmes using amitriptyline (a tricyclic antidepressant) to those using IPT. The study concluded that IPT was comparable in outcome to antidepressant treatment, and that a combination of IPT and antidepressants was even more effective than either treatment alone. The (USA) National Institute for Mental Health Treatment of Depression Collaborative Research Program (see below) also compared IPT to CBT and antidepressant medication and found IPT to be an effective treatment for mild-moderate depression and more effective than CBT for the treatment of severe depression (defined as a Hamilton Rating Scale for Depression score of over 20) (Elkin, et al., 1989).

A recent meta-analysis by Cuijpers, Geraedts, van Oppen, Andersson, Markowitz and van Straten (2011) of 38 studies which compared IPT to a control group (including no treatment, treatment with another therapy, pharmacotherapy, or a combination of psychotherapy and pharmacotherapy) which included 4356 patients concluded that IPT is efficacious for the treatment of depression. The study reported that '*compared with control groups, we found a moderate to large effect of IPT in the acute treatment of depression. We also found some indications that IPT had less efficacy than SSRI pharmacotherapy…We found indications that combination treatment with IPT and pharmacotherapy was somewhat more efficacious than pharmacotherapy alone… We did not find that IPT had greater efficacy than other psychotherapies, including CBT, although the number of studies was too small to draw definite conclusions*' (Cuijpers et al., 2011: 589).

### 2.4.4. Short-Term Psychodynamic Psychotherapy

Short-Term Psychodynamic Psychotherapy (STPP) is a term given to a number of similar therapy approaches based on psychodynamic principles that explore the influence of the past on the present, the promotion of insight, the identification and expression of avoided emotions and the identification of maladaptive relationship patterns. It works directly through the therapeutic relationship to effect therapeutic change (Luborsky, 1984; Malan 1979).

Leichsenring (2001) conducted a meta-analysis of six studies (involving a total of 416 patients) which compared STPP to CBT/ behavioural therapy. His study concluded that STPP yielded comparable results to CBT/ behavioural therapy in the short-term treatment of depression (once again, the findings of this study need to be interpreted

with caution, this time due to the small number of studies included and selection criteria that included studies of Interpersonal Psychotherapy).

A recent meta-analysis of 23 studies involving 1365 patients which investigated the outcome of STPP in the treatment of depression concluded that '*STPP results in a large and enduring decrease of depression levels, and that STPP is more effective than control conditions. On the basis of these findings, STPP may be considered to be an empirically validated treatment method for depression.*' (Driessen, Cuijpers, de Maat, Abbass, de Jonghe and Dekker, 2010; 35)

The meta-analysis findings which suggest that STPP has efficacy in the treatment of depression were recently supported by a RCT conducted by Salminen *et al*. (2008). The investigation of Salminen and colleagues took the form of a randomised controlled trial which compared the outcomes of STPP with fluoxetine antidepressant treatment for major depressive disorder. They found that both STPP and fluoxetine were effective at reducing depressive symptoms and improving general functioning and that there was no significant difference in effect between the two groups.

Although STPP does not have as extensive an evidence base as CBT or IPT, there is a convincing amount of evidence to recognise it as an effective treatment for depression.

**2.5.5. Counselling**

'Counselling' is a broad term which encompasses many different therapeutic models and techniques. The most common generic description of counselling refers to non-directive, person-centred counselling based on the work of Rogers (1957, 1961) and

developed by subsequent authors (Greenberg, Rice & Elliott, 1993; Mearns & Thorne, 2007). Within these manuals, counselling is characterised as the development of an accepting, genuine, empathic therapeutic relationship which is seen as providing the optimal conditions for therapeutic change and growth.

Bedi *et al*. (2000) conducted a partially-randomised preference trial (*n*=323) which compared the outcomes of counselling with the outcomes of courses of prescribed antidepressants in primary care settings in the UK. The study found that counselling and antidepressants were both equally effective at eight weeks when assessed using the BDI and the SF-36 (a well-validated health and functioning measure. See; Hays, Sherbourne and Mazel, 1995). Similarly, Ward *et al*. (2000) conducted a partially-randomised preference trial (*n*=464) and found that both (non-directive) counselling and CBT were equally effective for treatment of depression and superior to standard general practitioner care (this consisted of medication and regular reviews of patient progress and medication adherence).

The findings of these studies were partially replicated in a study (*n*= 464) conducted by King, Sibbald, Ward, Bower, Lloyd, Gabbay and Byford (2000). They investigated the efficacy of time-limited (twelve-session) psychological therapies in NHS-based general practice settings for patients diagnosed with mixed anxiety and depression. The study comprised of two parts, the first of which involved an RCT comparing CBT, non-directive (person-centred) counselling and standard General Practitioner-based treatment (involving medication). The second part of the investigation was a patient preference study comparing CBT with counselling. The two parts of the study demonstrated equivalent and statistically significant benefit from the two therapy

conditions at the end of treatment and at four-month follow up. The difference between the psychological therapies was not however significant in relation to standard GP treatment at the one-year follow-up point, and the study concluded that counselling, CBT and standard GP treatment were equally effective. Furthermore, cost-effectiveness of the three treatments was equivalent at the one-year follow-up. The study also demonstrated a statistically significant difference in levels of patient satisfaction between groups when assessed at the one-year follow-up. The patients who had received the non-directive counselling treatment reported greater sustained satisfaction - an interesting finding, which certainly supports counselling as a treatment that is both effective and appreciated by clients.

Watson, Gordon, Stermac, Kalogerakos, and Steckley (2003) conducted a randomised comparative trial (*n*=93) investigating outcomes of CBT and a specific variant of counselling, Process-Experiential Therapy (now known at 'Emotion Focused Therapy'-EFT[3]) for the treatment of depression. Their study concluded that the outcomes of the two therapies were equivalent, although they did note a significantly greater decrease in test scores of 'interpersonal problems' amongst the Process-Experiential/EFT group.

**2.4.6. Major Studies into Outcomes of Psychotherapy for Depression**

The United States National Institute for Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP) was a substantial quantitative research project (*n*=239) investigating the outcomes of programmes of both CBT and IPT for the treatment of depression (Elkin et al.*,* 1989; Elkin, 1994). This study included

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[3] PET/EFT (Elliott, Watson, Goldman and Greenberg, 2003; Greenberg and Watson, 2006) is an empirically-based development of person-centred therapy. PET/EFT focuses on facilitating client change and resolution of emotional distress using a synthesis of person-centred and gestalt techniques.

comparisons with courses of a tricyclic antidepressant and a placebo control group (both conditions including 'clinical management' consultations).  Each treatment condition demonstrated high levels of efficacy. There was remarkable similarity in outcomes across all treatment conditions. There was no statistically significant difference in overall recorded symptomatic levels between the two psychotherapy approaches, which were themselves comparable to those of the antidepressant treatment group (although for clients diagnosed with more severe depression, IPT did perform better than CBT).  In follow-up there was some evidence that those who had completed psychotherapy were less likely to have experienced relapse than those who had completed the medication or the placebo conditions, which suggests that psychotherapy produces effects which last beyond the termination of treatment (Shea, Widiger & Klein, 1992).

The second Sheffield Psychotherapy Project conducted by Shapiro, Barkham, Rees, Hardy, Reynolds and Startup (1994) investigated the outcomes of both CBT and a psychodynamic and interpersonal combined therapy for the short term programmes (i.e. either eight or sixteen sessions for each therapy- thus producing four treatment cells) for the treatment of depression ($n$=117).  The research team was comprised of therapists from each treatment approach; a strategy they believed might mitigate and reduce the potential effects of researcher allegiance and bias. Both therapies were demonstrated to be equally effective regardless of symptom severity.  Fifty-two percent of all who completed therapy met criteria for recovery by the end of the study, while 29% of patients in the study continued to be asymptomatic at one-year follow-up.

The study was replicated by Barkham *et al.* (1996) in a clinical setting. The findings of this second study (*n*=36) also indicated that both types of therapy were equally effective. There was some evidence suggesting those who engaged in sixteen-session programmes of therapy experienced greater improvement over those in the eight-session group, although gains were not maintained as well in this study as those reported by Shapiro *et al.* (1994).

## 2.4.7. Meta-Analytic Studies on Psychotherapy for Depression

Meta-analytic studies have consistently demonstrated the efficacy of psychotherapy for the treatment of depression. Steinbruek, Maxwell and Howard (1983) analysed data from 56 studies and found that psychotherapy had a large mean effect size of 1.22 for the treatment of depression, compared to antidepressant medication (largely tricyclics and MAOIs) which had a medium mean effect size of 0.61. They did not identify any significant difference between the types of therapy delivered and concluded that no specific psychotherapy appeared to be more efficacious than another. Robinson, Berman and Neimeyer (1990), also concluded that all 'bona fide' therapies were equally efficacious in the treatment of depression and that psychotherapy was comparable to pharmacotherapy in effect. These conclusions (psychotherapy is effective for the treatment of depression and that there is no significant difference between outcomes for different types of psychotherapy) were also supported by Wampold, Minami, Baskin and Callen Tierney (2002). They critiqued the meta-analytic study of Gloaguen *et. al.* (1998) which concluded that cognitive therapy was superior to 'other therapies' (i.e. non cognitive therapies). They examined the studies included in the Gloaguen *et. al.* (1998) paper and determined that a

number of therapies which did not meet the criteria of Wampold, Mondin, Moody, Stich, Benson and Ahn (1997) for designation as a 'bona fide therapy'[4] were included in the Gloaguen *et.al*. study and therefore the results of the study were flawed. When therapies which were not considered bona fide were removed and the data was re-analysed, the authors concluded that there was no evidence that cognitive therapy was superior to other bona fide therapies and that all bona fide therapies are equally efficacious for the treatment of depression (Wampold, Minami, Basken & Callen Tierney, 2002).

In a recent meta-analysis Cuijpers, van Straten, Andersson and van Oppen (2008) examined the findings of 53 studies (*n*=2757) *'in which seven major types of psychological treatment for mild to moderate adult depression (Cognitive–Behaviour Therapy, Nondirective Supportive Treatment, Behavioral Activation Treatment, Psychodynamic Treatment, Problem-Solving Therapy, Interpersonal Psychotherapy, and Social Skills Training) were directly compared with other psychological treatments*' (Cuijpers, et al., 2008: 909). In their study they concluded that there was no significant evidence for the superiority of any particular type of therapy over another in the treatment of depression, although interpersonal psychotherapy did appear to be slightly more efficacious (with an effect size of 0.20) and non-directive counselling appearing to be slightly less effective (effect size 0.13) than other therapies.  Cuijpers and his team produced a review of their series of meta-analysis studies and concluded

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[4] These criteria are that the therapy must be delivered by a clinician trained at Master's degree level, that therapy was conducted in face-to-face meetings with therapy tailored to individual client needs and that the therapy must either be of an established system of therapy, or related to a psychological process (e.g. operant conditioning) or that the therapy has a treatment manual available which guides its implementation.

that of the seven types of therapy included in the review, all were more or less equal to one another in terms of effectiveness (Cuijpers et al., 2011).

Berg and Høie (2010) conducted a systematic literature review of nine studies, six systematic reviews and three randomised controlled trials investigating psychotherapy as a treatment for depression with adults. Following their analysis they concluded that, *'according to analyses, patients receiving psychotherapy were three times more likely to experience fewer symptoms of depression up to nine months post treatment compared to those receiving general practitioner care or other treatment as usual. Also our pooled effect estimate was robust in favour of psychotherapy... there were few indications that one of the variants of psychotherapy is more or less efficacious than the others. Instead, it appeared that most patients will likely improve from psychotherapy treatment, irrespective of psychotherapy technique applied'* (Berg & Høie, 2010: 2198-2199). Once again, this review supports the position that all bone fide therapies are equally effective (Wampold, 2001) and supports the dodo bird verdict- that is, all bona fide therapies are equivalent in effect (Rosenzweig, 1936).

Finally, the UK Government's Improving Access to Psychological Therapies (IAPT) initiative has analysed data gathered from the first three years of the scheme. During that time, over one million people have been referred to IAPT services for therapy, around half of whom completed a course of treatment. The IAPT scheme has been widely recognised as being the largest provider of psychological therapies within the UK, although treatment tends to be limited to CBT. Despite the enthusiastic introduction of the scheme, the initiative's data shows rather low clinically significant recovery rates of around 45%, although around two-thirds of clients achieve reliable

improvement. Furthermore, the data set highlights a high drop-out rate, which would likely reduce overall effectiveness rates if included in the analysis (IAPT three-year report, Department of Health, 2012).

**2.4.8. Summary**

Overall, it is possible to state that good evidence exists to support the view that psychotherapy is generally an effective treatment for depression, with the caveat that not all forms of psychotherapy have an equally strong body of literature to support their effectiveness. Whilst certain studies suggest that specific therapies are superior in the treatment of depression, there are other studies which challenge their conclusions and which suggest that all competently-delivered, bona-fide therapies are likely to produce broadly equivalent results. Although TA therapy is at present a relatively under-researched approach to the treatment of depression, the body of literature which supports the 'dodo bird verdict' gives good cause to believe that TA might demonstrate effectiveness at a level comparable with other therapies.

# Section Five: The Process of Psychotherapy for Depression

## 2.5.1. Introduction

So far, this literature review has explored research into the relative effectiveness and efficacy of a number of psychological therapies used in the treatment of depression. Now the focus turns to the specific processes, techniques and approaches used by these forms of therapy and the evidence relating to how these impact on overall outcome. Currently, many therapeutic approaches and different forms of psychological intervention are known to be effective for the treatment of depression, however there is insufficient evidence to draw firm conclusions on the relative benefits of specific therapeutic mechanisms within the context of each type of therapeutic approach. Detailed discussion of the specific psychological mechanisms by which these processes are theorised to work is beyond the scope of this thesis. Instead, the focus here will be on identifying general principles and processes of change within psychotherapy both in general and relating specifically to the treatment of depression.

As with the literature relating to psychotherapy outcomes, the research literature relating to the therapy process stretches to many thousands of articles. This section of the literature review begins with a brief description of the available TA literature on process factors and then moves on to generic aspects of the therapeutic relationship that are believed to be effective. From there, the discussion moves onto consideration of the process variables identified from a key outcome study. It concludes with discussion of a series of empirically grounded principles of therapeutic change relating to treatment of depression.

Process-outcome studies are those which seek to '*identify the parts of… therapy… that, singly or in combination… (are) effectively therapeutic*' (Orlinksy, Grawe & Parks, 1994: 270). In other words, such studies investigate the key 'active ingredients' within a particular therapy.

## 2.5.2. Existing Process Research on TA Psychotherapy

At present, there is no published research which has specifically examined in any detail the process of individual TA psychotherapy . The exception to this is the RCT conducted by Cross, Sheehan and Khan (1982) which included asking clients (*n*=26) who has completed TA-based insight-oriented therapy (n=15) or behavioural therapy (*n*=15) to retrospectively complete a 32-item measure relating to which qualities of their therapist they found most helpful at both 4 and 12 month follow-up, thus involving a minimal evaluation of the therapy process. Clients who had received the TA-based treatment reported that factors such as the therapist's personality, feeling understood by their therapists and the therapist helping them to gain insight were important features of the therapy whereas clients who received the behavioural treatment reported that factors such as being encouraged to implement changes in behaviours and being supported to take responsibility as being most important. This suggests that in both types of therapy, the therapeutic relationship is of prime importance in supporting the client's change process, but will have a particular emphasis in line with the nature of the change process as conceptualised in each therapy approach.

Two studies have investigated the process of TA group therapy. These two studies are interesting, but are limited in their sampling. The first study, conducted by McNeel

(1982) involved an investigation based on a single therapy marathon, which was facilitated by two therapists. The second study, reported in Johnsson (2011), investigated 24 sessions of a single therapy group facilitated by one therapist. Additionally, the age of the data used by these studies might potentially limit the extent to which they are relevant to modern-day TA therapy; the McNeel study was conducted in the early 1980's and the Johnsson study used recordings of a group conducted over 25 years ago. Nevertheless, both studies make the case for the existence of particular technical features that appear to characterise TA group therapy, which may have some significant bearing on specific therapeutic processes.

McNeel (1982) conducted a detailed analysis of a weekend-long therapy marathon. In his study he transcribed the entire group proceedings and the recordings and transcripts were analysed using a team of six raters. McNeel and his raters identified 43 specific techniques or types of intervention which were used by the TA therapy marathon group leaders. These were grouped into seven categories. The first category was defined as *'creating an emphasis on personal power and responsibility within the client'* (they noted that this was often done in a confrontational style in order to create an atmosphere where change was promoted). The second category was defined as *'creating a nurturing environment'* (here, fun and expression of other positive feelings were encouraged within the group. This, they felt, provided support to the client). The third category related to the ways in which group leaders modelled specific behaviours and communication styles. The fourth category related to the challenging of maladaptive fantasies and reality testing (this identified implicit beliefs and processes that were considered to be limiting. These were then challenged using rational thinking and experiential methods). The fifth category concerned the confrontation of

incongruity in communication (this definition was strongly influenced by Gestalt therapy. Non-verbal signals, they observed, were frequently considered to reveal client resistance or self-sabotaging processes). The sixth category related to the use of specific experiential techniques, in particular 'two-chair' or 'empty chair' work. The final category related to structural and procedural rules relating to the conduct of the group and management of the group environment.

For the more recent paper (Johnsson, 2011), Johnsson and a second rater examined and coded transcripts drawn from ten (out of a total of 24) group sessions. The aspect noted here was the high level of therapist verbalisation- 41% of utterances within the transcripts were made by the therapist. Two main categories of intervention emerged: '*feeling contact*' (empathic responses which encouraged the client to express emotions) and '*contracting*'.  A number of other interventions were identified, including; '*talking to Parent projections*', '*make feeling statement*', '*mutual negotiation*' and '*specificity/clarity*'.

Despite the limitations these two studies (together with the findings from outcome of TA group therapy) point towards the use of active and experiential methods and a pro-active therapist stance within TA therapy.

Given the paucity of research on the process of TA therapy, it is necessary to look to the wider psychotherapy literature to examine potential process factors which may be present within TA therapy.

### 2.5.3. Characteristics of Effective Therapeutic Relationships

The American Psychological Association's (APA) Task Force on Evidence-Based Therapy Relationships has commissioned a series of meta-analyses, which have evaluated the evidence for a number of interventions in which the quality of the therapeutic relationship is considered key to the outcome. These interventions are based on the widely acknowledged view that it is the therapeutic relationship that has the greatest impact on the outcome of the therapy. These meta-analyses have evaluated various methods for building and tailoring the therapeutic relationship between therapist and client (Norcross & Wampold, 2011). The task force's study identified a series of process factors that are believed to have a significant impact on the overall outcome of therapy (these are listed in table 2.1). It is their recommendation that practitioners actively cultivate therapeutic relationships from these evidence-based principles and thereby tailor the therapy to suit individual needs in order to maximise outcome.

*Table 2.1. Task Force Conclusions on Aspects of Evidence-Based Therapy*

*Relationships*

| Demonstrably Effective Relationship/ Process Factors | Demonstrably Effective Methods of Tailoring the Therapy |
|---|---|
| **Working Alliance** (Horvath, Del Re, Fluckiger & Symonds, 2011)<br><br>**Cohesion in Group Therapy** (Burlingame, McClendon & Alonso, 2011)<br><br>**Empathy** (Elliott, Bohart, Watson & Greenberg, 2011)<br><br>**Collecting and Using with Client Feedback** (Lambert & Shimokawa, 2011) | **Reactance/ Resistance Level** (Beutler, Harwood, Michelson, Song & Holman, 2011)<br><br>**Client Preferences** (Swift, Callahan & Vollmer, 2011)<br><br>**Culture** (Smith, Rodriguez & Bernal, 2011)<br><br>**Religion/ Spirituality** (Worthington, Hook, Davis & McDaniel, 2011) |
| **Probably Effective Relationship/ Process Factors** | **Probably Effective Methods of Tailoring the Therapy** |
| **Goal Consensus and Collaboration** (Tryon & Winograd, 2011)<br><br>**Positive Regard** (Farber & Doolin, 2011) | **Stages of Change** (Norcross, Krebs & Prochaska, 2011)<br><br>**Coping Style** (Beutler, Harwood, Kimpara, Verdirame & Blau, 2011) |
| **Promising but Insufficient Evidence to Judge Relationship/ Process Factors** | **Promising but Insufficient Evidence Methods of Tailoring the Therapy** |
| **Congruence/ Genuineness** (Kolden, Klein, Wang & Austin, 2011)<br><br>**Repairing Alliance Ruptures** (Safran, Muran & Eubacks-Carter, 2011)<br><br>**Managing Countertransference** (Hayes, Gelso & Hummel, 2011) | **Client Expectations** (Constantino, Glass, Arnkoff, Ametrano & Smith, 2011)<br><br>**Attachment Style** (Levy, Ellison, Scott & Bernecker, 2011) |

Adapted from: Norcross and Wampold (2011)[5].

These factors are described by Norcross and Wampold (2011) as interactive in nature, and they argue that their effectiveness is dictated by how they are orchestrated for each individual client. In other words, these are synergistic factors. These factors tend

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[5] Note: References relate to the specific meta-analyses the conclusions were drawn from.

only to have a small effect size when considered singly. However, psychotherapy is a complex process which involves the application of a range of factors and variables. Thus, although any one factor may have a small effect size, the combination of individualised, responsive, interacting and synergistic factors can have a large impact on overall outcome. Norcross and Wampold (2011) go on to recommend that researchers explore the moderators and mediators of these factors and how they interact in practice to contribute towards positive outcomes of therapy.

### 2.5.4. Characteristics of Therapy Lacking Evidence of Effectiveness

Norcross and Wampold (2011) provide an interesting summary of what features of psychotherapy do *not* appear to work. Essentially, they identify the reverse of the above, proven, evidence-based characteristics as being ineffective, or potentially detrimental to outcome. '*One means of identifying ineffective qualities of the therapeutic relationship is to simply reverse the effective behaviors. Thus, what does not work includes a low quality alliance in individual psychotherapy…. Paucity of empathy, collaboration, consensus, and positive regard predict treatment drop out and failure. The ineffective practitioner will resist client feedback, ignore alliance ruptures, and discount his or her countertransference'* (Norcross & Wampold, 2011: 101). They also identify several therapist behaviours which are negatively correlated to a good outcome. These include; confrontation, therapist negativity towards the client, and the therapist taking a rigid approach to therapy and making assumptions about the strength of the relationship.

### 2.5.5. Process Variables Relating to Treatment of Depression: Findings from the NIMH-TDCRP

The National Institute for Mental Health Treatment of Depression Collaborative Research programme (NIMH-TDCRP) (Elkin, et al., 1989) is arguably one of the most significant and methodologically sound investigations in the history of psychotherapy research (Lambert and Bergin, 1994). In addition to reporting on the effects of different types of psychotherapy, pharmacotherapy and a placebo control on depression, the study also analysed a range of independent variables for their impact on outcome. One of the findings from the NIMH-TDCRP was that there was little difference in outcome between the different therapies with less severely depressed clients (Interpersonal therapy did appear to do slightly better with clients who were more severely depressed). It was hypothesised that the supportive relationship '*may be sufficient to bring about a significant reduction of depressive symptomatology*' (Elkin, 1994: 125). The differential performance of different treatment conditions within various sites also suggests that adherence to the treatment manual and/or therapist competence may have been a factor. A range of client variables, which included 'socio-demographic characteristics, diagnostic and course variables, function, personality and symptom variables' were recorded. (Elkin, 1994: 125) Few of these demonstrated any significant impact on outcome. Three variables which were statistically related to outcome included work, social and cognitive dysfunction. Interestingly, these variables interacted differently with the different treatment conditions, suggesting that each approach had a particular mode of action. For example, the findings suggested that those with lower social dysfunction (i.e. clients with fewer interpersonal problems) did better with interpersonal therapy and those

with less cognitive dysfunction (i.e. those with fewer cognitive distortions or less impairment due to negative thought processes) did better with cognitive-behavioural therapy (Sotsky, et al., 1991). In essence, 'the rich got richer'. This may be due to differences in clients' ability to access and make use of each therapy's *raison d'etre* as a catalyst for change. The lesson may be 'engage clients through their strengths'. Another explanation is that having at least one area where there is less dysfunction meant that the client was more suited to a short-term therapeutic intervention. Across therapies, clients who recorded either lower levels of cognitive dysfunction or higher levels of positive expectations about outcome of therapy, generally did better. Although relatively little data was collected relating to therapist variables and was focused on such matters as socio-demographic variables, level of training and experience and so forth, none of these were identified as significant in relation to overall outcome (Elkin, Falconnier, Matrinovich & Mahoney, 2006).

An analysis of 128 transcripts of sessions taken from the IPT and CBT conditions in the NIMH-TDCRP found that 'collaborative emotional exploration' was positively correlated with positive outcome (Coombs, Coleman & Jones, 2002). Collaborative emotional exploration included client activities, such as introspection, emotional expressiveness and engagement with therapy processes, as well as therapist activities, which included accurate empathic attunement and non-judgmental acceptance of the client. It is suggested that these client and therapist activities contributed positively to a climate where clients felt safe and understood in therapy and were therefore more able to explore and deal with painful emotional experiences. Educative/directive therapy processes (i.e. those whose function was to impart information or instruction to the client) were not significantly correlated with good outcome. This finding

supported previous research conducted by Jones and Pulos (1993), which concluded

that high levels of collaborative emotional exploration are associated with good

outcomes, whereas didactic/ educative approaches are not. The findings from these

two studies are particularly interesting since they suggest that 'psychoeducational'

interventions - which are highly characteristic of both CBT and TA therapy - may not be

effective or related to positive outcome.

## 2.5.6. Principles of Therapeutic Change in Treatment of Dysphoric Disorders

The American Psychological Association division 29 (Psychotherapy) also

commissioned a task force to synthesise findings from meta-analytic studies and

literature reviews in order to formulate principles of therapeutic change (Castonguay

& Beutler, 2006). As part of this initiative, principles of change were identified from

studies of psychotherapy for the treatment of depression, which include evaluation of

client and therapist factors, relationship factors and technique factors. The technique

factors were compiled from an analysis of the central change processes of therapies

that are listed by the APA's division 12 (Clinical Psychology) as 'empirically supported

therapies'. The task force's findings produced a series of empirically grounded

transtheoretical principles of therapeutic change (see Castonguay & Beutler, 2006).

Principles relating to client factors are comprised of several empirically supported

statements relating to clients' responses to therapy. The client's gender was not found

to determine any principle, nor was his or her socio-economic status, except in cases

of severe depression, where lower socio-economic status was associated with poorer

prognosis. Negative prognostic indicators include increased client age, co-morbid

personality disorders and higher levels of functional impairment. Both chronicity and

severity of problem are also indicators for poorer prognosis, as is lower levels of social support. Client preferences and expectations of treatment were not considered to be contributing factors, and expectations in particular were not shown to be associated with outcome in treatment of depression. Matching therapy to the client's stage of change, attachment style, and religious beliefs was considered to be beneficial. Finally, matching therapy to the client's level of reactivity (i.e. resistance to treatment) and coping style (externalising/ internalising style) was identified as helpful (Beutler, Blatt, Alimohamed, Levy & Angtuaco, 2006; Beutler, Castonguay & Follette, 2006).

The principles associated with relationship factors were largely identical to those listed above in table 2.1. (Castonguay et al., 2006). Six empirically grounded principles for guiding technique and interventions in the treatment of depression were identified by the task force. The six technique principles are;

> *'1) Challenge cognitive appraisals and behaviour with new experience.*
>
> *2) Increase and diversify the patient's access to contingent positive reinforcement while decreasing reinforcement for depressive and avoidant behaviours.*
>
> *3) Improve the patient's interpersonal social functioning.*
>
> *4) Improve the marital, family and social environment to reduce the establishment, maintenance, or recurrence of depressive behaviours.*
>
> *5) Improve awareness, acceptance, and regulation of emotion and promote change in maladaptive emotional responses.*

*6) The treatment process should be structured and an intervention focus should*

*be developed.'*

(Follette & Greenberg, 2006: 94)

These principles suggest that effective therapy for depression involves identification and revision of limiting and depressogenic beliefs, and interpretive frames. This is best achieved by an experiential approach whereby the individual is encouraged to challenge the validity of these harmful beliefs actively. The client is supported in understanding, accepting and regulating their emotions and in learning ways to transform depressogenic affective states. Furthermore, the individual is supported in finding new and more rewarding ways of interacting with others, which support change. This is done in the context of a focused and structured therapeutic process. Thus, optimal treatment of depression is a process which incorporates systematic change throughout cognitive, behavioural, affective and relational/ interpersonal domains within the context of a focused, experiential therapeutic framework.

### 2.5.7. Summary

The research presented here strongly suggests that there is a need to investigate the process factors that relate to outcome in individual TA therapy. The existing evidence implies that a range of therapeutic relationship factors are likely to contribute significantly to positive outcome, and that these are best implemented on an individually-tailored basis. It would also appear that specific demographic variables relating to both client and therapist do not influence outcome significantly. This review presents a series of empirically-grounded principles relating to the effective treatment of depression, which involve the active and experiential challenging of maladaptive

cognitive, behavioural, affective and relational aspects of the individual's process within a structured and strategically-designed therapeutic relationship. It seems feasible that these characteristics of therapy may be accountable if TA therapy demonstrates effectiveness for depression.

# Section Six: The Process and Outcome of Psychotherapy for Depression: Findings from Case Study Research

## 2.6.1. Introduction

Case study research offers a unique insight into the relationship between client factors, therapy process, and outcome. Despite the high prevalence of depression, there are surprisingly few case studies of its treatment within the psychotherapy research literature. Currently, there is no agreed method of conducting systematic meta-analysis of case studies[6]. This section presents a brief narrative review of significant case studies and cross-case analyses of psychotherapy for depression.

## 2.6.2. Clinical Case Studies

Several case studies of psychotherapy for depression (in clients where there is an absence of substantial co-morbidity or complicating factors arising from cultural identity) have been reported in the journal *Clinical Case Studies* (Layne, Porcerelli & Shahar, 2006; Rabinowitz & Cochran, 2008; Rude & Bates, 2005; Stricklin-Parker & Schneider, 2005). These articles provide an interesting glimpse into the therapy process and explore a number of client factors which may have influenced outcome. Unfortunately, many of these articles are somewhat flawed in that the cases do not report pre-post testing using valid and reliable measures or the use of qualitative data which somewhat limits the findings. Nevertheless, the cases are described in great detail and highlight the importance and interplay of case formulation, therapeutic interventions and complicating client factors and their influence over the outcome of the case.

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[6] See section 4.6.4 in method chapter for more discussion relating to cross-case analysis and case study meta-synthesis/ meta-analysis.

Shields, Murrell and Salsman (2006) reported the forty-five session psychodynamic-interpersonal psychotherapy of a 24 year old woman with moderate mixed anxiety and depression. The symptoms were assessed using a battery of tools, which included the OQ-45 (Lambert et al., 1996) and the Inventory of Interpersonal Problems (IIP) (Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988). At the end of the therapy the client demonstrated recovery on the OQ-45, and a healthier profile on the IIP circumplex. The case was analysed by the authors using Elliott's (2002) sceptic case non-therapy explanations of client change which suggested changes were likely to be a result of therapy and not due to other factors. In an eleven-month follow-up assessment, the client's progress was sustained, as measured by both the OQ-45 and IIP. Although the therapy was successful, the client was slow to respond to treatment and was complicated by the complexity of the client's presentation and characterological issues.

### 2.6.3. A Cross-Case Analysis of Psychodynamic Therapy for Depression

Hersoug (2010) conducted a cross-case comparison of three cases of psychodynamic therapy. The three clients all had depression and each received forty sessions of psychotherapy in an out-patient setting. The clients were screened pre-post therapy with a battery of measures including the SCL-90 (Derogatis, 1983) and the Inventory of Interpersonal Problems (IIP) (Horowitz, et al., 1988). The therapy process was also analysed using transcripts of sessions and other self and observer rated process measures. Two of the three clients had demonstrated clinically significant symptomatic and interpersonal improvements by the end of therapy which was sustained during a two-year follow up, whereas one client remained within the clinical range. The therapy

of the client with the best outcome was independently rated as being characterised by a greater frequency of relational interpretation, however it was also noted that the client appeared to be more engaged and more able to make use of the therapy than the other clients. Furthermore, the complexity and chronicity of the clients' problems and negative life events appeared to impact on differential response to treatment and maintenance of gains

**2.6.4. Examining the Process-Outcome Relationship in Psychotherapy for Depression: The Case of Emotion-Focused Therapy**

Arguably the most detailed use of case study research into the relationship between therapy process and outcome of psychotherapy for the treatment of depression has been conducted on the use of Emotion-Focused Therapy (EFT). EFT is an empirically-supported therapy approach which was developed from detailed analysis of positive outcome cases (Greenberg, Rice & Elliott, 1993). In particular, the model was developed to be readily implemented in a brief therapy format of sixteen to twenty sessions. Although several studies had demonstrated the efficacy of EFT for depression (Goldman, Greenberg and Angus, 2006; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos & Steckley, 2003), Watson, Goldman and Greenberg (2007) identified that no studies had been conducted which had highlighted the type of client this therapy might be most suitable for. To examine this issue further, they compared three good outcome cases with three poor outcome cases which were selected from three separate clinical trials of EFT for depression (Goldman, Greenberg & Angus, 2006; Greenberg and Watson, 1998; Watson, et al., 2003). In particular, they sought to examine the factors that were associated with good or poor

outcome by conducting a detailed analysis of each selected case and then performing a cross-case analysis of these cases.

The cases selected included data from a range of self-report measures including the Working Alliance Inventory (Horvath & Greenberg, 1989), the Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961), the Rosenberg Self-Esteem Inventory (1965) and the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988). Observer-rated measures such as the Experiencing Scale (Klein, Mathieur, Gendlin & Kiesler, 1969) and the Structural Analysis of Social Behaviour (Benjamin, 1974) were also used. The data from the self-report and observer rated measures was triangulated in order to generate a nuanced picture of structure and process of the therapy both within single sessions and across the duration of the sixteen to twenty weeks of treatment.

### 2.6.4.1. Client Factors Relating to Differential Response to Emotion-Focused Therapy

Although the clients in the case series were all depressed, each had unique features in terms of other presenting problems, history, and intrapsychic and interpersonal process. Watson *et al.* (2007) noted that all selected clients had experienced a negative, emotionally invalidating and critical early environment, often with abuse and/or neglect. Specifically, all the cases experienced a childhood that 'lacked adequate warmth, safety, and nurturing that would have allowed them to flourish and realize their potential' (Watson et al., 2007: 184). Although these features were common to all of the clients in their case series, the clients who had a good outcome to their therapy all had at least one person in their childhood who provided them with some care and nurturing. Conversely, the early history of the poor outcome cases

appeared to be 'barren of any support from another person in their environment' (Watson et al., 2007: 185).

All the clients in their series also experienced problems with affect regulation. Despite having difficulties with modulating emotions, the good outcome clients were all able to identify and express their feelings. In contrast, the poor outcome cases all had problems with identifying and expressing affect. Specifically, they tended to engage in avoidance or numbing processes to defend against emotional experiencing. This was due to an intense fear of their painful feelings. Consequently, the good outcome clients were able to actively engage with the emotional processing aspects of the therapy, whereas the poor outcome clients were reluctant to do so. This finding makes sense; the central feature of EFT is the engagement with and transformation of affect. It would be logical to conclude that in order to benefit from short term therapy that the client would need to begin therapy with some capacity to make use of the main mode of therapeutic action.

The good outcome clients all had a capacity to understand the role of their process in the perpetuation of their problems and were willing to experiment with new ways of responding to people and events. Associated with this, these clients all came into therapy with a clear sense of their goals for therapy. These clients were all able to activate and sustain a self-compassionate stance when guided to do so. Additionally, these cases were all characterised by a capacity for cognitive flexibility or ability to see alternative viewpoints in relation to themselves, others and the world. Furthermore, the clients in the good outcome group were all able to form a good working alliance with their therapist and enjoyed good social support. Overall the three positive

outcome cases all demonstrated high levels of engagement with therapy. In particular, these clients moved into deep emotional processing early within the therapy, and thus were able to make use of EFT's *modus operandi*.

In contrast, the three poor outcome bases all struggled to engage with the emotional processing aspects of EFT. This was due to fears of experiencing and expressing emotions and 'impoverished narratives' as evidenced in their poor ability to provide substantial detail about their life history (Watson, et al., 2007: 197). Two of these cases also appeared to have problems with the establishment of the therapeutic relationship. There is also evidence in the three poor outcome cases that the clients struggled with feelings of shame about their sense of vulnerability and experienced ambivalence about being in therapy. This shame and ambivalence effectively prevented these clients from engaging with the tasks of therapy and from feeling compassion for their vulnerabilities and appeared to have been associated with an abusive early environment. These clients also struggled to identify a clear focus of change in therapy and were overly focused on external events as opposed to making internal changes. These poor outcome cases also appeared to have little readiness to change and experienced a sense of hopelessness about their future and capacity to change.

### 2.6.5. Summary of Emergent Themes

These cases all suggest that the respective therapeutic approaches tend to have a primary mode of action based around a maximum of two domains. These domains are the cognitive, behavioural, affective and relational. Within each therapy, change is promoted through the emphasis on changing two of these domains, which then results

in change in other domains.  Even the cases which integrated several different approaches tended to focus on two primary domains. The cases also suggest that therapy is most effective when the process, tasks and rationale of the therapy closely matches the client's preferences.

The discussed articles also indicate that clarity of case formulation and reviewing the case formulation throughout therapy is beneficial to outcome.  Furthermore, there is some evidence to suggest that a shared collaborative framework is desirable. That notwithstanding, there was no evidence in these studies that the clients actively learnt the theory or language of the model in order to deepen and consolidate their therapeutic gains.

# Section Seven: Research Questions

Based on this review of the literature, and specifically the paucity of research on TA, two research questions have been identified.

**2.7.1. Primary Question:**

- Can TA psychotherapy be effective for short-term treatment of depression?

**2.7.2. Secondary Question:**

- What processes and factors influence the outcome of TA psychotherapy for depression?

# Chapter Three: Methodology

*This chapter begins with a brief discussion of philosophical and methodological principles and validity in psychotherapy research design. These highlight methodological choices which have relevance to the exploration of the research questions of this study. The role of researcher reflexivity in research is also discussed.  It concludes with a brief introduction to case study research and outlines the conceptual design of the present study.*

# Section One: Research Methodology

### 3.1.1. Introduction

The two research questions this study addresses are:

1) Can TA psychotherapy be effective for short-term treatment of depression? And

2) What processes and factors influence the outcome of TA psychotherapy for depression?

In order to understand how these questions can be explored, it is necessary to discuss different philosophies and approaches to psychotherapy research.

### 3.1.2. The Positivist Approach

Positivism is based on the belief that there is an objective, knowable 'truth' and that scientific enquiry is a search to discover the rules that determine reality. The goal of research therefore is to identify these rules and to develop scientific knowledge that is

quantifiable. The positivist 'ideal' of research is one of complete objectivity, conducted from a 'valueless' position. Research that is grounded in positivism begins by identifying and explicating a theoretical hypothesis to be tested (Crotty, 1998). Quantitative research methods (in particular experimental methods) are those most closely allied to the positivist perspective (Campbell & Stanley, 1963).

In quantitative research, carefully constructed experimental designs are used to allow the researcher to control variables and rule out other possible explanations so that clear statements of causality can be made. The intention is to test a theory or hypothesis in order to provide an explanation or prediction that may be replicated and that provides a statement that may be generalised (applying to all or large numbers of people, for example).

Clearly, positivism can contribute to the first research question which relates to the effectiveness of TA psychotherapy. In particular, it can answer questions relating to the magnitude of therapeutic change any given client might experience during the course of therapy within a particular, specified and measured dimension (e.g. symptoms). However, a quantitative approach has limitations in exploratory research or research which investigates psychotherapy process without pre-conceived hypotheses or in investigating outcomes which have not been specified and quantified from the outset.

### 3.1.3. The Constructivist Approach

'*Postmodern constructionism is a worldview based on the assumption that reality is not objectively knowable. Rather, reality is constructed by individuals and groups as a result of particular beliefs and historical, cultural and social contexts*' (Fishman, 1999: 95). The constructivist position holds that knowledge is 'constructed' and is

fundamentally linked to (and indivisible from) the way in which it is perceived.

Processes of perception and interpretation are viewed as subjective; each based on an individual's experience of the world. This creates a situation where the world can be viewed from multiple perspectives, each having validity within its own subjective context (Crotty, 1998).

Research conducted from a position of hermeneutic (or interpretive) constructivism does not begin with an initial theory or hypothesis, but seeks to investigate a phenomenon with the purpose of creating, or allowing a hypothesis to emerge from the data (Fishman, 1999). Additionally, a 'thick' description of the context of the study is provided to enable the reader to contextualise the study and its findings.

Qualitative research methods are more closely related to constructivism, with its emphasis on inductive knowledge and the researcher's own perspective in both designing the research and interpreting the data gathered. '*In the qualitative research paradigm, a primary focus is for researchers to capture authentically the lived experiences of people*.' (Onwuegbuzie & Johnson, 2006: 49).

Constructivist, qualitative research has strengths when used for initial exploration of an area within psychotherapy research and also in exploring the 'lived experience' of the therapist and/ or client. This includes understanding their experience of the therapy process and what they found to be personally meaningful. This makes qualitative approaches particularly suitable for an exploratory, discovery-oriented investigation of the process of psychotherapy and in generating a nuanced and contextually situated perspective on client change. Qualitative research is also capable

of generating hypotheses which can then be tested in subsequent research (McLeod, 2013b).

### 3.1.3.1 Validity in Qualitative Research

As qualitative research is focused on discovery and exploration and is conducted without tight experimental controls, and often relies on the researcher's interpretation of (what may be ambiguous) data, it poses challenging questions relating to validity. The issue of validity in qualitative research uses different terminology to that of quantitative research and is generally referred to as 'trustworthiness'. Lincoln and Guba (2000) proposed a framework for assessing the validity of qualitative research not couched in the language of positivism, which convincingly explicated the concept of trustworthiness. They identified four parallel criteria of 'trustworthiness', which have equivalence to concepts used to determine validity in quantitative research. These are: *credibility* (parallel to internal validity); *transferability* (parallel to external validity/generalisability); *dependability* (parallel to reliability) and *confirmability* (parallel to objectivity). (Lincoln & Guba, 2000)

Credibility relates to the internal consistency of the process of interpreting data and the extent to which the data can be considered valid. Evidence of credibility might come from prolonged engagement with the data or by providing a rich, detailed description of the data source (Morrow, 2005).

Transferability '*refers to the extent to which the reader is able to generalize the findings of a study to her or his own context and addresses the core issue of "how far a researcher may make claims for a general application of their [sic] theory" (Gasson, 2004, p.98).*' (Morrow, 2005: 252). This quality might be achieved by providing a

detailed and rich account of the data source, the context and a reflexive statement by the researcher.

Dependability alludes to the consistency of the data analysis approach used and may be promoted by making the process of data analysis used transparent (so that another researcher could examine the data and come to similar conclusions).

Confirmability refers to the extent to which the findings can be considered to represent the phenomena under investigation adequately (rather than some other phenomena) (Morrow, 2005).

Eliott, Fischer and Rennie (1999) developed a similar series of quality criteria for qualitative research in psychology. These criteria demand the provision of sufficient data to enable the reader to contextualise the study and to audit the research process and plausibility of the findings, or draw alternative conclusions, meanings or explanations from the same data. They also advocate the use of credibility checking procedures and triangulation. This might involve checking the accuracy of interpretation of the data with the subjects, the use of research auditors or multiple investigators, or the checking of data using multiple methods or determining if different types of data converge and are consistent with each other. The criteria of 'coherence' relates to the extent to which the research represents its findings '*in a way that achieves coherence and integration while preserving nuances in the data'* (Elliott, et al., 1999: 222-223). Finally, they urge the researcher to present their findings in a way that is engaging, plausible and which either confirms the reader's experience or enhances their knowledge of the subject (Elliott et al., 1999).

In describing constructivist perspectives on the trustworthiness of research, Morrow (2005) emphasises the importance of researcher reflexivity and the importance of 'triangulation' of data, which incorporates multiple perspectives on or in the data. Morrow also describes the importance of examining data for '*disconfirming evidence*' (Morrow, 2005: 256), which involves a systematic good-faith attempt to find alternative explanations to the data or aspects of the data that disconfirm the researcher's preliminary findings or expectations. She also emphasises the importance of presenting direct quotation to support interpretations so that the reader can verify the validity of the interpretation directly.

### 3.1.3.1. Hermeneutic Interpretation

The origin of hermeneutics is in the interpretation of text which may be incomplete or ambiguous (McLeod, 2011). It straddles ontology and epistemology from a constructivist perspective by conceptualising knowledge as being generated from multiple and contextually-informed perspectives in an on-going and co-created dialogue.

McLeod (2011) has identified five key principles of hermeneutic interpretation within psychotherapy research. These are: (a) the reader's empathic engagement with the author(s) of the text (in this case series, the client and therapist are authors); (b) a willingness to identify, examine and challenge one's existing understanding of the text. In this sense, hermeneutics is an inherently reflexive activity; (c) accounting for the meaning of the whole text, rather than selecting aspects which confirm one's pre-existing theory; (d) engagement in a back-and-forth movement between interpretation

of small sections of text and the total text and; (e) accepting that knowledge and new, deeper understanding arises through dialogue, which is never complete.

Clearly, hermeneutic interpretation is located within the constructivist paradigm. However, as hermeneutics draws conclusions from an evolving process of dialectic and abductive reasoning, it can also be integrated into a pragmatic perspective (Rennie, 2000).

### 3.1.4. The Pragmatic Approach

The pragmatic approach to psychological research was described by Fishman (1999) (inspired by the pragmatic philosophy of Peirce, James and Dewey) as an integrative research philosophy characterised by methodological pluralism. Rather than taking the position that positivism and constructivism are opposing and incommensurable, pragmatism seeks a creative synthesis of the two approaches that draws upon the relative strengths of each. The pragmatic approach is one where positivist and constructivist principles and methods are combined into a coherent whole (Fishman, 1999). Pragmatic research does not seek to refute the principles or findings of positivist or constructivist research. Indeed, the pragmatic paradigm considers both positivist and constructivist approaches to research to be valid means of advancing knowledge.

In line with postmodernism, pragmatism holds that an understanding of the context of knowledge is essential to making sense of and using knowledge; what is 'true' in one context is not necessarily 'true' in all. Furthermore, truth is considered to be an evolving process, that is, truth is conceived as the explanation or theory that is most true at the present time, (as opposed to being either a fixed, immutable truth or one

that is entirely subjective). Scientific statements based on a pragmatic approach are evaluated on their usefulness and applicability (Johnson & Onwuegbuzie, 2007). Pragmatic research draws from existing theory (as per positivism), but rather than testing an existing hypothesis or theory, it uses these as a 'guiding conception' (Fishman, 1999). '*The pragmatic approach is to rely on a version of abductive reasoning that moves back and forth between induction and deduction—first converting observations into theories and then assessing those theories through action*' (Morgan, 2007: 71).

Pragmatic research, like constructivist research, provides a detailed "thick" description of the context of the research to enable the reader to contextualise the study. This allows for the identification of a range of possible confounding or interacting variables that might influence the findings of the research. Pragmatism holds that pure objectivity and pure subjectivity form between them an artificial dichotomy that is unlikely to exist (Morgan, 2007). Rather, pragmatism seeks to reconcile differences in approach with a new conception: intersubjectivity, where '*there is no problem with asserting both that there is a single "real world" and that all individuals have their own unique interpretations of that world*' (Morgan, 2007: 72). Furthermore, it has been argued that because '*both approaches have inherent strengths and weaknesses, researchers should utilize the strengths of both techniques in order to understand better social phenomena*' (Onwuegbuzie & Leech, 2005:377).

The emphasis in pragmatic research is on exploring what practical benefit the findings have and how they might be creatively used in a range of situations. (Morgan, 2007) The pragmatic approach holds that it is important that the researcher ensures quality

control issues have guided the design, data collection, data analysis and writing-up phases of their research and that a realistic balance has been achieved between 'ideal' and 'practical' quality.

TA therapists have described TA as a pragmatic approach to psychotherapy (Tudor, 2001). Themes which occur through Berne's (1961; 1966; 1972) writing appear to have much in common with the development of pragmatic research methodology. TA has synthesised theories and techniques from a wide range of therapeutic approaches (see Tudor, 2001; Widdowson, 2010) therefore, the use of a pragmatic mixed-methods approach to investigate TA therapy is consistent with TA philosophy and practice. Within the present study, pragmatism offers a means to reconcile the strengths and limitations of both the positivist and constructivist approach and simultaneously address questions relating to process and outcome.

### 3.1.5. The Mixed Methods Approach

Psychotherapy is an activity that reflects the complexity of the human condition. Research investigating the outcome of psychotherapy has to account for the influences of extra-therapy events and context in the lives of clients. Also, therapy is not a simple activity in which the effect of single interventions can be neatly isolated. The nature of prolonged engagement and more intangible relational factors make the impact of interventions difficult to identify clearly and immediately. Research must account for this complexity.

Brannen (2005) makes the observation that many research projects attempt to answer multiple research questions that require more than one type of research. In such cases he calls for an integrative paradigm, using multiple research methods. The present

study (a search for answers to a range of research questions related to both the *process* and *outcome* of TA psychotherapy for the treatment of depression as conducted in a routine practice setting) fits this mould. In order to generate rich data to explore these questions while capturing some of the complexities of both the outcomes and the processes of therapy, a mixed methods approach was felt to be justified. The research was not intended to draw clear evidence of causality, but to generate explanatory theories related to the magnitude and mechanisms of therapeutic change.

## 3.1.6. Corroboration and Convergence: An Argument in Favour of a Mixed Methods Approach

The use of mixed methods research enables the researcher to examine the object of their investigation from different angles. The use of quantitative data lends objectivity, precision and specificity, while the use of qualitative data can add meaning and explanation to the findings. Additionally, a mixed methods approach assists with producing findings that can be mutually enhancing and that converge or corroborate each other in a way that is complementary. This complementarity can ultimately contribute to the development of a more convincing set of conclusions. Findings from mixed methods research might reveal contradictory results- a situation that can stimulate and inform further investigation (Greene, Caracelli and Graham, 1989; Brannen, 2005; Johnson & Onwuegbuzie, 2007).

In psychotherapy research, Dattilio, Edwards and Fishman (2010) argue neither quantitative nor qualitative research methods yield a complete picture of the therapy process or of the process of change. They state that '*the findings from one aspect shed*

*light on the meaning of findings from another, enhancing reliability and internal and*

*external validity… This allows for a more differentiated explanation of findings and*

*extrapolation of their implications for application to and dissemination in practice'*

(Dattilio et al., 2010: 431). They describe how mixed-methods research has provided a

detailed and nuanced picture of mechanisms of action that has considerably enhanced

the development of an effective mindfulness-based cognitive therapy by a research

team at Oxford University. They argue that systematic case study research (and in

particular cross-case comparison) based on a mixed-methods approach is ideal for

psychotherapy research since it provides contextual information, insight into the

client's experience of their problems, change mechanisms and so forth (Dattilio et al.,

2010).

# Section Two: Reflexivity: Contextualising Method Selection and Data Interpretation

### 3.2.1. Reflexivity: A Contribution of Qualitative Methodology

The concept of 'reflexivity' is important to this academic thesis since it constitutes a method to contextualise the researcher's engagement and allegiance with the subject matter (specifically, TA psychotherapy), selection of method and interpretive process. A number of authors have defined reflexivity and neatly articulated its value.

*'Reflexivity refers to a person turning back, to attend to how he or she has participated in forming a particular understanding or in taking an action'* (Fischer, 2009: 587). Reflexivity involves the identification and questioning of the process of one's own interpretation.  Within academic research, reflexivity is '*the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry*' (Etherington, 2004: 31-32).

'*Qualitative researchers accept that it is impossible to set aside one's own perspective totally (and do not claim to). Nevertheless, they believe that their self-reflective attempts to 'bracket' existing theory and their own values allow them to understand and represent their respondents' experiences and actions more adequately than would be otherwise possible'* (Elliott, et al., 1999:216).

Reflexivity is grounded in the post-modern research paradigm and stems from the observation that true objectivity is impossible; that the process of research and interpretation involves some degree of subjectivity, and that subjectivity is inevitably influenced by the researcher's values and beliefs. So the person as researcher is looked

upon as a key instrument of the research, and the researcher's beliefs, assumptions, feelings, thought patterns and behaviours are all assumed to bear influence on the design of the study, the act of data collection and the analysis of data, since all are selected, processed and filtered by the researcher and all will be shaped by the researcher's frame of reference. The process of engaging with the research reflexively requires the researcher to identify, understand, contextualise and challenge their pre-existing and emergent assumptions and views (Watt, 2007).

The researcher will usually conduct a review of existing literature relating to their chosen subject area. Since researchers tend to engage in research that is in some way personally meaningful to them - and often become emotionally invested in their area of investigation - the knowledge of their subject (however broad or deep) must to some degree be appraised and understood through the distorting lenses of personal meanings and emotions .This can interfere with the researcher's capacity to be sufficiently objective and to approach the research and the data with a sufficiently open and receptive mind (Watt, 2007).

The discipline of reflexivity enhances the validity and credibility of research by accounting for and addressing potential sources of bias (Stiles, 1993). It '*adds validity and rigour in research by providing information about the contexts in which data are located*' (Etherington, 2004; 37). Reflexive descriptions of the researcher's perspective allow the reader to understand the researcher's perspective, to contextualise the work, to evaluate the findings appropriately and to consider alternative explanations or interpretation of the data. Reflexivity is widely recognised as important in qualitative research and increasingly it is becoming appreciated that quantitative

research literature might be enhanced by researcher reflexivity. The choice of investigation topic, selection of sample, tools, and interpretation and presentation of results are all features of quantitative research, and will be subject to the influence of the quantitative researcher's subjectivity (Onwuegbuzie & Leech, 2005). That notwithstanding, there are some authors who critique the construct of reflexivity and challenge the prominence given to it by many researchers (e.g. Lynch, 2000) as well those who question the method of reflexivity used by researchers whilst inviting a 'space' for the researcher's subjectivity and unconscious in the interpretive process (e.g. Mauthner & Doucet, 2003; Romanyshyn, 2010).

Psychotherapy (from the position of both the therapist and client) is an implicitly reflexive activity. A core goal common to all psychological therapies is the enhancement of both client and therapist's '*ability to notice responses to the world… other people and events, and to use that knowledge to inform… actions, communications and understandings. To be reflexive we need to be aware of our personal responses and to be able to make choices about how we use them. We also need to be aware of the personal, social and cultural contexts in which we live and work and to understand how these impact on the ways we interpret our world*' (Etherington, 2004: 19).

Reflexivity is central to TA theory; TA practitioners are encouraged to identify their 'frame of reference' (Schiff et al., 1975) and their 'life script' (Berne, 1972) and to question the validity of these interpretive frameworks. TA practitioners are strongly encouraged to reflect upon and document how their own frame of reference and life script influence their work (Hargaden & Sills, 2002).

### 3.2.2. A Personal Reflexive Statement

My experience as a practitioner prior to this research was mostly with clients in long-term therapy: a therapy format I preferred since I was unconvinced that short-term therapy could have a substantial and lasting positive impact on clients. I was also practising with a more fluid, less structured style than that recommended in many introductory TA texts, in part because I had come to question the effectiveness of the detailed forms of contracting that many of these texts insisted upon. I had also moved away from the use of some of the more dramatic methods (such as two-chair work), preferring to focus on relational approaches to TA therapy because I suspected that these were the central change mechanisms at work.

Although my professional identity was firmly rooted in the theory and practice of TA psychotherapy, I had become increasingly interested in the common factors approach and points of convergence between therapies. Comparison of TA with other approaches seemed to suggest more similarities than differences. Nevertheless, I remained intrigued about the question of what could be considered unique about TA. An understanding of the 'active ingredients' of the approach that I had been immersed in for most of my professional career continued to remain elusive.

Throughout the duration of the research study documented here, I have continued both my therapy practice (8-10 clients per week in private practice, mostly long-term clients) and my involvement in the training (6 days per month) and supervision of trainee therapists (around 20 hours per month). I feel that the research process has had a substantial positive influence on my work with both clients and trainee therapists. My engagement with the research literature stimulated an evolving

reflexive narrative, which simultaneously drew from and informed discussions between myself and my clients and trainees.

### 3.2.2.1. An Outline of the Initial Expectations of the Author

I was confident that I would find that TA therapy would demonstrate some effectiveness for the treatment for depression. My expectation was that TA would demonstrate effectiveness that was roughly equivalent to other therapies. I expected that different TA therapists would practise differently to each other, and that different clients would require treatment approaches that were individually tailored to their own unique circumstances. I expected to find that the relational aspects of the therapy would be the most significant in facilitating change.

Despite my confidence in TA, I did harbour some tentative anxiety about the potential findings of this research, and in particular the professional crisis that might ensue if the data gathered were to challenge TA theory or show TA to be ineffective in practice.

### 3.2.2.2. An Appraisal of Influences on Choice of Research Design

From the outset this research was intended inform clinical practice. This demanded a research method that would yield findings of direct, practical relevance and applicability.

Much of the prior research into the relative effectiveness of psychological therapies involved quantitative research, a field in which I lacked experience. In addition, many of these studies sought to explore the 'superiority' of one approach over another, a practice that jarred with my belief that all therapeutic approaches have value and relevance for different clients and therapists. As a therapist, I had more interest in

exploring effective mechanisms of change whether they be unique to one therapeutic process or shared by all. Finding a method that enabled investigation of both process and outcome was my first challenge. The contribution of qualitative approaches in describing the 'lived experience' of participants and in their use for exploratory investigations seemed to more closely fit the direction I wanted to take my research.

Simultaneously however, I was aware that as a TA practitioner, issues of researcher allegiance and my own vested interest in positive findings would need to be addressed by using a method that was objective, systematic and incorporated a means of minimising such bias.

Consequently, I chose to use systematic case study research, utilising both quantitative and qualitative approaches in a 'mixed-methods' approach to investigate both the process and outcome of TA therapy in routine practice. This accounts for individuals' unique stories and lived experience within a pragmatic framework, providing me with the tools to conduct the research and produce robust evidence in line with my own interests.

# Section Three: Case Study Research[7]

## 3.3.1. Introduction

*'In the practice of psychotherapy, the most basic unit of study is the "case" (Eels, 2007). Single-case studies that allow for the examination of the detailed unfolding of events across time in the context of the case as a whole represent one of the most pragmatic and practice-oriented forms of psychotherapy research' (Iwakabe & Gazzola, 2009: 601).*

The development of psychotherapy has been influenced from the beginning by the writing and publishing of case studies. Freud's (1901, 1909) famous case studies were highly significant in the development of psychoanalysis. Case studies were also influential in the development of behavioural therapy (Wolpe, 1958). Most modalities of psychotherapy have been influenced by key case studies. Frequently they trigger innovative thinking about methods, and cases are commonly used to test out and verify the effectiveness of a new therapy or to explain key features of the therapy and how it works to a wider audience (see also Berne, 1961).

Stiles (2007) noted the power of case studies for theory building. For Stiles, the observations drawn from case studies enable the development of new theory, encourage the revision and modification of existing theory to encompass and incorporate new observations, explain previously unaccounted phenomena and can also assist in testing the validity of theoretical constructs (Flyvbjerg, 2006; McLeod, 2010; Stiles, 2007).

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[7] Parts of this section have previously been published in; Widdowson, M. (2011b). Case Study Research Methodology. *International Journal of Transactional Analysis Research,* 2(1): 25-34.

Despite the historical significance of case studies, there were until recently relatively few case study reports published in modern psychotherapy books and journals (two recent journals - *Clinical Case Studies* and *Pragmatic Case Studies in Psychotherapy* - now cater to the renewed interest in this form of academic material). TA literature lacks detailed case studies that provide the reader with a clear picture of the process and sufficient information to form their own conclusions regarding the outcome. In common with the case studies of Freud, the TA case studies that are available do each tell a story, but they do not provide the required evidence needed for objective scientific inquiry or for valid general conclusions to be drawn.

As the psychotherapy community has turned its attention to case study methodology, researchers have sought to find ways in which the case-study approach can be used to generate reliable and valid data (McLeod, 2010). Kiesler (1983) argued that research into change processes could be achieved through the use of '*small n or single-case studies*' (p.13) and that well-constructed systematic case studies could yield reliable evidence for investigating the impact of the therapy in effecting change.

### 3.3.2. Comparison of Large Sample Studies and Case Study Research: The Argument in Support of Case Study Research

A number of respected researchers have begun to question the dominance of Randomised Controlled Trials (RCTs) for researching psychotherapeutic outcomes. These researchers are calling for the development of an integrated research approach which in addition to RCT evidence, also incorporates a range of other research methods including practice-based, qualitative and systematic case study research (Barkham, Hardy & Mellor-Clark, 2010; Dattilio et al., 2010; McLeod & Elliott, 2011;

Westen, Novotny & Thompson-Brenner, 2004). Whilst large *n,* quantitative studies (such as RCT's) have been useful in establishing the efficacy of psychotherapy- both within tightly-controlled conditions as well as in routine practice (such as Stiles, et al., 2006; Stiles, et al., 2008), these studies have not been able to provide detailed information regarding the specific factors which have influenced the change process in individual clients (McLeod and Elliott, 2011).

Case studies typically present rich data about the client, the therapist, the process and outcome(s) of the therapy. One criticism of methods of psychotherapy research, such as randomised controlled trials (RCTs), is that they focus on large, generalised quantitative data, and that essentially the findings are reduced to a table of numbers which may not adequately capture the complexity of the therapy and other non-controllable variables. This critique of RCT method was developed by Elliott (2001), who describes RCT's as 'causally empty', in that they do not provide sufficient data for clear causal explanations to be drawn as to *how* or *why* a particular therapy has generated a particular change. In contrast, detailed case studies which account for and include a range of data (including factors from within and outside the therapy e.g. changes in a client's circumstances) and enable the identification of subtle and uncontrollable variables that may have influenced the process and/or outcome of the case.

Although RCT's are generally considered to be high in internal validity, some dissenters such as Datillio *et al*. (2010) consider RCT's to have problems with internal validity due to not accounting for 'softer', more intangible variables such as therapist responsiveness, therapeutic alliance, the impact of client hope and their perceptions of

the therapist's credibility. McLeod and Elliott (2011) describe some particular strengths of case study research. These include the ability to account and allow '*for the identification and analysis of complex patterns of interplay between different factors or processes*' (p.3) including contextual factors within each case, detailed exploration of how change takes place over time, as well as providing practice-relevant and accessible information for practitioners.  They also go on to argue that '*the quality of evidence generated by… intensive single-case outcome studies, is in many respects more credible than the evidence produced by RCTs and other large-scale studies. Because they use many different sources of information, readers and reviewers can be confident that systematic outcome-oriented case studies reflect the most accurate appraisal that is possible of the extent to which a client has been helped by therapy*' (McLeod & Elliott, 2011: 7).

### 3.3.3. Limitations of Existing Case Study Research

McLeod and Elliott (2011) note that the majority of published systematic case studies are of therapy conducted in university research clinics and that there is a paucity of published cases which have investigated routine practice. They argue that many of the case studies which have been conducted do not adequately reflect the type of work that is conducted by therapists in general, and therefore do not generate insights into routine, everyday practice.  They go on to argue that '*as a result, important learning is being lost, and opportunities are being missed to use case-based accounts of grassroots practice as a platform from which to build and develop other types of investigation. …If case study research is to fulfil its potential in respect of the evidence base for counselling and psychotherapy, it is essential that more systematic case*

*studies are carried out by practitioners in a wide range of therapy settings'* (McLeod &
Elliott, 2011: 8).

### 3.3.4. The Issue of Internal and External Validity in Case Study Research

The design of RCT's and other experimental studies generally involves the control of a
range of variables in order to produce a study with high internal validity. However, the
results of many such studies cannot be easily generalised to routine clinical practice
and so are considered to have low external validity. Conversely, naturalistic case study
research would generally be low in internal validity due to the absence of experimental
control of variables, but high in external validity due to their close relationship to
routine practice. In this sense, case study research may generate findings which are
'user friendly' and as such close the research-practice gap. Indeed many therapists
report that they are disengaged from research based on their perceptions that
research findings are often inaccessible or not relevant to their practice and that the
research they are most interested in is that which reflects the kind of work they do
with their usual client populations (see Widdowson, 2012a).

The present study has selected a balanced stance with regards to internal and external
validity. Internal validity was promoted through the recruitment of a clearly-defined
client group with inclusion and exclusion criteria and the use of adherence checks for
the therapy (see chapter four for further details). However, these criteria constituted
minimal restriction on the therapy or on type of client. The intention was to enhance
the external validity of the study by ensuring it corresponded closely to routine
practice. Westen, Novotny and Thompson-Brenner (2004) critique the validity of RCT's
stating that the tight restriction of the type of clients studied does not adequately

reflect routine practice. The selection criteria in the present study were selected to ensure a coherent client group were studied, but who reflected the kind of complex presentation commonly seen by therapists in routine practice.

As naturalistic studies are conducted without the tight control of variables, there are limitations to drawing conclusions of causality from their findings. As such, naturalistic studies need to be appraised in light of the potential influence of a range of factors on the results. It is however, not the intention in naturalistic, case study research to produce such conclusive findings of causality. Instead, the intention is to generate rich data. Furthermore, *'case study research is usually interested in a specific phenomenon and wishes to understand it completely, not by controlling variables but rather by observing all of the variables and their interacting relationships'* (Dooley, 2002: 336).

### 3.3.5. The Scope of Case Study Research

McLeod (2010) identifies four categories of research questions which can be investigated using case study method. The first category relates to *outcome* questions regarding the effectiveness of the therapy. This includes examining the extent to which therapy can be considered as the primary factor responsible for positive changes. The second of these categories relate to *theory-building* questions. These draw on the observations of the case for the purposes of testing, refining or developing theoretical models. The third category relates to *pragmatic* questions which primarily investigate the therapeutic strategies used that contributed to the outcome of the case and which may indicate principles of good practice. The final category involves questions relating to *experiential* or *narrative* aspects of the case, for example what was the client's or therapist's experience of the therapy. Different methods of case study research

address or emphasise each of these categories in different ways. Research which is designed to investigate research questions from multiples categories may require an approach which combines and synthesises more than one type of case study. Within the present study, research questions relating to both process and outcome required this type of synthesis.

### 3.3.6. Types of Case Studies

A number of authors describe the different kinds of case studies which can be conducted. It is necessary to provide a brief description of these, in order to contextualise and understand the present study and the rationale which informed the selection of the chosen case study method.

#### 3.3.6.1. Clinical Case Studies

A clinical case study is a narrative account of the therapy, written by the therapist. It is through clinical case studies that psychotherapy as a profession was developed (such as those of Freud). Whilst clinical case studies are important and valuable for the development of psychotherapy, they are based on the therapist's (subjective) account of the therapy they are not reliable for research purposes (Iwakabe & Gazzola, 2009).

Clearly, there is potential for the influence of the therapist's bias in clinical case studies. Indeed, the issue of bias and subjectivity in reporting has been a common critique of case study research. The use of rigorous case study methods can address this issue of bias to some extent. Flyvbjerg (2006) poses an interesting argument relating to researcher bias. He argues that case study research commonly results in a challenging of the researcher's '*preconceived views, assumptions, concepts, and*

*hypotheses'* (p.235). Flyvbjerg suggests that such challenge comes about due to the rich data revealed in case study method that illuminate exceptions to the rule.

### 3.3.6.2. Experimental Case Studies

Often known as *N*=1 studies, experimental case studies are used for testing specific interventions. A number of pre-therapy quantitative measurements are taken  to establish the stability of a problem or behaviour and as a baseline for measuring improvement. Then an intervention or approach is introduced and the effect on the problem is noted. If the problem changes as a result of the intervention it is then considered to be likely to have brought about the change.  Given the emphasis on behavioural change, and the outcome of specific, targeted interventions, the *N*=1 model has been almost exclusively used for the research of behavioural therapies. (Iwakabe & Gazzola, 2009; McLeod, 2010)

Whilst the *N*=1 design is a useful approach for measuring the impact of specific therapeutic interventions or the effectiveness of certain techniques, it does not account for 'soft' factors in the therapy, such as the impact of the therapeutic relationship on the change process, or the impact of external factors and extra-therapy events in facilitating change.

### 3.3.6.3. Systematic Case Studies

Systematic case studies (Iwakabe & Gazzola, 2009) rectify many of the methodological problems associated with clinical case studies. The means by which these methodological problems are resolved is through the use of *'data . . . gathered from multiple sources, such as questionnaires, therapist and observer ratings, and*

*participant interviews, to construct a rich and comprehensive account or case*

*summary, which is then triangulated in order to examine whether different sources of*

*data converge'* (Iwakabe & Gazzola, 2009: 602-3).

Kazdin (1981) produced one of the first papers focusing on quality recommendations for systematic case study research. These recommendations were clearly influenced by methods used in experimental *N*=1 case studies. Essentially, Kazdin's recommendations involve the use of multiple reliable and valid outcome measures which are repeated at regular intervals throughout the therapy to determine the extent of the client's change. The use of reliable and validated outcome measures is a key feature of Kazdin's argument, as these tools go beyond anecdotal reports to add a degree of scientific validation and therefore lend credibility to the argument that positive therapeutic change has indeed taken place. Identification of the stability of the problem prior to commencing therapy also addresses concerns that the client's problems were subject to fluctuation and that any change may have taken place as a result of spontaneous remission.

Kazdin (1981) also advocated the replication of the case study method with clients with similar problems. Replication of findings also addresses the issue of the change occurring by chance, and enables findings from the case series to be generalised. For example, if replicated systematic case study research demonstrates that a particular therapy shows repeated effectiveness in the treatment of a specific problem with a wide range of clients with an identical problem, it is possible to conclude the therapy being researched has some validity for the treatment of that specific problem or client population (McLeod, 2010).

A number of systematic case study methods have emerged which each have a slightly different focus and thus yield different types of results (see next chapter). Research questions which address multiple areas of focus may require the combination of case study methods. Fishman (2012) argues that there can be considerable advantage to such synthesis of case study designs as different methods enrich and complement the others by extending the areas of inquiry which can be extracted from a single case.

### 3.3.8. Summary of Chapter

This chapter has briefly discussed positivist, constructivist and pragmatic research philosophies and their associated methods and evaluated their ability to address the research questions. The issue of researcher subjectivity has been discussed in relation to reflexivity and its influence on the choice of study design. This has led to a brief outline of case study method. All of this offers a glimpse at the nature of the methodological choices the researcher faced. Space limitations have precluded a discussion with greater depth, or which would grapple with specific issues.

In the present study a combination of quantitative and qualitative methods were selected to provide the most comprehensive means of investigating the research questions. The use of standardised quantitative outcome measures provided a degree of confidence about the symptomatic changes the clients' experience, and the qualitative aspects invited clients to report on the experiential aspects of their changes and the process of change. These sources of data were combined within a systematic case study method, based on a pragmatic research philosophy. The primary case study method comprised an adjudicated, Hermeneutic Single-Case Efficacy Design, while also incorporating aspects of theory-building approaches.

# Chapter Four: Method

*This chapter describes the study design and measures used in the research. This includes a description of the research protocol and data analysis procedures used and discusses the ethical issues relating to the study*

## Section One: Study Design

### 4.1.1. Rationale for the Proposed Study

The primary aim of the project was to examine the effectiveness of Transactional Analysis psychotherapy in a controlled adjudicated clinical study. A secondary aim was to explore the factors associated with good and poor outcomes in this form of therapy.

The rationale for these aims was formed in view of some apparent similarities between the process of Transactional Analysis and other well-established and empirically supported therapies, and the existence of evidence of equivalence in effectiveness between different models of therapy (Rosenzweig, 1936; Wampold, 2001). The project rationale holds that it is reasonable to expect that TA psychotherapy for depression would be likely to yield effects comparable to other psychotherapies.

### 4.1.2 Research Questions

The present study researched the process and outcomes of a series of sixteen Transactional Analysis psychotherapy sessions, taking place between five therapist-client pairs across multiple sites. Each participating client forms one 'case' and the research included a cross-case analysis. Both quantitative and qualitative data was gathered and used both to investigate the process of change and to determine outcomes of the therapy.

*Primary Question:*

• Can TA psychotherapy be effective for short-term treatment of depression?

*Secondary Question:*

• What processes and factors influence the outcome of TA psychotherapy for depression?

## 4.1.3 Study Design

The research used a non-randomised, adjudicated clinical trial design (McLeod, 2010). This was influenced by recommendations and guidelines from Chambless and Hollon's (1998) seminal paper that defined criteria for empirically supported therapies.

Chambless and Hollon (1998) state that in order to be classified as 'empirically supported', a therapy needs to be investigated using a treatment manual (or its logical alternative), and in use with a clearly defined population with a specific problem (in the present study, people with depression). Such research must also use reliable and valid outcome measures that include some baseline measurement of the problems that are being targeted. For a therapy to obtain the designation of 'possibly efficacious' from case study methodology, Chambless and Hollon (1998) have provided a number of specific criteria, which include a minimum sample size of three. For a therapy to be designated as efficacious, positive findings must be replicated by a second independent research group with a minimum sample size of three or with a further six systematic case studies.

### 4.1.4. Change Process Research

Change process research *'is a necessary complement to randomized clinical trials (RCTs) and experimental or interpretive single-case causal designs. Both types of causal research design focus narrowly on establishing the existence of a causal relationship between therapy and client change but do not specify the nature of that relationship. Furthermore, it is now understood that scientists commonly do not accept newly proposed causal relationships unless there is a plausible explanation or narrative linking cause to effect'* (Elliott, 2010: 123).

Elliott (2010) identifies several varieties of change process research, each of which has its own strengths and weaknesses. The first is Quantitative Process-Outcome research where certain process variables (e.g. transference interpretations) are quantified from session transcripts and analysis examines if these correlate with outcome. One drawback to this approach is that the researcher must begin with a set hypothesis about a causal relationship.  This makes it difficult to use in exploratory research. A second limitation is that this does not necessarily account for the range of other factors, including therapist responsiveness (Stiles et al., 1998) and client variables which are likely to influence outcome.

The second change process variant Elliott (2010) identified was Microanalytic Sequential Process design. Here, the researcher observes  specific interventions or sequences of interventions to assess their immediate impact on the client and the direction of the therapy. As an approach this is particularly suitable for testing theories about the impact and directional unfolding of specific therapy processes. A limitation of this method is that it does not account for time-lag in therapeutic processes, and

furthermore, as it is focused on testing hypotheses '*it is not particularly good for discovery-oriented research'* (Elliott, 2010: 129).

The third method of change process research Elliott (2010) identified was Qualitative Helpful Factors design. This method involves asking clients directly what they found helpful (or unhelpful) in their therapy. The use of post-session questionnaires enables the researcher to identify relatively immediate impact and the use of post-therapy interviews allows the client to reflect on the whole process of therapy, which can include delayed effects. This method produces rich qualitative data which can be particularly helpful in systematic case studies. It also is relatively simple to administer and captures some of the humanistic philosophy of 'the client knows best'. However, as an approach it is limited by the capacity of clients to accurately identify and articulate processes and may be subject to attributional error, with the client influenced by expectations regarding change processes, or selecting events that were more memorable (as opposed to events which were actually more helpful) (Elliott, 2010). These limitations can be overcome, or at least managed by critical evaluation of the client's comments, combined with several other lines of evidence and exploration of alternative explanations in the analysis process. As an approach it is particularly suitable for discovery-based research.

Due to the nature of the research questions in the present study, the helpful factors design was selected as the most appropriate method to assist in the preliminary identification of process factors in combination with other methods. The open-ended qualitative approach was considered to be most suitable for incorporation into the

study design, given the lack of existing TA literature on therapy process, and the complexity of the nature and process of change.

The present study is based on the use of systematic case studies. Case study designs have been combined to address the different research questions. The primary method used for analysis of the cases, including forming conclusions relating to outcome and significant features of the therapy is an adjudicated design; specifically, Hermeneutic Single-Case Efficacy Design (Elliott, 2001, 2002). The rich case record included rich description of the technical features of the therapy process in order to identify key principles of therapeutic change. Finally, the cases were compared and contrasted to each other, using a theory-building strategy to enhance the pragmatic aspects of exploring the process of TA psychotherapy for depression.

### 4.1.5. Theory Building Case Study Research

The 'theory building' approach to systematic case study research in psychotherapy has largely been documented by Stiles (2007). He argues that the level of rich data and detailed analysis that a case study yields means that this method of research is ideally placed to develop, test or refine theories. The researcher examines the case and the explanatory theory, '*reconciling it with observations….(and) eliminating or modifying aspects that do not square with observations and extending the theory as new phenomena are observed'* (Stiles, 2010: 2).

The theory building approach which Stiles takes is a different position to Popper's (1959) principle of falsifiability. Within falsifiability, if a disconfirming example is found, the theory is considered to be invalid. With a theory building approach, theories which are disconfirmed in some way are not necessarily abandoned, but instead are adjusted

or amended to account for the new data or observed phenomenon.  This approach lends itself particularly well to case study research. Each case is likely to have aspects which confirm existing theory, as well as aspects which either do not fit or are unexplained by this existing theory.

Within the present study, theory building has been an area of focus. As TA psychotherapy has not previously been examined in a naturalistic setting for the treatment of depression, it was considered desirable to examine the cases to see if TA theory is an adequate treatment approach. Furthermore, it was also an intention of the researcher to explore whether TA therapy as conducted within routine practice differs from existing TA theory and whether TA theory would need to be modified or extended to account for any differences. It was considered possible that the cases would yield data relating to specific areas of TA theory or practice which were potentially effective and worthy of further investigation or of greater emphasis being placed on them within the TA literature.

### 4.1.6. Hermeneutic Single-Case Efficacy Design

Hermeneutic Single-Case Efficacy Design (HSCED) (Elliott, 2001, 2002) is a systematic case study method which is based on a quasi-legal framework of cross-examination of data and the exploration of alternative factors which may have influenced the outcome of the case (e.g. extra-therapy factors). The use of an adjudication panel to explore different interpretations of the case, critique the findings of the case study and determine the overall verdict of the case significantly addresses the issue of objectivity and researcher allegiance which may be present in other case study designs (Elliott, 2001; Fishman, 2012; McLeod, 2010). The HSCED method primarily addresses

questions relating to the effectiveness of a particular therapy case. HSCED was

considered to be the most suitable case study method for addressing the first research

question in this present study (which relates to outcome of TA therapy). A detailed

description of the HSCED method is presented in section six of this chapter.

# Section Two: Measures

*This section discusses the measures which were used in this study. Each tool will be described. This will include a brief description of the purpose of the measure and the rationale for its selection in this study.*

## 4.2.1 Measures

A summary table of measures used in this study and their purpose is presented overleaf.

### 4.2.1.1. Determining Level of Change: Clinical Significance and Reliable Change

Two quantitative methods of measuring changes in client outcome were used and as such are the key dependent variables in this study. These were: Clinically Significant Change (CSC) and Reliable Change Index (RCI). CSC is a measure of observed improvement in which the client no longer meets the technical diagnostic criteria for his or her disorder or problem. Effectively, this corresponds to concepts of 'cure'. RCI is an alternative indicator of positive client change (Jacobson, Follette and Revenstorf, 1984; Jacobson and Truax, 1991). It is recognised that clients often experience significant improvement during the course of therapy in the direction of greater health, but may not have improved to a clinically significant degree, i.e., they have not achieved 'cure'. The RCI is determined on the basis of statistical data for each measure and is set to indicate a level of improvement that demonstrates positive change has taken place that is of a sufficient magnitude to suggest that the change is not attributable to measurement error.

**Table 4.1.Summary of Measures Used**

| Quantitative Measure | Purpose of Measure |
|---|---|
| Beck Depression Inventory- II | Measures severity of depression and improvement in target symptom/ disorder |
| CORE-OM | Measures global distress and functional impairment |
| CORE-10 | Measures global distress and functional impairment |
| Personal Questionnaire | Individualised measure of the client's problems they wish to address in therapy |
| Contract Goals Completion Form | Individualised measure of achievement of client's therapy goals |
| Working Alliance Inventory (Short Form) | Quantitative process measure of strength of working alliance (form completed by both therapist and client) |
| **Primarily Qualitative Measures** | |
| Helpful Aspects of Therapy | Process measure relating to client's perception of what was helpful/ unhelpful in session |
| Change Interview | Client's reflections on their changes and their perceptions and attributions of the change process |
| **Therapist Completed Forms** | |
| Structured Therapist Notes | Standardised reporting form relating to focus and content of sessions, as therapist's use of theory/ method |
| Adherence Measure | Rating of therapist's competence and adherence to TA model of treatment of depression (completed by both therapist and supervisor) |

### 4.2.1.2. Questionnaires and Forms Completed and Returned

Each case required the completion of over one-hundred forms and questionnaires. Out of approximately five hundred potential forms from the five cases, only five forms were missing (representing approximately 1% of the maximum possible data set).

## 4.2.2. Quantitative Measures

### 4.2.2.1 Beck Depression Inventory- II

The Beck Depression Inventory–II (Beck, Steer & Garbin, 1988) is a self-completed 21-item measure, which has been extensively used in studies of psychotherapy for the treatment of depression. Its psychometric properties have therefore been thoroughly investigated. As a tool it has been well validated and repeatedly demonstrated to have high levels of specificity, internal consistency, sensitivity to change, reliability and strong content, discriminant, construct and convergent validity (Beck, et al., 1988).

Inventory items relate to specific depressive symptoms and scores indicate the severity of an individual's depression. The measure was originally developed by Beck and colleagues (Beck et al., 1961) from their clinical observations of main symptoms experienced by depressed patients. These symptoms include feelings of anhedonia, pessimism, sadness, worthlessness and guilt and somatic symptoms including sleeping problems, changes in appetite or interest in sex, fatigue and difficulties in concentrating.

Each of the 21 questions is answered using a four point scale. An example is;

0) *I do not feel sad*

1) *I feel sad*

2) *I feel sad all the time and cannot snap out of it*

3) *I feel so sad or unhappy that I cannot stand it*

The BDI-II takes approximately ten minutes to administer and score. The numerical scores for each question are added together to yield an overall score, which then indicate the level of severity of the client's depression. The clinical cut-off is a score of >10, and yields scores which can be classified into sub-clinical, mild, moderate, moderate-severe and severe bands of depression. RCI scores have been set for BDI-II at 5.78 (Beck et al., 1988; Seggar, Lambert & Hansen, 2002).  BDI-II was selected for use in this present study to measure severity and change in target symptoms because of its reliability, validity, wide-spread use and ease of administration.

### *4.2.2.2. Clinical Outcomes Routine Evaluation – Outcome Measure*

The Clinical Outcomes Routine Evaluation- Outcome Measure (CORE-OM) (Barkham, Mellor-Clark, Connell and Cahill, 2006) is a self-completed 34 item measure, yielding four sub-scales (well-being, psychological symptoms, functioning and risk) and a total clinical score which measures overall levels of global distress and functional impairment. Higher scores indicate higher levels of distress. The CORE-OM is a well-validated tool which is widely used in research into the outcomes of counselling and psychological therapies throughout the UK. A substantial amount of research supports its validity and reliability (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell and McGrath, 2000).

The measure asks clients to read each statement and indicate using a five-point scale how often they have felt in a particular way or how true a statement has been for them over the previous week.

For example;

*Question 1- I have felt terribly alone and isolated.*

*0= not at all. 1= only occasionally. 2= sometimes. 3= often. 4= most or all of the time.*

It was selected for use in this study for several reasons. Firstly, its widespread use throughout psychological therapy services in the UK would mean that the participating therapists would be likely to be familiar with its use. Secondly, this widespread use would mean that data gathered in the present study would be easily comparable to results from other UK-based effectiveness studies and was appropriate for measuring outcomes of routine practice. Thirdly, its reliability and validity were well established, and as it was developed for a clinical population and has a clear clinical cut-off point, this would assist with drawing conclusions about the outcomes of the cases. The broad-spectrum coverage of symptoms, distress and functioning meant that CORE-OM scores were considered to be a useful overall indicator of severity of client impairment and improvement during therapy.

The CORE-OM was administered at sessions one, eight and at session sixteen (or completion of therapy- whichever was sooner) and at each follow-up interval. The RCI value for CORE-OM was set at 6.0 (Connell & Barkham, 2007).

### 4.2.2.3. CORE-10

The CORE-10 (Connell & Barkham, 2007) is a ten-item self-report measure of global distress and functional impairment. The ten items were selected from the longer 34 item CORE-OM, and is quickly and easily administered and scored. CORE-10 yields a score of up to 40, with the clinical cut-off for scores being above 10. CORE-10 shows

strong convergence validity to CORE-OM scores, high sensitivity to change, and good reliability and validity. RCI scores for CORE-10 have been set at improvement of a minimum of 6 points (Connell & Barkham, 2007).

The CORE-10 was administered at the beginning of all remaining sessions in place of CORE-OM. It was used to provide data for monitoring client progress on a session-by-session basis.

### 4.2.2.4. Personal Questionnaire

The Personal Questionnaire (PQ) (Elliott, Mack & Shapiro, 1999) is an individualised, client-generated self-report outcome measure. The items in the PQ are generated by the client's presenting problems that they wish to address in therapy. The individual items on the measure were developed in the initial therapy session when the therapist assisted the client to articulate the main presenting problems that they wished to change in therapy. The items are then rated using a seven-point Likert scale according to how distressing each problem is to the client. In the initial session, the client also indicates how long they have had each problem which provides information relating to the stability of their presenting issues.

The PQ has generally strong convergent validity with other clinical measures and high test-retest reliability (Wagner & Elliott, 2004). The clinical cut-off point for PQ items is heuristically set at a rating of three, indicating that the problem has bothered the client 'a little' over the previous seven days. The Reliable Change Index has been set at change of one point, indicating a 'reasonable confidence' level of 0.2, which is considered to be a useful level for single case studies (Elliott, 2002; Wagner and Elliott, 2004).

In this research the PQ was used as a weekly outcome measure to monitor progress in problem resolution. In was selected partly because it is relatively quick and simple to develop, administer and score, and partly because it provides an individualised measure of client-specific change which is congruent with the humanistic philosophy of TA.

### 4.2.2.5. Contract Goals Completion Form

The Contract Goals Completion Form was a tool which was custom-made for this study. TA psychotherapy places great emphasis on client generated goals as forming the basis of the therapy direction and determining the therapy contract. Goal Attainment Scaling (Kiresuk & Sherman, 1968) is an established outcome measure procedure which involves the measurement of attainment of client goals throughout the therapy. Although Kiresuk and Sherman's procedure was not used in this present study, elements of it were used in the development of the Contract Goals Completion Form as an additional outcome measurement scale specific to this study by adapting the PQ problem form. The Contract Goals Completion Form scale was not tested for validity or reliability using any standardised system, but was developed as a practical tool, the face validity of which was intended to be tested through this study.

The problems the clients identified as part of the intake and PQ development procedure were used by the therapist as the starting point for a collaborative contracting process with the client regarding the client's goals for therapy, and many of these were then converted into contract goals during the first sessions of therapy to monitor progress and provide specific markers of improvement. The measure used a seven-point Likert scale, which was used as a weekly measure of the client's

completion of each therapy goal. For the purpose of this study, a score of five or above indicating that the client's goal had been 'considerably' achieved was heuristically set as representing substantial achievement of the client's goals and indicator of improvement.

The main reason for adapting the PQ problem form into a contract goals completion form was due to ease of use and familiarity of procedure. It was considered that both clients and therapists would become familiar with the PQ form, sidestepping the problems inherent in introducing a new scoring system (which may have been confusing, increasing the likelihood of scoring and measurement error).

### 4.2.2.6. Working Alliance Inventory-Short Form

The Working Alliance Inventory- Short Form (WAI-S) (Horvath and Greenberg, 1989; Tracey and Kokotovic, 1989) is a twelve-item quantitative process measure which is used to evaluate the strength of the working alliance.

WAI-S is a self-report form with specific versions for both client and therapist. It is used to evaluate the strength of the working alliance. The measure was based on Bordin's (1979) conceptualisation of a working alliance comprised of tasks, bonds and goals. The tool is easy to administer and has demonstrated good reliability and validity (Horvath and Greenberg, 1989; Horvath and Symonds, 1991). Despite widespread use in psychotherapy research, no normative interpretation scales are available to indicate the relative strength of the working alliance.

The WAI-S was administered to both clients and therapists at several points in the early phase of the therapy (sessions one, three and six). In line with previous research,

it was anticipated that good outcome cases would demonstrate a strong working alliance between the therapist and client.

### 4.2.3. Qualitative Measures

#### 4.2.3.1. Helpful Aspects of Therapy

The Helpful Aspects of Therapy (HAT) form (Llewelyn, 1988) is an open-ended qualitative process instrument, completed by the client at the end of each session. The HAT form asks the client to describe both the most and least helpful aspects of the therapy session and to rate the overall helpfulness/ unhelpfulness of the session using a nine-point scale (thus incorporating quantitative features). Additionally, the HAT invites clients to describe specific events within the session as being most and least helpful. Data from HAT measures were used to identify specific sessions or sections of particular sessions for further analysis.

#### 4.2.3.2. The Change Interview

The Change Interview is a semi-structured interview format developed by Elliott, Slatick and Urman (2001) for collecting qualitative data on the client's perception of therapy outcome. The interview protocol also includes questions that invite the client to identify those aspects of therapy that have been most or least helpful and also what the client's opinion is regarding factors that are responsible for their changes. Thus, the Change Interview yields rich qualitative data relating to both process and outcome of therapy.

Clients are also asked to list any changes they have noticed since starting therapy. These changes are rated on five-point Likert scales relating to how surprising or

expected the change was, how likely the change would have come about without therapy and how important the change was to them. This feature integrates quantitative aspects into the tool.

Example questions from the Change Interview include;

*3a. What changes, if any, have you noticed in yourself since therapy started? (For example, are you doing, feeling, or thinking differently from the way you did before? What specific ideas or new ways of thinking about things, if any, have you got from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)*

*5. Attributions: In general, what do you think has caused these various changes? In other words, what do you think might have brought them about? (Including things both outside of therapy and in therapy)*

The Change Interviews were audio recorded using a digital voice recorder and were transcribed. The digital voice recorder was securely stored in a locked cabinet at the researcher's home when not in use. Recordings were deleted once the interviews had been transcribed and after transcripts had been checked for accuracy.

### 4.2.3.3. Structured Therapist Notes

The therapists made detailed notes after each session using a structured form. These included process notes of the main themes and issues discussed in the session, the therapist's interventions/ treatment approach applied by the therapist both during the session and when reflecting on the session. The therapist also noted any important extra-therapy events which had occurred for the client since the previous session. The

structured therapist notes also invited the therapist to quantitatively self-rate the session according to how useful they felt the session had been for the client and provide an overall rating of their performance in the session.

### 4.2.3.4. Adherence Measures

In order to confirm that the therapists were practising true TA therapy - and that the therapy was being conducted competently - it was felt necessary to use an adherence scale. No TA adherence measures had been developed prior to the present study therefore it was necessary to construct one. It was not possible within the scope of this present study to develop an adherence measure which had been rigorously tested for reliability and validity. In light of this constraint a pragmatic, heuristic approach was adopted that would produce a measure with acceptable face validity.  The researcher firstly examined the existing TA literature on the treatment of depression to identify key recommended therapeutic tasks. The researcher also reviewed his case notes from clients successfully treated for depression from the previous five years to identify those TA theories and methods that appeared frequently in the session notes. Twelve key therapeutic tasks were identified as central to the TA treatment of depression. This list of twelve tasks was sent to two Teaching and Supervising Transactional Analysts and one of the Research Supervisors for auditing and face validity checking. All auditors agreed that the list represented a reasonably comprehensive and inclusive list of core therapeutic tasks, and that no major relevant TA theories or methods had been omitted.

This list of twelve tasks was then submitted to the UK's Institute of Transactional Analysis for publication in their quarterly magazine[8]. Informal feedback from readers confirmed that the list was comprehensive and covered the central therapeutic tasks for the treatment of depression, without being prescriptive or restrictive.

The researcher then examined a range of adherence measures used in other therapies to identify common methods of adherence measure construction. The list of twelve tasks was used as the basis for adherence measure items. A six-point Likert scale measure was selected which ranged from 'much improvement needed' to 'excellent'. An option for 'not applicable' was included, as it was recognised that not all key tasks would be used in each session. Two separate adherence forms were developed- a therapist self-report measure for evaluation at the end of each session and a supervisor's adherence measure for completion by the supervisor after each supervisory contact throughout the duration of the research therapy. The two measures were virtually identical, with minor changes in wording between the two forms to reflect the perspective of the rater.

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[8] See, Widdowson, M. (2011c). Depression in the frame. *The Transactional Analyst,* Autumn 2011, pp.5-11.

# Section Three: Procedure – The Research Protocol

## 4.3.1. Recruitment: Preliminary Process

The recruitment process began with supervisors. This was to ensure that therapists participating in the study would be assured of adequate support from a supervisor who was already comfortable and familiar with research. The supervisors were approached first as it was thought easiest if therapists were supervised by their regular supervisor. This would ensure continuity, quality control (the supervisors all knew the therapists well, and were confident in their ability to conduct competent and ethical therapy), and to avoid provoking additional stress amongst the therapists by requiring them to form a new supervisory relationship. Furthermore, findings from a focus group study indicated that in order to participate in research, the therapists sampled would want the support and encouragement of their supervisor (see Widdowson, 2012a).

A short presentation about the present study was delivered at a TA trainers and supervisors meeting. Those attending the meeting[9] (who were interested in the research) were informally invited to contact the researcher. These supervisors were then briefed about the research by telephone. Level of commitment required by both the supervisors and participating therapists was discussed. The supervisors were also sent a copy of the 'Information for Participating Therapists' document to ensure both that they were familiar with the nature of the project and that they felt able to provide appropriate support to the participating therapists.

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[9] The meeting was attended by approximately 40 trainers and supervisors. Approximately 12 of these expressed interest in the research.

On confirming their interest with the researcher, the supervisors were invited to a briefing meeting to discuss adherence checking procedures, record keeping and monitoring of the therapist's work (which would include listening to sample audio recordings of the therapist's work, in addition to the usual verbal report and discussion of therapy).

Participating supervisors were offered regular consultative support from the researcher, to ensure the smooth running of the research project. This tended to occur via a brief monthly telephone call.

### 4.3.2. Procedure for Recruiting and Training Therapists

The supervisors who had signalled a willingness to participate were asked to recommend therapists whose practice they supervised, who were Certified Transactional Analysis psychotherapists (CTAs) and who they considered to have the motivation to participate in this research project[10].

CTA status was taken to indicate a threshold measure of the competence of the participating therapists. To obtain CTA status, therapists are required to demonstrate competence in the delivery of transactional analysis psychotherapy, are assessed in both written and oral examinations and in addition must provide evidence of extensive practical experience. The written examination includes the assessment of an extended client case study. The oral examination includes assessment of audio recordings and transcripts of actual therapy sessions. In order to meet these requirements, CTAs must become familiar with audio recording client sessions. CTAs are also trained and assessed in the use of DSM-IV diagnosis.

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[10] In the end, eleven therapists were recommended and approached to participate

The researcher then directly approached the therapists recommended by supervisors. Therapists who expressed interest were briefed about the nature of the research project, sent an information pack and were invited to discuss any concerns or queries they had directly with the researcher. Nine therapists keen to participate were then asked to provide confirmation that they had met the entry requirements and then attended two free-of-charge half-day training events. These covered:

- An introduction to the methodology of the research

- Client inclusion and exclusion criteria

- A description of the research protocol and procedures

- Administration of outcome measurements

- An overview of depression- in particular, DSM-IV diagnostic criteria

- Discussion of existing TA literature on the treatment of depression

- Data recording and administration

The participating therapists were encouraged to follow their normal routine procedures as closely as possible throughout the course of therapy with participating clients. One participating therapist worked in a voluntary agency and so was subject to the agency's procedures. In this case, the researcher arranged to meet the agency manager to discuss the research, seek clearance from the agency for the therapist to participate, and for the agency to ensure that appropriate referral of a research client would take place.

During the training event, participating therapists were given a pack of materials (see appendices for copies of materials), which included:

- An 'Information for Participating Therapists' document

- Five copies of the 'Information for Participating Clients' document

- Five  copies of the 'Getting the Most Out of Therapy' document

- Informed consent forms (for therapists and clients)

- Release forms for audio recordings

- The research protocol

- Copies of therapist structured note pro-forma

- Copies of therapist adherence forms

- Copies of therapist adherence forms- supervisor version

- Copies of the outcome measurement forms

The researcher also collected some basic biographical data on the participating therapists, including information regarding their training and experience. These data were stored securely in a locked cabinet at the home of the researcher.

### 4.3.3. Recruitment of Clients

Since the study sought to employ a naturalistic, community-based sample, recruitment of clients took place via the participating therapists' usual referral sources. The therapists were advised to follow their normal procedure for initial contact and

assessment with potential clients as closely as possible (one therapist worked in a voluntary agency and the referral source was via the agency's normal procedures).

Clients considered suitable for inclusion in the study were approached by their therapist, introduced briefly to the research project and asked if he or she might be interested in participating. This was done either in the initial phone conversation with the client (if the client mentioned that they were suffering from depression), or in an initial intake interview (if the client did not disclose depression in the initial phone contact but did discuss it in person). In the case of the client seen in the agency setting, the agency manager (who conducted initial client assessments) discussed the possibility of participating with several suitable clients.

Each therapist conducted some basic screening (based on clinical interview and their usual procedures) in the initial appointment to determine both that the client met the DSM-IV diagnostic criteria for 'Major Depression' and to ensure the client did not meet the exclusion criteria (see below for criteria). It was stressed that participation in the research was entirely voluntary and that if a client did not wish to participate that it would not affect or prejudice any treatment they may engage in with the therapist. At this stage two clients chose not to participate, yet continued in therapy with the therapist.  Clients who signalled an interest in participating were given an information pack about the research and were then screened using CORE-OM and BDI-II to ensure they met inclusion criteria. The clients who met the inclusion criteria (and who did not meet exclusion criteria) and who continued to express an interest in participating were then asked to take a few days to read the information pack, and to let the therapist know if they wanted to participate in the research. This procedure ensured that clients

had adequate time to consider participation fully, to make an informed choice about participation and to minimise the potential risk of a client feeling coerced into participating.

Although data regarding number of clients approached to participate was not formally recorded, anecdotal reports from the participating therapists suggest that around 12 clients were invited to participate. Of these, six declined participation and six clients consented to undertake the initial intake procedure. On reflection, one of the therapists had concerns about the potential negative impact of participating on one client (who in intake interview revealed their childhood experiences were of needy and overly-intrusive parents), and discussed with the client the implications of engaging in the project and how this may unhelpfully repeat the client's past. Consequently, the client withdrew from the project.

### 4.3.4. Inclusion and Exclusion Criteria

Clients excluded from the study included those previously diagnosed with bipolar disorder, current substance or alcohol abuse, an active psychotic condition such as schizophrenia and those currently experiencing domestic abuse. Clients currently taking anti-depressant medication were also excluded from this study.

Inclusion criteria were that the client must be aged 18 or above, motivated to engage in therapy, fluent in English language and presently suffering from depression (as defined by DSM-IV criteria for Major Depressive Episode or Major Depressive Disorder

as determined by the therapist's clinical judgement). Additional inclusion criteria were that the client must score 15 or above on the CORE-OM and 16 or above on the BDI-II.

The exclusion criteria were chosen firstly for reasons of client safety. It was considered that clients in those categories would likely find the sixteen-session time limit inadequate for addressing their problems.  A second issue related to safety and therapist competence.  Many TA therapists have little or no training or experience working with these client groups and thus from an ethical perspective it was recognised that specialist services would be needed to provide safe, effective therapy. Yet another reason for applying these exclusion criteria was that these problems would present confounding variables that might complicate interpretation of the data gathered, potentially limiting the conclusions that might be drawn from each case (this is particularly the case for the use of anti-depressant medication).

The inclusion criteria were selected to ensure that the clients were clearly and identifiably suffering from depression, thus ensuring a coherent and clearly defined client group for research. This was considered important for the purposes of drawing conclusions from the case series as a whole and for enhancing the internal validity of the study. The 'minimum criteria' on CORE-OM and BDI-II were selected to ensure that participating clients' scores fell well within the clinical range and could not be attributed to transient mood fluctuations or other measurement error. An additional reason for this level was so that clinically significant improvement would meet reliable change criteria (Jacobson and Truax, 1991). The meeting of reliable and clinically significant change criteria would therefore increase the degree of confidence in statements relating to clinically significant improvement.

As the study intended to investigate routine practice within typical client groups, these criteria were chosen to permit accurate testing of the research questions while still allowing for reasonable variation in client presentation.

### 4.3.5. Participants[11]

The study recruited five supervisors, five therapists and five clients. These are listed in table 4.2. The research focused on the work conducted by the therapist-client dyads. The role of the supervisors within the research was limited to monitoring treatment integrity, adherence and competence checking.

**Table 4.2. Participants**

| Therapist | Client |
|-----------|--------|
| Mark [12] | Peter |
| David | Denise |
| Julie | Tom |
| Michelle | Linda |
| Christine | Kerry |

All participants were of White British ethnicity, with age range from late-twenties to mid-fifties. Two of the therapists were male and three female. Two of the clients were male, and three were female. The participating therapists and clients were from five

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[11] Details of the analysis team participants and judges will be described below in the section on the case analysis method.
[12] The therapists and clients in this study have all been given a pseudonym, with the exception of 'Mark', who is the researcher and one of the therapists in this study.

different geographical locations within the UK[13]. Four of the therapists were working in private practice, and one therapist (Michelle) was based in a low-cost voluntary agency. More detail about the participants will be included in each of the case studies.

## 4.3.6. Post-Recruitment Protocol

### 4.3.6.1. Intake Interview

Clients eligible and willing to participate in the study were instructed to make their own arrangements with the therapist for an intake interview. When arranging the intake interview, the therapists checked that the client had read the information pack and asked the clients if they had any concerns or queries about the research and, again, if they were still willing to participate.

The therapists were provided with a structured intake interview schedule for completion at the intake interview, but were advised to adapt it in order that it resembled their usual intake procedure as closely as possible. It was recommended that the therapists conduct their usual intake procedure for diagnosing the client and assessing his or her suitability to engage in therapy. This interview lasted for one hour, and it was again emphasised to clients that participation in the research was optional. Towards the end of this meeting, clients were verbally advised that all sessions would be audio recorded. They were given an informed consent form to read, sign and return to the therapist at the first session. Clients were given the 'How to Get the Most Out of Therapy' information leaflet. Clients were also asked to complete the following questionnaires:

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[13] Training days were held at three different locations in the UK- participating therapists attended the one closest to where they lived.

- Beck Depression Inventory-II

- CORE-OM

- Personal Questionnaire (completed collaboratively with the therapist)

During the initial session the client was invited to describe and list the main presenting problems they were seeking to address in therapy. Each of the problems which the client listed were recorded as items on the PQ. The therapist asked the client to estimate the duration of each problem they had listed in the PQ (This provided an estimate of the stability of each the client's problems). These problems then formed the items for the PQ form and were stated either in the client's own words, or in a paraphrased summary of each presenting problem. Each problem was then rated by the client using the seven-point scale to indicate how much it had bothered them over the past week.

Standard TA therapy practice involves the construction of clear goals and contracts for therapy, which are generally related to the client's presenting problems (Stewart, 2007). The therapists were requested to note any contract goals that had been negotiated with the client on the contract goals completion form as soon as specific goals had been agreed.

All appointments for subsequent therapy sessions were made directly between the therapists and their clients. The therapists advised the clients of their policies regarding fees, cancellations and so forth as per their usual procedures.

The therapists were advised to remind the client that the sessions would be audio recorded, and to review the consent forms verbally with the client. The consent forms

included an item relating to audio recordings. In the case of consent for audio recordings not being given (as was the case with one client), the therapist was advised to proceed with the therapy, but without making recordings. The consent forms were signed and retained in the client's file. Files were securely stored in locked cabinets in line with the therapist's usual record storage procedures.

The remainder of the session was conducted following the therapist's normal procedures. This included his or her usual method of forming a TA diagnosis and treatment plan.

### 4.3.6.2. Subsequent Therapy Sessions

Prior to the start of each therapy session, the client was asked to complete the following questionnaires:

- CORE-10

- PQ

At the beginning of each session the therapists obtained verbal consent from the client for audio recording of the session, prior to switching on the recording equipment.

The therapist was advised wherever possible to proceed with 'therapy as usual'- working with their client in a way that was as close to their normal practice (although it was acknowledged that completion of sessional outcome measures might likely be a significant deviation from their usual practice).

At the end of each session the client completed the Helpful Aspects of Therapy (HAT) form, and the therapist completed the Structured Session Notes and the Therapist Self-Scoring Adherence Form.

### 4.3.6.3. Working Alliance Inventory Procedure - End of Sessions 1, 3 and 6

At the end of sessions 1, 3 and 6, the client was given a copy of the Working Alliance Inventory (short form- client version) and was asked to complete it and immediately place it in a dated envelope, clearly marked with the client's code. This was done without showing the therapist the client's responses. The envelope was sealed by the client and given to the therapist who placed it in with the client's notes. The therapist also completed the Working Alliance Inventory (short form- therapist version), which was placed in a dated and sealed envelope and kept in the client's notes.

### 4.3.6.4. Supervision Arrangements

Each therapist was regularly supervised by their clinical supervisor, a process that included their work with research clients. Each supervision session was between 30 and 60 minutes long and at a frequency of no less than once a month, or every four sessions, whichever was sooner.  It was advised that wherever possible, the supervisor should listen to an audio extract of between five and fifteen minutes in duration of at least one therapy session.  At the end of each supervision session, the supervisor completed the Supervisor's Adherence Checklist relating to their supervisee's delivery of therapy with their research client. These forms were then posted to the researcher, and stored securely along with the file for each participating therapist.

### 4.3.6.5. Additional Consultative Support for Participating Therapists

Participating therapists had monthly telephone contact with the researcher to provide the therapist with additional support (after the initial interview with the client had taken place and throughout the therapy programme).  This support focused exclusively on their participation in the research and to check that the therapists were following the research procedures.

### 4.3.6.6. End of Therapy

Immediately prior to the final session, each client completed the BDI-II, CORE-OM and PQ. His or her therapist calculated the scores and discussed progress with the client. At the end of the session, the client completed a HAT form and the therapist completed both the adherence form and the structured notes as usual.

Therapists were asked to be mindful of, and attentive to issues relating to termination throughout the therapy. The therapy was conducted for a maximum of sixteen sessions. One client terminated therapy at session nine, and another client terminated therapy at session thirteen. A further client had two 30 minute 'maintenance' sessions during the follow-up period to check in with their therapist about their progress.

The therapists were advised to ensure that appropriate onward referral would be made in the event that a need for additional therapy beyond the allocated sixteen weeks was felt necessary. In the event, none of the clients in the study were referred for further therapy.

At the termination of therapy, the therapist obtained the client's consent to pass on their contact details to the researcher. They then advised the client that he or she

would be contacted within two weeks by the researcher to make arrangements for a follow-up interview. The client was once again asked to review and sign an informed consent form.

The therapist contacted the researcher to advise them that the client had concluded the therapy, and then arrangements were made both for passing the client notes and audio recordings of the sessions to the researcher and for the therapist and researcher to have a debriefing meeting.

### *4.3.6.7. Follow-Up Procedure*

The researcher contacted each participating client and a follow-up interview was arranged in the client's home town within one month of ending the therapy. The follow-up interview was conducted by the principal researcher in all but one of the cases (where the principal researcher was the therapist and where a research associate conducted the interview). Travel expenses up to £10 were reimbursed to clients attending the follow up interviews.

At the follow-up interview, the client completed the following questionnaires:

- BDI-II

- CORE-OM

- PQ

The interview then followed the procedures of the semi-structured Change Interview (Elliott, et al. 2001). The interviews were between 60 and 90 minutes in duration and were audio recorded. Audio recordings of the interviews were securely stored by the

researcher in a locked cabinet. The interviews were transcribed for the purposes of data analysis.

Each client was contacted by the researcher at three months and six months post-therapy. Clients completed the BDI-II, CORE-OM and PQ at these intervals and were asked to provide the researcher with any relevant information regarding their progress or any significant changes that had occurred during the follow up period. At each of these follow-up intervals clients were once again asked to complete an informed consent form.

**Figure 4.1. Research Protocol Flowchart**

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┌─────────────────────────────────────────────────────┐
│ Potential Client Contacts Participating Therapist    │
│                                                       │
│ Pre-Screening (telephone or at Initial appointment)  │
└─────────────────────────────────────────────────────┘
                        │
                        ▼
┌─────────────────────────────────────────────────────┐      ┌──────────────────────────────────────┐
│ Screening to involve checking for exclusion criteria │─────▶│ Exclusion Criteria Met                │
└─────────────────────────────────────────────────────┘      │                                        │
                        │                                     │ Client referred to alternative agency  │
                        ▼                                     │ (in cases where sufficient protection  │
┌─────────────────────────────────────────────────────┐      │ cannot be provided by the therapist)   │
│ Structured Intake Interview                           │      │ or offered 'therapy as usual' with the │
│                                                       │      │ therapist                              │
│    • CORE-OM                                          │      └──────────────────────────────────────┘
│    • BDI-II                                           │
│    • Personal Questionnaire (PQ)                      │
│    • Information sheet, consent forms                 │
│    • Getting the most out of therapy                 │
└─────────────────────────────────────────────────────┘
                        │
                        ▼
┌─────────────────────────────────────────────────────┐
│ Acceptance into Study                                 │
│                                                       │
│ CORE-OM & BDI-II & PQ including Contract Goals        │
│ Scale, problem duration at first session (if not     │
│ completed at intake)                                  │
└─────────────────────────────────────────────────────┘
                        │
                        ▼
┌─────────────────────────────────────────────────────┐      ┌──────────────────────────────────────┐
│ Therapy in blocks of 8 sessions                       │─────▶│           Each Session                │
└─────────────────────────────────────────────────────┘      │                                        │
                        │                                     │ Client          Therapist              │
                        ▼                                     │                                        │
┌─────────────────────────────────────────────────────┐      │ CORE-10         Structured Notes       │
│ Working Alliance Inventory (therapist and client      │      │                                        │
│ versions) at Sessions 1,3,6.                          │      │ PQ              Adherence Form         │
└─────────────────────────────────────────────────────┘      │                                        │
                        │                                     │ HAT                                     │
                        ▼                                     └──────────────────────────────────────┘
┌─────────────────────────────────────────────────────┐
│ BDI-II,  CORE-OM, PQ & HAT at Sessions 8,16  (or     │
│ final session if sooner)                              │
└─────────────────────────────────────────────────────┘
                        │
                        ▼
┌─────────────────────────────────────────────────────┐
│ Follow Up Interviews                                  │
│                                                       │
│ CORE-OM, BDI-II, PQ & Change Interview               │
└─────────────────────────────────────────────────────┘
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# Section Four: Ethical Issues

## 4.4.1. Introduction

McLeod (2010) identifies three main potential ethical problems in conducting case study research. These are: management of confidentiality, informed consent, and avoidance of exploitation or harm. These issues will be discussed in the following section, and specifically how they were managed in the present study.

## 4.4.2. Management of Confidentiality

Case study research presents particular difficulties with regards the ethical handling of confidentiality. In order for a case study to be appropriately contextualised and useful, large amounts of client details need to be presented. This level of specific client-related detail is far greater than would ever be reported in a 'large *n*' study and this might potentially reveal the client's identity by placing significant personal details (including details of the client's problems) in the public domain (McLeod, 2010).

Within the present study, the following precautions were taken to manage client confidentiality and protect client anonymity. Firstly, the therapists each chose a pseudonym for their client and all research documents refer to the client *only* using this pseudonym. The researcher was not made aware of the clients' names until the therapists had completed the cases, repeated the informed consent procedure and had gained explicit consent from the client to pass on their contact details to the researcher.

Each therapist's identity has been disguised (with the exception of the case in which the client was seen by the researcher). This was felt necessary for two reasons; firstly,

to protect therapists from potentially problematic or even shaming exposure of their work (particularly in poor outcome cases) and secondly, to protect client confidentiality. Associates of a client may be aware of the identity of the client's therapist and may therefore infer the identity of the client through deductive disclosure (Bond, 2004).

Sieck (2012) notes that therapists writing case reports that they know the client will ultimately read, may well (consciously or unconsciously) omit certain details or be more circumspect about what they write, thus potentially compromising the validity of the case report. In the present study, the case record was written by the researcher rather than the therapist (with the exception of the case of 'Peter'). Regarding the issue of concealing client identity in case studies, Sieck (2012) argues that *'creating an appropriately disguised case study requires a complex balancing act between concealing a client's identity for privacy purposes and presenting an accurate portrayal of the client and case. For instance, if a fictitious descriptor is added to a case study to further conceal a client, readers may interpret the characterization as a key component of the client's identity and the psychotherapist's treatment, thereby threatening the validity of the presentation'* (p.8). She recommends *'that it is often sufficient to change easily identifiable demographic variables (such as geographical location and unique physical characteristics), whereas multicultural variables (which are often key to the client's unique context) such as gender, ethnicity, and sexual orientation should generally be unchanged. If a clinician emphasizes a client's internal experience, rather than external descriptors, it is more likely that the client will be unrecognizable to others'* (Sieck, 2012: 8).

Within the present study, careful attention was paid to the level of detail presented about the client in the composition of the rich case records. Some minor demographic details were changed in line with Sieck's (2012) recommendations, however the validity of the case description was preserved by ensuring that none of the essential cultural or 'internal' variables were deleted, compromised or distorted. By necessity, this process is somewhat subjective, although the final descriptions were member-checked with both the participating therapists and the clients.

All client files, case notes and audio recordings were stored in locked cabinets when not in use. All electronic files containing identifiable client data were kept in password-protected encrypted files. This is in line with the BACP's ethical guidelines for counselling and psychotherapy research (Bond, 2004).

### 4.4.3. Informed Consent

Informed consent has been defined as, '*a shared decision-making process in which the professional communicates sufficient information to the other individual so that she or he may make an informed decision about participation in the professional relationship*' (Barnett, Wise, Johnson-Greene and Bucky, 2007: 179). Barnett *et al*. go on to specify that ideally informed consent should not be a 'one-off' procedure, but rather something that is repeated at various stages throughout any course of therapy. They also state that it requires the client to possess the mental capacity to consent freely - a position which is firmly embedded in the TA literature on contracting and the need for competence to consent entering into a contract (Steiner, 1974). Gabbard (2000) makes the point that due to transferential issues that a client may well consent to participation in research (or to have details of their therapy published) without being

fully aware of the implications of their choice (or even without being fully aware of the unconscious aspects of their decision-making process). Sieck (2012) notes that the very act of holding the therapy open to scrutiny (by research and/or publication) will inevitably impact the therapeutic relationship in some way.

In this study, clients were given an information pack about the research at the point at which their therapists initially raised the possibility of participating in the research. This provided a detailed description of the study, including the purposes of the research, what the research procedures would be, who the research was organised and overseen by, procedures for complaints, limitations and arrangements regarding confidentiality, and potential risks and benefits of participation. Clients were given a written informed consent form at the first session, which they signed and retained a copy, and again at the end of the therapy. Verbal consent was obtained at each session for audio recording and clients were sent a copy of their rich case record for member checking and were invited to request any amendments at the end of the research. Clients were asked to confirm that they were happy with how accurately and fairly they had been portrayed in the record, and were also happy that their personal details had been sufficiently disguised to preserve their anonymity. Clients were also asked to sign another consent form agreeing that the rich case record could be used for the purposes of research and publication. Thus, informed consent and on-going process consent (Grafanaki, 1996; McLeod, 2010) were obtained throughout this study.

In relation to informed consent around confidentiality, all clients were made aware (both in the information pack and verbally by their therapist) that the therapist would be discussing their case in supervision. This included an assurance that no identifying

details would be discussed with their supervisor. The clients were also made aware (both in writing and verbally) that the researcher, specified research associates and the researcher's supervisors would have full access to their notes, completed questionnaires and audio recordings of sessions. No raw, identifiable data was seen by anyone other than the therapist for each case and the researcher.

It is of course possible that the clients might have failed to appreciate and understand fully what they were agreeing to, however, it is noteworthy that several clients decided not to participate in the study after reading the information pack. This suggests that the process was relatively transparent. The repeated use of informed consent procedures also added another safeguard in case concerns arose as the client developed a fuller appreciation and understanding of the nature and scope of the study over time. Multiple opportunities to withdraw from the research were therefore instituted. It was considered by the researcher and the research supervisors that this procedure was sufficient to ensure that a satisfactory level of informed consent had been achieved.

### 4.4.4. Protection from Harm or Exploitation

The study posed certain challenges in relation to the protection of clients and participating therapists from any harm or exploitation. This was largely addressed through the provision of detailed information about the project, provision of high levels of support from the researcher and provision of the extensive informed consent procedures described above.

Therapists were requested to remain alert for any signs of client deterioration during the therapy and were encouraged to discuss this in supervision. In cases where

continuation in the study was not deemed to be in the client's best interests, the therapists were advised to withdraw the client from the study and to consider onward referral to appropriate services, which may include medical or psychiatric services.

As part of the researcher's commitment to duty of care, clients were advised in the information pack and at follow-up that they would be able to contact the researcher for follow-up support should participation in the research result in emotional distress. This was offered to the clients for a period of five years after concluding their therapy (in the case of the researcher's client, arrangements were made for a different local therapist to provide this support, if needed).

Participating therapists were required to have supervision on their cases at least once a month. This is in line with standard procedure recommended by the United Kingdom Council for Psychotherapy. As the researcher was one of the therapists, additional consultation and supervision was sought to manage the dual role of therapist/ researcher.

The monitoring of therapist competence was integral to the design of the protocol. When therapy is being so closely monitored and evaluated, there is the potential for malpractice to be uncovered in a way that might not normally come to light. The therapists and supervisors all agreed to a procedure regarding handling of malpractice, which involved contacting the supervisor directly and the chair of ethics of the therapists' governing body. The therapists and clients were all advised that in the case of an emergency or where malpractice was revealed, that the therapist would be removed from the study and contact details of another therapist would be provided to the client. In such a case the researcher would take appropriate action to deal with

malpractice (for example, by initiating a discussion with the therapist's supervisor or by contacting the chair of ethics of their professional body). Within the research information pack, clients and therapists were made aware of the complaints procedures. This included contact details for the research supervisors.

All of the therapists were in personal therapy for the duration of their involvement in the research. Whilst this was not a requirement for participation in the study, it *was* a requirement that they must have access to personal therapy should the need arise. The participating therapists were encouraged to discuss their participation in the project with their therapist. This was to give them an opportunity to explore their motivation and reasons for participation, any concerns they may have about participation and to gain emotional support through the research process. The background to this suggestion came from the focus group study (Widdowson, 2012a). In the focus groups, participants stated that they felt it would be important to have a range of support if participating in research into their practice. Supervision and personal therapy were both identified as desirable sources of support (see Widdowson, 2012a).

It was recognised that within any study that places great scrutiny on a therapist's practice, there is considerable potential for the therapist to feel shamed or exposed (particularly in poor outcome cases). This possibility was discussed with the therapists in the briefing meetings. It was also acknowledged that it would be likely that the therapist may feel some anxiety about the research procedures and so they were invited to seek consultative support from both the researcher and their supervisor to manage this.

In a naturalistic therapy study, it is important that participating therapists behave in a way as similar as possible to normal practice, in order to capture the subtleties of 'therapy as usual'. Nevertheless, it is inevitable that the level of scrutiny that the therapy is exposed to must influence therapists' behaviour to some degree. Allied to this, the therapist's own allegiance to TA might potentially result in pressure to 'produce positive results', and perhaps work harder than they normally would. During the briefings it was stressed that other than the recording procedures and time limits, the therapy should be conducted as close to their usual style and protocol as possible. Supervisors were also requested to stay alert to this and to ensure that the therapy was indeed conducted as 'naturally' as possible.

Finally, in relation to ethics, it is important to note that prior to the commencement of the research that the project was approved by the University of Leicester Research Ethics Committee.

# Section Five: Composing Credible and Valid Systematic Case Studies

### 4.5.1. Writing-Up the 'Rich Case Records'

Once the completed case files had been handed to the researcher, the case materials were reviewed and the researcher composed a case study. This case study included a brief description of the client, including relevant background details and history, presenting problems and diagnostic data (TA and DSM-IV) based on the initial intake interview forms. A session-by-session case narrative was compiled based on the therapist's structured session notes. The narrative included the main themes discussed in the session, the therapist's interventions and theoretical analysis of the session and/or case. Three sample audio recordings of sessions taken from each case were randomly selected to check that the therapist's notes were a reasonable and accurate representation of the content of the session. The sections selected for checking were each approximately twenty minutes long.

### *4.5.1.1. Credibility Checks: Member Checking Procedure*

Once completed, the therapy narratives were returned to the therapists for checking, in order to seek verification that the narrative represented a true account of the therapy. The therapists advised the researcher of any amendments needed. Any amended documentation was resubmitted for verification.

Following this, the Change Interview transcripts were analysed and data was grouped according to area of focus. The areas of focus were:

- Summary of client changes and ratings

- Helpful therapy processes

- Unhelpful therapy processes

- Difficult but potentially helpful therapy processes

- Incomplete aspects of therapy

- Helpful and hindering factors in the client's life situation

- Client's personal strengths (motivation to change)

- Helpful and unhelpful aspects of participating in the research

Some client responses related to more than one area of focus. Where this was the case, the response was listed in each area.

The rich case record was then sent to each client for him or her to verify that it constituted a true and accurate account of the therapy and interview data. Clients were invited to specify any changes they wanted the researcher to make to the rich case record, and the documents were changed accordingly and then sent to the client again for checking. Once this process was completed, the client completed an informed consent form indicating that they were satisfied with the document and that they gave their consent for the materials to be used for the purposes of the research and to be made publically available.

### 4.5.1.2. Credibility Checks: Adherence

At the end of each session, the therapists completed a self-report adherence form. In compiling the rich case records, the researcher checked these forms against the therapist's session notes for consistency. The supervisors also completed an adherence

form at the end of each supervision session with the therapists. This was returned

directly to the researcher.

# Section Six: Data Analysis

### 4.6.1. Hermeneutic Single-Case Efficacy Design[14]

As discussed in the literature review, for many years, psychotherapy research has been dominated by Randomised Controlled Trials (RCTs), which have been used to test claims made regarding the efficacy of different psychological therapies. Whilst such trials have provided compelling evidence regarding outcomes of therapy and at demonstrating that psychotherapy is an effective treatment for psychological problems, the tightly controlled conditions within which they have been conducted has been criticised as bearing little resemblance to the realities of the consulting room of most therapists. Furthermore, these studies have not been able to adequately capture the complexity of the client as an individual and his or her experience of therapy, and so have also been criticised as being 'causally empty' (Elliott, 2002) in that they have often not been able to provide detailed description as to how the clients changes have come about. Historically, case study research has been dismissed as unscientific, biased and as simply 'anecdotal evidence' (McLeod, 2010). Recent developments in case study research have begun to address these criticisms by putting forward systematic and robust methods for presenting case study research (Bohart, Berry and Wicks, 2011; Elliott, 2001, 2002; Fishman, 1999; Iwakabe and Gazzola, 2009; McLeod, 2010; Miller, 2004).

Elliott's Hermeneutic Single-Case Efficacy Design (HSCED) (Elliott, 2001, 2002) is an approach to case study research which is procedurally-defined and systematically

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[14] Large parts of this section where the HSCED method is described have been taken from the following published articles; Widdowson (2012b, 2012c, 2012d)

incorporates the critical-reflective cross-examination of both qualitative and quantitative data to develop a detailed and plausible argument that a client has changed as a result of therapy (Elliott, 2002; Stephen and Elliott, 2011). Furthermore, HSCED also involves good-faith attempts to developing plausible alternative explanations for the client's changes. Both arguments are critically evaluated and subjected to a quasi-legal interrogation, and judges are invited to make their verdict about the outcome of the case. Within HSCED, the research questions being investigated are;

*'Did the client change substantially over the course of therapy? Is this change substantially due to the effect of the therapy? What factors (including mediator and moderator variables) may be responsible for the change?'* (Stephen and Elliott, 2011; 231).

Within this present study, the judges were asked an additional question which was to provide a verdict classifying the outcome of the case as either good outcome, mixed outcome, or poor outcome.

As HSCED is a systematic case study approach (Iwakabe and Gazzola, 2009; McLeod, 2010), *'data (is) . . . gathered from multiple sources, such as questionnaires, therapist and observer ratings, and participant interviews, to construct a rich and comprehensive account or case summary, which is then triangulated in order to examine whether different sources of data converge.'* (Iwakabe and Gazzola, 2009: 602-3).

HSCED was initially developed as a practitioner-researcher model (McLeod, 1999) of research inquiry that would be accessible to single researchers, therapists and trainees wishing to systematically investigate cases for the purposes of research (Elliott, 2002;

Stephen and Elliott, 2011). As HSCED has developed, the analysis and cross-examination of evidence is now generally done by a team of researchers and the deliberations of the research team are sent to independent adjudicators who are '*invited to evaluate the evidence presented by the affirmative and sceptic teams and to give their opinions on the central research questions of client change and the causal role of the therapy in that change*' (Stephen and Elliott, 2011: 232).

The credibility of psychotherapy research can be undermined by the potential for researcher bias; researchers who have a particular allegiance to one type of therapy may inadvertently present a positive bias towards that therapy in their findings. In the present study, this has been addressed by inviting independent psychotherapy researchers (from non-TA therapeutic approaches) to adjudicate and draw expert conclusions regarding the outcome of the case.

The HSCED process involves the development of 'affirmative and sceptic arguments' and a cross-examination of the evidence of the case by independent psychotherapy researchers acting as judges to determine the outcome of the case, the salient features of the therapy which contributed to the client's changes and to explore alternative conclusions and possibilities regarding the process and outcome of the case. '*We argue that at the heart of the adjudicated case study approach is the requirement to test or "cross-examine" the evidence. The proposition is that if an alternative interpretation of the evidence is experienced as plausible by the judges or jurors, then the likelihood that the claim is valid must be diminished*' (Stephen and Elliott, 2011; 234). The use of independent psychotherapy researchers – researchers who use a different theoretical approach to the one being investigated - in the

adjudication process helps to reduce the risk of researcher allegiance and bias influencing the findings of the research and contributes to the robustness and also the impartiality of the conclusions.

HSCED does not involve statistical analysis of significance on a case-by-case basis, but instead uses principles drawn from the legal tradition to guide the process of forming a verdict. Using this quasi-legal framework, the standard of proof required has been heuristically established as somewhere between *'beyond reasonable doubt'* (equivalent to a 95% probability) and *'balance of probabilities'* (equivalent to >50% probability) at *'clear and convincing evidence'* (being equivalent to 80% probability) (Stephen and Elliott, 2011:237-238).

### 4.6.2. HSCED Data Analysis Procedure

Within the present study, the rich case records were compiled, and then four of the cases were submitted to analysis teams who developed the affirmative and sceptic arguments. The cases were analysed on completion of each case.

### *4.6.2.1. Participants- Analysis Teams*

The analysis team for the HSCED of Peter's case was comprised of three TA therapists and the researcher. The analysis team members were each known to the researcher and were invited to participate in this process on the qualifying basis of possession of applied analytical skills. All three members of the analysis team were experienced TA therapists possessing degrees in counselling or psychotherapy. Two members were Certified Transactional Analysts. The analysis team were given selected readings (Elliott, 2002; Elliott, et al., 2009) to familiarise them with the method, and were sent a

copy of the rich case record. Each member of the analysis team participated in developing both the affirmative and sceptic cases.

Following feedback from members of the analysis team from the case of Peter, the process was adapted for the remaining three HSCED cases.

The analysis team who generated the affirmative and sceptic arguments for the cases of Denise, Tom and Linda was comprised of seven students in training for the Certified Transactional Analyst (Psychotherapy) qualification, who had attended a two-day case study research analysis workshop. All post-foundation year trainees at the training institute involved were sent an e-mail invitation to attend and eventual participants were self-selecting. The workshop was intended to provide experiential learning of case study research analysis and was co-facilitated by the principal researcher alongside a Certified Transactional Analyst (Psychotherapy) who was known to the researcher and who had participated in the analysis of the case of 'Peter'. Participants had been sent copies of the rich case records, plus an article describing the HSCED method one week prior to the workshop. The workshop commenced with a one-hour presentation on the HSCED method, following which students read the rich case record and then were split into two groups: one group formed the affirmative case, and the second group formed the sceptic case. Each group was facilitated by one of the co-facilitators who assisted the group members in developing their arguments and lasted for two hours. The arguments were audio recorded and the facilitators also collated these on paper.

### 4.6.2.2. Participants- Judges

In all of the HSCED cases, independent judges were recruited to adjudicate and provide a verdict on the outcome of the cases. Judges were selected on the basis that they were therapists from another modality, with either experience of conducting an HSCED investigation or experience of conducting case study research. The judges were recommended to the author by Robert Elliott, the originator of the HSCED approach. None of the remaining judges were previously known to the researcher (with the exception of one judge (a research student from Leicester University).

### 4.6.3. Developing the Affirmative and Sceptic Cases and Rebuttals

The analysis teams then constructed the affirmative and sceptic cases using the following procedural guidelines:

### 4.6.3.1. Affirmative Case

The affirmative case was built by identifying positive and convincing evidence of client change as a result of therapy.  Elliott's (2002) guidance on HSCED procedure specifies that in order to make a convincing case that the client changed positively and that these changes were a result of therapy, the affirmative case must be built by identifying evidence for at least two of the following:

1. *Changes in stable problems: client experiences changes in long-standing problems*

2. *Retrospective attribution: client attributes therapy as being the primary cause of their changes*

3. *Outcome to process mapping: 'Content of the post-therapy qualitative or quantitative changes plausibly matches specific events, aspects, or processes within therapy' (Elliott et. al, 2009; 548)*

4. *Event-shift sequences: links between 'client reliable gains' in the PQ scores and 'significant within therapy' events*

### 4.6.3.2. Sceptic Case

The sceptic case was built on the development of a 'good-faith' argument formed to cast doubt on the affirmative case that the client changed and that these changes are attributable to therapy. It does this by examining the rich case record, identifying flaws in the affirmative argument and presenting alternative explanations that could account for all or most of the change reported. Evidence is collected to support eight possible non-therapy explanations. These are:

1. *Apparent changes are negative or irrelevant*

2. *Apparent changes are due to measurement or other statistical error*

3. *Apparent changes are due to relational factors (the client feeling appreciative of, or expressing their liking of the therapist or an attempt to please the therapist or researcher)*

4. *Apparent changes are due to the client conforming to cultural or personal expectancies of change in therapy*

5. *Improvement is due to resolution of a temporary state of distress or natural recovery*

6. *Improvement is due to extra-therapy factors (such as change in job or personal relationships etc.)*

7. *Improvement is due to biological factors (such as medication or herbal remedies)*

8. *Improvement is due to effects of being in the research*

### 4.6.3.3. Rebuttals

Following the quasi-legal method of cross-examination of arguments, the affirmative team examined the sceptic argument and responded to their critique by providing a counter-argument rebuttal, drawing on the data within the case as evidence. The affirmative rebuttals were then analysed by the sceptic team, who in turn provided a counter-argument designed to cast doubt on the validity of the affirmative team's claims. Thus, both the affirmative and sceptic claims had been presented, critiqued and defended in order to provide a detailed and balanced argument.

### 4.6.3.4 Adjudication Procedure

The complete rich case record, the affirmative cases, sceptic cases and rebuttals were all sent to the independent judges for adjudication. The judges were asked to examine the evidence and provide a verdict: good outcome case, mixed outcome case or poor outcome case. Judges were also asked to express their perceptions of client change, of changes attributable to therapy, and to indicate which aspects of the affirmative and sceptic arguments had informed their position. Finally, the judges were asked to comment on those factors in the therapy that they believed to have been helpful and those characteristics about the client that they believed contributed to the changes (moderator (therapy) and mediator (client) factors).

The judges presented their conclusions regarding the case on a pro-forma, using the following questions to guide and structure their responses;

*1.     To what extent did the client change over the course of therapy? (rated on a scale of 0-100% at 20-point intervals)*

*1a.    How certain are you? (rated on a scale of 0-100% at 20-point intervals)*

*1b.    What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion?  How did you make use of this evidence?*

*2.     To what extent is this change due to the therapy? (rated on a scale of 0-100% at 20-point intervals)*

*2a.    How certain are you?  (rated on a scale of 0-100% at 20-point intervals)*

*2b.    What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?*

*3.     Which therapy processes do you feel were helpful to the client?*

*4.     Which characteristics and/or personal resources of the client do you feel enabled her to make best use of her therapy?*

(Stephen, Elliott and Macleod, 2011)

The judges' responses were returned and collated by the researcher. Their verdicts were compiled together in a written commentary. The overall verdict of the outcome of the case was based on an average verdict of the judges, where possible relying on majority swing in verdict.

Out of the five available cases, four were subjected to the HSCED procedure. The remaining case was not put forward for HSCED as it was determined by the researcher that the outcome of the case was clearly a poor outcome case and that there was no advantage to conducting the HSCED procedure on this case (see results chapter, case five).

### 4.6.4. Existing Approaches to Cross-Case Analysis

Although case studies have been used within the field of psychotherapy research, there have been very few attempts to conduct cross-case analyses (Iwakabe and Gazzola, 2009). Within the broader psychotherapy literature, cross-case analyses were conducted by Strupp (1980a, b, c, d) which examined factors relating to outcome in good and poor outcome cases and the comparison of Dialectical-Behaviour Therapy and Emotion Focused Therapy in a recent issue of *Pragmatic Case Studies in Psychotherapy* (Burckell and McMain, 2011; Goldman, Watson and Greenberg, 2011; Watson, Goldman and Greenberg, 2011). Within the TA literature, a recent article by McLeod (2013a) conducted a cross-case analysis of three cases of TA therapy for people with long-term health conditions. Within these previous examples of cross-case analysis, it appears that there has been no systematic attempt to follow a set procedure, or systematise the cross-case analysis process and that the analysis has simply looked at potential variables that may be linked to overall outcome of the cases (Iwakabe, 2011). Furthermore, these cross-case analyses have not been substantively linked to theoretical constructs or linked to theory-building operations. It was the intention in the present study to address this by developing the cross-case analysis method and generating findings and practice principles which were firmly located

within TA theory and related to existing therapy process factors. The exception to this is the case series by Watson, Goldman and Greenberg (2007) which compared cases to identify potential factors involved in differential response to treatment and located these within the theoretical framework of Emotion-Focused Therapy.  In both the Watson *et al.* (2007) and the present case series, common themes, similarities and differences between cases were all noted. In this sense, both case series represent a form of meta-synthesis of single-case studies (Iwakabe and Gazzola, 2009).

### 4.6.5. Pluralistic Qualitative Data Analysis in Single and Cross-Case Analysis

The pragmatic and pluralistic approach outlined above was used to analyse the qualitative data generated by this research study. A cross-case analysis (see section 4.6.6. and chapter 6) was used to blend procedures from a number of qualitative methods. As most qualitative methods are considered to have a shared philosophical basis (Elliott and Timulak, 2005; McLeod, 2011) the approaches were seen to be mutually supportive, each focusing on non-overlapping areas of inquiry. The approach combined elements of grounded theory (Strauss and Corbin, 1990) and Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin, 2009). The iterative process of 'constant comparison' was taken from grounded theory (Strauss and Corbin, 1990) to identify themes and trends and idiosyncratic features within each case and across cases, and to examine evidence which supported the theory-building intention by confirming or disconfirming theory. However, the method did not extend to the grounded theory purpose of abstraction of core categories, but instead was focused on generating practice-based knowledge and principles. At this point, aspects of IPA were integrated into the data analysis process.  A feature of IPA is the use of

psychological constructs or theory to interpret interview data (Smith, et al., 2009; McLeod, 2011). Within this present study, TA was used as the primary interpretative framework.  The method of IPA begins with the researcher reading and re-reading transcript material to become immersed in the data and the informant's lived experience. Transcripts are annotated for points of interest, in particular those relating to descriptive comments, linguistic comments and conceptual comments. Themes are identified from the comments, and are compared to identify connections between emergent themes. The themes are then interpreted using psychological concepts of theories (McLeod, 2011; Smith, Flowers and Larkin, 2009). Finally, principles of narrative reconstruction (Smith and Osborn, 2003), again, taken from IPA were used to analyse the cases to generate a 'master sequence', using both generic therapy language and the specific language of TA.

### 4.6.6. Logical Operations in Data Analysis: Inductive and Abductive Reasoning

As stated above, the cross-case analysis involved an iterative process of constant comparison to analyse the case studies. The use of constant comparison method facilitated the identification of similarities and differences between cases. This process was done both at the case-by-case level, and also using groupings of cases. The cases were grouped according to outcome; good outcome, mixed outcome and poor outcome. The primary logical operation at the single-case level was inductive reasoning however the cross-case analysis incorporated aspects of both inductive and abductive reasoning.

Within the present study, the use of Hermeneutic Single-Case Efficacy Design was used to examine data in order to abstract phenomena in individual cases. Data were

analysed using a series of competing explanatory theories. That is, the evidence forwarded for the affirmative and sceptic cases was used to examine and evaluate these explanations to determine the best possible model for the observed change. At the level of individual case analysis, these explanatory theories were evaluated by the adjudication panel. These conclusions were then subjected to analysis of competing theories by the judges. For the cross-case analysis the use of the constant comparison method and induction was used to identify similarities and differences between cases. This process suggested potential mechanisms of action. From these, principles of practice were inferred. These were interpreted and conceptualised using existing cognitive and theoretical frameworks relating to psychotherapy process and outcome by the researcher and adjudicators.

This method is also consistent with the heuristic principle of Occam's razor, which considers the best theory to be the one which is most parsimonious and which uses the simplest explanation which comprehensively accounts for any given phenomena. Occam's razor does not necessarily require that explanations be simple and proscribe complexity, rather it encourages the generation of theory which is of sufficient depth to explain the phenomena without recourse to complex explanations. With Occam's' razor, theories do not have to be accurate, but are required to be the best available explanation at the present time. This principle is also of direct relevance to TA psychotherapy; Berne (1972) was a strong advocate of Occam's razor and encouraged transactional analysts to use this principle in generating their theories.

# Chapter Five: Results- The Case Studies

*This chapter presents the five case studies in this series. The case studies are based on the 'rich case records' and include interpretive representations of the 'voices' of the client, therapist, researcher, analysis teams and judges*

# Case One: Peter[15]

## 5.1.1. Client Description[16]

Peter was a 28 year old man who lived alone. At the time of entering therapy he was single, and had been unemployed ever since being made redundant two years previously. Peter had been educated to degree level. He had been diagnosed with depression by a psychiatrist five years earlier, and was not on medication, although he had previously had some therapy, which had been unsuccessful. Although he reported having a number of friends and acquaintances, he presented as being fairly socially isolated, seeing people infrequently. Peter had been bullied throughout school and had felt dominated through his childhood and into his adult life by his strict and highly critical father. His mother had been seriously ill for much of Peter's childhood and his only memories of her are of her being ill. Peter's mother died when he was a teenager and he recalled being in shock immediately following his mother's death and being told by various family members that he 'had to be strong and be a man now'. Consequently he has no recollection of any grieving.

He presented for therapy being aware of holding many buried feelings which he felt sure were driving his depression, but feeling unable to access them and feeling

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[15] This case has been published in Widdowson, M. (2012b). TA Treatment of Depression- A Hermeneutic Single-Case Efficacy Design Study- Peter. *International Journal of Transactional Analysis Research,* 3(1): 3-13.  The complete rich case record, including the affirmative and sceptic arguments and the judges forms are included as appendices in the same journal edition

[16] In each case, the client description was initially written and provided by the therapist. Any additions by the researcher were taken from the notes the therapist made at the client's initial interview.

disconnected from feelings in general other than a sense of sadness, despair and hopelessness.

Peter was an intelligent, reflective and articulate young man with evidence of strong psychological mindedness with clear and realistic expectations regarding the process of therapy. He appeared motivated to change, and had sought out therapy independently, doing quite careful research to find a therapist in private practice who he felt would have the necessary skills and experience to help him.

When Peter came for his initial appointment, the therapist's assessment identified that Peter was eligible to participate in the study (meeting DSM-IV criteria for Major Depressive Disorder, and with a CORE score of over 15 and a Beck Depression Inventory-II score of over 16) and that he did not meet any of the exclusion criteria. He was seen in a naturalistic therapy protocol in private practice. The research covered a period of sixteen sessions, although Peter attended two maintenance sessions after the research period to consolidate and develop his gains.

## 5.1.2. Therapist[17]

The researcher, a white British male was the therapist in this case (hereafter referred to in this case as 'the therapist'). The therapist is an experienced TA psychotherapist with many years of experience. Using a practitioner-researcher model (McLeod, 1999), the therapist engaged in both therapy and research activities in relation to this case, and this had been made transparent to Peter before, during and after the therapy. The therapist developed the rich case record and participated in developing the affirmative

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[17] The therapist in this case was also the researcher. The change interview was conducted by a research associate and the case record was audited by the research supervisors.

and sceptic cases, as well as contacting and requesting the participation of the judges.

The therapist was supervised on this case by an experienced Teaching and Supervising

Transactional Analyst on a monthly basis. Adherence measures were completed by

both the therapist and supervisor at regular intervals and were consistently scored as

'good' to 'excellent'.

### 5.1.3. Description of the Therapy Process

#### *5.1.3.1. Generic Description of the Therapy Process[18]*

Peter's therapy began with an initial phase of alliance formation, problem formulation,

and assessment using TA theory. This phase concluded with contracting for his overall

therapy goals in session three.

The early stage of therapy (up to session eight) primarily involved identifying Peter's

key internal processes, ways of interpreting the world and identifying and expressing

his feelings. Critical life events which had shaped the formation of Peter's cognitive-

affective and relational patterns were identified, explored and re-evaluated and he

was encouraged to express his emotions around these events and generate new

meaning.

The latter half of the therapy focused on Peter's interpersonal patterns and how these

had reinforced his maladaptive cognitive-affective patterns and on promoting

interpersonal change. In engaging with this interpersonal change process, Peter re-

evaluated his self-critical internal dialogue and effected changes to his self-concept.

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[18] In each case, the generic description of the therapy process is the researcher's analysis of the therapy process based on the therapist's notes. This is followed by a description which the researcher has interpreted from the client's qualitative data.

There was a two-week gap between sessions twelve and thirteen due to the therapist being ill. Peter experienced some decline during this period. The final session was spent reviewing Peter's changes and his experience of therapy.

Overall, his therapy involved the promotion of a sense of hope. The therapist's emotional engagement with him provided him with opportunities for experimenting with new ways of relating and live feedback on these interpersonal experiments.

### 5.1.3.2. Process of Therapy- Interpreted from Client HAT Forms and Change Interview

It appears that the formation of an empathic, genuine and accepting relationship enabled Peter to explore past events and the emotions surrounding these events. This included accounting for previously repressed feelings and his maladaptive beliefs about self, others and the world which arose from these events and how these had shaped his interpersonal patterns which reinforced these maladaptive beliefs. These maladaptive patterns were explored and re-evaluated and new interpretations/ conclusions were formed.  This was followed by exploration of how Peter could change these interpersonal patterns and create new positive experiences.

### 5.1.3.3. TA Description of Therapy Process- Taken from Therapist's Notes

The early phase of the therapy (the first three sessions) focused on developing a working alliance and included information gathering, problem identification, history taking, clarifying and empathic responding.  These processes facilitated the construction of a TA diagnosis/ case formulation and included compiling a racket system, identifying key life script themes, ego state structural analysis (including identifying internal ego state dialogue), emotional literacy work and initial deconfusion

(identification and expression of repressed affect) by exploring painful life events.
Peter's feelings were normalised and contextualised and the therapist highlighted
central aspects of Peter's life script relating to expectations of others. This initial phase
also included some decontamination and the challenging of discounting and racket
beliefs and culminated in negotiation and agreement around the formulation and
contracting for overall therapy goals.

The second phase of the therapy consisted of exploring significant life events and
dealing with the emotional aspects of these and the script decisions that Peter made in
response to these events  (deconfusion/ redecision) and exploration of how these
continued to influence his inner world (ego state dialogue) and interpersonal world
(transactions, stroking patterns, games and script), together with behavioural
contracting to support his changes.

### 5.1.4. Results

#### *5.1.4.1. Quantitative Outcome Data*

Peter's quantitative outcome data can be seen in table 5.1.1. His pre-therapy scores
were all well within the clinical range, and substantially above the caseness cut-off for
inclusion in this research. Peter's clinical score at point of entry to therapy using CORE-
OM was 21.76, indicating moderate levels of distress and functional impairment and
his BDI-II score was 35, indicating severe depression. By the end of therapy, Peter had
achieved clinically significant change on CORE-OM and PQ (see figures 5.1.1 and 5.1.2),
and had achieved reliable change on the BDI-II. Peter's gains continued into the follow-
up period, and were maintained at levels of clinically significant change.

**Table 5.1.1. Peter's Quantitative Outcome Data**

| | Recovery cut-off | Inclusion cut-off | Reliable Change Index | Pre-Therapy | Session 8 | Session 16 | 1 month Follow-up | 3 month Follow-up | 6 month Follow-up |
|---|---|---|---|---|---|---|---|---|---|
| Beck Depression Inventory-II | 10 | 16 | 5.78 | **35** | **32** | **20(+)** | 10(++) | 13 | 8(++) |
| CORE-OM | 10 | 15 | 6.0 | **21.7** | **20.2** | 12.9(+) | 5.2(++) | 11.9 | 5 (++) |
| Personal Questionnaire (mean score) | 3.00 | 3.50 | 1.0 | **5.83** | **4.71(+)** | 2.71(++) | 2.57(++) | 2.28(++) | 2.21(++) |

*Note: Values in bold are within clinical range. + indicates Reliable Change, ++ indicates clinically significant change .*

**Figure 5.1.1. Weekly CORE Scores**
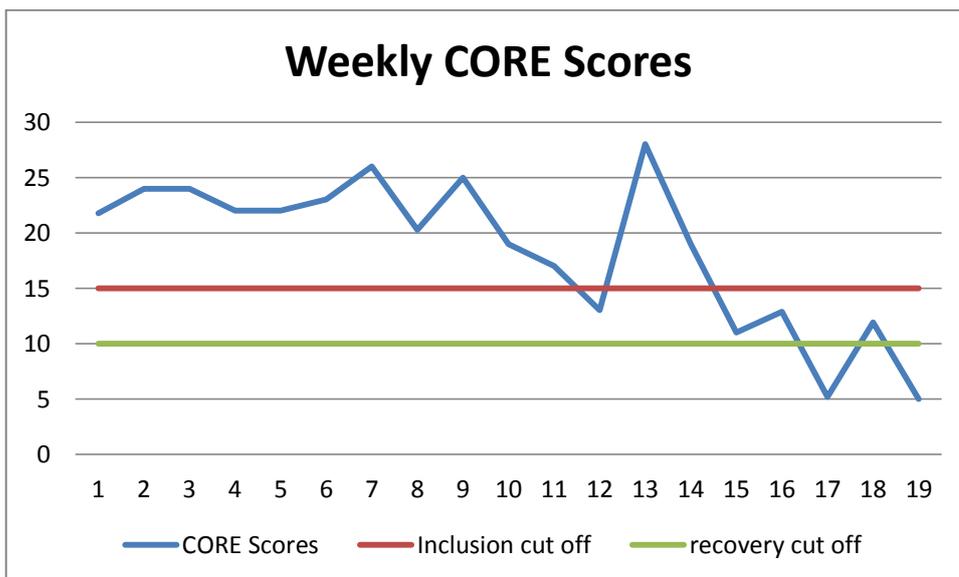


*Note: 17, 18 and 19 relate to scores from the three different follow-up periods*

**Figure 5.1.2. Weekly Mean PQ Scores**
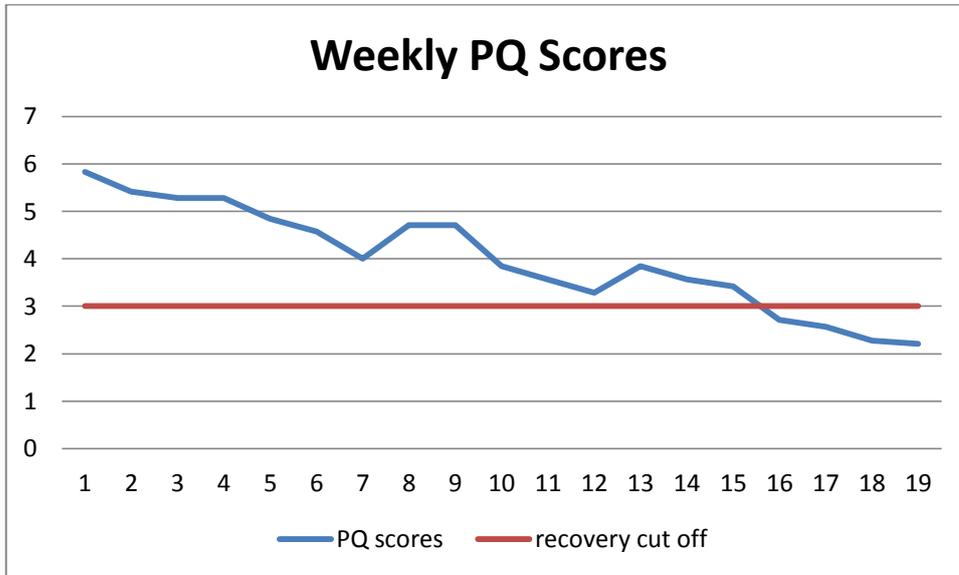


*Note: 17, 18 and 19 relate to scores from the three different follow-up periods*

*Table 5.1.2. Quantitative Process Data- Working Alliance Inventory*

The therapist and client both completed the short form Working Alliance Inventory at sessions 1, 3 and 6. Each item is rated on a six-point Likert scale, with higher scores indicating greater satisfaction. Data from this procedure is presented below.

| Session 1 | Client | Therapist |
|---|---|---|
| Mean Task | 5.25 | 6 |
| Mean Goals | 4.75 | 6.75 |
| Mean Bond | 5.25 | 6 |
| Overall Mean Score | 5.08 | 6.25 |
| Session 3 | | |
| Mean Task | 5.75 | 6.25 |
| Mean Goals | 6 | 6.75 |
| Mean Bond | 5.25 | 6.25 |
| Overall Mean Score | 5.66 | 6.41 |
| Session 6 | | |
| Mean Task | 5 | 6.25 |
| Mean Goals | 4.25 | 6 |
| Mean Bond | 5.25 | 6.5 |
| Overall Mean Score | 4.83 | 6.16 |
| Combined Mean Scores | | |
| Combined Mean Task | 5.3 | 6.16 |
| Combined Mean Goals | 5 | 6.5 |

| Combined Mean Bond | 5.25 | 6.25 |
| Combined Mean Score | 5.19 | 6.27 |

### 5.1.4.2. Qualitative Data

#### *5.1.4.2.1. Qualitative Process Data about Helpful Aspects of Therapy*

At the end of each therapy session, Peter completed the HAT form, indicating what had been helpful or hindering in the session. In each session he indicated at least one helpful event and no unhelpful or hindering events. Many of Peter's comments indicated the events he found most helpful were related to emotional processing, insights or new learning, for example;

In session 11, Peter said the most helpful part of the session had been *'Achieving the goal I had for the session- finding an experiential approach that will let me find a method of coping with emotions. It's inherently good, as it will be useful, and it's satisfying to achieve.'* (rated 9- 'extremely helpful') This appeared to correspond with the therapist's notes which indicated that the session had focused on deconfusion work- expressing and processing emotions.

In session 15,Peter and his therapist focused on identifying and addressing interpersonal problems and his HAT comments from the session were; '*Recognition of a deficiency in my interpersonal skills and the suggestion of a new approach. It gives me a way forward, to express myself with the confidence that I might be understood. An instant- "eureka!" '* (rated 9- 'extremely helpful)

### 5.1.4.2.2. Qualitative Outcome Data

In his follow-up Change Interview, Peter was asked to identify the main changes he felt had occurred during therapy. The changes are listed in table 5.1.3. He identified five changes; two of which related to changes in perspective from a negative, pessimistic outlook to a more balanced one and a similar change relating to the development of hope for the future.  Another change related to interpersonal changes, and the final change related to increased awareness of negative reinforcing patterns. He identified all five changes as both surprising and unlikely to have occurred without therapy. He identified two of these changes as 'extremely important', two as 'very important' and one as 'moderately important'.

**Table 5.1.3. Peter's Changes as Identified in Post-Therapy Change Interview**

| Change | How much expected/surprising change was [a] | How unlikely/likely change would have been without therapy [b] | Importance of change [c] |
|---|---|---|---|
| A shift in perspective from 'life is shit' to 'actually, maybe I'm not viewing things clearly' | 5 | 1 | 5 |
| Awareness of these reinforcing patterns and how I get into them | 5 | 1 | 4 |
| A sense of hope and possibilities for change | 5 | 1 | 3 |
| Starting to interpret things differently e.g. not expecting a fall, not expecting bad things to happen | 5 | 1 | 5 |
| Changes in how I feel in myself and in how I interact with others- interpersonal changes | 5 | 1 | 4 |

[a] The rating is on a scale from 1 to 5; 1= expected, 3= neither, 5= surprising

[b] The rating is on a scale from 1 to 5; 1=unlikely, 3=neither, 5=likely

[c] The rating is on a scale from 1 to 5; 1=slightly, 3 = moderately, 4=very, 5=extremely

### 5.1.4.3. Analysis of Change Interview Responses

For Peter, the increase in self-awareness was the main change for him during therapy

and was a catalyst for a series of other changes.

*C82: The things that have told me about myself and how I tick… I think that's probably been the most important one… and even the other things on the list like my interpersonal changes all of those fall under that fundamental change.*

*C83: If you know about yourself and can understand yourself, including the part of yourself that is depressed that allows you to make progress and to make changes… Before I came I was pretty blind to possibilities but I learned about myself.  That gave me the ability to see other ways of being, other ways of doing... It's like if you can't see something, can't perceive something it might as well not be there, you can't do anything about it.  As I learnt about myself, and that includes how my family impacts on me, all the things that make me tick.  I was then able to make changes*

He also described the relational ambience of the therapy as a comfortable and relaxed space and as one characterised by real human contact and emotional engagement.

*C87: It didn't feel clinical.  It didn't feel like [they were just] turning up for this time slot.*

*C89: Although [my therapist has been] incredibly professional in their interactions, it's not felt essentially as if I'm in a professional relationship… that I'm not having to guard myself and the rest of it and that's been very important.  Now, it has been intellectually… very professional and that the techniques etc. have all been professionally administered etc. but it's the subtext- the psychological subtext has been very different.  Because [my therapist and I] talked before about there being a message, in the underlying tone.  The message has always been professional the underlying tone has been, this is a building relationship.*

One interesting aspect of this quote is how Peter was referring to the 'psychological sub-text', which appears to indicate that he and his therapist were discussing 'ulterior transactions' as part of their exploration of communication and relationships. This suggests that Peter has integrated this concept, amongst other TA concepts which he now uses to understand both his own process as well as his interpersonal relationships.

### 5.1.5. HSCED Process

#### *5.1.5.1. Affirmative Case*

The affirmative case presented four lines of argument that Peter had changed substantially, and that these changes had been as a result of therapy. The first argument related to changes in long-standing problems- Peter identified five of his seven problems listed in his PQ had been of more than 10 years in duration. Peter achieved global reliable change on all outcome measures, and clinically significant change in two measures by the end of therapy, and clinically significant change on all three measures by the end of the follow-up period. Peter's retrospective attribution of the changes being unlikely to have come about without therapy from his post-therapy Change Interview was cited as another source of evidence. The affirmative case argued that Peter's comments in his HAT forms were consistent with TA therapy and the account of the therapy as described by the therapist and that direct and plausible correspondence was found between these events and the overall changes Peter identified in his Change Interview.

### 5.1.5.2. Sceptic Case

The sceptic case presented three main alternative arguments to the affirmative case. These were that although Peter had demonstrated improvement on quantitative outcome measures, his BDI-II scores were still within the clinical range at the end of therapy, as was one of his PQ scores. They also identified that in the three month follow-up, Peter reported deterioration on both CORE-OM and BDI-II scores to within clinical levels of distress, suggesting that Peter's changes had not been maintained. The sceptic case also considered that due to Peter's positive description of the therapy and the therapist in his Change Interview that it was possible that relational factors were influencing his report, and that despite his positive descriptions, he had not made any significant life changes during the course of therapy.

### 5.1.5.3. Affirmative Rebuttal

The affirmative rebuttal focused on the following arguments; that even though there had been some deterioration in Peter at the three-month follow-up, his PQ scores had shown improvement indicating that his problems had not returned. It was suggested that as all scores improved at the six month follow-up, that the deterioration represented a period of temporary distress and that it was possible that Peter had developed sufficient internal resources and had experienced sufficient personal change during the course of his therapy to enable him to overcome this period of distress effectively without experiencing relapse. Sceptic arguments of relational factors were countered by the affirmative rebuttal noting that the narrative of the case study suggests that at several points the client and therapist experienced difficulties and relationship ruptures which appeared to have been successfully resolved, and that

it is perhaps only to be expected that a client who had been through such rupture repairs would emphasise the relational skills of their therapist. Similarly, sceptic suggestions that the work was tinged by an overly positive glow were not supported by statements by the client that he felt he still had work to do, and felt that these statements added balance and credibility to claims that the therapy was effective and appropriate to the client's needs. Finally the affirmative rebuttal noted that even though Peter had not made any substantial life changes, that he had made a number of internal changes, and that his case included sufficient evidence of behavioural change. It was also noted that given Peter's circumstances (unemployment, being a part-time carer) that it was unrealistic to expect substantial life changes.

### 5.1.5.4. Sceptic Rebuttal

The sceptic rebuttal focused on the following argument; that at the end of therapy, the client experienced a temporary feeling of well-being, which arose from regular contact with his therapist, but did not exhibit any substantial shift in his relationships with other people, or in his everyday life on the whole. As a result, as the meetings with the therapist tailed off, his symptoms gradually returned. Furthermore, that although in the six month follow-up measurements Peter demonstrated an improvement in his scores from those at the three month follow-up, with reliable change occurring on his CORE scores, no further information is provided to account for either the increase in scores at the three month follow-up or the reduction in scores at the six month follow-up. The argument was put forward that this fluctuation may indicate that the impact of extra-therapy factors on Peter's symptoms is greater than has been indicated

previously, and/or that his symptoms are more reactive and responsive to external stressors than suggested in the case report.

## 5.1.6. Adjudication

Each judge independently produced their opinions and ratings of the case. Their individual conclusions are presented in table 5.1.4 below. A median score has been given to represent a balance of the two judge's conclusions. To summarise, the judges concluded that Peter had experienced clinically significant changes, although had not fully resolved all of his problems, and that these changes were substantially due to therapy.

### *5.1.6.1 Summary of Opinions Regarding How the Judges Categorised this Case*

The judges considered that data from the quantitative change measures (CORE, BDI-II and PQ) provided evidence of clinically significant changes in both client identified problems (PQ), global distress and functional impairment (CORE) and target symptoms (BDI-II). When paired with Peter's retrospective account from his Change Interview, this provided convincing evidence that positive change had taken place and was evidence to suggest this had been an effective therapy. They noted that Peter identified a number of problems of a long-standing nature which had achieved clinically significant change as indicated by PQ scores by the end of the therapy. Judge B commented that Peter had clearly had a significant experience and had '*gained a major increase in his self-awareness and self-understanding, he has experienced a genuine honest and accepting relationship in which difficulties have been discussed and survived. He appears to have maintained the progress that he achieved (as measured by CORE etc.) six months after the end of therapy. However he also recognised that*

*what he has gained in this therapy is a foundation for future work and identified further areas of his experience that he wished to explore.'* However, the judges noted that the evidence from the case indicated that Peter had not completely resolved all of his problems, and so were not able to state that the outcome was completely positive. The judges felt that if the pro forma instructions were taken literally, that the case appeared to be mixed outcome. Despite this, both judges clearly stated that on balance they felt that the therapy was successful and that this was a good outcome case.

### 5.1.6.2. Summary of Opinions Regarding the Extent to which the Client Changed

The judges concluded that Peter had changed considerably-substantially over the course of therapy, highlighting data from quantitative outcome measures and the Change Interview as providing convincing evidence that Peter had achieved clinically significant change. Judge A viewed the client's comments in his Change Interview as being wholly positive, which led her to be sceptical about the extent of his changes, although Judge B considered that Peter's Change Interview offered a more balanced perspective on his change process. Both judges commented that they would have liked more information on extra-therapy events and changes Peter had made.

Judge A commented that although Peter stated in both his HAT forms and the Change Interview that the therapy was helpful, he did not provide specific examples or details of the actual therapy processes which produced these changes, however she did concede that *'Perhaps it is unrealistic to expect that an individual who is not a therapist should, without any real prompting, be able to offer accurate, detail-rich and precise accounts of moments within therapy where change occurred'*

### 5.1.6.3. Summary of Opinions as to Whether the Changes were Due to Therapy

The judges noted that Peter appeared to be a motivated client with a readiness to engage which enabled him to make good use of the therapy. Both judges commented that motivation alone would be insufficient to produce change of this magnitude. One judge noted that as there were no significant changes in Peter's life during the course of therapy that it was '*logical to deduce… that therapy was the main agent of change*'. The second judge noted that '*the relational approach that the therapist adopted within this work was a significant factor in enabling Peter to participate fully and effectively in the therapy*'.

**Table 5.1.4. Adjudication Decisions**

| | Judge A | Judge B | Median |
|---|---|---|---|
| 1How would you categorise this case?<br>How certain are you? | | | |
| 1a Clearly good outcome (problem completely solved) | 40% | 60% | 50% |
| 1b Mixed Outcome (problem not completely solved) | 80% | 100% | 90% |
| 1c Negative/ Poor Outcome | 0% | 0% | 0% |
| 2 To what extent did the client change over the course of therapy? | 60%<br>Considerably | 80%<br>Substantially | 70%<br>Considerably-Substantially |
| 2a How certain are you? | 60% | 80% | 70% |
| 3 To what extent is this change due to therapy? | 80%<br>Substantially | 80%<br>Substantially | 80%<br>Substantially |
| 3a How certain are you? | 80% | 80% | 80% |

### 5.1.6.4. Mediator Factors

The judges were asked to comment on which therapy processes appeared to have been helpful to the client. Both judges agreed that from Peter's account that it was clear that his experience of the therapist as empathic, genuine, honest, accepting and caring, and the therapist's willingness to become emotionally engaged with him on a 'human level' had been highly significant.

One judge expressed their disappointment that Peter had not provided specific examples of interventions or events that had occurred in therapy. Nevertheless, both judges noted that the therapist's willingness to provide theoretical understanding to Peter had been helpful in developing his understanding of himself and his relationships, with one judge observing that this had clearly been done skilfully as it did not appear to negatively impact Peter's relationship with his therapist, despite Peter emphasising in his change interview that he had a very low tolerance for 'feeling managed'.

### 5.1.6.5. Moderator Factors

The judges were also asked to comment on which characteristics or personal resources of the client enabled him to make the best use of his therapy. Both judges agreed that Peter's investment in the process, his motivation and his desire to seek out the right therapy and therapist for him and his belief in therapy and his determination to overcome his initial discomfort had clearly enabled Peter to make the best possible use of his therapy.

### 5.1.7. Case Conclusion

The conclusions of the judges in this case were that Peter changed considerably-substantially, although not all of his problems were resolved, and that these changes were substantially due to therapy. Although Peter achieved clinically significant change on all quantitative measures, there were reasons to believe that he had not fully resolved all aspects of his depression within 16 weeks of therapy. In line with existing psychotherapy research into common factors, the therapeutic relationship was identified as being a primary cause of change. Peter identified a number of key changes that had come about as a result of his therapy- including changes in his perspective, interpersonal changes and the development of hope for his future.

# Case Two: Denise[19]

## 5.2.1. Client Description

Denise was a 46 year old social worker presenting with her third episode of depression which had been diagnosed by her family doctor.  At the time of entry into therapy she was on sick leave from work due to her depression and with her doctor's support had opted for talking therapy instead of antidepressant medication. She had previously had two periods of brief therapy; the first one over fifteen years ago at the time of her first depressive episode, and the second shortly after the sudden death in a car accident of her husband ten years earlier, which she had found to be helpful in dealing with her bereavement. This present episode of depression was the longest and the most severe she had experienced. She was single and lived with her two teenage children, with whom she reported having a generally good relationship.

Although she was on sick leave at the time of starting therapy, the therapist reported that Denise was well-groomed in appearance. Despite this she stated that she was not taking good care of herself- she was not eating well, had stopped exercising and was not listening to her body's signals, for example by not resting when tired. She described feeling a sense of despair and emptiness and felt like she was 'going through the motions' of life- unengaged and disinterested.  She described feeling continually tired. She was finding getting out of bed in the morning a struggle and had gradually withdrawn from socialising.

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[19] This case has been previously published in Widdowson, M. (2012c). TA Treatment of Depression- A Hermeneutic Single-Case Efficacy Design Study- Denise. *International Journal of Transactional Analysis Research,* 3(2): 3-14. Readers of the article were advised that the complete rich case record was available on request.

Denise had always enjoyed her job but recently was finding the demands of her role increasingly difficult to manage, and in particular was struggling to deal with the hostility which she often received from service users. Denise was also doing a part time Master's degree in social work which she had previously enjoyed but had got behind with the workload and was afraid she would not be able to manage the requirements of the course. As is often the case in people who work in helping professions (Malan, 1979), Denise was frequently called upon by members of both her immediate and extended family to sort problems out and felt that she was taken for granted.

She was the youngest of six children and often felt ignored and unimportant as a child. This was in contrast to her two older siblings who were clearly favoured by her parents and grandparents and was most shockingly manifested when she was sexually abused by older members of her extended family and by a school teacher. The school teacher was a serial offender and when his abusing came to light, Denise was interviewed by the police and eventually went to court aged eight to testify. Neither the court case nor the abuse were ever mentioned by her parents or family (both during and after the court case) and the whole thing was 'brushed under the carpet' and Denise was under the impression that she was not to speak of the abuse.

Denise was an intelligent and articulate woman. She had been introduced to Transactional Analysis by a colleague, and after reading a book about TA she actively sought out a TA therapist working in private practice. She had attended a one year course in counselling skills two years previously, and was familiar with the principles of therapy. Throughout the course of her therapy she continued to read about TA, and to apply TA theory to assist her self-understanding and to support her change process.

At her initial meeting with her therapist, the therapist ascertained that she did not meet any excluding criteria for participation in the study and conducted a brief clinical diagnostic interview to confirm diagnosis of major depressive disorder based on DSM-IV diagnostic criteria (American Psychiatric Association, 1994). She was screened using CORE-OM and BDI-II and met the criteria for 'caseness' and inclusion in the study. Denise's clinical score using CORE-OM was 21.1, indicating moderate levels of distress and functional impairment and her BDI-II score was 33, indicating severe depression. The therapy consisted of sixteen, weekly individual sessions.

**5.2.2. The Therapist**

The therapist in this case was David, a male white British therapist with over five years post-qualifying experience. He had approximately one hour of monthly supervision on this case with an experienced Teaching and Supervising Transactional Analyst. Adherence was scored throughout as 'good' to 'excellent'.

**5.2.3. Description of the Therapy Process**

***5.2.3.1. Generic Description of the Therapy Process***

Denise's therapy began with a phase of alliance building, problem formulation and assessment of her internal process and maladaptive interpersonal patterns which reinforced her views about herself and maintained her depression. This phase concluded with the agreement on the therapy contract and overall goals of therapy at session three.

The therapy involved significant revisiting of past experiences and normalising and validating her emotional responses to these and helping her to re-evaluate the

negative conclusions she made as a result of these events.  The therapeutic relationship and the climate of validation and acceptance appear to have enabled her to internalise a positive relational experience.

The second phase of the therapy was concerned with identifying interpersonal patterns which were maintaining her depression and challenging her self-critical internal dialogue and negative self-evaluation.  The ending phase focused on supporting her changes and action planning to promote continued growth.

### 5.2.3.2. Process of Therapy- Interpreted from Client HAT Forms and Change Interview

The therapy focused on forming a safe and supportive therapeutic relationship characterised by a quality of connection with the therapist, a sense of equality in the relationship, therapist authenticity and an emphasis on the client's autonomy and process of self-discovery.

The therapist offered his perspective regarding Denise's problems and process and provided Denise with feedback and observations based on TA theory to help Denise conceptualise her internal and interpersonal process.

Denise explored key life events including the emotional impact of these events and processed these emotions and re-evaluated conclusions and maladaptive views of self which had been formed following these experiences. There was a maintained emphasis on identifying and exploring maladaptive interpersonal patterns and on exploring new, healthier ways of relating to others, including within the therapy relationship.

### 5.2.3.3. TA Description of Therapy Process- Taken from Therapist's Notes

The initial phase of Denise's therapy (sessions one-three) consisted primarily of alliance forming, problem formulation, and diagnosis. The diagnosis included identifying major life script themes, developing a racket system, and ego state structural analysis which included identifying internal dialogue. The diagnosis also included identifying key interpersonal patterns which reinforce script and identifying an intrapsychic impasse relating to Denise's desire to take care of herself which was in conflict with a belief that to do so would be 'selfish' and 'bad'. This phase culminated in negotiation and agreement on overall therapy Contract goals.

The second phase (sessions four-sixteen) involved revisiting painful past experiences and expressing associated emotions (deconfusion) and validation and normalisation of these emotional reactions. This also involved re-evaluating the significance of these events in the formation of Denise's life script, and challenging the discounting of self (in particular in the areas of her abilities and thinking). Her self-critical and negative internal dialogue (ego states) which arose from these events and which was still on-going was challenged and the therapy emphasised replacing this with a soothing, nurturing (Nurturing Parent) inner dialogue. Current life events were explored and Denise's reactions to these was explored, linked to past events, normalised and validated.

This phase also included substantial exploration of current interpersonal patterns (transactions, stroking patterns, games), Denise's interpretation of current interactions and how these reinforce her script beliefs, impasse clarification and resolution

(around the conflict of 'doing what I want' versus 'being selfish') and behavioural

contracting/ action planning to change these interpersonal and behavioural patterns.

## 5.2.4. Results

### 5.2.4.1. Quantitative Outcome Data

Denise's quantitative outcome data is presented in table 5.2.1. All of Denise's initial

scores were well within clinical ranges and substantially higher than the caseness cut-

off for inclusion in the study. Her BDI-II score at entry into therapy was 33, indicating

severe depression and her CORE-OM score was 21.1, indicating moderate levels of

global distress and functional impairment.  Denise's BDI-II score had demonstrated

reliable change by session 8, and was maintained at session 16, then continuing to

improve to clinically significant levels of change at one-month follow up and

maintained throughout the follow-up period.  It is noteworthy at this point to mention

that Denise experienced two bereavements of elderly aunts in the latter half of her

therapy- a factor which the affirmative team discussed in their analysis of the case (see

below). Denise's CORE scores had attained clinically significant change by session 8,

and continued to improve (with some minor deterioration at the time of the

bereavements) throughout the rest of the therapy and during the follow-up period.

Denise's PQ scores showed steady improvement throughout therapy, achieving

clinically significant change by the end of therapy and showing continued

improvement throughout follow-up. See figures 5.2.1 and 5.2.1. for graphs illustrating

Denise's improvement on CORE and PQ.

**Table 5.2.1. Denise's Quantitative Outcome Data**

| | Recovery cut-off | Inclusion cut-off | Reliable Change Index | Pre-Therapy | Session 8 | Session 16 | 1 month Follow-up | 3 month Follow-up | 6 month Follow-up |
|---|---|---|---|---|---|---|---|---|---|
| Beck Depression Inventory-II | 10 | 16 | 5.78 | **33** | **17(+)** | **17 (+)** | 7 (++) | 8 (++) | 1 (++) |
| CORE-OM | 10 | 15 | 6.0 | **21.1** | 13.8 (+) | 7 (++) | 4 (++) | 7 (++) | 2 (++) |
| Personal Questionnaire (mean score) | 3.00 | 3.50 | 1.0 | **4.5** | **3.8** | 3.0 (++) | 2.0 (++) | 2.1 (++) | 1.6 (++) |

*Note: Values in bold are within clinical range. + indicates Reliable Change, ++ indicates clinically significant change.*

**Figure 5.2.1. Weekly CORE Scores**
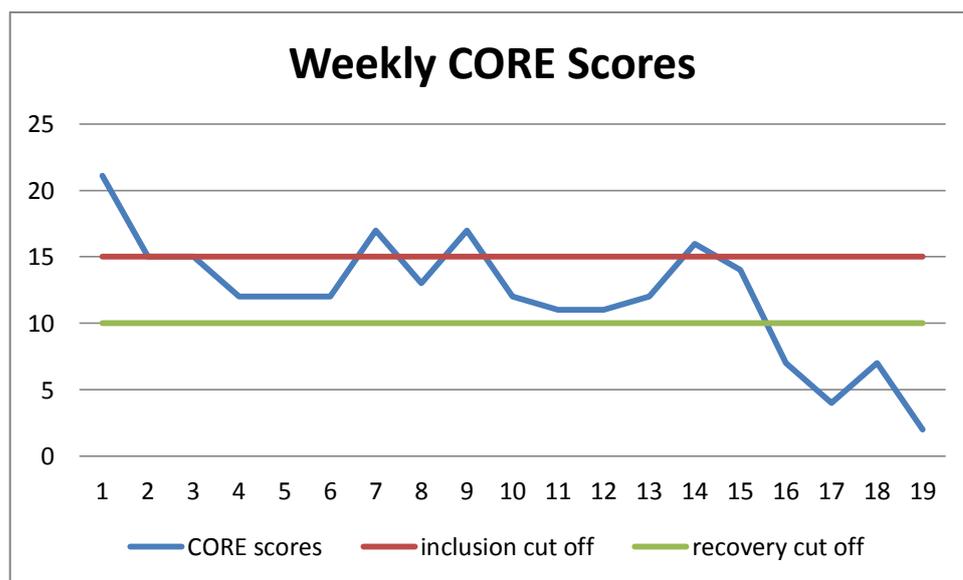


*Note: scores 17, 18 and 19 are taken from the three follow-up points*

**Figure 5.2.2. Weekly Mean PQ Score**
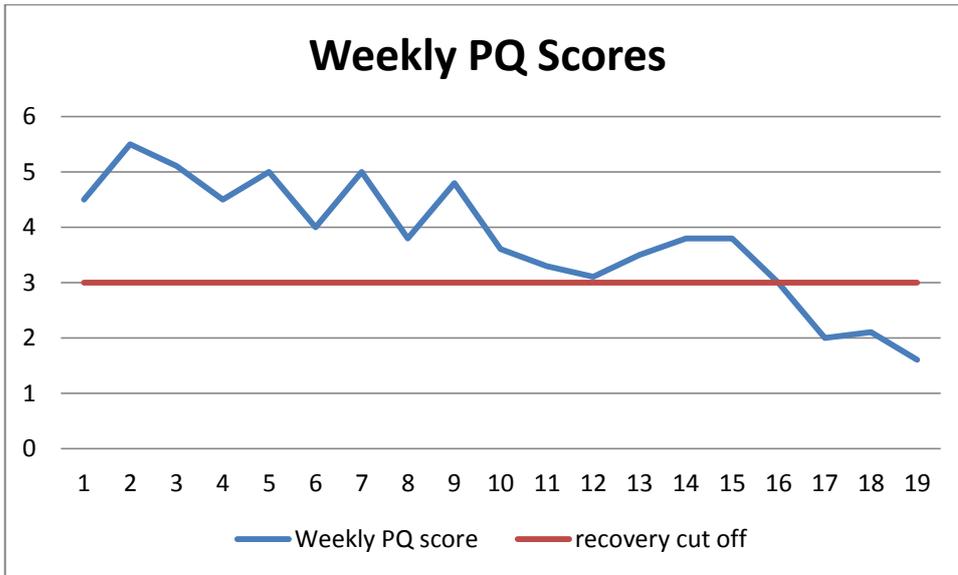


*Note: scores 17, 18 and 19 are taken from the three follow-up points*

*Table 5.2.2. Quantitative Process Data- Working Alliance Inventory*

The therapist and client both completed the short form Working Alliance Inventory at sessions 1, 3 and 6. Each item is rated on a six-point Likert scale, with higher scores indicating greater satisfaction. Data from this procedure is presented below..

| Session 1 | Client | Therapist |
|---|---|---|
| Mean Task | 6 | 5.75 |
| Mean Goals | 6.75 | 5.75 |
| Mean Bond | 6.75 | 6 |
| Overall Mean Score | 6.25 | 5.83 |
| Session 3 | | |
| Mean Task | 6.25 | 6.25 |
| Mean Goals | 6.5 | 6.5 |
| Mean Bond | 7 | 6.5 |
| Overall Mean Score | 6.58 | 6.41 |

| Session 6 | | |
|---|---|---|
| Mean Task | 6.75 | 6.25 |
| Mean Goals | 6.5 | 6.5 |
| Mean Bond | 6.75 | 6.75 |
| Overall Mean Score | 6.66 | 6.5 |

| Combined Mean Scores | Client | Therapist |
|---|---|---|
| Mean Task | 6.3 | 6.08 |
| Mean Goals | 6.58 | 6.25 |
| Mean Bond | 6.83 | 6.41 |
| Overall Mean Score | 6.49 | 6.24 |

## 5.2.4.2. Qualitative Data

### 5.2.4.2.1. Qualitative Process Data about Helpful Aspects of Therapy

Denise completed a HAT form at the end of fifteen of the sessions, indicating what had been helpful or hindering/ unhelpful in the session. She identified at least one helpful event on each of these forms, and did not identify any hindering or unhelpful events during the therapy. The majority of the helpful events Denise identified related to feeling safe and accepted and other aspects of the therapeutic relationship, to increased insight into her intrapsychic and interpersonal process and also to expressing previously unexpressed emotions which related to the therapist's focus on deconfusion. Examples taken directly from her responses include;

In session four: *'Getting in touch with my feelings. Feeling my feelings and knowing that they need to be acknowledged and allowed to be completed over time. Space in*

*the conversation, authenticity of the therapist. Feeling safe in the environment with my therapist. I got acknowledgement of myself and permission to work through what I need to do and to take as long as it takes'* (rated 8- 'greatly helpful')

In session six; *'The feeling of being in a safe environment in which I knew I was not going to be judged which allowed me to open up to speak about something I had never even alluded to anyone else about. Knowing that my therapist was experienced enough to guide me through the memories and that I was reassured that they could be revisited as appropriate. Also the invitation to explore the subject made me feel reassured that I could speak about it.'* (rated 8- 'greatly helpful'). *'Exploration of my family dynamics and the dichotomy of being seen by my family when they need me to do something.*' (rated 9- 'extremely helpful')

In session 12: *'Discussion which involved the question "what makes therapy work for you?" My answers include; being asked to really look at myself and how I function. Taking cognizance of the games I play, of my script. Knowing I am accepted as an intelligent human being who can think for myself and I am important in the whole process, as in I can make my own decision and be responsible for the consequences. What I got out of it is the knowledge and reassurance that I am OK. I'm an equal in this journey and my opinions and thoughts are valid. Learning how to look out for and accept the positives in my behaviour.'* (rated 8- 'greatly helpful')

*'Being able to feel joy and sadness in the same therapeutic hour without fear that the latter would detract from the former. Also facing up to my grief and knowing I can revisit this whenever I want to safely.'* (rated 9- 'extremely helpful')

### 5.2.4.2.2. Qualitative Outcome Data

In the Change Interview which took place at the one month follow-up, Denise identified ten changes which had occurred since starting therapy. The changes are listed in table 5.2.3. These changes primarily related to an increase in her self-esteem and self-confidence. One change related to the development of an optimistic outlook and another change clearly related to changes in how she interacts with others.

*Table 5.2.3. Denise's Changes as Identified in Post-Therapy Change Interview*

| Change | How expected/ surprising was the change [a] | How unlikely/likely change would have been without therapy [b] | Importance of change [c] |
|---|---|---|---|
| Decision Making | 1 | 1 | 5 |
| Confidence in my abilities | 3 | 1 | 5 |
| Confidence in myself | 5 | 1 | 5 |
| 'Core strength' | 1 | 1 | 5 |
| Giving Myself Permission | 3 | 1 | 5 |
| Improved Body Image | 5 | 1 | 5 |
| I feel happier in myself | 1 | 1 | 5 |
| Optimism | 5 | 1 | 5 |
| I feel more equal and less adapted in my relationships | 5 | 1 | 5 |
| I now see myself as important | 5 | 1 | 5 |

[a] The rating is on a scale from 1 to 5; 1= expected, 3= neither, 5= surprising

[b] The rating is on a scale from 1 to 5; 1=unlikely, 3=neither, 5=likely

[c] The rating is on a scale from 1 to 5; 1=slightly, 3 = moderately, 4=very, 5=extremely

### 5.2.4.2.3. Analysis of Change Interview Responses

For Denise, therapy was a safe space characterized by a sense of mutuality where she was treated as an equal and as having a valid contribution. She described a number of relational aspects about her therapy which clearly enabled her to 'go deeper' than she had done previously.

CD6: *when we were talking about me being sexually abused... I know I couldn't possibly have dealt with that alone. And actually I don't think I would have allowed it to come to the fore, I don't think I would have dealt with it if there hadn't been someone else there to help me. In fact I know I wouldn't. And the other part of that process is that is feeling safe and knowing I can say that within those walls and to my therapist and not feel at all judged and know that my therapist could cope with it.*

CD83: *I've always felt assured that [my therapist] could accept whatever I was saying. I remember going into my first therapy, and the therapist was really good. I liked her a lot, but my first feeling with her was that I don't think you'll be able to understand where I'm coming from… and I think I held back a bit in the things I told her. But equally there were things that didn't surface in my head until, well, a few years after. Like the sexual abuse stuff. I had that bound so deeply that it was never going to come out in that situation because I wouldn't have told that woman about it*

CD87: *There's the definite feeling that I'm as important in the relationship. I'm not being diagnosed and given a pill… It's about the fact that I can be vulnerable, and I can feel safe in that vulnerability. I have never felt in the slightest bit judged. And as I've also said, that the therapist could say 'hold on a minute, I'm not getting this' and we can discuss it and get to a point where we both understand it. Or not! And both feel*

*comfortable with that. But I feel that my therapy is as much about what I do and as much about what I contribute- it's not just telling a story- it's about…I can say… no I don't agree or I do agree or we have a discussion around what it is that's happening. And the other thing is, that as a therapist, they weren't afraid to say 'this is bringing something up for me' and then we can sort that bit out, which is also where I feel acknowledged as an intelligent human being who is perfectly capable of taking part on an equal basis.*

*CD88: Sharing. Openness, absolutely. And not feeling like I'm with my teacher. But knowing that [my therapist] knows exactly what they are doing.*

*CD112: feeling as much a part of, ah, the treatment. Feeling that my contribution is important. Its acknowledged that I've got things I need to deal with, and I can deal with them in a safe and secure environment, where I don't feel judged… and that if I feel that thing needs to be talked about and discussed again I can go back there, and to be heard and understood.*

She also described therapy as being a process of guided discovery where she was encouraged to find her own answers. She described a number of occasions where she was actively seeking that her therapist 'tell her' something, but that instead her therapist sought to facilitate her own process of learning and change;

*CD94: (there was one particular time) where I got the feeling that there is an answer to this, but if they'd told me the answer, that wouldn't have been me making the change. That would have been them telling me what to do… as I think about that, ok, there's a reassurance there is an answer there, there was a reassurance that they knew if I reflected on it that I would come to that conclusion, but equally if I didn't come to that*

*conclusion and came back the week after and said that I didn't get it, that I knew*

*they'd tell me and guide me.*

CD95: *…Because then it's in my perspective. It's mine. And that's the other thing,*

*guidance to find my own answers and my own perspective.*

She also described a process of increased self-awareness which has involved emotional

processing and re-evaluation and re-construction of her existing narrative.

CD96: *I think as my confidence is building, and as I feel more connected, and as I*

*become more self-aware, and as that brings me to find out who I really am, as I tease*

*out all these things that have caused me to be the way I've been, and as they get*

*sorted out and put into the place where its ok, as they become OK, I become OK.*

**5.2.5. HSCED Process**

*5.2.5.1. Affirmative Case*

The affirmative team argued that there were four main lines of argument which

provided clear and compelling evidence that Denise had changed substantially and

that these changes had been due to therapy. The first line of evidence put forward was

the changes in Denise's quantitative measures- by session sixteen she had achieved

clinically significant change on the CORE-OM and PQ and had achieved reliable change

on her BDI-II scores. The affirmative team put forward the argument that Denise was

still recovering from two bereavements and that her score on BDI-II at the end of

therapy was likely to be associated with the impact of these bereavements and cited

her improvement at the one-month follow up as evidence of this. At the one month

follow-up, Denise showed clinically significant change on all three measures which was

sustained throughout the remainder of the follow-up period. This was considered to be particularly compelling given the initial severity of Denise's depression. The affirmative team also highlighted that the items on Denise's PQ had all been long-standing problems and that these appeared to have been resolved during therapy and that this improvement had been maintained, suggesting she had experienced internal restructuring and resolution of factors which contributed to her depression. Evidence from Denise's Change Interview was also cited, including the development of a positive and optimistic outlook on life and her descriptions of significant changes made in her day-to-day life such as changes in her self-esteem, relationships, working patterns, self-care and financial matters.

The second line of evidence related to Denise's clear and unequivocal retrospective attribution that all of her changes were unlikely to have come about without therapy. The third line of evidence related to how there appeared to be convincing links between the therapy process (as described in the therapist's account and Denise's responses on the HAT forms) and the ten changes which Denise identified in her Change Interview. Finally, the affirmative team noted that there was clear evidence of significant event-shift sequences with reliable change (as measured by improvements on PQ and CORE scores) demonstrated after sessions seven, nine and fifteen.

### 5.2.5.2. Sceptic Case

The sceptic team considered that there was reason to believe that Denise's problems were more reactive to external events than her Change Interview might suggest and that her improvements could be explained by extra-therapy changes, such as changes in her working conditions and natural recovery from bereavement. The sceptic team

also highlighted that Denise's description of the therapy and therapist was extremely positive- despite her reporting feelings frustrated at several points in the therapy suggesting that relational factors may be influencing her report of the therapy. Additionally, the sceptic team considered that there was evidence that expectancy factors may have led Denise to overestimate the magnitude of her change. Associated with both relational and expectancy factors the sceptic team cited Denise's tendency to please other people as potentially casting doubt on the attribution of change to the therapy.

### 5.2.5.3. Affirmative Rebuttal

The affirmative rebuttal argued that although there had been many external changes in Denise's circumstances, she attributed these to changes she made in therapy. They noted that Denise's BDI-II scores at the one month follow-up suggested a rapid recovery from her bereavements thus indicating that deep changes had taken place in how she responded to stressful events. The affirmative team refuted the sceptic team's argument relating to relational factors, citing Denise's acknowledgment of her frustration at times during therapy as providing a balanced picture which did not suggest an overly positive view of the therapy process and that Denise's subsequent reflection on these occasions demonstrated that she had found these events to be therapeutic.

The affirmative team also refuted the sceptic argument of expectancy factors by considering that Denise's active selection of the type of therapy and the therapist had been the positive choice of an informed and intelligent woman who had carefully made these choices based on a clear appraisal and fairly sophisticated grasp of what

the therapy might involve. Linked to this, the affirmative team put forward the view that there was strong evidence that Denise's therapy had been carefully implemented and was linked to a clear and consistent case formulation and treatment plan. Finally, the affirmative team highlighted that Denise's changes on quantitative and qualitative outcome measures provided a consistent and compelling picture of substantial and lasting global changes.

### 5.2.5.4. Sceptic Rebuttal

The sceptic rebuttal included the view that Denise's description of the change process had been vague and lacking in detail of specific change events in therapy. Linked to this, they put forward that argument that extra-therapy factors may have played a much larger role in Denise's improvement than her attributions of change in her Change Interview. The sceptic rebuttal also highlighted Denise's tendency towards not trusting her own abilities, combined with a tendency towards pleasing others would make her highly pre-disposed towards underestimating her own contribution towards positive change and overestimating the influence of her therapist and the therapy.

### 5.2.6. Adjudication

The three judges independently reviewed the case materials and produced their reports regarding their verdicts on the case (see table 5.2.4) citing the evidence which had influenced their opinions and describing the factors they considered to have been significant in this case. To summarise, the judges concluded that Denise had experienced clinically significant change and had changed substantially and that these changes were substantially due to therapy.

### 5.2.6.1. Summary of Opinions of How the Judges Categorised this Case

There was unanimous verdict of the judges that the case was a clearly good outcome case, with a mean certainty of 86%. The judges considered that the combination of quantitative outcome data showing clinically significant change which was maintained throughout follow-up and the quantitative outcome data from the Change Interview provided convincing evidence that this was a clearly good outcome case, although the judges noted that external factors in Denise's life had probably had an impact in terms of reduced gains in the second half of therapy.

### 5.2.6.2. Summary of Opinions Regarding the Extent to which the Client Changed

Once again, there was a unanimous verdict of the judges that Denise had changed substantially, with all three judges concluding that the client's changes had been in the 80% range. The judges varied slightly in their level of confidence in this conclusion, although the mean certainty level was 80%.

### 5.2.6.3. Summary of Opinions as to Whether the Changes were Due to Therapy

The judges were unanimous in their conclusion that the changes experienced by Denise were substantially (80%) due to the effects of therapy. There was some variation in their degree of certainty about this, although the mean certainty level was also 80%. Judges A and B rejected the sceptic claims that Denise's improvement could be accounted for as an attempt to please her therapist and/or due to expectancy factors. To support their rejection of these arguments, they cited Denise's honest account of her frustrations in therapy, her surprise at many of her changes, the changes evident by the outcome measures, her substantial life changes and her

achievement of her therapy goals as evidence of clearly positive outcome which could

not be accounted for by the sceptic arguments. Furthermore, judges A and B rejected

the sceptic claims that Denise's account of the therapy was vague and felt that on the

contrary, Denise had provided a detailed account of the therapy process and her use of

TA language indicated that she had deeply integrated these changes. Judge C however

was somewhat persuaded by the sceptic argument that there may be evidence of

some 'pleasing' of the therapist or researcher, considering  Denise's reports as

containing uniformly positive comments about the therapy and the therapist.

**Table 5.2.4. Adjudication Decisions**

| | Judge A | Judge B | Judge C | Mean |
|---|---|---|---|---|
| 1How would you categorise this case?<br><br>How certain are you? | | | | |
| 1a Clearly good outcome (problem completely solved) | 100% | 80% | 80% | 86% |
| 1b Mixed Outcome (problem not completely solved) | 0% | 0% | 0% | 0% |
| 1c Negative/ Poor Outcome | 0% | 0% | 0% | 0% |
| 2 To what extent did the client change over the course of therapy? | 80%<br><br>Substantially | 80%<br><br>Substantially | 80%<br><br>Substantially | 80%<br><br>Substantially |
| 2a How certain are you? | 100% | 80% | 60% | 80% |
| 3 To what extent is this change due to therapy? | 80%<br><br>Substantially | 80%<br><br>Substantially | 80%<br><br>Substantially | 80%<br><br>Substantially |
| 3a How certain are you? | 100% | 80% | 60% | 80% |

### 5.2.6.4. Mediator Factors

The judges were asked to provide their opinion on which therapist characteristics and therapeutic factors had been most helpful in generating change. The judges agreed that the empathic, non-judgmental and encouraging stance of the therapist had been important in this case. The judges also agreed that the therapist's willingness to provide a rationale or use theory to explain and support the therapy and assist Denise in making links with and coming to terms with her past had also been important. Furthermore, judges A and B agreed that the therapist's focus on Denise's script and both their continued challenging of her script, an attentiveness to how it might be manifesting in the therapy and avoidance of unhelpful transference enactments of her script had also been a significant factor.

### 5.2.6.5. Moderator Factors

The judges were asked to provide their opinion on which personal characteristics and resources of the client enabled the client to make best use of the therapy and which enhanced the therapeutic process. All judges agreed that Denise's sense of hopefulness at the outset of therapy was an important factor. The judges also agreed that the fact that Denise was well-informed about both therapy and in particular, TA therapy had also been significant as had her making a clear and informed decision in choosing the right therapist. It was acknowledged that she was clearly well-motivated and had a number of clear goals for the therapy and a degree of insight from the outset and that these too had been important factors. Denise's courageousness and willingness to address difficult and painful material (e.g. sexual abuse) and her

continued attempts to integrate the insights gained in therapy into her everyday life was also identified as a key factor. Judge A identified Denise's willingness to accept her therapist's challenges and persist with finding her own answers to her problems had also been important.

### 5.2.7. Case Conclusion

The conclusions of the judges are that Denise changed substantially and that these changes were substantially due to the effects of therapy. Denise attained clinically significant change on all three quantitative outcome measures and had sustained her improvement throughout follow-up. Her change interview responses provided a clear and compelling argument regarding the magnitude and breadth of her changes and that these changes were primarily due to the effects of therapy.

Although the gains in the second half of the therapy were somewhat limited, it would appear that this was due to the impact of extra-therapy factors, in particular bereavement, and that once the acute grief phase had passed Denise continued to improve suggesting that the changes were deeply integrated and were self-maintaining. The importance of the therapeutic relationship is once again reaffirmed as crucial in promoting therapeutic change and there is preliminary evidence from this case to suggest that the use of TA for case formulation and in providing rationale/ explanation for the client is an effective approach when matched to the client's preferences and life script.

# Case Three: Tom[20]

## 5.3.1. Client Description

Tom was a 38 year old white British builder, who presented for private, weekly TA psychotherapy. Contrary to what one might expect from his tall, muscular build, he described feeling anxious and intimidated socially and feeling very down. He described problems with communicating with people, and often crippling levels of social inhibition. He felt he was stupid and useless, and had very poor self-esteem. He experienced what sounded like a relentless self-critical internal dialogue which was making him feel depressed. His symptoms included low mood, a loss of interest in things and feeling pessimistic and despondent about the future. Tom had a very difficult upbringing and was treated harshly- particularly by his mother, and had been bullied at school for having some speech difficulties.

He was in a long term, long distance relationship, which was generally positive. Despite this, he felt that his low mood, lack of interest and social inhibition was harming his relationship with his partner, and also preventing him from building his relationship with her children.

Tom had received six sessions of counselling in a primary care setting several years previously due to his difficulties with relating to others.  He found this experience supportive but limited.  Just prior to engaging in the therapy presented here, he had become interested in transactional analysis and had read several books about TA. He

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[20] This case has been previously published in Widdowson, M. (2012d). TA Treatment of Depression- A Hermeneutic Single-Case Efficacy Design Study- Tom. *International Journal of Transactional Analysis Research,* 3(2): 15-27. Readers of the article were advised that the complete rich case record was available on request.

found his reading on TA theory to be helpful and as a result actively sought out a TA therapist.

At the intake interview, the therapist conducted a brief clinical diagnostic interview to confirm diagnosis of major depressive disorder based on DSM-IV diagnostic criteria (American Psychiatric Association, 1994). Tom also met diagnostic criteria for comorbid social anxiety disorder. Tom's clinical score at point of entry to therapy using CORE-OM was 18, indicating mild levels of distress and functional impairment and his BDI-II score was 24, indicating moderate depression. He attended sixteen weekly sessions of individual therapy.

### 5.3.2. Therapist

The therapist in this case was 'Julie' who was a white, British therapist with over ten year's post-qualifying experience. Julie had at least one hour per month of supervision on this case with a Teaching and Supervising Transactional Analyst. Adherence was measured by Julie and her supervisor. The ratings were largely 'good', or 'excellent'. Two scales in one session were rated by Julie as 'adequate'.

### 5.3.3. Description of the Therapy Process

#### *5.3.3.1. Generic Description of the Therapy Process*

The initial phase of the therapy (sessions one to four) focused on identifying Tom's negative self-critical internal dialogue and maladaptive self-beliefs and exploring life events which had contributed to their formation. These sessions also involved identifying key interpersonal patterns which reinforced his maladaptive beliefs about

self. Negotiation and agreement on the therapy contract and goals for therapy was conducted in the first session.

The middle phase focused on identifying key life events and re-evaluating maladaptive conclusions Tom had drawn from these and the therapist adopting a strategy of actively seeking to understand and challenge Tom's negative self-critical internal dialogue. This stage of the therapy also included a relearning aspect which involved developing positive communication and interpersonal strategies. The therapist reported an alliance rupture in session six, which activated Tom's self-critical process. Julie sought to repair this in the session, and use this to support Tom's changes and to help him find ways to make sense of interpersonal difficulties that were not self-critical.

The therapy concluded with two ending sessions which focused on exploring how Tom could continue his growth and development and maintain personal resources.

### 5.3.3.2. Process of Therapy- Adapted from Client HAT Forms and Change Interview

The therapist created a safe, caring and empathic relationship and provided Tom with a clear rationale for the therapy and to understand his internal and interpersonal process.

This enabled Tom to explore the impact of past events and the emotional, cognitive and interpersonal consequences of these and also how subsequent interpersonal patterns had reinforced his maladaptive patterns.  This process enabled Tom to express emotions and tackle his self-critical process and replace it with a nurturing/

soothing internal dialogue and explore and experiment with new ways of relating to others.

### 5.3.3.3. TA Description of Therapy Process- Taken from Therapist's Notes

The initial phase of the therapy involved a collaborative and active diagnostic and intervention approach which identified key intrapsychic and interpersonal process and began to directly challenge these from the outset. These processes were conceptualised using the ego state model, contaminations, the racket system, drivers, injunctions and life script. Problem formulation and therapy contract goals were identified in session one. Following contracting, the initial phase of the therapy (sessions 1-4) consisted of Identifying life experiences which had shaped Tom's life script and formed the basis of his self-critical negative ego state dialogue and also involved the compilation of his racket system. Tom's emotional reactions to these life events were identified and the therapist adopted an empathic approach of affirmation, validation and normalisation of these reactions to encourage the internalisation of a more nurturing internal dialogue. The initial phase concluded with two sessions which used two-chair method. The two-chair method sessions consisted of identifying the origin of, and challenging Tom's negative self-dialogue and negative life script beliefs and replacing these with a positive internal dialogue.

The middle phase of the therapy (sessions five-nine) focused on continuing to identify and re-evaluate the early life experiences which formed Tom's life script and self-critical negative ego state dialogue and on identifying current interpersonal patterns that reinforced his life script, racket system and supported his self-critical ego state dialogue. This phase also developed the earlier work on challenging his self-critical

dialogue and negative introject and installing a positive nurturing/ soothing ego state dialogue. Behavioural contracting was used to support his changes.

The final phase of the therapy focused on communication, interpersonal learning, changing interpersonal patterns and supporting change in internal ego state dialogue. The therapy concluding with a review of the process and the therapy contract and identifying resources for future change.

### 5.3.4. Six Month Follow-Up

At the six month follow-up, Tom enclosed a note for the researcher with his forms which stated; '*you may find the answers on the questionnaires a little contradictory, as my feelings and thoughts are a bit confusing right now.  I moved to Liverpool, as you know, to live with my partner and her kids and love them very much and am happy living here. I am happy, contented and not really worried about the future. I've started a new job which will see us financially secure for as long as I work there. My new job seems to be giving me personal test after personal test and although I think I am doing OK, sometimes I doubt myself and think everyone else is better than me. There's generally been a big change in my responsibilities. I've also started a college course, which is quite challenging. It's taking a while to adjust and I'm not doing much else, other than going to the gym a lot. On the positive side, I'm not fearful for the future and I don't think I'm a failure anymore*.'

### 5.3.5. Results

#### 5.3.5.1 Quantitative Outcome Data

Tom's quantitative outcome data is presented in table 5.3.1. His initial score was within clinical range and above caseness cut-off, thus meeting inclusion criteria for the study. His pre-therapy BDI-II was 24, indicating moderate depression and his CORE-OM score was 18, indicating mild levels of global distress and functional impairment. All of Tom's quantitative outcome measures demonstrated clinically significant change by session 8, which was maintained throughout therapy and at the one and three-month follow-up periods. Clinically significant improvement on the BDI-II was also maintained at the six-month follow up, and the PQ and CORE data showed reliable change at the six-month follow-up.

### Table 5.3.1. Tom's Quantitative Outcome Data

|  | Recovery cut-off | Inclusion cut-off | Reliable Change Index | Pre-Therapy | Session 8 | Session 16 | 1 month Follow-up | 3 month Follow-up | 6 month Follow-up |
|---|---|---|---|---|---|---|---|---|---|
| Beck Depression Inventory-II | 10 | 16 | 5.78 | **24** | 7 (++) | 2 (++) | 0 (++) | 0 (++) | 6 (++) |
| CORE-OM | 10 | 15 | 6.0 | **18** | 6 (++) | 2 (++) | 1.7 (++) | 2 (++) | **13.5** |
| Personal Questionnaire (mean score) | 3.00 | 3.50 | 1.0 | **5.2** | 2.8 (++) | 2.0 (++) | 2.0 (++) | 1.6 (++) | **4.0 (+)** |

*Note: Values in bold are within clinical range. + indicates Reliable Change, ++ indicates clinically significant change.*

**Figure 5.3.1. Weekly CORE Scores**
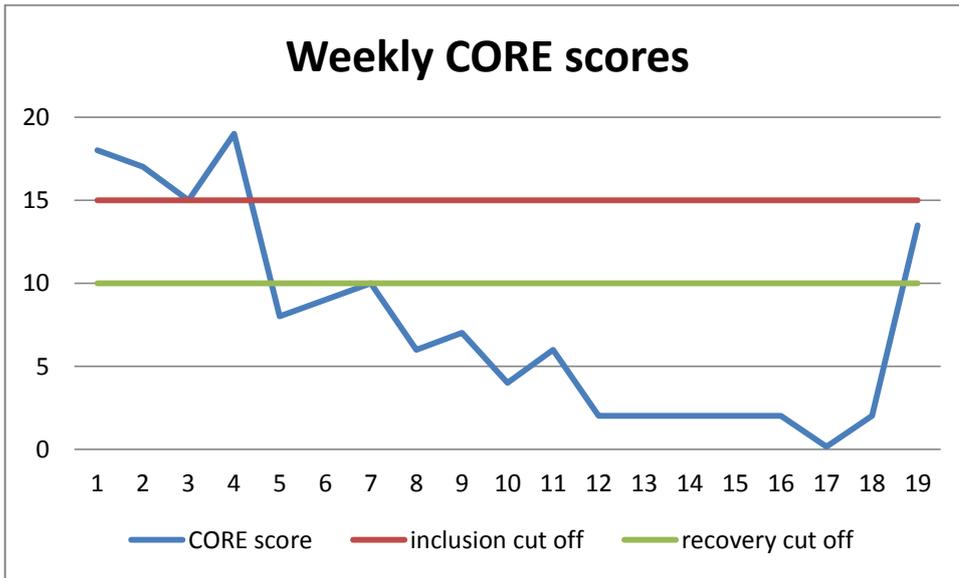


Weekly CORE scores

*Note: 17, 18 and 19 relate to follow-up periods*

**Figure 5.3.2. Weekly PQ Scores**



Weekly PQ Scores
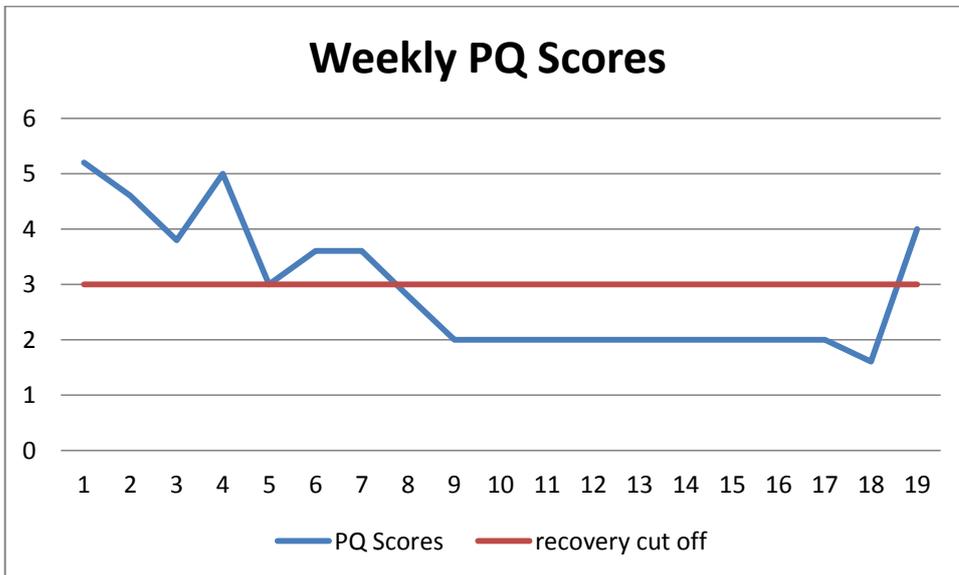
*Note: 17, 18 and 19 relate to follow-up periods*

### Tables 5.3.2.Quantitative Process Data- Working Alliance Inventory

The therapist and client both completed the short form Working Alliance Inventory at sessions 1, 3 and 6. Each item is rated on a six-point Likert scale, with higher scores indicating greater satisfaction. Data from this procedure is presented below.

| Session 1 | Client | Therapist |
|---|---|---|
| Mean Task | 6.5 | 6 |
| Mean Goals | 7 | 6.5 |
| Mean Bond | 6.25 | 6.25 |
| Overall Mean Score | 6.58 | 6.25 |
| Session 3 | | |
| Mean Task | Not collected | 6 |
| Mean Goals | Not collected | 6 |
| Mean Bond | Not collected | 6.25 |
| Overall Mean Score | Not collected | 6 |
| Session 6 | | |
| Mean Task | Not collected | 6 |
| Mean Goals | Not collected | 6 |
| Mean Bond | Not collected | 6 |
| Overall Mean Score | Not collected | 6 |
| Combined Mean Scores | | |
| Mean Task | 6.5 | 6 |
| Mean Goals | 7 | 6.16 |
| Mean Bond | 6.25 | 6.16 |
| Overall Mean Score | 6.58 | 6.16 |

**5.3.5.2. Qualitative Data**

*5.3.5.2.1. Qualitative Data about Helpful Aspects of Therapy*

Tom completed HAT forms at the end of each session and these provided detailed

information regarding specific within-session episodes, many of which were related to

work with his Child ego-state, two-chair work and Parent ego-state work to identify

and resolve aspects of his self-critical process. Other key within-session episodes were

connected to exploring his communication patterns and life script and improving his

communication and interpersonal style.

*5.3.5.2.2. Qualitative Outcome Data*

Tom participated in a 90 minute Change Interview at the follow-up interview, one

month after concluding his therapy. In the interview, he identified eight changes since

starting therapy. The changes are listed below in table 5.3.3. These changes primarily

related to changes in his self-esteem, his way of interpreting others and events and

changes in how he communicates and interacts with others.

**Table 5.3.3. Tom's Changes as Identified in Post-Therapy Change Interview**

| Change | How much expected/surprising change was [a] | How unlikely/likely change would have been without therapy [b] | Importance of change [c] |
|---|---|---|---|
| I now think I'm OK as a person | 1 | 1 | 5 |
| I feel positive and hopeful about my future | 2 | 1 | 5 |
| I have belief in myself and in my capabilities- I realize I can do anything if I really want to | 2 | 1 | 5 |
| I have stopped blaming myself for everything that goes wrong | 3 | 1 | 5 |
| I have developed problem solving skills | 3 | 1 | 5 |
| I have found ways to understand other people and communicate better | 5 | 1 | 5 |
| I have learned to take a step back in situations and not take things personally | 4 | 1 | 5 |
| I am more sociable and don't withdraw in social situations | 2 | 1 | 5 |

[a] The rating is on a scale from 1 to 5; 1= expected, 3= neither, 5= surprising

[b] The rating is on a scale from 1 to 5; 1=unlikely, 3=neither, 5=likely

[c] The rating is on a scale from 1 to 5; 1=slightly, 3 = moderately, 4=very, 5=extremely

### 5.3.5.3. Analysis of Change Interview Responses

Tom provided considerable idiosyncratic detail about the events in therapy which he found most significant. He described his self-critical internal dialogue and how this began to change during therapy, primarily as a result of two-chair technique (which he referred to as 'role playing'):

*CT122: Mm… through therapy it was the role play… A stage that was very good and it got me thinking about how I talked to myself in my head. I set up a load of things I say to myself and try to say these things every day and that's changed over the weeks as well. Eh, (short pause). 2 or 3 times a day I'll put my phone on the timer for 20 minutes and I lie on my bed and try, (laughs), "hypnotise myself" through the nice things I'm saying to myself. And I've started to think of the people who were my heroes as a child and get them telling me I'm good if you know what I mean?*

In this statement, Tom demonstrates how he had integrated the experiences in the therapy room and had made these his own by adapting them to continue a process of 'self-therapy' to support his growth and change. Tom's process of change clearly began in the first session with a well-judged exercise the therapist invited him to complete as between-session homework which appeared to facilitate considerable self-insight into the origin of his self-critical process. In therapy this was followed up by several sessions based on two-chair method.

*CT134-9: …. The first session she told me to write myself a dateline for homework and we came back and we went through the first 10-15 years and that was phew, that sticks out... I remember being in tears the whole session (laughs), eh, (short pause). In talking to my negative voice which was the first ever bit of role playing… I've done*

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*more than two role plays and I remember thinking as I was going home and thinking that was good I really learned something. 'Hot potato' role play- that stuck in my mind as well…I remember talking to my Child… I remember it being really, really important as I can remember my feelings at the time. I can remember my feelings now…It was just years… of emotion… maybe anger in there as well. Eh, (sighs) I think relief as well I suppose as I was doing that role play.*

Clearly the two-chair sessions had been highly significant experiences for Tom. Following this he described a progressive process of increased self-awareness, challenging his beliefs about himself, identifying the origins of his beliefs and gaining a sense of mastery and ability to change which was guided and facilitated by his therapist's nurturing and encouragement;

CT143: *…I think coming here has made me realise I have got a lot of self-criticism from my mind (short pause). Maybe I felt myself as, I don't know, not really bright, not really intelligent, so probably didn't do very well at school. I think coming here to therapy, [my therapist] would say "you've done this, you're working this out and you're working that out for yourself. So am here to guide you but you're doing it all yourself" and say "if you're not very clever you wouldn't be able to do all this". So that made me think you know, I can do things so the future is positive if I put my mind to something I can do it.*

He elaborated on his change process and how addressing his self-critical ego state dialogue and its origins and exploring his parents' behaviour facilitated broader interpersonal learning.

CT156-8: *When… things started to become better and work it's like a cog- other things started to go right… I think the main cogs were going through the negative voice…  I think obviously learning about… other people made me feel ok and… understand other people better…once I started to understand my parents …I started to get the jist of understanding other people.*

Tom provided some clear feedback on how he had experienced his therapist as striking a potent balance of empathy, supportiveness and perceptiveness.

CT166-8: *As a person she was very friendly, welcoming straight away.  She put me at ease which was very important… she was fantastic in the role play with me as a Child …Really supportive… non- judgemental… It seemed as though my Child had someone else there to… look after (me).  It was like an uncanny knack of saying the right thing at the right time and she knew exactly what I was feeling, when I was feeling it or seemed to do.  At times she could have just been, in there (pointing to his head and his chest).  I think there may have been some times where, (I was) holding something back, she'd notice straight away.  She'd say "is there something else?" and I'd say yeah there is and she knew straight away…so, I couldn't get away with anything (Laughs)…  Some things came out which were harder than others but she had a way of getting it*

**5.3.6. HSCED Process**

*5.3.6.1. Affirmative Case*

The affirmative team put forward four main lines of evidence which they argued provided clear and compelling evidence that Tom had changed substantially and that these changes had been due to therapy.

The first line of evidence related to significant changes indicated in quantitative and qualitative outcome measures. In compiling the PQ at the pre-therapy intake, Tom identified five main problems which he was seeking to resolve in psychotherapy, all of which were problems of over ten years in duration.  All five problems had changed at the level of clinical significance by session eight, and these changes continued through therapy, and two problems continued to improve slightly after conclusion of therapy by three-month follow-up. Despite some deterioration between three and six-month follow-up, Tom had continued to maintain reliable change from pre-therapy levels, supporting the argument that his changes had been significant and lasting. The affirmative team considered this to be convincing evidence that Tom changed substantially during the course of therapy, and that these were permanent changes.

The affirmative team also highlighted the detailed description of change that Tom provided in his Change Interview, which included changes in his self-esteem, confidence, problem-solving ability, style of relating to others and how he interpreted events. Additionally, the affirmative team noted Tom provided additional description of physical changes, such as changes in how he walks and interacts with others which had been pointed out to him by his girlfriend. There was also evidence of significant life changes- Tom had moved to a different city to live with his girlfriend and had left the job he had held since leaving school, starting a new more challenging job and starting a part-time college course.

The second line of evidence came from Tom's retrospective attribution that his changes had come about as a result of therapy. Although Tom had started his change and self-development process prior to starting therapy, he was clear that therapy had

been the main agent of change and described eight changes since starting therapy, and stated that all eight would have been unlikely to have occurred without therapy.

Tom's responses in the Helpful Aspects of Therapy forms provided a third line of evidence by suggesting strong plausible links between therapy interventions and events (for which Tom provided detailed and specific description) and Tom's overall changes. These related to changes in his self-esteem, self-critical process, increased insight into the origins of his problems, exploration of his relationships with others, interpersonal changes and the development of a sense of hope for the future.

The fourth line of evidence related to clear and convincing event-shift sequences where significant sessions (which Tom had rated as helpful and also described in his post-therapy Change Interview) corresponded with a subsequent reliable change on his weekly PQ and CORE scores. Although Tom demonstrated consistent gradual improvement from the outset, in particular, sessions four, seven and eight all seemed to result in substantial improvement and all of which were sessions which both Tom and his therapist highlighted as important. In the Change Interview Tom provided a description of the specific therapy events which took place in the sessions which he felt had produced these therapeutic shifts.

### 5.3.6.2. Sceptic Case

The sceptic team considered that although it was clear that Tom did indeed change, there was evidence to cast doubt on claims that these changes came about as a direct result of therapy. In particular, the sceptic team highlighted that there appeared to be strong evidence of expectancy factors in Tom's case and that it was also possible that his self-help efforts had a greater effect than the therapy and were a primary cause of

his changes. Furthermore, the sceptic team considered that it was possible that some of Tom's changes could be associated with a strong positive transference to his therapist (relational factors) as opposed to internal re-structuring. Finally, the sceptic team noted that although Tom had shown reliable improvement from pre-therapy levels, his scores on all outcome measures at six-month follow up had shown reliable deterioration from the three-month follow-up therefore suggesting that his changes were temporary and not associated with deep, permanent internal changes.

### 5.3.6.3. Affirmative Rebuttal

The rebuttal of the affirmative team rejected the possibility of relational factors as a significant factor which they considered was not supported by a detailed examination of the evidence. The affirmative team emphasized that although Tom was very positive about his therapy and his therapist his account was well balanced with a clear description of many aspects of the therapy which he found to be difficult and painful. Also, the affirmative team considered that Tom's description of the therapy process was plausible and realistic and his description of the therapy was not overly focused on the therapist, but more on the process of therapy- indeed Tom provided very little in the way of positive description of his therapist, preferring to describe specific within-therapy events.

The affirmative team highlighted that Tom's changes were maintained at the three-month follow-up and although they showed deterioration at the six-month follow up, argued that this was a temporary state of distress and could be entirely accounted for by the external changes in his life- he had moved to a different city, has started living with his partner and her children, had a new challenging job and had started a college

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course- all of which are major life changes and would be likely to require considerable adjustment. In support of this argument, they cited Tom's statement at six-month follow-up that he his 'happy, contented and not really worried about the future' and that he no longer feels like a failure, arguing that it would be unlikely that he would make these statements if his self-esteem had significantly deteriorated.

The affirmative team's rebuttal rejected the argument that Tom's changes could be accounted for by expectancy or due to the effects of self-help efforts by citing that although Tom had engaged in pre-therapy reading, in his Change Interview, he stated clearly that his reading had only taken him so far and that he was aware of the limitations of self-help strategies for facilitating change. The affirmative team also considered it only natural that a client would come to therapy with clear expectations of change in specific problem areas and would anticipate improvement in those areas, particularly if they had engaged in reading which explained the nature of the changes people can gain from therapy. They also noted that although Tom did have some positive expectations of change, he did indeed find some of his changes to be very surprising- in particular those relating to interpersonal changes. The affirmative team once again emphasized their view that Tom changed substantially and that the evidence that these changes were a result of therapy was so compelling and supported by triangulation of all quantitative and qualitative measures which converged to form repeatedly supported and substantiated evidence supporting these claims and that the arguments put forward by the sceptic team were not sufficient to account for changes of the magnitude of Tom's.

### 5.3.6.4. Sceptic Rebuttal

The sceptic rebuttal remained focused on the strong possibility of relational factors, expectancy and self-help strategies in promoting change. The sceptic rebuttal considered the possibility that the specific within-therapy events Tom described may have been highly emotional experiences for him, but not ones which produced lasting change. The sceptic rebuttal also emphasized the reliable deterioration in all of Tom's outcome measures to a level which moved him back into clinical levels of distress on his PQ and CORE scores as indicating that his changes were not permanent and that his optimism in his six-month follow-up statement may have been associated with 'wishful thinking' as opposed to deep internal changes. In particular, the sceptic team noted that at the six month follow-up Tom had started to experience a return in his self-criticism and feeling socially inferior to others, again suggesting his changes were temporary.

### 5.3.7. Adjudication

The three judges separately reviewed the rich case record and affirmative and sceptic cases and independently produced their reports regarding their verdicts on the case. The judges' verdicts and a mean score of all three judges' conclusions are presented below in table 5.3.4. To summarise, the majority verdict of the judges was that this was a positive outcome case, with Tom experiencing clinically significant change and had changed considerably-substantially and that these changes were considerably-substantially due to therapy.

### 5.3.7.1. Summary of Opinions of How the Judges Categorised this Case

There was a majority conclusion that this was a good outcome case, with two of the judges considering this to be a clearly good outcome case[21] and the third judge considering this to be a mixed outcome case (problem not completely solved). This gave a mean score for clearly positive outcome at 70% and a mean score for mixed outcome at 80%. The judges cited that both the qualitative data from the Change Interview and the quantitative outcome data demonstrated positive change with a general trend towards recovery. Judge C explained her scepticism about the outcome as relating to the decline at the six month follow up, and although she felt that Tom had clearly benefitted from therapy, she noted that he had experienced some deterioration and was struggling to manage some of his current stressors and that this suggested that Tom was not able to respond to these in a fully resourceful way which maintained his gains.

### 5.3.7.2. Summary of Opinions Regarding the Extent to which the Client Changed

The verdict of judges A and B was that Tom had changed substantially whilst judge C's verdict was that he had changed considerably, giving a mean score of Tom's changes during therapy of 73.3%. The judges all agreed on their level of confidence in their conclusions, with a certainty level of 80%.

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[21] One of the judges stated that they felt the overall outcome was good, although rated the mixed outcome verdict as higher than the good outcome verdict because they believed that Tom had not resolved *all* of his problems. Nevertheless, this judge asserted their view that the case was of an 'effective, good outcome case'

### 5.3.7.3. Summary of Opinions as to Whether the Changes Were Due to Therapy

Judges A and B were in agreement that that Tom's changes were substantially (80%) due to the effects of therapy, whereas judge C felt that his changes were considerably due to therapy (60%), which resulted in a mean verdict that Tom had changed considerably-substantially due to therapy (73.3%).

Judge C noted that the major life changes which Tom had made by the six-month follow-up provided persuasive evidence that Tom had changed to the extent that he was able to make radical changes in his life and build a satisfying relationship with his 'new family'. The judges were all in agreement that although his pre-therapy reading had been useful to him that this had not resulted in major life change and that it was unlikely that expectancy factors would produce these life changes. It was also noted by the judges that in spite of the deterioration at six months, Tom was able to maintain a positive outlook about his future.

**Table 5.3.4. Adjudication Decisions**

|  | Judge A | Judge B | Judge C | Mean |
|---|---|---|---|---|
| 1How would you categorise this case?<br><br>How certain are you? |  |  |  |  |
| 1a Clearly good outcome (problem completely solved) | 100% | 70% | 40% | 70% |
| 1b Mixed Outcome (problem not completely solved) | (score not given) | 100% | 60% | 80% |
| 1c Negative/ Poor Outcome | 0% | 0% | 20% | 6.6% |
| 2 To what extent did the client change over the course of therapy? | 80%<br><br>Substantially | 80%<br><br>Substantially | 60%<br><br>Considerably | 73.3%<br><br>Considerably-substantially |
| 2a How certain are you? | 100% | 80% | 60% | 80% |
| 3 To what extent is this change due to therapy? | 80%<br><br>Substantially | 80%<br><br>Substantially | 60%<br><br>Considerably | 73.3%<br><br>Considerably-substantially |
| 3a How certain are you? | 100% | 80% | 60% | 80% |

### 5.3.7.4. Mediator Factors

The judges were asked to provide their opinion on which therapist characteristics, therapeutic factors and processes had been most helpful in this case.

Judges A and B agreed that the therapist's use of two-chair methods had been pivotal in this case, and had helped Tom to deal with his self-critical process (largely associated with his harsh Parental introjects), express emotions, see things from a different perspective and in particular resolve aspects of his emotions and script decisions connected to his historical relationship with his mother.

Judge A noted that the 'life map' exercise at the outset of therapy had clearly been an important, emotional and helpful experience for Tom. Judge B also noted that aspects of the therapy which provided Tom with practical strategies for improving his communication style with others were also important and felt that the use of TA concepts to help Tom conceptualise his process (such as rackets, script, permissions and ego states) had also been helpful. Judge B highlighted the empathic, non-judgmental and highly active approach of the therapist had been important in this case and noted that the therapist successfully processed and repaired an alliance rupture at session six which had been helpful.

### 5.3.7.5. Moderator Factors

The judges were asked to comment on client factors, including the client's resources and approach to the therapy which had enabled them to make the most of the therapy and enhanced the therapy process. All judges agreed that Tom's pre-therapy reading and research into TA, hope for change and his clear motivation and readiness to

change had been helpful factors that had enabled him to engage with the therapist and the therapy process. The judges also agreed that Tom's determination and willingness to engage with painful emotions and life experiences and actively make use of the therapy to resolve. Judge C noted that Tom's desire to have a more satisfying relationship with his partner and her children and the fact that Tom was paying privately for therapy had also likely been motivating factors which had inspired to engage in the change process.

### 5.3.8. Case Conclusion

Overall, the therapy was effective for Tom, with the judges holding the view that he had resolved most of his issues and made considerable life changes, but had struggled to maintain some of his gains when under stress.

There were a number of interesting technical features relating to Tom's case, in particular, the use of two-chair techniques to address his self-critical process. As in the previous cases, the safety of the therapeutic relationship and the highly active therapist stance appeared to have been important factors, as was his proactive engagement with the therapy process.

# Case Four: Linda[22]

**5.4.1. Client Description**

Linda was a 45 year old woman who lived with her husband of over 20 years with whom she described having a loving and supportive relationship.  At the time of entering therapy Linda had been unemployed for over two years after having walked out of her last job where she had experienced bullying from the management team.  Since then she had been at college for a year studying digital graphics.  When she started therapy she said she had lost confidence in herself and her ability to put herself forward at interviews and to 'fit in'.

Linda had a difficult relationship with her mother and described her as a cold and critical woman and stated that she could not remember her mother praising or being nurturing towards her during her childhood. Due to all of this, and despite her mother having recently being diagnosed with terminal cancer, during the course of therapy Linda stated that she did not love her mother. Linda had a younger sister with whom she enjoyed a close relationship.

Linda had no previous experience of therapy and was apprehensive about the process and slightly ambivalent about attending, concerned that perhaps she was not in a 'bad enough way' to merit therapy time.  She was generally in good health and had a close circle of friends who she felt supported by.

She felt her main problem stemmed from her interaction with others.  She described herself as 'too much for others' and in situations in which another person might end up

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[22] This case has been published in Widdowson, M. (2013). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Linda' - a mixed outcome case. *International Journal of Transactional Analysis Research*, 4(2): 3-15. Readers of the article were advised that the complete rich case record was available on request.

feeling upset she ended up taking responsibility for the interaction and feeling guilty.  Over time she generally had lost her confidence and had effectively shut herself off from others and was doing less and less and staying in the house most of the time and avoiding socialising with others.  She was also feeling guilty about her emotional distance with her mother and was frustrated with herself and her 'lack of direction in life'.

Linda was an intelligent, thoughtful, articulate woman.  She had a good sense of humour and was able to reflect and challenge herself about the views she held about herself, others and her life.  She had a curiosity about her process and was robust in her challenge of her therapist if she felt something did not 'fit' for her.

Due to her unemployment, Linda could not afford private therapy so self-referred to a local voluntary agency and was allocated a therapist, paying a small donation for sessions.

At her initial meeting with her therapist, the therapist conducted a brief clinical diagnostic interview to confirm diagnosis of major depressive disorder based on DSM-IV diagnostic criteria. She was screened using CORE-OM and BDI-II and met the criteria for 'caseness' and inclusion in the study. Linda's clinical score using CORE-OM was 16, indicating mild levels of distress and functional impairment and her BDI-II score was 19, indicating mild depression. She was seen in a naturalistic therapy protocol for a period of nine weekly individual sessions. Linda had been offered up to 16 sessions, but felt sufficiently improved after 8 sessions and had found a new job and decided to end therapy, so attended for a final ending session.

### 5.4.2. Therapist

The therapist in this case was 'Michelle', a white British female therapist. At the time of starting therapy with Linda, Michelle had just over 1 year post qualifying experience.

### 5.4.3. Description of the Therapy Process

#### 5.4.3.1. Generic Description of the Therapy

The therapy primarily focused on identifying and challenging how Linda experienced and interpreted the world, her communication style and interactions with others, her activity levels, and the conclusions she drew about herself. The exception to this focus was in session four which mainly focused on exploring her relationship with her mother.

#### 5.4.3.2. Description of the Therapy Interpreted from HAT Forms and Change Interview

Linda described the therapy as being a focused and boundaried relationship which emphasised drawing out her assumptions and meaning-making processes and maladaptive beliefs about self, others and the world and the impact of these on her interpersonal relationships. The therapy sought to identify, explore and re-evaluate these thinking processes and interpersonal patterns. She described how her therapist had a clear expectation that Linda would implement changes and she enjoyed 'being held to account' in actively supported to change in this way.

### 5.4.3.3. TA Description of the Therapy- Taken from Therapist's Notes

The initial phase (sessions one to three) of the therapy consisted of problem formulation and the use of the ego state model and racket system to facilitate identifying maladaptive cognitive and behavioural patterns and ways of interpreting the world and others. This initial phase also included identifying self-critical dialogue and encouragement to move towards her goals.

The second phase (session four to seven) of the therapy involved exploring interpersonal patterns (transactions, games) and developing communication strategies, exploring her relationship with her mother which involved deconfusion by encouraging the expression of previously disavowed and repressed anger, challenging maladaptive beliefs about self and others (rackets, contaminations, discounting) and ways of interpreting the world and her self-critical internal dialogue. This concluded at session seven where the therapy moved to identifying contract goals and behavioural contracting for change.

The ending phase of the therapy (sessions eight and nine) involved accounting for and celebrating Linda's changes. The therapist reported some dissatisfaction with the ending, and stated that she had felt the process was by necessity rushed, and stated that she had wanted to spend time 'planning how she would deal with problems in the future'. Unfortunately, this was not possible, so Michelle attempted to end the therapy on a positive note.

### 5.4.4. Follow-Up

#### 5.4.4.1. Three Month Follow-Up

At the three month follow up, Linda completed the CORE-OM, BDI-II and PQ. She attached a note to the forms, letting the researcher know that things had been difficult over the previous few weeks- the company she had worked for had gone bust a month earlier, and she had been made redundant. She also informed the researcher that her mother had died two weeks prior to the follow-up, following a long deterioration during which Linda had taken on some carer responsibilities.  She also stated '*I realised when I filled in the form you might be concerned. Don't worry - last week was bad, but this week is a bit better. As you know, I have a lot of support - so when I'm down, there are people who can help. Despite having a setback, I still think the counselling helped. I'm better able to articulate my feelings and not bottle it all up.'*

#### 5.4.4.2. Six Month Follow-Up

At the six month follow-up, in addition to completing the CORE-OM, PQ and BDI-II Linda enclosed a note stating that; '*I am OK in general, but still unemployed and worried for the future.  I am not clear what I should do to increase my chances of employment, however I am keeping myself well physically through regular exercise, less drinking and taking care of myself emotionally. My mum died a few months ago and it's been fine dealing with her death. I don't feel we had unfinished business and I feel able to cope- I was sad, and still am, but am not wrecked by her death. Although it can appear as though I'm back to feeling as I was pre-therapy, I don't think I am. I am a bit up and down, but therapy has helped me be calmer and have a clear eyed look at my life. It's never going to be easy, but I don't feel utterly overwhelmed'.*

## 5.4.5. Results

### 5.4.5.1. Quantitative Outcome Data

Linda's quantitative outcome data is presented in table 5.4.1. Linda's initial scores were just above the 'caseness' cut-off range for inclusion in this study. Her BDI-II score at entry into therapy was 19, indicating mild depression and her CORE-OM score was 16, indicating mild levels of global distress and functional impairment.  Linda's CORE-OM and BDI-II scores had demonstrated clinically significant change by session eight, with all measures showing clinically significant change by session nine. This improvement was maintained at the first follow-up period, but then Linda showed marked deterioration at the three-month follow-up, with her BDI-II score showing reliable improvement to just above clinical levels of distress at the six-month follow-up.

**Table 5.4.1. Linda's Quantitative Outcome Data**

| | Recovery cut-off | Inclusion cut-off | Reliable Change Index | Pre-Therapy | Session 8 | Session 9 | 1 month Follow-up | 3 month Follow-up | 6 month Follow-up |
|---|---|---|---|---|---|---|---|---|---|
| Beck Depression Inventory-II | 10 | 16 | 5.78 | **19** | 2 (++) | 0 (++) | 0 (++) | **23** | 12 (+) |
| CORE-OM | 10 | 15 | 6.0 | **16** | 2 (++) | 2 (++) | 4 (++) | 11 | 11 |
| Personal Questionnaire (mean score) | 3.00 | 3.50 | 1.0 | **5** | **3.1 (+)** | 2.4 (++) | 2.1 (++) | **4.7** | **5** |

*Note: Values in bold are within clinical range. + indicates Reliable Change, ++ indicates clinically significant change.*

*Figure 5.4.1. Weekly CORE Scores*
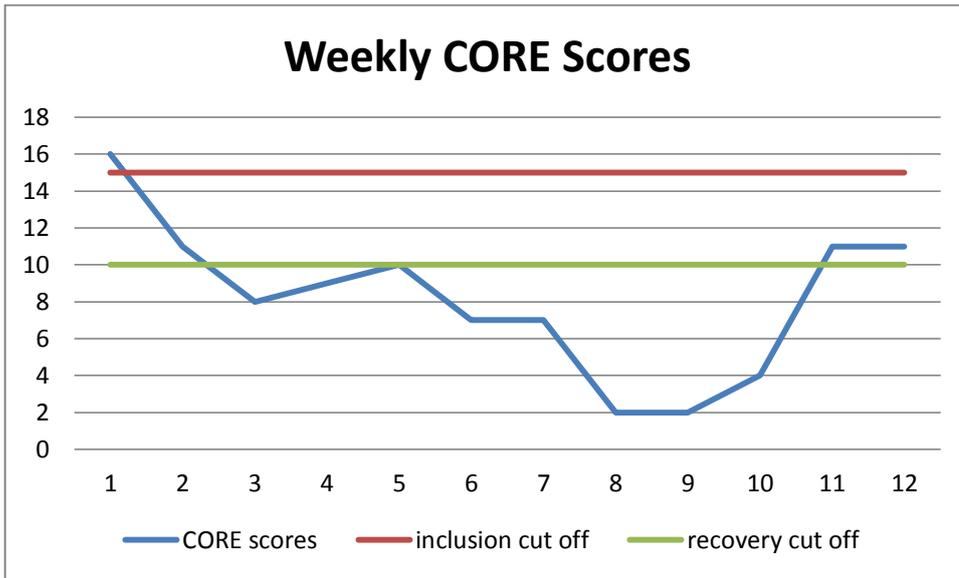


Weekly CORE Scores

*Note: 10, 11 and 12 relate to the follow-up periods*

*Figure 5.4.2. Weekly Mean PQ Scores*



PQ Scores
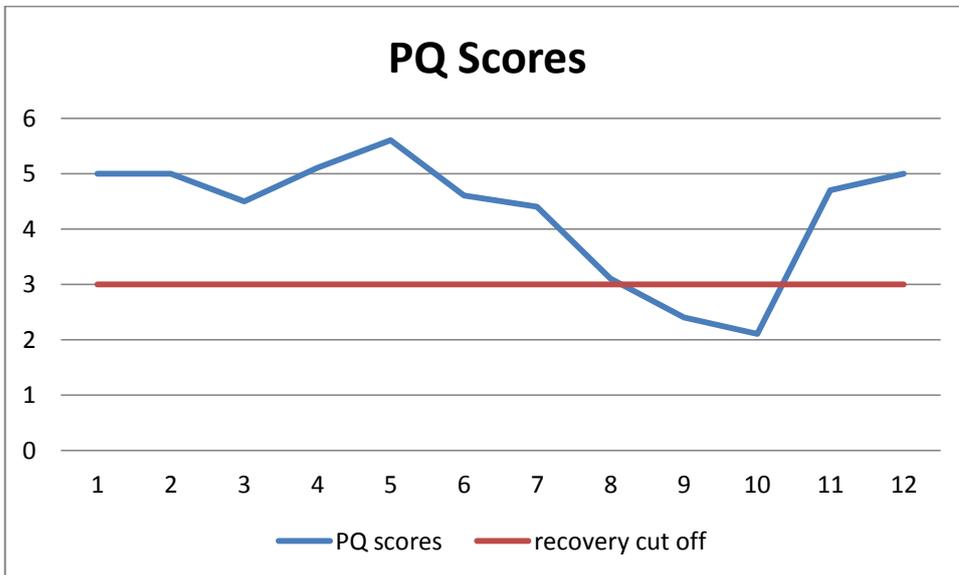
*Note: 10, 11 and 12 relate to the follow-up periods*

***Table 5.4.2. Quantitative Process Data- Working Alliance Inventory***

The therapist and client both completed the short form Working Alliance Inventory at sessions 1, 3 and 6. Each item is rated on a six-point Likert scale, with higher scores indicating greater satisfaction. Data from this procedure is presented below.

| ***Session 1*** | Client | Therapist |
|---|---|---|
| Task | 6 | 4.5 |
| Goals | 6 | 4.5 |
| Bond | 6.25 | 4.75 |
| Mean Score | 6.08 | 4.58 |
| ***Session 3*** | | |
| Task | 6.25 | 4.25 |
| Goals | 6.25 | 4.25 |
| Bond | 6 | 4.75 |
| Mean Score | 6.16 | 4.41 |
| ***Session 6*** | | |
| Task | 6.5 | 5 |
| Goals | 6 | 5 |
| Bond | 6.75 | 5.25 |
| Mean Score | 6.41 | 5.08 |
| ***Combined Mean Scores*** | | |
| Task | 6.25 | 4.58 |
| Goals | 6.08 | 4.58 |
| Bond | 6.33 | 4.91 |
| Mean Score | 6.21 | 4.69 |

### 5.4.5.3. Qualitative Outcome Data

Linda identified four main changes in her Change Interview. These are presented below in table 5.4.3.

**Table 5.4.3. Linda's Changes as Identified in Post-Therapy Change Interview**

| Change | How much expected/surprising change was [a] | How unlikely/likely change would have been without therapy [b] | Importance of change [c] |
|---|---|---|---|
| Feeling Calm and Competent | 2 | 2 | 5 |
| Not making assumptions and changing how I relate to people | 4 | 1 | 4 |
| Being more open, vulnerable and less tense | 2 | 1 | 3 |
| Feeling OK about my relationship with my mum and not feeling guilty | 4 | 1 | 5 |

[a] The ratings are on a scale from 1 to 5; 1= expected, 3= neither, 5= surprising

[b] The ratings are on a scale from 1 to 5; 1=unlikely, 3=neither, 5=likely

[c] The ratings are on a scale from 1 to 5; 1=slightly, 3 = moderately, 4=very, 5=extremely

### 5.4.5.4. Analysis of Change Interview responses

For Linda, the professional relationship aspect of the therapy was important.

CL2: ... *I really liked the professional relationship.  I liked that I was paying.  I liked that*

*this was an hour a week that I could take all that stuff and so it clarified things.  So if*

*you had things going on during the week you could just park that up and say I can take*

*that... She wasn't your friend who was going to say you are great and you're fine. You could be challenged, you know.*

CL15: *(in therapy), you have to go a bit deeper… Somebody maybe just asking you more pertinent questions, asking you to kind of look at what you're saying in a bit more depth*

She found the therapist's challenge and depth of questioning helped her to maintain focus on the problem areas and also in identifying and changing her maladaptive patterns

CL17-20: *So, it's kind of people picking things up that they might not have otherwise. But I suppose it could be just asking, "what do you mean by that?" or "why is this an issue?", or whatever. So, it is just going a bit deeper. I don't think it was… (short pause), again it's not magic. It's just talking but it is talking in a particular way… Which is more structured… I guess I it makes you consider things a bit more. It just makes you think through a bit more. I suppose in between sessions you are more aware of things that you have discussed and trying to kind of looking at that and think oh yeah, we talked about this and now in the situation and how I'm dealing with it and because it is more structured so there is somebody bringing you back to the main points.*

This combination of a safe, professional relationship and sustained focus on her inner process assisted her in challenging and disconfirming her maladaptive internal and interpersonal patterns.

CL46: *… well for me it's a lot about that relationship, right, so there has to be notions of trust and so you are in a room with somebody who trusts you, you trust and you can*

*talk about what you identify as being important to you. You are in the driving seat. What's bugging you, what's irritating you? You put it out there and there's a discussion about it. This is an equal relationship. There is not anyone telling you what to feel about it, what to think about it, what to do about it. It's putting stuff out there and kind of looking at it from different angles. I suppose it's like you put something down and you can walk around and you can look at it. You can examine it. It kind of takes it out of your head.*

CL52-4: *There is that process of kind of making yourself vulnerable, it has to go out there and again I suppose in the therapy situation you have got a safe space to do that. It's good to test things out if you like. Within there, all of things you have going round in your head thinking "I am bonkers". "This is just bonkers, why am I thinking that?" If you put it out there, oh look! You know, the world is still turning. Nothing has happened, no bad things have happened, you can talk about this. The world is here and everything is fine and this is ok.*

CL60: *It is a qualitative difference from just sitting down with your mates, your partner, whatever … So it's not just about the talking. Constructive dialogue… Where you have very, very strong focus on a particular thing and you are seeking to kind of deconstruct it, put it back together, do whatever with it to try and make sense of it.*

### 5.4.5.5. Additional comments

Linda was emphatic that participating in the research had not been problematic for her. She was also clear that there had not been any aspects of her therapy which had felt incomplete and she did not identify any aspects of therapy which had been

unhelpful. Although she stated that she had found the ego state model helpful, she did express a natural aversion to anything which might be 'putting people into boxes'.

### 5.4.6. HSCED Process

#### 5.4.6.1. Affirmative case

Linda identified nine main problems which she was seeking to resolve in psychotherapy, all of which had reliably changed by session eight and had changed at the level of clinical significance by session nine- the final session. These changes were sustained at one month follow-up. Although Linda demonstrated deterioration on outcome measures at both the three and six month follow-up periods, the affirmative team's perspective was that this could be accounted for by her mother's death and her long period of unemployment. Linda was quite emphatic in her statements at the three and six month follow-up that she felt different and felt that the therapy had helped and was coping with things differently to her pre-therapy state.

In considering the quantitative measures, the affirmative team highlighted that by session eight Linda's BDI-II scores had dropped 17 points to 2 and her CORE scores had dropped 14 points to 2- both within the 'normal range' which was maintained at one month follow-up. Her PQ scores also demonstrated clinically significant change by the end of therapy and at one month follow-up. Although there was some deterioration in Linda's PQ scores at six month follow-up compared to end of therapy, five of her nine scores still demonstrated reliable change from pre-therapy scores, again suggesting

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that some permanent changes had taken place, and that the deterioration was possibly a reactive effect of prolonged and extreme stress.

The affirmative team noted Linda's clarity and specificity in the changes she had experienced in her Change Interview, and in Linda's conviction in her three and six month follow-up statements that she was coping with things better than she had done prior to therapy. Associated with this, the affirmative team highlighted that Linda had identified five contract goals for her therapy which she felt she had achieved and which her three and six month statements suggest were maintained.

The affirmative team commented that throughout her Change Interview, Linda clearly attributed her changes to therapy and provided a clear and detailed description of therapy process which they argued provided a convincing account of change. Indeed, in both her HAT forms and her Change Interview, Linda provided considerable detail about the helpful aspects of the therapy process which the affirmative team considered provided clear and plausible links between therapy process and outcomes.

The affirmative team noted that although the biggest changes for Linda took place after her job offer, that her CORE scores had showed clinically significant change within the first three sessions- prior to her job interview, and that this provided evidence that therapy had been a causal factor in Linda's changes.

### 5.4.6.2. Sceptic Case

The sceptic team concluded that there was strong evidence to cast doubt on claims that Linda changed substantially and that these changes were due to therapy, highlighting three major lines of evidence. Firstly, Linda demonstrated the largest

change after securing a new job, suggesting external factors were highly significant in causing her apparent changes. Secondly, Linda's changes were not maintained during the follow-up, suggesting that her changes were temporary- indeed during the follow-up period Linda experienced a bereavement and redundancy and these clearly had a significant impact on her, leading to reliable deterioration which casts doubt on any claims of internal changes having taken place during therapy. Thirdly, there was reason to consider that relational factors and Linda's liking of her therapist may have accounted for some of her reported enthusiasm and positivity about therapy.

### 5.4.6.3. Affirmative Rebuttals

Linda was clear in her three and six month follow-up statements that although there was apparent deterioration, that she did not feel that she was in the same situation as she was prior to therapy and felt that she had made some permanent changes in how she related to others, and how she resourced herself. She was also clear that her deterioration was due to the effect of external factors- in particular her mother's death and her redundancy.

Linda described herself as analytical and cynical, and had been sceptical about therapy at the outset. The affirmative team considered that it was unlikely that someone like this would be painting an overly positive picture of therapy if she did not genuinely believe it to be true. She was clear that her therapist was active, often challenging, but that this was an aspect of the therapy that she welcomed. She also suggested that her therapist did not adopt an 'overly nice' position in relation to her and had clear expectations of Linda and that she had found this robust and challenging approach to be a catalyst for change which suited her own personality. Although Linda was positive

about her therapy, the affirmative team felt that her detailed and idiosyncratic account of the therapy process provided sufficient evidence that Linda's change was not due to relational factors.

### 5.4.6.4. Sceptic Rebuttals

The sceptic team maintained that Linda's deterioration in all her outcome measures cast substantial doubt over claims that Linda changed very much during therapy and that any changes were transient and not stable under stress.

Despite her statements during follow-up that she was handling problems differently, the sceptic team noted that several of her initial problems had returned to clinical levels. The sceptic team believed that there was a strong argument to believe that Linda's positive changes were more likely to be associated with extra-therapy factors- in particular getting a new job, rather than indicative of personal changes due to therapy.

### 5.4.7. Adjudication

All judges independently produced their opinions and ratings of the case which are presented in table 5.4.4. below. A mean score has been given to represent a balance of their conclusions. In summary, the judges felt that although Linda had benefitted from therapy that this was a clearly mixed outcome case.

### 5.4.7.1. Summary of Opinions Regarding How the Judges Categorised this Case

The judges agreed that there was evidence that Linda had changed during therapy, however noted her deterioration during the follow-up period as suggestive that her

changes had not been sustained and therefore concluded that this was a mixed outcome case.

Judge A commented '*the client clearly attributes her changes to therapy and provides idiosyncratic detail about how these changes have been maintained at follow-up even though the outcome scores would suggest otherwise. It would appear that the therapy process has given the client resources for coping despite distressing life events occurring post-therapy, and her qualitative accounts seem to confirm that she has found the process useful in helping her cope with these challenges.*' Judge C made similar comments, and was particularly struck by Linda's assertion that she was relating to people differently at the end of therapy.

The judges agreed that the impact of external factors had both positive and negative effects on the outcome of the therapy- with Linda improving considerably after succeeding in finding a job after her long unemployment during the course of therapy (she attributed her success in interview to therapy) and then her post-therapy decline which she attributed to the effects of bereavement and redundancy from her new job. It was considered by one judge a possibility that Linda was still in a period of adjustment following these events and that a longer follow-up period would have provided information on whether she would return to an improved level of functioning. Judge C noted that simultaneous improvement on CORE and BDI showed a convincing sign that real change had indeed taken place and agreed that adverse life-events post therapy were most likely the reason for her seeming deterioration, as opposed to any reversal of changes.

Judge B noted that in her statements during the follow-up, '*Linda described feeling differently and able to cope with situations better. It seems as if she changed her personal strategy to change from having to cope with things on her own and drinking alcohol to being willing to show her vulnerability and trust people to being accepting of her perceived weaknesses. This change allowed her to stay connected with others and being open to different perspectives or help. Also it appears that therapy helped her to cope with unfinished businesses related to her mother- she described throughout that the sense of guilt had been worked through. Also when being asked what helped her to get the job, she referred to her increased self-confidence… which she attributed to therapy'*. The conclusion of the judges was that although Linda had improved by the end of therapy these improvements could not be demonstrated to be stable and enduring.

### 5.4.7.2. Summary of Opinions Regarding the Extent to which the Client Changed

The majority verdict of the judges was that Linda had changed substantially *during* therapy- achieving reliable, clinical change, but these changes had not been sustained during the follow-up. Judges A and C noted that the affirmative team's argument that Linda's distress at the 3 month follow-up was due to the effects of acute grief and recent redundancy was plausible and was supported by improvement to sub-clinical range on BDI-II at six month follow-up. Judge A noted that '*there is a contradiction between the client's outcome scores, and the self-report statements about how she is coping, and doing better than the outcome measures would indicate. The question here is whether the outcome measures were accurately examining the areas of change reported, or whether the client was attempting to reconcile some dissonance she felt*

*about the process by affirming that she had indeed changed permanently despite the lack of evidence in the outcome scores.'*

### 5.4.7.3. Summary of Opinions as to Whether the Changes were Due to Therapy

The judges agreed that Linda had provided a detailed, consistent and idiosyncratic account of the key aspects of the change process but disagreed about the affirmative team's arguments regarding process-outcome matching and event-shift sequences, with judges A and C considering these to be plausible and judge B being unconvinced by them. Judge A in particular felt impacted by Linda's emphatic statements of the helpfulness of therapy in her change interview, stating '*The qualitative data from the Change Interview is important in this decision about whether the client changed during therapy. The client reports clearly indicate that she feel she changed substantially with 4 significant changes identified. These changes correspond to the client's therapeutic goals, and were identified as important/ very important by the client. I think this is corroborated by the evidence in particular HAT descriptions which correspond to these changes. Since particular therapy events were highlighted by the client as being helpful, and because these correspond with the identified changes at the follow-up interview, there is a more substantive argument that the process of therapy was helpful in bringing about client change'*. Judge C made very similar observations.

Judge B commented on the impact of external factors on the changes Linda experienced, in particular her new job which she felt '*prompted a substantial shift in outcomes and led to a rapid conclusion of therapy. Nevertheless, it appears that therapy facilitated this process by helping the client to gain more confidence in preparation for the job interview. I would question the stability of these changes,*

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*however, because outcomes during follow-up were negatively affected by external factors such as loss of job and death of mother. Undoubtedly, these factors would have had a significant impact on the client, but the qualitative reports from the client indicate that the changes during the course of therapy helped her to cope with these difficulties better, even some time after therapy ended.  It appears that therapy factors and external life factors are closely inter-linked in these outcome areas. For this reason, I would say that the changes the client reported at the end of therapy were largely the result of the therapy experience, but that external factors also played a role in moderating these effects.'* Judges B and C also went on to note Linda's clear retrospective attribution of therapy as a catalyst for change and being important to take into account and felt that this combined with the role Linda attributed to therapy in enabling her to work through her guilt and unfinished business in her relationship with her mother were all clear evidence that therapy positively contributed to her changes.

**Table 5.4.4. Adjudication Decisions**

|  | Judge A | Judge B | Judge C | Mean |
|---|---|---|---|---|
| 1How would you categorise this case? How certain are you? |  |  |  |  |
| 1a Clearly good outcome (problem completely solved) | 60% | (no score given) | 0% | Not Applicable |
| 1b Mixed Outcome (problem not completely solved) | 100% | 80% | 80% | 86% |
| 1c Negative/ Poor Outcome | 20% | (no score given) | 0% | Not Applicable |
| 2 To what extent did the client change over the course of therapy? | 60% | 80% | 60% | 66% |
| 2a How certain are you? | 80% | 80% | 80% | 80% |
| 3 To what extent is this change due to therapy? | 60% | (no score given) | 80% | 70% |
| 3a How certain are you? | 100% | (no score given) | 80% | 90% |

### 5.4.7.4. Mediator Factors

Judge A highlighted *'the… non-judgemental nature of the therapist (as being)… a very important factor in building a strong therapeutic alliance. This seems to have paved the way for the work done in therapy, as the client seemed able to trust her therapist, and to be challenged by her. The therapist's manner of questioning and challenging the client was an apparent mediator in the change process.'*

Judge B highlighted the role of feedback given to the client by her therapist as likely to have been an important mediator factor. In particular she highlighted *'Linda's remarks in the HAT descriptions that the feedback on her behaviours and way of being was helpful to her in beginning to think about a different way of being and relating to others.'* Judge B also noted the sense of trust and equality in a relationship with a fully engaged therapist and the structure and boundaries of the therapy as being likely mediator factors. Furthermore, judge B highlighted some key intervention approaches which Linda found helpful which included the therapist's sustained focus, in-depth questioning, exploration of issues and offering alternative perspectives. Judge B considered that these may have caused change by helping Linda to increase her awareness, change her frame of reference, develop a new narrative, encouraged and reinforced her change process. Judge B also commented that the main therapeutic strategy which appeared to be relevant in guiding this process was the therapist's focus on helping Linda to identify, re-evaluate and change problematic thinking and behaviour patterns.

Judge C highlighted the helpfulness of the use of theory to help Linda conceptualise her process, combined with a sense of equality in the relationship and of 'being met' by her therapist as significant.

All judges agreed that the therapist's affirmative, validating and permissive approach enabled Linda to experience a sense of acceptance and gave her hope that things might change. This was balanced with a sense of the therapist being strong, having a sense of humour and maintaining a stance that both encouraged Linda to take charge and make active changes and discouraged avoidance.

### 5.4.7.5. Moderator Factors

The judges were also asked to provide an opinion on which client characteristics or resources had been helpful to her in the process of change. The judges agreed that Linda appeared to have a strong social network which was supportive of her changes (in particular her new-found willingness to be emotionally vulnerable in relationships) and provided emotional resources to help her deal with difficult life events.  Another helpful factor was considered to have been the fact that Linda had identified problematic coping strategies and issues to work on in therapy prior to attending.

In addition, Linda's motivation, determination and active approach to change was highlighted as an adaptive change strategy as was her desire to both take charge of her life and be 'in the driving seat' of her own therapy.  Judges B and C noted that Linda took a series of active steps to breaking her vicious cycle of low self-confidence by pushing herself to go out into the world, her willingness to see things from different perspectives, and her engagement with the contradiction of striving for privacy whilst needing to open up, share problems and be vulnerable in her close relationships. Judge

B felt that this enabled Linda to challenge her characteristic way of being in relationships and enabled Linda to have corrective interpersonal experiences which supported her change.

### 5.4.8. Case Conclusion

Linda did indeed make positive changes during therapy, although these benefits were not sustained. It would seem that the therapy was ended prematurely and did not give Linda time to consolidate her gains or develop relapse prevention skills. It is difficult to tell whether the return of Linda's symptoms are connected to her bereavement and redundancy or represent a relapse. Nevertheless, Linda was clear that she had made a number of permanent changes in how she dealt with her feelings and related to others.

# Case Five: Kerry

### 5.5.1. Client Description

Kerry was a 40 year old woman who lived alone and who presented for therapy with moderate-severe recurrent depression. Ten months prior to starting therapy, she had been made redundant from an academic job in a university. She had attended counselling several times over a number of years for several sessions of 'crisis management', the latest was two years previously for around 6 sessions. She was in good physical health, although reported some excessive sleeping when she was coping with difficult feelings. Kerry has two younger sisters, with whom she has a difficult relationship. Her parents had a stormy and volatile relationship and divorced acrimoniously when she was 18. Her mother lives nearby but is emotionally unsupportive of Kerry. Her father lives a considerable distance away with his new wife. Kerry described both parents as having always been emotionally distant and she has no extended family.

Kerry's internal world was characterised by feelings of being inadequate and harsh self-critical internal dialogue. Interpersonally, she was socially isolated, with only a small number of friends, all of whom were very busy and lived a considerable distance away. At the point of entry into therapy, she was in a two-year stormy and destructive relationship with Wendy. During the course of therapy it became apparent that Kerry struggled with feelings of shame and internalised homophobia regarding her sexual orientation. She was an intelligent and reflective woman and was aware of her tendency to isolate herself. She took steps to keep physically active and exercise regularly as she knew this helped her well-being.

Kerry's clinical score at point of entry to therapy using CORE-OM was 27, indicating moderate-severe levels of distress and functional impairment and her BDI-II score was 27, indicating moderate-severe depression.

Kerry was keen to try and resolve her depression without medication, so found the therapist who was most conveniently located for her. The therapy was conducted in private practice, and due to her unemployment Kerry paid a reduced fee for her sessions. She had thirteen sessions in total.

### 5.5.2. Therapist

The therapist in this case was Christine, a white British woman with one year post-qualifying experience. Christine had one hour of supervision on her work with Kerry per month with an experienced Teaching and Supervising Transactional Analyst.

### 5.5.3. Description of the Therapy Process

#### *5.5.3.1. Generic Description of Therapy Process*

The first seven sessions focused on problem formulation, history taking and information gathering regarding Kerry's current relationship and interpersonal problems. Christine's focus during this time was on empathic enquiry, and analysis of Kerry's intrapsychic process relating to her self-critical internal dialogue, sense of shame and inadequacy and her negative beliefs about relationships and their origins in her childhood experiences. Christine used some behavioural contracting to encourage Kerry to make positive changes, in particular regarding her activity levels and social isolation.

The therapy was then interrupted by a four week break due to Christine being ill and then Kerry being away. During this time, Kerry had a very painful ending of her relationship with Wendy and sessions eight and nine were focused on processing these immediate interpersonal problems and the ending of the relationship and explored themes of isolation and hopelessness.

The third phase of the therapy (sessions 10-13) was focused on current interpersonal problems, in particular exploring Kerry's relationships with her siblings and her parents, her shame around her sexuality and needing to remain 'in the closet' to maintain her family's support and themes of isolation and hopelessness. Christine also helped Kerry identify and challenge her self-critical internal dialogue and to develop communication strategies to improve the relationships she had with her family and friends.  Kerry found some temporary work, which involved being out of town for several months. She felt that the best option was to end therapy, and so the therapy ended prematurely and fairly suddenly at session thirteen. The final session was spent reviewing the therapy process.

### 5.5.3.2. Description of the Therapy Adapted from HAT Forms and Change Interview

Kerry's therapy focused on developing her self-awareness, including exploring and re-evaluating past events and their impact on her, her needs and reactions in current situations and also identifying how current interpersonal patterns link to her past experiences.  As part of this she explored the influence of her parents on the development of her self-critical internal dialogue and started to explore ways of tackling and responding to this self-criticism.

During therapy she identified a number of issues which she hadn't considered before, including her shame about her sexuality, problems with trust and intimacy and her view of the world as a hostile place. In doing this she explored how these issues impact on her self-esteem and relationships and how these also influence her thoughts, feelings and patterns of behaviour.  The therapy included some exploration of coping strategies and ways to improve her current relationships.

Although she struggled with issues of trust and distance between her and her therapist and found the weekly gap between sessions difficult to manage she did find the sessions useful and gained a sense of relief from talking about her problems and discussing painful events.  Overall she felt that therapy had not been sufficiently long enough for deep, lasting change to occur.

### 5.5.3.3. TA Description of the Therapy Adapted from Therapist's Notes

The first seven sessions focused on problem formulation and initial diagnosis, developing a relationship history, including exploring current interpersonal relationships. The therapist used empathic enquiry, the compilation of a racket system, the drama triangle and life script theory to understand Kerry's experiences of shame and not being good enough and to understanding how her beliefs about relationships linked to childhood experiences. The ego state model was used to conceptualise her harsh self-critical internal dialogue and the therapist used some behavioural contracting to encourage change.

This was interrupted by a four week break due to therapist illness and then Kerry being away. During this time, Kerry ended her relationship with her partner and sessions

eight and nine were focused on processing these immediate interpersonal problems and the ending of the relationship and explored themes of isolation and hopelessness.

The final phase of the therapy (sessions ten to thirteen) was focused on current interpersonal problems, in particular exploring Kerry's relationships with her siblings and her parents, shame around sexuality and needing to remain 'in the closet' to maintain her family's support and themes of isolation and hopelessness. Christine also used ego state analysis to help Kerry identify and challenge her Parent ego state messages and self-critical internal dialogue and to develop communication strategies to improve the relationships she had with her family and friends. The therapy ended abruptly at session thirteen, leaving little scope for contingency planning or detailed termination process.

### 5.5.3.4. Therapist's Reflections on the Therapy Process

Christine reported some difficulties with the intake procedure and the demands of the research and found that she was anxious about filling in the forms correctly. In particular she struggled with the Personal Questionnaire, and as such did not follow her usual intake procedure. She reported that this had a negative impact on her ability to form a therapeutic relationship, and also interfered with her normal contracting procedure, which consequently led to no clear therapy contract being agreed with Kerry. Christine was also aware of a sense of distance between her and Kerry and noted that Kerry often seemed to avoid eye contact. She also made the following observation;

*'The other main problem with the therapy was the four week break following session seven, at which stage, Kerry was making reasonable progress. The end of the break*

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*coincided with the ending of her relationship, which I believe contributed to the very big increase in CORE scores in session 8. In addition, her temporary work contract which required working away for three months meant that the last five sessions took place over a period of a few weeks- again I suspect this had an impact on the scores as the ending was rather abrupt'.*

### 5.5.4. Results

### 5.5.4.1. Quantitative Outcome Data

A summary of data from the key outcome measures in Kerry's case is presented below in table 5.5.1. Scores from CORE and PQ as measured each session and during follow-up are presented in figures 5.5.1 and 5.5.2.

*Table 5.5.1. Kerry's Quantitative Outcome Data*

|  | Recovery cut-off | Inclusion cut-off | Reliable Change Index | Pre-Therapy | Session 8 | Session 13 | 2 month Follow-up | 6 month Follow-up |
|---|---|---|---|---|---|---|---|---|
| Beck Depression Inventory-II | 10 | 16 | 5.78 | **27** | **28** | **19 (+)** | **27** | **39 (-)** |
| CORE-OM | 10 | 15 | 6.0 | **27** | **22.9** | 14.1 (+) | **19.4 (+)** | **26.7** |
| Personal Questionnaire (mean score) | 3.00 | 3.50 | 1.0 | **4.4** | **5.08** | 4.08 | 5.0 | 5.5 (-) |

*Note: Values in bold are within clinical range. + indicates Reliable Change, ++ indicates clinically significant change, - indicates reliable deterioration*

*Figure 5.5.1. Weekly CORE Scores*
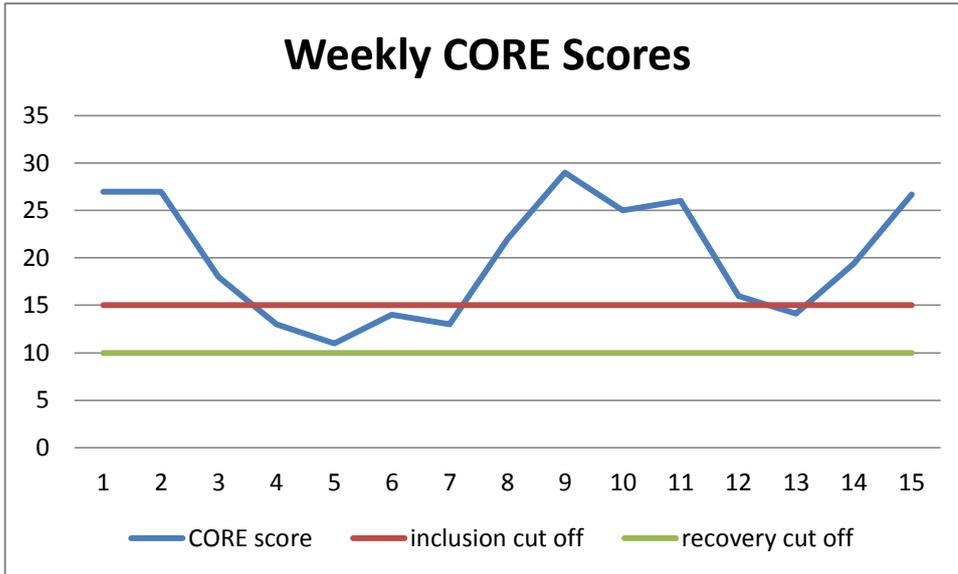


**Weekly CORE Scores**

*Note: scores 14 and 15 relate to the follow-up period*

*Figure 5.5.2. Weekly Mean PQ Scores*
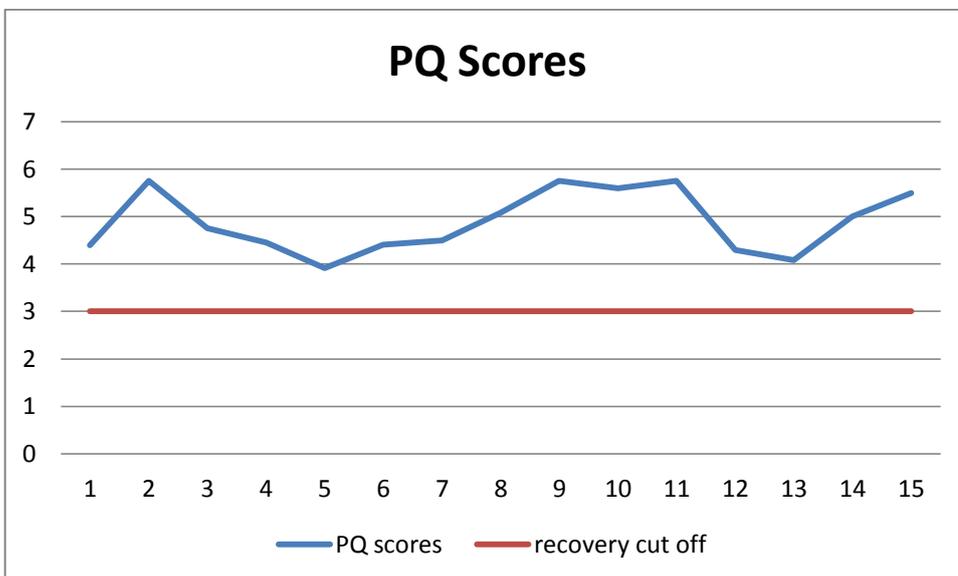


**PQ Scores**

*Note: scores 14 and 15 relate to the follow-up period*

Kerry's PQ items differed from those of the other clients in that hers mostly had an

'external focus'. Example items included; 'I cannot get a job', 'I feel rejected', 'I feel

homesick'. Kerry was clear that for her to feel better that these external circumstances

needed to change. This is in contrast with the other clients who described items which

were based on their internal experience or aspects of their life they could influence in

some way.

### *Table 5.5.2. Quantitative Process Data- Working Alliance Inventory*

The therapist and client both completed the short form Working Alliance Inventory at sessions 1, 3 and 6. Each item is rated on a six-point Likert scale, with higher scores indicating greater satisfaction. Data from this procedure is presented below.

| *Session 1* | Client | Therapist |
|---|---|---|
| Mean Task | 4.25 | 5 |
| Mean Goals | 4.75 | 5.25 |
| Mean Bond | 3.75 | 4.75 |
| Mean Score | 4.25 | 5 |
| *Session 3* | | |
| Mean Task | 5 | 4 |
| Mean Goals | 5 | 3.75 |
| Mean Bond | 4.75 | 4.25 |
| Mean Score | 4.91 | 4 |
| *Session 6* | | |
| Mean Task | 4.5 | 4.25 |
| Mean Goals | 4.5 | 4 |
| Mean  Bond | 3.75 | 4.5 |
| Mean Score | 4.25 | 4.25 |
| *Combined Mean Scores* | | |
| Task | 4.58 | 4.41 |
| Goals | 4.75 | 4.33 |
| Bond | 4.08 | 4.5 |
| Mean Score | 4.47 | 4.41 |

**5.5.4.2. Qualitative Data**

*5.5.4.2.1. Qualitative Process Data about Helpful Aspects of Therapy*

Kerry rated each session with a minimum of a score of 7 'moderately helpful', with five sessions rated 8 'greatly helpful', indicating that on the whole she was satisfied with the therapy and felt that the sessions were useful. She did not rate any sessions or any therapy events as hindering or unhelpful.

In several sessions, she stated that being able to talk to someone was providing her with some sense of relief. Most of her ratings related to increased insight relating to her past experiences and their influence on her now and insights into her current process, for example the impact of internalised homophobia on her self-criticism and sense of shame. She also rated several items relating to use of the ego state model as helpful.

**5.5.4.3. Analysis of the Case and Responses from Change Interview**

There were distinct signs of improvement during the first five sessions, until the four-week break. After the break- during which she had ended her relationship- there was a marked deterioration in her. Towards the end of the therapy Kerry's scores once again started to improve, although this was not sufficient to result in remission and this improvement did not last and she deteriorated once again during the follow-up period.

It is clear from the quantitative and qualitative data that therapy was not effective for Kerry. In the Change Interview, she reported that she still felt that she was depressed and was 'still finding life difficult', was 'struggling to cope with negative emotions' and

her unemployment and was not able to look at her future with a sense of optimism or enthusiasm. She was aware that she had particularly low self-esteem and recognised that she was very self-critical, anxious, paranoid, pessimistic and lacking in motivation and was aware that she was prone to destructive relationship patterns.

Overall, she felt that she had not changed substantially from therapy, although she felt that she had become more self-aware and reflective. In her view, developing self-awareness, gaining insight into patterns of behaviour and learning to manage difficult feelings were helpful aspects of her therapy. These aspects enabled her to gain '*some feeling of agency and control. I need to understand what is going wrong and the reasons behind it in order to see alternatives. The worst aspect of my feelings of depression is a sense that I have no control and am being overwhelmed by things I have no power to change. Self-awareness at least gives the power of understanding and makes things less overwhelming and frightening.*' During therapy, she often struggled to discuss her thoughts, feelings and behaviour as she often felt ashamed of them, and was unable to rationally explain them. She reported that as a result of therapy she had become aware of some issues that were affecting her that she had not previously been aware of- in particular her sense of shame around her sexuality (internalised homophobia). Kerry also became aware of the significance of how her relationship with her parents had contributed to her negative self-critical process.

Over the course of therapy, and in conjunction with discussions with Christine, she developed a weekly routine which included social contact and a range of activities including physical exercise. She had maintained this routine since ending therapy. She had also been keeping a reflective journal and started meditation- both of which she

said were helping with her self-awareness.  In spite of the fact that the therapy had not resulted in any remission of her depression, she reported that the therapy had been useful and supportive and had valued 'having someone to talk to about things'.

Kerry found the use of the ego state model had been helpful, and has assisted her to identify her negative thoughts and reactions and to challenge them. She also found that understanding ego states was helpful in managing overwhelming emotions – particularly '*connecting with an Adult state'*.  She described how she uses this: '*When thoughts and reactions become overwhelming, I try to step back and analyse whether this is a Child or Parent voice, and whether I can think about it from a different perspective. I also try to concentrate on my breathing and physical sensations*.'

In relation to the ego state model, she said that '*things that seem overwhelming can be made less so if you view them from a position of greater power and control. Recognising that it is the inner Child who is frightened or overwhelmed, rather than other, more Adult parts of the personality can help to put you in charge, or at least in a position of knowledge and responsibility. '*

When asked about what kind of preparation or induction to therapy would have helped, she stated that prior reading about TA psychotherapy would have been useful.

Kerry stated that the long break in the middle of the therapy had been particularly disruptive, and that she had '*lost momentum'* and found that it had eroded her sense of trust in her therapist and created a sense of distance in the therapy.  She was clear that she felt that she needed more frequent and longer-term therapy to resolve her depression.

In her change interview, she identified three changes, none of which she found surprising. She felt that two of these would have been somewhat unlikely to have taken place without therapy. All three changes were 'very important' to her. The changes Kerry identified are presented below in table 5.3.3.

*Table 5.5.3 Kerry's Changes as Identified in Post-Therapy Change Interview*

| The changes I have made since starting therapy | The change was: 1 Expected 3 Neither 5 Surprising | Without therapy the change was: 1 Unlikely 3 Neither 5 Likely | The importance of this change for me: 1 Not at all 3 Moderately 5 Extremely |
|---|---|---|---|
| 1 Becoming more self - aware/able to analyse thoughts and feelings. | 3 | 2 | 4 |
| 2 Have developed a more systematic approach to feeling better (imposed a work routine, keep socially active) | 3 | 3 | 4 |
| 3 Keeping a diary to record how I am feeling from day to day. | 3 | 2 | 4 |

[a] The ratings are on a scale from 1 to 5; 1= expected, 3= neither, 5= surprising

[b] The ratings are on a scale from 1 to 5; 1=unlikely, 3=neither, 5=likely

[c] The ratings are on a scale from 1 to 5; 1=slightly, 3 = moderately, 4=very, 5=extremely

### 5.5.5. Case Conclusion

It is clear that therapy was not effective for Kerry. Although she did improve when having regular sessions, the extent of these changes was relatively small and was not sustained. The impact of the break in the therapy and the acrimonious ending of her relationship coinciding at a critical phase of the therapy clearly had a detrimental effect on the outcome of the case.

There are however a number of features about Kerry's case which contrast against the other cases in this series. Firstly, the initial phase of therapy appeared to have been strained and Kerry and Christine struggled to achieve goal consensus or agreement on the tasks of therapy. Whilst Christine did identify some life script themes and maladaptive patterns for Kerry, she was unable to implement a systematic approach to challenge these. Similarly, some problematic interpersonal patterns were identified but Kerry was reluctant to change the way she related to others. Also, Kerry was somewhat doubtful that therapy would help. Furthermore, instead of carefully selecting a therapist with an approach that suited her she saw the nearest therapist.

### 5.6. Summary of Chapter

The cases in this chapter demonstrate that short-term TA therapy can be effective for some people who have depression. When significant improvement has taken place, it seems that the several months post-therapy are critical in ensuring that these gains are maintained and that the client feels sufficiently resourced to be able to deal with stressful situations. The use of HSCED as a method of analysis has been helpful in determining the outcome of cases where there is a somewhat ambiguous picture of

change, as well as identifying possible process factors which have influenced the outcome of the cases.

Despite the differences in outcomes, the clients in this study all found their sessions to be helpful and appeared to be satisfied with their therapy. Furthermore, the use of TA theory appears to have been significant in many of these cases.

The next chapter of this thesis is a cross-case analysis where the cases are compared and contrasted with each other to draw conclusions regarding factors which may influence therapeutic outcomes.

# Chapter Six

# Results: Cross-Case Analysis

*This chapter focuses on the factors and variables which may have contributed to outcome in the cases. Principles for practice for the purposes of training therapists are drawn from these factors and will be highlighted throughout. The chapter concludes with a summary table of findings.*

*'Case comparison… is one of the most powerful methods in case study research, since analyzing two or more similar types of cases with contrasting outcomes can result in generalizable knowledge that goes beyond what one single case study can offer.'*
(Iwakabe, 2010: 340-341)

### Table 6.1. Summary of Cases and Outcome

| Peter | Good outcome |
|-------|--------------|
| Denise | Good outcome |
| Tom | Good outcome |
| Linda | Mixed outcome |
| Kerry | Poor outcome |

## 6.1. Introduction

Out of the five cases in this series, three were clearly good outcome cases, one was a mixed outcome case and one was a poor outcome case (see table 6.1 above). In line

with criteria specified by Chambless and Hollon (1989), as three clearly good outcome cases are presented in this case series, this provides initial evidence that short-term TA therapy can be effective for the treatment of depression.  There are a number of variables which this cross-case analysis has highlighted which may be factors that have impacted on outcome. These will be summarised at the end of the chapter in tables 6.3.1., 6.3.2., 6.3.3. and 6.3.4.

## 6.2. Summary of Outcomes

All clients reported that the therapy had been useful. Peter, Denise, Tom and Linda all achieved clinically significant change during the course of the therapy. In the case of Kerry despite a poor overall outcome she had two periods during the therapy where her outcome measures demonstrated reliable change (factors which may have impacted on Kerry's progress are discussed below).

Recurring themes from the description of the clients changes from the Change Interviews indicate that the four clients with the best outcomes experienced interpersonal changes/ changes in their relationships and communications style, three clients noticed improvements in their problem solving abilities, three reported changes in how they interpret events, three experienced changes in their self-confidence and the three best outcome cases all experienced an increase in their sense of optimism and hope for the future. Also, these three clients reported at the end of therapy now feeling 'OK about themselves' and acknowledging their own worth. All clients also indicated that they felt more self-aware after the therapy and had a greater awareness of their maladaptive and self-reinforcing patterns. All of these reported outcomes are summarised on table 6.2 below.

**Table 6.2. Summary of Reported Outcomes of Therapy**

| Reported Change | Peter | Denise | Tom | Linda | Kerry |
|---|---|---|---|---|---|
| Greater Self-Awareness | X | X | X | X | X |
| Greater awareness of maladaptive patterns | X | X | X | X | X |
| Changes in interpretation of events | X | | X | X | |
| Interpersonal changes | X | X | X | X | |
| Increased problem solving ability | | X | X | | X |
| Increased self-confidence | | X | X | X | |
| Increased self-esteem- 'feeling OK about myself' | X | X | X | | |
| Optimism/ hope for future | X | X | X | | |

### 6.3.1. Client Experiences of Therapy

#### 6.3.1.1. Therapy was a 'Useful and Positive Experience'

All clients in this series (regardless of outcome) reported that the therapy was 'useful'.

Also none of the clients in this series reported any problematic or unhelpful aspects of

the therapy in either their HAT forms or in their Change Interview (although they all

discussed aspects of the therapy which were difficult or painful and several clients

discussed ruptures in the therapeutic alliance). Although no specific measure of client

satisfaction was used,  it appears from this that the clients felt that engaging in therapy

was a positive step and were satisfied with their therapy experience.  Peter described

his feelings about therapy as '*Possibly one of the most positive experiences of my life,*

*I'll be totally honest.  It's made a huge difference to me.  I feel much better and it's*

*been possibly the most supportive and confidence building, rebuilding experience I have*

*ever had'* (C3)

#### 6.3.1.2. Ability to Make Sense of any Decline

All clients (with the exception of Peter, for whom this information is not available) who

experienced some decline during follow-up had an understanding of why this had

happened and attributed this to external events.

#### 6.3.1.3. 'This Therapy Went Deeper than Previous Therapy'

Peter, Denise, Tom and Kerry had all had some previous therapy. Peter, Denise and

Tom all reported that this therapy had 'gone deeper' than their previous therapy. All

the clients in this case series reported having had a positive experience of therapy

from their participation in this study and felt that this would inspire them to seek out further therapy in future if they felt they needed it.

The clients - with the exception of Kerry- felt that their engagement in TA therapy had enabled them to resolve a number of underlying issues which contributed to the origin and maintenance of their depression and felt that this had been different to previous experiences of therapy. Denise was clear that her experience of TA therapy had helped her to explore these underlying issues and contrasted this with her past therapy;

*'When I think about being in the other types of therapy, nothing has got to the bottom of what has caused me to be living and existing the way I was… But, ah, using this therapy, TA, and understanding myself and understanding what happened and accepting what happened and acknowledging the depth and in some cases the severity of what happened, in exploring it and acknowledging…how that affected me'.* (CD82)

*CD84: The one thing that is different is that this therapy wants to understand what is going on and how I came to be like this. That other therapy wanted to ask what's happened for me today... And I've never found before that they want to go beneath the surface. They want to deal with what's happening there and then.* (CD84)

Similar comments were made by Peter, Tom and Linda so it would seem that the use of the TA model was useful in increasing the client's sense of self-awareness and in promoting a way of seeking to understand these underlying issues. These comments suggest the first 'principle for practice';

- *Principle One: It is recommended that therapists facilitate the client's understanding about the origins of their problems and to 'go deeper' than the*

*surface, symptomatic level. This includes helping clients to contextualise their*

*feelings, reactions and implicit learning which influence their current experience*

*and the relation of this to their past experiences.*

## 6.4. TA Specific Factors

This section begins with discussing conceptual frameworks and change mechanisms

which guided the therapy and appeared to have been useful, then moves on to aspects

of the process and structure of the therapy and concludes with a discussion of the

relational stance of the TA therapists in this study.

### 6.4.1. Use of TA theory to Conceptualise Own Process

Each of the clients in this case series used the language of TA theory in their Change

Interview demonstrating that the use of psychoeducational interventions and theory-

based explanations had been a feature of the therapy. In their appropriate and

relevant use of TA language, the clients demonstrated that they had integrated these

concepts. It would appear that the framework of TA theory gave the clients a way to

reflect upon and identify their internal and interpersonal experiences and enabled

them to take charge of and direct their own process of change.  This interesting aspect

of the cases would appear to be a distinctive feature of TA therapy as conducted

within this case series.  The use of TA language was embedded throughout the HAT

form responses and Change Interview narratives for each client. One example of the

use of this is in the clients' discussion of ego state theory.

### 6.4.2. Ego States

All five clients in this study reported that learning about and applying the ego state model was useful. It was used by the therapists to enable clients to make sense of their internal experience and reactions to events. The use of the language of ego states was repeatedly referred to in the qualitative data in this series. The only non-positive reference to ego state theory was made by Linda in her Change Interview where she expressed some reservations about 'compartmentalising', however she did go on to concede that ego state theory had been useful. This was confirmed in her HAT forms where she specifically said it was a useful model. Despite her poor outcome, Kerry provided the clearest description of how the ego state model had been useful to her;

*'I re-evaluated the influence that my parents had on me... I began to see that there were negative voices and ideas I was carrying around that come from my parents. I began to think about how far my ideas are shaped by those forces'* (CK3)

Here Kerry describes how she found the discussion around the Parent ego state had been useful in increasing her self-awareness about the origin of her beliefs. She went on to describe how she had then used the ego state theory to help her manage difficult emotions;

*'My negative thoughts and reactions to things are still present, but sometimes I am able to analyse these and challenge them. One specific idea that we discussed in therapy involved identifying the influence of childhood states and parental voices. I've found it useful when dealing with overwhelming emotion to connect instead with an Adult state separate from these, which is able to take responsibility and assume some*

*control. I have also developed a more systematic approach to getting rid of bad*

*feelings.'* (CK12)

*'When thoughts and reactions become overwhelming, I try to step back and analyse*

*whether this is a Child or Parent voice, and whether I can think about it from a different*

*perspective.'* (CK13)

*'Things that seem overwhelming can be made less so if you view them from a position*

*of greater power and control. Recognising that it is the inner Child who is frightened or*

*overwhelmed, rather than other, more Adult parts of the personality can help to put*

*you in charge, or at least in a position of knowledge and responsibility.'* (CK27)

In this last statement Kerry highlights how analysing her internal experience using ego

state theory has been useful and has then guided her towards ways of self-soothing,

increased her sense of self-agency and given her a conceptual framework to make

sense of distressing experiences.  The client statements suggest a further four

principles for practice;

- *Principle two: The judicious 'teaching' of clients about accessible models which*

  *are relevant to helping them to understand their experiences and process can*

  *be helpful. This approach may work best when the emphasis is on helping the*

  *client to reflect upon, understand and manage problematic internal*

  *experiences, to make sense of difficult or painful reactions and to understand*

  *maladaptive patterns. It can also be helpful to promote change in interpersonal*

  *relationships and to enhance the client's sense of agency.*

- *Principle three: The use of relevant theoretical concepts in the therapy can be helpful in assisting clients to take charge of their own process of change, in demystifying the therapy process and in giving clients tools to promote extra-therapy changes. The presentation of theoretical concepts is less effective when it is not clearly matched to the client's presentation or issues, and/or when delivered in a strongly didactic and dogmatic fashion.*

- *Principle four: When clients feel uncomfortable with categorisation, it can be helpful to present concepts 'potentially useful ways of understanding things', and to explain that these are theoretical models and not absolute truths.*

- *Principle five: The use of the ego state model can be helpful to assist clients in identifying, understanding and changing their (implicit) internal dialogue and in helping clients to work out what they can do independently to change their internal state when distressed.*

### 6.4.3. Changing Internal Dialogue from Critical to Nurturing

All of the clients in this case series (like the majority of people with depression) experienced an intensely self-critical internal dialogue. During the course of the therapy, this internal dialogue started to change to a more compassionate and self-nurturing internal dialogue for Peter, Denise and Tom. Linda also experienced some of this change in internal dialogue by coming to terms with her feelings about her mother and letting go of her sense of guilt. Kerry also managed to change her internal dialogue to some extent (as evident in the quotes above). Tom described the actual therapy processes used to change this internal dialogue:

*'Mm… through therapy it was the role play- that would be the first, a stage that was very good and it got me thinking of how I talked to myself in my head.  I set up a load of things I say to myself and try to say these things every day and that's changed over the weeks as well.  Eh, (short pause).  2 or 3 times a day I'll put my phone on the timer for 20 minutes and I lie on my bed and try, (laughs), hypnotise myself through the nice things I'm saying to myself.  And I've started to think of the people who were my heroes as a child and get them telling me how good if you know what I mean?'* (CT122)

Analysis of the therapist's notes show that the therapist used two-chair method at several points in the therapy to highlight and change Tom's self-critical ego state dialogue. During this process, the therapist invited Tom to take part in a procedure known in TA as 'self reparenting', which involves the client counteracting their negative internal dialogue with positive, self-nurturing statements. It appears from Tom's description that he continued this process at home using visualisation methods. The conceptual framework of ego state theory combined with the therapy procedures based on this gave Tom a means to understand his internal process and develop his own ways to support his therapy.

- *Principle six: Clients who are keen to engage in 'homework activities' can be encouraged to use the concepts discussed in the session to creatively engage with the change process, for example through the use of visualisation, reflection or writing techniques.  It is recommended that homework activities are simple to implement and that they avoid complex or lengthy tasks. Where 'homework' is used as a treatment method, it is advisable to check in with the client in subsequent sessions what the outcome of this was.*

- *Principle seven: Clients who have a strong and clearly identifiable self-critical process can be invited to engage in two-chair work to address both the self-critical process and to develop self-compassion and nurturing.*

### 6.4.4. Identifying and Challenging Maladaptive Patterns

TA theory conceptualises the maladaptive cognitive-affective interpretive framework of the client as a network of interlinked beliefs, memories and symptoms which it describes as the racket system (Erskine and Zalcman, 1979). All of the therapists in this study provided a racket system diagram with their case notes and their session narratives indicate that this was a central conceptual framework for facilitating change (a combined racket system with examples from the cases is presented overleaf. Please note these are examples presented for illustration purposes and not analysed categories). All of the clients in this study reported gaining greater insight into their own maladaptive patterns and associated internal process and experience and described that this has been useful in helping them to changing these maladaptive patterns.

## Figure 6.1. Prototype Combined Racket (Script) System

Note: Numerals after each item indicate the number of clients this item applied to.

These items are presented as examples, and not analysed categories.

| Script Beliefs (intrapsychic system) | Racket Displays (behavioural interface) | Reinforcing Memories (interpersonal system) |
|---|---|---|
| **1) Self:**<br>*I will never be good enough(IIII)*<br>*I am inadequate (IIII)*<br>*I've done something wrong/ It's all my fault (III)*<br>*I cannot have needs or get what I want (III)*<br>*I must put other people before me (II)*<br>*I am not important (II)*<br>*I cannot say no (II)*<br>*I am powerless (II)*<br>**2) Others:**<br>*Are selfish and uncaring (IIII)*<br>*Are better than me. Will reject me (III)*<br>*Will criticise or reject me if I express my feelings or make independent decisions (II)*<br>*Are unreliable and untrustworthy (II)*<br>**3) The World:**<br>*Life has no meaning (II)*<br>*The world is a cruel and unfair place (II)*<br>*Life is shit and then you die (II)*<br>*Life is confusing (I)*<br>*Life is to be avoided (I)*<br>*Life is difficult (I)*<br>**Repressed Feelings/ Needs:**<br>*Positive feelings about self (IIIII)*<br>*Anger (III)*<br>*Self-Assertion (III)*<br>*Grief (II)* | **Observable:**<br>*Avoidance of activities/ withdrawal (IIIII)*<br>*Being 'invisible' (IIII)*<br>*Passivity (IIII)*<br>*Silent and unemotional/ lack of emotional expressiveness (II)*<br><br>**Internal:**<br>*Despair (IIIII)*<br>*Strong self-criticism (IIIII)*<br>*Lack of energy/ feeling 'run down' and loss of interest(IIII)*<br>*Tension (III)*<br>*Poor concentration/ memory (III)*<br>*Rumination (III)*<br>*Guilt (II)*<br>*Low self-confidence (II)*<br>**Fantasies/ Expectations:**<br>*Paranoid- expects criticism/ attack / rejection (IIIII)*<br>*Isolation(IIIII)*<br>*My future is bleak and hopeless (II)*<br>*I will never be heard, taken seriously and respected (I)*<br>*I want to be rescued (I)* | **Childhood:**<br>*Bullying (III)*<br>*Bereavement/ loss (III)*<br>*Lack of praise (III)*<br>*Repeated Criticism (III)*<br>*Being given too much responsibility* (II)<br>*'Traumatic events'* (II)<br><br>**Adult life:**<br>*Redundancy (III)*<br>*End of relationship (II)*<br>*Conflict (II)*<br>*Bereavement (I)*<br>**Social/ Environmental:**<br>*Isolation (III)*<br>*Stress at work (II)*<br>*Other people at work or in family taking advantage (II)*<br>*Current 'critical' family environment (II)* |

Adapted from: Erskine and Zalcman (1979), Erskine (2010).

(see section 2.1.2.4 for explanation of the racket system).

### 6.4.5. Experiential Identification and Disconfirmation of Pathogenic Beliefs and Relationship Expectations

TA theory conceptualises the client's beliefs and expectations as operating within an implicit narrative called 'the life script'. The therapists in the successful cases appear to have been attentive to identifying the client's (usually implicit) pathogenic beliefs and expectations about relationships, actively attending to how these were manifesting in the therapy, and seeking to act differently in order to disconfirm these. This corresponds to TA concepts relating to the client's life script and their racket system. Within the three best outcome cases and the case of Linda, a key aspect of their life script was identified in the first session. In contrast, Christine also noted Kerry's key life script theme, although appears to have struggled to engage Kerry in a way that disconfirmed her script beliefs and expectations.

The clients with the better outcomes appeared to have been able to re-evaluate and change their views about themselves, others and the world (and to some extent, their future). This was true for Peter, Denise and Tom and to some extent Linda (although Linda's confidence in the future may well have been seriously shaken by her subsequent redundancy). Kerry was not able to re-evaluate and disconfirm her beliefs and expectations during the course of the therapy. It is possible that she would have been able to do so with a longer or more intense therapy, but she was not able to do so within the timeframe of the research.

Peter described this process of identifying and disconfirming his beliefs and expectations:

'*Therapy has been breaking those contextual associations and breaking that model and showing other avenues and ways of being which then allows new experiences to be interpreted in a new and different light, which can lead to older experiences being re-interpreted.*' (C42)

The process of disconfirmation appears to have been experiential and based on identification of the interpretive framework of the client and the therapist's active engagement in challenging this framework and the client's narrative.

- *Principle eight: Therapists are advised to remain attentive to the client's implicit narrative, in particular the narratives which relate to their self-concept and those which relate to their experiences of self and other in relationships. Once the therapist has identified a potential narrative theme, this can be checked with the client that this 'makes sense' to them. The therapist and client can then work collaboratively to seek ways of challenging this narrative. In particular, it may be useful to be  attentive to the manifestation of this theme in the therapy in order to engage the client in a process of systematic experiential disconfirmation and re-evaluation/ re-writing to a less limiting narrative.*
- *Principle nine: Exploring the client's past and present problematic relational experiences can be useful in assisting the client in changing negative self-beliefs and relational patterns which maintain their depression.*

### 6.4.6. Narrative-Emotional Processing

The clients in this series experienced changes in how they identify, express and experience emotions including long-standing emotions and emotions connected to

specific aspects of their narrative or significant life events. TA theory does not have a consistent and detailed theory relating to affect, but instead draws on several aspects of theory to understand this. In particular, the concepts of the racket system and the process of deconfusion relate to affect, as do procedures relating to the redecision approach to TA. The redecision methods seek to change cognitive-affective processes using visualisation-based reconstruction of specific events. As part of this the client is encouraged to intensify their affective experience, re-evaluate the event and construct a new meaning to change their narrative. In relation to this, at different stages throughout therapy, Peter, Denise and Tom in particular all started to feel anger about past experiences of maltreatment and begin to assert themselves in their interpersonal relationships as a result of this new affect-driven reconstruction of their narratives. Associated with this, they started to transform their central affective experiences of depression and develop positive feelings in relation to their self.

- *Principle ten: Where possible, the therapist can help the client to identify specific events from their past and the implicit learning/ narrative that they draw from these events. Once these events and the associated learning/ narrative have been identified, the therapist can engage the client in experiential cognitive-affective work to re-evaluate and change any negative or limiting aspects of the narrative .*

### 6.4.7. Improving Communication and Interpersonal Changes

Peter, Denise, Tom  and Linda reported the usefulness of exploring, understanding and changing their communication style and described that they had made changes in how they interact with others. Analysis of the therapists notes and the clients HAT forms

show that a range of TA theories (for example transactions, strokes and games) were regularly used throughout the course of the therapy to assist the client in making interpersonal changes. In addition to theory-based explanation, changes were supported by the use of  active coaching and relational problem-solving guided by the therapists. Furthermore, the therapists appeared to provide  feedback to the client about how they experienced them and how they might be experienced by others (this was identified explicitly as a mediator factor by one of the judges in the case of Linda).

- *Principle eleven: It can be useful to explore with the client their interpersonal relationships and how these (perhaps inadvertently) reinforce their problems. Helping clients reflect upon and change their ways of communicating with others can be useful. This can be facilitated by active coaching and educational approaches which develop the client's communication and relational skills. Providing direct interpersonal feedback can also be helpful in supporting the client's change process*

### 6.4.8. Contracting

The three best outcome cases all involved significant contracting for therapy goals within the first three sessions. In contrast, Linda did not complete goals contracting until session five and it is particularly noteworthy that in the case of Kerry no contract goals were identified during the therapy. This suggests that the focus on clear contracting for therapy goals in the early phase of therapy may be significant in relation to outcome. This appears to have been reflected in the WAI data for Denise, Tom and Linda who all rated the agreement over tasks and goals of therapy as over 6. Peter's mean ratings for tasks and goals were 5 or over, indicating reasonable

agreement over these dimensions of the therapy, whereas Kerry's mean score on the WAI was only 4.47, indicating low levels of goal and task consensus.

Behavioural contracting regarding between-session activities ('homework') was a feature in all cases in this series. These behavioural contracts appear to have had three main purposes, the first of which was to either promote or deepen client awareness- often deepening material covered in the session or as preparation for the following session. The second purpose was to encourage the client to engage and experiment with behaviours which would systematically but gradually break their unhelpful patterns of behaviour or relating. The third purpose for behavioural contracting was related to encouraging the development of self-nurturing behaviours.

With the exception of two of Peter's ratings (which were rated at 4- 'moderately'), the three best outcome cases and Linda all reported a rating of at least five on the contract goals achievement form at their last session indicating that these clients felt that they had achieved their goals 'considerably' or 'very considerably'. No clients rated any of their goals at 7 'maximum possible', indicating that they all felt that some improvement could be made with their initial goals.

TA places great emphasis on the importance and centrality of establishing clear contracts for the goals of therapy and also encourages explicit contracting for the tasks and process of therapy. The absence of these combined with the poor outcome in Kerry's case when contrasted to the agreement and achievement of contract goals in the other cases suggests that contractual method may be a key therapeutic process in TA.

- *Principle twelve: It can be helpful to facilitate the client in articulating their problems to engage in a collaborative therapy goals discussion as early in the therapy as possible. As clients are not always clear about their goals at the outset of therapy, this process may take several sessions. As the therapy progresses, these goals can be refined or adjusted according to the client's changing presentation or wishes.*

- *Principle thirteen: It can be useful to be clear with clients about the tasks and process of therapy and to clarify how they want the therapy to proceed.*

- *Principle fourteen: Extra-therapy 'homework' can be a useful adjunct to the therapy process. The therapist and client can engage in a collaborative discussion to choose or design homework tasks which best suit the therapy process at that time. These might include tasks which deepen the client's awareness, tasks which invite clients to change self-limiting or problematic behaviours, or tasks which enhance a self-compassionate and self-nurturing stance.*

### 6.4.9. Formulation-Focused Therapy

The cases in this series are sufficiently varied to demonstrate that the TA therapy as delivered in this research tended to be based on a clear, individualised case formulation and that a flexible approach to therapy can be developed to suit the individual client's needs, presenting problem and process. The model both allowed and facilitated the construction of a formulation based around several key theoretical concepts which then guided the therapy according to the client's individual circumstances. The process of case formulation appeared to take place from the very

outset of therapy, with the therapist identifying key aspects of the client's process and addressing these even in the first session in using a sequential and systematic but fluid and flexible approach.

- *Principle fifteen: Wherever possible, the therapist should construct a clear case formulation which incorporates the client's goals and a conceptualisation of the client's core issues and use this as a guide to focus the therapy. This formulation can be revised and adjusted as the therapy progresses and as issues are resolved or new ones emerge.*

## 6.5. Relational Aspects of TA Therapy

### 6.5.1. Mutuality and Equality in the Therapy

Although the principle of promoting equality and mutuality within the therapeutic relationship is not exclusive to TA, this is a central and defining characteristic of TA therapy which is perhaps most simply described using the TA phrase of 'I'm OK-You're OK'. Mutuality is also emphasised in the TA principle of contractual method, and the therapy process is demystified by the therapist using the accessible language of TA to help the client conceptualise their own process. Denise described her experience of this aspect of the therapeutic relationship as;

*'There's the definite feeling that I'm important in the relationship. I'm not being diagnosed and given a pill… It's about the fact that I can be vulnerable, and I can feel safe in that vulnerability. I have never felt in the slightest bit judged… But I feel that my therapy is as much about what I do and as much about what I contribute- it's not just telling a story- it's about, right ok, I can say right, no, I don't agree or I do agree or we have a discussion around what it is that's happening. And the other thing is, that as a*

*therapist, they weren't afraid to say 'this is bringing something up for me' and then we can sort that bit out, which is also where I feel acknowledged as an intelligent human being who is, ah, perfectly capable of taking part on an equal basis.'* (CD87)

This quote from Denise also highlights the therapist's use of self-disclosure as a therapeutic tool. It seems that Denise experienced this as a respectful approach and one which both validated her and encouraged her to be more open and vulnerable in response.

- *Principle sixteen: The creation of a collaborative safe space where the client can be open and vulnerable is usually an important part of the change process. Collaborative goal setting, demystifying the therapy process, ensuring that the client feels a sense of equality and mutuality in the relationship and appropriate therapist self-disclosure can all strengthen the sense of safety in the relationship.*

### 6.5.2. Potency

A central theoretical concept in TA therapy is therapist 'potency' which relates to a psychological strength of character of the therapist which is experienced by the client and facilitates the client's change process. This is a concept which is difficult to accurately grasp, and yet is one which appears to have been a feature in the cases of Peter, Denise, Tom and Linda and which can be perhaps best be identified by a grouping or clustering of certain interpersonal qualities combined with a therapeutic stance. Each of these clients describes aspects of their therapist's way of being which indicate that their therapist was warm, 'present', 'contactful', humorous, 'on their

side', perceptive and willing to hold the client to account. Linda described her therapist as;

'A *strong woman, because she has a sense of humour, because we could have a laugh and because she wouldn't just let me get away with things.'* (CL178)

Tom also described his therapist's relational stance:

'*As a person she was very friendly, welcoming straight away.  She put me at ease which was very important.  Mm, she was fantastic in the role play with me as a Child which I needed at the time. Really supportive.'* (CT166)

'*Obviously non-judgemental.  Again for me which is very important.  Especially in the role play as me as a Child.  It seemed as though my Child had someone else there to eh (short pause), look after (me).  It was like an uncanny knack of saying the right thing at the right time and she knew exactly what I was feeling, when I was feeling it or seemed to do.  At times she could have just been, in there (pointing to his head and his chest).  I think there may have been some times where, not because I wanted to be, but holding something back, she'd notice straight away.  She'd say is there something else? And I'd say yeah there is and she knew straight away.'* (CT167)

'*So, I couldn't get away with anything (Laughs) - Not that I wanted to.  Some things came out which were harder than others but she had a way of getting it.'* (CT168)

A further aspect of this is the client's sense of a 'strength of character' in the therapist which includes the therapist having the capacity to accept whatever the client may tell them and also the ability to tolerate intense feelings in the therapy. Linked to this has been the client's sense that the therapist was willing to accompany them on their

therapeutic journey and would not emotionally abandon them. In this sense, the clients have felt that they had a resourceful ally who was familiar with the terrain of the therapy process and who they could feel confident that their therapist was competent, skilful and who ultimately knew what they were doing. Denise described the relational ambience of her therapy and her sense of her therapist as being characterised by:

*'Sharing. Openness, absolutely. And not feeling like I'm with my teacher. But knowing that [my therapist] knows exactly what they are doing.'* (CD88)

There is a sense of the therapist being a real, vibrant, emotionally open and responsive person (an aspect which was identified by many of the HSCED judges). It would appear that the client's perception of the therapist as having potency is an essential pre-requisite for change in TA therapy.

- *Principle seventeen: The sense of safety may be enhanced when the therapist is open, genuine, contactful, warm, perceptive, non-judgmental and is emotionally robust and willing to challenge the client when necessary.*

### 6.5.3. Permission

A number of the clients in this case series also either explicitly or implicitly referred to 'permission' in their change interview.  The theme of therapy being a space where the client is given permission to be themselves, to explore their thoughts and feelings, to express these thoughts, feelings and experiences and share aspects of themselves they feel ashamed about. Experimenting with new behaviours and new ways of being with

others seems to be an implicit sub-text throughout the accounts of the clients in this series.  Linda explains how permission worked for her in the therapy:

*'You know my confidence was not good that so your immediate reaction to anything is that "I am not worthy, I am not worthy".  To find the space and to gradually work on that and going, "this is fine.  You are allowed to do this"... Again having that space and somebody again I suppose mm, affirming that you are a person in the world and this is fine.  You are allowed to do this.'* (CL26)

*'This is fine, you are a person.  Its ok, you can feel like this.'* (CL27)

*'So there was also kind of supportive and encouraging things.  It was like you're not daft to do this.  You can give it a shot. You are not going to fall flat on your face.  You are not going to be judged.  This is fine.  The world isn't going to give you a big slap in the face for going out there and doing that.  I think that was helpful for even if I had come to the conclusion oh, this is what I need to do, I'm not sure I would have done it if there wasn't somebody in the background with a metaphorical stick going, "go on, go on".'* (CL71)

*'Talking, getting it out.  The kind of sense that... (short pause)  It's ok to feel like this, it's understandable to feel like this, that you can change how you feel.  This is something that  ... It's not a rut that you're stuck in forever.  It's not a groove that you have to, you know, you can change.'* (CL134)

It would appear that Linda experienced the ambience of the therapy as an antidote to her internal sense of invalidation and one which encouraged her to experiment with new ways of being.

- *Principle eighteen: The sense of safety and the client's change process may be enhanced when the therapist actively seeks to create a permissive climate. This can include encouraging the client to take risks in the session, to explore difficult and painful material and to experiment with new ways of being and relating to others.*

- *Principle nineteen: The relationship may be strengthened by the therapist's validation and acceptance of the client. It is possible that this experience is internalised by the client and helps to overcome their negative self-judgment.*

## 6.6. Client Factors

### 6.6.1. Hope/ Expectations for Therapy

Three best outcome clients all had positive expectations of therapy prior to commencing therapy. Linda and Kerry were more cynical and doubtful about the benefits and effect of therapy. The role this might have played in the cases is unclear. It is possible that initial hope and positive expectations somehow 'primed' the clients and made them more receptive to change. An alternative explanation is that the three best outcome clients may have inaccurately attributed their change to therapy in order to justify their initial hope. The judges in the HSCED's ruled out hope as a major change factor however it is possible that it nevertheless had some interaction with other variables to influence the change process.

### 6.6.2. Active and Deliberate Choice of Therapist by Client

All of the clients in this study actively sought out therapy. They were recruited from the therapist's usual referral procedure as opposed to being recruited specifically for

the purposes of research. All of them apart from Linda (who was seen in an agency setting and allocated a therapist by the agency management after attending an assessment session) actively selected the specific therapist with whom they worked (although in the case of Kerry, she saw the most conveniently located therapist). Consequently conclusions around impact of client choice of specific therapist cannot be demonstrated. Although Linda was seen in an agency, she paid a reduced fee, and therefore all clients in this study paid for their own therapy. However, Denise and Tom both chose to seek out a TA therapist and Peter had done some selection and had read a detailed description of his therapist's style and practice method (which included a brief description of TA therapy) and contacted his therapist on the basis of this information. This difference is interesting and suggests that the client's active seeking out of a therapist of a particular approach which makes sense to the client has a positive impact on outcome.

### 6.6.3. Pre-Therapy Preparation

In the three best outcome cases the clients had engaged in considerable pre-therapy preparation. Both Tom and Denise and to some extent, Peter had read about therapy in general prior to seeking treatment and had some understanding of the tasks and process of therapy. Tom and Denise (and to some extent, Peter) were specifically familiar with a range of TA concepts and felt that these were useful in enabling them to understand their own process.

- *Principle twenty: Providing the client with pre-therapy information about the nature, tasks and process of therapy and some accessible theoretical material*

*can be useful to help the client make an informed choice about starting therapy*

*and to actively engage with the therapy process.*

### 6.6.4. Motivation Level

Although all of the clients reported wanting to feel better, there may have been

differences in their levels of motivation for change and determination to make the

most of the therapy. Peter, Tom, Denise and Linda were all very active in their therapy

and made significant active changes. In contrast, Kerry did not appear to either want or

feel able to implement direct and substantial behavioural change (she did make some

changes, but these were relatively small changes). Severity of depression did not

appear to be a factor here, as both Peter and Denise had initial levels of depression

and functional impairment greater than Kerry's.

Peter, Denise and Tom all reported long-standing problems and the judges all

commented that they appeared to be determined to push through any discomfort in

therapy in order to make changes. Although it would appear reasonable to expect that

the longer someone has had a problem, the more resistant it may be to change, it is

possible that the duration of these problems had a motivating effect and the duration

of distress may have encouraged Peter, Denise and Tom to implement substantial

efforts to change.

- *Principle twenty-one: Assessing and addressing the client's initial level of*

   *motivation for therapy and interventions which help the client to push through*

   *initial discomfort may help the client to engage with the therapy process.*

### 6.6.5. Early Life Experiences

All of the clients in this case series had some kind of subjective experience of childhood where they felt 'unloved' by parents who they described as critical and were in environments which were lacking in praise and nurturing. All had a core script belief that there was something 'fundamentally wrong' about them and all '...*had caretakers who were unpredictable, invalidating, and critical. Their early home lives lacked adequate warmth, safety and nurturing that would have allowed them to flourish and realize their potential'* (Watson, Goldman& Greenberg, 2007: 184). Both Peter and Tom also described having been bullied throughout school. It would appear that these early life experiences may predispose individuals towards a vulnerability to depression in adulthood.

### 6.6.6. Isolation

All of the clients in this study reported a subjective sense of isolation at the outset combined with a degree of social isolation. In particular, Kerry appeared to be the most isolated- she was living in a different city from her friends and family (who were often unavailable to talk), she was unemployed and during the course of therapy ended her relationship, thus increasing her sense of isolation. Furthermore, Kerry's 'closeted' homosexuality may have been a factor here- she felt ashamed of her sexuality and felt unable to disclose it to anyone, which may have left her feeling more isolated and less 'known' by others. Also, she was unable to share her distress over her relationship break up with anyone outside of therapy. It is possible that isolation may act as a precipitating and maintaining factor in depression and also that a client's capacity to reduce their sense of isolation may be a factor in outcome of therapy.

- *Principle twenty-two: Assisting the client in addressing experiences of isolation can be helpful in overcoming depression.*

### 6.6.7. Demographic Factors

There is no evidence to consider a range of demographic factors as being relevant in the process or outcome of these cases. The small sample size may be a factor in this and may mean that identifiable patterns which would be apparent from a larger group are obscured. Nevertheless, age did not appear to be a factor- Kerry was older than both Peter and Tom. Education did not appear to be a factor either- although Peter, Denise, Linda and Kerry were all educated to degree level (Kerry to PhD level), Tom had only completed secondary education and left school with no qualifications. The clients and therapists in this study were all white and British and therefore any conclusions need to be approached with caution and understood as applying within the context of white British therapist-client dyads. All clients within this study had differing relationship status (Peter was single, Denise was widowed, Tom was in a relationship and eventually cohabiting, Linda was married and Kerry was in a problematic relationship at the onset of therapy but single towards the end) so no conclusions regarding relationship status can be drawn.

### 6.6.8. Psychosocial Stressors

All clients in this study were experiencing family problems/ problems with their primary support group at entry to and during therapy. This may have been a factor in the aetiology and/ or maintenance of their depression, and may have been a factor in their recovery- all clients with the exception of Kerry made significant changes to their relationships with their primary support group. It is possible that improvements in

these relationships further supported the client's changes and interrupted maladaptive reinforcing interpersonal patterns. All clients also reported problems with their social relationships at the point of entry into therapy, and all with the exception of Kerry changed how they related to others and experienced marked improvements in their social functioning by the end of therapy. It appears from the above that neither problems with primary support group or social relationships at the outset were predictive of outcome in these cases, but engagement in making active changes to these relationships may have been. Kerry was in a problematic and stormy relationship when she started therapy, and had a particularly difficult and painful ending of this relationship during therapy. She was quite clear that this had had a significant negative effect on her, and had negatively impacted on her outcomes.

Although unemployment was a feature for Kerry, Linda and Peter no pattern relating to outcome has been identified; for Peter the therapy was effective, for Linda the picture was mixed and for Kerry, the therapy was not effective. For all three of these clients, their unemployment was an issue within the therapy and in particular in relation to their self-esteem, sense of validity as a person and reinforced their beliefs that others viewed them negatively by having a socially undesirable status. Associated with this, Denise was experiencing occupational problems at the point of entry into therapy but had resolved these by the end of therapy.

All clients experienced some psychosocial stress either during therapy or during follow up as a result of major events- in particular Tom and Linda, and it is likely that these stressors were a major cause of their decline. Peter experienced some decline at the three-month follow up, although there is no data available to indicate if this was due

to a stressor. It appears to be the case that the therapy did not necessarily equip them to cope effectively with future stressors. Examination of the rich case records suggests that very little time was spent on the ending phase of the therapy and that the ending phase seemed to be more focused on celebration of changes and review of the process of therapy and less focused on contingency planning for negative future events. It is possible that such planning may have been beneficial and enhanced the client's capacities to cope in times of extreme stress.

### 6.6.9. Impact of Negative Life Events

Several of the clients in this study experienced significant negative life events either during therapy or follow-up. Denise experienced two bereavements, Linda experienced bereavement and redundancy and Kerry experienced a particularly acrimonious relationship break-up. It is possible that during therapy (and the immediate follow-up period) that people need a period of relative external stability. It is also possible that the therapy did not adequately equip them to deal with these problems or focus on contingency management during the termination phase.

- *Principle twenty-three: Contingency planning and resourcing clients to manage future problems may be helpful in preventing relapse.*

### 6.6.10. Internal/ External Focus of Problem Description

Kerry's problems listed in her PQ mostly appeared to have an external focus- that is, they were focused on her feelings about external events, rather than about her internal experience or behaviour. This is in contrast to the PQ problems listed by Peter, Denise, Tom and to some extent Linda. For Kerry, little could be done in therapy to

change these external factors, so it is possible that this, combined with her

externalising focus was an obstacle to positive change. It seems surprising that her PQ

items were largely external in focus as despite knowing she had a negative

interpretation style and self-hatred, these did not appear as problems in the initial PQ.

During the course of therapy, Kerry had two periods where her BDI-II and CORE scores

demonstrated reliable change however this was not paralleled in her PQ scores. It is

possible that this was due to the limited change in her external circumstances which

meant that PQ items with an external focus were not sensitive to any internal change

which may have been taking place or that the external focus prevented significant

change taking place.

- *Principle twenty-four:  In identifying problems and constructing therapy goals it can be helpful for the therapist  to guide the client towards internal changes or towards goals which they can directly change, rather than goals based on events beyond their direct control.*

## 6.7. Generic Therapy Factors

### 6.7.1. Length of Therapy

The three best outcome cases all completed the full sixteen sessions of therapy. It was

noted by the judges that both Peter and Tom appeared to have had some residual

issues which were not fully resolved during the course of the therapy, so it is possible

that a longer therapy would have had greater effect. It is also possible that on-going

maintenance therapy may have addressed residual issues as and when they arose.

The two poorer outcome cases, Linda and Kerry had 9 and 13 sessions respectively. It appears that this was not sufficient to result in permanent, stable changes. It appears possible that longer therapy is more effective.

### 6.7.2. Pattern of Recovery

All of the clients in this study appeared to have experienced positive reliable change on at least one outcome measure around session seven or eight. It is possible that around this time the therapy had started to have a cumulative effect and that this marks the beginning of internal restructuring.

### 6.7.3. Working Alliance Inventory Data

In the cross-case analysis the WAI-S scores were analysed individually, and then the results for Peter, Denise and Tom were grouped as the good outcome cases, Linda as the mixed outcome case and Kerry as the poor outcome case. The results were compared to see if any patterns emerged.

An interesting and surprising pattern was that the therapist's scores appeared to match outcome in the cases- for the three good outcome cases the therapist's scores were all >6 on each sub-scale and overall, whereas the client's scores for these three cases are all >5. Linda's scores were all >6, but her therapist's scores were 5 or less. Both the therapist and clients scores in Kerry's case were <5. As this is a small sample size, and two of Tom's measures are missing, it is impossible to draw a clear conclusion about this, however this pattern is different to the one suggested by Horvath and Symonds (1991) who considered the client's ratings of working alliance to be more predictive of outcomes than the therapist's ratings. This finding is also interesting

given that Peter, Denise and Tom all had high levels of initial hope and reported high levels of satisfaction with their therapy. This is also noteworthy in light of the sceptic arguments in these three cases that these clients may have idealised their therapists- although their alliances with their therapists were positive, at these three marking points they were not all uniformly in the 'strong alliance' band.

A study by Mallinckrodt and Nelson (1991) found that alliance ratings- particularly the task and goal sub-scales were rated more highly by clients of more experienced therapists. In this present research, the therapists of Peter, Denise and Tom were substantially more experienced than the therapists of Linda and Kerry. It is impossible to determine if this finding is a chance occurrence or what factors produced this effect, if such an effect is present. However, it is possible that greater therapist experience produces greater level of expertise and confidence in their abilities which from a TA perspective may result in greater therapist potency (Steiner, 1968). An alternative explanation is that these therapists were consciously or unconsciously attentive to subtle indicators of positive alliance.

Regardless of the reasons, it appears that a good working alliance was likely to have been a therapeutic factor in these cases.

### 6.7.4. Resolution of Alliance Ruptures

Three best outcome cases all described successful resolution of alliance ruptures. Linda did not report any alliance ruptures in her therapy, which may have meant that she did not have an experience of successful resolution of relationship problems. Furthermore, Kerry and her therapist did not appear to have resolved alliance ruptures which occurred during the outset and at several stages during the therapy. It is possible that

the successful resolution of alliance ruptures results in significant change, gives the client a corrective relational experience and strengthens the therapeutic alliance, thus contributing to the therapy outcome.

- *Principle twenty-five: Attentiveness to repairing alliance ruptures and addressing interruptions in the therapy may be useful.*

### 6.7.5. Impact of Interruption to Therapy

Interruption of continuity in weekly sessions may have been a factor in some of these cases. Kerry had a marked deterioration at the time of the four-week break in her therapy.  Also, Peter experienced some minor deterioration when therapy was disrupted for several weeks due to therapist illness. Denise also experienced some minor deterioration after a break in the therapy, although this may have been due to the effects of her illness and bereavement. It appears to be reasonable to suggest that disruption in the therapy process is best avoided where possible and may result in some decline.

### 6.8. Therapist Factors

### 6.8.1. Empathy

Most of the HSCED judges commented that the therapists in these four cases appeared to have been highly empathic. In contrast, Christine commented that she often felt as though she was struggling to be empathic towards Kerry. It is possible that the therapist's experience of empathy is communicated to the client and that this has a positive effect on outcome.

### 6.8.2. Experience of Therapist

The three best outcome cases in this series were conducted by therapists with over five years post-qualifying experience. In contrast, the two worst outcome cases were conducted by therapists with only one year post-qualifying experience. It is possible that level of therapist experience had an influence on outcome. The reasons why this might be possible are not clear, although it is perhaps connected with the therapist's competence at responding to some of the above mentioned variables.

### 6.8.3. Adherence/ Competence

In the three best outcome cases the therapists reported good adherence and competence on their adherence forms. The therapists in the case of Linda and Kerry were more critical and less confident of their competence and adherence, which were reflected in their scores. It would appear that there was some accuracy in their reporting and that their scores were not simply representative of an overly-critical view of their work.  In all cases, the supervisor's rating of the therapist's adherence was good, although the three best outcome cases were rated as higher in competence and adherence than the other two cases. Overall, it seems reasonable to conclude that higher ratings of adherence and competence have a positive impact on outcome of therapy.

| Table 6.3.1. TA / Therapy Specific Factors | Peter GOOD OUTCOME | Denise GOOD OUTCOME | Tom GOOD OUTCOME | Linda MIXED OUTCOME | Kerry POOR OUTCOME | Pragmatic practice principles/ Conclusions |
|---|---|---|---|---|---|---|
| **Use of TA theory to conceptualise own process** | Client had clearly integrated a range of TA theory to conceptualise own process- evident in HAT and Change Interview responses | Client had clearly integrated a range of TA theory to conceptualise own process- evident in HAT and Change Interview responses | Client had clearly integrated a range of TA theory to conceptualise own process- evident in HAT and Change Interview responses | Client made some references to TA theory to conceptualise own process | Client had clearly integrated TA ego state theory to conceptualise own process- evident in HAT and Change Interview responses | Learning relevant TA theory to understand and conceptualise one's own process is helpful to clients |
| **Ego State model** | Client reported this to be very useful | Client reported this to be very useful | Client reported this to be very useful | Client reported this to be very useful, but did express some reservation about it in Change Interview | Client reported this to be very useful | Use of and teaching ego state model to client is helpful |
| **Changing internal dialogue from critical to nurturing** | Evidence of change in internal dialogue | Strong evidence of change in internal dialogue | Strong evidence of change in internal dialogue. This was a substantial focus of therapy | Some evidence of change in self-image/ perceptions and internal dialogue | No evidence of any change in internal dialogue | Focus on changing internal dialogue from critical to nurturing is helpful |
| **Identifying and challenging maladaptive patterns** | Maladaptive pattern identified in first few sessions and sustained focus and re-evaluation of this throughout therapy | Maladaptive pattern identified in first few sessions and sustained focus and re-evaluation of this throughout therapy | Maladaptive pattern identified in first few sessions and sustained focus and re-evaluation of this throughout therapy | Maladaptive pattern identified in first few sessions and was key focus in therapy | Maladaptive pattern identified in first few sessions. Frequently the focus of the therapy but less focused than other cases | Early identification of maladaptive pattern which then guided focus of therapy is beneficial to outcome |
| **Identifying and disconfirming pathogenic beliefs and expectations** | Key life-script theme identified in session 1. Focus on challenging and re-evaluating these | Key life-script theme identified in session 1. Strong focus on challenging and re- | Key life-script theme identified in session 1. Strong focus on challenging and re- | Key life-script theme identified in sessions 1-3. Some focus on challenging and re- | Main life-script themes identified in first few sessions. Focus somewhat present, but | Identification of key life-script theme identified early in therapy and as guiding focus to |

| | | | | | | |
|---|---|---|---|---|---|---|
| | maintained throughout therapy | evaluating these maintained throughout therapy | evaluating these maintained throughout therapy | evaluating these throughout therapy | disappeared when faced with intense client distress | therapy is beneficial to outcome |
| **Improved communication and interpersonal changes** | Strong and prolonged exploration and changing of communication style and interpersonal relationships | Strong and prolonged exploration and changing of communication style and interpersonal relationships | Strong and prolonged exploration and changing of communication style and interpersonal relationships | Considerable focus on exploration and changing of communication style and interpersonal relationships | Some focus on exploration and changing of communication style and interpersonal relationships- client reluctant to implement | Strong and prolonged focus on improving communication and interpersonal relationships is beneficial to outcome |
| **Narrative-Emotional processing** | Significant change in emotions about past followed by re-evaluation and re-writing of narrative-emotional themes | Significant change in emotions about past followed by re-evaluation and re-writing of narrative-emotional themes | Significant change in emotions about past followed by re-evaluation and re-writing of narrative-emotional themes | Minor change in emotions about past and some re-evaluation of narrative themes | Minor change in emotions about past and some re-evaluation of narrative themes | Processing and re-working of narrative and associated emotions is conducive to positive change |
| **Contracting** | Significant contracting for goals by session 3 | Significant contracting for goals by session 3 | Significant contracting done in first session | Contract goals agreed in session 5 | No contract goals agreed | Negotiation and agreement of contract goals by session 3 is beneficial to outcome. Clear agreement of goals is essential to positive outcome |
| **Formulation-focused therapy** | Therapy clearly and consistently focused on a clear case formulation and treatment plan | Therapy clearly and consistently focused on a clear case formulation and treatment plan | Therapy clearly and consistently focused on a clear case formulation and treatment plan | Therapy somewhat focused on case formulation and treatment plan | Therapy somewhat focused on case formulation and treatment plan | Therapy is more effective when it is consistently based on a clear case formulation and |

| | | | | | | treatment plan |
|---|---|---|---|---|---|---|
| **Mutuality** | Emphasis on mutuality and equality in relationship important to client | Emphasis on mutuality and equality in relationship important to client | Emphasis on mutuality and equality in relationship important to client | Emphasis on mutuality and equality in relationship important to client | Emphasis on mutuality and equality in relationship important to client | A therapeutic relationship which is characterised by mutuality and equality is a characteristic feature of TA therapy |
| **Active Therapist Approach** | Clearly active therapist approach | Clearly active therapist approach | Clearly active therapist approach | Clearly active therapist approach | Clearly active therapist approach | TA therapy is characterised by an active therapist approach |
| **Therapist 'Potency'** | Therapist style corresponds with TA concept of 'potency' | Therapist style corresponds with TA concept of 'potency' | Therapist style corresponds with TA concept of 'potency' | Therapist style corresponds with TA concept of 'potency' | No discussion of therapist style | The client experiencing the therapist as 'potent' is likely to be a facilitative factor |
| **'Permission'** | Implicit reference to 'permission' in change interview | Frequent explicit and implicit reference to 'permission' in change interview | Frequent explicit and implicit reference to 'permission' in change interview | Frequent explicit and implicit reference to 'permission' in change interview | No reference to 'permission' in change interview | The client experiencing the therapy as a permissive and encouraging space it likely to be a facilitative factor |
| **Resolution of Alliance Ruptures** | Successful resolution of alliance rupture evident in case report | Successful resolution of alliance rupture evident in case report | Successful resolution of alliance rupture evident in case report | No reported alliance rupture in case report | Several alliance ruptures evident, which do not appear to have been processed or repaired | Effective and swift identification, processing, repair and resolution of alliance ruptures is beneficial to outcome |

**Table 6.3.2. Summary of Cross-Case Analysis- Client Factors**

| Client Factors | Peter<br>GOOD OUTCOME | Denise<br>GOOD OUTCOME | Tom<br>GOOD OUTCOME | Linda<br>MIXED OUTCOME | Kerry<br>POOR OUTCOME | Pragmatic practice principles/ conclusions |
|---|---|---|---|---|---|---|
| **Hope/ Expectations for Therapy** | Positive and hopeful about outcome of therapy | Positive and hopeful about outcome of therapy | Positive and hopeful about outcome of therapy | Somewhat cynical about therapy | Somewhat cynical about therapy | Hope about outcome of therapy influences outcome |
| **Deliberate and Active Choice of Therapist** | Actively sought out specific therapist after doing careful research | Actively sought out specific therapist. Deliberate choice of TA therapist | Actively sought out specific therapist. Deliberate Choice of TA therapist | Sought out therapy via an agency | Contacted the 'nearest available therapist' | Active and deliberate choice of therapist influences outcome |
| **Motivation Level** | Obvious high levels of motivation. Active participant in making changes | Obvious high levels of motivation. Active participant in making changes | Obvious high levels of motivation. Active participant in making changes | Motivation apparent. Active participant in making changes | Did not feel able to make direct and substantial behavioural changes | High motivation and active implementation of life changes influences outcome |
| **Early Life Experiences** | Mother died during Peter's childhood, Father highly critical and domineering. Bullied at school. Felt ignored and unimportant | Reported parents as being unsupportive and critical. Sexually abused. Felt ignored and unimportant | Highly critical and harsh parents. Bullied at school | Highly critical and unsupportive mother | Emotionally distant and unsupportive parents. Acrimonious divorce of parents during teenage years | Absence of nurturing and support and presence of critical parents were early life experiences of all clients in this |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | study and appeared to be depressogenic in nature. |
| **Isolation** | Experienced isolation internally and in relation to family. Somewhat socially isolated with little available support | Experienced isolation internally and in relation to family. Some social support available | Experienced isolation internally and in relation to family. Some social support available | Experienced isolation internally. Some social support available | Very isolated. No available social support | Isolation as a subjective experience is a feature of depression |
| **Demographic Factors** | White British, single, educated to degree level | White British, widowed, educated to degree level | White British, in relationship, educated to secondary level | White British, Married, educated to degree level | White British, in problematic relationship, educated to doctoral level | Results apply to White British client-therapist dyads. Education and relationship status not a factor in outcome |
| **Psychosocial Stressors** | Problems with primary support group and social relationships- improved during therapy. Unemployed | Problems with primary support group and social relationships- improved during therapy. Some occupational problems. | Problems with primary support group and social relationships- improved during therapy. No occupational problems. | Problems with primary support group and social relationships- improved during therapy. Unemployed. | Problems with primary support group and social relationships- no improvement. Unemployed. | Problems with interpersonal relationships common amongst this client group. Improvement in these during therapy is beneficial to outcome |
| **Pre-Therapy Preparation** | Good understanding about therapy and | Good understanding of therapy, good | Some understanding of therapy, good | Little understanding about therapy, no | Little understanding about therapy, no | Some understanding |

| | | | | | | |
|---|---|---|---|---|---|---|
| | some knowledge about TA theory | knowledge about TA theory | knowledge of TA theory | knowledge of TA | knowledge of TA | of therapy and in particular TA prior to therapy is helpful |
| **Internal/ External Problem Description** | Problems described have internal focus | Problems described have internal focus | Problems described have internal focus | Most problems described have internal focus although some have external focus | Problems described have external focus | Client identifies problems as internally-focused is helpful |
| **Impact of Negative Life Events** | No major negative life events during therapy or follow-up | Bereavements during therapy | Moved to new city to cohabit, new job, college course during follow-up | Mother died and was made redundant during follow-up | Difficult relationship break-up during therapy | Negative life events have an impact on outcome and pattern of recovery. Contingency planning during termination phase would be helpful |

**Table 6.3.3. Summary of Cross-Case Analysis- Generic Therapy Factors**

| | Peter GOOD OUTCOME | Denise GOOD OUTCOME | Tom GOOD OUTCOME | Linda MIXED OUTCOME | Kerry POOR OUTCOME | Pragmatic practice principles/ conclusions |
|---|---|---|---|---|---|---|
| **Length of Therapy** | 16 sessions | 16 sessions | 16 sessions | 9 sessions | 13 sessions | Longer therapy is more useful |
| **Pattern of Recovery** | Reliable change by session 8 | Reliable change by session 8 | Clinically significant change by session 8 | Clinically significant change by session 8 | Reliable change by session 8 | Important changes and improvement |

| | | | | | | takes place within the first eight sessions |
|---|---|---|---|---|---|---|
| **Impact of Interruption to Therapy** | Some deterioration when therapy interrupted | Some deterioration when interrupted but may have been due to bereavement and illness | No deterioration when interrupted by holiday | No deterioration when interrupted by holiday | Significant deterioration when therapy interrupted | Therapy adversely affected by interruption in therapy process. |
| **Working Alliance Inventory** | Client mean score >5 Therapist mean score >6 | Client mean score >5 Therapist mean score >6 | Available client mean score >5 Therapist mean score >6 | Client mean score >6 Therapist mean score 5 or less | Both therapist and client scores <5 | Higher ratings of working alliance likely to be predictive of outcome. Therapist experiencing strong alliance with client is possibly a helpful factor |

**Table 6.3.4. Summary of Cross-Case Analysis- Therapist Factors**

| | Peter GOOD OUTCOME | Denise GOOD OUTCOME | Tom GOOD OUTCOME | Linda MIXED OUTCOME | Kerry POOR OUTCOME | Pragmatic practice principles/ conclusions |
|---|---|---|---|---|---|---|
| **Experience of Therapist** | Over 5 years post-qualifying experience | Over 5 years post-qualifying experience | Over 5 years post-qualifying experience | One year post-qualifying experience | One year post-qualifying experience | Greater therapist experience may result in better outcome |
| **Adherence and Competence** | Generally good-excellent | Generally good-excellent | Generally good-excellent | Generally good | Generally satisfactory-good | Good-excellent adherence and |

| | | | | | | competence may result in better outcome |
|---|---|---|---|---|---|---|
| **Empathy** | Highly empathic therapist | Highly empathic therapist | Highly empathic therapist | Highly empathic therapist | Therapist struggled being empathic towards client | High levels of empathy associated with positive outcome |
| **Therapist demographic features** | Male, White British therapist | Male, White British therapist | Female, White British therapist | Female, White British therapist | Female, White British therapist | No conclusions can be drawn regarding the impact of the available therapist demographic variables |

**6.9. Summary of Chapter**

This cross-case analysis has presented a wide range of variables as potentially significant in relation to outcome. Due to the nature of the research design, it is not possible to draw clear causal conclusions about the impact of these variables, although some do appear to have strong indicators that they may have influenced the outcome of the therapy (e.g. impact of length of therapy, client actively seeking out therapist, pre-therapy preparation, usefulness of TA model for collaborative working, contracting for therapy goals and so on). Furthermore, due to the complex nature of the human condition and of the practice of psychotherapy it appears probable that within each case these variables each had a greater or lesser impact and that it was the combination and interaction of these variables in each case which contributed to the eventual outcome.

# Chapter Seven: Discussion

*This discussion focuses on the key findings of this study, and their relationship to the research questions. The findings are reviewed in relation to previous research. Theory and practice implications and implications for development of research method are discussed. The strengths and limitations of the study are also reviewed*

# Section One: Summary of Key Findings

### 7.1.1. Introduction

Transactional Analysis is an under-researched psychotherapy. This study is the most detailed investigation into the effectiveness of individual TA therapy within a single defined diagnostic category to date. No previous research has evaluated the outcome of individual TA therapy for depression. Nor have previous studies investigated the process of individual TA therapy within routine practice, although two studies have investigated the process of group TA therapy (Johnsson, 2011; McNeel, 1979). Consequently, this present study provides an original contribution to the TA psychotherapy literature by providing some evidence of the effectiveness of TA for depression. The case series produced three positive outcome cases, one mixed-outcome case and one poor outcome case. The findings demonstrate clinically significant change and support TA as an effective therapy for depression. The cases also supplement the general psychotherapy literature in demonstrating positive outcomes of therapy for depression. (In the one poor outcome case, the client did appear to improve at times when the therapy was frequent and regular. These changes were somewhat limited and were not sustained, but detailed analysis of the data indicates that the client did appear to experience some benefits from the therapy). All

clients in this case series reported being satisfied with the therapy they received, which suggests that TA is an approach that a range of clients may find helpful and appropriate to their needs.

**7.1.2. Summary of Findings in Relation to Research Questions**

*7.1.2.1. Outcome and Effectiveness of TA for Depression: The Primary Research Question*

The primary research question was: 'Can TA psychotherapy be effective for short-term treatment of depression?' Psychotherapy in general is known to be an effective treatment for depression; competently-delivered *bona-fide* psychological therapies produce comparable outcomes (Wampold, 2001). This suggests that TA would also demonstrate effectiveness at a level equivalent to other therapies. The findings of the present study broadly support these statements. This study has generated foundation evidence of the effectiveness of TA psychotherapy in the treatment of depression (if evaluated using the criteria established by Chambless and Hollon [1998] relating to definitions of 'evidence-based' therapy). This argument is strengthened by the design of the study which allowed for the detailed consideration of alternative or extra-therapy factors that might have been responsible for client change. As none were found, this suggests that the changes experienced by the clients were likely to be due to the effects of TA therapy. These preliminary findings establish TA as a highly promising approach to treating depression; one that warrants further research.

*7.1.2.2. Processes and Factors Influencing the Outcome of TA Psychotherapy for*

*Depression*

The secondary research question focused on the processes and factors that affected the outcome of individual TA psychotherapy for treatment of depression within the cases. The findings highlight five main process factors that strongly influenced the outcome of the case and which are characteristic features of TA psychotherapy. These form a robust framework for an emerging model of TA treatment of depression.

The five emergent process factors most critical to successful outcomes of TA therapy were as follows:

1. The client's involvement in his or her choice of therapist.

2. Use of Transactional Analysis as a collaborative conceptual framework for understanding the client's process.

3. Development of a collaborative case formulation process that organises the work and direction of the therapy.

4. A combination of cognitive, behavioural, affective, and relational processes that are informed by a developmental perspective.

5. Use of homework to develop insight and interpersonal change.

# Section Two: Contextual Discussion of Findings

*This section will focus on the relationship of the findings of the study to existing literature.*

*This section will look at issues of effectiveness and outcome, specific techniques within TA,*

*patterns of recovery, relapse and comorbidity and then finally process factors*

## 7.2.1. Introduction

Direct comparison of the findings with previous research is made difficult, not only because so few systematic case studies or case series of therapy for depression exist, but also because of differences in research methods and research questions used. Many of the cases presented in Watson, Goldman and Greenberg (2007) and Goldman, Watson and Greenberg (2011) for example, on the use of Emotion-Focused Therapy (e.g. emotional experiencing and processing) focus more on process rather outcome. Within some of the case series that do exist there is a lack of clarity about process and method of cross-case analysis.

## 7.2.2. Review of Findings in the Context of Transactional Analysis Literature

Although the existing body of research into the effectiveness of TA is small compared to many other therapies, that conducted has generally reported positive findings. There are three previous studies of TA therapy which are of direct relevance to the present study. Only one study specifically investigated the effectiveness of TA for treatment of depression: the controlled trial conducted by Fetsch and Sprinkle (1982). Their study found that four weeks of TA group therapy was sufficient to produce reliable improvement in cases of mild depression. The findings of the present study are concordant with this. It must be noted that the levels of severity of depression suffered by clients in the present case series was more

varied than those in the Fetsch and Sprinkle study, contributing to wider variation in the recorded range of responses and patterns of improvement.

In a study looking at the effectiveness of therapies in routine practice, van Rijn *et al.* (2011) found that short-term TA therapy had comparable effectiveness to Integrative Counselling Psychology and (using a benchmarking strategy) found that both approaches demonstrated effectiveness equivalent to CBT as delivered within the Improving Access to Psychological Therapies (IAPT) initiative. Within the IAPT scheme the expected benchmark recovery rate for clients receiving therapy for depression is set at 54% of clients (Clark et al., 2009). Van Rijn *et al.* found that short-term TA therapy had a recovery rate of 57%. If the van Rijn *et al.* (2011) and IAPT data (Clark et al., 2009) are used as benchmarks, a similar proportion of the clients in this series recovered.

More useful here, is the case series by McLeod (2013a), which investigated TA therapy for long-term health conditions. She found TA to be a flexible and versatile therapeutic approach that could be readily tailored to suit the individual client's needs. This finding reflects the findings of the present study, which emphasises the value of the therapists capacity to adjust the therapeutic approach according to the evolving issues and preferences of the client.

### 7.2.3. Review of Findings in the Context of Literature on Specific TA Techniques

An analysis of the therapists notes and client HAT forms in this case series suggest a wide range of TA methods were used in each case. These were compared with weekly outcome measures and the Change Interview data to highlight specific event-shift sequences (Elliott, 2002). One of the cases stands out as providing strong evidence about the use of two

specific TA techniques and the event-shift sequences associated with these. This was the case of Tom, and the creative combination of self-reparenting and two-chair methods in his therapy.

The positive use of 'self-reparenting' as a therapeutic intervention in Tom's case supports the findings of Wissink (1994), who found that participants in a six-week TA-based self-reparenting group experienced a significant increase in self-esteem. A control group showed no increase in self-esteem during the same time period, suggesting that the self-reparenting method was effective at increasing self-esteem, feelings of self-efficacy and self-actualisation. Similar findings were reported by Noriega Gayol (1997) who used a TA group therapy intervention based on principles of contracting, self-reparenting and redecision therapy and found that participants experienced a statistically significant improvement in measures of self-esteem. Tom's therapy was based on strong, clear contracts and also included substantial use of self-reparenting and redecision therapy techniques (in particular, two-chair methods). This indicates that with the right client-therapist relationship these methods are effective. Further research to investigate the effect of contextual factors on the outcome of these therapeutic strategies is warranted.

### 7.2.4. Review of Findings in the Context of Research on the Influence of Severity of Depression on Outcome

The cases of Peter and Denise provide evidence of the effectiveness of TA psychotherapy as a treatment for severe depression (as measured by improvements on BDI-II). In both cases, marked improvement was recorded. The meta-analyses of Driessen *et al.* (2010) and Cuijpers *et al.* (2011) concluded that initial severity of depression did not negatively impact on recovery and the efficacy of psychotherapy. Conversely van Rijn *et al.* (2011) claimed that

severity of initial symptoms does negatively impact on outcomes. The relationship between

initial severity and outcome is thus still debated and further research is needed to examine

the interaction of client, therapist and process factors which result in successful therapy

with severe depression.

**7.2.5. Review of Findings in the Context of Process Factors Research**

*7.2.5.1. Relationship to Existing Research on the Process of TA Psychotherapy*

McNeel (1982) described TA group therapy as characterised by a proactive therapist

approach and a strong emphasis on change and personal responsibility. Furthermore, he

noted that the use of humour and behavioural modelling were also a regular feature of TA

therapy sessions.  Johnsson (2011) also found TA therapy to be characterised by a highly

active therapist stance.  The present study reflects these studies' observations in the five

clients' accounts of the change process (identified in their Change Interviews). The

therapists in the present study were described as taking an active role in the therapy, using

both supportive and confrontational techniques to facilitate the change process. This was

combined with cognitive-affective experiential techniques and behavioural contracting

which challenged maladaptive and limiting beliefs and patterns.

*7.2.5.2. Review of the Findings in the Context of the Conclusions of the APA Task Force on*

*Evidence-Based Therapy Relationships*

Peter, Denise, Tom and Linda all spoke in their Change Interview about the importance of

the therapeutic relationship and the overall relational ambience of the therapy. These

findings appear to support existing literature regarding the importance of the therapeutic

relationship to positive outcome in therapy (Norcross & Wampold, 2011). Specifically, the

findings support some of the conclusions of the meta-analyses commissioned by the APA

task force regarding factors that are believed to have a positive impact on outcome. A

summary of the task force findings and their relationship to the findings of the present

study are listed in a table overleaf. The task force recommended that practitioners combine

these relationship process factors (e.g. empathy, repair of alliance ruptures) and adjust the

therapy according to client presentation (e.g. preferences, stage of change) to maximise

therapeutic outcome (see section 2.5.3.).

**Table 7.1: Summary of Process Factors Identified by APA Task Force and their Relationship to this Case Series**

| Clearly indicated factors | Summary of evidence from cases |
|---|---|
| **Client Preferences** (Swift, Callahan & Vollmer, 2011) | Present in all positive outcome cases, not present in mixed/ poor outcome cases |
| **Client Expectations** (Constantino, Glass, Arnkoff, Ametrano & Smith, 2011) | Present in all positive outcome cases, less present in mixed/ poor outcome cases |
| **Factors with some evidence** | |
| **Working Alliance** (Horvath, Del Re, Fluckiger & Symonds, 2011) | Positive outcome cases had stronger alliance |
| **Goal Consensus and Collaboration** (Tryon & Winograd, 2011) | Present in all positive outcome cases. Problems with goal consensus and collaboration in poorer outcome cases |
| **Factors which may have influenced outcome** | |
| **Repairing Alliance Ruptures** (Safran, Muran & Eubacks-Carter, 2011) | Present in all good outcome cases, unresolved ruptures present in poor outcome case |
| **Matching therapy to client Stages of Change** (Norcross, Krebs & Prochaska, 2011) | Some indicators that this may have been a factor in good outcome cases |
| **Matching therapy to client Coping Style** (Beutler, Harwood, Verdirame, Kimpara & Blau, 2011) | The case of Kerry shows an externalising view of problems, suggesting different coping styles may be relevant |

### 7.2.5.3. Clearly Indicated Factors: Effect of Client Preferences and Expectations of Therapy

Each of the three clients with the best outcomes invested considerable time and energy seeking out and choosing Transactional Analysis therapy and selecting his or her therapist. Linda was allocated a therapist by an agency and Kerry saw the most conveniently located therapist (in her Change Interview she expressed a preference for psychoanalytic therapy). The experience of these clients reflects the meta-analysis findings of Swift, Callahan and Vollmer (2011), who concluded that clients undergoing therapy in line with their preferences were less likely to drop out of therapy and were more likely to have better outcomes. Constantino, Arnkoff, Glass, Ametrano and Smith (2011) found a small but significant positive effect from optimistic prognostic expectations and realistic expectations about what therapy would involve on overall treatment outcome. Here, Peter, Denise and Tom all had positive expectations about therapy and also a clear sense of what therapy would involve. In contrast both Linda and Kerry were more cynical about whether therapy would help. Kerry had previously had counselling for 'crisis-management' on several occasions and each time had only attended two sessions and was more ambivalent about therapy.

### 7.2.5.4. Clearly Indicated Factors: Expectations about the Tasks of Therapy and Preparedness for Therapy

A review of attrition by Barrett *et al*. (2008) reported drop-out rates from therapy as high as 65%. The National Audit of Psychological Therapies (Royal College of Psychiatrists, 2011) identified a median drop-out rate of 19%, which rose to as high as 50% in some services within the IAPT programme. A study by Reis and Brown (2006) identified higher levels of

client psychological mindedness[23] being predictive of client retention. Within the present study, all the therapists in the study reported that in their opinion that their clients appeared to have high levels of psychological mindedness and none dropped out of their therapeutic programme. All clients within this study received a role induction document titled 'how to get the most out of therapy'. Previous studies (Walitzer, Dermen and Connors, 1999; Guajardo and Anderson, 2007) indicate that providing role induction material to clients reduces drop- out rates, so it is possible that the provision of the document in the present study also contributed to client retention.

### 7.2.5.5. Review of Factors Believed to be Unhelpful

Norcross and Wampold (2011) identified factors that were ineffective or detrimental to outcome. These included poor alliance and inadequate repair of alliance ruptures[24]. Both these factors appeared to have been relevant to the poor outcome in the case of Kerry. Furthermore, Norcross and Wampold suggested the use of confrontation as a therapeutic technique was particularly prone to having a detrimental effect on overall outcome. However, qualitative data from this case series indicates that the clients welcomed the use of confrontation. The clients also reported warm, supportive relationships with their therapists so it is likely that these relationship factors enabled the clients to make use of confrontation without any detrimental effect. This capacity to combine support and confrontation effectively is a characteristic feature of TA therapy.

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[23] 'psychological mindedness' relates to the client's capacity for reflection and self-observation and their capacity to conceptualise their problems in relation to psychological factors. This also includes holding the view that one's actions might be influenced by unconscious factors and by childhood influences.
[24] An alliance rupture is a point at which the therapeutic relationship is under some strain (Safran & Muran, 2003)

### 7.2.5.6. Review of Process Factors Identified in the NIMH-TDCRP Study

In line with the findings of Elkin (1994) and Elkin *et al.* (2006), the case series found that the strength of the therapeutic relationship positively affected outcome, as did high levels of adherence and therapist competence.

In the present study, TA was characterised by a high degree of flexibility that permits adaptation to cognitive, affective, behavioural, relational and existential factors according to client preferences and clinical need. In contrast, the findings of Sotsky *et al.* (1991) argued that the client's ability to make use of the strengths of each therapy was related to their initial levels of impairment in a range of areas (e.g. those who experienced poor interpersonal relationships did worse in Interpersonal Therapy than those who had good relationships). The present study suggests that TA is a therapeutic approach which has the capacity to focus on different areas of client strength before moving into areas of greater impairment. This gives TA a potential capacity to engage a greater range of clients.

Coombs *et al*. (2002) argue that it is collaborative emotional exploration within the context of a safe, non-judgemental empathic therapeutic relationship that is central to therapy. This was supported by the present study. However, Coombs and colleagues and also Jones and Pulos (1993) argued that educative and directive approaches to therapy were not effective or related to positive outcome. In the present study, each of the five clients positively endorsed the educative aspects of their therapy and the significance of this to overall outcome. From the regular use of TA theory-based psychoeducational methods present in all the cases, it appears that this is characteristic of TA therapy. It is of note that these findings suggest that contrary to the research of Jones and Pulos (1993) and Coombs *et al*. (2002), psychoeducational interventions may have value.  From the above, it would seem

that TA as conducted in this case series ; a) balanced support and confrontation, b) was able to be adjusted to fit the client's strengths and needs, and c) utilised psychoeducational interventions effectively.

### 7.2.5.7. Review of the Principles of Therapeutic Change in Treatment of Dysphoric Disorders

Beutler, Castonguay and Follette (2006), Castonguay and Beutler (2006), and Follette and Greenberg (2006) identified a number of significant factors and 'transtheoretical principles' of therapeutic change in depression (see literature review section 2.5.6). Although the small sample size precludes statistical analysis, the present study suggests that client factors such as greater age and socio-economic status did *not* adversely affect the outcome of the cases, irrespective of initial severity of depression (also see 7.2.4. above). A further disconfirmation of the task force's findings relates to the issue of client preferences and expectations of therapy. The task force were inconclusive on the matter, whereas within the present study client preferences and expectations of therapy appeared to be highly significant in relation to overall outcome.

The six empirically grounded principles for technique and interventions are supported in the present study. These principles provide a broad set of guidance which is drawn from a wide range of therapies. They suggest that therapy that successfully resolves depression would require a systematic and experiential approach that challenges a combination of depressogenic cognitive, affective, behavioural and relational processes (Follette & Greenberg, 2006). Despite highlighting these principles, their model does not address how all of these principles can be coherently combined in one therapy noting that different therapeutic approaches will emphasise different principles and change mechanisms. As the

successful cases in this series appear to have largely conformed to all of these principles, TA provides a coherent framework which integrates these principles within one therapeutic approach.

### 7.2.5.8. Relationship to Previous Case Series

The case series by Watson, Goldman and Greenberg (2007) which investigated the use of Emotion-Focused Therapy (EFT) for depression most closely resembles the present study and is therefore a good source for comparison of findings. Watson *et al.* (2007) found that the clients in their study all had early home lives which were characterised by high levels of criticism and low levels of nurturing and warmth. In the present study all clients report similar negative childhood experiences.

Differential response to treatment in the Watson *et al.* (2007) study appeared to be highly influenced by the clients' ability to experience, express and regulate their emotions. Impaired ability to engage with the emotional processing tasks which are a central part of EFT was associated with poor outcome. Furthermore, shame related to emotional vulnerability, poor ability to identify an early life narrative, a focus on external events rather than internal change combined with a sense of hopelessness were also features of the poor outcome cases. Within the present study, the client's ability to engage with emotional processing was not a factor, as TA therapy was able to flexibly engage clients in different ways (for example, using cognitive, behavioural or relational change mechanisms) according to their presenting problem and preferences. The focus on external events as opposed to internal change combined with a sense of hopelessness also appeared to be relevant; Kerry (who had a poor outcome) was focused on external change and felt hopeless, whereas Peter, Denise and Tom were all internally-focused and hopeful about therapy.

# Section Three: Implications for Theory and Practice

## 7.3.1. Introduction

This discussion now moves on to a range of theoretical and practice-based implications for the development of TA therapy as a whole and specifically relating to its application in cases of depression.  This section focuses primarily on findings drawn from the cross-case analysis and applies both abductive reasoning and Stiles (2007) theory-building approach to suggest implications for TA theory and practice.  The theoretical and practice implications discussed here have numerous points of connection with a range of theoretical approaches. In line with the theory-building aspect of this thesis, the primary focus will be on the development of TA therapy. A summary of the theory-building extensions to TA theory and practice is presented in table 7.2.

## 7.3.2 Theoretical Implications

### 7.3.2.1. Engagement with the Theoretical Model and Language of TA

The cases in this series documented each clients use of TA to conceptualise their own process and manage their internal and interpersonal experiences. In theoretical terms, TA holds that this can be understood as enabling clients to either stay or return to their Adult ego state. From a more general psychotherapeutic perspective, it might be thought that this process enables clients to develop a systematic approach to self-reflection that was then used to self-generate options in how to respond- both internally and externally- to different situations. The use of TA theory also gave the clients a way to make sense of frightening or distressing experiences by helping them to gain insight into their reactions and increase

their sense of self-efficacy[25]. This engagement with the language and theory of the model appears to be a distinctive feature of TA and is unusual compared to many other therapies. There is no existing research on the engagement of clients with theoretical material and so further investigation of the impact of this is warranted.

### 7.3.2.2. Pre-Therapy Preparation / Role Induction

A key finding is that clients who had some pre-therapy understanding of TA theory and the process of therapy had better outcomes than those with none. One implication of this is that standardised role induction materials could be developed specifically for the purpose of client education about the theory and process of therapy. The use of such materials could be tested and evaluated for their impact on outcomes and client engagement in therapy.

### 7.3.2.3. 'Challenging Avoidance'

The use of homework in TA practice is primarily intended to serve two purposes: firstly, development of self-awareness, and secondly to promote behavioural experimentation to challenge specific maladaptive patterns. TA therapists traditionally promote active change in their clients and will negotiate with the client to plan specific actions that they believe will help the client move towards their overall therapy goals (Stewart, 2007). All of the therapists in this study engaged their clients in behavioural contracting. Analysis of the case studies highlighted an implicit conceptualisation that drives this process- namely the, challenging of avoidance. This was documented in a number of the cases. Specifically, it was noted in Peter section  5.1.3.2;  Denise in her change interview responses and the judges' comments;  in the case of Tom at 5.3.3.1 and his change interview responses, particularly

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[25] This was evident in Tom's HAT form responses in 5.3.5.2.1. and his change interview responses. Kerry also described her use of the ego state model in her change interview responses.

CT166-8 and the judges' description of mediator factors; in the case of Linda at 5.4.3.1. in

her change interview responses and the judges' description of mediator and moderator

factors; and in Kerry 5.5.3.1. This is of theoretical significance because although avoidance is

acknowledged in several therapy approaches and has links to several aspects of TA theory,

there is not a specific TA concept relating to avoidance.  Avoidance would fit most closely

within the concept and taxonomy of passive behaviours (Schiff, et al., 1975). This extension

of TA theory could give rise to a clear framework for intervention related to avoidance that

would strengthen the application of TA therapy with this client group.

### 7.3.2.4. 'Vicious Cycles'

Another observation was that the therapists in this present study all actively sought to help

their clients break patterns of behaviour that might (inadvertently) reinforce their

depression. This appears to have been a conscious therapeutic strategy. However, no direct

theoretical concept exists within existing TA literature to act as a theoretical basis for this

intervention approach. A theoretical extension that might accommodate this could be

described as 'vicious cycles'. This concept is similar to one used in behavioural therapy

(Veale, 2008) whereby a client's symptoms (e.g. depression) lead to a series of avoidant or

maladaptive behaviours (such as social withdrawal), which in turn reinforce the symptom

(such as lack of positive experiences).

### 7.3.2.5. Future Expectations

Another theoretical extension relates directly to the racket system (Erskine & Zalcman,

1979). The clients in this study all presented with pessimistic views of the future, and the

three clients with the best outcomes all reported feeling optimistic about the future at the

end of therapy. Existing TA theory does not include a specific concept relating to future

expectations. The racket system accommodates beliefs about self, others and the world, as

well as fantasies (see 2.1.2.4.). The inclusion of future expectations would seem to be an

intuitive extension of this model encouraging TA therapists to address negative and

pessimistic expectations.

### 7.3.2.6. Systematic Experiential Disconfirmation

TA therapists tend to pay close attention to the client's life script and its manifestations. The

therapists in the three best outcome cases all actively and deliberately managed the therapy

to avoid inadvertently reinforcing the client's life script in the therapy process[26]. Instead, the

therapists appeared to focus on challenging their client's life script. This evidence suggests

the therapists were working with an implicit principle that could be described as 'systematic

experiential disconfirmation'. This is a process which has not previously been articulated in

TA theory and constitutes a proposed additional extension to TA practice as a therapeutic

strategy. In practice, experiential disconfirmation appears to integrate cognitive, affective,

behavioural and relational aspects within a perspective informed by TA developmental

theory. For the clients in this study, interpersonal learning and changes in their ways of

communicating and relating to others were important parts of their change process[27].

### 7.3.2.7. Internal Dialogue

The changing of internal dialogue from self-criticism to self-compassion/ self-nurturing was

a key feature of the change process in the better outcome cases. This supports the TA goal

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[26] For example, see 5.2.6.4. where the judges highlighted the sustained focus on and challenge of Denise's life script
[27] This was highlighted in the following places: Peter sections  5.3.5.1, 5.1.4.2.1. and  Table 5.1.3; Denise Table 5.2.3.; Tom Table 5.3.3., mediator factors and in Linda Table 5.4.3.

of changing 'Critical Parent' internal dialogue to 'Nurturing Parent' internal dialogue. Given the centrality of self-criticism in depression, this mechanism is likely to be an important feature of any effective TA models or treatment manuals for depression.

### 7.3.2.8. TA: An Integrative, Pluralistic Approach to Psychotherapy?

*'(TA) probably represents the most fully articulated integrative model of human personality and functioning currently in use within the therapy community' (McLeod, 2009; 265)*

The findings of this study suggest that TA is an integrative and pluralistic approach to therapy. Despite several efforts to provide a unified model of psychotherapy integration no single framework has emerged, although a number of models for integration have been suggested. The integrationist strategy of *assimilative integration* (McLeod, 2009; Messer, 1992) has a long tradition within the TA literature. Since its inception, TA therapists have drawn on theories and methods from other approaches and integrated these into the theoretical framework of TA (Tudor, 2001). This is in contrast to methods of integration such as technical eclecticism (McLeod, 2009; Norcross, 2005), the common factors approach (Duncan & Miller, 2000) and theoretical integration (McLeod, 2009).

When considered from the perspective of integration by combining different therapeutic approaches, several TA authors have argued that TA is an integrative approach through its combination of humanistic/ existential, cognitive-behavioural and psychodynamic theories and methods (Clarkson, 1992; Schlegel, 1998; Tudor, 2001; Widdowson, 2010)[28]. The cases in this series support this, in that they all contain features which are characteristic of these three streams of psychotherapy theory.

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[28] See also chapter two, section one.

The present case series also provide evidence that TA is a pluralistic model. The pluralistic approach to psychotherapy integration is based on '*the assumption that different clients are likely to benefit from different therapeutic methods at different points in time, and that therapists should work collaboratively with clients to help them identify what they want from therapy and how they might achieve it*' (Cooper & McLeod, 2011: 7-8). This appears to be a close fit to the way that TA therapists work; each client is assessed and an individualised treatment plan is developed according to the client's needs. The therapist then tailors the therapy according to these needs and matches their overall approach with the client's preferences, adjusting this over time and in line with the client's progression through therapy. This matching draws on a wide range of techniques which range across methods from humanistic, cognitive-behavioural and psychodynamic approaches, but which are coherently organised by TA theory. Where TA differs from a pluralistic approach is in its use of a single theoretical system to guide and inform the therapy and from which interventions can be selected.

### 7.3.2.9. Integration Across Domains

The client conceptualisation, process of change and selection of interventions in different approaches tends to focus on two primary domains. These are the cognitive and behavioural, the affective and relational domains. For example, Cognitive-Behavioural therapists promote change through their emphasis on changing cognition and behaviour domains of their clients' process. Similarly, Emotion-Focused Therapy and Psychodynamic Therapy (although different in theoretical basis) promote change primarily through the affective-relational domains. Whilst these different approaches do include the use of interventions from other domains, they are primarily based on their focus in two areas. In

contrast, TA, as evidenced in this case series, both conceptualises the client and promotes change in cognitive, affective, behavioural and relational domains using an integrative and coherent framework which is capable of being flexibly applied to each case according to presenting problem(s) and client preferences. It would appear that this is a unique and significant contribution that TA makes to psychotherapy.

### 7.3.3. Implications for Practice

#### *7.3.3.1. Integrative Case Formulation and Therapy Implementation*

The main practical implication of this study relates to the flexibility of TA as an approach which can be tailored to the client, their preferences and presenting issues and which coherently integrates the cognitive, behavioural, affective and relational domains of human functioning. The clients in this case series were varied in terms of background, clinical problem and presentation and each of the therapists worked differently with his or her client, even within the bounds of a TA framework. The good outcome cases in this series were characterised by clear, individualised case formulations and an approach to therapy that was developed to suit the individual client's needs, presenting problem and process. The TA model facilitated the construction of a formulation based around the practical application of several key theoretical concepts that then guided the therapy according to the client's individual circumstances.

When the initial process of problem formulation and generation of goals for therapy are considered, it is desirable for the therapist to encourage the client to articulate their problems and therapy goals clearly (in terms of internal or interpersonal changes, as opposed to changes that are associated with external factors). This would focus the therapy

on internal changes, such as self-esteem, the way the client interprets and processes experiences and so on. Changes in these areas are likely to enhance the client's sense of self-efficacy and agency which in turn would challenge the client's depressogenic beliefs, internal experiences and interpersonal patterns. This would promote the overall goal of therapy; the recovery from depression.

The emphasis on contracting and the generation of clear, well-defined goals for therapy appears to have been supported in the successful cases. It is possible that clear contracting is a central factor in determining outcome of TA therapy by acting as a lynchpin which bridges theoretical conceptualisation with therapy method upon which the entire therapy rests[29].

### 7.3.3.2. Using the Therapeutic Relationship to Promote Hope and Active Change

Findings from the qualitative data support several strands within the existing TA literature regarding the optimal management of the therapeutic relationship. This includes the development of a pro-active therapist stance, empathic responding, appropriate self-disclosure and enhancement of therapist relational qualities, e.g. 'potency' (Hargaden & Sills, 2002; Stewart, 2007; Widdowson, 2010). What is missing from the TA literature is guidance on how the therapeutic relationship can be used to facilitate the enhancement of the client's positive expectations of therapy and in encouraging clients to take their change process out of the therapy room into their everyday lives. Expectation enhancement and supporting positive hope for therapy helps clients with depression, as they often start therapy feeling demoralised and lacking in positive hope for the future (Beck et al., 1979).

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[29] The early use of contracting was described in the descriptions of the therapy process in the cases of Peter, Denise and Tom. The case of Linda did not involve clear outcome contracting until session five. The absence of overall therapy goal contracting is notable in the case of Kerry. Kerry's therapist also commented on this in her reflections on the process.

### 7.3.3.3. Supporting Client Choices

There are clear indications of the benefits of supporting client choice and preferences in the type of therapy and therapist they access. One obvious recommendation from this is to encourage therapists to provide prospective clients with detailed information about their background and approach to therapy in order to facilitate the early agreement of the tasks of therapy and thus promote client engagement. Furthermore, the provision of materials for the purpose of pre-therapy preparation is recommended. This includes material regarding the process and tasks of therapy and a delineation of the different roles of the therapist and client as well as some initial information about the theory of TA. These materials could be produced generically in the form of a 'client manual for TA therapy', thus providing some degree of standardisation and quality control of materials that on a practical level would likely save valuable time for busy therapists.  It would also be desirable for therapy agencies to consider the possibility of modifying their intake procedures so that client preferences in terms of therapist and therapy type are taken into account wherever possible.

### 7.3.3.4. Achieving Optimal Duration of Therapy

This study offers preliminary evidence that sixteen sessions of therapy is sufficient to produce a clinically significant response. In contrast, the outcomes were poorer for the two clients who had shorter therapy. Due to the small sample size, firm conclusions cannot be drawn about optimal duration of therapy, warranting further research to investigate optimal treatment length.

Furthermore, there is some evidence that breaks within the therapy programme were detrimental to outcome[30]. This is in line with previous research conducted by Reardon, Cukrowicz, Reeves and Joiner (2002) and that of Kraft, Puschner and Kordy (2006). Although breaks and gaps in therapy are sometimes unavoidable due to illness, planned breaks are undesirable and may adversely impact client progress during the course of a relatively short therapy intervention. Providing clients with information (such as printed materials) about how such interruptions in therapy are best managed may be helpful.

An additional recommendation from the findings of this study is to engage in contingency planning and resourcing the client to maintain gains in anticipated or unexpected stressful times in the future. Peter, Tom and Linda all struggled to maintain their gains at various points during the follow up. Analysis of these cases suggests that contingency planning was a minor part of the termination phase of the therapy[31].

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[30] Peter was making steady progress then experienced some minor deterioration in scores at session 13, just after a break in therapy due to therapist illness. There was also a long gap in case of Kerry between sessions 7 and 8 due to therapist illness. Prior to this break in sessions, Kerry had been making good progress. See description in Kerry sections 5.5.3.1, 5.5.3.4.

[31] In the case of Linda, her early withdrawal from therapy meant that the therapist did not have sufficient time to engage in contingency planning. There was some mention of 'future planning' in the cases of Peter and Tom, although the therapists' notes from these cases suggest it was a small part of only one session.

**Table 7.2 Summary of Theory-Building Extensions to TA Theory and Practice**

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**Summary of main theory-building extensions to TA theory and practice from this study**

1. **Standardised materials about TA** theory and the process of TA therapy can be produced to promote client engagement with therapy. These should include information about the roles of therapist and client and how the client can maximise their change process by active engagement with therapy tasks and 'homework'

2. Emphasis on using **between-session homework** which focuses on deepening self-awareness or challenges maladaptive patterns to support the change process and to take the experience of therapy into the client's everyday life

3. Addition of **'Avoidance'** as a fifth passive behaviour to passivity theory (Schiff, et al. 1975)

4. Addition of **'Vicious Cycles'** concept to explain how behaviour maintains symptoms and maladaptive patterns and used as a heuristic bridge between the TA theories of passivity (Schiff, et al. 1975) and the Racket System (Erskine and Zalcman, 1979)

5. Extension of the Racket System to include **'beliefs about the future'**

6. Addition of **'Systematic Experiential Disconfirmation'** as a theoretical concept and principle for practice. This should integrate cognitive, affective, behavioural and relational aspects

7. TA therapy for depression should explicitly **focus on changing internal dialogue** from self-criticism to self-compassion/ self-nurturing using ego state theory

8. TA therapy which is consistently and systematically based on a **clear case formulation** is more effective. TA literature needs to focus on methods for assisting practitioners to create case formulations

9. Problem formulation and therapy goals should be framed in terms of **internal or interpersonal changes**

10. **Contractual method is a lynchpin** of TA therapy which is essential for effective implementation of the model

11. **Therapist Potency** (Steiner, 1968) is central to the formation of the therapeutic relationship and the client's change process

12. **Expectation enhancement** supports the client in engaging with the therapist and begins to change depressogenic negative expectations

13. **Sixteen sessions of focused therapy** can be sufficient to produce clinically significant change

14. **Interruptions in therapy** need to be carefully managed and discussed with the client

15. **Active contingency planning** during the termination phase may prevent relapse

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# Section Four: Tensions, Strengths and Limitations

## 7.4.1. Introduction

Within well-constructed psychotherapy research, all researchers must address certain tensions in the design of their investigation. To some extent, these tensions are resolved by determining the aims and scope of the research and the research questions, and also through the reasoned selection of an appropriate research design. The way that these tensions are resolved in the practical research process generates a series of strengths and limitations.

Firstly, it is necessary to identify what kind of knowledge can be drawn from the study in order to both appraise and critically evaluate its findings. Again, this is largely determined by the nature of the investigation and the aims of the study in question. Within the present study, the aim was to generate rich data on a small sample of several naturally-occurring cases in routine practice. It was not the intention of the research to create strong and wide-ranging generalisations or correlations or statements of causality, as may have been the product of a study seeking to emphasise tight control of variables through the application of inferential statistical techniques. Nevertheless, this does need to be acknowledged as a limitation that contextualises the results.

Within the present study, the strengths and limitations relate primarily to issues that can be conceptually grouped into several over-arching themes. These are: validity, credibility, trustworthiness and transferability. This discussion will now address these issues in a manner congruent with the design of the study by presenting opposing and competing

examinations of the study in relation to each (this section will conclude with a table presenting the procedural methods that were used to enhance the credibility, trustworthiness and transferability of the findings).

## 7.4.2. Tensions Around Validity

When considered from the viewpoint of validity using quantitative research concepts (Shadish, Cook & Campbell, 2001), the present study was based on a series of *a priori* assumptions. In particular, the assumption was made that the construct validity of the diagnostic category of depression, and the existence of TA psychotherapy as a distinct modality were all previously established (and therefore not the subject of this investigation). Associated with this, the statistical validity of the quantitative outcome measures in this study was also considered to have been previously established.

The study included the use of an adherence scale which had not been validated. Although the scale was considered by the principal researcher to have had reasonable face validity, no testing or statistical analysis of this tool had taken place prior to the study. Consequently, there is a potential threat to the validity of conclusions regarding adherence and therapist competence. This was mitigated to some extent by the use of supervisor evaluations, but these were not standardised and also were based on the same measure.

The therapy was not delivered according to a pre-determined treatment manual. As the study was focused on a naturalistic design, the use of a manual was not part of the study design. Nevertheless, the absence of a manual does limit the internal validity of the findings (Eifert, Schulte, Zvolensky, Lejuez & Lau, 1997).

As a practice-based, naturalistic effectiveness study, the experimental control of variables was not a priority in the design of this project. Similarly, the use of a control group was not believed to be appropriate for this design. Within case studies, internal validity is increased through the use of convergence in multiple data sources, and through a clear research protocol. Nevertheless, the nature of the study does negatively impact on the internal validity of the research. The present study examined the process and outcome of therapy with a slightly modified naturalistic protocol of self-selected clients presenting for therapy, with therapists who were operating in settings representative of where the majority of TA therapy is conducted.  This, combined with the relative free-reign of the therapists to conduct 'therapy as usual' (within the constraint of prescribed length of therapy) means that high levels of external validity can be assumed. Although the study did not use a treatment manual and sought to have minimal influence over the therapy process, a question does remain regarding the degree of influence the pre-research training and the adherence form had on the therapists and the therapy process. It is possible that these may have been experienced (consciously or unconsciously) by the therapists as suggesting a 'correct way to do TA therapy for depression'. This generates a tension regarding the issue of ensuring that the therapy conducted was indeed TA therapy versus prescribing the nature of the therapy process. The feedback from the teaching and supervising transactional analysts who audited the proposed form was that the twelve tasks presented were sufficiently wide ranging to capture the essence of TA therapy as they believe it to be practiced by the majority of TA therapists. Nevertheless this does raise a potential limitation regarding the influence such procedures had on the therapy, and thus potentially impacts on the representativeness of the therapy in the cases and on the transferability of the findings (see below).

This discussion now addresses the strengths and limitations of the study in relation to issues of credibility, trustworthiness and transferability. Although these three concepts are discrete, in practice there is considerable overlap and issues often relate to more than one concept. Where this is the case, both concepts will be referred to. Both strengths and limitations will be addressed in relation to credibility, trustworthiness and transferability, respectively.

### 7.4.3. Credibility

#### 7.4.3.1. Threats to Credibility

It is possible to identify a series of potential threats, including the operationalisation of variables and disorder-based variables.

***7.4.3.1.1. Sub-types of depression***: Depression (as defined in this project) was determined by the use of DSM-IV criteria, which relies on presence of a range of symptoms to generate the diagnosis. Several authors have criticised this approach to depression, suggesting that aetiology, clinical presentation and a range of other factors are likely to be relevant and that may have significant impact on determining the course of illness and response to treatment (Luyten, et al., 2006). It is possible the clients in this present study were experiencing different sub-types of depression or depression which had different routes of pathogenesis or dynamics which may account for differential response to treatment. Further research which investigates the impact of depression sub-type on outcome would be desirable.

***7.4.3.1.2. Measurement and subjectivity***: As stated above, depression was defined operationally and quantifiably using DSM-IV criteria and scores on BDI-II. Whilst these are useful heuristics, they do not fully capture the essence of the lived experience of

depression. Similarly, whilst changes in scores represent something measureable, they do not indicate how the change has been experienced or how it may have come about. Qualitative methods have been used to address these limitations, although in themselves they are also limited in that they are necessarily coloured by the individual's subjective sense and the limits of their insight and capacity to accurately identify and explain phenomena. Also, the client's insight into the mechanisms of change may be somewhat limited.

**7.4.3.1.3. Lack of standardisation of diagnosis:** Two of the study clients had formally been diagnosed with depression by medical practitioners. The diagnostic procedure within the TA programme of therapy was based on the therapist's clinical judgment and results from BDI-II screening. There was no requirement for diagnosis to be verified independently, and there was no standardisation in how therapists formed their diagnostic conclusions. The use of a structured interview protocol such as the Structured Clinical Interview for DSM-IV (First, Williams, Spitzer & Gibbons, 2007) or the Hamilton Rating Scale for Depression (Hamilton, 1967) could have addressed this.

**7.4.3.1.4. Deterioration- relapse or transient reaction? :** Depression is often a chronic and recurring disorder (Piccinelli & Wilkinson ,1994). Each of the clients in this study reported experiencing depression for considerable amounts of time (i.e. several years) before entering the study, which may account for the return of some depressive symptoms during the follow-up period. Also, it is possible that the apparent deterioration was due to transient factors (for example, Tom's change in circumstances such as moving to a new city, starting a new job and returning to education and Linda's redundancy and bereavement). A longer follow-up period of two years would have provided further data relating to stability

of change and recovery from stressors. This time span would cover the usual expected course of depression and relapse (American Psychiatric Association, 1994; Piccinelli & Wilkinson, 1994). The clients in this study reported a degree of chronicity and recurrence of their depression, and a longer follow-up would have explored any on-going susceptibility to depression and risk of relapse.

### 7.4.3.2. Enhancements to Credibility

*7.4.3.2.1. Absence of data attrition and high client satisfaction:* There was no data attrition from clients dropping out or withdrawing from the project. Although minor administration errors resulted in a small number of forms not being completed, on the whole the rate of completion of all forms and records was very good (only five forms out of a total of five hundred were missing). Due to external demands two clients had to stop the therapy before the allocated sixteen sessions, although they made this clear that this was due to circumstance rather than active choice to finish therapy early. All the clients in this study completed the full follow-up procedure. Despite variation in overall outcome, all clients were clear that they had found the therapy to be a useful and positive experience. Clients openly acknowledged difficulties they had experienced during therapy, but no negative experiences of the therapy were reported in any of the cases. This absence of data attrition and the high levels of client satisfaction enhance the credibility of the findings.

### 7.4.4. Trustworthiness

### 7.4.4.1. Threats to Trustworthiness

The primary threats to the trustworthiness of the findings relate to issues of bias.

***7.4.4.1.1. Potential measurement error or recall bias***: Clients were initially assessed using self-report measures at a single point, which may have been unreliable and subject to recall bias (Raphael, 1987). Use of testing at several points and use of multiple measures prior to commencing therapy would have indicated stability of problems (Kazdin, 1981).

***7.4.4.1.2. Potential for spontaneous remission***: Since the study did not employ a prolonged pre-therapy measurement period and/or a control group and so lacked the comparative information these would generate, it is possible that the improvement the clients obtained was due simply to the passage of time and spontaneous remission/ improvement (as opposed to indicative of substantial effects of therapy). The potential for spontaneous remission poses a potential threat to the trustworthiness of the findings. However, a study conducted by Barkham *et al.* (2007) investigated the stability of CORE-OM and BDI scores over time amongst a clinical sample of 1684 clients between the points of referral and entry into therapy. They found a remarkable stability in scores for periods of up to six months. It is acknowledged however that without prolonged pre-therapy data, it is not possible to draw firm conclusions on this issue.

***7.4.4.1.3. Researcher allegiance bias***: A potential limitation in the case of Peter was that Peter's therapist was the also the principal researcher. The possible effects of this dual-role were addressed by the use of a critical-reflective stance, by having the case audited by the research supervisors and by subjecting the case to adjudication. Nevertheless, it is possible that some inadvertent bias may have crept into this case. Any effectiveness or efficacy study conducted by a therapist who shares allegiance with the model under investigation runs the risk of being distorted by researcher allegiance bias (Hollon, 1999; Luborsky, Singer and Luborsky, 1975; Rosenthal, 1963, 1966). This possibility needs to be accounted for in the

findings of this present study, although the use of independent psychotherapy researchers acting as judges on each of four cases was used as a strategy to reduce this risk.

*7.4.4.1.4. Analysis team bias:* A potential limitation of the HSCED analyses was that as well as being part of the analysis teams, the researcher was either the current or former course tutor of members of the analysis team, which may have inadvertently influenced their responses. Despite the thoroughness of their arguments, it is also possible that their relative inexperience may have limited their sensitivity and judgment- particularly in relation to identifying the sceptic arguments (the analysis team admitted some difficulty in constructing a sceptic argument for the case of Tom) (See DiGiorgianni, 2011; Stephen & Elliott, 2011). Although no guidance has been developed relating to optimal training of analysis team members, inexperience does need to be considered as a potential factor. Furthermore, the time limits of the analysis process may have foreclosed a deeper understanding and analysis of the case materials. *Judges' bias:* The judges in the cases were all psychotherapists, and so ostensibly already convinced about the effectiveness of therapy, so this may have biased their verdicts. It is possible that introducing lay people into the analysis and adjudication process may result in different conclusions being drawn and would certainly be an interesting avenue for further exploration. The judges also tended to frame their interpretations and the factors they considered significant in each case in terms of their own theoretical perspective[32]. Consequently, the issue of judges' bias cannot be ruled out. The use of a modality-specific adjudicator may also provide interesting theory-based insights that were potentially overlooked.

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[32] Only one of the judges was not originally trained in Person-Centred Therapy. In each of the HSCED's, the judges emphasised the importance of therapist empathy. It is possible that their theoretical background generated some bias relating to the importance of this factor in each case.

### 7.4.4.2. Enhancements to Trustworthiness

*7.4.4.2.1. Triangulation and member checking:* The use of a range of quantitative and qualitative measures facilitates triangulation in case study research. Also, the inclusion of the therapist and client voices in the development of the rich case records, together with member checking procedures provides a degree of quality control in the data and their interpretation. The combination of multiple methods and the member checking process supports the trustworthiness and credibility of the findings.

*7.4.4.2.2. Use of independent adjudicators to counterbalance researcher allegiance:* Although the main data analysis was conducted by the researcher, the use of analysis teams for the HSCED cases enabled different perspectives on the data to emerge. The cases were systematically analysed to encourage critical analysis and the emergence of alternative explanations for the cases. Linked to this, the use of a number of external, independent psychotherapy researchers from different theoretical modalities acting as adjudicators on the cases strengthens the degree of confidence in the findings. This also goes some way to addressing issues of researcher allegiance.

### 7.4.5. Transferability

*7.4.5.1. Threats to Transferability*

*7.4.5.1.1. Diversity of sample:* In relation to transferability of findings, it is important to note that the sample of therapists and clients were white, British and based within the UK, and therefore the results may be culture-bound. It is possible that different results would have been obtained with a wider client group, or drawing on clients and therapists from different cultural backgrounds.

***7.4.5.1.2. Potential selection bias****:* The therapists in this present study were all personally approached and recruited directly (prior to the study all were known to the researcher). Although an attempt was made to recruit therapists with a range of personal styles, it is possible that some inadvertent selection bias may have influenced the recruitment process. Although there is no evidence within the qualitative data, it is possible that in some respects the therapists represented *too wide* a range of therapy styles, which may in turn have resulted in obscuring some findings regarding optimal therapist style. Associated with this, the time limits of the research meant that the therapists were conscious of screening potential clients for selection and several reported not asking clients who appeared to have particularly complex problems. This could have had both positive and negative influences on the internal and external validity of the study and of the results- by not including clients with complex problems, the sample may have been more homogenous with regards to diagnosis. However, this may mean that the sample was not representative of 'the usual client' presenting for therapy, thus potentially threatening the transferability of findings. Futhermore, no data was recorded regarding the total number of clients who were approached to participate, or of numbers who declined. This may present a limitation regarding the representativeness of the sample  and in considering the potential for selection bias in the recruitment process.

***7.4.5.1.3. Imposing time-limits on the therapy****:* Although figures are not available, anecdotal evidence would suggest that longer-term therapy of around two years in duration is the norm amongst TA therapists treating people with depression in private practice. It is possible that a naturalistic study that did not prescribe treatment length might have had a greater and more lasting effect, however due to the time constraints of this project, the

therapy had to be delivered within a discrete and relatively short time frame. Longer term therapy would also have an impact in terms of drawing comparisons between TA and other therapies. Nevertheless, treatment length does need to be considered as a factor. It is possible that the time limits of the present project led to the therapists practising differently to normal. Although the therapists were asked to conduct the therapy 'as usual' (as close to their normal style as possible) it is possible that the demands of the research influenced their practice. One area where the research did influence their practice was in relation to the duration of the therapy. The therapists all stated that normally they would not impose time-limits on the length of therapy with their clients. Consequently, the time restrictions related to the research are a potential threat to transferability.

### 7.4.5.2. Enhancements to Transferability

*7.4.5.2.1. Situating the sample within routine clinical practice:* The research design was an effectiveness study that examined the process and outcomes of TA conducted in routine practice using a modified naturalistic protocol. As such, the therapy took place within the contexts that the majority of TA therapy is practised. Four of the cases were private practice therapy and one was within a voluntary counselling agency. This greatly enhances the external validity of the findings. The clients in this series all self-selected for psychotherapy and actively sought out a therapist. No clients who satisfied the inclusion/ exclusion criteria and who agreed to take part were excluded from the study. This increases the external validity of the findings and provides reasonable evidence for the effectiveness of TA therapy for the treatment of depression as it is commonly practised. Furthermore, in contrast to many RCTs where therapists have a high ratio of supervision, the therapists in the present

study all had monthly supervision. This is congruent with the normal practice of a large number of therapists operating in routine practice settings.

***7.4.5.2.2. Accounting for contextual factors***: In each of the presented cases, extra-therapy factors have been considered and accounted for within the analysis, thus enhancing the degree of confidence in the conclusions of the judges as being the best practical and possible explanation for the client's change. The accounting of extra-therapy factors also applies to the case of Kerry, which was considered to be a clear-cut poor outcome case but was still analysed to consider a range of external factors and variables which might have impacted on the outcome. The presentation of a range of contextual factors within each case study facilitates the formation of judgments about the relative impact each may have had on the overall outcome. This, combined with the use of a cross-case analysis with a diverse client group assists with the transferability of findings into routine clinical practice.

**Table 7.3. Methods Used to Enhance Credibility, Trustworthiness and Transferability of Findings**

| Credibility | Trustworthiness | Transferability |
|---|---|---|
| 1)Triangulation of data | 1)Triangulation of data | 1) Triangulation of data |
| 2) Interview data quoted in text | 2) Interview data quoted in text | 2) Rich contextualisation of client, therapy setting and therapist in case record |
| 3) Using a team to analyse the data | 3) Using a team to analyse the data | 3) Sample situated within routine practice |
| 4) Using independent adjudicators to determine 'verdict' on outcome and identify key moderator and mediator factors | 4) Using independent adjudicators to determine 'verdict' on outcome and identify key moderator and mediator factors | 4) Presentation of findings as 'principles for practice' |
| 5) Using a member checking procedure by asking clients and therapists to comment on and verify the accuracy of the rich case record | 5) Using a member checking procedure by asking clients and therapists to comment on and verify the accuracy of the rich case record | 5) Using both generic and TA theory-specific methods to report the findings |
| 6) Use of supervisors to verify adherence and competence of therapists | 6) Use of supervisors to verify adherence and competence of therapists | |
| 7) Use of a standardised data analysis method (HSCED) | 7) Use of a standardised data analysis method (HSCED) | |
| 8) Constant comparative method of cross-case data analysis | 8) Constant comparative method of cross-case data analysis | |
| 9) Discussion of researcher bias and use of independent adjudicators to balance this to some degree | 9) Discussion of researcher bias and use of independent adjudicators to balance this to some degree | |
| 10) No attrition and high levels of reported satisfaction | | |

# Section Five: Implications for Development of Case Study Methodology

### 7.5.1. Introduction

This study was based on a practice-based sample and investigated the process and outcome of routine practice. This has tested the practicality of systematic case study research within a community-based sample, with therapists practising outside the confines of a university research clinic. The high level of compliance with the protocol suggests that this method is highly suitable for use in such settings and as such offers a viable solution to addressing the research-practice gap (Morrow-Bradley & Elliott, 1986). The active engagement of a number of trainees in the analysis process following minimal training also suggests that this is a practical method of providing experiential, practice-based research training.

There are four primary areas where the present study has contributed to the development of research method. These are; firstly, the development of HSCED case analysis; secondly, the development of HSCED adjudication procedures; thirdly, highlighting limitations of the HSCED model; and fourthly, the development of cross-case analysis procedure.

### 7.5.2. Development of HSCED Affirmative/ Sceptic Case Analysis Procedure

Within previous research that has used HSCED method, the affirmative and sceptic arguments have been developed by the researcher and an associate or a team of four graduate students (Elliott, 2009), with two members assigned to develop the affirmative and sceptic cases. Previous cases have not identified the desirable characteristics of affirmative/ sceptic team members. The present case series took this process further by (in

the first case - Peter) recruiting three qualified TA therapists and (in the remaining cases) recruiting a team of seven students (divided into two facilitated teams) to develop the arguments. These arguments (and rebuttals) were all formed within a single day. The students received minimal training in the method, but nevertheless approached the task conscientiously. The use of facilitators for the two teams to guide the process and seek group consensus was inspired by the use of a 'foreman' in juries in the legal framework. It was considered that this would be a natural extension of the quasi-legal framework used by HSCED.

Therefore, the present study contributes to the affirmative and sceptic case analysis procedure by utilising larger groups, led by a facilitator and constructing the arguments and rebuttals within a single day. Although it was not part of this research, it is perhaps noteworthy that three analysis team members have subsequently gone on to conduct case study research.

### 7.5.3. Development of HSCED Adjudication Procedure

This present study has also assisted with the development of the HSCED method by adding specific features and procedures. In addition to the use of trainee groups for the development of the affirmative and sceptic cases, the adjudication procedure has been expanded. Firstly, three completely independent adjudicators were recruited for each case (this is in contrast with previously published HSCED studies which have included judges from within their own modality; see Elliott et al., 2009; Stephen et al., 2011). This addition to HSCED method provides a counterbalance to potential researcher allegiance and bias effects. This enhances both the credibility and trustworthiness of the findings, since the outcome of the cases had been defined by independent judges.

The second feature added to the adjudication procedure was that judges were asked to provide their verdict as to what extent they thought the case was a good outcome, mixed outcome or poor outcome case and to rate their degree of confidence in their rating for each of these potential outcomes. Previous HSCED studies have not asked judges to provide their opinion regarding whether the case was good, mixed or poor outcome, but have focused on the judges views of the extent to which the client changed and the extent to which that could be attributed to therapy.

### 7.5.4. Limitations of HSCED Method

Whilst the HSCED method rigorously addresses questions relating to effectiveness and outcome of a case, it is weaker in identifying detail of events or micro-processes in therapy and also has 'difficulty in identifying clear, unambiguous links' (Elliott, Greenberg, Watson, Timulak & Friere, 2013: 514) with causal therapy processes. This is due to the emphasis HSCED places on outcome data and on the adjudication findings.

Although the construction of the affirmative cases involves identifying significant sessions by examining weekly progress using outcome measures and checks these against HAT data and therapist notes, this can only offer a preliminary indication of key interventions/ therapy episodes. As a method, HSCED does not closely examine the narrative of cases, which might suggest significant events. Although the adjudication procedure in HSCED identifies *potential* moderator and mediator factors, the design does not support a detailed analysis of specific therapy episodes/ interventions. Complementing HSCED with a pragmatic or narrative re-analysis of any given case may go some way to addressing this limitation.

Specifically within this case series, session transcripts were not used as part of the analysis which has limited the exploration of the change process both within and across cases. At present, the identified process factors suggest starting points for future research such as task analysis which would draw on transcript data to identify the fine-grained detail of effective process in TA therapy.

### 7.5.5. Development of Cross-Case Analysis Method

Finally, prior to this study, cross-case analysis procedures had not been clearly defined within the psychotherapy literature. This required the present study to examine and synthesise existing literature regarding cross-case analysis and develop original procedures (see below). Furthermore, many previous cross-case analyses are not clearly and identifiably linked to theoretical models. The present study deliberately and systematically sought to firmly locate the findings within the TA framework due to the pragmatic nature of the study design. This enables findings to be understood and examined within their own context and facilitates the transferability of findings by others within the TA community.

The cross-case analysis method used was based on the grouping of cases according to outcome. This was combined with the grounded theory method of 'constant comparison' (Glaser & Strauss, 1967) to identify similarities and idiosyncratic features both across and within cases. This was also informed by the theory-building framework proposed by Stiles (2007). Thus, the cross-case analysis was primarily an iterative, inductive process, which incorporated some features of abduction. The analysis has facilitated the generation of a series of explanatory concepts which have been combined to produce a series of theory-building propositions which can be tested in future research.

## 7.6. Summary of Chapter

This chapter firstly identified that TA therapy has demonstrated that it can be effective for the treatment of depression, and using a benchmarking approach, appears to have effectiveness comparable with other therapies. The findings of this study have added support to a range of previous psychotherapy research, although have challenged research which suggests that severity has a relationship to therapy outcome, indicating that further research is needed to examine the interaction of client, therapist and therapy factors which result in positive outcomes.

The findings of the present study suggest that TA therapists have an active intervention style and combine support and confrontation to promote change. It appears that matching of therapist and therapy style with client preferences and pre-therapy preparation is desirable in enhancing therapy outcome. Furthermore, TA therapy has a clear framework for utilising psychoeducational methods and promoting a collaborative approach to psychotherapy by the use of shared language and theory. TA appears to be an integrative and pluralistic approach to therapy which promotes change by combining cognitive, behavioural, affective and relational interventions and tailoring these to the client's presenting problem, process and preferences. Several theory-building extensions to TA theory have been proposed. The use of a shared language framework and the integrative nature of TA are proposed as being distinctive features of this therapy.

The study has identified some limitations of HSCED method, specifically relating to identification of specific therapy events or micro-processes. This study has also extended research method through the incorporation of several additions to HSCED method and through the development of cross-case analysis method.

# Chapter Eight: Conclusion

*This chapter summarises the thesis including the key findings and original contribution of*

*this research. Directions for future research are identified*

## 8.1. Brief Summary of Thesis

Depression is a common mental health problem which leads many of its sufferers to the

offices of psychotherapists. Epidemiological studies estimate that between 10% and 20% of

the population will experience depression during their lifetime (American Psychiatric

Association, 1994; Kessler, et al., 2003; Office of National Statistics, 2000). During 2011, 47.6

million prescriptions for antidepressant medication were issued in England alone (The

Health and Social Care Information Centre, 2011). Depression is also considered to be the

fourth most common cause of disease burden amongst women and the seventh amongst

men (Moussavi et al., 2007; Ustun et al., 2004). These figures highlight the significant public

health problem that depression poses.

Although a range of psychotherapies have demonstrated their effectiveness for the

treatment of depression, no single therapeutic approach has proven to be universally

effective for all clients. Whilst some studies and meta-analyses claim that one type of

therapy may be superior to another, there are many studies which counter this claim by

asserting that all bona fide therapies are roughly equivalent in effect (Cuijpers et al, 2008;

Cuijpers et al, 2010; Lambert and Bergin, 1994; Robinson, Berman and Neimeyer, 1990;

Wampold, 2001; Wampold et al, 2002). At present, there is insufficient evidence to

conclusively state whether any therapy is superior or if all therapies are comparable with

each other.

It is possible that different therapeutic approaches are best suited to different types of clients. Also clients often have differing preferences regarding the type of therapy they want, how they want their therapy to be conducted, and the type of therapist they will feel most comfortable working with. The provision of a wide range of different therapies maximises the potential for clients to access the therapy that is most appropriate to their needs.

Despite some variables showing promise as predictors of therapy outcome, there are a wide range of variables and factors which are as yet unknown that influence an individual client's responsiveness to treatment. Further research is needed to explore the interactions between client, therapist, and therapeutic approach in order to move the profession closer to answering the question posed by Paul (1967); *'What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?'* (p.111)

Although Transactional Analysis is a widely-practiced psychotherapy which has been in existence since the 1960's, it has been relatively under-researched and consequently little data exists regarding its effectiveness. The 'dodo bird effect' (Rosenzweig, 1936) which refers to the hypothesis of equivalence between therapies would suggest that TA psychotherapy has results which are comparable to other therapies and would be likely to be effective for treatment of depression. It is not sufficient to rely on the 'dodo bird effect'- it is important to conduct scientifically robust research to enable any given therapy to rightly claim effectiveness and to assist with the search for its 'active ingredients' and in exploring the factors which determine its outcome.

This study utilised case study research to explore the effectiveness of TA psychotherapy in routine practice with a naturally occurring sample of clients presenting with depression. Case study research was selected as a method of investigation due to its capacity to generate rich data connected to a range of client, therapist and therapeutic approach factors, in addition to providing data about the outcome of therapy on a client-by-client basis. Thus, the effectiveness of TA with this client group could be investigated.

Case study method, and in particular, Hermeneutic Single-Case Efficacy Design (HSCED) (Elliott, 2001, 2002) was used to analyse the cases. A panel of independent psychotherapy researchers adjudicated four of the cases to determine a verdict regarding outcome of each case. The judges also provided their opinions about what had been the significant process factors which had contributed most to the outcome of each case. All cases in this series were then subjected to a cross-case analysis whereby they were compared to each other to examine if any patterns which may have influenced outcome could be identified. In line with the pragmatic and theory-building aspects of this study, the cross-case analysis suggested twenty-five principles for practice, which can be used for the purposes of training TA psychotherapists. Analysis of the findings has also suggested fifteen theory-building contributions to TA theory which can be tested in future research.

This study was conducted to investigate two research questions. The primary research question was; 'Can TA psychotherapy be effective for short-term treatment of depression?' The secondary research question was; 'What processes and factors influence the outcome of TA psychotherapy for depression?'

**8.2. Summary of Original Contributions to Knowledge and Key Findings**

The primary finding from this thesis is that TA has been demonstrated to be an effective therapy for the treatment of depression. Specifically, it has demonstrated effectiveness when delivered in a short-term format of sixteen sessions, in community-based routine practice and with clients with varying severity of depression. The overall outcome of the therapy did not appear to be influenced by a number of client or therapist demographic factors[33] although it is possible that greater therapist experience may have been beneficial. Even in the cases which had a mixed or poor outcome, the clients reported having had a positive experience of TA therapy and identified a number of aspects of the approach to be helpful. This study has also demonstrated that TA therapy is a versatile and flexible approach which can be tailored to suit a client's preferences and to respond to a range of presenting issues.

As an approach, TA is strongly theoretically-based. TA therapists routinely introduce their clients to TA theory for psychoeducational purposes. The TA therapist also uses their theory to create a framework for case conceptualisation and treatment implementation. These two uses of TA theory are combined to create a collaborative therapeutic approach with the aim of facilitating the development of insight and therapeutic change and promoting client engagement with therapy. All the clients in this series engaged with and integrated the theoretical aspects of TA therapy and used the theory to understand their process, to make meaning and to take an active role in their recovery. The use of theory and theoretically-based shared language in therapy is   worthy of further research.

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[33] Although this study did not identify any client or therapist demographic factors which were associated with outcome, it is important to note that all clients and therapists in this study were White British, and therefore the findings are somewhat culturally-limited. Further research is needed to explore if race and culture are factors associated with outcome of TA therapy.

The cases in this series also suggested that the negotiation of clear treatment contracts and goals for therapy early in the therapy is both desirable for positive outcome and central to the effectiveness of the TA model. There is some preliminary evidence regarding therapist style in TA therapy. In particular, the therapists appeared to be proactive in their approach and to combine warmth and support with a robust confrontational style. There is clear evidence in this case series that TA is an integrative approach which works with the clients' central cognitive, affective, relational and behavioural maladaptive patterns and engages the client in a process of guided awareness, re-evaluation and systematic experiential disconfirmation of these.

A strong theme which emerged in this study was that matching of therapist style with client preferences and pre-therapy client preparation/ role induction was beneficial to outcome. Indeed, the three good outcome cases were all of clients who had a good understanding of the nature and process of psychotherapy and had actively sought out a therapist who matched their preferences. This matching appears to have enabled the clients to fully engage with the therapy process from the outset. The use of TA theory was also significant. All of the clients in this series repeatedly mentioned TA concepts in post-session questionnaires and in follow-up interviews. It seems that the clients were able to make use of theory to reflect on and manage distressing experiences, make sense of their own process and to take charge of their own process of change.

The investigation of naturally-occurring cases which were not subjected to control of variables somewhat limits the conclusions that can be drawn from this study. Specifically, the absence of a treatment manual to guide the therapy impacts on potential replication and the use of a small sample limits the generalisations which can be drawn. That

notwithstanding, the cases were all conducted within the context of community-based routine practice and demonstrated that TA is an effective therapy for depression. This supports the transferability of findings into similar settings and also suggests that the principles for practice may be readily utilised by therapists and in the training of therapists.

Any psychotherapy outcome research conducted by a practitioner with allegiance to the model under investigation is potentially compromised by issues of bias. Similarly, case studies have been traditionally criticised as being at risk of subjective bias in reporting. Within this case series, a range of quantitative and qualitative tools were used to facilitate triangulation and convergence in findings. A member checking procedure was used and the overall verdict of four of the cases was determined by independent psychotherapy researchers of different theoretical allegiance to the researcher. These procedures contributed to the credibility and trustworthiness of the findings.

The use of case study method and case series has been under-utilised as a research approach within the field of psychotherapy. This is in spite of the central and often pivotal role that case studies have played in the development of theoretical approaches and the profession of psychotherapy. Systematic case study method was selected for its ability to provide rich data on both process and outcome of each case and to facilitate the exploration of how a range of factors may impact on therapy outcome.

This study has developed the HSCED method, and integrated aspects of pragmatic case design. Team-based case analysis has been developed, and the adjudication process was developed by drawing solely on independent psychotherapy researchers. Furthermore, the adjudication method was developed by asking the judges to provide a verdict regarding the outcome of each case; namely whether they considered the case to be a good outcome,

mixed outcome or poor outcome. Finally, the method of cross-case analysis has been developed in this thesis. In particular, the use of constant comparison and induction to facilitate cross-case analysis has been developed.

Two new tools were developed for the purposes of this research; a Contract Goals Completion form, which was an adaptation of  the Personal Questionnaire and a TA for depression therapist adherence scale.  These measures appeared to have face validity and further research which explores their validity is indicated.

## 8.3. Implications for Future Research

The findings and limitations of the present study suggest a number of possible avenues for future research.  These are all broadly connected to outcome and effectiveness and involve the manipulation of key variables to examine their relationship to therapy outcome. This approach would address some of the limitations of the present research, primarily limitations which were connected to the naturalistic research design.

### 8.3.1 Further Effectiveness and Efficacy Studies

The present study demonstrated that TA can be an effective therapy for depression, however further research is needed to replicate the results.  In particular, studies which investigate the outcome of TA therapy for depression with a wider range of clients and therapists is warranted to examine variables which may impact on outcome or which provides insights relating to the findings of this case series. This includes examining the effectiveness of TA therapy for depression with therapists and/or clients who are not White British.

The cross-case analysis suggested several interesting technical features which may influence outcome and which can easily be explored. In particular, in light of the striking commonality of all three good outcome cases of having made an active choice of therapist/ type of therapy suggests one line of research. That is, investigation on the effect of client preparation, orientation to therapy, role induction and their impact on outcome of therapy. All the clients in the series reported that the use of TA theory was beneficial. Therefore, research which examines the impact of the use of standardised workbooks or materials about TA therapy as alternatives or adjuncts to therapy would be useful. The researcher intends to use the findings of the cross-case analysis (including the principles for practice) as the basis for a TA treatment manual which can then be tested for efficacy and effectiveness. As such, the present study can be seen as a pilot study which suggests that there may be value in conducting a Randomised Controlled Trial of TA therapy for depression.

### 8.3.2. Use of Different Measures- Exploring Varieties of Client Change Outcomes

Of the changes that the clients in this case series reported, several suggest areas for further investigation. Firstly, it became clear that interpersonal change was highly significant to the clients in this study however no outcome measures relating to this domain were used. Future research which uses a measure such as the *Inventory of Interpersonal Problems* (Horowitz, et al., 1988) would be useful to quantify the nature and level of such interpersonal changes which come about as a result of TA therapy. Secondly, several clients in this study reported: increased well-being, optimism, self-acceptance, self-esteem, confidence and other similar improvements. The use of tools which measures potential increases in these areas would be useful in establishing the extent to which TA therapy can

facilitate positive changes in the domain of well-being and positivity. These investigations could be done either in a large scale study, or further case series.

### 8.3.3. Practice-Based Case Study Effectiveness Studies with other Diagnostic Categories

As previously discussed, TA is a relatively under-researched therapeutic approach. The use of case study method in this research demonstrates that this is a practical, robust and viable method which can be expanded by TA practitioners into other clinical areas (e.g. anxiety and other disorders). This would significantly broaden the TA evidence and knowledge base. The high level of compliance with the protocol and data completion within the present study suggests that the protocol can be readily used for practice-based research. The protocol can act as a template for systematic case study research and be adapted to investigate the use of TA therapy for other disorders.

### 8.3.4 Impact of Characterological Issues on Outcome

Characterological issues were not addressed in this research. Although none of the clients presented with a diagnosable axis II disorder, the screening process did not account for personality traits such as neuroticism (Kendler et al., 2004) and self-critical perfectionism (Blatt, 1995; Blatt and Zuroff, 2005; Zuroff et al., 2000) which may have had a significant impact on the response to treatment of the clients in this study (see Westen et al., 2004; Luyten, et al., 2006). Consequently, further research is needed to determine the significance of characterological issues and their impact on outcomes of TA therapy for depression.

### 8.3.5. Use of Two-Chair Techniques for Self-Criticism

The case of Tom suggested that TA two-chair techniques may be helpful in overcoming self-criticism. From the single-case of Tom, there was insufficient data to indicate why he was so receptive to this particular method. Further research which explores the type of clients/ client process such methods are most suitable for would be as useful addition to the TA literature. Certainly there is scope for research which investigates this method either as a component of therapy, or in assessing a short-term intervention based on two-chair techniques specifically for the treatment of self-criticism.

### 8.3.6. Use of Maintenance Therapy for Relapse Prevention

Several studies have highlighted the utility of maintenance treatments (Frank, 1991; Hollon, et al., 2002). In light of the poorer outcomes for the two clients who had the shortest therapy, and some decline in two of the positive outcome cases, further research which incorporates the use of maintenance therapy and/ or longer term therapy would be useful to indicate optimal treatment length and the use of maintenance therapy for relapse prevention.

### 8.4. Summary of Chapter

Depression is a significant and prevalent mental health problem. Many therapies have demonstrated effectiveness for treatment of depression, although TA has previously been an under-researched approach. The present study was the first detailed examination of the process and outcome of TA psychotherapy for depression, and was based on case study research of naturally-occurring cases in routine practice. Case study method and cross-case analysis techniques have been developed during the course of this investigation.

The findings from this study have highlighted the desirability of matching client and therapy approach and suggested that pre-therapy preparation/ role induction is beneficial to the outcome of therapy. In this study, TA has demonstrated effectiveness for treatment of depression and has been found to be a versatile, integrative approach which utilises change mechanisms across the cognitive, behavioural, affective and relational domains. This is done by matching the therapy to the client's preferences and process. TA provides a coherent, collaborative framework and shared language for therapy and offers clients a means to understand their own process and to make positive changes. The integrative nature of TA and the use of shared language are two distinctive features of the approach and which make a useful contribution to the wider psychotherapy literature. Further research is warranted to confirm and develop these findings.

# Appendix A: Documentation

1. Information document for participating clients
2. Informed consent (client) form
3. Informed consent (case study) form
4. Contract goals completion form
5. Therapist adherence checklist

# The Process and Outcome of Transactional Analysis Psychotherapy for the Treatment of Depression- Information for Participating Clients

**About the Research**

We are investigating transactional analysis (TA) psychotherapy, and in particular how it can be used in the treatment of depression. Transactional analysis is widely used in psychotherapy in the UK and in Europe. TA therapists report good results from using TA with a wide range of clients, although there has been little formal research into TA therapy. This research project is exploring the processes and outcomes of TA therapy in the treatment of depression. Previous research suggests that the different types of therapy are roughly equivalent to each other in terms of effectiveness, and we anticipate finding that TA has outcomes which are equal to other types of therapy. TA shares many theories and methods with other types of therapy which are known to be effective which is why we feel confident in predicting generally good outcomes.

All the therapists participating in this research are trained and qualified in TA psychotherapy and work actively and respectfully with clients to help them explore their experiences; this enables clients to make sense of them and to help them make changes in their life through the development of a collaborative working relationship. In general, therapy differs from other ways of helping in that it refrains from giving advice but encourages clients to find their own solutions to their problems and supports them in achieving these.

**Other goals of this research are:**

1. Improving the training and effectiveness of TA therapists by teaching them how to integrate the findings of the research into therapy and therapy training courses and developing better ways of studying psychotherapy

2. Improving the effectiveness of therapists through understanding the ways in which therapeutic change takes place and in refining how therapists deliver therapy. Other specific research projects may be developed but you will receive additional information about these if you are asked to take part.

If you are eligible for this study and are willing to take part, you will be offered TA psychotherapy from the therapist you have contacted.

**Who is doing the research?**

The principal researcher is Mark Widdowson, MSc (TA psychotherapy), Teaching and Supervising Transactional Analyst, UKCP Registered Psychotherapist. Mark is a Ph.D student at the University of Leciester and is investigating the process and outcome of TA psychotherapy in the treatment of depression for his doctoral research. The whole research is being overseen by Professor Sue Wheeler at the University of Leicester, and Professor John McLeod at the University of Abertay, Dundee. If you have any concerns or queries about the research you may contact Mark directly either via e-mail at; mdjw2@le.ac.uk or by telephone by calling ███████████.

The research has been approved by the Research Ethics Committee at the University of Leicester and follows the research ethics guidelines of the British Association for Counselling and Psychotherapy (BACP).

**Complaints**

If you wish to make a complaint about the therapy or the research you may contact Mark, the principal researcher directly or you may contact Professor Wheeler at the University of Leicester. Her e-mail address is; sw103@leicester.ac.uk

**About the Therapists**

All the therapists participating in this study are professionally registered, trained and experienced therapists each with a minimum of five years training, and over 750 hours of experience in working with clients. The therapists have been carefully selected to ensure that you will be receiving good quality therapy from a properly trained and experienced therapist.

All the therapists who will be providing the therapy are professionally registered members of professional counselling and psychotherapy organisations and have professional indemnity insurance and abide by the codes of ethics and practice of their professional organisations. As qualified TA therapists, all the therapists are registered with the United Kingdom Council for Psychotherapy. The therapist you are working with will give you more information regarding any additional organisations they are affiliated to.

All UKCP registered therapists, regardless of their level of training or experience must have regular clinical supervision where they discuss their work and their case load. The therapists participating in this study will be receiving regular supervision, which will help monitor their work and to provide a safeguard as to the quality of the therapy that you will receive.

**What will I be required to do for this study?**

The number of therapy sessions will be agreed between the therapist and yourself during the first few weeks of therapy. This agreement will form part of a therapy contract that will be reviewed regularly. You can be offered up to a maximum of 16 weekly sessions of 50 minutes.  Previous research suggests that 16 sessions of therapy is sufficient for most people with mild-moderate depression to obtain significant relief from their symptoms.

- In the course of the study, we will ask you to give us information about your therapy, including your perceptions of your problems and how you are functioning, as well as your experience of specific therapy sessions.

- We will ask you to fill out four short questionnaires each week, and to have your sessions audio recorded. You will need to allow extra time both before and after your sessions to fill out the questionnaires.  The time needed for filling these out will usually be around 20 minutes in total each week.

- At the end of the first, third and sixth sessions you will also be asked to complete an additional short questionnaire relating to how you are experiencing your therapist and how you are working together.  This will take less than ten minutes to complete.

- In addition, after every eight sessions, at the end of treatment, and at two follow up interviews after your therapy has finished, we will ask you to fill out more questionnaires and be interviewed by a member of the research team about your experience of therapy. The researcher who will conduct the follow up interviews will also be a qualified therapist.

The point of all this is to help us discover information that may be useful for developing and evaluating TA psychotherapy in routine practice and specifically in the treatment of depression, and to improve the training of TA psychotherapists.

Two of the questionnaires that are used every eight sessions are included in this information pack. If you are interested in participating in the therapy, please fill these out and bring them along to the first session with your therapist. These forms will enable us to track the changes you make as a result of the therapy.

**This research involves several stages:**

1. First, after making contact with your therapist, your therapist will have invited you to attend a preliminary intake interview session- this is normal procedure for beginning therapy and the therapist will have discussed the option of participation in this research in the interview. The intake interviews normally take around one hour, although your therapist will have advised you as to their usual procedure for these intake interviews. The main purpose of this session is for us to make sure that therapy is appropriate for you, and to give you some information about the research.

- Your therapist will ask you some questions about: the kinds of problems you are currently having; your current relationships and employment details; problems you have had in the past; and your personal history (including details of the family you grew up in), to make sure that they can help you or that you do not have some other condition that indicates the need for a different approach.

- For the purposes of the research, we will not be able to see you if you are currently in psychotherapy or counselling elsewhere or if you are on antidepressant medication. You will not be suitable to take part in this research if you are going through current severe substance misuse, active psychotic condition or current domestic violence. In these cases, you will be advised of the options available to you for accessing therapy.

- If you are interested in participating in the research, you will then be asked to read this information sheet and to sign the consent form. Please read over this information and the consent form carefully and make sure you understand it; note anything that may be unclear or that may be of concern to you, so you can discuss it with your therapist; do not sign the consent form yet.

- If you decide you would like to participate and if you fit our guidelines, you will be asked to sign the consent form, and to complete some additional questionnaires prior to your first therapy session. Participation in the research is entirely optional and if you decide not to participate, you will still be able to access therapy.

- You will be given an information sheet on how you can get the most out of therapy, which also discusses some of the things you can expect to happen in the sessions.

2.  In the study, you will work with your therapist up to a maximum of 16 sessions; the specific amount will be agreed by you and your therapist during the first few weeks of therapy. Together you will agree a therapy contract which will be your working agreement with your therapist about the nature of your therapy and the focus of your therapy.  You will meet with your therapist once each week for 50 minutes.

- Each of these sessions will be audio recorded

- Immediately before and after each session, you will be asked to fill out brief questionnaires about how you are doing or about your experience of the session.  The completion of the questionnaires should take about 20 minutes each week.

- At the end of each session, you will complete a short questionnaire which is used to evaluate the session. If you feel the session was good, we want to know why it was good and what made it good. If you feel the session wasn't so good, we also want to know why it wasn't so good and what could have been different. During the data analysis phase of the research we may compare your session evaluations with a transcript of the session, to see if we can identify important and effective features of TA therapy and to help us learn more about what can be improved.

In entering into a therapy contract, you will be asked to commit to attending sessions regularly and to avoid cancelling at short notice wherever possible. Your therapist will advise you of the procedure for cancellation or rearrangement of sessions.

3.  At the end of therapy and at a follow-up session, you will meet with a member of the research team (this will be someone else and not the therapist you have worked with), who will interview you about your problems and your experience of therapy, and ask you to complete some additional questionnaires. This should take about one to one and a half hours each time.

**CONFIDENTIALITY**:  We routinely use audio recordings for the purposes of supervision and for the research, and in the consent form we are asking for your permission for that.  We will separately ask you to give us permission to keep the recordings of your sessions and research interviews for research purposes, including training other therapists.  Because it is important for us to protect your confidentiality, we will be taking several precautions.

- First of all, we will be using codes instead of names to identify all of the recordings and questionnaires.

- In addition, we will edit your name and any other identifying information from any transcripts we might make of parts of your sessions.

- We will disguise any information we might record in transcripts, notes, case studies or in material for publication when describing your case, for example, your profession, age, marital status, number of children and so on might be changed to help conceal your identity and reduce the chances that you could be identified in any way.

- The recordings will be stored on a password-protected computer, and back-ups will be stored in locked filing cabinets.

- Only your therapist, their supervisor and approved research staff will be allowed to have access to these recordings.

- Unless you tell us otherwise, questionnaires and recordings will be separated from your personal details and kept for a maximum of 5 years providing there is scientific reason to do so by the principal researcher and the research team. Questionnaires will be destroyed and recordings will be erased when there is no longer any scientific use for this data. We will review these issues with you after every eight sessions and again at the end as part of the follow up interview process.

- There are some situations that can arise in which we may have to take action to protect you or someone else from harm and have to reveal information that has come to light in interviewing a participant in this study or during therapy sessions. An example is where information was revealed that there was a child being abused by someone. If such a situation arises, we would limit the disclosure to what is absolutely necessary. We would also make every effort to fully discuss it with you beforehand. Your therapist will advise you of their policies and procedures regarding confidentiality.

**POSSIBLE RISKS AND WHAT TO DO ABOUT THEM**: Before you consent to take part in this study, we want you to know about the possible risks of doing so, and how you can reduce those risks.

1. <u>Self-consciousness about being recorded</u>. Although most people in the past have been able to disregard the recording equipment, a few have felt inhibited or self-conscious and have found it difficult to talk about deeply personal matters. If you think being audio recorded will interfere with your receiving help in therapy, please do not volunteer for this study. Audio recording is valuable for research and supervision purposes and to help us find out more about the things we are investigating. You may have concerns about the recordings or what will happen to them- please see below for more information. If you have any outstanding queries, you may discuss these with your therapist, or with the principal researcher.

2. <u>Getting bored with all the forms</u>. There are a lot of forms to fill out for this research, and some people find them tedious and boring. Most clients find them interesting and a helpful addition to their therapy which helps them to reflect on and account for the changes that they are making. Please do not volunteer for this research if you hate filling out forms.

3. <u>Getting worse</u>. Most clients experience temporary emotional discomfort or distress during therapy, including strong emotions as a natural part of the process. The therapist will work actively with you to help you deal with any painful emotions that may surface. If, however, you are seriously concerned about this, you may wish to reconsider volunteering for this study. If you volunteer and problems do occur, please report them to your therapist, who will do their best to address the difficulty. It may even turn out that the therapy is either not helping or, in rare instances, is causing harm; in such cases, it may be necessary to stop therapy or to refer you to a different form of treatment.

4. <u>Not getting better</u>. It is also possible that, at the end of your treatment, you may be in need of further therapy. If you feel you need further treatment, you and your therapist can discuss possible options. For example, they may offer you a referral to another therapist, type of therapy, or agency. This discussion will begin well in advance of your agreed ending date and will not be left until the end so you will have time to prepare

Starting therapy can be challenging and we recognise that things can happen that make it seem difficult to carry on with therapy. You are free to leave at any stage. We do, however, stress that it can be helpful for you to take the chance to discuss any difficulties with your therapist or one of the research team so we can address any problems that you raise directly

**POTENTIAL BENEFITS**: In contrast to the risks listed above, there may also be some direct and indirect benefits for you or other people if you choose to take part in this study:

1. As a result of the treatment, you are likely to feel better and less bothered by the problems you have been having. Previous research suggests that most clients experience significant improvement through therapy.

2. Previous clients have reported that completing the research questionnaires and interviews helped them to get more out of their treatment. These procedures may also help you learn things about yourself.

3. As you will be completing questionnaires at each session your progress will be closely monitored and evaluated and the therapy you will receive will be refined to increase the benefits you will obtain from the therapy.

Finally, you will be helping us better understand how TA therapy works, and in particular how we can use TA therapy in the treatment of depression. The research will also help psychotherapists develop better ways of helping other people, and assist us in our training our post graduate students.

**What notes are kept?**

Your therapist will make some notes after each session, which will record the themes and issues that you both discussed in the session, what they did (what interventions they made and what theories and methods they used), and how you both seemed to be working together.

Your therapist will not be keeping detailed notes relating to specific events from your life and will keep your notes in such a way that your anonymity is preserved (see below). All notes will be stored securely in a locked cabinet and a code will be used instead of your name. Only your therapist and the principal researcher will know who the codes relate to.

The notes are firstly to help your therapist monitor and review your work together and secondly for research purposes. The notes will be used in the research to help us identify how therapists understand and work with particular themes or issues and also to see if we can identify common themes which affect people with depression. It is possible we may find that different therapists work differently with similar issues or problems, and we want to know why, what influences their way of working, and also what the outcome is of different ways of working.

You are entitled to see any notes kept about you and you can request a copy of your notes from your therapist.  If you have any concerns or queries about the notes which are kept about you, you can discuss this with your therapist and/ or the principal researcher.

Why will the therapy sessions be audio-recorded and what will happen to the recordings?

All of the therapy sessions will be audio-recorded. The recordings of sessions will potentially be used for several purposes:

- Your therapist might listen to segments of sessions for the purposes of reviewing the work as a part of their routine reflection and review on their work

- Your therapist might play excerpts of the recording in their clinical supervision. All therapists, regardless of their experience have regular on-going supervision, which helps ensure the quality of the therapy you will receive. This will help your therapist to refine their work with you. Any extracts that your therapist might play in supervision will not include details which might identify you.

- Some sessions, or some extracts from sessions will be transcribed (typed up) for the purposes of researching the process of therapy

- No names or places will be included in the transcripts, and all details which might lead you, someone else or a particular place to be identified will be omitted to preserve your anonymity and ensure that no one who might read any transcript could recognise you or someone else.

- Only your therapist, their supervisor and up to two members of the research team will listen to any recordings of the sessions.  This means only professionals involved either directly or indirectly in your therapy will hear any part of the recordings.

- Once the research has finished, the recordings will be destroyed.

- All recordings will be stored securely until they are destroyed

**What will happen to the transcripts?**

The transcripts are an important part of the research process. Transcripts of sessions or segments of sessions will be analysed by the researcher to help our research into the therapy process.  Some anonymised transcripts may be included in the PhD thesis of the principal researcher. Some suitably disguised and anonymised transcripts may be used in professional publications.  Some of the therapy cases will be written up as case studies which will be used to help us understand the therapy process in more depth.  You will be asked at the end of your therapy if you are willing for a case study to be written about you. Your identity will be heavily concealed in any material which is written about you to preserve your anonymity.

**What are the follow-up Interviews and why are they being done?**

A member of the research team will contact you after you have finished therapy, and several months after the end of the therapy to arrange an interview with you to evaluate your experience of

therapy.  We want to hear honest feedback about the therapy process and your experiences of therapy and of being part of the research.  This will help us to understand more about:

- How people change throughout therapy

- Which aspects of the therapy have been most helpful to you

- How we can improve therapy

You will also be asked to complete some additional questionnaires so we can evaluate your progress. The interview and completing the questionnaires should take about one to one and a half hours each time.

**Thank you for your interest in this research.**

**The Process and Outcome of Transactional Analysis Psychotherapy in the Treatment of Depression Research**

**INFORMED CONSENT AGREEMENT** (v2)

Please indicate Yes/ No to each item and sign the form in the space provided at the end

I, _____, have received a full description of the purposes and procedures of this research; specifically:

1. I understand what I will be asked to do, as well as the possible risks and benefits of my taking part.   Yes/ No

2. I voluntarily consent to participate on the basis of the description of the study provided above.  Yes/ No

3. I realise that, by taking part, I may experience painful emotions or may feel bored or inhibited by the research procedures, and that if I require additional immediate treatment, it might be at my own expense.  Yes/ No

4. I understand that, if any of these things happen, I can discuss them with my therapist or the principal researcher.  Yes/ No

5. I understand that the professional researchers managing this project may discontinue my participation at any time if it is not in my best interests or the interests of the research. Yes/ No

6. I realise that I may withdraw my consent and participation at any time, without giving a reason and without any of my rights being affected, and also that I can ask to have my data withdrawn from the study at any time, during or after my participation.  Yes/ No

7. I also understand that I may ask questions about the study at any time before, during, and after it has been conducted.  Yes/ No

8. I agree that the questionnaire and interview data that I provide for the project can be analysed for the purposes of research, and give permission for these records to be stored so that further study of them can be undertaken.  Yes/ No

9. I give my permission for my sessions to be recorded for supervision purposes, and that I will later be able to specify the specific research and training uses I will allow to be made of those recordings.  Yes/ No

10. I understand and agree that data gathered from my sessions will be used to examine trends and themes relating to the sample of clients in this study. Yes/ No

11.  I understand and agree that an anonymised case study may be written about my therapy and that I will be asked again at the end of my therapy if I am willing for a case study to be written about me and my therapy.  Yes/ No

12. I understand that all the information I give will be treated with the utmost confidentiality and that my anonymity will be respected at all times. I am aware that I can refrain from answering any question about which I feel uncomfortable. Yes/ No

Finally, in signing this agreement, I confirm that

- I over 18 years of age;

- That I am aware of what my participation involves and any potential risks;

- That all my questions concerning the study have been answered to my satisfaction.

SIGNED_____ DATE _____

NAME _____

RESEARCH ASSOCIATE _____

SIGNED _____DATE _____

**The Process and Outcome of Transactional Analysis Psychotherapy in the Treatment of Depression Research**

**INFORMED CONSENT AGREEMENT – Final Version Case study Consent (v1)**

Please indicate Yes/ No to each item and sign the form in the space provided at the end

I, _____, have received a full description of the purposes and procedures of this research; specifically:

13. *I* understand what I am being asked to do, as well as the possible risks and benefits of my taking part.   Yes/ No

14. *I* voluntarily consent to participate on the basis of the description of the study provided. Yes/ No

15. I understand that the professional researchers managing this project may discontinue my participation at any time if it is not in my best interests or the interests of the research. Yes/ No

16. I realise that I may withdraw my consent and participation at any time, without giving a reason and without any of my rights being affected, and also that I can ask to have my data withdrawn from the study at any time, during or after my participation.  Yes/ No

17. I also understand that I may ask questions about the study at any time before, during, and after it has been conducted.  Yes/ No

18. I agree that the questionnaire and interview data that I provide for the project can be analysed for the purposes of research, and give permission for these records to be stored so that further study of them can be undertaken.  Yes/ No

19. I give my permission for extracts of audio recordings of my sessions to be analysed for research purposes, and that I will later be able to specify the specific research and training uses I will allow to be made of those recordings.  Yes/ No

20. I understand and agree that data gathered from my sessions and the follow-up procedures will be used to examine trends and themes relating to the sample of clients in this study. Yes/ No

21.  I agree that an anonymised case study can be written about my therapy.  Yes/ No

22. I understand that all the information I give will be treated with the utmost confidentiality and that my anonymity will be respected at all times. I am aware that I can refrain from answering any question about which I feel uncomfortable. Yes/ No

23. I agree that my outcome data (CORE, PQ, BDI and HAT) may be included in the research data analysis. Yes/No

24. I agree to the case study I have been shown to be used for the purposes of research and teaching. Yes/ No

25. I agree to the case study that I have been shown being used either (please delete as applicable) Yes/ No

    -With amendments

    -As it is

26. I agree to the transcripts of the follow-up interview being included in the case study. Yes/No

27. I agree to transcripts of extracts of sessions I have seen being included in the case study. Yes/No

28. I agree that the case study may be included in the thesis of the researcher. Yes/No

29. I agree that the case study may be used for the teaching and training of psychotherapists. Yes/No

30. I agree that the data and the case study may be submitted for publication in professional journals and presented at scientific and professional meetings. Yes/No

Finally, in signing this agreement, I confirm that

- I over 18 years of age;

- That I am aware of what my participation involves and any potential risks;

- That all my questions concerning the study have been answered to my satisfaction.

SIGNED_____ DATE _____

NAME _____

RESEARCH ASSOCIATE _____

SIGNED _____DATE _____

Today's date: _____

**Contract Goals Completion Form**

Instructions:  Please complete before each session.  Rate each of the following contract goals you and your therapist identified for your therapy, according to how much each item has been completed. Base your answer on your experiences over the past seven days, including today.

| Therapy Contract Goal | Not At All | Very Little | Little | Moder-ately | Consid-erably | Very Consid-erably | Maxi-mum Possible |
|---|---|---|---|---|---|---|---|
| 1. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Please use an extra sheet if needed for additional items | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Transactional Analysis Psychotherapy for Depression- Therapist Adherence Checklist**

The twelve therapeutic tasks listed below constitute the essential core treatment plan for depression. Please tick next to each item to indicate whether you attended to this task in the therapy session and give yourself a score using the six-point rating scale below for each item. If the item is not applicable, please circle the N/A option. In the notes section, under each item and before the scale, please indicate how far you and the client achieved that item. Please also indicate with an asterisk which three items you focused on most in the session

| | |
|---|---|
| **1** | **Much improvement in application needed: I felt like a beginner, as if I didn't have the concept** |
| **2** | **Moderate improvement needed: I seemed like an advanced beginner, who is beginning to do this, but needs to work on the concept more.** |
| **3** | **Slight improvement in application needed: I need to make a focused effort to do more of this.** |
| **4** | **Adequate application of principle: I did enough of this, but needs to keep working on improving how well I do it.** |
| **5** | **Good application of principle: I did enough of this and did it skillfully.** |
| **6** | **Excellent application of principle: I did this consistently and even applied it in a creative way.** |

**Key Therapeutic Tasks in Transactional Analysis Treatment of Depression**

1) **Create an 'I'm OK- You're OK' relationship where the client feels safe enough to explore their thoughts, feelings and experiences and begin to internalise the experience of being accepted**
   **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

2) **Identify, reflect upon the origins of and re-evaluate self-critical ego state dialogue**
   **Notes:**

| Much imp. needed | Mod. Imp. needed | Slight imp needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

3) **Identify, re-evaluate and challenge contaminations and script beliefs which negatively impact on the individual's self-concept and expectations of others and life**
   **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

4) **Support the individual to recognise, re-evaluate and challenge self-limiting systems of thinking, behaviour and experience which maintain the depression (racket system)**
   **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

5) **Explore, reflect upon and change stroking patterns (accepting positive strokes, giving self positive strokes, reduction in negative self-stroking/ self-criticism)**
   **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

6) **Identify and challenge discounting and grandiosity (e.g 'if things go wrong it is my fault' - discounts external factors and is grandiose about role of self)**
   **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

7) **Support the reflection upon and re-evaluation of life experiences that have contributed to a sense of worthlessness**
   **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

8) **Support the individual to make new decisions about how they will view themselves, relate to others and engage with the world**
   **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp. needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

9) **Support the deconfusion process whereby the individual identifies, expresses and reflects upon repressed feelings (including repressed anger and working through of grief and loss)**
   **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp. needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

10) **Support the individual to explore and experiment with new ways of relating to others which enhance self-worth**
    **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp. needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

11) **Designing and negotiating behavioural contracts such as awareness exercises homework, self-care contracts, exercise, diet and sleep hygiene contracts.**
    **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

12) **Facilitate the client's attachment to and engagement with life, others and the world**
    **Notes:**

| Much imp. needed | Mod. imp. needed | Slight imp needed | Adequate | Good | Excellent | Not Applicable |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | N/A |

# Appendix B: Dissemination of Findings

Many sections of this thesis have been published or submitted for publication in peer-reviewed journals. The intention has been to disseminate the findings as early and as thoroughly as possible. An additional intention has been to produce articles which are accessible to beginning trainees and which will support research in transactional analysis. Consequently, the writing style has been deliberately chosen to facilitate this process. A full list of published articles and conference proceedings where findings or materials associated with this research have been disseminated is presented below.

**Refereed articles in Academic Journals**

(2013) TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study- "Linda"-A mixed-outcome case. *International Journal of Transactional Analysis Research,* 4(2)

(2012) Perceptions of Psychotherapy Trainees of Psychotherapy Research. *Counselling and Psychotherapy Research,* 12(3)

(2012) TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study- Case Three: "Tom". *International Journal of Transactional Analysis Research*, 3(2)

(2012) TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study- Case Two: "Denise". *International Journal of Transactional Analysis Research,* 3(2)

(2012) TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study- 'Peter'. International Journal of Transactional Analysis Research, 3(1)

(in press) TA psychotherapy: A literature review of the existing research evidence. (submitted to *Transactional Analysis Journal*, 24th October 2010)

(2011) Depression: Diagnosis, Sub-types, Patterns of Recovery and Psychotherapeutic Models – a Literature Review. *Transactional Analysis Journal*, 41(4): 351-364

(2011) Case Study Research Methodology. *International Journal of Transactional Analysis Research.* 2(1)


**Other refereed articles:**

(2012) TA: An Evidence-Based Therapy by 2020?. *The Transactional Analyst*, Autumn 2012.

(2011) Depression in the Frame: Key Therapeutic Tasks in the Treatment of Depression. *The Transactional Analyst*, Autumn 2011.

(2011) Depression Self-Help. *The Transactional Analyst*, Autumn 2011

**Non-refereed articles:**

(2009) Generating a Research Evidence-Base for TA: Suggested Amendments to the CTA Written Exam. *EATA News*, June, 2009


**Refereed and published conference proceedings:**

Closing keynote plenary, National Transactional Analysis Conference, Cheltenham, April 2013.

'Case Study Research: A Primer', National Transactional Analysis Conference, Cheltenham, April 2013.

'Three Positive Outcome TA Psychotherapy Cases: Hermeneutic Single-Case Efficacy Design Research in practice'. Keynote speech for the 2nd European Association for Transactional Analysis Research Conference, Putteridge Bury, UK. 12-13 November 2012.

'Case Study Research: A Primer' 2nd European Association for Transactional Analysis Research Conference, Putteridge Bury, UK. 12-13 November 2012.

'Perceptions of Psychotherapy Trainees of Psychotherapy Research', 2nd EATA Research Conference, Putteridge Bury, UK. 12-13 November 2012.

'Perceptions of Psychotherapy Trainees of Psychotherapy Research', 18th Annual BACP Research Conference, Edinburgh, 11-12 May 2012.

'Process and Outcome of TA Psychotherapy for Treatment of Depression', 18th Annual BACP Research Conference, Edinburgh, 11-12 May 2012.

'TA: An Evidence-Based Therapy by 2020?', ITA Conference, Harrogate, April 2012.

'The Therapist's Perspective on Participation in Research: Learning From Experience'. 42nd Annual Meeting of the Society for Psychotherapy Research. Panel Member. Bern, Switzerland, June 2011.


**Lectures**

Lectio Magistralis, University of Padua, Department of Philosophy, Sociology, Education and Applied Psychology, 11th and 12th May, 2013

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