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Outcome Measures in Transactional Analysis Clinical Practice: Presentation of Research Methodology

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Abstract

This article introduces the research methodology underpinning a study on how Transactional Analysis practitioners use Outcome Measure data in diagnosis, contracting and treatment planning. After a brief literature review of outcome measures and details of the formulation of the research questions, it continues with the author's understanding of Interpretative Phenomenological Analysis, which was the methodology used within the research, and how that aligns with transactional analysis. The further focus of this paper includes the ethical considerations, the inclusion criteria for research participants, the structure and planned content of the research interviews, and a description of the data analysis method. The final data analysis stage is still running so detailed findings will follow in later publications. A previous article by the author set out the rationale for the research, and the intention of this article is to present the research method so that it can be critiqued and replicated.

Keywords

transactional analysis, outcome measures, interpretative phenomenological analysis, research

Introduction

This article follows on from Remfrey Foote (2023), which set out the rationale in the literature for the research study exploring how Transactional Analysts (TA) use outcome measures in TA diagnosis, contracting and treatment planning. This article is written in a style that invites the reader to review and critique how the study was conducted, and possibly to replicate it on the same or a different topic. This will be followed up by further findings and results as they become available.

By way of an introduction, TA research and literature provide evidence-based research on the effectiveness of TA in the treatment of anxiety, depression, and other mental health issues.

A gap persists in the TA and broader psychotherapy research in how practitioners might use Outcome Measures (OM) data in their clinical case formulation. This article describes a research study about using OMs such as Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell & McGrath, 2000); Generalised Anxiety Disorder Version (GAD-7) (Spitzer, Kroenke, Williams & Lowe, 2006); Patient Health Questionnaire Version 9 (PHQ-9) (Kroenke, Spitzer & Williams, 1999); Outcome Rating Scale (Duncan & Miller, 2000); and Session Rating Scale (Duncan, Miller, Sparks, Claud, Reynolds, Brown & Johnson, 2003).

The outcome measures, PHQ-9, GAD-7 and CORE-OM, are traditionally used by counsellors and psychotherapists to indicate the client's response to treatment and whether there is improvement, plateauing or deterioration. An online (during the Covid pandemic) 12-participant, semi-structured, doctoral research study was conducted involving TA practitioners, under the auspices of the UK University of Salford, using Interpretative Phenomenological Analysis (IPA) as a phenomenological, hermeneutic and idiographic methodology (Smith, Flowers and Larkin, 2022), to explore TA practitioner participants lived experience and meaning-making of TA diagnosis, contracting and treatment planning using OMs. This research seeks to explore participants' decision-making in the TA diagnosis, contracting and treatment planning process by I, the researcher (as the inquirer), from the participants (the knowers); this is known as the epistemological position. This article aims to describe the research design in detail; material will follow afterwards with the results.

Brief Review of Outcome Measures

Case formulation is an unfamiliar term to most TA practitioners, who understand this process as TA diagnosis, contract, and treatment planning. Case formulation in other psychotherapy modalities is described by Eells (1997) as a rigorous process "... guided by a set of ideas about what has caused and is perpetuating a patient's interpersonal, intrapsychic or behavioural problems, and what that patient needs to feel better." (p.ix) and a "... blueprint guiding treatment, as a marker for change …" (p.2). Hence, case formulation includes a psychosocial, developmental, social, and medical history and planning for psychotherapeutic interventions relevant to the client's TA diagnosis, contract and treatment plan. TA diagnosis, contract and treatment plans have specific identifiable stages that align with the concept of case formulation familiar to other psychotherapeutic modalities.

Entering the term 'Outcome Measure' into a well-known search engine will generate 1,240,000,000 results. Allied Health Professionals, Early Years Educators, Mental Health and Learning Disability Services, Primary and Secondary Health Services in the NHS, and counselling and psychotherapy use OMs. OMs seek to establish "... whether change has taken place between the start and the end of a process, as such outcome measurement often usefully considers points in between" (Evans & Carlyle, 2021, p.8-9). OM's cited are free to use once registered online with their developers: Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell & McGrath, 2000); Generalised Anxiety Disorder Version (GAD-7) (Spitzer, Kroenke, Williams & Lowe, 2006); Patient Health Questionnaire Version 9 (PHQ-9) (Kroenke, Spitzer and Williams, 1999); Outcome Rating Scale (Duncan & Miller, 2000); and Session Rating Scale (Miller, Duncan & Johnson, 2002).

A search of the archives of the *International Journal of Transactional Analysis Research and Practice (IJTARP*) and the *Transactional Analysis Journal (TAJ*) generated many articles where OMs track clients' responses to TA treatment, principally in case study research in support of TA as an effective counselling and psychotherapy modality for the treatment of mental health issues in clinical practice (van Rijn, Wild & Moran, 2011; van Rijn & Wild, 2013, 2016; Benelli, Revello, Piccirillo, Mazzetti, Calvo, Palmieri & Widdowson, 2016, 2017; Benelli, Filanti, Musso, Calvo, Mannarini, Palmieri & Widdowson, 2017; Gentelet & Widdowson, 2016; Widdowson, 2011, 2020). A previous related article (Remfrey Foote, 2023) covered how the use of OMs by counsellors and psychotherapists can be contentious and seen as inhibitory to the therapeutic process. Although there is mention of how OMs might be influential in changing treatment strategies (McAleavey, de Jong, Nissen-Lie, Boswell, Moltu, & Lutz, 2024) and Låver, McAleavey, Valaker, Castonguay, & Moltu (2023) analysis of 31 qualitative research studies found that OMs were involved in treatment planning decisions or a shift in treatment focus but did not explore this from a clinician's perspective. More research literature is needed on how OM data is integrated into practitioners' case formulation clinical practice. This research study seeks to address the gap in how OMs are used in TA therapists' clinical decision-making to inform their diagnosis, contract and treatment plans.

Research Questions

The study presented here is from a different perspective rather than a nomothetic measure to track a client's response to TA treatment. It explores how TA psychotherapists dynamically integrate OMs into their clients' diagnostic, contracting and treatment planning processes. Hence, the research question was:

- How does a TA psychotherapist's lived experience of and making sense of outcome measure data influence their clinical decision-making in TA diagnosis, contracting and treatment planning?

There are components to this question that benefit from being examined separately and therefore structured the data collection method and the participant interviews; the research questions were:

1. How do TA psychotherapists make sense of their experience using OMs, and how does this influence their clinical decision-making?
2. How do TA psychotherapists make sense of their experience of using OMs related to theories of clinical decision-making, TA, and evidence-based clinical practice?

This seeks to make what might be an implicit activity held within participants' intuitive models of clinical decision-making into more explicit expressions of their clinical options when using OMs and how this data is integrated into the TA diagnosis, contract, and treatment planning process.

Theoretical Considerations of the Research Methodology

This research seeks to explore participants' decision-making in the TA diagnosis, contracting and treatment planning process by I, the researcher (as the inquirer) from the participants (the knowers); this is known as the epistemological position. There is a duality of the researcher's role as an 'outsider', the inquirer, exploring participants' idiographic lived experience as the 'insider', the knower. Both the 'insider 'and 'outsider 'share the experience of the

phenomenon, with the participant and researcher being TA psychotherapists who use OMs; this is a shared aspect of identity and is a reflexive reality of the research (Creswell & Poth, 2018). Being both inquirer and insider drives and motivates the exploration and investigation into the phenomenon in question; this guides the qualitative inquiry and analysis throughout the research process; being mindful of the tension between partial bracketing and researcher bias helps to ensure rigour through an open and transparent transcription paper trail (Smith et al, 2022).

Epistemology is concerned with how individuals acquire temporal knowledge and differentiate between the truthful and untruthful (McLeod, 2011). This aspect of the philosophical stance concerns the theoretical sources of knowledge of this phenomenon and how there is a clear differentiation between excellent quality and truth rather than deceptive, untruthful knowledge. How might this research contribute to the knowledge of TA psychotherapists' decision-making? Will this research be novel, contribute from a different viewpoint, and be seen by others as truthful? Based on the ontological assumptions thus far, this epistemological stance considers participants' subjective meanings, opinions, feelings, beliefs, intuitive knowledge and judgements of OMs and individual use in clinical practice. This research hopes to generate qualitative, non-quantifiable data, such as words, body language, and vocal intonation, as knowledge, following an interpretivist research philosophy. This approach lends itself to where the social phenomena are explored in depth and in the context of the naturalistic research environment. This epistemological stance would support an idiographic research lens, where participants' perspectives on their personal and professional experience of the phenomenon of clinical decision-making using OMs can be both truthful, valid, and valuable (Bager-Charleson & McBeath, 2020).

The ontological stance considers the researcher's and participant's nature of reality and how the world is perceived and experienced from multiple and subjective perspectives (Creswell & Poth, 2018). The ontological foundation of this research embraces the concept that multiple realities exist for participants and researchers as each person perceives their frame of reference relating to themselves, others, and the wider world. Participant words offer a window into their reality, captured verbatim in transcribed responses to questions, and thereby, subsequent themes become evident (Creswell & Poth, 2018). This research's nature of truth and reality is from a subjectivist, socially constructed, relativist and interpretivist perspective (Etherington, 2004; Bager-Charlson & McBeath, 2020). Bryman (2012) defines social constructivism as an "... ontological position which asserts that social phenomena and their meanings are continually being accomplished by social actors" (p.83). The ontological relativism of this research is the construction of a co-created subjectively shared reality (Bager-Charleson & McBeath, 2020) of how participants reveal how they use OMs in clinical practice. Ontological interpretivism "... assumes that social phenomena and their meanings are constantly being revised through social interaction and language" (Bager-Charleson & McBeath, 2020, p.6). In this study, participant responses and reactions to the interview questions and the discussions that flow back and forth will be unique to that moment. Multiple subjective, individual, varying versions of reality and truth exist from the researcher's and participant's (as the social actor's) perspective or frame of reference. This perspective includes how the participant thinks about OMs, their personal and professional background, the influences of their TA training and their rationale and reasons for using OMs; and what has influenced participants' reality regarding the benefits and drawbacks, particular preferences for specific OMs and not others and how they decide which OM to use with which client, when and why? Importantly, for this research study, what do they do with the OM data and their multiple thoughts and feelings in their decision-making process? This version of truth can be continuously revised, allowing for and enabling numerous versions of a subjectivist, socially constructed reality created in the relational space between participant and researcher.

The axiological approach focuses on how value-laden or value-free the researcher's frame of reference is towards the phenomena under investigation. There needs to be a holding of awareness and sensitivity and taking care of how interview questions and the later interpretation of participant responses can reveal values and shape the interview narrative (Creswell & Poth, 2018). Axiology primarily refers to the research aims and attempts to clarify if the research is trying to explain, predict or understand a phenomenon. There is a seeking to understand the phenomena rather than to explain or predict what happens when a participant uses OMs in clinical practice. There is an understanding that each participant has an 'insider' experience of this phenomenon whilst acknowledging that the researcher is both an 'insider' and an 'outsider' looking into participant clinical practices. The researcher is a TA psychotherapist who uses OM data in the diagnosis, contracting and treatment planning process with clients and understands there is a value-laden perspective. The research explores participants' lived experiences of this phenomenon to understand how each makes meaning from this

aspect of clinical practice, which may or may not be convergent or divergent from the researcher's experience. This lived experience will include the researcher's and participant's interpretations and meaning-making of the phenomenon of how OMs are used in clinical practice. There is a reflexive exploration of whether participants' lived experience converges or diverges with the researcher's experience of clinical decision-making (Creswell & Poth, 2018). Both researcher and participants may share their individual and idiosyncratic value-bound opinions, judgements and experiences, which are integral to the research as this necessitates maintaining an essential level of reflexivity in the research process as the value-laden narrative has been co-created between the participants and researcher.

The methodological foundations of ontology, epistemology, and axiology are key considerations in the qualitative research methodology of choice. Participants' individual reality of their experience is subjective, multiple, and complex. This research study seeks to capture their lived experiences at a cognitive and emotional level, expressed in their linguistic style. This research study aims to access participants to make sense of their worlds, individual experiences, realities, 'truth', and relationship with the topic under research (ontology). Our shared or divergent values, beliefs, opinions, and experiences of the phenomena we explore together are not value-free, neutral, and impartial, being integral to and, therefore, inseparable from the data (axiology). This study is interested in the participants' idiographic immersion in their lived experience (Smith & Nizza, 2022) and hence needs an experiential interpretation of their human-lived experience rather than a discursive or descriptive qualitative approach.

The research methodology, philosophical foundations of ontology, epistemology, and axiology, and the exploration of the qualitative landscape in this research study naturally led to IPA as a research methodology. Developed in the 1990's by British psychologist Jonathan Smith (McLeod, 2011), Larkin and Thompson (2011) offer a clear definition: "IPA is an approach to qualitative analysis with a particularly psychological interest in how people make sense of their experience … 'giving voice' (capturing and reflecting upon the principal claims and concerns of the research participants) and 'making sense' (offering an interpretation of this material, which is grounded in the accounts, but may use psychological concepts to extend beyond them) ..." (p.101). (parentheses in original).

Transactional Analysis and IPA - Shared Phenomenology

There is a natural synergy between the phenomenology of TA and IPA. TA has been described as a systematic phenomenology (Berne, 1961; Nuttall, 2006). TA came about at a time when the traditional medical model of 'subject-object', where 'doctor knows best' was beginning to be challenged. Philosophers Husserl (1900/2013), a phenomenologist, and Heidegger (1962/1967), an existential phenomenologist, were at the forefront of valuing the patients' or clients' subjective experience of 'being there' and 'being in the world' (Rotondo, 2020). Nuttall (2006) adds that TA is an existential phenomenology, where the individual seeks to make sense of everyday life, and that psychological distress is the individual's strategy of 'being-in-the-world' (Heidegger, 1962/67) to make meaning of life. IPA is a methodological phenomenology, and therefore, TA and IPA share how an individual makes sense of their experiences and create meaning in their lives and world in an individual, ontic, factual and absolute existence, and ontologically, 'being-in-the-world', as human beings (Heidegger, 1962/67; Nuttall, 2006; Tosi, 2008; Rotondo, 2020). These concepts closely align with Berne's (1977) phenomenological diagnosis, which illustrates how an individual's Parent and Child ego states, their past experiences become an aspect of the present (Cohn, 1997), holding sway over the Adult (the present reality), and reflecting the individual's way of 'being in the world'.

Phenomenological philosophy arose soon after the Second World War; the German philosopher Husserl (1931/2013) refuted the traditionally accepted view that physical objects are separate from other objects and that knowledge about these objects stays the same. Husserl believed objects are interconnected and that knowledge about the objects changed and evolved (Groenwald, 2004). Heidegger, a hermeneutic phenomenologist and a student of Husserl, introduced the idea of 'there-being,' translated from the word 'dasein,' the intrapersonal, interpersonal and extrapersonal, what goes on inside and between people and their world as they see or perceive it being and their individual experience of everyday existence (Dreyfus, 1991). Merleau-Ponty (1945/62) stresses that it is the embodied, somatic experience of the individual and how this sense of our bodies connects and shapes our perception and interpretation of others and the world. Heidegger (1962/1967) explains "Our first, last and constant tasks in interpreting is never to allow our .forecon-ception to be presented to us by fancies and popular

conceptions, but rather to make the scientific theme secure by working out the forestructures in terms of the things themselves.*"* (p.195).

Phenomenology is at the heart of IPA and TA. Husserl was the first to expound on the essence of an experience or phenomenon and wanted us to focus on the individual's perception of the world to *"*go back to the things themselves" *(*Husserl, 1900/2001, p.168). Smith and Nizza (2022) shed light on Husserl's (1900/2001) crypticism; "... the core components of our consciousness… to put aside existing scientific constructs or any presupposed view of the world, which can act as a concealing barrier from experience under investigation, to focus on our perception of the world… through one's conscious awareness and reflection…". (p.7).

Clinical Decision-Making

The theoretical foundations of IPA, phenomenology, hermeneutics and idiography are compatible with the clinical decision-making focus of this research (Table 1). The nature of the phenomenon to be researched and explored is the psychotherapists' intuitive and heuristic reasoning and clinical decision-making when using OMs in case formulation.

This research seeks to explore how each participant makes sense of lived experience and to capture, collect, and make sense of, and in turn, interpret, the essence of participants' cognitive and affective processes in clinical decision-making. This is understood as the Double Hermeneutic (Smith et al, 2022), where participants seek to make sense of clinical decision-making using OMs, and the researcher interprets and makes sense of the participants' sense-making (Smith et al, 2022; Finlay, 2011). Participants' idiographic experience of clinical decision-making in the context of work with clients is in the interaction between personal and professional values and clients' individual needs in the case formulation process (Anderson, Slark & Gott, 2019). Phenomenology bids us to take time and immerse ourselves in the characteristics under investigation (Finlay, 2011). Smith and Nizza (2022) add, "... the focus on examining lived experience through one's conscious awareness and reflection are central to most phenomenological methods of inquiry, including IPA." (p.7).

There are preconceptions, foreunderstandings, conscious awareness, and unconscious elements to be considered, such as earlier experiences, expectations, and assumptions of the phenomenon of clinical decision-making, which intrude into the research space, making bracketing when interpreting the research data partially, rather than completely, achievable. It is Smith et al (2022), who comments that "... the manner in which Heidegger unpacks the relationship between interpretative work and the fore-structure of our understanding should cause us to re-evaluate the role of bracketing in the interpretative of qualitative data." (p. 25)

The use of IPA methodology in understanding participants' lived experience brings into explicit awareness what may be mostly heuristic, implicit, and intuitive. This is System 1 thinking, whereas System 2 thinking is a slower, deliberate, and reflexive process (Kahneman, 2003). There is a curiosity and interest in how the interview process can shed light on participants' System 1 and 2 thinking in the TA diagnostic, contracting and treatment planning process. This clinical decision-making illustrates the Double Hermeneutic (Smith et al, 2022), as participants make sense of their lived decision-making experience utilising System 1 and 2 thinking whilst the researcher interprets and makes sense of participants' sense-making.

Theoretical foundation	Compatibility with clinical decision-making research
Phenomenology: a focus on conscious experience. Elucidating the memories, perceptions and judgements of participants.	Understanding the lived experience of decision making, with detailed recall of sensory, cognitive and emotional components.
Hermeneutics: a focus on interpretation. Insights gained through in-depth, iterative analysis of whole and part.	Understanding how healthcare professionals make sense of complex and dynamic situations and limited data, and how they recall, reflect on and represent their experiences.
Idiography: a focus on the individual. Considering specific experiences, people and contexts.	Understanding individual decisions and the interaction between the personal values of healthcare professionals and their patients.

Table 1: Theoretical foundations of IPA and compatibility with clinical decision-making research (Anderson, Slack & Gott, 2019, p.92)

TA Psychotherapy and IPA data collection methods share parallel skills and competencies in interview skills, clinical reflexivity, intuition, somatic awareness, empathy, transparency, and interpretation (Finlay, 2011). The combined clinical TA theory and practice synthesised with OM data and clinical decision-making are the lived experiences to be explored and translated from the implicit realm into an explicit dialogue between participant and researcher.

Hermeneutics

Hermeneutics is the theory and practice of interpretation (Smith & Nizza, 2022); the interpretation of participants' meaning from the individual parts of the text, words, sentences and the whole verbatim transcript, and then making sense and meaning from participants' lived experience. Figure 1 illustrates the 'Hermeneutic Circle' (Schwandt, 2007), a conceptual and diagrammatic representation of how the researcher can move from the interpretation of the participant's words within the transcript and develop an understanding of a phenomenon in parts of the text such as words, sentences, paragraphs in the text and also the whole text of the transcript in its entirety. This hermeneutic circle is a dynamic, reflexive, and ongoing process (Kincheloe & McLaren, 2008).

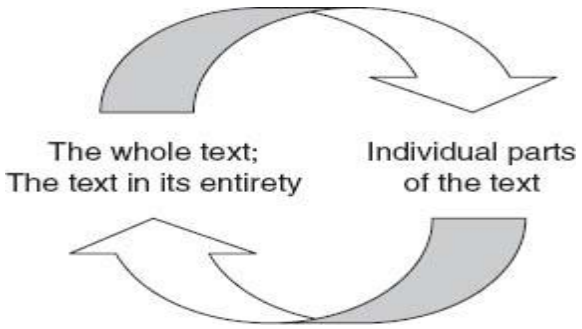


Figure 1: The Hermeneutic Circle (Schwandt, 2007, p.133)

There is an understanding that the hermeneutic circle requires repeated immersion into participants' words, the individual parts of the text and the narrative they tell, going backwards and forward between the parts and the text in its entirety, with the focus on the phenomenon being researched (Wilding & Whiteford, 2005). The single hermeneutic, in which participants understand and interpret their experience, is the First Hermeneutic. The Double Hermeneutic is where the second level of interpretation occurs, as the researcher makes sense of the participant making sense of the phenomenon (Smith et al, 2022; Finlay, 2011). The IPA researcher hopes to evoke and then capture the participants' spoken and unspoken narratives to access their verbal, interactional, societal, and somatic environment (Larkin & Thompson, 2011).

Idiography

Idiographic research concerns the individual's lived experience with no prior assumptions; each case is treated on its own merit, and analysed individually (Finlay, 2011). IPA is idiographic and focused on the 'particular', so looks at the detail and depth of analysis and therefore uses small, purposive sample sizes (Smith et al, 2022). Each participant brings their own experience and response to the phenomenon to the research, which means this is not a prescriptive or generalisable process to a wider population. IPA's value is interpreting the individual's experience and sense-making of the experience (Bager-Charleson & McBeath, 2020). Participant narrative, as it unfolds, seeks to capture the idiographic, the individual's level of perspective; words and language only used by them have significance. IPA bids us enter the participant's world through the portal of semi-structured interviews, to make meaning and interpretation via the transcription, and develop themes and search for connections (McLeod, 2001). The wider research study with 12 participants' data with idiographic analyses, will search for patterns, either converging with other participants data as a shared theme or single individual themes called divergences (Finlay, 2011).

Ethical Considerations

Having described the theoretical considerations about the methodology, here are the ethical considerations. The underlying philosophical tenets of ethics arise from deontology; i.e. doing what is right and good, and the consequentialist emphasis on achieving positive outcomes (Thompson & Chambers, 2011). From these philosophical roots emerge four fundamental ethical principles: respect for autonomy, the individual's right to make decisions and informed choices; beneficence to account for the risk and benefit to the participant; non-maleficence to do no harm to the individual; and finally, justice where all participants are treated fairly and equally (Thompson & Chambers, 2011). The ethical researcher, throughout the research process, is required to be critically reflexive, and self-aware of what is happening; of their thoughts and motivations, and find their way through the challenges of the ethical process and dilemmas that arise, with sensitivity (Barton, 2020; Finlay & McFerran, 2019).

As a psychotherapist researcher, there is a duty to follow the University of Salford and the professional bodies' ethical codes and guidance for research. It is important to be mindful of the protection of the participant and wider society; this includes the

participant disclosing information about their clients during the research interviews. There needs to be vigilance for the safety of clients and protection from professional malpractice, and procedures were put in place whereby the researcher can communicate with the practitioner's clinical supervisor or professional registration body. Responsibility for managing potential and actual risk, avoidance of harm, informed consent, anonymity, and confidentiality falls to the researcher (Smith et al, 2022; BACP, 2019; Smith & Nizza, 2022).

The UK Association for Transactional Analysis (UKATA), the UK Council for Psychotherapy (UKCP) and the European Association for TA (EATA), with each of whom the researcher is a registrant, do not currently offer this research guidance, although each offers a general ethical framework for therapeutic practice, which incorporates a core ethical code with principles enshrined which are transferable into research (UKATA Code of Ethics and the Requirements and Recommendations for Professional Practice, 2019; UKCP Code of Ethics and Professional Practice, 2019; EATA Ethical Code 2007/2011. These ethical codes focus on the client and beneficence and non-maleficence

The author took cognisance of the British Psychological Society's (2021) *Ethics Guidelines for Internet-Mediated Research (IMR),* which reiterate the overarching principles of respect for the autonomy, privacy and dignity of individuals and communities; scientific integrity of the research project to meet standards of quality, integrity and contribution, and that the analysis, inferences and interpretations are valid and trustworthy; social responsibility and maintaining respect for and the avoidance of disrupting social structures by carefully considering the research study's consequences, unintended consequences and outcomes; and maximising benefits and minimising harm by ensuring the research has scientific value and protecting participants from harm by gaining valid informed consent, ensuring anonymity and confidentiality.

For this research study, the researcher adopted the British Association for Counselling and Psychotherapy (BACP) *Ethical Guidelines for Research in the Counselling Professions* (BACP, 2019) as they are a professional registering body that includes TA psychotherapists as registrants. The application to the University of Salford Ethics Committee was approved on 2/3/2022. Doing what is right and good in this research involves the integrity and trustworthiness of the researcher to ensure this is done truthfully and transparently from the initial Ethics Committee process, ensuring adherence to their systems and processes and ongoing overseeing by research supervisors who advise on the ethical and also procedural aspects of the research to ensure the researcher adheres to ethical principles for the protection of participants.

Confidentiality and Anonymity: there is an essential distinction between confidentiality and anonymity in research. The researcher cannot promise confidentiality as this implies that only the participants and researcher can access the data generated and that nothing would be shared outside that space. Confidentiality would not be attainable due to the nature of IPA research, in which verbatim participant quotes are included in the writing-up process. Anonymity requires the protection of the participants' identifiable information and demographics by using pseudonyms (Finlay, 2020).

The participants could be identifiable due to the small pool and community of TA psychotherapists and to protect and preserve their anonymity the decision has been made not to include a portrait of individual participants nor offer brief biographical details . As part of the Participant Information Sheet and Consent forms process makes clear, their data is held on a University of Salford database. The interview data is recorded, handled, processed, stored for up to 5 years and destroyed following the GDPR UK legislation. The electronic data is anonymised and given a research code; data is held on a password-protected computer accessed only by the researcher. Paper/taped and transcribed data will be stored in a locked cabinet within a locked office and accessed only by the researcher. The anonymised data may be used for future studies; if so, further approval will be sought from participants, and data will be used anonymously. The researcher's supervisors can access identifiable data to monitor the quality and for audit purposes.

Time taken for reflection was essential to consider the assignment of participants' pseudonyms whilst maintaining their anonymity, but also attending to minimise the power differential between researcher and participants in decolonisation, giving participants names that reflect their "… identities … ethno-linguistic backgrounds, family histories, and cultural legacy …" (Wang, Ramdani, Sun, Bose, & Gao (2024, p.2). Not giving participants who are not English, Anglicised names and using names from participants ethnolinguistic backgrounds is a step towards *" …* epistemic and cognitive justice *…"* (Ndhlovu, 2021, p.193) in this research. The participants are advised that results will be included in the PhD thesis and examination process and may be published in peer-reviewed journal articles. The researcher ensures that the participants are not identifiable in the final thesis or journal articles/ publications. This procedure follows the GDPR UK

legislation, minimising the personal data obtained and securely storing the data. This sensitive data is password-protected (Finlay, 2020).

*Informed Consent: t*his is a key part of the ethical research process and begins with the Participant Information Sheet (PIS), which enables participants to learn what the research is about, why the researcher has approached them and what to expect from an interview (Smith et al, 2022). The PIS was sent to each participant who responded and showed interest in taking part in the research study and gave detailed information on how the interview would be conducted, timescales, the disadvantages, risks, and benefits of taking part, how anonymity, data protection and security would be ensured, and the researchers' and supervisors' contact details so participants could make contact to get their questions answered. Participants were advised that participation in this study is voluntary and that they have the right to refuse to take part or to leave the study if they wish, up to a month after their interview, without having to give a reason, and their data will not be used. If they withdraw from the study after a month of their interview, all the information and data collected from them to date will continue to be used. However, their name will be removed from all the study files, and there will be no fear of penalty.

After the PIS was sent out, the consent forms were sent electronically to the participants who agreed to participate. The participants were asked to read and sign each section to indicate that they have received and read the PIS, that their participation is voluntary, they have the option to withdraw up to one month after their interview, the process for the anonymous sharing of their data, that there would be a video and audiotape of the interview, and that verbatim quotes would be used from their interview. Valid consent must be given freely and without coercion by participants who understand their participation rights and can consent (Steffen, 2016). Informed and valid consent is not a single event at the start of the participatory process. It is an ongoing and dynamic process, reviewed as participants understand more fully what their participation entails as the research unfolds (BACP, 2019) and ascertained again at the start of the online interview.

*Protection from Harm and Exploitation: a*s a fellow TA psychotherapist exploring participants' clinical decision-making in the use of outcome measures in case formulation, there is no explicit hierarchical or formal authority held by the researcher (such as a manager, supervisor, trainer, or therapist) in the professional relationship before the research study (BACP, 2019). There may be an inherent sense of authority as a researcher asking about participants' clinical practice and how they make complex and sensitive decisions about their work with clients. Participants may view the researcher as an 'expert' in this field of practice or experience stress in sharing their clinical practice and may fear criticism or judgement of their clinical decisions. This issue requires close attention and action if a power differential becomes evident during the research process; This was attended to early in participant and researcher contact when invitations to take part were sent out via the STAA, UKATA, EATA and UKCP. Therapists responded to the researcher directly, and an initial dialogue took place where the research study was talked about with them and their questions were answered about what was involved, when the interviews could take place and practical issues; this helped to be an 'ice-breaking' event and an opportunity to decide if this were something they would like to take part in or not. The research interviews aimed to have a collegial semi-structured discussion, free of criticism or judgement, allowing the researcher to access the participant's lived experience of using OMs. This attention to the researcher/participant relationship very early in the contact process worked well. It enabled an OK-OK relationship to develop and enabled open communication during the research interview process.

TA psychotherapists usually have access to regular supervision and personal therapy where they can take issues. They were also offered a *Debriefing Form for Participants* after the research interview. This form gave them time to reflect and the opportunity to communicate how they had experienced the process, from the first recruitment contact to the interview process. They were allowed to talk about any positive or negative thoughts or feelings they had experienced and a clear ending to their participation. The *Debriefing Form* arises from the ethical principle of non-maleficence to ensure as much as possible that the research process has not caused distress or harm; it was also an opportunity to thank participants for their valuable contribution.

Online Data Collection in Qualitative Research: participants were protected whilst conducting online research interviews using ethical principles and the research infrastructure, (BACP, 2019; GDPR UK law; University of Salford Ethics Committee), including using Research Supervisors. The recent technical advances and the growth of encrypted online communication portals, such as Microsoft Teams, made up for in-person contact, as this was prohibited during the COVID-19 pandemic. This virtual interview space where practitioners and the researcher met for the first time meant a rapid attempt to build a relationship without the customary social preamble of arriving and meeting in the physical space. The importance of deliberately

spending time in introductions to one another helped to build trust and cooperation whilst answering any questions they had, checking again about informed consent, and that they were located in a safe and confidential space for the interview, free of interruptions and distractions (Engward, Goldspink, Iancu, Kersey & Wood, 2022). As a psychotherapist, interviewing practitioners who also worked online established a sense of closeness, a rapid building of rapport, and a mutually respectful relationship that elicited a rich depth of data. There was an awareness that practitioners were in their environment for the interview, and the online space did seem to engender a sense of close affiliation, which was helpful when there was more sensitive self-disclosure (Gray, Wong-Wylie, Rempel & Cook, 2020). Important consideration was given to how the online interview process allowed the researcher to respond in the moment to participants' reactions, whether verbal or non-verbal, and explore these responses in greater depth (Kristiansen, 2022).

Sampling and Recruitment of Participants

This study recruited participants, of whom eight were Certified Transactional Analysts (Psychotherapy) (CTA-P), and 4 were in training to achieve that status and had each done at least 4 years of training in TA psychotherapy. For readers not familiar with TA qualifications, CTA means they have completed a level of training and competence comprehensively assessed in a written and oral examination following extensive practical experience. The written CTA(P) examination is a client case study, and the oral examination is the live assessment of audio recordings and verbatim transcripts of the therapist and client working together. This examination assesses the TA therapists' TA diagnosis, contracting and treatment planning skills. This aspect of TA training and the examination process is an applicable and transferable skill for exploring how participants might synthesise OM data into clinical decision-making and case formulation work. Participants recruited to the study are English-speaking and based in the United Kingdom to avoid researching across legal and national jurisdictions (BACP, 2019).

The recruitment was via the UKCP, UKATA, EATA and the Scottish Transactional Analysis Association (STAA). These organisations agreed to circulate an invitation (by their email circulation list) to their registrant members, giving them a broad overview of the research study and asking them to contact (giving the researcher's academic email address) for more information and to discuss whether they would like to participate.

The small sample size of 12 participants provides sufficient data to investigate the participants' shared and disparate experiences of the phenomena (Smith & Eatough, 2021) in depth and breadth. This challenged the traditional numerical sample size of participants. The value of the research is within in-depth interviews that generate rich, detailed accounts. This study recruited 12 participants as a recommended sample size for a PhD research study (Smith & Nizza, 2022; Smith & Eatough, 2021; Smith et al., 2022; Hefferon & Gil-Rodriquez, 2011) to seek depth and breadth in the data generated rather than a shallow descriptive analysis of a larger sample size (Smith at al, 2022).

The careful and deliberate purposive sampling method sought out individual TA psychotherapists who worked in private practice and were most likely to have experienced the phenomenon under exploration of clinical decision-making in case formulation and found this experience meaningful (Denzin & Lincoln, 2006; Silverman, 2020; Smith et al, 2022).

This sample of TA psychotherapist participants will have made individual clinical decisions on how and why they use OMs in private practice. This decision contrasts with TA psychotherapists working within organisations (for example, the NHS, University Student Services, or Charities) with specific requirements and directives for their employed psychotherapists to use OMs. These organisations often seek objective measures linked to applications for funding and monitoring, performance management or service target-driven.

Once potential participants responded to the letter of invitation circulated by the professional organisations, the researcher replied to and contacted potential participants via email. The initial contact via email was to offer to meet online with potential participants to brief them about the research and to ascertain if they met the inclusion criteria and then wished to proceed as a research participant. This aspect of the research protocol, where online contact is made, was subject to and considering COVID-19 pandemic restrictions.

Semi-structured Interview Guide: Interview Questions & Prompts

The interview guide was designed to ask open questions, moving the interview from a broad and open-ended place intended as an introduction and establishing a warm rapport with participants, to more specific, still open-ended questions to gather participants' idiographic data relevant to the research questions. It was not intended that participants answered every question or prompt below; however,

every participant was asked specific prompts related to the research questions.

Introduction and Broad Initial Question

1. Tell me about how you use outcome measures in your work with clients.

Follow-up potential prompts to facilitate the research conversation

2. Tell me about your private practice, areas of work you specialise in, and why.
3. Why did you decide to train in Transactional Analysis?
4. How did you find out about/come across Outcome Measures in therapy?
5. How did you decide to implement OMs into your practice with clients? What process did you use to decide?

Areas of possible exploration using prompts

6. Tell me about the particular OMs you use and why you use those.
7. How do you decide which OM to use with each client and when?
8. How do you present OMs to your clients (before/ at the time/after the session)?
9. Do you have a system or order you use OMs with your clients?

The focus of the prompts moves into further detailed research conversation

10. Tell me about a recent client who comes to mind and the process you went through in deciding which OM to use and why.
11. What did you do next?
12. When do you look at the OM data/scores?
13. What do you do next?

Specific prompts related to the research questions

14. How do you use the OM questionnaire responses from the client?
15. How might the data be used in your TA diagnosis of the client?
16. How might the data be used in your TA contracting process with the client?
17. How might the data be used in your TA treatment planning process?
18. Talk me through how you do this.

The IPA Data Analysis Process

The IPA transcription method processes the verbatim data of the words spoken by participants into a detailed analytical seven-step framework (Smith et al, 2022). A step-by-step guide to IPA data analysis can be found in Smith at al (2022) and Smith and Nizza (2022) . It is summarised here and illustrated in Figures 2, 3 and 4:

1. *Step One*: Figure 2 illustrates the format for analysing the participants' verbatim transcription. The transcript is in the central column when the participant and researcher speak. The colours or shading make connecting the transcript's *Exploratory Noting* and *Experiential Statement* columns more straightforward to follow and associate with one another in the text. The *Transcript column* involves intensive listening to and watching the video recording of participants' semi-structured interviews and several repeated transcript readings. This process enables interaction and depth in familiarisation with the data. A written reflective journal of this step kept separately from the data, enables a record of how participant's words, facial expressions, body language, utterances, vocal tone and speech patterns had a significant somatic and emotional impact (Smith et al, 2022). This reflective journal captured the impact of the interview on both participants from an idiographic perspective. It offered the researcher a deeper, richer analysis from the added dimension of verbal and nonverbal communication.

2. *Step Two*: (Figure 2) is the *Exploratory Noting* phase, where the researcher explores the participant's thoughts, feelings, reflections, memories, beliefs and attitudes, expressed in the transcript, towards OMs in TA diagnosis, contracting and treatment planning. These exploratory observations are the double hermeneutic where the researcher interprets how the participant makes sense of their experiences of the phenomenon and uses OMs in case formulation.

3. *Step Three*: (Figure 2) is the construction of *Experiential Statements* by condensing and summarising the Exploratory Notes (Smith et al, 2022).

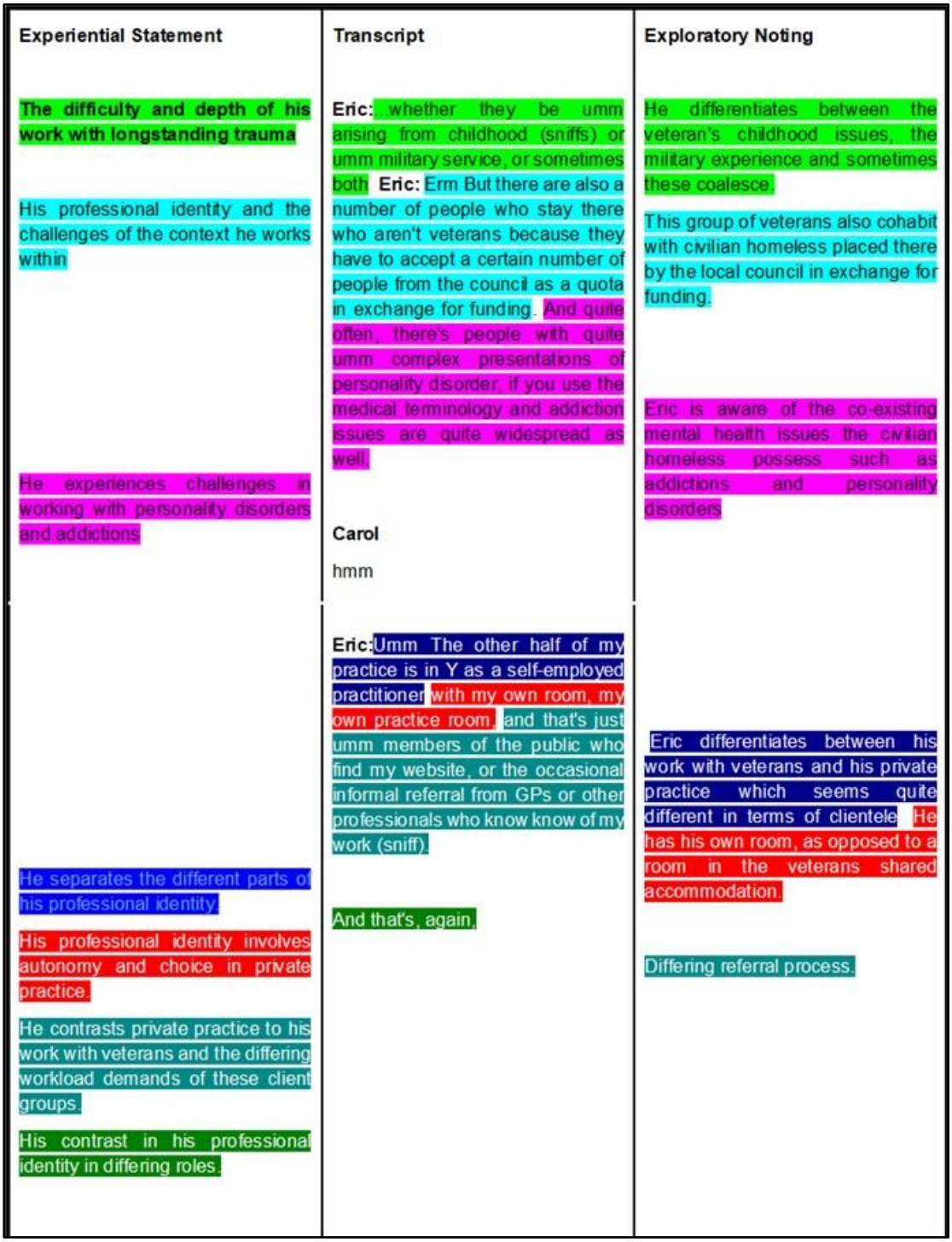
4. *Step Four*: (Figure 3) looks for connections across all the Experiential Statements; this was a cut-out exercise of all the Experiential Statements as paper strips, identifiable by writing the page and line number from the transcript. The paper strips were then moved into stacks that connected or had a link with each other. The paper strip stacks of Experiential Statements are then moved back and forth until all the paper strips are allocated and only then is a heading applied, to capture the essence of the topic created (Smith et al, 2022).

5. *Step Five*: (Figure 4) gathered all the Experiential Statements under headings and organised them into *Personal Experiential Themes* (PETs) tables. PETs are topic headings at the participant's individual and idiographic

level (Personal); Experiential refers to their lived experience, and Themes refer to the overarching concepts. The PETs will be included in a future article to detail the process thoroughly.

6. *Step Six*: involves Steps One to Five for each of the twelve participant cases.

7. *Step Seven*: is the final stage of the analysis, where all 12 participants' PETs will be brought together in a table to develop the Group Experiential Themes (GETs), where a cross-case analysis will ascertain convergences and divergences between all the participants (Smith at al, 2022). This step is still in progress and will be reported on in a future article.



Experiential Statement	Transcript	Exploratory Noting
The difficulty and depth of his work with longstanding trauma	**Eric:** whether they be umm arising from childhood (sniffs) or umm military service, or sometimes both **Eric:** Erm But there are also a number of people who stay there who aren't veterans because they have to accept a certain number of people from the council as a quota in exchange for funding. And quite often, there's people with quite umm complex presentations of personality disorder, if you use the medical terminology and addiction issues are quite widespread as well.	He differentiates between the veteran's childhood issues, the military experience and sometimes these coalesce.
His professional identity and the challenges of the context he works within		This group of veterans also cohabit with civilian homeless placed there by the local council in exchange for funding.
He experiences challenges in working with personality disorders and addictions	**Carol** hmm	Eric is aware of the co-existing mental health issues the civilian homeless possess such as addictions and personality disorders
	Eric: Umm The other half of my practice is in Y as a self-employed practitioner with my own room, my own practice room, and that's just umm members of the public who find my website, or the occasional informal referral from GPs or other professionals who know know of my work (sniff).	Eric differentiates between his work with veterans and his private practice which seems quite different in terms of clientele. He has his own room, as opposed to a room in the veterans shared accommodation.
He separates the different parts of his professional identity.	And that's, again.	
His professional identity involves autonomy and choice in private practice.		Differing referral process.
He contrasts private practice to his work with veterans and the differing workload demands of these client groups.		
His contrast in his professional identity in differing roles.		

Figure 2: An Excerpt from a participant Transcript to Illustrate Steps One to Three in IPA

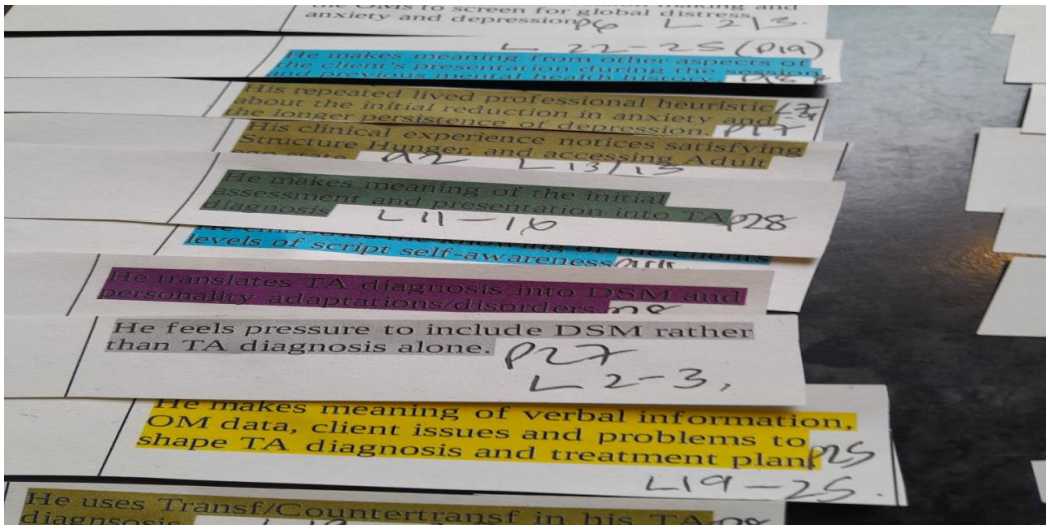


Figure 3: An Excerpt from a participant Transcript to Illustrate Step Four of the IPA

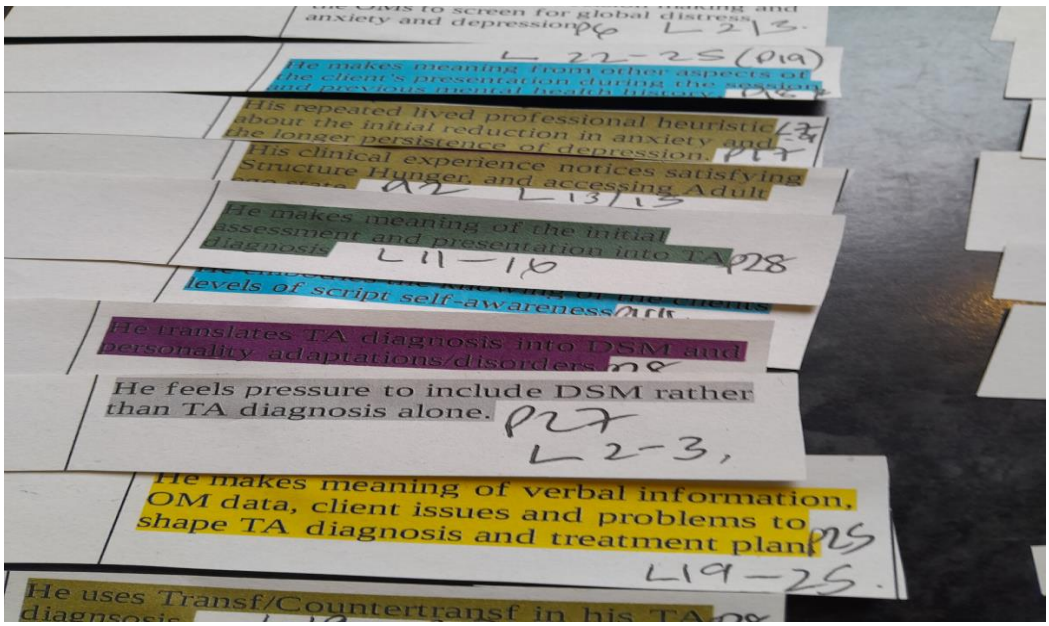


Figure 4: An Excerpt from a participant Transcript to Illustrate Step Five of the IPA

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Editor's Note: the author has shown some references using initials of organisations so here is the 'code':

BACP = British Association for Counselling and Psychotherapy
BPS = British Psychological Society
EATA = European Association for Transactional Analysis
UKATA = United Kingdom Association for Transactional Analysis
UKCP = United Kingdom Council for Psychotherapy

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