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How Do Transactional Analysis Counsellors and Psychotherapists Use Outcome Measures in TA Diagnosis, Contracting and Treatment Planning: An Interpretative Phenomenological Analysis of a Single Case Study - 'Joe'.

Abstract

As part of a series of articles about doctoral research into how transactional analysis practitioners apply outcome measures, this article presents a worked example as a case study of a participant who is a Certified Transactional Analyst (Psychotherapy) and a clinical supervisor who uses outcome measures in TA diagnosis, contracting and treatment planning in his clinical practice. It shows the results of Personal Experiential Themes at two stages, in order to demonstrate the process used by the researcher to sort first into themes and then to complete an in-depth idiographic analysis and hermeneutic interpretation of the phenomenon.

Keywords

transactional analysis, outcome measures, interpretative phenomenological analysis, case formulation, clinical decision making.

Editor's Note

Please note that this is the third article in a series of papers about this research study. They are therefore giving much detail that would not be possible if we only published one article. As this is an open-access journal you can easily access the previous articles at https://ijtarp.org/article/view/23769 and https://ijtarp.org/article/view/23781

Also, in order to demonstrate how the researcher repeats some stages of this research, we are presenting two stages of the analysis of this case study even though you will see as you read on that some of the conclusions are the same. The repetition is maintained in order to show both analyses and to present an accurate view of the amount of work and stages involved in this research.

Introduction

In Remfrey Foote (2023), the first article in this series about this research study appeared, explaining that it would be doctoral research. This included a review of what the author meant by 'outcome measures' (OM) and alternative labels used by other authors; how instead of OMs practitioners might use hunches subject to the three types of bias – "confirmation, overconfidence, and blind spot" (Lilienfeld and Lynn, 2015, p.6); and how there are positive and negative perceptions of OMs. That article concluded with the comment that "Research continues to show that OMs have high validity and reliability and can be used across different modalities as a rapid assessment tool supplying data on a client's progress, plateauing and deterioration. OM data supplements clinical judgment and provides an opportunity for the counsellor or psychotherapist to intervene and review the client's treatment plan and direction." (Remfrey Foote, 2023, p.11).

This was followed by Remfrey Foote (2024) with a thorough presentation of the research methodology. This included the main research question of "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?" (p.40). It was followed by a theoretical description of the research methodology, including ethical considerations, how participants were selected, and details of the seven stages of the research. This included the semi-structured research questions used, which are repeated here for ease of reference as Table 1, because this article now presents the results for a specific participant for the relevant stages of the

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.

Table 1: Semi-Structured Interview Questions (Remfrey Foote, 2024, p.48)

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." (Remfrey Foote, 2023, p.39).

These stages consist of the researcher keeping a separate reflective journal of how the "Participant's words, facial expressions, body language, utterances, vocal tone and speech patterns had a significant somatic and emotional impact … captured the impact of the interview on both participants … offered the researcher a deeper, richer analysis from the added dimension of verbal and non-verbal communication." (p.48). They also included the researcher repeatedly watching the video of the interview to allow absorption of "the participant's thoughts, feelings, reflections, memories, beliefs and attitudes, expressed in the transcript, towards OMs in TA diagnosis, contracting and treatment planning." (p.48).

As the researcher does these two stages, they are marking notes on the transcript as exploratory notes, so the third stage can be to summarise these in the form of some connections that can lead them to become experiential statements of "… what have we learned about the meaning of the experience to the participant in this portion of text." (Smith & Nizza, 2022, p.39). These are all colour-coded on the transcript, which includes the page numbers and lines involved, so these can be cut up and sorted into topics, and eventually in stage five they are organised into Personal Experiential Themes (PETs) for each individual participant – which will of course be brought together in a table of Group Experiential Themes (GETs) - the next article.

As you read on, you will be presented with two analyses: the initial analysis and the revised idiographic analysis after further deeper iterative hermeneutic interpretation. Between the two analyses, the researcher continued analysing the PETs of the other participants and then revisited each of them in turn. This single case study 'Joe' is presented as an example of a rich source of idiographic lived experience of the phenomenon and, as the first case analysed, familiarised the researcher "... with the complete research cycle" (Smith & Nizza, 2022, p. 49).

The initial analysis of Joe

Participant 1, 'Joe' is a 51-year-old white male who lives and works in private practice in the United Kingdom. He qualified as a Certified Transactional Analyst (Psychotherapy) over 10 years ago and is qualified as a clinical supervisor. He also works part-time as a psychotherapist for a charity and is employed as a paid therapist.

The Experiential Themes from 'Joe's' data are grouped into the following four Personal Experiential Themes:

A: How 'Joe' makes sense of his professional identity; *"String to the bow."*

B: The use of OMs in funding applications; *"Cementing in place."*

C: 'Joe's' thinking fast and slow; "*Allow things to come to the surface."*

D: 'Joe's' use of OMs in TA case management; "*When you cross reference numerical scores."*

Below is shown how the title of each PET (e.g. PET A: 'Joe's' sense of professional identity) brings together the convergence of the experiential statements clustered under subthemes (e.g. Theme 1: He makes sense of his diverse roles as a psychotherapist) with the page and line number (e.g. Page 4, Line 4), and underneath 'Joe's' quotes from the transcript (Smith & Nizza, 2022).

PET A: Interpretation of how 'Joe' makes sense of his professional identity; *"String to the bow."*

This section of the IPA explores 'Joe's' sense of his professional identity as a TA psychotherapist and provides the backdrop and context of his professional and clinical lifeworld in which he practises (Eatough & Shaw, 2019; Smith, Flowers & Larkin, 2022). 'Joe's' idiographic perspective gives his first-hand experience of what it is like to be a TA psychotherapist who uses OMs to make sense and meaning of this phenomenon. In his experience as a human making meaning in subthemes 1-5, he makes sense of his four diverse roles as a psychotherapist at the coal-face of direct client contact as a trauma-informed, psychodynamic TA therapist, sole trader as a self-employed TA psychotherapist, a clinical supervisor of other psychotherapists and trainees, and his drive to influence policymakers on the effectiveness of TA as a modality. 'Joe' recognises and is explicit in subthemes 2 and 3 about providing clinical supervision;

"I have two, sometimes, three supervisees per month." (P4, L11-14).

Considering his other professional responsibilities, he deliberately keeps this aspect of his workload manageable. 'Joe' then foregrounds:

"I don't have really that much more capacity for supervision, but it has a nice additional string to the bow." (P5, L8-11).

His sense of capacity, of feeling full-up and that being a supervisor with another 'string to his bow,' is a safety net financially in his self-employed clinical practice, which he can expand or contract if other areas of his income dry up. This careful way he plans his caseload and workload gives an insight into 'Joe's' personal and professional world, where he gives thoughtfulness and care as a people-centred TA psychotherapist (Eatough & Shaw, 2019).

Subtheme 1 begins to unveil his somatic discomfort in the ambivalence and internal conflict he experiences with which clients he chooses to use OMs:

"It's just effectively on half of my practice I tend to use the most often." This is his veteran caseload which comes "... *under the auspices of my private practice."* (P10, L15-16).

Whereas in subtheme 5, his private practice clients have mood disorders such as anxiety and depression, where he uses OMs less often rather than with veterans with severe mental health issues. This approach may be due to multi-disciplinary team functioning and communication between 'Joe' and other providers within the veterans setting and his sense-making of how OM use is more mainstream than in the TA community. In subtheme 9:

"I think anybody who's worked in NHS settings or more formal treatment settings will probably be more familiar or comfortable with them." (P51, L15-18).

'Joe' makes sense of his somatic sense of discomfort in straddling two diverse professional life-worlds where he and NHS [UK National Health Service] staff have a shared understanding and language about OMs; this aspect of his professional identity differs with his TA community. All humans need to belong and connect with other humans at a deeply somatic level, share customs and ideas, and feel a part of the group's cultural norms (Allen, Kern, Rozek, McInerney & Slavich, 2021). In 'Joe's' case, a sense of belonging and a shared professional identity comes under stress when he adjusts or adapts his practice to the prevailing norms of the professional group he is with. The double hermeneutic makes sense of his dilemma of belonging as both an 'insider' and 'outsider' regarding OM use in his clinical practice.

'Joe', in subtheme 8, develops his felt sense of the dichotomy of being simultaneously an 'insider' with NHS staff and an 'outsider' with the TA community. As an 'insider,' he makes meaning of how NHS staff and he shared an understanding:

"And, so I kind of understood them that, what they were talking about, knew something about how they were used." (P47, L5-7).

'Joe' makes sense of how as an 'outsider' in his OM use in the TA community, he experiences a feeling of ambivalence in wanting to defend his colleagues whilst recognising his internal conflict at holding a distinct perspective:

"... or in terms of the TA community, I don't think we know about. I suspect that, like any other modality, there's probably a broad range of opinions and some people would view them as important, even necessary." (P51, L2-7).

'Joe' makes further meaning of his feelings as an 'outsider,' as a TA supervisee:

"To my knowledge, I don't think the other participants used outcome measures, or at least they haven't had reason to bring them to the group." (P50, L10-14).

There is a sense here that 'Joe' may not feel safe sharing that he uses OMs and his fears of being ostracised by TA colleagues. In subtheme 10 he recognises and is explicit about his fear and how he makes meaning of his TA colleagues' rejective response to him using OMs:

"And others would probably be quite reluctant … quite averse or just not terribly interested in that way of working." (P51, L10-15).

'Joe' makes sense of how he was introduced to OMs over ten years ago, four years after his core TA training:

"I think it might have been CPD, after my core training. I mean, it was alluded to in the latter stages of our training, or, not in detail. Which really, I think I might have gone to an event where Mark Widdowson was speaking about research, we just really moved into that field." (P46, L8-15).

He is reflective here on the meaning of the *"embodied, temporal and relational"* (Eatough & Shaw, 2019) in the context of feeling an 'outsider' in the TA community.

'Joe', in subtheme 8 and later in the transcript, reflects and reveals the dilemma of being an 'outsider' holding contradictory beliefs about OMs and recognising and being explicit about the benefits of OMs in supervision:

"*Umm, I guess the point where I would most naturally come up is when you're presenting a new client, as part of the relaying the relevant information from the initial assessment, relevant to whatever the supervision issue is, perhaps around protection issues, perhaps around risk, perhaps around the need to involve other professionals."* (P53, L6-15).

'Joe', in subtheme 11, embodies his dichotomy of being both an 'insider' and 'outsider' when he publishes his research in a TA journal on his psychotherapy work with clients using OMs as evidence-based practice:

"Um, so yes, I mean, it's very hard to assess what impact or how, what is the reach of a piece of research like that … so one hopes it gets out." (P58, L5-11).

He makes meaning of his feelings of uncertainty and expresses tentativeness about his research making a difference in the TA community. 'Joe', in subtheme 10, reflects on his embodied excitement at contributing to TA research:

"And I suppose that the questionnaires were one part of starting to formalise the gathering of the data with a view to writing something, really to further the reputation of TA to a reputable treatment model." (P49, L14-18 and P50, L2-3).

'Joe's' lived experience of his professional life-world sheds light on his ontological, human experience of being-in-the-world "... in which the unifications of opposites are recognised as real, naturally reflective of the whole, and fundamentally meaningful in terms of lived experience." (Willis, Grace & Roy, 2008, p.34).

PET B: Interpretation of the use of OMs in funding applications; *"Cementing in place."*

TA Psychotherapists working within the third sector are asked to participate in funding applications to large statutory organisations such as the NHS or local government bodies. Psychotherapists and counsellors provide direct care to the charity's service users and can provide valuable qualitative information and quantitative data to strengthen charitable bodies' applications for funding (Cooper, 2012; Callaly, Hyland, Coombs & Trauer, 2006; Wolpert, Curtis-Tyler & Edbrooke-Childs, 2014). 'Joe', in subtheme 1, makes meaning of his participation in the bid for funding process:

"*One thing I'd forgotten to mention, actually, as a use of the measures was that I prepared a brief report for the charity that I work in, and they use some of the data as part of a funding application."* (P54, L8)

He deepens the meaning this has for him in subtheme 1 that his contribution to the funding application includes nomothetic data of numbers of clients seen and sessions delivered; he makes sense of being able to demonstrate evidence-based practice and capture how clients have developed in response to the additional funding using OMs. 'Joe' embodies his sense of effectiveness and satisfaction as a psychotherapist who uses OMs and provides quantitative and qualitative data on how he demonstrates client's improvement and changes to their mental health and quality of life:

"*Not just being able to say, so many veterans have been seen, or I've had so many sessions in this period. But actually, been able to show the change, that taken some elements of the change that has*

happened as a result of that funding provision." (P56, L10-15 and P57, L1).

He is explicit and recognises he does not rely on clinical judgement alone, overestimating or being overly confident in his clinical judgement (Hannan, Lambert, Hremon, Nielsen, Samrt, Shimokawa & Sutton, 2005; Hatfield, McCullough, Frantz & Krieger, 2010). He acknowledges that the input of OMs tracks the changes and improvements in his client's mental health and well-being.

PET C: Interpretation of 'Joe's' Thinking Fast and Slow; *"Allow things to come to the surface."*

'Joe' embodies his System 1 (fast, intuitive, pattern recognising, heuristic) thinking as this develops into System 2 thinking (cautious, logical, reasoning, and analytical) as he makes sense of the client data he has collected (Bate, Hutchinson, Underhill & Maskrey, 2012; Beresford & Sloper, 2008; Kahneman, 2012) which includes OMs and client intake information.

In subtheme 1 'Joe' makes meaning of and embodies his System 1 (his first impression) as this shifts into System 2 (developing his assessment further):

"So that, and then when I, when I've done the initial assessment, which I initially complete in pencil, because I might want to move the information around later on. And also, I can sort of tidy it up in terms of my thinking as well." (P28, L22-27).

He goes on to recognise and be explicit about his actions in more detail as he shifts from System 1 into System 2 thinking later in the task (Julmi, 2019), taking his time, and allowing his reflective process to appear:

"*So, I go back over it once the clients left at some point between then and the first session and ink in the assessment with a pen."* (P28, L27 and P29, L1-2).

'Joe' embodies an affective reaction in his awareness when he reviews his first gathered data (System 1) which connects to his "Clinical Mindlines" (Gabbay & LeMay, 2011) developing into System 2 decision-making:

"*But when I rearrange the data on the page, it's, it seems to trigger certain awareness or certain connections and starts to inform my treatment planning."* (P29, L18-20).

He listens to and attends to his "reflection-in-action" (Schön, 1983; Gergen, 1973) what was out of 'Joe's' first awareness comes into his direct awareness as System 2 decision-making:

"*So, it's sort of incrementalist sort of routine, really, that I've adopted, that just seems to allow things to come to the surface that I maybe wasn't completely aware of during the initial assessment itself."* (P29, L14-19).

'Joe' makes meaning of how his individual experience of "reflection-in-action" (Schön, 1983) helps him to make sense of the shift from System 1 to System 2 thinking (Evans & Stanowich, 2013; Kahneman, 2013):

"But in the process of doing that, it helps me start to formulate my thinking a bit more of an orderly fashion." (P29, L4-6).

In subtheme 2, 'Joe' makes meaning of his embodied reflectivity. He dives deeper into System 2 thinking and explores how he processes the client's OM scores, which support his decision-making process:

"*When they bring them back, I would take them away and think about them."* (P40, L2-4).

He makes sense of how his emergent decision-making process develops and unfolds over critical periods and continues to be shaped between client sessions and in clinical supervision:

"*And also reviewing it in my own time, between sessions and sometimes in supervision if necessary."* (P26, L10-12).

'Joe' makes sense and meaning, using his embodied intuition gleaned from the OM data to predict a client's deterioration ahead of a stressful event; this would allow 'Joe' to offer compensatory support and treatment:

"*So, and sometimes it would allow me to anticipate something coming, in terms of either a significant moment in the work or a crisis of some kind, because there will be a deterioration in some, somewhat, in advance of a significant moment in the treatment."* (P15, L9-15).

'Joe' recognises and is explicit about how his embodied intuition with the OM data enabled him to pace the therapy and provide additional support to the client during stressful periods of their ongoing mental health and well-being. 'Joe' could also track the OM data as it revealed and overlaid the clients' responses to areas of stress in their lives:

"But, but, suppose this alerted me to the need to be a little more cautious in advance, yeah, you could more or less map it across to events in their lives." (P15, L16-20).

PET D: 'Joe's' Use of OMs in TA Case Management; *"When you cross reference numerical scores".*

This part of the IPA explores 'Joe's' use of OMs in the TA psychotherapy intake, assessment, diagnosis, contracting, and treatment planning process. At the same time, he considers and makes sense of complex concepts and manages client risk and protection. 'Joe' shares his lived experiences on the challenges of administering OMs and decision-making about the termination of therapy and the client's prognosis.

In subtheme 1, 'Joe' recognises and is explicit about the structure of his initial psychotherapy intake and client assessment process. This task can appear on the surface as an administrative task, but this belies the importance of the psychotherapist's potency and protection of the client (Crossman, 1966) and begins the development of the therapeutic relationship and working alliance (Bordin, 1994; Duncan, Miller, Sparks, Claud, Reynolds, Brown & Johnson, 2003; Bachelor & Horvath, 1999):

"*And during that initial assessment, which is generally about three-quarters of an hour long, I have quite a detailed initial assessment form."* (P28, L2-5).

'Joe', as part of the first intake session, gives the client three OMs to complete and return to him at the next session: CORE-OM (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell & McGrath, 2000), GAD7 (Spitzer, Kroenke, Williams & Lowe, 2006), and PHQ9 (Kroenke, Spitzer & Williams, 1999). These three respectively measure global functioning and levels of distress, anxiety, and depression, which 'Joe' can then make sense of as a first baseline measurement to subsequently track the client's progress, plateauing or deterioration (Lambert and Harmon, 2018):

"*So, umm I would give them the set of three umm, at the initial assessment stage to take away and complete."* (P6, L7-9).

In subtheme 2, 'Joe' makes sense of his initial assessment process to include psychotherapeutic data on the client's own, their family relationships, medical history, and previous experience of counselling or psychotherapy:

"*Some of which refers to families' questions or family structure on some of its around medical issues around medication or prior experience of counselling and therapy."* (P28, L7-11).

In subtheme 3, 'Joe' makes meaning of and takes care in interpreting the OM data at an individualised level with each client to make sense of their experience and to embody empathy (Reiss, 2017): "*Otherwise, it's just an arbitrary number with a scale attached to it, which doesn't really capture an individual's experience at all."* (P32, L1-4).

'Joe' makes sense of his understanding of PHQ9, CORE-OM and GAD7 level of detail in measuring the parameters of the individual clients' signs and symptoms of a mood disorder:

"*In fact, I think PHQ9 does make reference to eating and drinking as well in terms of overeating or undereating. Sleep is referred to in all three of those questionnaires, in one form or another."* (P25, L10-15).

'Joe' recognises and is explicit about how the OM responses that enquire about relationships with others can give an early sign of the client's attachment style (Ainsworth & Bowlby, 1991), script (Berne, 1966) and transferential (Berne, 1968) issues likely to occur in psychotherapy:

"*In terms of their reported behaviours and social settings that might correspond loosely to the history they give me of the attachments within their family of origin."*(P33, L1-5).

In subtheme 4, 'Joe' recognises and is explicit about how his use of OMs is contextualised with other clinical client information (Stewart, Chambless & Baron, 2012), rather than as a stand-alone source of data on which to make clinical case management decisions:

"*So, I don't think it's a quality in and of themselves in the questionnaires. If used like that, I would suggest it probably feels a bit arbitrary, if you try and isolate them from the other data."* (P30, L18-22).

'Joe' expands his thinking further in making sense of the OM data, which supplements and correlates with other sources of client information (Lilienfield & Lynn, 2014; Tarescavage & Ben-Porath, 2017):

"*So, in that way, their responses can umm show sort of a consistent pattern of relating when in conjunction with these other sources of information."* (P33, L7-10).

'Joe' incorporates a third aspect when he contextualises OM data and clinical assessment information in the exploration and discussion with the client, to draw their attention to the trajectory of their current, previous and latest OM scores to share when there has been improvement, plateauing or deterioration in their mental health and well-being (Lambert & Harmon, 2018):

"*And then probably in a subsequent session we might, I might raise what, what was noticeable about either the score, the last set of scores or the trend in the scores and discuss that with the client at that point."* (P40, L5-10).

'Joe' further expounds on this topic (subtheme 6) when he makes meaning of this triumvirate of information, firstly from the client during the therapy session, secondly 'Joe's' in therapy session assessment and earlier TA case management data (TA diagnosis, contract, and treatment plan), and finally the current and previously tracked OM scores:

"*So again, between sort of triangulating between the verbal data, the clients giving you in the session, that numerical of soft data from the questionnaires or around that."* (P25, L15-19).

In subtheme 5, 'Joe' makes meaning from an embodied heuristic of a gut feeling, or hunch, triggered by a pattern of change in OM scores which he can root in the evidence-based practice of measurement-based care (Lilienfield & Lynn, 2014) which would indicate the pattern of change in a temporary decrease in the clients' anxiety and a corresponding temporary increase in their depressive symptoms before they recover from their mood disorder. 'Joe' echoes Widdowson (2015) predictive heuristic and he experiences clients having a sharp upwards increase in deterioration in depressive symptoms whilst their anxiety decreases and then a downwards improvement trajectory in both anxiety and depression:

"*Not, not in a perfect pattern of course, there were spikes in it, but generally that, that initial drop of anxiety, increase in depression than before."* (P17, L17-20).

In subtheme 9, 'Joe's' embodied sense-making of the uncertainty of long-term trauma work and his lived experience of the heuristic where deterioration precedes improvement and recovery from a mood disorder. 'Joe's', *"knowledge-in-practice-in-context"* (Gabbay & LeMay, 2011) develops from his sense of uncertainty:

"That sort of emotional material that's been stirred up, and people can feel worse before they feel better too." (P12, L4-7).

'Joe' recognises and is explicit about how he records and tracks OM data which helps him, in complex long-term client work, to manage his embodied feelings of uncertainty and reassure him of his effectiveness (Murphy, 2012):

"Over the course of work, which tends to be long-term work, we do have an extended run of data coming in." (P7, L7-10).

'Joe' experiences an embodied anticipation as he waits for OM data to track the client's response to psychotherapy (Ionita, Ciquier & Fitzpatrick, 2020; Hatfield & Ogles, 2004):

"... and the data is gathered, and hopefully trends emerge." (P7, L7-8).

His lived and embodied experience of feeling more certain, settles and soothes him as the OM data shows that his client has improved over time, he does not rely on clinical judgement alone, and it is the nomothetic data that gives him feedback on clinical and statistically significant change and improvement in the client's mental health and well-being (Anker, Duncan & Sparks, 2009; Reese, Norsworthy & Rowlands, 2009; Reese, Toland, Slone & Norsworthy, 2010):

"That I could see statistically significant change, as it's called, or clinically significant." (P14, L5-7).

'Joe' makes meaning of the OM data to confirm his clinical effectiveness in providing evidence-based psychotherapy to his clients (Wampold & Imel, 2015):

"For me, of the effectiveness of what I was doing." (P14, L2-3).

Subthemes 10-13 are where 'Joe' makes meaning of his lived experience in using CORE-OM, GAD 7 and PHQ9 to screen and manage the risk of the client's suicide or self-harming (Holloway, 1973; Boyd & Cowles-Boyd, 1980; Evans, Connell, Barkham, Margison, McGrath, Mellor-Clark & Audin, 2002), differentiating between these in defining suicidal ideation when he would implement a safety plan and communicate with the client's primary healthcare providers.

'Joe' makes meaning of how he risks assesses the client from their OM scores:

"*The other, the other context that might be, questionnaires might come up when is, when there was that level of risk present."* (P22, L6-8).

He makes sense of the CORE-OM questions which screen for levels of client risk of self-harm or to others (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell, & McGrath, 2000), over the last week, which are Questions 6, 9, 16, 22, 24 and 34 scored zero (not at all) ranging to four (most or all of the time):

"There are specific questions on the CORE-OM, 34-point scale about suicidal, suicidal ideation, suicidal risk of acting out." (P19, L2-5).

He recognises and is explicit about how he makes sense of the risk to the client based on a high-risk score from CORE-OM, GAD 7 and PHQ 9, as well as from other client information such as past history and how the client presents in the session:

"*Well, it wouldn't be purely from the outcome measures. I suppose it would be very, very high*

scores on all three questionnaires." (P18, L28-34, P19, L1-2).

'Joe's' lived experience of using CORE-OM to assess the client's risk of suicide or self-harm is made in the context of their global assessment of functioning (Chopra, Hanlon, Boland, Harrison, Timpson & Saini, 2022):

"*Yeah, I think that level of detail tends to come from the CORE-OM 34 questionnaire, which, as I've already mentioned has specific questions about suicidal ideation. But it also has questions about the degree of social engagement, personality and relationships and patterns of eating and drinking."* (P25, L3-10).

He embodies a sense of concern as he reflects on his use of OMs along with escape hatch theory (Holloway, 1973; Boyd & Cowles-Boyd, 1980), and as Stewart (2010) puts succinctly, these are suicide, homicide and psychosis if the clients CORE-OM or PHQ 9 scores indicate an emerging risk or if existing risk increases. How he manages this in the moment (van Rijn, 2016):

"And I would find, in retrospect, that, that would sort of influence my thinking about escape hatches, suicide risk. Maybe doing a sort of suicide risk assessment based on the level of scores, or a change in those scores, or deterioration." (P16, L23-29).

'Joe' makes sense of other sources of client data available to him to assess the client's risk of self-harm thoroughly (Chopra et al., 2022):

"So*, really the data from the questionnaires wouldn't be used to assess suicide risk in isolation, it would be just part of the general picture, from various sources as to what was going on to the client at that point."* (P19, L18-23).

'Joe' embodies how he differentiates between the client's passively expressed suicidal ideation, thinking about, or having ideas about suicide (Harmer, Lee, Duong, & Saadabadi, 2023) and active suicidal ideation; he would explore this with the client and further assess the client risk using a technique developed by Drye, Goulding & Goulding (1973) "No matter what happens I will not kill myself, accidentally or on purpose, at any time" (p.128).

'Joe' uses his clinical decision-making skills alongside the OM scores on risk and is explicit about how he uses the technique with the client:

"*If there was a heightened risk of acting out, not, not ideation, so much, people can sometimes overreact to the ideation side of it. But if there was a distinct chance of acting out, then I would then implement a number of different little tools I have for assessing suicide risk, one of them by a man called Bob Drye, which is basically to repeat certain statements and get the client to kind of report what their internal experiences, while they're making those statements."* (P20, L4-15).

'Joe' reflects on the point that he would escalate his concerns about a client's risk to themselves, others, or suspect psychosis in formulating a safety plan and sharing this with other professionals involved in the client's mental health care where OMs are a shared and common language in multidisciplinary communications:

"To speak to their GP, or their consultant psychiatrist, and so that the questionnaire scores, or indeed, scores that they'd collected in their work might be discussed at that point." (P22-23, L12-14 and 1-2).

In subthemes 14 and 15, 'Joe' reflects on how he manages the challenges and practicalities of clients completing and returning the OMs; he makes meaning of his focus on the therapy session that clients complete them before the session:

"*I don't get them to complete it in the session."* (P6, L9-10).

'Joe' makes meaning of his embodied empathy, noticing his client's discomfort when they complete the OMs whilst 'Joe' waits until they have finished:

"*I think, I think would struggle with just sitting and filling in a form in my presence."* (P8, L15-17).

In subthemes 17-20, 'Joe' explores the TA contracting process, initially the contract is on how he makes sense of the timescales involved in the use of OMs:

"*Umm completed between the session and then they bring it back next time, and then if they're, umm, obviously, if they consented to do this, then they'll complete a set every four weeks."* (P7, L5).

'Joe' makes meaning of which OMs he uses, how he assesses which clients to use OM and how often he makes a TA contract with individual clients:

"So, the three measures I have used or continue to use and not continuously with all clients, but with some clients are, umm, the CORE-OM 34-point questionnaire, the GAD7 questionnaire and the PHQ 9, depression scale questionnaire." (P5, L12-15 and P6, L1-3).

He makes meaning of how OM scores can enlighten and individualise a sessional TA contract with the client for that therapy session, momentarily, or completely change the focus of the therapeutic work: *"And it may inform what we do in that session, or a change of tack, perhaps a spell in the work."* (P40, L10-13).

‘Joe’ makes sense of how he conceptualises the use of OMs as a part of the formulation of the TA Treatment Triangle (Guichard, 1987; Stewart, 1996):

“And, that you know, interventions for them to have that sort of Treatment Triangle Model.” (P26, L1-3).

In subtheme 20, ‘Joe’ makes meaning of how he makes a TA contract (Sills, 2006) with the client to plan the termination of therapy as he tracks their OM scores over several sessions to gauge the client's response to a gradual reduction in sessions and his embodied decision making:

“*So, we might, for example, be looking for consistently subclinical scores, over a number of sessions to inform when we either reduce frequency or stop the second sessions altogether. Sometimes when I reduce the frequency, and then keep an eye on those scores, to see what impact that reduced therapeutic input has. Are the positive changes stable without additional support?”* (P38, L5-13).

In subtheme 21, ‘Joe’ makes sense of how he uses OMs in the TA diagnostic process to explore and identify the client’s presenting issue or how they experience a problem, which helps ‘Joe’ begin to shape both the TA diagnosis and treatment plan:

“*Perhaps exploring some of their scores with the client, you tend to get a picture of what the key presenting issue or the, the most problematic issues are. And that will tend to shape first of all diagnosis, but also treatment planning.”* (P25, L19-25).

‘Joe’ makes meaning from the CORE-OM responses to inform his TA diagnosis of life positions (Berne, 1962), script (Berne, 1961, 1975; O’Reilly-Knapp & Erskine, 2010), injunctions (Goulding & Goulding, 1976), and drivers (Kahler & Capers, 1974):

“*Yes, in terms of, if we stick with the questions on the CORE-OM about relationship patterns, it might allow me to make some initial judgement of their life positions, of their relational script, certain injunctions, driver behaviours, in terms of Pleasing People, for example.”* (P34, L6-12).

‘Joe’ shares his lived experience of how OMs and TA diagnosis connect in his psychotherapy work:

“The *TA, I mean, you could probably use any particular TA models.”* (P34, L12-15).

He recognises and is explicit about how OMs and TA diagnosis are cross-referenced with his clinical assessment and in-session information to be meaningful:

“*Yes, it only becomes meaningful, in diagnostic terms, when, when cross-referenced.”* (P31, L10-12).

He makes deeper meaning from the CORE-OM responses, which relate to interpersonal relationships which could indicate the client’s attachment style and personality adaptations (Berne, 1963; Masterson, 2004):

“*I suppose so, an example would be the questions around patterns of relating or style of relating to others in the CORE-OM questionnaire. That might parallel in some ways, some issues they’re talking about in terms of abandonment or avoidance.”* (P32, L13-20).

In subthemes 22-27, ‘Joe’ explores how he begins the TA Treatment Planning (Minikin, 2008) process at the first intake session:

“*And then at that point I might be starting to think of treatment planning in a more formal way, about what, what, what approach seems most useful based on what this client said, and what their past experience of treatment has been.”* (P29, L6-12).

‘Joe’ makes sense of how OMs help him to track and establish where he and the client are in the treatment planning process (Berne, 1975; Widdowson, 2010):

“*Also, umm giving in sometimes, give an indication of what stage we’re at in the treatment plan.”* (P17, L5-7).

He embodies his treatment plan heuristic in the decontamination of the Adult ego state (Berne, 1961, 1966) using OMs (GAD 7 and PHQ 9) to monitor the client's levels of anxiety and depression:

“*And you could see that in the, more generally happened would be the, there’s be an initial fall in the anxiety levels. And the depression scale would increase as they were dealing with the underlying emotional material, and then both of them would tend to fall.”* (P17, L9-15).

‘Joe’ makes meaning of the treatment plan heuristic and expects an increase in the client's depression (PHQ 9) as their anxiety (GAD7) decreases:

“*So, that’s also, as I say, on the depression scale, sometimes there’s a deterioration.”* (P16, L21-23).

‘Joe’ experiences a somatic sense of relief and reassurance as the client responds to the treatment plan as he tracks the progress:

“I could track people’s progress.” (P15, L1).

He makes sense of using the OM graph to track both the client's response to the treatment plan and to establish the stage of the treatment plan:

“So, you can get sort of, get a sense when you were on the curves, the data was, or what stage you were in, in the treatment.” (P18, L4-6).

'Joe' makes meaning from how the client reads through and completes the OM as being a neurological technique to process their trauma by engaging the Adult ego state, improving their self-awareness and ability to reflect on the responses to the OM questions and rating their experiences, which supports the decontamination process (Berne, 1961, 1966) and improves their ability to self-regulate:

"*Sometimes, it was quite good to pause and engage the part of the brain responsible for writing, and which is involved with managing trauma, and be able to onto paper was quite a grounding experience for them."* (P12, L16-21).

'Joe' recognises and is explicit about how the contamination of the Adult by the Parent and Child ego states and the subsequent critical (by Parent) intrapsychic dialogue (to the Child) generates anxiety in the client, addressed through sharing this process in the psychoeducation of the client. This decontamination of the Adult (Berne, 1961, 1966) enables the client to exert social control over damaging behaviour (Stewart, 1996) and subsequent symptomatic relief from the pain of anxiety and/or depression (Stewart, 1996; Berne, 1975) allows the client to experience a reduction in the level of anxiety:

"*Or, psychoeducation, on the internal mechanisms of anxiety, umm, to bring that level of anxiety down a few notches, and so the subsequent work could happen."* (P16, L13-14).

'Joe' embodies the decontamination (Berne, 1961, 1966) of the Adult ego state stage of the treatment planning process, with a client who has a high GAD7 score, by being explicit in the psychoeducative process by teaching the client practical techniques to support their self-regulation. Psychoeducation strengthens the Adult ego state by firming up boundaries between all the ego states, grounding the client in reality and their experience of social control and symptomatic relief (Berne, 1975):

"*Well, for example, with the umm, GAD 7 anxiety score, umm, someone presenting with a very high level of anxiety on the scale. To some extent, now, I'd always do this anyway, but it would become a priority to teach some anxiety management techniques."* (P16, L4-10).

'Joe' makes sense of the client's improvement in their GAD 7 scores in response to psychoeducational interventions to decontaminate (Berne, 1961, 1966) the Adult ego state and the client's sustained ability to self-regulate with evidence of social control and symptomatic relief (Berne, 1975):

"*You're certainly looking for a drop in the GAD7 scores, consistently, having implemented things like breathing exercises and mindfulness exercises."* (P45, L12-16).

'Joe' recognises and is explicit about how he makes meaning of the improvement in OM scores to be maintained over time and under stressful circumstances and the client's continued resilience and ability to cope under pressure:

"So, that, that would be a way that I'd be looking for those to be, remain low, even when certain potentially distressing life events are going on." (P43, L16-19).

'Joe' reflects on his lived experience of how he uses OMs to gauge the client's readiness for a psychotherapeutic ending of treatment when social control, symptomatic relief, and transference cure, where the client substitutes the therapist for their original parent is established (Stewart, 1996; Berne, 1975):

"Sometimes when I reduce the frequency and then keep an eye on those scores to see what impact that reduced therapeutic input has." (P38, L9-12).

'Joe' makes meaning from OM data (CORE-OM, GAD7 and PHQ9) to establish the client's readiness to bring psychotherapy to a close when their scores are in the healthy, non-clinical cut-off range and in TA terms he envisages this as the final stage of script cure as the clients Adult, rather than their Parent or Child ego state, takes over control of the personality (Stewart, 1996; Berne, 1975):

"In terms of cure, in terms of outcome measures I guess I've already mentioned that you're looking for a consistent pattern of lower than clinically significant scores across the measures." (P43, L6-11).

Summary of Key Findings and Interpretations

Professional Identity: "String to the bow."

'Joe's' professional lifeworld is reflected in the *'strings to his bow'* of his private practice, third sector and his role as a clinical supervisor (Eatough & Shaw, 2019; Smith, Flowers & Larkin, 2022). The double hermeneutic of interpretation, where the researcher makes sense of 'Joe', makes sense of his lived experience and how his use of OMs is not mainstream in the TA community (Smith, Larkin & Flowers, 2009). He expresses his felt sense and need to belong and share connections with other professionals (Allen et al., 2021). Although he sees himself integrating his private practice and third-sector psychotherapy work, it seems OMs delineate between these aspects of his practice. Using the nomenclature of 'outsider' and 'insider,' in using OMs to mark the importance of 'Joe's' professional lived experience and the dichotomy of being an 'outsider'

in the TA community and an 'insider' with colleagues in the NHS, for example.

'Joe' seems to demarcate these two professional worlds by using OMs in his charity realm and shared experience with NHS staff, and his TA professional world by not sharing his experience of using OMs with TA colleagues. Social psychologists call this the Subjective Group Dynamics (SGD) model (Abrams, De Moura, Hutchison & Viki, 2005) and use the terms 'ingroup' and 'outgroup' to denote tolerated, included, and rejected actions or perspectives to the group's norms (Abrams et al, 2005). 'Joe's' lived experience (PET A: subtheme 9) is to subscribe to an ingroup that uses OMs and simultaneously an outgroup that does not (PET A: subtheme 8). He navigates this SGD to be included by both groups and avoid rejection by either group norms (Abrams et al, 2005). Psychotherapists who do use OMs on the UKCP register of Humanistic and Integrative Psychotherapists (E. Dunn, personal communication, February 25, 2021) and UKATA (A. Davey, personal communication, February 2nd, 2021) range from 7% to 36%. This means 64% to 93% of TA (UKATA members) and Humanistic and Integrative Psychotherapists (UKCP members) do not use OMs. This then begs the question of which is the outgroup and which is the ingroup; therefore, 'Joe's' dilemma becomes clearer.

The UKCP and UKATA data aligns with other countries' experiences of OM uptake. The USA is between 13.9% to 37% (Hatfield & Ogles, 2004; Phelps, Eisman & Kohout, 1998; Bickman, Rosof-Williams, Salzer, Summerfelt, Noser, Wilson & Karver, 2000; Lewis et al. 2019; Jensen-Doss, Hsaimes, Smith, Lyon, Lewis, Stanick & Hawley, 2018). Only 12% of psychotherapists in Canada use OMs (Ionita et al., 2020). In contrast, all NHS therapists in the UK working in the IAPT service must submit OM data monthly (NHS Digital, 2023); this contrasts with a lower uptake rate among private practitioners (Stringer, 2023).

Supporting applications for funding: "Cementing in place."

Psychotherapists in the third sector may be asked to contribute data from their work with service users to their bids for funding from statutory organisations such as local authorities or the NHS (Wolpert et al., 2014). 'Joe's' lived experience of working in both private practice and the third sector brings into focus the impact of health economics and the cost-effectiveness of psychotherapy for his private clients and work with veterans. Commissioners of services and private clients seek the most return with their available resources (Evans & Carlyle, 2021). 'Joe' makes sense of the economic imperatives in using OMs that are free to access and are completed by his clients (Evans & Carlyle, 2021). 'Joe' makes meaning of how he uses OM data to measure the client response and improvement to effective treatment, rather than just offering TA treatment alone (Lambert, 2010).This effectiveness in psychotherapy has been seen in many research studies that indicate that psychotherapy moderates the risk of self-harm and admission to secondary care (Gabbard, Lazar, Hornberger & Spiegel, 1997; Boswell, Kraus, Constantino, Bugatti & Castonguay, 2017), and 90% of studies showed economic savings of £5,000 per client, per year compared to a control group of clients not receiving therapy (Gabbard et al., 1997; Cooper 2012).

The economic impact of clients in private practice may be less clear as data is not readily available; however, improving clients' mental health is likely to impact other parts of the health systems, such as GP consultations and treatment and referral to secondary care providers. 'Joe' embodies his use of OMs in providing evidence-based practice to his clients, paying close attention to their improvement, plateauing or deterioration and responding to these through individualised changes of their TA diagnosis, contract and, or treatment planning.

Thinking Fast and Slow (System 1 and System 2 decision making): "Allow things to come to the surface."

'Joe' recognises and is explicit about how OMs support his clinical decision-making both at a System 1, which is fast, intuitive, pattern recognising and heuristic, and System 2 level, which is cautious, logical, reasoning and analytical, and how he connects and integrates both systems (Bate et al., 2012; Beresford & Sloper, 2008; Kahneman, 2012). In System 1 clinical thinking, 'Joe' *"sketches"* out in pencil, on paper, his initial thoughts, impressions and assessment of the client as they emerge *"... to allow things to come to the surface."* He has an embodied and intuitive awareness of his decision-making process. Cozolino (2020) explains "… we evolved to use information from our bodies, such as muscle tone, heart rate, endocrine activity... to make rapid decisions... " (p.51).

'Joe's' intuitive process enables him to look ahead and be anticipatory in advance of stressors likely to precipitate a deterioration in the client's OM data. 'Joe' then consolidates his reflective System 2 thinking (Julmi, 2019) by using ink, rearranging data on the paper, allowing himself to become fully aware, consciously organising his thinking, reflecting on the data during and between sessions and in supervision (Schön, 1983; Gergen, 1973).

The Psychotherapist's use of OMs in TA Case Management: "When you cross-reference the numerical scores."

'Joe' shares his lived experience of how he uses OMs, such as the CORE-OM, GAD7 and PHQ9 in his TA diagnosis, contracting and treatment planning or case management process. 'Joe' contracts with the client to complete the OMs at the first therapy session and then every four weeks to track their response, check for improvement, and intervene if the client shows signs of plateauing or deterioration (Lambert & Harmon, 2018). OMs are individualised to the client *"otherwise, it's just an arbitrary number with a scale attached to it, which doesn't capture an individual's experience at all"* (P32, L1-4). His approach supports the establishment of the working alliance and therapeutic relationship (Bordin, 1994; Bachelor & Horvath, 1999; Horvath, 2018), which are essential prerequisites in treatment planning for a successful outcome in therapy. Indeed, clients who complete an OM in therapy are known to have a more positive outcome (van Rijn, Wild & Moran, 2011).

'Joe' embodies the triangulation of TA diagnosis, contract and treatment planning with the client's verbal in-session account and OM data, and changes to any of the three parts impact how he updates elements of the TA diagnosis, contract or treatment plan *"... it only becomes meaningful, in diagnostic terms, when, when cross-referenced"* (P 31, L12-15). He illustrates this triangulation process as his lived experience of using OMs *"... may inform what we do in the session, or a change of tack, perhaps a spell in the work"* (P40, L10-13). He uses a sailing metaphor to show his ability to change direction in response to what the client is expressing by contracting for time to focus on a specific piece of therapeutic work and making a contract with the client as they review together the trajectory of their OMs. This approach enables 'Joe' to share with the client any improvement, plateauing or deterioration in their mental health and well-being (Lambert & Harmon, 2018): *"... what was noticeable about either the score, the last set of scores, or the trend in the scores and discuss that with the client at that point."* (P40, L5-10).

'Joe' makes sense from the client OM data in the TA diagnostic process to *"... get a picture of what the key presenting issue or the, the most problematic issues are ... that will tend to shape first of all diagnosis, but also treatment planning"* (P25, L19-25). He refers to CORE-OM data to help him shape TA diagnosis concepts (P34, L6-12) such as life positions, script, injunctions and drivers: *" I mean you could probably use any particular TA models"* (P34, L12-15). 'Joe' deepens his sense of using CORE-OM to understand the client's interpersonal relationships, attachment style and personality adaptations "... *around patterns of relating or style of relating to others ... in terms of abandonment or avoidance*." (P32, L13-20).

As part of the TA diagnostic process, 'Joe' embodies the heuristic pattern he looks out for in the OM scores which show a decrease in the client's anxiety levels with an associated increase in their depressive symptoms as a precursor to recovery from their mood disorder *"not, not in a perfect pattern of course, there were spikes in it, but generally, that., that initial drop in anxiety, increase in depression... "* (P17, L17-20) *"... as they were dealing with the underlying emotional material, and then both of them would tend to fall*" (P17, L9-15). This heuristic pattern in the PHQ9 scores for depression and GAD7 for anxiety is a marker in the treatment plan *"I could track people's progress"* (P15, L1).

'Joe' makes sense of OM data to tell him where he and the client are in the treatment planning (Widdowson, 2010) *"... give an indication of what stage we're at in the treatment plan*" (P17, L5-7). 'Joe' tracked the OM data to show how the client was responding to the treatment plan and to guide him where he was in the process *" so, you can get sort of, get a sense when you were on the curves, the data was, or what stage you were in, in the treatment*." (P18, L4-6).

'Joe' recognises and is explicit about the strategies he employs in the treatment planning process, first to support the decontamination of the Adult ego state (Berne, 1961, 1966) in the client's completion of the OM in engaging their sense of self-awareness, self-reflection and self-regulation: *" sometimes, it was quite good to pause and engage the part of the brain responsible for writing, and which is involved with managing trauma, and be able to onto paper was quite a grounding experience for them"* (P12, L 16-21). 'Joe' makes meaning of TA psychoeducation with his clients, with high GAD 7 scores, to teach them: *"... on the internal mechanisms of anxiety, umm, to bring that level of anxiety down a few notches, and so the subsequent work could happen*" (P16, L13-14) *"... would become a priority to teach some anxiety management techniques*" (P16, L4-10). 'Joe' watches for improvement in the clients GAD7 scores *"... having implemented things like breathing exercises and mindfulness exercises."* (P45, L12-16) and would check the scores for the clients coping and resilience under stress *"... I'd be looking for those to be, remain low, even when certain potentially distressing life events are going on."* (P43, L16-19).

'Joe' reflects on his lived experience of how he uses OMs to inform his decision to work towards ending psychotherapy based on the clients' levels of social control, symptomatic relief and transference cure (Stewart, 1996; Berne, 1975): *"... I reduce the frequency and then keep an eye on those scores to see what impact that reduced therapeutic input has."*

(P38, L9-12) *"In terms of Cure, in terms of outcome measures, I guess I've already mentioned that you're looking for a consistent pattern of lower than clinically significant scores across the measures.*" (P43, L6-11).

Finally, 'Joe' recognises and is explicit about how he uses CORE-OM, PHQ9 to screen and make sense of the client's risk of self-harm and suicide *"there are specific questions on the CORE-OM, 34-point scale about suicidal, suicidal ideation, suicidal risk of acting out."* (P19, L2-5). 'Joe' makes sense of other sources of client information such as their history and how they present in the session *"... it wouldn't purely from the outcome measures*... " (P18, L28-34 and P19, L1-2) *"... maybe doing a sort of suicide risk assessment based on the level of scores, or a change in those scores, or deterioration."* (P16, L23-29). As well as protective factors in the clients *"... the degree or social engagement, personality and relationships and patterns of eating and drinking*" (P25, L3-10) and *"... the data from questionnaires wouldn't be used to assess suicide risk in isolation, it would be just part of the general picture, from various sources as to what was going on with the client at that point*" (P19, L18-23), 'Joe' recognises and is explicit about how he safeguards the client, sharing his concerns if he assesses the client at risk with other professionals involved in the clients care *" To speak to their GP, or their consultant psychiatrist, and so the questionnaire scores, or indeed, scores that they'd collected in their work might be discussed at that point.*" (P22, L12-14 and P23, L1-2).

The Final Analysis of 'Joe'

The initial analysis was revisited after the rest of the participants' interviews had been analysed. Presenting 'Joe' as a single case study was a powerful and compelling way to demonstrate the idiographic experiences of one individual and his responses to a semi-structured in-depth interview about how he thinks, feels and uses OMs in his clinical practice (Smith et al, 2009). 'Joe' was chosen for this single case study because he was the first participant whose data had been worked through by the researcher over the first six steps of IPA. This strategy enabled the distance between the first round of analysis and the final twelfth participant. The researcher then cast fresh eyes on the data analysis process with which to revisit 'Joe's' PETs. The final seventh stage of the IPA remains as the cross-case analysis across and between all 12 participants, which is ongoing.

The single case study approach demonstrated a developmental working through including all the stages of analysis, supporting and integrating the learning, and the intricacies of IPA (Smith & Nizza, 2022). 'Joe's' lived experience of the phenomena of his data thus far shows a rich depth of focus and idiographic detail and insight into his life world (Smith & Nizza, 2022; Smith, Flowers & Larkin, 2022). At this stage, the PETs saw the clustering, collapsing, and merging of the experiential statements and quotes, where there is repetition, and presented the more idiographic additional quotes from 'Joe' to illustrate depth within the subthemes (Smith & Nizza, 2022). The initial single case study was presented to the University examiners, and what follows below is the results of a second analysis of 'Joe's' data as it will be included in the final data analysis process. Some duplication will occur with the initial analysis – this is retained so that each analysis is complete in itself. All 12 participants' PETs are completed, Step Seven of the IPA is in progress, and all 12 participants' data is involved in a cross-case analysis as the Group Experiential Themes (GETs).

Editor's Note

A reminder that we are repeating the two stages so that they can be seen as they were done. The only editing in the following has been to shorten references to include 'et al' when they have already appeared.

The Experiential Themes from 'Joe's' data were grouped into the following four Personal Experiential Themes:

PET A: How 'Joe' makes sense of his professional identity; *"String to the bow."* (P5, L8-11).

PET B: The use of OMs in funding applications; *"Cementing in place."* (P54, L8-11).

PET C: 'Joe's' thinking fast and slow; "*Allow things to come to the surface."* (P29, L14-19).

PET D: 'Joe's' use of OMs in TA case formulation (TA diagnosis, contracting and treatment planning); "*When you cross reference numerical scores."* (P31, L 2-4).

The title of each PET (e.g. PET A: 'Joe's' sense of professional identity) brings together the convergence of the experiential statements clustered under a subtheme (e.g. Theme 1: He makes sense of his diverse roles as a psychotherapist) with the page and line number, and underneath 'Joe's' quotes from the transcript (Smith & Nizza, 2022). Including the page and line number(s) with each of 'Joe's' verbatim quote enables the location of the

original source of the data within the transcript. "This is part of the documenting the evidence trail- showing you where you obtained the statement and reminding you what the participant said that prompted it." (Smith & Nizza, 2022, p. 46).

'Joe's' PET A: How 'Joe' makes sense of his professional identity; *"String to the bow."* (P5, L8-11).

The first PET (A) in the interpretative analysis of 'Joe's' single case study provides a rich first-hand account of his professional identity and experience as a TA psychotherapist who has four diverse yet interconnected roles working with clients who experienced trauma, a self-employed sole trading practitioner, clinical supervisor, and researcher. His combined clinical caseload has clients with severe Post Traumatic Stress Disorder and mild to moderate anxiety and depression. His experience contrasts two diverse professional worlds where he has a shared sense of identity with NHS staff familiar with OMs and with whom he works closely, distinct from his TA community, where OMs are not a common language:

"And, so I kind of understood them that, what they were talking about, knew something about how they were used." (P47, L5-7).

'Joe' experiences an embodied understanding of being both an insider with NHS colleagues and an outsider regarding OM use in his TA private practice and as a supervisor and supervisee:

" ... or in terms of the TA community, I don't think we know about. I suspect that, like any other modality, there's probably a broad range of opinions, and some people would view them as important, even necessary." (P51, L2-7).

He makes sense of this and suggests how OM use in TA supervision might offer data for the first intake assessment, help identify supervision issues, and manage client risk by safeguarding and communicating with other mental health practitioners:

"*Umm, I guess the point where I would most naturally come up is when you're presenting a new client, as part of the relaying the relevant information from the initial assessment, relevant to whatever the supervision issue is, perhaps around protection issues, perhaps around risk, perhaps around the need to involve other professionals."* (Joe, P53, L6-15).

'Joe's' professional lifeworld is encountered in the *'strings to his bow'* of his private practice, third sector and his role as a clinical supervisor (Eatough & Shaw, 2019; Smith et al., 2022). The double hermeneutic, making sense of 'Joe', makes sense of his lived experience and how his use of OMs is not mainstream in the TA community (Smith et al, 2009). He expresses his felt sense and need to belong and share connections with other professionals (Allen et al., 2021) and how his choice to use OMs aligns with:

" ... anybody who's worked in NHS settings ... will probably be more familiar and comfortable with them." (P51, L15-18).

The double hermeneutic (Smith et al, 2009), making sense of 'Joe', makes sense of his lived experience and how his use of OMs is not mainstream in the TA community:

" ... be quite reluctant ... quite averse or just not terribly interested in that way of working" (P51, L10-15).

Although he sees himself integrating his private practice and third-sector psychotherapy work, it seems OMs delineate between these aspects of his practice. Using the nomenclature 'outsider' and 'insider' in using OMs to mark the importance of 'Joe's' professional lived experience and the dichotomy of being an 'outsider' in the TA community and an 'insider' with colleagues in the NHS, for example, 'Joe' seems able to demarcate these two professional worlds by using OMs in his charity realm, sharing experiences with NHS staff and his TA professional world, and not sharing his expertise in using OMs with TA colleagues:

" I don't think the other participants used outcome measures …" (P50, L10-14).

Social psychologists call this the Subjective Group Dynamics (SGD) model (Abrams et al, 2005) and use the terms 'ingroup' and 'outgroup' to denote tolerated, included, and rejected actions or perspectives to the group's norms (Abrams et al., 2005). 'Joe's' lived experience (PET A: subtheme 9) is to subscribe to an ingroup that uses OMs and simultaneously an outgroup who do not (PET A: subtheme 8). He navigates this SGD to be included by both groups and avoid rejection by either group norms (Abrams et al., 2005). 'Joe's' creative response to this dilemma may be explained in part by psychotherapists who do use OMs on the UKCP Register of Humanistic and Integrative Psychotherapists (E. Dunn, personal communication, February 25, 2021) and UKATA (A. Davey, personal communication, February 2nd, 2021), of between 7% to 36%. So, approximately 64% to 93% of TA (UKATA members) and Humanistic and Integrative Psychotherapists (UKCP members) do not use OMs. These approximate figures then beg the question of which is the outgroup and which is the ingroup; therefore, 'Joe's' dilemma becomes clearer.

The UKCP and UKATA data aligns with other countries' experiences of OM uptake. In the USA it is between 13.9% to 37% (Hatfield & Ogles, 2004; Phelps et al, 1998; Bickman et al., 2000; Lewis, Boyd, Puspitasari, Navarro, Howard, Kassab & Kroenke, 2019; Jensen-Doss et al., 2018). Only 12% of counsellors and psychotherapists in Canada use OMs (Canadian Psychological Association, 2019). In contrast, all NHS therapists in the UK working in the IAPT service must submit OM data monthly (NHS Digital, 2023); this contrasts with a lower uptake rate among private practitioners (Stringer, 2023).

'Joe's' PET B: Supporting funding applications: "Cementing in place." (P54, L8-11)

The second PET (B) explores 'Joe's' experience providing OM data to support third-sector applications for initial, ongoing, and permanent funding:

" *... a use of the measures was that I prepared a brief report for the charity that I work in, and they use some of the data as part of a funding application."* (P54, L8).

He distinguishes the data he gives as being both quantitative OM information and the number of sessions offered, as well as qualitative information on clients' improvement and positive changes in their mental health and well-being and, therefore, his effectiveness in the service he provides to his clients:

"*Not just being able to say, so many veterans have been seen, or I've had so many sessions in this period. But actually, been able to show the change, that taken some elements of the change that has happened as a result of that funding provision."* (P56, L10-15 and P57, L1).

Counsellors and psychotherapists in the third sector may be asked to contribute data from their work with service users to their bids for funding from statutory organisations such as local authorities or the NHS (Wolpert et al., 2014). 'Joe's' lived experience of working in both private practice and the third sector highlights the impact of health economics and the cost-effectiveness of psychotherapy for his private clients and work with veterans. Commissioners of services and private clients, for that matter, are looking to get the most return within their available resources (Evans & Carlyle, 2021). 'Joe' makes sense of the economic imperatives in using OMs that are free to access and are completed by his clients (Evans & Carlyle, 2021). 'Joe' makes sense in using OM data to measure the client's response and improvement to effective treatment rather than just offering TA treatment alone (Lambert, 2010). This effectiveness in psychotherapy in several research studies indicates that psychotherapy moderates the risk of self-harm and admission to secondary care (Gabbard et al., 1997; Boswell et al., 2017), and 90% of studies showed economic savings of £5,000 per client, per year compared to a control group of clients not receiving therapy (Gabbard et al., 1997; Cooper 2012).

The economic impact on clients in private practice is not readily available. However, improvement in the client's mental health is likely to have an impact on other parts of the health systems, such as GP consultations and treatment and referral to secondary care providers. 'Joe' embodies his use of OMs in providing evidence-based practice to his clients, paying close attention to their improvement, plateauing or deterioration and responding to these through individualised changes in their TA diagnosis and treatment planning.

'Joe's' PET C: Thinking Fast and Slow (System 1 and System 2 decision making): "Allow things to come to the surface." (P29, L14-19)

In the third PET (C), 'Joe' explores and communicates his meaning in System 1 and System 2 thinking and how OMs support the synergy between these two distinct systems of clinical thinking and decision-making. 'Joe' embodies his initial impression in the intake session when he is in System 1 thinking (fast, intuitive, pattern recognising, heuristic). Completing his first intuitive assessment of the client in pencil, he begins to become aware:

"... when I rearrange the data on the page... it seems to trigger certain awareness or certain connections and starts to inform my treatment planning." (P29, L18-20).

He recognises a familiar pattern and heightened awareness, which presents as gut feelings or hunches about the client's issues. 'Joe' allows himself time for the initial assessment information to evolve into System 2 thinking, where his clinical decision-making is more cautious, logical, reasoning, and analytical where he uses language such as:

"... move the information around later on.. tidy it up in terms of my thinking…," (P28, L22-27) *"… go back over it,"* (P28, L27 and P29, L1-2) *"... allow things to come to the surface that I maybe wasn't completely aware of during the initial assessment ... " "... it helps me start to formulate my thinking a bit more of an orderly fashion."* (P29, L4-6).

'Joe' includes the clients' OM scores in his System 2 thinking and decision-making, taking time to process the OM data fully between sessions and in his clinical supervision. 'Joe' applies an intuitive heuristic based on the OMs to anticipate a stressful event or positive or negative change in the work or the client's circumstances, which could be tracked and charted.

'Joe' recognises and is explicit about how OMs support his clinical decision-making both at a System 1, which is fast, intuitive, pattern identifying and heuristic, and System 2 level, which is cautious, logical, reasoning and analytical and how he connects and integrates both systems (Bate et al., 2012; Beresford & Sloper, 2008; Kahneman, 2012). In System 1 clinical thinking, 'Joe' *"sketches"* out in pencil, on paper, his initial thoughts, impressions and assessment of the client as they emerge; he has an embodied and intuitive awareness of his decision-making process:

"... to allow things to come to the surface" (P29, L14-19)

As Cozolino (2020) explains "… we evolved to use information from our bodies, such as muscle tone, heart rate, endocrine activity ... to make rapid decisions ... " (p.51). 'Joe's' intuitive process enables him to look ahead and be anticipatory in advance of stressors likely to precipitate a deterioration in the client's OM data:

"... sometimes it would allow me to anticipate something coming, in terms of either a significant moment in the work or a crisis ... because there will be a deterioration … in advance of a significant moment in the treatment." (P15, L9-15).

'Joe' then consolidates his reflective System 2 thinking (Julmi, 2019) by using ink, rearranging data on the paper, allowing himself to become fully aware, consciously organising his thinking, reflecting on the data during and between sessions and in supervision (Schön, 1983; Gergen, 1973):

"... I go back ... once the clients left at some point between then and the first session, and ink in the assessment with a pen." (P28, L27 and P29, L1-2).

'Joe's' PET D: The Counsellor and Psychotherapist's Use of OMs in TA Case Formulation (TA Diagnosis, Contracting and Treatment Planning): "When you cross-reference the numerical scores."

In the fourth PET(D), 'Joe' shares his lived experience of how he uses OMs in TA diagnosis, contracting and treatment planning and uses the CORE-OM (Evans et al, 2000), GAD-7 (Spitzer et al., 2006) and PHQ-9 (Kroenke et al, 1999) as a baseline, initial measurement of global functioning, distress and levels of anxiety, depression and risk of self-harm.

TA Diagnosis

'Joe' makes sense from the client OM data in the TA diagnostic process to:

"*... get a picture of what the key presenting issue or the, the most problematic issues are ... that will tend to shape first of all diagnosis, but also treatment planning"* (P25, L19-25).

He refers to his synthesis of CORE-OM (Evans et al., 2000) data to help him shape TA diagnosis concepts (P34, L6-12) such as life positions (Berne, 1962), script (Berne, 1961, 1975; O'Reilly-Knapp & Erskine, 2010), injunctions (Goulding & Goulding, 1976), and drivers (Kahler & Capers, 1974) and reflects as he speaks about how CORE-OM responses synergise with TA diagnostic concepts in general:

"... if we stick with the questions on the CORE-OM about relationship patterns, it might allow me to make some initial judgment of their life positions ... relational script ... injunctions, driver behaviours, in terms of Pleasing People I mean you could probably use any particular TA models …" (P34, L6-12).

'Joe' deepens his sense of using CORE-OM (Evans et al, 2000) to understand the client's interpersonal transactions and relationships, attachment style and personality adaptations (Berne, 1963; Ainsworth & Bowlby, 1991; Masterson, 2004):

"*... an example would be the questions around patterns of relating or style of relating to others in the CORE-OM questionnaire. That might parallel ... some issues they're talking about in terms of abandonment or avoidance."* (P32, L13-20).

'Joe' makes sense of the client's transference and his embodied countertransference in the TA diagnostic process which gives him insight into their intrapsychic and interpersonal relational processes:

'*I might also make some comments around transference, countertransference, initial impress-ions of that.'* (P28, L19-22).

As part of the TA diagnostic process, 'Joe' embodies the heuristic pattern he looks out for in the OM scores which show a decrease in the client's anxiety levels with an associated increase in their depressive symptoms as a precursor to recovery from their mood disorder:

"*... not in a perfect pattern of course, there were spikes in it, but generally, that., that initial drop in anxiety, increase in depression ... " (*P17, L17-20) *" ... as they were dealing with the underlying emotional material, and then both of them would tend to fall"* (P17, L9-15).

This heuristic pattern is reflected in the PHQ-9 scores, which measure depression and GAD-7 scores for anxiety as a marker in the treatment plan:

*"I could track people's progress." (*P15, L1).

Importantly 'Joe' recognises and is explicit about how OMs can support TA diagnosis in the context of

his global clinical assessment and the client to therapist in-session narrative:

"... it only become meaningful, in diagnostic terms ... when cross-referenced." (P31, L10-12).

TA Contracting

Berne (1966) defines a contract in TA therapy as "... an explicit bilateral commitment to a well-defined course of action' (p. 362). According to Berne the interpersonal contract between client and therapist has three components: administrative, professional and psychological. This section explores how 'Joe' uses OMs in all three aspects of the contract between himself and the client. Bilateral agreement on a contract with a client is a crucial tenet of TA theory and clinical practice.

The *administrative contract* includes practicalities for private practice, such as appointment times, the place where the client comes for therapy or online, how long the therapy session is (such as 45, 50, or 60 minutes), information sharing (GDPR), confidentiality, the therapist's fees (paid by the client or a third person) and their cancellation policy (Berne, 1966; Sills, 2006). This would also include how they use OMs with their client in clinical practice, e.g. rationale for use, type of OM, frequency (such as weekly or monthly), sharing OM data and tracking.

'Joe' contracts with the client to complete the OMs:

'*... completed between the session and then they bring it back next time, and then if they're, umm, obviously, if they consented to do this, then they'll complete a set every four weeks'.* (P7, L-5).

It makes sense to 'Joe' to send the OMs out to the client to complete via email before the therapy session, giving the client privacy and time to fill in the OM, and he then can review the OM score at the start of the session without using the time within the session for the client to fill in the form while he waits. He responds with empathy to his client's discomfort when completing the OMs:

'*... I think would struggle with just sitting and filling in a form in my presence.'* (P8, L 15-17).

'Joe' tends to send the client the PHQ-9 (Kroenke et al, 1999), GAD-7 (Spitzer et al., 2006) and CORE-OM (Evans et al., 2000) before the first session and contracts with the client to use these:

'So*, the three measures I have used or continue to use and not continuously with all clients, but with some clients are, umm, the CORE-OM 34-point questionnaire, the GAD7 questionnaire and the PHQ 9, depression scale questionnaire.'* (P5, L12-15 and P6, L 1-3).

He makes the decision, based on the client's responses, how often to use an OM (weekly or monthly) and which one is indicated to use next to monitor levels of anxiety, depression or global functioning. How the client scores each OM will help the therapist to decide on the professional contract.

The *professional contract* involves the mutual agreement of specific *goals* and *tasks* for therapy (Berne, 1966; Sills, 2006) in evidence-based TA clinical practice. The research seeks to understand if OMs monitor the client's response to the treatment contract and explore if and how OMs support the goals and tasks of therapy. Clients come to therapy with a wide range of issues that usually cause distress and seek symptomatic relief, the first stage of cure in TA theory and practice (Widdowson, 2024). 'Joe's' use of OMs assists both the client and therapist in identifying and specifying the client's distress, such as their scores around anxiety, depression, relationships, self-worth, self-esteem, patterns of sleep and eating, areas of risk, and by their scores how much distress is impacting on the client's ability to function. This information gleaned from the OMs helps the client and therapist talk about what they understand to be therapy goals, and the tasks are how this is to be achieved and are action-oriented. The OMs can then measure and monitor the client's response to therapy and enable adjustments to be made to the contract should the client improve, deteriorate or stabilise:

"And it may inform what we do in that session, or a change of tack, perhaps a spell in the work." (P40, L10-13).

'Joe' uses the OMs early in the therapeutic work as part of the exploratory contract to exclude OM items which the client rates as low scoring (zero or not at all) and focus on the items which the client scores at a three or four (CORE-OM) or more than half the days or nearly every day (PHQ-9 and GAD-7). This then helps the therapist and client to move into a clarifying contract where the client has an increased self-awareness, and the therapist can help the client identify and understand their issue (Sills, 2006):

'*It's maybe a softer contract or element to it. It's not a hard behavioural contracting.'* (P40, L19-20).

'Joe' also finds that OMs assist the client as their self-awareness and understanding develop to focus on particular behavioural outcomes using psycho-educative methods such as relaxation techniques, breathing exercises, or sleep hygiene interventions. He embodies how he uses the GAD7 scores to decontaminate the Adult ego state in treatment planning:

"*Well, for example, with the umm, GAD 7 anxiety score, umm, someone presenting with a very high level of anxiety on the scale. To some extent, now, I'd always do this anyway, but it would become a*

priority to teach some anxiety management techniques." (P16, L 4-10).

Campbell, Ju, King & Rutherford's (2022) systematic review of 50 qualitative research studies cited clients who found that OMs helped them *" ... see how far they've come and how far they needed to go."* (p.1615).

The *psychological* component of the contract is out of direct awareness (Sills, 2006). It establishes and develops the working alliance (Bordin, 1979, 1994) and therapeutic bond (Widdowson, 2024), the container of the therapeutic relationship. The psychological contract also includes working with the client's transference and the therapist's countertransference. The participants use OMs having a conscious awareness of how this can inform the psychological contract, combining the nomothetic data with therapeutic enquiry. The process contract (Lee, 1997), as Widdowson (2024) explains "... which invite the client into a here-and-now process of engagement, exploration and experimentation ... to determine the next movement." (p.182).

'Joe' uses TA contracting (Sills, 2006) with clients from the start of his work to use OMs, as well as contracting within the therapy session in response to OM scores which highlight a particular issue. He conceptualises this in the context of the TA treatment triangle (Guichard, 1987; Stewart, 1996), and makes meaning of the OM data to formulate a triangle (TA contract, diagnosis, and treatment plan:

'*And, that you know, interventions for them to have that sort of treatment triangle model.'* (P26, L1-3)

'Joe' includes changes to the TA contract, diagnosis and treatment plan in response to the sessional OM scores. The OMs, tracked over time, can start the discussion and planning for the ending or termination of therapy. 'Joe' gradually reduces the frequency of treatment and monitors the client's OMs over time for stability before ending therapy. 'Joe' utilises CORE-OM responses in making TA diagnoses of life positions, script, injunctions, drivers, transactions (Berne, 1964; Clarkson, 1992) and games (Berne, 1964), and he *"cross-references"* (P31, L 2-4) and *"triangulates"* (P25, L15-19) OM data with his ongoing clinical assessment and in-session client presentation.

'Joe' contracts with the client the use of OMs, and the scores are tracked and monitored by him to see how the client responds to psychotherapeutic treatment and whether there is improvement, plateauing or deterioration (Lambert & Harmon, 2018). 'Joe' can then decide, with other sources of clinical information, to adjust or change treatment planning interventions. He makes sense of all three client information sources:

"... between sort of triangulating between the verbal data, the clients giving you in the session, that numerical, of soft data from the questionnaires or around that." (P25, L15-19).

The triangulation of three reference points, the client's self-reporting during the psychotherapy session, the nomothetic OM data, and the exploration he makes based on the content of the client's session and the OM scores to understand the embodied impact and detail of their individual lived experience of their mental health and well-being:

"... as part of the triangulation of different sources of data, that the questionnaires have generally shown that some of the early stages of treatment are starting to take effect." (P45, L21-25).

'Joe' pays attention to his embodied hunches or gut feelings with clients in how heuristics are recognisable patterns in their recovery from anxiety and depression; when the GAD 7 score decreases as their anxiety improves and the PHQ9 score increases, their symptoms of depression intensify:

"... not in a perfect pattern ... there were spikes in it ... that initial drop of anxiety, increase in depression." (P17, L17-20).

OMs and Managing the Risk of Self-Harm

'Joe' recognises and is explicit about how he uses CORE-OM and PHQ-9 to screen and make sense of the client's risk of self-harm and suicide; he pays close attention to client safeguarding issues using OMs to screen for and manage the client's risk of self-harm and suicide in the context of the client's history:

"... there are specific questions on the CORE-OM, 34-point scale about suicidal, suicidal ideation, suicidal risk of acting out." (P19, L2-5).

'Joe' makes sense of other sources of client information, such as their previous history and how they present in the session:

"... it wouldn't purely from the outcome measures ... " (P18, L28-34 and P19, L1-2).

"... maybe doing a… suicide risk assessment based on the level of scores, or a change in those scores, or deterioration." (P16, L23-29).

Importantly 'Joe's' assessment of the client's risk of self-harm takes into account the client's protective factors:

"... the degree or social engagement, personality and relationships and patterns of eating and drinking" (P25, L3-10) and *"... the data from questionnaires*

wouldn't be used to assess suicide risk in isolation, it would be just part of the general picture, from various sources as to what was going on with the client at that point." (P19, L18-23).

'Joe' recognises and is explicit about how he safeguards the client. He reflects on how he would escalate his concerns about a client's risk to themselves or others, using and referring to the client's OM scores, which indicate an increase in risk. If he assesses the client at risk, he will share this information with other key mental health professionals involved in the client's care:

"To speak to their GP or their consultant psychiatrist, and so the questionnaire scores, or indeed, scores that they'd collected in their work might be discussed at that point." (P22, L12-14 and P23, L1-2).

TA Treatment Planning

In TA treatment planning, 'Joe' makes sense of how he uses an OM tracking system to monitor the client's response to the treatment plan and to establish which stage of the treatment plan they are in and where they need to go next. 'Joe's' lived experience of using CORE-OM, PHQ9 and GAD7 to ascertain where he is in the treatment planning process:

"*Also ... give an indication of what stage we're at in the treatment plan."* (P17, L5-7).

'Joe' gathers together the pencil draft from the intake session and begins to build a treatment plan in ink:

"*And then at that point I might be starting to think of treatment planning in a more formal way, about what, what, what approach seems most useful based on what this client said, and what their past experience of treatment has been."* (P29, L6-12).

He emphasises that the decontamination of the Adult ego state (Berne, 1961, 1966) is the first phase of the treatment plan to firm up boundaries between Parent, Adult and Child to facilitate social control and symptomatic relief in the initial stages of script cure (Berne, 1975). 'Joe' recognises and is explicit about the interventions he uses in the decontamination process, such as the client completing the OMs as a grounding experience, psychoeducation, anxiety management techniques (Breathing and Mindfulness exercises) and uses GAD7 to monitor the client's response. He makes sense of the improvement in GAD7 scores in response to psychoeducational work to decontaminate Adult ego state:

"*You're certainly looking for a drop in the GAD7 scores, consistently, having implemented things like breathing exercises and mindfulness exercises."* (P45, L12-16).

He recognizes and is explicit about the contamination of the Adult by the Parent and Child ego states and the decontamination process in the restoration of executive functioning and in the reduction of levels of anxiety:

"*... psychoeducation, on the internal mechanisms of anxiety, umm, to bring that level of anxiety down a few notches, and so the subsequent work could happen."* (P16, L13-14).

'Joe' shares his lived experience of how he uses OMs in his TA diagnosis, contracting and treatment planning or case formulation process. 'Joe' contracts with the client to complete the OMs at the first therapy session and then every four weeks to track their response, check for improvement, and intervene if the client shows signs of plateauing or deterioration (Lambert & Harmon, 2018). 'Joe's' use of OMs is individualised to the client:

"... otherwise, it's just an arbitrary number with a scale attached to it, which doesn't capture an individual's experience at all." (P32, L1-4).

This supports the establishment of the working alliance and therapeutic relationship (Bordin, 1994; Bachelor & Horvath, 1999; Horvath, 2018), an essential prerequisite in treatment planning for a successful outcome in therapy. Indeed, clients who complete an OM in treatment are known to have more favourable outcomes (van Rijn, Wild & Moran, 2011).

'Joe' embodies the triangulation of TA diagnosis, contract and treatment planning with the client's verbal, in-session account and OM data, and changes to any of the three parts impact how he updates elements of the TA diagnosis, contract or treatment plan (Figure 1):

" it only becomes meaningful, in diagnostic terms, when, when cross-referenced" (P 31, L12-15).

He illustrates this triangulation process as his lived experience of using OMs. He uses a sailing metaphor to show his ability to change direction in response to what the client is expressing by contracting for time to focus on a specific piece of therapeutic work and making a contract with the client as they review together the trajectory of their OMs:

"... may inform what we do in the session, or a change of tack, perhaps a spell in the work" (P40, L10-13).

This approach enables 'Joe' to share with the client any improvement, plateauing or deterioration in their mental health and well-being (Lambert & Harmon, 2018):

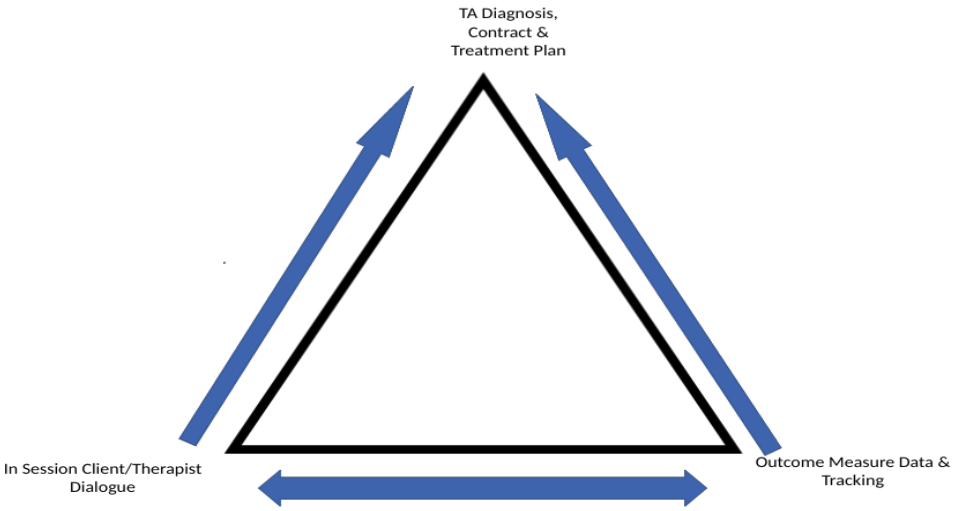

Figure 1: The Triangulation of TA Diagnosis, Contract and Treatment Plan, with In Session Client/Therapist Dialogue and OM data tracking.

"... what was noticeable client's either the score, the last set of scores, or the trend in the scores and discuss that with the client at that point." (P40, L5-10).

'Joe' makes sense of OM data to tell him where he and the client are in the treatment planning process (Widdowson, 2010):

"*... give an indication of what stage we're at in the treatment plan"* (P17, L5-7).

'Joe' tracked the OM data to show how the client was responding to the treatment plan and to guide him where he was in the process:

"so, you can get sort of, get a sense when you were on the curves, the data was, or what stage you were in, in the treatment." (P18, L4-6).

'Joe' recognises and is explicit about the strategies he employs in the treatment planning process, first to support the decontamination of the Adult ego state (Berne, 1961, 1966) in the client's completion of the OM in engaging their sense of self-awareness, self-reflection and self-regulation:

"... sometimes, it was quite good to pause and engage the part of the brain responsible for writing, and which is involved with managing trauma, and be able to onto paper was quite a grounding experience for them" (P12, L 16-21).

'Joe' makes meaning of TA psychoeducation with his clients, with high GAD 7 scores, to teach them:

"... on the internal mechanisms of anxiety, umm, to bring that level of anxiety down a few notches, and so the subsequent work could happen" (P16, L13-14) *"... would become a priority to teach some anxiety management techniques"* (P16, L4-10).

'Joe' watches for improvement in the GAD7 scores and would check the scores for coping and resilience under stress:

"... having implemented things like breathing exercises and mindfulness exercises." (P45, L12-16). He goes on, *"... I'd be looking for those to be, remain low, even when certain potentially distressing life events are going on."* (P43, L16-19).

'Joe' reflects on his lived experience of how he uses OMs to inform his decision to work towards ending psychotherapy based on the clients' levels of social control, symptomatic relief and transference cure (Stewart, 1996; Berne, 1975):

"... I reduce the frequency and then keep an eye on those scores to see what impact that reduced therapeutic input has. Are the positive changes stable without additional support." (P38, L9-12).

"In terms of cure, in terms of outcome measures, I guess I've already mentioned that you're looking for a consistent pattern of lower than clinically significant scores across the measures." (P43, L6-11).

What Next

This article discusses the findings of this single case study, considering the current evidence base and theoretical frameworks. Notably, 'Joe's' individual embodied (Merleau-Ponty, 1964) intrapersonal experience of himself as a psychotherapist, his interpersonal expertise and relationships with clients and colleagues, and the extrapersonal experience of his lifeworld (Eatough & Shaw, 2019), which includes

TA as well as the broader environment in which he lives and works (Heidegger 1962/1967; Dreyfus, 1991). The researcher and 'Joe's' world perspectives are individuals, yet both exist in the same professional world as TA psychotherapists, a shared and common experience (Heidegger, 1982; Eatough & Shaw, 2019).

This single case study presents 'Joe's' lived experience using OMs in TA case formulation and management. It addresses the fundamental compatibility question between the combination of nomothetic OMs and their synergy with evidence-based TA clinical practice. The elements of OMs and case formulation are presented, examined and explored in the four PETs. Each of 'Joe's' PETs are presented in detail, offering a compelling and cohesive narrative. **'**Joe's' single case study has presented his idiographic perspective on incorporating OMs in his TA psychotherapy practice. The interpretation of his meaning-making is an attempt to make sense of 'Joe' making sense of his life world (Double Hermeneutic).

This presentation of findings as a single case study invites an opportunity to reflect on and make sense of what has been discovered in the data. There is acceptance of the need to bracket any assumptions by the researcher, which can only ever be partial, as once something is known, it is difficult to put it entirely to one side. Vos (2023) suggests a helpful strategy to bracket and increase *dependability* and trustworthiness is to take a break from the data after initial coding, with IPA, after reading and re-reading the transcripts before exploratory noting, and then another break before forming the experiential statements. These regular breaks brought the researcher a fresh perspective on the interpretative process at each iterative stage, and as you have seen, going back again allowed a different result to emerge.

The influence of how the research study began, from a curiosity around clinical practice to the initial research proposal, literature review, interview guide, ethics application, sampling, and participant interviews, creates the dilemma of being as impartial and unbiased as possible. 'Trustworthiness' in qualitative research has replaced terms such as 'reliability' and 'validity', which are more familiar to quantitative research (Rodham, Fox & Doran, 2013), as a way to be transparent about the researcher's assumptions, experiences and values (Clarke, 2009).

The challenge remains of how the interpretation of the data can be entirely trustworthy when it is inherently subjective. IPA offers a clear trail of participants' responses, with the researcher making sense of the participants' phenomena and the double hermeneutic, which is also made explicit in the exploratory notes and experiential statements. This element of trustworthiness is whether *'*confirmability' of the research findings, based on the participant's words, can be traced to the original transcript. This aspect of reflexivity strengthened during research supervision sessions where supervisors questioned interpretations, biases and assumptions and held the researcher accountable for decisions. The importance of trustworthiness is how the researcher's background as a TA psychotherapist who uses OMs in TA diagnosis, contracting, and treatment planning are essential adjuncts to providing evidence-based care to clients, which clarifies the researcher's positioning.

Credibility is a vital aspect of trustworthiness, reflected in homogenous purposive sampling to capture participants' freely expressed views on their practice, which come through in the rich dataset of the transcription (Vos, 2023) and followed along into the seven steps of IPA. Another aspect of trustworthiness is that given the research study's infrastructure, such as the interview guide, purposive sampling and use of IPA, there would be transferability (Vos, 2023), which replaces the terms generalisability and external validity, which would see the applicability of the research findings to similar contexts, situations and other individuals.

This research study recruited 12 participants to develop a deep understanding of the phenomenon from multiple lived experiences for cross-case comparison of convergences and divergences when the GETs undergo analysis; this is the triangulation process within trustworthiness (Vos, 2023). Authenticity is ensuring the participants' and researcher's voices are throughout the research, the participants' sense-making and lived experiences are represented and honoured throughout, and the researcher seeks to empower the expression of their values, address the power differential and social justice issues such as their client's access to evidence-based practice (Vos, 2023).

The work is ongoing in terms of the other participants' PETs and moving into the GETs and cross-case analysis and the next article will bring those together.

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References

Abrams, D., De Moura, G.R., Hutchison, P., & Viki, T. (2005). When bad becomes good (and vice versa): why social exclusion is not based on difference. In D. Abrams, M. A. Hogg & J.M. Marques. (Eds). *Social psychology of inclusion and exclusion.* Psychology Press.

Ainsworth, M. D. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist, 46*, 331-341.

Allen, K. A., Kern, M. L., Rozek, C. S., McInerney, D., & Slavich, G. M. (2021). Belonging: A Review of Conceptual Issues, an Integrative Framework, and Directions for Future Research. *Australian Journal of Psychology, 73*(1),87–102. https://doi.org/10.1080/00049530.2021.1883409

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using Client Feedback to Improve Couple Therapy Outcomes: A Randomized Clinical Trial in a Naturalistic Setting. *Journal of Consulting and Clinical Psychology, 77*(4), 693–704. https://doi.org/10.1037/a0016062

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller. (Eds). *The heart and soul of change: Common factors in effective psychotherapy, medicine, and human services* (133–178). American Psychological Association.

Bate, L., Hutchinson, A., Underhill, J., & Maskrey, N. (2012). How clinical decisions are made. *British Journal of Clinical Pharmacology, 74*(4), 614-620. https://doi.org/10.1111/j.1365-2125.2012.04366.x

Beresford, B. & Sloper, T. (2008). *Understanding the Dynamics of Decision-Making and Choice: A Scoping Study of Key Psychological Theories to Inform the Design and Analysis of the Panel Study*. The University of York Social Policy Research Unit.

Berne, E. (1961). *Transactional analysis in psychotherapy: A systematic individual and social psychiatry*. Grove Press. https://doi.org/10.1037/11495-000

Berne, E. (1962). Classification of Positions, *Transactional Analysis Bulletin, 1*(3), 23.

Berne, E. (1963). *The structure and dynamics of groups and organisations*. Ballantine.

Berne, E. (1966). *Principles of Group Treatment.* Grove Press.

Berne, E. (1968). *Games People Play: The Basic Handbook of Transactional Analysis.* Grove Press.

Berne, E. (1975). *Transactional analysis in psychotherapy: A systematic individual and social psychiatry*. Souvenir Press. (Original work published in 1961)

Bickman, L., Rosof-Williams, J., Salzer, M. S., Summerfelt, W. T., Noser, K., Wilson, S. J., & Karver, M. S. (2000). What information do clinicians value for monitoring adolescent client progress and outcomes? *Professional Psychology: Research and Practice, 31*(1), 70-74. https://doi.org/10.1037/0735-7028.31.1.70

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(30), 252–260.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg. (Eds). *The working alliance: Theory, research, and practice.* (13–37). Wiley.

Boswell, J. F, Kraus, D. R, Constantino, M.J., Bugatti, M., & Castonguay, L.G. (2017). The implications of therapist effects for routine practice, policy, and training. In L. G. Castonguay and C.E. Hill. (Eds). *How and why are some therapists better than others?* American Psychological Association.

Boyd, H.S., & Cowles-Boyd, L. (1980). Blocking Tragic Scripts. *Transactional Analysis Journal, 10*(3);227-9.

Callaly, T., Hyland, M., Coombs, T., & Trauer, T. (2006). Routine outcome measurement in public mental health: Results of a clinician survey. *Australian Health Review, 30*(2), 164. https://doi.org/10.1071/ah06016

Campbell, R., Ju, A., King, M.T., & Rutherford, C. (2022). Perceived benefits and limitations of using patient-reported outcome measures in clinical practice with individual patients: a systematic review of qualitative studies. *Qual Life Res. 31*(6):1597-1620. https://pubmed.ncbi.nlm.nih.gov/34580822/

Chopra, J., Hanlon, C. A., Boland, J., Harrison, R., Timpson, H., & Saini, P. (2022). A case series study of an innovative community-based brief psychological model for men in suicidal crisis. *Journal of Mental Health (Abingdon, England)*, *31*(3), 392–401. https://doi.org/10.1080/09638237.2021.1979489

Clarke, C. (2009). An Introduction to Interpretative Phenomenological Analysis: A Useful Approach for Occupational Therapy Research. *The British Journal of Occupational Therapy*, *72*(1), 37–39. https://doi.org/10.1177/030802260907200107

Clarkson, P. (1992). *Transactional analysis psychotherapy: An integrated approach*. Tavistock/Routledge.

Cooper, M. (2012). *Essential research findings in counselling and psychotherapy: The facts are friendly*. Sage.

Cozolino, L. (2020) *Neuroscience for Clinicians.* New York: W.W Norton and Company

Crossman, P. (1966). Permission and Protection. *Transactional Analysis Bulletin, 5*(19), 482-484.

Davey, A. 92021), personal communication, February 2.

Dreyfus, H. L. (1991). *Being-in-the-world: A commentary on Heidegger's being in time, Division I (Vol. 1)*. MIT Press.

Drye, R.C., Goulding, R.L., & Goulding, M.E. (1973). No-suicide decisions: Patient monitoring of suicidal risk. *American Journal of Psychiatry, 130,* 171–174.

Duncan, B., Miller, S., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. (2003). The Session Rating Scale: preliminary psychometric properties of a "working" alliance measurement. *Journal of Brief Therapy, 3*(1), 3-12.

Dunn, E. (2021). Personal communication, February 25.

Eatough, V., & Shaw, K. (2019). "It's like having an evil twin": an interpretative phenomenological analysis of the lifeworld of a person with Parkinson's disease. *Journal of Research in Nursing*, *24*(1-2), 49–58. https://doi.org/10.1177/1744987118821396

Evans, C., & Carlyle, J.-A. (2021). *Outcome measures and evaluation in Counselling and psychotherapy*. Sage Publishing.

Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE–OM. *The British Journal of Psychiatry, 180*(1), 51-60.

Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., & McGrath, G. 2000). CORE: Clinical Outcomes in Routine Evaluation. *Journal of Mental Health, 9*(3), 247–255. https://doi.org/10.1080/jmh.9.3.247.255

Evans, J. S., & Stanovich, K. E. (2013). Dual-Process Theories of Higher Cognition. *Perspectives on Psychological Science, 8*(3), 223-241. https://doi.org/10.1177/1745691612460685

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. J. Wiley.

Fishman, D. B. (1999). *The case for pragmatic psychology*. New York University Press.

Gabbard, G.O., Lazar, S., Hornberger, J., & Spiegel, D. (1997). The economic impact of psychotherapy: a review. *American Journal of Psychiatry, 154,* 147-155.

Gabbay, J., & LeMay, A. L. (2011). *Practice-based evidence for healthcare: Clinical mindlines*. Routledge.

Gergen, K. J. (1973). Social psychology as history. *Journal of Personality and Social Psychology, 26*(2), 309-320. https://doi.org/10.1037/h0034436

Goulding, R., & Goulding, M. (1976). Injunctions, Decisions, and Redecisions. *Transactional Analysis Journal, 6*(1), 41-48. https://doi.org/10.1177/036215377600600110

Guichard, M. (1987). *Writing the Long Case Study*. Workshop Presentation, EATA Conference, Chamonix (Unpublished).

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, 61*(2), 155-163. https://doi.org/10.1002/jclp.20108

Harmer, B., Lee, S., Duong, T. V. H., & Saadabadi, A. (2023). *Suicidal Ideation*. In StatPearls (Internet). StatPearls Publishing.

Hatfield, D. R., & Ogles, B. M. (2004). The Use of Outcome Measures by Psychologists in Clinical Practice. *Professional Psychology: Research and Practice, 35*(5), 485-491. https://doi.org/10.1037/0735-7028.35.5.485

Hatfield, D., McCullough, L., Frantz, S. H., & Krieger, K. (2010). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology & Psychotherapy*. https://doi.org/10.1002/cpp.656

Heidegger, M. (1962/1967). *Being and Time*. Blackwell.

Heidegger, M. (1982). *The Basic Problems of Phenomenology,* Indiana University Press.

Holloway, W. (1973). Shut the Escape Hatch. In W. Holloway. *The monograph series of Midwest Institute for Human Understanding*. Midwest Institute For Human Understanding.

Horvath, A. O. (2018). Research on the alliance: Knowledge in search of a theory. *Psychotherapy Research, 28*(4), 499–516. https://doi.org/10.1080/10503307.2017.1373204

Ionita, G., Ciquier, G., & Fitzpatrick, M. (2020). Barriers and facilitators to the use of progress-monitoring measures in psychotherapy. *Canadian Psychology/Psychologie Canadienne, 61*(3), 245-256. https://doi.org/10.1037/cap0000205

Jensen-Doss, A., Haimes, E. M. B., Smith, A. M., Lyon, A. R., Lewis, C. C., Stanick, C. F., & Hawley, K. M. (2018). Monitoring Treatment Progress and Providing Feedback is Viewed Favorably but Rarely Used in Practice. *Administration and Policy in Mental Health and Mental Health Services Research, 45*(1), 48–61. https://doi.org/10.1007/s10488-016-0763-0

Joe References

Julmi, C. (2019). When rational decision-making becomes irrational: A critical assessment and re-conceptualization of intuition effectiveness. *Business Research, 12*(1), 291-314. https://doi.org/10.1007/s40685-019-0096-4

Kahler, T. & Capers, H. (1974). The Miniscript, *Transactional Analysis Journal, 4*(1), 26-42. https://doi.org/10.1177/036215377400400110

Kahneman, D. (2012). *Thinking, fast and slow*. Penguin Psychology.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (1999). Patient Health Questionnaire-9.*PsycTESTS Dataset*. https://doi.org/10.1037/t06165-000

Lambert, M. J., & Harmon, K. L. (2018). The merits of implementing routine outcome monitoring in clinical practice. *Clinical Psychology: Science and Practice, 25*(4), Article e12268. https://doi.org/10.1111/cpsp.12268

Lambert, M.J. (2010). Prevention *of Treatment Failure: The Use of Measuring, Monitoring, and Feedback in Clinical Practice.* American Psychological Association.

Lee, A. (1997). Process Contracts. In C. Sills. (Ed.). *Contracts in Counselling*. (94-112). Sage Publications.

Lewis, C. C., Boyd, M., Puspitasari, A., Navarro, E., Howard, J., Kassab, H.,& Kroenke, K. (2019). Implementing Measurement-Based Care in Behavioral Health. *JAMA Psychiatry, 76*(3), 324. https://doi.org/10.1001/jamapsychiatry.2018.33

Lilienfeld, S.O. & Lynn, S.J. (2014). *Errors/Biases in Clinical Decision Making*. In R.L. Cautin and S.O. Lilienfeld. (Eds). *The Encyclopedia of Clinical Psychology*. Wiley. https://doi.org/10.1002/9781118625392.wbecp567

Masterson, J. F. (2004). Evolution of the Masterson Approach. In J. F. Masterson & A. R. Lieberman. (Eds). *A therapist's guide to the personality disorders: The Masterson Approach* (1–11). Zeig, Tucker & Theisen.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. 2nd Edition. Sage.

Merleau-Ponty, M. (1964). *The primacy of perception.* (W. Cobb, translator). Northwestern University Press.

Minikin, K. (2008). Treatment Planning. *ITA News, 37,* 13-14.

Murphy. (2012). The relationship between progress feedback and therapeutic outcome in student counselling: A randomised control trial. *Counselling Psychology Quarterly, 25*(1), 1–18.

NHSDigital. (2023). https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/iapt-data-set-v2.0-archived-guidance-documents

O'Reilly-Knapp, M., & Erskine, R. G. (2010). The Script System: An Unconscious Organization of Experience. *International Journal of Integrative Psychotherapy*, *1*(2), 13–28.

Phelps, R., Eisman, E. J., & Kohout, J. (1998). Psychological practice and managed care: Results of the CAPP practitioner survey. *Professional Psychology: Research and Practice, 29*(1), 31-36. https://doi.org/10.1037/0735-7028.29.1.31

Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training, 46*(4), 418-431. https://doi.org/10.1037/a0017901

Reese, R. J., Toland, M. D., Slone, N. C., & Norsworthy, L. A. (2010). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy, 47*(4), 616-630. https://doi.org/10.1037/a0021182

Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R.,& Chisholm, R. R. (2009). Using Client Feedback in Psychotherapy Training: An Analysis of its Influence on Supervision and Counselor Self-Efficacy. *Training and Education in Professional Psychology*, *3*(3), 157–168. https://doi.org/10.1037/a0015673

Remfrey Foote, C. (2023). How Outcome Measures Could Support Transactional Analysts in Clinical Practice to Improve Treatment Trajectories, Manage Risk, Minimise Client Drop-Out Rates and Support Clinical Supervision. *International Journal of Transactional Analysis Research & Practice*, *14*(2), 3–16. https://doi.org/10.29044/v14i2p3

Remfrey Foote, C. (2024). Outcome Measures in Transactional Analysis Clinical Practice: Presentation of Research Methodology . *International Journal of Transactional Analysis Research & Practice*, *15*(1), 39-53. https://doi.org/10.29044/v15i1p39

Riess H. (2017). The Science of Empathy. *Journal of Patient Experience*, *4*(2), 74–77. https://doi.org/10.1177/2374373517699267

Rodham, K., Fox, F., & Doran, N. (2015). Exploring analytical trustworthiness and the process of reaching consensus in interpretative phenomenological analysis: lost in transcription. *International Journal of Social Research Methodology*, *18*(1), 59–71. https://doi.org/10.1080/13645579.2013.852368

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action.* Basic Books.

Sills, C. (2006). *Contracts for counselling and psychotherapy: Professional skills for counsellors*. Sage Publications.

Smith, J. A., & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis*. American Psychological Association.

Smith, J. A., Flowers, P., & Larkin, M. (2022*). Interpretative phenomenological analysis: theory, method, and research. 2nd edition*. Sage.

Smith, J. A., Larkin, M., & Flowers, P. (2009). *Interpretative phenomenological analysis: Theory, method, and research*. Sage.

Spitzer R. L., Kroenke K., Williams J. B. W., & Löwe B. (2006). A brief measure for assessing generalized anxiety disorder the GAD-7. *Arch. Intern. Med., 166,* 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Stewart, I. (1996) *Developing transactional analysis counselling*. Sage.

Stewart, I. (2010). *The three ways out: Escape Hatches*. In R. G. Erskine. (Edr). *Life Scripts: A Transactional Analysis of Unconscious Relational Patterns*. Routledge. https://doi.org/10.4324/9780429476686

Stewart, R. E., Chambless, D. L., & Baron, J. (2012). Theoretical and practical barriers to practitioners' willingness to seek training in empirically supported treatments. *Journal of Clinical Psychology, 68*(1), 8–23. https://doi.org/10.1002/jclp.20832

Stringer, H. (2023). Measurement-based care is giving psychologists and their patients a better picture of treatment progress. *Monitor on Psychology*, *54*(4) (online). https://www.apa.org/monitor/2023/06/measurement-based-care-patients-treatment

Tarescavage, A.M., & Ben-Porath, Y. S. (2017). Avoiding Cognitive Biases in Clinical Decision Making: Commentary on "Evidence-Based Assessment as an Integrative Model for Applying Psychological Science to Guide the Voyage of Treatment." *Clinical Psychology, 24*(4), 367–369. https://doi.org/10.1111/cpsp.12220

Van Rijn, B. (2016) The role of routine outcomes evaluation in developing reflexivity in clinical practice. *The Psychotherapist, (62), 34-36.*

Van Rijn, B., Wild, C., & Moran, P. (2011). Evaluating the Outcomes of Transactional Analysis and Integrative Counselling Psychology within UK Primary Care Settings. *International Journal of Transactional Analysis Research & Practice, 2*(2), 34–43. https://doi.org/10.29044/v2i2p34

Vos, J. (2023). *Doing research in psychological therapies: A step-by-step guide*. Sage.

Wampold, B. & Imel, Z. E. (2015). *The great psychotherapy debate. The evidence for what makes psychotherapy work*. Routledge.

Widdowson, M. (2010). Transactional Analysis: 100 Key Points and Techniques. Routledge. https://doi.org/10.4324/9780203868393

Widdowson, M. (2015). *Transactional Analysis for Depression: A step-by-step treatment manual*. Routledge. https://doi.org/10.4324/9781315746630

Widdowson, M. (2024). Transactional Analysis: 100 Key Points and Techniques (Second edition). Routledge. https://doi.org/10.4324/9781003375890

Willis, D. G., Grace, P. J., & Roy, C. (2008). A central unifying focus for the discipline: Facilitating humanization, meaning, choice, quality of life, and healing in living and dying. *Advances in Nursing Science*, *31*(1), E28–E40. https://doi.org/10.1097/01.ANS.0000311534.04059.d9

Wolpert, M., Curtis-Tyler, K., & Edbrooke-Childs, J. (2014). A Qualitative Exploration of Patient and Clinician Views on Patient Reported Outcome Measures in Child Mental Health and Diabetes Services. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(3), 309-315. https://doi.org/10.1007/s10488-014-0586-9