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# Editorial



My usual exciting time in preparing an issue has been very much tinged with sadness this time – you will see below that I include two Obituaries of my colleagues and friends within the TA community – plus my own article refers to wars and I am very conscious that wars are ongoing that impact on my colleagues and friends in several countries.

However, this is still an exciting issue to bring to readers.

We begin with the third article in our series from Carol Remfrey Foote. Carol is conducting a huge research project about investigating the use of outcome measures as a contribution to TA diagnosis, contracting and treatment planning. She is providing us with a series of articles so we can really follow what she is doing, critique it, quote from it – and maybe copy it!

Carol introduced her project in 2023 and earlier this year she provided a detailed account of the research methodology. We are an open access journal so you can easily read these, free, on the website.

This issue she has provided us with detailed analyses of what she discovered from a Certified Transactional Analysis (CTA Psychotherapy) who is one of the research participants. The original analysis was done earlier this year for submission to the university but the research methodology requires it to be done again at a later stage – so she has allowed us to publish both versions to show how the methodology works and what changes as she gets further through the research process. In other words, how she analysed the participant she started with, and how her analysis changed after she had considered the data from several other research participants.

Again, Carol has provided enough information that anyone can copy what she is doing – and we look forward to the final instalment (or instalments) in 2025.

Next, we have another fascinating set of ideas from Tony White. This time he prompts us to think about how we understand the impact of childhood developmental stages on the therapeutic alliance, by deconstructing the therapeutic alliance.

Tony gives us a useful overview of how Ellen Bader and Pete Pearson work, made even more useful because they do not appear to have published since many years ago. He also invites us to consider what kind of TA theory we apply in the sense of: redecision TA where we assume the locus of control is within the client; classical TA where script change comes from the therapist doing something to the client; or relational TA where the change comes from the client and therapist relating.

The third article is by me. As part of my series of free books that I am issuing as reviews and critiques, I am constantly reviewing new material to update them. I have been getting increasingly concerned about material appearing that appears to imply that TA can 'cure' neurodiversity and 'prevent' wars. I am therefore proposing that we need a new school of TA – biological – to reflect that everything is not scripted. We have known for many years that some early TA beliefs about the brain, addiction, homosexuality, and so on, are not scripted. Increasingly we learn we are human animals. I am proposing that we need to take biology and genetics into account more.

Biology is also associated with the final two items in this issue – the Obituaries for Ian Stewart and Mark Widdowson. Whatever our script says, and even if we have adopted the positive script that Fanita English (1988) suggests, we cannot avoid the biological impact on our health. Two big losses to the TA community.

## References

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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):

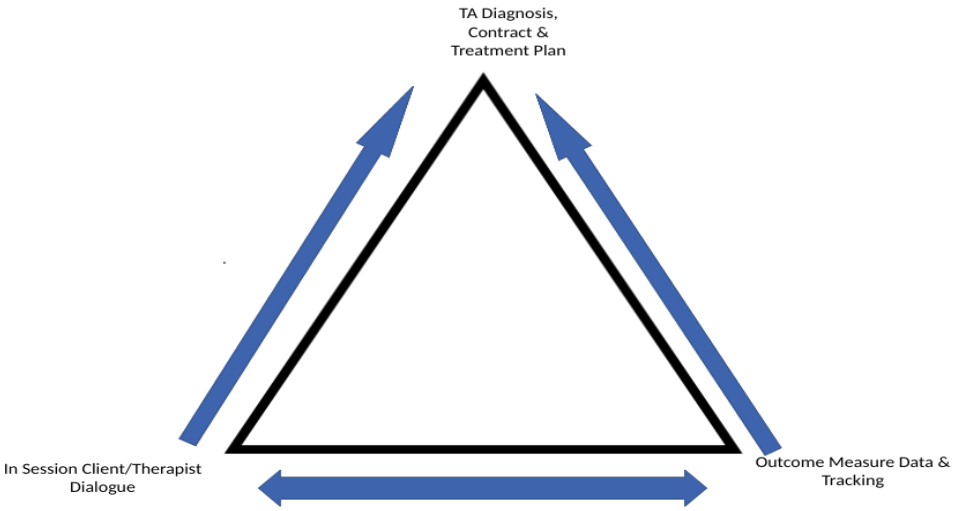


*Figure 1: The Triangulation of TA Diagnosis, Contract and Treatment Plan, with In Session Client/Therapist Dialogue and OM data tracking.*

*"... 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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# Understanding the impact of childhood developmental stages on the therapeutic alliance: Deconstruction of the therapeutic alliance viewed from a developmental perspective



## Abstract

*The author challenges the usual divisions into one person and two person therapeutic approaches, and the emphases on I 'ness versus we 'ness, by applying the childhood stages of development through symbiosis/attachment followed by autonomy/ differentiation to what is needed as the client revisits these stages in creating a relationship with a practitioner. Regardless of therapeutic techniques used, the practitioner needs to be alert to the inevitable switch from positive attachment to the apparent conflict as the client seeks to establish a separation from a parent figure that may not have happened in childhood.*

## Key words

Symbiosis, attachment, autonomy, differentiation, transference, therapeutic alliance

## Editor's Note

*When this article was first submitted, I was concerned that it had such old TA references. However, as Brad McLean (2023) tells us, there is a lack of current material about relationship therapy, and many of the authors have continued developing their material outside the TA community. This article is therefore a very useful development of what our readers may not be familiar with, especially the younger ones.* 😉

## Introduction

If two people have a relationship of any length:

1. First they will form an attachment. This is where the relational school focuses and may well get lost in the 'we-ness' of relationships.

2. The people will then (after a period of time) set about detaching from each other. This is where the redecision school focuses, and may get lost in the 'I-ness' of relationships.

In symmetrical relationships, like a marriage or friendship, this happens equally on both sides. In asymmetrical relationships, like the therapeutic relationship or the teacher/student relationship, then it happens more to the less 'powerful 'party. Longer-term clients will do this especially so it needs to be dealt with. This article shows how I use the Bader & Pearson (1983, 1988) model as a way of understanding what the client will do and explaining the process that will occur, whether we are working in one- or two-person approaches.

Long-term relationship-based therapies are most often what Stark (1999) refers to as a two-person psychology, where both the therapist and the client are seen to be personally involved in the change of the client. Indeed, some see the therapist changing as well in the process. Freud (1989) began the tradition when he highlighted the importance of the transference relationship between the client and the therapist. Many since then have believed the same and discussed the therapeutic relationship between client and therapist at length including such prominent figures like Carl Rogers (1951).

However, much psychotherapy around the world probably uses the one-person psychology approach, such as cognitive behavioural therapy (CBT), about which Sequeira and Mytton (2023) state "… is arguably the most influential and widely validated psychotherapeutic model in the world." (p.352). Hanley and Winter (2023) discuss a wide variety of current psychotherapies and add to CBT, EMDR, exposure therapy, gestalt therapy, and compassion-focused therapy.

Another way in which we can consider the different therapy approaches is in the practitioner's perspective about locus of control (LOC). I (White, 2020) propose:

- "Internal LOC – the client is responsible for their own thoughts, feelings and behaviours. Script change comes from the client doing something to self. Redecision TA.
- External LOC – the client is not responsible for their own thoughts, feelings and behaviours. Script change comes from the therapist doing something to the client. Classical TA.
- Relational LOC – the client therapist relationship is responsible for their thoughts, feelings and behaviours. Script change comes from the client and therapist relating. Relational TA" (p.16-17). (bullets added).

## Childhood Development

The three-phase model presented in Figure 1 illustrates the normal developmental process one finds in child development. After birth the child sets about finding an attachment to form with a mother-like person as shown in Figure 1a. In TA, as highlighted by Schiff (1975), the child is said to seek to enter into a symbiosis with a parent. Indeed this process is one of the core themes of study in the whole field of developmental psychology. If the child does not manage to form a successful symbiosis then ultimately it will die. Berne never actually discussed the idea of attachment; however as editor (Berne, 1969) he did devote an entire edition of the *Transactional Analysis Bulletin* to the work of Schiff and reparenting schizophrenics. Symbiosis is of course central to that approach of reparenting and Berne is clearly is speaking most highly of this approach to this major mental illness.

Bowlby (1971) wrote an entire book dedicated to attachment. Bowlby (1973) then set about writing an extensive treatise on 'Separation'. First the child seeks out an attachment or a fusion of identity with mother and then it seeks out liberation or detachment from mother. It seeks to establish its own individual identity. Indeed Bowlby (1973) called one of the final chapters of his book "Secure attachment and the growth of self reliance."(p.366). He said this is the penultimate chapter of the book about how a young person can achieve a state of self reliance with the encouragement of the parents for the child, and that the penultimate state is one of self reliance.

Margaret Mahler also spent an entire career studying the same topics, which she called separation and individuation (Mahler, Pine and Bergman, 1975). How the child both separates from mother and then individuates. It seeks to answer the question - Who am I? If I am not part of mother as I was in the attachment, then who am I? She, like Bowlby, proposed that the goal of child development is to achieve a state of individuation where the attachment with mother has been fully deconstructed. Mahler et al also suggested some phases and sub-phases: normal autistic phase, normal symbiosis phase, differentiation subphase, practicing subphase, rapprochement subphase and object constancy subphase. Below I will show how Bader and Pearson based their model on Mahler's phases.

Erik Erikson (1959) studied the same process with his developmental theory of the 'psychosocial and psychosexual epigenesis' of the child, and most notably his fifth stage of development of identity versus identity diffusion. Like Mahler and Bowlby, he viewed the child as seeking to understand and establish itself as a fully autonomous person with a clear identity. Such an identity gives the child a sense of being a person with a history, a stability and a continuity of self that is recognisable by others. The child and teenager seek to achieve the state as shown in Figure 1b. No longer is there a fusion of identity with mother in a symbiosis but now the person perceives self to have their own boundary around themself. A sense of being in one's own skin with a sense of self separate to any others. Berne (1964) originally presented this diagram and called it the structural diagram of ego states.

If this state is achieved then the person can go onto a relationship as shown in Figure 1c, where all the transactions can occur freely and by choice. The individual is able to use all transactions with all ego states and therefore have a 'full' relationship in this way. As we can see in Figure 1a, only a limited number of transactions can occur. One cannot be fully in a relationship unless they have firstly achieved a state of being fully not in a relationship. A state of full autonomy or of full individuation, where one has a sense of a complete boundary around self, allows one to enter into a full relationship. Some do not achieve that sense of full individuation and they return to the original symbiotic relationship (Figure 1a) but with someone other than the original parent figure.

Of course, some who enter psychotherapy are doing that. The person enters into a symbiosis with the therapist in an attempt to again achieve full separation shown in Figure 1b. They re-establish the original symbiosis with mother or father by transferring it onto the therapist. This is particularly so for people who have identity problems. They have never reached a fully established identity (Figure 1b) and thus develop what is called an identity disorder.

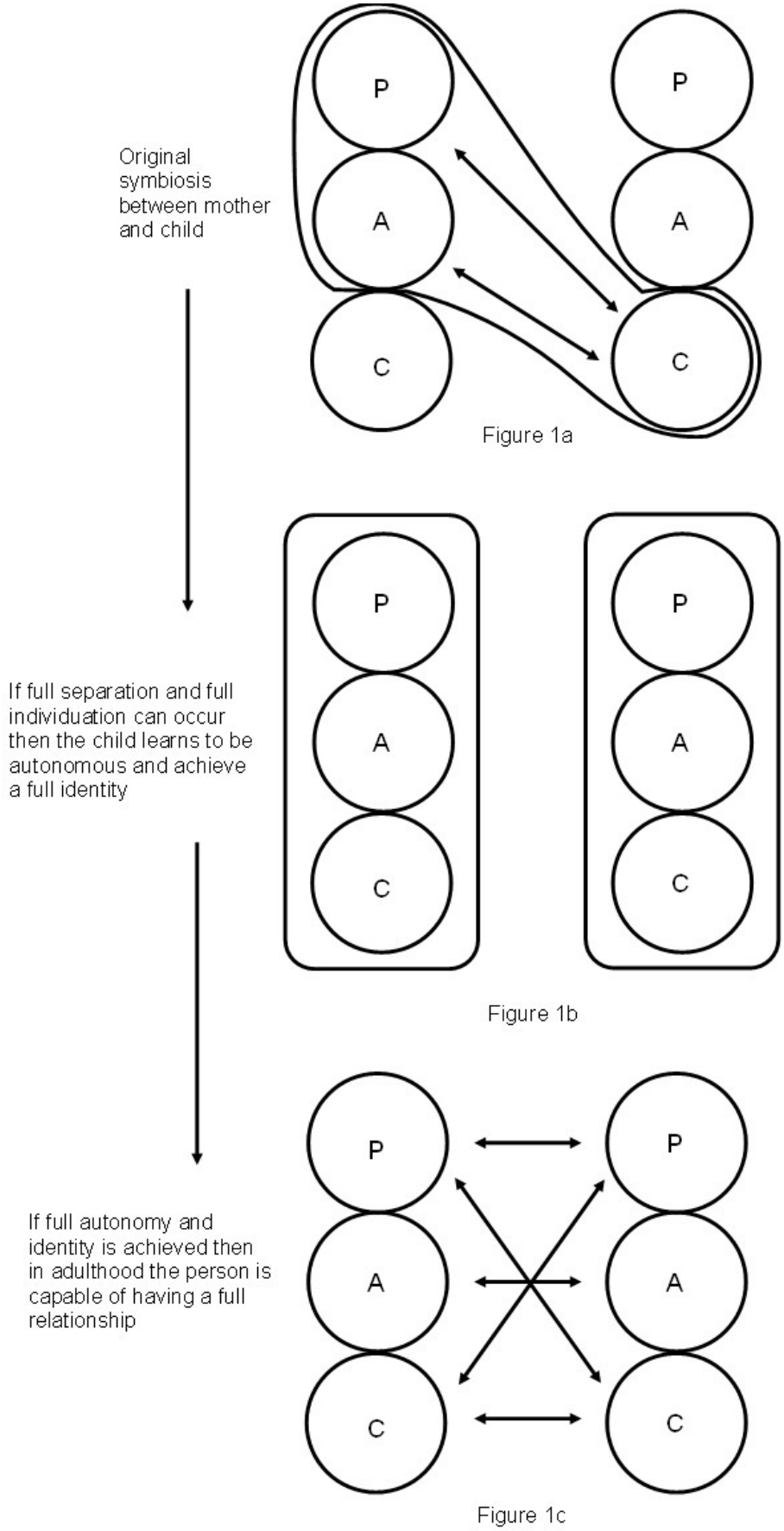


*Figure 1: Stages of Development*

They remain uncertain about a variety of issues related to identity, including their long term goals and career choices, friendship patterns, morals and values.

## Adulthood Relationships

This process has been described by others over the years; firstly by Freud (1966) who talked about the transference being ambivalent. That is, it has positive, affectionate aspects as well as hostile and negative attitudes directed towards the therapist. Often, early in therapy, there will be therapeutic successes that accompany the positive and affectionate attitude to the therapist. In more recent times Hargaden and Sills (2002) have called this the idealising transference. They noted that the therapist is idealised by the client and this is often accompanied by feelings of love and tenderness. This positive transference is what helps the original symbiosis (and attachment) develop. The positive transference leads to attachment and symbiosis formation - Figure 1a; afterwards negative transference leads to separation and individuation - Figure 1b.

Freud observed that the client will initially seek to develop an attachment with the therapist through the positive transference and then seek to separate and individuate by the use of the negative transference. The client is naturally driven to repeat the process described in Figure 1. To move from Figure 1a to 1b and finally to 1c, hopefully avoiding returning to 1a as originally happened in childhood. It is natural and unconscious for the client to redo this process in relation to the therapist. However this is not unique to the therapeutic relationship but is describing the process in a multitude of relationships, romantic and non-romantic. Bader and Pearson (1988) demonstrated this by describing the same occurring in romantic relationships or indeed any coupling relationship between two adults.

It seems the process described so comprehensively by Bowlby begins with relationship formation of the young child and its attempt to form a connection or attachment to the other. Once done, it then sets about separating or detaching and breaking down the attachment it just so desperately sought. This same process of positive transference followed by negative transference is the pattern that is taken into many adult relationships, be they romantic, friendships, therapeutic, work relationships, teacher-student relationships, and so forth.

The Bader and Pearson model gives an explanation for this; that we all have a drive to be, know and feel ourselves as autonomous with a sense of individuality. At the same time we all have a desire to be able to be in a relationship and form emotional connections that can endure conflicts, disharmony and ruptures. When in a relationship the long-term outcome is fifty percent out of your control; the other fifty percent depends on what the other person decides to do. Therefore seeing that the relationship can withstand a period of 'negative transference' provides confidence in its longer term survival. It indicates that the Child ego state of the other is significantly involved in this relationship, thus building strength and trust in the longevity of the relationship.

## The Bader & Pearson Model

We had Bowlby talk about attachment and separation and Freud talk of positive and negative transference. Fortunately this process of positive and then negative reactions has been significantly expanded upon by Bader and Pearson (1988), who used the work of Margaret Mahler to do this. The stages Bader and Pearson use are:

- Autistic phase
- Symbiosis phase
- Differentiation phase
- Practicing phase
- Rapprochement phase

The model being described here will focus on the symbiotic, differentiation and practicing phases to explain the development of the therapeutic relationship. Of course the situation discussed here is somewhat different than the Bader & Pearson model is describing. They are talking about the usual coupling between two people in a romantic relationship or perhaps a friendship type of relationship. The therapeutic relationship can be different sometimes as it can be an asymmetrical one like the child-parent relationship. Sometimes the power and competency of the two parties involved differs greatly. In such instances the process of the stages described here occurs primarily on the client's side, as also happens on the child's side in the mother-child relationship.

### Autistic

The autistic stage is not relevant to the stages of couplehood as it is where the newborn child responds totally to its own internal needs in the first two months of life. It is trying to integrate itself physiologically into the world and to establish a homeostatic equilibrium in itself.

### Symbiosis

In adulthood the first phase of couple formation begins with the symbiotic stage. This is the stage of being madly in love and sometimes referred to as the 'honeymoon stage 'of the relationship. The lives and personalities of the two parties merge and there is a fusion and loss of boundary between the two parties.

This is the process of attachment and, as noted above, why people are good at starting relationships. It is the 'feel good' time of the relationship, with a sense of affection and connection between the two people.

In most relationships this is a time of harmony and pleasant feelings for both parties. As mentioned before, this is when the client can experience an idealised transference of the therapist. Certain features or activities of therapists are seen to enhance especially this type of transference; Viederman (2011) says the therapist can do the following:

- Therapist conveys understanding of the client's experience (empathy);
- The therapist echoes back to the client their experience so the patient feels heard;
- They provide meaning and understanding to a client's behaviours and feelings, that the client was unaware of - leaving the client feeling the therapist is an 'expert;.
- The client has freedom of expression without criticism from the therapist;
- The therapist displays an attitude of hope for the client.

As one can imagine, this is a pleasant process for the client and there can be spontaneous changes in the client at this stage. However as Freud noted, changes in the period of positive transference are fragile as they can disappear when the negative transference arrives and the client can seem to go backwards. This is because giving up symptoms by the client in the positive transference can be seen as an attempt to obtain love from the therapist. When the negative transference arrives, the client is no longer seeking such love so the original problems then reappear. For example a client may spontaneously give up smoking in the positive transference when they have not even presented the problem of smoking as an issue to deal with. With the subsequent appearance of the negative transference, the client takes up smoking again and may even express disappointment in the therapy as a consequence of this. It is these spontaneous changes the client reports in the positive transference that one needs to be cautious with; ones that the client may have not mentioned before or presented for therapy and just occur anyway.

With regard to the symbiosis or the positive transference stage of treatment, Hargaden and Sills (2002) stated, "The first, and arguably the most important task facing the therapist as she [sic] embarks on the therapeutic journey with her client, is to establish and maintain a resilient working alliance with her client." (p.31). However there is a second subsequent part that also needs to be mentioned - the deconstruction of the working alliance with the client. The move from Figure 1a to 1b for the therapeutic relationship is just as important as initially establishing the relationship described in Figure 1a. Hence we arrive at the next two stages of the Bader & Pearson model which articulate how the client moves from Figure 1a to 1b.

### Differentiation

After the attachment has begun to develop, the person will eventually feel the need to emerge from the symbiosis and establish their own boundaries and sense of individuality. The client seeks to understand and highlight their differences from the therapist. How am I different? The therapist needs to seize the moment when differences between them become apparent and highlight them. Often this can be differences in the Parent ego state such as values and views of what matters in life, plus any different Child ego state views about the meaning of life, what are desirable goals in life, feeling reactions and so forth.

This is also where the theory of emotional autonomy becomes apparent. White (2024) proposes two models of emotions, emotional autonomy theory (EAT) and emotional contagion theory (ECT). ECT is the view that, at least in some instances, people's emotions are not completely separate and one can transfer their feelings to another or one can somehow have the experience of another's emotions. On the other hand, EAT says that people's emotions are completely separate and different and one can only ever understand and feel their own emotions and never someone else's. This is a key part to differentiation as feelings are such personal things. The client needs to understand that this is an intimate and personal part of myself and my experience is separate and different from the therapist's. The role of the therapist is to bring this to the attention of the client. The more a client chooses to believe the idea of ECT for themselves, the less differentiation they will achieve and the more they will see the feelings between self and the therapist as confused and not with a clear boundary. Hence their sense of identity will remain more confused with others. The more the client accepts EAT, the more sense of differentiation they will feel from the therapist and the more the therapy alliance is deconstructed.

Historically in TA we have had a clear example of this EAT approach to differentiation for the client with the Goulding and Goulding development of redecision therapy, where the idea of a person being separate and an individual is at the core of the philosophy. For example Mary Goulding (1985) states "For twenty-

five years I have been teaching thousands of people some facts that you probably already know:

> You are in charge of your behaviour.
> You are in charge of your thoughts.
> You are in charge of your feelings.
> You are in charge of your body." (p.1).

In addition, McNeel (1975) completed a doctoral dissertation on how Goulding and Goulding worked and the central features of the redecision approach over a weekend therapy group. He noted this quality of differentiation with the following: "Separateness (S). Important for any client is the understanding that he [sic] is separate from other people ... Throughout the weekend the Gouldings encourage people to see themselves as separate and self sufficient." (p.122-123). This redecision philosophy approach will clearly assist the client to achieve a state of differentiation and begin the move from Figure 1a to 1b.

At this stage the therapist is beginning to deconstruct the therapeutic alliance, when the client starts to display their negative transference and a desire to highlight differences. The therapist begins to feel the client draw away and out of the therapeutic alliance. They demonstrate the desire to grow and separate from the therapist, and eventually outgrow the therapist where they are no longer needed like they once were. Instead of the central figure they once were in the client's life, the therapist now becomes just one of the group of relationships the client has. This of course takes some time to happen but most often the end result is the therapist loses their psychological importance to the client.

Games, enactments and relationship ruptures can also be attempts by the client to achieve a state of differentiation, especially with games and enactments that push people apart. For example, anger pushes people apart so if the client is starting to create relationship ruptures which are angry and conflictual, this could be because they are attempting to deconstruct that alliance and seek to achieve a sense of individuality and being non-relational.

Freud (1966) also noted this in his discussion of negative transference, which he said is typified by resistance and hostile feelings. Bowlby (1973) titles his book, *Separation: Anxiety and Anger*. Again we see the link being made between separation and anger and resistance. I wrote (White, 1997) "One of the advantages of anger is to provide a way of breaking the bond with mother and father, thereby allowing a new sense of independence." (p.196). The same theme is being presented here. Anger is a very useful emotion for people due to its separating properties. It allows people to separate psychologically and feel more individual. If a client is creating enactments or games which lead to hostile and conflictual outcomes then it must be considered that the client is wanting to deconstruct the therapeutic alliance. They have tired of the symbiosis or closeness of the alliance and want to feel more as an individual.

At this stage I may ask the client a question like, "What do you dislike about me or find tiresome?". Answers to this question vary widely. Some clients will find it hard to provide one example; when that happens it may be that the client is still in the phase of idealised transference. If a client is in the negative transference stage and is prepared to speak their mind, then the list can be long and brutal! So the therapist must be ready for that if they seek to use this way to encourage differentiation of the client from the therapist.

### Practicing

The next phase Bader and Pearson (1988) proposed is the stage of practicing. This is the final phase in the deconstruction of the therapeutic alliance from the side of the client and the desire to reach a state of individuation as shown in Figure 1b. They wrote "Autonomy and individuation are primary; at this point the partners are rediscovering themselves as individuals." (p.11). As mentioned before, the therapeutic alliance is an asymmetrical relationship so it is the client who is primarily rediscovering self and striving for autonomy at this stage.

One key in doing this is the establishment of relationships away from the therapist. The client may become somewhat self-centred and have less interest in the thinking and feelings of the therapist. The therapist may begin to feel somewhat obsolete and the narcissistic therapist may struggle here as they start to feel like the client no longer views them as important or central to their life and well-being. Practicing is about the client having their relationships external to the therapeutic relationship increase in importance.

If the client is inclined they may begin studies or trainings of some kind with other psychotherapy trainers and therapists, or going to workshops or attending one off therapy groups with visiting therapists. Then reporting back on how great that teacher or therapist was and all the important information they received. When this happens the therapeutic alliance is now being seriously deconstructed by the client. Hopefully the therapist can handle this change and encourage the client with it instead of taking it personally and counter-transference problems arise. The therapist hopefully is actively encouraging the client to do this and seeking to discuss with the client their other important relationships outside the therapy room. Highlighting them, talking about the new (or even

old) attachments and friendships and what they mean to the client. Again this is how the therapist can actively seek to deconstruct the therapeutic alliance.

The conflict of the differentiation stage can still continue in practicing. Games, enactments and ruptures may happen here as well. Hopefully, conflict resolution can be successfully maintained. Providing the client with information about how relationships go through processes as shown in Figure 1 can be helpful, as can any way of providing Adult ego state support for the deconstruction process that is occurring anyway. Bibliotherapy can be useful here as it involves the client reading about others' experiences; Caroline Shrodes (1949) described three stages – 1. Identification, 2. Catharsis means feeling for who they are reading about, 3. Insight.

### Rapprochement

This phase is not relevant to the development and deconstruction of the therapeutic relationship as its addresses the much longer-term relationship one can have in a non-therapeutic relationship such as a friendship or romantic relationship. The therapy relationship is about achieving a goal to assist one with their mental health. Once this goal is achieved the relationship will cease. There is no need to carry it on further as there is with a marriage or friendship.

## Using the relationship for deconstruction

One finally needs to consider the effects on the symbiosis and individuation of the client that is not about WHAT is done in psychotherapy but HOW it is done. It could be said that this has more powerful effects on the client than all of the factors discussed already because it is more subtle, unconscious and occurs at a deep relational level. The client and therapist have a relationship so one must consider if that relationship supports building up the alliance or supports the deconstruction of the therapeutic alliance. This is what the client is currently living in with the therapist and hence can be seen as a powerful factor in the deconstruction of the relationship. What would happen if the client is ready to move into the differentiation phase of deconstruction and yet the relationship with the therapist is promoting relationship building found in the symbiosis stage?

Figure 2 is prompted by previous material (White, 2020, 2023) and illustrates how we can use both treatment options that Stark (1999) presents with her idea of a two-person and one-person psychology. In

Figure 2a (two-person approach) we see the client has a sense of the therapy as an encounter with therapist. The therapist brings the focus of treatment onto the relationship between the two. It is all about how they interact and the dynamics of their interactions. This of course builds and fosters the development of the relationship and so is useful in the alliance building phase of treatment as shown in Figure 1a or the symbiosis stage. However eventually most clients move onto the phase of differentiation or negative transference and then they are wanting to deconstruct this relationship. To help the client do this the therapist has to change the therapy away from focusing on their relationship to encouraging the client to do therapy that is about the client alone, and to help the client get a sense of therapy as not involving the therapist. Figure 2b shows how the therapist can refocus the therapy away from them (and relationship building) onto a one person treatment style. The client then gets a sense of the therapy not involving the therapist and more as an activity which they do more on their own without the therapist involved in everything. The client gets a sense of the therapy being free from the therapist and their relationship. Exactly what feeds into the mindset of the average teenager: "Will you give me some space and let me do it on my own!"

In White (2023) I showed Figure 2 with the two chair technique that one finds in redecision therapy but it can be any technique. The important point is that, as you compare Figures 2a and 2b, you can see how the client gets a different sense of the therapy; the move away from a sense of "We" are doing this therapy, to a sense of "I" am doing this therapy. If a therapist is wanting to help the client separate but uses the two person approach then they are contradicting self and sending a double message to the client - Do as I say, not as I do. The therapist is saying to the client that their separation is a good thing to be expected but the way they are doing therapy (Figure 2a) is saying that you are not separate in how we are doing the current therapy.

This paper has highlighted the progression of the therapeutic relationship over time, and adopted Freud's idea that often the negative transference will follow the positive or idealising transference with the client. It has taken the work of Bader and Pearson and apples it more generally to the therapeutic relationship. Their developmental view of couples is applied to a developmental view of the therapeutic alliance. In addition it also adopts the work of Stark, with the one- and two-person approaches, to describe how the therapist can work with both to help the client deconstruct the relationship.

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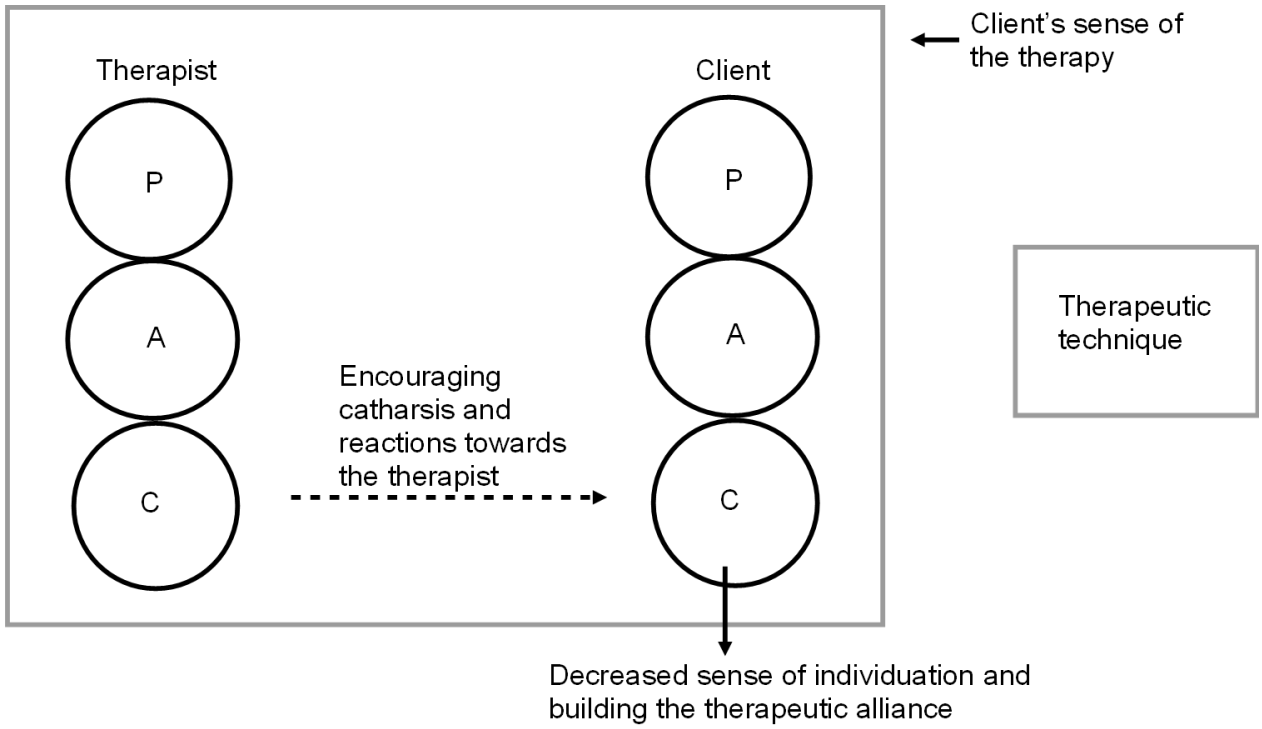


Figure 2a. Two person psychology

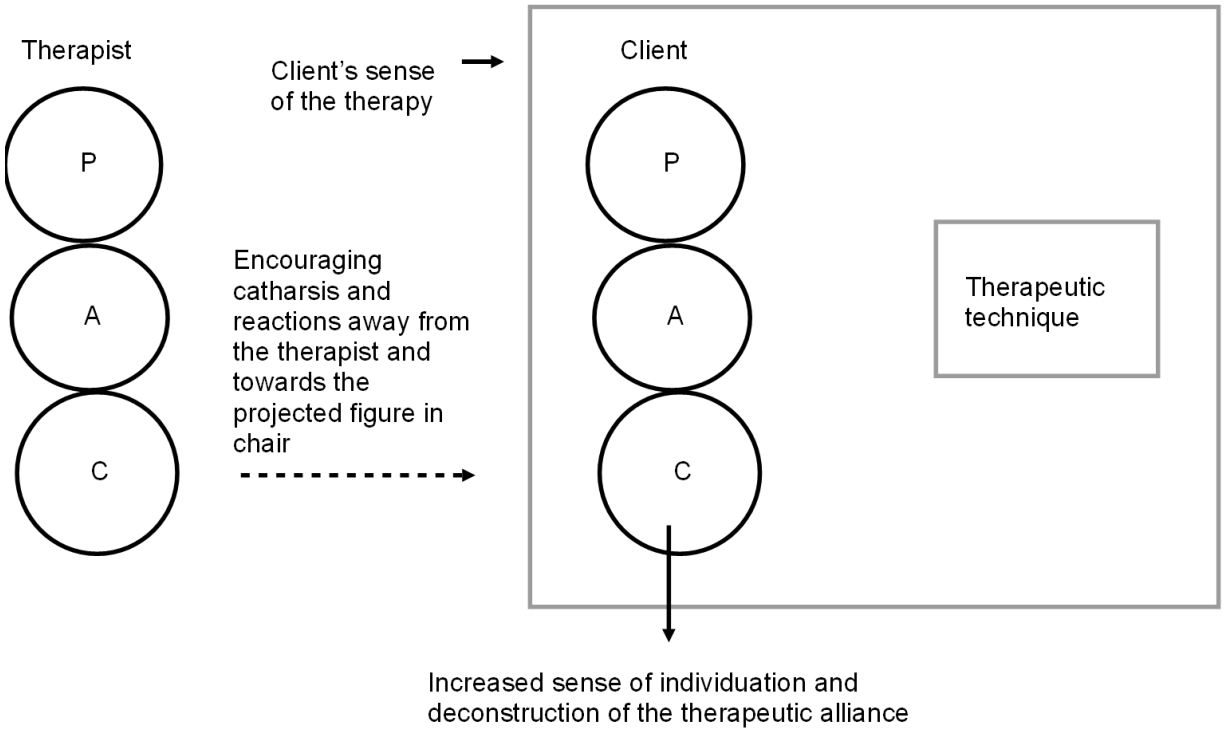


Figure 2b. One person psychology

*Figure 2: One- or two-person psychology*

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# Does TA need a Biological School?



## Abstract

*This article addresses the question of whether we need a new school of Biological Transactional Analysis in reaction to the increasing focus within TA publications on neurodiversity and war. It considers how are we similar to other animals which are not scripted as humans are but show some of the same patterns of behaviour; how some TA concepts and values are inappropriate in some cultures, and challenges the TA approach to war as a psychological process that can be 'cured'. It concludes that we need take more account of health as well as context.*

## Key words

Transactional analysis, biological TA, schools of TA, war, neurodiversity, genetics

## Introduction

In 2022 I began publishing a series of reviews and critiques of TA concepts as they had been developed over the years since Berne had started the process of introducing TA. These were provided as free open-access books (see https://sherwoodpublishing.com to download). I focused on English publications as my own language but also because the International and European TA Associations (ITAA and EATA) have English as their official language, and produce their own publications in English.

When I began the series of free books, I began with one called *TA from Then to Now: Core Themes* (Hay, 2022), in which I described 11 different TA schools, as shown in Table 1. When I came to produce the second edition of that same book (Hay, 2024a), I added two more schools and chapters – spiritual and ecological – plus a mention of the social cognitive school in Italy that was increasingly being written about in English. Table 2 shows the additional schools, plus I highlighted in that edition that Integrative, Process Communication, Developmental, and Social Cognitive have their own separate qualifications not operated by ITAA/EATA.

Now I am considering whether I need to produce a third edition of the book to include a new school called Biological TA – to counter the impression that TA can 'cure' anything. I have been prompted by so much appearing recently about neurodiversity and wars (references later); although these do not claim cures they give the impression that TA practitioners are working with them rather than stressing that we can only offer support with the psychological impacts of them. It reminds me of how Graham Barnes (2004) told us about how homophobic Eric Berne was; Pamela Levin (2010) told us about how racist Berne was; and Berne (1964) himself told us that war was [no more than] a psychological game, when he wrote "The grimmest of all, of course, is 'War'." (p.45). We can excuse Berne because he was writing so many years ago, but we should take into account what science has taught us since.

We have known for years that some TA concepts have been presented inaccurately. For instance, we have known since after the end of the Vietnam War that addictions are genetic and not script (Robins, Davis & Goodwin, 1974). It was not true that bystanders watched Kitty Genovese being attacked (Clarkson, 1987; Kassin, 2017). We have also known that ego states do not match a neat simplified idea of three parts of the brain. And it is over 30 years since I suggested we stopped using names of games that imply rape is a game or refer to women as bitches (Hay, 1993) or that we imply a physical disability is a game (Hay, 1995) but Rapo, NIGYSOB and Wooden Leg are still used.

A few years ago I (Hay, 2021) wrote about four different dynamics that had occurred within the TA community that challenged the notion that our colleagues behave more ethically after they have spent years learning TA. These included: my experiences of being invited to help another with an ethics case that they had been forced to bring; how a Manifesto had been issued and adopted by ITAA and EATA that likened the behaviours of refugees and politicians to playing psychological games; how I was advised to use a non-existent complaint policy when EATA reneged on their support of a journal set up for them (this journal that continued without their support); and how ITAA and EATA (and others) cancelled the

| School | Originators | Principles |
|---|---|---|
| Classical | Berne | analyse, decontaminate the Adult ego state; share the TA theory with the client |
| Cathexis | Schiff | use regression and create a healthy symbiosis; create a reparenting relationship |
| Redecision | Goulding & Goulding | the power is in the patient; we can re-decide in the Child ego state |
| Integrative | Erskine | inquiry, attunement, involvement |
| Psychodynamic | Moiso, Novellino | transference, countertransference |
| Process Communication | Kahler | process, personality type |
| Personality Adaptations | Joines, Stewart | adaptations, contact and target areas |
| Co-creative | Summers & Tudor | co-creation of reality |
| Constructivist | Allen, Loria | we construct our reality |
| Developmental | Hay | health rather than pathology and development rather than cure |
| Relational | Sills & Hargaden | use the relationship with the therapist to bring about change |

*Table 1: Schools of TA (Hay, 2022, p.4-5)*

| School | Originators | Principles |
|---|---|---|
| Social-Cognitive# | Scilligo | ego states as schemas |
| Spirituality | James, Mellacqua | spiritual self, betweenness |
| Ecological | Barrow & Marshall | ecological space rather than relational space. |

*Table 2: Additional Schools of TA (Hay, 2024a, p.5)*

World TA Conference 2020 after Covid emerged even though it had already been rescheduled for three years later plus an online conference had been set up, and the cancellation involved considerable financial losses for all participants under UK law.

Hence, we need some alternative explanations of what happens because being scripted does not explain even our own behaviours. Apart from how my colleagues have behaved, how did I develop – or was I born with - an I'm OK, You're not OK life position, when born during a war that lasted until I was three years old, and to a soldier father who made it clear that he did not want a child. So how come I did not finish up as I'm not OK and nobody else is OK? Maybe we need to consider biology more.

Humans are animals, and it is hard to believe that other animals, and birds, fish and insects, even worms, are scripted by what their parents do or communicate. What happens when people are neurodiverse? How does the TA concept of autonomy fit cultures other than California in the 1960's? And why do humans still have wars when the results are so terrible? I will address these questions in the rest of this article.

## Humans are Animals

Within TA we often equate consciousness with self-awareness, autonomy and/or (structural/internal) Adult ego state and being in the here-and-now. The following selection are some ideas that, for me, illustrate how other animals (and birds, insects, etc) are similar to humans – so vice versa applies – we are in many ways similar to other animals and no one expects to apply TA to them. Some TA practitioners work with animals but their focus is on how that benefits the human clients – maybe we should change that.

40 scientists who work with animals have initiated *The New York Declaration on Animal Consciousness* (Andrews, Birch, Sibo & Sims, 2024). They describe consciousness as having a variety of meanings, including phenomenal consciousness or sentience, sensory experiences that may feel good or bad, and how subjective experience requires more than the mere ability to detect stimuli but does not require language or reason. They caution that they are not talking about proof or certainty but that the behaviours evidenced provide strong scientific support for saying that there is a realistic possibility of consciousness. There are now there are 536 signatures to the Declaration, dated as April 19, 2024, plus some great photos, and several examples at the link shown in the References.

Other examples where other animals are similar to humans include:

- *Mating for Life* – in theory, humans do this although increasingly this is no longer true and

often only applies because of religious or other cultural effects. Swans , beavers, gibbons

macaroni penguins, sandhill cranes and bald eagles also mate for life, and prairie voles even foster the young of others.

- *Leadership* – Meyer, Cassidy, Stahler, Brandell, Anton, Stahler & Smith (2022) found that grey wolves in Wyoming infected by a common parasite are 11 times more likely than uninfected ones to start a new pack, and 46 times more likely to become leaders – and often the only wolf in the pack that breeds. Maybe this would explain why some humans become leaders – the authors suggest that one third of humans might be infected ☺.
- *Homosexual Animals* – the fact that the world's largest Adélie penguin colony in Antarctica contained many gay animals was hidden when the research was published early in the 19th century (Bagawan, 2019). Nowadays it is obvious that many animals, including humans, are gay and examples are abundant on Google – at least in countries where it is not still regarded as illegal.

Some other ways in which animals act the same as humans include:

- *Monkeys* – mirror neurons were first described in 1992 (di Pellegrino, Fadiga, Fogassi, Gallese & Rizzolatti, 1992; Rizzolatti, Fadiga, Gallese & Fogassi, 1992) when monkeys were seen to copy an experimenter or another monkey performing an action, such as grasping a food morsel. Researchers also put a complex vending machine with two groups of semi-wild chimpanzees and none of them could work out how to do it until the researchers trained one mid-to-high-ranking adult female in each group and they showed the others how to do it.
- *Farm Animals* – pigs show signs of empathy because they will work out how to open a pen in order to rescue trapped companions; cows put together that like each other begin grooming each other, whereas if they are put with cows they do not like, they start head-butting; goats will seek help from a human when they are presented with food in a bowl they cannot access. It has also been found that goats, like dogs, can distinguish between pictures of happy and angry people; they can find food more quickly if they observed where the humans were hiding it; and they seem to understand what we mean when we point at something. And goats will help other goats to reach food they cannot reach themselves.
- *Bees* – Bridges, Royka, Wilson, Lockwood, Richter, Juusola & Chittka (2024) trained some individual bees how to open a box to get at a treat, other bees observed what the trained bees did and were able to follow the entire sequence.
- *Birds* – since the 1940's, trained pigeons have been used to peck at screens for missiles; zebra finches that babble are actually imitating adult birds so they can memorise the sounds they hear and later imitate the songs, just as children learn language; Japanese tits apparently flutter their wings to say "after you" to indicate that they are allowing their mate to enter the nest first – it seems Japanese birds behave politely just like Japanese people.
- *Worms* – I cannot resist mentioning a research study reported on by NTA Nowogrodzki (2024) that shows even worms have memories. Apparently, a worm can be trained to dislike a smell by being starved for a short time. They then remember that they dislike the odour for about two hours.

## The Values of TA and Neurodivergence

### Okayness

Recently Bill Cornell (2024) commented on the Codes of Ethics of ITAA and EATA as if they hold some values that we hold in common, although he does not mention various conflicts including those I have described in my introduction. Those examples reinforce Cornell's suggestion that we need to move on from OKness as a primary value of TA; however, he still refers to only four life positions. These have been extended by Graham Barnes' (1981), Tony White (1994, 1995, 1997) and me (Hay, 2000, 2009, 2012, 2014), and many mistake Ernst's (1971) descriptions of behaviours as being the same thing that Eric Berne was writing about. Hence it is doubtful whether the OKness that is regarded as a primary value of TA is even understood in similar ways by members of our community.

Although I notice his lack of references, I fully agree with Cornell's suggestion that we need different values for TA. He concludes his article with a list of 11 "values, hopes, aspirations, and wishes that we may hold as transactional analysts" (p.122), which include factors that might well prove difficult for colleagues living in non-democratic countries in the world, such as recognising the impacts of social or political environments, engaging in more open and challenging relationships, and challenging social and cultural norms.

This reminds me of Vladimir Goussakovski (2009) writing that "… after a transactional analysis workshop in a mid-Asian country, one woman said to me that it all was very interesting, but if she shared these ideas

of “I’m OK, You’re OK” with her husband, he would kill her.” (p.323). Although this was written many years ago, we know that in many countries the same culture still applies, and even in Goussakovski’s own country, many people have left because it is dangerous to challenge the leadership.

Applying a TA approach that was generally developed within California in the 1960’s makes an article by Jackson and Medvedev (2024) even more relevant. These authors analyse survey data scanning 1981 to 2022, from 76 different national cultures (*n* = equals 406,185) and conclude “Values emphasising tolerance and self-expression have diverged most likely, especially between high income Western countries and the rest of the world. We also find that countries with similar per capita GDP levels have held similar values over the last 40 years. … values have diverged globally but converged regionally.” (Abstract, p.1). Hence, we need to factor in cultures much more than we do when we pass on TA concepts.

## Neurodivergence

Cornell’s article appeared in an issue which was devoted to neurodivergence. As Editor, Thunnissen (2024) paraphrased Cornell’s article as including “acceptance of disowned or shamed aspects of ourselves as well as reaching out to others, discussing instead of depersonalizing and demonizing all those different from ourselves. (p.111). As Cornell’s article is about these ‘dark times’, in which he seems to include wars, I am puzzled at the implication that individuals should feel shame about wars begun by others, and I am disappointed to realise that many of my colleagues feel shame about being different even though they are within the TA community. Either way, it is not a good ‘advertisement’ for TA and reminds me of the risk within the TA community of placing the responsibility for playing a game with individuals instead of recognising that they may have no choices if they born with any form of divergence that is not accepted within their society.

When I read TA material about neurodivergence and how many authors are sharing their own experiences, I am prompted to reflect on my own. I have a grandson, born in 1996, with whom I interact only by clapping my hands to make loud noises, both of us smiling a lot, which indicates that we are paying attention to each other (unconditional strokes). I am aware that when I hear what children are doing nowadays to get the label of ADHD, they seem ‘normal’ to me, at least compared to my grandson, my own childhood, and what my grandfather told me about what he did as a boy.

Perhaps my approach has been shaped by experiences – during my childhood I had a father who returned from World War II with ADHD; I had contact with a man of short stature (called at that time a midget) as a friend of my father; I knew that my uncle was homosexual and knew it was illegal so it was a family secret; I pronounced (and still do) speech in a different way to neighbours and at school because my grandmother had a Cockney (i.e. lower class) accent; from 11 years old I was the only child in the class at school from local government housing (i.e. lower class again); my mother had a period of being a Jehovah’s Witness so expected me to marry the first ‘boyfriend’ I had from 14 years old. Hence, maybe I can be seen as fitting the diagnosis of ADHD – and I wonder whether everyone who learns to be a TA practitioner is also neurodivergent.

Also, when writing about his therapy work with clients with some form of neurodiversity (Asperger’s but that is no longer an acceptable term), Flowerdew (2016) wrote “There is misunderstanding, misattunement, hurt and grief for all concerned.” (p.20). When I read that, I cannot help thinking that it often describes any interactions between any people - maybe we are all neurovariant.

Steven Porges (1995, 2011, 2017, 2024) introduced polyvagal theory and described it as we are all biologically different. This theory explains how our responses of flight, flight or freeze to emotional stress come from our heart and brain, linked together, based on our need to feel safe through connection to others as “a primary biological imperative for humans.” (Porges, 2017, p.7) (underlining added). He differentiates polyvagal theory from the traditional view of the autonomic nervous system because that supports defence instead of health when we need to react, and because our autonomic state is also our physiological state.

Porges also comments that we have “bottom-up and top-down strategies. We have bottom-up strategies in which our body subjugates our brain and conveys feelings associated with adjustments to stress and danger that impact on our ability to perceive the world. But we also have top-down strategies that we can use to put ourselves into safe environments … “ (2017, p.206). When he was asked a question about working with adult children of spectrum adults, Porges reminds us of the need to recognise the impact on the feeling of safety and security on those who have survived “world wars, the depression, and things we don’t even think about in our culture today.” (p.206).

## Autonomy

I have challenged (Hay, 2024b) the idea of how Berne suggested we needed to be autonomous in a way that might be appropriate only in North America, Western Europe and similar cultures. As shown in Figure 1, I have suggested that to Berne’s components of autonomy of awareness, spontaneity and intimacy (called awareness, alternatives, attachment) we also need to be authentic, accountable, and appropriate -

| |
|---|
| *awareness* - being in the here-and-now, knowing who we and others really are; |
| *alternatives* - having several options for how we might behave, being able to choose what to do; |
| *attachment* - being able to connect and bond with other people; |
| *authenticity* - knowing that we can be our real selves and still be OK, not having to wear a mask; |
| *accountability* – accepting responsibility for our own behaviour, recognising that we act based on our own decisions (and that we can change previous decisions); |
| *appropriate* **–** the choices we make in order to function safely in whatever context within which we find ourselves. |

*Figure 1: Autonomy (Hay, 2024b, p.29-30 summarised)*

we need to make choices to function safely in whatever context within which we find ourselves, especially if we live in cultures where some behaviours have very negative consequences. The key is that the person chooses to fit in with the context rather than believing they have no choice.

### PANDAS

An article by Lucy McDonald (2024) seems a good way to end this section about neurodiversity and biology. McDonald tells us that there is an illness called PANDAS - paediatric autoimmune neuro-psychiatric disorders associated with streptococcal infections - and this is a subset of PANS - paediatric acute-onset neuropsychiatric syndrome - which is triggered by a misdirected immune response and can often be mistaken for a psychiatric condition. She gives a case study about a 12-year-old who had suddenly changed from being an outgoing child to being frightened to leave his room, and had been seen by two doctors, two psychiatrists and two psychologists, and given antipsychotics and antidepressants that were making no difference. When PANDAS was shown via blood tests, he got better within a few days when given antibiotics.

## War

As I wrote in my introduction, I am prompted to include this subject here because of several articles that have appeared in the *Transactional Analysis Journal* (*TAJ)*, including a recent one that referred to how Berne applied TA to the topic of war. I am doubtful about how my colleagues make it appear that TA can prevent wars. I have a strong objection to thinking of war as a game. I suspect that war is more biological than psychological, and I hope I have shown above how humans are basically animals, albeit with the power of speech.

The articles about war within the *TAJ* began when Leonard Campos (2014) introduced the game of 'Tyrants and Terrorists' to show how a game of war can start, labelling it as a game on the basis of how Berne (1972) analysed games. Campos went on to propose that "… transactional analysts, working together with the international community, can contribute their expertise to preventing war." (Abstract, p.1). He commented on whether wars can be called games but then mentioned gladiatorial contests in ancient Rome, lethal family feuds, genocide, and specified civil, religious and military wars. He also admitted that it is sensitive to refer to a game and that such a label is emotionally unacceptable "to the wounded, maimed, crippled, brain-damaged, traumatized, or depressed soldiers returning from the battlefields of Iraq and Afghanistan [to whom war] is probably not subjectively experienced as a game." (p.69). He described war as a metaphor because people use the word when talking about wars, or battles, against drugs, poverty, cancer, and even in the name of the [childrens'] game of tug-of-war.

He goes on to comment that "… conflict is an inevitable part of being human … political, religious, ethnic, and national differences divide people but do not necessarily involve them in violent conflicts – unless individuals are radicalised by extremism." (p.70). He then describes events such as between the USA, Israel and Palestine and the USA strike against Iran as retaliation for the attack on the New York World Trade Centre, as being on the drama triangle. He went on to give examples of crossed and duplex transactions between what he refers to as peacemakers, before claiming that TA could work with international mediators to expose these hidden barriers.

In this article, Campos next illustrated how war can be aligned to Berne's original game analysis of thesis, aims, roles, social dynamics, examples, social paradigms, moves, and the advantages of the drama itself, pride, national solidarity, medals, profits, and as an outlet for aggression. The antithesis is to have the "… international community working collaboratively with the United Nations and its peacemaking agencies. This includes transactional analysts with intervention skills that can help prevent a conflict from escalating into a war." (p.76). This was written only 10 years ago - where are these people who have such skills?

A year later, Campos (2015) provided another article called "Cultural Scripting for Forever Wars" (Title, p.1). He began by mentioning the ongoing conflicts in Syria from 1274 BC but then concentrated on the USA. He commented on the 1776 *Declaration of Independence*

and the war that followed against the British [with no mention of the inhabitants of the USA before that!]; mentioned that many USA presidents had been former military officers; mentioned also the right to bear arms; and described the leaders of the USA as script carriers. He then wrote about script beliefs that include such aspects as: you win or you lose, kill or be killed, fight to the death, we were just following orders, and several others. He suggests how these exist at the family level, at the military subculture level, and at the broader national cultural level, before adding that these include aspects such as patriotism, displaying superpower, polarised thinking, fear of terrorism, and a "collective memory of old unforgiven injustices." (p.284). Again, Campos claims that TA can combat a cultural script of forever war.

In the same issue of the *TAJ*, Rod Sandle (2015) referred to Campos' 2014 article a couple of times briefly. Sandle also mentioned other TA authors in more detail, including Berne, Steiner, Cornell, Hargaden, Erskine, Sills, Tudor and Kahler, as well as drawing on non-TA authors Freud, Reich and Federn; he comments on the conflict within the TA community about the Take It driver in 2008, before going on to propose that Freudian sexual therapy generates a "process full of conflict. At its peak, it constitutes warfare with those who are or have become members of another group …" (p.294). He recommends that we consider sexual theory in our understanding of script. Although he concludes with a comment on "the links between narcissism and war" (p.298), he includes only a case study with a client whose only connection to war appeared to be he believed he was hidden inside a tank.

Several years later, Irina Filipache (2022) wrote about oppression in a totalitarian country. Although she does not mention war, she wrote that the Romanian Communist Party offered an illusion, and referenced Berne for the comment that shattering such illusions "occurs most commonly in wartime" (Berne, 1972, p.152). Hence this might support the concept of a just and/or necessary war because she describes how the totalitarian regime ensured pathology, hindered the maturation process, and instilled shame and hatred.

A year later, Keith Tudor (2023) entitled his article "War – a Transactional Analysis Analysis" (Title, p.1) and in the Abstract he wrote that it was to apply Berne's group theory to the topic of war. He gives us a review of previous TA publications about war, including Berne (1946/2020) writing about psycho-neurosis under the title of *Human Nature in Peace and War*, about a chapter in a different book (Berne, 1947) that did not appear in a later edition of the same book (Berne, 1969/1971), how Berne used war as an example of violation of the group structure (Berne, 1963), and how Berne named war as the grimmest game (Berne, 1964/1968). Apart from Berne, Tudor mentions how Campos (2014, 2015) provided most of what we have about war as a TA community.

Tudor goes on to review Berne's material on groups and relate this to wars such as invasions as when different powers claim a major internal boundary is within their own external boundary. He also describes Berne's (1963) processes by which a group can be terminated – decay, destruction, disruption – and how these are preceded by infiltration, erosion and attrition. However, it is not clear in Tudor's material where killing people by bombing them fits into Berne's ideas, unless we believe these are third-degree psychological games.

Tudor summarises that Berne used a few examples of war and conflict to illustrate his group and organisational theory [which theory later Tudor claims is little known although it is used very much by organisational TA consultants]. He also mentions politics but makes no reference to the politics described by me (Hay, 2021) within the TA community, or his own experiences of conflict within the TA community about the Take It driver as described by Sandle (2015) above, in spite of telling us to think "in terms of the therapist knowing, surviving, and processing their infiltrative, disruptive, erosive, and decaying parts or tendencies in order to remain open, reflective, curious, critical, creative, and facilitative." (p.319). He does not mention that this may not only happen when practitioners are with clients!

Finally, in this section I am mentioning a very recent article by Karen Minikin (2024) who describes her own intergenerational trauma as she considers the impact of the partition of India and Pakistan, and on her husband whose father and mother were both active with World War II. However, she also tells us that her father managed to achieve a Master's degree in politics in Pakistan, his family funded his travel to the UK and he attended the London School of Economics. Maybe the main impact on her was the racism that was rampant in the UK at that time [and sometimes still is]. He even had to deal with racism against Karen when he discovered that the daycare centre shut her up alone because she was brown.

## A Biological School of TA

When I first listed the schools of TA (Hay, 2022), I described Developmental TA, which I introduced many years ago to counter the emphasis I experienced within the other schools on psychotherapy. Although the Institute of Developmental TA (IDTA) that I set up with colleagues ended up closing after what happened when Covid emerged in 2020, there is still a developmental school that encompasses the non--psychotherapy fields of TA qualifications offered by ITAA and EATA. I am now proposing that we need an

additional school that relates to both developmental and psychotherapy TA.

Hopefully, readers will agree based on what I have covered above about how similar humans are to animals, how some TA concepts and values clearly do not apply to every culture in the world, and how we need to avoid presenting TA as if it can cure neurodiversity and wars. Hence, we need more of an emphasis on biological considerations – some things seem to be 'built in' to people – including TA practitioners as well as our clients.

Even Berne (1961) wrote about the protocol as what we arrive with before the script develops, so maybe Berne was identifying that there is something biological within us. However, in his final book (Berne, 1972) he no longer had protocol within the index and only referred to a "primal protocol" (p.98) which he described as the skeleton of the script and as formed within the first two years of life. He did write in 1972 that "The child is born free, but he soon learns different." (p.98) and we might query whether anyone is born free when we consider biology.

Hence, I am proposing that we describe ourselves as practising TA within a biological school, as using TA to help people maximise their quality of life taking into account their health and their context. In other words, we do not assume script is enough of an explanation and take into account the limitations (and benefits) of the biological aspects of humans. This means we need to keep up-to-date with research about our bodies and brains, as well as paying more attention to cultural contexts.

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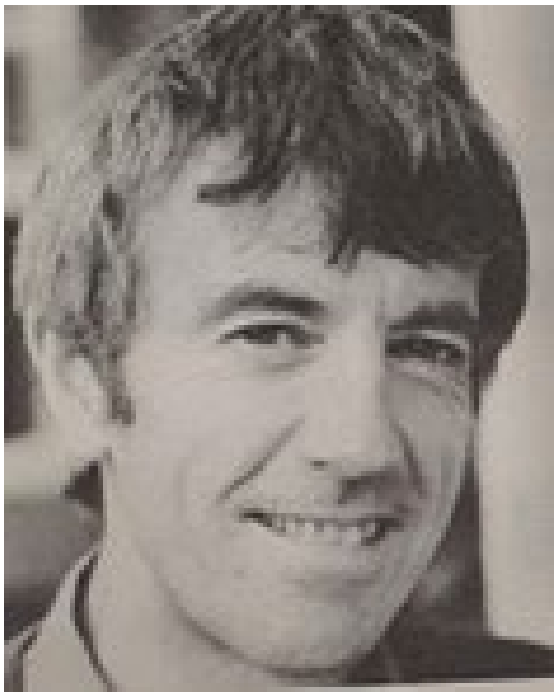
# Obituary – Ian Stewart





I am using a photo from the 1987 edition of *TA Today* because that is how I prefer to remember Ian! He had a big influence on my life, including running the Training Endorsement Workshop that I attended when I was preparing to take my TSTA examination in 1992.

A few years later, he encouraged me to set up the Institute of Developmental Transactional Analysis (IDTA) in 2003, after I had served as president of EATA and ITAA. This was because he realised how much the main UK TA Association was focused on psychotherapy – so he was so very supportive to me in terms of having a different association. And I still remember that support as I create new TA initiatives nowadays.

It is interesting for me to recall how he was almost alone within the UK Institute of Transactional Analysis (ITA as it was then before becoming UKATA) to recognise that we needed a separate association for those of us who were not practising TA psychotherapy.

A few years later, when he and Vann Joines produced the second edition of *TA Today* in 2012, he included a personal quote from me within that book and sent me a copy of the edition that I treasure because it has such a nice thank you message within it from Ian about my help with the chapter on Organisations & Education.

I am relieved that his health would have meant that he would have had no idea how our colleagues behaved within the current UK associations, and ITAA and EATA, in 2020 when they chose to blame IDTA for their own cancellation of the World TA Conference 2020 due to Covid, which in turn led us to close IDTA.

Thanks to Ian, the IDTA lasted many years and I am sure he would welcome that we are now putting our energy into some other initiatives that widen the impact of TA, including the World Online Transactional Analysis Association (https://wotaa.org) and the International Centre for Transactional Analysis Qualifications (https://ictaq.org).

Ian – your support lives on!

Julie Hay

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# Obituary – Mark Widdowson



We have lost a fantastic supporter of this journal, a wonderful colleague and TA friend, and a great transactional analyst.

Mark's contributions to *IJTAR (International Journal of TA Research* as it was called when launched for EATA) began in the second issue and were spread out until last year, by which time it had become *IJTARP* (with the addition of *Practice* in 2017 when EATA decided not to continue their involvement).

It would take several pages to show the references for his articles – you can see them if you go to https://ijtarp.org and search the Archives for his name.

Mark began with an article about Case Study Research Methodology and followed that up with a complete issue of the journal provided by him on a case study about depression. In the next issue he provided two more case studies, and then provided an article based on his keynote at the Research Conference we organised in 2012.

There are a couple of issues containing extra case studies from him, and many that he contributed to by Enrico Benelli at al. Later he was involved with Mil Rosseau in terms of researching an organisational initiative. Finally, last year he was a co-author and supervisor of Claire Bowers, with the two of them working on neurodivergence.

Mark has made a major contribution to our knowledge of *hermeneutic single-case efficacy design study,* especially applied to depression, and to research in general, especially via so many case studies.

We are certainly going to miss you, Mark! I very much hope that your copious material will encourage others to follow in your footsteps.

Julie Hay