

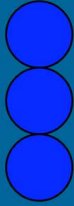


International Journal of Transactional Analysis Research

Volume 3, Issue 2 – July 2012

ISSN 2218-3159

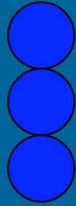
<https://doi.org/10.29044/v3i2>



Volume 3 Issue 2 July 2012

Contents

Editorial <i>Julie Hay</i>	2
TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Denise' <i>Mark Widdowson</i>	3
TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Tom' <i>Mark Widdowson</i>	15
The presence of injunctions in clinical and non--clinical populations <i>Danijela Budiša, Vesna Gavrilov-Jerković, Aleksandra Dickov, Nikola Vučković, Sladjana Martinovic Mitrovic</i>	28



Editorial

Julie Hay

Once again we are fortunate to have the contrast between quantitative and qualitative research, with much statistical analysis from Danijela Budiša and her colleagues and two more case studies from Mark Widdowson.

In a recent item in *The Psychotherapist*, Andrew Wadge (2012) quotes Bowlby (2005) on the need for both the art and science of psychotherapy. Wadge comments that ". . . we need to be clear when we are behaving as therapists and when we are research scientists . . . As scientists, we exercise a high degree of criticism, challenging data and theories . . . but we seek different qualities in a therapist." (p.15)

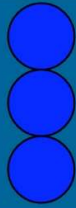
Wadge's premise is that we can be both scientist and therapist – and I would say scientist and practitioner because this applies to all fields of TA application. Our two authors in this issue provide us with helpful examples that demonstrate very different ways that we can be scientists about our work as practitioners.

Of particular note this time is that Mark Widdowson has now had published all three of his articles in this series of Hermeneutic Single-Case Efficacy Design Studies. (His first case report appeared in the previous issue of IJTAR). Publication of the third case means that TA can now be considered for recognition as 'possibly efficacious for the treatment of depression'. An extremely exciting development for the TA community!

Along with Roland Johnsson, whose Ph.D. research material appeared in IJTAR 2.2, Mark Widdowson will be a keynote speaker at the forthcoming EATA 2nd TA Research Conference which takes place in the UK November 12-13. Please go to www.taresearch.org for details, booking form and presenter proposal form

Reference

Wadge, A (2012) Struggling the worlds of research and practice – lessons from Bowlby. *The Psychotherapist* 31 15-15



TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Denise'

© 2012 Mark Widdowson

Abstract

Hermeneutic Single-Case Efficacy Design (HSCED) is a systematic case study research method involving the cross-examination of mixed method data to generate both plausible arguments that the client changed due to therapy and alternative explanations. The present study uses HSCED to investigate the outcome of short-term TA psychotherapy with a woman with severe depression. The objective of the research was to investigate the effectiveness of short-term TA therapy for the treatment of depression and to explore and identify key aspects of the TA therapy process and associated factors promoting change amongst effective cases. To enhance rigour and to address potential for researcher allegiance, independent psychotherapy researchers have adjudicated the case and offer a verdict on outcome. The conclusion of the adjudicators is that the client changed substantially, and that these changes were substantially due to the effects of therapy.

Additional rigour was introduced into the HSCED approach for this 2nd case through the use of a more stringent classification of change, an increased reliable change index score, a higher standard of proof, the use of two teams to develop the affirmative and sceptic cases, and the addition of a third judge.

Key words

Depression; Hermeneutic Single-Case Efficacy Design; Case Study Research; Transactional Analysis Psychotherapy.

Editor's Note: For the 1st paper in this series, which appeared in IJTAR 3:1, the author provided detailed appendices: the case record, affirmative and sceptic cases, judges' opinions, and various templates including adherence checklists.

Introduction

This article presents the case of 'Denise', a 46 year old white British female social worker who engaged in short-term TA psychotherapy for the treatment of depression. This article is the second in a series of systematic case studies (Iwakabe and Gazzola, 2009; McLeod, 2010) conducted by the author as part of his doctoral research investigating the process and outcome of (short-term) TA psychotherapy for the treatment of depression. In line with the first case in this series (Widdowson, 2012), the aim of this present case was to use case study methodology to analyse the effectiveness of TA therapy for the treatment of depression and to conduct a detailed analysis regarding the process of therapy.

This present case contributes to the literature on outcomes of TA psychotherapy for treatment of depression. The existing evidence-base supporting use of TA therapy for depression is small, but nevertheless shows TA is a promising intervention. The two main studies within the TA research literature regarding depression are those of Fetsch and Sprinkle (1982), which found short-term TA group therapy to be an effective intervention for men with mild-moderate depression and the first case in this series (Widdowson, 2012) which found short-term individual TA therapy to have been effective in a single-case for the treatment of severe depression. Further supporting evidence comes from the findings of a meta-analysis by Bledsoe and Grote (2006) which found that a group-based approach which integrated TA, CBT and psychoeducation was effective for the treatment of post-partum depression and the recent research conducted by van Rijn, Wild and Moran (2011) which compared short term TA therapy and short-term integrative counselling psychology in primary care settings in the UK and concluded that TA therapy was comparable to

integrative counselling psychology and using a benchmarking strategy, produced an equivalent recovery rate to CBT.

This present study is contributing to this literature by utilising the replication of method and findings in case study research with clients from a single, clinically-defined diagnostic category (in this case, people who have depression) to enhance the degree of confidence one can have in the efficacy of short-term TA psychotherapy for the treatment of depression. This present case concludes with some cross-case analysis and aggregation of findings from the first case in this series by identifying similarities between cases and analysis of client factors (moderator variables) and therapeutic processes (mediator variables). It is the replication of findings, and in particular the identification of specific factors in each case which enable the process of generalisation of findings in case study research (Iwakabe and Gazzola, 2009; McLeod, 2010). Generalizations from individual case studies need to be interpreted with caution and need to be made in consideration of the characteristics of each case (Miller, 2011). Further replication of this approach using a heterogeneous sample of clients will enable greater discrimination between factors relating to the client, the therapist and the therapeutic approach that determine outcome.

Replicating the methodology in the previous case in this series, this present case uses Hermeneutic Single-Case Efficacy Design (HSCED) (Elliott, 2001, 2002; Stephen and Elliott, 2011) to 'evaluate the efficacy of psychotherapy on a case by case basis by asking:

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

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

who use a different theoretical approach to the one being investigated - in the adjudication process helps to reduce the risk of researcher allegiance and bias influencing the findings of the research and contributes to the robustness and also the impartiality of the conclusions.

The HSCED procedure has been described in Widdowson (2012) and will not be described in detail in this introduction, although following on from the first case in this series and in conjunction with discussions with Robert Elliott, the originator of this method and wider developments in the use of HSCED method, a greater degree of stringency has been applied to this present case to strengthen the robustness of the method and the findings.

The first of these is the use of clinically significant change, rather than 'change below level of caseness' as applied in the case of 'Peter'. The second relates to the increase in reliable change index (Jacobson and Truax, 1991) score on the Personal Questionnaire scores from 0.53 in the case of 'Peter' to 1.0 in this present case. The third change relates to the standard of proof required in this present study. In line with developments in HSCED method and congruent with the quasi-legal framework used in HSCED, the standard of proof required has been heuristically set at between 'beyond reasonable doubt' (equivalent to a 95% probability) and 'balance of probabilities' (equivalent to >50% probability) at 'clear and convincing evidence' which has been defined by Stephen and Elliott (2011) as being equivalent to 80% probability. Despite this increased stringency in the present study, if retrospectively applied to the case of 'Peter' (Widdowson, 2012) the findings in that case remain unchanged.

An additional change to this present study is the use of two separate teams to develop the affirmative and sceptic cases. One of the objectives of this case series has been to encourage the use of case study methodology within the TA community, and to further this process, the author conducted a 'case study research analysis workshop' attended by TA psychotherapy trainees to give them real, practical experience of participating in the research analysis process. The trainees were given an introductory lecture to the HSCED method and reviewed several cases and formulated the affirmative and sceptic cases (see below).

The final change in this present case is the use of three instead of two judges. It was assumed that determining the overall verdict of three judges would facilitate the drawing of conclusions in the case of disagreement over fine details between judges or by introducing the principle of balance of verdict by swing in majority or from generating the mean of results.

One advantage of the compilation of the 'rich case record' used in systematic case study methodology (McLeod, 2010) is that it provides a detailed description of the case, its context and its unique features which can facilitate the drawing of conclusions regarding the effective ingredients which produced a therapeutic outcome. The use of the rich case record in this study utilises both the therapist's and the client's voices, by integrating the therapist's notes and the client's comments in their post-session qualitative questionnaires and their Change Interview (the case record is available from the researcher, on request) and quantitative data from client self-report outcome measures. One feature of the case record is the emphasis placed on the client's comments, reflections and views. Thus, the use of the client as the 'primary witness' is congruent with a humanistic approach which values the client and does not create an unhelpful hierarchy which over-values the therapist's account.

Method

Participants

Client

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

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

Denise had always enjoyed her job but recently was finding the demands of her role increasingly difficult to

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

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

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

The therapist gave Denise an information pack about the study, and several days later she contacted the therapist to say that she would like to participate in the research. She completed an informed consent form, although did not give consent for audio recordings of sessions to be made.

At the end of therapy, she once again completed an informed consent form and agreed for her case to be written up for the purposes of research and teaching and for publication. She was given the 'rich case record' when completed for checking and gave consent for the document to be used and agreed that it was an accurate representation of her therapy. She was seen in a naturalistic therapy protocol for a period of sixteen weekly individual sessions.

Therapist and Treatment

The therapist in this case was David, a male white British therapist who was a Certified Transactional Analyst (Psychotherapy) with over five years post-qualifying experience and a Teaching and Supervising Transactional Analyst (Psychotherapy). He had approximately one hour of monthly supervision on this case with an experienced Teaching and Supervising Transactional Analyst. For reasons of confidentiality

and to preserve the client's anonymity, the identity of the therapist has been obscured. David was involved in the development of the rich case record, and the construction of the affirmative and sceptic arguments.

The therapist provided short-term TA therapy which worked to the therapeutic tasks shown in the Adherence Checklists (Widdowson, 2012: App 7&8). As the research was a naturalistic study, the therapist conducted the therapy in line with their usual practice and procedures and created an individualised approach to match the client's needs. Essentially, the therapy process began with an initial alliance formation/ diagnostic/ contracting phase which involved identification of Denise's key script themes, racket system, internal dialogue (ego states/ structural analysis) and key interpersonal patterns which reinforced her script.

The second phase of the therapy (sessions 4-16) involved revisiting painful past experiences from the client's history and expressing associated emotions (deconfusion) and validation and normalisation of these emotional reactions. This also involved re-evaluating the significance of these events in the formation of the client's script, and challenging her discounting of self and her self-critical negative internal dialogue (ego states) and replacing this with a more soothing nurturing inner dialogue. This phase also included substantial exploration of current interpersonal patterns (transactions, stroking patterns, games), the client's interpretation of current interactions and how these were reinforcing the client's script, and work which focused on changing these patterns. A full account of the therapy is contained in the rich case record which is available on request from the author.

Analysis Team

The analysis team who generated the affirmative and sceptic arguments was comprised of 7 students in training for the Certified Transactional Analyst (Psychotherapy) qualification, who attended a full-day case study research analysis workshop. All post-foundation year trainees at the training institute involved were sent an e-mail invitation to attend and participants in the analysis self-selected. The workshop was intended to provide experiential learning of case study research analysis and was co-facilitated by the author and Katie Banks, Certified Transactional Analyst (Psychotherapy). (Ms Banks had participated in the analysis of the case of 'Peter'). Participants had been sent copies of the rich case records, plus an article describing the HSCED method one week prior to the workshop. The workshop commenced with a one-hour presentation on the HSCED method, following which the students read the rich case record and were split into two groups; one group formed the affirmative case, and the second group formed the sceptic case. Each group was facilitated by one of the co-facilitators who

assisted the group members in developing their arguments.

Judges

The three independent judges were selected on the basis that they were therapists from another modality, and had experience of participating in a HSCED investigation. The judges were recommended to the author by Robert Elliott, the originator of the HSCED approach and none of the judges were previously known to the researcher. The judges were Jane Balmforth, a person-centred counsellor working in a HE college who is currently doing a PhD in Counselling at the University of Strathclyde studying significant client disclosures in therapy; Anja Rutten, a counsellor and lecturer in counselling and psychology at Staffordshire University who is currently doing a PhD with the University of Strathclyde investigating person-centred/ emotion-focused therapy for people with Asperger's syndrome; and Susan Stephen, a Person-Centred BACP accredited counsellor working in private practice who has a background in law and a master's degree in counselling, and who also acted as a judge in the case of 'Peter' (see Widdowson, 2012).

Measures

In line with procedures and guidelines for the development of a systematic case study (Iwakabe and Gazzola, 2009; McLeod, 2010), multiple tools were used to build up a complex and detailed collection of quantitative and qualitative data and to assist in the compilation of the rich case record.

(The section below has been reproduced from Widdowson, 2012 as all measures and the procedure for administration of these was identical to the previously reported case of 'Peter')

Quantitative Outcome Measures

Two standardised self-report outcome measures were selected to measure target symptoms (Beck Depression Inventory- BDI-II) (Beck et al. 1996) and global distress/ functional impairment (CORE-OM) (Barkham et al., 2006). These were administered before the first session, and at sessions 8 (mid-way through therapy) and 16 (end of therapy). These measures were also administered at the one-month, three-month and six-month follow up periods. These measures were evaluated according to clinical significance (client moved into a non-clinical range score) and Reliable Change Index (Jacobson and Truax, 1991) (non-clinically significant change). See Table 1 for Reliable Change Index (RCI) values for each measure.

Weekly Outcome Measures

In order to measure on-going progress, and to facilitate the identification of key therapeutic events which produce significant change, two weekly outcome measures were administered prior to the start of each session.

These were CORE-10 (Connell & Barkham 2007), a ten item shortened version of the CORE-OM which has good correlation with CORE-OM scores and can be used to monitor change. The second measure was the simplified Personal Questionnaire (PQ) (Elliott, et al, 1999). This is a client-generated measure in which clients specify the problems they are wanting to address in their therapy, and rate their problems according to how distressing they are finding each problem. The PQ was also administered at each of the three follow-up intervals.

Qualitative Outcome Measurement

Qualitative outcome data was collected one month after the conclusion of the therapy. The client was interviewed using the Change Interview protocol (Elliott, 2001) - a semi-structured qualitative change measure which invites the client to explain how they feel they have changed since starting therapy, how they think these changes came about, what they felt was helpful or hindering in the therapy, and what changes they feel they still need to make. As part of this, the client identifies key changes they have made and indicates using a five-point scale whether they expected these changes, how likely these changes would have been without therapy, and how important they feel these changes to be.

Qualitative Data about Helpful Aspects of Therapy

In order to gain data regarding specific events or aspects of the therapy the client found useful, the client completed the Helpful Aspects of Therapy (HAT) (Llewelyn, 1988) at the end of each session. The HAT asks the client to describe both the most and least helpful aspects of the therapy session and to rate the helpfulness/ unhelpfulness of the session.

Therapist Notes

The therapist also completed a structured session notes form at the end of each session. The therapist provided a brief description of the session and key issues, therapy process, the theories and interventions they used and indicated how helpful they felt the session was for the client.

Adherence

The therapist also completed a twelve-item adherence form at the end of each session, rating the session on a six-point scale. The therapist's supervisor also rated the therapist's work using the same form to verify therapist competence and adherence in providing identifiably TA therapy. (Widdowson, 2012: 5-6)

HSCED Analysis Procedure

(Note: this section has also been reproduced from Widdowson, 2012 as the guidelines for the development of both the affirmative and sceptic cases are identical to those for the previous case)

Affirmative Case

The affirmative case is built by identifying positive and convincing evidence to support a claim that the client changed and that these changes primarily came about as a result of therapy. In line with HSCED procedure, to make a convincing case that the client changed positively and as a result of therapy, the affirmative case must be built by identifying evidence for at least two of the following:

1. changes in stable problems: client experiences changes in long-standing problems
2. retrospective attribution: client attributes therapy as being the primary cause of their changes
3. outcome to process mapping: 'Content of the post-therapy qualitative or quantitative changes plausibly matches specific events, aspects, or processes within therapy' (Elliott et. al, 2009; 548)
4. event-shift sequences: links between 'client reliable gains' in the PQ scores and 'significant within therapy' events

Sceptic Case

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

1. Apparent changes are negative or irrelevant
2. Apparent changes are due to measurement or other statistical error
3. Apparent changes are due to relational factors (the client feeling appreciative of, or expressing their liking of the therapist or an attempt to please the therapist or researcher) (note, this is a term used in the HSCED approach and does not refer to the impact of the therapeutic relationship as a vehicle for change and relates to factors not directly within the therapy process. The reader is invited to notice the different ways that 'relational' is used within this report, which include this criteria, the therapeutic relationship and a relational approach to therapy)
4. Apparent changes are due to the client conforming to cultural or personal expectancies of change in therapy
5. Improvement is due to resolution of a temporary state of distress or natural recovery
6. Improvement is due to extra-therapy factors (such as change in job or personal relationships etc)
7. Improvement is due to biological factors (such as medication or herbal remedies)

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

Once the sceptic case had been presented, the affirmative team developed rebuttals to the sceptic case. The sceptic team then developed further rebuttals to the affirmative rebuttals, thus providing a detailed and balanced argument.

Adjudication Procedure

The rich case record and the affirmative and sceptic cases and rebuttals were then sent to the independent judges for adjudication. The judges were asked to examine the evidence and provide their verdict as to whether the case was a clearly good outcome case, a mixed outcome case, or a poor outcome case; to what extent the client had changed and to what extent these changes had been a result of therapy; and to indicate which aspects of the affirmative and sceptic arguments had informed their position. The judges were also asked to comment on what factors in the therapy did they consider to have been helpful and which characteristics about the client did they think had contributed to the changes. (Widdowson, 2012: 6)

Results

Quantitative Outcome Data

Denise's quantitative outcome data is presented in Table 1. As can be seen, all of Denise's initial scores were well within clinical ranges and substantially higher than the caseness cut-off for inclusion in the study. Her BDI-II score at entry into therapy was 33, indicating severe depression and her CORE-OM score was 21.1, indicating moderate levels of global distress and functional impairment. Denise's BDI-II score had demonstrated reliable change by session 8, and was maintained at session 16, then continuing to improve to clinically significant levels of change at one-month follow up and maintained throughout the follow-up period. It is noteworthy at this point to mention that Denise experienced two bereavements in the latter half of her therapy- a factor which the affirmative team discussed in their analysis of the case. Denise's CORE scores had attained clinically significant change by session 8, and continued to improve through the end of therapy (with some minor deterioration at the time of the bereavements) and during the follow-up period. Denise's PQ scores showed steady improvement throughout therapy, achieving clinically significant change by the end of therapy and showing continued improvement throughout follow-up.

Qualitative Process Data

Denise completed a HAT form at the end of fifteen of the sessions, indicating what had been helpful or hindering/unhelpful in the session. She identified at least one helpful event on each of these forms, and did not identify any hindering or unhelpful events during the therapy. The majority of the helpful events Denise

identified related to feeling safe and accepted and other aspects of the therapeutic relationship, to increased insight into her intrapsychic and interpersonal process and also to expressing previously unexpressed emotions which related to the therapist's focus on deconfusion. Examples include:

In session 4: 'Getting in touch with my feelings. Feeling my feelings and knowing that they need to be acknowledged and allowed to be completed over time. Space in the conversation, authenticity of the therapist. Feeling safe in the environment with my therapist. I got acknowledgement of myself and permission to work through what I need to do and to take as long as it takes' (rated 8- 'greatly helpful')

In session 6; 'In this session it was the feeling of being in a safe environment in which I knew I was not going to be judged which allowed me to open up to speak about something I had never even alluded to anyone else about. Knowing that my therapist was experienced enough to guide me through the memories and that I was reassured that they could be revisited as appropriate. Also the invitation to explore the subject made me feel reassured that I could speak about it. (rated 8- 'greatly helpful')

Exploration of my family dynamics and the dichotomy of being seen by my family when they need me to do something.' (rated 9 - 'extremely helpful')

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

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

Qualitative Outcome Data

In the Change Interview which took place at the one-month follow-up, Denise identified ten changes which had occurred since starting therapy. The changes are listed in Table 2. These changes primarily related to an increase in her self-esteem and self-confidence. One change related to the development of an optimistic outlook and another change clearly related to changes in how she interacts with others.

Table 1: Denise's Quantitative Outcome Data

	Beck Depression Inventory-II	CORE-OM	Personal Questionnaire (mean score)
Clinical cut-off	10	10	3.00
Caseness cut-off	16	15	3.50
Reliable Change Index	5.78	4.8	1.00
Pre-Therapy	33	21.1	4.5
Session 8	17(+)	13.8(++)	3.8
Session 16	17(+)	7(++)	3.0(++)
1 month Follow-up	7(++)	4(++)	2.0(++)
3 month Follow-up	8(++)	7(++)	2.1(++)
6 month Follow-up	1(++)	2(++)	1.6(++)

Note: Values in **bold italic** are within clinical range. + indicates Reliable Change, ++ indicates change to below 'caseness' level.

Figure 1: Weekly and Follow-Up CORE-10 scores (clinical significance 10)

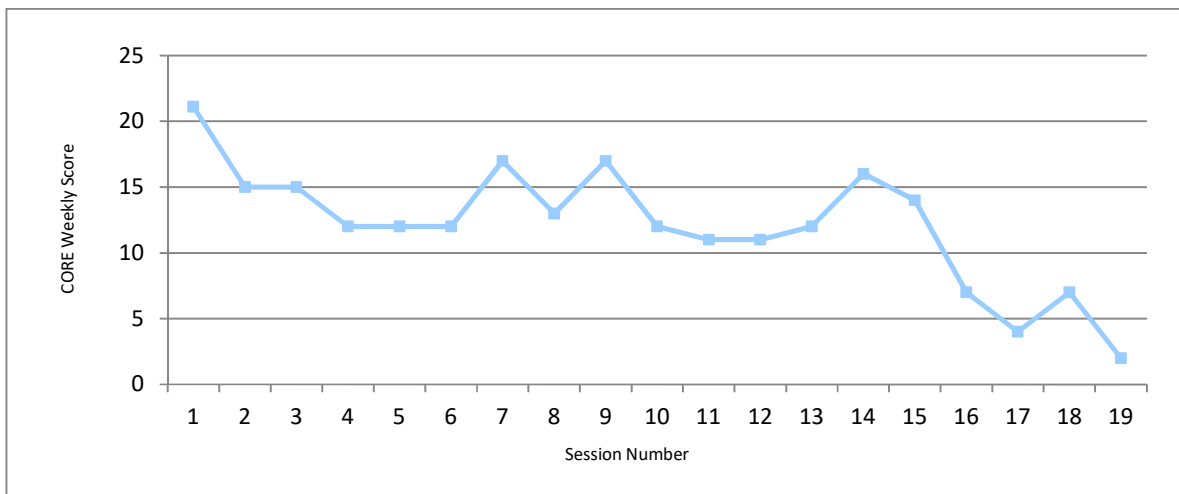


Figure 2: Weekly and Follow-Up mean PQ scores (clinical significance 3)

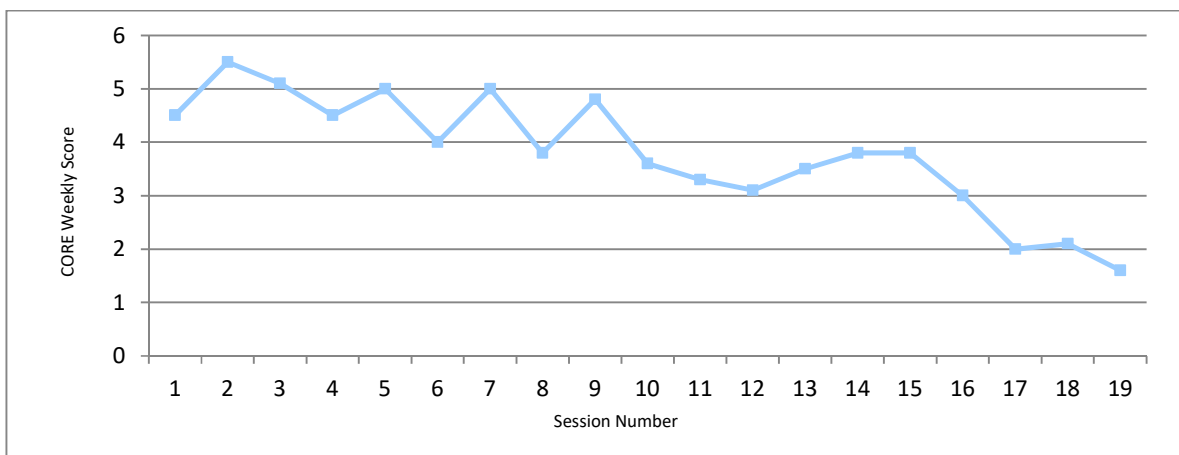


Table 2: Denise's changes as identified in post-therapy Change Interview

Change	How much expected/surprising change was ^a	How unlikely/likely change would have been without therapy ^b	Importance of change ^c
Decision Making	1	1	5
Confidence in my abilities	3	1	5
Confidence in myself	5	1	5
'Core Strength'	1	1	5
Giving myself permission	3	1	5
Improved Body Image	5	1	5
I feel happier in myself	1	1	5
Optimism	5	1	5
I feel more equal and less adapted in my relationships	5	1	5
I now see myself as important	5	1	5

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

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

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

Affirmative Case

The affirmative team argued that there were four main lines of argument which provided clear and compelling evidence that Denise had changed substantially and that these changes had been due to therapy. The first line of evidence put forward was the changes in Denise's quantitative measures- by session sixteen she had achieved clinically significant change on the CORE-OM and PQ and had achieved reliable change on her BDI-II scores. The affirmative team put forward the argument that Denise was still recovering from two bereavements and that her score on BDI-II at the end of therapy was likely to be associated with the impact of these bereavements and cited her improvement at the one-month follow up as evidence of this. At the one month follow-up, Denise showed clinically significant change on all three measures which was sustained throughout the remainder of the follow-up period. This was considered to be particularly compelling given the

initial severity of Denise's depression. The affirmative team also highlighted that the items on Denise's PQ had all been long-standing problems and that these appeared to have been resolved during therapy and that this improvement had been maintained, suggesting she had experienced internal restructuring and resolution of factors which contributed to her depression. Evidence from Denise's Change Interview was also cited, including the development of a positive and optimistic outlook on life and her descriptions of significant changes made in her day-to-day life such as changes in her self-esteem, relationships, working patterns, self-care and financial matters.

The second line of evidence related to Denise's clear and unequivocal retrospective attribution that all of her changes were unlikely to have come about without therapy. The third line of evidence related to how there appeared to be convincing links between the therapy process (as described in the therapist's account and Denise's responses on the HAT forms) and the ten changes which Denise identified in her Change Interview. Finally, the affirmative team noted that there was clear evidence of significant event-shift sequences with reliable change (as measured by improvements on PQ and CORE scores) demonstrated after sessions seven, nine and fifteen.

Sceptic Case

The sceptic team considered that there was reason to believe that Denise's problems were more reactive to external events than her Change Interview might suggest and that her improvements could be explained by extra-therapy changes, such as changes in her working conditions and natural recovery from bereavement. The sceptic team also highlighted that Denise's description of the therapy and therapist was extremely positive- despite her reporting feelings frustrated at several points in the therapy suggesting that (social) relational factors may be influencing her report of the therapy. Additionally, the sceptic team considered that there was evidence that expectancy factors may have led Denise to overestimate the magnitude of her change. Associated with both relational and expectancy factors the sceptic team cited Denise's tendency to please other people as potentially casting doubt on the attribution of change to the therapy.

Affirmative Rebuttal

The affirmative rebuttal argued that although there had been many external changes in Denise's circumstances, she attributed these to changes she made in therapy and noted that Denise's BDI-II scores at the one-month follow-up suggested a rapid recovery from her bereavements thus indicating that deep changes had taken place in how she responded to stressful events. The affirmative team refuted the sceptic team's argument relating to relational factors,

citing Denise's acknowledgment of her frustration at times during therapy as providing a balanced picture which did not suggest an overly positive view of the therapy process and that Denise's subsequent reflection on these occasions demonstrated that she had found these events to be therapeutic.

The affirmative team also refuted the sceptic argument of expectancy factors by considering that Denise's active selection of the type of therapy and the therapist had been the positive choice of an informed and intelligent woman who had carefully made these choices based on a clear appraisal and fairly sophisticated grasp of what the therapy might involve. Linked to this, the affirmative team put forward the view that there was strong evidence that Denise's therapy had been carefully implemented and of being linked to a clear and consistent case formulation and treatment plan throughout. Finally, the affirmative team highlighted that Denise's changes on quantitative and qualitative outcome measures provided a consistent, clear and compelling picture of substantial and lasting global changes.

Sceptic Rebuttal

The sceptic rebuttal included the view that Denise's description of the change process had been vague and lacking in detail of specific change events in therapy. Linked to this, they put forward that argument that extra-therapy factors may have played a much larger role in Denise's improvement than her attributions of change in her Change Interview. The sceptic rebuttal also highlighted Denise's tendency towards not trusting her own abilities, combined with a tendency towards pleasing others would make her highly pre-disposed towards underestimating her own contribution towards positive change and overestimating the influence of her therapist and the therapy.

Adjudication

The three judges independently reviewed the case materials and produced their reports regarding their verdicts on the case, citing the evidence which had influenced their opinions and describing the factors they considered to have been significant in this case. The judges' verdicts and a mean score of all three judges' conclusions are presented in Table 3. To summarise, the judges concluded that Denise had experienced clinically significant change and had changed substantially and that these changes were substantially due to therapy.

Summary of opinions regarding how the judges would categorise this case

(Clearly good outcome - problem completely solved, Mixed outcome - problem not completely solved, Negative/ Poor Outcome)

There was unanimous verdict of the judges that the case was a clearly good outcome case, with a mean certainty of 86%. The judges considered that the combination of quantitative outcome data showing clinically significant change which was maintained throughout follow-up and the quantitative outcome data from the Change Interview provided convincing evidence that this was a clearly good outcome case, although the judges noted that external factors in Denise's life had probably had an impact in terms of reduced gains in the second half of therapy.

Summary of opinions regarding the extent to which the client had changed

Once again, there was a unanimous verdict of the judges that Denise had changed substantially, with all three judges concluding that the client's changes had been in the 80% range. The judges varied slightly in their level of confidence in this conclusion, although the mean certainty level was 80%.

Summary of opinions as to whether the changes were due to the therapy

The judges were unanimous in their conclusion that the changes experienced by Denise were substantially (80%) due to the effects of therapy. There was some variation in their degree of certainty about this, although the mean certainty level was also 80%. Judges A and B rejected the sceptic claims that Denise's improvement could be accounted for as an attempt to please her therapist and/or due to expectancy factors. To support their rejection of these arguments, they cited Denise's honest account of her frustrations in therapy, her surprise at many of her changes, the changes evident by the outcome measures, her substantial life changes and her achievement of her therapy goals as evidence of clearly positive outcome which could not be accounted for by the sceptic arguments.

Furthermore, judges A and B rejected the sceptic claims that Denise's account of the therapy was vague and felt that on the contrary, Denise has provided a detailed account of the therapy process and that her use of TA language indicated that she had deeply integrated these changes. Judge C, however was somewhat persuaded by the sceptic argument that there may be evidence of some 'pleasing' of the therapist or researcher, in view of the fact that Denise's reports contained uniformly positive comments about the therapy and the therapist.

Mediator factors

The judges were asked to provide their opinion on which therapist characteristics and therapeutic factors had been most helpful in generating change. The judges agreed that the empathic, non-judgmental and encouraging stance of the therapist had been important

Table 3: Adjudication decisions

	Judge A	Judge B	Judge C	Median/Mean
1. How would you categorise this case? How certain are you?				
1a. Clearly good outcome (problem completely solved)	100%	80%	80%	86%
1b. Mixed Outcome (problem not completely solved)	0%	0%	0%	0%
1c. Negative/Poor Outcome	0%	0%	0%	0%
2. To what extent did the client change over the course of therapy?	80% Substantially	80% Substantially	80% Substantially	80% Substantially
2a. How certain are you?	100%	80%	60%	80%
3. To what extent is this change due to therapy?	80% Substantially	80% Substantially	80% Substantially	80% Substantially
3a. How certain are you?	100%	80%	60%	80%

in this case. The judges also agreed that the therapist's willingness to provide a rationale or use theory to explain and support the therapy and assist Denise in making links with and coming to terms with her past had also been important. Furthermore, judges A and B agreed that the therapist's focus on Denise's script and both their continued challenging of her script, an attentiveness to how it might be manifesting in the therapy and avoidance of unhelpful transference enactments of her script had also been a significant factor.

Moderator factors

The judges were asked to provide their opinion on which personal characteristics and resources of the client enabled the client to make best use of the therapy and enhanced the therapeutic process. All judges agreed that Denise's sense of hopefulness at the outset of therapy was an important factor. The judges also agreed that the fact that Denise was well-informed about both therapy and in particular, TA therapy had also been significant as had her making a clear and informed decision in choosing the right therapist. It was acknowledged that she was clearly well-motivated and had a number of clear goals for the therapy and a degree of insight from the outset and that these too had been important factors. Denise's courageousness and willingness to address difficult and painful material (e.g. sexual abuse) and her continued attempts to integrate the insights gained in therapy into her everyday life was also identified as a key factor.

Judge A identified Denise's willingness to accept her therapist's challenges and persist with finding her own answers to her problems had also been important.

Discussion

Once again, replicating the findings in the case of 'Peter', TA psychotherapy was a successful treatment for severe depression. These results also seem to support the conclusions of the meta-analysis of Cuijpers et al (2011) that initial severity of depression did not appear to negatively impact on the efficacy of psychotherapy, however do not support the conclusions of van Rijn et al (2011) that severity of initial symptoms negatively impacted on outcomes and therefore further research is warranted to investigate the relationship between initial severity and other factors which may contribute to outcome.

This positive replication of the effectiveness of short-term TA therapy for the treatment of depression in a second systematic case study clearly indicates that TA psychotherapy shows considerable promise as a psychological therapy for the treatment of depression and is another step forward to the recognition of TA as an evidence-based therapy.

In line with much previous research, the quality of the therapeutic relationship appeared to be significant to the outcome. A TA perspective on important aspects of the therapeutic relationship appear to be that it was characterised by an 'I'm OK- You're OK' style of relating, therapist permissiveness and nurturing which emphasised the client's autonomy and capacity to change combined with careful attention not to inadvertently reinforce the client's script beliefs in the therapy process. Furthermore, also in line with existing research and the previously published case of 'Peter' from this present series, the impact of client hope and expectations (Constantino, et al. 2011), motivation

(Zuroff, et al. 2007) and client preferences (Swift, et al. 2011) appear to have been significant factors contributing towards the positive outcome in this case. Additional features which this case shares with the case of Peter include the therapist's clear case formulation and willingness to explore theoretical explanation with the client as being helpful, the courageousness of client to commit to the process and push themselves through difficult and painful therapy processes.

Similar to the case of Peter, this present case did not appear to identify specific mechanisms of action or interventions/ therapy episodes which produced significant change and therefore further research is indicated which would explore and identify effective therapeutic procedures, in addition to therapeutic relationship factors.

Limitations

A potential limitation of this case is that the researcher was either the current or former course tutor of the members of the analysis team, and this may have inadvertently influenced their responses. Despite the thoroughness of their arguments, it is also possible that their relative inexperience may have limited their arguments. The possibility of researcher bias is one which needs to be accounted for in the findings of this present study, although the use of three independent psychotherapy researchers acting as judges was used as a strategy to reduce this risk.

Conclusion

The conclusions of the judges are that Denise changed substantially and that these changes were substantially due to the effects of therapy. Denise attained clinically significant change on all three quantitative outcome measures and had sustained her improvement throughout follow-up. Her change interview responses provided a clear and compelling argument regarding the magnitude and breadth of her changes and that these changes were primarily due to the effects of therapy.

Although the gains in the second half of the therapy were somewhat limited, it would appear that this was due to the impact of extra-therapy factors, in particular bereavement and that once the acute grief phase had passed, Denise continued to improve, suggesting that the changes were deeply integrated and were self-maintaining. The importance of the therapeutic relationship is once again reaffirmed as crucial in promoting therapeutic change and there is preliminary evidence from this case and the case of Peter to suggest that the use of TA for case formulation and in providing rationale/ explanation for the client is an effective approach when matched to the client's preferences and life script.

This present case strengthens the argument put forward in the case of Peter that short-term TA psychotherapy clearly has promise as a treatment for depression. Furthermore, it would appear that TA psychotherapy has promise as a treatment with severe depression with clients who are motivated, actively engaged in the treatment process and who feel 'well-matched' to their therapist.

Mark Widdowson, *Teaching and Supervising Transactional Analyst (Psychotherapy)*, Associate Director, The Berne Institute, Ph D student, University of Leicester, can be contacted on: mark.widdowson1@btopenworld.com

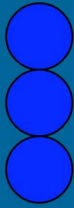
The author wishes to thank the members of the analysis team: Jane Bernard, Isabel Burns, Phil Crawley, Mike Day, David Harford, Colin Kerr and Owen Vaughan. Particular thanks also are due to Katie Banks for her invaluable contribution.

The author also acknowledges with grateful thanks the support of Physis Training in Edinburgh, which provided the venue and participants for the workshop at which the affirmative and sceptic cases were developed.

References

- American Psychiatric Association (Ed.) (1994) *Diagnostic and Statistical Manual of Mental Disorders- fourth edition*. Washington, DC: American Psychiatric Association
- Barkham, M., Mellor-Clark, J., Connell, J., and Cahill, J. (2006). A core approach to practice-based evidence: a brief history of the origins and applications of the CORE-OM and CORE system. *Counselling and Psychotherapy Research*, 6(1): 3-15.
- Beck, A.T., Ward, C.H., Mendelssohn, M.J. and Erbaugh J. (1961) 'An inventory for measuring depression'. *Archives of General Psychiatry*, 4:561-571
- Beck, A.T., Steer, R.A., Brown, G.K. (1996) *Manual for Beck Depression Inventory II (BDI-II)*. San Antonio, TX: Psychology Corporation
- Bledsoe, S.E., and Grote, N.K. (2006) 'Treating depression during pregnancy and post-partum: A preliminary meta-analysis'. *Research on Social Work Practice*. 16(2): 109-20.
- Chambless, D.L. and Hollon, S.D. (1998) Defining Empirically Supported Therapies. *Journal of Consulting and Clinical Psychology*, 66(1): 7-18
- Constantino, M.J., Arnkoff, D.B., Glass, C.R., Ametrano, R. M. Smith, J.Z. (2011) 'Expectations', *Journal of Clinical Psychology: In Session*. 67(2): 184-192
- Connell, J. & Barkham, M. (2007). CORE-10 User Manual, Version 1.1. CORE System Trust & CORE Information Management Systems Ltd
- Cuijpers, P., Andersson G., Donker T. and van Straten, A. 'Psychological treatment of depression: Results of a series of meta-analyses', *Nordic Journal of Psychiatry*, 65: 354-364

- Elliott, R. (2001). Hermeneutic single case efficacy design (HSCED): An overview. In K.J. Schneider, J.F.T. Bugental & J.F. Fraser (eds.), *Handbook of Humanistic Psychology* (pp315-324), Thousand Oaks, CA: Sage.
- Elliott, R. (2002) Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12(1): 1-21
- Elliott, R., Mack, C., & Shapiro, D. (1999). Simplified Personal Questionnaire Procedure. (On-line). Available: <http://www.experiential-researchers.org/instruments/elliott/PQProcedure.doc> Downloaded 25 January 2012
- Elliott, R., Partyka, R., Alperin, R., Dobrenski, R., Wagner, J., Messer, S.B., Watson, J.C. and Castonguay, L.G.(2009) 'An adjudicated hermeneutic single-case efficacy design study of experiential therapy for panic/phobia'. *Psychotherapy Research*, 19(4-5): 543-557
- Fetsch, R. J., and Sprinkle, R. L. (1982) 'Stroking treatment effects on depressed males', *Transactional Analysis Journal*, 12(3): 213-7
- Iwakabe, S. & Gazzola, N. (2009) From single-case studies to practice-based knowledge: aggregating and synthesizing case studies. *Psychotherapy Research*, 19, 601-611
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59: 12-19
- Llewelyn, S. (1988) Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, 27, 223-238.
- McLeod, J. (2010). *Case Study Research in Counselling and Psychotherapy*. London: Sage
- Miller, R.B. (2011) 'Real Clinical Trials (RCT) – Panels of Psychological Inquiry for Transforming Anecdotal Data into Clinical Facts and Validated Judgments: Introduction to a Pilot Test with the Case of "Anna" ', *Pragmatic Case Studies in Psychotherapy*, 7(1): 6-36 (article available at: <http://pcsp.libraries.rutgers.edu> Downloaded 4th March 2011)
- Stephen, S and Elliott, R. (2011) „ the Adjudicated Case Study Method. *Pragmatic Case Studies in Psychotherapy*, 7(1): 230-241 (article available at: <http://pcsp.libraries.rutgers.edu>) Downloaded 4th March 2011
- Swift, J.K., Callahan, J.L. and Vollmer, B.M. (2011) 'Preferences', *Journal of Clinical Psychology: In Session*. 67(2): 155-165
- van Rijn, B., Wild, C., and Moran, P. (2011) 'Evaluating the Outcomes of Transactional Analysis and Integrative Counselling Psychology within UK Primary Care Settings', *International Journal of Transactional Analysis Research*. 2(2): 34-43
- Widdowson, M. (2012) 'TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study – "Peter" ', *International Journal of Transactional Analysis Research*. 3(1): 3-13
- Zuroff, D.C., Koestner, R., Moskowitz, D.S., McBride, C. Marshall, M. and Bagby, R.M. 'Autonomous motivation for therapy: A new common factor in brief treatments for depression', *Psychotherapy Research*. 17(2): 137-147



TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Tom'

© 2012 Mark Widdowson

Abstract

Hermeneutic Single-Case Efficacy Design (HSCED) is a systematic case study research method involving the cross-examination of mixed method data to generate both plausible arguments that the client changed due to therapy and alternative explanations. The present study uses HSCED to investigate the outcome of short-term TA psychotherapy with a man with moderate depression and comorbid social anxiety. The objective of the research was to investigate the effectiveness of short-term TA therapy for the treatment of depression and to explore and identify key aspects of the TA therapy process and associated factors promoting change amongst effective cases. To enhance rigour and address potential for researcher allegiance, independent psychotherapy researchers have adjudicated the case and offer a verdict on outcome. The majority verdict of two judges in this case was that this was a positive outcome case and that the client had changed substantially and that these changes were substantially due to the effects of therapy. The third judge's conclusion was that this was a mixed outcome case, and that the client had changed considerably and that this had been considerably due to therapy.

This is the 3rd case reported on and additional rigour was introduced into the HSCED approach in the same way as reported in the accompanying paper about the 2nd case. (IJTAR 3:2, 3-14)

Key words

Depression; Hermeneutic Single-Case Efficacy Design; Case Study Research; Transactional Analysis Psychotherapy.

Editor's Notes: For the 1st paper in this series, which appeared in IJTAR 3:1, the author provided detailed appendices: the case record, affirmative and sceptic cases, judges' opinions, and various templates including adherence checklists.

Introduction

This article presents the case of 'Tom', a 38 year old white British male builder who engaged in short-term TA psychotherapy for the treatment of depression and social anxiety. This article is the third in a series of systematic case studies (Iwakabe & Gazzola, 2009; McLeod, 2010) conducted by the author as part of his doctoral research investigating the process and outcome of (short-term) TA psychotherapy for the treatment of depression. In line with the previous cases in this series (Widdowson, 2012a, 2012b), the aim of this present case was to use case study methodology to analyse the effectiveness of TA therapy for the treatment of depression and to conduct a detailed analysis regarding the process of therapy.

This present case contributes to the literature on outcomes of TA psychotherapy for treatment of depression in the same way as described for the 2nd case (Widdowson 2012b) so that rationale and review of prior research will not be repeated here. In summary, this present case uses Hermeneutic Single-Case Efficacy Design (HSCED) (Elliott, 2001, 2002; Stephen & Elliott, 2011), enhanced as described for the 2nd case, to 'evaluate the efficacy of psychotherapy on a case by case basis by asking:

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

Increasingly, psychotherapy researchers are questioning the dominance of Randomised Controlled Trials (RCT's) within psychotherapy research and are calling for an integrated research approach which in

addition to RCT evidence also incorporates a range of other research methods including practice-based, qualitative and systematic case study research (Barkham et al 2010; Dattilio et al, 2010; McLeod & Elliott, 2011).

Whilst large *n*, quantitative studies (such as RCT's) have been incredibly useful in establishing the efficacy of psychotherapy, both within tightly-controlled conditions as well as in routine practice (such as Stiles, et al, 2008), these studies have not been able to provide detailed information regarding the specific factors which have influenced the change process in individual clients (McLeod & Elliott, 2011). Although RCT's are generally considered to be high in internal validity, Dattilio et al (2010) consider RCT's to have problems with internal validity due to not accounting for 'softer', more intangible variables such as therapist responsiveness, therapeutic alliance, the impact of client hope and their perceptions of the therapist's credibility.

McLeod & Elliott (2011) describe some particular strengths of case study research as including the ability to account and allow "for the identification and analysis of complex patterns of interplay between different factors or processes" (p. 3) including contextual factors within each case, detailed exploration of how change takes place over time, and providing practice-relevant and accessible information for practitioners.

They go on to state that "the quality of evidence generated by . . . intensive single-case outcome studies, is in many respects more credible than the evidence produced by RCTs and other large-scale studies. Because they use many different sources of information, readers and reviewers can be confident that systematic outcome-oriented case studies reflect the most accurate appraisal that is possible of the extent to which a client has been helped by therapy. By contrast, large-scale studies represent aggregations of outcome estimates based on much more limited evidence for each case. The value of case study evidence in establishing the effectiveness of therapeutic intervention has been recognised by several leading authors on evidence-based policymaking (e.g. APA Presidential Taskforce, 2006; Chambless & Hollon, 1998; Edwards, Dattilio, & Bromley, 2004; Medical Research Council, 2008)." (p. 7). They also note that the majority of published systematic case studies are of therapy conducted in university research clinics and that there is a paucity of published cases of therapy as it tends to be conducted in everyday, routine clinical practice with the type of clients who tend to present for therapy in routine practice.

This present case series is different in that all of the therapists participating in this case series were working

in the type of settings that many therapists practice in (this and the previous two cases were of therapy conducted in private practice) and the clients were all clients who self-referred and presented for psychotherapy. In order to learn more about what TA psychotherapists actually do in practice, the therapy in this case series was subject to limited amounts of intrusion in the therapy process and therapists were invited to conduct the therapy as closely to what they would normally do, with the obvious exceptions of the recording procedures required for the research. Similarly, very limited inclusion and exclusion criteria were applied to ensure that the clients in this case series most closely resembled the type of clients that most therapists might encounter on a daily basis. The intention here was to facilitate the process of generalisation from this case series and the transfer of the research findings by therapists into their practice.

This present case analyses the process and outcome of sixteen sessions of TA therapy with 'Tom'. A central feature of Tom's depression and social anxiety was his self-critical internal dialogue and a significant amount of the therapy was focused on addressing this self-criticism, which was conceptualised as a negative ego state dialogue. Self-criticism has been recognised as a significant component of depression (Bagby, et al 1992) and social anxiety (Cox, et al 2000; Cox, et al 2004) and it has been speculated that it is possible that these disorders share a common pathway of introjective psychopathology (Blatt, 1991) which is characterised by low self-esteem, feelings of inferiority, negative beliefs about one's value and worth and negative comparison to others. It would appear that these introjective aspects of the process of depression and social anxiety are also a feature of a number of other psychological disorders, making self-criticism an important transdiagnostic clinical concept and one which may prove fruitful for change when it is the focus of sustained and intensive therapeutic efforts.

Self-criticism is presumed to originate in negative relational experiences which become introjected into the individual's psyche where they are replayed internally (Blatt, 1991) and it has been suggested that therapy which intensively targets self-criticism may have a substantial impact on depression, social anxiety and other introjective disorders (Cox, et al 2002; Cox, et al 2004). Sachs-Ericsson et al (2006) also noted a relationship between parental verbal abuse and self-criticism and internalizing symptoms - a factor which appears to have been relevant in Tom's case. Within a TA framework, self-criticism tends to be viewed as a negative internal dialogue between Parent and Child ego states (Berne, 1972; Goulding & Goulding, 1979; Woollams & Brown, 1979; Stewart & Joines, 1987; Clarkson, 1992; Widdowson, 2010)

Method

Participants

Client

Tom was a 38 year old white British builder, who presented for private, weekly TA psychotherapy. Contrary to what one might expect from his tall, muscular build, he described feeling anxious and intimidated socially and feeling very down. He described problems with communicating with people, and often crippling levels of social inhibition. He felt he was stupid and useless, and had very poor self-esteem. He described what sounded like a relentless self-critical internal dialogue which was making him feel depressed. He described low mood, a loss of interest in things and feeling pessimistic and despondent about the future. Tom had a very difficult upbringing and was treated harshly, particularly by his mother and had been bullied at school for having some speech difficulties.

He was in a long term, long distance relationship, which was generally positive, although he often also felt inhibited around his partner's three children. He felt that his low mood, lack of interest and social inhibition was harming his relationship with his partner, and also preventing him from building his relationship with her children.

Tom had received six sessions of counselling in a primary care setting several years previously due to his difficulties with relating to others. He found this experience supportive but limited. Just prior to engaging in the therapy presented here, he had become interested in transactional analysis and had read several books about TA. He found his reading on TA theory to be helpful and as a result actively sought out a TA therapist.

At the intake interview, the therapist determined that Tom did not meet any excluding criteria for participation in the study (psychosis, domestic violence, active drug/alcohol abuse) and conducted a brief clinical diagnostic interview to confirm diagnosis of major depressive disorder based on DSM-IV diagnostic criteria (APA, 1994). Tom also met diagnostic criteria for comorbid social anxiety disorder. Tom's clinical score at point of entry to therapy using CORE-OM was 18, indicating mild levels of distress and functional impairment and his BDI-II score was 24, indicating moderate depression. Tom was given an information pack about the research project and invited to participate.

He completed an informed consent form at the beginning and end of therapy and during the follow-up procedure. He was seen in a naturalistic therapy protocol for sixteen weekly sessions. Audio recordings were made of the sessions and several sessions have been randomly checked by the researcher for

adherence to TA therapy and for quality checking and were rated as excellent both in quality and adherence by the therapist, the supervisor and the researcher. Using a members checking procedure, Tom was given the 'rich case record' to review and to confirm his consent for the document to be used and he agreed that it was an accurate representation of the therapy.

Therapist and Treatment

The therapist in this case was 'Julie' who was a white, British therapist with over ten year's post-qualifying experience. Julie had at least one hour per month of supervision on this case with a Teaching and Supervising Transactional Analyst (Psychotherapy). Due to ethical concerns relating to preserving the client's confidentiality and anonymity, further details of the therapist have been withheld from this article.

The therapist provided short-term TA therapy which worked to the therapeutic tasks shown in the Adherence Checklists (Widdowson, 2012: App 7&8). As the research was a naturalistic study, the therapist conducted the therapy in line with their usual practice and procedures and created an individualised approach to match the client's needs.

The initial phase of the therapy involved a collaborative and active diagnostic and intervention approach. Session one focused on problem formulation and negotiating therapy contract goals, then this phase (sessions 2-4) consisted of Identifying life experiences which had shaped Tom's script and formed the basis of his self-critical negative ego state dialogue and his racket system. Tom's emotional reactions to these life events were identified and the therapist adopted an empathic approach of affirmation, validation and normalisation of these reactions to encourage the internalisation of a more nurturing internal dialogue. The initial phase concluded with two sessions utilising two-chair method for Identifying and challenging his negative ego state dialogue and script beliefs.

The middle phase of the therapy (sessions 5-9) focused on identifying and re-evaluating early life experiences which formed his script and self-critical ego state dialogue and on identifying current interpersonal patterns that reinforce these. This phase also included challenging the self-critical dialogue and negative introject and using self-reparenting strategies to install a positive nurturing/ soothing ego state dialogue.

The final phase of the therapy focused on communication, interpersonal learning, changing interpersonal patterns and supporting change in internal ego state dialogue. The therapy concluded with a review of the process and identifying resources for future change. A full account of the therapy is contained in the rich case record which is available from the author on request.

Analysis Team

The analysis team who generated the affirmative and sceptic arguments was comprised of 7 students in training for the Certified Transactional Analyst (Psychotherapy) qualification, who attended a full-day case study research analysis workshop. All post-foundation year trainees at the training institute involved were sent an e-mail invitation to attend and participants in the analysis self-selected. The workshop was intended to provide experiential learning of case study research analysis and was co-facilitated by the author and Katie Banks, Certified Transactional Analyst (Psychotherapy). (Ms Banks had participated in the analysis of the case of 'Peter'). Participants had been sent copies of the rich case records, plus an article describing the HSCED method one week prior to the workshop. The workshop commenced with a one-hour presentation on the HSCED method, following which the students read the rich case record and were split into two groups; one group formed the affirmative case, and the second group formed the sceptic case. Each group was facilitated by one of the co-facilitators who assisted the group members in developing their arguments.

Judges

The three independent judges were selected on the basis that they were therapists from another modality, and had experience of participating in a HSCED investigation. The judges were Jane Balmforth, a person-centred counsellor working in a Higher Education college who is currently doing a PhD in Counselling at the University of Strathclyde studying significant client disclosures in therapy, and who was also a judge in the case for Denise (Widdowson 2012b); Katrin Heinrich, a person-centred/emotion-focused counsellor from Germany with a background in economics and Human Resources who is currently conducting a HSCED study for her MSc in counseling with the University of Strathclyde; and Dr Julie Folkes-Skinner, a psychodynamic counsellor and therapist who is a lecturer in psychodynamic counseling at the University of Leicester.

Measures

In line with procedures and guidelines for the development of a systematic case study (Iwakabe & Gazzola, 2009; McLeod, 2010), multiple tools were used to build up a complex and detailed collection of quantitative and qualitative data and to assist in the compilation of the rich case record.

(The section below has been reproduced from Widdowson, 2012 as all measures and the procedure for administration of these was identical to the previously reported case of 'Peter')

Quantitative Outcome Measures

Two standardised self-report outcome measures were selected to measure target symptoms (Beck Depression

Inventory- BDI-II) (Beck et al 1996) and global distress/functional impairment (CORE-OM) (Barkham et al, 2006). These were administered before the first session, and at sessions 8 (mid-way through therapy) and 16 (end of therapy). These measures were also administered at the one-month, three-month and six-month follow up periods. These measures were evaluated according to clinical significance (client moved into a non-clinical range score) and Reliable Change Index (Jacobson & Truax, 1991) (non-clinically significant change). See Table 1 for Reliable Change Index (RCI) values for each measure.

Weekly Outcome Measures

In order to measure on-going progress, and to facilitate the identification of key therapeutic events which produce significant change, two weekly outcome measures were administered prior to the start of each session. These were CORE-10 (Connell & Barkham 2007), a ten item shortened version of the CORE-OM which has good correlation with CORE-OM scores and can be used to monitor change. The second measure was the simplified Personal Questionnaire (PQ) (Elliott, et al, 1999). This is a client-generated measure in which clients specify the problems they are wanting to address in their therapy, and rate their problems according to how distressing they are finding each problem. The PQ was also administered at each of the three follow-up intervals.

Qualitative Outcome Measurement

Qualitative outcome data was collected one month after the conclusion of the therapy. The client was interviewed using the Change Interview protocol (Elliott, 2001) - a semi-structured qualitative change measure which invites the client to explain how they feel they have changed since starting therapy, how they think these changes came about, what they felt was helpful or hindering in the therapy, and what changes they feel they still need to make. As part of this, the client identifies key changes they have made and indicates using a five-point scale whether they expected these changes, how likely these changes would have been without therapy, and how important they feel these changes to be.

Qualitative Data about Helpful Aspects of Therapy

In order to gain data regarding specific events or aspects of the therapy the client found useful, the client completed the Helpful Aspects of Therapy (HAT) (Llewelyn, 1988) at the end of each session. The HAT asks the client to describe both the most and least helpful aspects of the therapy session and to rate the helpfulness/unhelpfulness of the session.

Therapist Notes

The therapist also completed a structured session notes form at the end of each session. The therapist provided a brief description of the session and key issues,

therapy process, the theories and interventions they used and indicated how helpful they felt the session was for the client.

Adherence

The therapist also completed a twelve-item adherence form at the end of each session, rating the session on a six-point scale. The therapist's supervisor also rated the therapist's work using the same form to verify therapist competence and adherence in providing identifiable TA therapy. (Widdowson, 2012: 5-6)

HSCED Analysis Procedure

(Note: this section has also been reproduced from Widdowson, 2012 as the guidelines for the development of both the affirmative and sceptic cases are identical to those for the previous case)

Affirmative Case

The affirmative case is built by identifying positive and convincing evidence to support a claim that the client changed and that these changes primarily came about as a result of therapy. In line with HSCED procedure, to make a convincing case that the client changed positively and as a result of therapy, the affirmative case must be built by identifying evidence for at least two of the following:

1. changes in stable problems: client experiences changes in long-standing problems
2. retrospective attribution: client attributes therapy as being the primary cause of their changes
3. outcome to process mapping: 'Content of the post-therapy qualitative or quantitative changes plausibly matches specific events, aspects, or processes within therapy' (Elliott et. al, 2009; 548)
4. event-shift sequences: links between 'client reliable gains' in the PQ scores and 'significant within therapy' events

Sceptic Case

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

1. Apparent changes are negative or irrelevant
2. Apparent changes are due to measurement or other statistical error
3. Apparent changes are due to relational factors (the client feeling appreciative of, or expressing their liking of the therapist or an attempt to please the therapist or researcher) (note, this is a term used in the

HSCED approach and does not refer to the impact of the therapeutic relationship as a vehicle for change and relates to factors not directly within the therapy process. The reader is invited to notice the different ways that 'relational' is used within this report, which include this criteria, the therapeutic relationship and a relational approach to therapy)

4. Apparent changes are due to the client conforming to cultural or personal expectancies of change in therapy
5. Improvement is due to resolution of a temporary state of distress or natural recovery
6. Improvement is due to extra-therapy factors (such as change in job or personal relationships etc)
7. Improvement is due to biological factors (such as medication or herbal remedies)
8. Improvement is due to effects of being in the research

Once the sceptic case had been presented, the affirmative team developed rebuttals to the sceptic case. The sceptic team then developed further rebuttals to the affirmative rebuttals, thus providing a detailed and balanced argument.

Adjudication Procedure

The rich case record and the affirmative and sceptic cases and rebuttals were then sent to the independent judges for adjudication. The judges were asked to examine the evidence and provide their verdict as to whether the case was a clearly good outcome case, a mixed outcome case, or a poor outcome case; to what extent the client had changed and to what extent these changes had been a result of therapy; and to indicate which aspects of the affirmative and sceptic arguments had informed their position. The judges were also asked to comment on what factors in the therapy did they consider to have been helpful and which characteristics about the client contributed to the changes. (Widdowson, 2012: 6)

Results

Quantitative Outcome Data

Tom's quantitative outcome data is presented in Table 1. His initial score was within clinical range and above caseness cut-off, thus meeting inclusion criteria for the study. His pre-therapy BDI-II was 24, indicating moderate depression and his CORE-OM score was 18, indicating mild levels of global distress and functional impairment. All of Tom's quantitative outcome measures demonstrated clinically significant change by session 8, which was maintained throughout therapy and at the one and three-month follow-up periods. Clinically significant improvement on the BDI-II was also maintained at the six-month follow up, and the PQ and CORE data showed reliable change at the six-month follow-up.

Qualitative Process Data

Tom completed HAT forms at the end of each session and these provided detailed information regarding specific within-session episodes, many of which were related to work with his Child ego-state, two-chair work and Parent ego-state work to identify and resolve aspects of his self-critical process (see examples below from sessions 4, 7 and 8). Other key within-session episodes were connected to exploring his communication patterns and life script and improving his communication and interpersonal style. Tom identified at least one helpful event or theme from each session. The lowest rating for any one event was 7 - 'moderately helpful'. Eleven therapy events were rated at 8 - 'greatly helpful' and one event was rated at 9 - 'extremely helpful'. Examples of responses from Tom's HAT forms include;

Session 4: 'Talked at length about the negative voices in my head. Talked to my negative voice in the session. I and my negative voice came to a compromise to work together to protect my child. Realising my negative voice has been serving a purpose. It has been protecting me as a child, but I learned to make it protect me in a more positive way.' (rated 8.5 - 'greatly-extremely helpful')

Session 6: 'We chatted about rackets and the racket feelings I've built up over the years. A racket system was drawn up to show my beliefs, feelings, behaviours and memories while feeling down. Finding ways to give back my racket feelings to my parents' (rated 8 - 'greatly helpful')

Session 7: 'I played the part of myself and my mother. I talked about my mother's childhood, adult life and her role in parenting. I got a clearer insight into the troubles and inadequacies she had as a child and realized she passed them onto me.' (rated 8.5 - 'greatly-extremely helpful')

Session 8: 'I gave my mother the 'hot potato' back that she'd given to me as a child. After looking back to a very bad childhood experience, I was able to go back and defend my child against my mother. I found the event very satisfying' (rated 9 - 'extremely helpful')

Session 12: 'Talking about ways to communicate better. Really enjoyable. Felt like I was learning as well as in therapy. Learning the different ways of communicating with people' (rated 8.5 - 'greatly- extremely helpful')

Qualitative Outcome Data

Tom participated in a 90 minute Change Interview at the follow-up interview, one month after concluding his therapy. In the interview, he identified eight changes since starting therapy. The changes are listed below in Table 2. These changes primarily related to changes in his self-esteem, his way of interpreting others and

events and changes in how he communicates and interacts with others

Affirmative Case

The affirmative team put forward four main lines of evidence which they argued provided clear and compelling evidence that Tom had changed substantially and that these changes had been due to therapy.

The first line of evidence related to significant changes indicated in quantitative and qualitative outcome measures. In compiling the PQ at the pre-therapy intake, Tom identified five main problems which he was seeking to resolve in psychotherapy, all of which were problems of over ten years in duration. All five problems had changed at the level of clinical significance by session 8, and these changes continued through therapy, and two problems continued to improve slightly after conclusion of therapy by three-month follow-up. Despite some deterioration between three and six-month follow-up, Tom had continued to maintain reliable change from pre-therapy levels, supporting the argument that his changes had been significant and lasting. The affirmative team considered this to be convincing evidence that Tom changed substantially during the course of therapy, and that these were permanent changes.

The affirmative team also highlighted the detailed description of change that Tom provided in his Change Interview, which included changes in his self-esteem, confidence, problem-solving ability, style of relating to others and how he interpreted events. Additionally, the affirmative team noted that Tom provided additional description of physical changes, such as changes in how he walks and interacts with others which had been pointed out to him by his girlfriend. There was also evidence of significant life changes- Tom had moved to a different city to live with his girlfriend and had left the job he had held since leaving school, starting a new, more challenging job and starting a part-time college course.

The second line of evidence came from Tom's retrospective attribution that his changes had come about as a result of therapy. Although Tom had started his change and self-development process prior to starting therapy, he was clear that therapy had been the main agent of change and described eight changes since starting therapy, and stated that all eight would have been unlikely to have occurred without therapy.

Tom's responses in the Helpful Aspects of Therapy forms provided a third line of evidence by suggesting strong plausible links between therapy interventions and events (for which Tom provided detailed and specific description) and Tom's overall changes. These related to changes in his self-esteem, self-critical process,

Table 1: Tom's Quantitative Outcome Data

	Beck Depression Inventory-II	CORE-OM	Personal Questionnaire (mean score)
Clinical cut-off	10	10	3.00
Caseness cut-off	16	15	3.50
Reliable Change Index	5.78	4.8	0.53
Pre-Therapy	24	18	5.2
Session 8	7 (++)	6(++)	2.8
Session 16	2 (++)	2(++)	2.0
1 month Follow-up	0 (++)	1.7(++)	2.0
3 month Follow-up	0 (++)	2(++)	1.6
6 month Follow-up	6 (++)	13.5(++)	4.0

Note: Values in **bold italic** are within clinical range. + indicates Reliable Change, ++ indicates change to below 'caseness' level.

Figure 1: Weekly and Follow-Up CORE-10 scores (clinical significance 10)

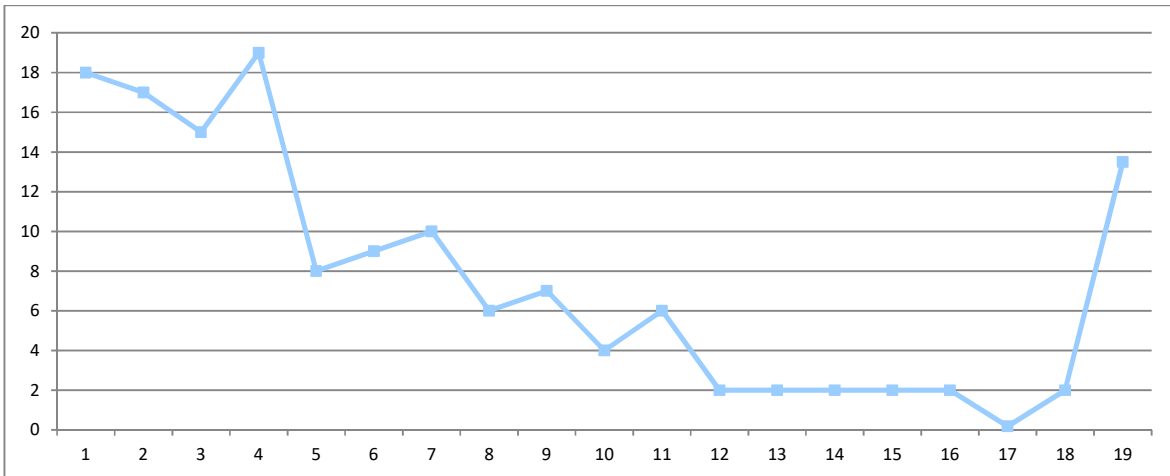


Figure 2: Weekly and Follow-Up mean PQ scores (clinical significance 3)

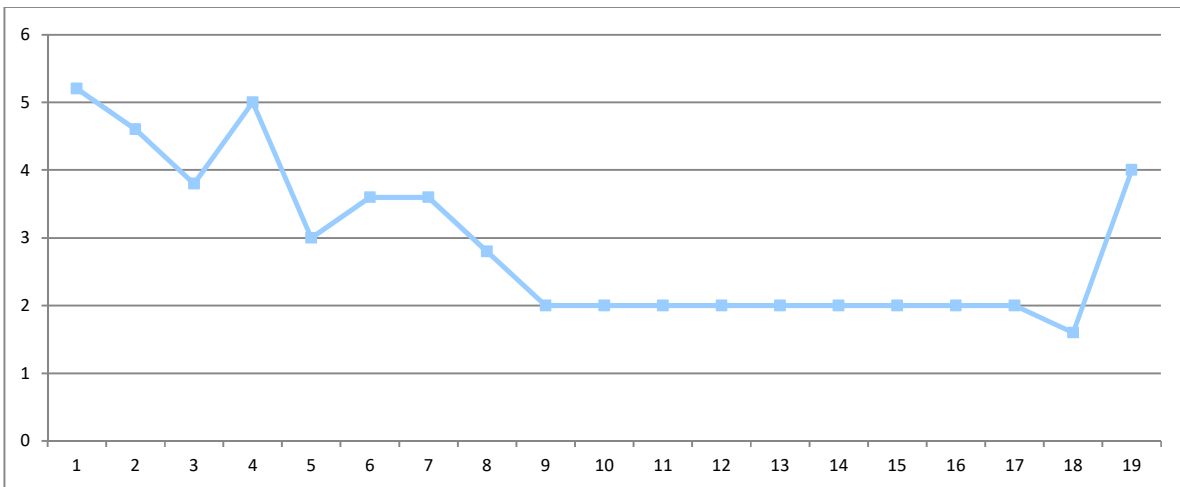


Table 2: Tom's changes as identified in post-therapy Change Interview

Change	How much expected/surprising change was ^a	How unlikely/likely change would have been without therapy ^b	Importance of change ^c
I now think I'm OK as a person	1	1	5
I feel positive and hopeful about my future	2	1	5
I have belief in myself and in my capabilities – I realise I can do anything if I really want to	2	1	5
I have stopped blaming myself for everything that goes wrong	3	1	5
I have developed problem solving skills	3	1	5
I have found ways to understand other people and communicate better	5	1	5
I have learned to take a step back in situations and not take things personally	4	1	5
I am more sociable and don't withdraw in social situations	2	1	5

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

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

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

increased insight into the origins of his problems, exploration of his relationships with others, interpersonal changes and the development of a sense of hope for the future.

The fourth line of evidence related to clear and convincing event-shift sequences where significant sessions (which Tom had rated as helpful and also described in his post-therapy Change Interview) corresponded with a subsequent reliable change on his weekly PQ and CORE scores. Although Tom demonstrated consistent gradual improvement from the outset, sessions 4, 7 and 8 in particular all seemed to

result in substantial improvement and were sessions which both Tom and his therapist highlighted as important. In the Change Interview Tom provided a description of the specific therapy events which took place in the sessions which he felt had produced these therapeutic shifts.

Sceptic Case

The sceptic team considered that although it was clear that Tom did indeed change, there was evidence to cast doubt on claims that these changes came about as a direct result of therapy. In particular, the sceptic team highlighted that there appeared to be strong evidence of expectancy factors in Tom's case and that it was also possible that his self-help efforts had a greater effect than the therapy and were a primary cause of his changes. Furthermore, the sceptic team considered that it was possible that some of Tom's changes could be associated with a strong positive transference to his therapist (relational factors) as opposed to internal re-structuring. Finally, the sceptic team noted that although Tom had shown reliable improvement from pre-therapy levels, his scores on all outcome measures at six-month follow up had shown reliable deterioration from the three-month follow-up therefore suggesting that his changes were temporary and not associated with deep, permanent internal changes.

Affirmative Rebuttal

The rebuttal of the affirmative team rejected the possibility of relational factors as a significant factor which they considered was not supported by a detailed examination of the evidence. The affirmative team emphasized that, although Tom was very positive about his therapy and his therapist, his account was well balanced with a clear description of many aspects of the therapy which he found to be difficult and painful. Also, the affirmative team considered that Tom's description of the therapy process was plausible and realistic and his description of the therapy was not overly focused on the therapist, but more on the process of therapy - indeed Tom provided very little in the way of positive description of his therapist, preferring to describe specific within-therapy events.

The affirmative team highlighted that Tom's changes were maintained at the three-month follow-up and although they showed deterioration at the six-month follow up, argued that this was a temporary state of distress and could be entirely accounted for by the external changes in his life - he had moved to a different city, has started living with his partner and her children, had a new challenging job and had started a college course - all of which are major life changes and would be likely to require considerable adjustment. In support of this argument, they cited Tom's statement at six-month follow-up that he was "happy, contented and not

really worried about the future” and that he no longer feels like a failure, arguing that it would be unlikely that he would make these statements if his self-esteem had significantly deteriorated.

The affirmative team’s rebuttal rejected the argument that Tom’s changes could be accounted for by expectancy or due to the effects of self-help efforts by citing that although Tom had engaged in pre-therapy reading, in his Change Interview he stated clearly that his reading had only taken him so far and that he was aware of the limitations of self-help strategies for facilitating change. The affirmative team also considered it only natural that a client would come to therapy with clear expectations of change in specific problem areas and would anticipate improvement in those areas, particularly if they had engaged in reading which explained the nature of the changes people can gain from therapy. They also noted that although Tom did have some positive expectations of change, he did indeed find some of his changes to be very surprising - in particular those relating to interpersonal changes.

The affirmative team once again emphasized their view that Tom changed substantially and that the evidence that these changes were a result of therapy was so compelling and supported by triangulation of all quantitative and qualitative measures which converged to form repeatedly supported and substantiated evidence supporting these claims, and that the arguments put forward by the sceptic team were not sufficient to account for changes of the magnitude of Tom’s.

[Sceptic Rebuttal](#)

The sceptic rebuttal remained focused on the strong possibility of relational factors, expectancy and self-help strategies in promoting change. The sceptic rebuttal also considered the possibility that the specific within-therapy events Tom described may have been highly emotional experiences for him, but not ones which produced lasting change.

Additionally the sceptic rebuttal emphasised the reliable deterioration in all of Tom’s outcome measures, to a level which moved him back into clinical levels of distress on his PQ and CORE scores, as indicating that his changes were not permanent and that his optimism in his six-month follow-up statement may have been associated with ‘wishful thinking’ as opposed to deep internal changes. In particular, the sceptic team noted that at the six-month follow-up Tom had started to experience a return in his self-criticism and feeling socially inferior to others, again suggesting his changes were temporary.

[Adjudication](#)

The three judges separately reviewed the rich case record and affirmative and sceptic cases and

independently produced their reports regarding their verdicts on the case. Their reports included reference to the particular evidence they had drawn on in forming their opinions and described the moderator and mediator factors which they considered were significant in the case. The judges’ verdicts and a mean score of all three judges’ conclusions are presented below in Table 3.

The majority verdict of the judges was that this was a positive outcome case, with Tom experiencing clinically significant change and had changed considerably-substantially and that these changes were considerably-substantially due to therapy.

[Summary of opinions regarding how the judges would categorise this case](#)

(Clearly good outcome - problem completely solved, Mixed outcome - problem not completely solved, Negative/ Poor Outcome)

There was a majority conclusion that this was a good outcome case, with two of the judges considering this a clearly good outcome case and the third judge considering this a mixed outcome case (problem not completely solved). This gave a mean score for clearly positive outcome at 70% and a mean score for mixed outcome at 80%. The judges cited that both the qualitative data from the Change Interview and the quantitative outcome data demonstrated positive change with a general trend towards recovery. Judge C explained her scepticism about the outcome as relating to the decline at the six-month follow up, and although she felt that Tom had clearly benefitted from therapy, he had experienced some deterioration and was struggling to manage some of his current stressors and this suggested that Tom was not able to respond to these in a fully resourceful way which maintained his gains.

[Summary of opinions regarding the extent to which the client had changed](#)

The verdict of judges A and B was that Tom had changed substantially whilst judge C’s verdict was that he had changed considerably, giving a mean score of Tom’s changes during therapy of 73.3%. The judges all agreed on their level of confidence in their conclusions, with a certainty level of 80%.

[Summary of opinions as to whether the changes were due to the therapy](#)

Judges A and B were in agreement that Tom’s changes were substantially (80%) due to the effects of therapy, whereas judge C felt that his changes were considerably due to therapy (60%), which resulted in a mean verdict that Tom had changed considerably-substantially due to therapy (73.3%).

Judge C noted that the major life changes which Tom had made by the six-month follow-up provided

Table 3: Adjudication decisions

	Judge A	Judge B	Judge C	Mean
1. How would you categorise this case? How certain are you?				
1a. Clearly good outcome (problem completely solved)	100%	70%	40%	70%
1b. Mixed Outcome (problem not completely solved)	(score not given)	100%	60%	80%
1c. Negative/Poor Outcome	0%	0%	20%	6.6%
2. To what extent did the client change over the course of therapy?	80% Substantially	80% Substantially	60% Considerably	73.3% Considerably-Substantially
2a. How certain are you?	100%	80%	60%	80%
3. To what extent is this change due to therapy?	80% Substantially	80% Substantially	60% Considerably	73.3% Considerably-Substantially
3a. How certain are you?	100%	80%	60%	80%

persuasive evidence that Tom had changed to the extent that he was able to make radical changes in his life and build a satisfying relationship with his 'new family'. The judges were all in agreement that although his pre-therapy reading had been useful to him, this had not resulted in major life change and that it was unlikely that expectancy factors would produce these life changes. It was also noted by the judges that in spite of the deterioration at six-months, Tom was able to maintain a positive outlook about his future.

Mediator factors

The judges were asked to provide their opinion on which therapist characteristics, therapeutic factors and processes had been most helpful in this case.

Judges A and B agreed that the therapist's use of two-chair methods had been pivotal in this case, and had helped Tom to deal with his self-critical process (largely associated with his harsh Parental introjects), express emotions, see things from a different perspective and in particular resolve aspects of his emotions and script decisions connected to his historical relationship with his mother.

Judge A noted that the 'life map' exercise at the outset of therapy had clearly been an important, emotional and helpful experience for Tom. Judge B also noted that aspects of the therapy which provided Tom with practical strategies for improving his communication style with others were also important and felt that the use of TA concepts to help Tom conceptualise his process (such as rackets, script, permissions and ego

states) had also been helpful. Judge B highlighted the empathic, non-judgmental and highly active approach of the therapist had been important in this case and noted that the therapist successfully processed and repaired an alliance rupture at session 6 which had been helpful.

Moderator factors

The judges were asked to comment on client factors, including the client's resources and approach to the therapy which had enabled them to make the most of the therapy and enhanced the therapy process. All judges agreed that Tom's pre-therapy reading and research into TA, hope for change and his clear motivation and readiness to change had been helpful factors that had enabled him to engage with the therapist and the therapy process. The judges also agreed that Tom's determination and willingness to engage with painful emotions and life experiences, and to actively make use of the therapy to resolve painful emotions associated with his past, his problems and underlying issues had been a factor. Judge C noted that Tom's desire to have a more satisfying relationship with his partner and her children and the fact that Tom was paying privately for therapy had also likely been motivating factors which had inspired him to engage in the change process.

Discussion

The majority conclusion of the judges was that this was a clearly good outcome case, with the caveat that there was evidence to suggest Tom was experiencing some difficulties associated with his life changes at the six-month follow-up. There were several interesting

technical features in this present case which are highly relevant to TA therapists and which suggest further avenues for future research.

The positive use of self-reparenting as a therapeutic intervention in Tom's case adds support to the study conducted by Wissink (1994) who found that participants in a six week TA-based self-reparenting group experienced a significant increase in self-esteem. A control group had no increase in self-esteem during the same time period, suggesting that the self-reparenting method was effective at increasing self-esteem, feelings of self-efficacy and self-actualisation. This would suggest that as a method, self-reparenting holds promise and that further research which investigates the outcome of self-reparenting is warranted.

Tom made extensive use of two-chair techniques at several points during his therapy and this was highlighted by the judges as a significant intervention which yielded several critical change points. This supports the findings of Shahar et al (2011) who recently conducted a study which concluded that the use of two-chair work with clients who were self-critical was associated with significant increase in self-compassion and significant decreases in self-criticism, depressive symptoms and anxiety. This study is of particular relevance to TA therapists, as it was investigating the use of Emotion-Focused Therapy (EFT); an empirically-supported therapy which integrates principles of person-centred and gestalt therapy and which extensively utilises two-chair methods. EFT therapists view self-criticism as a key component of several psychological disorders and conceptualise self-criticism as "a conflict split between two aspects of the self, where one part of the self harshly criticizes, judges, evaluates and blocks the experiences and healthy needs of another, more submissive part of the self" (p. 763). They use a "two-chair intervention (where) the client is asked to enact a dialogue between the inner critic and the experiencing self using two chairs. The client is asked to "be" the inner critic and speak to the experiencing self using one chair and then enact the experiencing self and respond to the self-critical attacks from the second chair. During the dialogue, the client switches chairs whenever the roles are switched, using empathic guidance and emotion coaching from the therapist to explore, process and provide space for expressing emotions and needs associated with each part of the self" (p. 763).

Clearly, this method has direct parallels with rededication methods in TA psychotherapy, and in particular the Parent Interview (McNeel, 1979) and Impasse Resolution (Goulding & Goulding, 1979). This suggests that further research which investigates the outcomes of the use of TA and in particular rededication methods for

therapy of self-criticism may prove fruitful in the treatment of a wide range of disorders.

Most significantly for the TA community, this third positive outcome case which demonstrated clinically significant change means that TA psychotherapy now has modest research evidence for the treatment of depression and that we are able to state that TA has met initial criteria to be considered as an evidence-based therapy for the treatment of depression, meeting criteria as *possibly efficacious* for the treatment of depression (Chambless & Hollon, 1998). Clearly further positive replication will strengthen these claims, and a further six positive outcome cases will enable TA therapy to meet criteria for being *demonstrably efficacious* for the treatment of depression.

A cross-case comparison with the previous cases in this series is starting to highlight a number of significant trends which appear to have had a positive impact on the success of these cases. Firstly, the impact of client motivation and readiness for change (Zuroff, et al 2007) and client preferences in terms of choice of therapy and therapist (Swift, et al 2011) was important in this case, as well as the cases of Peter (Widdowson, 2012a) and Denise (Widdowson, 2012b) suggesting that these factors may be significant in contributing to positive outcomes of therapy. Therapeutic relationship factors were once again significant, with the active therapist approach and an atmosphere of permissiveness and the genuine caring of the therapist all being important factors in the outcome.

Limitations

There was some variability in how the judges presented their verdicts. The judges were not given any specific instructions in how to complete the forms and it is possible that detailed instruction for judges in giving their verdict may have resulted in more agreement or consistency in how they presented their conclusions as percentages.

The sceptic team conceded that they struggled to form their argument as they were of the general opinion that this was a good outcome case. This may have resulted in their argument being less well-formed than that of the affirmative team. Similarly, the analysis team and judges were all psychotherapists, and so already convinced of the effectiveness of therapy, and it is possible that introducing lay people into the analysis and adjudication process may result in different conclusions being drawn.

Tom showed some decline at the six-month follow-up period and although it is possible that this was associated with stresses from his life changes, a longer follow-up period in future cases may provide more information on long-term benefit from therapy.

Judge C speculated that more detailed analysis of Tom's CORE sub-scales, particularly those relating to problems and functioning, may have revealed a more nuanced and accurate picture of his situation at the six-month follow up, perhaps indicating that his functioning had improved in spite of a deterioration in his problems. This is an interesting point, and one which is worthy of further investigation.

Furthermore, this was not a 'pure' case of depression and it is possible that Tom's comorbid social anxiety may have provided some ambiguity in the outcomes and makes interpretation of findings, including conclusions regarding the effectiveness of TA as a specific treatment for depression, somewhat problematic. Nevertheless, the case of Tom is one which will no doubt resonate with many TA practitioners as being similar to many cases they encounter in everyday routine practice, and therefore the applicability and generalisability of the findings from this case appear to have high face validity.

Conclusion

This present study once again found TA psychotherapy to be an effective treatment for depression and supports the previous TA research by Fetsch & Sprinkle (1982), van Rijn et al (2011) and Widdowson (2012a; 2012b) and significantly adds to the TA evidence base by providing a third positive outcome systematic case study, thus enabling TA to be considered for recognition as possibly efficacious for the treatment of depression (Chambless & Hollon, 1998).

This present study complements the previous two cases in supporting the view that client motivation, readiness to change and the client actively seeking out and engaging with a TA therapist are likely to be significant factors influencing the outcome. Again, a good therapeutic relationship with an active and empathic therapist appeared to have been significant. This present case also suggests that further research into specific TA therapeutic processes, in particular self-reparenting and two-chair work, is warranted.

Mark Widdowson, *Teaching and Supervising Transactional Analyst (Psychotherapy), Associate Director, The Berne Institute, Ph D student, University of Leicester, can be contacted on: mark.widdowson1@btopenworld.com*

The author wishes to thank the members of the analysis team: Jane Bernard, Isabel Burns, Phil Crawley, Mike Day, David Harford, Colin Kerr and Owen Vaughan. Particular thanks also are due to Katie Banks for her invaluable contribution in co-facilitating the analysis groups.

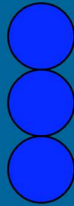
The author also acknowledges with grateful thanks the support of Physis Training in Edinburgh, which provided

the venue and participants for the workshop at which the affirmative and sceptic cases were developed.

References

- American Psychiatric Association (Ed.) (1994) *Diagnostic and Statistical Manual of Mental Disorders- fourth edition*. Washington, DC: American Psychiatric Association
- Bagby, R.M., Cox, B. J., Schuller, D.R., Levitt, A.J., Swinson, R.P. & Joffe, R.T., (1992) 'Diagnostic specificity of the dependent and self-critical personality dimensions in major depression', *Journal of Affective Disorders*, 26: 59-64
- Barkham, M., Mellor-Clark, J., Connell, J., & Cahill, J. (2006). A core approach to practice-based evidence: a brief history of the origins and applications of the CORE-OM and CORE system. *Counselling and Psychotherapy Research*, 6(1): 3-15.
- Beck, A.T., Ward, C.H., Mendelssohn, M.J. & Erbaugh J. (1961) 'An inventory for measuring depression'. *Archives of General Psychiatry*, 4: 561-571
- Beck, A.T., Steer, R.A., & Brown, G.K. (1996) *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation
- Berne, E. (1972) *What do you say after you say hello?*, New York: Corgi
- Blatt, S.J (1991) 'A cognitive morphology of psychopathology', *Journal of Nervous and Mental Disorders*, 179: 449- 458
- Chambless, D.L. & Hollon, S.D. (1998) Defining Empirically Supported Therapies. *Journal of Consulting and Clinical Psychology*, 66(1): 7-18
- Clarkson, P. (1992) *Transactional Analysis: An Integrated Approach*. Hove: Routledge
- Cox, B.J., Rector, N.A., Bagby, R.M., Swinson, R.P., Levitt, A.J. & Joffe, R.T. (2000) 'Is self-criticism unique for depression? A comparison with social phobia', *Journal of Affective Disorders*, 57: 223-228
- Cox, B.J., Walker, J.R., Enns, M.W. & Karpinski, D.C. (2002) 'Self-criticism in generalized social phobia and response to cognitive behavioral treatment'. *Behavioural Therapy*, 33: 479-491
- Cox, B.J., Fleet, C. & Stein, M.B. (2004) 'Self-criticism and social phobia in the US national comorbidity survey', *Journal of Affective Disorders*, 82: 227-234
- Dattilio, F.M., Edwards, D.J.A., & Fishman, D.B. (2010) 'Case studies within a mixed methods paradigm: Toward a resolution of the alienation between researcher and practitioner in psychotherapy research.' *Psychotherapy Theory, Research, Practice, Training*, 47(4): 427-441
- Elliott, R. (2001). Hermeneutic single case efficacy design (HSCED): An overview. In K.J. Schneider, J.F.T. Bugental & J.F. Fraser (eds.), *Handbook of Humanistic Psychology* (pp315-324), Thousand Oaks, CA: Sage.
- Elliott, R. (2002) Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12(1): 1-21
- Fetsch, R. J., & Sprinkle, R. L. (1982) 'Stroking treatment effects on depressed males', *Transactional Analysis Journal*, 12(3): 213-7
- Iwakabe, S. & Gazzola, N. (2009) From single-case studies to practice-based knowledge: aggregating and synthesizing case studies. *Psychotherapy Research*, 19, 601-611

- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59: 12-19
- Llewelyn, S. (1988) Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, 27, 223-238.
- McLeod, J. (2010). *Case Study Research in Counselling and Psychotherapy*. London: Sage
- McLeod, J. & Elliott, R. (2011) 'Systematic case study research: A practice-oriented introduction to building an evidence base for counselling and psychotherapy', *Counselling and Psychotherapy Research*, 11(1): 1-10
- Sachs-Ericsson, N., Verona, E., Joiner, T. & Preacher, K.J. (2006) 'Parental verbal abuse and the mediating role of self-criticism in adult internalizing disorders', *Journal of Affective Disorders*, 93: 71-78
- Shahar, B., Carlin, E.R., Engle, D.E., Hegde, J., Szepeswol, O. & Arkowitz, H. (in press) 'A pilot investigation of emotion-focused two-chair dialogue intervention for self-criticism', *Clinical Psychology and Psychotherapy*, DOI: 10.1002/cpp.762
- Stephen, S & Elliott, R. (2011) 'The Adjudicated Case Study Method' *Pragmatic Case Studies in Psychotherapy*, 7(1): 230-241 (article available at: <http://pcsp.libraries.rutgers.edu>) Downloaded 4th March 2011
- Stephen, S., Elliott, R. & MacLeod, R. (2011) 'Person-centred therapy with a client experiencing social anxiety difficulties: A hermeneutic single case efficacy design', *Counselling and Psychotherapy Research*, 11(1): 55-66
- Stewart, I. & Joines, V. (1987) *TA Today: A New Introduction to Transactional Analysis*. Nottingham: Lifespace
- Swift, J.K., Callahan, J.L. & Vollmer, B.M. (2011) 'Preferences', *Journal of Clinical Psychology: In Session*. 67(2): 155-165
- van Rijn, B., Wild, C., & Moran, P. (2011) 'Evaluating the Outcomes of Transactional Analysis and Integrative Counselling Psychology within UK Primary Care Settings', *International Journal of Transactional Analysis Research*. 2(2): 34-43
- Widdowson, M. (2010) *Transactional Analysis: 100 Key Points and Techniques*. Hove: Routledge
- Widdowson, M. (2011) 'Case Study Research Methodology', *International Journal of Transactional Analysis Research*. 2(1): 25-34
- Widdowson, M. (2012a) 'TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - "Peter"', *International Journal of Transactional Analysis Research*. 3(1): 3-13
- Widdowson, M. (2012b) 'TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study- "Denise"', *International Journal of Transactional Analysis Research* 3 (2) 3-14
- Wissink, L. M. (1994) 'A validation of transactional analysis in increasing self-esteem among participants in a self-reparenting program'. *Transactional Analysis Journal*. 24(3): 189-96.
- Woollams, S. & Brown, M. (1979) *TA: The Total Handbook of Transactional Analysis*. NJ: Prentice-Hall
- Zuroff, D.C., Koestner, R., Moskowitz, D.S., McBride, C. Marshall, M. & Bagby, R.M. 'Autonomous motivation for therapy: A new common factor in brief treatments for depression', *Psychotherapy Research*. 17(2): 137-147



The presence of injunctions in clinical and non-clinical populations

© 2012 Danijela Budiša, Vesna Gavrilov-Jerković, Aleksandra Dickov, Nikola Vučković, Sladjana Martinovic Mitrovic

Abstract

Various authors within the transactional analysis community have postulated that a person's life script is formed on the basis of received injunctions, that people with mental disorders have more destructive and numerous injunctions and that people with depressive and paranoid pathology have different sets of injunctions, with *Don't belong* being more common in paranoid disorders and *Don't be important* in depressive disorders. This research was conducted to check such assertions, and used Script Injunctions Scale (Gavrilov-Jerković et al., 2010) applied to a convenience sample of 100 adult subjects identified as non-clinical via interviews and 100 adult subjects, equally divided between paranoid and depressive, identified by psychiatrist classification based on ICD-10 criteria. The results provide partially expected validation, with statistically significant difference between the non-clinical and clinical part of the sample. The clinical group had statistically significantly higher scores on the 12 injunctions studied. Subjects with depressive characteristics had seven Injunctions which were more pronounced *Don't feel*, *Don't exist*, *Don't be well*, *Don't be a child*, *Don't*, *Don't think*, and *Don't be close Injunctions*.

Key words

Transactional Analysis, Injunctions, Depressive, Paranoid

Introduction

Definitions

Berne (1972) defined injunctions as repeated and traumatic early parental messages that lead to chronic dysfunction in vital areas of life. It is considered that injunctions limit one's freedom, i.e. they discourage a child's development and make life more difficult (Lammers 1994). Berne postulated that injunctions act automatically, like an 'electrode', independent from the will of other parts of child's personality (p. 115-117).

Injunctions are also defined as negatively formulated messages that limit autonomy. It is assumed that they are often non-verbal and transmitted at the psychological level of communication (Stewart and Joines, 1996). Goulding & Goulding (1979) ascribed injunctions to parental influence, as well as to child activity. They considered that the child's script would be determined by the parental messages that the child has recognised and accepted as important. They also assumed that there are some messages the parent never conveys to the child, but which the child alone has directed to themselves. Therefore, according to their theoretical stance, the script and early decisions are auto-determined, rather than hetero-determined as suggested by Berne. In their view, the reason why parents communicate injunctions most likely lies in their feelings of inadequacy, confusion, discontent, anxiety, unhappiness, disappointment, anger, frustration, and secret desires. Injunctions originate from the parent's Child ego state.

Lists of injunctions

Goulding & Goulding (1976) defined the first list of injunctions and later made several additions to it (Goulding and Goulding, 1978). One of the variations of the list comprises the following injunctions: *Don't exist*, *Don't be important*, *Don't be you*, *Don't be a child*, *Don't grow up*, *Don't succeed*, *Don't be close*, *Don't belong*, *Don't think* (either about a forbidden topic or differently from your parents), *Don't feel* (a forbidden feeling or different from parents), *Don't be well* (or *Don't be sane*), and *Don't* (prohibition of various activities conveyed by a hyper-protective mother).

McNeel (1976) extended considerably the Goulding & Goulding list whereas Hartman & Narboe (1974) believed that there are only two fundamental injunctions: *Don't exist* and *Don't be sane*. Other injunctions, such as *Don't belong* and *Don't succeed*, provide an exit that does not imply death or insanity.

Links to mental disorders

According to transactional analysis theory, it is assumed that a person's life script is formed on the basis of received injunctions. Furthermore, it is believed that people with mental disorders have more destructive and numerous injunctions, and that people with depressive and paranoid pathology have different sets of injunctions. According to several authors (Ernst, 1971, Berne, 1972, Steiner, 1974, Goulding & Goulding, 1979, Erskine & Zalcman, 1979, Joines & Stewart, 2002), typical injunctions for those with paranoid disorders include: *don't be a child, don't be close, don't feel (fear, sadness, guilt), don't belong*, whilst those with depressive disorders might have permissions *to exist* and *to be important* but countered by injunctions: *don't be you, don't grow up, don't think, don't feel (angry), don't be a child*.

Several authors have undertaken research into injunctions and different Script Questionnaires have been used clinically for years, including Berne (1972), Steiner (1967) and Holloway (1973). Drego (1994) made a scale called the 'Drego Injunction Scale' and Björk (1997) published a study showing that the scale was not valid when it came to different injunctions, but had a certain validity in measuring hamartic life script.

Italian author Scilligo et al (1999) constructed the ESPERO scale to test injunctions according to Goulding & Goulding's classification and drivers according to Kahler's (1975) definition. Scilligo's research confirmed that injunctions are a theoretical concept that can be tested using a questionnaire. Johnsson (2011) published a study in which he showed that the inter-assessor reliability in script diagnosis on an overall basis was moderate and low on a specific level.

Objectives of Research

Clearly, these concepts have both theoretical and practical implications for the understanding of diagnostic and therapeutic work with people with different psychopathological manifestations, including depressive and paranoid symptoms. However, it should be noted that these postulates still do not have sufficient empirical support within the TA theoretical framework. This empirical deficiency can be found not only in the concept of injunctions, but also, unfortunately, in much of TA theory, in the sense that there have been few studies on TA constructs in different psychopathological categories and nonclinical populations.

Operationalisation of this theoretical construct can enable assessment of the psychotherapeutic work on injunctions, and better and more valid clinical evaluation of the client's initial condition, especially if the norms have been formed on the nonclinical population. Furthermore, evaluation of the concept of injunctions on different clinical populations may indirectly contribute to the assessment of relative expression of other

psychopathological tendencies. For example, if a person has the *Don't belong* injunction, we can assume that his cognitive schemes, behavioural and emotional characteristics will be maladaptive following the paranoid type. Confirmation of the possibility of assessing the concept of injunctions can therefore enable more effective therapeutic work that would be directed at the basic problems in the client's psychological functioning.

From the above-mentioned theoretical implications and the implied significance of examining theoretical concepts in TA, especially in the context of relations between clinical and nonclinical populations, arose the objectives of our study:

1. testing the potential of the theoretical concept of injunctions to differentiate nonclinical and clinical populations;
2. among clinical populations, to differentiate paranoid from depressive subjects;
3. to determine the structure of injunctions specific for these two clinical populations.

Methods

The design of the research was non-experimental (correlational). Script injunction is the dependent variable, operationalised through subjects' answers to Script Injunctions Scale (Gavrilov-Jerković et al., 2010).

The non-clinical sample of 100 subjects was collected in several companies in Novi Sad and vicinity, following the principle of convenience sample. The only eliminatory criterion within the non-clinical sample was if they ever received psychiatric treatment, which was determined in an interview. The fulfilment of the diagnostic criteria for the spectrum of depressive and paranoid disorders was assessed by treating psychiatrists, who classified the subjects according to a diagnostic interview and the ICD-10 diagnostic criteria (WHO, 1992).

Control variables were depression as a personality trait and tendency to paranoid ideation and hypersensitivity, as assessed by the questionnaires. These were included in the study as a means to control the presence of depressive and paranoid characteristics in the nonclinical group as well as to control the validity of the psychiatric diagnosis in the clinical group. A number of demographic variables, such as sex, age, marital status, education, employment, which could be helpful in the interpretation of results obtained on the dependent variable, were also recorded. It should be emphasized that differences in the variables education and employment between the clinical and nonclinical group were expected, considering professional deterioration of the clinical population.

Table 1: Examples of items (translated) comprising 12 subscales

Injunction	No. of items	Examples
Don't Be!	10	I have an impression that everything is my fault; I am a nuisance to everyone.
Don't be You!	3	Persons of the opposite sex have it much easier throughout life; My parents wanted a child of the opposite sex than I am.
Don't be a child!	2	I was often not allowed to play; I can't find fun in anything.
Don't Grow up!	6	I decidedly dislike responsibility; i would like to always remain a child, in that way I would have less problems in life.
Don't Succeed!	6	I almost never do something properly; I was criticized that I never do things well enough.
Don't!	6	I have a hard time making a decision; I worry more than other people if I shall make a mistake when I have to do something.
Don't be Important!	6	I am not as worthy as other people; I have an impression I was not important to my parents
Don't Belong!	8	I have an impression that I don't belong to my family; I don't have much in common with my family.
Don't be Close!	5	I was rarely fondled as a child; I have difficulties befriending people.
Don't be Well!	3	Parents paid attention to me only when I was sick; They were telling me that I am crazy when I was a child.
Don't Think!	8	I think I am slower to understand than other people; I find it difficult to concentrate.
Don't Feel!	8	I very often have a problem to determine what I really feel; As a child, I was not allowed to express what I really felt.

Research instruments used in the study:

Script Injunction Scale (Gavrilov-Jerković et al., 2010) was used to evaluate script injunctions. This scale measures the degree and type of the 12 script injunctions that a person was exposed to during childhood and has accepted as a part of self image. It contains 71 items formulated as statements to which subjects specify their level of agreement on a five-point Likert scale. The reliability of the whole scale expressed as Cronbach alpha coefficient is 0.96 and of the subscales is between 0.48 and 0.83. The Scale has good concurrent and discriminant validity. Examples of certain items (translated) within the subscales are given in the Table 1, as well as the number of items comprising each subscale.

LD Scale, Scale of depressive personality (Novović et al., 2007), is comprised of 26 items and is based on Schneider's (1958) description of depressive personality, that Akiskal (1997) has formalised into seven traits:

1. calm, introverted, passive and non-assertive
2. dreary, pessimistic, serious and incapable of humour
3. self-critical, self-accusing and self-demeaning

4. sceptical, hyper-critical and hard to please
5. scrupulous, responsible and self-disciplined
6. reflective and concerned
7. preoccupied with negative events, feelings of inadequacy and own flaws

This Scale is also five-point, Likert type. Obtained reliability of this scale expressed by Cronbach's alpha coefficient is 0.87.

Pa Scale (Biro, 1995), or paranoid syndrome scale, assesses sensitivity, hostility and tendency to paranoid interpretation. The reliability of the scale expressed as Cronbach alpha coefficient is 0.88.

Biographic data were provided by subjects, by choosing from the answers listed on the first page of the battery of questionnaires.

Subjects

The sample belonged to the convenience type, comprised of 200 subjects, 100 from nonclinical and 100 from clinical adult population. The clinical part of the sample consisted of equal numbers of subjects with depressive and paranoid disorders. Subjects were

classified in the clinical groups based on the psychiatric diagnosis, established according to the ICD-10 (WHO 1992) criteria. The group of depressive disorders included subjects with dominant depressive symptoms (F32.0, F32.1, F32.2, F32.8, F32.9, F33.0, F33.1, F33.2, F33.4, F33.8, F33.9), excluding bipolar affective disorder, schizoaffective disorder, post-schizophrenic depression, cyclothymia, dysthymia, other and unspecified mood disorders. The group of paranoid disorders included subjects with dominant paranoid symptoms, either paranoid personality disorders or compensated psychotic non-schizophrenic disorders (F22.0 in remission, F23.0 in remission, F 23.3 in remission and F60.0). Patients with the listed diagnoses were treated ambulatory or hospitalised.

Statistical analysis of data was performed using the software SPSS 15.0 (SPSS 2006).

Demographic characteristics of the sample

The total sample consisted of 38% men and 62% women. The distribution by gender was not representative for the population. The average age of subjects was 40, with standard deviation 10 years; the youngest participant was 19 and the oldest 68 years.

Three groups were statistically significantly different by age, in that the group of patients with depressive disorder was significantly older than non-clinical groups ($F=7,502$; $DF=2$; $p=.001$).

Subjects were also significantly different as regards the education level, with those in the clinical part of the sample having significantly lower level of education (Pearson's chi-square= $30,959$; $DF=6$; $p=.000$).

Non-clinical and clinical groups were statistically different in employment status. The non-clinical group had significantly more employed subjects (Pearson's chi-square= $92,425$; $DF=8$; $p=.000$).

Three groups were statistically different in marital status; the non-clinical group and the group of patients with depressive disorders had more subjects who were married, while patients in the group of paranoid subjects were mostly single (Pearson's chi-square= $33,814$; $DF=6$; $p=.000$).

The possible impact of these demographic variables to the value of the dependent variable was checked later through statistical procedures.

Results

Difference in injunctions between the clinical and nonclinical group

Discriminant analysis determined one significant discriminant function (Table 2). The discriminant function was defined by higher scores on all injunction subscales (Table 3).

As expected, the clinical group had statistically significant higher scores on all injunctions (Tables 4 and 5). Our results are in accordance with TA theoretical assumptions described above, that each form of psychopathology involves the presence of injunctions.

The differences obtained on univariate tests indicated that the nonclinical and clinical group also differ on all injunctions.

Table 2: Parameters of isolated discriminant function

	Function 1
Charact. Root	.468(a)
% variance	100.0
Cumulative %	100.0
Canonical Correlation	.565
Wilks' Lambda	.681
Chi-square	73.320
Df	12
P	.000*

Table 3: Structure matrix of the discriminant function

	Function 1
Don't exist	.858*
Don't think	.827*
Don't feel	.826*
Don't be important	.737*
Don't be well	.730*
Don't succeed	.719*
Don't be close	.685*
Don't belong	.667*
Don't grow up	.575*
Don't be a child	.537*
Don't	.535*
Don't be you	.409*

Table 4: Group centroids on the discriminant function

	Function 1
Nonclinical	-.677
Clinical	.684

Table 5: Descriptive group indicators on studied variables

	Nonclinical		Depressive		Paranoid	
	Mean	SD	Mean	SD	Mean	SD
Don't exist	12.38	3.336	23.16	9.244	16.80	6.643
Don't be you	5.47	2.372	7.40	2.900	6.47	2.829
Don't be a child	2.94	1.246	5.00	2.799	3.76	2.006
Don't grow up	10.95	3.854	14.94	5.152	13.90	4.753
Don't succeed	8.97	3.141	13.32	5.077	12.73	4.877
Don't	13.87	4.532	18.62	5.170	16.16	4.905
Don't be important	8.10	2.783	12.88	5.232	11.43	4.713
Don't belong	12.85	4.914	18.64	6.433	17.47	6.526
Don't be close	7.57	3.092	12.16	4.528	10.35	4.684
Don't be well	4.18	1.850	7.60	3.136	5.76	2.697
Don't think	13.22	4.633	21.58	7.503	18.53	6.746
Don't feel	14.91	4.643	24.24	7.258	18.98	5.851

Difference in injunctions between depressive and paranoid subjects

A statistically significant discriminant function was isolated for the two clinical groups (Table 6).

The discriminant function was defined by a higher score on the following injunction scales: *Don't feel, Don't exist, Don't be well, Don't be a child, Don't, Don't think, and Don't be close* (Table 7).

As can be seen in Table 8, the group of subjects with depressive disorders had higher scores on the discriminant function, which means that subjects in this group had overall higher scores on the above-mentioned set of injunctions. This finding indicates that depressive subjects reported that they were exposed to various messages that basically communicated that they were not OK, that is, that they should not exist, express their opinions, feelings and needs, be healthy, get close to other people and have initiative, and that they have been receiving these messages more frequently than paranoid subjects. On the other hand, the paranoid group had a lower score on all of these injunctions, which might be due to their minimizing of their own psychopathology. These results will be addressed in more detail in the final discussion section of the results.

Differences between depressive and paranoid subjects on the LD and Pa scales

Discriminant analysis was carried out in order to determine the difference between the two clinical groups on the LD and Pa scales. One statistically significant discriminant function was extracted that was

defined by a high score on the LD scale and a somewhat less high score on the Pa scale (Tables 9 and 10).

The group of depressive subjects had higher scores on the isolated function, which means that depressive subjects had higher scores on both LD and Pa scales (Table 11).

In the univariate analysis of the equality of arithmetic means of the two groups, one can see that there is no significant difference between depressive and paranoid subjects on the Pa scale (Table 12).

Results indicate that, as was expected, depressive subjects had higher scores on the scale of depression as a trait and showed tendencies that fall within the scope of depressive personality. The finding that may seem unusual at first glance, that depressive subjects also scored higher on the hypersensitivity scale, can be explained by their sensitivity but also their tendency to exaggerate, whereby it is possible that paranoid subjects understated their own psychopathological symptoms, considering that the Pa scale is a standardised instrument whose discriminating value has been proven multiple times. This finding questions the reliability of the diagnoses in the depressive spectrum, which is much more heterogeneous in comparison with diagnoses from the paranoid spectrum. Depression is often met as a secondary phenomenon in other psychopathological conditions, which is frequently unrecognised in the clinical practice. These assumptions will be considered in more detail in the discussion of the results.

Table 6: Parameters of the isolated discriminant function

	Function 1
Charact. Root	.390(a)
% variance	100.0
Cumulative %	100.0
Canonical Correlation	.529
Wilks' Lambda	.720
Chi-square	29.939
Df	12
P	.003*

Table 7: Matrix of the isolated discriminant function structure

	Function 1
Don't feel	.645
Don't exist	.639
Don't be well	.510
Don't be a child	.413
Don't	.394
Don't think	.346
Don't be close	.319
Don't be you	.263
Don't be important	.236
Don't grow up	.170
Don't belong	.146
Don't succeed	.095

Table 8: Group centroids on the discriminant function

Group	Function 1
Depressive	.612
Paranoid	-.624

Table 9: Parameters of the isolated discriminant function

	Function 1
Charact. Root	.212(a)
% variance	100.0
Cumulative %	100.0
Canonical Correlation	.418
Wilks' Lambda	.825
Chi-square	18.481
Df	2
P	.000*

Table 10: Matrix of the discriminant function structure

Group	Function 1
Depression – total	.978
Pa – total	.384

Table 11: Group centroids on the discriminant function

Group	Function 1
Depressive	.451
Paranoid	-.461

Table 12: Testing of the equivalence between the group means

	Wilks' Lambda	F	df1	df2	p
Pa – total	.970	3.031	1	97	.085
Depression – total	.831	19.688	1	97	.000*

Table 13: Canonical correlation between the LD and Pa scores and injunctions and significance of canonical correlations

	Canonical correlation	Wilks' Lambda	Chi-square	DF	P
1	.842	.248	265.782	24.000	.000
2	.387	.850	30.880	11.000	.001

Table 14: Canonical loadings for the LD and Pa set

	1	2
Pa – total	-.877	-.480
D – total	-.931	.365

Table 15: Canonical loadings for the injunctions set

	1	2
Don't exist	-.895	-.162
Don't be you	-.633	.001
Don't be a child	-.759	-.230
Don't grow up	-.465	.060
Don't succeed	-.716	.124
Don't	-.557	.397
Don't be important	-.722	-.095
Don't belong	-.687	-.487
Don't be close	-.722	-.291
Don't be well	-.800	-.231
Don't think	-.852	.266
Don't feel	-.894	-.038

in a positive direction, so we termed this dimension **don't and Belong** (Table 15). This structure of injunctions is more common in depressive than in paranoid disorders (Stewart & Joines, 1996). The first canonical function explained 54.2% and the second only 5.9% of the variance.

There is significant association between the absence of depressive and paranoid symptoms and the absence of injunctions, which is in line with the theoretical expectations within TA theory. In addition, also in accordance with the TA theory, the results show that the higher the proneness of a person to manifest depressive personality traits, the higher is the probability of having the injunction *Don't*, and not having the injunction *Don't belong*. These findings could corroborate Beck at al's (1983) theory of dysfunctional cognitive schema, i.e. of sociotropy as a personality dimension. Sociotropic personalities, which can be found as one of the subgroups of depressive population, show orientation to people; in particular they show a pronounced need to be accepted and intimate, and when they lose it they become depressed.

The first canonical dimension explained 38.4% and the second only 0.9% of the variance of the second set. The first canonical dimension of the second set explained 58% and the second one only 2.7% of the variance of the first set.

Correlation between injunctions and the LD and Pa scores

In order to clarify the results obtained (for the clinical groups), we decided to perform the canonical correlation analysis of the linkage of injunctions with the height of the score on LD and Pa scales, in order to see the character of the differences between the two clinical groups when the differentiation criterion is not psychiatric diagnosis but rather an objectivised approach of classifying subjects into these two groups of psychopathological disorders. Two statistically significant correlations were found (Table 13).

The first canonical function, within the first set of variables, was characterised by low scores on both the LD and Pa scale (Table 14). The second canonical function was characterised by low scores on the Pa scale and higher score on the LD scale. We termed the first canonical function **absence of depressive and paranoid characteristics** and the second one **depressive characteristics**. The first canonical function of the first set explained 81.8% of variance and the second 18.2% of variance of the first set.

In the second set of variables, the first canonical function was characterised by low score on all injunctions, so we termed it **absence of injunctions**. The second canonical function was defined by the injunction *don't belong* in a negative direction and *don't*.

Effects of demographic and control variables on injunctions

We found a statistically significant effect ($F=1.304$, $p=.011$, $df=2$) of the variable educational level ($F=3.424$, $p=.004$, $df=6$) and a combined effect of the variables group, sex and employment status ($F=2.128$, $p=.019$, $df=12$). It was expected that belonging to one of the groups (nonclinical, depressive or paranoid) would have a statistically significant effect on injunctions. The clinical group had a higher average score on all injunctions. As regards educational level, subjects with only elementary school education had the highest average score on all injunctions. Retired and unemployed subjects from the depressive group, male and female almost equally, had the highest average score on most injunctions.

We can assume that the significant effect of the variable educational level found in the study was because the clinical groups comprised considerably more subjects with lower educational level due to decreased professional functioning, and that this result is not a real effect of the variable educational level on injunctions. The combined effect of the three above mentioned variables was expected in light of our findings that patients with depressive disorder have highest scores on injunctions, similarly distributed male and female, who also most frequently had impaired professional functioning.

Discussion

Subjects with depressive and paranoid symptoms scored significantly higher on almost all injunctions, which is in line with the theoretical assumptions of TA. We have already mentioned that Berne (1972) emphasised that injunctions lead to chronic dysfunction in vital areas of life, which is certainly commonly seen in persons with mental illnesses. According to the World Health Organisation (1992) recommendations for classification of mental disorders, adequate functioning in vital areas of life is indeed one of the major criteria for differentiating psychopathology and mental health. Our results show that the concept of injunctions can differentiate between persons with and without mental disorders.

The difference found between depressive and paranoid subjects in injunctions suggests that depressive subjects were exposed to more destructive messages than paranoid subjects, in both content and frequency. This may be a result of the tendency of depressive subjects to overestimate and paranoid subjects to underestimate their own mental problems. It is also possible that the described differences result from the fact that persons with depressive traits are aware of their script pathology, unlike paranoid subjects who might deny it. These assumptions need to become the topic of future research.

The Pa scale score which we found to be higher in subjects with depressive disorders than in subjects with paranoid disorders is rather confounding. It seems that the shortcomings of self-report techniques in clinical research have become most apparent here; unless we exclude the possibility that depressive subjects are more sensitive than paranoid subjects, which is in our opinion highly improbable. It seems more likely that subjects with depressive disorders overestimated whereas subjects with paranoid disorders underestimated their mental problems. These results have shown that depressive persons tend to see themselves as victims of mistakes made by others, which is probably not that unexpected.

The results of the canonical correlation analysis of injunctions and scores on LD and Pa scales indicate statistically significant correlation between the absence of depressive and paranoid disturbances and the absence of injunctions, as well as between depressive characteristics and the dimension defined by the injunction *Don't* (positive correlation) and *Don't belong* (negative correlation). These findings are clearly in line with our theoretical assumptions, although they still do not clarify the structure of injunctions in paranoid subjects. Further studies in this area would help clarify the inconsistencies surrounding the potential of the concept of injunctions to differentiate between persons with various disorders, in this case depressive and paranoid.

As regards self-report techniques used in our study, the situation may be additionally complicated by the problems related to comprehension of the verbal content in the clinical population, considering the significantly lower educational level in the clinical part of the study sample. In order to overcome the shortcomings of possible incomprehension of the verbal content in the clinical population, we propose that clinical observation and/or structured clinical interviews should be used complementary to the questionnaire technique, as this should improve validity of data.

Furthermore, in order to overcome possible limitations of applied instruments, it is important that they are uniform in that they measure subject's personality traits and current psychological state. If possible, the so-called trait and state scales should be used, in order to improve the objectified assessment of the type of psychopathological disorder. In addition, controlling scales would considerably alleviate the problem of conscious and unconscious censorship of responses in the applied questionnaires. It is a longer and more expensive way to improve research instruments; however, it would undoubtedly improve the validity of research data.

So far we can only assume which factor or combination of factors has/have contributed to the confounding results. We are more certain that these factors pertain to methodological limitations of our study, or clinical research in general. In order to clarify potential reasons for this, it is important to tackle the issue of the validity of psychiatric diagnosis. As has already been said, diagnoses for the group of depressive disorders are much more heterogeneous than those from paranoid disorders, since depression is seen as a secondary phenomenon in most psychopathological categories. To improve the reliability of psychiatric diagnosis, we believe it would be useful to introduce diagnosis from both first and second axis according to the DSM-IV (APA 2000) criteria, in order to avoid overlapping of states and traits, i.e. to separate these two aspects of psychological functioning, to know which phenomenon belongs to which aspect. Of course, we do not claim that this will always be possible. It would be useful also to apply some of the 'objectified' instruments for assessing the type of psycho-pathological disorder, such as standardised symptom check lists. Finally, we should not overlook the possibility of comorbidity of the two studied syndromes, despite the attempts at precise psychiatric diagnosis, which, even when very mildly expressed, can obscure the character of the differences between these two clinical groups.

It is worth mentioning the demographic differences between the clinical and nonclinical part of the sample. These differences were expected and unavoidable and should be kept in mind when designing a study and especially statistical analysis. Although in our study

they did not prove to have a crucial effect on dependent variables, they should be controlled in order for research to have methodological validity. Otherwise, the sample should be equable following the demographic variables, which is a rather uneconomical way in clinical research in every respect except strictly methodological.

Conclusion

We can conclude that the hypotheses which the study aimed to test got partly expected confirmation. The clinical group scored significantly higher on all injunctions. Compared with paranoid subjects, depressive subjects were more likely to have the following injunctions: *Don't feel, Don't exist, Don't be well, Don't be a child, Don't, Don't think, and Don't be close*. Depressive characteristics were associated with *Don't* and the absence of *Don't belong*.

Author affiliations

Danijela Budiša: Centre for extended treatment of drug addicts, Clinic for Treatment of Drug Addiction, Institute of Psychiatry, Clinical Centre of Vojvodina

Vesna Gavrilov-Jerković: Psychology Department, Faculty of Philosophy, Novi Sad

Aleksandra Dickov, Nikola Vučković & Sladjana Martinovic Mitrovic: Clinic for Treatment of Drug Addiction, Institute of Psychiatry, Clinical Centre of Vojvodina

Danijela Budiša can be contacted at danijela1@neobee.net

References

Akiskal, H.S. & Cassano, G.B. (1997). *Dystimia and the spectrum of chronic depressions*. New York: Guilford Press.

American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text revision*, Washington DC: American Psychiatric Association

Beck, A. T., Rush, A. J., Shaw, B. F. & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Beck, A. T., Epstein, N., & Harrison, R. (1983). Cognitions, attitudes and personality dimensions in depression. *British Journal of Cognitive Psychotherapy*, 1, 1-16.

Berne, Eric (1972). *What do you say after you say hello? Psychology of human destiny*. New York: Grove Press

Biro, M. (1995). *Dijagnostička procena ličnosti MMPI-202*. Novi Sad: Futura publikacije, Filozofski fakultet.

Björk, A. (1997). *The Script concept in Transactional Analysis from a Family therapy perspective*. Unit for Postgraduate Psychotherapy Training and Education, Lund University.

Drego, P. (1994). *Happy Family – Parenting through Family Rituals*. Bombay: Vision Wordtronic Ltd.

Ernst, F (1971). The OK corral: the grid for get on with. *Transactional Analysis Journal*, 1, 33-42.

Erskine R., Zalcman, M. (1979). The racket system. *Transactional Analysis Journal*, 9, 51-59.

Gavrilov-Jerković, V., Budiša, D., Lekić-Babić, N., & Čolović, P. (2010). Procena skriptnih zabrana (SSZ-skala). U: Biro, M., Smederevac, S., Novović (ur.) Procena psiholoških i psihopatoloških fenomena, CPP, Beograd, 123-140.

Goulding, R & Goulding, M (1976) Injunctions, decisions and redecisions *Transactional Analysis Journal*, 6:1, 41-48

Goulding, Robert L. & Mary M. (1978) *The Power is in the Patient* San Francisco: TA Press

Goulding, M. & Goulding, R. (1979). *Changing lives through redecision therapy*. New York: Grove press.

Hartman, C & Narboe, N (1974) Catastrophic Injunctions *Transactional Analysis Journal* 4: 2 10-12

Holloway, W.H. (1977). Transactional analysis: An integrative view. In Barnes, G., (ed.) *Transactional Analysis After Eric Berne*. London: Harper & Row.

Johnsson, R. (2011). Client Assessment in Transactional Analysis – A Study of the Reliability and Validity of the Ohlsson, Björk and Johnsson Script Questionnaire. *International Journal for Transactional Analysis Research*, 2, 19-33.

Joines, V. & Stewart, I. (2002). *Personality adaptations*. Chapel Hill: Lifespace publishing.

Kahler, Taibi (1975) Drivers: The Key to the Process of Scripts *Transactional Analysis Journal* 5:3 280-284

Lammers, W.(1994). Injunctions as an impairment to healthy ego-state functioning. *Transactional analysis Journal*, 24, 250-265.

McNeel, J The Parent Interview *Transactional Analysis Journal*, 1976, 6(1), 61-68

Novović, Z., Nedimović, T., & Biro, M. (2007). Stanje depresivnosti: sindrom ili raspoloženje? *Psihologija*, 40, 447-461.

Scilligo, P., D'Aversa, C., Liverano, A., Schietroma S, & Guglielmotti, F. (1999). Il questionario ESPERO: la misurazione delle ingiunzioni e delle controingiunzioni. *Psicologia Psicoterapia e Salute*, 5, 137-166.

Schneider, K. (1958). Psychopathic personalities. *Psychology*, 62, 1181-1196.

SPSS (2006) *SPSS 15.00* Chicago: SPSS Inc Downloaded 1 September 2011 via <http://en.softonic.com>

Steiner, C. (1967). A script checklist. *Transactional Analysis Bulletin*, 6, 38-40.

Steiner, C. (1974). *Scripts people live. Transactional analysis of life scripts*. New York: Grove press.

Stewart, I. & Joines, W. (1996). *TA Today: A new introduction to Transactional analysis*. Nottingham: Russell Press Ltd.

World Health Organisation (1992). Svetska zdravstvena organizacija ICD-10 Klasifikacija mentalnih poremećaja i poremećaja ponašanja: Klinički opisi i dijagnostička uputstva. Beograd: Zavod za izdavanje udžbenika.