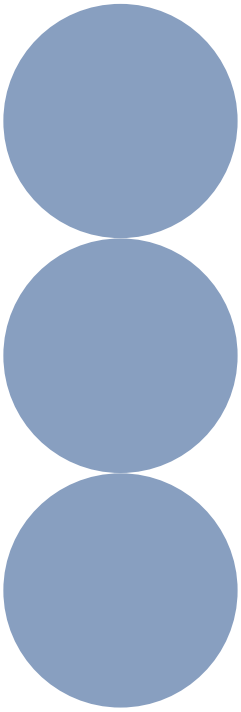

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## Contents

Editorial 2
*Julie Hay*

TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Linda' – a mixed outcome case 3
*Mark Widdowson*

TA Treatment of Emetophobia - A Systematic Case Study - 'Peter' 16
*Colin Kerr*

Preliminary Evaluation of Outcomes of Transactional Analysis Psychotherapy for Armed Forces Veterans presenting with Post-Traumatic Stress Disorder 27
*David Harford*

An Analysis of Dominant Working Styles in Different Professions in Macedonia 30
*Marina Pavlovska*

IJTAR
International Journal of Transactional Analysis Research

*4* (2), 2

https://doi.org/10.29044/v4i2p2



# Editorial

Julie Hay

Welcome to our 7th issue.

Many years ago, Sterling (1959) wrote of the dangers of researchers not publishing their work when the results were nonsignificant, commenting that such work might be repeated by others until a chance significant result could be an 'error of the first kind' - the incorrect rejection of a true null hypothesis. Soon after, Popper (1963) wrote that every refutation should be regarded as a great success. In spite of that, it has taken many years for scientific journals to change the common policy of not publishing 'negative' results.

IJTAR policy is to be open and transparent and publish any research, regardless of outcomes. We are, therefore, very pleased to have the 4th in Mark Widdowson's series of case studies on TA treatment of depression, with its mixed outcome.

This is followed by a similar case study, using elements of Single Case Study Efficacy Design (HSCED) (Elliott 2002) and this time applied by the author/researcher Colin Kerr to TA treatment of emetophobia. Colin provides us with a thorough review of the nature of emetophobia before demonstrating that his TA psychotherapy approach led to significant change for the client.

The next paper is a preliminary outline of a pilot project and shows how TA psychotherapy seems likely to be of benefit to clients with post-traumatic stress disorder (PTSD). We look forward to seeing the final paper on this when David Harford completes his research.

Our final paper in this issue is a quantitative study within the organisational field of TA application, with Marina Pavlovska using Hay's (1992) Working Styles Questionnaire to check out the distribution of styles against three of the professions defined by the State Statistical Office (2011) of Macedonia – Economist, Legal Advisor and IT Expert.

So, we continue our cross-fields and international coverage, with three accounts of TA psychotherapy case studies and one developmental TA quantitative style study of working styles applied to professions – with the psychotherapy papers from the UK and the developmental TA study done in Macedonia.

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# TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Linda' - a mixed outcome case



## 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 is the fourth article of a case series which has investigated the process and outcome of transactional analysis psychotherapy using Hermeneutic Single-Case Efficacy Design (Elliott 2002). The client, Linda, was a 45 year old white British woman with mild depression who attended nine sessions of therapy. The conclusion of the judges was that this was a mixed-outcome case: whilst the client improved over the course of therapy and was positive about her experience of therapy, her changes did not last when she experienced considerable stressful events during follow-up. Linda provided a detailed and idiosyncratic description of the aspects of the therapy which were most helpful for her. A cross-case comparison with other cases in this series suggests several interesting features which are worthy of further investigation. Specifically, the use of a shared theoretical framework and an egalitarian therapeutic relationship were helpful. As with other cases in this series, the client experienced positive changes in her interpersonal relationships suggesting that this outcome of TA therapy warrants further investigation*

## 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 is the fourth and final Hermeneutic Single-Case Efficacy Design (Elliott, 2002) study in the current case series conducted by the author as part of his doctoral research investigating the process and outcome of TA psychotherapy for depression. This case presents an ambiguous picture of change where an initial examination of the results suggests no clear and immediately obvious conclusion regarding outcome. This is perhaps the sort of situation where HSCED shows particular strength as an investigation method by developing arguments which account for this mixed picture of change and then seeking external verdicts regarding the outcome of the case.

HSCED (Elliott, et al., 2009) is a systematic case study research method which examines individual cases and can be used to:

(a) evaluate whether change has occurred;

(b) examine evidence causally linking client change to the therapy;

(c) evaluate alternative explanations for client change; and

(d) identify the specific processes that appear to have been responsible for change.

Evidence taken from a rich case record is subjected to an intensive analysis and cross-examination. This process concludes with an adjudication procedure whereby judges offer their verdict regarding the outcome of the case; this includes consideration of extra-therapy events as contributing to client change and a number of process variables from within the therapy that may have been beneficial. The evidence that is used in a HSCED study is based on a rich case record of the client and their therapy and uses both quantitative and qualitative data

which is sifted through, evaluated and triangulated with other data sources to generate plausible arguments regarding the extent and process of change within the individual case.

Three previous HSCED-based case studies have demonstrated the effectiveness of TA psychotherapy for the treatment of depression (Widdowson, 2012a, b, c). Specifically, these cases have shown that TA can be an effective therapy for depression when delivered in routine clinical practice, in private practice settings, with clients who actively sought out TA therapy and with white British therapist and client dyads.

Case study research is rapidly gaining momentum within the TA world, with several researchers contributing to the TA evidence-base using case studies. In addition to the cases of Widdowson (2012a, b, c), case studies have been used to demonstrate the effectiveness of TA for people with long term health conditions (McLeod, 2013) and (in this present journal) with a client with emetophobia (Kerr, 2013). Clearly further research needs to be done to both replicate and confirm these findings and to push the accumulation of evidence of the effectiveness of TA into applications with other client groups.

Such case study research provides a good example of the use of methodological pluralism (Slife & Gantt, 1999) whereby a range of research methods can be combined to develop a compelling body of evidence. For example, the above studies complement the quantitatively-based study of van Rijn et al. (2011) which also found TA to be an effective therapeutic approach. Furthermore, as case study research accumulates, it becomes easier to make comparisons between cases and to increase specificity and transferability of findings by using cross-case analysis methods (Iwakabe and Gazzola, 2009; Iwakabe, 2011). This article concludes with a brief cross-case analysis which compares the findings from this case to others in this series.

## Method

### Participants

#### Client

Linda was a 45 year old woman who lived with her husband of over 20 years, with whom she described having a loving and supportive relationship. At the time of entering therapy Linda had been unemployed for over two years after having walked out of her last job where she had experienced bullying from the management team. Since then she had been at college for a year studying digital graphics. When she started therapy she said she had lost confidence in herself and her ability to put herself forward at interviews and to 'fit in'.

Linda had a difficult relationship with her mother and described her as a cold and critical woman and stated that she could not remember her mother praising or being nurturing towards her during her childhood. Due to all of this, and despite her mother having recently being diagnosed with terminal cancer, during the course of therapy Linda stated that she did not love her mother. Linda had a younger sister with whom she enjoyed a close relationship.

Linda had no previous experience of therapy and was apprehensive about the process and slightly ambivalent about attending, concerned that perhaps she was not in a 'bad enough way' to merit therapy time. She was generally in good health and had a close circle of friends by whom she felt supported.

She felt her main problem stemmed from her interaction with others. She described herself as 'too much for others' and in situations in which another person might end up feeling upset she ended up taking responsibility for the interaction and feeling guilty. Over time she generally had lost her confidence and had effectively shut herself off from others and was doing less and less and staying in the house most of the time and avoiding socialising with others. She was also feeling guilty about her emotional distance with her mother and was frustrated with herself and her 'lack of direction in life'.

Linda was an intelligent, thoughtful, articulate woman. She had a good sense of humour and was able to reflect and challenge herself about the views she held about herself, others and her life. She had a curiosity about her process and was robust in her challenge of the therapist if she was unsure or felt something did not fit for her.

Due to her unemployment, Linda could not afford private therapy so self-referred to a local voluntary agency and was allocated a therapist, paying a small donation for sessions. At her initial meeting with her therapist, the therapist 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. Linda's clinical score using CORE-OM was 16, indicating mild levels of distress and functional impairment and her BDI-II score was 19, indicating mild depression. She was seen in a naturalistic therapy protocol for a period of nine weekly individual sessions. Linda had been offered up to 16 sessions, but felt sufficiently improved after 8 sessions and had found a new job so decided to end therapy and attended for a final ending session.

#### Therapist and Treatment

The therapist in this case was 'Michelle', a 42 year old, white British female therapist. At the time of starting therapy with Linda, Michelle had just over 1 year post qualifying experience as a Certified Transactional Analyst (Psychotherapy). Michelle had at least one hour of supervision per month on her work with Linda with an

experienced Provisional Teaching and Supervising Transactional Analyst (Psychotherapy).

The therapy primarily focused on identifying and challenging how Linda experienced and interpreted the world, interactions with others and the conclusions she drew about herself. The exception to this focus was in session four which mainly focused on exploring her relationship with her mother.

From a TA perspective, the therapy consisted of an initial phase (sessions one to three) of the therapy focused on problem formulation and the use of the ego state model and racket system to facilitate identifying maladaptive cognitive and behavioural patterns and ways of interpreting the world and others. This initial phase also included identifying self-critical dialogue and encouragement to move towards her goals. The second phase (sessions four to seven) of the therapy involved exploring interpersonal patterns (transactions, games) and developing communication strategies, exploring her relationship with her mother which involved deconfusion by encouraging the expression of previously disavowed and repressed anger, challenging maladaptive beliefs about self and others (rackets, contaminations, discounting) and ways of interpreting the world and her self-critical internal dialogue. This phase concluded at session seven when the therapy moved to identifying specific contract goals and behavioural contracting for change. The ending phase of the therapy (sessions eight and nine) involved accounting for and celebrating Linda's changes.

In her Change Interview and HAT forms, Linda described the therapy as being a focused and boundaried relationship which emphasised drawing out her assumptions and meaning-making processes and maladaptive beliefs about self, others and the world and the impact of these on her interpersonal relationships. She also described how the therapy sought to identify, explore and re-evaluate these thinking processes and interpersonal patterns and involved Linda 'being held to account' and both expected to implement changes and given active encouragement to support these changes.

### Analysis Team

*(This paragraph is reproduced from Widdowson 2012b, c, as the analysis team members and process of analysis was identical)*

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 judges in this case were; Dr Meghan Craig, a phenomenological-existential oriented counselling psychologist based in London; Katrin Heinrich, a person-centred/emotion-focused counsellor from Germany who is currently conducting a HSCED study for her MSc in Counselling with the University of Strathclyde and Catherine Cowie, a person-centred therapist based in Scotland. Prior to working as a therapist, Catherine was a lecturer in physics, mathematics and statistics. She has a particular interest in client change processes in therapy.

### Measures

*(The section below has been reproduced from Widdowson, 2012a 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 et al 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 et al, 2002) - 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, 2012a: 53-55)

## HSCED Analysis Procedure

*(Note: this section has also been reproduced from Widdowson, 2012a 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 they considered to have been helpful and which characteristics about the client did they think had contributed to the changes. (Widdowson, 2012a: 6)

## Results

### Quantitative Outcome Data

Linda's quantitative outcome data is presented in Table 1 and Figures 1 and 2. Linda's initial scores were just above the 'caseness' cut-off range for inclusion in this study. Her BDI-II score at entry into therapy was 19, indicating mild depression and her CORE-OM score was 16, indicating mild levels of global distress and functional impairment. Linda's CORE-OM and BDI-II scores had demonstrated clinically significant change by session eight, with all measures showing clinically significant change by session nine. This improvement was maintained at the first follow-up period, but then Linda showed marked deterioration at the three-month follow-up, with her BDI-II score showing reliable improvement to just above clinical levels of distress at the six-month follow-up.

### Qualitative Process Data

Linda's changes as identified in post-therapy Change Interview are shown in Table 2.

#### Client Feedback from Three Month Follow-Up

At the three month follow up, Linda completed the CORE-OM, BDI-II and PQ. She attached a note to the forms, letting the researcher know that things had been difficult over the previous few weeks. The company she had worked for had gone bust a month earlier, and she had been made redundant. She also informed the researcher that her mother had died two weeks prior to the follow-up, following a long deterioration during which Linda had taken on some carer responsibilities. She also stated 'I realised when I filled in the form you might be concerned. Don't worry - last week was bad, but this week is a bit better. As you know, I have a lot of support - so when I'm down, there are people who can help. Despite having a setback, I still think the (therapy) helped. I'm better able to articulate my feelings and not bottle it all up.'

#### Client Feedback from Six Month Follow-Up

At the six month follow-up, in addition to completing the CORE-OM, PQ and BDI-II Linda enclosed a note stating that; 'I am OK in general, but still unemployed and worried for the future. I am not clear what I should do to increase my chances of employment, however I am keeping myself well physically through regular exercise, less drinking and taking care of myself emotionally. My mum died a few months ago and it's been fine dealing with her death. I don't feel we had unfinished business and I feel able to cope - I was sad, and still am, but am not wrecked by her death. Although it can appear as though I'm back to feeling as I was pre-therapy, I don't think I am. I am a bit up and down, but therapy has helped me be calmer and have a clear eyed look at my life. It's never going to be easy, but I don't feel utterly overwhelmed'.

#### *Analysis of Change Interview responses*

For Linda, the professional relationship aspect of the therapy was important.

CL2: … *I really liked the professional relationship. I liked that I was paying. I liked that this was an hour a week that I could take all that stuff and so it clarified things. So if you had things going on during the week you could just park that up and say I can take that... She wasn't your friend who was going to say you are great and you're fine. You could be challenged, you know.*

CL15: *(in therapy), you have to go a bit deeper… Somebody maybe just asking you more pertinent questions, asking you to kind of look at what you're saying in a bit more depth*

She found the therapist's challenge and depth of questioning helped her to maintain focus on the problem areas and also in identifying and changing her maladaptive patterns

*CL17-20: So, it's kind of people picking things up that they might not have otherwise. But I suppose it could be just asking, "What do you mean by that?" or "why is this an issue?", or whatever. So, it is just going a bit deeper. I don't think it was… (short pause), again it's not magic. It's just talking but it is talking in a particular way… Which is more structured… I guess I it makes you consider things a bit more. It just makes you think through a bit more. I suppose in between sessions you are more aware of things that you have discussed and trying to kind of looking at that and think oh yeah, we talked about this and now in the situation and how I'm dealing with it and because it is more structured so there is somebody bringing you back to the main points.*

This combination of a safe, professional relationship and sustained focus on her inner process assisted her in challenging and disconfirming her maladaptive internal and interpersonal patterns.

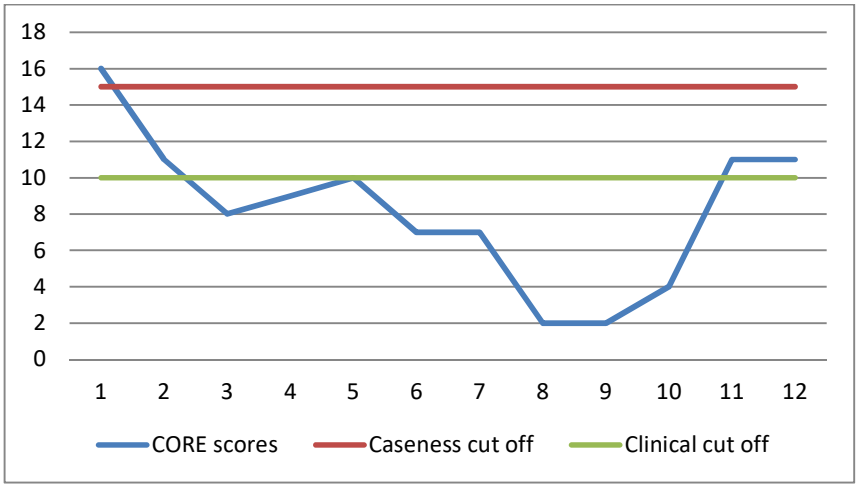
CL46: … *well for me it's a lot about that relationship, right, so there has to be notions of trust and so you are in a*

*Table 1: Linda'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 | 46.0 | 1.00 |
| **Pre-Therapy** | ***19*** | ***16*** | ***5*** |
| **Session 8** | *2 (++)* | *2 (++)* | ***3.1 (+)*** |
| **Session 9** | *0 (++)* | 2 (++) | 2.4 (++) |
| **1 month Follow-up** | 0 (++) | 4 (++) | 2.1 (++) |
| **3 month Follow-up** | **23 (-)** | 11 (+) | **4.7** |
| **6 month Follow-up** | 12 (+) | 11 (+) | **5** |

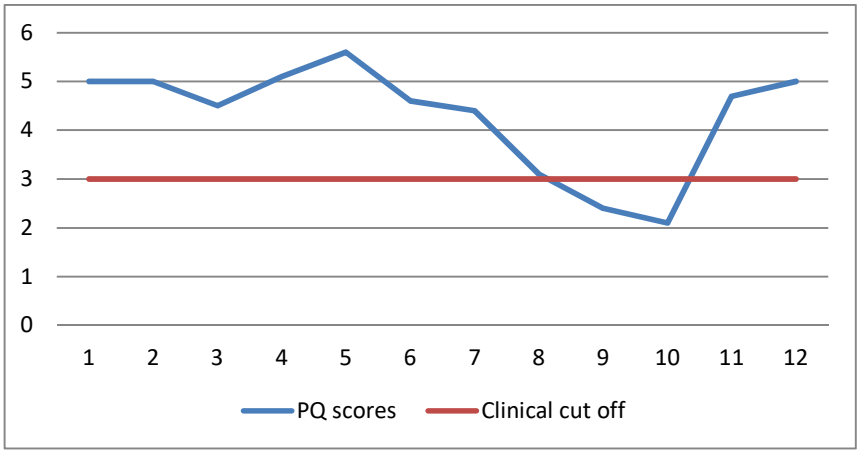
**Note:** Values in ***bold*** are within clinical range. + indicates Reliable Change, ++ indicates clinically significant change.

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




*Note: 10, 11 and 12 relate to the follow-up periods*

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




*Note: 10, 11 and 12 relate to the follow-up periods*

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

| Change | How much expected/surprising change was [a] | How unlikely/ likely change would have been without therapy [b] | Importance of change [c] |
|---|---|---|---|
| Feeling calm and competent | 2 | 2 | 5 |
| Not making assumptions and changing how I relate to people | 4 | 1 | 4 |
| Being more open, vulnerable and less tense | 2 | 1 | 3 |
| Feeling OK about my relationship with my mum and not feeling guilty | 4 | 1 | 5 |

[a,b] The rating is on a scale from 1 to 5;
1= expected, 3= neither, 5= surprising
[c] The rating is on a scale from 1 to 5;
1=slightly, 3 = moderately, 4=very, 5=extremely

*room with somebody who trusts you, you trust and you can talk about what you identify as being important to you. You are in the driving seat. What's bugging you, what's irritating you? You put it out there and there's a discussion about it. This is an equal relationship. There is not anyone telling you what to feel about it, what to think about it, what to do about it. It's putting stuff out there and kind of looking at it from different angles. I suppose it's like you put something down and you can walk around and you can look at it. You can examine it. It kind of takes it out of your head*

CL52-4: *There is that process of kind of making yourself vulnerable, it has to go out there and again I suppose in the therapy situation you have got a safe space to do that. It's good to test things out if you like. Within there, all of things you have going round in your head thinking "I am bonkers". This is just bonkers, why am I thinking that? If you put it out there, oh look! You know, the world is still turning. Nothing has happened, no bad things have happened, you can talk about this. The world is here and everything is fine and this is ok.*

CL60: *It is a qualitative difference from just sitting down with your mates, your partner, whatever … So it's not just about the talking. Constructive dialogue… Where you have very, very strong focus on a particular thing and you are seeking to kind of deconstruct it, put it back together, do whatever with it to try and make sense of it*

*Additional comments*

Linda was emphatic that participating in the research had not been problematic for her. She was also clear that there had not been any aspects of her therapy which had felt incomplete and she did not identify any aspects of therapy which had been unhelpful. Although she stated that she had found the ego state model helpful, she did express a natural aversion to anything which might be 'putting people into boxes'.

## HSCED Analysis

### Affirmative Case

Linda identified nine main problems which she was seeking to resolve in psychotherapy, all of which had reliably changed by session eight and had changed at the level of clinical significance by the final ninth session. These changes were sustained at one-month follow-up. Although Linda demonstrated deterioration on outcome measures at both the three and six-month follow-up periods, the affirmative team's perspective was that this could be accounted for by her mother's death and her long period of unemployment. Linda was quite emphatic in her statements at the three and six-month follow-up that she felt different and that the therapy had helped and that she was coping with things differently to her pre-therapy state.

In considering the quantitative measures, the affirmative team highlighted that by session eight Linda's BDI-II scores had dropped 17 points to 2 and her CORE scores had dropped 14 points to 2 - both within the 'normal range' which was maintained at one month follow-up. Her PQ scores also demonstrated clinically significant change by the end of therapy and at one month follow-up. Although there was some deterioration in Linda's PQ scores at six-month follow-up compared to end of therapy, five of her nine scores still demonstrated reliable change from pre-therapy scores, again suggesting that some permanent changes had taken place, and that the deterioration was possibly a reactive effect of prolonged and extreme stress.

The affirmative team noted Linda's clarity and specificity in the changes she had experienced in her Change Interview, and in Linda's conviction in her three and six month follow-up statements that she was coping with things better than she had done prior to therapy. Associated with this, the affirmative team highlighted that Linda has identified five contract goals for her therapy which she felt she had achieved and which her three and six month statements suggest were maintained. These were:

- To work out what I want to do in my life
- To feel OK about my relationship with my mother
- To check out assumptions I make
- To share my vulnerability with family and friends
- To challenge the beliefs I hold about myself

The affirmative team noted that throughout her Change Interview, Linda clearly attributed her changes to therapy and provided a clear and detailed description of therapy process which they argued provided a convincing account of change. Indeed, in both her HAT forms and her Change Interview, Linda provided considerable detail about the helpful aspects of the therapy process which the affirmative team considered provided clear and plausible links between therapy process and outcomes.

The affirmative team also noted that although the biggest changes for Linda took place after her job offer, her CORE scores had showed clinically significant change within the first three sessions, prior to her job interview, and that this provided evidence that therapy had been a causal factor in Linda's changes.

### Sceptic Case

The sceptic team concluded that there was strong evidence to cast doubt on claims that Linda changed substantially and that these changes were due to therapy, highlighting three major lines of evidence. Firstly, Linda demonstrated the largest change after securing a new job, suggesting external factors were highly significant in causing her apparent changes. Secondly, Linda's changes were not maintained during the follow-up, suggesting that her changes were temporary - indeed during the follow-up period Linda experienced a bereavement and redundancy and these clearly had a significant impact on her, leading to reliable deterioration which casts doubt on any claims of internal changes having taken place during therapy. Thirdly, the sceptic team felt that there was reason to consider that relational factors and Linda's liking of her therapist may have accounted for some of her reported enthusiasm and positivity about therapy.

### Affirmative Rebuttal

Linda was clear in her three and six month follow-up statements that although there was apparent deterioration, she did not feel that she was in the same situation as she was prior to therapy. Furthermore, she felt that she had made some permanent changes in how she related to others, and how she resourced herself. She was also clear that her deterioration was due to the effect of external factors - in particular her mother's death and her redundancy.

Linda described herself as analytical and cynical, and had been sceptical about therapy at the outset. In light of this, the affirmative team considered it unlikely that someone with this degree of scepticism would be painting an overly positive picture of therapy if they did not genuinely believe it to be true. She was clear that her therapist was active and often challenging, but that this was an aspect of the therapy that she welcomed. She also suggested that her therapist did not adopt an 'overly nice' position in relation to her and had clear expectations of Linda and that she had found this robust and challenging approach to be a catalyst for change which suited her own personality. Although Linda was positive about her therapy, the affirmative team felt that her detailed and idiosyncratic account of the therapy process provided sufficient evidence that Linda's change was not due to relational factors.

### Sceptic Rebuttal

The sceptic team maintained that Linda's deterioration in all her outcome measures cast substantial doubt over claims that Linda changed very much during therapy and that any changes were transient and not stable under stress. Despite her statements during follow-up that she was handling problems differently, the sceptic team noted that several of her initial problems had returned to clinical levels. The sceptic team believed that there was a strong argument to believe that Linda's positive changes were more likely to be associated with extra-therapy factors, in particular getting a new job, rather than indicative of personal changes due to therapy.

### Adjudication

All judges independently produced their opinions and ratings of the case which are presented in Table 3. A mean score has been given to represent a balance of their conclusions.

To summarise, the judges concluded that Linda had indeed changed during therapy, and that therapy had been important in facilitating these changes, but that these changes were not lasting and were not sustained in response to stressors.

### 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)

The judges agreed that there was evidence that Linda had changed during therapy; however they noted her deterioration during the follow-up period as suggestive that her changes had not been sustained and therefore concluded that this was a mixed outcome case.

Judge A commented 'the client clearly attributes her changes to therapy and provides idiosyncratic detail about how these changes have been maintained at follow-up even though the outcome scores would suggest otherwise. It would appear that the therapy process has given the client resources for coping despite distressing life events occurring post-therapy, and her qualitative accounts seem to confirm that she has found the process useful in helping her cope with these challenges.' Judge C made similar comments, and was particularly struck by Linda's assertion that she was relating to people differently at the end of therapy.

The judges agreed that the impact of external factors had both positive and negative effects on the outcome of the

therapy, with Linda improving considerably during the course of therapy after succeeding in finding a job after her long unemployment (she attributed her success in interview to therapy) and then her post-therapy decline which she attributed to the effects of bereavement and redundancy from her new job.

One judge considered the possibility that Linda was still in a period of adjustment following these events and that a longer follow-up period would have provided information on whether she would return to an improved level of functioning. Judge C noted that simultaneous improvement on CORE and BDI showed a convincing sign that real change had indeed taken place and agreed that adverse life-events post therapy were most likely the reason for her seeming deterioration, as opposed to any reversal of changes.

Judge B noted that in her statements during the follow-up, 'Linda described feeling differently and able to cope with situations better. It seems as if she changed her personal strategy to change (Mackrill, 2008) from having to cope with things on her own and drinking alcohol to being willing to show her vulnerability and trust people to being accepting of her perceived weaknesses. This change allowed her to stay connected with others and being open to different perspectives or help. Also it appears that therapy helped her to cope with unfinished businesses related to her mother; she described throughout that the sense of guilt had been worked through. Also when being asked what helped her to get the job, she referred to her increased self-confidence which she attributed to therapy.

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

The majority verdict of the judges was that Linda had changed substantially *during* therapy - achieving reliable, clinical change, but these changes had not been sustained during the follow-up.

Judges A and C noted that the affirmative team's argument that Linda's distress at the 3 month follow-up was due to the effects of acute grief and recent redundancy was plausible and was supported by improvement to sub-clinical range on BDI-II at six month follow-up.

Judge A noted that 'there is a contradiction between the client's outcome scores, and the self-report statements about how she is coping, and doing better than the outcome measures would indicate. The question here is whether the outcome measures were accurately examining the areas of change reported, or whether the client was attempting to reconcile some dissonance she felt about the process by affirming that she had indeed changed permanently despite the lack of evidence in the outcome scores.'

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

The judges agreed that Linda had provided a detailed, consistent and idiosyncratic account of the key aspects of the change process but disagreed about the affirmative team's arguments regarding process-outcome matching and event-shift sequences, with judges A and C considering these to be plausible and judge B being unconvinced by them. Judge A in particular felt impacted by Linda's emphatic statements of the helpfulness of therapy in her change interview, stating 'The qualitative data from the Change Interview is important in this decision about whether the client changed during therapy. The client reports clearly indicate that she feel she changed substantially with four significant changes identified. These changes correspond to the client's therapeutic goals, and were identified as important/very important by the client. I think this is corroborated by the evidence in particular HAT descriptions which correspond to these changes. Since particular therapy events were highlighted by the client as being helpful, and because these correspond with the identified changes at the follow-up interview, there is a more substantive argument that the process of therapy was helpful in bringing about client change'. Judge C made very similar observations.

Judge B commented on the impact of external factors on the changes Linda experienced, in particular her new job which she felt 'prompted a substantial shift in outcomes and led to a rapid conclusion of therapy. Nevertheless, it appears that therapy facilitated this process by helping the client to gain more confidence in preparation for the job interview. I would question the stability of these changes, however, because outcomes during follow-up were negatively affected by external factors such as loss of job and death of mother. Undoubtedly, these factors would have had a significant impact on the client, but the qualitative reports from the client indicate that the changes during the course of therapy helped her to cope with these difficulties better, even some time after therapy ended. It appears that therapy factors and external life factors are closely inter-linked in these outcome areas. For this reason, I would say that the changes the client reported at the end of therapy were largely the result of the therapy experience, but that external factors also played a role in moderating these effects.'

Judges B and C also went on to note Linda's clear retrospective attribution of therapy as a catalyst for change and being important to take into account and felt that this, combined with the role Linda attributed to therapy in enabling her to work through her guilt and unfinished business in her relationship with her mother, were all clear evidence that therapy positively contributed to her changes.

### Mediator factors

Judge A highlighted 'the… non-judgemental nature of the therapist (as being)… a very important factor in building a strong therapeutic alliance. This seems to have paved the way for the work done in therapy, as the client seemed able to trust her therapist, and to be challenged by her. The therapist's manner of questioning and challenging the client was an apparent mediator in the change process.

Judge B highlighted the role of feedback given to the client by her therapist as likely to have been an important mediator factor. In particular she highlighted Linda's' remarks in the HAT descriptions that the feedback on her behaviours and way of being was helpful to her in beginning to think about a different way of being and relating to others.' Judge B also noted the sense of trust and equality in a relationship with a fully engaged therapist and the structure and boundaries of the therapy as being likely mediator factors. Furthermore, judge B highlighted some key intervention approaches which Linda found helpful, which included the therapist's sustained focus, in-depth questioning, exploration of issues and offering alternative perspectives. Judge B considered that these may have caused change by helping Linda to increase her awareness, change her frame of reference, develop a new narrative, encouraged and reinforced her change process. Judge B also commented that the main therapeutic strategy which appeared to be relevant in guiding this process was the therapist's focus on helping Linda to identify, re-evaluate and change problematic thinking and behaviour patterns.

Judge C highlighted the helpfulness of the use of theory to help Linda conceptualise her process, combined with a sense of equality in the relationship and of 'being met' by her therapist as significant.

All judges agreed that the therapist's affirmative, validating and permissive approach enabled Linda to experience a sense of acceptance and gave her hope that things might change. This was balanced with a sense of the therapist being strong, having a sense of humour and maintaining a stance that both encouraged Linda to take charge and make active changes and discouraged avoidance.

### Moderator factors

The judges were also asked to provide an opinion on which client characteristics or resources had been helpful to them in the process of change. The judges agreed that Linda appeared to have a strong social network which was supportive of her changes (in particular her new-found willingness to be emotionally vulnerable in relationships) and provided emotional resources to help her deal with difficult life events. Another helpful factor was considered to have been the fact that Linda had identified problematic coping strategies and issues to work on in therapy prior to attending.

*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) | 60% | (no score given) | 0% | (mean cannot be calculated) |
| 1b. Mixed Outcome (problem not completely solved) | 100% | 80% | 80% | 86% |
| 1c. Negative/Poor Outcome | 20% | (no score given) | 0% | (mean cannot be calculated) |
| 2. To what extent did the client change over the course of therapy? | 60% | 80% | 60% | 66% |
| 2a. How certain are you? | 80% | 80% | 80% | 80% |
| 3. To what extent is this change due to therapy? | 60% | (no score given) | 80% | 70% |
| 3a. How certain are you? | 100% | (no score given) | 80% | 90% |

In addition, Linda's motivation, determination and active approach to change was highlighted as an adaptive change strategy, as was her desire to take charge of her life and be 'in the driving seat' of her own therapy. Judges B and C noted that Linda took a series of active steps to breaking her vicious cycle of low self-confidence by pushing herself to go out into the world, her willingness to see things from different perspectives, and her engagement with the contradiction of striving for privacy whilst needing to open up, share problems and be vulnerable in her close relationships. Judge B felt that this enabled Linda to challenge her characteristic way of being in relationships and enabled Linda to have corrective interpersonal experiences which supported her change.

## Discussion

Unfortunately, this case does not add further support to the findings from the cases of Peter, Denise and Tom (see, Widdowson, 2012a, b, and c) with regards the effectiveness of TA psychotherapy for depression. However, this is not a completely poor outcome case, and there are many features of this case which raise some interesting questions about how we can maximise the effectiveness of therapy. It is clear that Linda did indeed change during therapy and found therapy to be a useful experience. It is also clear that the therapy was not sufficient to resource Linda for the difficult times she would face in the months after finishing therapy. As soon as Linda obtained her job around session 8, she was keen to finish therapy. This was earlier than the therapist had expected, and consequently did not give the therapist sufficient time to help Linda with contingency planning and ensuring that she had adequate resources for the future.

A cross-case analysis of the cases in this series has been conducted which has broadly followed the grounded theory method of *constant comparison.* This has suggested a number of variables and factors which may have influenced the outcome of the therapy and which suggest avenues for further investigation.

Unlike the previous cases (Widdowson, 2012a, b, c), Linda had no knowledge of TA or of therapy prior to starting therapy. It is possible that pre-therapy preparation may be beneficial to outcome. As with the previous cases in this series, Linda's therapist presented relevant TA theory to conceptualise and discuss Linda's problems with her and Linda reported that this had been helpful to her. These findings suggest that the psychoeducational components of TA therapy are beneficial. Associated with the use of theory to generate insight, the therapy involved considerable attention to changing both Linda's internal way of interpreting and responding to the world; i.e. to changing her script and her transactional patterns, and Linda found this to be helpful.

In contrast to the previous three cases, Linda was somewhat sceptical and ambivalent about starting therapy, which may have limited her engagement in the process. Another contrast to the previous cases was the fact that the clients in those cases all actively and specifically sought out a TA therapist, whereas Linda saw the therapist which was allocated to her by the agency. One potential implication for this is that it may be possible that client preferences have an influence on overall outcome of the case. However, Linda found the therapy to be helpful and enjoyed a positive relationship with a therapist she perceived as strong and potent; as in the previous three cases, she also reported experiencing the therapy as being a place where she felt like an equal and as an egalitarian process.

Another similarity with previous cases in this series was that Linda also described an early environment where she felt criticised and undermined. This would suggest that the experience of a non-nurturing and critical environment results in a vulnerability to depression.

Linda, and the clients in the previous cases, experienced improvement in her interpersonal relationships during the therapy. Unfortunately, none of the outcome measures used in this study addressed interpersonal functioning so it is impossible to quantify the magnitude and significance of this change. Further research which examines positive change in interpersonal relationships is clearly warranted.

Linda experienced some considerable life difficulties following therapy, which precipitated considerable distress. Unfortunately, Linda ended therapy early and abruptly, which gave the therapist little opportunity to engage in contingency planning or relapse prevention work. Although insufficient data is available to draw conclusions on this matter, it is possible that attention to relapse prevention and resourcing clients may be beneficial and assist in the maintenance of changes. When contrasted with the cases of Peter, Denise and Tom, Linda's therapy is considerably shorter and it would appear to be plausible to consider that this was a factor.

### Limitations

As with previous cases in this series, the researcher was involved in the analysis teams and had been a former tutor for the group members, which may have influenced their arguments. Also, the analysis team had a relatively short amount of time to construct their arguments, and it is possible that a more detailed picture would have emerged if they had been given more time. Although the conclusions of the judges was that this was a mixed outcome case, the judges were all therapists, and so it is possible that this may have influenced their findings. The use of a lay person acting as a judge in future investigations may be interesting and reveal alternative ways of looking at cases.

Linda was clear in her statements and qualitative data that she had made interpersonal changes. This matches the findings from the previous three cases in this series. Unfortunately, no measures of interpersonal change were used, and so consequently it is difficult to determine the extent or nature of interpersonal change with these clients. Future research which includes such a measure is warranted.

## Conclusion

The findings of this case suggest that although the client did in fact change as a result of therapy, these changes were not sustained. As a result, this case does not add to the literature on the effectiveness of TA. However, this case does highlight a number of factors which may be relevant to outcome. Linda also provided some interesting and insightful comments about the process and nature of therapy. Overall, the case raises some interesting questions about the nature of therapeutic change. It also raises interesting questions about how evidence from cases is evaluated and in particular, which sources of evidence are more influential in forming conclusions.

Clearly, more research needs to be done to investigate the process and outcome of TA psychotherapy. Specifically, further research which explores the effectiveness of TA for depression is needed to strengthen our existing evidence base.

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# TA Treatment of Emetophobia – A Systematic Case Study – 'Peter'



## Abstract

*This study reports on the application of elements of Hermeneutic Single Case Efficacy Design (HSCED) (Elliott 2002) to a 39 session TA-based psychotherapy intervention with a 19 year old white male student in the UK who was suffering from emetophobia. The author, who was also the researcher, provides literature reviews on emetophobia clinical characteristics, contrasts it with other phobias, and reviews prior research including TA-based approaches to phobias generally. HSCED Methodology is briefly described; quantitative outcome measures are obtained and analysed using GAD-7 (Spritzer et al 2006) and SPQ (Elliott et al 1999), and qualitative measures via a rich case record, session recordings/transcripts, and a 4-month follow-up interview. Bohart at al's (2011) 56 criteria for evidence adjudication were used alongside HSCED criteria. There was strong evidence of significant client changes, and that these changes were the result of the therapy.*

## Key Words

Emetophobia, Hermeneutic Single Case Efficacy, Case Study Research, Transactional Analysis Psychotherapy

## Introduction

Phobic disorders are organised into three main categories under Anxiety Disorders in the Diagnostic and Statistical Manual (DSM-IV TR), namely Social Phobia, Specific Phobia and Agoraphobia (APA 2000). Emetophobia is classified under Specific Phobia (Other Type). Specific phobias are found across cultures although the prevalence, phobic objects/situations and gender differences vary (Lewis-Fernandez et al 2009). Within the UK, there is currently no specific NICE (National Institute for Health & Clinical Excellence) guideline for the treatment of Specific Phobia (NCCMH 2011).

Looking at the available research on emetophobia, successful treatment is poor and dropout rates from treatment high (Veale and Lambrou 2006). In addition, a number of the studies reviewed suggest that emetophobia be considered in a separate category from specific phobia (Boschen 2007, Vandereycken 2011) in a similar way that social phobia and agoraphobia are. With early onset, chronic course, few if any periods of remission, and associated with significant distress and restriction in daily life as well as being considered more difficult to treat, I believe that emetophobia is a condition in urgent need of research (Lipsitz at al 2001, Hunter and Antony 2009).

There are a variety of theories as to the acquisition and maintenance of phobias (Davey 2008, Hersen and Bellack 1999, Gelder at al 2001) that inform a variety of treatment approaches. In the case of emetophobia, I could find no documented transactional analysis approach and mixed success with pharmaceutical and cognitive behavioural approaches (Lipsitz et al 2001).

Case study research has been used in the TA literature by Widdowson (2012a, b, c, 2013) and McLeod (2012) and these have demonstrated TA to be effective for the treatment of depression and for working with people with long-term health conditions. This article presents a research case study exploring the effectiveness of a TA approach for the treatment of emetophobia in adults.

## Literature Review

### Emetophobia – Clinical Picture

In a study comparing 100 individuals with vomit phobia to a group suffering with panic disorder and a control group, Veale and Lambrou (2006) add to an earlier survey of 56 emetophobics carried out by Lipsitz et al (2001) to provide a clinical picture of emetophobia which *is summarised in Table 1.*

**Table 1 – Clinical Picture of Emetophobia (Constructed from Lipsitz et al 2001 and Veale and Lambrou 2006)**

| Variable | Value |
|---|---|
| Mean age of onset | 9.8 years |
| Described as first becoming a problem | 11.6 years |
| Mean duration of vomit phobia | 25.9 years |
| Equal fear of vomiting alone and in public | 77% |
| Fear of self-vomiting mainly | 41% |
| Fear self and others vomiting equally | 47% |
| More concerned about vomiting alone or in the presence of others | In the presence of others |
| Frequency of vomiting | no different from normal population |
| Sensations of nausea | almost every day or every other day |
| Anxiety inventory | significantly higher compared to those with panic disorder |
| Interpretation of feeling sick | "I am going to vomit"<br>"I will be paralysed with fear" |
| Associated symptomology | Panic attacks |
| Feared consequences of vomiting | Losing control, becoming ill, choking, dying, fainting, others not wanting to know me, others finding me repulsive |
| Safety seeking behaviours | "looking for an escape route"<br>"trying to keep a tight control on their behaviour"<br>"taking medication"<br>"reading"<br>"sucking antacids/mints"<br>"moving very slowly" |
| Avoidance behaviours | a wide range including illegal substances, being around drunks, fairground rides, people who are ill, boats, holidays abroad, aeroplane travel, drinking alcohol, crowded places, public transport, eating from salad bars or buffets, visiting others in hospital, pubs, eating at restaurants, public toilets, specific foods, pregnancy, surgery |
| Need to differentiate presenting features from other disorders | Obsessive- Compulsive Disorder, Panic Disorder, Social Anxiety |
| Gender bias | Majority female |

### Approaches to Phobias Generally

Choy et al (2007) suggests that "most (specific) phobias respond robustly to in vivo exposure" (p 226), but goes on to highlight that this approach, although apparently successful for those who complete the treatment, "is associated with high dropout rates and low treatment acceptance" (p.266) highlighting that the research "should be interpreted with some caution" (p.282). This is echoed in a meta-analysis of RCTs by Wolitzky-Taylor et al (2008).

Holmes (1982) describes formal research carried out demonstrating the validity of a psychodynamic-attachment based understanding of agoraphobia. Ruiter and van Ijzendoorn (1992) also carried out research confirming the relationship between attachment issues and agoraphobia. In terms of social phobia, there are a number of recent studies that confirm the association of insecure attachment with the development of social phobia (Knappe et al 2012). Bowlby (1973) demonstrated the impact of poor attachment with school phobia and agoraphobia; Klein (1964) reported on a sample of female adult patients with panic and agoraphobia having a history of separation anxiety or school phobia.

### Approaches to treatment of emetophobia

In line with the treatment for other specific phobias, exposure-based therapy is the most common approach mentioned in the literature for emetophobia (McFadyen

and Wyness 1983, Phillips 1985, Hunter and Antony 2009). In the Veale and Lambrou (2006) study, 70% of the vomit phobics had approached their GPs and been referred: 20.3% received behaviour therapy (which was the least effective), 17.9% received cognitive behaviour therapy (moderately effective), 41.3% received medication (mildly effective).

In an outcome study with 7 patients using exposure treatment based on film of people vomiting, Phillips (1985) reported initial success with all seven subjects, although the phobia returned to some following treatment. Wijesinghe (1974) successfully used flooding and hypnotherapy on a 24 year old woman. McFadyen and Wyness (1983) present a successful single case study with a young woman using graduated exposure. There appear to be no single case studies with male subjects.

Whereas earlier behavioural approaches focused on the external – for example the smell of vomit - Lipsitz et al (2001), Veale and Lambrou (2006) and Boschen (2007) highlighted that internal sensations (e.g. of nausea) were key to understanding emetophobia. However, van Overveld et al (2008) demonstrated that individuals suffering from emetophobia have significantly elevated levels of both disgust propensity and disgust sensitivity. This may partly explain the high levels of avoidance of situations where a disgust stimulus is likely, such as public toilets, food smells, etc.

Although exposure-based approaches seem to have been successful in the treatment of some phobias, the relative lack of success with emetophobia leads me to agree with Boschen (2007), Hunter and Antony (2009) and Vandereycken (2011) about the need for a separate classification for emetophobia, reflecting a greater difference to other specific phobias and more in common with panic disorder and agoraphobia. Interestingly, van Overveld et al (2008), referring to social phobia, agoraphobia and panic disorder, comments that "the appearance of comorbid disorders starts only after the onset of emetophobia" (p.525).

Hunter and Antony (2009) present the successful treatment of a young woman using exposure and psychoeducation where the client remembered a specific incident where she vomited in public and the negative reaction of her parents to this; however, as with some cases of agoraphobia (Thomson 1986) it is possible that there may be a more complex etiology and need for a more integrated approach.

Studies carried out to date seem to omit three potentially important factors: family dynamics, underlying psychological factors and the therapeutic relationship. These omissions may provide a clue to the mixed outcome success. Lambert and Barley (2002) showed the primacy of the therapeutic relationship in the successful outcome of psychotherapy in general. The mixed success with emetophobia reported in the literature may be due in part to the quality of the relationship between client and therapist.

### Transactional analysis approaches to phobias

Transactional Analysis understands phobia to be located in the Child ego-state (Berne 1966) and potentially comprising contamination (Berne 1961) and destructive script decisions (Goulding and Goulding 1978); suggestions in the TA literature as to how such contaminations and script decisions arise (English 1977, Goulding & Goulding 1978, 1979, Kottwitz 1984, Thomson 1986, English 1996, Janoff 1997, Ohlson 2005) can be summarised as:

- early primary caregiver abuse, neglect, inconsistent attention or overprotection
- family dynamics – modelling, attribution, associated or observational learning
- an attempt at defence against an intolerable fear which the individual cannot control

Goulding & Goulding (1978) identify the phobic defence as arising from specific parental injunctions: "phobias are Child decisions made to protect oneself" (p 228). Phobias associated with a "Don't Exist" injunction include any activity or situation where there is a danger of dying, such as high places, water, underground, flying, lifts etc. They suggest that a child receiving a "Don't exist" injunction can develop a phobia as one of three responses to the injunction:

1. Initially decide to kill themselves so that their parent(s) will be sorry, but then become fearful at the decision and develop a phobia for self-protection.
2. Be so fearful that they "displace the fear onto something more controllable" (p.229).
3. Develop a phobic fear of the medium, possibly through magic thinking e.g. after having a near death experience by drowning, develop a phobia of water

English (1977, 1996) highlights that although phobias are dysfunctional, they function to protect the individual from the original parental injunctions. She gives the example of a phobia of fire protecting an individual believing, "I must get hurt to be loved" (p.296).

In the case of family dynamics, ways that a phobia might be established in an individual include modelling by a parent or parents (Stewart and Joines 1987), attributions from parents (Holtby 1973) and/or transgenerational hot potato or episcript (English 1996), where a parents' fear can be transmitted to a child.

There appear to be no formal case studies on the TA treatment of phobias although journal articles and book

chapters do describe working with a variety of phobias including heights, water, insects (Goulding and Goulding 1978, Kottwitz 1984), panic disorder and agoraphobia (Thomson 1986, Janoff 1997) and flying (Ohlson 2005), all reporting positive outcomes.

Although there is no single common approach, the above studies all mention employing decontamination techniques (psychoeducation, desensitisitation and exploring catastrophic beliefs). The Redecision approaches also include working with the past scene, addressing the original injunction (where this can be found) through redecision work, self-reparenting and therapist affirmation. Janoff (1997) and Thomson (1986) also mention the use of empathic transactions and the importance of reparenting.

## Research Question

My motivation for carrying out this research was largely to determine whether TA is effective for working with phobia, particularly emetophobia, in order to inform my own choices about working with phobia in the future.

## Ethical Considerations

Care was taken to discuss the nature of the research with the client who agreed to be involved in the research. This included a discussion of, and agreement on, who would see the raw data and how the data would be anonymised for wider publication.

In all this, the priority of the client work was emphasised whatever decision the client arrived at, and it was also emphasised that the client could withdraw from the research element at any time.

## Research Methodology

### Introduction

This study used a combination of quantitative and qualitative measures as part of a rich case study based on the original HSCED design by Elliott (2002) and incorporating adjudication based on the pragmatic case evaluation method described by Bohart et al (2011). This approach was chosen in order to minimise any intrusion into the therapists' normal way of working but at the same time provide a rich case to consider and tools to interpret the data.

The research evaluation was initially conducted using a critical-reflective practitioner-researcher model (McLeod, 1999). In line with guidelines for conducting case study research developed by McLeod (2010) relating to credibility and trustworthiness. The research process, data and findings were supervised and audited by Mark Widdowson, Teaching and Supervising Transactional Analyst (Psychotherapy). This research supervisor/ auditor was selected due to his expertise in case study research methods. Although Elliott et al (2009) state that the analysis of the data can be carried out by the individual practitioner-researcher, having the findings audited by a third party goes further in addressing issues of researcher bias.

### Quantitative Outcome Measures

GAD-7 (Spitzer et al 2006) was used at the assessment session, regularly throughout therapy and at separate follow-up sessions. The GAD-7 is a self-completed questionnaire based on ICD-10 diagnostic criteria for anxiety and is widely used in therapy research.

An individualised Simplified Personal Questionnaire (SPQ) (Elliott et al 1999) tailored to the specific presenting issues of the client was collaboratively constructed at the first therapy session and completed regularly throughout therapy and at the follow-up sessions. This type of questionnaire has been found to be particularly effective for measuring therapeutic change (Greenberg and Watson 1998) and fits well with the TA concept of an agreed therapeutic contract (Berne 1966).

### Qualitative Outcome Measures

All sessions were recorded with therapist notes on each session written up following the session and kept with the case file.

An open-ended qualitative interview was carried out at the end of therapy to explore the client's progress and experience of therapy. A similar interview was carried out 4 months later. Both interviews were transcribed and used as the basis for the qualitative evaluation.

### Data Analysis

Data from the GAD-7 and SPQ questionnaires were plotted to show any change between first signing up for therapy, during therapy and in the 4 months following completion of therapy.

In order to assist in a critical evaluation of change and the plausible causes of change, use was made of the 56 criteria proposed by Bohart et al (2011) for a jury adjudication of the evidence. The rich case record was carefully examined for evidence in order to answer the two basic questions: (a) did the client change, and (b) if so, is there evidence that psychotherapy caused or contributed to the change (p.145).

The first 39 criteria were used to provide an evaluation, based on a preponderance of the evidence, as to whether the client changed. The remaining 17 questions were similarly used to evaluate whether it was the therapy that helped bring about this change.

In order to examine in more detail whether something outside the therapy could have brought about any change, the criteria from HSCED (Elliott 2002) for evaluating non-therapy explanations for change was also used. Again, the transcripts of the change interviews

were examined for "… descriptions of changes experienced over the course of therapy" and "… client descriptions of their attributions for these changes…" (Elliott 2002, p4).

Data from the therapist notes and individual recorded sessions were reviewed where there was a need to look in more detail at specific events.

## Participation

### Client

Inclusion criteria for the study was any client over 18 years of age and fulfilling the criteria for emetophobia. Exclusion criteria included any client with a history of mental illness (as self reported) or personality disorders as indicated by DSM IV (APA 2000). The client, Peter, was chosen from the therapists' normal client workload, being the first client to present with emetophobia.

Peter had been on anti-anxiety medication for eight months when I first saw him in weekly individual therapy. His GP initially suggested he may have an eating disorder and subsequently that he had a vomit phobia.

Peter is a 19 year old white male student, just completed his first year of university, living at home with his parents. In the first session, I found that he engaged with me easily and seemed generally relaxed, although he did say that he hadn't eaten all day so he wouldn't be worried about vomiting.

Peter said that his phobia relating to vomit gradually developed over time. He stopped going out anywhere because he felt sick and if he had to go out he became very anxious. His anxiety was around anything to do with vomit – being sick, feeling sick, talking about sick or disgusting things, food smells, parties (where someone might be sick), and his own vomit. If he had to go somewhere outside, he would not eat that day and would try to make himself sick before he left the house so there was nothing in his stomach to vomit. He did this every morning before university. He also expressed concern when asked about what the future might hold for him; whether he would be able to keep attending university or ever get a job.

I noted that his experience and behaviours were typical of the clinical picture presented earlier of emetophobia (Lipsitz et al 2001, Veale and Lambrou 2006).

### TA Diagnosis, Contract, Treatment Plan and Intervention

While there were a number of possible causes and contributing factors, I decided on a working diagnosis of a Child and Parent contamination along with attachment issues (Bowlby 1973, Thomson 1986) that, along with a traumatic incident at school, resulted in a split-off or partially excluded Child ego-state (Berne 1961, Hargaden and Sills 2002). I found it most convenient to think about the client as living out this script presentation as a 'Phobic Anxiety' Racket System (Erskine and Zalcman 1979) where a phobic response is one of his main script displays and ensures proximity to his primary attachment figure and secure base.

We negotiated an outcome-focused behavioural contract (Berne 1966, Stewart 2006) to be able to live a normal life like other young men his age with some specific measures relating to taking part in and enjoying a number of activities he currently avoided.

I followed a treatment plan based on Woollams and Brown (1978): Motivation, Establish a Working Alliance, Decontamination, Deconfusion, Redecision, Relearning, and Termination. Whilst having its own fully informed model of the personality, TA has a psychodynamic underpinning, relational emphasis and incorporates cognitive-behavioural techniques (Berne 1961, Hargaden and Sills 2002, Stuart 2007, Widdowson 2010, Novellino 2012).

The study imposed no narrow focus on specific TA interventions. This approach was chosen to ensure that the therapist was not constrained in his normal way of working. Key TA concepts and tools, including contracting, use of the ego-state model, developing and use of a therapeutic relationship, therapeutic operations, psycho-education, empathic transactions, strokes, decontamination, racket analysis, and deconfusion were all used (Berne 1961, Clark 1991, Erskine and Zalcman 1979, Hargaden and Sills 2002, Novellino 2012, Stewart 2007, Widdowson 2010).

### Therapist/Researcher

I have been practicing as a psychotherapeutic counsellor in a voluntary capacity at a Community Health Project for five years. I see adult clients presenting with a variety of symptoms including depression, anxiety, developmental trauma and relationship issues.

I have a core, four year training in Transaction Analysis psychotherapy, a Diploma and MSc in TA Counselling and am a Practitioner Member with the Confederation of Scottish Counselling Agencies (COSCA). As well as having a similar philosophical outlook to my own, TA provides me with a comprehensive theory of personality and development, a theory of psychopathology and change, and a rich set of diagnostic tools and techniques to work with a client to achieve symptomatic relief and personal change.

I draw from all schools of TA as well as from other traditions and inform my practice with research. As well as adhering to the COSCA (2007) and ITA (2008) Code of Ethics and Practice, I have TA Supervision twice a month.

## Results

### Quantitative Outcome Data

The results from the SPQ and GAD-7 are summarised in Table 2 and Figures 1 and 2.

#### SPQ

Peter's scores varied considerably during the earlier stages of therapy, as during the holidays from university he tended to stay in the house and avoid any phobic provoking stimuli (e.g. sessions 2, 6, 12). As therapy proceeded, he engaged more in making choices to eat more and go out socially. The large peak at session 33 and 34 was where he started a part time job. At session 37 he reported that "going back to uni has been a walk in the park" and "my anxiety is definitely subsiding because I've not been noticing it recently".

The scores show that Peter achieved clinically significant change which remained stable at the follow-up sessions.

#### GAD-7

The GAD-7 scores highlight the nature of phobia with Peter generally only experiencing higher levels of anxiety when fearful of encountering or actually encountering phobic stimuli, the most frequent of which was around travelling to and from university and being at university.

After session 36 he did not experience any anxiety travelling and being at university and remarked that his anxiety over exams had a different quality which he considered 'normal' anxiety and which he did not see as a problem.

What this shows I believe is that Peter did not suffer from general anxiety and that his periods of anxiety were short-lived, amounting to single episodes.

The higher scores at the beginning of therapy may have indicated an anxiety related to starting therapy. The scores for the remainder of therapy are fairly stable. Ignoring the initial high scores, there does appear to be a reduction in his general anxiety over the last seven sessions and follow-up which are in agreement with Peter's self-report.

### Qualitative Outcome Data

The full analysis using the 56 criteria proposed by Bohart et al (2011) for a jury adjudication of the evidence and criteria from HSCED (Elliott 2002) for evaluating non-therapy explanations for change are available from the author. The following section provides a flavour of the evidence from the follow-up interviews.

#### Evidence that the Client Changed

Peter himself verbalised that he had made considerable progress. He firstly mentioned noticing that he is no longer anxious all the time: travelling and being at university is no longer an issue for him at all, as reported above for Session 37 SPQ score. He noted that he was also now going to university when he doesn't need to in order to use the equipment.

He also noted that he no longer seemed to be afraid of certain foods, food smells or eating (both larger quantities, before going out, eating out, and eating a wider variety of foods).

When asked, he agreed that it was at least six months since he last made himself gag to check that he wouldn't be sick when he went out.

Peter recalled his fear at the beginning of therapy that he might not be able to get a job because of his phobic anxiety and that he might end up housebound. He noted that he is now more positive about getting and having a job in the future, although he doesn't know yet what he might want to do if he doesn't get a good degree.

I asked him what else he noticed was different. He mentioned that previously his mind was often blank and had a tendency to go blank – especially if there was something potentially anxiety-provoking on the horizon. Now he is aware of thinking. He believes that previously it was because he was too afraid of what to do or what needed to be done, whereas now he believes that he can tolerate anxiety and so can think about what he needs to do.

He also noted that there were "some things I'm no longer thinking about – I'm not avoiding thinking about them because it would be anxious, I'm not thinking about them because I *know* I'm not anxious."

At the 4 month follow-up session, Peter mentioned that he had been physically sick a few weeks earlier and just said to himself, "Oh well, get on with the rest of the day " adding that "it didn't bother me at all".

Peter also mentioned that he had been continuing to go out for meals, had been at a party and out with a female friend a couple of times – "I phoned xxxxx and we went out for the day…I really enjoyed it…wasn't anxious at all."

I asked him about vomit. He said it's still something he finds disgusting, but he no longer feels sick or anxious thinking about it.

I asked him how his parents are with him. He said "Mum and dad are really pleased. I'm eating more, put on weight and I've eaten everything when we went out – and had dessert!"

I asked him if there was anything else. He said he had been more irritable and went on to say, "I don't feel so limited. I can go out and do other things. I don't need to stay in the house".

Based on a more detailed analysis using 39 criteria to facilitate determining whether a client has changed (Bohart

*Table 2: SPQ and GAD-7 Results*

| | SPQ (mean) | GAD-7 |
|---|---|---|
| Clinical cut off | 3 | 5 |
| Pre-Therapy | 5.14 | 9 |
| Session 9 | 3.85 | 3 |
| Session 19 | 2.28 | 3 |
| Session 29 | 2.28 | 2 |
| Session 39 | 1.85 | 2 |
| 6 Week follow-up | 1.57 | 1 |
| 4 Month follow-up | 1.28 | 2 |
| 9 Month follow-up | 1.28 | 1 |

*Figure 1: SPQ Mean Score across Sessions and Follow-ups*

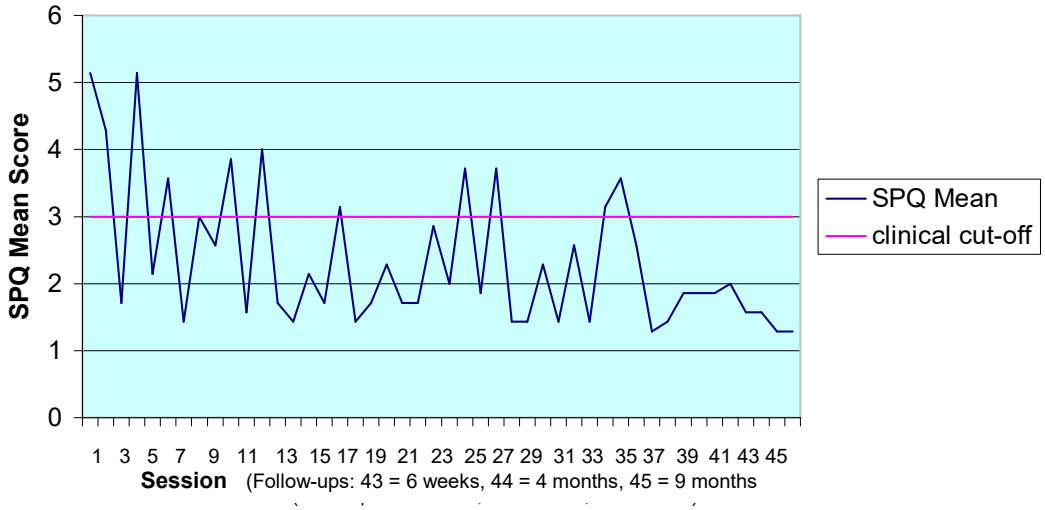
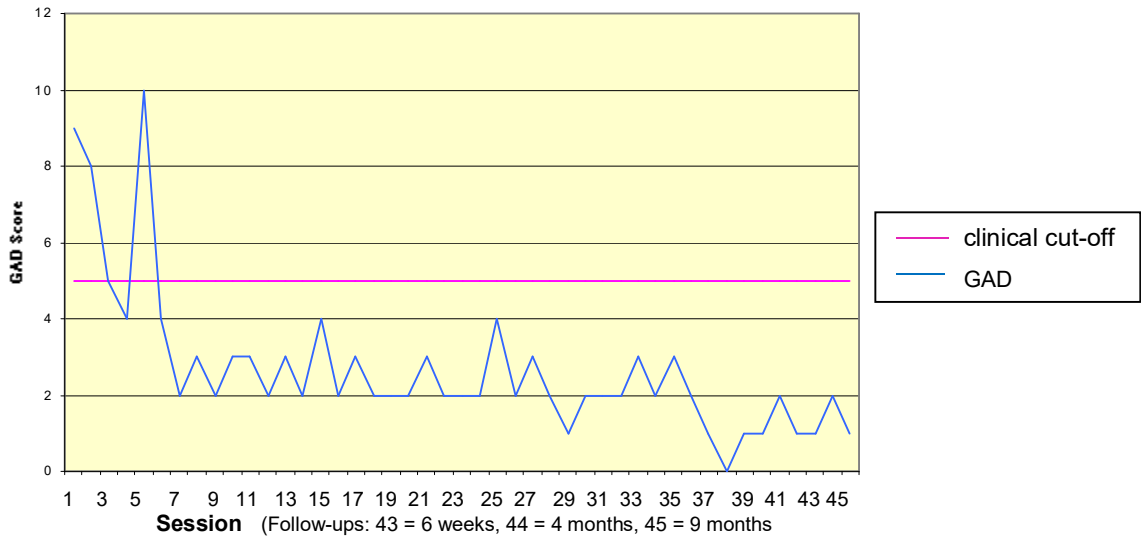



*Figure 2: GAD Scores across Sessions and Follow-Ups*



et al 2011), there is clear evidence in 18 of the criteria, some evidence for a further 13 criteria and no evidence in 6 of the criteria. Two criteria were considered not applicable for this client. Based on this analysis, there is sufficient evidence to argue that the client changed.

### Evidence that it was the therapy that helped

In response to my asking to what he attributed the changes, Peter replied, "The therapy and doing stuff". He went on to say that it was gradual since the holidays. I asked him if it was related in any way to the part time job. He said he didn't know, but it was after that that he started to do more things. He said, "When I started (therapy) I didn't really think that anything would change, but I also didn't want to end up …housebound".

I asked him what specifically about the therapy had helped him change. He hesitated and then said, "I don't know. To talk about stuff as it happened; to talk about stuff before it happened. It's been good to have someone to talk to that's not involved but interested." He also mentioned the structure of coming to therapy regularly as being helpful: he tried things and gained confidence to try more things. He noted that there was no light bulb moment but that over time he gradually got better.

I asked him if there was anything specific that he felt helped. He mentioned the various diagrams we did, "I found these interesting. I learnt and it helped being able to understand about (my) stuff".

I asked him if there was anything else outside therapy that could have had an impact on him changing. Again he hesitated and then said, "No, I didn't do anything."

I asked him if there could have been anything else, like for example, him just deciding to be different. Again he said "I don't know" and then added, "A different attitude. I would say that I'm thinking more positively." He went on to talk about his re-sits and the fact he is thinking about them and what he needs to do, quite a change for him. I asked him if he was anxious about them. He said "No, well just like most people would be – I've got to do better this time, but I'm not overwhelmed".

When asked if there was anything that he found wasn't helpful he replied "the guided fantasies".

When asked him if he had any ideas what his phobia had been about, he responded "No, I still don't know. I don't think I'll ever know".

Based on a more detailed analysis using 17 criteria to facilitate determining whether therapy aided change (Bohart et al 2011), there is clear evidence in 9 of the criteria and some evidence for a further 8 criteria. Further analysis to specifically evaluate the presence of non-therapy explanations for change (Elliott 2002) showed clear evidence that the client's self activation outside therapy contributed to significant change, but equally clear evidence that this activation was brought about by the therapy itself.

There is, in conclusion, sufficient evidence against a non-therapy explanation for change and sufficient evidence to show that the therapy positively contributed to change.

## Discussion

The evidence from the quantitative and qualitative data demonstrates convincingly that the client changed considerably over the course of therapy.

Measurement against the 17 criteria evaluating whether therapy helped (Bohart at al 2011), suggests this to be the case. Further evidence from an evaluation of non-therapy explanations for change based on the HSCED model (Elliott 2002) adds support by showing that change did not appear to be attributable to extra-therapy events. It could be suggested that the changes would have happened over time with or without therapy; however research on emetophobia highlights no cases where change or recovery took place without therapeutic intervention or in less than an average 25 years (Veale and Lambrou 2006).

Peter's onset of emetophobia was gradual, becoming serious enough to seek advice in the months before I first saw him, and during therapy he did not have relapses to health. Lipsitz et al (2001) noted that emetophobia is persistent with no periods of remission. In Peters' case change has been persistent through the follow-up sessions.

The case presented used a number of TA concepts and interventions which paralleled aspects of the behavioural and cognitive-behavioural treatments carried out for emetophobia. So, for example, during decontamination there was a significant element of education around the physiology of panic and techniques to reduce escalating panic, and around the meaning of gastrointestinal sensations (Boschen 2007, Lipsitz 2001). There was also an element of graded exposure in the form of guided fantasies, leading up to the clients' experience of a job interview and a part time job (Phillips 1985).

The literature mentioned a high fall-out rate from treatment approaches (Veale and Lambrou 2006), which I believe may in some cases have been related to clients being unable to manage the anxiety associated with treatment (e.g. exposure interventions). I believe that development of the therapeutic relationship and a specific attachment to me as his therapist enabled Peter, gradually over time, to reappraise his phobia anxieties. Getting and enjoying a part-time job towards the end of therapy marked a significant and important turning point for him. This event, I believe, along with the development of a new Nurturing Parent and decontaminated Adult,

allowed Peter to make (re)decisions and experience a greater level of autonomy.

The client in this case aligned with the majority of the presenting features of emetophobia presented in the literature (Lipsitz et al 2001, Veale and Lambrou 2006) with the notable exception that the client was male: the majority of cases presented and the general reported prevalence of emetophobia is in females. This may reflect a social frame of reference (Schiff et al 1975) where males are more embarrassed to seek help for such a condition.

### Validity and Limitations

The presenting symptoms and inclusion criteria for the study is representative of a large proportion of clients experiencing emetophobia (Lipsitz et al 2001, Veale and Lambrou 2006) and therefore potentially replicable.

The study makes use of a number of proven instruments to capture and analyse data along with triangulation of the results from the objective outcome data (questionnaires), client story (interviews) and the therapist (notes).

Internal validity is further enhanced by having a six week period following the initial assessment, to confirm the stability of symptoms and client experience prior to starting therapy.

External factors potentially influencing the clients' improvement (or deterioration) are captured through notes from the session reviews and the final interviews and reviewed against the HCSED criteria for non-therapy explanations for change (Elliott 2002).

Although operationally the practice of TA can be described from key publications and papers, there remains a wide latitude in the choices, application and way of being of individual TA therapists, which would make a close replication difficult.

This was work with a single individual and although his presentation and reported experience of emetophobia aligned with published research, and although the study shows that TA has been effective in the case of this client and therefore **can** be effective for emetophobia, it cannot yet be said to be an effective treatment for emetophobia in general.

## Conclusion

Peter improved significantly and achieved symptomatic relief and social control. He went from living an extremely restricted life at the beginning of therapy to exercising autonomy and starting to explore the wider world around him. The evidence strongly suggests his use of therapy was the main vehicle Peter used to enable him to make these significant changes in his life. The study has shown that a TA approach has been effective in the case of this client and therefore can be effective for emetophobia.

I might infer from what I observe that as well as addressing the contaminations, he has also readdressed the imbalance in his attachment-exploration system (Berne 1961, Goulding and Goulding 1979, Mikulincer and Shaver 2007). However, the research process did not directly measure the attachment aspect of emetophobia and this requires further study.

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# Preliminary Evaluation of Outcomes of Transactional Analysis Psychotherapy for Armed Forces Veterans presenting with Post-Traumatic Stress Disorder



## Abstract

*This brief outline presents some initial findings from a pilot project conducted within a charity setting in the UK, examining clinical outcomes for a cohort of armed forces veterans presenting with post-traumatic stress disorder (PTSD). Outcomes were measured using CORE-OM (Evans et al 2000), PHQ-9 (Kroenke et al 2001) and GAD-7 (Spitzer et al 2006). Preliminary findings show that positive Reliable Change on global distress and anxiety had taken place within 16 sessions. These results suggest that transactional analysis psychotherapy has promise for treatment of PTSD with this client group and that further research is warranted.*

## Key words

Post-Traumatic Stress Disorder, PTSD, CORE-OM, PHQ-9, GAD-7, Armed Forces Veterans, Transactional Analysis Psychotherapy

## Introduction

The working hypothesis chosen for this pilot project was that 'transactional analysis psychotherapy is an effective treatment for post-traumatic stress disorder (PTSD)'. At the time of writing, there is no published research investigating the effectiveness of TA psychotherapy in the treatment of PTSD, nor is there any written record of CORE-OM, PHQ-9 and GAD-7 questionnaires being employed in the provision of TA psychotherapy in this clinical context and with this client group. Guidelines issued by the UK National Institute for Clinical Excellence (NICE 2005) state that 'there is as yet no convincing evidence for a clinically important effect of (other therapies) on PTSD (p.19) and instead, recommends “a course of trauma-focused psychological treatment, trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR])” (p.4). There is, therefore, a strong case for building the evidence base for TA psychotherapy in the treatment of PTSD and, thereby, influencing health policy and strategy within the UK National Health Service (NHS) and at local and national government levels.

The motivation for the pilot project was the author's identification of this clear gap in the available research literature, coupled with an awareness that it is highly unusual for a private practitioner to be afforded the opportunity of providing long-term TA psychotherapy on an indefinite basis with no limit on the number of sessions available for each client. In addition, there has been intense media coverage of the problems faced by military personnel returning from Afghanistan and Iraq in recent years, which has brought the need for a broader range of effective treatments for PTSD sharply into focus.

## Method

### Participants

The participants were six male armed forces veterans, all of whom had been formally diagnosed with PTSD deriving from various traumatic experiences encountered while serving in the armed forces. Participants were referred for psychotherapy by the independent charity providing their accommodation, care and support. The therapy was conducted as part of a pilot project using a naturalistic protocol within a room provided by the charity within their premises. All six participants were aware that their questionnaire responses would be collected and used for both fundraising and research purposes and gave their full written consent for this process.

### Therapy

The form of TA psychotherapy chosen was primarily the integrative model advanced by Erskine (1993) and Erskine and Trautmann (1996), with an emphasis on facilitating internal contact (Erskine, 1993) with previously repressed affect, providing an attuned response to that affect and strengthening veterans' Integrating Adult (Tudor, 2003) capacity “to reflect upon and integrate their own archaic states as well as past introjects, and draw on them in the service of present-

centred relating" (p.202). This integrative model was augmented by the relational TA approach outlined by Hargaden and Sills (2002), where sustained empathic transactions (Clark, 1991) and strict observance of boundaries were used to provide 'the "safe container [of an attuned therapeutic relationship] in which the [veterans could] begin to integrate" (p.29) their fragmented selves, rediscover lost skills and resources and begin to build a number of mutually beneficial interpersonal relationships and a more rewarding and meaningful life.

### Data Collection

The CORE-OM questionnaire (Evans et al 2000) is a 34-item generic measure of psychological distress, which is pan-theoretical and pan-diagnostic and, therefore, readily applied to any TA psychotherapy context as a means of assessing mental well-being before, during and after treatment. This measure is widely used across the NHS and by independent counselling and psychotherapy providers.

Gathered concurrently were multiple-choice answers to the nine-point PHQ-9 Depression Severity (Kroenke et al 2001) and seven-point GAD-7 (Spitzer et al 2006) indicators: again, these are widely used in both NHS and private settings and the latter has been trialled successfully with clients presenting with PTSD.

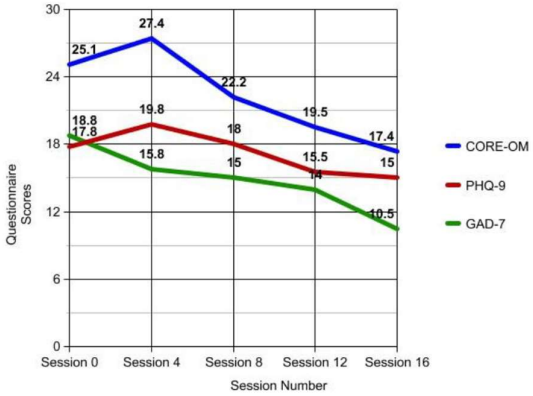
Responses to CORE-OM, PHQ-9 and GAD-7 were collected from all six veterans at four-weekly intervals from assessment onwards, to measure changes in global distress/functioning, depressive symptoms and anxiety. In addition, a mean figure was calculated for each type of questionnaire. At the time of writing, complete results have been gathered for six veterans for a period of sixteen sessions of individual TA therapy. These are shown in Figure 1.

## Results

Pre-treatment levels of symptoms among all six veterans were in the clinical range of severity. The results gathered during ongoing treatment appeared to correspond with prior expectations that some emotional "turbulence [would] occur as part of the change process" (Widdowson 2010 p.203); more specifically, that veterans would feel somewhat worse before they began to improve as they made internal contact (Erskine, 1993) with previously repressed affect, leading to a temporary intensification of their distress.

The results for the CORE-OM and GAD-7 questionnaires demonstrate Reliable Change over the sixteen sessions, but not quite at the level of Clinically Significant Change. In other words, the veterans' overall mental well-being has improved significantly over the course of TA treatment to an extent beyond that which could be accounted for by non-clinical factors, such as measurement error - but not yet to the extent that their symptoms have reduced to levels found within the so-called "normal" wider population.

***Figure 1: Mean CORE-OM, PHQ-9 and GAD-7 Scores for 6 clients***




## Discussion

These pilot project findings offer an encouraging level of support for the working hypothesis that 'TA psychotherapy is an effective treatment for PTSD' and suggest that further research investigating the process and outcome of therapy for PTSD is warranted. However, it must be noted that these are only preliminary results from the pilot project and that a more extensive programme of data collection is underway with a larger cohort of veterans employing a wider array of statistical measures and additional tools. Based on the results gathered so far, in this pilot project both anxiety and, to a lesser extent, depression appear to gradually reduce as, within the non-intrusive safety of an empathic therapeutic relationship, the veterans re-experience previously repressed affect, obtain the longed-for attuned response to their pain and then slowly build their Integrating Adult to reflect upon and integrate archaic states and introjects, and draw on them for present-centred relating (as quoted above Tudor 2003).

The use of CORE-OM, PHQ-9 and GAD-7 questionnaires with this challenging client group has proved a useful addition to established TA psychotherapy practice.

Prior to commencing this research, there were concerns that such methods might present a counter-therapeutic intrusion of bureaucracy into fragile therapeutic alliances. Carefully contracted use of questionnaires appears, instead, to have gone some way to satisfying veterans' structure-hunger (Berne, 1961) in the face of self-fragmentation, provided "a degree of emotional containment" (Widdowson 2010 p.203) and afforded a way for these vulnerable clients to measure and conceptualise their labile phenomenological experience.

Furthermore, this approach has included the veterans fully in the unfolding process of their therapy, which is

congruent with Berne's (1961, 1966) inclusive treatment ethos.

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# An Analysis of Dominant Working Styles in Different Professions in Macedonia



## Abstract

*A convenience sample of 90 employees working as Economists, Legal Advisors or IT Experts within three companies in Skopje, Macedonia completed the Working Styles Questionnaire (Hay 1992) and it was found that there were statistically significant differences in working style preferences between the professions. These differences are discussed in relationship to the National Nomenclature of Professions of Macedonia (State Statistical Office 2011) and implications for human resources management are briefly reviewed. Limitations are identified relating to the size and specific location of the subjects. It is concluded that the hypothesis that there will be differences between dominant working styles of the professions is accepted. An explanation is included which clarifies the distinction between drivers (Kahler & Capers 1974, Kahler 1975, 2008) and working styles (Hay & Williams 1989, Hay 1993, 2009).*

## Key words

Working Styles, Drivers, Professions, Economist, Legal Advisor, IT Expert, Human Resource Management, Transactional Analysis

## Introduction

The study reported here is an investigation into the presence of working styles (Hay & Williams 1989, Hay 1993/2009) using the Working Styles Questionnaire (Hay 1992) which was developed as part of Hay's work on positioning working styles as the healthy expression of drivers (Kahler & Capers 1974, Kahler 1975, 2008). Participants who were due to attend training programmes being run by the author and the consultant were invited to voluntarily complete the questionnaires and the results were analysed to identify variations in working styles between the professions of Economist, Legal Advisor and IT Expert.

Kahler and Hay, writing as above about drivers and working styles respectively, both comment on how each has its own specific characteristics, such as orientation from or toward people, behavioural indicators (words, voice, posture, facial expressions and gestures), preferred styles of social interaction in contact, positive and negative characteristics, specific reactions to problems and stress, etc. Hay acknowledges that her work was based on the early work of Kahler but stresses that she opted for a focus on healthy functioning rather than pathology. She explains that working styles are positive manifestations of an unconscious set of behaviours learned in early childhood.

### Clarification of concepts

Kahler (Kahler & Capers 1974) introduced the five drivers; in Kahler (2008) he described how he had developed them through watching videotapes for several weeks during 1971 and that he had named them drivers after Freud's drive, or basic instinct, to repetitive behaviour. Kahler (1975) described drivers as "behaviours that last from a split-second to no more than seven seconds" (p.280). Gellert (1975) suggested that there were more drivers than Kahler had identified. Mescavage & Silver (1977) proposed, based on a sample of 194 cases, that there were only three drivers. Tudor (2008) proposed the existence of a sixth driver.

An early reference to positive drivers was made by Klein (1987). Hay (Hay & Williams 1989) also began to focus on the positive aspects of drivers and introduced the term 'working styles' as a label for these. Clarkson (1992) then also wrote about the positive qualities of drivers. Hay (1992, 1993/2009) introduced a Working Styles Questionnaire that reflected the concept of working styles being the ways in which drivers were often regarded as strengths within organisational settings, particularly when they were within the conscious awareness of the individual rather than being subconscious attempts to get recognition from others; the questionnaire also reflects that the strengths come with some pitfalls.

### Professions

The professions of Economist, Legal Advisor and IT Expert included in this research are defined in accordance with the National Nomenclature of Professions of Macedonia (hereinafter referred to as NNPM), published by the State Statistical Office (2011) of the Republic of Macedonia (translated by the author).

The Economist, single group coding 2631, is defined as: "Economists conduct research, control data, analyse information and prepare reports and plans for solving existing economical and business problems, develop models for analysis, explanation and prediction of economic movements and models. They advise business-economic or other groups, and government, how to formulate solutions for existing and predicted economical and business problems."

Legal Advisor, single group coding 2611, is defined as: "Legal Advisors give legal advice to clients, prepare legal documents, represent the clients before administrative boards and tribunals, defend cases and prosecute in legal courts and give instructions how to defend (appeal) in higher courts."

IT Experts, single group coding 25, is defined as: "Experts for information and communication technology conduct research, plan, design, test, update and develop rules and operational methods in order to improve systems of information and communication technology and concepts about specific applications, programs, databases, etc. in order to achieve optimal performance and data security."

### Previous Empirical Research

Ohlsson (2010) listed 326 researches all conducted or approved by researchers trained for scientific research. These studies generally show scientific evidence of the positive impact of the theory of transactional analysis and its methods in several areas of applicability, although most are about psychotherapeutic application of theory, with only 5% related to issues associated with its organisational application. Of these, none are related to working styles as the concept.

Kahler (1974) identified five drivers, and developed it (Kahler 1979) by connecting it to other concepts of transactional analysis in a complex theory of personality which he called the Process Model. Later Kahler (1982) adapted the Process Model for organisational application and named it Process Communication Model (PCM). He developed a corresponding questionnaire (Personal Pattern Inventory, PPI) to determine personality types and his website (Kahler 2013) gives details of various studies. However, the foregoing were generally in educational settings.

## Research Questions

The objective of this research is to investigate the prevalence of working styles in the professions in Macedonia of Economist, Legal Advisor, and IT Expert. The questions this research is aiming to answer are:

1. What are the dominant working styles in the selected professions in Macedonia?

2. Is there a difference between their dominant working styles?

3. What are the implications of working styles regarding the management of human resources?

## Methodology

A convenience sample was used in the research, consisting of 90 employees from 3 organizations in Skopje, Macedonia. All were due to attend communication trainings to be conducted by the author and the consultant to the research. They were employed as Economists, Legal Advisors or IT Experts and their job descriptions were in accordance with the job descriptions in the NNPM.

Only gender and occupation were noted; with hindsight it might have been useful to have collected data on length of time in profession.

*Table 1. The sample*

| | Economists | | Legal Advisors | | IT Experts | |
|---|---|---|---|---|---|---|
| male | 10 | 33% | 15 | 50% | 23 | 77% |
| female | 20 | 67% | 15 | 50% | 7 | 23% |
| Σ | **30** | **33%** | **30** | **33%** | **30** | **33%** |

The dominant working styles were identified using the Working Styles Questionnaire (WSQ) by Hay (1992). Each of the working styles can occur with intensity from 0 to 40. The working styles with the highest scores were taken into consideration during the interpretation of the results as the first or the first two highest scores are considered primary dominant working styles while the next highest is the secondary dominant working style.

The questionnaire was translated by the author. A pilot research was conducted prior to the main research as this questionnaire was not standardized for the Macedonian population or language. The pilot research was made with 15 participants (5 employees from each of the 3 professions) and no major changes were made to the questionnaire.

The participants completed the questionnaire voluntarily, within their organisations, in the period February-December 2011. Participants were seated in groups, and were given unlimited time to complete paper copies of the questionnaire; they usually took 30-40 minutes.

Tests were scored by the author and consultant, and participants were given the results in a written report that contained a graphic presentation and short commentary.

## Results

### Analysis of the differences between the working styles in the three professions

As shown in Figures 1 & 4, for Economists Please People and Be Perfect are primary dominant working styles while Try Hard is a secondary dominant working style.

As shown in Figures 2 & 4, for Legal Advisors Please People is a primary dominant working style and Be Perfect is a secondary dominant working style.

As shown in Figures 3 & 4, for IT Experts Be Perfect could be identified as a primary dominant working style and Please People is a secondary dominant working style.

In Table 2, the basic descriptive statistics are shown in groups and in Figure 4 the differences in the dominant working styles between different professions are clearly noticeable. During the initial interpretation we looked at overlapping of line segments; below the significance of the differences between dominant working styles is more precisely calculated using t-test.

### Analysis of the main descriptive statistics

The t-test, as a statistical method for determining the significance of differences between arithmetic means, was used for analysing the differences between the research variables. Because the total number of examinees is smaller than 100, the formula for calculating the significance of differences between arithmetic means of small and independent samples was used to calculate the significance of differences between arithmetic means.

The t-test statistical indicator can be used only if it is proven that the variances of the two groups are homogenous. That can be determined by calculating the F statistic which, if not above the critical value of a certain number of degrees of freedom, indicates that the t-test can be used. Otherwise, a modified formula for calculating the t-test which does not assume equality between variances should be used.

To determine if there is statistically significant difference between different professions in relation to the presence of the five working styles, a comparison of the differences between arithmetic means of each working style in each profession using the t-test is shown in the following.

#### Hurry Up

As indicated in Table 3, for Hurry Up, statistic F does not exceed the critical value for 58 degrees of freedom at the level of 95%, i.e. $p > 0.05$, for all three combinations of groups, which indicates that the variance of the groups is homogenous and t-test can be used.

The values of the t-tests indicate that a statistically significant difference is not found between the arithmetic means of the employees in the professions Economists and Legal Advisors, and between the employees in the professions IT Experts and Legal Advisors ($t = 0.89$, $df = 58$, $p > 0.05$; $t = 1.09$, $df = 58$, $p > 0.05$). Statistically significant difference was found between the arithmetic means between employees in the professions Economists and IT Experts ($t = 2.12$, $df = 58$, $p < 0.05$).

#### Be Perfect

As shown in Table 4, for Be Perfect statistic F does not exceed the critical value for 58 degrees of freedom at the level of 95%, i.e. $p > 0.05$, for all three combinations of groups, which indicates that the variance of the groups is homogenous and t-test can be used.

The values of the t-tests indicate that a statistically significant difference was found between the arithmetic means of the employees in the professions Economists and Legal Advisors, and between the employees in the professions Economists and IT Experts ($t=2.04$, $df= 58$, $p<0.05$; $t=1.85$, $df= 58$, $p<0.05$). Statistically significant difference was not found between the arithmetic means between employees in the professions Legal Advisors and IT Experts ($t= 0.39$, $df= 58$, $p>0.05$).

#### Please People

As shown in Table 5, for Please People statistic F does not exceed the critical value for 58 degrees of freedom at the level of 95%, i.e. $p > 0.05$, for all three combinations of groups, which indicates that the variance of the groups is homogenous and t-test can be used.

The values of the t-tests indicate that a statistically significant difference was found between the arithmetic means of the employees in the professions Economists and Legal Advisors, between the employees in the professions IT Experts and Legal Advisors and between Economists and IT Experts ($t=1.86$, $df= 58$, $p<0.05$; $t=2.47$, $df= 58$, $p<0.01$; $t=4.41$, $df= 58$, $p<0.01$).

#### Try Hard

Table 6 for Try Hard indicates that statistic F does not exceed the critical value for 58 degrees of freedom at the level of 95%, i.e. $p > 0.05$, for the combinations of the groups Economists and Legal Advisors and Economists and IT Experts, which indicates that the variance of the groups is homogenous and t-test can be used. However, in the combinations of the groups Legal Advisors and IR experts Statistic F exceeds the critical value for 58 degrees of freedom at the level of 99%, i.e. $p<0.01$, indicating that the variance is heterogeneous so the

*Figure 1. Presence of the five working styles in the profession Economist*


*Figure 2. Presence of the five working styles in the profession Legal Advisor*


*Figure 3. Presence of the five working styles in the profession IT Expert*

*Table 2. Main descriptive statistics of the variables Working styles and Professions*

| Working style | | Economists | Legal Advisors | IT Experts |
|---|---|---|---|---|
| **Hurry Up** | N | 30 | 30 | 30 |
| | M | 24 | 23 | 22 |
| | SD | 4.84 | 5.03 | 3.88 |
| **Be Perfect** | N | 30 | 30 | 30 |
| | M | 30 | 27 | 28 |
| | SD | 4.41 | 5.06 | 4.11 |
| **Please People** | N | 30 | 30 | 30 |
| | M | 31 | 29 | 27 |
| | SD | 3.99 | 3.94 | 3.56 |
| **Try Hard** | N | 30 | 30 | 30 |
| | M | 28 | 24 | 26 |
| | SD | 4.85 | 5.82 | 3.4 |
| **Be Strong** | N | 30 | 30 | 30 |
| | M | 23 | 24 | 24 |
| | SD | 4.46 | 4.37 | 3.67 |

*Figure 4. Confidence interval error bars*

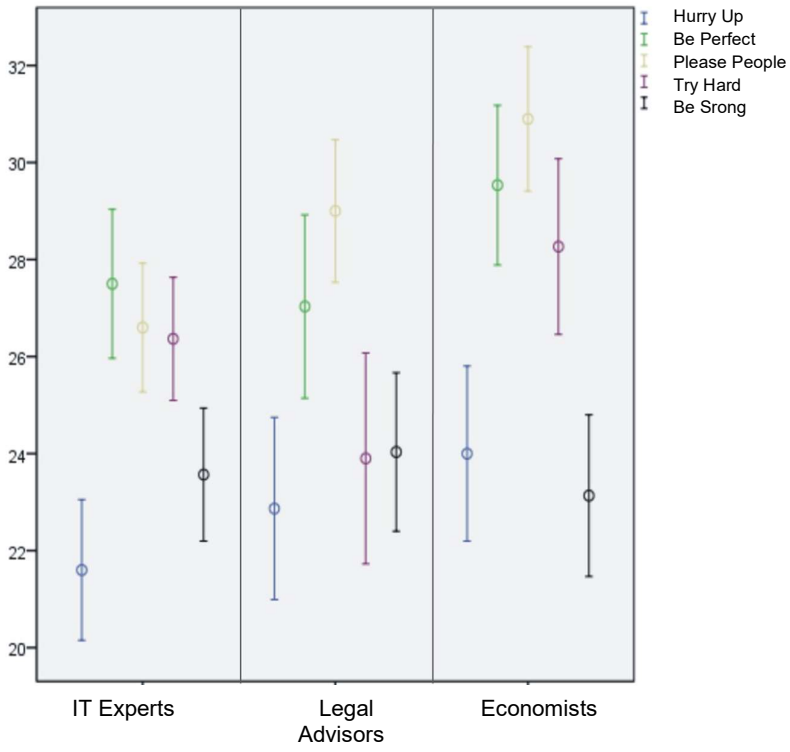

*Table 3: Analysis of the differences between the three professions regarding the working style Hurry Up*

| | Group 1 Economists | | | Group 2 Legal Advisors | | | F - test | | t-test | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Working style Hurry Up** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-test | df | p |
| | 30 | 24 | 4.84 | 30 | 23 | 5.02 | 0.004 | p>0.05 | 0.89 | 58 | p>0.05 |
| | **Group 1 IT Experts** | | | **Group 2 Legal Advisors** | | | **F - test** | | **t-test** | | |
| **Working style Hurry Up** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-test | df | p |
| | 30 | 22 | 3.88 | 30 | 23 | 5.02 | 1.75 | p>0.05 | 1.09 | 58 | p>0.05 |
| | **Group 1 Economists** | | | **Group2 IT Experts** | | | **F - test** | | **t-test** | | |
| **Working style Hurry Up** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-test | df | P |
| | 30 | 24 | 4.84 | 30 | 22 | 3.88 | 1.74 | p>0.05 | 2.12 | 58 | p<0.05 |

*Table 4: Analysis of the differences between the three professions regarding the working style Be Perfect*

| | Group 1 Economists | | | Group 2 Legal Advisors | | | F - test | | t-test | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Working style Be Perfect** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 30 | 4.41 | 30 | 27 | 5.06 | 0.41 | p>0.05 | 2.04 | 58 | p<0.05 |
| | **Group 1 IT Experts** | | | **Group 2 Legal Advisors** | | | **F - test** | | **t-test** | | |
| **Working style Be Perfect** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 28 | 4.11 | 30 | 27 | 5.06 | 1.49 | p>0.05 | 0.39 | 58 | p>0.05 |
| | **Group 1 Economists** | | | **Group2 IT Experts** | | | **F - test** | | **t-test** | | |
| **Working style Be Perfect** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 30 | 4.41 | 30 | 28 | 4.11 | 0.42 | p>0.05 | 1.85 | 58 | p<0.05 |

*Table 5: Analysis of the differences between the three professions regarding the working style Please People*

| | Group 1 Economists | | | Group 2 Legal Advisors | | | F - test | | t-test | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Working style Please People** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 31 | 3.99 | 30 | 29 | 3.94 | 0.15 | p>0.05 | 1.86 | 58 | p<0.05 |
| | **Group 1 IT Experts** | | | **Group 2 Legal Advisors** | | | **F - test** | | **t-test** | | |
| **Working style Please People** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 27 | 3.56 | 30 | 29 | 3.94 | 0.34 | p>0.05 | 2.47 | 58 | p<0.01 |
| | **Group 1 Economists** | | | **Group2 IT Experts** | | | **F - test** | | **t-test** | | |
| **Working style Please People** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 31 | 3.99 | 30 | 27 | 3.56 | 0.01 | p>0.05 | 4.41 | 58 | p<0.01 |

*Table 6: Analysis of the differences between the three professions regarding the working style Try Hard*

| | Group 1 Economists | | | Group 2 Legal Advisors | | | F - test | | t-test | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Working style Try Hard** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 28 | 4.85 | 30 | 24 | 5.82 | 1.07 | p>0.05 | 3.16 | 58 | p<0.01 |
| | **Group 1 IT Experts** | | | **Group 2 Legal Advisors** | | | **F - test** | | **t-test** | | |
| **Working style Try Hard** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 26 | 3.4 | 30 | 24 | 5.82 | 8.06 | p<0.01 | 2.04 | 58 | p<0.05 |
| | **Group 1 Economists** | | | **Group2 IT Experts** | | | **F - test** | | **t-test** | | |
| **Working style Try Hard** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 28 | 4.85 | 30 | 26 | 3.4 | 3.53 | p>0.05 | 1.75 | 58 | p<0.05 |

*Table 7: Analysis of the differences between the three professions regarding the working style Be Strong*

| | Group 1 Economists | | | Group 2 Legal Advisors | | | F - test | | t-test | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Working style Be Strong** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 23 | 4.46 | 30 | 24 | 4.37 | 0.38 | p>0.05 | 0.79 | 58 | p>0.05 |
| | **Group 1 IT Experts** | | | **Group 2 Legal Advisors** | | | **F - test** | | **t-test** | | |
| **Working style Be Strong** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 24 | 3.67 | 30 | 24 | 4.37 | 2.66 | p>0.05 | 0.47 | 58 | p>0.05 |
| | **Group 1 Economists** | | | **Group2 IT Experts** | | | **F - test** | | **t-test** | | |
| **Working style Be Strong** | N1 | M1 | SD1 | N2 | M2 | SD2 | F | p | t-тест | df | p |
| | 30 | 23 | 4.46 | 30 | 24 | 3.67 | 0.65 | p>0.05 | 0.41 | 58 | p>0.05 |

value of the t-test is calculated with the formula that assumes heterogeneous variances.

The values of the t-tests indicate that a statistically significant difference was found between the arithmetic means of the employees in the professions Economists and Legal Advisors, between the employees in the professions IT Experts and Legal Advisors and between Economists and IT Experts ($t=3.16$, $df= 58$, $p<0.01$; $t=2.04$, $df= 58$, $p<0.05$; $t=1.75$, $df= 58$, $p<0.05$ ).

### Be Strong

In Table 7 it can be seen that for Be Strong F does not exceed the critical value for 58 degrees of freedom at the level of 95%, i.e. $p> 0.05$, for all three combinations of groups, which indicates that the variance of the groups is homogenous and t-test can be used.

The values of the t-tests indicate that a statistically significant difference was found between the arithmetic means of the employees in the professions Economists

and Legal Advisors, between the employees in the professions IT Experts and Legal Advisors and between Economists and IT Experts (t=0.79, df= 58, p>0.05; t=0.47, df= 58, p>0.05; t=0.41, df= 58, p>0.05).

## Discussion

The analyses indicate the following implications concerning the matching of working style characteristics in the three professions covered by this survey with the way they are defined in the NNPM.

The Please People working style is the primary dominant style of the employees in the professions Economist and Legal Advisor, but not of the IT Experts. This tends to support the tasks in the job description of Economists and Legal Advisors including “focus on helping others”; the professions are defined in the NNPM as "*Economists ... are giving advice to business - economic and other groups ...* ", "*Legal Advisors are giving legal advice to clients ...* “

In contrast, IT Experts are more focused on information processing rather than interacting with people "*... explore, plan, design, test, promote and develop principles and operational work methods...* ". This again supports the presence of Be Perfect as the primary dominant working style of the employees in this profession, which is characterized by referring to the driver (Kahler, 2006) as having strong logic, organising skills and ability to recognize and synthesize facts. Please People, as secondary dominant working style, is still present among employees in this profession because ultimately their work brings products that make life easier for other people.

The Be Perfect working style is also one of the primary working styles of the Economists, which coincides with the need to "*… do research, control data, analyse information and prepare reports and plans in order to address the current economic and business problems, develop models for analysing, explaining and predicting economic trends and patterns ...* " (NNPM)

The Be Perfect working style is a secondary dominant working style of the Legal Advisors included in this research. This relates to the nature of their work which requires interpretation and representation of high moral principles. More than analysis and processing of information, one of the main features of individuals with a dominant working style Be Perfect is complying with high ethical standards (Žanko, 1999).

The Try Hard working style is a secondary dominant style of the Economists and IT Experts included in this research. The characteristics of this working style, as success in problem solving, monitoring all possibilities and finding all the implications and addressing all aspects of the task including what others missed (Hay, 1993/2009), are consistent with the definition of the profession of Economists *"... develop models to analyse, explain and predict economic trends and patterns ... formulating solutions to existing and predicted economic and business problems*" (NNPM). The above mentioned characteristics also correspond to the job description of the profession IT Expert *"... promote and develop principles and operational work methods in order to improve systems and concepts of information and communication technologies ... to achieve optimal performance and data security*" (NNPM).

The Try Hard working style is not present at all as a dominant working style in the profession Legal Advisor. It could be explained by the clearly established principles within the profession in the form of laws and regulations which does not require finding new and innovative solutions. On the other hand, it is quite common for the profession IT Experts, where Try Hard is present as a secondary dominant working style.

Taking the above into account, the question arises of whether people choose their professions because of their personality characteristics or whether the nature of the profession develops such personality characteristics or maybe strengthens them. The first view seems more likely: Wicklein & Rojewski (1995) explored the relationship between psychological personality types and professional orientation among teachers of technological sciences and found, consistent with findings from previous researches in this area, that teachers with high scores on the scale of sensitivity (sensing, S) teach more practical courses, and teachers with high scores on the scale of intuition (intuition, N) teach more theoretical courses.

The second implication concerns the applicability of the concept of dominant working styles in different areas of human resources management. Within the professional selection of staff, the concept of working styles can be used as a tool for verifying the presence of the necessary skills and abilities in accordance with the job qualification. Kahler (2013) has used PCM (in which the basis are the drivers) in the selection of astronauts for NASA (National Aeronautics and Space Administration) for more than 10 years.

The concept of working styles is also applicable in the field of employee motivation. Kahler (2006) summarizes the incentive strategies that can be used to direct people towards optimal performance. Hay (1993/2009) also provides suggestions on motivation via stroke preferences, channels of communication and leadership styles.

## Limitations

The nature of the sample means that the results are specific to certain occupational groups in Macedonia and may not apply elsewhere. This limitation is compounded because the original English questionnaire was

translated into Macedonian, so may no longer be comparable with versions in English or other translations. However, the procedure and results may serve as a starting point for a broader analysis of the research problem.

It is likely that it will be beneficial to use the concept of working styles in combination with other selective methods. As confirmed through literature, combined selective methods have the greatest predictive power (Armstrong, 2005).

The limitation which is brought by the use of psychological personality characteristics to explain organizational behaviour and manage human resources must also be taken as a limitation of this study. Firstly, possible tendencies for stereotyping and categorizing based on psychological tests scores should be taken into consideration and personality characteristics should be understood as "... *an individual preferred style of approaching and dealing with the world*" (Wicklein & Rojewski 1995; p.71).

Secondly, for a deeper understanding of the complexities of the personality in an organizational context, it is necessary to include more variables beside personality traits.

Although the completion of the questionnaire was voluntary, participants may not have believed this because they were due to attend a training programme to be run by the author and consultant. Hence, they may have been concerned that a refusal might lead to relationship issues during the training programme. This might have been especially the case for those participants whose primary working style was Please People. It might also have meant that participants responded in ways they thought would be most acceptable to the trainer and counsellor.

Issues that are not addressed in this study and whose answers can be used for a deeper understanding of the subject of research are: Are people whose dominant working styles overlap with dominant styles represented in their profession more successful in their work performance? Do they have greater job satisfaction and motivation? Are they less likely to leave their workplace?

## Conclusions

Based on the results of this study, the general hypothesis that there is a difference between the dominant working styles among employees in the professions Economist, Legal Advisor and IT Expert is accepted.

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