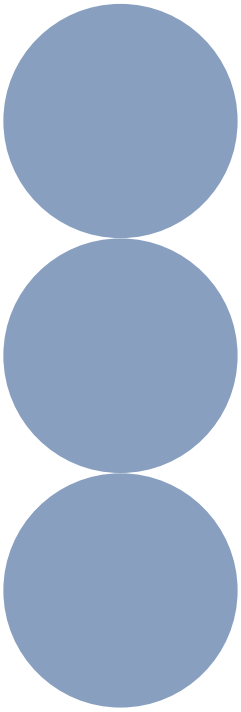

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Editorial

Julie Hay

The most personally enjoyable part of my role as Editor is the international contact it provides. The published list before this issue includes Austria, Belgium (on TA work in 19 countries across Europe, Asia, Africa and the Middle East) China, Germany, Italy, Macedonia, the Netherlands, Romania, Russia, Serbia, Sweden and the UK.

And now we can add Germany (again), Switzerland, Spain (compared to UK), plus two more UK papers including one that involved 83 adjudicators in Italy.

For our next issue, we are currently reviewing studies and hope to extend our coverage to Brazil and South Africa.

We also continue our wide range of aspects being researched, with papers in this issue relating to:

- A series of three linked research studies in Germany into the impact on participants of in-company TA-based coaching, the links with empowerment within the company, and the key elements associated with the effectiveness of the coaching;
- Coping styles and support needs of male partners of alcoholics in Switzerland, linked to TA concepts;
- Development and investigation of an evaluation method for measuring routine outcomes of TA psychotherapy within an academically-oriented training institute setting in the UK and private practice in Spain;
- Results of TA psychotherapy for combat veterans with PTSD within a residential facility in the UK, showing positive 'reliable change' on global distress, depression and anxiety in short-term and long-term treatment groups;
- IJTAR's first pragmatic adjudicated case study, showing a 'good outcome' evaluation for the effectiveness of TA psychotherapy for depression with comorbid anxiety.

We also have the first of what I hope will become many book reviews – this time of Cathy McQuaid's research into the TA counselling and psychotherapy training process in the UK and how it impacts on students. This book summarises the key findings in a way that serves as guidance for students – in the next IJTAR issue we expect to have a paper that presents the research method and results.

New Administrative Editor – Wendy Moore

I am delighted to announce that IJTAR has a new Administrative Editor – Wendy Moore. Wendy is (what I regard with great relief as) an expert in understanding technical issues about internet hosting, formatting our journal issues, and getting IJTAR listed in databases.

Wendy is initially concentrating on ensuring our online procedures are working effectively, and has already stimulated our hosting service to upgrade the software used when she queried the lack of functionality in some areas.

She has handled the formatting of this issue so some of our authors and reviewers have already had contact with her. I will continue to liaise with authors about the content of their papers and Wendy will deal with the technicalities of production, including the review processes.

My email address is now Editor@ijtar.org; Wendy can be contacted directly on AdminEditor@ijtar.org.

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Systemic Transactional Analysis Coaching: A study of effective conditions, consequences and effects on organisational culture

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Abstract

The paper describes content and process of an ongoing in-house 'individual coached within a group' coaching programme run over many years in Germany, utilising various concepts including classical, systemic and systemic organisational transactional analysis and three sequential research studies covering the perceived usefulness of the coaching programme to individuals and their organisation, the correlations between attendance at the programme and professional advancement within the organisation, and the factors identified by participants as contributing to the effectiveness of the programme

The initial survey-based study identified the primary factor as the extent to which participants had been able to deal with their personally-identified most important individual issue or problem. The second study applied QCA (Qualitative Comparative Analysis) (Ragin 1987, 2000, 2008) and showed a correlation between the autonomous variables of participation in the group and the interdependent variable of 'additional empowerment' by the company. The third study used frequency and valence analysis of responses to a questionnaire completed by 38 managers to identify the key elements that they believed contributed to the effectiveness of the coaching programme.

The author concludes that such programmes are effective but complex so require the coach to have psychological, pedagogical, leadership and management expertise and that this be applied within an organisational learning culture.

Key words

effectiveness research, in-house coaching, group coaching, , transactional analysis, systemic transactional analysis, qualitative comparative analysis, valence analysis, frequency analysis

Introduction

Today there are numerous different approaches and models of coaching, which this author describes as a professional relationship in which a coach works with a client to achieve certain goals of the client in terms of personal and professional competencies. The current series of three linked studies concerns coaching in the group, which the Deutscher Bundesverband Coaching (2012) (DBVC, German Coaching Association) describes as "a coaching type with several persons without interdependencies being coached as a group. Their issues are thematically oriented in a way that makes sure the participants are able to learn from each other and with each other" (p. 30). The coaching system presented in this project falls within this category with one exception, in that the main focus was not coaching the group but coaching the individual in the group. Systemic transactional analysis, as a combination of transactional analysis and systemic concepts, both coming from short term counselling approaches, are the source of the methods used in the coaching.

Literature Review - Coaching research in general and for the group coaching setting

Coaching research is not far developed in the provision of evidence that really describes the field in its core, results and impacts. As an anonymous coach said – "We need evidence-based coaching more than eminence-based coaching".

Carter (2013) suggests that coaching programmes are sets of organised coaching relationships. Commenting on her research in British companies and public institutions that coaching is often combined with training, she points out that scientific evaluation has not become part of the standard and recommends study of the success factors of coaching programs, under which she

subsumes the company context, the program design and the stakeholders.

After looking at the state of the art in coaching research, Cushion & Lyle (2013) concludes that "Coaching research is not yet at a stage where the influence of funding agencies or publishing policies impacts the 'weight of focused research'. A diverse research community or 'schools' have developed reflecting personal agendas that are seldom coaching specific, but driven by disciplinary or sub-disciplinary outcomes. This may be understandable in an under-theorised field, but recourse to models and theories from other fields has limited value in building a coherent conceptual or theoretical body of knowledge . . . Too often, this means that the 'coaching' within the research is superficial or secondary." (p. 104)

"A critical examination of the field in terms of conceptual development, research direction and research evidence provides a framework to understand and bridge the 'theory-practice' gap (p. 101). Coaching remains, relatively speaking, under-researched with existing research tending to be "sparse, unfocussed and subjective" (LeUnes, 2007, p. 403, quoted by Cushion & Lyle, 2013, p. 103).

Other researchers have a more optimistic view. Although coaching is relatively new, its research may be biased by commercial interests, it is close to other professional applications and there are a lot of research results that we can use like pieces in a puzzle. According to Möller and Kotte (2012) research on the effectiveness, pre-conditions and factors for effectiveness is in a beginning state. In their eyes the kind of research papers available offer the same variety as the very diverse market (Ely et al. 2010, Greif 2008; Künzli 2009).

Greif (2008) of the University of Osnabrück looked over the whole research literature on coaching and developed a structure model for the effects of result oriented coaching:

1. Preconditions – on the side of the coach and the client
2. Success factors
3. Specific results
4. General applicable results.

Kirkpatrick (2006) proposed a four-level-taxonomy for evaluation

1. 'Happiness'-Indices – Surveys on consumer satisfaction
2. Measurement of Learning – changed skills, changed attitudes
3. Measurement of Transfers – behaviour changes at the work place
4. Evaluation of the economic success – return on investment

For the field of coaching in the group we can build on the results that Ebner (2013) posits to be the advantages and disadvantages of coaching in the group, as in Table 1.

Advantages of the group context	**Disadvantages of the group context**
Bigger pool of solution alternatives (Lippmann, 2006)	Supposition: similar problems or questions (Lippmann, 2006)
Multiple feedbacks (Goodstone & Diamante,1998)	No group context in acute crisis (George & Christiani, 1990)
Supporting of learning by positive reinforcement and *vicarious learning* (Bandura, 1977)	Limited motivation to open oneself in group context (Lippmann, 2006)
Higher motivation by the presence of colleagues (George & Christiani, 1990)	Limited bringing in of personal issues/psychic stress of individuals not treatable with same attention
Supporting the *installation of hope* (George & Dustin, 1988)	Establishing of group norms (George & Christiani, 1990; Goodstone & Diamante, 1998)
Self-reflection orientation tends to become group norm (Wicklund & Frey, 1993)	Higher challenges to the coach (George & Christiani, 1990)
Deepened elaboration (Stebler et al., 1994)	
Increased variety of methods	
Time- and cost-efficiency/economy	
Recruiting of coaches from the circle of former coaches	

Table 1: Advantages and disadvantages of the group context (table reproduced with permission from Ebner, 2013, p. 198, translated by the author GM)

Research Questions

Table 2 illustrates how the current research was linked to Greif's (2008) structure of research and Kirkpatrick's (2006) four-level-taxonomy, yielding three fields of questions:

A. a first piece was about how much the coachees had felt able to discuss issues and what this had led to

B. a second piece of research was about the connection between the variable kind of participation in the group and the variable empowerment of responsibilities by the company

C. a third part was about the participants' experiences of being in the coaching group

Greif (2008)	Research Questions		Kirkpatrick (2006)
Preconditions	(C)	-	1. 'Happiness' Indices
Success factors	(C)	(A),(C)	2. Measurement of Learning
Specific results	(A),(B)	(A)	3. Measurement of results
Generally applicable results	-	(B)	4. Return on investment

Table 2: Structure, Taxonomy and Research Questions

These question fields became more specific questions:

A1. What did participants find most useful about being in the coaching groups?

A2. What was the impact on their personal development as managers?

A3. In what ways do they believe the organisation benefitted from them having been in the coaching groups?

B. What, if any, correlations are there between participation in the groups and being given additional responsibilities by the organisation?

C. Which factors are identified by participants as contributing to the effectiveness of the coaching groups?

The coaching programme

The following describes the key elements of the circumstances that were the subject of the research.

Principles

The in-house coaching program was guided by the following principles:

Systemic orientation - when working with individuals or groups, their systemic interconnectedness within the organisational setting has to be taken into account.

The whole is more than the sum of its parts; the synergy effect has to be expressed (Ennen & Richter, 2010). Furthermore, this allows for the effects of the reality construct being undertaken by individuals and groups within organisations. Hence methods of systemic transactional analysis (Schmid 1994, 2003; Mohr 2008) and systemic organisational analysis (Mohr 2006a, 2006b, 2009a, 2010) played a prominent role in the coaching.

A *Personality-focused approach based on transactional analysis* targets the development of the participants' personalities. This refers to their professional roles and is aimed holistically at their behaviour, thinking, and feeling and shaping of relationships. Role Theory (Schmid 2003; Mohr 2010) as well as the concept of Ego-States (Hagehülsmann & Hagehülsmann 2001; Mohr 2009b) are model theories on which the holistic design of thinking, feeling and behaviour are based.

Ethics: Regardless of whether it concerns individuals or several persons, every kind of work with a client system is guided by ethical rules. This is especially true for today's "Economics dangling on a string". (Mohr 2012). Personal information and data related to in-house counselling are kept confidential. Confidentiality issues merit special attention, because in-house counselling has to be kept apart from a company´s human resources development, which of course is very much interested in obtaining the information for individual and corporate human resources planning.

Resource-saving approach and sustainable development: today's scarcest resource is time. Measures need to be planned in a way that makes it possible to achieve a desired change with an economic input of resources. Alibi measures or activities (Look at us, we have done something!) should not be implemented because they have a damaging influence on sustainable positive developments. That means for example that managers and staff should not be merely placed in events; an adequate 'architecture' of person-to-person conversations, tasks handled on-site, and measures for small and large groups must be scheduled to promote development.

Continuing quality improvement: this includes a requirement to permanently improve the quality of one´s measures. Essentially this means constant further education and supervision for everyone working within the unit, including the consultant. Continuous evaluation of the programme contributes to improving its quality and an analysis of effects and evaluation of transfer are consistent processes in consultancy.

Unity of diagnosis and intervention: even the first contact with a client is a source of diagnostic information as well as an intervention; the relationship between consultant and client is shaped as a change-oriented kind of relationship from the beginning. Even if a behaviour is not changed, something changes in a person´s assessment or approach. De Shazer (1990) wrote that the point is to have clients instead of visitors or moaners, or even co-therapists as Schmidt (2005) added. Coaching is shaped

by its effects on communication. A coach does not permit denigrations of others (Mohr 2008) without intervening. The underlying basis has to be not to allow hidden levels of communication that make devaluation possible. The emphasis on this fact is important because many clients arrive with a pre-conceived notion concerning the measures without any previous professional diagnosis, especially for in-house coaching where providers may be perceived as vicarious agents of the company. Hence, at the beginning of an educational measure there has to be an initial diagnosis to determine what kind of measures matches the specific question, and this is decided upon together with the client.

Group Elements

Participation in the groups and the research was voluntary, the groups were closed, and meetings were held outside core time, usually in the evening between 17.00 and 19.00 hrs. Groups were formed with members not being in direct organisational relationships. The groups were assembled by the coach after initial conversations in such a way that coherent groups with members of similar background experience but a good mixture of other aspects (temperament, gender) were formed to make joint learning possible.

Groups were formed with members at similar hierarchical levels, to avoid the possibility that higher-level managers would be concerned to be more advanced in their management abilities. Schmid & Messmer (2005) suggest the impact on corporate culture of a vertical team but this would have increased the complexity of the groups and changed the focus.

Based on the experience that many peer counselling initiatives are phased out over time, this model was intended to achieve greater sustainability. To make it more interesting for participants, it should have a certain stimulation (Berne 1966) and this was ensured not only through the input of changing issues which gave the whole activity a kind of 'academy flavour', but also through 'tour' interventions (e.g. visits to workplaces) and pooling two groups for one meeting (which went well but which groups chose not to repeat too often).

The well-defined presence of a professional coach as head of group meetings was essential. Previous experiences with network groups without an independent head started enthusiastically, but always petered out over time. There is no doubt that peer supervision groups in social professions or Balint (1957) groups in health professions are viable over long periods of time even without having a definite leader. My experiences with peer groups in managing are not as encouraging, however.

A contract regulated attendance for the ten meetings – vacation time included – of the closed coaching groups. Absence was excused for just cause. Every meeting of each coaching group contained these four elements: (1) current role statement with initial feedback; (2) input of up-to-date management issues; (3) discussion of case studies from day-to-day practice; (4) conclusion with short evaluation at the end. These elements with their clear structuring allow for many different ways of modification.

(1) Current role statement: this had four perspectives: a brief review of developments after the last meeting; orientation in the here and now; current concerns of participants in their leadership roles; and issues their staff are dealing with at the moment. Even at this stage it was possible for the coach to give a personal-professional feedback to an individual's personal development and the image the person presents, characterized by respect. This included a possible reframing of the coachee´s frame of reference.

In addition, every participant was given the opportunity to ask for a detailed coaching of a personal concern in the form of a case study or a question. This also served to increase attentiveness and the differentiation between perspectives. Leadership roles and staff roles sometimes focus on different topics, e.g. when dealing with demands placed on personnel or participation in labour disputes. It is then that the leadership role issues become obvious. The 'No. 1 – role' idea of is helpful in this context: Within the framework of organisational roles the leadership role can become the role of the employers´ representative. This leads towards focusing on the roles in the company but still makes it possible for participants to report on those elements of their private life important for their lifestyle-integration and work-life-balance.

The initial statement was always accompanied by the question regarding the current state of task fulfilment and target achievement. The reason for this procedure was the fact that it would not make sense to talk about marginal sensitivities or comprehension question among participants if there were more pressing economic problems. Altogether this first part was used to determine the current emotional state of all coachees. The first, brief feedback delivered a frame of reference with intervention characteristics, maybe as appreciation of an accomplishment, empathy or an offer of talking about an issue in detail. An offer to use an issue as case example during the meeting could be included. In addition, behaviour modification reinforcement was used in this context to support any progress made since the last meeting.

(2) Input of up-to-date management issues: usually this meant a short presentation (up to 10 mins) of current discussions in management literature or economic trends relevant for participants with accompanying exercise or discussion (20 min). Thus participants became familiar with fundamental principles of leadership psychology within two years. Sometimes, if a lot of coaching questions were made, this part was shifted to the next meeting, because coaching had the highest priority.

(3) Discussion of case studies from day-to-day practice: These case studies were designed as coaching by the coach with the participation of other group members. In

exceptional cases, executive managers well-versed in coaching conducted single coaching-units within the group under supervision by the coach. With a time-span of up to 90 minutes this part took the longest in every meeting.

(4) Conclusion: The last part of each meeting gave participants the opportunity to focus on and share with the group the principal insights they had gained. This included another chance for intervention by the coach in case somebody forgot something essential or something needed to be clarified.

Transactional analysis concepts applied to process

The sequence described above fits well with Hewitt's (1995, 2003) four-phase model: a *contact* phase ending with a contract, an agreement on procedure; a *content phase* which is concluded with a *decision* concerning the focus, which *new engagement* can refer to behaviour, thinking, feeling or self-perception; a *consolidation phase* that is a time to operationalize the decision made, to develop and check implementation possibilities for and in reality and which ends when the new features are integrated; and a *conclusion phase* with a definition of the results and, if need be, further deductions. Another model applied was the Toblerone (Schmid 2003; Mohr 2008), (see Figure 1) meaning that group members experience an increase in competency regarding leadership and marketing, in theoretical knowledge and practical experience, from each session to the next. In this model, the three corners of the 'Toblerone' shape are the ingredients for a learning process developing a professional personality:

Field competence: the ability and willingness to quickly learn the ropes in a new area of expertise are very important traits. Field competence is applied professional competence. The exchange and sharing of experience among members are especially significant.

Soft-fact theoretical knowledge: executive managers had stated during a previously conducted study (Mohr 2008) that theoretical knowledge regarding leadership, communication etc. (e.g. Zur Bonsen 2009; Heinloth 2011) learned during coaching sessions had made a critical difference for them. Theoretical knowledge is seen as essential in other areas of expertise but companies often expect people to learn leadership 'along the way'. Theoretical knowledge also serves to clarify one´s self-perception.

Practical testing (action and evaluation): People often repeatedly find themselves in specific situations without gaining any experience. Experience is gained only by actively evaluating how it went.

Transactional analysis concepts applied to content

The content used within the groups included various concepts of classical transactional analysis such as autonomy (Berne, 1961; Stewart & Joines, 1990), ego states (Berne, 1961; Temple, 2002; Mohr, 2000),

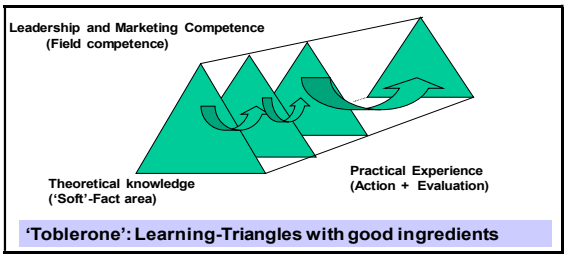

Figure 1: The 'Toblerone-Model' - figure based on Schmid (2003)

transactions (Berne, 1961), symbiosis (Schiff 1975), games (Berne, 1964; Dehner, 2001), and drivers (Kahler, 1977) as well as more recent organisational transactional analysis concepts like the role concept (Schmid, 2003; Mohr, 2011), the role symbiosis concept (Schmid, 2003; Mohr, 2006a),) and the system dynamics model (Mohr, 2006a; Mohr, 2011).

The TA models were used by the *intervention techniques* of Berne (1966). Based on a contract for every piece of work in the coaching, the eight techniques of interrogation, specification, confrontation, explanation, confirmation, illustration, interpretation and crystallisation were used in a coaching appropriate way. This means that they were focused to the here-and-now and participants were not invited to mentally process in an earlier life time (regressive work). The models were applied from a developmental perspective (Hay, 2006). Although some of the models originally were founded by Berne to describe pathological behaviour, in the coaching they are used in a neutral way with both opportunity of describing a problematic side but also to show the specifications and resources of a person. For example, drivers can be seen as negatively causing aspects that limit a person, or as specific working styles that include very relevant resources (Hay, 1993).

Concepts of systemic transactional analysis (Mohr 2008) and systemic organisational analysis (Mohr 2006a),) were utilised, for example, through the model of role worlds (Schmid 1994) which in its current version lists five role worlds (Mohr 2012), as shown in Figure 2. Participants acquire awareness concerning the difference between a person and a role as well as about their own roles in the worlds of company organisation, occupational qualification, private world and community world. That means that coaching need not be limited to mere business skills, but is designed broadly towards the development of a personal professionalism in terms of life coaching (Buer & Schmidt-Lellek 2008; Schmidt-Lellek & Buer 2011). In particular, they learn how to perceive and advance their company organisation and occupational qualification roles professionally. In most cases, an executive manager's self-monitoring with the aspect of incorporating all the role worlds is given priority in coaching. When one perspective is not realised in the long run, problems usually result.

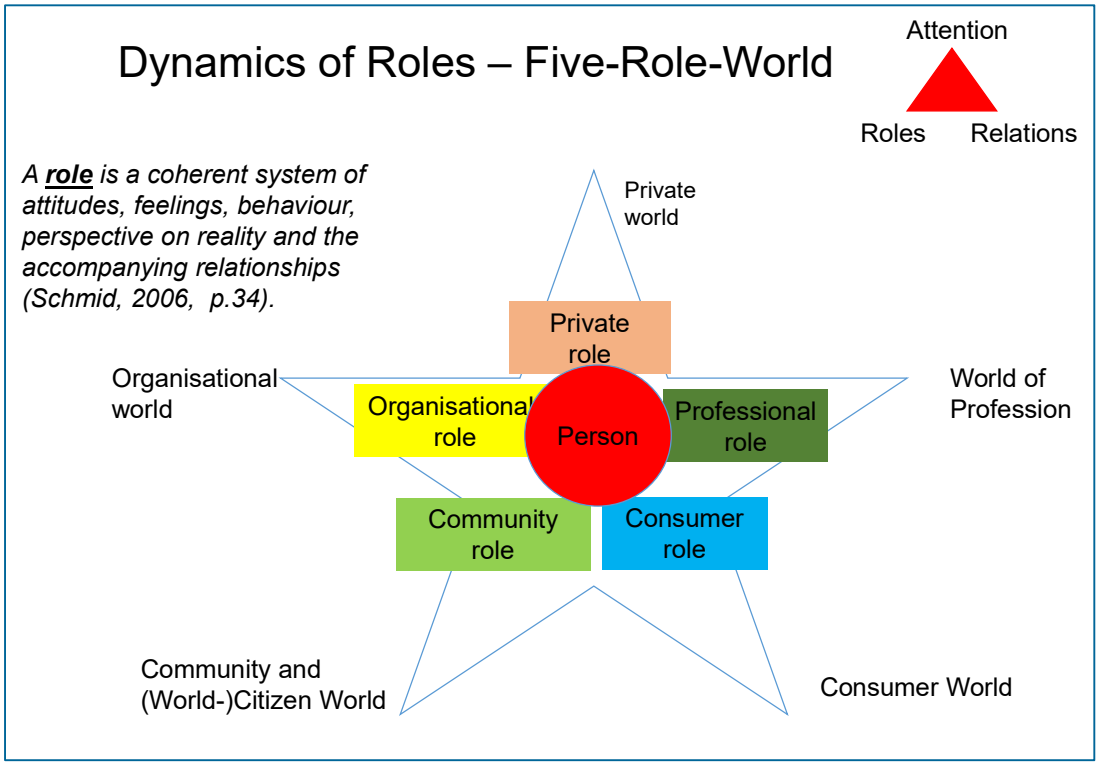

Figure 2: Schmid's (1994) and Mohr's (2012) Model of Role Worlds

Dynamic Fields	Ten System Dynamics	Questions
System Structure	1. Dynamics of Attention	What are people within the organisation (or unit) currently mainly occupied with? What is the relationship between the topic that currently gets the most attention and the actual goals of the unit?
	2. Dynamics of Roles	Which roles are present within the system? What are their attributes? Are these currently changing and, if so, how?
	3. Dynamics of Relationships	How are roles and persons correlated? What basic messages exist between role protagonists?
System Processes	4. Communication Dynamics	What is typical for the way people communicate?
	5. Dynamics of Problem Solving	What problems exist at the moment? How are they dealt with?
	6. Dynamics of Success	How is success achieved or avoided?
System Balances	7. Dynamics of Balances	Who would like to keep which balance? What balance is aimed for?
	8. Dynamics of Recursivity	How are similar principles put into effect on different levels of the organisation?
System Pulsation	9. Dynamics of External System Pulsation (external boundary, openness, closeness)	How are the outer boundaries of the system presently evolving? What measures are necessary to achieve an adequate openness and closeness?
	10. Dynamics of Internal System Pulsation (internal borderlines, subsystems)	What relevant subsystems can presently be distinguished within the organisation and what are their effects?

Table 3: Model of Ten System Dynamics (Mohr 2006b)

Also applied was the model of Ten System Dynamics (Mohr 2006a) shown as Table 3, which helps to analyse every organisational unit as to its current performance and initiate steps for development and improvement. It combines the business-oriented management role and the people-oriented leadership role. Thus, this tool can always be used for stocktaking in everyday coaching. Organizational units of executive managers can consistently be analysed and supported as to their potential.

The model of the ten system dynamics was particularly used to elaborate what is needed in the moment in the teams of the coached managers: which dynamics have certain problems and have to be addressed by management measures?

Ethics

As formulated in the general contract of the groups it was clear that no personal or department information was brought out of the group room or even given to the personnel department. This was also contracted with the head of the personnel department. The professional ethics of the coach as psychologist also gave the legal base for that.

The participants were informed that the data were to be dealt with anonymously. The handling of the data was managed in a way that no estimation or answer of a single person could be redirected to the person.

Study A: What is important in coaching groups?

Methodology A

The first study in January 2007 was to investigate what participants judged important for their learning in the coaching in the year 2006. It was a survey with an evaluation questionnaire that focused on the effects and results that the participants experienced. Results were subjected to content analysis.

Participants A: were 45 managers of the company that had been in the coaching program in 2006. They led teams of 4 to 24 employees, and most had opted for an education in the German “Duales Bildungssystem” (Dual Education System – working in a company accompanied by one professional school day a week). Half of them had also higher education with university degree. There were approximately 50% men, 50% women. The age range was 29 to 54.

The company: was a local service provider for private and corporate customers with stationery distribution. After long-standing tradition it experienced more turbulent times during the previous ten years and was finally taken over by a larger trust under state influence. Due to product disparity the company was not fully assimilated but allowed to function as a discrete unity under the condition of achieving financial objectives. At the time of the survey the company employed 1600 members of staff and about 250 executives on four hierarchical levels.

General market conditions: The company´s market was very much affected by the financial and economic crises. Consumers reacted very cautiously to the company´s products. The fact that many customers were dependant on basic services provided and were thus a rather faithful clientele had a stabilizing effect, although their migration to internet competitors increased steadily. The earnings generated by providing basic services constituted the financial basis. In addition the company attempted to generate increased transactions through more sophisticated products.

General systemic framework for in-house coaching: There was a long and continuous tradition of innovative education, going back 150 years. The company had always actively supported junior staff development, especially the promotion of its own staff. Only a few external workers, for example with a university degree, were employed. Personnel were socialized into the company through its in-house training system. The company´s Coaching unit was instigated and set up in 1999.

Results A

The highest result was in response to the question about the extent to which participants had been able to discuss in the group the issues and problems that were important to them. 76.5% gave the highest rating of ‘fully satisfactory’ and 94.1% found the group coaching to be instrumental in critical challenges during the year. In addition, other advantages identified included improvement of cooperation, self-management, problem-solving orientation, and manner of cooperation in the group.

References were made to *improving cooperation* with members of staff (suggestions concerning attitude towards staff, sorting out difficult problems with staff) and continued with *personal development* as to self-management (demeanour more poised, new points of view in muddled situations, acquirement of new perspectives as to procedure, lessening of self-stress, increased self-esteem, clarification of own role-competency, goal-oriented course of action, self-criticism).

A majority of executive managers emphasized the focus on *problem-solving* (working out solutions for specific problems, developing different problem-solving strategies allowing for own problems as well as for problems of members of staff, solutions actually being implemented). Overall it became clear that the benefit was not only seen in specific issues being discussed, but also in a culture of development.

Almost everyone emphasized the manner of *cooperation.* Key words like trusting, open and honest cooperation, discretion, ideal number of participants, homogeneous group, and communicative critical discourse were mentioned. Other important aspects stated were controlling the way the groups worked

(highest priority for especially pressing problems, inviting participants to state current problems, immediate focus on the root of a problem, agreement with participants) and the autonomous as well as joint development of solutions (finding solutions to problems, autonomous development of solutions, combining own issues with those of others and with theory, support during decisions, suggestions, assistance for further development).

Under *personal development of executive managers,* there were six dimensions: respecting one´s own personality, respecting the personality of members of staff; dealing with crisis situations better; receiving feedback on own behaviour; dealing with change processes within the organisation; and role-awareness as manager within the company and as partner or parent in private life.

For *perspective of system qualification,* the following effects were described: increased willingness to take up advanced training by members of staff; more direct ways of dealing with conflict; vitalization of communication; better communication and cooperation in collaboration; improved team spirit and development of team spirit in organisation unit on-site; and strenthening of positive attitudes.

Discussion A

These results definitely speak in favour of using in-house coaching as a means of furthering the education of executive managers. The degree to which they perceived they had got support for their major challenge of the year was particularly encouraging.

Study B: Empowerment and delegation of responsibility by the company in relation to participation in the coaching program

Methodology B

The research was conducted in 2010.

Initially, an analysis using Qualitative Comparative Analysis (QCA) by Ragin (1987, 2000, 2008) was conducted to find out whether participation in a coaching group influenced the professional advancement of the group members. QCA is an algorithmic procedure that was developed as a method between case studies and conventional covariance analyses, able to deliver conclusions as to sufficient and necessary conditions even with limited numbers of cases. It makes it possible to determine configurations of independent variables in socio-scientific contexts e.g. organisational, leading towards a definite specificity of the target variable.

Equifinality is possible, meaning that different configurations of independent variables lead towards a specific result (Fiss 2007). As Katz & Kahn (1978) emphasise “A system can reach the same final state from different initial conditions and by a variety of different paths” (p. 30, quoted by Fiss 2007, p. 1181). On this basis, QCA as an interesting empirical method is increasingly applied within organisational-theory and economic contexts (Jackson 2005; Bentrop & Schneider 2012).

QCA was developed by Kagin based on Boolean Algebra with a conceptual foundation in set-theoretical thinking. The algorithm constructed on this basis makes possible conclusions as to acceptable and necessary conditions, and provides information on precisely how much the incidence of specific values of independent variables result in specific magnitudes of the dependent variables, as well as how the absence of specific values of the independent variables leads to the non-occurrence of the dependent variables´ magnitudes.

The QCA used in this context was the fsQCA (fuzzy set Qualitative Comparative Analysis) (Wagemann & Schneider 2007). The situations observed concerning dependent and independent variables were scaled in specific metric increments with a spectrum between 0 and 1.

Independent variables were the length of participation in a coaching group and the meetings´ presence quota. The length of participation ran from ‘almost no participation’, when people only ‘got a taste’ and then left the group for good to participants with a short duration of participation (up to one year) to participation up to or over three years. Participation was voluntary and absence was allowed in case of good reasons and a timely ‘sick note’ or a ‘very important unforeseeable business date’.

The calibration for the presence quota was measured in a six-level spectrum with the levels being:

0	almost no participation
0.2	marginal presence
0.4	presence with significant gaps
0.6	obvious presence with absence due to external reasons (2-3 of 10 meetings/year)
0.8	marginal absence
1	almost complete presence

The resulting variable investigated was ‘Transfer of additional responsibility by the company’. The decisions concerning the transfer of responsibility were made exclusively by the company’s management and human resource department with no regard to the coaching groups and, because of the coach’s professional discretion, also without his expertise. Three levels were chosen for this criterion:

1. The highest level consisted of a conventional promotion towards a higher executive position in a higher hierarchical level, with more staff and higher remuneration (highest value).

2. A somewhat lower categorization was give to a transfer to a leadership position on the same hierarchical level, but with significantly more staff (at least + 50 %) and usually higher remuneration.

3. The transfer of an important project task or an additional role (mentor, marketing coach), and an official transfer of responsibility from a hitherto provisional position to a definite, unlimited role, were each given a low, but visible value.

Participants B: The 65 participants were managers aged from 29 to 57, working in locally different departments of the company.

Results B

As shown in Table 4, the presence quota (the frequent and continuous participation in coaching-groups) was significantly associated with a higher incidence of transfer of responsibility, and in cases of very consistent presence this was highly associated. The consistency value rating the degree of correlation between independent and resulting variable with scores from 0 (no consistency) to 1 (total consistency) added up to 0.82 for both independent variables. The correlation is rather obvious, even assuming a high scale of about 0.75 (Wagemann & Schneider, 2007) for a meaningful value. The 'coverage'-value, the amount of cases accounted for, is rather high, too, with a value of 0.85. Another result showed that participants with no significant presence quota could not expect any transfer of responsibility at all.

The length of participation had a somewhat lower significance. With a degree of about 70% it could be assumed that at least once, but possibly repeatedly, additional responsibility was transferred on permanent coaching-group participants. A necessary condition emerged: without consistency of presence and length of participation even members of coaching-groups were not promoted. The length of participation played a significant role, too, but as soon as it exceeded one year, it was not that important any more.

QCA-Criteria		**Relevance points** (Wagemann & Schneider, 2007)
Consistency	0.82	0.75
Coverage	0.85	0.70

Table 4: QCA Criteria

Other independent variables like gender (male, female) or whether someone worked in the factory or in marketing were checked but had no significant influence on the transfer of responsibility; even combinations like 'female marketing staff with high attendance quota and participation between one and three years' did not result in a higher likelihood of responsibility transfer.

Discussion B

The individual attendance decision, being somewhat constrained because of the groups being closed and because of the necessity of 'sick notes', becomes an interesting quantity in hindsight because of the different ways of handling it. It is closely connected to a third person's totally independent decision, namely, the transfer of responsibility. That means that people who repeatedly concern themselves with the issue of development in the coaching process and who are there for others, too, are obviously spotted for a higher degree of responsibility oftener than those people who do not. The connection between the attendance and engagement in the coaching and the outcome of being given more responsibility might not be the fundamental causal connection. Maybe people who show engagement in the coaching program also do that elsewhere. But it is still interesting that participation in a coaching program also seems to show a very strong correlation between the coaching engagement and the outcome of empowerment.

Study C: Research about effective conditions in coaching-groups

Methodology C

Towards the end of 2010 we conducted another research into the effective conditions of the in-house coaching system that had been installed - What is effective in the coaching-groups? This is definitely connected to another question: What makes managers invest their time after their work schedule in coaching?

All 65 executive managers within the system of coaching groups at the time of the survey were given a questionnaire with open-ended questions on the aspects they found important in coaching. The return ratio was very good. Within the three week period the survey was conducted, the differentiated answers of 38 participants, equalling 60% of the total number of participants were on hand. Altogether the survey resulted in 106 differentiated answers with 403 single items describing the participants´ experiences of the effects of coaching groups. A content analysis (Berelson 1952; Mayring 2010) using frequency analysis and valence analysis was done. A frequency analysis studies how often certain terms are being used; a valence analysis evaluates the validation of the terms.

Participants B (same as in Study A): The 65 participants were managers aged from 29 to 57, working in locally different departments of the company.

Results C

Table 5 shows the six fields of content analysed and the proportions of mentions. The answers given were very much individually diverse; they show that the individual orientation and thus individual outcomes are of central significance for coaching. There are only a few issues mentioned frequently and even those not very often. The manner of cooperation, a variable of relationship and system, was mentioned in 24.5% of the answers.

Adding all terms describing cooperation, collaboration, mutual support, team, networking and group makes it evident that this area has the greatest significance. The second most frequent item mentioned were aspects of leadership with a total of 19.8%, a not really surprising result considering the fact that the survey dealt with

group coaching for executive managers, but which nevertheless was significant in terms of the focus of such measures.

Characteristics of Effective Conditions	%
(1) Basic concept of the coaching group	30.22
(2) Specific issues dealt with	11.32
(3) General set-up	5.67
(4) Role-specific outputs	16.98
(5) Output quality	15.09
(6) Effects on corporate culture and system	20.75

Table 5: Content Themes

(1) Basic concept of the coaching group: The basic concept and manner of working in a coaching group were picked out as central theme by 30.22% of the participants in their statements. Special emphasis was put on a professional fundamental policy making practice-oriented learning possible. That includes the theoretical basis of the procedure which was continually referred to by the coach. All methods applied were substantiated and explained. The professional approach was further characterized by the facilitator offering specific individual coaching as well as by 'neutral' feedback - as seen from the participants´ perspective - and support regarding several issues. Comment by one participant included: "*Since rather confidential matters are sometimes being discussed it is essential to have an appropriate degree of trust in all the members of a group*". Reliability, trust, discretion and candour are the attributes characteristic for the coaching group, according to participants.

Many answers referred to the process of working in groups. The coach's neutrality and autonomy is seen as an important factor. Process elements of the coaching procedure play a prominent role as well. Continually having pointed out several different options for action is one example. Concerning the depth of the approach to solving the problem, there is an appropriate amount of adaptation to necessity, e.g. stimulation, if needed, meaning there was no 'standard procedure', no standard sequence initiated in response to certain questions; intervention was shaped by the needs, and not always 'let's talk about it' or 'let's do a role simulation'. Resource-conserving, especially time conserving procedures were noticed ("*fast, efficient, immediately transferable*"). The learning process was based on a practical, concrete foundation. The issues and the process had a sound theoretical basis.

(2) Content and issues: With regards to content, the issues were mentioned in 11.32% of all answers. 'Leadership' is the term mentioned most. Exploration of the meaning of this term and questions of motivation seem to be important. For many group members with multiple roles, especially marketing roles, leadership is a necessary evil, but it can evolve to a fun job through having a forum dedicated to problem-solving. A quotation: "*There are continuous leadership instructions given, based on trust and discretion, accompanying the development of the executive manager*". Other recurring issues are the pressures as to goals and time especially for marketing staff, a problem aggravated because of the financial crisis which made all transactions with customers more difficult. Especially individual, essential "*my organisational unit's concerns*" and "*my own pressing wishes*" are experienced as crucial. There is a certain amount of individuality associated with coaching and group coaching. That includes solutions for personal leadership tasks as well as change processes within the company. Current issues serve to keep up-to-date. The fact that financial pressure, goal-oriented pressure and business strategies that also appeared in other units are being dealt with in a demand-oriented manner is also mentioned in the answers. The chance to be able to "*let off some steam*", "*to get something off one´s chest*" and to "*recharge one´s batteries*" is seen as equally important.

(3) General set-up: An environment with beneficial conditions, an aspect generally seen as important by human resource managers – and thus often the topic of 'satisfaction questionnaires' – seems to be of less importance to the members of a coaching group and was only mentioned in 5.56% of all statements. Even then the statements referred to the composition of the group – which was controlled – as well as to the fact that participation was voluntary or on the cost/efficiency ratio, especially in terms of time and results. External set-up conditions like accommodation or catering were not mentioned. Even frequent problems with finding a parking space near the educational centre was never cause for complaint. Although the meetings were held within the company, in an educational centre lying only a little bit off the premises, it was experienced as "*something outside normal routine*".

(4) Role-specific outputs and results: 16.98% of the answers referred to specific roles, especially to leadership and marketing roles. Notably, concerning leadership issues there is a lot of input in the groups, but also "*practical stuff*" referring to marketing, which was mentioned repeatedly. In the answers, the complete leadership process is represented, starting with accepting and shaping the leadership role. The interrelationship of professional role and leadership role as well as one´s own role within the company were mentioned.

Other role-oriented results were modern, development-oriented leadership, the initiation and implementation of a leadership conception or becoming acquainted with leadership techniques matched to individual needs. Human resources development and economic thinking and acting support this. Role competency included stress management, problem solving and a better evaluation of

one´s own personality. Leadership theories have to be implemented, special conversational situations for difficult discussions with employees have to be structured and maybe simulated as well. Ideas concerning personnel management or dealing with difficult employees or customers as well as a better orientation of own organisational unit are role-specific outputs.

(5) Output quality and feasibility: Altogether 15.09% of the answers refer judgmentally to output quality (valence analysis). Common outputs are mentioned in 11.32% of the answers. Very simply, keywords like "*help", "hints*" or "*proposals*" are mentioned. The emotional "*outlet effects*" (letting off steam) or clarifications, already stated above, also have to be mentioned again here. In detail, specific preparations for situations, an increased level of knowledge and theoretical "*equipment*" are listed. Participants seem to see the focus in structure and new concepts, less on conserving and stabilizing traditional methods or a historical review of the 'good old days'. The focus is decidedly on developing the new.

Topicality is seen as another important issue. It is put into effect through the current requests experienced and put forth by group members, but also through topical management subjects introduced by the coach. 3.77% emphasize other aspects of output quality. Feasible results are achieved very fast. It was said that approaches to solving a problem are new. Individuality is highlighted; there are no standard, but only individual, "*custom-tailored*" solutions. Easily transferable and individual problem-solving solutions for leadership issues are highlighted. Quote: "*Comparing notes regularly has a positive influence on resilience, frustration tolerance and therefore on the health status of executive managers*."

(6) System and corporate-culture variables: For participants, this category seems to be one focal point as to effects. 20.75% of the answers dealt with effects on corporate culture and system. Some typical quotes: "*Networks within the company come into existence and help solving issues occurring during routine work faster and thus more efficiently, which benefits everybody involved*." "*There is an increasing amount of understanding when it comes to the wishes and problems of other subunits*." "*A better understanding is established, a sense of solidarity within the company, that transcends the specific organisational unit*. " One effect mentioned even reaches into the private world, it is "*weight off the private partner´s shoulders*." "*Individual problems can be looked at from different perspectives, new manners of dealing with it can be developed*." The communication in connection with change processes (implementation of new team and group structures) is being accompanied and developed through group coaching. "*The better every single executive manager's training, the higher the staffs´ quality*."

Discussion C

(1) As to singularity of these results: These results with the coaching groups are similar to experiences made with short-term counselling. De Shazer (1990) reported on his research on the work of Milton Erickson, one of the most important practicing psychotherapists of the 20th century. De Shazer and his Milwaukee-based research group were able to find seven strategic clusters in his procedural method. Doing this, they discovered a problem with the seventh category. This residual category contained a lot of incomparable methods and included 45% of all case studies. Doubling the numbers of categories to 14 did not help, because it resulted in the 14th category, the new residual category, still containing 35% of all cases. This shows that the setting of individual patterns is significant. This individual orientation is an integral part of in-house group coaching.

(2) Explicit emphasis on group and teamwork: This corresponds with results from other fields, such as the training of consultants, showing that group-cohesion was an immensely important factor determining the success of the education (Rauen 2007). Coaching groups work rather intensely because of temporal limits, but nevertheless this seems to make sense when working with managers who incorporate the training into their daily routine. Compared to events lasting one or several days and entailing a certain amount of deliberate slowing down with specific rituals for arrival and starting playing a major role, this makes a more resource-oriented, efficient approach necessary. Participants seem to experience this as very appropriate and would have reacted with astonishment to more classical seminar rituals.

(3) Trust and discretion within in-house coaching groups: It is rather interesting to note that in all this time – 10 years – not one case of indiscretion as to personal information has come to attention, although about 120 participants passed through the groups. There is only one case that was reported, of a new female group member who complained to her boss that her coach did not always show the company's merits. During the next meeting she was corrected by another group member who explained the meaning and the approach of coaching to her. This particular case was not without the possibility of leading to significant complications, taking into account the sensitivity of in-house personnel development, because trust can be lost by a single event. In addition, the system of coaching groups was dependent on the support of higher-level executive managers. The important means of existence for the coaching group system was endangered by this event, but it turned out all right because of the immediate correction by another member. In that way, the coaching groups illustrated the positive effects on company culture, because an in-house coaching system can only become part of an organisation if it proves to be immune to external lack of understanding.

(4) Active support, problem actualization, review, mobilization of resources: This is what coaching is about. These issues emphasized by Grawe (1994) can implicitly be deduced from the answers of the participants and are

surely included, even though they are not distinctly mentioned in open interviews. Participants see effective conditions within a different frame of reference. Especially the aspects of relationships of this form of cooperation, a rather difficult issue in an in-house setting, as well as the pedagogic aspect of management and leadership issues have to be added.

Conclusions: Consequences for in-house group coaching with systemic transactional analysis

As an overall result several points of reference emerge. Group coaching in the leadership and management area is a very complex, compact personnel development tool. It needs:

1. A learning culture characterised by a protective setting (rules for composition of group, discretion, secrecy as to personal information, openness, trust);

2. General expertise in all aspects of working and professional life (blanket competency);

3. Expertise as to field-specific questions of management (specialist field management knowledge - from the branch to the directorate);

4. Psychological expertise (highly qualified coaching role);

5. Up-to-date leadership and management knowledge (academic training, constantly being up-to-date in terms of scientific discussions);

6. Expertise as to pedagogy, group dynamics and method competence (training and input-units adjusted to groups working on different levels and with time limits).

Coherence seems to be of the essence. If only one of the six elements is missing, there will be no success, since all of them have to be served because of the individuality of effective conditions. It seems that these are necessary conditions that all have to be guaranteed. Only then will specific problem situations be resolved, resulting in an activity with long-term attraction.

In addition, another central point of reference is the *connection to practical leading and managing*. Everyday leadership practice offers many causes and opportunities to reflect on and improve leadership. Hands-on learning processes thrive on specific conditions. Of central importance is a protective setting. Coaching group members do not primarily learn a technique, but how to best deploy themselves and their own personality in leadership relations within the company. Just learning techniques does not help at all; to learn about leadership means self-development, and this needs a safe, discreet setting. That can only be provided by an authorized leader or coach who runs no risk of coming into conflict with other roles, and who can legally guarantee the necessary discretion even towards the company, which other role-bearers in leadership or personnel capacities entrusted with disciplinary decisions emphatically cannot.

A second essential aspect is *professional diversity as to activities in the coaching groups*. With the square shaped by field competence, method competence, theory competence and personal competence (Erpenbeck & Rosenstiel 2007; Mohr 2008) as goal of their professionalization, executive managers' experience integrated learning due to a well-structured, intervallic procedure. This means that the group leader needs an extensive command of the perspectives of professionalization mentioned above. Accordingly, the requirements are quite exacting. They include coaching and supervision competence, pedagogic competence, being up-to-date as to modern leadership theory and research as well as field competence concerning the working environment of the group members.

The *coaching competence* of the leader is the third aspect, in order to be able to accompany others in their professional environment and support their development. This especially includes providing the freedom and the chance to enlarge their own spectrum within the confines of the group coaching's time limit.

The leader's *knowledge as to the company's own, specific culture* should not be disregarded, either. This includes the company's transactions in as many dimensions as possible as well as the specific company itself. This knowledge makes suitable solutions within a limited time frame possible. By undergoing supervision themself the leader maintains their own internal distance and keeps from becoming professionally blinkered.

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References

Balint, M. (1957) *The Doctor, his Patient and the Illness*, London: Pitman

Bandura, Albert (1977). Self-efficacy: Toward a unifying theory of behavioral change.*Psychological Review, 84,* 191–215.

Bentrop, C., & Schneider, M. (2012) *Neo-Tayloristic or Holistic Work Group: Flexible Production and the Not So High Performance Work Practices in German Maschinenbau*. Study presented at QCA-Konferenz der Universität Hamburg, 1 June 2012.

Berelson, B. (1952) *Content Analysis in Communication Research*. Glencoe III: Free Press.

Berne, E. (1961) *Transactional Analysis in Psychotherapy*, New York: Ballantine Books.

Berne, E. (1964) *Games People Play*, New York: Ballantyne Books

Berne, E. (1966) *Principles of Group Treatment*, Menlo Park, C: Shea Books.

Buer, F., & Schmidt-Lellek, C. (2008) *Life-Coaching. Über Sinn, Glück und Verantwortung in der Arbeit*. Göttingen: Vandenhoeck & Ruprecht.

Carter, A. (2013) Coaching programmes in work settings, in Wegener, R, Fritze, A & Loebbert, M, *Coaching-practice fields – research and practice in dialogue* (Praxisfelder – Forschung und Praxis im Dialog), Heidelberg: Springer, 415-426.

Cushion, C. & Lyle, J. (2013): Conceptualising Sport-Coaching – Progressing the Field, in: Wegener/Fritze/Loebbert, *Coaching-practice fields – research and practice in dialogue* (Praxisfelder – Forschung und Praxis im Dialog), Heidelberg: Springer, 100-110.

Dehner, U. (2001) *The daily games in offices. (Die alltäglichen Spielchen im Büro),* Frankfurt a.M: Campus.

De Shazer, S. (1990) *Der Dreh. Überraschende Wendungen und Lösungen in der Kurzzeittherapie*. Heidelberg: Carl Auer.

Deutscher Bundesverband Coaching (Ed.) (2012) *Coaching as Profession (Coaching als Profession - Leitlinien und Empfehlungen für die Entwicklung von Coaching als Profession, Kompendium mit den Professionsstandards des DBVC* (4., erw. Aufl.). Osnabrück: DBVC Geschäftsstelle.

Ebner, K. (2013) Standardized Coaching for young scientists and students (Standardisiertes Coaching für Nachwuchswissenschaftler und Studierende), in Wegener/Fritze/Loebbert, *Coaching-practice fields – research and practice in dialogue* (Praxisfelder – Forschung und Praxis im Dialog), Heidelberg: Springer, 101-210.

Ely, K., Boyce, L.A., Nelson, H.K., Zaccaro, S.J., Hernez-Broome, G. & Whyman, W. (2010) *Evaluating Leadership Coaching: A Review and Integrated Framework*. http://www.dtic.mil/dtic/tr/fulltext/u2/a524494.pdf accessed 24 June 2014

Ennen, E., & Richter, A. (2010) The Whole is More Than the Sum of Its Parts – Or Is It? A Review of the Empirical Literature on Complementaries in Organizations. *Journal of Management*, 36 (1), 207-233.

Erpenbeck, J., & von Rosenstiel., L. (Eds.) (2007) *Handbuch Kompetenzmessung.* Stuttgart: Schäffer Poeschel.

Fiss, P. (2007) A set-theoretical approach to organizational configurations. *Academy of Management Review*, 32 (4), 1180-1198.

George, Rickey L., & Christiani, Therese Stridde (1990). *Counseling. Theory and Practice* (3. Auflage). Englewood Cliffs, NJ: Prentice-Hall.

George, Rickey L., & Dustin, Dick (1988). *Group Counseling: Theory And Practice.*Englewood Cliffs, NJ: Prentice-Hall.

Goodstone, Michael S., & Diamante, Thomas (1998). Organizational Use of Therapeutic Change. Strengthening Multisource Feedback Systems Through Interdisciplinary Coaching. *Consulting Psychology Journal: Practice and Research, 50*(3), 153–163.

Grawe, K. (1994) Psychotherapie ohne Grenzen. *Verhaltenstherapie und psychosoziale Praxis*, Jg., Heft 357-370.

Greif, S. (2008) *Coaching und ergebnisorientierte Selbstreflektion*. Göttingen: Hogrefe.

Hagehülsmann, U., & Hagehülsmann, H. (2001) *Der Mensch im Spannungsfeld seiner Organisation*. Paderborn: Junfermann.

Hay, J. (1993): *Working it Out at work.* Watford: Sherwood Publishing.

Hay, J. (2006): Developmental Transactional Analysis, in Mohr, G. & Steinert, T. *Growth and Change for Organizations*, Bonn: Kulturpolitische Gesellschaft, 62-78.

Heinloth, S. (2011) *Praxishandbuch für Führungskräfte*. München: Hanser.

Hewitt, G. (1995) Cycles of psychotherapy, *Transactional Analysis Journal*, 25: 3, 200-207.

Hewitt, G. (2003) Cycles of supervision, Presentation at the ITAA-Conference, Oaxaca, Mexico.

Jackson, G. (2005) Employee Representation in the Board Compared: A Fuzzy Sets Analysis of Corporate Governance, Unionism, and Political Institutions. *Industrielle Beziehungen*, 12 (3), 1-28.

Kahler, T. (1977) The Miniscript (Das Miniskript). In Barnes, G, Transactional Analysis after Eric Berne u.a. *Transaktionsanalyse* seit Eric Berne, Bd 2; Berlin, 91-132.

Katz, D. & Kahn, R.L. (1978) *The social psychology of organizations*, (2nd ed.), New York: Wiley.

Kirkpatrick, D.L. (2006) *Evaluating Training Programs: The Four Levels (3. Aufl.).* San Francisco: Berret-Koehler.

Künzli, H. (2009) Wirksamkeitsforschung im Führungskräfte-Coaching, in *Organisationsberatung, Supervision, Coaching* 16, 4-19.

LeUnes, A. (2007) Modelling the complexity of the coaching process: A commentary.*International Journal of Sport Science and Coaching, 2*(4), 403–406.

Lippmann, Eric (2006). *Coaching. Angewandte Psychologie für die Beratungspraxis.*Berlin: Springer.

Mayring, P. (2010) *Qualitative Inhaltsanalyse*. (11 akt. u. überarb. Aufl.). Weinheim: Beltz.

Mohr, G. (2000) *Lebendige Unternehmen führen*. Frankfurt: FAZ-Buchverlag.

Mohr, G. (2006a) Dynamic Organizational Analysis, in Mohr, G. & Steinert, T. (Eds): *Growth and Change for Organizations*, Bonn: Kulturpolitische Gesellschaft, 79-101.

Mohr, G. (2006b). *Systemische Organisationsanalyse, Grundlagen und Dynamiken der Organisationsentwicklung*. Bergisch Gladbach: EHP.

Mohr, G. (2008). *Coaching und Selbstcoaching mit Transaktionsanalyse. Professionelle Beratung zu beruflicher und persönlicher Entwicklung*. Bergisch Gladbach: EHP.

Mohr, G. (2009a) *Wirtschaftskrise und neue Orientierung*. Berlin: ProBusiness.

Mohr, G. (2009b) Ego states: The Unity and the Differentiation Theory (Ichzustände: Die Einheits- und die Unterschiedstheorie), in *Zeitschrift für Transaktionsanalyse*, 3, 26. Jahrg 199-218.

Mohr, G. (2010) *Workbook Coaching und Organisationsentwicklung*. Bergisch Gladbach: EHP.

Mohr, G. (2011) *Individual and organizational TA for the 21st Century*, Berlin: Pro Business.

Mohr, G. (2012) Ethik in einer Wirtschaft am seidenen Faden, in *Zeitschrift für Transaktionsanalyse*, 29 (2), 77-99.

Möller, H. & Kotte, S. (2012). Aktueller Forschungsstand und Implikationen für die Zukunft der Coachingforschung. in Deutscher Bundesverband Coaching e.V. (Eds.). *Leitlinien und Empfehlungen für die Entwicklung von Coaching als Profession: Kompendium mit den Professionsstandards des DBVC* (4. erw. Aufl.) Osnabrück: DBVC 129-138

Ragin, C. (1987) *The comparative method: Moving beyond qualitative and quantitative strategies*. Berkeley: University of California Press.

Ragin, C. (2000) *Fuzzy set social science*. Chicago: University of Chicago Press.

Ragin, C. (2008) *Redesigning social inquiry: Fuzzy sets and beyond*. Chicago: University of Chicago Press.

Rauen, C. (2007) http://www.rauen.de/coaching-artikel/coaching-index-qualitaetsmodell.htm. accessed 24 June 2014

Schiff, J. (1975) *Cathexis Reader*, New York: Harper & Row.

Schmid, B. (1994) *Wo ist der Wind, wenn er nicht weht*, Paderborn: Junfermann.

Schmid, B. (2003) *Systemische Professionalität und Transaktionsanalyse*. Bergisch Gladbach: EHP.

Schmid, B (2006) Transactional Analysis and Social Roles in Möhr, G & Steinert, T (eds) *Growth and Change for Organisations: Transactional Analysis New Developments 1995-2006*, Bonn: Kulturpolitische Gesellschaft 32-61

Schmid, B., & Messmer, A. (2005) *Systemische Personal-, Organisations- und Kulturentwicklung*. Bergisch Gladbach: EHP.

Schmidt, G. (2005) *Einführung in die hypnosystemische Therapie und Beratung*. Heidelberg: Carl Auer.

Schmidt-Lellek, C., & Buer, F. (Eds.) (2011) *Life-Coaching in der Praxis. Wie Coaches umfassend beraten*. Göttingen: Vandenhoek & Ruprecht.

Stebler, Rita, Reusser, Kurt, & Pauli, Christine (1994). Interaktive Lehr-Lern-Umgebungen. Didaktische Arrangements im Dienste des gründlichen Verstehens.in Kurt Reusser & Marianne Reusser-Weyeneth (Hrsg.), *Verstehen. Psychologischer Prozess und didaktische Aufgabe* (S. 227–261). Bern: Huber.

Stewart, I. & Joines, V. (1990) *Die Transaktionsanalyse*, Freiburg: Herder.

Temple, S. (2002) Functional Fluency *Zeitschrift für Transaktionsanalyse* 4, 251-269.

Wagemann, C., & Schneider, C. (2007) *Qualitative Comparative Analysis (QCA) und Fuzzy Sets: Ein Lehrbuch für Anwender und jene, die es werden wollen*. Opladen: Budrich.

Wicklund, Robert A., & Frey, Dieter (1993). Die Theorie der Selbstaufmerksamkeit. in Dieter Frey & Martin Irle (Hrsg.), *Theorien der Sozialpsychologie. Band I: Kognitive Theorien* (S. 155–173). Bern: Huber.

Zur Bonsen, M. (2009). *Leading with life: Lebendigkeit im Unternehmen freisetzen und nutzen Weisbaden: Gabler*

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An investigation into the support needs of male partners of female alcoholics in Switzerland

Abstract

This exploratory study presents analysis of narrative interviews with three subjects conducted in Switzerland in 2009 to explore the support needs of male partners of female alcoholics. Different concepts on coping styles are introduced and interpreted in the light of several transactional analysis and other concepts. The content of the interviews was categorised according to structuring and typifying analysis. The results indicate that the main needs for support relate to issues of partnership and parenthood, to the image of addiction in society, and to financial and administrative issues, and hence are different to stressors identified by other researchers for female partners of male alcoholics and from support needs of close-one's of the mentally ill.

Key words

partner, alcoholic, stressors, gender, coping styles, support, narrative interviews, content analysis, transactional analysis

***Editor's Note**: This article contains a number of references to references given by other authors. The writer did not have access to the original sources at the time the study was undertaken so these references have been retained in the interests of academic integrity*.

Introduction – Why male partners

According to Addiction Information Switzerland (2008, formerly SFA) 600,000 of the c. 7 million inhabitants of Switzerland were abusing or were addicted to alcohol; many of these will have partners. The writer was aware that much research into addiction and the role of partners had focused on female partners of male addicts, whereas not much is known about male partners (Orford et al 2005). It was noted that over 10 years a third of patients in the addiction department of a psychiatric hospital in Switzerland had been female.

Orford et al's (2005) study of 299 interviews over three continents had focused on close ones and Noriega Gayol's (2004) research in Mexico was focused on female partners of male alcohol addicts. Walter et al (2006) found that living with a partner had a greater preventive influence on relapse than stress coping skills, whereas Sieber (2005) points out that women with alcohol addiction issues seem to profit less than men from partnership and marriage.

According to a study by the Swiss Office for Health (BAG 2008), quoting Schuler, Rüesch et al (2007) women have strong bonds with different people (e.g. partner, children, relatives, friends) but men rely mainly on their female partners for socio-emotional support. Female alcoholics often have conflicts in their families and partnerships (Beer, 2001, quoting Blankfield & Maritz, 1990) and experience little support from them as well as particularly little from their partners (Eisenbach-Stangl, 1997 quoting Haver & Franck, 1997). They are less confident about the possibility of resolving their marital problems (Kelly, Halford & Young, 2000, in Anderson & Baumberger, 2006). Women with alcohol dependency report high aggressiveness of their partners (Miller et al, 1989; Miller & Downs, 1993, in Anderson & Baumberger 2006).

Oppl (2002, quoting Kaufmann and Kaufmann, 1983) from a systemic perspective identifies two main attachment styles of addicts: being enmeshed (which may be out of fear of abandonment) and detached (which may be out of fear of engulfment/overwhelming). As 77% of all women with addiction disorders of all kinds live in stable addiction relationships, whereas 33% of male addicts do (figures for Switzerland), and as violence and terror (of both sexes) occurs more often in these relationships (Graf, Annaheim & Messerli, 2006) the writer speculated that the attachment-style of female addicts might be disorganised in some cases, as being conflict-avoidant despite obvious and manifest ambivalence (afte Liegle & Lüscher, 2008) and often encountered with traumatized persons (Brisch, 2003).

In a study conducted at about the same time as the one reported here (and not known about by the author at the time) , Stutz, Schläfli, Eggli & Ridinger (2011-2012, 2012) questioned partners of alcoholics upon their partner's entering and exiting treatment in several addiction clinics

in Switzerland between January 2009 and June 2010. 71% of the participants were female. They interpreted their findings as indicating that male and female partners of alcohol addicts mainly have a wish to get individual information on different aspects of alcohol dependence as well as support referring to conflicts of the couple and the family.

The study reported here was designed to investigate the needs for support of male partners of female alcoholics, through the analysis of narrative interviews, which focused on the question: What support did you experience?

Theoretical background

Stressors of partners and close ones

An extract from the definition of addiction by Kruse & Körkel (2005) may shed light on the issue of relationship with addicts ". . .addicted behaviour . . . under aspects of relational dynamics serves the regulation of closeness, distance and differentiation behaviour in a way that no threatening relation conflicts are resulting" (p. 14) Hunter-Reel, McCrady & Hildebrandt (2009) state that it is the most supportive person in the social network of an addicted person who has the most influence, followed by a number of supportive relationships and abstinent friendships. Marlatt & Witkiewitz (2009) suggest that contacts with abstinent peers are helpful and found that participants in Alcoholics Anonymous had fewer relapses. According to them, positive reinforced socio-emotional support is a determinant factor for recovery.

According to Orford et al's study (2005) on coping with addicts, partners make more coping efforts than other close ones. Kurt (2006) in a lecture indicated stressors for close ones of the mentally ill as shown in Table 1.

81-84% of close ones are worried because of lacking information, they feel insecure and are overburdened with the symptoms
64-78% worry about treatment, feel helpless and powerless, lonely and solely responsible and they feel not taken serious
72% suffer from health problems following the illness of their loved one
66% are scared of the future
54% of the partners (male and female) and parents carry financial burdens (44% for treatment, 57% for everyday life, 15% for extraordinary expenses)
44% experience grief and loss
41% are afraid of relapse and suicide
31% feel shame and stigmatization
22% feel guilt
21% spend a lot of time taking care of their ill beloved ones (6-10 hrs/week)

Table 1 Stressors for close ones of the mentally ill (after Kurt 2006)

These findings stand in contrast to the common understanding of professionals that close ones of addicts feel mainly ashamed and guilty because of their own contribution to the illness and the stigmatisation of society that goes with it (Orford et al, 2005). Howells & Orford (2006), in a study on (mainly female) partners with interventions in their own right, describe the unusually high level of distress and the breaking down in tears as partners came to the first session, many with guilt feelings of betraying their partners by doing so, which made it additionally hard to talk. The irrational blame of society for not controlling their partners drinking adds guilt and shame and undermines self-esteem. Nearly all of the partners in that study "...had a degree of ambivalence about whether the drinking was serious" (p. 65).

The generational researchers Liegle & Lüscher (2008), state that the two main tasks in mutual responsibility of co-living generations are contingency and ambivalence. Contingency is to them the implicit task in coping with uncertainties and destiny, the insight into the unavoidable of the new as well as the necessity of risking it. To cope with the partner's addiction, partners face exactly these challenges. To connote ambivalences as well as contingencies positively, accepting them and being able to discuss them openly is to Liegle & Lüscher (2008) a sign of secure attachment, which they call emancipatory attachment. In reference to our topic this means that the partners would need to have a secure attachment style.

Those who do not cope with the stressors well may develop somatic illnesses (Schaef 1987; Orford et al, 2005) and psychological symptoms of anxiety and depression (Orford et al 2005; Kahler, McCrady & Epstein, 2003). The World Health Organization (2004) quotes Room et al (2002), who state that there are also social problems evolving around employment, financial issues and social integration. Orford et al (2005) state that the primary stressor for the ones co-living with addicts is the threat to self-esteem.

Transactional analysis and coping styles

Steiner (1971) describes five roles in psychological games of alcoholics, which he considers to be countertransference reactions. We can substitute partners for his references to therapists:

1. Persecutor (similar description by Schweitzer & von Schlippe, 2007): anger about behaviour of addict, stricter rules, discrimination or ignoring of statements, not wanting to perceive success, negative attributions out of bitter grudge

2. Rescuer (similar descriptions by Schaef, 1987, Klein, 2001, Noriega Gayol, 2004, Schweitzer & von Schlippe, 2007): emotional over-engagement, over-estimation of own potency, non-perception of capabilities of addicts

3. Patsy (similar description by Schaef, 1987): seeking intellectual explanations instead of problem solving in pragmatic everyday life, non-perception of here-and-now of the addict (e.g. drunkenness), does the recovery for and without the addict

4. Connection (similar description by Schweitzer & von Schlippe, 2007): provides the addict with the needed substance to his/her own advantage

5. It: (similar descriptions by Kruse & Körkel, 2005, Heigl-Evers, Helas & Vollmer, 1993): the alcohol is perceived and treated as a unit outside the addict (e.g. by the alcohol addicted therapist - here partner)

We can name these countertransference reactions, which show as patterns of behaviour and therefore create roles. Kouwenhoven, Kiltz & Elbing (2002) state that the phenomenological appearances of ego states (in the functional model) are rule-bound connected to the behavioural patterns as roles. Thus as transactional analysts we suppose that Rescuer behaviour is a manifestation of negative Nurturing Parent and Persecutor behaviour is a manifestation of negative Critical Parent. We suppose that Rescuer and Persecutor behaviour stems from the same ego state, Parent, into which the addicts may invite their partners by under-responsible behaviour (English, 1992). Noriega Gayol's study (2004) shows more Rescuer behaviour on the part of the Mexican wives, due to unresolved symbiosis and parentification (after Miller, 1981).

In Patsy we see behaviour that reminds us of tangential responses, which seem to manifest Adapted Child behaviour by avoiding confrontation in the here-and-now and by Trying Hard (Kahler 1975). Connection seems to be manifesting negative Free Child behaviour (as unscrupulous) and It may show a manifestation of Rebellious (revengeful) Child (I am interested in treating your illness, but not you, as I can't do it for myself).

We can compare Steiner's roles against the work on three main coping styles of partners by Copello at al (2000) as shown in Table 2. It seems likely that there is a combination of Persecutor and Rescuer as well as Patsy roles within the Committed coping style whereas the Connection role appears to be included in either the Tolerant or Withdrawn coping style. The It role might be viewed as a Tolerant coping style, when we consider the thoughts to be: Others don't understand me (either). In Steiner's description there is no Withdrawn style, as he was talking about therapists' contertransference reactions.

The writer assumes that systems are organising around alcohol as a central focus (Brown & Lewis, 1999). The entire thinking, feeling, perception and behaviour is focused around alcoholism, and alcoholism at the same time is denied, to protect the addict, oneself and the entire system from expected negative reactions of others and from reactions from one's own inner psyche. Brown & Lewis (1999), state that this leads to chaos, confusion, mistrust, loneliness, and alienation from oneself and isolation from others. This also means that one's own feelings and needs may not be felt or even perceived. The injunctions which these systems are acting upon are: Don't speak, Don't trust anyone, Don't feel (Black, 1981). These are subsequently narrowing one's own capabilities of perception and action in problem solving for oneself or the system, and one's own developmental possibilities, as described by Noriega Gayol (2004) in the sense of a dysfunctional relational pattern which is based on specific behaviour.

	Committed	Tolerant	Withdrawn
Description of relating	active transactions between close one and addict, focus is problem solving	some transactions, sometimes action is missing, takes away negative consequences for addict	attempts to create distance between oneself and addict, some uncertainty, some need to look after oneself
Thoughts	I have to be capable of changing him/her	others don't understand him/her	the less we are together the better
Emotions	angry, hurt, responsible	powerless, guilty	self-secure or upset
Behaviour	observe, control	give money	avoid addict because of drinking
Possible roles in games	Persecutor, Rescuer, Patsy	Connection, It	Connection
Possible advantages	could make close ones feel able to do something positive	avoids conflict	can help close ones not become Rescuers
Possible disadvantages	could be very strenuous and cause much resent	close ones left feeling taken advantage of	close ones could feel bad about, as they are excluding or rejecting addict

Table 2 Coping styles of partners of addicts, after Copello et al (2000)

For the couples level, we can identify that both partners need to differentiate their feelings, needs, thoughts and actions from one another and start talking and negotiating with each other as separate beings (Brown & Lewis, 1999). According to Bader & Pearson (1988) a symbiotic couple is defined by not clearly differentiating the I from the Not I, sustaining the merger into one I, by avoidance of self-definition and by not making the boundaries clear.

Gender Comparisons

Klein (2002) states that male partners of addicted women separate more often than female partners do from addicted men. Lutz, Appelt & Cohen (1980) each studied twenty husbands of alcoholics and of depressed wives and found that under comparable conditions, the husbands of alcoholics felt more burdened, especially in the interpersonal area. As the female support source is lacking with addiction being present and the wife not functioning as expected, separation seems to be the logical conclusion for men.

The collected and interpreted data about gender differences in male and female partners are shown in Table 3.

Methodology

Narrative Interviews

The interviewer was trained to do narrative interviews at ARGE Bildungsmanagement Vienna. This training involved listening to interviewees unfold their reality around a specified question, asking informative questions solely to avoid misunderstandings, and showing compassion and offering immediate helpful information rather than remaining neutral if the interviewee became emotionally distressed. In this approach missing information is given from an ethical standpoint to minimize harm if suffering is exhibited by the interviewee (as with B with the children and C with finances and own health).

At the beginning of the interviews for this study, the partners filled in a 5-question survey on demographics. Narrative interviews of 1 to 2 hours length were then conducted individually with three partners/husbands of female alcoholics regarding the one question "What support did you experience?"

Kruse (2009 quoting Helfferich 2005), states that the meaning of a term itself can only be understood in the situational context of the use of that term. Narrative interviews in this sense serve the purpose to discover the varieties and contingencies of 'reality' to describe complex patterns, in which the interviewed subjects describe their conceptualised realities. The aim of asking only one question is, therefore, to have the interviewee conceptualise his/her own reality around this one term.

The content of the interviews was put in contrast to theory as comparison-horizon (Bohnsack, 2008), or alternative perspective. The experience of the writer influenced the selection of the interview materials, the categorisations and the chosen literature. As Kruse suggests, we need to be aware of our own presuppositive theoretical concepts and be critically self-reflective, to allow for empirical new findings.

Ethical Considerations

The writer was permitted to interview the husbands of wives being hospitalized in a University Psychiatric Hospital in Switzerland. Approval was given to the project by the Ethical Commission of the State and by the Clinic, based on the written design of the study and the consent forms.

The husbands and their wives gave their informed consent separately, after an informative talk about the interview topic, the interviewer, the interview location, the length of the interview and its purpose. They signed an agreement that covered being interviewed by the researcher, having the interview recorded and having the results published anonymously. They were assured that the recordings would be destroyed latest six months after termination of the researcher's Masters studies, and that only other professionals under professional confidentiality conditions would read any of the transcribed interviews. They had the right to demand their destruction at any time before that. They were informed that this was the researcher's private undertaking and were given the address of the training institute. They were granted the right to withdraw their agreement at any time without having to give any reason.

The Subjects

3 interviews were conducted. The husbands were all Swiss, not addicted themselves, and with wives who were hospitalized due to relapse at the time of the interview. Details are summarised in Table 4.

The writer also checked whether the interviewees had participated in self-help groups for close ones, and none had. The writer used categorising to identify the main stressors of male partners to compare these with those for close ones of mentally ill and female partners. To identify any specific causal relationships between coping style and motivation for action and intent to act, the writer used typifying analysis. The writer also identified some 'extraordinary' statements in line with Gläser & Laudel's (1999) comment that the extraordinary statements must be included in the qualitative research as part of a system of conditions which cause reactions, and the mechanisms between them, in order to explain causal relationships and to identify determinants of human behaviour, thinking and feeling.

Area of life	Male partner	Female partner
Role	Persecutor, angry-controlling (Steiner 1971)	Rescuer, caring-controlling (Noriega Gayol 2004; Welter-Enderlin & Jellouschek 2002)
Life position	I'm Okay – You're not Okay when you are drinking	I'm Okay, when I am able to control your behaviour (Orford et al 2005) – You're Okay when you are not drinking
Coping with stigmatisation	I fear not being taken seriously by others; she doesn't want other people to know	nobody shall know; they would blame me, if they knew (Howells & Orford, 2006)
Socio-emotional sources of support, enhancing own health and wellbeing	female partner (BAG, 2008; Hüther 2009)	male partner, children, relatives, friends (BAG, 2008)
Expressions of aggression	demanding (Kelly, Halford & Young 2002) directly to partner through control of substance, reserves, money, friends etc. (Walter 2006) indirectly through the power of decision making and taking on responsibilities for the functioning of the household and thereby creating dependency and power differences	indirectly through making oneself available as a source of socio-emotional and sexual support (Noriega Gayol 2004) indirectly through the power of decision making and taking on responsibilities for the functioning of the household and thereby creating dependency and power differences symptoms of anxiety and depression (Orford et al 2005) as internalised aggression
Feeling alone, helpless, despairing, abandoned	yes	yes
Participation in self-help-groups	fewer men than women (Al-Anon Switzerland 2009; Eisenbach-Stangl 1997)	more often women than men preference for Al-Anon (Eisenbach-Stangl 1997)
Prevalence for allowing support for problems (social, health)	lower (BAG 2008)	higher for youth and adults, no information available for older age (BAG 2008)
Probability to leave partner	high (Klein 2002)	low
Ambivalence in relationship	existing	existing
Providing for the family	main providers (BAG 2008)	responsibility for caretaking within the family and household (BAG 2008, Howells & Orford, 2006)
Reacting positively to the coping style of partner concerning the drinking	internalising drinkers (more female): less (Künzler 2000)	externalising drinkers (more male): yes (Künzler 2000)
Probability of symbiotic stage of couple relationship (after Bader & Pearson, 2000)	high	high

Table 3 Gender comparisons

	A	B	C
age husband / age wife ±	75 / 50	40 / 40	63 / 61
relationship duration in years	20	over 20	40
profession husband	yes	no, but was business owner	yes, had higher position
actual work situation husband	retired	houseman	retired
income	both pension/ she partly	wife pension	both pension
fortune	yes, using it up	yes, using it up	none, used up
years of addiction of wife	20	1	10
Children's ages	-	±8, 10, 12	3, ±30-40
duration of interview	1.5 hr	1 hr	2 hrs
attachment style of partner, intuitively interpreted by writer	Enmeshed	Disorg-anised	Detached

Table 4 Socio-demographics of husband/couple and duration of interview

Analysis

The transcribed interviews of this study were evaluated according to structuring (Socher, oral lecture, 2009; Mayring, 2003) and typifying content analysis (Flick, 2006; Gläser & Laudel, 1999).

In addition to concepts within the literature, a significant input to the categorization came via the previously mentioned workshop by Kurt (2006) on research of the stressors of close ones of the mentally ill, as described above. Eleven categories were built, of which two were elaborated inductively: (1) Knowledge of partner's illness and (9) Own inner picture of the partner. The other nine categories were as indicated within Table 5, which also shows how some were subsequently combined to present a total of seven rankings.

Results

Typifying analysis

According to Flick (2006), typifying shall contain the main cases as well as counterexamples and shall show case adversities as well as case comparisons. Examples of statements of interviewees are:

1. Talking to others

A: *She demanded that I don't talk, not to anybody*

B: *I fear the reaction of my colleagues, therefore I broke off the contact*

C: *And it was difficult to keep in contact, because if you want to meet with a colleague it costs money.*

2. Not communicating as a couple or family

A: *I don't tell her anything anymore that is upsetting me, because I fear a relapse*

B: *I don't know about the stress of my kids, it's difficult*

C: *Communication with my wife is zero*

3. Feeling lonely, helpless, ill and tired

A: *I get to the point, where I can't anymore, at all. It hurts and my brain isn't working anymore*

B: *My aggressivity certainly stems from my helplessness, because I don't know how to react*

C: *I don't want any support for my exhaustion. The slightest efforts I make lead to heavy pains*

4. Ambivalence: being alone - staying together

A: *I wanted to leave many times, but I can't leave her alone - I love her. I want to be with her, despite her illness*

B: *I wouldn't know where to go with the children, if I got divorced - I wouldn't leave her*

C: *I have to take care of my wife at home - If we were together it would be 40 years*

5. Leading one's life

A: *I can't go on like that. Maybe our age difference is too big. I have very different ideas and attitudes about life than she does. I wish she took on the leading role in the relationship.*

B: *I am missing the contact with my colleagues, since my wife's illness. I will get back to work in a year, when my wife isn't going to the clinic anymore. I am a father and I have responsibilities. I will not let go of my kids.*

C: *I stay home and only care for the most necessary*

6. Extraordinary statement of the interviewee

A: *Others brought the dog back and left my drunken wife in the roadside ditch*

B: *My mother* (a now recovered alcoholic, *insertion by the writer*) *was lying around unconsciously or was suicidal and I was the only person there. Alcohol and benzodiazepines are a deadly mixture*

C: *If you would have known this woman before...*

We can see some evidence of attachment styles in these statements as well: A is rather enmeshed (compare statements 1, 2, 3, 4, 5); B is rather disorganised (compare statements 1, 2, 4, 5, 6) and C seems to have developed a rather detached style (compare statements 2, 4, 5, 6).

As causal relationships between coping style and the motivation for action (Bohnsack, 2008, referring to Weber, 1976/1922, in Schütz, 1974/1932) we see in these statements that the motives for action (because of -) can be described as:

- A believes he can influence his partner
- B prevents death of his mother back then (of partner here-and-now) and being abandoned by her
- C acts out of a sense of duty and to save his self-esteem as a former authority in his village and to honour the former efforts of his wife for their family and social engagement in the village

As causal relationships between coping style and intent for action (Bohnsack, 2008, referring to Weber, 1976/1922, in Schütz, 1974/1932), we see in these statements that the intents to act (to -) can be described as:

- A states that he wants to remain with his partner, to enjoy his free life as an elderly person together with her, to have her at his side, when he falls ill and frail.
- B wants to stay together with his partner, to hold the family together and avoid the catastrophe
- C doesn't want to get divorced from his partner, wants to care for his family till the end as she has done. That provides him with a sense of integrity - and he prevents catastrophe because he needs to prove that his actions make sense

Comparing the traditional expectations on male and female partners to the situation of the wives of the interviewees in this study, the writer found the following gender-related and generational aspects. These might further underline the assumptions on attachment styles.

- The wife of interviewee A has two sisters but it was she who had been looking after her father in his home till his death, whilst managing his business. Her partner might be wishing for her to look after him as well, as he wants her to take over responsibilities.
- The wife of interviewee B has been working in their own business with the husband (till they gave it up) and she is responsible for household and children, when at home. Her partner wants her to come back and function in the family again.
- The wife of interviewee C has exhaustingly cared for their youngest son, who was born severely physically handicapped, till his recovery after many operations, besides doing the housework, looking after their daughter and being very involved in the social life of the community. Due to physical invalidity since a stroke, she is incapable of looking after the grandchildren. Her partner states that she has been a wonderful wife, not integrating her characteristics with the ill person she has become.

The interviewees A and C mentioned the merits of their wives in caretaking (Boszormenyi-Nagy & Spark, 2001); interviewee B, being from another generation, with schoolchildren at home, expressed his gratitude for her efforts by wishing her to be back and taking her role in the family again. These expectations might be a clue to alcohol-dependent wives not profiting from marriage as much as male partners do (compare to Sieber, 2005).

Structuring analysis

An overall analysis of mentions of support/lack of support was conducted and is shown in Table 5. The categories of couple and parenthood, and of knowing, understanding and coping with the illness, as well as the categories of coping with own wellbeing and social inclusion, have been combined into totals for these related aspects. Ratios are shown for lack of support: support.

Discussion

These findings are based on a very small number of subjects so must be viewed with caution but may nevertheless indicate areas for future attention.

There are less than half as many mentions of support than there are of lack of support. 320:145 in a ratio of 2.2:1, although it can be seen in Table 5 that there are variations for particular categories. For instance, there is a significant difference between ‘knowing about the partner’s illness’ and ‘understanding the illness’.

There is a particularly high ratio of lack of support relating to the image of addiction in society (6.6: 1).

Lack of support for coping with own feelings is high, as is lack of support for dealing with financial and administrative issues.

The most mentions of lack of support and of support were in the areas of issues of the couple and parenthood, about the illness and coping with the ill partner. Comparing Table 5 to Table 1: Stressors of close ones of the mentally ill, we find a new domain in first place of need for support on the issues of the couple and parenthood. Similar needs to close ones are: support for coping with the illness, own health issues and emotional stress, own feelings, maintaining contacts and own activities, and planning for own life.

The stressors of female partners differ mainly from these findings with male partners in the domain of being responsible for the behaviour of the male partner as a

Categories of support	Rank	Lack of support		Support experienced		Ratio of lack of support: support
		No.	%	No.	%	
4, support for the realisation of own plans for the shaping of life together with the partner and the maintaining of common relations		34		12		2.8 : 1
5, support for issues of couple and of parenthood		63		23		27.1
9, support for coping with the partners image of the addicted spouse		17		13		13.1
Total	**1**	**114**	**35%**	**48**	**33%**	**2.4 : 1**
1, support for knowing about the partner's illness		2		12		0.2 : 1
2, support for understanding the illness		24		9		27.1
3, support for interventions in coping with the ill partner		57		28		20.1
Total	**2**	**83**	**26%**	**49**	**34%**	**1.7 : 1**
7, support for coping with own health and emotional stress	3	40	12%	23	16%	1.7 : 1
11, support for coping with own feelings	4	25	8%	7	5%	3.5 : 1
8, support for coping with maintaining own contacts and the undertaking of own activities	5	22	7%	10	7%	2.2 : 1
10, support for the image of addiction in society	6	20	6%	3	2%	6.6 : 1
6, support in dealing with financial and administrative issues	7	16	5%	5	3%	3.2 : 1
Total in %		**320**	**99%**	**145**	**100%**	**2.2 : 1**

Table 5 Analysis of categories showing lack of support and support

gender-related issue (Orford et al 2005; Howells &Orford, 2006). Female partners (with their children) are also more often dependent on their partners financially than are male partners, which creates additional existential distress for them (BAG, 2008; Howells & Orford, 2006). However male partners might suffer more from the absence of their partner, due to lack of socio-emotional support from their identified main source and psychologically less easy access to a helper system (BAG, 2008). Hence male partners are more likely to leave their partnerships (Klein, 2002).

Compared to coping styles of female partners we might expect that men are therefore more likely to cope in a withdrawn way. However, in this study that was only partly the case with interviewee C, who wanted to create a clear boundary for himself and place his wife in a nursing home for good. Interviewees A and B showed a mixture of committed and tolerant coping styles, although the motivation for this kind of action for A might have been to make himself feel good (experience some self-effectiveness) whereas interviewees B and C seem to be more interested in avoiding the feared catastrophe from happening. Interviewee C might also be looking out for the caretaking for his wife being organised, to maintain his integrity (after Erikson, 1966). Interviewee B wants to avoid his wife committing suicide, as he believes he prevented his (at the time) alcohol-abusing mother.

As indicated in Table 3, it is considered that men and women seem to differ in coping style, with men being more likely in the Persecutor role and women more likely in the Rescuer role. According to Künzler's study (2000), male partners' coping styles do not affect their partners drinking as much as female partners' coping styles do.

Switzerland is both a modern and traditional oriented country: women's' right to vote on national level came only in 1971 and on all local levels not until 1991. Equal rights in marriage were legalised in 1988; before that husbands made all the decisions and wives were expected to look after household and children, according to their husband's guidance. Women in Switzerland also traditionally care for the next and former generation, including the grandchildren. Six out of ten care-needing relatives are being looked after in private homes; 80% of the caregivers for these and grandchildren are women.

As dealing with (life) threatening new situations is activating former attachment and role behaviours (compare Liegle and Lüscher 2008 above), we can see how this might have affected the partners and have led to a halt in the differentiation process of the couple (compare Kruse & Körkel 2005 and Bader & Pearson 1988 as mentioned above).

	A	B	C
Hypothesized attachment style	enmeshed	disorg-anised	detached
Coping style	committed and tolerant	committed and tolerant	tolerant and withdrawn
Possible roles in games	Persecutor, Rescuer, Patsy	Connection, It	Connection

Table 6 Hypothesised relationships of attachment style and coping styles and Steiner's (1971) psychological game roles

Limitations of the Study

This study involved only 3 interviewees so can only be regarded as an experimental version that hopefully will be followed by further research.

Furthermore, the study was designed, operated, analysed and evaluated by the writer, whereas Lamnek (2005) suggests that the collection and/or evaluation of data by several persons would allow for higher reliability (or objectivity). A different method of thematic analyses might also have generated different categories, and different researchers might have categorised the interview contents under different headings.

An advantage of having a female interviewer might have been that accessing emotions was easier for interviewees, who each cried during the interview. On the other hand, taboo topics like sexuality and violence might have been more accessible with a male interviewer. The writer's interest in distinguishing the needs of male partners from those of female partners and other close ones may well have biased the findings. The researcher's use of an empathic rather than neutral style of interviewing might also have influenced the answers.

Attachment styles and coping styles have not been analysed and are only hypothesized; another area for future research.

Conclusion

It is hoped that this study, although only small and experimental, will generate ideas for future research. The analysis of the 3 interviews has shown that the needs of male partners of female alcoholics might be different from the needs of female partners of male alcoholics. If this result can be replicated, it will provide important information for those responsible for supporting the partners of alcoholics and the concerned couples and families.

The literature review and background study has also provided suggestions for how transactional analysis concepts can be viewed and applied to partners of alcohol addicts. Examples here have included Steiner's (1971) psychological game roles, deriving from countertransference reactions of people in contact with alcoholics; ego states and roles after Kouwenhoven, Kiltz & Elbing (2002); English's (1992) over - and under-responsible behaviour-patterns; and generational transference aspects after Noriega Gayol (2004).

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References

Anderson, Peter & Baumberger, Ben, (2006), *Alcohol in Europe, A report for the European Commission,* , Chapter 5, Health EU http://ec.europa.eu/health/index_en.htm accessed 10 June.2014

Bader, Ellyn & Pearson, Peter T., (1988*), In Quest of the Mythical Mate*, Florence Kentucky: Brunner/Mazel

BAG (Schweizerische Eidgenossenschaft: Bundesamt für Gesundheit, Hg (2008), http://www.bag.admin.ch/themen/gesundheitspolitik/00394/00402/index.html?lang=de accessed 21 July.09

Beer, Ragnar, (2001), Merkmale von Partnerschaftszielen als Veränderungs-Mediatoren in der verhaltenstherapeutischen Kurzzeit-Paartherapie, www.user.gwdg.de/^^rbeer/dissertation_beer.pdf accessed 14.November 2010

Black, Claudia, (1981*), It will never happen to me!* Random House Publishing Group, USA

Blankfield, A & Maritz, J S (1990) Female Alcoholics. IV. Admission problems and patterns. *Acta Psychiatrica Scandinavica* Dec 82: 6 445-50

Bohnsack, Ralf, (2008), *Rekonstruktive Sozialforschung*, Opladen, Farmington Hills: Barbara Budrich

Boszormenyi-Nagy, Ivan & Spark, Geraldine M, (2001/1981), *Unsichtbare Bindungen*, Stuttgart: Klett-Cotta

Brisch, Karl Heinz, (2003), Bindungsstörungen und Trauma, In Brisch, Karl Heinz & Hellbrügge, Theodor (Hg.), *Bindung und Trauma* (S. 105-135), Stuttgart: Klett-Cotta

Brown, Stephanie & Lewis, Virginia, (1999), *The Alcoholic Family in Recovery*, The Guilford Press, New York

Copello, Alex, Orford, Jim, Velleman, Richard, Templeton, Lorna & Krishnan, Mya, (2000), Methods for reducing alcohol

and drug related family harm in non-specialist settings, *Journal of Medical Health*, 9, 3, p. 329-343

Eisenbach-Stangl, Irmgard, (1997), Selbsthilfe und Sucht, *Wiener Zeitschrift für Suchtforschung*, 20-3/4, S. 71-75

English, Fanita, (1992/1982), Es ging doch gut - was ging denn schief? *Beziehungen in Partnerschaft, Familie und Beruf*, München: Christian Kaiser

Erikson, Erik H, (1966), *Identität und Lebenszyklus*, Zürich: buchklub Ex Libris

Flick, Uwe, (2006/1998), *An introduction to qualitative research*, London: Sage Publications

Gläser, Jochen & Laudel, Grit, (1999), Theoriegeleitete Textanalyse? Das Potential einer variablenorientierten qualitativen Inhaltsanalyse, www.bibliothek.wzb.eu/pdf/1999/p99-401.pdf accessed 11 July 2009

Graf, Michel, in Zusammenarbeit mit Annaheim, Beatrice & Messerli, Jeanine, (2006), *Sucht und Männlichkeit*, Lausanne: SFA Verlag

Haver B, Franck J. (1997) The Karolinska Project for Early Treatment of Women with Alcohol Addiction. A review of a unique research program. European *Addiction Research.* 3:30–6

Heigl-Evers, Annelise, Helas, Irene & Vollmer, Heinz C., (1993), Hgb., *Eingrenzung und Ausgrenzung, Zur Indikation und Kontraindikation für Suchttherapien*, Göttingen: Vandenhoeck & Ruprecht

Helfferich, C (2005): *Qualität qualitativer Daten. Ein Schulungsmanual zur Durchführung qualitativer Einzelinterviews 2 Auflage*. Wiesbaden: Verlag für Sozialwissenschaften.

Howells, Elizabeth, Orford, Jim, (2006) Coping with a problem drinker: A therapeutic intervention for the partners of problem drinkers in their own right, *Journal of Substance Use*, 11, 1

Hunter-Reel, Dorian, McCrady, Barbara & Hildebrandt, Thomas, (2009), Emphasizing interpersonal factors: an extension of the Witkiewitz and Marlatt relapse model, *Addiction*, 104/8, p. 1281-1290

Kahler, Christopher W., McCrady, Barbara S., Epstein, Elizabeth E., (2003), Sources of distress among women in treatment with their alcoholic partners, *Journal of Substance Abuse Treatment*

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

Karpman, S (1968) Fairy tales and script drama analysis. *Transactional Analysis Bulletin* 7, 39-43

Kaufman, A.S., & Kaufman, N.L. (1983). *Kaufman Assessment Battery for Children*. Circle Pines, MN: American Guidance Service

Kelly, Adrian B., Halford, W. Kim, & Young, Ross M, (2002) Couple Communication and Female Problem Drinking: A Behavioral Observation Study, *Psychology of Addictive Behavior*, 16, p. 269-271

Klein, Michael, (2001), Das personale Umfeld von Suchtkranken. In Tretter, Felix & Müller, Angelica (Hg.), *Psychologische Therapie der Sucht, Grundlagen, Diagnostik, Therapie*, p. 201-229. Göttingen: Hogrefe

Klein, Michael, (2002), Mit einem suchtkranken Partner zusammen leben, In Staatsinstitut für Frühpädagogik (IFP), *Das Familienhandbuch*, S. 1-6, www.familienhandbuch.de/cmain/f_Aktuelles/a_Partnerschaft/s_636.html accessed 21 July 09

Kouwenhoven, Maarten , Kiltz, Rolf Reiner, Elbin, Ulrich, (2002), Schwere Persönlichkeitsstörungen, Transaktionsanalytische Behandlung nach dem Cathexis-Ansatz, Wien New York: Springer-Verlag

Kruse, Gunther & Körkel, Joachim, (2005), Rückfall bei Alkoholabhängigkeit, Bonn: Psychiatrie-Verlag

Kruse, Jan, (2009), Qualitative Sozialforschung - interkulturell gelesen. die Reflexion des Selbstauslegung im Akt des Fremdverstehens. FQS Qualitative Sozialforschung, Volume 10, No. 1, Art. 16., www.qualitative-research.net/index.php/fqs/article/viewArticle/1209/2639 accessed 10 June 2014

Künzler, Alfred, (2000), The Patients Intimate Partner in Couple Alcohol Treatment, Benefits by Matching Therapy, Saarbrücken: VDM Verlag Dr. Müller

Kurt, Hans (2006) lecture at the "Forum of Phaseal Systemic Family and Couple Therapy", in Zurich

Lamnek, Siegfried (2005/1988), Qualitative Sozialforschung, Weinheim, Basel: Beltz

Liegle, Ludwig & Lüscher, Kurt, (2008), Generative Sozialisation, www.kurtluescher.de/generationenpubl./htlm, accessed 2 August 2009

Lutz, M., Appelt, H., Cohen, R., (1980), Belastungsfaktoren in den Familien alkoholkranker und depressiver Frauen aus der Sicht der Ehemänner, Social Psychiatry 15, S. 137 – 144,

Marlatt, Alan & Witkiewitz, Katie, (2009), Further exploring the interpersonal dynamics of relapse, *Addiction*, 104/8, p. 1291-1292

Mayring, Philipp (2003). *Einführung in die qualitative Sozialforschung* [Introduction to qualitative social research] (5th edition). Weinheim: Beltz-UTB

Miller BA, Downs WR. 1993. The impact of family violence on the use of alcohol by women: research indicates that women with alcohol problems have experienced high rates of violence during their childhoods and as adults. *Alcohol Health Research World* 17(2):137.42

Miller, Alice (1981), Das Drama des begabten Kindes, Frankfurt am Main: Suhrkamp

Miller, N.S., Gold, M.S., Belkin, B.M. and Klahr, A.L. (1989) Family history and diagnosis of alcohol dependence in cocaine dependence. *Psychiatry Research 29, 113*- 12 1.

Noriega Gayol, Gloria, (2004), Codependence: A Transgenerational Script. *Transactional Analysis Journal*, 34/4, S. 312-322

Oppl, Michel, (2002), Süchtiges Verhalten, Missbrauch und Abhängigkeit, in Wirsching, Michael & Scheib, Peter (Hg.), *Paar- und Familientherapie*, S. 425-438, Berlin Heidelberg: Springer

Orford, Jim, Natera, Guillermo, Copello, Alex, Atkinson, Carol, Mora, Jazmin, Velleman, Richard, Crundall, Ian, Tiburcio, Marcela, Templeton, Lorna & Walley, Gwen, (2005), Coping with Alcohol and Drug Problems, The Experiences of Family Members in three Contrasting Cultures, Hove East Sussex: Routledge

Room, R., D. Jernigan, B. Carlini-Marlatt, O. Gureje, K. Mäkelä, M. Marshall, and others. 2002. *Alcohol in Developing Societies: A Public Health Approach*. Helsinki: Finnish Foundation for Alcohol Studies.

Schaef, Anne Wilson, (1996/1987), Im Zeitalter der Sucht, München: DTV

Schuler, D, Rüesch,P & Weiss, C (2007) *Psychische Gesundheit in der Schweiz – Monitoring*, Arbeitsdokument Neuchâtel: Swiss Health Observatory

Schütz, Alfred (1974/1932) *Der sinnhafte Aufbau der sozialen Welt: Eine Einleitung in die verstehenden Soziologie*, Frankfurt: Suhrkamp

Schweitzer, Jochen, von Schlippe, Arist, (2007), Lehrbuch der Systemischen Therapie und Beratung II, Göttingen: Vandenhoeck & Ruprecht

Sieber, Martin (2005), Frauen, Männer und der Alkohol, www.uzh/news/articles/2005/1555, accessed 10 May 2009

Socher, Rainer, (2009) *Vorlesung am Kurs: Wissenschaftliches Arbeiten*, Wien: ARGE-Bildungsmanagement

Steiner, Claude, (1971), Games Alcoholics Play, New York: Ballantine Books

Stutz, S, Schläfli, K, Eggli, P, & Ridinger, M (2011-2012) Bedeutung der Erwartungen Angehöriger an die stationäre Behandlung von Alkoholabhängigen [The role of expectations among family members toward inpatient treatment of alcohol addicts] *Abhängigkeiten*, 3/2011-1/2012, 118-128

Stutz S., Schläfli K., Eggli P. & Ridinger M. (2012). Angehörigenarbeit in der stationären Behandlung von

Walter, Marc, Gerhard, Urs, Duersteler-MacFarland, Kenneth, Weijers, Heinz-Gerd, Boening, Jobst, Wiesbeck, Gerhard A., (2006), Social Factors but Not Stress-Coping Styles Predict Relapse in Detoxified Alcoholics, *Neuropsychology*, 54, S. 100-106

Walter, Willi, (2006), Gender, Geschlecht und Männerforschung, in: von Braun, Christina & Stephan, Inge (Eds), *Gender Studien*, S. 91-110, Stuttgart: Metzler

Weber, M (1976/1922) *Wirtschaft und Gesellschaft. Grundriss der Verstehenden Soziologie* Tübingen: Mohr-Siebeck

Welter-Enderlin, Rosmarie & Jellouschek, Hans, (2002), Systemische Paartherapie - Ein integratives Konzept, In Wirsching, Michael & Scheib, Peter (Hg.), *Paar- und Familientherapie*, S. 199-226, Berlin Heidelberg: Springer

World Health Organisation, Department of Health, (2004), *Global Status of Alcohol, Health and Substance Abuse*, Vol. 1, www.who.int ....Substance abuse Publications and Documents, accessed 10 June 2014

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Challenges to Developing Routine Outcomes Evaluation in Different Practice Settings and Cultures: A Naturalistic Enquiry in Spain and the UK

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Abstract

A naturalistic sessional evaluation of routine outcomes of psychotherapy from a range of theoretical orientations including transactional analysis, using standardised measures for depression, anxiety, general distress and working alliance, was conducted across completed therapy interventions by 113 therapists with 263 clients within an academic institution in the UK and across stages of therapy by 10 therapists with 26 clients in three independent clinics in Spain. Outcomes in both countries demonstrated clinical gains but it was found that such evaluation methodology was more easily applied within a training institute than in private practice; it also appeared to better fit the UK professional climate of evaluation. Suggestions are made concerning the introduction of such research in future.

Key words

Naturalistic enquiry; Routine outcomes; Transactional Analysis Psychotherapy

Introduction

Transactional analysis psychotherapy is conducted in a number of practice settings and cultures. This project was funded by EATA (European Association for Transactional Analysis) in 2011 to explore the possibility of developing psychotherapy evaluation within settings that included private practice and academic organisations in different countries. In this case, one site was a large low cost clinic situated within a training institute in the UK where evaluation has already been established (Van Rijn & Wild, 2013), and the others were independent psychotherapy clinics in Spain, where this type of evaluation was new. In both countries, transactional analysis psychotherapy was practiced alongside other approaches to psychotherapy. This paper presents the research and outcomes in these sites and discusses challenges and learning arising from it.

The paper offers a set of conclusions and recommendations for implementing naturalistic evaluation within non-academic psychotherapy practice settings

Literature

Choice of methodology in evaluation of psychotherapy is particularly important in the field, with a great divide between practitioners and researchers and an equally great need to develop a research evidence base and gain statutory recognition. In transactional analysis an international network with agreed standards of certification and evaluation potentially offers an opportunity to develop multi site, multicultural research that could explore and evaluate the application of the approach in different contexts.

Developing a research evidence base for effectiveness and efficacy of psychotherapy is of great importance to the recognition of theoretical approaches. This could be achieved using different methodologies. The current 'gold standard' of research in many health and statutory settings is still a randomised control trial, which gives findings about 'efficacy' of psychotherapy. Theoretical approaches with this type of research evidence (such as CBT), have been accepted as treatments in statutory clinical guidelines within the UK. This type of research has also given findings about the efficacy of psychotherapy in general through different meta–analyses.

Using these findings, (Lambert & Barley, 2002; Lambert & Ogles, 2004; J. C. Norcross & Wampold, 2011; Wampold, 2001), emphasised the so called 'common factors' in psychotherapy rooted in the therapeutic relationship, over the theoretical approach. However, randomised control trials are normally beyond the resources of ordinary practitioners and clinics. They require a highly structured approach to research design in order to demonstrate causality. This relies on develop-

ing a representative clinical sample and requires randomisation and availability of control groups, as well as research specific recruitment, training and evaluation of the therapist's work, normally involving a treatment manual.

A different approach to measuring effectiveness of practice - 'practice based evidence' - involves evaluating the flow and outcomes of therapy as it is practiced in ordinary settings. .

In the UK, recognition of prevalence of problems such as depression and anxiety in the population by the Department of Health (DoH, 2002) and the establishment of the stepped care model for treatment in the National Health Service (NHS), have emphasised the importance of collecting routine outcome data in order to develop the quality of services (CSIP Choice and Access Team, 2007). Routine evaluation of outcomes in these settings involves sessional evaluation of psychotherapy using standardised questionnaires.

Generic counselling has also been evaluated in primary care in individual effectiveness studies (Mellor-Clark, Connell, Barkham & Cummins, 2001; Stiles, Barkham, Twigg, Mellor-Clark & Cooper, 2006, (Connell, Barkham, & Mellor-Clark, 2008) and systematic reviews (Bower, Rowland, & Hardy, 2003; Hill, Brettle, Jenkins, & Hulme, 2008). All demonstrated its effectiveness in primary health care.

However, practice based evaluation faces a lot of challenges. Clients present to therapy with a range of issues. They are not randomly assigned to treatment conditions and although we can measure the changes they achieve, our findings will always be limited. We cannot ascribe their change to therapy, because we are unable to control and measure for other variables. The percentage of clients completing the measures is often very limited and there is frequently no evidence of the approach practiced by therapists. This limits the internal validity of the research design (Clark, Fairburn, & Wessely, 2008). To an extent this could be counterbalanced by their external validity, or the fact that they are generally representative of clinical practice. (Stirman, DeRubeis, Crits-Christoph, & Brody, 2003) and have a potential to develop it (Rao, Hendry, & Watson, 2010).

Therefore, in choosing methodology useful to ordinary practice settings we need to consider a type of evaluation that would enable comparison to national and international benchmarks and comparisons between different sites. An important aspect of this is also in choosing a methodology that the therapists and clients can engage with and that has a potential to enhance therapy. Naturalistic evaluation has already been in use in student practice within Metanoia Institute in the UK (Van Rijn & Wild, 2013) and in health settings (van Rijn, Wild, & Moran, 2011) and demonstrated good completion rates and engagement with the methods of evaluation. It was therefore of interest to explore whether this methodology could be used again within a different culture and setting.

Research Aims and Methodology

The aim of the research team was to test out the methodology of an open, non-randomised, practice based evaluation model in two different types of settings and find out whether it was successful in measuring outcomes and able to engage the clients and therapists. Both were measured by the levels of data completeness which needed to reach at least 90% to comply with IAPT benchmarks (Clark, Layard, Smithies, Richards, Suckling & Wright , 2009) and repeat the outcomes of the previous studies (Van Rijn & Wild, 2013; Van Rijn, Wild, & Moran, 2012). If this was the case in both settings, it would suggest that this method of evaluation could be appropriate in different cultures and practice settings. Outcomes of therapy were also measured in order to illustrate how this type of evaluation could contribute to developing an evidence base for an approach.

Research Sites

Metanoia Counselling and Psychotherapy Service (MCPS) in the UK

The counselling and psychotherapy service where the research took place has been operating since 1995. MCPS provides low cost counselling and psychotherapy to the general public, who self-refer to the service. Treatment can be extended up to one year, depending on the client's need and availability. The wide range in the length of therapy is unusual in the statutory services in the UK, which tend to offer a set number of sessions, rarely extending to 20.

MCPS became a research clinic in 2010 following an evaluation project in primary care (van Rijn et al., 2011). The outcomes within this current project have been measured between September 2011 and April 2013.

Independent Clinics in Spain

Three independent clinics located in different parts of Spain participated in the research clinic. All the Spanish research has been coordinated and managed by the Institute for Psychosocial Studies "Xoan Vicente Viqueira" (University of La Coruña, Spain). Length of therapy was not limited by the setting.

Therapists

Therapists within the UK

Therapists were students at Metanoia Institute who were in their first practice placement. They were engaged in different training courses: Transactional Analysis Psychotherapy (MSc); Gestalt Psychotherapy (MSc); Integrative Psychotherapy and Counselling Psychology (based on Gilbert & Orlans, 2010) (MSc in Integrative Psychotherapy and DPsych in Counselling Psychology); Person Centred Counselling (BSc and MSc). Students were entitled to work at the clinic after being observed and assessed by their tutors as being ready to start to work with clients. They had regular clinical supervision at a ratio of one hour of supervision per six hours of clinical

practice. There were 22 supervisors for the 113 therapists taking part.

Therapists within Spain

The level of therapists' experience varied. All therapists were working full- or part-time in different private practice clinics and had completed training in either Transactional Analysis or Integrative Psychotherapy. 10 therapists were involved in the project; four of those had more than five years in practice, six had less. There was no data available about their supervision arrangements.

Clients

Clients UK site

Clients self-referred to the service. Of the 304 clients during the year, 263 had an assessment session and at least one therapy session. The profile of the clients for the year remained unchanged compared to the years prior to evaluation and reflected the ethnic mix of the area:

- 63.3% of clients were female.
- 50% white British, 22.5% other white including Irish and Scottish, 21.8% Asian and Black
- 50.6% in full time employment. 21.7% unemployed, 10.8% part time unemployed, 10.8 self-employed, 1.8% students, 1.8 % retired
- Average age was 39.4.4% of clients were 21 or under and 19% were over 50.

Clients Spanish sites

Clients in Spain also self-referred to the service. 26 took part in research. Evaluation involved 11.5% of clients who were at the beginning of therapy and 88.5% who were already in therapy, within a range of 0-48 month's duration.

The profile of the clients was:

- 76.9 % of clients were female.
- 36 % in full-time employment, 16 % unemployed, 8 % self-employed, 16 % in part-time employment, 12 % in temporary employment, 4 % living with parents, and 8 % retired.
- The average age of the sample was 37, 8 years old, with a range from 16 to 59. 8 % were under 21 and 20 % were over 50 years old.

The number of clients who refused to take part in research was not recorded for either site.

Therapy

Therapy UK Site

After the initial contact, clients had an assessment session. The assessment format had previously been developed for the service by the Head of Clinical and Research Services at Metanoia Institute (Bager-Charleson & Van Rijn, 2011) and highlighted presenting issues such as current symptoms and functioning, developmental history and risk.

Assessors referred clients to practitioners for four exploratory sessions. The aim was to decide whether a working relationship and a focus for therapy could be established. A client would be referred on if they decided to change therapist, or if a therapist considered themself unable to meet the needs of a client.

Therapists were taught and instructed to use the outcome measures as an integrated part of relational therapy, as well as for research. These conversations usually took place at the beginning of each session, when clients handed measures back to therapists. Clients' aims were discussed alongside any changes they noticed during the week, whether they were positive or negative. A working alliance measure was used to encourage feedback and attention to the therapeutic relationship. The aim was to encourage responsiveness in therapists, as an essential component of effective psychotherapy (Norcross, 2002). Even though therapists worked within their own theoretical approach, this expectation of careful tracking of clients' responses aimed to develop a pluralistic therapeutic stance (Cooper & McLeod, 2011).

The proportion of each theoretical orientation within the clinic was: Integrative Psychotherapy and Counselling Psychology 46 %, Person Centred Counselling 31%, Gestalt Psychotherapy 11.8%, Transactional Analysis psychotherapy 11.2%.

Therapy Spanish Site

In the case of new clients, therapists undertook a first assessment session which inquired into the presenting problem, developmental history, risk, and previous experiences with the presenting problem. Within this first assessment session, clients were also informed about the research clinic, its objectives and usefulness for the therapeutic process and they were asked for consent. Experienced therapists were instructed to approach all new clients for inclusion into the evaluation, as well as their ongoing clients.

For the Spanish sample, the proportions were: 46.2% Transactional Analysis psychotherapy, 53.8% Integrative Psychotherapy.

Measures

Both sites used the following measures each session:

- Patient Health Questionnaire, PHQ-9, (Kroenke, Spitzer, & Williams, 2001): a nine item questionnaire which distinguished between clinical and non-clinical populations; Coefficient α 0.91)
- General Anxiety Measure, GAD -7(Spitzer, Kroenke, Williams, & Lowe, 2006): a seven item questionnaire which was originally developed for Generalized Anxiety Disorder and found to have sensitivity for other anxiety disorders. Coefficient α 0.92 (Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007); Coefficient α 0.92

- Working Alliance Inventory, WAI (Horvath, 1986): a 12 item questionnaire developed to measure working alliance as defined by Bordin (1979); Coefficient α 0.93 (Horvath, 1986).

Ethical Considerations

Clients had a right to withdraw from the project at any time during treatment. Outcomes were discussed transparently between the therapists and the clients. All the data was confidential and anonymised before analysis.

Therapists chose to practice within the research clinic.

The Metanoia Institute Ethics Committee (an independent body approved by Middlesex University) had given an ethical consent to the project.

The project was also approved by the Ethics Committee of the University of La Coruña, which made sure it complied with research ethical codes.

Results

Table 1 shows a percentage of complete data sets for clients who have had one assessment session and at least one therapy session. The only measure completed in under 90% of cases was the relationship measure, WAI, for both samples.

Data Completeness %	PHQ-9	GAD-7	CORE 10	WAI
GROUP 263 (UK)	91.6	91.6	90	70
GROUP 26 (Spain)	91.2	91.2	100	80

Table 1 Data Completeness

Descriptive statistics UK

The descriptive statistics in Table 2 show that post-therapy scores in the UK were generally low with the exception of the WAI which was high. The standard deviation demonstrates a moderate dispersion of scores from the mean with greater variance observed on the WAI.

Improvement Rates Spanish Sites

Improvement rates were calculated to illustrate the outcomes of the therapeutic process within the clinic and in order to understand the outcomes on clients' symptoms and problems, as well as on the working alliance. Criteria for improvement were calculated by the difference between scores at the start and the end of therapy. Table 3 shows the percentages of clients that showed improvement, no change or deteriorated during the course of the evaluation in the Spanish sample. The UK clinic was able to calculate reliable and clinical change for the sample and this is discussed below.

%	PHQ-9	GAD-7	Core 10	WAI
Improved	57.7	73.1	65.4	34.6
No Change	15.4	7.7	15.4	23.1
Deteriorated	26.9	19.2	19.2	22,3
No Data	0	0	0	20

Table 3: Percentage Improvement Rates, Spanish Sites

Clinical and Reliable Change UK Site

Clinically significant change is change that has taken a client from a score typical of high reported distress of a client group to a score typical of a normal population. Reliable Change (RC) measures whether clients have changed sufficiently that the change is unlikely to be due to simple measurement unreliability.

This has been calculated using the standard deviation of the difference between pre and post scores and the Cronbach's alpha of the measures (indicated previously under Measures. Table 4 illustrates the reliable change scores for the UK sample, indicating how much a client will have needed to change in order for that change to be considered reliable.

	Std Deviation	Std Error	Change Score
PHQ-9	6.306	2.52	4.94 (5)
GAD-7	6.037	2.56	5.02 (5)
CORE-10	7.642	4.59	8.99 (9)

Table 4 Reliable Change Scores, UK Site

Table 5 shows that 42.5% of clients in the UK site achieved a clinically reliable level of change in therapy which involved at least one session following the assessment. 44.4% did not show enough change to be considered reliable change, and 5.7% deteriorated.

The percentage improvement clearly supported the descriptive statistics. Moderate percentages of improvement demonstrated low scores at the end of therapy in comparison to the start of therapy. To examine this further, the data were tested to establish if these improvements rates were significant.

	PHQ-9		GAD-7		CORE 10		WAI	
	S1	Post	S1	Post	S1	Post	S1	Post
Mean	12.04	7.41	11	7.01	18.18	12.23	21	67.07
Sd	6.82	6.04	5.57	5.54	7.89	8.32	5.29	13.7

Table 2 Descriptive Statistics, UK Site

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%	PHQ-9	GAD-7	Core 10
Improved	42.5	36.4	29.9
No Reliable Change	44.4	52.5	59
Deteriorated	5.7	3.8	2.7
No Data	7.3	7.3	8.4

Table 5 Percentage Reliable Improvement Rates, UK Site

It was found that there were significant differences from pre to post therapy calculated using a T-test with moderate effect sizes using Cohen's d, as shown in Table 6.

Significance of Improvement Rates	Mean	SD	Effect Size	n
PHQ-9	4.28	6.32	0.6	240
GAD-7	3.86	5.9	0.6	240
Core 10	5.74	7.63	0.7	238
WAI	-6.33	14.52	0.4	166

T-test is significant at $P < 0.01$

Table 6 Significance of Improvement rates, UK site

Significance of Improvement Rates Spanish Sites

Analyses of clinically significant and reliable change were not calculated for the Spanish site.

Significance of improvement rates were calculated using T-test and Cohen´s d. Effect sizes are small for PHQ-9 and WAI, and moderate for GAD 7 and CORE 10. Table 7 shows the results on the significance of improvement rates.

Significance of Improvement Rates	Mean	SD	Effect Size	n
PHQ-9	6.85	6.31	0.22	26
GAD-7	5.73	4.7	0.51	26
Core 10	10.08	6.5	0.51	26
WAI	64.50	8.13	0.22	26

T-test significant at $P < 0.01$.

Table 7 Significance of Improvement Rates, Spanish Site

Discussion

Contrary to the expectations of the research team, this project has not demonstrated that the same type of naturalistic evaluation could be used effectively in different settings. Although evaluation in each sample suggested that both sites yielded positive outcomes for clients in terms of depression, levels of anxiety and general distress, the results were not comparable due to a number of differences between the samples. The more important learning in this project was in exploring differences and difficulties in establishing credible evaluation within different practice settings and reflecting on increasing levels of engagement.

Outcomes

It was not possible to compare the outcomes in different research sites, because of differences in the sample size and the way in which evaluation was conducted. Therefore, any comparisons serve only as an illustration.

Outcomes within the UK sample demonstrated evaluation of the therapy clients received from the beginning to end. These outcomes were comparable with previously published clinic findings and this suggested their reliability in achieving outcomes in reducing depression, anxiety and general distress.

The sample within the Spanish sites was similar in composition in terms of age, employment rates and gender, even though it was considerably smaller. The evaluation gave a picture of a stage of therapy, rather than psychotherapy outcomes. It was difficult to reach full conclusions about effectiveness because the clients were at different stages of therapy. However, it is clear from the outcomes that the clients have made gains, particularly in the areas of anxiety and general distress.

Project Set Up

The clinic within Metanoia Institute has been established as a research clinic for a number of years. Students who applied to practice within it knew that evaluation was going to be a part of their practice placement. This was often difficult because MCPS was the first placement for the majority of students and their anxiety was often considerable. This was addressed in their one day induction training at the start of the placement. The training day was an opportunity to talk through best practice in using evaluation.

The training day also involved working in triads, in order to practice introducing the measures with clients. The anxiety expressed by students mainly involved fear of evaluation, its possible impact on the clients and the flow of therapy, and additional workload (and costs) of supervision.

Private clinics in Spain had a very different set up. Evaluation has not been a part of their practice and they were geographically diverse. There was no official training by the researcher but information was provided by phone and email contact.

Therapists frequently refused to participate and among the most cited motives were: unpaid additions to the workload, concerns about having to audio record the sessions, and concerns about own work being evaluated by others, even when the confidentiality and anonymity

of the data were explained. These anxieties were similar to those expressed by students in other naturalistic research (Rao, et al., 2010). At Metanoia Institute these anxieties could be sufficiently contained by the existing academic culture, enabling the therapists to engage with the project. The need to start a practice placement could be seen as an important motivation and a help in counterbalancing fears of evaluation.

Client Engagement

Clients who took part in evaluation in both settings showed high completion rates. This is not unusual within naturalistic evaluation which shows that clients value an opportunity to monitor how they are progressing in therapy (Miller, Duncan, Brown, Sorrel, & Chalk, 2006) and an opportunity to give feedback to therapists (Lambert & Barley, 2002). However, therapist engagement with evaluation is essential in making this effective for clients. All therapists were instructed to use the outcome measures as an integrated part of the therapy process, and all therapists were also instructed on what each instrument measured. It was interesting that Spanish therapists reported that they discussed changes with clients at the beginning of the evaluation, but that after a while clients reported fatigue with filling in the same questionnaires every week and these the discussions ceased after a few months. This was not the case with the majority of clients within the UK clinic. However, it may have been that the therapists were not themselves interested in the measures, so they were seen as 'administration' and separate from therapy.

Professional Culture

Although psychotherapy within the UK is practiced within a range of settings, professional climate is impacted by the emphasis on evaluation within the health services, and the recognition of research based psychotherapies. Many therapists who work within organisations are required to use routine outcome evaluation in their practice. Although in this research we found that fears and anxieties amongst the therapists were very similar, students within the UK site were more likely to engage with evaluation and engage their clients. They were motivated in a different way, and supported by their supervisors and training environments.

Therapists in Spain do not practice within the same professional climate. Routine outcomes evaluation is not common practice and qualified therapists working for themselves have little external incentive to engage in this additional piece of work, which is frequently where the gap between researchers and practitioners occurs.

Adherence

Adherence to the approach was not monitored in this project, due to the differences in the supervision arrangements within the sites. For this reason, no assertions about the effectiveness of the approach have been made.

Conclusions and Recommendations

In view of so many difficulties in establishing routine outcomes evaluation in this project, the question emerges about the options for transactional analysis in developing a research evidence base. One of these options involves the use of different methodologies, particularly outside academic environments, such as case study research (McLeod, 2010; Widdowson, 2012), and other qualitative and mixed methodologies.

However, in addition to that, outcomes research will remain an important part of the evidence required in establishing effectiveness of any therapeutic approach to psychotherapy. This could continue to be conducted within large clinics in academic and health settings, although that approach would leave a large part of psychotherapy practice in transactional analysis under-researched an under-represented. Our suggestion is that for optimum success in implementing this type of research in different settings, it will be essential to engage the psychotherapists more fully by:

- Developing a programme of research seminars and information for the therapists
- Ensuring that face to face training takes place prior to any research project
- Offering supervision that would combine reflection on clinical and research process and support therapists in using the methodology for clinical development as well as research.

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References

Bager-Charleson, S., & Van Rijn, B. (2011). *Understanding Assessment in Counselling and Psychotherapy*: Exeter: Learning Matters.

Bordin, E. S. (1979). The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research, Practice, 16*(3), 252-260.

Bower, P., Rowland, N., & Hardy, G. (2003). The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis. *Psychological Medicine, 33*(2), 203-215.

Clark, D. M., Fairburn, C. G., & Wessely, S. (2008). Psychological treatment outcomes in routine NHS services: a commentary on Stiles et al. (2007). *Psychological Medicine, 38*(5), 629-634.

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two demonstration sites. *Behaviour Research and Therapy, 47*, 910-920.

Connell, J., Barkham, M., & Mellor-Clark, J. (2008). The effectiveness of UK student counselling services: an analysis using the CORE System. *British Journal of Guidance & Counselling, 36*(1), 1-18.

Cooper, M., & McLeod, J. (2011). *Pluralistic Counselling and Psychotherapy*: London: Sage.

CSIP Choice and Access Team. (2007). *Commissioning a Brighter Future. Improving Access to Psychological Therapies. A Positive Practice Guide*. London: Department of Health.

DoH. (2002). A National Service Framework for Mental Health: London: Department of Health.

Gilbert, M., & Orlans, V. (2010). *Integrative Therapy: 100 Key Points and Techniques* Hove: Routledge.

Hill, A., Brettle, A., Jenkins, P., & Hulme, C. (Eds.). (2008). *Counselling in Primary Care: a Systematic Review of evidence*: Lutterworth: British Association for Counselling and Psychotherapy.

Horvath, A. O. (1986). *Another Approach to Assess the Counselling Relationship: The Working Alliance*. Paper presented at the American Educational Research Association, San Francisco.

Kroenke, K., Spitzer, R. L., Williams, J., Monahan, P. O., & Lowe, B. (2007). Anxiety Disorders in Primary Care: Prevalence, Impairment, Comorbidity, and Detection. *Annals of Internal Medicine, 146* 317-325.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a Brief Depression Severity Measure. *Journal of General and Internal Medicine, 16*, 606-613.

Lambert, M. J., & Barley, E. D. (2002). Research Summary on the Therapeutic Relationship and Psychotherapy Outcome. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work. Therapist Contributions and Responsiveness to Patients* Oxford: Oxford Press 17-32

Lambert, M. J., & Ogles, B. M. (2004). The Efficacy and Effectiveness of Psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change* (Fifth Edition): Wiley & Sons Inc.

McLeod, J. (2010). *Case Study Research in Counselling and Psychotherapy*: Sage Publications.

Miller, S., Duncan, B., L., Brown, J., Sorrel, R., & Chalk, M. B. (2006). Using Formal Client Feedback to Improve Retention and Outcome: Making Ongoing Real -Time Assessment Feasible. *Journal of Brief Therapy, 5*(1), 5-21.

Norcross, J. (Ed.). (2002). *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients*: Oxford: Oxford University Press.

Norcross, J. C., & Wampold, B. (2011). Evidence- Based Therapy Relationships. In J. C. Norcross (Ed.), *Psychotherapy Relationships That Work. Second Edition* Oxford: Oxford University Press. 423-429

Rao, A. S., Hendry, G., & Watson, R. (2010). The Implementation of Routine Outcome Measures in a Tier 3 Psychological Therapies Service: The Process of Enhancing Data Quality and Reflections of Implementation Challenges. *Counselling & Psychotherapy Research, 10*(1), 32-38.

Spitzer, R. L., Kroenke, R., Williams, J. B., & Lowe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: the GAD-7. *Archives of Internal Medicine, 166*, 1092-1097.

Stirman, S. W., DeRubeis, R. J., Crits-Christoph, P., & Brody, P. E. (2003). Are samples in randomized controlled trials of psychotherapy representative of community outpatients? A new methodology and initial findings. *Journal of Consulting and Clinical Psychology, 71*(6), 963-972.

Van Rijn, B., & Wild, C. (2013). Humanistic and Integrative Therapies for Anxiety and Depression: Practice-Based Evaluation of Transactional Analysis, Gestalt, and Integrative Psychotherapies and Person-Centered Counseling. *Transactional Analysis Journal, 43*(2), 150-163.

van Rijn, B., Wild, C., & Moran, P. (2011). Evaluating the Outcomes of Transactional Analysis and Integrative Counselling Psychology within UK Primary Care Settings. *International Journal of Transactional Analysis Research, 2*(2), 34-43.

van Rijn, B., Wild, C., & Moran, P. (2012). Evaluation of Integrative Counselling Psychology and Transactional Analysis in Primary Care Health Setting. *Journal of Integrative Research, Counselling and Psychotherapy, 1*(1), 36-46.

Wampold, B. (2001). *The Great Psychotherapy Debate*: Lawrence Erlbaum Associates.

Widdowson, M. (2012). TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Denise'. *International Journal of Transactional Analysis Research, 3*(2) 3-14.

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Quantitative and Qualitative Outcomes of Transactional Analysis Psychotherapy with Male Armed Forces Veterans in the UK presenting with Post-Traumatic Stress Disorder

Abstract

This paper presents findings from a two-year research project conducted within a live-in residential charity setting in the UK, examining clinical outcomes of TA psychotherapy among 15 male armed forces veterans presenting with severe PTSD (post-traumatic stress disorder) and other comorbid disorders. Outcomes were measured for short-term (24 sessions) and long-term (52 sessions) transactional analysis (TA) treatment using the quantitative CORE-OM (Evans, Mellor-Clark, Margison, Barkham, McGrath, Connell & Audin, 2000), PHQ-9 (Kroenke, Spitzer & Williams, 2001) and GAD-7 (Spitzer, Kroenke, Williams & Löwe, 2006) questionnaires and the qualitative Change Interview (Elliott, Slatick, & Urman, 2001, as cited in Frommer & Rennie, 2001). Quantitative findings show that positive Reliable Change on global distress, depression and anxiety has taken place within both the short-term and long-term treatment groups with some clients achieving Clinically Significant Change on these measures. Qualitative findings arising from thematic analysis (Braun & Clarke, 2006) indicate that a broad spectrum of therapist factors and psychotherapy process factors within the TA therapy delivered were beneficial for this particular client group. The negative influence of a number of psychosocial factors on the veterans' well-being is also discussed based on numerical data and interview responses. Overall, these results suggest that TA psychotherapy can be effective in the treatment of PTSD among combat veterans.

Key Words

Transactional analysis psychotherapy, PTSD, Post-Traumatic Stress Disorder, Armed Forces Veterans, CORE-OM, PHQ-9, GAD-7, Change Interview

Introduction

The aim of this research project was to investigate whether transactional analysis (TA) psychotherapy can be an effective treatment for post-traumatic stress disorder (PTSD) in ex-servicemen and women. Among the authors' motivations for pursuing this extensive study were the encouraging results generated by an earlier pilot study (Harford, 2013) in the same setting, together with their identification of a clear gap in the available TA research literature. There was also an awareness that it is highly unusual for a private practitioner to secure the opportunity of providing long-term TA psychotherapy on an indefinite basis with no limit on the number of sessions available for each client and all sessions funded by an independent charitable organisation. In addition, there has been intense media coverage of the problems faced by military personnel returning from Afghanistan and Iraq in recent years, the *Broken by Battle* edition of the BBC's Panorama programme (BBC 2013) being one memorable example, and this increased public awareness, combined with an attendant increase in the number of veterans willing to seek assistance, and limited NHS provision, has brought the need for a broader range of effective treatments for PTSD sharply into focus.

Definition of Post-Traumatic Stress Disorder

PTSD is a psychiatric disorder which presents after the individual has experienced a severe traumatic event, such as an assault, or accident which involves injury or threat of death, or witnessing severe injury, death, or threat of injury or death for others, where the individual experienced emotions such as powerlessness, horror and terror. Symptoms include recurrent intrusive thoughts and images related to the trauma (flashbacks), avoidance of stimuli which remind the individual of the trauma in some way, intense distress and physiological reactivity, nightmares, persistent anxiety and dissociative phenomena (American Psychiatric Association, 1994).

Literature Review

At the time of writing, the only published research investigating the effectiveness of TA psychotherapy in the treatment of PTSD is the pilot study conducted by Harford (2013). Based on a sample of 6 veterans and

quantitative data gathered across 16 sessions of treatment, he concluded that " . . . 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 . . . 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' (Tudor, 2003, p.202)". (Harford, 2013, p.28)

Harford (2013) goes on to suggest that these initial results, "offer an encouraging level of support for the working hypothesis that 'TA psychotherapy is an effective treatment for PTSD' " (p.28), though with the qualification that "further research investigating the process and outcome of [TA] therapy for PTSD is warranted" (p.28). The present paper is based on a two-year research project which immediately followed this pilot study and is the first full-scale analysis of the effectiveness of TA psychotherapy with this client group.

The available TA theoretical literature on PTSD is also relatively slim, though this has been addressed to some extent by the July and October 2012 editions of the *Transactional Analysis Journal*, which feature several articles exploring TA approaches to the treatment of trauma in adults; the former collection, in particular, examining survivors of torture, intentional violence and other conflict-related extremities of human experience. Clarkson (1987) provides one of the earliest TA theories relevant to this study in her concept of the Bystander, who "By not challenging or intervening . . . [gives] tacit permission to the abuse of power occurring in their environment" (p.82); a position all too familiar to some of the participants in Harford's (2013) pilot study, who reported being haunted by profound guilt over their involvement "passively in violent, or oppressive situations" (Clarkson, 1987, p.82). A useful entry point for any consideration of the self-protective function of dissociative defences in the face of traumatic experience is supplied by Erskine (1993), who suggests that dissociation "allows a person to remove [themselves] cognitively and emotionally from the experience and to physically adapt and behaviourally conform to external demands" (Erskine, 1993, p.184). Of particular significance with regard to PTSD, he adds that "Continuing the dissociation after a traumatic event enables a person to disengage from [relational] needs and emotions and to evade the memory and its devastating impact" (p.184). He goes on to offer an integrative approach to treatment that advocates empathic inquiry, attunement and involvement with the aim of "integration of affect-laden experiences…intrapsychic reorganization of the [veterans'] beliefs . . . and the integration of the dissociated parts of the personality" (p.190). Such integrative models of aetiology, symptomology and treatment (Erskine, 1993; Erskine & Trautmann, 1996) informed key aspects of the TA psychotherapy delivered to the veterans participating in this study.

Pomeroy (1998) suggests that neuroscience may be helpful in conceptualising trauma by considering how the limbic system has the "ability to pre-emptively activate the survival mode system when it believes it detects a threat" (p.332). She proposes that this has relevance to the aetiology and symptomology of PTSD, which she believes occurs "when the limbic system is unable to return [executive] control to the neocortex" (p.335). She also provides a treatment plan for adults affected by trauma and PTSD, which corresponds closely to treatment plans offered within other psychotherapy modalities (see below) and adds insights from neuroscience that can be used to underpin the reparative models of the integrative school (Erskine, 1993; Erskine & Trautmann, 1996). Though focussing primarily on dissociative identity disorder (American Psychiatric Association, 1994), Korol (1998), meanwhile, offers a concise summary of the goal of treatment as "two fold: 1) to become aware of and accept disowned parts (i.e., ego states) and 2) to become able to contact other people while maintaining a sense of self" (p.115), a dual emphasis on the need for intrapsychic and interpersonal contact (Erskine, 1993) that, again, played a significant role in the therapy examined by this research.

Building on Pomeroy's (1998) depiction of PTSD as "a limbic system disorder" (p.335), Stuthridge (2006) foregrounds the implicit, explicit and autobiographical memory systems and, combining these neurological insights with Tudor's (2003) view of "neopsychic function as a process of integration, reflective function, and narrative" (p.272), envisages trauma as precipitating a breakdown in the Adult capacity for "integrating disparate Parent and Child ego states into a unified sense of self" (p.271), resulting in a fragmentation of the traumatic experience and the subsequent intrusion of "dissociated memory fragments, smells, images, and sensations that are not located in time and space" (p.274). She moves on to outline her relational TA approach, which employs attunement within the therapeutic relationship to resolve transferential enactments and facilitate neopsychic integration of dissociated Parent and Child fragments, and concludes by warning that "Trauma therapies that focus on outside, recall of events, and abreaction are insufficient to bring about lasting change" (p.282), which makes for an interesting comparison with current National Institute for Clinical Excellence Guidelines (2005) (see below).

More recently, Caizzi (2012) provides an unsettling insight into the effects of torture, where "the power of the [injunctions and counterinjunctions] a victim receives during torture is so deep that it impacts and changes his or her script protocol" (p.167), which later manifests in various types of somatisation and intense Persecutor/Victim (Karpman 1968) transferential enactments. As this extremity of trauma is "embodied in the subsymbolic mode, by which the patient

communicates to the therapist what happened in the there and then through what is happening in the here and now" (Caizzi, 2012, p.169), like Stuthridge (2006), Caizzi's treatment considerations favour a relational TA approach, whereby client and therapist mutually cocreate (Summers & Tudor, 2000) and facilitate Adult integration of their shifting patterns of transference and countertransference, but with a body-orientated focus on supporting the client to identify, understand and, thereby, exert neocortical control over their "affective, somatic, sensory, and motor modes of mental processing" (Caizzi, 2012, p.168). Picking up on her earlier suggestion (Stuthridge, 2006) of a link between childhood trauma and adult-onset PTSD, Stuthridge (2012) comments on her work with earthquake survivors that "in every case in which posttraumatic stress symptoms escalated over time rather than subsiding, the client revealed a history of childhood trauma" (p.239). In the ensuing material, the innovative blend of neuroscience and relational TA first advanced in Stuthridge (2006) is reframed within the overarching metaphor of the Christchurch earthquake, such that "Bridging the [dissociative and cotransferential] fault lines in the interpersonal realm increases continuity within the self and expands [neopsychic] possibilities for affect regulation and intimacy" (p.239).

Non TA perspectives include the work of Davies and Frawley (1994), who offer a concise psychoanalytic treatment plan involving "1. containment 2. recovery and disclosure of traumatic memories . . . 3. symbolization and encoding of memory and experience; 4. integration of disparate self and object systems . . . and 5. internalization of a new object relationship" (p.202), which, although intended for adult survivors of childhood sexual abuse, bears a marked resemblance to both Pomeroy (1998) and Stuthridge's (2006, 2012) TA models. Perhaps the most familiar account of the treatment of PTSD and other trauma-focused disorders, however, is found in Rothschild (2000), who, citing Van Der Kolk (2004), advocates that "Therapy needs to consist of helping people to stay in their bodies and to understand these bodily sensations" (p.3); an attention to the somatic dimension of trauma that she saw as undervalued in contemporary psychotherapy. As described by Caizzi (2012), Rothschild sees the goal of treatment as supporting clients to "transform negative implicit memories of relationships by creating a newly encoded positive experience of attachment" (p.172), or, in object-relational terms, internalizing "a new representation of a caring relationship in both mind and body" (p.172).

Moving on to the research literature, Schnurr and Friedman (1997) furnish a brief overview of contemporary PTSD research; most notably, that PTSD is '"associated with . . . early conduct problems, childhood adversity . . . poor social support after a trauma" (p.13) and that researchers must be aware of ethnocultural limitations of their conclusions, as "the diagnostic criteria for PTSD and most of the current data . . . are based primarily on research and clinical experience with North American or European individuals" (p.16). Meanwhile, after debating the relative bias and distortions within the available studies, Wampold at al (2010), supply a convenient summary table of "specific ingredients and . . . common factors" (p.931) found in all effective treatments for PTSD, as shown in Table 1.

Cogent psychological rationale that is acceptable to patient
Systematic set of treatment actions consistent with the rationale
Development and monitoring of a safe, respectful, and trusting therapeutic relationship
Collaborative agreement about tasks and goals in therapy
Nurturing hope and creating a sense of self efficacy
Psychoeducation about PTSD
Opportunity to talk about trauma (i.e., tell stories)
Ensuring the patient's safety, especially if the patient has been victimized as in the case of domestic violence, neighbourhood violence, or abuse
Helping patients learn how to avoid revictimization
Identifying patient resources, strengths, survival skills and intra and interpersonal resources and building resilience
Teaching coping skills
Examination of behavioural chain of events
Exposure (covert in session and in vivo outside of session)
Making sense of traumatic event and patient's reaction to event
Patient attribution of change to his or her own efforts
Encouragement to generate and use social supports
Relapse prevention

Table 1: Possible Factors Important to Successful Treatments of PTSD (Wampold et al, 2010, p.931, reproduced with permission)

With respect to clinical practice in the United States, four main approaches are indicated for the treatment of PTSD, of which three can be considered variants of Cognitive-Behavioural Therapy (CBT). At the 'classic'

end of the cognitive-behavioural spectrum are Cognitive Processing Therapy (CPT), where "the primary focus of therapy is to modify beliefs about the meaning and implications of the traumatic event" (American Psychological Association, 2014a), and Present Centred Therapy (PCT), where the focus is on "altering present maladaptive relation patterns/behaviors . . . providing psychoeducation regarding the impact of trauma on the client's life, and . . . teaching the use of problem solving strategies" (American Psychological Association, 2014b). Neither of these involve any controlled exposure, or cognitive restructuring. Prolonged Exposure (PE), comprising "the gradual confrontation of the traumatic memory, including thoughts, objects, environments, and situations that remind [clients] of the trauma" (American Psychological Association, 2014c), forms the other recommended cognitive approach. Eye Movement Desensitization Reprocessing (EMDR) is also cited in the APA Division 12 list as an empirically supported treatment for PTSD (American Psychological Association, 2014d), though not without reference to ongoing controversy around its efficacy and mechanisms of action.

At present, no solid evidence exists for the efficacy of humanistic therapies with PTSD. In terms of UK health policy, National Institute for Clinical Excellence Guideline CG26 (2005) states 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])" (2005, p.4). As Harford (2013) highlighted, there remains "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 NHS and at local and national government levels" (p.27).

A meta-analysis conducted by Benish, Imel and Wampold (2008) found no evidence of superiority of one therapy over any other and found no significant difference in efficacy between therapies included in their meta-analysis. They concluded that "bona fide psychotherapies produce equivalent benefits for patients with PTSD." (p. 746). In light of this, it would seem reasonable to expect that TA therapy would also produce broadly comparable effectiveness in the treatment of PTSD.

Despite its chronicity, recovery rates amongst people receiving psychotherapy for PTSD are promising. A multidimensional meta-analysis of 26 studies on efficacy of psychotherapy (usually cognitive-behavioural therapy variants or EMDR, as discussed above) for PTSD conducted by Bradley, Greene, Russ, Dutra and Westen (2005) found that 67% of clients with PTSD who complete treatment will not meet diagnostic criteria at termination of therapy and 54% of clients would be considered 'improved' (indicating Reliable Change, but not Clinically Significant Change). These figures offer a useful benchmark for comparing the effectiveness of the TA delivered in this study with existing empirically supported therapies. Notwithstanding these encouraging measures, of the studies examined by Bradley et al. (2005), veterans with combat-related trauma tended not to fare so well from therapy and typically demonstrated a slightly lower recovery rate. This might be accounted for by the distinctive character and high prevalence of other harmful influences on veterans' mental health, not least of which are high rates of alcohol and substance addiction, perhaps exacerbated by a heavy drinking Cultural Parent (Drego, 1983) influence within the armed forces, personality and attachment problems arising from difficult childhoods prior to joining up, homelessness following discharge, relationship breakdowns whilst on duty and a lack of suitable treatment, recognition and reparation from the authorities in the immediate aftermath of their traumatic experiences.

Method

Participants

The participants were 15 white, British, male armed forces veterans between the ages of 32 and 64 years, all of whom had been medically diagnosed with PTSD by a physician or psychiatrist prior to the commencement of this study in accordance with *DSM IV* (American Psychiatric Association, 1994), or *ICD 10* (World Health Organisation, 1992) criteria, and had endured a variety of traumatic experiences while serving in the British armed forces.

All were living within a dedicated residential care facility with 24-hour staffing provision operated by an independent charity responsible for their accommodation, social care and day-to-day needs. This intensive support was necessary due to the severity of the veterans' PTSD symptoms, which, on account of the destructive impact on their relationships, livelihoods and ability to function safely in society, had rendered them homeless. Consequently, all the therapy examined by this study was conducted in a dedicated room within this same residential facility. 8 of the 15 veterans had recent histories of substance or alcohol addiction, which were managed by qualified professionals from other specialist agencies and monitored by the charity's key workers. Furthermore, all 15 men in the sample had additional medically diagnosed comorbid conditions (see Tables 2 & 3). This is perhaps unsurprising, given that they were all living in supported accommodation and exhibited severe functional impairment.

It is also worth noting that comorbidity, particularly with Axis One disorders (American Psychiatric Association, 1994) such as depression, anxiety and substance abuse, tends to be highly prevalent amongst individuals with PTSD, with up to 83% of individuals having at least one other comorbid condition (Breslau, Davis, Andreski & Peterson (1991). The presence of severe comorbidity needs to be taken into account when considering therapeutic outcomes with this sample.

Long-term Clients (52 sessions)						
Client	**Age**	**Comorbid Disorders**	**Childhood Trauma?**	**GAF at Session 0**	**Number of Sessions**	**Reason for termination**
A	54	300.21 Panic Disorder w/Agoraphobia	Y	44	52	N/A
B	39	296.89 Bipolar II Disorder, Depressed, Rapid Cycling	Y	30	52	N/A
C	48	301.0 Paranoid Personality Disorder 300.15 Dissociative Disorder NOS	Y	48	52	N/A
D	64	300.4 Dysthymic Disorder 300.21 Panic Disorder w/Agoraphobia	N	38	52	N/A
E	49	300.4 Dysthymic Disorder 300.02 Generalized Anxiety Disorder	N	51	52	N/A
F	38	301.0 Paranoid Personality Disorder 300.01 Panic Disorder	Y	41	34	Involuntary
G	54	301.4 Obsessive-Compulsive Personality Disorder 300.02 Generalized Anxiety Disorder	N	54	52	N/A
H	50	301.0 Paranoid Personality Disorder 300.01 Panic Disorder, 311 Depressive Disorder NOS	N	31	50	Involuntary

Table 2: Characteristics of sample undertaking long term therapy

Short-term Clients (24 sessions)						
Client	**Age**	**Comorbid Disorders**	**Childhood Trauma?**	**GAF at Session 0**	**Number of Sessions**	**Reason for termination**
I	40	301.9 Personality Disorder NOS 300.01 Panic Disorder	Y	39	22	Voluntary
J	35	301.0 Paranoid Personality Disorder 300.21 Panic Disorder w/Agoraphobia	N	37	24	Voluntary
K	58	300.01 Panic Disorder 300.02 Generalized Anxiety Disorder	Y	44	12	Voluntary
L	51	311 Depressive Disorder NOS 300.01 Panic Disorder	N	58	12	Voluntary
M	48	300.15 Dissociative Disorder NOS	Y	39	24	Voluntary
N	52	300.4 Dysthymic Disorder 300.21 Panic Disorder w/Agoraphobia	Y	36	24	Voluntary
O	32	300.01 Panic Disorder	Y	42	11	Voluntary

Table 3 Characteristics of sample undertaking short term therapy

Individual veterans were referred for psychotherapy based on non-clinical assessments of need by the operations manager and three key workers employed by the charity. Following the successful pilot project with an initial cohort of 6 male veterans (Harford, 2013), the charity decided to extend the TA psychotherapy provision indefinitely and, in addition to the pilot cohort, a further 9 male veterans agreed to participate in this full-scale study. In accordance with current ethical guidelines, all 15 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. Additional written consent was received from 8 of the 15 veterans to undergo the Change Interview (Elliott, Slatick, & Urman, 2001, as cited in Frommer & Rennie, 2001), having been given "clear and explicit" (Institute of Transactional Analysis, 2008, p.5) assurances that any information that might identify them would be omitted or anonymised in order to maintain complete confidentiality. All research was conducted using a naturalistic protocol within the same designated therapy room provided by the charity within their premises.

As can be seen in Table 2, 2 veterans terminated treatment involuntarily at the behest of the charity's management for reasons it is inappropriate to explain here. In addition, there were 8 veterans who received psychotherapy under the same arrangements and consented to provide quantitative data, but were excluded from this study: 3 did not meet criteria for a diagnosis of PTSD; 1 provided anomalous responses indicative of marked over-adaptation (Schiff & Schiff, 1971) to the therapist; 4 attended insufficient sessions for their responses to be deemed statistically valid. Another 5 veterans declined to participate in any aspect of this study from the outset of their treatment.

Therapy

As with the original pilot study (Harford 2013), the form of TA psychotherapy chosen was rooted primarily in the integrative TA model advanced by Erskine (1993) and Erskine and Trautmann (1996), with an emphasis on facilitating intrapsychic contact with dissociatively "encapsulated traumatic experiences, hidden needs" (Erskine, 1993, p.185) and 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). However, the authors were mindful of Cornell and Bonds-White's (2001) critique of the limitations of an over-reliance on the integrative model, with its attendant risk of promoting "a temporary, mutually gratifying narcissistic merger" (p.72) between therapist and client. Consequently, inspired by their support for Bollas' (1989) stance, which emphasises the need for "a balanced therapeutic process serving the dual functions of soothing and disturbing the client" (p.80), the integrative foundations of the treatment were augmented with a two-person (Stark, 2000) relational focus on the cotransferential (Summers and Tudor, 2000) domain, as pioneered by Hargaden and Sills (2002) and, later, applied to the treatment of trauma and PTSD by Stuthridge (2006, 2012) and Caizzi (2012). Here, the therapist observes, participates in and makes available for mutual analysis the "transferential enactments [that] provide a crucial voice for implicit relational patterns and excluded [or dissociated] ego states" (Stuthridge, 2006, p.277) and, through an iterative "process of attunement, rupture, and repair" (Stuthridge, 2006, p.277), slowly challenges and rewrites the client's traumatic script (Stuthridge, 2006). In this way, aided by strict observance of ethical and professional boundaries, the therapist (Harford) in this study was able to provide "the 'safe container' in which the [veterans could] begin to integrate" (Hargaden & Sills, 2002, p.29) their fragmented selves, rediscover lost skills and resources and begin to build mutually beneficial interpersonal relationships and more rewarding and meaningful lives.

There was also a strong psychoeducational component to the chosen therapeutic approach; this, in part, reflecting Erskine (1993) and Erskine and Trautmann's (1996) attention to depathologising, or normalising clients' symptoms as a subset of therapeutic involvement, whereby Adult assurance is provided that "the client's experience [of PTSD] is a normal defensive reaction . . . that many people would have if they encountered similar" (Erskine & Trautmann, 1996, p.325) traumatic events. In addition, several veterans had commented during their initial assessments that, although prescribed breathing exercises in the past, they had been disinclined to practice them independently as the clinicians involved had not explained their underlying neurophysiological purpose. Responding to this overt request for Adult information, a combination of Pomeroy's (1998) summary of neocortical versus limbic system function and Stuthridge's (2006) account of implicit, explicit and autobiographical memory systems was used to underpin a range of simple breathing and grounding exercises with the intention of supporting veterans to cultivate a mindful capacity to "observe the contents of their awareness without judgement and without letting themselves get caught up in or identified with any particular content of awareness" (Safran & Muran, 2003, p.210) and gradually "returning executive control to the Adult ego state and the neocortex" (Pomeroy, 1998, p.338).

Data Collection

Quantitative

A battery of measures was used to determine baseline severity of symptoms and their improvement over the course of therapy. These were the CORE-OM (Evans et al, 2000), PHQ-9 (Kroenke et al, 2001) and GAD-7 (Spitzer et al, 2006) questionnaires, which were administered every four sessions commencing with a pre-treatment ('Session 0') set of responses completed

between the initial assessment and first full treatment session. The CORE-OM is a "34 item generic measure of psychological distress, which is pan-theoretical . . . pan-diagnostic" (Core ims, 2003) and, therefore, readily applied to any TA psychotherapy context as a means of assessing mental well-being before, during and after treatment. This tool is widely used across the NHS and, also, among independent counselling and psychotherapy providers to evaluate the impact and effectiveness of a variety of mental health interventions. Gathered concurrently were total scores from the nine point PHQ-9 Depression Severity and seven point GAD-7 Anxiety Severity indicators; again, both widely used in a wide range of NHS and private settings and the latter, in particular, having been trialled successfully for clients presenting with PTSD (Kroenke, Spitzer, Williams, Monahan & Löwe, 2007). As well as generating numerical indicators of change in global distress and functioning, depressive symptoms and levels of anxiety for individual veterans, a mean figure was calculated for each questionnaire type across all 15 veterans and, in addition, for the 7 veterans identified as short-term clients (those receiving up to 24 sessions of treatment) and the other 8 veterans composing the long-term cohort (those receiving up to 52 sessions of treatment). Due to the small sample size, it is not possible to conduct detailed statistical analysis, or present inferential statistics. Instead, simple descriptive statistics will be used; more specifically, thresholds for Reliable Change and Clinically Significant Change for CORE-OM, PHQ-9 and GAD-7 which correspond with the established precedents detailed in the Appendix.

Qualitative

Of the total sample of 15 veterans, 8 individuals agreed to undertake a recorded semi-structured interview, separate to their ongoing treatment and conducted by the therapist at the same location. This consisted of a simplified version of the Change Interview (Elliott et al, 2001, as cited in Frommer & Rennie, 2001) lasting no longer than one hour. Compared with purely quantitative measures, the Change Interview "can be more sensitive to negative or unexpected effects while also allowing [researchers] to understand . . . [clients'] experience of therapy [via] questions about changes over therapy, and also questions about the processes that may have brought about change" (Elliott, Watson, Goldman & Greenberg, 2003). Of the 8 veterans who agreed to be interviewed, only 1 individual originated from the short-term (24 sessions) cohort, whereas 7 of the 8 veterans from the long-term (52 sessions) cohort gave their consent for the process. Once the therapist (Harford) had transcribed the 8 digital recordings and carefully anonymised, or omitted any identifying details that might compromise client confidentiality, the second author (Widdowson) examined the qualitative data using thematic analysis (Braun & Clarke, 2006). This is an inductive approach to data analysis whereby themes are extracted from the collated transcript material and is similar to grounded theory in that the data is not distorted to fit pre-existing hypotheses, or theories. Transcripts of the Change Interviews were read several times to immerse the researcher in the available data. The transcripts were then annotated with identifying codes which captured discrete concepts, or meanings evident in the participants' replies to the interviewer's questions. Once labelled, these codings were subjected to a process of constant comparison, whereby they were grouped repeatedly according to similarity so as to generate a number of salient themes. As this iterative process unfolded, progressively higher order themes were generated until all data had been accounted for, no further themes emerged and the data analysis was considered complete.

Data Auditing

In an effort to address the potential for bias and deficits in experimental validity highlighted by Wampold et al (2010), including those unintended distortions arising when "therapists have an allegiance to . . . treatments or are . . . supervised by researchers who have an allegiance" (p.930), and although the authors are both qualified practitioners in TA psychotherapy, only one (Harford) was involved in the clinical treatment, collection of questionnaires and interviewing of the veterans, while the other's (Widdowson) role was limited to carrying out the qualitative data analysis and co-authoring this paper. In the interests of enhancing the credibility and trustworthiness of the findings even further, the thematic analysis (Braun & Clarke, 2006) used to examine the qualitative data was checked and audited by Professor Caroline Hollins Martin from the University of Salford, who was selected on account of having neither personal, or professional allegiances to the topic or outcomes of this research. With respect to Wampold et al's (2010) latter concern, all clinical supervision for the therapist was obtained from an unconnected third practitioner.

Quantitative Results

Quantitative Results: Long-term clients (52 sessions)

See Tables 4, 5, 6 and Figures 1, 2 and 3.

CORE-OM: Pre-treatment levels of symptoms among all 8 veterans undergoing longer-term treatment were in the clinical range of severity, with 2 being classified as 'severe', 3 as 'moderate to severe', 2 as 'moderate' and 1 as 'mild' under the original scoring criteria (CORE ims, 2003). However, this rather mixed starting point is potentially misleading, as 2 of the 3 veterans beginning treatment with 'mild', or 'moderate' symptoms deteriorated to the 'severe' level within 8 sessions. As in the earlier pilot study (Harford, 2013), these results appear to accord with the researchers' 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. (Harford, 2013, p.28)

	SESSION NUMBER													
CLIENT	0	4	8	12	16	20	24	28	32	36	40	44	48	52
A	22.9	27.4	16.5	23.8	14.1	29.1	12.9	22.4	21.8	23.8	22.3	17.1	13.5	20.1
B	23.2	29.1	18.5	22.6	14.7	16.5	10.3	19.7	21.4	8.5	18.8	22.1	18.5	15.9
C	22.1	27.1	22.6	7.9	8.8	11.2	8.2	20	3.2	15	7.6	4.4	16.2	3.2
D	16.8	22.1	25.9	23.2	21.2	20	24.7	25.9	27.4	23.5	19.7	20.6	19.7	19.1
E	25.6	19.7	18.2	14.1	21.8	22.9	23.8	22.9	24.4	25	22.3	23.5	21.8	20
F	12.1	13.5	26.2	23.8	21.8	20.6	25	20.6	12.9					
G	15.6	15.6	11.8	16.8	10.3	17.9	19.7	8.8	9.4	22.6	19.4	7.4	10.9	13.8
H	28.5	28.8	28.2	25.6	25.3	30.6	29.7	27.1						
MEAN	20.9	22.9	21	19.7	17.3	21.1	19.3	20.9	17.2	19.7	18.4	15.9	16.8	15.4

Table 4: Mean Clinical Core-OM score: 8 long-term clients

	SESSION NUMBER													
CLIENT	0	4	8	12	16	20	24	28	32	36	40	44	48	52
A	17	24	18	21	13	24	7	16	14	17	19	14	12	14
B	16	14	18	19	18	16	12	17	20	12	12	15	11	11
C	21	18	14	4	4	8	2	16	3	9	6	6	16	2
D	16	16	20	19	18	18	21	23	24	21	19	21	19	17
E	20	15	9	11	15	19	16	20	21	16	20	18	12	13
F	16	12	18	19	22	18	9	9	2					
G	6	10	10	12	7	11	15	5	8	17	14	6	8	7
H	21	23	22	18	17	21	21	21						
MEAN	16.6	16.5	16.1	15.4	14.3	16.9	12.9	15.9	13.1	15.3	15	13.3	13	10.7

Table 5: Mean PHQ-9 score: 8 long-term clients

	SESSION NUMBER													
CLIENT	0	4	8	12	16	20	24	28	32	36	40	44	48	52
A	19	19	13	16	8	20	12	14	14	20	13	12	9	14
B	20	9	17	21	13	18	11	15	20	9	12	14	9	11
C	19	18	14	4	4	14	0	16	2	12	5	0	15	1
D	15	14	17	16	16	14	17	17	18	17	14	16	14	13
E	11	9	6	5	12	12	14	14	12	13	13	12	7	7
F	9	8	21	17	17	12	15	9	9					
G	10	6	5	12	3	10	13	6	9	11	12	6	6	9
H	17	17	17	15	17	16	17	16						
MEAN	15	12.5	13.8	13.3	11.3	14.5	12.4	13.4	12	13.7	11.5	10	10	9.2

Table 6: Mean GAD-7 score: 8 long-term clients

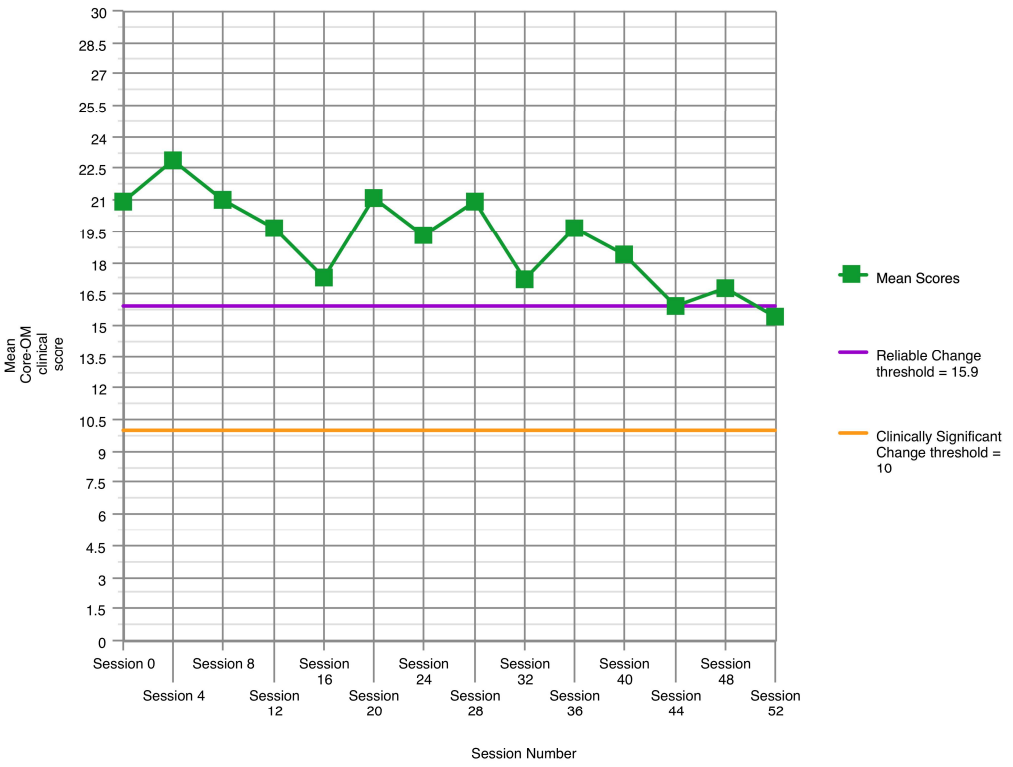

Figure 1: Table 4: Mean Clinical Core-OM score: 8 long-term clients

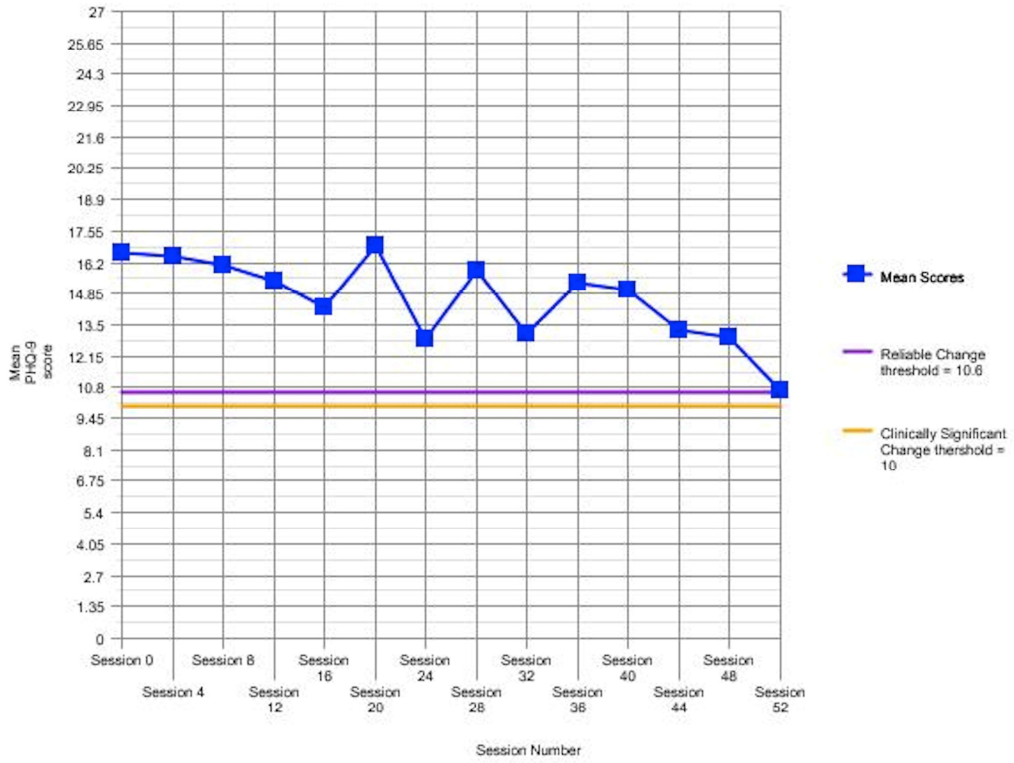

Figure 2: Table 5: Mean PHQ-9 score: 8 long-term clients

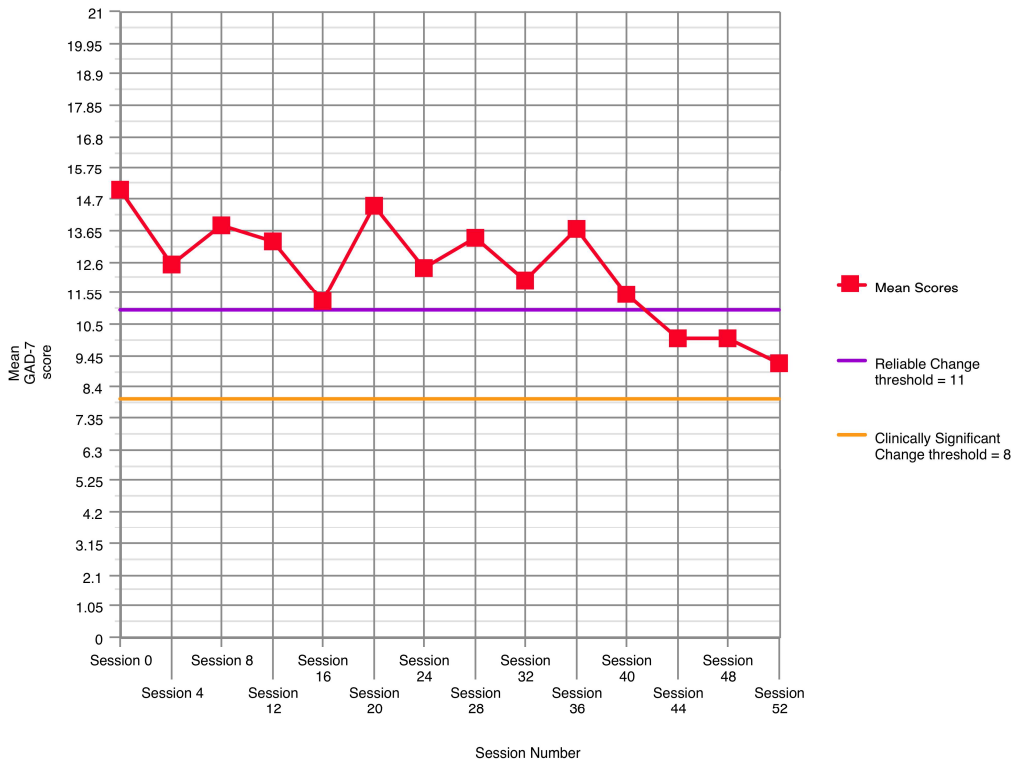

Figure 3: Table 6: Mean GAD-7 score: 8 long-term clients

After 52 sessions, the mean clinical CORE-OM score demonstrates Reliable Change with an improvement of 5.5 over the course of treatment. Client C, in particular, shows a dramatic improvement and attains Clinically Significant Change with a reduction of 18.9 to a level well below the clinical cut-off. Even those veterans whose pre-treatment and final scores are ostensibly less encouraging display marked improvements after reaching their peak scores, a pattern which might be accounted for by the gradual “dissolution of fixated contact-interrupting [dissociative] defenses” (Erskine, 1993, p.190) and reintegration of repressed affect alluded to in Harford (2013) above. From this latter perspective, the results for all but 1 veteran (H) could be interpreted as evidencing Reliable Change, with Client C remaining the sole example of Clinically Significant Change. Generally speaking, then, it appears that the veterans' overall mental well-being has improved significantly to a level beyond that which could be accounted for by nonclinical factors (e.g. measurement error), but only in 1 case to the extent of a nonclinical score comparable with the so-called “normal” population.

PHQ-9: Pre-treatment symptoms of depression for the long-term veteran cohort were in the clinical range of severity in all but 1 case, with 3 veterans meeting the scoring criteria for 'major depression (severe)' and another 4 sitting within the 'major depression (moderate)' category, as defined by Kroenke et al (2001). After 52 sessions, the mean PHQ-9 score falls short by a tiny margin of the chosen Reliable Change threshold with an improvement of 5.958333, rather than the required 6.0, assuming neither Session 0 nor Session 52 figures are adjusted to one decimal place. Again, Client C alone evidences Clinically Significant Change with a sharp reduction of depressive symptoms to a point well within a nonclinical classification, although not without pronounced spikes at Sessions 28 and 48, which, with reference to the Change Interview data summarised later, may reflect the negative impact of extra-therapeutic factors during these phases of treatment. 2 veterans (E and F) show Reliable Change based on Kroenke et al's (2001) criteria, while, if the previous point regarding measurement from peak scores onwards is taken into account, the results from a further 2 clients (A and B) could also be argued to demonstrate Reliable Change.

Although these results are less convincing in their support for the authors' hypothesis that 'TA psychotherapy can be an effective treatment for PTSD in ex-servicemen and women', the shortfall is minimal and it is worth considering that consistent Reliable Change, or even Clinically Significant Change may yet be attained by further veterans, as their course of treatment in 5 cases has continued beyond 52 sessions.

GAD-7: Pre-treatment symptoms of anxiety for the long-term cohort were all in the clinical range of severity, with 5 veterans meriting a 'severe' classification, another 2 presenting at the 'moderate' level and 1 displaying 'mild' anxiety in accordance with Spitzer et al's (2006) scale. After 52 sessions, the mean GAD-7 score reduced by 5.8, which exceeds the chosen threshold for Reliable Change. Once again, Client C is the sole veteran achieving Clinically Significant Change, improving from 'severe' anxiety levels at Session 0 to a near perfect nonclinical score of 1 by Session 52, although, again, with marked setbacks at Sessions 28 and 48. 3 veterans (A, B and E) demonstrate Reliable Change based on Spitzer et al's (2006) criteria, while another client (F) might conceivably be seen as evidencing Reliable Change if measurement from peak scores onwards is permitted, as suggested earlier. As with the CORE-OM values, the GAD-7 results for the long-term veteran cohort appear to provide strong supporting evidence that it was the course of TA psychotherapy, rather than any nonclinical factors, that facilitated this upswing in the veterans' mental well-being.

Quantitative Results: Short-term clients (24 sessions):

See Tables 7, 8 9 and Figures 4, 5 and 6.

CORE-OM: Pre-treatment symptom levels among all 7 veterans undergoing short-term treatment were in the clinical range of severity, with 5 being ranked as 'severe', 1 as 'moderate to severe' and 1 as 'moderate' under the established scoring criteria (CORE ims, 2003). After 24 sessions, the mean clinical CORE-OM score demonstrates Reliable Change with an improvement of 7.8 over the course of treatment, though with a noticeable reduction in the rate of positive change from Session 12 onwards. Client L, in particular, exhibits a dramatic improvement and attains Clinically Significant Change with a reduction of 14.4 to a level far below the clinical cut-off. In summary, it appears that the veterans' overall mental well-being has been enhanced significantly over 24 sessions to levels beyond that which could be explained by nonclinical factors, but, again, only in 1 case to a degree comparable with the 'normal' population.

PHQ-9: Pre-treatment symptoms of depression among the 7 veterans in the short-term cohort were all in the clinical range of severity, with 4 veterans meriting a 'major depression (severe)' designation, 1 falling within the 'major depression (moderate)' category and the other 3 exhibiting 'dysthymia, minor depression, major depression (mild)', as defined by Kroenke et al (2001). However, as with the clinical CORE-OM results for the long-term cohort, the individual veterans' scores deserve closer inspection, as Client I commences treatment in the 'dysthymia, minor depression, major depression (mild)' band, but deteriorates to the 'major depression (severe)' level within 4 sessions. Though less prominent than that present in the long-term CORE-OM scores, this slight variance in the short-term PHQ-9 results would appear to offer a modicum of additional support for Harford's prediction " . . . 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." (Harford, 2013, p.28)

After 24 sessions, the mean PHQ-9 score falls just short of Reliable Change with a reduction of 5.0, rather than the necessary 6.0 required to surpass the reference threshold. This appears to be the consequence of an increase in depressive symptoms from Session 20 onwards, which coincides with a slowing of respective recovery rates for the short-term mean clinical CORE-OM and GAD-7 measurements. Nevertheless, examined individually, Client L achieves Clinically Significant Change with a reduction in symptoms to a position well within a nonclinical classification, albeit from a lower pre-treatment score. Meanwhile, in arguably a more impressive turnaround, Client J completed his 24 sessions at the clinical cut-off score of 10 having commenced treatment in the 'major depression (severe)' category at 22. Including this latter marginal case, then, 3 veterans (I, J and M) attain Reliable Change based on Kroenke et al's (2001) benchmark, while, if the previous point regarding measurement from peak scores onwards is taken into account, the results gathered from Client I can be viewed as a further instance of Clinically Significant Change.

In parallel with the PHQ-9 figures for the long-term veteran cohort, these short-term results provide somewhat less support for the authors' research hypothesis, but, again, the deficit is relatively small and it is possible that Reliable Change, or even Clinically Significant Change may have been attained by more veterans had their course of treatment continued up to 24 sessions and beyond.

GAD-7: Pre-treatment symptoms of anxiety for the short-term cohort were all in the clinical range of severity, with 5 veterans occupying the 'severe' category, 1 at 'moderate' level and 1 evidencing 'mild' symptoms based on Spitzer et al's (2006) codings. After 24 sessions, the mean GAD-7 score reduced by 4.6, which satisfies the conditions for Reliable Change, although it is worth noting that a mean improvement of 5.1 was achieved by Session 12. Once again, Client L was the only veteran to demonstrate Clinically Significant Change outright, arriving at a near perfect nonclinical score of 1 by Session 12, albeit from a 'mild' pre-treatment initial measurement. However, Client M finished treatment right on the GAD-7 clinical cut-off with a score of 8 having begun in the 'severe' category at 16, which could be seen as a more impressive outcome. Applying a strict reading of the conditions for Clinically Significant Change, then, 4 veterans (I, K, M and N) achieved Reliable Change using Spitzer et al's (2006) criteria, though it is conceivable that Clients J and N might have attained similar outcomes had their treatment advanced beyond 24 sessions. In summary, the GAD-7 results for the

	SESSION NUMBER						
CLIENT	0	4	8	12	16	20	24
I	28.5	24.7	25	23.5	23.5	18.8	
J	28.5	22.1	17.9	20	16.8	18.2	17.9
K	29.1	23.5	23.5	22.1			
L	19.4	7.1	11.2	5			
M	23.2	16.2	18.8	10.6	14.4	16.8	16.2
N	28.2	28.2	26.2	23.2	22.6	20.9	21.6
O	27.6	17.4	20				
MEAN	26.4	19.9	20.4	17.4	19.3	18.7	18.6

Table 7: Mean Clinical Core-OM score: 7 short-term clients

	SESSION NUMBER						
CLIENT	0	4	8	12	16	20	24
I	14	20	18	18	14	8	
J	22	13	7	12	6	12	10
K	23	21	22	19			
L	13	10	10	5			
M	22	15	18	10	7	12	14
N	22	22	22	18	20	20	18
O	17	13	12				
MEAN	19	16.3	15.6	13.7	11.8	13	14

Table 8: Mean PHQ-9 score: 7 short-term clients

	SESSION NUMBER						
CLIENT	0	4	8	12	16	20	24
I	19	16	14	15	14	10	
J	14	13	9	12	18	13	11
K	18	17	15	12			
L	9	4	6	1			
M	16	11	17	11	7	10	8
N	18	16	17	16	15	16	16
O	20	10	12				
MEAN	16.3	12.4	12.9	11.2	13.5	12.3	11.7

Table 9: Mean GAD-7 score: 7 short-term clients

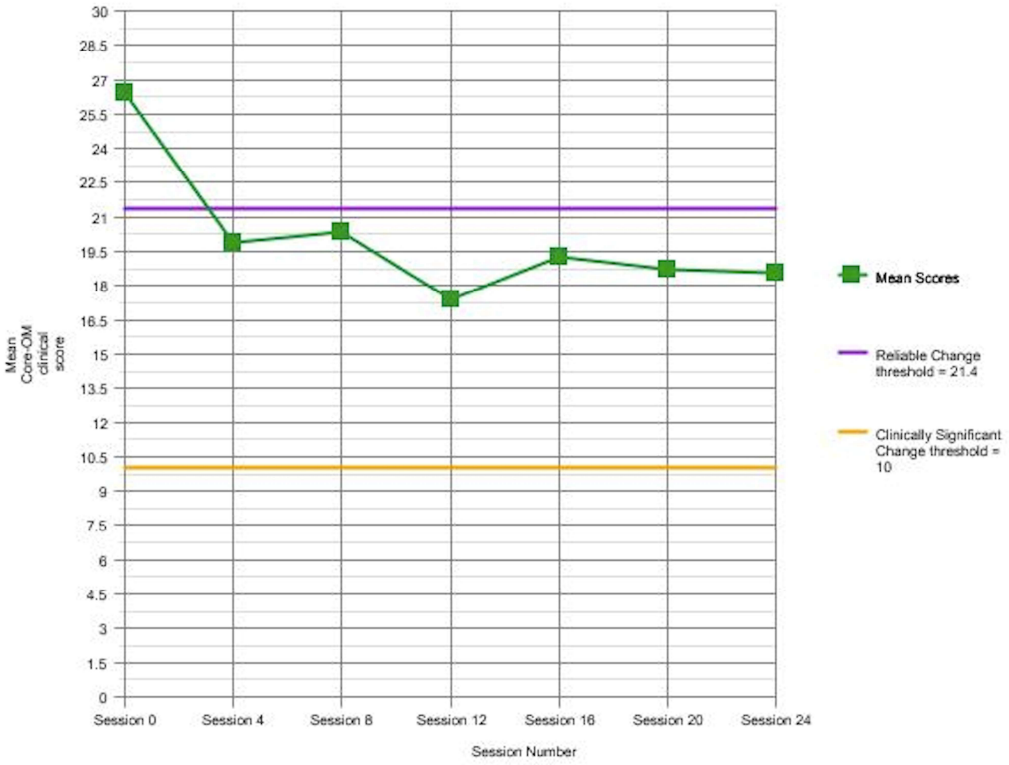

Figure 4: Mean Clinical Core-OM score: 7 short-term clients

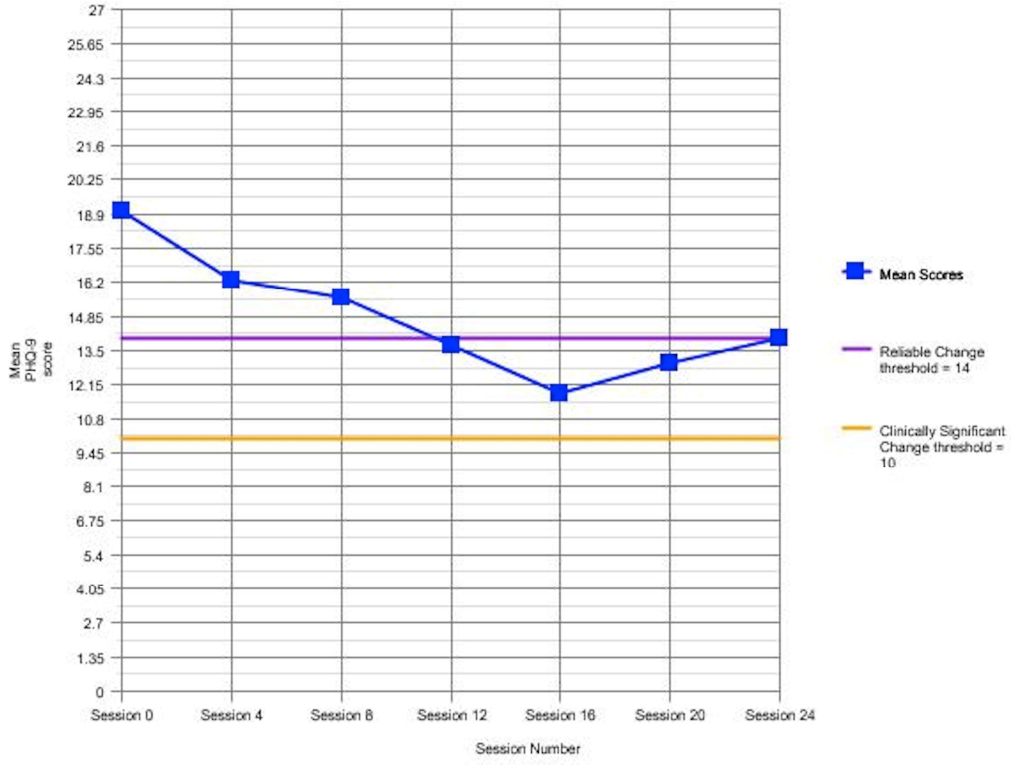

Figure 5: Mean PHQ-9 score: 7 short-term clients

Figure 6: Mean GAD-7 score: 7 short-term clients

short-term cohort furnish further evidence that it was the course of TA psychotherapy, rather than nonclinical factors that elicited these improvements in the veterans' mental welfare.

Quantitative Results: All clients (24 session and 52 session cohorts combined):

See Tables 10, 11, 12 and Figures 7, 8 and 9

CORE-OM: After 52 sessions, the mean clinical CORE-OM scores for all 15 veterans demonstrate Reliable Change with an improvement of 8.0 over the course of treatment, though with several setbacks between Sessions 20 and 36 - an intriguing phenomenon echoed in the mean clinical CORE-OM scores for the 8 veterans receiving long-term treatment. Overall, compared with the results for the long-term and short-term veteran cohorts, the combined figures for overall mental well-being also signify a marked improvement beyond that which could be accounted for by nonclinical factors, and are broadly consistent with both the rate and extent of positive change for the 24 session and 52 session groups.

PHQ-9: Unlike the results for the short-term and long-term cohorts, the mean PHQ-9 scores for all 15 veterans after 52 sessions meet the criteria for Reliable Change convincingly with a reduction of 7.0. Furthermore, the reduction in depressive symptoms is, again, reasonably consistent and features the same uneven phase between Sessions 20 and 36 found in both the mean PHQ-9 scores for the long-term cohort and the clinical CORE-OM scores mentioned above. These temporary anomalies may also help to explain the apparent deterioration of depressive symptoms from Session 20 onwards in the PHQ-9 results for the short-term veteran cohort and, consequently, the authors were inclined to speculate whether some of the negative extra-therapeutic influences outlined in the various Change Interview (Elliott et al, 2001, as cited in Frommer & Rennie, 2001) responses might have contributed to this episodic variance.

GAD-7: As with the encouraging amelioration of symptoms indicated by the clinical CORE-OM and PHQ-9 results above, the mean GAD-7 scores for all 15 veterans across 52 sessions reduced by 6.4, which more than satisfies the chosen conditions for Reliable Change. Once again, there is an unsettled period of renewed anxiety between Sessions 20 and 36, which could be accounted for by extra-therapeutic factors, such as the destabilising impact of benefits assessments, conflict between staff and service users within the residential care facility and other detrimental influences alluded to in the following qualitative data.

	SESSION NUMBER													
CLIENT	0	4	8	12	16	20	24	28	32	36	40	44	48	52
A	22.9	27.4	16.5	23.8	14.1	29.1	12.9	22.4	21.8	23.8	22.3	17.1	13.5	20.1
B	23.2	29.1	18.5	22.6	14.7	16.5	10.3	19.7	21.4	8.5	18.8	22.1	18.5	15.9
C	22.1	27.1	22.6	7.9	8.8	11.2	8.2	20	3.2	15	7.6	4.4	16.2	3.2
D	16.8	22.1	25.9	23.2	21.2	20	24.7	25.9	27.4	23.5	19.7	20.6	19.7	19.1
E	25.6	19.7	18.2	14.1	21.8	22.9	23.8	22.9	24.4	25	22.3	23.5	21.8	20
F	12.1	13.5	26.2	23.8	21.8	20.6	25	20.6	12.9					
G	15.6	15.6	11.8	16.8	10.3	17.9	19.7	8.8	9.4	22.6	19.4	7.4	10.9	13.8
H	28.5	28.8	28.2	25.6	25.3	30.6	29.7	27.1						
I	28.5	24.7	25	23.5	23.5	18.8								
J	28.5	22.1	17.9	20	16.8	18.2	17.9							
K	29.1	23.5	23.5	22.1										
L	19.4	7.1	11.2	5										
M	23.2	16.2	18.8	10.6	14.4	16.8	16.2							
N	28.2	28.2	26.2	23.2	22.6	20.9	21.6							
O	27.6	17.4	20											
MEAN	23.4	21.5	20.7	18.7	17.9	20.3	19.1	20.9	17.2	19.7	18.4	15.9	16.8	15.4

Table 10: Mean Clinical Core-OM score: all clients

	SESSION NUMBER													
CLIENT	0	4	8	12	16	20	24	28	32	36	40	44	48	52
A	17	24	18	21	13	24	7	16	14	17	19	14	12	14
B	16	14	18	19	18	16	12	17	20	12	12	15	11	11
C	21	18	14	4	4	8	2	16	3	9	6	6	16	2
D	16	16	20	19	18	18	21	23	24	21	19	21	19	17
E	20	15	9	11	15	19	16	20	21	16	20	18	12	13
F	16	12	18	19	22	18	9	9	2					
G	6	10	10	12	7	11	15	5	8	17	14	6	8	7
H	21	23	22	18	17	21	21	21						
I	14	20	18	18	14	8								
J	22	13	7	12	6	12	10							
K	23	21	22	19										
L	13	10	10	5										
M	22	15	18	10	7	12	14							
N	22	22	22	18	20	20	18							
O	17	13	12											
MEAN	17.7	16.4	15.9	14.6	13.4	15.6	13.2	15.9	13.1	15.3	15	13.3	13	10.7

Table 11: Mean PHQ-9 score: all clients

	SESSION NUMBER													
CLIENT	0	4	8	12	16	20	24	28	32	36	40	44	48	52
A	19	19	13	16	8	20	12	14	14	20	13	12	9	14
B	20	9	17	21	13	18	11	15	20	9	12	14	9	11
C	19	18	14	4	4	14	0	16	2	12	5	0	15	1
D	15	14	17	16	16	14	17	17	18	17	14	16	14	13
E	11	9	6	5	12	12	14	14	12	13	13	12	7	7
F	9	8	21	17	17	12	15	9	9					
G	10	6	5	12	3	10	13	6	9	11	12	6	6	9
H	17	17	17	15	17	16	17	16						
I	19	16	14	15	14	10								
J	14	13	9	12	18	13	11							
K	18	17	15	12										
L	9	4	6	1										
M	16	11	17	11	7	10	8							
N	18	16	17	16	15	16	16							
O	20	10	12											
MEAN	15.6	12.5	13.3	12.4	12	13.8	12.2	13.4	12	13.7	11.5	10	10	9.2

Table 12: Mean GAD-7 score: all clients

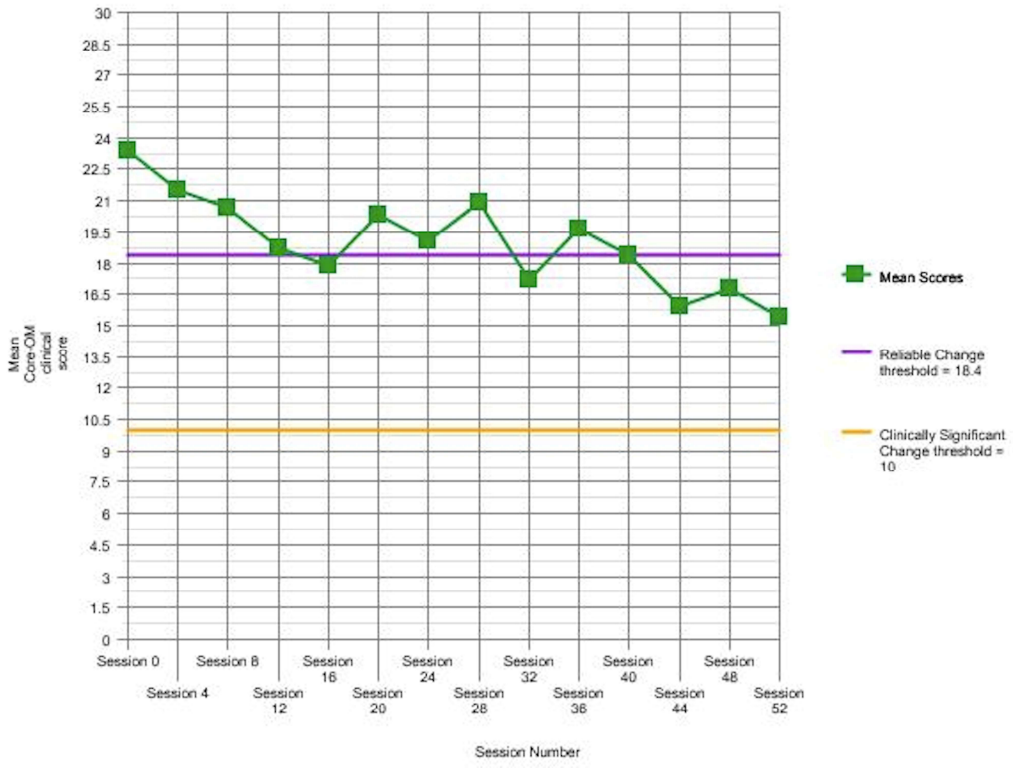

Figure 7: Mean Clinical CORE OM Score: all clients

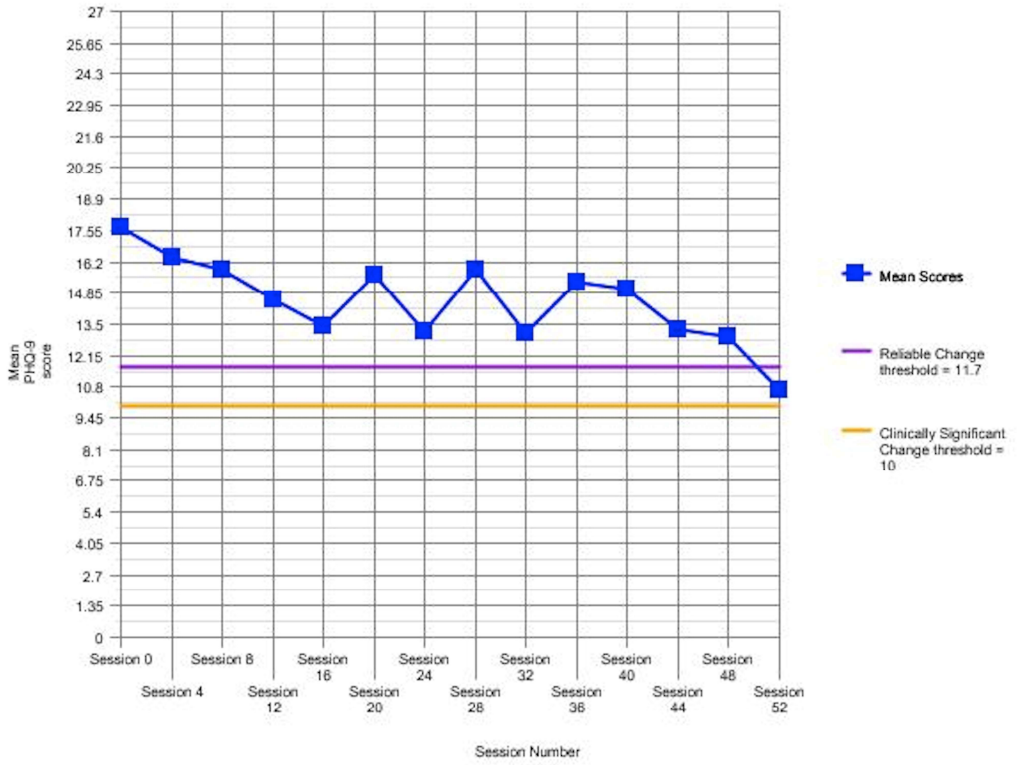

Figure 8: Mean PHQ-9 score: all clients

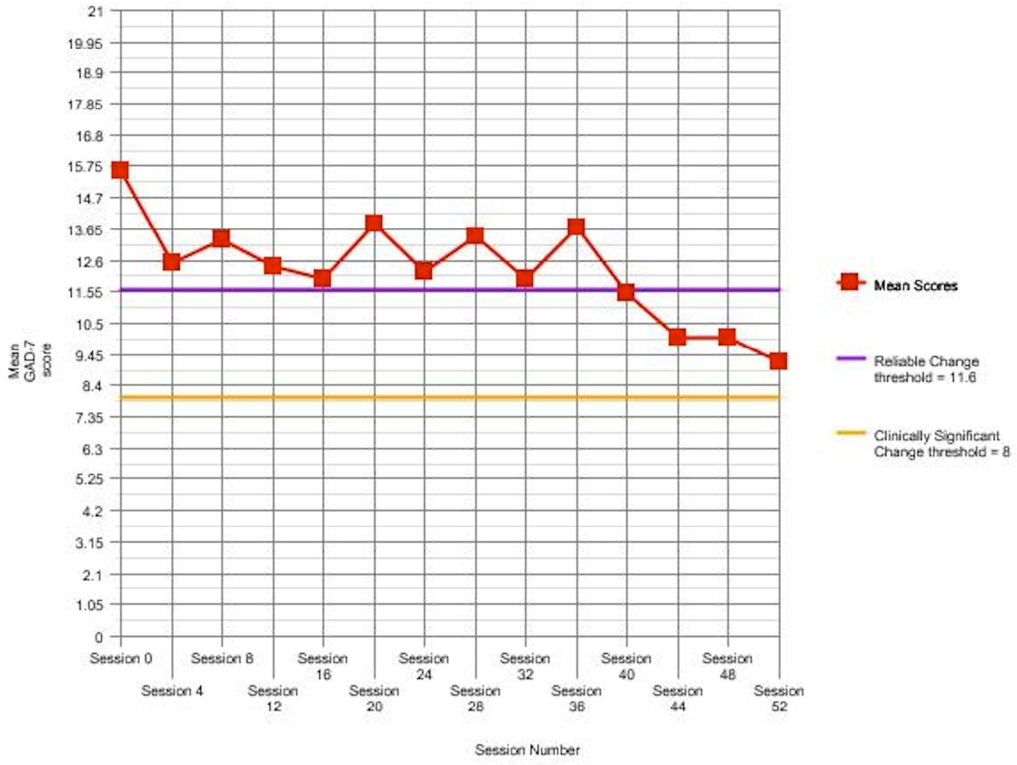

Figure 9: Mean GAD-7 score: all clients

Qualitative Results

Qualitative Results: Client Changes, Outcomes of TA Psychotherapy

As an integral part of their Change Interviews (Elliott et al, 2001, as cited in Frommer & Rennie, 2001), the 8 participating veterans were asked to describe the predominant intrapsychic and interpersonal changes they had noticed since commencing TA psychotherapy. The collated transcripts revealed considerable depth, range and specificity to the positive changes the veterans had experienced and, having been subjected to thematic analysis (Braun & Clarke, 2006), were grouped into conceptual categories by the second author (Widdowson). As depicted in Table 13, three of these conceptual categories referred to 'Interpersonal Changes', though, within this overarching classification, discrete clusters of subsidiary changes were also identified; all of which were sufficiently distinct to warrant separate sub-categorisation and consideration on their own merits.

Note: numbers after the items relate to the number of veterans who *specified that particular change*

Interpersonal Changes: Increased Assertiveness	**Interpersonal Changes: Improved Communication**	**Interpersonal Changes: Improved Relationships**
Assertiveness and willingness to challenge others appropriately (4)	Improved communication (4)	Improved (sexual) relationships (2)
Asking for what I want and asking for help (2)	Interpersonal learning	Have developed friendships (4)
	Better listening skills	Positive feedback from family about how I'm doing
	Increased openness, empathy and connection with others (2)	Developed trust in therapist
Symptom Reduction	**Improved Coping**	**Increased Well-Being**
Improvement in PTSD symptoms (2)	Improved coping strategies (3)	Increased optimism (4)
Greater understanding of origins of PTSD symptoms	Increased flexibility in responding to life situations	Decreased pessimism
Reduced hypervigilance		Increased confidence (2)
Reduced sense of threat from others		Greater activity and engagement in the world (2)
Made peace with the past (2)		Increased motivation to pursue activities (2)
Reduced depression symptoms		Improved self-care
Fewer disturbing dreams		Ready to move to independent living
Reduced alcohol consumption (2)		
Reduced suicidality		
Reduced hyperactivity		
Increased Affect Regulation	**Improved Cognitive Functioning**	**Self-awareness**
More able to manage anxiety (5)	Thinking more clearly and reduced confusion	Increased self-awareness (5)
Increased ability to manage my feelings	Improved reasoning and making sense of things (2)	Increased self-reflection (2)
Better anger management (3)	Reduced paranoid ideation	Normalisation of symptoms, PTSD symptoms are understandable
More willing to show my feelings	Less jumping to conclusions and black-and-white thinking	
Feeling stronger and more stable (2)	Reduced rumination and dwelling on things	
Increased awareness of emotions (2)		

Table 13: Conceptual Categories of Change for 8 Veterans' Change Interview Responses (after Braun & Clarke, 2006)

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Superordinate Themes

Three superordinate themes were classified, each with sub themes, as shown in Tables 10, 11 and 12.

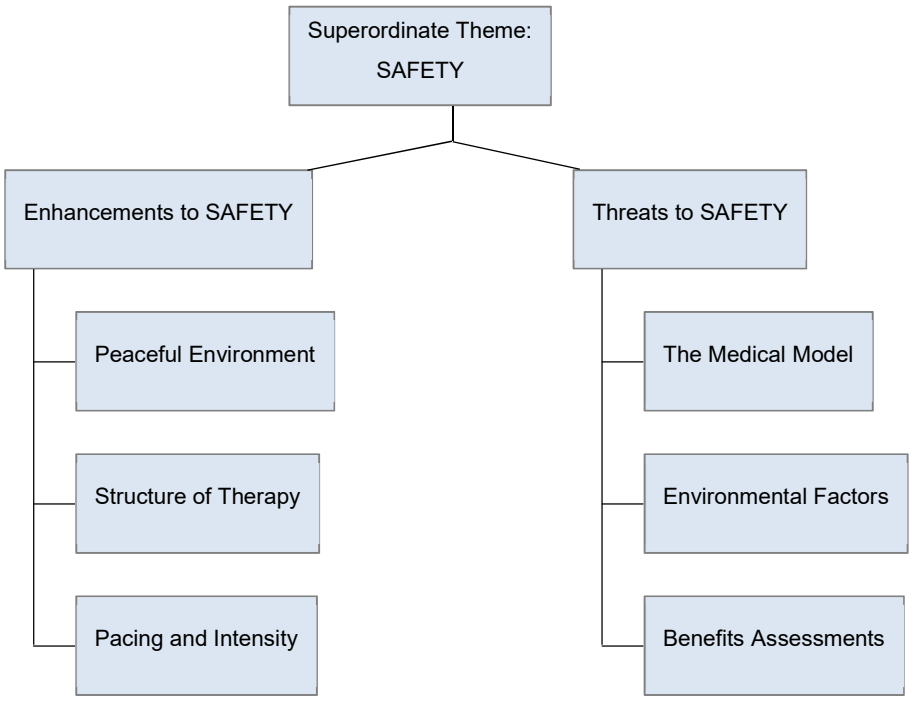

Figure 10: Themes related to Safety

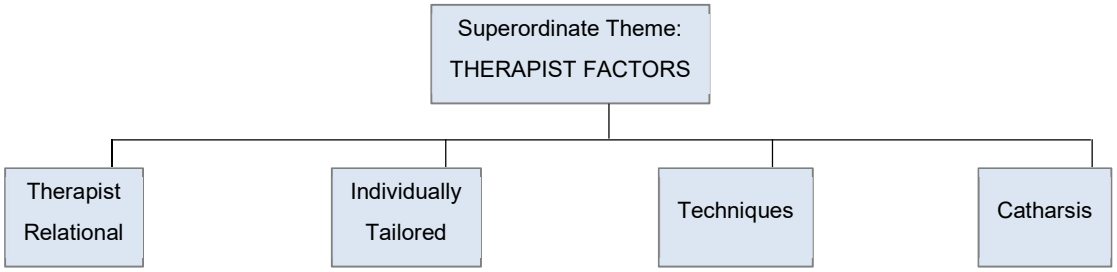

Figure 11: Superordinate Theme 2: Therapist Factors:

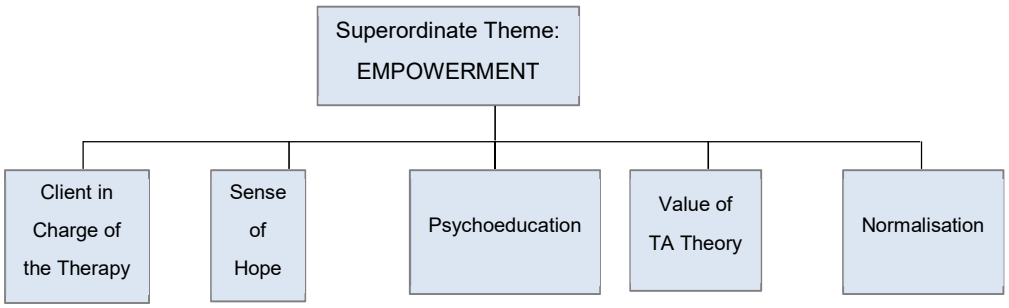

Figure 12: Superordinate Theme 3: Empowerment

Qualitative Results: Psychotherapy Process Factors

Superordinate Theme 1: Safety

The issue of client safety was prominent in all 8 of the veterans' transcripts and highlights the vital importance of the therapist supplying robust and consistent Protection (Crossman, 1966) when working with such a vulnerable group of people. Here are just two examples of this paramount concern:

Client F9: "*Whatever day I leave therapy, its kind of given me a boost for the day . . . and kind of a new energy . . . It's helped me to do things that otherwise I wouldn't have done . . . to be more outgoing, or to go for a walk . . . if I didn't feel like going for a walk, to know that it's safe enough to go for a walk, without being judged*".

Client C4: "*While I'm talking to you I feel safe. So, in a way, my little bubble that's around me has . . . been extended and . . . it's around the both of us, so, I actually feel . . . as safe as I would do inside my own little bubble . . . But, because I've now got you inside, I'm able to think about widening that bubble to include . . . other people and my interactions with them. Whereas, beforehand, I wouldn't even have thought of doing that*".

1.1 Enhancements to Safety

1.1.1. Theme: Peaceful Environment: Several veterans described how much they valued the calm and peaceful environment provided not only in their residential unit, but specifically in the therapy room. Sub-themes relating to the therapy room included that it was quiet and free from distractions and that it featured some decorative additions introduced by the therapist (e.g. soothing pictures on the walls) which encouraged them to express themselves. Sub-themes of safety relating to the residential unit included that it was a safe place for them to live, where they could get their physical needs attended to (e.g. meals and laundry) and where they had an allocated key worker who could support them with everyday tasks of living. It is worth noting, however, that some veterans reported feeling "unsafe" in the residential unit and commented on several destabilising and distressing factors.

Client D8: "*A quiet room, and no-one else around . . . It does build up a wall of safety, if you want, yes . . . a sense of security*".

Client G7: "*Totally relaxing, a neutral room . . . It's not walking into that . . . hospital environment, you know, the full suit and the name badges . . . The relaxing interaction, the whole environment of the room makes a big difference*".

1.1.2. Theme: Structure of therapy: There were several indications that the structure, or as Drego (1983) would say, "the technicality, or, Adult type contents . . . the actual organization" (p.225), of the therapy provided had a clear relationship to the sense of psychological safety the veterans experienced during their sessions. Sub-themes included the weekly frequency and dependable regularity of the therapy, which they felt was "*just right*", and that the individual therapy format was easier to tolerate and, therefore, preferable to group therapy, as illustrated below:

Client D4: "*The one-to-one sessions, as opposed to . . . group sessions, or whatever . . . [For] someone that's shy, or is reluctant to talk about it, it's easier to talk face-to-face than in a group", "Over time, it . . . builds up one's confidence*".

Client A7: "*It was weekly, so it was consistent . . . It was consistently getting better, so, you could see the changes*".

Client B4: "*It's actually got better, because of my routine . . . To start the week, just that . . . session with yourself is brilliant, because it sets me up for the week, you know . . . It gives me a head check for the full week*".

These findings in relation to the structural characteristics of therapy provision are likely to be particularly useful to practitioners who may be planning on developing such services themselves and might serve as a guide to the preferred format for delivering treatment.

1.1.3. Theme: Pacing and Intensity: All 8 veterans mentioned that the pacing and intensity of the therapy were crucial to their engagement, their sense of safety and, thereby, the likelihood of beneficial outcomes emerging from the process. This appears to underline Rothschild's (2000) cardinal advice that a competent and safe therapist should "know where the brakes are, and how to use them, before one applies the accelerator" (p.79). One key sub-theme was the therapist's ability to regulate the client's affect by, in turn, heightening and tempering the emotional intensity of the therapy, which, as referred to earlier, accords with Bollas' (1989) endorsement of "a balanced therapeutic process serving the dual functions of soothing and disturbing the client" (Cornell & Bonds-White, 2001, p.80). A further sub-theme alluded to the therapist's attention to carefully pacing and regulating the veterans' disclosures. As evidenced below, this cautious approach was particularly welcome when applied to the disclosure of traumatic events witnessed, or experienced under combat conditions and the resultant obligation of the veterans to conceal official military secrets:

Client D5: "*But . . . you've stopped it and changed tack, when you saw it was getting a bit . . . too much for me", "You didn't press, and that was good, 'cause you saw it was too . . . stressful, I suppose", "You knew . . . the boundary*".

Client E10: "*I'm quite happy with the pace it's going along with . . . So, I can just take my time and just . . . it helps to digest it over the week, you know, think about things and how it all fits in*".

Client D6: "*You were sensitive not to . . . delve into the details and what have you of various . . . situations regarding military service", "You seem to know . . . where to draw the line . . . without pushing, or invading into that side that one cannot talk about*."

1.2. Threats to Safety

At the opposing end of the spectrum, several transcripts contained references to a number of threats to the veterans' sense of safety. These were progressively grouped into the following themes:

1.2.1 Theme: The Medical Model: 3 veterans described negative prior experiences with general practitioners and mental health professionals operating from the medical model of pathology and intervention. The following excerpts, in particular, suggest that the veterans found a purely symptom-based treatment approach to be depersonalised and, therefore, detrimental to their welfare:

Client G15: "*What I found with the clinical approach, especially when I came out of the army and it probably was PTSD . . . they were labelling [with diagnoses], you know, which you've never done with me, as such . . . That's all they looked at. They never tried to see a broader picture . . . You've helped me put [my PTSD] into context with a lot of other things; family, acquired head injury . . . things we've eliminated, or gone over*".

Client A24: "*All they're treating is . . . 'Right, OK, you're not sleeping. Right, we'll give you sleeping tablets. OK, you're feeling depressed, OK we'll give you that mirtazapine. All they're doing is treating the symptoms. They're not looking at the bigger picture*".

Furthermore, the absence of continuity of care and poor communication between mental health services, or successive practitioners was a serious problem for 1 veteran:

Client B22: "*Every time, it was a different psychiatrist . . . They had this file, and then they just said, you know, 'How are you today, [name]?' . . . It was just not going anywhere*".

1 veteran commented extensively on several negative experiences he had endured with other therapeutic approaches and modalities attempted in the past:

Client G26: *"I personally couldn't have any of this . . . brick wall approach, like EMDR, that type of thing . . . purely technique-y type of stuff . . . I couldn't have a technique that says, 'Right, we're forgetting about [me], we're forgetting about the past and family', that transactional [analysis] approach . . . other factors, 'You're here to talk about combat stress. Right, what did you do in the [conflict zone]? How many people did you see get killed?' This, that and other . . . You cannot do that! . . . Mechanical . . . It's too fast; it's too in-your-face".*

This extract also highlights the need for appropriate pacing and intensity of therapeutic interventions so as to "minimize the potential for reinforcing [trauma] through iatrogenic shaming" (Widdowson, 2010, p.240) and, further, the need to create an individually tailored therapy for each client.

1.2.2. Theme: Environmental Factors: Several veterans commented on extra-therapeutic factors deriving from their living environment which exerted a negative impact on their mental well-being and, consequently, inhibited their progress in treatment. In relation to their fellow veterans and, more specifically, the effects of institutionalisation, four of the men described how conflict between residents could have a destabilising effect on everyone living in the unit. In addition, despite generally positive comments about the residential care facility, several of the men expressed major concerns relating to the standard of care provided within the unit. A significant problem raised by 3 veterans was the regular occurrence of breaches in confidentiality, whilst the second most common issue (voiced by 2 veterans) was the perception that some of the charity's staff needed more training on mental health awareness and best practice.

Client L14: *"One [fellow veteran] in this whole building can create a hell for people . . . and stir things up and create bad, bad energies throughout the whole place . . . A lot of [the veterans] are institutionalised . . . So, any switch in their normal pattern is massive for them, you know? And then, of course, it's fear, anger, and it shows itself . . . [in] the amount of fights we've had".*

Client A16*: "It's the confidentiality thing everybody's scared of here, because some of the [charity's] staff . . . You're scared in case they're talking about you, which we know they do".*

Client L11: *"Certain staff . . . They're not trained well enough to deal with . . . the mental problems that the guys in here have . . . [Staff] can trigger off people [veterans' symptoms], and I've seen it on a regular basis".*

1.2.3. Theme: Benefits Assessments: 7 veterans reported having encountered difficulties with the UK welfare benefits agencies during the course of therapy which they perceived as detrimental to their mental health, including highly stressful assessment procedures for eligibility. These experiences were uniformly reported as characterised by excessive bureaucracy, inefficiency and rigidity:

Client D11: [On Department for Work and Pensions benefit *assessments]:* "*You fill out all the forms, you post them away . . . Then they send you another batch, and then another batch, and then something else, and then they say, oh, they've lost it! . . . You go from one office to another office to another . . . 'Oh no! We haven't got it, they've got it'. You go to them: 'Oh no, we haven't got it; so-and-so's got it' . . . You can't pin down where it is in the process that you are with them, because they don't know themselves, because they keep on passing you . . . like pass the parcel . . . It builds up frustration, annoyance, anger . . . despondency . . . I sometimes*

wonder whether it's worthwhile . . . So, that brings you back to . . . thoughts of suicide again".

Client A18: "*[Regarding benefit assessments] I couldn't believe the questions they [ATOS] were asking . . . You weren't getting a fair play . . . a fair shot at it, you knew that with ATOS . . . I used coping strategies quite a lot during that period . . . It was never the money, it was just the unfairness of ATOS that was getting to me . . . It was bad . . . It was upsetting me . . . but with the coping strategies, again, I got through it*".

Client C11: "*[Referring to Department of Work and Pensions / ATOS] If it hadn't been for the key workers being here . . . them actually dealing with them and helping me with the forms, I'd have been in a right state! . . . It's not set up really to help you at all, what they're doing. They're so rigid themselves. Maybe they could do with this therapy! . . . Because they stick solely to the letter and there's nothing in between, so, if you don't conform to the letter, then you ain't going to get it*".

The worrying picture emerging from the qualitative analysis corresponds markedly with fluctuations in the numerical data generated by the CORE-OM (Evans et al, 2000), PHQ-9 (Kroenke et al, 2001) and GAD-7 (Spitzer et al, 2006) questionnaires. Among those participants in this study who have encountered problems with their benefits claims, or have been required to be reassessed for proof of continued eligibility, all experienced a pronounced deterioration in their mental well-being during the process, together with an attendant increase in their PTSD symptoms.

A wider political and policy debate regarding the appropriateness of these benefits assessments and the manner in which they are conducted is beyond the scope of this paper. However, there is plentiful evidence in both the quantitative data (which shows 'spikes' of symptom deterioration that coincide with the timing of involvement with the benefits agencies) and the qualitative interviews conducted for this study, to lead the authors to believe that such assessments and their associated correspondence are significantly detrimental to the mental welfare of this client group.

Superordinate Theme 2: Therapist Factors:

Positive influences originating from the therapist were cited by all 8 veterans as a second superordinate factor contributing to their beneficial experience of TA psychotherapy. Following thematic analysis (Braun & Clarke, 2006), these therapist factors were categorised into the following themes:

2.1 Theme: Therapist Relational Qualities

Providing further reinforcement to established evidence (Luborsky, Singer & Luborsky, 1975; Gaston, 1990; Assay & Lambert, 1999; Paley & Lawton, 2001) that the quality of the therapeutic relationship is the paramount curative factor in all effective psychotherapy, the following excerpts were typical:

Client G6: "*You've also got that personality as well, where, there's sometimes, I don't want to go there, but I will, because I know there's that kind of two-way process. I think you would stop me if I went down some bad avenue . . . There's that kind of trust element*".

Client B7: "*But you're understanding, just even listening and then tweaking and helping me try and make sense of what I'm going through*".

Client B10: "*Comfortable . . . As soon as I walk in the room and sit down with you, I feel comfortable . . . I can sense when somebody's agitated. I can sense when somebody's peaceful", "I always feel comfortable with you and talking to you . . . that I've not experienced with anybody else in my whole life before*".

In particular, reflecting guidance from the integrative school of TA that genuinely empathic "inquiry begins with the assumption that the therapist knows nothing about the client's experience and therefore must continually strive to understand the subjective meaning of the client's behavior and intrapsychic process" (Erskine & Trautmann, 1996, p.318), the following excerpt suggests that the therapist was deeply attentive to the client and sought to respect their own wisdom, whilst also maintaining a process-directive stance:

Client A12: "*You would actually sit there and listen", "I was the teacher and you were learning from me", "It was being understood and listened to . . . and acting on it and telling me what I could do to help that situation . . . and I acted on it. So, I was taking that on board*".

The healing function of therapeutic dialogue in "helping the individual regain control over dissociative processes . . . accessing both the limbic system and the neocortex to repattern the traumatic experience" (Pomeroy, 1998, p.338), including the deconstruction and reconstruction of perspectives and stories, so as to "develop the Adult capacity for reflective function and self-narrative" (Stuthridge, 2006, p. 281), was highlighted by 1 of the veterans as follows:

Client E1: "*I've felt it's been extremely helpful in my present case . . . I could come and speak and we'd put different perspectives on things, different words, different ideas, because I would think something and just put my own thought to it and it would probably be a blinkered thought and that one thought only*".

2.2 Theme: Individually Tailored Therapy

Another important therapist factor which emerged from the qualitative analysis was that the veterans recognised and valued that the therapy was individually tailored to their unique needs and preferences.

Client G5: "*I had a bit of a knowledge from psychology and that in the background. So, I think it was . . . [my] interest in the transactional [analysis theory] as well, which made it a bit easier to sit and chat with you*".

Client G8: "*The . . . personalisation, that you're not a number, or anything like that*".

2.3 Theme: Techniques

A number of therapeutic techniques were alluded to in the transcripts, although many such references consisted merely of vague descriptions, rather than precise attributions of efficacy. For instance, the following extract highlights the benefits of reflective journal writing:

Client B18: "*It's been great . . . for me to write down every day what I do [in a diary brought to sessions], to tell you how . . . what my life is like and how I'm going through my life right now*".

3 veterans, meanwhile, spoke of the value of learning a variety of mindfulness techniques:

Client B19: "*Now . . . I've just slowed down and just took count of what's actually in front of me, picked out the positive things that I like in my life…Breathing does help me . . . Take a breath, take a breath . . . So, now I can take a breath without somebody telling me*".

Client D10: "*Trying, for example, the breathing exercises . . . to relax and calm down*".

Client K8: "*The spirituality, the meditation, they've been the two biggest factors in all this, you know. They've been immense . . . The meditation . . . just unbelievable what that's capable of doing*".

From a TA perspective, the reflective journal writing and mindfulness techniques were integrated into the therapy to promote both the recovery of Adult functioning and, consequently, the "capacity to reflect upon and integrate . . . archaic [or dissociated] states as well as past introjects" (Tudor, 2003, p.202) and, also, to assist veterans with self-regulation of their "affective, somatic, sensory, and motor modes of mental processing" (Caizzi, 2012, p.168).

2.4 Theme: Catharsis

All 8 veterans described their psychotherapy treatment as a cathartic experience, which they characterised as a painful, but ultimately necessary phase in their healing. In addition, recalling Schnurr and Friedman's (1997) observation that PTSD is '"associated with . . . early conduct problems, childhood adversity . . . poor social support after a trauma" (p.13) and, similarly, Stuthridge's (2006) remark that "disorganized attachment in children predicts dissociative symptoms in adults" (p.274), veterans often mentioned the resolution of fixated trauma deriving from their early lives as essential to their recovery. Subsidiary themes of "letting go" and forgiveness also featured in the transcripts, as the veterans recalled a process of coming to terms with painful memories held in their earliest Child ego states, as well as subsequent military extremities of experience.

Client G12: "*It's the first time for a lifetime I've actually picked up a hankie [paper tissue] from that box and really let it go*".

Client B20: "*Remember that time I told you about my Dad? . . . Going and telling you that helped immensely. I don't know what it is, but, just, for me to talk to you to tell you what had actually happened, about what my Dad was feeling, and how it happened*".

Client C14: "*I'm feeling a lot of pain from [examining his childhood experiences]. The more I open up to it, the more pain I'm feeling, but, I suppose, pain has got to be felt for understanding and all that to come . . . That's the only bad side to the therapy . . . For me to understand it, I've got to feel the . . . the pain again, and I would rather not . . . The need to . . . open up far outweighs the pain I'm getting*".

Client F15: "*Talking about incidents that happened to me in my childhood . . . When I used to talk to my family about them, because they were the only people you . . . apparently, you could trust, and to be knocked back from them . . . In therapy, I feel like I'm free to . . . Well, not initially, but now I feel I'm free to talk about hurtful things in the past, or whatever, and it's . . . it's full of a kind of sense of healing about it*".

Client F16: "*Bringing up the past as well . . . you're opening old wounds and . . . old memories come back in . . . But, in the long run . . . It was a necessity, you know, to get better . . . Opening up wounds and stuff for them to be healed . . . It's doing the trick*"

Superordinate Theme 3: Empowerment

The broad concept of personal empowerment constituted a third superordinate factor arising from analysis of the veterans' interview responses, within which the following themes were detected:

3.1 Theme: Client in Charge of the Therapy

Client E8: "*What I like as well I'm not forced into saying anything, which is important . . . It seems as though I can pick the topic; what I want to talk about, what's important*".

Consistent with Wampold et al's (2010) table of "specific ingredients and . . . common factors" (p.931) found in all effective PTSD treatments (see Table 1), the veterans' sense that they were directing the course of therapy was a notable theme and extended to the application of specific therapeutic techniques (e.g. cognitive behavioural problem-solving strategies). These strategies were offered to veterans in the form of Adult-enhancing options and then, modelling "collaborative agreement about tasks and goals in therapy" (Wampold at al, 2010, p.931), the final choice over whether to pursue them was left entirely to each individual. The following excerpts describe just such a positive Nurturing Parent experience, where the client's autonomy (Berne, 1964) was respected:

Client C7: "*When I have got a problem, you've . . . reiterated the procedure that I could use to resolve the issue . . . but you've left the decision to me. You've not forced me to do it. You've left the decision for me to do, and the fact that you were willing . . . you did that meant that I can accept it more . . . I've learnt from that, and I use the same procedure with my kids . . . I will advise them and then I will be there for them when they make*

the wrong decision, or if they make a decision and it goes wrong, I'm still there . . . I've not forced them to act".

Client G16: "*I know I've got the kind of like safety word . . . I can hold my hand and say '[Therapist name], we're not going in this direction' . . . You will not push me in a direction I don't want to go, and that's the good thing*".

In the following quotation, a veteran recounts another empowering experience of directing the agenda, but also acknowledges the need for any effective therapist to "challenge habitual assumptions and relationship patterns and create sufficient turbulence for new structures to emerge" (Holmes, 2001, p.17):

Client E11: "*I can bring anything to the forum, so to speak, to talk about, but you do question [challenge] me back, obviously, which is important . . . to help*".

3.2 Theme: Sense of hope

For 2 veterans, there was a distinct sub-theme centred around developing and maintaining a positive vision for the future and, in particular, the hope of moving towards a meaningful and contactful (Erskine & Trautmann, 1996) return to civilian life.

Client F18: "*I'm extremely grateful and thankful for therapy . . . Hopefully, I can get back to a sense of normality within my life. Well, I feel like I'm getting there now, so I feel, if I can get this far in the short space of time since I've seen you, over the next while . . . I can . . . even get more better, so I've got good expectations*".

Client A26: "*[On returning to independent living in the community] It's no use going back if I'm not ready, I could . . . end up back here . . . And now I'm looking forward to it, which . . . I wouldn't even have done this, going back thing on its own without the therapy . . . I thought I was here for life. I thought, 'This is it' "*.

3.3 Theme: Psychoeducation

Various didactic aspects of the therapy were judged beneficial by the veterans interviewed in this sample. Of particular value were those psychoeducational interventions which assisted veterans to understand the intrapsychic process and psychobiological symptoms of PTSD, which justifies Pomeroy's (1998) emphasis on "education about the common symptoms of traumatic stress reactions so the person is assured, with regard to his or her safety, that he or she is not going crazy" (p.338). As demonstrated below, mention was also made of the CORE-OM (Evans et al, 2000), PHQ-9 (Kroenke et al, 2001) and GAD-7 (Spitzer et al, 2006) questionnaires as being intrinsically helpful in strengthening the veterans' capacity to conceptualise their fluid and, often, intense experiences:

Client E3: "*You've explained to me the processes that are taking place in the body, without me knowing whether . . . what's wrong with me . . . and it's [his brain, his thinking] all been, like, defragmented like a computer, if you know what I mean, and things slowly, but surely are starting to probably find their place again. That is a big factor, yeah, making sense of it [PTSD symptoms]*".

Client E12: "*I think my [questionnaire] scores have shown me I've . . . improved dramatically, then there's been a spike, and . . . I bet you they probably tie in to the dates when I've received really grotty [official] letters . . . They reflect directly, I think, the dates of . . . letters*".

3.4 Theme: Value of TA theory

5 veterans made explicit reference to the fact that learning a number of TA models had played an important role in helping them to make sense of their phenomenological experience. This positive reaction to the teaching of relevant theory would appear to support established psychoanalytic and TA treatment plans which emphasise "symbolization and encoding of memory and experience" (Davies & Frawley, 1994, p.202) as an essential phase of "returning executive control to the Adult ego state and the neocortex" (Pomeroy, 1998, p.338).

Client G14: "*I think what I like about the transactional [analysis] is the way that you do look at it from a lot of aspects; from emotion, from the past, from family . . . So, things that I thought in the past, sometimes, were irrelevant . . . I can now put more into context*".

Client G17: "*The fact about the transactional [analysis diagrams] as well . . . I'm a visualization kind of person . . . There's your Parental [ego state], there's this and . . . you can see how it overlaps and how it all fits together*".

Client K10: "*See how you've got the [ego states diagram], maybe get that . . . get some sheets made up with that, you know, so when you're explaining it, the [veterans] can take a sheet away with them, because it's a good [diagram]*".

3.5 Theme: Normalisation

The positive impact of normalisation was mentioned by all 8 veterans as an essential component of their treatment by way of facilitating a "change [in] the way [they] . . . categorize or define their internal experience or their behavioural attempts at coping from a pathological . . . perspective to one that respects archaic attempts at resolution of conflicts" (Erskine & Trautmann, 1996, p.325). Sub-themes were also evident in relation to helping the veterans make sense of their subjective experiences and "create a coherent self-narrative" (Stuthridge, 2006. p.282), as can be seen in the following excerpts:

Client F4: "*Your reassurance . . . the way you analyse things and feed it back to me, you know. The way I perceive it [his anxiety and PTSD symptoms] then is, you know, sounds normal . . . which I never got before on a professional level*".

Client B7: "*But you're understanding, just even listening and then tweaking and helping me try and make sense of what I'm going through*".

Other Positive Outcomes

Changes in psychiatric medication: Almost all of the veterans undergoing the Change Interview (Elliott et al, 2001, as cited in Frommer & Rennie, 2001) reported significant alterations to their prescriptions for psychiatric medication during their psychotherapy treatment; 5 veterans had their dosages of various antidepressants, anxiolytics and sedatives reduced, or terminated altogether. Table 14 provides a convenient summary of these changes, many of which might be attributed, at least in part, to the positive influence of TA psychotherapy.

Transition to independent living: Out of the total sample of 15 veterans who participated in this research, 5 individuals have recovered sufficiently from their PTSD, other comorbid disorders and associated lifestyle problems to move out of 24-hour residential care and resume living independently in the local community. Veterans undergoing both long-term (52 session) and short-term (24 session) psychotherapy treatment achieved this notable milestone, with 2 individuals from the long-term cohort (Clients A and B) and 3 from the short-term cohort (Clients L, M and O) securing their own tenancy by the time the final quantitative scores were collected and all interviews completed.

Data Limitations

General: Notwithstanding the precautions taken by the authors to allay concerns raised by Wampold et al (2010) around the experimental validity of clinical research in the field, there remain a number of potential sources of bias and distortion that must be taken into account in any interpretation of the results of this study. Significant among these is that both authors "clearly have an allegiance to a particular treatment" (Wampold et al, 2010, p.930) and might be considered to have a vested interest in finding supporting evidence for their working hypothesis. There was also a notable "Duality of Roles" (Institute of Transactional Analysis, 2008, pp.10, 12) for one of the authors (Harford), as the practitioner delivering TA psychotherapy to the chosen sample of veterans and the researcher collecting their quantitative and qualitative responses. The potential for bias inherent in practitioner research was to some extent mitigated by the second author, who audited the quantitative results and conducted the qualitative data analysis.

The selection criteria for the veterans involved in the study are also open to question in that, although all participants had received prior formal diagnoses of PTSD from qualified medical professionals with reference to the *DSM IV* (American Psychiatric Association, 1994), the choice of which veterans were referred for psychotherapy was left to the management of the independent charity so there may have been other, nonclinical motives for the choices made, such as the organisation's own policies, priorities and concerns.

Returning to relevant TA theory, of particular note in the context of this research is Stuthridge's (2006) observation that "disorganized attachment in children predicts dissociative symptoms in adults" (Stuthridge, 2006, p.274), which led the authors to question to what extent the combat-related PTSD exhibited by veterans participating in this study, several of whom originated in highly dysfunctional families, had been exacerbated by insecure and, sometimes, abusive attachments during childhood. Perhaps, therefore, these individuals were exhibiting what Schnurr and Friedman (1997) label "Complex PTSD" (p.15) and might warrant research on their own as a separate cohort presenting with a distinct disorder. Extrapolating from those same authors' cautionary advice on the cultural and ethnic specificity of

Client	Medication	Increase / Decrease	Nature of change
A	Zopiclone	Decrease	Daily dosage reduced by one third
B	Diazepam	Decrease	Dosage reduced from 25mg/day to 20mg/day
C	Mirtazapine	Decrease	Stopped completely
D	Fluoxetine	Increase	Daily dosage increased by 50%
F	Citalopram	Increase	Dosage increased from 20mg/day to 30mg/day
G	Amitriptyline	Decrease	Dosage reduced from 20-30mg/day to 10mg/day
L	Sertraline	Decrease	Daily dosage reduced by one third
	Mirtazapine	Decrease	Daily dosage reduced by 50%

Table 14: Changes in Psychiatric Medication during TA Psychotherapy Treatment

much extant research into the effectiveness of psychotherapy in treating PTSD, there is also the fact that all 15 veterans in this study were male and, mindful of Shadbolt's (2004) comments on the curative necessity of the twinship transference (Kohut, 1984) and sameness experiences in the therapeutic relationship, it is interesting to speculate how the results might have differed had there been female veterans available for study.

Quantitative Data: Moving on to possible weaknesses within the quantitative data, it must be noted that not all the veterans in the short-term and long-term cohorts completed their respective 24 and 52 sessions and, therefore, the individual CORE-OM (Evans et al, 2000), PHQ-9 (Kroenke et al, 2001) and GAD-7 (Spitzer et al, 2006) data sets are necessarily incomplete and the mean figures derived from them subject to proportionate statistical error. This issue is less marked for the long-term cohort, where 6 of the 8 veterans completed 52 sessions with only Client F terminating after 34 sessions and Client H declining to complete further questionnaires after 28 sessions and terminating altogether after 50 sessions. More problematic in this regard are the short-term group in which Client O received only 11 sessions, Clients K and L received just 12 sessions, while Client I underwent 22 sessions. The explanations for these early terminations also contain some variation, with both Client F and H's endings being involuntary and imposed by the charity's management, Clients J and O leaving voluntarily, but without fulfilling their contractual agreement to undertake one final session following the decision to terminate, and Clients I, K and L finishing voluntarily and in accordance with their agreed contracts. In an effort to mitigate the impact of these inconsistencies on experimental validity, mean CORE-OM (Evans et al, 2000), PHQ-9 (Kroenke et al, 2001) and GAD-7 (Spitzer et al, 2006) figures for all 15 veterans have been provided by the authors for analysis alongside those originating from the distinct long-term and short-term cohorts. A comparison of all three data sets shows them to be relatively consistent and provides a degree of reassurance that these variations in the numbers of sessions received have not unduly distorted the encouraging patterns and trends evident within the quantitative results.

Arguably more serious in terms of potentially compromising the experimental validity of this data is the influence of external psychosocial factors on the mental well-being of the participants at various stages of their treatment. Foremost among these are the impact of eligibility assessments for state benefits and the effects of interpersonal conflict within the resident veteran population and between participating veterans and the charity staff, both of which figure prominently in the collated Change Interview responses. The causal role and degree of influence of these psychosocial factors in exacerbating the veterans' symptoms and hampering their treatment were not measured in this study and, as discussed further below, could potentially be a source of anomalies in the quantitative data obtained.

Qualitative Data: Despite addressing the same themes and being governed by the same protocol, the Change Interview (Elliott et al, 2001, as cited in Frommer & Rennie, 2001) employed in this study is, by its very nature as a semi-structured interview, subject to some variance from one respondent to the next. Although the interview was limited to one hour in duration and conducted in accordance with the numbered order of topics with all 8 veterans in the sample, the exact wording, tone and emphasis of the researcher's questions, together with any intermittent comments and requests for clarification, introduce a degree of singularity to the process. The qualitative data obtained, therefore, may be subject to bias and distortion by the practitioner researcher, who, consciously, or otherwise, may have asked questions, or commented in a leading way, perhaps discounting (Mellor & Schiff, 1975), or, in turn, over-emphasizing certain aspects of the clients' answers, so as to build a strong supporting case for the working hypothesis. That said, such biases are common to most forms of qualitative research and the thematic analysis (Braun & Clarke, 2006) utilised in this study is a well-established technique with a proven track record of support and critique. Furthermore, as the veterans sampled were by definition traumatised, extremely vulnerable and struggled with issues of trust in relationships, it was considered inappropriate for an outsider to be brought in for the purposes of interviewing, as this would likely cause undue distress and, perhaps, countertherapeutic iatrogenic shaming (Widdowson, 2010). Taken as a whole, then, these risks to the integrity of the results were partially mitigated by the presence of a second author conducting the qualitative data analysis and the additional safeguard of an unconnected and suitably qualified third party in Professor Caroline Hollins Martin (University of Salford) to audit the process of qualitative analysis.

Discussion

It is heartening to observe that Wampold et al's (2010) checklist of effective treatments for PTSD matches the psychotherapeutic methods adopted with the participants in this research extremely closely, with only "Exposure . . . in vivo outside of [the] session" (p.931) absent from the chosen TA approach. Even so, many of the veterans agreed inter-session contracts to conduct controlled exposure experiments in their own time, which involved practicing breathing exercises and mindfulness techniques while in the presence of triggering stimuli, such as crowd situations, travelling on busy public transport, or walking along narrow alleyways overlooked by high windows. It is perhaps unsurprising, then, that, viewed as a whole, the data gathered in this extensive study points decisively to considerable improvements in the psychological well-being of the veterans receiving TA psychotherapy in both the short-term (up to 24 sessions) and longer-term (up to 52 sessions) formats and, there-

fore, offers solid confirmation of Harford's (2013) pilot findings that both anxiety and, to a lesser extent, depression appear to gradually reduce as, within the nonintrusive 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" (Tudor, 2003, p.202).

Concentrating initially on the quantitative outcomes and measuring from peak scores rather than from pre-treatment levels, 2 of the 15 veterans achieved Clinically Significant Change on their mean clinical CORE-OM (Evans et al, 2000) scores, 3 of the 15 attained Clinically Significant Change on their mean PHQ-9 (Kroenke et al, 2001) scores and 2 of the 15 finished with Clinically Significant Change on their GAD-7 (Spitzer et al, 2006) scores. By comparison with Bradley et al's (2005) benchmark of 67% from a meta-analysis on the efficacy of psychotherapy as a treatment for PTSD, this equates to an overall mean of 16% of veterans in this study no longer meeting the diagnostic criteria for PTSD by the end of their respective 24, or 52 sessions. These results appear disappointing, but can still be considered positive given the severity and chronicity of comorbidity, addiction and other lifestyle problems exhibited by the sample population, combined with the harmful effects of the various negative extra-therapeutic factors pinpointed by the qualitative data. As noted earlier, there is also the fact that 5 veterans in the long-term cohort went on to receive further treatment beyond 52 sessions and may well have attained Clinically Significant Change had it been possible to include this additional data in the current analysis. Furthermore, it is worth noting that the PHQ-9 (Kroenke et al, 2001) and GAD-7 (Spitzer et al, 2006) scales are not exclusive diagnostic indicators for PTSD, but, rather, a broad spectrum of Axis One disorders (American Psychiatric Association, 1994) and, consequently, the therapist's (Harford) judgement was that, based on the *DSM IV* (American Psychiatric Association, 1994) criteria alone, 8 of the 15 veterans sampled no longer met sufficient criteria for a diagnosis of PTSD at termination. This can be construed as a phenomenological form of 'clinically significant change' and presents a much better percentage score of 53% for consideration alongside Bradley et al's (2005) results. Less contentious is the fact that 14 of the 15 veterans achieved Reliable Change on their mean clinical CORE-OM (Evans et al, 2000) scores, 9 of the 15 attain Reliable Change on their mean PHQ-9 (Kroenke et al, 2001) scores and 10 of the 15 completed treatment with Reliable Change on their GAD-7 (Spitzer et al, 2006) scores. Employing the same comparison, this yields an overall mean of 73% of veterans in this study meriting a description of 'improved' (indicating Reliable Change), which compares very favourably with Bradley at al's (2005) benchmark of 54%.

The qualitative outcomes in Table 13 illustrate an impressive range, depth and specificity of beneficial outcomes reported by the veterans undergoing interviews as a direct consequence of their TA psychotherapy treatment. Echoing Korol's (1998) comments on the dual goals of treatment, these positive changes are evident in both the intrapsychic and interpersonal domains, with veterans enjoying new friendships and sexual relationships, improved interactions with authority figures, greater relational assertiveness and trust and an increased capacity for empathic contact and mentalisation (Bateman & Fonagy, 2006), as well as the internal advantages of reduced symptoms, a broader repertoire and deepened capacity for cognitive and affective self-regulation and a much greater understanding, acceptance and sense of normalisation (Erskine 1993; Erskine & Trautmann, 1996) in relation to the psychobiological dimensions of their phenomenological experience. Additionally, the authors have been very encouraged by a number of potentially far-reaching changes in the veterans' lifestyles, with 5 individuals achieving the transition to independent living in the community, 5 evidencing a reduction of dosage or a complete cessation of their prescriptions for psychoactive medication, several reducing their dependence on alcohol and recreational drugs and others commencing academic courses of learning, vocational training, or participating in voluntary work with a view to eventually securing employment.

Within this same qualitative data, a number of recurring themes emerged from the collated transcripts which, in the authors' opinion, deserve extensive research analysis of their own. The most prominent is the psychological impact on vulnerable adults with mental health issues of benefits assessments carried out by the UK welfare agencies, or various commercial concerns under the auspices of national government. Based on comparative analysis of veterans' qualitative responses with their quantitative data and the timing of several pronounced phases of deterioration in their symptoms, there appears to be a direct causal relationship between enforced attendance at benefits eligibility assessments and related health assessments, and between the arrival of related written correspondence and increased symptoms of anxiety and depression. Both forms of contact with officialdom appeared to be linked to an adverse influence on progress in therapy.

It is not possible to attribute these fluctuations directly to the impact of benefits and capacity work assessments based on the data presented in this study. The authors acknowledge that the results observed might be due to factors such as the veterans' perceptions of the assessment process, rather than the practical and relational reality of how they are conducted, and that the sample size of 15 represents a tiny fraction of the total number of individuals drawn from the client group undergoing such procedures across the UK. However, in recent years there has been extensive media criticism

of the accuracy, care standards and levels of sensitivity employed during these assessments, along with the propriety of involving commercial interests in such delicate procedures with vulnerable people (Wintour, 2013; Fagg, 2012; Toynbee, 2014). Such adverse coverage has been mirrored by the UK Department for Work and Pensions' own Public Accounts Committee, which noted that "Poor decision-making causes claimants considerable distress . . . The Work Capability Assessment process has a disproportionate impact on the most vulnerable claimants. The standardised "tick-box" approach fails to adequately account for rare, variable or mental health conditions and this can lead to greater inaccuracies in decision-making for these particular claimant groups" (Department of Work and Pensions, 2012). This issue clearly warrants closer inspection; including analysis of how the present UK welfare system may not be in line with the guiding principles and codes of best practice underpinning both the Mental Health Act 2007 and Mental Health (Care and Treatment) (Scotland) Act 2003.

As noted in Harford's (2013) earlier pilot study, contrary to the practitioner-researcher's prior misgivings that the use of questionnaires with this extremely vulnerable client group "might present a countertherapeutic intrusion of bureaucracy into fragile therapeutic alliances" (p.28), their introduction has, in fact, proved an invaluable aspect of the veterans' treatment, as referred to explicitly in a number of interview responses. As well as providing a convenient rough measure of progress for the therapist and generating precious evidence of success for the charity's ongoing efforts to secure external funding for the psychotherapy programme, the sensitively "contracted use of [CORE-OM, PHQ-9 and GAD-7] questionnaires appears . . . 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." (Harford, 2013, p.28).

In the light of these findings, the authors would invite all TA practitioners to consider incorporating these relatively straightforward statistical measures into their practice wherever possible, as there are clear benefits to be gained for all concerned in the process.

Conclusion

Over the two-year duration of this study, a compelling body of evidence has been gathered in support of the authors' initial hypothesis that 'TA psychotherapy can be an effective treatment for PTSD in ex-servicemen and women'. Indeed, yet more corroboration of the enduring efficacy of TA with this client group could still emerge, as, on account of the positive outcomes detailed in this paper, the charity concerned has committed to funding the psychotherapy programme for the veterans under their care and support indefinitely so further opportunities for research on related topics will be readily available. In particular, opportunities to explore the effectiveness of TA psychotherapy as a treatment for PTSD among female veterans, those from different social and cultural backgrounds and, also, further investigation of the predisposing influence of childhood trauma would be most welcome.

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References

American Psychiatric Association (1994). *DSM IV TR: Diagnostic and Statistical Manual of Mental Disorders.* Washington (DC): American Psychiatric Press.

American Psychological Association (2014a). Cognitive Processing Therapy for Post-Traumatic Stress Disorder. http://www.div12.org/PsychologicalTreatments/treatments/ptsd_cognitive.html accessed 7 July 2014

American Psychological Association (2014b). Present-Centered Therapy for Post-Traumatic Stress Disorder. http://www.div12.org/PsychologicalTreatments/treatments/ptsd_present.html accessed 7 July 2014

American Psychological Association (2014c). Prolonged Exposure for Post-Traumatic Stress Disorder. http://www.div12.org/PsychologicalTreatments/treatments/ptsd_exposure.html accessed 7 July 2014

American Psychological Association (2014d). Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder.http://www.div12.org/PsychologicalTreatments/treatments/ptsd_emdr.html accessed 7 July 2014

Assay, T.P. & Lambert, M.J. (1999). The empirical case for the common factors in therapy: quantitative findings. In M.A.Hubble, B.L. Duncan & S.D. Miller (Eds.), *The Heart and Soul of Change: What Works in Therapy*. Washington DC: APA Press.

BBC (2013) Panorama –Broken by Battle (last shown 16 Aug 2013) http://www.bbc.co.uk/programmes/b0377vnc accessed 7 July 2014

Bateman, A.W. & Fonagy, P. (2006). *Mentalization-Based Treatment for Borderline Personality Disorder: A Practical Guide*. Oxford: Oxford University Press.

Benish, S.G., Imel, Z. E. & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review,* 28: 746,758.

Berne, E (1961). *Transactional Analysis in Psychotherapy*. New York: Grove Press.

Berne, E (1964). *Games People Play*. New York: Grove Press.

Bollas, C. (1989). *Forces of Destiny.* Northvale NJ: Jason Aranson.

Bradley, R., Greene, J., Russ, E., Dutra, L. & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD, *American Journal of Psychiatry,* 162: 214,227.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2)

Breslau, N, Davis, G.C., Andreski, P. & Peterson, E. (1991).Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry,* 48:216–222.

Caizzi, C. (2012). Embodied Trauma: Using the Subsymbolic Mode to Access and Change Script Protocol in Traumatized Adults. *Transactional Analysis Journal, 42*(3)

Clarkson, P. (1987). The Bystander Role. *Transactional Analysis Journal, 17*(3)

CORE ims. (2003). CORE Measurement Tools. http://www.coreims.co.uk/About_Measurement_CORE_Tools.html accessed 7 July 2014

Cornell, W. & Bonds-White, F. (2001). Therapeutic Relatedness in Transactional Analysis: The Truth of Love or the Love of Truth. *Transactional Analysis Journal, 31*(1)

Crossman, P. (1966). Permission and protection. *Transactional Analysis Bulletin*, *5*(19)

Davies J. & Frawley, M. (1994). *Treating the Adult Survivor of Childhood Sexual Abuse: A Psychoanalytic Perspective*. New York: Basic Books.

Department of Work and Pensions. (2012).Contract management of medical services - Public Accounts Committee. http://www.publications.parliament.uk/pa/cm201213/cmselect/cmpubacc/744/74403.htm accessed 7 July 2014

Drego, P. (1983). The Cultural Parent. *Transactional Analysis Journal*, *13*(4)

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative Change Process Research on Psychotherapy: Alternative Strategies. In Frommer, J. & Rennie D.L. (Eds.), *Qualitative Psychotherapy Research: Methods and Methodology*. Lengerich, Germany: Pabst Science Publishers.

Elliott, R., Watson, J., Goldman, R. & Greenberg, L. (2003). *Learning Emotion-Focused Therapy, Supplemental Materials*. http://www.process,experiential.org/learning/supplemental/chap3.2.html accessed 7 Juky 2014

Erskine, R. (1993). Inquiry, Attunement and Involvement in the Psychotherapy of Dissociation. *Transactional Analysis Journal, 23*(4)

Erskine, R. & Trautmann, R. (1996). Methods of an Integrative Psychotherapy. *Transactional Analysis Psychotherapy, 26*(4)

Evans, C, Mellor-Clark, J, Margison, F, Barkham, M, McGrath, G, Connell, J, Audin, K. (2000). Clinical Outcomes in Routine Evaluation: The CORE-OM. *Journal of Mental Health, 9*

Fagg, A. (2012). *Sickness benefit contractor Atos Healthcare to review letters*. http://www.bbc.co.uk/news/uk-19370200 accessed 7 July 2014

Frommer, J. & Rennie, D.L. (Eds.). (2001). *Qualitative Psychotherapy Research Methods and Methodology.* Berlin: Pabst Science Publishers

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: theoretical and empirical considerations. *Psychotherapy*, *27*

Harford, D. (2013). Preliminary Outcomes of Transactional Analysis Psychotherapy for Armed Forces Veterans Presenting with Posttraumatic Stress Disorder. *International Journal of TA Research, 4*(2)

Hargaden, H. & Sills, C. (2002). *Transactional Analysis Psychotherapy: A Relational Perspective*. London: Routledge.

Holmes, J. (2001). *The Search for the Secure Base: Attachment Theory and Psychotherapy*. Hove: Routledge.

Institute of Transactional Analysis (2008). ITA Code of Ethics. Now UKATA Code of Ethics http://www.uktransactionalanalysis.co.uk/ethics accessed 7 July 2014

Karpman, S (1968) Fairy tales and script drama analysis. *Transactional Analysis Bulletin* 7, 39-43

Kohut, H. (1984). *How Does Analysis Cure?* Chicago: University of Chicago Press.

Korol, J. (1998). Confluence, Isolation, and Contact in Psychotherapy with Clients Who Dissociate. *Transactional Analysis Journal, 28*(2)

Kroenke, K, Spitzer, R, Williams J. (2001). The PHQ-9: Validity of a Brief Depression Severity Measure. *Journal of General Internal Medicine, 16*

Kroenke, K., Spitzer R., Williams, J., Monahan, P. & Löwe B. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Annals of Internal Medicine, 146*(5)

Luborsky, L, Singer, B. & Luborsky, L. (1975). Comparative studies of psychotherapies: is it true that "everyone has won and all must have prizes"? *Archives of General Psychiatry*, *32*

Mellor, K. & Schiff, E. (1975). Discounting. *Transactional Analysis Journal*, *5*(3)

National Institute for Clinical Excellence. (2005). *CG26 – Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care*. London: NICE.

Paley, G. & Lawton, D. (2001). The importance of the therapeutic relationship in NHS therapy provision. *Counselling and Psychotherapy Research, 1*(1)

Pomeroy, W. (1998). Trauma, Regression, and Recovery. *Transactional Analysis Journal, 28*(4)

Rothschild, B. (2000). *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*. New York: W.W.Norton.

Rothschild, B. (2003). *The Body Remembers Casebook: Unifying Methods and Models in the Treatment of Trauma and PTSD*. New York: W.W. Norton.

Safran, J.D. & Muran, C.J. (2003). *Negotiating the Therapeutic Alliance: A Relational Treatment Guide*. New York: Guildford Press.

Schiff, A. & Schiff, J. (1971). Passivity. *Transactional Analysis Journal*, *1*(1)

Schnurr, P. & Friedman, M. (1997). An Overview of Research Findings on the Nature of Posttraumatic Stress Disorder. *In Session: Psychotherapy in Practice, 3*(4)

Shadbolt, C. (2004). Homophobia and Gay Affirmative Transactional Analysis. *Transactional Analysis Journal, 34*(2)

Spitzer, R, Kroenke, K, Williams J, Löwe B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Archives of Internal Medicine, 166*

Stark, M. (2000). *Modes of Therapeutic Action*. Northvale NJ: Jason Aranson.

Stuthridge, J. (2006). Inside Out: A Transactional Analysis Model of Trauma. *Transactional Analysis Journal, 36*(4)

Stuthridge, J. (2012). Traversing the Fault Lines: Trauma and Enactment. *Transactional Analysis Journal, 42*(4)

Summers, G. & Tudor, K. (2000). Cocreative Transactional Analysis. *Transactional Analysis Journal, 30*(1)

Toynbee, P. (2014). Mentally ill people need to be helped, not hounded. http://www.theguardian.com/commentisfree/2014/jul/08/mentally-ill-need-help-not-bullying-by-the-state accessed 7 July 2014

Tudor, K. (2003). The Neopsyche: The Integrating Adult Ego State. In Sills, C. & Hargaden, H. (Eds.), *Ego States*. London: Worth Publishing.

Van Der Kolk, B.A. (2004). The Psychobiology of Post-Traumatic Stress Disorder. in Panskepp, J. (Ed.), *Textbook of Biological Psychiatry*. Hoboken NJ: Wiley.

Wampold, B, Imel, Z, Laska, K, Benish, S, Miller, S, Fluckiger, C, Del Re, A, Baardseth, T, Budge, S. (2010). Determining what works in the treatment of PTSD. *Clinical Psychology Review, 30*

Widdowson, M. (2010). *Transactional Analysis: 100 Key Points & Techniques*. London: Routledge.

Wintour, P. (2013). Disabled benefits claimants test: Atos reports found 'unacceptably poor http://www.theguardian.com/society/2013/jul/22/disabled-benefits-claimants-test-atos accessed 7 July 2014

World Health Organisation. (1992). *ICD-10 Classifications of Mental and Behavioural Disorder: Clinical Descriptions and Diagnostic Guidelines*. Geneva. World Health Organisation.

Appendix: Statistical Thresholds: CORE-OM, PHQ-9, GAD-7

Clinical Core-OM http://www.coreims.co.uk/About_Core_System_How_Used.html

Clinical cut-off = 10.0

Reliable Change = Reduction of 5.0 or more

Clinically Significant Change = client achieving 9.9 or less

Severe:	25.0+
Moderate to severe:	20.0+
Moderate:	15.0+
Mild:	10.0+
Nonclinical:	0 - 9.9

PHQ-9 http://www.iapt.nhs.uk/pbr/currency,model,description/clinical,outcomes/

Clinical cut-off = 10

Reliable Change = Reduction of 6, or more

Clinically Significant Change = a PHQ-9 score less than 10 and a 50% decline from the pre-treatment score [Kroenke, K, Spitzer, R, Williams J. (2001)]

Major depression (severe):	20+
Major depression (moderate):	15-19
Dysthymia, minor depression, major depression (mild):	10-14
Nonclinical:	0-9

GAD-7 http://www.iapt.nhs.uk/pbr/currency,model,description/clinical,outcomes/

Clinical cut-off = 8

Reliable Change = Reduction of 4 or more

Clinically Significant Change = a GAD-7 score less than 8 and a 50% decline from the pre-treatment score

[Spitzer, R, Kroenke, K, Williams J, Löwe B. (2006)]

Severe:	15-21
Moderate:	10-14
Mild:	8-9
Nonclinical:	0-7

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Transactional Analysis Psychotherapy for a Case of Mixed Anxiety & Depression: A Pragmatic Adjudicated Case Study – 'Alastair'

Abstract

Using an original method of case evaluation which involved an analysis panel of over 80 Italian psychologists and included a lay case evaluation, the author has investigated the effectiveness of transactional analysis psychotherapy for a case of mixed anxiety and depression with a 39 year old white British male who attended 14 weekly sessions. CORE-OM (Evans, Mellor-Clark , Margison, Barkham, Audin, Connell and McGrath, 2000), PHQ-9 (Kroenke, Spitzer & Williams, 2001), GAD-7) Spitzer, Kroenke, Williams & Löwe, 2006, Hamilton Rating Scale for Depression (Hamilton, 1980) were used for screening and also for outcome measurement, along with Session Rating Scale (SRS v.3.0) (Duncan, Miller, Sparks, Claud, Reynolds, Brown and Johnson, 2003) and Comparative Psychotherapy Process Scale (CPPS) (Hilsenroth, Blagys, Ackerman, Bonge and Blais, 2005), within an overall adjudicational case study method. The conclusion of the analysis panel and the lay judge was unanimously that this was a good outcome case and that the client's changes had been as a direct result of therapy. Previous case study research has demonstrated that TA is effective for depression, and this present case provides foundation evidence for the effectiveness of TA for depression with comorbid anxiety.

Key words

anxiety, depression, case study research, Pragmatic Adjudication Case Study, transactional analysis psychotherapy

Introduction

The evidence base for the effectiveness of transactional analysis (TA) psychotherapy is rapidly gaining ground. Two large scale studies have demonstrated the effectiveness of short-term TA psychotherapy for reducing overall distress, depression and anxiety symptoms (van Rijn, Wild and Moran, 2011; van Rijn and Wild, 2013) and have demonstrated that TA, gestalt, person centred and integrative counselling psychology have comparable outcomes (van Rijn and Wild, 2013). Three previous case studies have demonstrated the effectiveness of transactional analysis psychotherapy for the treatment of depression (Widdowson, 2012a, 2012b, 2012c). In one of those cases (Widdowson, 2012c), the client appeared to have considerable anxiety; however this was not measured in the study and therefore conclusions regarding the effectiveness of TA for comorbid depression and anxiety could not be drawn. This present case study examines the process and outcome of brief, 14-session therapy with 'Alastair'- a white British man presenting with mixed depression and anxiety.

This case study draws on several research designs; firstly, the case is presented using *pragmatic* design. Pragmatic case studies focus on the clinical process in an attempt to elicit aspects of best practice (Fishman, 1999; McLeod, 2010). The case study was evaluated using an adjudicational method. Adjudicational case studies rely on a quasi-legal framework drawing on a panel of judges for forming conclusions regarding the outcome of the case and possible factors which have influenced the outcome (Bohart, Berry and Wicks, 2011; Elliott, 2002; McLeod, 2010). This present case has utilised a novel approach for evaluating the case by drawing on a large group of psychologists and also by the use of a lay judge. Although several published adjudicated cases have suggested that there may be value in recruiting lay judges in the adjudication process (see Stephen and Elliott, 2011), the author is not aware of any previous studies which have actually done so.

The aim of this present case study was to investigate the process and outcome of short-term TA psychotherapy for the treatment of mixed depression and anxiety. The author, who was the therapist in this case, had developed a manual for the treatment of depression (Widdowson, in press) and a further aim of this case study was to provide a pilot evaluation of the treatment manual for comorbid anxiety and depression.

Client and Case Formulation

Case Context

Alastair had weekly individual psychotherapy with a therapist in private practice. He independently sought out his therapist, who was the author was the therapist in this case. At the time of conducting the therapy, the therapist was a 39 year old white British male with 16 years of clinical experience. The therapist is a teaching and supervising transactional analyst and a post-doctoral psychotherapy researcher.

Client

To preserve the client's anonymity, some details have been changed: however the client description and description of the therapy process are still 'close enough' to give the reader a clear sense of the client and the therapy. Any changes made do not adversely affect the validity of the case study or change crucial variables.

Alastair was a 42 year old senior executive who initially presented for therapy for "*problems with self-confidence and self-esteem"*. He was well-dressed in a stylish suit and well-groomed, suntanned, and had a warm, friendly manner about him and the therapist found him to be instantly likeable. Alastair grew up in a small town in rural Scotland and was the eldest of three children. His parents had divorced when he was ten years old, and to some extent he had blamed himself for this. He had not enjoyed school and after the divorce felt different to the other children. He also became aware of his parents not having very much money when compared to families in the area who were largely middle-class and relatively affluent. He reported having a "*decent*" relationship with his parents and siblings but said that they were not very close or warm or affectionate with each other. He had left school at 16 and gained an apprenticeship in a local engineering firm where he had done exceedingly well. He completed day-release degree education whilst working, gradually gaining promotions and seniority in the company. Six months prior to attending therapy he had been given a substantial promotion onto the board of directors. Although his work performance was excellent, he was personally struggling with this and in particular with feelings of inferiority, of "*not being good enough*" and was concerned that he would eventually get demoted or fired. He was particularly struggling with his feelings relating to and stirred up by frequent board meetings and presentations he had to make. It was these concerns which had prompted him to seek out therapy. He was married, with two boys aged 9 and 7. He reported a good relationship with his wife, but felt that he did not quite know how to relate to his children and was afraid that they would grow distant over time. Socially, he was quite isolated, seeing a small group of friends fairly infrequently. He said that he had never spoken to anyone about how he felt before and was a little apprehensive about therapy.

The purpose of the initial meeting was to clarify his presenting problems, form a working alliance, conduct induction into the tasks of therapy and clarify process expectations, and for the therapist to conduct a mini diagnostic interview. His therapist identified a persistent, chronic low-grade depression and some anxiety using DSM-IV criteria (American Psychiatric Association, 1994).. There was no indication of any other disorder. He was screened using CORE-OM (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell and McGrath, 2000) PHQ-9 (Kroenke, Spitzer & Williams, 2001) and GAD-7 (Spitzer, Kroenke, Williams & Löwe, 2006). His initial CORE score was 15 indicating mild levels of global distress and functional impairment. His PHQ-9 score indicated mild depression and his GAD-7 score indicated severe anxiety. Therapist scored Hamilton Rating Scale for Depression (Hamilton, 1980) score was 15, also indicating mild depression. Alastair completed CORE-OM, PHQ-9 and GAD-7 every fourth session and also at his final session and at follow-up intervals of one month, three months and six months.

Strengths: Alastair was warm, friendly and energetic (in spite of his anxiety and depression). He was an intelligent and articulate man who appeared to be very open and receptive to new experiences and had a curiosity about the world. Although he initially struggled with identifying and expressing his feelings, he engaged well with this aspect of the therapy. His initial apprehension about therapy soon disappeared and he enthusiastically participated in the process. He was very active and committed to the therapy process and consistently performed all negotiated homework tasks with considerable care, attention and effort. Prior to attending therapy, Alastair had read a number of self-help books, which he had found interesting, but which had not resulted in any change in how he felt. Nevertheless, his reading had given him some insight into what he might get out of therapy and in identifying issues he could address in sessions.

Case formulation

Alastair's depression and anxiety were conceptualised as sharing a common introjective pathway (Blatt, 1974). This resulted in a highly self-critical ego state dialogue (Berne, 1961; Widdowson, 2010, 2011). It was considered that for therapy to be effective this introjective process would need to be dismantled and replaced. The self-critical introjective process was influenced by his script beliefs (Stewart and Joines, 1987) which were formed from implicit learning during childhood, and then subsequently reinforced through distortions and negative interpretation of events which was replayed via his script system (Erskine, 2010). This had negative interpersonal consequences which repeatedly reinforced his core script belief of "*not being good enough*". Furthermore, positive feelings such as joy and pride were disallowed. These factors combined meant that Alastair had developed a self-perpetuating system which he was unable to challenge alone.

This case formulation is consistent with the framework presented in the TA treatment manual (Widdowson, in press) on which this therapy was based. The author had

previously conducted a case series which investigated the use of TA psychotherapy for depression. This case was used as 'proof of concept' pilot study to test out whether the principles of the manual would work in practice and specifically if they would be suitable for mixed anxiety and depression. The treatment manual places great emphasis on the intake procedure and client role induction.

Therapy Process

Alastair attended a preliminary mutual assessment session. The therapist engaged Alastair in some initial exploration regarding the problems he was seeking help for in therapy, a mini diagnostic interview and some discussion about the tasks and process of therapy as part of the role induction procedure. The therapist also raised the potential for Alastair to engage in research in this meeting.

The first therapy session was spent on some further history-taking, problem formulation, goal setting and the therapist explaining how the therapy would work, and clarifying expectations. Part of the problem formulation process involved the generation of a basic case formulation, which the therapist checked with Alastair for purposes of verification and consensus agreement.

In the second session, Alastair described his chronic feelings of inferiority which he had felt since childhood. The therapist gave Alastair several positive strokes (Steiner, 1974) during the session and noticed how Alastair deftly discounted them (Schiff et al., 1975). This was explained by the therapist as a strategy which maintained Alastair's sense of inferiority, and he invited Alastair to practice simply and graciously accepting positive strokes which came his way. This was framed by the therapist to Alastair as accepting a gift which was freely given, and that just as he enjoyed doing things which made other people feel good, his acceptance of strokes would likely enable others to enjoy the good feelings they produced in him. It was also suggested that if he found any adverse consequences to practicing stroke acceptance he could quickly reverse his behaviour.

Session 3 began with more detailed exploration of the origin of Alastair's feelings of inadequacy in childhood, and his script decision to remain "*closed*" to other people. Alastair felt that if he opened up to others, they would think less of him, and thus confirm his inferiority. The therapist proceeded with deconfusion (Berne, 1961, 1966; Hargaden & Sills, 2002, Widdowson, 2010) and assisted Alastair in expressing his sense of shame, and his historic sadness and fear. To support this, the therapist explained the interpersonal nature of feelings and how attuned responses from others can change emotions. The session concluded with some behavioural contracting around "*letting other people in*", in particular, his wife.

Alastair started session 4 by reporting that he had started experimenting with opening up more to his wife, and had been surprised by her positive response to this. The remainder of this session and session 5 continued with more exploration of his self-limiting narrative and script beliefs around not being good enough. Alastair was invited to pay attention to when this belief was influencing him, and to actively question whether or not the belief was valid. The therapist conceptualised this as decontamination (Berne, 1961; Woollams & Brown, 1979), which would weaken the influence of the script belief and start to interrupt Alastair's self-critical ego state dialogue. Alastair was also invited to experiment with wondering what it might be like if he did see himself as good enough, and what the negative consequence of this would be, if any. This was seen by the therapist as a strategy which would challenge the limiting narrative of his script, and also continue the process of deconfusion by encouraging a surfacing of Alastair's anxieties and Child fantasies around issues of worth.

Session 6 focused on deconfusion, and in particular how Alastair prevented himself from feeling joy, pride and self-confidence. The therapist engaged Alastair in some discussion of these 'forbidden feelings', and Alastair explained how he was afraid that if he experienced joy that "*things would go wrong*", and that pride would automatically lead to being arrogant and narcissistic. The therapist considered this to be a key dynamic in Alastair's depression. The therapist's approach was not to challenge or confront this directly, but to invite Alastair to spend the week noticing whether stopping oneself from feeling joy would actually prevent anything bad from happening, and also whether people who felt a sense of pride were always arrogant, narcissistic and selfish. This would generate experiences which would cause cognitive dissonance (Festinger, 1957) and thus facilitate the change process. The therapist's stance here was of empathic enquiry (Erskine, Moursund and Trautmann, 1999; Hargaden and Sills, 2002), and inviting Alastair to develop a more self-compassionate stance and understand how these beliefs were born out of positive intentions.

Alastair arrived for session 7 clearly excited and bursting to tell his therapist "*some good news*". He had been out with his friends a few evenings previously and decided to tell them that he had struggled with feelings of depression and anxiety for many years, and also that he was in therapy. Their reactions astounded him. Instead of judging him, as he expected, they were warm and accepting. Two of his friends disclosed that they too had similar feelings, and one was also in therapy. The terrible rejection he feared did not happen, and instead he found his relationships were strengthened. The session went on to explore how he had often felt responsible for the happiness or unhappiness of others, and the origin of this in his fantasies of blame around the time of his parents' divorce. Following on from the previous session, he described how he had realised that bad things would happen, regardless of whether he felt happy or depressed, and that worrying about them only had the

effect of making him anxious. Furthermore, he had also noticed how someone who reported directly to him at work had been proud of an achievement and Alastair noticed that pride did not necessarily mean arrogance or narcissism. He noticed one of his children feeling pride and seeming to "*grow*" from this positive feeling. He realised it was possible to feel pride "*quietly*" and "*healthily*". The therapist considered this a breakthrough session, as Alastair was starting to re-evaluate his script narrative and find disconfirming evidence in his day to day life.

Session 8 focused on Alastair's beliefs about "*how he should be*", and his sense of guilt and shame over his emotional responses. This exploration began when he described the previous week's events. He had been on a family holiday with his wife, children, his mother and step-father and his sister and her husband and children. The holiday had not been a positive experience for him, as he realised that he was continually preoccupied with ensuring "*everyone was having a good time*". As the holiday progressed, his awareness of his sense of responsibility for everyone's happiness had grown, and he had started to question whether this position was appropriate or helpful. As the week wore on, he gradually stopped trying to keep everyone happy and he noticed that there were no negative consequences of this. He was however still struggling with some guilt, which was related to his feelings of anger towards his sister and his step-father, who had both behaved quite badly on occasions during the holiday. He believed that his anger was somehow 'wrong, and wondered if this was evidence that he was 'a bad person'. The therapist used decontamination to facilitate change in Alastair's view of feelings and invited Alastair into various in vivo experiments about feelings and in particular, anger. This helped to normalise these emotions. After this exploration, Alastair made a throw-away remark which revealed he had been experiencing some anxiety prior to the session about 'being boring'- a fear which often preoccupied him. With this, his sense of responsibility for the happiness of others had been transferentially replayed in the therapy. The therapist invited Alastair to describe what it was like for him to be in relation to another when he did not know whether they found him boring or not. In doing this, Alastair spontaneously identified that there had not been any indications that his therapist was bored during any of their sessions. The therapist concluded the session then and invited Alastair to continue to reflect on this after the session.

Alastair was noticeably different when he arrived for session 9. He triumphantly stated that he had come to the conclusion that it was 'ok to feel his feelings'. The therapist considered this to indicate that Alastair had made a spontaneous redecision (Goulding & Goulding, 1979). There was evidence to support this, including him reporting that he had felt angry during the previous week and had not felt guilty about this. On further discussion, it appeared that he had also reached a point of self-acceptance. He stated that he had realised that he was not a bad person, and that actually he believed that he was a good person, even though he had flaws. He described how he had been "*enjoying being himself*", had been feeling optimistic about his future and had not felt wracked with guilt even once.

In session 10, Alastair explored the origins of his sense that he "*should be different to who he was*". The therapist understood this to represent Alastair's continuing re-evaluation of his 'don't be you' injunction (Goulding & Goulding, 1979). He described occasions during his childhood where he had felt "*second best*" and "*not good enough*" and how he no longer believed these to be the case. He did however describe a lingering concern that people might not like him. The therapist brought this into the therapeutic relationship and invited Alastair to reflect upon what it was like for him to be in therapy with someone who he felt disliked him. It appeared that this generated some cognitive dissonance and did not square with Alastair's experience of the therapist. He stated "*I've no reason to think you dislike me, and lots of reasons to think the opposite. Come to think about it, I don't know why I've been worrying about things like this. I get really nice feedback from people, and there is no reason for them to lie. Besides, it's not possible to be liked by everyone, so I'm being unrealistic there. As long as I like myself and that the people I care about like me then it really doesn't matter that much*." The therapist considered that this was evidence of further redecision.

Session 11 focused mostly on Alastair's strong sense of social justice and fairness. This was framed as a positive attribute, although in the past had led him to overcompensate in situations where he felt people were being treated unfairly by others. He also explored his strong sense that people "*should feel good about what they are doing. I don't want my workplace to be somewhere that grinds people down. I think we have a responsibility to care for our employees and pay attention to their well-being, above and beyond simple health and safety*." The therapist inquired about the aspects of Alastair's job which had brought him the most satisfaction. He described that aspects which involved coaching, mentoring and so on were the most satisfying tasks. The therapist suggested that perhaps he might explore whether it was possible for him to adjust his workload so that he could do more of this. Alastair was excited by this prospect and felt that this was all within his existing portfolio. The therapist also checked whether Alastair still felt happy with himself and that he had a right to feel all his feelings and this was confirmed.

Alastair's new, positive and relaxed attitude was evident from the beginning of session 12. He reported how his colleagues and his wife had all commented on how he was more relaxed and seemed happier. He described feeling happy and engaged in life and was enjoying a greater sense of connection to others, and in particular, his children. He also reported that his performance at tennis had considerably improved and had been

commented on by the friends he played with. He attributed this to "*being more present and more confident in general*". Conscious of the planned ending in a few weeks, the therapist shifted the focus of the session to relapse prevention. They explored potential prodromal symptoms or processes that Alastair would need to look out for. These were; comparing himself negatively to others, being overly concerned about what others think of him, over-preparing and loss of ability to be in the moment. To support this, the therapist taught Alastair some simple mindfulness techniques in the session and invited him to get a guided mindfulness CD and buy a book on mindfulness.

Alastair started session 13 by describing how he had successfully adjusted his work calendar to enable him to do more of the tasks he enjoyed. He described how he had been practicing mindfulness daily and was finding this incredibly useful. He was also pleasantly surprised to find how enthusiastic his fellow board members had been about this. He spoke about how he had really started to value the uniqueness of himself and others and had let go of negatively comparing himself to others. Instead he realised that he had some weaknesses, but that these were balanced with strengths and that this made him "*no better but no worse than anyone else."* The therapist picked up a card from his bookcase which had the UN declaration of human rights (United Nations, 1948) on it, and asked Alastair to read out articles one and two; "All human beings are born free and equal in dignity and rights" and "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind". The therapist asked Alastair if he agreed with these statements, and then asked Alastair if there was any reason that these might not apply to him. Alastair said he could think of no reason, and then smiled as he recognised the point the therapist had been making.

The final session was devoted to the ending process. During the session, Alastair and his therapist reviewed the entire therapy, discussing and celebrating key changes Alastair had made, specific life events and how he had handled them differently, and the changes in his outcome measure scores (which included the final scores from the beginning of this session). The therapist also reviewed and reinforced Alastair's contingency planning and relapse prevention skills. The informed consent procedure for participating in the research was repeated. Overall, the session was positive and upbeat in nature.

Three month follow-up feedback

At the three month follow-up interval, Alastair completed the CORE-OM, PHQ-9 and GAD-7. The therapist invited Alastair to pass on any information about how he was doing. Alastair responded by saying that "*things are going really well, at home and at work and I'm experiencing so many day to day activities in a completely different way than ever before! I'm much less stressed, less self-critical and much more at ease with life and myself. I still have some times when I find myself making negative comparisons with others, being overly concerned with what others are thinking or procrastinating but these are very rare and I seem able to move on quite quickly*."

Six month follow-up feedback

At the six month follow-up, Alastair repeated the outcome measures and provided the following statement regarding how he was doing; *"I'm doing really well and have been able to maintain a much more positive outlook on life and seem to have kept going and made progress with all of the positive changes that you helped me make. I still have slightly self-critical tendencies and find myself drifting towards making negative comparisons with others but I am now getting quite good at recognising what's happening and having a quiet word with myself so that I don't dwell on it for too long. I've also been working on mindfulness techniques and getting quite good at relaxing and enjoying the moment much more than ever before. Can't thank you enough for your help - it really has been life changing for me but more importantly for my family and especially my kids who now have access to a much more attentive, more focused and less stressed dad!"*

Quantitative Results

Session Rating Scale

The Session Rating Scale (SRS v.3.0) (Duncan, Miller, Sparks, Claud, Reynolds, Brown and Johnson, 2003) is a four-item client self-report measure. The client is asked to provide feedback on ten-point scales relating to their experience of the session. The four items relate to the therapeutic relationship (feeling understood and accepted), focus on client-directed goals for the session, the client's perception of the suitability of the therapist's approach, and an overall rating. As part of the regular and on-going review of the therapy, the therapist invited Alastair to rate his experience of therapy using the SRS at regular intervals. Alastair gave a mean score on all scales of 9.5 throughout the therapy, indicating high levels of satisfaction with the therapy and a strong working alliance.

Comparative Psychotherapy Process Scale Data

The Comparative Psychotherapy Process Scale (CPPS) (Hilsenroth, Blagys, Ackerman, Bonge and Blais, 2005) was administered on two occasions during treatment. Alastair was asked to comment on his experiences of all the sessions so far (or since last measurement point in the case of the second administration). This was used to evaluate whether the TA therapy he received was more similar to CBT or Psychodynamic therapy. The CPPS is a 20-item measure with 10 items each relating to procedures which are characteristically cognitive-behavioural or psychodynamic in nature. Each sub-scale yields a mean score between 0 (uncharacteristic) and 6 (extremely characteristic). Interestingly, Alastair's scores on both sub-scales were a mean of 5.4, indicating that the therapy was equally very characteristic of both CBT and psychodynamic therapy.

Adjudication Process

Case Analysis

The rich case record (McLeod, 2010) was constructed by the author. This included all the collected data from the case, which included quantitative data from outcome and process measures and qualitative data from client interview.

Adjudication

The rich case record was examined, analysed and adjudicated by 83 psychologists who attended a two-day case study research training workshop which was organised by the Centre for Dynamic Psychology, Padua, Italy. Participants in this workshop read the case and discussed it in small groups. All participants then engaged in a group discussion to see if a consensus could be agreed regarding the outcome of the case. The 56 criteria as developed by Bohart, Berry and Wicks (2011) were used to evaluate the case. Bohart et al (2011) developed these criteria as a method of examining psychotherapy case study evidence to enable adjudicators to form clear conclusions regarding the outcome of the case and to identify factors which are likely to have been significant to the outcome of the case. These criteria fall into three broad groupings; the first of which examines the evidence as to whether the client has changed or not. The second group examines evidence for specific changes the client may have made. The third group explores whether there is sufficiently plausible evidence to conclude that the client's changes are due to therapy. Elliott's (2002) eight non-therapy, alternative arguments were also used as a means of examining if there was evidence in the case that the therapy was not effective or if therapy was not the primary causal agent in the client's change process.

Although the use of teams of judges is standard practice in adjudicated case studies, the author is not aware of any previous studies which have drawn on such a large group of professionals for this purpose.

Previous adjudicated case studies have tended to rely on the verdicts of other psychotherapy researchers. As such, it is possible that some inadvertent bias may creep into the adjudication process as it could be argued that as therapists they would be predisposed to having a positive view of psychotherapy. In order to mitigate against this potential bias, the author recruited a lay person to act as a judge in this case and to balance the views of the psychologists who evaluated the case. The lay judge was Paul Pinder, a lawyer who had a degree in chemistry and a post-graduate qualification in secondary education. This judge was known to the author prior to this study, and was approached to participate on the basis of having this dual background in science and law. It was considered that this combination would predispose him towards objective and scientific evaluation of evidence in forming his conclusions on the case. Although it has been suggested in a number of previous papers, the introduction of a lay judge into a case adjudication process is a novel approach in case study research method. Both the panel of psychologists and the lay judge were instructed to examine the rich case record and evaluate it using the 56 criteria proposed by Bohart et al (2011) and the eight non-therapy explanations proposed by Elliott (2002). The panel and the lay judge were also instructed to evaluate each criterion individually and to form their judgement based on whether there was 'clear and convincing evidence' (Stephen and Elliott, 2011) in the case materials that each criterion had been met.

	Session 1	Session 4	Session 8	Session 12	Session 14	1 month follow-up	3 month follow-up	6 month follow-up
CORE-OM	**15** Mild	11.1 Sub-clinical	**15.3** Mild	0.2 Normal	0.2 Normal	0 Normal	0.2 Normal	0.2 Normal
PHQ-9	**10** Mild	6 Mild	6 Mild	0 Normal	0 Normal	1 Normal	1 Normal	0 Normal
HRSD`	**15** Mild	(not scored)	(not scored)	(not scored)	2 Normal	2 Normal	(not scored)	(not scored)
GAD-7	**17** Severe	7 Moderate	5 Mild	5 Mild	3 Sub-clinical	1 Normal	2 Normal	1 Normal

(Scores in bold are in clinical range)

Clinical cut-off points: CORE-OM; >10. PHQ-9; >10. GAD-7; > 8; Reliable Change Index values: CORE-OM improvement of six points, PHQ-9 improvement of six points, GAD-7 improvement of four points.

Table 1: Quantitative Outcome Data

Concluding Evaluation of the process and outcome of therapy

Overall, the analysis team and the lay judge unanimously concluded that the case was a clearly good outcome case, that the client had made many positive changes and that these were clearly as a result of therapy.

Evidence that the client changed

The first 39 criteria examine the case to identify evidence that the client changed. 10 were not applicable to Alastair's case. In the case record, there was clear evidence for each of the remaining 29 criteria that Alastair had changed. This was considered to be clear and unambiguous evidence for positive change and outcome.

These criteria included: that the client stated that he had changed and provided specific information about the changes he had experienced since starting therapy and was able to provide supporting detail and examples. The changes seemed plausible and clearly related to the client's presenting problems and intended direction of change and growth. Alastair's changes included a reduction in symptoms and an increase in subjective well-being, and was confirmed by comments and observations made from his family and associates.

The analysis team noted that Alastair's quantitative outcome measures demonstrated clinically significant change on all four measures, and that this provided evidence of symptomatic change. However, the view of the analysis team and the lay judge was that the qualitative evidence from Alastair's Change Interview was considered to provide an argument which was more compelling and detailed than the quantitative measures. In this Alastair described how he was more relaxed in general and had a greater ability to "*be in the moment*". He provided a moving description of changes in his relationship with his children which seemed to capture the essence of the improvements in his quality of life:

C14-C18: "*It is like I'm experiencing everything for the first time. Like, just going shopping for the first time, (laughs)! Ah, I find it quite hard to explain. I can't articulate exactly what I mean but I have enjoyed it. Just everyday things in a way that I have never before in my whole life. My mind hasn't been busy with doubts or questions or just worrying about things or thinking something completely different. I have been much more sort of enjoying the moment, as it were. Whether that's at work or with family particularly, ah, things that I would have regarded as a bit of a waste of time. Yeah. Like in the morning. Previously, you know I would have been awake, in the shower, at work in no time. Now I really enjoy having a cup of tea with my kids and they'll tell me what they are playing on the iPad. I would have regarded that as a complete waste of time before and I would have been already thinking about something else probably. So, I've enjoyed things like that, going out for a meal, going to the shops, or watching a TV programme with the kids. Things I wouldn't have taken any pleasure whatsoever before, but actually it's like a new experience almost, it feels that different*."

Throughout the interview, Alastair provided consistent examples of how he had learnt to let go of worries and preoccupations and live in and enjoy his here-and-now experience. This appears to have had a considerable positive impact on his overall quality of life. This also seems to have taken place alongside a greater degree of self-acceptance and a letting go of expectations that other people would negatively evaluate him.

C21: "*Yeah, I just feel so much more contented with myself and less critical of myself. Just, you know - it's a bit of a general word - happy, but much happier*"

C24: "*In the past little comments that had been made I would have been worried about them all night, and nothing would have happened. I'm not troubled by that anymore. I'd still like to naturally like please and impress people, you know, not in a show off kind of way, but I'd still take pleasure from that. Ah, I'm not sort of worried all the time that I am being successful or making a good impression. I'm much more comfortable in my own self, if you know what I mean?"*

He described learning to accept praise and experiencing positive and realistic changes in his self-image. These positive changes in his self-esteem, a reduction in his negative self-critical internal dialogue, and more relaxed approach to life suggest that he has resolved his anxiety and depression.

C81: "*The biggest one is enjoying the moment more without being preoccupied for whatever reason. Definitely not worrying about things as much. You know in the past I'd still worry about something if there was a problem to worry about but now I'm not making up things to worry about or worrying unnecessarily. I'm definitely more contented with myself and the life I've got. Before I wasn't really very happy with it. I worry much less of what people think and I'm much more positive about the future. Eh, I've lost that sense of impending doom that I always had over everything. It was better to go wrong than to go too right. Now I can handle praise and criticism better without feeling so uncomfortable. I imagine people disliking me less (laughs) and I feel mentally stronger and more resilient to any sort of knockbacks or things that don't go exactly to plan. I'll deal with them, whatever they are.*"

The description of the therapy process reported changes in Alastair in sessions 7, 9, 10, 12, 13. These changes were considered to be plausible and clearly related to the type of work that was taking place in the therapy. The analysis team felt that although it was constructed from the therapist's notes, there was sufficient evidence in the case narrative to conclude that the therapy work was critical in stimulating these changes.

Evidence that changes were due to therapy

The remaining 17 criteria examine the case for evidence that the client's changes were a result of therapy. Of

these 16 the team could find no evidence for change due to therapy in one criterion, and inconclusive evidence for a further two criteria. The analysis concluded that there was clear and unequivocal evidence for changes being due to therapy in the remaining 13 criteria. This was considered to be clear and unambiguous evidence that the clients changes were due to the effects of therapy.

These included Alastair's clear statements that he believed that his changes were directly due to therapy, and that he was able to provide details of a plausible trajectory of change. Alastair freely discussed aspects of therapy which he found difficult, suggesting that his experiences were not subject to an overly-positive view. There was evidence that descriptions provided Alastair's interview regarding the therapist's relational qualities and a sustained and focused therapeutic approach were consistent with the case formulation, treatment plan and the therapist's notes. Alastair provided specific information about the therapist's use of support and challenge and how an effective balance had been struck between these two aspects of therapy which he had appreciated and which had promoted his growth (see below). Finally, Alastair reported that there were no significant extra-therapy events which could account for his change, and provided evidence of changes which he strongly believed occurred as a direct result of his engagement in therapy.

Alternative explanations for change

The analysis team and the lay judge examined the case using Elliott's (2002) non-therapy explanations for change. The two arguments that the client's changes were due to attempts to please the therapist, or wishful thinking and self-correction, were considered to be explanations which may have been relevant in this case. The conclusion of the analysis team and the lay judge was that there was no clear evidence to support any of these alternative explanations. Specifically, although Alastair had clearly had a positive experience with his therapist, his Change Interview was realistic and plausible. Furthermore, Alastair was able to provide a detailed and consistent but idiosyncratic description of his current circumstances and changes which suggested that his account of his changes was a good representation of his experiences. Despite this, the team did wonder if there was some possibility that Alastair might be down-playing his current difficulties. The argument relating to client expectation was ruled out as Alastair reported that he was surprised by most of his changes, and that the ones he was less surprised about had exceeded his expectations. His description of his life post therapy suggested that he had internalised the change process and integrated a range of positive resources. The argument that changes were due to self-correction was also rejected as although Alastair had used self-help materials, he had used these prior to therapy and reported that these had made no positive impact on his problems. Although he had used self-help methods since starting therapy, these were tools which were suggested to him by his therapist and therefore can be considered to be part of the treatment. Furthermore, Alastair's changes were already firmly in place before he started the self-help methods (namely, mindfulness) as recommended by his therapist, and his Change Interview suggested that the therapeutic relationship had been highly significant in facilitating change.

Analysis of key therapeutic strategies

The analysis team offered some perspectives on the key therapeutic strategies which could be identified in Alastair's qualitative data. The lay judge also provided some interesting insights on his perspectives regarding the key processes of change at work in the therapy which corresponded almost identically with the views of the analysis team.

The therapeutic relationship was highlighted as being highly significant to the outcome of this case. Alastair described quickly feeling at ease with his therapist, which helped him to open up and to overcome some of his embarrassment and discomfort around talking about himself. This turned into a broader sense of being comfortable in therapy. A significant aspect of this was what Alastair described as an atmosphere of permission throughout the therapy:

C184-186: "*And there's somehow… I kind of feel like there's an almost like a sort of permission thing going on, you know. Where it is alright to have the feelings in the first place and it's alright to 'park them up'. I actually thought there would be a lot more digging about in the childhood stuff. But in the end, we discussed it, moved on, parked it up and that was it. I feel that I have been kind of been given permission to just forget everything through that process. Not blank it out - but just . . . accept it and see that it is silly and pointless and needn't have influenced me in the way that it might have done. So, I think your reassurances and putting away concerns about even talking about . . . And sort of reassurance about the feeling that I had that it was too trivial to be speaking about, and getting professional help, all that made a massive difference to just being able to sort of run through stuff and then move on, you know".*

A key mechanism appears to have been a sustained and focused exploration and deconstruction of issues. Associated with this, Alastair reported that he had found his therapist's robust but empathic use of challenge and confrontation to have been helpful in assisting him to view things in a different way:

C195-C200: "*There are loads of things really. But, just even practical things - talking about work things, which you know, you've not painted a bad picture but the fact you were able to see potential in difficult situations or things that made me feel uncomfortable. How you were able to give advice about how I could look at it a different way - sort of 'would that be so bad?' You know . . . Yeah and just the way, you know you present a different "what ifs" and scenarios to the same thing, to get me to think about it more clearly and from a different perspective and*

actually. Yeah, I find that quite. Ah . . . It's a bit intangible, I can't say - you'll know better than me and how you've managed to steer me. Yeah, but you know I just felt . . . I suppose it's just, probably things I might have been thinking anyway but different ways of dealing with things but you've made it sound more ah, just added a bit of authority to something I might have voiced around the irrational thinking about stuff like that . Hearing it from someone else. And in the nicest possible way you've challenged me over certain things to just get over it or get over myself! That's not a bad thing, in fact it's been really good! When you've sort of said "What can come out of thinking that way? Why do you think that way?" That challenge and lots of good advice. I've needed that badly (laughs) Yeah, yeah. A nice atmosphere where I can come and kick a few things around with you. You got me focused on things I particularly want to talk about and that will be useful to me. In a way it's helped me to sort of move on or get over things, if I've needed to get over, ah, and also help me understand rationalise a bit the way in which I've felt a certain way about something. You've forced me to confront the fact that it's not that bad."

C255-C258: "*Ah, also being a bit blunt about you know, on the sort of more "get over yourself" type of thing. You did say that a couple of times on a couple of things! But in a nice sort of way. It always felt right. It was never inappropriate. And you weren't over indulgent in things either…In particular there was a real lack of any sort of 'judgementalness' on your part (laughs) as well which was really helpful. I never felt in the least bit judged. So you've been firm, but I've always felt good about it. Like you had my best interests at heart."*

C217: "*You've definitely reframed things that I've said in terms of - what, is it like this, or is it like that? Yeah, I know that you have done it all the time with different things as we've looked at it from a different way. Would it be so bad if it was this or if the other person thought that? Would that be bad?"*

C221-C222: "*Yeah, I was worried about what people thought of me and you've said a few times "give me specific examples," you know, "why is it so bad if they might think differently about that?" Yeah, you give me a bit of reality check on some things really eh, yeah, lots of different things actually. Definitely a reality test. Things were . . . Well, I thought things were quite bad and thought me and everything else was terrible and they weren't particularly. I was making it like that with the way I thought about things and how I felt about stuff."*

The therapy involved helping Alastair to explore and come to terms with his past but without the therapy being overly-focused on this:

C248-250: "*Eh, well I had this preconception that it's all about your childhood and imprints and all that sort of stuff. And ah, it's been quite helpful to have touched on things some of those things without spending hours on, you know, my relationship with my parents and that sort of thing. Em, so it was really helpful just recognising that it's got an impact on everyone and probably from a young age and actually You don't have to go back and play mind games to wipe it all out, just have to, you know . . . (pause) Come to terms with whatever it is and but it's part of who you are and . . . So that was really helpful*. "

In this sense it would appear that Alastair stated to conceptualise his life script, explore and accept past hurt and to integrate this new acceptance into a new narrative. As part of this process, Alastair reported that learning about TA theory was useful. This included understanding his script and his development - how he came to be how he was:

C294-301: "*I'm taking a bit of time for things and for me and also for other people. Yeah, definitely, it's you know, it's taken me the last few weeks to really notice a big difference from it. It's all helped with the enjoying the moment much more whatever that might be . . . Also learning about transactional analysis - life scripts and ego states and stuff that I was interested in. But it did help me with some of things in how I would naturally feel as a result of things in early life. Not specific events, but just general feelings at the time you carry with you that make an impact in how you are. I don't feel negatively about the past or anything, but I've understood how it's influenced who I was and who I have become. Making sense of some things in my childhood I've understood influences on me as a person - who I am now that I didn't think particularly were important. I understand better how it's been some of the things I want to change about myself that have come from that stuff. So, I think the theory is quite handy and you talking about it has got me a bit more interested in it and I've done a bit more background reading on it after sessions and since we finished as well. That's really helped me to make sense of it all - all what was going on for me*."

Discussion

This is the fourth case study which has demonstrated the effectiveness of TA psychotherapy for depression, and the second case study investigating the outcome of TA psychotherapy for a man with mixed depression and anxiety. Due to the fact that this case was of mixed anxiety and depression, this potentially acts as a limitation as it does not increase confidence in the specificity of TA for depression *only*, however it does highlight the clinical effectiveness of TA, when used in routine practice with a client with comorbid depression and anxiety. Although the research evidence is gathering, further replications are needed to firmly establish TA as an empirically supported therapy for depression as well as for mixed anxiety and depression. This present case also provides some support for the utility of the treatment manual which was used to guide the therapy. Further research is clearly needed to investigate and validate the treatment manual.

With regards to limitations of the case, it is possible that the multiple roles that the author took within the case (therapist, compiler of case record and facilitator of the

panel of psychologists) may have inadvertently allowed researcher bias to influence the research process and overall conclusions drawn. Similarly, as the lay judge was an associate of the author, it is possible that the process may have been unconsciously influenced. Nevertheless, many of the psychologists did not have any allegiance to TA, and the lay judge was chosen for his objectivity and of him having no personal or professional allegiance to either TA or psychotherapy as a whole. Although consensus was reached in the meeting of the panel of psychologists regarding the conclusions of the case, it is impossible to tell if the power of the group acted to silence any dissenting voices. Despite this, it would appear that there is clear and convincing evidence that the client changed substantially and that these changes were due to the effects of TA therapy.

The finding which suggested that the therapy in this case was equally like both psychodynamic and cognitive-behavioural therapy is intriguing, and suggests that an examination of TA therapy which investigates its similarities in process to these types of therapy is warranted.

Comparison to previous cases

The case of Alastair most closely resembles that of 'Tom' (see Widdowson, 2012c). Both Alastair and Tom had depression with co-morbid anxiety, although Tom's depression was moderate and Alastair's depression was mild at point of entry into therapy. Although no measure of Tom's anxiety was taken during his therapy, a re-analysis of the case record suggests that his anxiety was not as severe as Alastair's. Nevertheless, both cases seem to provide foundation evidence of the effectiveness of TA psychotherapy for mixed anxiety and depression.

Both Tom and Alastair were around the same age, and both were white, British men. The therapists in the two cases were roughly matched in terms of level of experience, although Tom's therapist was white British female and Alastair's therapist was white British male. This would suggest that therapist gender is not likely to be a significant factor in determining outcome of the case.

There is considerable similarity in therapeutic factors between the present case and the cases of 'Peter' (Widdowson, 2012a), 'Denise' (Widdowson 2012b), 'Tom' (Widdowson, 2012c) and 'Linda' (Widdowson, 2013). In all of these cases the therapeutic relationship appears to be characterised by an atmosphere of permission, combined with emotional support with robust challenge. The most significant change appears to have taken place when the therapy was experiential. The therapeutic process appears in all of these cases to involve significant deconstruction of past events, examining and reframing these, finding new perspectives and creating new meaning. As part of this process of finding new meaning, all of these cases suggest that learning about TA theory was helpful for the client to understand and change their own process and the use of the shared language of TA created a collaborative and egalitarian framework for the therapy.

Conclusion

This case has provided initial evidence that TA therapy can be effective for the treatment of mixed depression and anxiety and also adds to the existing evidence regarding the effectiveness of TA therapy for depression. The case also provides preliminary evidence that the TA treatment manual used in this case is a promising approach for the psychotherapy of depression.

The findings also suggest new directions in TA-based psychotherapy process research, which might include, for example, research which explores the similarities and differences between TA and other forms of therapy (specifically cognitive-behavioural therapy and TA) and research which investigates primary change mechanisms in TA therapy as well as particular therapeutic strategies (e.g. experiential focus) which might be most productive in maximising therapeutic change.

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References

American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders* 4th edition (DSM-IV). Washington DC: American Psychiatric Association

Berne, E. (1961) *Transactional analysis in psychotherapy*. New York: Grove Press.

Blatt, S. (1974). Levels of object representation in anaclytic and introjective depression. *Psychoanalytic Study of the Child*, 29: 107–157.

Bohart, A.C., Berry, M. and Wicks, C. (2011). Developing a systematic framework for utilizing discrete types of qualitative data as therapy research evidence. *Pragmatic Case Studies in Psychotherapy*, 7(1): 145-155.

Duncan, B.L., Miller, S. D., Sparks, J.A., Claud, D.A., Reynolds, L.R., Brown, J. and Johnson, L.D. (2003). The session rating scale: preliminary psychometric properties of a 'working' alliance measure. *Journal of Brief Therapy,* 3(1): 3-12.

Elliott, R. (2002). Hermeneutic single case efficacy design. *Psychotherapy Research*, 12: 1-20.

Erskine, R.G. (2010). *Life scripts: a transactional analysis of unconscious relational patterns*. London: Karnac.

Erskine, R., Moursund, J. & Trautmann, R. (1999). *Beyond Empathy: A therapy of contact-in-relationships.* New York: Routledge.

Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J. and McGrath, G. (2000). CORE: clinical outcomes in routine evaluation. *Journal of Mental Health*, 9(3): 247-255.

Festinger, L. (1957). *A Theory of Cognitive Dissonance*. California: Stanford University Press.

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

Goulding, M.M. and Goulding, R.L (1979). *Changing lives through redecision therapy*. New York: Grove Press.

Hamilton, M (1980) Rating depressive patients. *Journal of Clinical Psychiatry*. 41: 21-24

Hargaden, H & Sills C (2002) Transactional *Analysis – A Relational Perspective* Hove: Brunner-Routledge

Hilsenroth, M. J., Blagys, M.D., Ackerman, S.J., Bonge, D.R. and Blais, M.A. (2005). Measuring psychodynamic-interpersonal and cognitive-behavioural techniques: development of the comparative psychotherapy process scale. *Psychotherapy: Theory, Research, Practice, Training,* 42(3): 340-356.

Kroenke, K, Spitzer, R, Williams J. (2001). The PHQ-9: Validity of a Brief Depression Severity Measure. *Journal of General Internal Medicine*, 16

McLeod, J. (2010). *Case study research in counselling and psychotherapy*. London: Sage.

Schiff, J. L., Schiff, A. W., Mellor, K., Schiff, E., Schiff, S., Richman, D., Fishman, J. Wolz, L., Fishman, C., and Momb, D. (1975). *The cathexis reader: transactional analysis treatment of psychosis.* New York: Harper and Row.

Spitzer, R, Kroenke, K, Williams J, Löwe B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Archives of Internal Medicine*, 166.

Steiner, C. (1974). *Scripts people live*. New York: Grove.

Stephen, S. and Elliott, R. (2011). Developing the adjudicated case study method. *Pragmatic Case Studies in Psychotherapy,* 7(1): 230-241.

Stewart, I. and Joines, V. (1987). *TA Today: a new introduction to transactional analysis.* Nottingham: Lifespace.

United Nations (1948). *Universal declaration of human rights.* http://www.un.org/en/documents/udhr accessed 7 July 2014

Van Rijn, B. and Wild, C. (2013). Humanistic and integrative therapies for anxiety and depression: practice-based evaluation of transactional analysis, gestalt, and integrative psychotherapies and person-centered counselling. *Transactional Analysis Journal,* 43(2): 150-163.

van Rijn, B., Wild, C. and Moran, P. (2011). Evaluating the outcomes of transactional analysis psychotherapy and integrative counselling psychology within UK primary care settings. *International Journal of Transactional Analysis Research*, 2(2):34-43.

Widdowson, M. (2010). *Transactional analysis: 100 key points and techniques*. Hove: Routledge.

Widdowson, M. (2011). Depression: diagnosis, sub-types, patterns of recovery and psychotherapeutic models – a literature review. *Transactional Analysis Journal,* 41(4): 351-364.

Widdowson, M. (2012a). TA treatment of depression - a hermeneutic single-case efficacy design study - 'Peter'. *International Journal of Transactional Analysis Research*, 3(1): 3-13.

Widdowson, M. (2012b). TA treatment of depression - a hermeneutic single-case efficacy design study – 'Denise'. *International Journal of Transactional Analysis Research*, 3(2): 3-14.

Widdowson, M. (2012c). TA treatment of depression - a hermeneutic single-case efficacy design study- 'Tom'. *International Journal of Transactional Analysis Research*, 3(2): 15-27.

Widdowson, M. (2013). TA Treatment of depression- A hermeneutic single-case efficacy design stud y- 'Linda' – a mixed outcome case. *International Journal of Transactional Analysis Research*, 4(2): 3-15.

Widdowson, M. (in press) Transactional Analysis for depression: A step-by-step treatment guide. Hove: Routledge.

Woollams, S. and Brown, M. (1979). *Transactional analysis*. Dexter: Huron Valley Institute

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Book Review: *What you really need to know about Counselling and Psychotherapy Training*

Cathy McQuaid, London and New York: Routledge, 2014, 200 pages

Julie Hay

Subtitled as An Essential Guide, this book presents the results of Cathy McQuaid's doctoral research in a way that makes it useful to students considering their training options, in the expectation that this will result in " . . . The most rewarding and transformative experience they have ever encountered, and one that can be deeply reparative . . . [Rather than one that leaves them feeling] puzzled, confused, frustrated, and even betrayed, when they discover the reality of what they have taken on." (p.1)

During her research, McQuaid writes that she interviewed about 50, ranging from those who decided not to finish the training through to those who went on from their initial training to qualify as trainers themselves. She used Interpretative Phenomenological Analysis (IPA) (Smith, 1995) and identified five main themes and five main concerns.

As for a research paper, the first chapter provides the 'literature review' – in this case definitions of counselling and psychotherapy, theories of learning, and some useful tables detailing academic levels and qualifications, with the latter relating the UK & Northern Ireland (UK/NI) to the European Qualifications Framework (EQF).

Chapter 2 continues the background review with a helpful summary of counselling and psychotherapy modalities. McQuaid sensibly limits the 400 or so differently named approaches in Karasu's (1986) survey to those accredited nowadays by the main professional bodies. She describes Art, Drama and Music therapies; Cognitive Analytic and Cognitive Behavioural; Existential and Personal Construct as subdivisions of Constructivist; Family, Couples and Systemic; Humanistic and Integrative which includes Gestalt; Person-Centred; Psychosynthesis and Transpersonal alongside Transactional Analysis; Hypno-psychotherapy; Psychoanalysis, including Group Analysis and Jungian Analysis; and Sexual and Relationship.

The third chapter outlines entry requirements and course curricula because the lack of clarity about these was a key finding of McQuaid's research.

In Chapter 4, McQuaid describes the personal impact of training and the relevance of (and generally requirement of professional bodies) for personal therapy during training. Reflective practices are also described as a set of key skills. A checklist is provided with questions to ask a potential therapist.

The impact on self is continued in Chapter 5, where McQuaid presents the six main themes of: relationship with the trainer; bonding between peers; the transformational impact of the training; the nature of the training group; the importance of ethics; and the sense of belonging during and after the training. Here McQuaid links her research findings to various theories, including phases of transformational learning (Mezirow, 1991), group stages (Tuckman, 1965), and attachment (Ainsworth & Bell, 1970). I have my doubts about the wisdom of including the unconscious competence model (which McQuaid references to Robinson 1974 although this attribution has been challenged elsewhere) because I doubt that it is ever a 'good thing' for a therapist to relax into unconscious competence. I also thought that Berne's (1963) concept of group imagoes would have provided more reflective understanding of group processes, and would have made clearer the tendency to psychologically recreate our families of origin.

In Chapter 6, McQuaid comments that all of the interviewees said they reached a stage of disillusionment with their course, usually between the second and third years. In my view, being told this

will be an effective normalisation for a student. McQuaid also provides information on the ways in which disillusionment may be prompted, such as expectations not being met, the challenge of academic work, the unexpectedly high level of personal change, the eventual realisation that it is not easy to find clients or jobs, coupled with the difficulties of achieving a satisfactory financial situation. Various suggestions are included to help deal with these themes.

Chapter 7 goes on to provide more specific ideas about employment opportunities and how the various qualification options affect job prospects. A 'political' view is presented about the implications of statutory and voluntary registration, and the availability of accreditation and registration systems run by various UK/NI associations and the European Association for Psychotherapy (EAP).

The final chapter presents a 12-step plan of action, referring back to the questions that McQuaid includes at the end of each of the previous chapters. This is supported by Appendices that list the main accreditation/regulatory bodies and other relevant professional organisations, provide examples of logbook templates and a personal learning contract, and a glossary of terms used in the book.

This highly practical book is an excellent example of the usefulness of research, as McQuaid presents the results of her IPA in ways that are easily comprehended by the reader. I suggest it will become 'required reading' for all potential counselling and psychotherapy students; even those outside the UK/NI will find much of interest. I look forward to the publication of McQuaid's research paper, hopefully in the next issue of IJTAR.

References

Ainsworth, M D S & Bell, S M (1970) Attachment, exploration, and separation: illustrated by the behaviour of one-year-olds in a strange situation. *Child Development*, 41 49-67

Berne, E (1963) *Structure and Dynamics of Organizations and Groups* Philadelphia: Lippincott

Karasu, T B (1986) The specificity versus nonspecificity dilemma: toward identifying therapeutic change agents. *American Journal of Psychiatry* 143 687-695

Mezirow, J (1991) *Transformative Dimensions in Adult Learning.* San Francisco, CA; Jossey-Bass

Robinson, W L (1974) Conscious competency – the mark of a competent instructor. *Personnel Journal*, 53 538-539

Smith, J A (1995) Semi-structured interviewing and qualitative analysis. in Smith,J A, Harre, R &Van Langenhouve, L (eds) (1995) *Rethinking Methods in Psychology.* London: Sage

Tuckman, B (1965) Developmental sequence in small groups. *Psychological Bulletin* 63 (6) 384-399