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Editorial

Julie Hay

This has been a very exciting issue to work on. It began with what seemed to be an interesting article – and it has grown into a complete issue devoted to a specific approach to research that can be readily copied across the TA community.

As it says in the Abstract, Mark Widdowson has applied a hermeneutic single-case efficacy design to demonstrate that transactional analysis has indeed functioned as a useful treatment for depression. Although this is a one-case study, I know that Mark has conducted more, and I am looking forward to publishing more articles from him in future issues.

In the meantime, Mark has very generously provided us with a comprehensive set of supporting papers, which we are publishing as a series of appendices. This turns what was already a very competent academic article into something much more significant. As you will see as you read on, you have all you need in this issue of IJTAR to enable you to duplicate the study that Mark is describing. It is my fervent hope that many of you will be as inspired by this as I have been, and I look forward to being able to publish many more articles, and hence to build up enough case material to demonstrate what those of us in the TA community already know intuitively about the positive impact of TA.

I am conscious that some of you will be thinking as you read on that this is a clinical case study and is therefore irrelevant to you because you practice in the educational or organisational fields of application of TA. I urge you to think again! The methods described in the article can easily be applied in a non-clinical context. And just as the author will be happy to advise any researchers who wish to follow in his footsteps, as an Editor who happens to be qualified in the educational and organisational fields, I will be happy to answer questions about how you might convert the processes.

Our Layout Editor has commented on the amount of material contained in this issue. In fact, what she said was "This has being like setting out a book." Indeed, there would certainly have been scope for Mark to have had this published as a book. It is even more creditworthy, therefore, that he has supported IJTAR by giving the materials to us.

So, as you read on, think about demonstrating your gratitude to Mark Widdowson by setting up your own research studies – and, of course, submitting your articles for publication in future issues of IJTAR. In that way, we can support him in his aim of establishing TA as a proven evidence-based approach.



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

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Abstract

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

The author provides detailed appendices to encourage others to replicate the research and add to the body of knowledge based on the HSCED process.

Key words

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

Introduction

In this article, the author presents the therapy of Peter, a 28 year old man who sought out therapy for the treatment of depression. This article is the first in a series of HSCED studies conducted by the author as part of his doctoral research investigating the process and outcome of TA psychotherapy for the treatment of depression. The objective of the research is to investigate the effectiveness of short-term TA therapy for the treatment of depression and to explore and

identify key aspects of the TA therapy process and associated factors promoting change amongst effective cases. Although depression is one of the most common disorders TA psychotherapists see in practice, the author has only been able to identify one piece of research investigating the outcome of a TA therapy group for the treatment of depression (Fetsch and Sprinkle, 1982). Despite this paucity of TA research on depression, various TA authors have offered theoretical perspectives on the treatment of depression (see Widdowson, 2011b for a summary of the TA literature on depression).

It is the author's aim to develop the TA literature and research evidence-base regarding the effectiveness of TA for the treatment of depression, and by presenting examples of case study research, to encourage the TA community, who are experienced at producing detailed case studies, to engage with case study research and contribute to the TA evidence base. The full, rich case record, the affirmative and sceptic cases, and the Judges Opinions are therefore provided as appendices, along with templates for Information for Participating Clients, Informed Consent Agreement, Therapist Session Notes, Therapist Adherence Checklist, and Supervisor Adherence Checklist.

The client has read the case report and given his consent for the report and extracts from the Change Interview to be included in and published in scientific professional journals.

For many years, psychotherapy research has been dominated by Randomised Controlled Trials (RCTs), which have been used to make claims regarding the efficacy of different therapies. Whilst such trials have provided compelling evidence regarding outcomes of therapy and demonstrated that psychotherapy is an effective treatment for psychological problems, the tightly controlled conditions within which they have been conducted have been criticised as bearing little

resemblance to the realities of the consulting rooms of most therapists. Furthermore, these studies have not been able to adequately capture the complexity of the client and the therapy and have also been criticised as being 'causally empty' (Elliott, 2002) in that they have not been able to provide detailed description as to how the clients changes have come about. Historically, case study research has been dismissed as unscientific, biased and as simply 'anecdotal evidence' (McLeod, 2010). Recent developments in case study research have begun to address these criticisms by putting forward systematic and robust methods for presenting case study research (Fishman, 1999; Elliott, 2001, 2002; Miller, 2004; Iwakabe and Gazzola, 2009; Bohart et al, 2011; McLeod, 2010).

Elliott's Hermeneutic Single-Case Efficacy Design (HSCED) (Elliott, 2001, 2002) is an approach to case study research which is procedurally-defined and systematically incorporates the critical-reflective cross-examination of both qualitative and quantitative data to develop a detailed and plausible argument that a client has changed as a result of therapy (Elliott, 2002; Stephen and Elliott, 2011). Furthermore, HSCED also involves good-faith attempts to developing plausible alternative explanations for the client's changes. Both arguments are critically evaluated and subjected to a quasi-legal interrogation, and judges are invited to make their verdict about the outcome of the case. Within HSCED, the research questions being investigated are:

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

In this present study, the judges were asked an additional question, which was to provide a verdict classifying the outcome of the case as either good outcome, mixed outcome, or poor outcome.

As HSCED is a systematic case study approach (Iwakabe and Gazzola, 2009; McLeod, 2010), "data (is) ...gathered from multiple sources, such as questionnaires, therapist and observer ratings, and participant interviews, to construct a rich and comprehensive account or case summary, which is then triangulated in order to examine whether different sources of data converge." (Iwakabe and Gazzola, 2009: 602-3).

HSCED was initially developed as a practitioner-researcher model (McLeod, 1999) of research inquiry that would be accessible to single researchers, therapists and trainees wishing to systematically investigate cases for the purposes of research (Elliott, 2002; Stephen and Elliott, 2011). As HSCED has

developed, the analysis and cross-examination of evidence is now generally done by a team of researchers and the deliberations of the research team are sent to independent adjudicators who are 'invited to evaluate the evidence presented by the affirmative and sceptic teams and to give their opinions on the central research questions of client change and the causal role of the therapy in that change' (Stephen and Elliott, 2011: 232).

The credibility of psychotherapy research can be undermined by the potential for researcher bias - that is, researchers who have a particular allegiance to one type of therapy may inadvertently present a positive bias towards that therapy in their findings. In the present study, this has been addressed by inviting two independent psychotherapy researchers to adjudicate and draw expert conclusions regarding the outcome of the case.

Method

Participants

Client

Peter was a 28 year old man who lived alone. At the time of entering therapy he was single, and had been unemployed ever since being made redundant two years previously. Peter had been educated to degree level. He had been diagnosed with depression by a psychiatrist five years earlier, and was not on medication, although he had previously had some therapy which had been unsuccessful. Although he reported having a reasonable number of friends and acquaintances, he presented as being fairly socially isolated, seeing people infrequently. Peter had been bullied throughout school and had felt dominated through his childhood by his strict father. Peter's mother died when he was a teenager and he recalled being in shock immediately following his mother's death and being told by various family members that he 'had to be strong and be a man now'. Consequently he has no recollection of any grieving.

He presented for therapy being aware of holding many buried feelings which he felt sure were driving his depression, but feeling unable to access them and feeling disconnected from feelings in general other than a sense of sadness, despair and hopelessness.

Peter was an intelligent, reflective and articulate young man with evidence of strong psychological mindedness with clear and realistic expectations regarding the process of therapy. He appeared motivated to change, and had sought out therapy independently, doing quite careful research to find a therapist in private practice who he felt would have the necessary skills and experience to help him. He travelled for quite some distance to see his therapist, again suggesting that he was well motivated.

When Peter came for his initial appointment, the therapist's assessment identified that Peter was eligible to participate in the study, meeting DSM-IV (American Psychiatric Association, 1994) criteria for Major Depressive Disorder, and meeting 'caseness' criteria of a CORE (Barkham et al, 2006) score of over 15 and a Beck Depression Inventory-II (Beck et al, 1961; Beck et al, 1996) score of over 16, and that he did not meet any of the exclusion criteria (e.g. psychosis, bipolar disorder, antidepressant medication, or alcohol or drug abuse and was not experiencing domestic violence). The therapist described the study to Peter and gave him an information pack regarding the research to take away and read. Peter contacted the therapist several days later, stating he would like to participate in the research, and he attended for an intake interview where he completed the outcome measures and a consent form. Peter's scores on CORE-OM indicated moderate distress and functional impairment and his BDI-II score indicated severe depression, which was confirmed in clinical interview. Peter also completed a consent form and release of audio recordings form at the end of the therapy, and has given his permission for his case to be used for the purposes of teaching and research, and to be published in professional journals. He was seen in a naturalistic therapy protocol in private practice. The research covered a period of sixteen sessions, although Peter attended a number of maintenance sessions after the research period to consolidate and develop his gains.

Therapist

The author, a 38 year old British male was the therapist in this case. He is an experienced TA psychotherapist with 15 years of experience, and a former course tutor to the three members of the analysis team. Using a practitioner-researcher model (McLeod, 1999), the therapist engaged in both therapy and research activities in relation to this case, and this had been made transparent to Peter before, during and after the therapy. The author developed the rich case record and participated in developing the affirmative and sceptic cases, as well as contacting and requesting the participation of the judges. The therapist was supervised on this case by an experienced Teaching and Supervising Transactional Analyst on a monthly basis.

Analysis Team

The analysis team was comprised of three therapists (Katie Banks, Julia McLeod and Cholena Mountain) and the author. The analysis team were all known to the author and were invited to participate in this process on the basis of particular skills the author felt they had which would be useful in conducting the analysis and was partly due to reasons of convenience and ease of recruitment of members of the team. All three members of the analysis team were experienced therapists and have master's degrees in counselling or psychotherapy and two members are internationally accredited as Certified Transactional Analysts (Psychotherapy

specialism) (KB and CM). One member has a background in law (KB), and another has also has a master's degree in applied psychology and has experience of working in a psychotherapy research clinic and conducting psychotherapy research (JM). The analysis team were given selected reading to familiarise them with the method, and were sent a copy of the rich case record. Each member of the analysis team participated in developing both the affirmative and sceptic cases.

Judges

The two independent judges were selected on the basis that they were therapists from another modality, and had experience of conducting a HSCED investigation. The judges were recommended to the author by Robert Elliott, the originator of the HSCED approach and neither judge was known to the researcher. The judges were Rachel MacLeod, a counselling psychologist working in the UK National Health Service, who has a doctorate in counselling psychology and a diploma in Person-Centred Counselling and Susan Stephen, a Person-Centred BACP accredited counsellor working in private practice who has a background in law and a masters degree in counselling.

Measures

In order to build the rich case record, and to compile multiple sources of evidence, Peter completed a number of quantitative and qualitative procedures which are described below. The therapist also completed detailed, structured session notes and an adherence form (see appendices).

Quantitative Outcome Measures

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

Weekly Outcome Measures

In order to measure on-going progress, and to facilitate the identification of key therapeutic events which produce significant change, two weekly outcome measures were administered prior to the start of each session. These were CORE-10 (Connell & Barkham 2007), a ten item shortened version of the CORE-OM which has good correlation with CORE-OM scores and can be used to monitor change. The second measure was the simplified Personal Questionnaire (PQ) (Elliott, et al,

1999). This is a client-generated measure in which clients specify the problems they are wanting to address in their therapy, and rate their problems according to how distressing they are finding each problem. The PQ was also administered at each of the three follow-up intervals.

Qualitative Outcome Measurement

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

Qualitative Data about Helpful Aspects of Therapy

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

Therapist Notes

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

Adherence

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

HSCED Analysis Procedure

Affirmative Case

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

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

Sceptic Case

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

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

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

Adjudication Procedure

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

Results

Quantitative Outcome Data

Quantitative outcome data for Peter can be seen in Table 1. His pre-therapy scores were all well within the clinical range, and substantially above the caseness cut-off for inclusion in this research. Peter's clinical score at point of entry to therapy using CORE-OM was 21.76, indicating moderate levels of distress and functional impairment and his BDI-II score was 35, indicating severe depression. By the end of therapy, Peter had achieved clinically significant change on CORE-OM and PQ, and had achieved reliable change on the BDI-II. Peter's gains continued into the follow-up period, and were maintained at levels of clinically significant change.

At the end of each therapy session, Peter completed the HAT form, indicating what had been helpful or hindering in the session. In each session he indicated at least one helpful event and no unhelpful or hindering

events. Many of Peter's comments indicated the events he found most helpful were related to emotional processing, insights or new learning. For example:

- In session 11, Peter said the most helpful part of the session had been 'Achieving the goal I had for the session - finding an experiential approach that will let me find a method of coping with emotions. It's inherently good, as it will be useful, and it's satisfying to achieve.' (rated 9 - 'extremely helpful') This appeared to correspond with the therapist's notes which indicated that the session had focused on deconfusion work - expressing and processing emotions.

- In session 15, Peter and the therapist focused on identifying and addressing interpersonal problems and his HAT comments from the session were; 'Recognition of a deficiency in my interpersonal skills and the suggestion of a new approach. It gives me a way forward, to express myself with the confidence that I might be understood. An instant - "eureka!" '(rated 9 - 'extremely helpful')

Qualitative Outcome Data

In his follow-up Change Interview, Peter was asked to identify the main changes he felt had occurred during therapy. The changes are listed in Table 2. He identified five changes, two of which related to changes in perspective from a negative, pessimistic outlook to a more balanced one and a similar change relating to the development of hope for the future. Another change related to interpersonal changes, and the final change related to increased awareness of negative reinforcing patterns.

Table 1. Peter's Outcome Data

	Beck Depression Inventory-II	CORE-OM	Personal Questionnaire (mean score)
Clinical cut-off	10	10	3.00
Caseness cut-off	16	15	3.50
Reliable Change Index	5.78	4.8	0.53
Pre-Therapy	35	21.7	5.83
Session 8	32	20.2	4.71(+)
Session 16	20.0(+)	12.9(++)	2.71(++)
1 month Follow-up	10.0(++)	5.2(++)	2.57(++)
3 month Follow-up	13.0(++)	11.9(++)	2.28(++)
6 month Follow-up	8.0(++)	5.0(++)	2.21(++)

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

Figure 1. Weekly CORE-10 scores

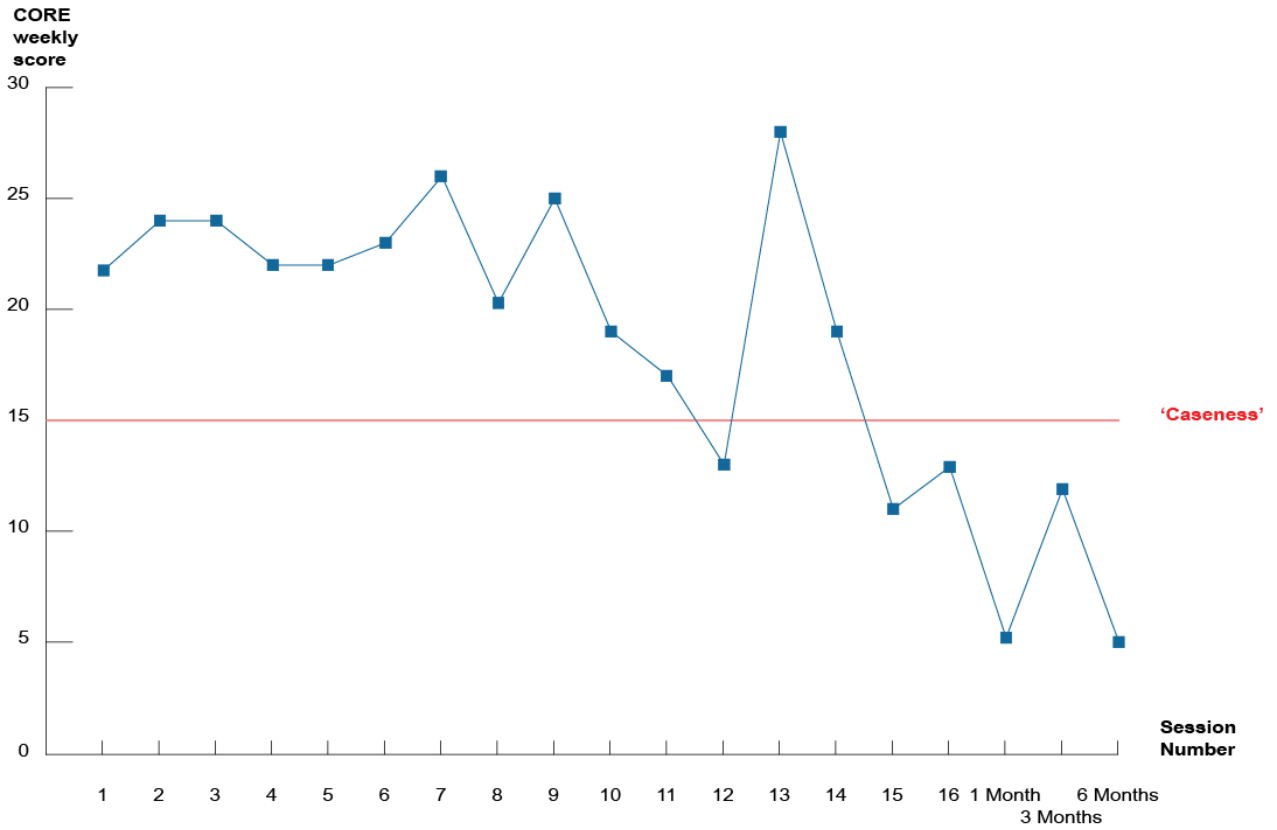
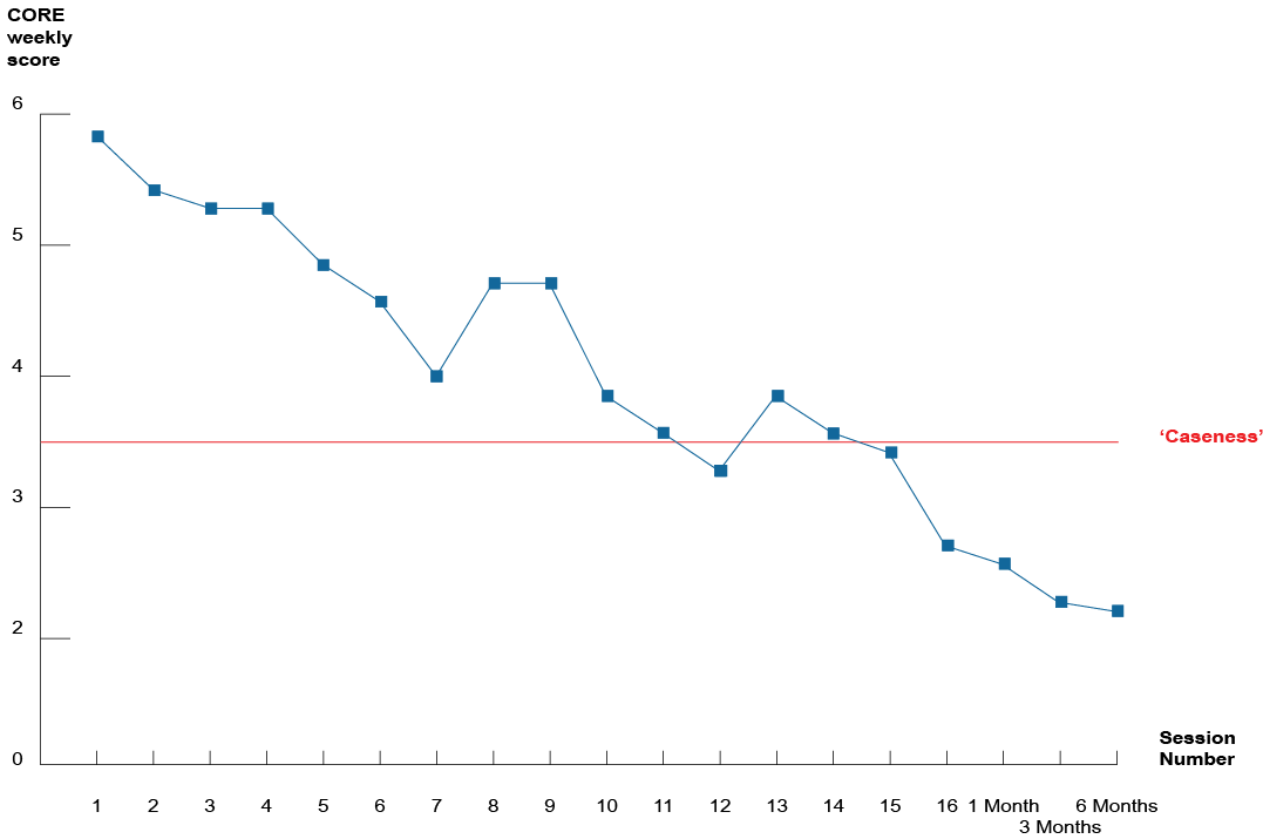


Figure 2. Weekly mean PQ scores



He identified all five changes as both surprising and unlikely to have occurred without therapy. He identified two of these changes as 'extremely important', two as 'very important' and one as 'moderately important'.

Table 2. Peter's changes as identified in post-therapy Change Interview

Change	How much expected/surprising change was ^a	How unlikely/likely change would have been without therapy ^b	Importance of change ^c
A shift in perspective from 'life is shit' to 'actually, maybe I'm not viewing things clearly'	5	1	5
Awareness of these reinforcing patterns and how I get into them	5	1	4
A sense of hope and possibilities for change	5	1	3
Starting to interpret things differently e.g. not expecting a fall, not expecting bad things to happen	5	1	5
Changes in how I feel in myself and in how I interact with others - interpersonal changes	5	1	4

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

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

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

Affirmative Case

Below is a summary of the affirmative and sceptic cases and their rebuttals. The full document can be seen in Appendix 2.

The affirmative case presented four lines of argument that Peter had changed substantially, and that these changes had been as a result of therapy. The first argument related to changes in long-standing problems. Peter identified five of his seven problems listed in his PQ as of more than 10 years in duration and that he had achieved global reliable change on all outcome measures, clinically significant change in two measures by the end of therapy, and clinically significant change on all three measures by the end of the follow-up period. Peter's retrospective attribution during his post-therapy Change Interview of the changes being unlikely to have come about without therapy was cited as another source of evidence. The affirmative case

argued that Peter's comments in his HAT forms were consistent with TA therapy and the account of the therapy as described by the therapist and that direct and plausible correspondence was found between these events and the overall changes Peter identified in his Change Interview.

Sceptic Case

The sceptic case presented three main alternative arguments to the affirmative case. These were that although Peter had demonstrated improvement on quantitative outcome measures, his BDI-II scores were still within the clinical range at the end of therapy, as was one of his PQ scores. They also identified that in the second follow-up, Peter reported deterioration on both CORE-OM and BDI-II scores to within clinical levels of distress, suggesting that Peter's changes had not been maintained. The sceptic case also considered that due to Peter's positive description of the therapy and the therapist in his Change Interview, it was possible that (social) relational factors were influencing his report, and that despite his positive descriptions, he had not made any significant life changes during the course of therapy.

Affirmative Rebuttal

The affirmative rebuttal included the argument that even though there had been some deterioration in Peter at follow-up two, his PQ scores had shown improvement indicating that his problems had not returned. It was suggested that as all scores improved at follow-up three, that the deterioration represented a period of temporary distress and that it was possible that Peter had developed sufficient internal resources and had experienced sufficient personal change during the course of his therapy to enable him to overcome this period of distress effectively without experiencing relapse.

Sceptic arguments of relational factors were countered by the affirmative rebuttal noting that the narrative of the case study suggests that at several points the client and therapist experienced difficulties and relationship ruptures which appeared to have been successfully resolved, and that it is perhaps only to be expected that a client who had been through such rupture repairs would emphasise the relational skills of their therapist.

Similarly, sceptic suggestions that the work was tinged by an overly positive glow were not supported by statements by the client that he felt he still had work to do, and felt that these statements added balance and credibility to claims that the therapy was effective and appropriate to the client's needs.

Finally the affirmative rebuttal noted that even though Peter had not made any substantial life changes, he had made a number of internal changes, and that his case included sufficient evidence of behavioural change. It was also noted that given Peter's circumstances (unemployment, being a part-time carer) it was unrealistic to expect substantial life changes.

Sceptic Rebuttal

The sceptic rebuttal focused on the argument that at the end of therapy, the client experienced a temporary feeling of well-being, which arose from regular contact with his therapist, but did not exhibit any substantial shift in his relationships with other people, or in his everyday life as a whole. As a result, as the meetings with the therapist tailed off, his symptoms gradually returned. Furthermore, that although in the third (six month) follow-up measurements Peter demonstrated an improvement in his scores from those at the second (three month) follow-up, with reliable change occurring on his CORE scores, no further information is provided to account for either the increase in scores at the three-month follow-up or the reduction in scores at the six-month follow-up. The argument was put forward that this fluctuation may indicate that the impact of extra-therapy factors on Peter's symptoms is greater than has been indicated previously, and/or that his symptoms are more reactive and responsive to external stressors than suggested in the case report.

Adjudication

Each judge independently produced their opinions and ratings of the case. Their individual conclusions are presented in Table 3. A median score has been given to represent a balance of the two judge's conclusions. To summarise, the judges concluded that Peter had experienced clinically significant changes, although had not fully resolved his problems, and that these changes were substantially due to therapy.

Summary of opinions regarding how the judges would categorise this case

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

The judges considered that data from the quantitative change measures (CORE, BDI-II and PQ) provided evidence of clinically significant changes in both client identified problems (PQ), global distress and functional impairment (CORE) and target symptoms (BDI-II). Paired with Peter's retrospective account from his Change Interview, this provided convincing evidence that positive change had taken place and was evidence to suggest this had been an effective therapy. They noted that Peter identified a number of problems of a long-standing nature which had achieved clinically significant change as indicated by PQ scores by the end of the therapy.

Judge B commented that Peter had clearly had a significant experience and had 'gained a major increase in his self-awareness and self-understanding, he has experienced a genuine honest and accepting relationship in which difficulties have been discussed and survived. He appears to have maintained the progress that he achieved (as measured by CORE etc) six months after the end of therapy. However he also

recognised that what he has gained in this therapy is a foundation for future work and identified further areas of his experience that he wished to explore.' However, the judges noted that the evidence from the case indicated that Peter had not completely resolved all of his problems, and so were not able to state that the outcome was completely positive and therefore concluded that the outcome of the case was 'mixed outcome'.

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

The judges concluded that Peter had changed considerably-substantially over the course of therapy, highlighting data from quantitative outcome measures and the Change Interview as providing convincing evidence that Peter had achieved clinically significant change. Judge A viewed the client's comments in his Change Interview as being wholly positive, which led her to be sceptical about the extent of his changes, although Judge B considered that Peter's Change Interview offered a more balanced perspective on his change process. Both judges commented that they would have liked more information on extra-therapy events and changes Peter had made.

Judge A commented that although Peter stated in both his HAT forms and the Change Interview that the therapy was helpful, he did not provide specific examples or details of the actual therapy processes which produced these changes. However she did concede that 'Perhaps it is unrealistic to expect that an individual who is not a therapist should, without any real prompting, be able to offer accurate, detail-rich and precise accounts of moments within therapy where change occurred'.

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

The judges noted that Peter appeared to be a motivated client with a readiness to engage which enabled him to make good use of the therapy. Both judges commented that motivation alone would be insufficient to produce change of this magnitude. One judge noted that as there were no significant changes in Peter's life during the course of therapy that it was 'logical to deduce... that therapy was the main agent of change'. The second judge noted that 'the relational approach that the therapist adopted within this work was a significant factor in enabling Peter to participate fully and effectively in the therapy'.

Mediator factors

The judges were asked to comment on which therapy processes appeared to have been helpful to the client. Both judges agreed that from Peter's account it was clear that his experience of the therapist as empathic, genuine, honest, accepting and caring, and the therapist's willingness to become emotionally engaged with him on a 'human level', had been highly significant.

Table 3. Adjudication decisions

	Judge A	Judge B	Median
1. How would you categorise this case?			
How certain are you?			
1a. Clearly good outcome (problem completely solved)	40%	60%	50%
1b. Mixed Outcome (problem not completely solved)	80%	100%	90%
1c. Negative/Poor Outcome	0%	0%	0%
2. To what extent did the client change over the course of therapy?	60% Considerably	80% Substantially	70% Considerably-Substantially
2a. How certain are you?	60% Considerably	80% Substantially	70% Considerably-Substantially
3. To what extent is this change due to therapy?	80% Substantially	80% Substantially	80% Substantially
3a. How certain are you?	80% Substantially	80% Substantially	80% Substantially

One judge expressed their disappointment that Peter had not provided specific examples of interventions or events that had occurred in therapy. Nevertheless, both judges noted that the therapist's willingness to provide theoretical understanding to Peter had been helpful in developing his understanding of himself and his relationships, with one judge observing that this had clearly been done skilfully as it did not appear to negatively impact Peter's relationship with his therapist, despite Peter emphasising in his change interview that he had a very low tolerance for 'feeling managed'.

Moderator factors

The judges were also asked to comment on which characteristics or personal resources of the client enabled him to make the best use of his therapy. Both judges agreed that Peter's investment in the process, his motivation and his desire to seek out the right

therapy and therapist for him and his belief in therapy and his determination to overcome his initial discomfort had clearly enabled Peter to make the best possible use of his therapy.

Discussion

This case raises interesting questions regarding what constitutes valid and convincing evidence, and the importance of accounting for the client context. It also provides data which support the objective of the research which was to investigate the process and outcome of short-term TA psychotherapy for the treatment of depression, by identifying key factors which impact on the process and a clear statement of outcome. With regard to relevant process factors, this study also verifies several aspects of previous research regarding factors which positively influence therapy outcome, namely: the importance of client motivation, willingness and ability to engage; the importance of a good match between therapist, therapy approach and the client; and the centrality of the therapeutic relationship in effecting change (Norcross, 2002).

This case also provides initial evidence that short-term TA therapy can be effective for the treatment of depression, even at quite high levels of severity.

Although there was some difference in the judge's verdicts regarding the magnitude of the client's change, they were in agreement that the client clearly had changed positively and that therapy was highly likely to have been the primary causative factor in these changes.

What is missing from this case is a detailed understanding of the processes and specific mechanisms of change. Future studies are warranted to explore these mechanisms and it is anticipated that the other cases in this case series will provide such data and facilitate the development and refinement of TA theory and practice for the treatment of depression.

Limitations

One limitation of this present study is the potential impact of the author being both the therapist and a researcher. Even though a critical-reflective stance was used in developing the case report, and this work has been checked by the author's research supervisors and clinical supervisors, it is possible that some inadvertent bias may have crept into the report.

Furthermore, as the author was also a former tutor of the three members of the analysis team, and participated in the analysis in order to facilitate the process, this may also have influenced the findings. In order to reduce this possibility, members of the analysis team were not consciously aware that the researcher was the therapist in this case. In the rich case record, the therapist's identity was obscured and this appeared to have been successful as in the report of one member of the analysis team they had assumed the therapist was female.

It is hoped that the use of independent judges, who were not made aware of the therapist's identity, has mitigated against any potential bias. As only two judges were used in this study, where there was a difference in opinion, a median verdict was selected. It is possible that a third judge would have carried the balance in one direction resulting in a majority verdict, thus influencing the conclusions regarding outcome in this case.

It is unfortunate that the Change Interview did not include a more rigorous exploration of extra-therapy factors with the client, in particular in the period after concluding therapy to provide evidence regarding whether the client's continued improvement was a continuation and building upon changes made in therapy or whether these were to do with extra-therapy factors.

Conclusion

The conclusions of the judges in this case are that Peter changed considerably-substantially, although not all of his problems were resolved, and that these changes were substantially due to therapy. Although Peter achieved clinically significant change on all quantitative measures, there were reasons to believe that he had not fully resolved all aspects of his depression within 16 weeks of therapy. In line with existing psychotherapy research into common factors, the therapeutic relationship was identified as being a primary cause of change. Peter identified a number of key changes that had come about as a result of his therapy - including changes in his perspective, interpersonal changes and the development of hope for his future. Although this single case cannot be used as clear evidence that TA therapy is effective for the treatment of depression, it nevertheless provides evidence that TA therapy has been effective in the treatment of depression for a man who had chronic, severe depression. With sufficient replication of these findings, it is possible that claims that TA therapy is effective for depression can be made. Furthermore, the present case has demonstrated that outcomes of therapy can be ambiguous, and that it is not always possible to make clear-cut and definitive statements of clear cause-effect relationships between therapy and outcome due to the complexity of factors present in each case.

Future Research Considerations

It is possible to meet criteria for being considered to be an established, efficacious, empirically supported therapy solely through the use of case study research. As few as nine published cases of positive replication of findings of outcomes of a particular therapy for a specific disorder are needed to meet these criteria (Chambless and Hollon, 1998).

The TA community already has expertise in producing detailed case studies as part of the international certification process and the small-scale nature of such research means it is feasible to rapidly accumulate

positive evidence demonstrating TA's effectiveness for the treatment of depression, or any other disorder. Because case study research accounts for the context of the client and the therapy and a range of factors which impact on the case outcome, and incorporates both quantitative and qualitative data, it is an approach which is highly congruent with and relevant to the philosophy and approach of TA therapy (see Widdowson, 2011a).

The team-based approach of HSCED is a rigorous process that can be used to demonstrate TA as an effective therapeutic approach. Small, independent teams of perhaps three TA therapists could replicate the methodology used in this article to develop the evidence base of TA psychotherapy. Each published case or case series (with, say, three cases) would substantially add to the evidence base of TA and provide a balance to the limitations in this present case.

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Appendix 1: Rich Case Record

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Section 1: Background/Ethical Issues

Confidentiality

In order to preserve the client's confidentiality some of the client's biographical details have been disguised.

Consent

The therapist raised the option of Peter participating in the research during their initial contact, and gave Peter an information sheet about the research and an informed consent form. Peter was aware from the outset that the therapy was part of a research project. Verbal consent was sought at every session for audio recording, and the informed consent procedure was repeated at the end of the therapy. Peter has also reviewed the client description and description of the therapy process and has given his consent for these to be included in the research and used for the purposes of publication.

Therapist competence, treatment integrity and adherence to TA model

The therapist conducting this psychotherapy was a qualified (CTA) transactional analysis psychotherapist with over 5 years of post-qualifying experience. The therapist had supervision once a month on their work with this client, and their supervisor completed an adherence checklist form after each supervisory contact to confirm the therapist's adherence to a TA psychotherapy approach. All of the therapist's self-completed adherence checklist forms (completed after every session) and the supervisor's adherence checklist forms confirmed either 'good' or 'excellent' application of specific features of TA therapy for the treatment of depression, suggesting the therapy was consistently and coherently delivered at a high level of competence and was identifiable TA psychotherapy.

Context of Therapy

Peter had weekly, individual psychotherapy with a therapist in private practice. Although his therapy was private, he paid a reduced fee.

Section 2: The Client

Client Description

Peter was a 28 year old man who lived alone, but near to several family members. At the time of entering therapy he was single, and had been unemployed ever since being made redundant two years previously. Peter had been educated to degree level. He had been diagnosed with depression by a psychiatrist five years earlier, and was not on medication, although he had been prescribed antidepressants previously but had discontinued these 9 months prior to starting therapy due to their side effects and lack of impact on his mood. He had previously engaged in brief Cognitive-Behavioural Therapy (CBT), but this had been discontinued as he did not respond to the treatment and the therapist recommended he seek psychotherapy. His general health was good although he reported very poor self-care and sleep disturbance, alternating between insomnia and hypersomnia. Peter is the youngest of four children. One sister and one brother live close to him and he sees them several times a week. His other sibling lives in a different city and they have little contact. Peter and his sister both acted as the main carers for their elderly and infirm father. Peter's mother had died when Peter was 13 years old.

Although he reported having a reasonable number of friends and acquaintances, he presented as being fairly socially isolated, seeing people infrequently. Peter had been bullied throughout school and had felt dominated through his childhood by his strict father. Peter recalled being in shock immediately following his mother's death and being told by various family members that he 'had to be strong and be a man now'. Consequently he has no recollection of any grieving.

He presented for therapy being aware of holding many buried feelings which he felt sure were driving his depression, but feeling unable to access them and feeling disconnected from feelings in general other than a sense of sadness, despair and hopelessness.

Strengths

Peter was an intelligent, reflective and articulate young man with evidence of strong psychological mindedness. His previous experience of therapy had 'primed' him in terms of his expectations of therapy and the process of therapy. He was well-read and informed about psychology and psychotherapy. He appeared motivated to change, and had sought out therapy independently, doing quite careful research to find a therapist who he felt would have the necessary skills and experience to help him. He travelled for quite some distance to see his therapist, again suggesting that he was well motivated.

DSM-IV Diagnosis

The therapist made a DSM-IV multi-axial diagnosis based on data from the initial interview with the client and clinical judgement.

- Axis I - Major Depressive Disorder
- Axis II - No Diagnosis
- Axis III - No Diagnosis
- Axis IV - Problems related to primary support group, social environment and occupational problems.
- Axis V - Global Assessment of Functioning score: 54 (on entry to therapy)

Screening with outcome measures

Peter's clinical score at point of entry to therapy using CORE-OM was 21.76, indicating moderate levels of distress and functional impairment and his BDI-II score was 35, indicating severe depression. The severity of Peter's depression would have warranted the prescribing of antidepressant medication, however due to his previous experiences of medication he wanted to pursue talking therapy instead and his family doctor was supportive of this choice. For further information on Peter's scores on outcome measures, see the section on quantitative outcome data below.

TA Diagnosis:

Injunctions

- Don't Be Important [your needs aren't important]; Don't Be Close; Don't Belong; Don't Be a Child [be a man]; Don't Be You [you're not good enough]; Don't Feel; Don't (do anything) [whatever you do is not good enough] (Goulding and Goulding, 1979).
- Don't Want [because you don't deserve it]; Don't Feel Successful [inadequacy, sense of inferiority]; Don't Enjoy [anhedonia and a lack of a sense of a 'right' to enjoy life] (McNeel, 2010).

Table 4: Peter's Racket (Script) System (Erskine and Zalczman, 1979; O'Reilly-Knapp and Erskine, 2010)

Script Beliefs (intrapsychic system)	Racket Displays (behavioural interface)	Reinforcing Memories (interpersonal system)
1. Self: I am inadequate I will never be good enough	Observable: Being 'invisible' Withdrawal	Childhood: Bullying Death of Mother Lack of praise Repeated criticism
2. Others: Are selfish and uncaring Will reject or criticise me	Internal: Lack of energy Problems with sleeping Guilt Low self-confidence Tension Loss of interest Poor concentration/ memory	Adult life: Redundancy
3. The World: Is an unfair and cruel place Life has no meaning	Fantasies/ Expectations: My future is bleak and hopeless	Social/ Environmental: Current family situation
Repressed Feelings/ Needs: Anger Grief Needs for- validation & significance; acceptance; confirmation of personal experience; self-definition; the need to have an impact		

Contracting

The therapeutic contracts developed in the therapy were exploratory and clarifying contracts (Sills, 2006). Peter's therapeutic contracts related to increasing levels of self-awareness which he identified as being necessary to his change process. Peter also identified the need for therapy that would assist him to contact feelings which he felt were inaccessible to him. He has previously engaged in cognitive-behavioural therapy but had not found this to be effective. In particular the 'behavioural activation' aspects of CBT had been difficult for Peter as he felt he had been unable to make behavioural changes without both developing his self-awareness and identifying and expressing his 'hidden feelings'.

Peter and the therapist engaged in some exploratory and alliance building work in the first few sessions, agreeing in session three on a series of contract goals for his therapy. The contract goals were initially based on the problems Peter identified as areas he wanted to focus on (see problems in Personal Questionnaire data below) and were constructed in dialogue with his therapist. Both Peter and his therapist agreed these were suitable goals and areas of focus for the therapy. Nine separate contract goals for the therapy were identified. These were;

- I want to know 'what makes me tick' and drives who I am
- I want to access and express the 'hidden pain'
- I want a more normal body clock
- I want more consistency in my mood without the 'plummeting down'
- I want to explore my feelings around my mother's death
- I want to explore my feelings of being 'crushed'
- I want to understand and explore the impact my family relationships have on me
- I want to feel OK about myself
- I want to deepen my ability to connect more deeply with others.

Treatment Plan

The basic framework of treatment planning in this case was the '12 point treatment formulation' developed by the researcher (Widdowson, 2011). The therapist adapted this by 'tailoring' features of this treatment plan according to the individual presentation, identified problems, diagnosis, process and contract goals of the client.

Section 3: Description of the Therapy

Process

The following description of the therapy process was based on the therapist's session notes.

Session 1

This session was spent mostly in identifying and clarifying a number of Peter's issues and exploring the significance of a number of childhood events and their

impact on Peter. In particular, the session focused on the death of Peter's mother, his father's continuous criticism of him and his experiences of being bullied at school.

Therapist interventions and theories

The therapist mostly used enquiry and empathic responding throughout the session (Erskine, Moursund and Trautmann, 1999; Hargaden and Sills, 2002; Widdowson, 2010). Other key interventions included specification and interpretation (Berne, 1966; Hargaden and Sills, 2002) and some initial contracting concerning the tasks and goals of the therapy (Stewart, 2007). The therapist was also gaining information to compile a racket system diagram, (Erskine and Zalzman, 1979) and the empathic responding was intended to begin the process of deconfusion by facilitating Peter's connection to his feelings and providing a safe therapeutic environment (Woollams and Brown, 1979; Clarkson, 1992).

Session 2

The session continued from the previous session in exploring Peter's experiences of bullying at school and his father's on-going criticism of him.

Therapist interventions and theories

During structural analysis (Berne, 1961; Stewart and Joines, 1987; Widdowson, 2010) the therapist noted Peter's experiences of shame, sadness, anger and sense of 'not being good enough' and the critical stance of Peter's father. The therapist drew the ego state model for Peter, explaining where these different experiences might be located (sense of inadequacy located in Child, criticism located in Parent), and explained the concept of dialogue between ego states. The therapist continued the process of deconfusion by encouraging Peter's expression of shame, sadness and anger and empathically responding to these expressions. The therapist also encouraged Peter to resume social activities but did not suggest specific behavioural contracts for extra-therapy activities.

Session 3

Peter reported he had been socialising more since the last session, which he was pleased about, although he had found it difficult and had experienced urges to withdraw. The session then moved into a discussion around the circumstances and events surrounding the death of his mother. Peter found this difficult due to his memories being obscured. His therapist noted that at times Peter seemed quite emotional but trying to hold back his feelings.

Therapist interventions and theories

The therapist worked primarily using empathic interventions and normalised and contextualised many of Peter's reactions to his mother's death. The therapist attempted to increase the affective charge in the session, but was conscious of not overwhelming Peter by 'pushing too hard'. The therapist also became aware of the potential that Peter might transferenceally be

unconsciously seeking to please the therapist and 'get it right' to avoid criticism. The therapist identified this possibility through countertransference responses which the therapist concluded might be concordant reactive countertransference (Clarkson, 1992).

Session 4

Peter spent most of this session feeling angry. He expressed his anger at his sense that the world is an unfair and unjust place and that most people are selfish and uncaring. He expressed ambivalence about expressing his anger- he knew some of his anger was justified, however he expressed a strong fear of being like his father and of his anger being unmanageable and out of control.

Therapist interventions and theories:

The therapist sought to continue Peter's emotional literacy work (Clarkson, 1992; Steiner and Perry, 1999; Tudor and Widdowson, 2001) and support the expression of his feelings and the deconfusion process. The therapist maintained an empathic stance, and normalised many of Peter's historical emotional reactions. The therapist noted that Peter's sense of the world being an unfair and unjust place and of other people being selfish and uncaring as probably being components of Peter's racket beliefs, but did not challenge these, and instead sought to empathically understand how Peter had come to these conclusions. The therapist also introduced some feedback for Peter relating to the therapist's sense that Peter had a highly developed sense of social justice.

Session 5

Peter began the session discussing his concerns for a friend of his, Lee, who was experiencing a relationship breakdown. Peter talked about the moral imperative for him to support Lee, regardless of the cost to himself. The session went on to discuss Peter's generalised sense of loss following the death of his mother, and in particular the loss of unconditional strokes and acceptance. Peter recognised that he struggles to accept positive strokes.

Therapist interventions and theories

The therapist continued an empathic stance and also explained the concept of strokes. The therapist also made an interpretation that Peter attempts to 'keep invisible' to avoid criticism, but in doing so misses out on receiving positive strokes.

Session 6

Peter began the session by informing his therapist that Lee's relationship had completely broken down and that Peter had invited Lee to stay at his house. Peter expressed strong concern over Lee's well-being and in particular his alarm at the intensity of Lee's distress. He wanted to clarify something from the previous session - he expressed that he had been surprised and puzzled by the therapist's positive stroke of 'I look forward to

seeing you' and wanted to know why the therapist looked forward to seeing him.

Peter spoke in an emotionally distant manner regarding his sense that the world is an unfair place, and of his experiences of his father's criticism. He spent a lot of this session feeling angry. As Peter became more aware of his anger, he eventually went quiet and the therapist had a sense of Peter withdrawing, suggesting an alliance rupture. The therapist enquired into Peter's experiencing and Peter revealed he was feeling 'a bit angry' towards his therapist because his therapist was stimulating and intensifying Peter's anger.

Therapist interventions and theories

The therapist's main aim in this session was deconfusion. The material was conceptualised using structural analysis and deconfusion (supporting the expression of the anger Peter held in his Child ego state) and relational rupture/repair, the racket system and the expression of loss underneath the anger and Peter's sense of longing. The therapist also drew Peter's attention to Peter's tendency to automatically reject or discount positive strokes.

Session 7

Peter once again began the session by discussing the situation he was in with his friend, Lee. Lee had spent all of the previous week alternating between crying and despair and hostility, which had often been directed at Peter. Peter intellectually knew that Lee was hurting and just 'lashing out', but was finding it extremely difficult to manage the feelings of inadequacy that Lee's criticism and hostility stimulated. He recognised that he had emotionally deteriorated over the past week (see CORE-10 scores) but was able to rationalise this deterioration as being related to the stressful situation he was in. Peter also expressed that whilst intellectually he knew he was doing what was right and therefore had a sense of being 'a decent person', he could not at present experience this emotionally as a sense of being 'OK'.

Therapist interventions and theories

The therapist identified and clarified a number of existential issues Peter was struggling with as well as Peter's need to live his life according to his own morals and values. The therapist raised with Peter his sense that there had been a number of alliance ruptures in the early part of the session where the therapist had kept misunderstanding Peter. He invited Peter into a discussion regarding his experience of being misunderstood by his therapist. The therapist supported Peter in expressing his sense of irritation towards his therapist for the misunderstandings and empathically responded and normalised his irritation. The therapist used principles of Inquiry, Attunement and Involvement (Erskine 1993) throughout the session.

Session 8

The therapist began the session by reviewing the therapy so far. Peter expressed that he was happy with the way the therapy was going, and that he wanted to continue to focus on his originally identified problems and contract goals. The session continued with exploration into Peter's relationships with his family members, and the impact of their subtle but continuous criticism of Peter.

Therapist interventions and theories

Following the re-contracting and review process, the therapist focused on Peter's 'I'm Not OK- You're OK' life position and how the interactions with his family members provided many negative strokes. The therapist noted Peter had begun to question the validity of the criticism and stroked Peter's emergent sense that he needed to follow his own path in life and life according to his own 'moral compass'. The therapist also supported Peter in identifying, questioning and ultimately rejecting unfair and unjustified negative strokes.

Session 9

The session focused on how Peter had begun to recognise the extent of criticism and negative strokes he received from his family members in various interactions over the previous week.

Therapist interventions and theories

The therapist explained the concept of cumulative and relational trauma to Peter (Erskine, Moursund and Trautmann, 1999; DeYoung, 2003). The therapist also noted a number of Peter's relational needs emerging in the session - particularly his need to express his gratitude towards the therapist. The therapist continued to support Peter in identifying, questioning and rejecting unfair negative strokes and how the transactions with his family members activated a self-critical Parent-Child internal dialogue accompanied by Peter's sense of inadequacy.

Session 10

This session almost exclusively focused on a number of existential themes which Peter was experiencing (**see HAT and transcript- highly important session**), and in particular how they linked to his script and the games (Berne, 1972; Stewart and Joines, 1987) he was drawn into.

Peter began to express a sense of understanding and forgiveness towards his father for his criticism and expressed his appreciation that his father had clearly struggled with his own feelings of grief following the death of his wife and how this had obviously impacted on his ability to emotionally take care of his grieving son. The therapist had a strong sense that Peter's understanding, forgiveness and acceptance was congruent and appropriate.

Therapist interventions and theories

Towards the end of the session, Peter began to express his gratitude to his therapist, but stopped and looked at

his therapist. The two of them sat in silence for a moment, experiencing an 'intersubjective moment of meeting' (Stern, 2004) - both implicitly understanding each other and experiencing a strong sense of connection.

Session 11

The session initially continued with exploration into how subtle criticism would lead Peter into self-doubt and self-criticism. This exploration followed Peter discussing the feelings he had been left with following a confrontation with his brother where Peter challenged his brother's criticism of him, but was left doubting himself afterwards. The therapist explained the concept of social and psychological transactions to Peter, and how Peter's critical Parent ego state was activated at such times. Peter contacted his Child feelings of despair and hopelessness during such instances and his desire to withdraw.

Therapist interventions and theories

The therapist was keen to deepen the deconfusion process by seeking to develop Peter's affective tolerance and affective regulation in this session, so invited Peter to 'stay with his feelings' whilst maintaining empathic contact with Peter. The therapist supported the deconfusion process by inviting Peter to express his sense of inadequacy, shame and his desire to withdraw during and following experiences of criticism.

Three days after the session, Peter e-mailed his therapist with the following:

I've been reflecting on my fundamental feelings of inadequacy. I think I have had some insights that I think may be correct but I'd like an outside perspective to judge whether my insights and views are reasonable. Whilst I understand it's more important whether I think it's reasonable, I know that emotionally I need to compare my considerations to someone else's opinion in order to feel like I'm being fair and not just deluding myself. So, in light of this, does this seem like a fair appraisal of my situation?

I have deep-seated feelings of inadequacy. I feel this way because: nothing I have done has ever been good enough; Because - when it has been good enough - nobody has ever communicated to me that it was; Because they held me to impossible standards; Because they did not have sympathy for my situation; Because my family do not communicate with subtle indicators of their care and concern and because often they have told me I wasn't good enough. These feelings hurt me because I am sorry for my inadequacy. I care about the opinions of others and everyone genuinely matters to me.

Conclusion: I assumed a degree of sympathy and care in other people that wasn't there, because those feelings are natural - fundamental - to me. When others held me to standards that it was impossible to satisfy, I

assumed that this was because of an inadequacy on my part, rather than realising that they lacked the sympathy and care to realise that their standards were inappropriate to me. I have never been inadequate: the expectations of me have been inappropriate, and the people who placed them on me were inadequate in their sympathy and care.

Session 12

The session began with Peter and his therapist discussing Peter's e-mail and the therapist supporting Peter's analysis of his situation and the life experiences which had contributed towards his sense of inadequacy. Peter continued to challenge and reject this sense of inadequacy and the associated script decisions.

Therapist interventions and theories

The therapist supported Peter's analysis of interactions using analysis of transactions and game analysis as theoretical frameworks. The therapist used heighteners (McNeel, 1976) to support Peter in his expression of 'I am not inadequate' and to promote a redecision. The therapist noted an experiential sense that Peter was indeed experiencing himself as being 'good enough' and reflected this back to Peter.

Therapist hypothesis of the therapeutic process

In evaluating his life experiences, Peter began to question the behaviours of others towards him. In doing so, he got angry and was encouraged in the session to express his anger. This directly challenged his Don't Feel injunction, and also was part of the deconfusion process of expressing the underlying repressed feelings which fuel his racket system. Peter experienced the therapist's empathy and used the sessions to assist with emotional regulation (exposure?) and in doing so decontaminated fears of being out of control. The expression and validation of his anger (by a supportive 'other') enabled him to 'complete the cycle' and 'deal with unfinished business' and so move through a cycle of grief and to acceptance (Clark, 2001). This enabled Peter to examine and re-evaluate his script decisions (inadequacy) and to make a spontaneous redecision.

Session 13

Following an unexpected two week break in sessions due to the therapist being ill, Peter returned to therapy feeling 'in a dark place'. He had contacted some feelings of destructiveness and a sense of being deserving of pain and undeserving of recovery and peace. Although he recognised the feeling as being long-standing in nature, he wondered if this experience had been triggered by the possibility of recovery.

Therapist interventions and theories

The therapist maintained an empathic stance, and worked 'indirectly' with understanding the feelings, as opposed to Peter's desire to 'know where it comes from' by direct questioning. As Peter would often respond

quite rapidly, the therapist invited him to slow down and pause before responding, to 'make space' for the 'hidden feelings' and to enable Peter to become aware of the ego state dialogue which was just at the edge of his awareness. The therapist understood the problem as being a repressed feeling of futile rage and hostility, held in Child (possibly associated with experiences of childhood bullying) and an internalised punitive Parent, composed of many figures from Peter's past. The therapist invited Peter to develop a compassionate stance in relation to the hurting, angry Child ego state and to attempt to 'understand the sense of anger held in that part of you'. The therapist viewed the work to be structural analysis incorporating deconfusion of the Child.

Peter's CORE scores at the beginning of the session showed a marked increase from the previous session, which the therapist understood to be representative of Peter's deconfusion process and associated with the emergence and awareness of the 'hidden' distressing feelings. The therapist also considered the intensification of Peter's critical Parent messages as being a script backlash process, whereby Peter was challenging his script which in turn activated introjected prohibitions in his Parent.

Session 14

Peter's CORE scores had dropped quite significantly from the previous week's elevated scores, which the therapist considered to confirm their hypothesis about Peter's distress at the beginning of the previous session as being a script backlash reaction. Peter had found the understanding of his internal process and ego state dialogue in the previous session to be helpful, and wanted to continue his session exploring this process and re-evaluating the 'voices' of the dialogue as he had begun to question the validity of the harsh Parental messages he experienced. He went on to link the Parent 'voice' to experiences where he had been dominated in power-plays, and he explored the impact of power-plays on him in his day-to-day life. The session concluded with a discussion around existential issues of meaning and meaninglessness.

Therapist Interventions and Theories

The therapist continued with some structural analysis and moved to impasse clarification work, by inviting Peter to be aware of the 'battle between the two voices'. The therapist sought to intensify the strength of the 'fight back' in Peter's Child, and also to support Peter's Adult ego state to identify, re-evaluate and begin to reject the Parental critical voice. The therapist sought to validate Peter's awareness of power-plays and loaned Peter some reading material by Steiner (Steiner and Perry, 1999) which discussed power-plays. The therapist engaged with Peter in his discussion of existential issues, and occasionally provided a 'devil's advocate position', to invite Peter to evaluate where aspects of the critical ego state dialogue and his script beliefs

maintained a position of despair and to promote Peter's sense of choice over his destiny. The therapist felt that the session felt very 'full' and that a lot of ground had been covered which would promote Peter's capacity to resolve the impasse and make a redecision. This view was supported in an e-mail the therapist received several days after the session, where Peter described reflecting on the session and deciding he was no longer going to 'accept the tyranny of the Parent' and that he 'understood and forgave his child'. He described using his Adult ego state to identify and reject the critical Parent dialogue.

Session 15

Peter began his session excitedly telling his therapist about a social event he had arranged. Following his decision to reject the critical Parent dialogue, he contacted several friends and invited them to a dinner party at his home, which had been successful. Peter felt this was symbolic of his internal 'shift' as previously he had not initiated social contact or arranged events. The session continued with Peter discussing his desire for a sense of deep connection and acceptance from others, but recognising the limitations of achieving this given his current social and familial circumstances. He discussed his sense of needing to keep certain thoughts and feelings out of relationships as they would not be understood or accepted. This 'shutting out' was in order to prevent an experience of rejection and so confound his sense of alienation, and he recognised that, ironically, this kept him out of full relational contact with others. He went on to want to explore the possibilities he has for being able to obtain intimacy with others. The session finished with some discussion regarding termination of the therapy and Peter expressed a wish to have 'maintenance' sessions after the period of research therapy had been concluded.

Therapist Interventions and Theories

The therapist continued to maintain an empathic, inquiring stance in order to help Peter articulate his feelings of disconnection and longing for intimacy. From the perspective of a relational approach, the therapist understood Peter's sense of needing to keep aspects of himself out of his relationships, but combined this with classical TA methods to help Peter understand the internal and interpersonal processes involved in relational disconnection and connection. The activation of Peter's desire for intimacy was viewed by the therapist as indicative of the activation of Peter's physis (Berne, 1972; Clarkson, 1992) and suggestive of a resolution of the impasse (Mellor, 1980) Peter previously experienced and an implicit redecision that he was now 'good enough' to enter into relationships. Peter expressed a sense of despair about being able to 'work out how to connect' to people, as he had tried many times previously to express himself and had either not been understood or had been dismissed or rejected. The therapist offered Peter the suggestion that maybe he might need to find a way to communicate

his inner experience on this deep level using the language of the person he was speaking to, adjusting his transactional stimulus in order to maximise the potential for an intimate and accepting response. This approach was a revelation to Peter who described it as a 'eureka moment'.

Session 16

Peter wanted to spend the session addressing some issues which he felt were connected and which he felt contributed to a number of the problems he experienced. He expressed that their resolution would be important in ensuring his continued progress. He described feeling that he struggled with managing stress and wanted to explore strategies for stress management. He also described that although his mood was much more stable than it had been prior to therapy, he often experienced a sense of anhedonia which impacted on his motivation, focus, concentration and capacity to experience relational contact with others. The therapist and Peter also made arrangements for Peter's follow-up interview and for the maintenance therapy sessions now the main phase of the therapy had been concluded.

Therapist Interventions and Theories

The therapist understood Peter's growing sense of 'wanting more' as being indicative of an impasse - he was now more acutely aware of his emotions and his responses to situations, and was aware of a growing desire for more relational contact with others, but felt somehow prevented from obtaining what he wanted and needed. The therapist worked using impasse clarification and invited Peter to be more aware of the 'push-pull' of the impasse in his daily life. The therapist also raised the issue of 'permission' (Crossman, 1966) with Peter and invited Peter to reflect upon and notice if he experienced an internal sense of having permission to enjoy and engage with life with the hope that Peter would be able to continue this work by himself and if, by being able to give himself permission to enjoy, he would mobilise internal strength to resolve the impasse spontaneously. The therapist also recommended that Peter learn mindfulness meditation as a method to help him to manage stress and improve his concentration and gave Peter some recommendations for books about mindfulness to help him maintain and strengthen his gains in therapy.

Transference and countertransference issues - the therapist's reflections

The therapist noted that at first Peter presented as rather reserved and wondered if this was in part due to Peter's expectations and previous experiences of therapy and in part due to a general sense of reserve in relationships. The therapist speculated that it was probably a combination of both. During the initial sessions, Peter often expressed his gratitude to his therapist, which the therapist understood as an important expression of his relational needs (Erskine

and Trautmann 1996) or perhaps as an indicator Peter was 'taking in some emotional nourishment' from the therapy perhaps via introjective transference (Hargaden and Sills, 2002). The therapist also was under the impression that in the first half of the therapy Peter had an underlying expectation that he would be criticised, emotionally attacked or rejected. The therapist commented that this impression seemed to dwindle in the second half of the therapy process, which may be significant in relation to Peter's improvement in the latter sessions.

The therapist's countertransference towards Peter was benign and positive - the therapist liked Peter and enjoyed his intelligence and caring nature. The therapist reported in the early part of the therapy having a strong sense of 'wanting to get it right' with Peter. It is possible this might be some concordant countertransference (with the therapist identifying with a similar process in Peter's psyche) or could have been related to the demands of participating in the research and a sense of exposure and scrutiny of their work.

Additional comments on the therapist's approach

Peter had initially reported that his previous CBT (which by all accounts was delivered by a competent therapist) had been ineffective so his TA therapist avoided techniques which might be considered analogous to CBT, such as 'behavioural activation' (behavioural contracting) and 'thought challenging'. As his therapist tends to work more relationally, this adjustment was relatively straight-forward. The exception to this is Peter's therapist gave him a handout relating to 'sleep hygiene' to assist with Peter's problems with his body clock, although Peter's implementation of the sleep hygiene methods was never discussed in therapy.

Section 4: Quantitative Outcome Data

Measures Used

For the research Peter completed a number of detailed quantitative and qualitative measures at initial screening, after session 8, and at the end of therapy. The measures used were CORE-OM (Barkham et al 2006), the Beck Depression Inventory-II (Beck, et al. 1961; Beck, et al. 1996) and a simplified Personal Questionnaire (Wagner and Elliott, 2004). Peter also completed weekly monitoring using the CORE-10 (a validated screening measure which has good correlations with CORE-OM scores) and the simplified Personal Questionnaire to monitor his progress in therapy, as well as completing the Helpful Aspects of Therapy measure (Llewelyn, 1988) - a qualitative measure where the client indicates what was helpful to them in the therapy session.

Editor's Note: Table 2 and Figures 1 and 2 referred to below are included in the main article so are not reproduced here.

The quantitative outcome measures were analysed for clinical significance to indicate whether the client demonstrated clinically significant change indicating a movement from a clinical to a non-clinical score (Jacobson and Truax, 1991). Movement to a non-clinical score is indicated by ++. In *Table 1: Peter's Outcome Data* and *Figure 1: Weekly CORE-10 Monitoring Data*, 'caseness cut-offs' indicate the score needed for inclusion in the study. Where the client's score is in the clinical range, the score is highlighted in the table in bold. An indicator was used for a Reliable Change Index, to measure whether the client had achieved reliable change.

Personal Questionnaire Data

An adapted version of the simplified Personal Questionnaire (Wagner & Elliott, 2004) was used to identify the main problems the client wished to resolve in therapy. During the intake interview the client identified the severity of each problem using a 7 point Likert scale, whereby a score of one indicates that the problem is not causing the client any distress at all through to 7 whereby the problem is causing the client the maximum distress possible. The client completed this main PQ problem severity rating form at the beginning of each session to allow for monitoring of the client's progress through the therapy. The clinical cut off for this measurement is the value 3.5 and scores greater than this are considered as being in the clinical range and causing the client distress. Scores of less than 3 are problems which are causing the client little distress. The mean PQ scores across therapy can be seen in the table 5 below. Scores which are in the clinical range are highlighted in bold (Figure 2).

Section 5: Helpful & Hindering Aspects of Therapy

The Helpful Aspects of Therapy form (Llewelyn, 1988) was completed by the client at the end of each session. The form asks the client to describe what aspects of the session or particular events within the session were most helpful or meaningful. The form asks the client to rate these aspects of event using a 9-point Likert scale where 9: extremely helpful and 1: extremely hindering. In this case analysis is reported only of the items which were rated as moderately, greatly or extremely helpful.

The mean session rating was 7.78 'moderately-greatly helpful'. In the client's weekly HAT forms, two sessions were rated as 'neutral'. No sessions or episodes within sessions were rated as 'hindering'.

Table 5: PQ Ratings and Duration

	Duration of the problem	Pre	Mid	End	1 month Follow up	3 month Follow up	6 month Follow up
1. I don't know what makes me tick	>10 years	7	4	4	4	3	
2. My body clock is very disrupted	6-10 years	6	6	4	4	5	
3. My mood is inconsistent	>10 years	5	4	3	2	3	
4. I don't feel OK about myself	>10 years	6	6	4	4	1	
5. I am not sure how my family relationships impact on me	>10 years	7	7	2	2	2	
6. Disconnected from my feelings	>10 years	7	4	1	1	1	
7. Problems with memory & concentration [item 7 added by client at session 2]	6-10 years	5	2	1	1	1	

Table 6: Helpful Aspects of Therapy

Rating key: Extremely (9); Greatly (8) or Moderately (7) Helpful

Session no	Helpful aspect/ What Made it Helpful	Rating		
			Bringing the elements of my family dynamics into focus	7
1	When the therapist said 'the word that comes to mind is crushed' it put a lot of my feelings into perspective and put my problem into stark relief in a very raw, but helpful way. It made me admit/acknowledge something I couldn't see on my own.	8	9	Deciding where to go next. Direction is good as I felt aimless today.
2	Admitting/explaining my perspective and intentions in the bullying incident. I'd never admitted it before, never felt that I'd be believed and something old and sore and forgotten brought to the surface. Parent/Adult/Child model explanation	7.5 7	10	Admitting my conception of who and how I am, my drive for literal altruism at personal cost. It's an expression of who I am, and an acknowledgement of my 'uncomfortable sanity'. It's the basis for who I will choose to be.
5	Realising that my family hasn't conveyed the feeling of their unconditional support and love. Helps me to understand what makes me tick. Discussion of my withdrawn nature	8 7	11	Achieving the goal I had for the session-finding an experiential approach that will let me find a method of coping with emotions. It's inherently good, as it will be useful, and it's satisfying to achieve.
6	Expressing/ understanding my fundamental drive of anger and awareness of the break that makes it: self-knowledge Improving my therapist's understanding of me - it's nice to be understood.	9 6	12	Recognizing that strokes containing the criticism of 'you're inadequate' set off my depression. Helps me to look for, identify and reject these strokes.
7	Elaboration of my emotional needs regarding fulfillment in life. Felt like it laid groundwork for later sessions.	7	13	A deconstruction of the probably psychological reasons behind my feelings. Understanding.
8	Reassurance of the validity and correctness of my criticisms of both my family and society, and of my response to these. The reassurance helped me maintain objectivity and perspective.	9	14	The discussion; it feels like groundwork for future resolution. I got a feeling of progress.
			15	Recognition of a deficiency in my interpersonal skills and the suggestion of a new approach. It gives me a way forward, to express myself with the confidence that I might be understood. An instant- "eureka!" Clarification of my position in my family.
			16	Realising that the negative part of my personality has a block on my positive feelings. Knowing this, I can work against it.

Section 6: Change Interview Data

The client participated in two follow-up Change Interviews; one interview two weeks after concluding therapy and the second interview three months after concluding therapy. The Change Interview protocol invites the client to reflect on the therapy and to identify specific changes they experienced during the course of therapy. The client is invited to comment on the mechanisms of those changes and what they attribute those changes to. The data in Table 2 (*main article*) relates to changes the client identified in his first follow-up interview.

Helpful Therapy Processes Identified in Follow-up one Change Interview

C3: Possibly one of the most positive experiences of my life, I'll be totally honest. It's made a huge difference to me. I feel much better and it's been possibly the most supportive and confidence building, rebuilding experiences I have ever had. Primarily, for me anyway it's been confirming a lot of stuff that I've often felt where (my therapist) has been able to contextualise or put into words and what it's been for me more than anything been a way for me to clarify both my problems and what makes me tick, and how those two things feed each other in a way.

R12: So was there anything in the therapy that helped you, or encouraged you set aside those inhibitions and also I'm wondering if there's anything that happened or was a factor that might have encouraged them to stay? If you see what I mean

C12: I know what you mean. I don't think there was anything in therapy which encouraged inhibitions in communication at all. Not in the slightest. [My therapist has] been incredibly good. I mean, I don't mind saying this and I'm not meaning to compliment [them] but for the record for the tape [they] have been incredibly good at putting me at ease and I'd say that honestly, one of the things that have made a huge difference to me is, the fact that when my time-keeping has not been great, [they have] been accepting of that and not made a big deal about it. Even when I've meant to have a much shorter session [they were] usually ok about it and just kind of been fine with it. That has made the biggest difference in the world to me... And similarly, [their] mannerisms in general. [My therapist is] very good at not just talking but kind of contextualising, and feeling through things on behalf of people to a little extent. At least helping them to feel through it. All that sort of stuff altogether has been tremendously good for me. [My therapist has] also shown a general interest and kind of assisting with things like lending me some books... All that stuff has made a difference, the human element essentially. [they may have been] my therapist but I also feel that they were being genuine as a human being.

C13: Yeah, I say that also, for me, again I don't know how this will be applicable for others, but for me I have a very, very low tolerance for feeling that I have been managed or kind of that I am being socially manipulated or anything at all like that. I mean even if someone hates my guts I infinitely have more respect for them if they are honest about it. I have almost never, I think there's only one occasion I have ever felt that [my therapist was] managing me slightly. Almost all the time [they have] been entirely genuine and open and honest and that's been great. The only time I ever felt [they] were a little bit like that and that's me being a bit paranoid. I mentioned to [them] at the time which was, I think it was about something arranging a session or... [item removed due to confidentiality]. I just said that I thought [they] were being a little 'salesman like' there and to be totally honest in retrospect I don't think [they] even were. I think I was just me being paranoid as I'm used to it from other people. Yeah, fundamentally that honesty, that interpersonal honesty is the greatest thing, you know? I will say this, if [my therapist does] have like particularly strong different opinions or anything else that [they have] held back, [they've] one it so perfectly that I have been completely oblivious to.

C15: I would say that primarily [my therapist has] seemed interested, you know, [they have] been actively engaged in what's going on with me. Even when it hasn't always been, you know, on my part I haven't been on my best or at my nicest or even like I say stupid shit which I mean well but completely phrase in the wrong way or similar. [My therapist has] been interested and engaged and it's that engagement, that being interested, that genuine kind of sense of care. You know I have the impression that [they] have a regard for my mental well-being.

C16: as I've more emotionally opened up and recovered during therapy I have felt that, I do feel that [my therapist has been engaged and does actually care and that has made the biggest difference I'd say in opening up. 'Cause I mean you can't open up to someone who doesn't seem that they genuinely care.

C17: ...You know, but when you have someone who apart from all the clinical stuff, [does] seem engaged clinically and intellectually yes definitely but [they] seem like that on some level emotionally or interpersonally engaged and that I'd say is the biggest factor. It's that interest and engagement. I'd like to say that it can't be faked, maybe it can, I don't know, but it certainly I think is probably the most important part for me.

C42: ...Therapy has been breaking those contextual associations and breaking that model and showing other avenues and ways of being which then allows new experiences to be interpreted in a new and different light, which can lead to older experiences being re-interpreted.

R82: I'm very curious about what specific bits of therapy have been most useful?

C82: The things that have told me about myself and how I tick. I somehow found when I first came in, I think that's probably been the most important one I put down there and even the other things on the list like my interpersonal changes all of those fall under that fundamental change in. I don't want to be clichéd and 'know thyself' and all that sort of nonsense but at the same time, yeah, it is true

R83: So it's something about self-awareness and self-understanding?

C83: Yes, if you know about yourself and can understand yourself, including the part of yourself that is depressed that allows you to make progress and to make changes. 'Cause without knowledge, again it's the idea about, before I came I was pretty blind to possibilities but I learned about myself. That gave me the ability to see other ways of being, other ways of doing. It's that kind of being armed. It's like if you can't see something, can't perceive something it might as well not be there, you can't do anything about it. As I learnt about myself, and that includes how my family impacts on me, all the things that make me tick. I was then able to make changes. Some of it was slow, some was difficult, some of it was painful but the point is that it is that self- understanding.

R84: So, can I just check I'm understanding you right? Something about contacting things that were hidden? Contacting parts of yourself that were hidden that has been quite important?

C85: Yeah, I'd say that the main thing about it is that it's bringing things out into the open so that they can be dealt with. It's not just bringing individually things out. 'Here is this component let's deal with it' but also a knowledge of self, what makes me tick etc has facilitated that and allowed me to make those changes. That I would say is the most fundamental thing that I have got from therapy.

C86: Now, as for things [my therapist has] done, see, I can't think of any particular incidents that stand out beyond the fact that where there has been instantly [my therapist has] brought something into focus and I've had a kind of epiphany sort of moment those have brought major changes. If you're asking what [my therapist has] done to contribute to that I can only... their skills as a therapist and I don't know enough to be able to analyse that. This isn't a very helpful answer in terms of research but I can't think of anything direct. The supportive and nurturing almost if you will of part of the therapist client relationship that we have going has facilitated it to happen but in terms of individual stuff [my therapist has] done where I can go yes that was really good. I can't think of anything in particular that stands out. It may be

and I don't mean this as a compliment I mean this as a natural form. It may be that actually [my therapist is] just so good essentially that all the stuff [my therapist has] done as a therapist has been equally contributive and equally good.

C87: I'd say that, it was something I touched on before the supportive part that things didn't just kind of necessarily end with just the therapy sort of material. It didn't feel clinical. It didn't feel like [they were just] turning up for this time slot and I'll set this time slot and all the rest of it. There was a couple of times I'd sent a text outside, similar [and my therapist] replied to them. Lent a book. This sort of stuff really mattered. I'd say that in fact that without that stuff none of the other gains made would have been possible because the communication wouldn't have been possible and the honesty, the interpersonal honesty that I've been trying to do, wouldn't have been possible. I'd say that matters. I'd say that would be the most important. I'd say part or contributing thing because it's enabled everything else.

C89: A lot of the time, although [my therapist has been] incredibly professional in their interactions, it's not felt essentially as if I'm in a professional relationship. Professionally you go to the Doctor and say well Doctor I'm here about x,y & z. you know, and they all have this bedside manner and that enables things. It's not felt as if I'm in a professional environment so to speak, that I'm not having to guard myself and the rest of it and that's been very important. Now, it has been intellectually and where I've said very professional and that the techniques etc have all been professionally administered etc. but it's the subtext - the psychological subtext has been very different. 'Cause [my therapist and I] talked before about there being a message, in the underlying tone. The message has always been professional the underlying tone has been, this is a building relationship. Mostly one way, providing therapy to myself, but you know, there you go

R90: There was something about what you said there I was... want to lead back to something that you said previously to see that I understand. It's like yes there has been a professional relationship but within that there has been a real sense of closeness and interpersonal contact?

C90: Yes, and I would say that it's the most important part I think. Because, you know, you could train any robot to have a knowledge of the techniques etc and maybe able to administer them too with advanced recognition etc. but the interpersonal human component which, again the human component is the emotional component, there is no separating the two, that's what makes therapy possible I think. I can't really take someone's advice, take their opinions, take their lessons if you don't feel they're engaged, you don't feel they're interested

Unhelpful Therapy Processes

Peter did not identify any therapy processes or aspects of the therapy that were unhelpful in either his weekly HAT forms, or in his follow-up Change Interview.

Difficult but potentially helpful therapy processes

C7: ...So at first it was very difficult to open up about some things inside and it took a lot of effort to get going at first or at least in retrospect it didn't take a lot of effort but maybe felt like it was more at the time. 'Cause talking to someone frankly and openly and to have them concerned about your mental well-being is very alien. It's alien to people in general. It's very strange but over time it's been one of the things that I look forward to. Even on days that I have nothing compulsive to talk about and I have nothing urgent that I need to deal with. It's been very supportive and for me has made a huge personal difference and I think, yeah, that's it in a nutshell. Difficult at first and a couple of times I've had to, especially at the start when I was at a much worse place and much lower motivation, had to make a bit of an effort to get myself going but over time that eased up.

C92: There's certainly been nothing that has been disappointing. I can say that with honesty. I don't think I'm looking back through rose tinted glasses when I say that. 'Cause even times when I have been to therapy and it feels like nothing has particularly happened at that session I've even said at the time I felt like it was building or ground work, I don't think that... Now, as for other stuff which I've felt... There's been sessions where I've burst into tears or had to admit difficult facts about myself and the rest of it but I wouldn't say that they were especially traumatic in themselves in these events.

Incomplete aspects of therapy

C31: [in response to a question about how the client sees himself now] (Pause) A good guy and that's all I can say for certain. I still have a kind of empathic blind spot about how other people view me. I think it's partly 'cause I don't know myself I can't really begin to predict how others might view me. I could pull up a whole bunch of names and such but I don't necessarily believe that anymore. But I just don't know. That's being honest, and I'm not troubled by that. I think it's probably positive for the most part. I just don't know.

C33: I could give this also perfect answers where it would be 'I would remove my vice impulses' and all that kind of stuff but honestly I'd like to improve my concentration. My ability to stick on top of, things, my endurance. To stay at a task from day to day. That's the only thing I would change about myself right now and I am in the process of changing it. Other things about myself, nothing that cannot be easily fixed, or at least, kind of corrected a bit. You know?

C94: Well, I would, it's something that really feel it should be touched on because it's kind of... it's one of

those things that I said that totally should do this and then other stuff and it was a different time and basically therapy has all worked fine and I think the only reason it didn't cover it was time constraints which is I think at some point is going to be good to go back and look at my past, particularly events from my mum's death etc and some of the pain and stuff there. So I think I'm still carrying that inside and it's not a source of distress to me but I think it's something I need to kind of unearth, keep out and kind of deal with.

C96: We have touched on that in quite more depth and we haven't necessarily about my mum and her death. But nevertheless there is still an element of sadness there, an element of distress which hasn't been touched yet and the other outside bit, the therapy block we did, the other therapy has going to be touched on. That's the only thing I would say. The only reason it didn't get touched on was time constraints.

Helpful & Hindering Factors in client's life situation

Peter did not indicate any helpful factors in his life situation. His therapist stated that Peter did often indicate that his unemployment, initial social isolation and on-going experiences of criticism by his family were hindering factors for him.

Client's Personal Strengths: (Motivation to change)

(See also client description in section 2 above)

C8: (in response to how client overcame inhibitions and initial awkwardness of therapy) This might sound really simple but I just forced myself. I immediately just said 'damn the consequences' essentially. I mean for a lot of people that's maybe not so easy, and it wasn't particularly for me. I think part of the reason it went well for me was I always say that based entirely of my own volition by taking charge of it... in the past I think part of the problem was I didn't follow what I felt I should to help myself essentially. You know I let other people see me in that regard. I let other people make decisions for me on my behalf for my own mental well-being and when I came to therapy it was me kind of making a decision...

C9: I actually said this seems right for me. And I thought that, well maybe in an alternate universe that if [my therapist] turned out not to be a great therapist I thought well, so what, at least I'll have given it a try. I felt that taking the active role, that was important. Maybe a large part of it was self-determination and the confidence and kind of grounding that gives but that made a huge difference to me. I think that's what made it easier to open up about stuff.

R10: Is there something, if I'm understanding you, is there something about trusting yourself, trusting your instincts?

C10: Very much so I'd say yes. Essentially it's one thing to be kind of put in a place and be told to do something

whatever, which isn't, I haven't been forced into therapy before essentially but it's a very different experience to go 'this is what I want to do' and kind of lay it all out and work through it yourself than it is to be kind of told to.

Helpful & Unhelpful Aspects of participating in the Research

C4: One of the major things that has done that is the ability to gauge my progress over time and being able to look back and say, well compared to how I was. Partly, I suppose a little bit for me was seeing the scores and forms, although that was not the main thing that did it, it was emotionally looking back at how I used to be and how I am now and how experiences have led me through that. I'm not done. I do occasionally have a day when it's bit like a relapse.

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Appendix 2: Affirmative and Sceptic Briefs and Rebuttals

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Note

The arguments presented here are made to facilitate the analysis of change in this case through the presentation of contrasting views; they are not necessarily the personal views of the authors.

Affirmative Brief

Positive Evidence

The purpose of this analysis is firstly to draw conclusions about two questions:

1. Client changed substantially over therapy
2. Therapy contributed substantially to those changes.

It is our conclusion that the client changed substantially over the course of therapy and that therapy contributed substantially to his changes. Furthermore we conclude there were no other major factors which contributed to or caused the client's changes.

There are a number of types of evidence which can be used to support these conclusions. The types of evidence are:

1. changes in stable problems
2. retrospective attribution
3. outcome to process mapping
4. links between client reliable gains in the PQ scores and significant within therapy events
5. within therapy process-outcome correlation.

For this affirmative case to be plausible and robust, the causal inference provided by direct evidence

Table B1: Summary of Outcome Data

	Beck Depression Inventory-II	CORE-OM	Personal Questionnaire (mean score)
Clinical cut-off	10	10	3.00
Caseness cut-off	16	15	3.5
Reliable Change Index	5.78	4.8	0.53
Pre-Therapy	35	21.7	5.83
Session 8	32	20.2	4.71(+)
Session 16	20(+)	12.9(++)	2.71(++)
1 month Follow-up	10(++)	5.2(++)	2.57(++)
3 month Follow-up	13(++)	11.9(++)	2.28(++)

must be demonstrated in at least two of these five types of evidence.

1. Change in stable problems

In his Personal questionnaire Peter described a number of issues he wanted to resolve in therapy (Table B2), all of which were long-standing problems for him of at least six years in duration. At the end of therapy, and sustained at follow up, Peter had achieved positive change with each problem he had identified at the beginning of therapy. This can be taken as an indication that Peter had resolved or made significant changes in problems which had been long standing concerns of his. From Change Interview data, Peter reported that these changes were all very unlikely to have occurred without therapy.

Table B2: Client Issues

	Duration of the problem	Pre	Mid	End	1 month Follow up	3 month Follow up
1. I don't know what makes me tick	>10 years	7	4	4	4	3
2. My body clock is very disrupted	6-10 years	6	6	4	4	5
3. My mood is inconsistent	>10 years	5	4	3	2	3
4. I don't feel OK about myself	>10 years	6	6	4	4	1
5. I am not sure how my family relationships impact on me	>10 years	7	7	2	2	2
6. Disconnected from my feelings	>10 years	7	4	1	1	1
7. Problems with memory & concentration [item 7 added by client at session 2]	6-10 years	5	2	1	1	1

Peter identified seven problems he wished to address in therapy. At the end of therapy Peter's PQ scores had moved into non-clinical range of distress on four of these problems. The remaining three problems all showed a significant improvement of at least two points by the end of therapy and maintained at follow-up.

Our analysis of Peter's weekly PQ scores suggests he experienced a gradual movement in the direction of positive change. There were two temporary increases in Peter's PQ scores, at session 8 and session 13, which reflected temporary increase in distress. We consider the increase at session 8 to be linked to external factors, and the increase at session 13 to be linked to the 'script backlash process' the therapist describes. Both increases in distress were temporary and both were followed by marked improvement suggesting that Peter had experienced some rather significant change or resolution in engaging with these issues. We also note that Peter continued to maintain, and even make further changes in 6 of his PQ items after the period of research therapy was concluded. It is possible these changes may have been sustained and continued as a result of his 'maintenance therapy'. Nevertheless, we note that considerable change occurred to long-standing problems. His mean PQ score at the beginning of therapy was 5.83 indicating that his problems were bothering him 'considerably' to 'very considerably'. His mean PQ score had reduced at the end of therapy to 2.71 indicating his problems were bothering him 'very little' to 'little' and therefore indicating that he had moved out of the clinical range of distress on the problems he identified. This mean score was again reduced by the second follow-up to 2.27. This was a drop on mean PQ scores throughout his therapy of 3.56 points.

We consider these changes to be substantial, given that Peter identified five of his problems as being over ten years in duration, and the remaining two as being between six and ten years in duration.

Peter's CORE-OM scores indicated a movement from a level of moderate distress and impairment into the non-

clinical range. Similarly, his scores from the BDI-II indicated movement from severe depression into a non-clinical range.

Comparison of Peter's PQ, CORE-10 and BDI-II scores all indicate movement out of clinical levels of distress to non-clinical levels across all three measures, adding weight to the argument that Peter has experienced clinically significant levels of change.

Of the five overall changes Peter identified in his follow-up change interview, he rated one of these changes as 'moderately' important, two as 'very' important, and two as 'extremely' important.

2. Retrospective attribution of changes to therapy

In Peter's follow-up interviews he identified that all of the changes he made would have been unlikely to have occurred without therapy.

Data from change interview provides evidence that the client attributes his change process to therapy. In particular:

C3: the client reports: "possibly one of the most positive experiences... it's made a huge difference to me"

C7: "it's very strange but over time it's been one of the things that I look forward... and for me has made a huge personal difference".

C81: the client reports; "Therapy has been the means for change."

In Peter's Change Interview he identified five major changes. He stated that he was surprised by all five of these changes, and that he felt that these changes were very unlikely to have come about without therapy.

3. Outcome to process mapping

Outcome-to-process mapping refers to the correspondence between specific events in therapy and overall changes experienced by the client as a result of

Table B3: Outcome to Process Mapping

Outcome (changes described at Post-therapy follow up interview)	Process (HAT Descriptions)	
A shift in perspective from 'life is shit' to 'actually, maybe I'm not viewing things clearly'	<p>Session 8: Reassurance of the validity and correctness of my criticisms of both my family and society, and of my response to these. The reassurance helped me maintain objectivity and perspective. <i>(Helpfulness - 9)</i></p> <p>Session 16: Realising that the negative part of my personality has a block on my positive feelings. Knowing this, I can work against it. <i>(Helpfulness - 9)</i></p>	<p>be useful, and it's satisfying to achieve. <i>(Helpfulness- 9)</i></p> <p>Session 14: The discussion; it feels like groundwork for future resolution. I got a feeling of progress. <i>(Helpfulness - 8)</i></p> <p>Session 16: Realising that the negative part of my personality has a block on my positive feelings. Knowing this, I can work against it</p> <hr/> <p>Starting to interpret things differently e.g. not expecting a fall, not expecting bad things to happen</p> <p>Session 8: Reassurance of the validity and correctness of my criticisms of both my family and society, and of my response to these. The reassurance helped me maintain objectivity and perspective. <i>(Helpfulness - 9)</i></p> <p>Bringing the elements of my family dynamics into focus. <i>(Helpfulness - 7)</i></p> <p>Session 12: Recognizing that strokes containing the criticism of 'you're inadequate' set off my depression. Helps me to look for, identify and reject these strokes. <i>(Helpfulness - 8)</i></p> <p>Session 16: Realising that the negative part of my personality has a block on my positive feelings. Knowing this, I can work against it. <i>(Helpfulness - 9)</i></p>
Awareness of these reinforcing patterns and how I get into them	<p>Session 5: Realising that my family hasn't conveyed the feeling of their unconditional support and love. Helps me to understand what makes me tick. <i>(Helpfulness - 8)</i></p> <p>Discussion of my withdrawn nature. <i>(Helpfulness - 7)</i></p> <p>Session 10: Admitting my conception of who and how I am, my drive for literal altruism at personal cost. It's an expression of who I am, and an acknowledgement of my 'uncomfortable sanity'. It's the basis for who I will choose to be. <i>(Helpfulness - 9)</i></p> <p>Session 12: Recognizing that strokes containing the criticism of 'you're inadequate' set off my depression. Helps me to look for, identify and reject these strokes. <i>(Helpfulness - 8)</i></p> <p>Session 16: Realising that the negative part of my personality has a block on my positive feelings. Knowing this, I can work against it. <i>(Helpfulness - 9)</i></p>	<p>Changes in how I feel in myself and in how I interact with others- interpersonal changes</p> <p>Session 7: Elaboration of my emotional needs regarding fulfilment in life. Felt like it laid groundwork for later sessions. <i>(Helpfulness - 7)</i></p> <p>Session 13: A deconstruction of the probably psychological reasons behind my feelings. Understanding. <i>(Helpfulness - 7)</i></p> <p>Session 11: Achieving the goal I had for the session-finding an experiential approach that will let me find a method of coping with emotions. It's inherently good, as it will be useful, and it's satisfying to achieve. <i>(Helpfulness - 9)</i></p> <p>Session 15: Recognition of a deficiency in my interpersonal skills and the suggestion of a new approach. It gives me a way forward, to express myself with the confidence that I might be understood. An instant- "eureka!" <i>(Helpfulness - 9)</i></p>
A sense of hope and possibilities for change	<p>Session 7: Elaboration of my emotional needs regarding fulfilment in life. Felt like it laid groundwork for later sessions. <i>(Helpfulness - 7)</i></p> <p>Session 11: Achieving the goal I had for the session-finding an experiential approach that will let me find a method of coping with emotions. It's inherently good, as it will</p>	

therapy. The 'Helpful Aspects of Therapy' form (HAT) was completed by the client at the end of each session and provides us with regular and immediate reports of what Peter found helpful in his therapy sessions. Details of helpful aspects of sessions which Peter highlighted as most helpful (a rating of >7) have been linked here to the changes Peter identified in his follow-up change interview.

We note that the changes Peter identified in his HAT forms were most frequently connected to increased self-awareness and interpersonal changes. Peter also identified helpful aspects of therapy as involving identifying and changing reinforcing patterns, and changes in emotion/ emotional expressiveness and self-acceptance. These changes are consistent with a TA approach to therapy which places joint emphasis on internal (intrapsychic change) and on interpersonal changes. The aim of TA therapy is for the client to move to an 'I'm OK-You're OK' life position indicating self-acceptance and respectful and growthful relating to others. We also note the aspects of affective change link to the therapist's use of

deconfusion and the changes in identifying and changing self-reinforcing patterns links to the therapist's use of transactions, strokes, games, rackets and scripts. All of the changes indicated here are also congruent with the 12 point plan/TA psychotherapy formulation for depression identified in this research.

4. Event-Shift Sequences (links between reliable gains in the PQ scores and significant within therapy events)

Although Peter's mean PQ scores tended to show gradual and consistent change over the course of the therapy, no significant items (where there had been a reduction in mean score by at least 1 point) were identified which could indicate specific event-shift sequences relating to the use of specific techniques and substantial improvement on PQ scores.

Analysis of the therapist notes, when compared to the data on Peter's HAT forms, indicate direct correlations to the therapist's interventions (events) and the aspects Peter found most helpful (shifts).

Table B4: Client Comments related to Therapist Interventions

Session no	Helpful aspect/What Made it Helpful	Rating	Therapist Interventions
1	When the therapist said 'the word that comes to mind is crushed' it put a lot of my feelings into perspective and put my problem into stark relief in a very raw, but helpful way. It made me admit/acknowledge something I couldn't see on my own	8	The therapist uses the interventions of "interpretation" and "specification" which are specific to TA theory and there is a direct correlation with the client's rating and comments
2	Admitting/ explaining my perspective and intentions in the bullying incident. I'd never admitted it before, never felt that I'd be believed and something old and sore and forgotten brought to the surface. Parent/Adult/Child model explanation	7.5 7	Explanation of the PAC model is significant to the client's rating and the Structural Analysis enabled the client's expression of a shameful past experience.
5	Realising that my family hasn't conveyed the feeling of their unconditional support and love. Helps me to understand what makes me tick. Discussion of my withdrawn nature	8 7	The therapist explains the concept of strokes and the client is able to make the link to what is missing in his relationship with his family.
6	Expressing/ understanding my fundamental drive of anger and awareness of the break that makes it: self-knowledge Improving my therapist's understanding of me, it's nice to be understood	9 6	The therapist's use of structural analysis and deconfusion work enabled the client to express/understand his drive of anger
7	Elaboration of my emotional needs regarding fulfilment in life. Felt like it laid groundwork for later sessions.	7	Therapist use of Inquiry, Attunement and Involvement, exploration of existential issues and rupture/ repair models
8	Reassurance of the validity and correctness of my criticisms of both my family and society, and of my response to these. The reassurance helped me maintain objectivity and perspective. Bringing the elements of my family dynamics into focus	9 7	The therapist's use of the TA theories of contracting, life positions and strokes has a direct correlation with the client's ratings and comments

9	Deciding where to go next. Direction is good as I felt aimless today	7	Therapist explanation of relational trauma and relational needs. Therapist supporting client with on-going rejection of negative strokes and the impact they have on his self-esteem and feelings of inadequacy
10	Admitting my conception of who and how I am, my drive for literal altruism at personal cost. It's an expression of who I am, and an acknowledgement of my 'uncomfortable sanity'. It's the basis for who I will choose to be	9	Existential exploration, game and script analysis
11	Achieving the goal I had for the session- finding an experiential approach that will let me find a method of coping with emotions. It's inherently good, as it will be useful, and it's satisfying to achieve.	9	Therapist use of empathic approach and deconfusion process
12	Recognizing that strokes containing the criticism of 'you're inadequate' set off my depression. Helps me to look for, identify and reject these strokes	8	The client links the session to the theory of Strokes. In addition the therapist used transactions, game theory and heighteners to aid the client's move towards a rededication
13	A deconstruction of the probably psychological reasons behind my feelings. Understanding.	7	The therapist's use of structural analysis enabled the client to further understanding and awareness
14	The discussion; it feels like groundwork for future resolution. I got a feeling of progress	8	The session continued with further work on internal processes and ego state dialogue which the client felt was progress.
15	Recognition of a deficiency in my interpersonal skills and the suggestion of a new approach. It gives me a way forward, to express myself with the confidence that I might be understood. An instant "eureka!" Clarification of my position in my family	9 8	This session shows a direct correlation between the therapist's use of the theories of intrapsychic and interpersonal processes (demonstrated using Classical TA theories of transactions etc) and the client's ratings after the session.
16	Realising that the negative part of my personality has a block on my positive feelings. Knowing this, I can work against it	9	The therapist uses impasse clarification and permissions to further the therapy work. The client makes the link between the therapy session and his greater level of self-awareness as per his ratings after the session

5. Session-by-session process-outcome correlation

The affirmative analysis team could not identify any major session-by-session process-outcome correlations.

Conclusion

We put forward the evidence that four out of five criteria have been met, namely:

- Peter demonstrated considerable change in stable problems.
- Peter attributed these changes to therapy.
- There is a correlation between the therapy process and the overall changes Peter made as a result of therapy.
- There are plausible links between the therapist's interventions, events in therapy which Peter found to be significant and his overall change.

We conclude from this that Peter changed considerably during the period of the therapy and that these changes occurred as a result of therapy.

Sceptic Case

1. The apparent changes are negative (i.e. involve deterioration) or irrelevant (i.e. involve unimportant or trivial variables).

Although analysis of the changes Peter experienced using data from quantitative measures suggest positive change, and that he identified these changes as important, there were several points in the therapy where he reported deterioration. Also, data from the second follow-up with Peter suggest some deterioration from their previous improvement, which could indicate that the client's changes were not stable or long-lasting. One item on Peter's PQ form relating to a disrupted body clock showed fluctuation throughout

therapy, and was still in the clinical range at the end of therapy.

At the end of therapy, although Peter's BDI-II score demonstrated improvement, it was still in the clinical range of scores. These scores continued to improve beyond the period of the research, although as he continued to have 'maintenance therapy', it is difficult to determine whether this continued improvement was as a result of therapy or of a trend towards a 'self-correcting process' and part of the natural course of his depression or spontaneous remission.

Furthermore, although at the end of therapy and at the second follow-up, the client's CORE scores and BDI-II scores were below the 'caseness cut-off' level, they were still in the sub-clinical range, which could indicate only temporary improvement and the presence of sub-clinical levels of distress which would return to levels of 'diagnosable severity' once the therapy had finished.

2. The apparent changes are due to statistical artefacts or random error, including measurement error, experiment-wise error from using multiple change measures, or regression to the mean.

We note that Peter's changes using quantitative measures showed improvement greater than criteria levels for Reliable Change Index improvement. Although multiple measures were used throughout the research, there does not always appear to be consistency between Peter's PQ scores and his BDI-II and CORE scores, particularly in the first half of the therapy.

Furthermore, we note that other than the initial pre-test scores, there are no multiple pre-test scores available so we cannot rule out the possibility of regression to the mean. As Peter met RCI criteria on all three measures used, we do not consider 'experiment-wise error' (chance occurrence) to be a factor.

3. The apparent changes reflect relational artefacts such as global "hello-goodbye" effects on the part of a client expressing his or her liking for the therapist, wanting to make the therapist feel good, or trying to justify his or her ending therapy.

It is possible that relational artefacts have influenced Peter's scores and reporting on his therapy. For instance, Peter actively sought out the therapist as someone he believed to be the best therapist available for him, and his reports of the therapist are very positive and do not include any negative description of the therapist or of disappointment in the therapy process (despite some issues not being addressed in the therapy) [see change interview, particularly mother's death issues].

His description of his therapist in his change interview is extremely positive, despite the therapist reporting several instances of 'alliance rupture' and

of Peter being angry with his therapist in sessions. The client's description of the therapy process tended to focus on the therapist's positive relational skills rather than particular interventions or specific therapist technical skills.

Furthermore, in his change interview, Peter describes his internal change process without reference to the therapist or to specific procedures or interventions which occurred within the therapy. We note that Peter clearly liked his therapist and therefore consider relational artefacts may be relevant in this case.

It was difficult to determine whether the client was being influenced by specific TA interventions, or simply through the chance to talk to someone he trusted and liked. We particularly note that Peter did not make use of 'TA language' in his change interview, and did not mention specific therapist interventions, or events within therapy, but rather discussed a broad 'relational ambience'.

4. The apparent changes are due to cultural or personal expectancy artefacts; that is, expectations or "scripts" for change in therapy.

Peter often used 'psychological language' to describe his change process which might suggest he is basing his change on expectancy of a 'script' for change in therapy (for example, C36 and parts of C37, C38, C39 and C42). We note that sometimes the language he used in his descriptions of his change process was quite 'intellectual' and referred to more general and perhaps even vague changes, as opposed to specific and concrete changes.

In particular we note that Peter did not make substantial external life changes during therapy, or in the period of follow-up. There was also some distancing, and generalised language in his description, for example; C7 'Cause talking to someone frankly and openly and to have them concerned about your mental well-being is very alien. It's alien to people in general'.

In C3, Peter says 'I think that I might actually be fully cured and be able to do all the things I actually want to do in life and for me that's golden.' Later in the interview he appears to contradict this slightly by saying in C4 'I do occasionally have a day when it's bit like a relapse', and in C18 he describes some feelings of anxiety and nervousness and that 'I don't feel that I'm fully recovered just yet'. In C96 he also describes not having done much work in therapy about his feelings regarding his mother's death.

Due to his use of 'psychological language', and the slight inconsistencies in his reporting, we consider there is some evidence to suggest the client is attributing his change to therapy due to personal and cultural expectancy artefacts.

5. There is credible improvement, but it involves a temporary initial state of distress or dysfunction reverting to normal baseline via corrective or self-limiting processes unrelated to therapy.

Although we note that credible improvement occurred throughout the period Peter engaged in the research, we cannot rule out that any changes that Peter experienced were not changes associated with the natural course of major depressive disorder or related to spontaneous remission.

6. There is credible improvement, but it is due to extra-therapy life events, such as changes in relationships or work.

There were no significant life changes, or changes in external circumstances that occurred during Peter's therapy. The changes that did occur were changes which he initiated (such as changes in behaviour and in how he related to others) and were changes which he attributed to therapy. Nevertheless, we note that the client did not make significant life changes throughout the course of therapy which we feel might undermine the argument that he had made substantial and credible improvement as a result of therapy.

7. There is credible improvement, but it is due to unidirectional psychobiological processes, such as psychopharmacological medications, herbal remedies, or recovery of hormonal balance following biological insult.

We conclude that there is no evidence of the existence of any new psychobiological factors which might have influenced Peter's change process.

8. There is credible improvement but it is due to the reactive effects of being in research.

It is possible that participation in the research gave Peter a sense of contributing to a 'greater good' and doing something meaningful which had a direct impact on his mood, and in particular counteracted his sense of inadequacy. His participation may have provided him with a sense of altruism which might have provided him with a temporary increase in his self-esteem.

Rebuttals

Note

During the period when the affirmative and sceptic cases were being prepared, further follow-up data was obtained. This data has been added to Table B1 and is shown in the six-month follow-up row in Table B5.

Table B5: Updated Summary of Outcome Data

	Beck Depression Inventory-II	CORE-OM	Personal Questionnaire (mean score)
Clinical cut-off	10	10	3.00
Caseness cut-off	16	15	3.5
Reliable Change Index	5.78	4.8	0.53
Pre-Therapy	35	21.7	5.83
Session 8	32	20.2	4.71(+)
Session 16	20(+)	12.9(++)	2.71(++)
1 month Follow-up	10(++)	5.2(++)	2.57(++)
3 month Follow-up	13(++)	11.9(++)	2.28(++)
6 month Follow-up	8(++)	5(++)	2.21(++)

Affirmative rebuttal to sceptic case

Note

The arguments presented here are made to facilitate the analysis of change in this case through the presentation of contrasting views; they are not necessarily the personal views of the authors.

The rebuttals presented here are concerned with items 1-6 from the sceptic case.

1. The apparent changes are negative (i.e., involve deterioration) or irrelevant (i.e., involve unimportant or trivial variables).

The client's scores on all three quantitative outcome measures had improved considerably by the end of therapy and the client had achieved reliable change on all three measures.

Although there was some deterioration on CORE-10/CORE-OM and BDI-II scores between the first and second follow-up measurements, these still remained below the 'caseness' level and within sub-clinical ranges. Whilst the deterioration which occurred in the client's CORE scores did meet criteria for reliable change, the deterioration on the client's BDI-II scores did not. In spite of this deterioration on CORE and BDI-II measures, the client's mean PQ scores continued to show improvement, indicating that the issues the client originally came to therapy to address had not returned. The client experienced a drop of 3 points on the mean scores of the PQ which would suggest major and clinically significant change to the client's presenting

problems which was maintained after the end of therapy. At the six-month follow-up, Peter's BDI-II and CORE scores had returned to below the clinical cut-off, which may suggest that the increase in distress measured at the three-month follow-up represented a period of temporary distress or difficulty or a response to a significant stressor. It is possible that Peter had developed sufficient internal resources and had experienced sufficient personal change during the course of his therapy to enable him to overcome this period of distress effectively without experiencing relapse.

The sceptic team point to small changes on the PQ item 'My body clock is very disrupted'. Although there is insufficient data to fully explain the slower rate of change on this item, the item has nevertheless demonstrated reliable change from pre-therapy measures. It is possible that this item may relate to a 'characterological symptom' (Kopta et al, 1994). In their study, Kopta and his associates identified several symptoms relating to sleep which were slow to respond to psychotherapy. In particular the symptom 'trouble falling asleep' was estimated to require more than 104 sessions for 50% of clients to have achieved clinically significant change. As such, and in relation to this present study it is perhaps not surprising that 16 sessions of therapy did not result in clinically significant change for this item, and therefore the argument that minimal change on this item suggests the therapy was ineffective is something of a flawed argument. In relation to extra-therapy factors, as the client is not in employment, it is possible that there is not the same imperative to maintain a regular sleep routine.

Finally, in response to the sceptic team's query regarding whether this issue was central to Peter's experience of depression, we note that in his follow up interview the client indicates that he did not think this was a central issue in his experience of depression (see extracts below).

The sceptic team also highlight a relatively small degree of change in the PQ item 'My mood is inconsistent'. Again, this item demonstrated reliable change and clinically significant change which was maintained throughout the follow up period. It is possible that this item did not change as dramatically as some of the other items due to the client experiencing greater reactivity in his feelings as the therapy proceeded. Given that the client was disconnected from his feelings prior to therapy, this might be an expected and positive change as a result of therapy. This view seems to be strengthened by the client referencing experiencing positive feelings in the transcript extract below:

C104: '(on discussing 'my body clock is disrupted)... I said way back that it was probably going to be one of the last things to change as I think it's a symptom of other stuff essentially. My mood is inconsistent. I'd say my mood is much more consistent now. I don't have it plummeting down the same way as I did. Ok, occasionally

I might have a bad or off day but it doesn't feel anywhere near as frequent. Now I am getting the reverse. Now I'm getting days that are good, just actually genuinely 'oh god I'm happy to be alive', which I'd never have thought of at the start. That one is much less of a problem.'

C109: (on discussing whether he would change the PQ items) 'The only thing I can think of conceptually is conceptually reorder them which I can do in hindsight, which I couldn't do at the time. Which is some of these are causes of other ones like 'my body clock is very disrupted'. That's a product of a lot of other stuff going on there. I don't think it's an inherent problem in and of itself.'

2. The apparent changes reflect relational artefacts such as global "hello-goodbye" effects on the part of a client expressing his or her liking for the therapist, wanting to make the therapist feel good, or trying to justify his or her ending therapy.

Rather than seeing the client's positive attitude to his therapist as an aspect of relational artefacts we would expect and indeed look for this positive attitude towards the therapist at this early stage in the work (16 sessions) when working relationally with a client like Peter. The therapist states earlier in the case study that he/she tends to work more relationally (Section 3 Therapist's comments) and as such would be likely to have worked with introjective transference (Hargaden and Sills, 2002) and that the client experienced this as a meeting of their relational needs (Erskine and Trautmann, 1996) (see also the narrative of the therapy process where the therapist identified working with relational needs). Given Peter's history (for example, his mother's death, experience of criticism and few personal relationships) it is possible that holding the therapist in an idealising transference may actually be evidence to support the argument that the client experienced positive change. We also note the finding from many previous research studies which highlights the importance of the therapeutic relationship as the most important factor in the change process, and as such, this present case is congruent with such findings.

The narrative of the case study suggests that at several points the client and therapist experienced difficulties and relationship ruptures. It would appear that these were successfully resolved, and again, it is perhaps only to be expected that a client who had been through such rupture repairs would emphasise the relational skills of their therapist. Perhaps this might be even more so for a client who had a history characterised by relational misattunement?

Suggestions that the work is tinged by an overly positive glow are not supported by statements by the client that he felt he still had work to do, and that the therapy did not go into great detail in certain areas (for example exploring his feelings about his mother's death). Indeed it could be argued that these client statements actually add credibility to claims that the therapy was highly

effective and appropriate to the client's needs by offering a balanced, rather than solely positive view.

Furthermore, rather than seeing the client's descriptions of the therapy as being focused on the therapist's relational qualities, we consider this to be evidence of the therapist's technical skill in applying technique flexibly and unobtrusively. Again, in light of the therapist's identified 'relational' approach, we would expect these features to be more significant in the change process as opposed to more specific techniques and procedures.

Nevertheless, it is clear that not only did the therapist use TA theory to guide their thinking and intervention, but that they actively discussed TA theory with their client. In the HAT forms, the client specifically mentioned the concept of strokes and ego states. In the follow up interview, the client uses the phrase 'consensual reality', a phrase used in the cathexis approach to TA. We also consider that the client's descriptions of his changes correspond to specific aspects of TA theory; his 'change in perspective' and changes in expectations both suggest a change in his life script, his increased awareness of his reinforcing patterns suggests change in relation to his life script, rackets and games, and changes in how he interacts with others suggest changes in his ego states, transaction patterns, stroking patterns, games, rackets and life script. All of these aspects of TA theory were discussed in the therapist's notes and the case narrative, so we feel that the client's changes can be attributed to active and specific application of TA theory and method, in addition to more general 'therapeutic common factors'.

3. The apparent changes are due to cultural or personal expectancy artefacts; that is, expectations or "scripts" for change in therapy.

We feel that the arguments that the client's changes were associated with expectancy are undermined by several lines of evidence. Firstly, the client reported deterioration at several points in therapy, and indeed his CORE score at the second follow up period shows some deterioration, which suggest that rather than reflecting expectancy, these scores reflect an honest engagement with the research process and self-appraisal of his situation. In the follow up interview, the client identified all of his major changes as 'surprising' and unexpected which suggests that self-suggestion, hope and expectancy were not features which would account for the client's changes.

The client also describes a series of plausible changes, which, as stated above, appear to correlate with the mechanisms and theories used in TA therapy. Furthermore, the client describes the core changes which he experienced and changes which followed on from these. He also specified the links between these changes and describes the change process.

It is also possible that a depressed client who had engaged in previous therapy which had not resulted in change would enter a second period of therapy with little sense of hope for change. This possibility may also have been true for Peter, as he stated a significant change for him was an increased sense of hope for the future, suggesting that the therapy had impacted on his feelings of hopelessness and despondency.

Whilst we note that the client at times used 'psychological language' to describe his change process, we consider that this is to be expected given his previous experience of therapy and his interest in psychology. Again, in line with our previous argument, some of the language he used in both the HAT forms and the change interview suggest he was actively using TA concepts to understand his internal process, his change process and his therapy.

Finally, the contradictions put forward by the sceptic case regarding the quote from the change interview statement C3 are in our view statements that are misunderstood. What Peter refers to is a hope that he might be cured at some point in the future. He states: "For the first time, obviously I'm not finished my long-term therapy yet but I feel like I might actually be able to be fully cured and not have relapses". This statement cited as a change due to expectancy artefacts, is a quotation which we feel is not true to the intended meaning stated by Peter in C3.

4. There is credible improvement, but it involves a temporary initial state of distress or dysfunction reverting to normal baseline via corrective or self-limiting processes unrelated to therapy.

Peter reported a baseline stability in the intensity and duration of his problems (as evidenced by his previous diagnosis of depression). He had previously tried medication and some short-term therapy which had resulted in minimal change and had not significantly impacted on his depressive symptoms or process. Both of these factors would suggest that his problems were not a temporary state of distress which would pass naturally.

Whilst Peter did show some improvement on some scales post-therapy, we suggest that it is possible that the therapy had triggered a series of on-going internal changes for Peter which continued after the therapy had concluded.

Furthermore, Peter attributed the changes he made due to the therapy he received as part of this research project. For these reasons, we conclude that Peter's improvement cannot be attributed to an easing of a state of acute distress, a reverting to a 'normal baseline', or a self-limiting process and his changes came about as a result of his therapy.

5. There is credible improvement, but it is due to extra-therapy life events, such as changes in relationships or work.

There were no significant life changes, or changes in external circumstances that occurred during Peter's therapy. The changes that did occur for Peter included changes in his self-concept and changes in his behaviour and in how he related to others, all of which were changes which he attributed to therapy. As these changes cannot be attributed to major external changes in his life and personal circumstances, we conclude that these changes, which the client considered to be important, occurred as a direct result of his therapy, and were not as a result of other extra-therapy events.

The primary changes which the client reported are indeed changes in perspective (frame of reference), changes in his self-concept and changes in how he relates to others. We consider that such changes are a central part of the depression recovery process and in some ways perhaps more important than major changes in behaviour or life-changes. Also, if the client had made significant changes, it could be possible that a circular argument could be created which attributed positive change to these 'extra therapy events'. We also note the client's previous engagement in CBT and ineffectiveness of behavioural activation approaches in producing symptomatic relief.

Nevertheless, we do note that there is evidence of behavioural change. In session 3 the therapist successfully encouraged the client to engage in more social contact, and also in session 15 Peter described initiating social contact which had gone well, indicating a shift to a more pro-active social stance. We think that for a depressed client with poor self-esteem, low confidence and who is socially isolated that this is a significant change in behaviour.

Also, in the follow-up interview the client made various comments that he considered that the therapy had involved significant ground work which he would use to implement substantial life-changes at a later date after a period of consolidation. Given the relatively short length of time of the therapy, we think this is entirely reasonable, and given the severity of his original symptoms, is entirely appropriate.

Finally, we think there is a need to consider Peter's role as a part-time carer. It is possible that this provides very real limits on what is practical and possible for him in terms of major external life change. Additionally, we also note that Peter is unemployed, and as such has

limited financial resources available which may also add to the limits of what is practical and possible for him in relation to major life changes.

Sceptic Rebuttal to Affirmative Case

The affirmative discussion of the question of the client's disruptive body clock reflects a careful and valuable further analysis of the data, and seems convincing.

However, the affirmative rebuttal does not effectively challenge the key sceptic position: at the end of therapy, the client experienced a temporary feeling of well-being, which arose from regular contact with his therapist, but did not exhibit any substantial shift in his relationships with other people, or in his everyday life as a whole. As a result, as the meetings with the therapist tailed off, his symptoms gradually returned. This analysis is reinforced by the fact that the Change Interview was conducted largely from an 'affirmative' position – the interviewer was not active enough in seeking information that would be relevant to the sceptic case.

We also note that in the third (six month) follow-up measurements Peter demonstrated an improvement in his scores from those at the second (three month) follow-up, with reliable change occurring on his CORE scores. No further information is provided to account for either the increase in scores at the three-month follow-up or the reduction in scores at the six-month follow-up. This fluctuation may indicate that the impact of extra-therapy factors on Peter's symptoms is greater than has been indicated previously, and/or that his symptoms are more reactive and responsive to external stressors than suggested in the case report, and that changes he has made have been due to extra-therapy factors, instead of due to therapy.

From a sceptic position, several of the lines of argument made by the affirmative team are just not relevant. The research task is to determine whether a good outcome occurred – arguments that rely on an analysis of the therapy process as being constructive, or on what might be expected in a certain number of sessions, are of theoretical interest but do not directly address the question of whether a good outcome was observed.

The sceptic view is that Peter was helped, in terms of learning about himself and gaining insight, but that these are not sufficient to sustain a claim that clinically significant and lasting change took place in his functioning in the world.



Appendix 3: Judges' Opinions

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Using HSCED Instructions for Judges and Opinion Pro Forma (7/11v.1) (layout altered to suit IJTAR formatting)

Judge A

appropriate answer and change to bold type or a different colour.)

Completing the adjudication process

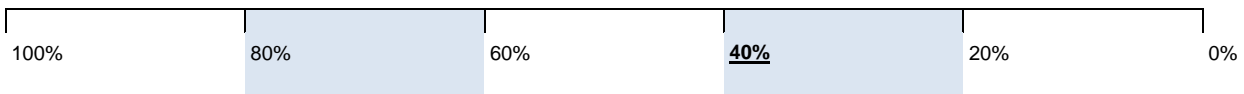
Please highlight your answers on the scales provided (for example, use your mouse to highlight the

In answering the rest of the questions, please use whatever space you need in order to give a full response.

1. How would you categorise this case?

Clearly Good Outcome (problem completely solved)

1a. How certain are you?



Mixed Outcome (problem not completely solved, or a mixture of positive and negative outcomes)

1b. How certain are you?



Negative/ Poor Outcome

1c. How certain are you?



1d. What information presented in the case report and in the affirmative and sceptic cases most greatly influenced you in reaching this conclusion? How did you use the evidence presented to inform your thinking?

Taking the client's account of his own process at face value, I could see clearly that change had taken place. His own retrospective account in the Change Interview that positive change had taken place, paired with the

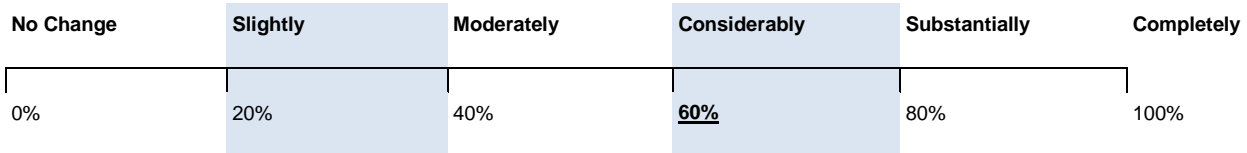
presence of Global Reliable Change on the quantitative change measures, provided convincing evidence that positive change took place. Five out of his seven PQ items had a duration of over ten years. By the end of therapy each of these items had reduced in severity to a non-clinical level. Such shifts on the PQ, taken at face value, are clearly indicative of a very effective intervention. I also noted that the client had cited many helpful aspects of therapy in the HAT forms, and had rated these highly.

I wondered, however, whether the client's extremely positive account of therapy was a little too good to be true. I note that Peter sought out this therapy, and accessed it privately, after an unsuccessful engagement with CBT. It is possible that he entered this therapy with a "now or never" attitude to his own recovery, and therefore a high investment in its positive outcome. The phenomenon of Cognitive Dissonance would rule that, if this were the case, his positive retrospective evaluation of the process was inevitable. On review of the Rich Case Record, I noted that Peter gave a wholly-positive retrospective account of therapy in the Change Interview. He uses superlative language – and ventures into hyperbole – to communicate the strength of his feelings about the success of the process. For example, he tells the researcher that therapy has been "the most supportive and confidence building, rebuilding experiences I've ever had;" that inhibitions were not there "in the slightest" and that therapy was

"incredibly good" and made a "huge difference" to him. I also note that Peter reported no negative events whatsoever in his HAT form over the sessions (despite his therapist noting a few occasions where ruptures or tensions occurred). These factors speak to me of a fairly black and white, extreme, cognitive style, whereby Peter is prone to taking one polar stance and standing by it completely. In this case, CBT: poor; my new therapist: The best in the world. This thinking style is, of course, consistent with a depressive thinking style. I wonder, then, if the nature of Peter's initial difficulties has served to colour his reaction to this process to some extent, and perhaps led him to over-report the extent of his changes.

Having said that, I can see that substantial gains did take place, and would not seek to over-rule Peter's own measure of this process with the above notes. In light of this thinking, I concluded that a mixed outcome seems most likely here.

2. To what extent did the client change over the course of therapy?



2a. How certain are you?



2b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

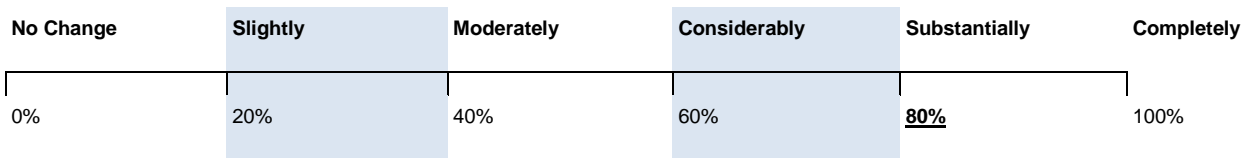
Again, the client's own assertions in the change Interview that he changed are convincing, and must be afforded most weight out of all sources. The statistically significant shifts on the quantitative change measures support Peter's spoken assertions.

I refrained from judging him to have changed "substantially" or "completely" as a number of elements of the data presented cause me to question the absolute reliability of Peter's account of his own change. One such element is detailed above, regarding my noticing his somewhat all-or-nothing style of evaluation. A second element is Peter's descriptions of the changes noted in the HAT forms. I noted with interest that, while he rates sessions as very helpful and offers wordy narratives as to why sessions were helpful, his account often lacks specific details or examples. For example, Session 11, he identifies "finding an experiential approach that will let me find a method of coping with emotions. It's

inherently good, as it will be useful, and it's satisfying to achieve" as a helpful aspect of the session, and gives this the maximum rating of nine for helpfulness. What I notice in such an example is that his description gives absolutely no indication of what processes within the session led him to making this finding. In order to be convinced by such an example, I would want to hear what actually went on between him and the therapist in the moment that he went from not having this "experiential approach" to having it. I would also like to know what this "experiential approach" looks like.

My certainty that change was only "considerable" is rated at only 60%, as I must acknowledge that I have approached the client's account with a fairly sceptical eye. Perhaps it is unrealistic to expect that an individual who is not a therapist should, without any real prompting, be able to offer accurate, detail-rich and precise accounts of moments within therapy where change occurred. It is possible that, with further questioning by a researcher, Peter would have been able to cite exact moments, feelings, challenges or processes in therapy that led to these changes, and were helpful.

3. To what extent is this change due to the therapy?



3a. How certain are you?



3b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

The Affirmative side emphasise that Peter’s therapy was the only change or new influence in his life at this time. He was not in a relationship, did not have a job, and did not experience any noteworthy life transitions. It is logical to deduce from this that therapy was the main agent of change.

However, as the Sceptic team highlight, Peter sought this therapy on his own. This strongly suggests that he had a level of motivation and readiness to engage that primed him to make the best-possible use of his therapeutic opportunity. It is indeed likely that this factor was a contributor to his gains. However, therapy was a necessary component to engage with his motivation and allow him to move forward to the point that these gains could be made; motivation alone is very unlikely to have been enough. This is further supported by Peter’s own rating of his changes as very unlikely without therapy.

4. Which therapy processes (mediator factors) do you feel were helpful to the client?

From Peter’s own account, it is clear that the therapists’ empathy, offering of a theoretical model, and being involved in the process on a human level were the most important factors of this therapy’s success. Peter noted specifics around the therapist being OK about him appearing late or needing to change appointment times, and lending him a book, as showing him that the therapist was involved on a personal level. This emerges at the most important strand of the reparative process, based on Peter’s narrative.

I was disappointed that Peter was not pushed to go into more detail about what exactly he meant by some of the terms he used to explain why therapy had been so effective. For example, he talked a lot about the therapist being “interested and engaged”; I would have liked to hear HOW the therapist demonstrated this to Peter – was it with words? Actions? In another way?

I think, as psychotherapy researchers, we are all in agreement that the therapeutic relationship is central to predicting any outcome, and that things like warmth, genuineness and acceptance are the essence of that relationship. What we need to ask now is “what processes in therapy allow for the communication and thriving of these processes in a way that is evident to and felt by the client?”

Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled him to make best use of his therapy?

It is fairly evident that Peter was invested in this process from the outset. He was motivated to seek out a therapist he believed to be appropriate for him, and he attended his sessions. It seems that readiness and motivation on Peter’s part were the main components of what allowed him to make the best of therapy. As pointed out, Peter uses psychological language to talk about his experience (so much so that I wondered whether his degree is in Psychology). While this could be seen to have functioned as an expectancy artefact to some extent, I think it also demonstrated that Peter ultimately believes in the potential of therapy, and believes that his problems are not beyond help. As he entered the process with this attitude, he and the therapist were able to embark on the process of bringing about change, without having to spend time and energy fostering his motivation. It is inevitable that this enabled him to make the best possible use of his therapy.

Judge B

Completing the adjudication process

Please highlight your answers on the scales provided (for example, use your mouse to highlight the appropriate answer and change to bold type or a different colour.)

In answering the rest of the questions, please use whatever space you need in order to give a full response.

5. How would you categorise this case?

Clearly Good Outcome (problem completely solved)

6a. How certain are you?



Mixed Outcome (problem not completely solved, or a mixture of positive and negative outcomes)

6b. How certain are you?



Negative/ Poor Outcome

6c. How certain are you?



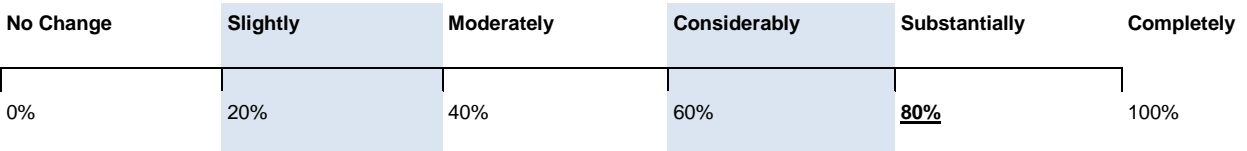
6d. What information presented in the case report and in the affirmative and sceptic cases most greatly influenced you in reaching this conclusion? How did you use the evidence presented to inform your thinking?

I disagreed with the sceptic team’s argument that “an analysis of the therapy process being constructive or on what might be expected in a certain number of sessions” is irrelevant to the definition of a good outcome. It seems to me that the definition of a good outcome has to take into account the type of outcome viewed as constructive within that therapeutic approach, and what might be anticipated within the time allocated to the process. In Peter’s case, his post-therapy PQ scores and the changes that he reported at his 1 month follow up interview support the argument that he substantially achieved his contract goals for therapy. The degree of change experienced by Peter can also be compared with that of other clients participating in other therapeutic

approaches because of the researcher’s use of the standardised measures, CORE and BDI-II. The data on these measures indicate that Peter experienced clinically significant change, which is generally understood to be a good outcome.

However there is insufficient evidence for me to feel certain that Peter’s problem of depression is “completely solved” as a result of this therapeutic experience (which is your definition of a “clearly good outcome”). Clearly Peter has had a significant experience: he has gained a major increase in his self-awareness and self-understanding, he has experienced a genuine honest and accepting relationship in which difficulties have been discussed and survived. He appears to have maintained the progress that he achieved (as measured by CORE etc) six months after the end of therapy. However he also recognised that what he has gained in this therapy is a foundation for future work and identified further areas of his experience that he wished to explore.

6. To what extent did the client change over the course of therapy?



7a. How certain are you?



7b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

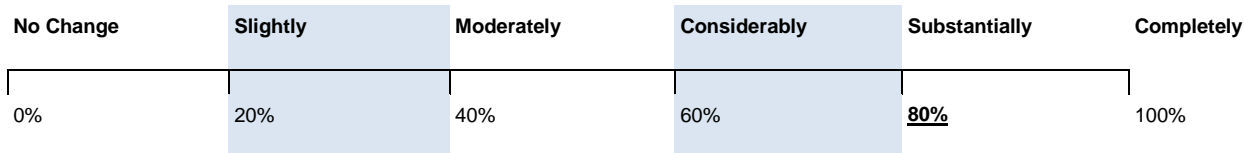
In my opinion, the data collected gave convincing support to the affirmative team’s argument that the client changed substantially over the course of therapy. The quantitative data demonstrated clinically significant change not only in Peter’s self-identified problems (PQ), but also in his general functioning (CORE) and his experience of depression (BDI-II). I accepted the reported evidence that the difficulties that Peter sought to address in the therapy were of a long-standing nature and rejected the sceptic team’s argument that the quantitative data may have been affected by regression to the mean.

The 1, 3 and 6 month follow up quantitative data gave weight to the inference that the changes in Peter’s self-identified problems, general functioning and experience of depression may be maintained over a longer period. However I would have liked to have had more information (e.g. access to the interview

transcripts) that would have helped me put into context Peter’s scores at his 3 months and 6 months follow up points – for example, how much additional therapy he had undertaken, what extra-therapy events had occurred, what stressors he was currently experiencing or had negotiated. This information would also have helped me to consider more fully the sceptic team’s criticism that there was little evidence that the changes that Peter experienced in relationship with his therapist had a wider and long-term impact on his relationships outside the therapy room.

I felt that the changes reported by Peter at his 1 month follow up interview, which reflected his understanding of the shifts in his experience of himself, his life and relationships, provided a useful context within which to make sense of the changes seen in his quantitative data. I accepted the affirmative team’s argument that there was balance in Peter’s testimony, that he recognised that there was further work for him to do – and therefore rejected the sceptic team’s assertion that the data he provided may have been unduly influenced by relational artefacts, hope or expectation.

7. To what extent is this change due to the therapy?



8a. How certain are you?



8b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

I found Peter’s descriptions of helpful events in the HAT forms that he completed at the end of each session to be a strong source of evidence that the therapy was a key factor in the change that he experienced.

The affirmative team presented convincing analyses of the connection between Peter’s descriptions of helpful events in therapy and the changes that he experienced in himself as a result of therapy, as well as session by session comparisons between what Peter found helpful and the therapist’s interventions. I felt that this evidence countered the sceptic team’s argument that Peter did not report particular interventions or specific techniques at his follow up interview and noted that the sceptic team did not respond to these lines of argument in their rebuttal.

Based on Peter’s comments at his 1 month follow up interview, there is no doubt for me that the relational approach that the therapist adopted within this work was a significant factor in enabling Peter to participate fully and effectively in the therapy. In addition, Peter’s motivation to change and readiness to engage with a genuine, interested and skilled therapist whose approach fitted his experiences, played a fundamental role in the effectiveness of the therapy.

8. Which therapy processes (mediator factors) do you feel were helpful to the client?

- Peter’s experience of his therapist as genuine, honest, accepting, interested in him and willing to become emotionally engaged with him.
- His therapist’s ability to empathise with Peter and to “contextualise and feel... through things” (C12). Peter talks about the therapist bringing his experiences into focus, resulting in an “epiphany sort of moment that has brought major changes” (C86).

- It is clear from the therapist's notes that s/he used a TA theoretical framework in developing her/his relationship with Peter e.g. strokes. This must have been delivered in a highly competent way as her/his application of theory did not detract from Peter's experience of the relationship: as he himself said, he has "a very, very low tolerance for feeling that (he) has been managed or... socially manipulated" (C13).
- Peter appears to have found discussion of theory helpful in developing his understanding of himself and his relationship with others.

9. Which characteristics and/or personal resources of the client (moderator factors) do you feel enabled him to make best use of his therapy?

- His readiness to engage with his difficulties.
- His previous knowledge and understanding of therapy and his desire to find the right therapy and therapist for him.
- Peter's determination to make use of the opportunity despite the discomfort, e.g. forcing himself to overcome the "initial awkwardness" of therapy.
- His ability to engage intellectually and emotionally with the therapy on offer.
- His ability to reflect on and articulate his process.



Appendix 4: Template of Information for Clients

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The Process and Outcome of Transactional Analysis Psychotherapy for the Treatment of Depression - Information for Participating Clients

About the Research

We are investigating transactional analysis (TA) psychotherapy, and in particular how it can be used in the treatment of depression. Transactional Analysis is widely used in psychotherapy in the UK and in Europe. TA therapists report good results from using TA with a wide range of clients, although there has been little formal research into TA therapy. This research project is exploring the processes and outcomes of TA therapy in the treatment of depression. Previous research suggests that the different types of therapy are roughly equivalent to each other in terms of effectiveness, and we anticipate finding that TA has outcomes which are equal to other types of therapy. TA shares many theories and methods with other types of therapy which are known to be effective which is why we feel confident in predicting generally good outcomes.

All the therapists participating in this research are trained and qualified in TA psychotherapy and work actively and respectfully with clients to help them explore their experiences; this enables clients to make sense of them and to help them make changes in their life through the development of a collaborative working relationship. In general, therapy differs from other ways of helping in that it refrains from giving advice but encourages clients to find their own solutions to their problems and supports them in achieving these.

Other goals of this research are:

1. Improving the training and effectiveness of TA therapists by teaching them how to integrate the findings of the research into therapy and therapy training courses and developing better ways of studying psychotherapy.

2. Improving the effectiveness of therapists through understanding the ways in which therapeutic change takes place and in refining how therapists deliver therapy. Other specific research projects may be developed but you will receive additional information about these if you are asked to take part.

If you are eligible for this study and are willing to take part, you will be offered TA psychotherapy from the therapist you have contacted.

Who is doing the research?

The principal researcher is Mark Widdowson, MSc (TA Psychotherapy), Teaching and Supervising Transactional Analyst, UKCP Registered Psychotherapist. Mark is a PhD student at the University of Leicester and is investigating the process and outcome of TA psychotherapy in the treatment of depression for his doctoral research. The whole research is being overseen by Professor Sue Wheeler at the University of Leicester, and Professor John McLeod at the University of Abertay, Dundee. If you have any concerns or queries about the research you may contact Mark directly either via e-mail at [REDACTED] or by telephone by calling [REDACTED].

The research has been approved by the Research Ethics Committee at the University of Leicester and follows the research ethics guidelines of the British Association for Counselling and Psychotherapy (BACP).

Complaints

If you wish to make a complaint about the therapy or the research you may contact Mark, the principal researcher directly or you may contact Professor Wheeler at the University of Leicester. Her e-mail address is [REDACTED].

About the Therapists

All the therapists participating in this study are professionally registered, trained and experienced therapists each with a minimum of five years training and over 750 hours of experience in working with clients. The therapists have been carefully selected to

ensure that you will be receiving good quality therapy from a properly trained and experienced therapist.

All the therapists who will be providing the therapy are professionally registered members of professional counselling and psychotherapy organisations and have professional indemnity insurance and abide by the codes of ethics and practice of their professional organisations. As qualified TA therapists, all the therapists are registered with the United Kingdom Council for Psychotherapy. The therapist you are working with will give you more information regarding any additional organisations they are affiliated to.

All UKCP registered therapists, regardless of their level of training or experience must have regular clinical supervision where they discuss their work and their case load. The therapists participating in this study will be receiving regular supervision, which will help monitor their work and to provide a safeguard as to the quality of the therapy that you will receive.

What will I be required to do for this study?

The number of therapy sessions will be agreed between the therapist and yourself during the first few weeks of therapy. This agreement will form part of a therapy contract that will be reviewed regularly. You can be offered up to a maximum of 16 weekly sessions of 50 minutes. Previous research suggests that 16 sessions of therapy is sufficient for most people with mild-moderate depression to obtain significant relief from their symptoms.

In the course of the study, we will ask you to give us information about your therapy, including your perceptions of your problems and how you are functioning, as well as your experience of specific therapy sessions.

We will ask you to fill out four short questionnaires each week, and to have your sessions audio recorded. You will need to allow extra time both before and after your sessions to fill out the questionnaires. The time needed for filling these out will usually be around 20 minutes in total each week.

At the end of the first, third and sixth sessions you will also be asked to complete an additional short questionnaire relating to how you are experiencing your therapist and how you are working together. This will take less than ten minutes to complete.

In addition, after every eight sessions, at the end of treatment, and at two follow up interviews after your therapy has finished, we will ask you to fill out more questionnaires and be interviewed by a member of the research team about your experience of therapy. The researcher who will conduct the follow up interviews will also be a qualified therapist.

The point of all this is to help us discover information that may be useful for developing and evaluating TA psychotherapy in routine practice and specifically in the treatment of depression, and to improve the training of TA psychotherapists.

Two of the questionnaires that are used every eight sessions are included in this information pack. If you are interested in participating in the therapy, please fill these out and bring them along to the first session with your therapist. These forms will enable us to track the changes you make as a result of the therapy.

This research involves several stages:

1. First, after making contact with your therapist, your therapist will have invited you to attend a preliminary intake interview session. This is normal procedure for beginning therapy and the therapist will have discussed the option of participation in this research in the interview. The intake interviews normally take around one hour, although your therapist will have advised you as to their usual procedure for these intake interviews. The main purpose of this session is for us to make sure that therapy is appropriate for you, and to give you some information about the research.

Your therapist will ask you some questions about: the kinds of problems you are currently having; your current relationships and employment details; problems you have had in the past; and your personal history (including details of the family you grew up in), to make sure that they can help you or that you do not have some other condition that indicates the need for a different approach.

For the purposes of the research, we will not be able to see you if you are currently in psychotherapy or counselling elsewhere or if you are on antidepressant medication. You will not be suitable to take part in this research if you are going through current severe substance misuse, active psychotic condition or current domestic violence. In these cases, you will be advised of the options available to you for accessing therapy.

If you are interested in participating in the research, you will then be asked to read this information sheet and to sign the consent form. Please read over this information and the consent form carefully and make sure you understand it; note anything that may be unclear or that may be of concern to you, so you can discuss it with your therapist; do not sign the consent form yet.

If you decide you would like to participate and if you fit our guidelines, you will be asked to sign the consent form, and to complete some additional questionnaires prior to your first therapy session. Participation in the research is entirely optional and if you decide not to participate, you will still be able to access therapy.

You will be given an information sheet on how you can get the most out of therapy, which also discusses some of the things you can expect to happen in the sessions.

2. In the study, you will work with your therapist up to a maximum of 16 sessions; the specific amount will be agreed by you and your therapist during the first few weeks of therapy. Together you will agree a therapy contract which will be your working agreement with your therapist about the nature of your therapy and the focus of your therapy. You will meet with your therapist once each week for 50 minutes.

Each of these sessions will be audio recorded

Immediately before and after each session, you will be asked to fill out brief questionnaires about how you are doing or about your experience of the session. The completion of the questionnaires should take about 20 minutes each week.

At the end of each session, you will complete a short questionnaire which is used to evaluate the session. If you feel the session was good, we want to know why it was good and what made it good. If you feel the session wasn't so good, we also want to know why it wasn't so good and what could have been different. During the data analysis phase of the research we may compare your session evaluations with a transcript of the session, to see if we can identify important and effective features of TA therapy and to help us learn more about what can be improved.

In entering into a therapy contract, you will be asked to commit to attending sessions regularly and to avoid cancelling at short notice wherever possible. Your therapist will advise you of the procedure for cancellation or rearrangement of sessions.

3. At the end of therapy and at a follow-up session, you will meet with a member of the research team (this will be someone else and not the therapist you have worked with), who will interview you about your problems and your experience of therapy, and ask you to complete some additional questionnaires. This should take about one to one and a half hours each time.

CONFIDENTIALITY

We routinely use audio recordings for the purposes of supervision and for the research, and in the consent form we are asking for your permission for that. We will separately ask you to give us permission to keep the recordings of your sessions and research interviews for research purposes, including training other therapists. Because it is important for us to protect your confidentiality, we will be taking several precautions:

- First of all, we will be using codes instead of names to identify all of the recordings and questionnaires.

- In addition, we will edit your name and any other identifying information from any transcripts we might make of parts of your sessions.

- We will disguise any information we might record in transcripts, notes, case studies or in material for publication when describing your case, for example, your profession, age, marital status, number of children and so on might be changed to help conceal your identity and reduce the chances that you could be identified in any way.

- The recordings will be stored on a password-protected computer, and back-ups will be stored in locked filing cabinets.

- Only your therapist, their supervisor and approved research staff will be allowed to have access to these recordings.

- Unless you tell us otherwise, questionnaires and recordings will be separated from your personal details and kept for a maximum of 5 years, providing there is scientific reason to do so, by the principal researcher and the research team. Questionnaires will be destroyed and recordings will be erased when there is no longer any scientific use for this data. We will review these issues with you after every eight sessions and again at the end as part of the follow up interview process.

- There are some situations that can arise in which we may have to take action to protect you or someone else from harm and have to reveal information that has come to light in interviewing a participant in this study or during therapy sessions. An example is where information was revealed that there was a child being abused by someone. If such a situation arises, we would limit the disclosure to what is absolutely necessary. We would also make every effort to fully discuss it with you beforehand. Your therapist will advise you of their policies and procedures regarding confidentiality.

POSSIBLE RISKS AND WHAT TO DO ABOUT THEM

Before you consent to take part in this study, we want you to know about the possible risks of doing so, and how you can reduce those risks.

1. Self-consciousness about being recorded.

Although most people in the past have been able to disregard the recording equipment, a few have felt inhibited or self-conscious and have found it difficult to talk about deeply personal matters. If you think being

audio recorded will interfere with your receiving help in therapy, please do not volunteer for this study. Audio recording is valuable for research and supervision purposes and to help us find out more about the things we are investigating. You may have concerns about the recordings or what will happen to them - please see below for more information. If you have any outstanding queries, you may discuss these with your therapist, or with the principal researcher.

2. Getting bored with all the forms.

There are a lot of forms to fill out for this research, and some people find them tedious and boring. Most clients find them interesting and a helpful addition to their therapy which helps them to reflect on and account for the changes that they are making. Please do not volunteer for this research if you hate filling out forms.

3. Getting worse.

Most clients experience temporary emotional discomfort or distress during therapy, including strong emotions as a natural part of the process. The therapist will work actively with you to help you deal with any painful emotions that may surface. If, however, you are seriously concerned about this, you may wish to reconsider volunteering for this study. If you volunteer and problems do occur, please report them to your therapist, who will do their best to address the difficulty. It may even turn out that the therapy is either not helping or, in rare instances, is causing harm; in such cases, it may be necessary to stop therapy or to refer you to a different form of treatment.

4. Not getting better

It is also possible that, at the end of your treatment, you may be in need of further therapy. If you feel you need further treatment, you and your therapist can discuss possible options. For example, they may offer you a referral to another therapist, type of therapy, or agency. This discussion will begin well in advance of your agreed ending date and will not be left until the end, so you will have time to prepare.

Starting therapy can be challenging and we recognise that things can happen that make it seem difficult to carry on with therapy. You are free to leave at any stage. We do, however, stress that it can be helpful for you to take the chance to discuss any difficulties with your therapist or one of the research team so we can address directly any problems that you raise.

POTENTIAL BENEFITS

In contrast to the risks listed above, there may also be some direct and indirect benefits for you or other people if you choose to take part in this study:

- As a result of the treatment, you are likely to feel better and less bothered by the problems you have been having. Previous research suggests that most clients experience significant improvement through therapy.

- Previous clients have reported that completing the research questionnaires and interviews helped them to get more out of their treatment. These procedures may also help you learn things about yourself.

- As you will be completing questionnaires at each session your progress will be closely monitored and evaluated and the therapy you will receive will be refined to increase the benefits you will obtain from the therapy.

Finally, you will be helping us better understand how TA therapy works, and in particular how we can use TA therapy in the treatment of depression. The research will also help psychotherapists develop better ways of helping other people, and assist us in training our post graduate students.

What notes are kept?

Your therapist will make some notes after each session, which will record the themes and issues that you both discussed in the session, what they did (what interventions they made and what theories and methods they used), and how you both seemed to be working together.

Your therapist will not be keeping detailed notes relating to specific events from your life and will keep your notes in such a way that your anonymity is preserved (see below). All notes will be stored securely in a locked cabinet and a code will be used instead of your name. Only your therapist and the principal researcher will know who the codes relate to.

The notes are firstly to help your therapist monitor and review your work together and secondly for research purposes. The notes will be used in the research to help us identify how therapists understand and work with particular themes or issues and also to see if we can identify common themes which affect people with depression. It is possible we may find that different therapists work differently with similar issues or problems, and we want to know why, what influences their way of working, and also what the outcome is of different ways of working.

You are entitled to see any notes kept about you and you can request a copy of your notes from your therapist. If you have any concerns or queries about the notes which are kept about you, you can discuss this with your therapist and/or the principal researcher.

Why will the therapy sessions be audio-recorded and what will happen to the recordings?

All of the therapy sessions will be audio-recorded. The recordings of sessions will potentially be used for several purposes:

- Your therapist might listen to segments of sessions for the purposes of reviewing the work as a part of their routine reflection and review on their work.

- Your therapist might play excerpts of the recording in their clinical supervision. All therapists, regardless of their experience, have regular on-going supervision, which helps ensure the quality of the therapy you will receive. This will help your therapist to refine their work with you. Any extracts that your therapist might play in supervision will not include details which might identify you.

- Some sessions, or some extracts from sessions, will be transcribed (typed up) for the purposes of researching the process of therapy.

- No names or places will be included in the transcripts, and all details which might lead you, someone else or a particular place, to be identified will be omitted to preserve your anonymity and ensure that no one who might read any transcript could recognise you or someone else.

- Only your therapist, their supervisor and up to two members of the research team will listen to any recordings of the sessions. This means only professionals involved either directly or indirectly in your therapy will hear any part of the recordings.

- Once the research has finished, the recordings will be destroyed.

- All recordings will be stored securely until they are destroyed

What will happen to the transcripts?

The transcripts are an important part of the research process. Transcripts of sessions or segments of sessions will be analysed by the researcher to help our

research into the therapy process. Some anonymised transcripts may be included in the Ph D thesis of the principal researcher. Some suitably disguised and anonymised transcripts may be used in professional publications. Some of the therapy cases will be written up as case studies which will be used to help us understand the therapy process in more depth. You will be asked at the end of your therapy if you are willing for a case study to be written about you. Your identity will be heavily concealed in any material which is written about you to preserve your anonymity.

What are the follow-up interviews and why are they being done?

A member of the research team will contact you after you have finished therapy, and several months after the end of the therapy to arrange an interview with you to evaluate your experience of therapy. We want to hear honest feedback about the therapy process and your experiences of therapy and of being part of the research. This will help us to understand more about:

- How people change throughout therapy
- Which aspects of the therapy have been most helpful to you
- How we can improve therapy

You will also be asked to complete some additional questionnaires so we can evaluate your progress. The interview and completing the questionnaires should take about one to one and a half hours each time.

Thank you for your interest in this research.



Appendix 5: Template of Informed Consent Agreement

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The Process and Outcome of Transactional Analysis Psychotherapy in the Treatment of Depression Research

INFORMED CONSENT AGREEMENT

Please indicate **Yes/ No** to each item and sign the form in the space provided at the end

I,, have received a full description of the purposes and procedures of this research; specifically:

1. I understand what I will be asked to do, as well as the possible risks and benefits of my taking part.

Yes/ No

2. I voluntarily consent to participate on the basis of the description of the study provided above.

Yes/ No

3. I realise that, by taking part, I may experience painful emotions or may feel bored or inhibited by the research procedures, and that if I require additional immediate treatment, it might be at my own expense.

Yes/ No

4. I understand that, if any of these things happen, I can discuss them with my therapist or the principal researcher.

Yes/ No

5. I understand that the professional researchers managing this project may discontinue my participation at any time if it is not in my best interests or the interests of the research.

Yes/ No

6. I realise that I may withdraw my consent and participation at any time, without giving a reason and without any of my rights being affected, and also that I can ask to have my data withdrawn from the study at any time, during or after my participation.

Yes/ No

7. I also understand that I may ask questions about the study at any time before, during, and after it has been conducted.

Yes/ No

8. I agree that the questionnaire and interview data that I provide for the project can be analysed for the purposes of research, and give permission for these records to be stored so that further study of them can be undertaken.

Yes/ No

9. I give my permission for my sessions to be recorded for supervision purposes, and that I will later be able to specify the specific research and training uses I will allow to be made of those recordings.

Yes/ No

10. I understand and agree that data gathered from my sessions will be used to examine trends and themes relating to the sample of clients in this study.

Yes/ No

11. I understand and agree that an anonymised case study may be written about my therapy and that I will be asked again at the end of my therapy if I am willing for a case study to be written about me and my therapy.

Yes/ No

12. I understand that all the information I give will be treated with the utmost confidentiality and that my anonymity will be respected at all times. I am aware that I can refrain from answering any question about which I feel uncomfortable.

Yes/ No

Finally, in signing this agreement, I confirm that:

- I over 18 years of age;
- That I am aware of what my participation involves and any potential risks;
- That all my questions concerning the study have been answered to my satisfaction.

Signed: **Date:**

Name:

Research/ Associate:

Signed: **Date:**



Appendix 6: Template of Therapist Session Notes

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Case:

Session: **Date Completed:**

Therapist:

I. Process Notes

1. Brief summary of main interventions, episodes and events of session. Please also indicate any key theories (this can include TA or non-TA concepts) which you were using in thinking about the work during the session, or in reflecting upon the session (use other side of page if necessary):

.....

.....

.....

.....

2. Transference/ Countertransference issues and themes:

.....

.....

.....

.....

3. Brief summary of main themes of session:

.....

.....

.....

.....

4. Ideas for next time (from self & supervision) :

.....

.....

.....

.....

5. Important Extra-therapy Events (e.g., relationships, work, injury/illness, changes in medication, self-help efforts)

.....
.....
.....
.....

II. Use of Principles of TA Psychotherapy

1. What were the client goals that were being addressed by the work in this session?

.....
.....
.....

2. What was the contract for this session and how did it relate to these goals?

.....
.....
.....

3. What methods and interventions were being used to facilitate completion of these goals and the session contract?

.....
.....
.....

4. What methods and interventions were used to facilitate the overall therapy contract and the treatment plan?

.....
.....
.....

5. Briefly describe any particularly powerful part of the session or any parts which felt important and indicate roughly in the session when this occurred.

.....
.....
.....

6. Which schools or approaches of TA did you use most in this session

.....
.....
.....

III. Overall Session Ratings:

1. Please rate how helpful or hindering to your client you think this session was overall. (Check one answer only)

THIS SESSION WAS:

- 1. Extremely hindering
- 2. Greatly hindering
- 3. Moderately hindering
- 4. Slightly hindering
- 5. Neither helpful nor hindering; neutral
- 6. Slightly helpful
- 7. Moderately helpful
- 8. Greatly helpful
- 9. Extremely helpful

2. How do you feel about the session you have just completed with your client?

- 1. Perfect
- 2. Excellent
- 3. Very good
- 4. Pretty good
- 5. Fair
- 6. Pretty poor
- 7. Very poor

3. How much progress do you feel your client made in dealing with his/her problems in this session?

- 1. A great deal of progress
- 2. Considerable progress
- 3. Moderate progress
- 4. Some progress
- 5. A little progress
- 6. Didn't get anywhere in this session
- 7. In some ways their problems have got worse this session

Appendix 7: Template of Therapist Adherence Checklist

Transactional Analysis Psychotherapy for Depression - Therapist Adherence Checklist

Therapist Adherence Scale.

Therapist:

Client Code:

Session Number: **Date:**

The twelve therapeutic tasks listed below constitute the essential core treatment plan for depression. Please tick next to each item to indicate whether you attended to this task in the therapy session and give yourself a score using the six-point rating scale below for each item. If the item is not applicable, please circle the N/A option. In the notes section, under each item and before the scale, please indicate how far you and the client achieved that item. Please also indicate with an asterisk which three items you focused on most in the session

1. Much improvement in application needed: I felt like a beginner, as if I didn't have the concept.
2. Moderate improvement needed: I seemed like an advanced beginner, who is beginning to do this, but needs to work on the concept more.
3. Slight improvement in application needed: I need to make a focused effort to do more of this.
4. Adequate application of principle: I did enough of this, but need to keep working on improving how well I do it.
5. Good application of principle: I did enough of this and did it skillfully.
6. Excellent application of principle: I did this consistently and even applied it in a creative way.

Key Therapeutic Tasks in Transactional Analysis Treatment of Depression

1. Create an 'I'm OK- You're OK' relationship where the client feels safe enough to explore their thoughts, feelings and experiences and begin to internalise the experience of being accepted

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

2. Identify, reflect upon the origins of and re-evaluate self-critical ego state dialogue

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

3. Identify, re-evaluate and challenge contaminations and script beliefs which negatively impact on the individual's self-concept and expectations of others and life

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

4. Support the individual to recognise, re-evaluate and challenge self-limiting systems of thinking, behaviour and experience which maintain the depression (racket system)

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

5. Explore, reflect upon and change stroking patterns (accepting positive strokes, giving self positive strokes, reduction in negative self-stroking/ self-criticism)

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

6. Identify and challenge discounting and grandiosity (e.g 'if things go wrong it is my fault' - discounts external factors and is grandiose about role of self)

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

7. Support the reflection upon and re-evaluation of life experiences that have contributed to a sense of worthlessness

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

8. Support the individual to make new decisions about how they will view themselves, relate to others and engage with the world

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

9. Support the deconfusion process whereby the individual identifies, expresses and reflects upon repressed feelings (including repressed anger and working through of grief and loss)

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

10. Support the individual to explore and experiment with new ways of relating to others which enhance self-worth

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

11. Designing and negotiating behavioural contracts such as awareness exercises homework, self-care contracts, exercise, diet and sleep hygiene contracts.

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

12. Facilitate the client's attachment to and engagement with life, others and the world

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

Appendix 8: Template of Supervisor’s Adherence Checklist

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Transactional Analysis Psychotherapy for Depression - Supervisor’s Adherence Checklist

Therapist:

Supervisor:

Date Completed:

This form is for completion by the supervisor of the participating therapist and will be used for the purposes of quality control and ensuring that competent TA therapy has been delivered to the clients participating in the research.

The twelve therapeutic tasks listed below constitute the essential core treatment plan for depression. Please tick next to each item to indicate whether you feel the therapist is attending to this task in the therapy and give the therapist a rating using the six-point scale for each item. Please circle the N/A option if the item is not applicable. In the notes section, under each item and before the scale, please indicate how far the therapist achieved that item.

- 1 Much improvement in application needed: the therapist felt like a beginner, as if they didn't have the concept.
- 2 Moderate improvement needed: the therapist seemed like an advanced beginner, who is beginning to do this, but needs to work on the concept more.
- 3 Slight improvement in application needed: the therapist needs to make a focused effort to do more of this.
- 4 Adequate application of principle: the therapist did enough of this, but needs to keep working on improving how well they do it.
- 5 Good application of principle: the therapist did enough of this and did it skillfully.
- 6 Excellent application of principle: the therapist did this consistently and even applied it in a creative way.

Key Therapeutic Tasks in Transactional Analysis Treatment of Depression

- 1. Create an 'I'm OK- You're OK' relationship where the client feels safe enough to explore their thoughts, feelings and experiences and begin to internalise the experience of being accepted

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

2. Identify, reflect upon the origins of and re-evaluate self-critical ego state dialogue

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

3. Identify, re-evaluate and challenge contaminations and script beliefs which negatively impact on the individual's self-concept and expectations of others and life

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

4. Support the individual to recognise, re-evaluate and challenge self-limiting systems of thinking, behaviour and experience which maintain the depression (racket system)

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

5. Explore, reflect upon and change stroking patterns (accepting positive strokes, giving self positive strokes, reduction in negative self-stroking/ self-criticism)

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

6. Identify and challenge discounting and grandiosity (e.g 'if things go wrong it is my fault' - discounts external factors and is grandiose about role of self)

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

7. Support the reflection upon and re-evaluation of life experiences that have contributed to a sense of worthlessness

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

8. Support the individual to make new decisions about how they will view themselves, relate to others and engage with the world

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

9. Support the deconfusion process whereby the individual identifies, expresses and reflects upon repressed feelings (including repressed anger and working through of grief and loss)

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

10. Support the individual to explore and experiment with new ways of relating to others which enhance self-worth

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

11. Designing and negotiating behavioural contracts such as awareness exercises homework, self-care contracts, exercise, diet and sleep hygiene contracts.

Notes:

Much improvement needed	Moderate improvement needed	Slight improvement needed	Adequate	Good	Excellent	Not Applicable
1	2	3	4	5	6	N/A

