IJTAR International Journal of Transactional Analysis Research

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

Abstract

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

Key Words

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

Introduction

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

Definition of Post-Traumatic Stress Disorder

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

Literature Review

At the time of writing, the only published research investigating the effectiveness of TA psychotherapy in

the treatment of PTSD is the pilot study conducted by Harford (2013). Based on a sample of 6 veterans and quantitative data gathered across 16 sessions of treatment, he concluded that " . . . anxiety and, to a lesser extent, depression appear to gradually reduce as, within the non-intrusive safety of an empathic therapeutic relationship, the veterans re-experience previously repressed affect, obtain the longed-for attuned response to their pain and then slowly build their Integrating Adult . . . capacity 'to reflect upon and integrate their own archaic states as well as past introjects, and . . . draw on them in the service of present-centred relating' (Tudor, 2003, p.202)". (Harford, 2013, p.28)

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

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

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

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

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

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

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

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

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

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

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

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

At present, no solid evidence exists for the efficacy of humanistic therapies with PTSD. In terms of UK health policy, National Institute for Clinical Excellence Guideline CG26 (2005) states that "there is as yet no convincing evidence for a clinically important effect of [other therapies] on PTSD" (p.19) and instead, recommends "a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR])" (2005, p.4). As Harford (2013) highlighted, there remains "a strong case for building the evidence base for TA psychotherapy in the treatment of PTSD and, thereby, influencing health policy and strategy within the NHS and at local and national government levels" (p.27).

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

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

Method

Participants

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

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

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

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

Table 2: Characteristics of sample undertaking long term therapy

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

Table 3 Characteristics of sample undertaking short term therapy

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

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

Therapy

As with the original pilot study (Harford 2013), the form of TA psychotherapy chosen was rooted primarily in the integrative TA model advanced by Erskine (1993) and Erskine and Trautmann (1996), with an emphasis on facilitating intrapsychic contact with dissociatively "encapsulated traumatic experiences, hidden needs" (Erskine, 1993, p.185) and repressed affect, providing an attuned response to that affect and strengthening veterans' Integrating Adult (Tudor, 2003) capacity "to reflect upon and integrate their own archaic states as well as past introjects, and . . . draw on them in the service of present-centred relating" (p.202). However, the authors were mindful of Cornell and Bonds-White's (2001) critique of the limitations of an over-reliance on the integrative model, with its attendant risk of promoting "a temporary, mutually gratifying narcissistic merger" (p.72) between therapist and client. Consequently, inspired by their support for Bollas' (1989) stance, which emphasises the need for "a balanced therapeutic process serving the dual functions of soothing and disturbing the client" (p.80), the integrative foundations of the treatment were augmented with a two-person (Stark, 2000) relational focus on the cotransferential (Summers and Tudor, 2000) domain, as pioneered by Hargaden and Sills (2002) and, later, applied to the treatment of trauma and PTSD by Stuthridge (2006, 2012) and Caizzi (2012). Here, the therapist observes, participates in and makes available for mutual analysis the "transferential enactments [that] provide a crucial voice for implicit relational patterns and excluded [or dissociated] ego states" (Stuthridge, 2006, p.277) and, through an iterative "process of attunement, rupture, and repair" (Stuthridge, 2006, p.277), slowly challenges and rewrites the client's traumatic script (Stuthridge, 2006). In this way, aided by strict observance of ethical and professional boundaries, the therapist (Harford) in this study was able to provide "the 'safe container' in which the [veterans could] begin to integrate" (Hargaden & Sills, 2002, p.29) their fragmented selves, rediscover lost skills and resources and begin to build mutually beneficial interpersonal relationships and more rewarding and meaningful lives.

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

Data Collection

Quantitative

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

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

Qualitative

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

Data Auditing

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

Quantitative Results

Quantitative Results: Long-term clients (52 sessions)

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

CORE-OM: Pre-treatment levels of symptoms among all 8 veterans undergoing longer-term treatment were in the clinical range of severity, with 2 being classified as 'severe', 3 as 'moderate to severe', 2 as 'moderate' and 1 as 'mild' under the original scoring criteria (CORE ims, 2003). However, this rather mixed starting point is potentially misleading, as 2 of the 3 veterans beginning treatment with 'mild', or 'moderate' symptoms deteriorated to the 'severe' level within 8 sessions. As in the earlier pilot study (Harford, 2013), these results appear to accord with the researchers' prior expectations that some emotional "turbulence [would] occur as part of the change process" (Widdowson, 2010, p.203); more specifically, that veterans would feel somewhat worse before they began to improve as they made internal contact (Erskine, 1993) with previously repressed affect, leading to a temporary intensification of their distress. (Harford, 2013, p.28)

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

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

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

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

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

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

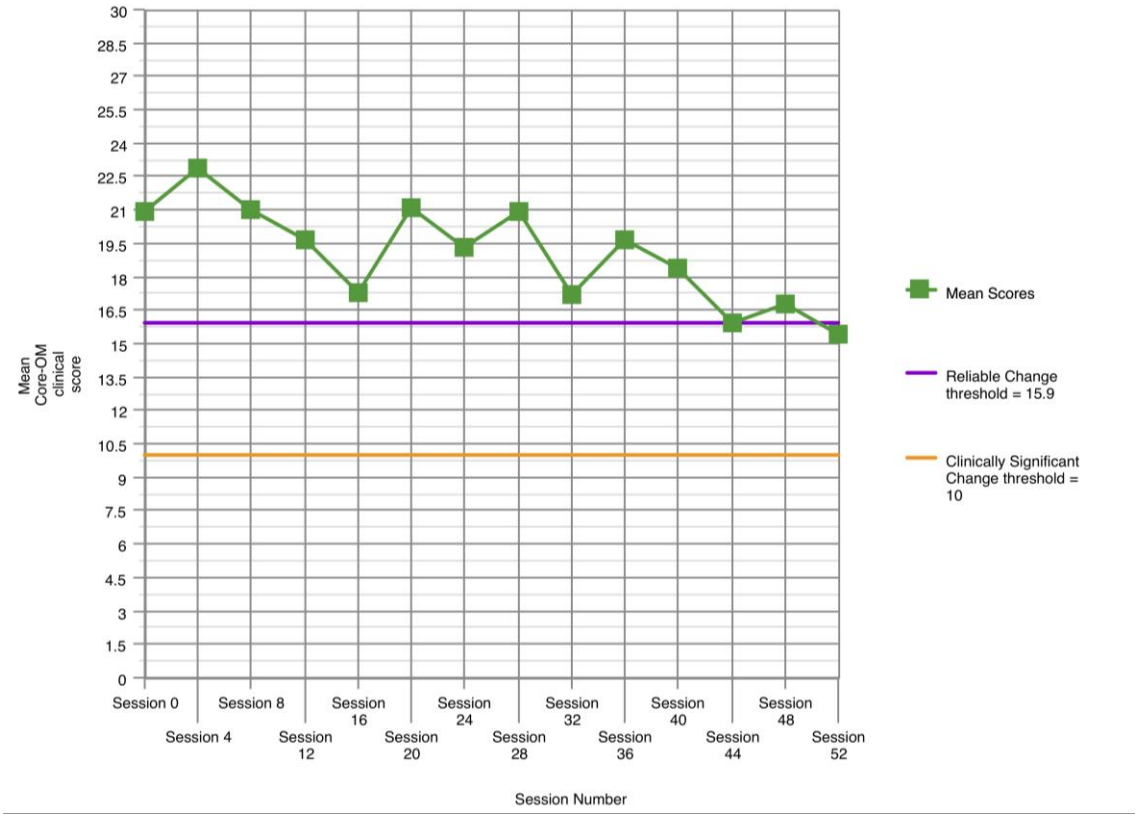

Figure 1: Table 4: Mean Clinical Core-OM score: 8 long-term clients

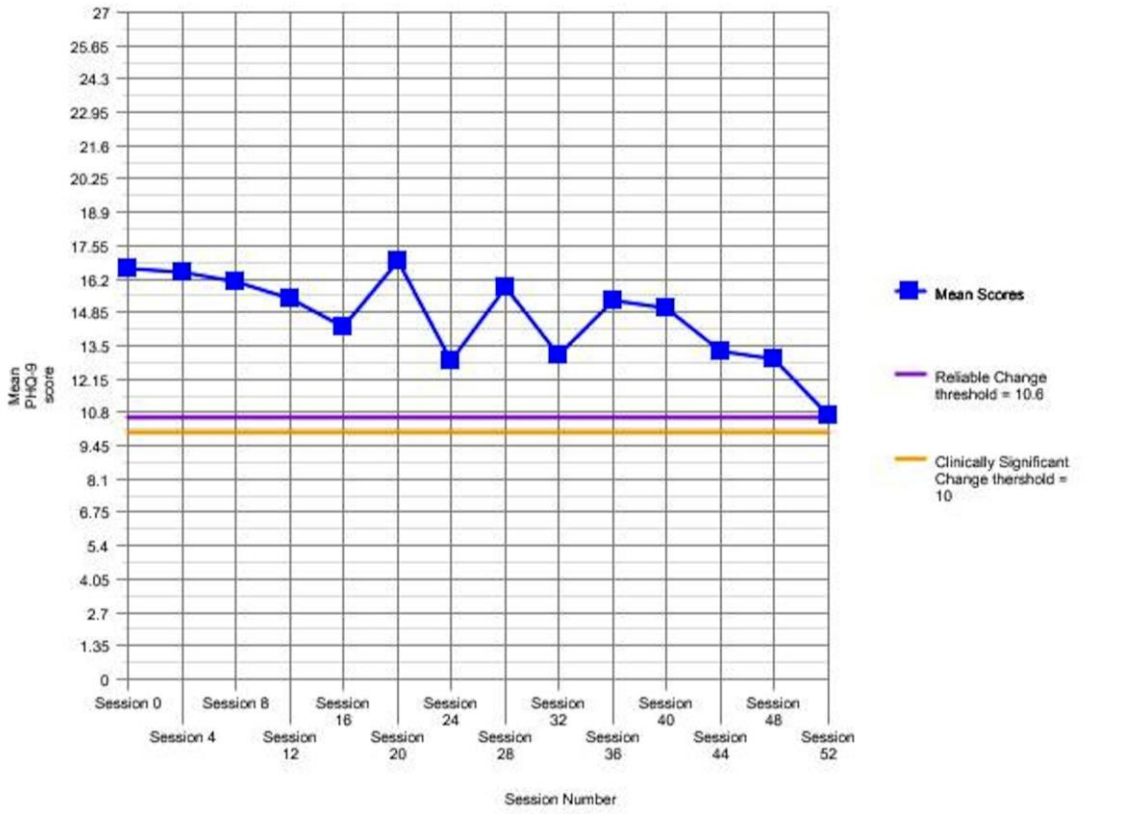

Figure 2: Table 5: Mean PHQ-9 score: 8 long-term clients

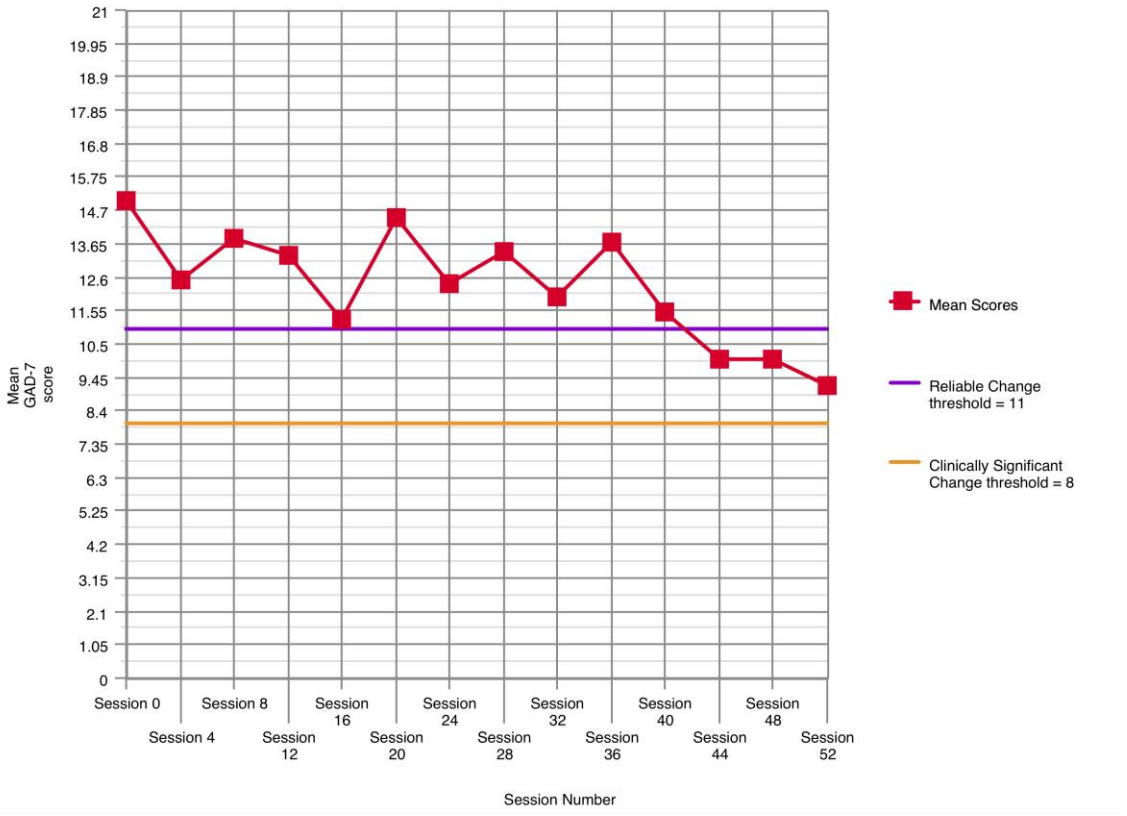

Figure 3: Table 6: Mean GAD-7 score: 8 long-term clients

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

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

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

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

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

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

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

PHQ-9: Pre-treatment symptoms of depression among the 7 veterans in the short-term cohort were all in the clinical range of severity, with 4 veterans meriting a 'major depression (severe)' designation, 1 falling within the 'major depression (moderate)' category and the other 3 exhibiting 'dysthymia, minor depression, major depression (mild)', as defined by Kroenke et al (2001). However, as with the clinical CORE-OM results for the long-term cohort, the individual veterans' scores deserve closer inspection, as Client I commences treatment in the 'dysthymia, minor depression, major depression (mild)' band, but deteriorates to the 'major depression (severe)' level within 4 sessions. Though less prominent than that present in the long-term CORE-OM scores, this slight variance in the short-term PHQ-9 results would appear to offer a modicum of additional support for Harford's prediction " . . . that veterans would feel somewhat worse before they began to improve as they made internal contact (Erskine, 1993) with previously repressed affect, leading to a temporary intensification of their distress." (Harford, 2013, p.28)

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

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

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

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

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

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

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

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

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

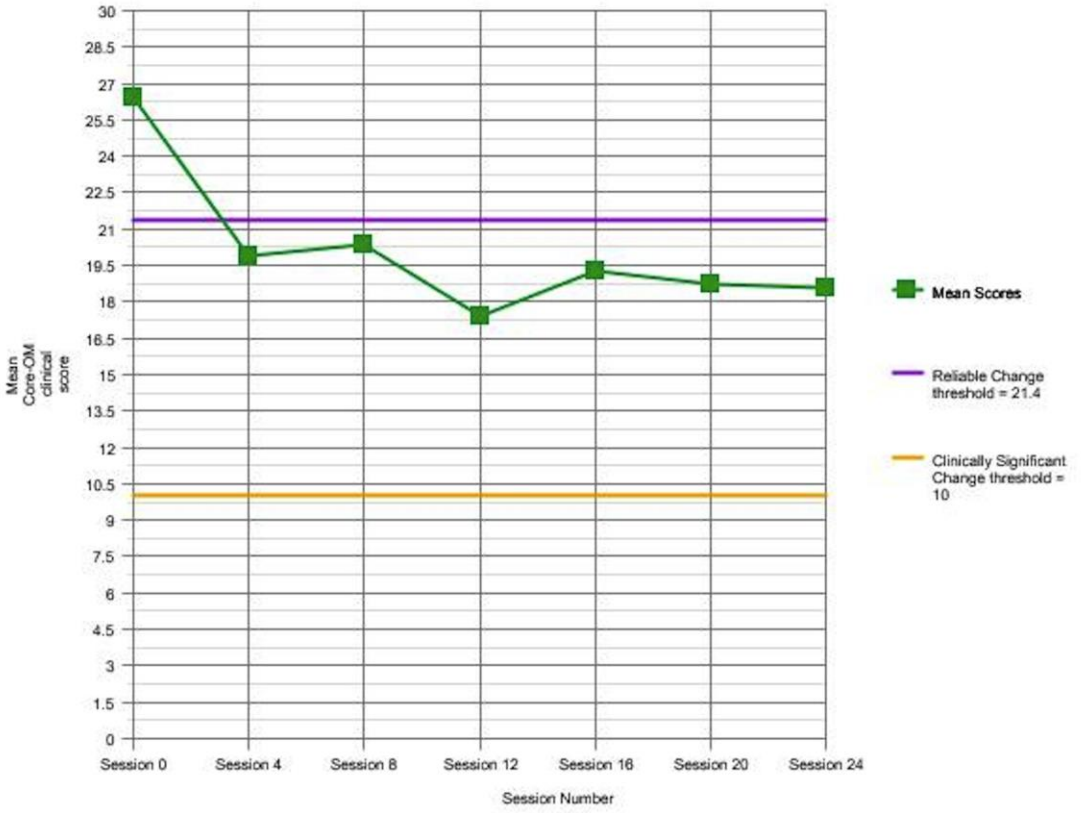

Figure 4: Mean Clinical Core-OM score: 7 short-term clients

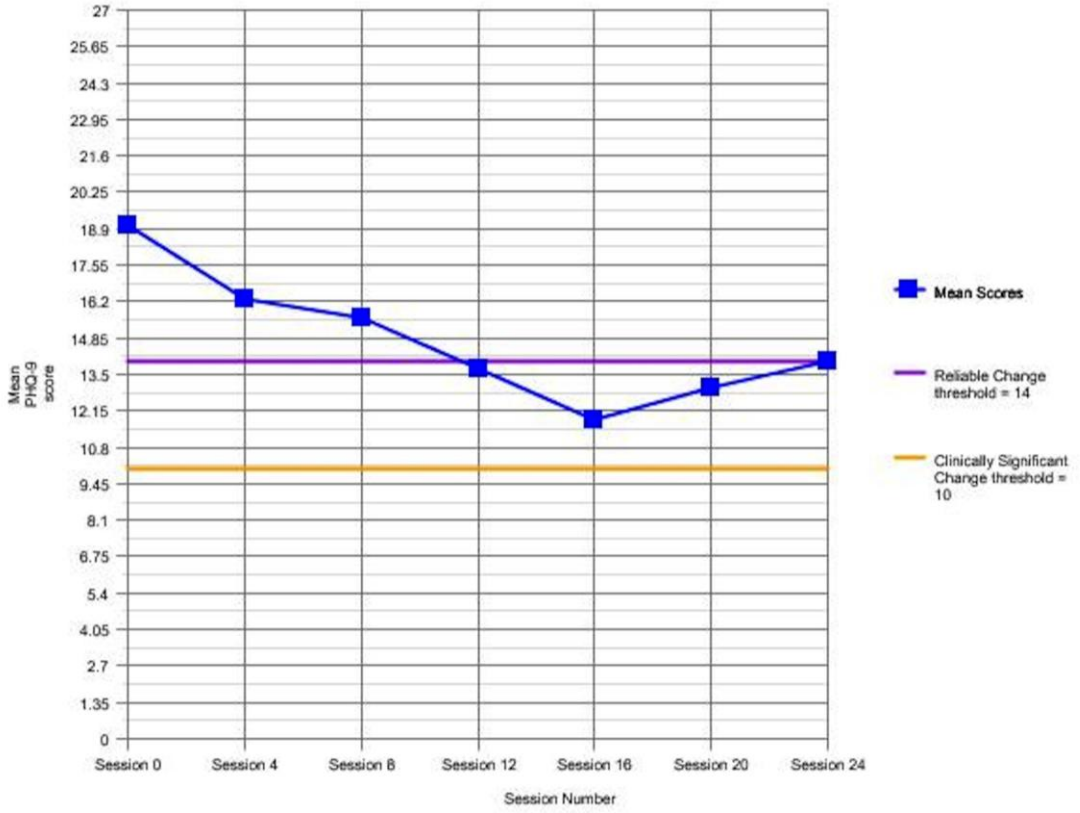

Figure 5: Mean PHQ-9 score: 7 short-term clients

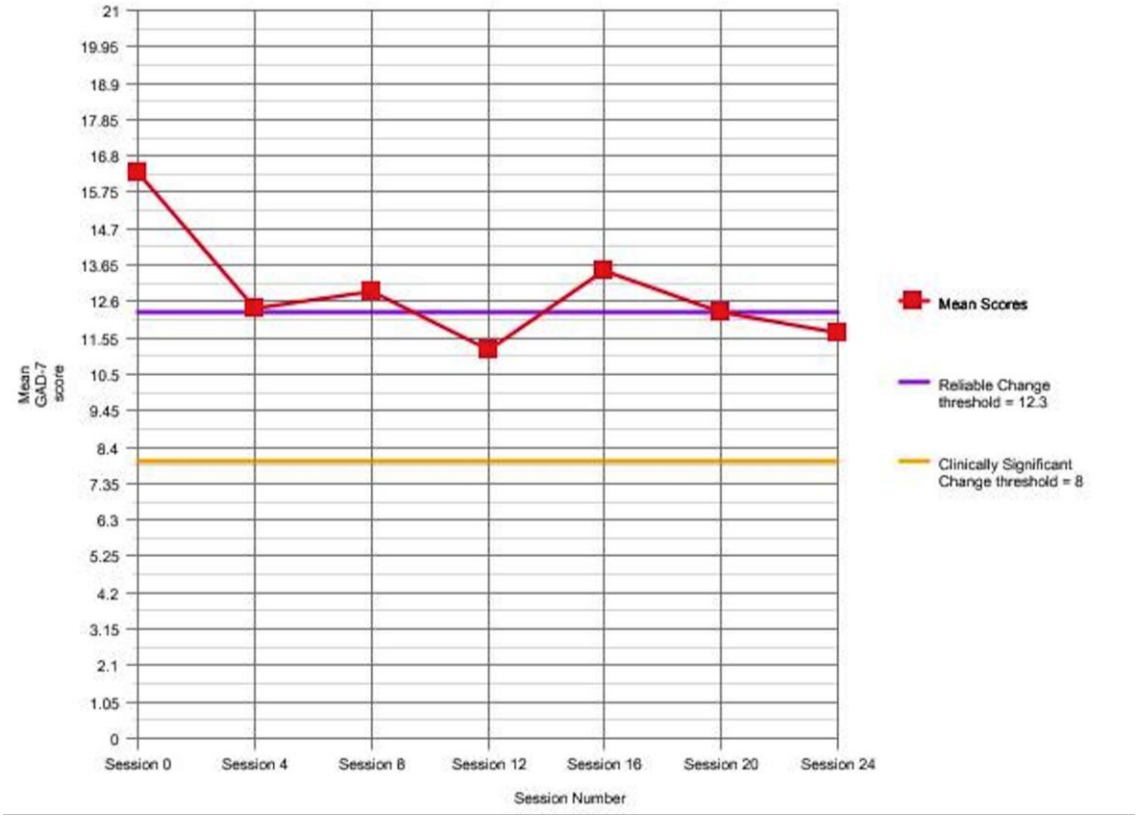

Figure 6: Mean GAD-7 score: 7 short-term clients

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

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

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

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

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

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

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

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

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

Table 11: Mean PHQ-9 score: all clients

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

Table 12: Mean GAD-7 score: all clients

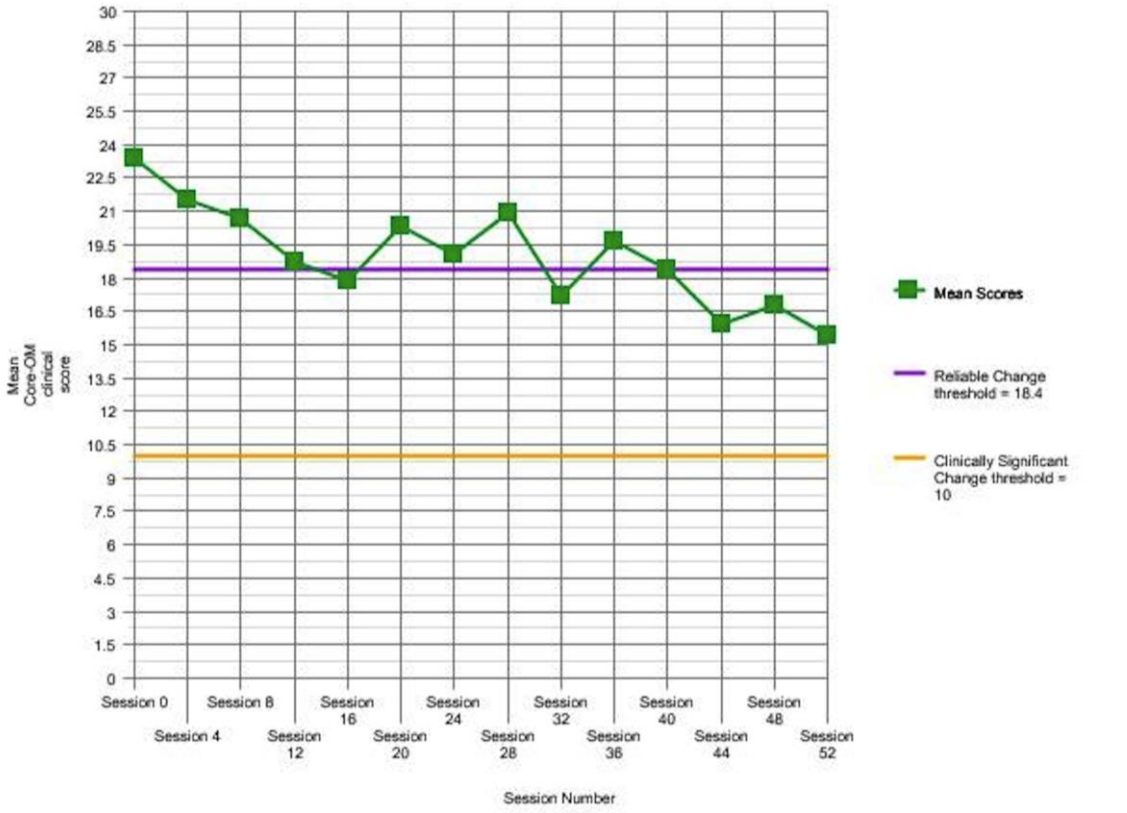

Figure 7: Mean Clinical CORE OM Score: all clients

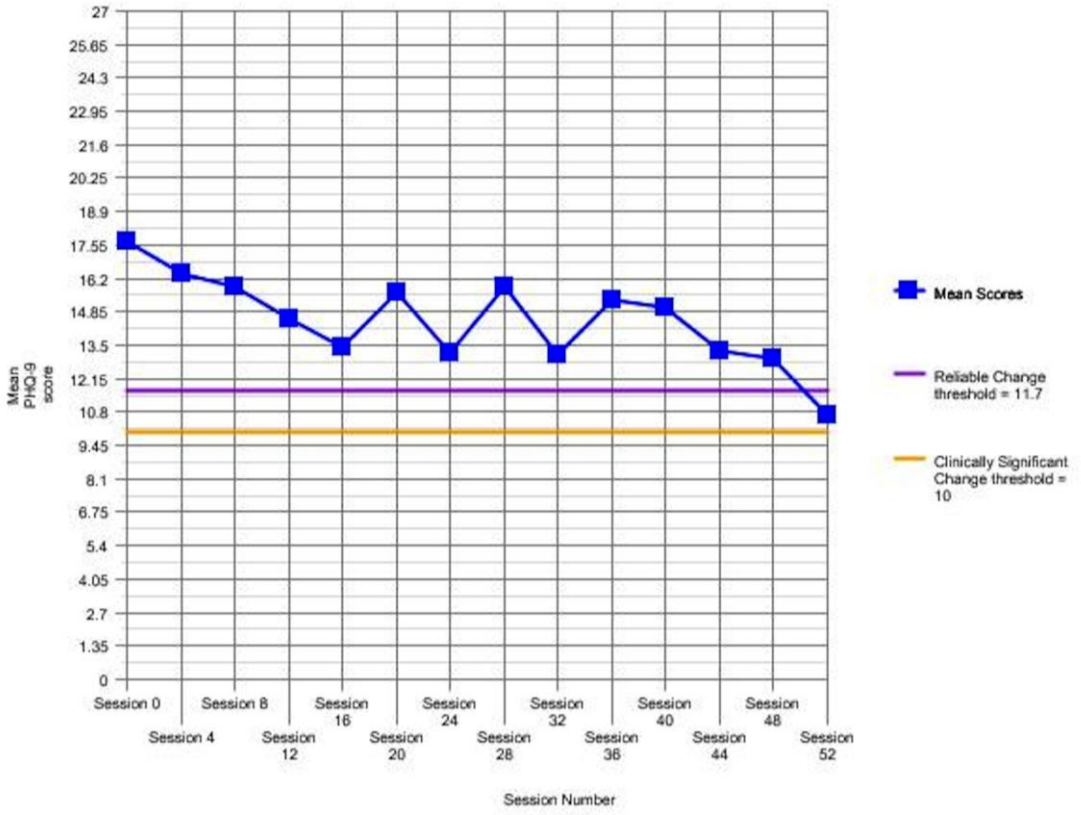

Figure 8: Mean PHQ-9 score: all clients

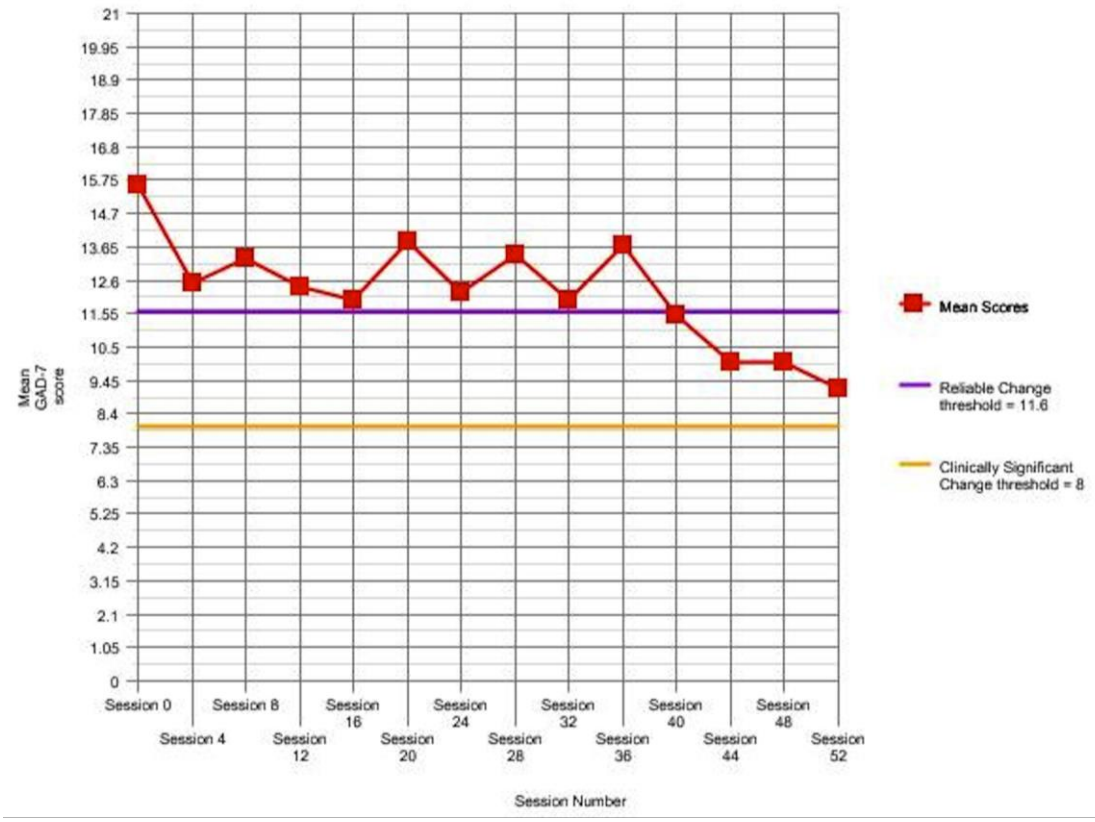

Figure 9: Mean GAD-7 score: all clients

Qualitative Results

Qualitative Results: Client Changes, Outcomes of TA Psychotherapy

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

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

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

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

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Superordinate Themes

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

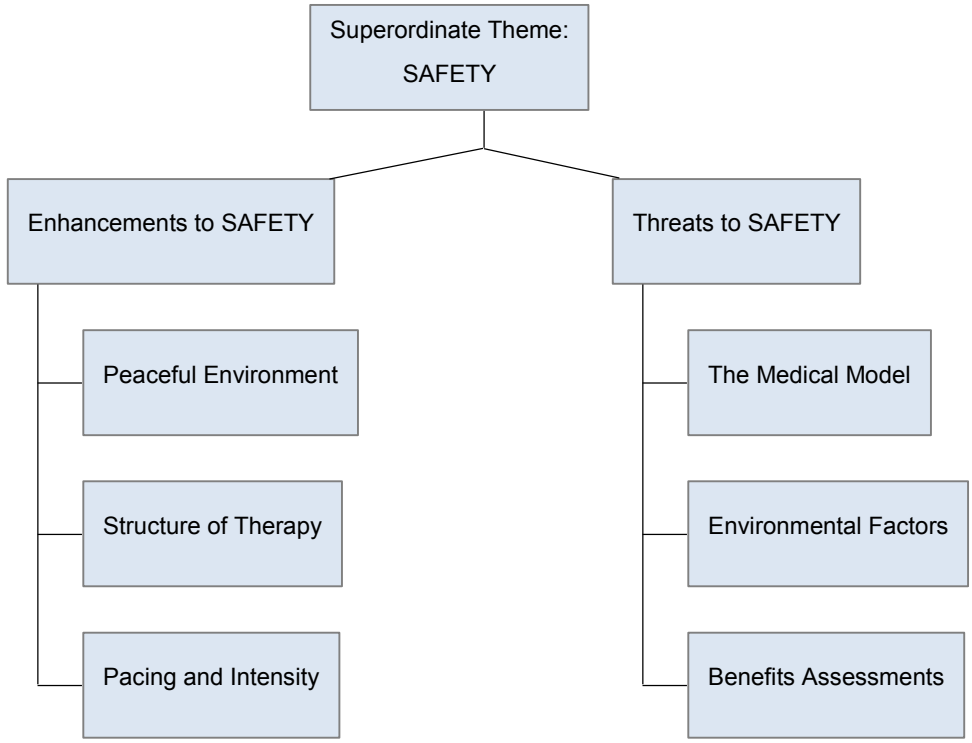

Figure 10: Themes related to Safety

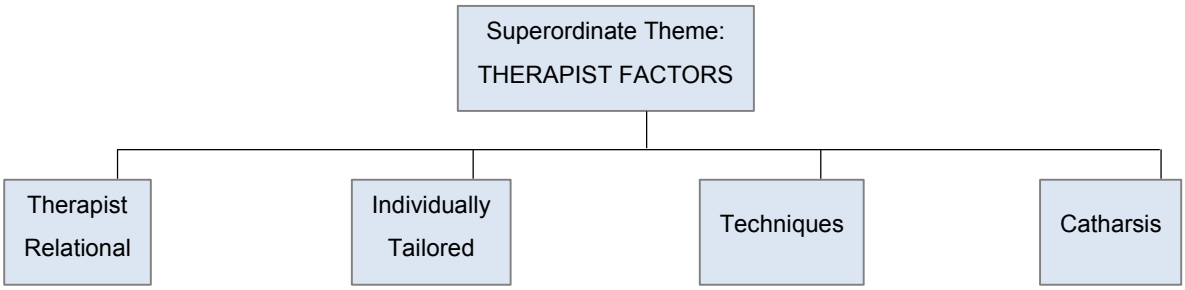

Figure 11: Superordinate Theme 2: Therapist Factors:

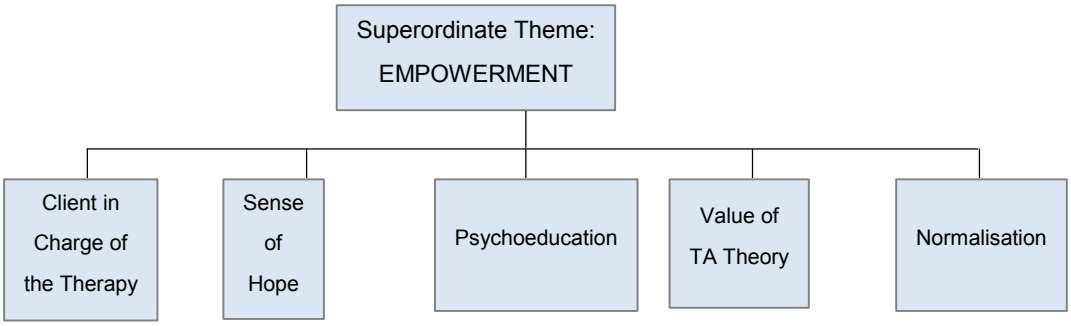

Figure 12: Superordinate Theme 3: Empowerment

Qualitative Results: Psychotherapy Process Factors

Superordinate Theme 1: Safety

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

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

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

1.1 Enhancements to Safety

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

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

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

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

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

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

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

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

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

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

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

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

1.2. Threats to Safety

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Superordinate Theme 2: Therapist Factors:

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

2.1 Theme: Therapist Relational Qualities

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

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

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

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

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

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

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

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

2.2 Theme: Individually Tailored Therapy

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

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

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

2.3 Theme: Techniques

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

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

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

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

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

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

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

2.4 Theme: Catharsis

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

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

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

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

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

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

Superordinate Theme 3: Empowerment

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

3.1 Theme: Client in Charge of the Therapy

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

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

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

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

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

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

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

3.2 Theme: Sense of hope

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

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

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

3.3 Theme: Psychoeducation

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

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

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

3.4 Theme: Value of TA theory

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

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

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

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

3.5 Theme: Normalisation

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

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

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

Other Positive Outcomes

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

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

Data Limitations

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

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

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

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

Table 14: Changes in Psychiatric Medication during TA Psychotherapy Treatment

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

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

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

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

Discussion

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

fore, offers solid confirmation of Harford's (2013) pilot findings that both anxiety and, to a lesser extent, depression appear to gradually reduce as, within the nonintrusive safety of an empathic therapeutic relationship, the veterans re-experience previously repressed affect, obtain the longed, for attuned response to their pain and then slowly build their Integrating Adult to "reflect upon and integrate archaic states and introjects, and draw on them for present, centred relating" (Tudor, 2003, p.202).

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

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

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

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

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

As noted in Harford's (2013) earlier pilot study, contrary to the practitioner-researcher's prior misgivings that the use of questionnaires with this extremely vulnerable client group "might present a countertherapeutic intrusion of bureaucracy into fragile therapeutic alliances" (p.28), their introduction has, in fact, proved an invaluable aspect of the veterans' treatment, as referred to explicitly in a number of interview responses. As well as providing a convenient rough measure of progress for the therapist and generating precious evidence of success for the charity's ongoing efforts to secure external funding for the psychotherapy programme, the sensitively "contracted use of [CORE-OM, PHQ-9 and GAD-7] questionnaires appears . . . to have gone some way to satisfying veterans' structure hunger (Berne, 1961) in the face of self-fragmentation, provided "a degree of emotional containment" (Widdowson, 2010, p.203) and afforded a way for these vulnerable clients to measure and conceptualise their labile phenomenological experience." (Harford, 2013, p.28).

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

Conclusion

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

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

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

Clinical cut-off = 10.0

Reliable Change = Reduction of 5.0 or more

Clinically Significant Change = client achieving 9.9 or less

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

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

Clinical cut-off = 10

Reliable Change = Reduction of 6, or more

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

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

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

Clinical cut-off = 8

Reliable Change = Reduction of 4 or more

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

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

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