Paradoxical Alliances in Transactional Analysis Psychotherapy:

A Systematic Adjudicated Case Study : '*Marie'*

Bernard Gentelet and Dr Mark Widdowson

Abstract

Using an original therapeutic technique called 'Paradoxical Alliances', the first author has investigated the effectiveness of this therapeutic intervention during a case of Transactional Analysis Psychotherapy for a 37 year old white French female, Marie, during two sets of sessions. The authors advance the hypothesis that using paradoxical alliances can be an effective technique in the treatment of anxiety disorders and a useful addition to existing TA methods. Marie's first set of sessions occurred before the first author had developed the paradoxical alliances approach, and the therapy had some benefits, but did not result in any deep, lasting change for the client. In the second series of sessions, the first author applied the paradoxical alliances technique, which resulted in a deep and lasting improvement in Marie's anxiety attacks.

Key words

Anxiety disorders, case study research, Paradoxical Alliances, Transactional Analysis (TA) Psychotherapy (.)

Introduction

A number of recent research articles have demonstrated the effectiveness of TA psychotherapy for the treatment of anxiety and anxiety symptoms (van Rijn, Wild and Moran, 2011; van Rijn and Wild, 2013). Despite this, and the prevalence of anxiety disorders (around 18.1% of the population experience anxiety disorders within any given year- see Kessler, Chiu, Demler & Walters, 2005) there is very limited literature that specifically addresses the treatment of anxiety from a Transactional Analysis perspective.

This study used a systematic case study research method, combining elements of n=1 and pragmatic case study research designs (McLeod, 2010) to investigate the process and outcome of TA psychotherapy using the paradoxical alliances intervention for the treatment of repetitive anxiety attacks. The case study meets criteria for a pragmatic case study, since it addresses practical problems in local and time-specific contexts, rather than focusing on abstract and quantitative knowledge (Fishman, 1999).

As case study research can lack objectivity, especially in cases such as this present study, where one of the authors is also the therapist, in order to achieve critical distance from the experience of working with the client, the first author used an adjudication procedure (see Widdowson, 2011) by asking a number of non-TA psychotherapy professionals to review the case, and offer their opinions regarding both the outcome of the case, and the critical aspects (interventions) of the case which resulted in client change.

The use of non-TA psychotherapy professionals in the adjudication process goes some way to addressing issues connected to researcher allegiance bias, as these therapists have no prior allegiance to TA and can therefore be considered to be independent judges of the effectiveness of the therapy and of the overall outcome of the case.

The case study is also an n=1 study since it addresses effectiveness questions about the outcome of the case, specifically, the research question, 'Can paradoxical alliances be an effective intervention in the TA treatment of anxiety?'.
The aim of an n=1 study is to be as precise as possible about what is caused by what. In other words, the purpose of valid and reliable measurement in an n=1 study is to identify what has changed, in response to a specific intervention at a specific time, and whether the changes the client experienced were a result of the intervention she/he received and not merely a reflection of random variability or spontaneous remission.

This case includes the use of assessment instruments administered during Marie's therapy and during a follow-up, one year later. The client's scores on a set of 3 standardised and validated self-report measures were completed at several intervals. These were:
• At the beginning of the therapy
• At the end of the first set of sessions
• At the beginning of the second set of sessions (which occurred a few months after the end of the first set of sessions)
• At the end of therapy
• At follow-up meetings three months, six months, nine months and one year after the end of the therapy.

Author reflexivity

The first author was the therapist in this case. He is a 55 year old French psychotherapist, got a Master of Science in psychotherapy validated at Middlesex University (London), is a Certified Transactional Analyst (CTA) and holder of the European Certificate of Psychotherapy , working in his own private practice. Over time, the first author followed his clinical judgement and started to experiment with paradoxical interventions and developed the TA-based paradoxical alliances intervention. The first author noted that this intervention appeared to be highly effective for use with a range of anxiety disorders, including panic attacks and some phobias (agoraphobia, claustrophobia and a specific sub-type of social anxiety where the sufferer experiences anxiety about blushing).

Throughout the duration of Marie's therapy, the first author received monthly supervision from a teaching and supervising transactional analyst and also attended a monthly peer supervision group in which he regularly presented the progression of his research, his discoveries and his experiences with Marie. The second author was the research supervisor for this case. He is a teaching and supervising transactional analyst, and is an experienced psychotherapy researcher, with specific expertise in case study research.

Ethical Issues

Given the specific ethical issues associated with case study research (see McLeod, 2010), the first author obtained formal, written consent from Marie for the case material to be published. Marie gave her permission at several stages. In addition, a member checking procedure was used, whereby Marie read a draft of this paper before publication, verified the accuracy of the contents, confirmed her permission for this case to be published. These documents are retained by the first author and have been seen by the second author. In accordance with guidelines relating to client confidentiality, some identifying details have been changed, however, the essential facts about the case remain the same.

Defining paradoxical alliances

The method involves the use of two different paradoxical alliances:

1) Allowing the symptom: Usually clients come to 'get rid of' their symptoms. Conversely and paradoxically, the therapist helps the client to feel and understand how these symptoms were smart ways to cope with his or her childhood situation.

2) Prescribing the symptom: The therapist creates a 'shock' in the client's mind by specifically and deliberately prescribing the client express his symptom right now (or later, but at a specified time).The client is unable to experience his symptom 'on demand', and is surprised by this inability. The uncontrollable becomes paradoxically controllable, thus allowing the client to see how he can have a paradoxical hold on his symptom.

The client: Marie

At the beginning of her therapy, Marie was a 37 year old social worker. She was referred by 'word of mouth' from a friend of hers who had previously seen the first author for psychotherapy. In her own words, Marie came to therapy 'to empty something'.Marie's parents divorced when she was seven years old, and she described her father as a '*weak, absent and alcoholic man*'. She had only seen him once since her parents divorced and said 'For me, he is nothing'.
She described her mother as a manipulative, seductive and 'octopus' woman. After the divorce, Marie's mother put Marie and her siblings into the car, drove half the distance between her house and her now ex-husband's house and said to the children '*Now you choose between me and your father*'. Although Marie felt that she would have liked to live with her father, she chose her mother because she did not want to be separated from her siblings who immediately chose their mother. Marie ended her description of her mother by saying '*I would like to abandon her. I don't want her to be part of my life any more'.*

Marie described having a good relationship with her siblings and reported that she enjoyed school where her busy, cheerful, and over-adapted behaviour was warmly welcomed by her teachers. Marie was married to Eric, a down-to-Earth vineyard worker who was described by Marie as '*My stable pillar when things move too much*'. She depicted their marriage as stable, supportive relationship with a playful social life and a satisfying sex life. Marie and Eric have two children.

Strengths

Marie was warm, easy going and energetic despite her anxiety. She was intelligent and eager to undertake her therapy as she saw her anxiety attacks occurring more and more frequently.
She completed all the contracted homework tasks with compliance and efficiency. It is the view of the authors that these strengths helped Marie to harvest a good outcome from therapy.

Extra therapy events and resources

Since Marie depicted her husband so positively the therapist chose to enlist the support of this 'stable pillar' as a therapeutic ally for Marie. This help will be detailed further in the description of the sessions. Her job was also and still is an area of positive resource for Marie.

The Therapy Process

The first set of 25 sessions

The first six sessions: forming the therapeutic alliance, contracting and diagnosis

These sessions focused on starting the therapeutic process. From the outset, Marie was clear that she was attending therapy to address her anxiety. The therapist took a detailed history of Marie and explained his ways of working and thoughts on the process of therapy and an outline of his proposed treatment plan. Marie expressed at first that she wanted 'to understand' why she was so anxious, and so she and the therapist agreed to begin the therapy by focusing on increasing Marie's insight and understanding about her anxiety. At this time, the first author had not developed his thinking about paradoxical alliances, so his treatment plan was mainly to reduce Marie's overall level general anxiety with a range of the usual TA concepts and tools.
During these first sessions, the therapist taught Marie relevant TA concepts to help her understand her anxiety. These included: the theory of ego states, personality adaptations and drivers.
Marie enjoyed learning about these concepts and felt that this was helping her to achieve her contract goal of '*Understanding how I became who I am*'.

Sessions 6-10: Deepening the exploration of Marie's 'madness'.

Prior to engaging Marie in a process of deconfusion of her Child ego state (Berne, 1961), the therapist chose to focus on protection (Crossman, 1966). Within the TA literature, the therapist found the most specific guidance for providing protection for clients who envision madness as an option in the work of Boyd (1980), Goulding (1972) and Holloway (1973) which focuses primarily on the use of the 'escape hatch closure' technique. In line with the guidance of these authors, the therapist began to assess the risk of Marie's madness by exploring any situations in which Marie felt she could become 'mad'.

Sessions 10-15 : The no-madness decision.

As a result of the previous sessions, Marie fully understood the importance of taking active steps to ensure she would not 'go mad'.
In describing his thinking about this process, the therapist used a metaphor of a boat. He explained to Marie how the therapy can be seen as a kind of crossing the ocean and how his job is to be the skipper who accompanies her during this crossing. However, before starting the crossing, the skipper sees a crack in the hull of the boat. He decides that it is dangerous to attempt to cross the ocean without fixing the crack and so decides to repair the boat.
Drawing on the boat metaphor, in this instance, the crack is the risk of Marie decompensating and 'going mad'.
The therapist proposed that the way to fix this crack was through the use of escape hatch closure; specifically a no-madness decision.
Marie, who sometimes sailed on the French Riviera was delighted with this metaphor and agreed to commit herself to a no-madness decision (White, 2011).
Despite her willingness to engage with the process, at first, Marie was not able to make a firm commitment from her Adult ego state. The therapist noticed evidence to suggest that Marie was engaging with the process from a contaminated Adult position and used the following statements to explore any potential resistance to the no-madness decision: '*From which part of you does this very tiny smile come from when you state your new decision?*'; '*If this tiny smile could talk, what would it say?'; 'If this tiny smile was a person from your childhood, who would it be ?*' and so forth.
At the end of this process, Marie was able to firmly commit herself from her Adult ego state to a no-madness decision.

Prior to the introduction of the no-madness decision, the therapist also engaged Marie in a discussion about :
1. What it would meant for her to become 'mad'?
2. What would happen to her if she became ‘mad' (psychiatric hospital, etc…)?
3. What would happen to others if she became 'mad' (her mother, her children, her husband and so on)?
4. What would happen to the 'Marie & her therapist's’ relationship if she became 'mad'?
5. Who would be sad or happy if she became ‘mad'?

Sessions 15-25: Reducing the general level of anxiety.

These sessions primarily drew on the use of a Classical TA (Widdowson, 2010) approach.
Marie and her therapist explored a number of situations where she felt she might potentially not be able to cope with things. This included her job, her marriage and her relationship with her mother. These sessions mainly focused on decontaminating her Adult ego state from her prejudices and beliefs. Marie saw how these contaminations could lead to harmful or undesirable outcomes in a number of different situations, and also resulted in Marie experiencing a negative, anxious expectation for future situations.
In the last session, Marie stated ‘*I am no longer afraid of madness; I know how to cope with my mother and I am no longer in symbiosis with my husband*’. As these three outcomes addressed Marie’s therapy contract goals, the therapist and Marie agreed to end the therapy.

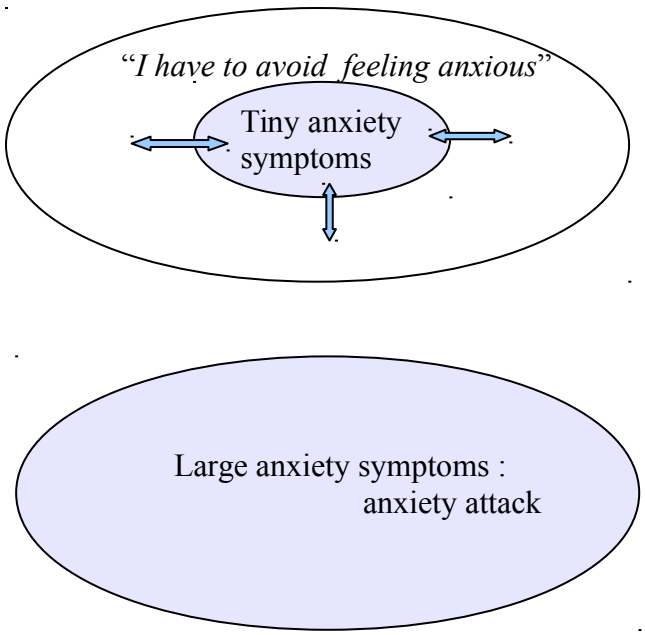
Commentary on this first set of sessions

This first set of sessions helped Marie to decontaminate her Adult ego state and to generally feel better, however, the tools used were not powerful and sharp enough to deconfuse her Child ego state. These sessions taught Marie how to deal more successfully with situations occurring in day-to-day life. This allowed Marie to reduce her overall global level of anxiety by teaching her how to cope differently with everyday situations with her mother, her husband, and so on.
By learning how to have different transactions with others, Marie probably learned how to avoid anxiety rather than to cure it.
She learned how to avoid ‘the bomb’ of an anxiety attack before it exploded; but she did not learn how to experience herself as sane if this bomb exploded.
Indeed, these sessions did not teach her how to cope with exceptional situations like when she experienced an acute anxiety attack in a very remote area during a trek, which occurred a few weeks after the end of this set of sessions. This experience generated in Marie a profound, physical fear of her ‘madness’, which the therapist considered may reside in Marie’s C1 or perhaps C0 ego states. This deep bodily-experienced fear is seen by the first author as the background of Marie’s anxiety attacks.
Many of the clients seen by both authors who have experienced severe and intense anxiety attacks describe it as a switch from ‘fear with thoughts’ to a kind of ‘fear without thoughts’; a bodily-experienced fear. Paraphrasing Berne's metaphor of the splinter in the toe (Berne, 1971); when a splinter in the toe is located in an area that cannot be reached by words, tools other than words are needed to reach it and remove it.
Physiologically, these reactions may be associated with an over-activation of the amygdalae, whereby bodily fear takes control of a person, which in turn ‘unplugs’ the neocortex and maintains the fear-driven and fear-focused internal dialogue inside the limbic system (Gil, 2014).
In TA terms, this process temporarily decommissions the Adult ego state, putting a developmentally early Child ego state, especially C1 or perhaps C0, in command.

The second set of 24 sessions: Using the technique of Paradoxical Alliance

Session 26 and theoretical reflections on 'Why Marie came back'.

A few months after the first set of sessions, Marie returned to the office. Insidiously, her fear of going mad had returned. An anxiety attack in an extremely remote and isolated location had led Marie to come into contact with an experience which she named 'the monster' and which the therapist understood to mean her fear of going mad, which he believed had been hidden away in Marie's Child ego state, in her C1 or C0.
In describing the anxiety attack, Marie reported that she noticed some mild anxiety due to the sheer remoteness and 'wildness' of the location'; the next village was 6 hours walking distance away, and the area did not have any signal coverage. Marie began to think '*Surely this is not a good place to start to feel anxious*', and so she began to fight these feelings and this idea, and the more she fought them, the more they returned and increased in intensity.
Below is a diagram of 'What happened to Marie in this remote area'. In the diagram, her mild anxiety symptoms fuelled her thought of '*Due to the absence of any potential to be rescued, I must avoid feeling anxious*'. But, in return, this belief of '*I must avoid feeling anxious*' fuelled the core symptom, which increased in magnitude, which in turn fuelled Marie's belief that she 'must avoid feeling anxious', thus creating a self-perpetuating vicious cycle (Widdowson, 2014).



The authors consider that Marie's mild anxiety symptoms were connected to her personality characteristics that predispose her towards anxiety, combined with the remoteness of the area, but that the resulting anxiety attack was due to the belief that she 'must avoid….'.
When considering temperament or characterological issues, the authors recognise that although an individual may experience profound, deep change, some tendencies will remain: if you fold a sheet of paper, and then unfold it, no matter how much one tries to smooth the paper out, a fold or at least a trace of a fold will remain.
The authors recognise that all people, regardless of personality traits or type will experience anxiety from time-to-time, but in situations such as the one described in this case, the belief '*I have to avoid anxious feelings*' is a major obstacle in the cure of anxiety. It is the view of the authors that a redecision of beliefs about the necessity of avoiding anxiety, which is replaced by an acceptance of the experience of anxiety, can make a significant contribution to a deep and lasting treatment of anxiety disorders.

To return to the story of Marie, the therapist conceptualised Marie's process as relating to her early childhood, where Marie 'decided' in her A1 that in order to receive recognition from her mother, that she must be insane, and thus developed a 'Don't be sane' injunction.
She counterbalanced this injunction by developing a 'Be perfect' driver, which allowed her to completely avoid any display of madness, providing she maintained her counterscript position (Berne, 1972).

Session 27-34: Accompanying Marie in her anxiety.

In these sessions, the therapist helped Marie to understand that her symptoms were likely to be connected to some childhood decision or experience and were probably designed to help her to adapt to her environment and cope with her mother. Therefore, she could 'thank' her symptoms, instead of trying to criticise or fight them.
The therapist then assisted Marie to generate an eidetic (Berne, 1964) vision of her anxiety by not avoiding the symptoms of anxiety, by not attempting to calm these feelings down, but instead, just observing them in her body, her breath and her emotions. She reported feeling a strange sense of calm developing within herself after starting to allow the anxiety. Following this, whenever she started to feel anxious during a session, Marie and her therapist observed Marie's compulsion to avoid the anxiety.

Session 34: Bringing in Marie's husband as a therapeutic ally

After some discussion and clear contracting about the nature and purpose of the session, it was decided that Marie and her husband would attend a joint session. Marie wanted her therapist to help her explain to her husband how he could best deal with Marie when she was having an anxiety attack. Marie's husband quickly understood the therapist's treatment approach and agreed not to ask Marie to calm down and to just 'be with' Marie if she was experience severe anxiety.

Towards the end of this session and as part of the contracting process, the therapist and Marie decided that Marie would attend group therapy, led by the first author.

Sessions 35-40: Increasing the first Paradoxical Alliance in a therapy group.

The first author used the group to provide a sense of physical accompaniment.
He sought to build a secure container in which Marie could allow herself to experience what she described as "*my monster*", meaning, '*going to the extreme depth of my anxiety attack physically and emotionally, with no avoidance*'.
Together, Marie and the first author went deeper and deeper in feeling her anxiety.
Sometimes, Marie shouted '*I am falling down into a well, I'm scared and petrified to go there*'.
Sometimes she grabbed the first author's hands, shouting '*If I go there, will I come back?*'; '*What will happen if I can't come back?*'.
The therapist explained to Marie that if she couldn't 'come back' from her anxiety attack and experienced a psychiatric emergency that he would contact a psychiatrist colleague and meet with him to explain to him what had happened to Marie. He then went on to explain how then he would continue her therapy by regularly visiting her in psychiatric hospital, with the psychiatrist's permission. This intervention was carefully chosen to encourage Marie to integrate into her Child ego state that the therapist would not allow their alliance to be destroyed by her 'madness'.
During each of Marie's encounters with her anxiety, the therapist maintained physical proximity to her. In one session, she re-experienced a situation first experienced when she was 6 years old, staying alone at home one evening because her parents were out and feeling so afraid of this loneliness that she became afraid that she would die if she didn't calm down her increasing fears.

After meeting 'her monster' eye to eye (the therapist believed that Marie saw the same 'monster' when she was 6, being left alone at home by her parents), Marie was increasingly able to go into her Child ego state (C1) where her 'monster' was located whilst keeping in contact with her Adult ego state. Throughout these regressions, Marie was able to see and understand what had happened and maintained a clear memory of the experiences. She was also able to communicate and clearly identify and provide phenomenological diagnosis (Berne, 1961) of the origin of these feelings by statements such as " *Right now, I'm feeling the same body sensations as when I was 6, alone in my parent's house*". The therapist considered all of these as indicative that Marie was engaged in a deep process of deconfusion of her Child ego state.

Sessions 40-49: The second Paradoxical Alliance.

Having observed that Marie's Adult ego state was accessible during regressions, the therapist introduced another Paradoxical Alliance. In one group session, another client who was experiencing deep emotions was speaking about his feelings of abandonment by his father.
Whilst listening to this, Marie began to feel the symptoms of a coming anxiety attack. So the therapist said to Marie: "It is OK to have an anxiety attack in this session Marie. What about having it right now rather than in a few minutes?". Marie was visibly surprised by this paradoxical demand, which appeared to create a sense of shock in Marie (Kourilsky, 2008).
This 2nd Paradoxical Alliance could also be called 'The active permission for the symptom'; or 'The prescriptive permission for the symptom'.

When the therapist asked her to have an anxiety attack right away , Marie tried; tried again; and failed. She was shocked : '*It is strange, it is the first time I experienced these strong symptoms without them leading to an anxiety attack*'. '*I am feeling the strange sensation of failing and winning at the same time*'.In all subsequent sessions, the therapist asked Marie to increase her symptoms at the first sign of anxiety. Each time, Marie failed, and once said: "*I failed because the group and the therapist are there, so I am feeling secure*". So, the therapist asked her to always carry a small notebook in her handbag and to practise the same exercise of 'increasing her symptoms' when alone. Marie was also asked to make notes in her notebook of what she feels in her body, and what thoughts and feelings she experienced when practising the exercise.
The aim of this 'notebook exercise' is to maintain a 'reachable' Adult ego state, to avoid the 'disconnection' of the neocortex. Indeed, writing is a function that facilitates the neocortex staying 'in action'.
Despite specific instructions and repeated attempts, Marie failed to have an anxiety attack outside of the therapy room. She said to the group: "*OK, I now understand that the more I want to avoid my symptoms, the more they increase and, strangely enough, the more I allow them to increase, the more they decrease. I'm seeing that I have now a lever on them. This lever is completely paradoxical but it works and that is the main point* ".
She reported that in different day-to-day situations she was allowing her symptoms to increase and yet paradoxically had not had a single anxiety attack. The therapist initiated a discussion with Marie about this, and they decided that Marie had overcome her anxiety, and was '80% cured'. They decided that Marie would end therapy and that the next few sessions would be spent on monitoring her situation and celebrating her changes.

Results

Quantitative data results

Marie completed CORE-OM, PHQ-9 and GAD-7 outcome measures on eight occasions.
These were at the beginning and end of each of the two sets of therapy sessions, together with 3 month, 6 month, 9 month and one year follow up intervals to check for stability of change.

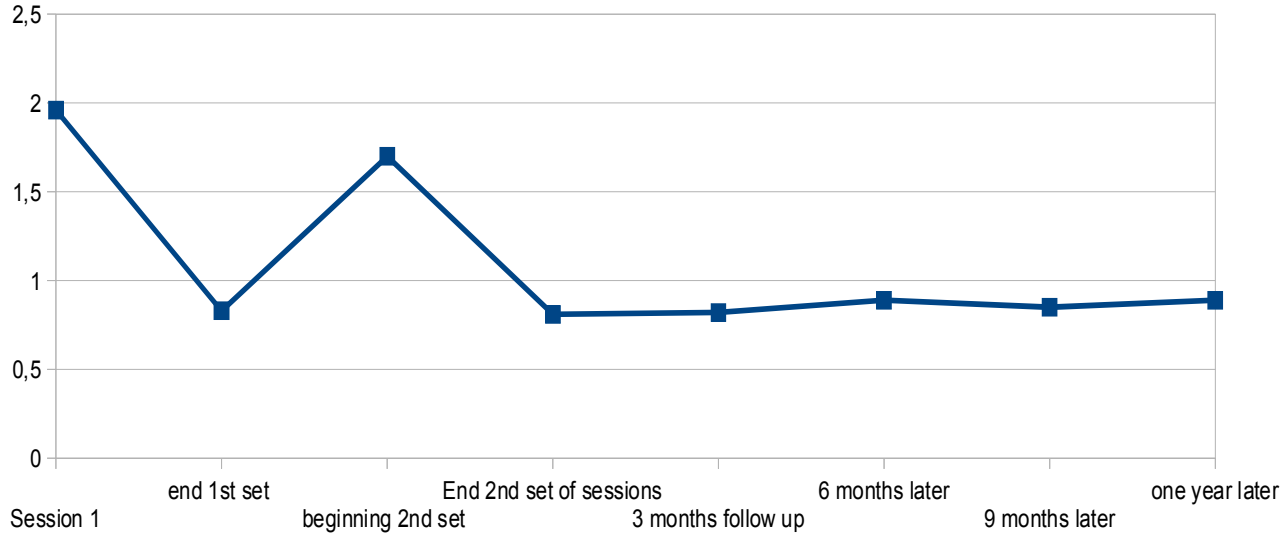
The CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure):

The CORE-OM is a 34-item generic measure of psychological distress and functioning.
It is described in more detail at the COREIMS website: www.coreims.co.uk

The mean score for a non clinical population = 0,88
The mean score for a clinical population = 1,86 (source : COREIMS)

Marie's CORE-OM scores indicate she got :

- clinical distress and functioning at the beginning of the first set of sessions (in which the therapist worked without paradoxical alliances)
- non-clinical distress and functioning at the end of this first set of sessions. As we can see on the following CORE-OM board, this result, because of working without paradoxical alliances, was not stable. Indeed, she came back to therapy, a few weeks later, in a state of:
- clinical distress and functioning at the beginning of the second set of sessions
- non clinical distress and functioning at the end of this second set of sessions(in which the therapist worked with paradoxical alliances). This time and because of working with paradoxical alliances, the result was stable for at least one year :

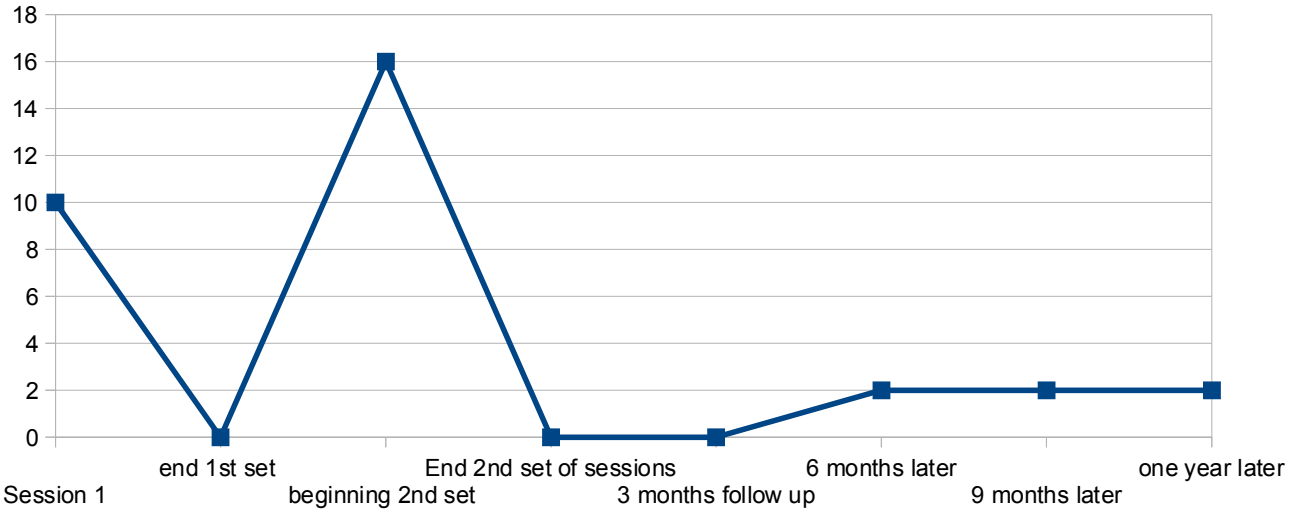


PHQ-9 (Patient Health Questionnaire)

The PHQ-9 is a nine-item, self-report questionnaire which measures symptoms of depression. It is described in more detail at the Pfizer website: http://www.phqscreeners.com/

Marie's PHQ-9 scores indicate she had:

- moderate depression at the beginning of the first set of sessions (in which the therapist worked without paradoxical alliances)
- minimal depression at the end of this first set of sessions. As we can see on the following PHQ-9 board, this result, because of working without paradoxical alliances, was not stable. Indeed, she came back to therapy, a few weeks later, in a state of :
- moderately-severe depression at the beginning of the second set of sessions
- minimal depression at the end of this second set of sessions (in which the therapist worked with paradoxical alliances). This time and because of working with paradoxical alliances, the result was stable for at least one year :

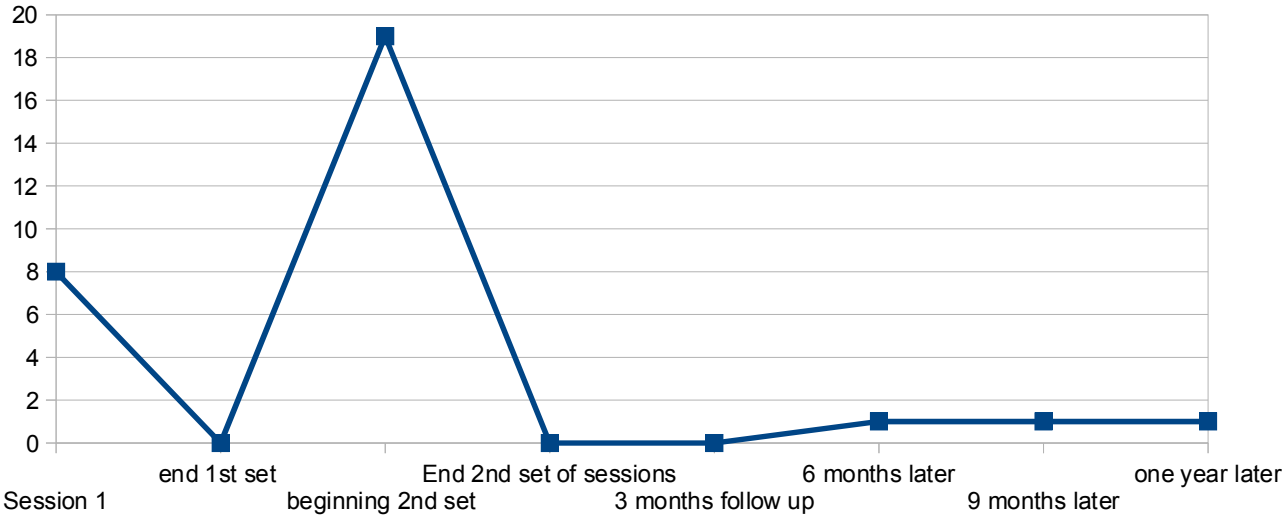


GAD-7 (Generalised Anxiety Disorder)

This easy to use self-administered patient questionnaire was developed as a screening severity measure for generalised anxiety disorder.

Marie's GAD-7 scores indicate she had:

- mild general anxiety at the beginning of the first set of sessions (in which the therapist worked without paradoxical alliances)
- normal general anxiety at the end of this first set of sessions. As we can see on the following GAD-7 board, this result, because of working without paradoxical alliances, was not stable. Indeed, she came back to therapy, a few weeks later, with a:
- severe general anxiety at the beginning of the second set of sessions
- normal general anxiety at the end of this second set of sessions(in which the therapist worked with paradoxical alliances). This time and because of working with paradoxical alliances, the result was stable for at least one year :



Adjudication process:

In order to mitigate against the potential for researcher allegiance bias (,) a panel of ten non-TA psychotherapy professionals (most of whom were psychoanalysts) were contacted and sent a copy of the rich case record, and the adjudication form for them to make their comments and express their opinion as to the nature and extent of Marie's changes.
Six forms were returned, which was considered to have provided a sufficiently robust adjudication response to draw conclusions on the nature and extent of change in this case.
Copies of the judges' responses are available on request from the first author.
The six judges who responded were: Victoria Baugier, Nathalie Castelli, Elizabeth Gourageot, M.N Donzelot, Gerard Mercier and Mathilde Mongin.

The adjudication form asked the following questions:
1) To what extent do you believe that Marie overcame her problems (anxiety). Please indicate on a scale of 1-10 (1 not at all, 10 completely).
The mean response from the judges was **8**.
2) What evidence did you use to come to this conclusion?
3) What do you believe were the significant interventions/ moments in therapy which resulted in change for Marie?
4) How effective do you feel the 'double paradoxical' intervention was in helping Marie overcome her problems? Please indicate on a scale of 1-10.
The mean response from the judges was **8.3**
5) What evidence did you use to come to this conclusion?

All of the judges considered that the paradoxical alliances technique was valuable in assisting Marie to overcome her anxiety. These responses demonstrate that the panel of six (non-TA) psychotherapy professionals considered the technique to be effective and also considered the case to be a clearly good outcome case.

Discussion:

It is clear from the case narrative, the quantitative outcome data, and the attestations of the six judges that there was a positive outcome in this case. Marie experienced clinically significant change on all outcome measures by the end of therapy, and this was sustained at the 3, 6, 9 and 12 month follow-up intervals. This supports the research conducted by van Rijn, Moran and Wild (2011) and van Rijn and Wild (2013) that found TA psychotherapy to be an effective therapy for anxiety symptoms.
The present study supports the value of the systematic case study research method to investigate the process and outcome of TA psychotherapy with different client presenting problems, such as in the work of McLeod (2011), Widdowson (2012a,b,c), and Kerr (2013), who found TA to be an effective therapeutic approach for people with long term health conditions, depression and emetophobia, respectively.
It is important to note some strengths and limitations of the present study. Firstly, the case is of a white, French therapist working with a white, French client. Consequently, it is not possible to generalise the findings beyond the specific cultural context in which the therapy was conducted.
It is noteworthy though, that the therapy was conducted in private practice, as were the cases reported by Widdowson (2012a,b,c) and Kerr (2013). This is significant as the psychotherapy research literature is dominated by effectiveness studies conducted in university clinics or healthcare settings. In such contexts, the therapists tend to be well resourced and supported by a team of colleagues from both a clinical perspective and in conducting research. The present study,

when combined with the aforementioned studies suggests that case study research is a useful method for practitioner research and is relatively easy to integrate into routine practice.
There are some potential limitations to the use of self-report outcome measures. Such measures rely on the accuracy of the client's perceptions, and thus can be easily influenced by memory effects or cognitive biases. Similarly, there may be an influence of social desirability effects for some clients. In the present case study, such effects are not obvious (although this does not mean that they do not necessarily exist) due to the return of Marie's symptoms after her first set of therapy sessions and the stability of her changes as evidenced at 3,6, 9 and 12 month follow up intervals.

The underpinning theory of paradoxical alliances and the findings of this present case support the theory of the role of avoidance and vicious cycles in the development and maintenance of psychological disorders as suggested by Widdowson (2014).

Guidance for transactional analysts who intend to work with Paradoxical Alliances

Important limitations:
The technique has only been tested with clients who could be considered to be within the neurotic range. It is the view of the authors that this technique is not suitable for psychotic clients, unless conducted by a psychiatrist or under the direct observation and supervision of a psychiatrist.
Paradoxical alliances should only be used where there is a sufficiently strong therapeutic alliance.

From a TA perspective, as the use of paradoxical alliances requires the client to go deeper and deeper into his/ her anxiety attack or phobic response, it is important to ensure that the client's Adult ego state is always accessible and reachable, even when the client is regressed into a Child ego state.
We advise patience, and suggest that the method be used slowly, increasing the client's tolerance of distressing affect gradually. Although the method can be suitable for brief or longer term therapy, the use of paradoxical alliances in therapy may in some cases last several months.

A step-by-step guide to using paradoxical alliances in TA psychotherapy

1. During the first session, ask the client to complete a number of outcome measures. We recommend the use of CORE-OM, GAD-7 and PHQ-9 in order to be able to check the client's progress through therapy and to provide a clear and (relatively) objective measure of the client's changes at the end of therapy.

2. Assist the client in understanding the developmental origins of his or her symptoms.
Specifically, we suggest that the therapist spends a few sessions helping the client to explore how, in the environment in which she/he grew up their symptoms were a useful adaptation to this world and how they helped her/him to cope with their situation. We believe it is essential to support the client in developing a positive orientation towards their symptoms, and for them to honour the creativity and positive intention of their little professor (Adult in the Child ; A1 ego state). This is the first Paradoxical Alliance.

3. The majority of the therapy should be spent using your preferred way of working
(e.g. classical TA, redecision or relational TA or a combination of approaches) to reduce
the client's overall global level of anxiety. The regular use of outcome measures (specifically, CORE-OM and GAD-7) will help the therapist and client to determine if general reductions in

anxiety symptoms are occurring.

4. Once the client's overall levels of anxiety have started to decrease, explain the process, and over several sessions lead the client towards the conditions in which the client usually gets an anxiety attack or phobic response. Then, as soon as the client experiences the beginning of their symptoms, simultaneously request and encourage them to deliberately increase these symptoms. We encourage you to be creative and to use whatever you want to create these anxiety conditions. For example: the first author remembers waiting outside the toilet at his office, while a client who had voluntarily locked himself in the toilet described his symptoms of claustrophobia.
This is the second Paradoxical Alliance.

5. After having practised the previous step many times, ask the client to gradually put him/herself into a situation which would normally provoke anxious symptoms outside of the therapy room with a confident person acting as a 'therapeutic ally' (for example, their partner , their best friend, etc...) and to voluntarily have an anxiety attack or a phobic response. We recommend that prior to doing this, that the therapeutic ally is briefed on 'how to cope with a person experiencing an anxiety attack' . Ask the client to notice and write down as many details of his symptoms as possible. This procedure is to support the activation of the client's Adult ego state.

Conclusion

There is sufficient evidence in this case study to demonstrate that TA psychotherapy can be effective for the treatment of anxiety, and that to suggest that the technique of paradoxical alliances is an effective intervention which can be used in the TA treatment of anxiety disorders. An analysis of this case by a panel of independent psychoanalysis professionals considered this to be a clearly good outcome case, and considered that the technique of paradoxical alliances to have been central to the client's change process.
In the light of the results of this case and the results of the studies by van Rijn, Moran and Wild (2011) and van Rijn and Wild (2013) which demonstrated the effectiveness of TA therapy for reducing anxiety symptoms, further case study research and larger scale studies investigating the effectiveness of TA psychotherapy for anxiety is warranted.

References

American Psychiatric Association (1980) Diagnostic and statistical manual of mental disorders 3rd edition (DSM-III). Washington DC: American Psychiatric Association

Aveline, M. (2005) Clinical case studies : their place in evidence-place practice. Psychodynamic Practice, 11, 132-52.

Bergeret, J. (2000) Psychologie Clinique, 110. Masson. Paris

Berne, E. (1964) Games People Play. Grove Press, New York, 193-197 (French Edition)

Berne, E. (1971) Away from the Theory of the impact of Interpersonal Interaction on Nonverbal Participation. Transactional Analysis Journal. 1:1, 1971, (pp. 11-12)

Berne, E. (1972). What do you say after you say hello ? Grove Press, New York.

Bichi, E.L. (2008) A case history : from traumatic repetition towards psychic representability. International Journal of Psychoanalysis , 89, 541-60

Boyd, HS. (1980) Blocking tragic scripts. Transactional Analysis Journal 10, 3, 227-9

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

Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J. and McGrath,

G. (2000). CORE: clinical outcomes in routine evaluation. Journal of Mental Health, 9(3): 247-255.
Fishman, D.B. (1999) The Case for a Pragmatic Psychology. New York : New York University Press
Gil, R. (2014) Neuropsychologie. 6th edition. Elsevier Masson, Paris
Goulding, R. (1972) New Directions in Transactional Analysis : Creating an Environment for Redecision and Change. New York: Brunner/Mazel
Goulding, R & M. (1978). The power is in the patient. TA press, San Francisco
Greshman, F.M. (1996) Treatment integrity in single-subject research. Design and analysis of single case research. Mahwah, NJ : Laurence Erlbaum.
Jeanclaude, C (2010) . Fondamentaux freudiens de la psychanalyse. De Boeck, Bruxelles
Jeanclaude, C (2008). Freud et la question de l'angoisse. De Boeck, Bruxelles
Hargaden, H & Sills, C. (2002). Transactional Analysis. A relational perspective. Routledge. London & New York
Holloway, WH. (1973) Shut the Escape Hatches: The Monograph series. Medina, OH.Midwest Institute for Human Understanding.
Joines, V & Stewart I (2008a). Personality Adaptations. Lifespace Publishing. Melton Nothingham and Chapel Hill.
Joines, V & Stewart I (2008b). Personality Adaptations. Lifespace Publishing. Melton Nothingham and Chapel Hill. 72-5
Joines, V & Stewart I (2002). Personality Adaptations. Lifespace Publishing. Melton Nothingham and Chapel Hill. Joines Personality Adaptations Questionaire 389-391
Kalher, T.(1975) 'Drivers: the key to the process of script'. Transactional Analysis Journal, 5, 3, 280-4
Kahler, T. (1979). Process therapy in brief. Human Development Publications. Little Rock, Arkansas. (4-5)
Kessler, R.C., Chiu, W.T., Demler, O. & Walters E.E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 62(6):617-27.
Kourilsky, F. Du désir au plaisir de changer (From desire to pleasure to change). Paris : Dunod Press. 204-205 (for the French Edition)
Llewelyn, S. (1988) Psychological therapy as viewed by clients and therapists. British Journal of Clinical Psychology, 27, 223-238.
McLeod, J. (2010). Case Study Research in counselling and psychotherapy. Sage, London
NREP. (2000) . H.A.T form. Copyright © 2000 Network for Research on Experiential Psychotherapies
Spitzer, R, Kroenke, K, Williams J, Löwe B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. Archives of Internal Medicine, 166.
Spitzer RL, Kroenke K, Williams JB (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. JAMA.Nov 10;282(18):1737- 44
Stark, M (2000). Modes of Therapeutic Action. Northwale: Jason Aronson
Steiner, C.(1974). Scripts people live: transactional analysis of live script. New York: Grove Press.
Steiner, C.(1974b). Scripts people live: Transactional analysis of life scripts. New York: Grove Press. 119-120
Stewart, I & Joines,V (2012). TA today, A new introduction in Transactional Analysis. Lifespace Publishing. Melton Mowbray and Chapel Hill.
Swede, S (1977a). How Eric Berne practised Transactional Analysis. San Francisco : Boyce Productions
Swede, S (1977b). How Eric Berne practised Transactional Analysis. San Francisco : Boyce Productions. 25.

Townend, M. & Smith, M.E. (2007) A case study of cognitive-behavioural psychotherapy with a perpetrator of domestic abuse. Clinical Case Studies, 6, 443-53.
Van Rijn, B., Wild, C. and Moran, P. (2011). Evaluating the outcome of TA psychotherapy and integrative counselling psychology within UK primary care settings. International Journal of Transactional Analysis Research, 2(2): 34-43
Van Rijn, B. and Wild, C.(2013). Humanistic and integrative therapies for anxiety and depression : practice based evaluation of Transactional Analysis, gestalt and integrative psychotherapies and personal centred counselling. Transactional Analysis Journal, 43(2): 150-153
Ware, P (1983). Personality adaptations. Transactional Analysis Journal, 13(1), 11-19
Watzlawick, P. How to fail most successfully. Paris: Editions du Seuil for the French Edition
White,T. (2011). Working with suicidal individuals. Philadelphia,PA: Jessica Kingsley Publishers. Ebook chapter 14.
Widdowson,M. (2010). Transactional Analysis, 100 key points & techniques. Routledge, London & &New York.