Paradoxical Alliances in Transactional Analysis Psychotherapy for Anxiety: A Systematic Adjudicated Case Study

Bernard Gentelet & Mark Widdowson

Abstract

This article considers the use of the technique of paradoxical alliances in transactional analysis psychotherapy with a 37-year-old white French woman over two sets of sessions. The authors hypothesize that this technique, which has not yet been widely used in TA, can be effective in the treatment of anxiety disorders and offers a useful addition to existing transactional analysis methods. The first set of sessions with the client occurred before the paradoxical alliances approach had been developed, and although therapy had some benefits, it did not result in lasting change for the client. In the second set of sessions, the paradoxical alliances technique was applied and resulted in a deep, lasting improvement in the client's anxiety attacks.

Keywords: anxiety disorders case study research paradoxical alliances transactional analysis psychotherapy

A number of recent research articles have demonstrated the effectiveness of transactional analysis psychotherapy for the treatment of anxiety and anxiety symptoms (van Rijn & Wild, 2013; van Rijn, Wild, & Moran, 2011). Despite these 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 not much in the literature specifically addressing the treatment of anxiety from a transactional analysis perspective.

The study described here 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 transactional analysis psychotherapy using a paradoxical alliances intervention for the treatment of repetitive anxiety attacks. The case study meets criteria for a pragmatic case study because it addresses practical problems in local and time-specific contexts rather than focusing on abstract and quantitative knowledge (Fishman, 1999).

Case study research can lack objectivity, especially in cases such as those in this study in which one of the researchers was also the therapist. To achieve critical distance from the experience of working with the client, we used an adjudication procedure (Widdowson, 2011) in which several non-TA psychotherapy professionals were asked to review the case and offer their opinions regarding both the outcome and the critical aspects (interventions) that resulted in client change. This use of non-TA psychotherapy professionals went some way in addressing issues related to researcher allegiance bias because the adjudicators had no prior allegiance to TA and could therefore be considered independent judges of the effectiveness of the therapy and the overall outcome of the case.

The case study is also an N = 1 study because it addresses effectiveness questions about the outcome of the case, specifically, the research question: "Can paradoxical alliances be an effective intervention in the transactional analysis 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 this kind of 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 and not merely a reflection of random variability or spontaneous remission.

The case in this study included the use of assessment instruments administered during the therapy and a follow-up 1 year later. The client's scores on a set of three standardized and validated self-report measures were completed at several intervals:

-At the beginning of 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 3 months, 6 months, 9 months, and 1 year after the end of the therapy

Author Reflexivity

I (BG) served as the therapist in this case. I am a 55-year-old French psychotherapist who received a Master of Science degree in psychotherapy validated at Middlesex University (London). I am also a Certified Transactional Analyst (psychotherapy) working in private practice and hold the European Certificate of Psychotherapy. Over time, I began experimenting with paradoxical interventions and developed what I call a TA-based paradoxical alliances intervention, which appeared highly effective with a range of anxiety disorders, including panic attacks and some phobias (agoraphobia, claustrophobia, and a subtype of social anxiety in which the sufferer experiences anxiety about blushing).

Throughout the therapy described here, I received monthly supervision from a Teaching and Supervising Transactional Analyst and also attended a monthly peer supervision group in which I regularly presented my research, discoveries, and experiences with the client. The coauthor of this article (MW) was the research supervisor for this case. He is a Teaching and Supervising Transactional Analyst (psychotherapy) and an experienced psychotherapy researcher with specific expertise in case study research.

Ethical Issues

Given the ethical issues associated with case study research (see McLeod, 2010), I obtained formal, written consent from the client for the case material to be published. She gave her permission at several stages. In addition, a member checking procedure was used whereby she read a draft of the article before publication, verified the accuracy of the contents, and confirmed her permission for publication. I retain these documents, and they have been seen by MW. In accordance with guidelines relating to client confidentiality, some identifying details have been changed, although the essential facts about the case remain the same.

Defining Paradoxical Alliances

The method used in this case involves the use of two paradoxical techniques:

Allowing the symptom: Rather than using the phrase allowing the symptom, as is common in many paradoxical techniques, we think it is more appropriate to think in terms of making an alliance with the symptoms. Usually clients come to therapy to eliminate 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 circumstances.

Prescribing the symptom: The therapist creates a shock in the client's mind by specifically and deliberately prescribing the expression of the client's symptom right now (or later, but at a specified time).The client is unable to experience his or her symptom on demand and is surprised by this. The uncontrollable becomes paradoxically controllable, thus allowing the client to see how he or she can have a paradoxical hold on the symptom. This technique comes from the Mental Research Institute (Palo Alto, California), especially the approach developed by Paul Watzlawick (1988; Watzlawick, Weakland, & Fisch, 1974), in which the first author (BG) was trained.

The Client: Marie

At the beginning of the therapy, Marie was a 37-year-old social worker. She was referred by word of mouth from a friend who had previously seen me (BG) for psychotherapy. In her words, Marie came to therapy "to empty something." Her parents divorced when she was 7, and she described her father as a "weak, absent, and alcoholic man." She saw him only once after the divorce and said, "For me, he is nothing." Marie described her mother as a manipulative, seductive "octopus" woman. After the divorce, she put Marie and her siblings into the car, drove half the distance between her house and her then ex-husband's house, and said to her children, "Now you choose between me and your father." Although Marie 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 said, "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 had enjoyed school, where her busy, cheerful, and overadapted behavior was warmly welcomed by her teachers. Marie was married to Eric, a down-to-earth vineyard worker whom Marie described as "my stable pillar when things move too much." She depicted their marriage as a stable, supportive relationship with a playful social life and a satisfying sex life. Marie and Eric have two children.

Marie had a number of strengths: She was warm, easygoing, and energetic despite her anxiety. She was intelligent and eager to undertake her therapy because she saw her anxiety attacks occurring with increasing frequency. She completed all the contracted homework tasks efficiently, and in our view, these strengths helped Marie to harvest a good outcome from therapy.

Because Marie described her husband so positively, I chose to enlist his support as a therapeutic ally for her. This help will be detailed later in the description of the sessions. Her job was also and still is a positive resource for Marie.

The First Set of 25 Sessions

Sessions 1-6

The first six sessions focused on developing the therapeutic alliance, contracting, and diagnosis. From the outset, Marie was clear that she was coming to therapy to address her anxiety. I (BG) took a detailed history, explained my ways of working and thoughts on the therapy process, and offered

an outline of my proposed treatment plan. Marie initially said that she wanted to understand why she was so anxious, so we agreed to begin the therapy by focusing on increasing her insight into and understanding about her anxiety. At this time, I had not developed my thinking about paradoxical alliances, so my treatment plan was mainly to reduce Marie's overall level of general anxiety using a range of the usual transactional analysis concepts and tools.

During these first sessions, I taught Marie relevant transactional analysis concepts to help her understand her anxiety. These included the theory of ego states, personality adaptations, and drivers. She enjoyed learning them and felt that they helped her to achieve her contract goal of "understanding how I became who I am."

Sessions 7-10: Deepening the Exploration of Marie's Madness

Prior to engaging Marie in deconfusing her Child ego state (Berne, 1961), I focused on protection (Crossman, 1966). In the transactional analysis literature, I 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), all of whom focused primarily on the technique of closing escape hatches. In line with their ideas, I began to assess the risk of Marie's madness by exploring those situations in which she felt she could become mad.

Sessions 11-15: 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 my thinking about this process, I used the metaphor of a boat. I explained how the therapy could be seen as crossing the ocean and how my job was to be the skipper who accompanied her during this crossing. However, before starting the journey, I saw a crack in the boat's hull and decided that it is dangerous to attempt the crossing without first fixing the crack and repairing the boat. From the perspective of this metaphor, the crack was the risk of Marie decompensating and going mad. I proposed that the way to fix the crack was to close the escape hatch, 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 not to go mad. I noticed evidence to suggest that she 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 introducing the idea of the no-madness decision, I also engaged Marie in a discussion about several questions:

- What would it mean for her to become mad?

- What would happen to her if she became mad (psychiatric hospital, etc.)?

-What would happen to others if she became mad (her mother, her children, her husband, etc.)

- What would happen to her relationship with me if she became mad?

-Who would be sad or happy if she became mad?

Sessions 16-25: Reducing Marie's General Level of Anxiety

These sessions primarily drew on the use of a classical transactional analysis (Widdowson, 2010) approach. Marie and I explored a number of situations in which she felt she might not be able to cope. This included her job, her marriage, and her relationship with her mother. We 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 some situations as well as negative, anxious expectations about future situations. In the last session, Marie stated, "I am no longer afraid of madness. I know how to cope with my mother and am no longer symbiotic with my husband." Given that these outcomes addressed Marie's therapy contract goals, we agreed to end the therapy.

Commentary on the First Set of Sessions

The first set of sessions helped Marie to decontaminate her Adult ego state and generally feel better. However, the tools used were not powerful and focused enough to deconfuse her Child ego state. These sessions taught Marie how to deal more successfully with her day-to-day life and reduce her overall global level of anxiety by showing her how to cope differently with everyday situations with her mother, her husband, and others. By learning how to transact differently, Marie probably learned how to avoid anxiety rather than being cured of it. She discovered how to avoid the bomb of an anxiety attack before it exploded, although she did not learn how to experience herself as sane if it did explode.

Indeed, these sessions did not teach her how to cope with exceptional situations such as when she experienced an acute anxiety attack in a 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 I thought might reside in her somatic Child (C1) (or perhaps the archaic part of C1, that is, C0) ego state. I saw this deep, bodily-experienced fear as the background of her anxiety attacks.

Many of our clients who have experienced severe and intense anxiety attacks have described it as a switch from fear with thoughts to fear without thoughts, that is, as a bodily-experienced fear. Paraphrasing Berne's (1971) metaphor of the splinter in the toe (pp. 11-12), when the splinter is located in an area that cannot be reached by words, tools other than words are needed to remove it. Physiologically, these reactions may be associated with an overactivation of the amygdala whereby bodily fear takes control of the person, which in turn unplugs the neocortex and maintains the fear-driven and fear-focused internal dialogue inside the limbic system (Gil, 2014). In transactional analysis 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 Paradoxical Alliances Technique

Session 26 and Theoretical Reflections on Why Marie Came Back

A few months after the first set of sessions ended, Marie returned to therapy with me. Insidiously, her fear of going mad was back. An anxiety attack in an extremely remote and isolated physical location had led Marie to experience what she called "the monster." I understood that as her fear of going mad, which I believed had been hidden in her Child ego state (C1 or C0).

In describing that anxiety attack, Marie said 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 feeling anxious," and so she began to fight the feelings. But the more she fought them, the more they increased.

Figure 1 shows what happened to Marie in that situation. Her mild anxiety symptoms fueled the thought that "due to the absence of any potential for being rescued, I must avoid feeling anxious." However, then her belief "I must avoid feeling anxious" fueled the core symptom, which increased in magnitude and, in turn, fueled Marie's belief that she "must avoid feeling anxious." This created a self-perpetuating, vicious cycle (Widdowson, 2014).

We viewed Marie's mild anxiety symptoms as connected to personality characteristics that predisposed her to anxiety combined with her being in such a remote location, but her resulting anxiety attack was due to the belief that she "must avoid…." When considering temperament or characterological issues, we recognize that although an individual may experience profound, deep change, some tendencies will remain. Just as when you fold a sheet of paper and then unfold it, no matter how much you try to smooth the paper out, a fold or at least the trace of a fold will remain. We recognize that everyone, regardless of personality traits or type, will experience anxiety from time to time. But in situations such as the one described by Marie, the belief "I have to avoid anxious feelings" is a major obstacle to cure. We think redeciding beliefs about the necessity of avoiding anxiety, which is replaced by accepting the experience of that feeling, can contribute significantly to a deep, lasting treatment for anxiety disorders.

To return to Marie's story, I conceptualized Marie's process as relating to her early childhood, at which time she decided in the Adult in her Child (A1) that to receive recognition from her mother, she must be insane. She thus developed a Don't Be Sane injunction. She counterbalanced that by developing a "Be perfect" driver, which allowed her to avoid any display of madness, providing she maintained her counterscript position (Berne, 1972).

Sessions 27-33: Accompanying Marie in Her Anxiety

In these sessions, I 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 criticize or fight them. I then assisted Marie in generating an eidetic (Berne, 1964) vision of her anxiety by not avoiding her symptoms and not attempting to calm them down, but instead, just observing them in her body, breath, and emotions. She reported feeling a strange sense of calm within herself after starting to allow the anxiety. Thereafter, whenever she started to feel anxious during a session, Marie and I observed her compulsion to avoid the feeling.

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, we decided that Marie and her husband would attend a joint session. Marie wanted me to help her explain to her husband how he could best deal with her when she was having an anxiety attack. Her husband quickly understood my treatment approach and agreed not to ask Marie to calm down and to just be with her if she was severely anxious. Toward the end of the session and as part of the contracting process, Marie and I decided that she would join one of my therapy groups.

Sessions 35-40: Increasing the First Paradoxical Alliance in a Therapy Group

I used the group to provide a sense of physical accompaniment, that is, to build a secure container in which Marie could allow herself to experience what she described as her "monster." By this she meant going to the extreme depth of her anxiety attack physically and emotionally, with no avoidance. Together, Marie and I went deeper and deeper into feeling her anxiety. Sometimes, Marie would shout, "I am falling down into a well, I'm scared and petrified to go there!" Sometimes she grabbed my hands and yelled, "If I go there, will I come back?" or "What will happen if I can't come back?" I explained that if she could not come back from her anxiety attack and experienced a psychiatric emergency, I would contact a psychiatrist colleague and meet with him to explain what had happened. I said I would continue her therapy by regularly visiting her in a psychiatric hospital, with the psychiatrist's permission. This intervention was carefully chosen to encourage Marie to integrate into her Child ego state that I would not allow our alliance to be destroyed by her madness.

During each of Marie's encounters with her anxiety, I maintained physical proximity to her. In one session, she reexperienced something that had first happened when she was 6 years old. She was home alone one evening because her parents were out, and she was so overcome by loneliness that she was afraid she would die if she did not calm her increasing fears. After meeting her monster eye to eye (I believe that Marie experienced the same monster when she was 6), Marie was increasingly able to go into her Child ego state (C1) where her monster was located while sustaining contact with her Adult ego state. Throughout these regressions, Marie was able to understand what had happened and to maintain a clear memory of the experience. She was also able to identify and provide phenomenological diagnosis (Berne, 1961) of the origin of these feelings with statements such as, "Right now, I'm feeling the same body sensations as I did when I was 6 and alone in my parent's house." I considered those to be indicators that Marie was engaged in deeply deconfusing her Child ego state.

Sessions 41-49: The Second Paradoxical Alliance

Having observed that Marie's Adult ego state was accessible during regressions, I introduced another paradoxical alliance. In a group session, another client who was experiencing deep emotions was speaking about feeling abandoned by his father. While listening to this, Marie began to feel the symptoms of a coming anxiety attack. So I said to her, "It is OK to have an anxiety attack in this session? What about having it right now rather than in a few minutes?" She was visibly surprised and a bit shocked by this paradoxical demand (Kourilsky, 2008). This second paradoxical alliance could also be referred to as an active permission for the symptom or a prescriptive permission for the symptom.

When I encouraged her to have an anxiety attack right away, Marie tried, tried again, and failed. She was shocked: “It’s strange, it’s the first time I experienced these strong symptoms without them leading to an anxiety attack. I feel the strange sensation of failing and winning at the same time.” In all subsequent sessions, I asked Marie to increase her symptoms at the first sign of anxiety. She failed each time, once commenting, “I failed because the group and the therapist are there, so I am feeling secure.” So I asked her to carry a small notebook in her handbag and to practice the same exercise of increasing her symptoms when she was alone and to write down what she felt in her body and what thoughts and feelings she experienced when practicing the exercise. The aim of the notebook exercise was to maintain a reachable Adult ego state and avoid disconnecting from the neocortex. Indeed, writing is a function that helps keep the neocortex engaged.

Despite specific instructions and repeated attempts, Marie failed to have an anxiety attack outside of therapy. 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 now have a lever to use in working with them. This lever is completely paradoxical, but it works and that is the main point.” She reported that in various day-to-day situations she was allowing her symptoms to increase and yet, paradoxically, had not had a single anxiety attack. I initiated a discussion with her about this, and we decided that Marie had overcome her anxiety and was 80% cured. We agreed that she would end therapy and to spend the last few sessions monitoring her situation and celebrating her changes.

Quantitative Data Results

Marie completed CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure), PHQ-9 (Patient Health Questionnaire), and GAD-7 (Generalized Anxiety Disorder) outcome measures on eight occasions: at the beginning and end of each of the two sets of therapy sessions together with 3-month, 6-month, 9-month, and 1-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 nonclinical population is 0.88. The mean score for a clinical population is 1.86 (source: COREIMS). Marie’s CORE-OM scores indicated:

She had clinical distress and functioning at the beginning of the first set of sessions (during which the therapist worked without paradoxical alliances).

She had nonclinical distress and functioning at the end of the first set of sessions. As we can see on the CORE-OM board (Figure 2), this result, because of working without paradoxical alliances, was not stable. Indeed, Marie returned to therapy a few weeks later. At that point she had clinical distress and functioning at the beginning of the second set of sessions.

She had nonclinical distress and functioning at the end of the second set of sessions (during which the therapist used paradoxical alliances). This time and because of working with paradoxical alliances, the result was stable for at least 1 year.

PHQ-9 (Patient Health Questionnaire)

The PHQ-9 is a nine-item, self-report questionnaire that measures symptoms of depression (Spitzer, Kroenke, & Williams, 1999). It is described in more detail at the Pfizer website: http://www.phqscreeners.com/. Marie's PHQ-9 scores indicated:

She had moderate depression at the beginning of the first set of sessions (during which the therapist worked without paradoxical alliances).

She had minimal depression at the end of the first set of sessions. As we can see on the PHQ-9 board (Figure 3), this result, because of working without paradoxical alliances, was not stable. Indeed, Marie returned to therapy a few weeks later. At that point she had moderately severe depression at the beginning of the second set of sessions.

She had minimal depression at the end of the second set of sessions (during which the therapist worked with paradoxical alliances). This time, and because of working with paradoxical alliances, the result was stable for at least 1 year.

GAD-7 (Generalized Anxiety Disorder)

This easy-to-use self-administered patient questionnaire was developed as a screening measure for severity of generalized anxiety disorder (Spitzer, Kroenke, Williams, & Löwe, 2006). Marie's GAD-7 scores indicated:

She had mild general anxiety at the beginning of the first set of sessions (during which the therapist worked without paradoxical alliances).

She had normal general anxiety at the end of this first set of sessions. As we can see on the GAD-7 board (Figure 4), this result, because of working without paradoxical alliances, was not stable. Indeed, Marie returned to therapy a few weeks later.At that point she had severe general anxiety at the beginning of the second set of sessions.

She had normal general anxiety at the end of the second set of sessions (during which the therapist worked with paradoxical alliances). This time and because of working with paradoxical alliances, the result was stable for at least 1 year.

Adjudication Process

To mitigate against the potential for researcher allegiance bias, a panel of 10 non-TA psychotherapy professionals (most of whom are psychoanalysts) were contacted and sent a copy of the rich case record (McLeod, 2010) and the adjudication form on which they could give their opinion on the nature and extent of Marie's changes.

Six forms were returned, which is considered a sufficiently robust adjudication response to draw conclusions about the nature and extent of the changes in Marie's 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 that 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 the paradoxical alliances technique to have been valuable in assisting Marie in overcoming her anxiety. These responses demonstrate that the panel of six non-TA psychotherapy professionals considered the technique to be effective and also considered the outcome in Marie's case to be good.

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 Marie's case. She 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 transactional analysis psychotherapy to be effective for anxiety symptoms.

The present study supports the value of the systematic case study research method for investigating the process and outcome of TA psychotherapy with different client presenting problems, such as in the work of McLeod (2013), Widdowson (2012a, 2012b, 2012c), and Kerr (2013). They found transactional analysis 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. First, the case is of a white, French therapist working with a white, French client. Consequently, it is not possible to generalize the findings beyond the specific cultural context in which the therapy was conducted.

It is noteworthy, however, that the therapy was conducted in private practice, as were the cases reported by Widdowson and Kerr just cited. This is significant because 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 studies of McLeod, Widdowson, and Kerr, 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, which 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 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 on Working With Paradoxical Alliances

Important Limitations

The paradoxical alliance technique has only been tested with clients who could be considered neurotic. We believe the 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 when there is a sufficiently strong therapeutic alliance.

From a transactional analysis perspective, because the use of paradoxical alliances requires the client to go deeper and deeper into his or her anxiety attack or phobic response, it is important to ensure that the person's Adult ego state is always accessible and reachable, even when the client is regressed to a Child ego state.

We advise patience and suggest that the method be used slowly, increasing the client's tolerance for 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

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

Assist the client in understanding the developmental origins of his or her symptoms. Specifically, we suggest that the therapist spend a few sessions helping the client to explore how, in the environment in which he or she grew up, his or her symptoms were a useful adaptation and how they helped him or her to cope with that situation. We believe it is essential to support the client in developing a positive orientation toward his or her symptoms and for the person to honor the creativity and positive intent of his or her Little Professor (Adult in the Child or A1 ego state). This is the first paradoxical alliance.

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

Once the client's overall levels of anxiety have started to decrease, explain the process, and over several sessions, lead him or her toward the conditions in which he or she usually experiences an anxiety attack or phobic response. Then, as soon as the client experiences the beginning of his or her

symptoms, simultaneously request and encourage the person to deliberately increase those symptoms. We encourage you to be creative and use whatever you want to create the anxiety conditions. For example, I (BG) remember waiting outside the toilet at my office while a client who had voluntarily locked himself inside described his symptoms of claustrophobia. This is the second paradoxical alliance.

After having practiced the previous step many times, ask the client to gradually put himself or herself into a situation that would normally provoke anxious symptoms outside of the therapy room with a confident person acting as a therapeutic ally (e.g., a partner, good 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 or her symptoms as possible. This procedure is designed to support activation of the client's Adult ego state.

Conclusion

There is sufficient evidence in this case study to demonstrate that transactional analysis psychotherapy can be effective for the treatment of anxiety and to suggest that the technique of paradoxical alliances is an effective intervention that can be used in the TA treatment of anxiety disorders. An analysis of this case by a panel of independent psychoanalysis professionals considered this case to have a good outcome and that the technique of paradoxical alliances was central to the client's change process.

In 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), all of which demonstrated the effectiveness of transactional analysis therapy for reducing anxiety symptoms, further case study research and larger-scale studies investigating the effectiveness of TA psychotherapy for anxiety are warranted.

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Author Biographies

Bernard Gentelet, MSc in TA, Certified Transactional Analyst (psychotherapy), lives in France, where he has a private practice. He can be reached at 175 rue de Besancon, 39000 Lons Le Saunier, France; email: bernardgentelet39@gmail.com.

Mark Widdowson, PhD, MSc, ECP, FHEA, is a Teaching and Supervising Transactional Analyst (psychotherapy) and a UKCP and European Association for Psychotherapy-registered psychotherapist. He is the author of Transactional Analysis: 100 Key Points and Techniques and

Transactional Analysis for Depression: A Step-By-Step Treatment Manual (both published by Routledge) and is an active psychotherapy researcher. He is also a lecturer in counseling and psychotherapy at the University of Salford. Mark can be reached at Room 348, Mary Seacole Building, School of Nursing, Midwifery and Social Work, University of Salford, Salford M6 6PU, United Kingdom; email: m.widdowson@salford.ac.uk.

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