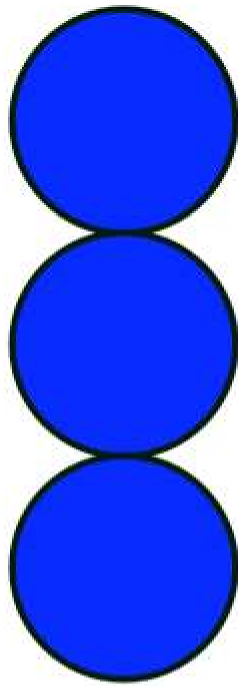

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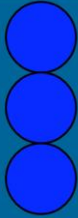

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Editorial

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A bumper issue of research and practice and a truly international collection from authors in Brazil, Italy, India, and the UK.

We begin the issue with two more Hermeneutic Single-Case Efficacy Design (HSCED) case studies, presenting us with the sixth and seventh of the second Italian systematic replication of the series began in Volume 3, Issue 1 – when Mark Widdowson began the process by providing us with all the necessary working papers.

These are followed by another research study, this time in India and into the relationship between ego states and neuroticism.

Then another practice article in our series where we are providing translations of material published in South America in Portuguese. This time we have material on the development of the Little Professor.

Next we have something which is not by a TA author, that raises interesting points about research methodologies, illustrating this with what has happened within the UK. We have permission to reproduce a position paper from a large number of stakeholders, who are challenging the government about significant flaws in the way in which guidelines were published about the Recognition and Management of Depression in Adults. A cautionary tale, especially when TA authors continue to refer to research studies in the past even though the methodology used is no longer seen as robust enough.

By coincidence, the final article in this issue is also about India; it is a summary of the various TA concepts that have emerged over the years from authors in that country.

I will finish this Editorial by reminding all of you that IJTARP is listed in the Directory of Open Access Journals (www.doaj.org); that authors retain their copyright and can put their papers on Academia (www.academia.edu), which now indicates that it is accessed by over 106 million academics (last time it was only 90 million!) - and anywhere else. Help us raise the profile of TA generally by alerting your colleagues to the existence of this free open access journal.

Finally – a nudge – if you have not done so already, please consider making a donation when you finish reading. We are currently financed by a non-profit education foundation which cannot continue to provide the level of income needed to publish a professional journal – we need donations.

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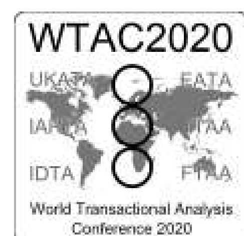

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TA Treatment of Depression. A Simplified Hermeneutic Single-Case Efficacy Design Study - Giovanni

© 2019 Mariavittoria Zanchetta, Laura Farina, Stefano Morena & Enrico Benelli

Abstract

This study is inspired by previous case series replications of Hermeneutic Single-Case Efficacy Design which aimed to evaluate the effectiveness of a manualised transactional analysis treatment for depressive disorders and depressive personality. We address problems and difficulties that emerged in previous case series, such as: spending time in training a group of people to conduct the hermeneutic analysis, organising the involvement of external judges to give the final adjudication, and dealing with inconsistencies between quantitative and qualitative data. This study suggests a simplified method to conduct the hermeneutic analysis that requires one person only, maintaining its validity. We integrated hermeneutic design with the pragmatic case evaluation methodology in order to follow pre-defined criteria in analysing qualitative material. Furthermore, we present a way to use the Script System to detect changes in depressive symptomatology and depressive personality. We tested this approach to HSCED in the case of 'Giovanni, a 17-year old white Italian male who attended 16 sessions of transactional analysis psychotherapy with a white Italian woman specialsing in psychotherapy with 2 years of clinical experience. The client satisfied DSM-5 criteria for moderate major depressive disorder and generalised anxiety disorder. This is the second investigation which has evaluated the effectiveness of transactional analysis psychotherapy for depressed adolescents.

Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Pragmatic Case Evaluation; Transactional Analysis Psychotherapy; Major Depressive Disorder; Generalized Anxiety Disorder; Adolescence.

Introduction

Recently, since the publication of the first Hermeneutic Single-Case Efficacy Design (HSCED) applied to transactional analysis (TA) treatment of depression (Widdowson, 2012a) there have been one direct replication of three single cases (Widdowson, 2012b, 2012c, 2013) and three Italian systematic replications of three single cases each (Benelli, Revello, Piccirillo, Mazzetti, Calvo, Palmieri, Sambin & Widdowson, 2016a; Benelli, Scottà, Barreca, Palmieri, Calvo, De Renoche, Colussi, Sambin, & Widdowson, 2016b; Benelli, Boschetti, Piccirillo, Quagliotti, Calvo, Palmieri, Sambin, & Widdowson, 2016c; Benelli, Moretti, Cavallero, Greco, Calvo, Mannarini, Palmieri & Widdowson, 2017a; Benelli, Filanti, Musso, Calvo, Mannarini, Palmieri & Widdowson, 2017b; Benelli, Bergamaschi, Capoferri, Morena, Calvo, Mannarini, Palmieri, Zanchetta & Widdowson, 2017c; Benelli, Procacci, Fornaro, Calvo, Mannarini, Palmieri & Zanchetta, 2018a; Benelli, Gentilesca, Boschetti, Piccirillo, Calvo, Mannarini, Palmieri & Zanchetta, 2018b; Benelli, Vulpiani, Cavallero, Calvo, Mannarini, Palmieri & Zanchetta, 2018c) aiming to recognise TA psychotherapy for depression as an Empirically Supported Treatment. Moreover, with the HSCED methodology Kerr (2013) evaluated TA treatment for emetophobia. However, even if HSCED has demonstrated being an important and valid way to demonstrate the efficacy of TA, its application remained secluded in these three groups of research. A reason for this short-range application might be due to the onerous investment a hermeneutic design requires. We identified two main difficulties in conducting a HSCED: (a) involving a group of people and training them to conduct the hermeneutic analysis, which is time-consuming and probably possible only in an academic environment; and (b) including judges who have to read a substantial amount of qualitative data, interpret it, along with quantitative data, and who must emit a verdict on the outcome of the case (good-, mixed-, or poor-outcome case), which is extremely demanding. Therefore, less expensive methods are necessary to evaluate the efficacy of a single-case in clinical practice.

In order to overcome these problems, in this simplified HSCED we decided to propose a variation of Elliott's

(Elliott, 2002; Elliott, Partyka, Wagner, Alperin, Dobrenski, Messer, Watson & Castonguay, 2009) traditional method and of previous case series replications published in this journal. For problem (a) we suggest that the hermeneutic analysis can be conducted by one person only. However, leaving the analysis to a single person eliminates the multi-perspective control, reducing internal validity. To overcome this limitation, we decided to implement an additional method to analyse qualitative data in a more structured and systematic way, improving also internal validity: the 56 criteria of Bohart, hereinafter referred by us for ease of reference as 'Bohart's grid' (Bohart, Berry & Wicks, 2011; Bohart & Humphreys, 2000; Bohart, Tallman, Byock & Mackrill, 2011) for pragmatic case evaluation, already introduced in the case of 'Alastair' (Widdowson, 2014).

Bohart's grid allowed us also to solve problem (b). Involving judges to reach a final verdict on outcome was necessary to evaluate the efficacy of both treatment and hermeneutic analysis, which has been largely demonstrated with all previous case series in this journal. Therefore, for cases in which there are not substantial discordances between quantitative and qualitative data, the adjudication procedure can be left to the reader or to the researcher (Benelli, De Carlo, Biffi & McLeod, 2015), who can resort to Bohart's grid for further matters.

Moreover, we identified another difficulty in some previous hermeneutic analyses: in fact, there have been cases (Benelli at al, 2016b, 2018a) in which hermeneutic teams have found difficulties in bringing evidence for both affirmative and sceptic briefs and rebuttals when significant incongruences emerged. Thanks to previous case series work, we have been able to pin-point these problematic aspects, and decided to shift the focus from evident changes in the client's behaviour to deeper and internal modifications. In an additional chapter in the Italian translation of *Transactional Analysis Treatment for Depression* (Widdowson, 2016), Benelli (2018) shows that it might be improbable for depression and depressive symptoms to exist outside of a structure of personality. Personality is a range of internal psychological processes (motivations, fantasies, peculiar patterns of thought and feeling, ways of experience of self and others, coping strategies, etc) which represents the individual in that circumstance (relationship, environment, culture, etc) (Lingiardi & McWilliams, 2018). Many clients are not aware of their personality disorder and are referred to the clinician by third parties, and others seek therapy for symptoms. However, even if dysfunctional aspects of personality are not clearly expressed as therapy goals, these are both directly and indirectly faced by the therapist and might inevitably undergo changes during therapeutic work. Therefore, it is sufficient for the researcher to keep in mind the client's pathological aspects of personality at the beginning of therapy and keep track of any modification in the course and at the end of therapy. For these reasons, we decided to aim our attention also to pathological representations tied to depressive personalities using SWAP-200 (Westen & Shedler, 1999a, 1999b) taxonomy, which divides dysphoric (depressive) personality in five subtypes: avoidant, high functioning, dependent-victimised, emotionally dys-regulated, and hostile-oppositional. A method to monitor deeper changes in depressive personalities is using the Racket System (Erskine & Zalcman, 1976), nowadays called Script System (O'Reilly-Knapp & Erskine, 2010), as suggested in Benelli's (2018) chapter.

The Script System is largely used in TA and its goals are listed in *Transactional Analysis: 100 Key Points and Techniques* (Widdowson, 2009).

The Script System helps both therapist and researcher to have a quick snapshot of the client's dynamics, identify script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories. The application of the analysis of the Script System in session transcriptions is innovative, because it allows focus not only on client's sufferance described in the Personal Questionnaire (PQ) (Elliott, Shapiro & Mack, 1999; Elliott, Wagner, Sales, Rodger, Alves & Cafè, 2016) but also monitors how different internal representations are established in the various phases of therapy. Moreover, using the Script System allows keeping track of possible incongruences between quantitative and qualitative data and resolve them by bringing evidence from the words of both client and therapist.

The general aim of this single case is to investigate the effectiveness of the manualised TA treatment of depression (Widdowson, 2016) with this simplified HSCED. Specifically, in this case we address the theme of focusing both on symptoms and personality disorders in diagnosis, treatment planning and treatment.

Major Depressive Disorder (MDD) affects all age groups, and is considered the fourth leading cause of disability in Europe and North America, calculated by Disability Adjusted Live Years (DALYs) (Murray et al., 2012). Depression in childhood and adolescence has an estimated prevalence of 2,8% amongst children and 5,9% amongst adolescents (Costello, Erkanli & Angold, 2006). In childhood and adolescence, it is also common to see a clinical presentation of comorbid anxiety and affective disorders, with some evidence that the former anxiety precedes and could cause the latter affective disorder (Seligman & Ollendick, 1998). Therefore, it appears appropriate to develop standardised inter-ventions targeting MDD in childhood and adolescence.

The present study analyses the treatment of 'Giovanni', a 17-year-old Italian young boy with a diagnosis of moderate major depressive disorder for more than six

years, in comorbidity with generalised anxiety disorder, worsening in the last two years when he began feeling terrified by one of his teachers. The primary outcome is the depressive and anxious symptomatology and the secondary outcomes are global distress and severity of personal problems.

Ethical Considerations

The research protocol follows the requirements of the ethical code for Research in Psychotherapy of the Italian Association of Psychology, and the American Psychological Association guidelines on the rights and confidentiality of research participants. The research protocol has been approved by the Ethical Committee of the University of Padua. Before entering the treatment, clients received an information pack, including a detailed description of the research protocol, and they gave a signed informed consent and written permission to include segments of disguised transcripts of sessions or interviews within scientific articles or conference presentations. Clients were informed that they would have received therapy even if they decided not to participate in the research and that they were able to withdraw from the study at any point, without any negative impact on their therapy. All aspects of the case material were disguised, so that neither the client nor third parties are identifiable. All changes are made in such a way that does not lead the reader to draw false conclusions related to the described clinical phenomena. Finally, as a member checking procedure, the final article was presented to clients, who read the manuscript and confirmed that it was a true and accurate record of the therapy and gave their final written consent for its publication.

Method

Inclusion and exclusion criteria

Psychotherapists participating in this case series were invited to include in their studies the first new client with a disorder within the depressive spectrum as described in DSM-5 (Major, Persistent or Other Depressive Disorders) (American Psychiatric Association, 2013) who agreed to participate in the research. Other current psychotherapy, active psychosis, domestic violence, bipolar disorder, active current use of antidepressant medication, alcohol or drug abuse were all considered as exclusion criteria. As the overall aim of this project is to study the effectiveness of TA psychotherapy in routine clinical practice, comorbidity is normally accepted and both inclusion and exclusion criteria are evaluated on a case by case.

Client

Giovanni is a 17 year-old white Italian male who lives with his parents and three older siblings in a small city in north Italy. He has difficulties in relating with his father, described like someone who only cares about his son's school grades, and also in the relationship with his two older siblings, with whom he does not interact frequently. He reports that in his family his privacy is not respected, especially when he is in the bathroom and in his room. Giovanni is an intelligent, curious, creative and playful teenager, with many positive values, and who has bad self-reflective and evaluative capacities, due to a low self-esteem (dysphoric high functioning depressive Script System, script beliefs about others: others are better; dysphoric-dependent victimised Script System, script beliefs about others: I need others' help). Giovanni has few friends, but he is afraid to ask them to go out together because he fears he would only receive rejections (dysphoric high functioning depressive Script System, needs and feelings and fantasies: fear of abandonment; dysphoric-dependent victimised Script System, needs and feelings: fear of rejections), therefore he prefers to spend his free time on his computer playing online videogames and creating gameplay videos for his channel with a friend. He is somewhat expert in computers and technology, however this ability is not shared with his family, nor recognised by his parents, especially by his father (dysphoric high functioning depressive Script System, reinforcing experiences through old emotional memories: repression of joy). Giovanni feels neither understood nor listened to by his parents and friends, sometimes he feels bullied and when he engages in cyber bullying he always defends other victims (dysphoric high functioning depressive Script System, observable behaviours: Victim and Saviour). Nevertheless, Giovanni reports working very hard on his homework to obtain generally good grades, and to not wasting time playing on his computer if he has an exam to prepare. Moreover, he reports that due to his school duties, his parents do not allow him to go out on weekends during the school year (dysphoric-dependent victimised Script System, script beliefs about self: I cannot decide what to do), practice sports or play a musical instrument. He reports having difficulties in mathematical classes only during written exams, which led him to fail and to resit the final exams at the end of the summer. In the course of therapy (between session 12 and 13), he is administered some tests for the evaluation of any learning disability, which he also did when he was younger, and receives a dyscalculia diagnosis. Finally, Giovanni reports great difficulties in relating with one school teacher, who seems to terrify him when he is having an oral exam and when she corrects his mistakes; this is the reason that led him ask for help and seek therapy.

Therapist

The psychotherapist was a 38-year-old, white, Italian woman with 2 years clinical experience. For this case, she received monthly supervision by a Provisional Teaching and Supervising Transactional Analyst (Psychotherapy) (PTSTA-P) with 16 years experience.

Intake sessions

The client attended five individual pre-treatment sessions (0A, 0B, 0C, 0D, 0E), which were focused on explaining the research project, obtaining consensus, conducting a diagnostic evaluation according to DSM-5 criteria (American Psychiatric Association, 2013), defining the problems he was seeking help for in therapy along with their duration and severity, developing a case formulation including TA diagnosis, treatment plan and contract, and collecting a stable baseline of self-reported measure for primary (depression and anxiety) and secondary (global distress and personal problems and problematic behaviours) outcomes.

DSM 5 Diagnosis

During the diagnostic phase, Giovanni was assessed as meeting DSM 5 diagnostic criteria of moderate major depressive disorder: he experienced depressed mood in daily activities for more than one year, most of the day, nearly every day (criterion A1), decreased pleasure in most activities (A2), restlessness when he felt anxious (A5), overwhelming feelings of worthlessness (A7), diminished ability to think and concentrate (A8). Giovanni also met DSM 5 diagnostic criteria of generalised anxiety disorder: excessive anxiety and worry (criterion A), that were uncontrollable (B), easily fatigued (C2), difficulty in concentration (C3) and muscle tension (C5). Between session 12 and 13 he also met criteria for mild Specific Learning Disorder with impairment in mathematics: he had difficulties in calculation (criterion A5) and difficulties with mathematical reasoning (A6).

Knowing the level of an individual's personality functioning and personality traits provides the therapist with fundamental information for treatment planning. According to the alternative model for personality disorder in DSM 5 Section III, a personality diagnosis was also conducted. This diagnosis allows for assessment of: 1) the level of impairment in personality functioning, and 2) personality traits. Giovanni showed impairment ranging in the level of organization, and personality traits of identity, self-direction, anxiousness and depressivity.

Case formulation

TA Diagnosis

Case formulation was conducted according the TA diagnostic categories presented in the treatment manual. Giovanni assumed a life position (Ernst, 1971; Berne 1972) of I'm Not OK, You're Not OK, that interacted with his stroke economy (Steiner, 1974), which was characterised by an absence of positive strokes and abundance of negative strokes. This in turn led to internalization of an under active and under-functioning internal Nurturing Parent and an over-active internal Critical Parent, which activated intense self-critical internal dialogues (Kapur, 1987). Furthermore, the underlying Injunctions (Goulding & Goulding, 1976): "Don't be well" (no one ever pays attention to me), "Don't trust" (often I feel I am betrayed), "Don't belong" (I feel like no one likes me), "Don't want" (I give up easily), "Don't be separate" (I feel I exist in the opinion of others and try my best to create a pleasing image), "Don't be engaged in your own life" (there are many things in life I won't do, but would like to do), "Don't think" (I'm not very smart and I feel inferior), "Don't feel" (no one cares what I feel) were also identified. In the drama triangle (Karpman, 1968) he assumes the role of Rescuer with friends or strangers when he joined in with cyber bullying, Victim when feeling helpless in front of failure (the teacher picks on me; I cannot manage to do this alone; I'm not good enough), and Persecutor with people he did not like or did not know (they probably all do drugs, I don't want to go out with them). Observable drivers (Kahler, 1975) of Try Hard and Be Strong were also identified.

The Script System

In TA, the Script System (O'Reilly-Knapp & Erskine, 2010), previously called the Racket System (Erskine & Zalcman, 1979), allows to keep in mind all the associations of the client, like script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories. Giovanni shows a dysphoric-depressive high functioning Script System (others are better than him, he fears being abandoned, he ignores his needs) and a dysphoric dependent victimised Script System (I cannot decide on my own, I need others, fear rejections, passive aggressiveness). Moreover, the Script System involved all of the above-mentioned thoughts and behavioural manifestations, as well as repressed primary anger when his privacy is not respected and his needs are unheard by his parents, which was covered by secondary sadness, helplessness, loneliness, which in turn triggered the memory recall of episodes of criticism and neglect. Finally, his script conclusions and decisions (Berne, 1961) were observable through script beliefs and contaminations (Berne, 1961; Stewart & Joines, 1987, 2012) such as: "I feel I'm not good enough", "I need others to help me", "others don't listen to me", "I don't like others", "others don't like me", "I feel judged".

Treatment plan

The therapy followed the manualised therapy protocol of Widdowson (2016). The treatment plan for Giovanni's depression primarily focused on creating a therapeutic alliance, providing permissions (Crossman, 1966) congruent with the client's injunctions, namely: *trust*, *belong*, *don't give up* and *believe*. Therapy was based on recognition and decontamination of script beliefs and emotion regulation, on changing internal dialogue from Critical to Nurturing Parent, on the creation of an I'm OK-You're OK relationship, and widening his script, providing reassurance and substituting emotional parasites, supporting him to express his needs and wishes.

Therapy process summary

Contract

In the first part of therapy, Giovanni asked to learn how to protect himself from the terror he felt in front of his teacher. From session 10, he asked to learn how to face his fear of feeling judged by others which prevented him from going out with his friends.

Sessions 1-8

In session 1 Giovanni talks about his relationship with peers and girls, his interests and free time, and the therapist tries to stimulate his wishes and pleasant memories of enjoyable activities he used to do when he was younger. In session 2 he speaks about his parents' expectations of his school grades, how he experiences school and relationships with his classmates, and his incapacity to handle stressful situations (i.e. oral examinations). The therapist helps Giovanni review some strategies he uses to cope with his anxiety, exploring possible past traumatic experiences. In session 3 he talks about the feeling of unfairness, both with peers and authorities, bringing a school episode, and the therapist works on the emotions he felt during that day. In session 4 Giovanni speaks about his fear of falling asleep and themes of death, love and anger emerged, and the therapist investigates his emotions and behaviours about these arguments. In session 5 he critically talks about his difficulties in creating friendly relationships and possible love relationships, and the therapist works on other ways of evaluating his own capacities, focusing on functional strategies he already used in the past. In session 6 Giovanni speaks about his anger toward his friend's brother who mistreats him and other players while playing online videogames. The therapist tries to connect this episode to what happens at school with his teacher, and at home when his parents do not respect his spaces. In session 7 Giovanni talks about school duties (many examinations because the end of the academic year is close) and about his ungrateful relationship with his father who approaches his son only to discuss school grades. The therapist uses empathic transactions. In session 8 Giovanni reports improvements in relating with the teacher that scares him and speaks also about his anger and feeling of not belonging in his family due to the difficult relationship with his father, and the therapist tries to stimulate Giovanni to emerge from this passivity with his father.

Sessions 9-16

In session 9 Giovanni is sad because he failed in two out of three tests at school, and the therapist works on his depreciation, reinforcing his positive strategies to cope with problems (i.e. organise study and homework, reduce anxiety). In session 10 school is over but he is very tired and sad because in September he will not see many of his classmates any more. The therapist tries to suggest meeting his friends outside school boundaries, but he refuses, fearing rejections by his friends. In session 11 Giovanni speaks about his anger, which expression shifts from desires of vengeance to repression mixed with powerlessness, and his desire to keep relationships with his classmates but fearing any possible rejection. The therapist tries to reinforce his desire to keep these relationships and works on his fears. In session 12 Giovanni is happier and more relaxed than usual and he speaks about a pleasant weekend spent with his cousin and friend of his, which allowed the therapist to work on his fears of being rejected by peers. In session 13 he depreciates his enthusiasm for the pleasant weekend spent with his cousin, and speaks about his anger towards his parents who he feels do not recognise his needs and wishes. The therapist works on permissions and recognition of his emotions. In session 14 Giovanni speaks about a creative work he is doing with a friend but keeps depreciating his capacities and fearing criticism by others who will see it. The therapist works on his fear of being judged which blocks him from growing. In session 15 resistances to exposure in relationships emerge, tied to his magical belief that others will understand his wishes and therefore his inexpression of them, and the therapist works on the depreciation of himself. In session 16 Giovanni brings pleasant experiences spent with some friends and the therapist embraces the possibility to speak about nice things too. Finally, they speak about the end of the research and of the possibility to resume therapy after the summer break if he wants.

Notes

Unlike previous cases in which the client attended three follow-up sessions at 1-, 3- and 6-month after the end of therapy, Giovanni attended only two follow-up sessions at 1- and 8-months.

Hermeneutic Analyst

Despite recent literature suggesting that hermeneutic analysis should be carried out by expert psychotherapists (Wall Kwee, Hu & McDonald, 2016), in this case only one hermeneutic analyst was involved, a first-year TA psychotherapist student, who was taught the principles of hermeneutic analysis in a course on case study research at the University of Padua, by Professor John McLeod. Following the indications of Elliott et al. (2009), the researcher assumed both affirmative and sceptic positions, and created affirmative and sceptic briefs and rebuttals. Client's depressive personality was monitored from assessment phase throughout the entire therapy work and in follow up phase, to keep track of any change in the Script System. Furthermore, the hermeneutic analyst used Bohart's grid to enrich the evaluation of the case and resolve slight incongruences between quantitative and qualitative data.

Measures

Statistical Analysis

All quantitative outcome measures were evaluated according to Reliable and Clinically Significant Change (RCSC) (Jacobson & Truax, 1991), where "change" stands for an improvement (RCSI) or for a deterioration (RCSD). Clinical significance (CS) is obtained when the observed score on an outcome measure drops under a cut-off score that discriminates clinical and non-clinical populations. For example, the PHQ-9 considers a score of ≥10 as an indicator of current moderate major depression (Kroenke, Spitzer & Williams, 2001). It is important to consider that even under the cut-off score there may be a subclinical disorder. For example, the PHQ-9 considers a score between 0 and 4 an indication of 'healthy' condition, and a score between 5 and 9 as an indicator of mild (subclinical) depression. Reliable Change Index (RCI) is a statistic that enables the determination of the magnitude of change score necessary to consider a statistically reliable change on an outcome measure (Jacobson and Truax, 1991). In particular, it is helpful in minimising Type I errors which occur when cases with no meaningful symptom change are assumed to have improved. For example, Richards and Borglin (2011) proposed that a reduction of at least 6 points in the PHQ-9 score would be indicative of a reliable improvement. Only when we observe the presence of both CS and RCI, do we have a RCSC, which is considered a robust method for assessing recovery in psychological interventions (Evans, Margison & Barkham, 1998; Delgadillo, McMillan, Leach, Lucock, Gilbody & Wood, 2014). To control experimentwise error which occurs when multiple significance tests are conducted on change measures, we consider that a RCSC is required in at least two out of three outcome measures, thus demonstrating a Global Reliable Change (GRC) (Elliott, 2015).

Quantitative Measures

Four standardised self-report outcome measures were selected to measure primary (depression and anxiety) and secondary outcomes (global distress and personal problems).

Patient Health Questionnaire 9-item for depression (PHQ-9) (Spitzer, Kroenke & Williams, 1999) scores each of the nine DSM 5 criteria from 0 ('not at all') to 3 ('nearly every day'), providing a total score of depression. It has been validated for use in primary care (Cameron, Crawford, Lawton, et al, 2008). Scores up to 4 are considered 'healthy', scores of 5, 10, 15 and 20 are taken as the cut-off point for mild, moderate, moderately severe and severe depression, respectively. PHQ-9 score ≥10 has a sensitivity of 88% and a specificity of 88% for major depression (Kroenke, Spitzer, & Williams, 2001) and scores of <10 are considered subclinical. A change of at least 6 points on PHQ-9 score is considered to assess a reliable improvement or deterioration (RCI).

Generalised Anxiety Disorder 7-item for anxiety (*GAD-7) (*Spitzer, Kroenke, Williams, & Löwe, 2006), which scores each of the seven DSM 5 criteria as 0 ('not at all'), 1 ('several days'), 2 ('more than half the days'), and 3 ('nearly every day'), respectively, providing a total score for anxiety. Scores up to 4 are considered 'healthy', scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD and score <10 are considered subclinical. It is moderately good at screening three other common anxiety disorders – panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%) (Kroenke, Spitzer, Williams, et al, 2007). A change of at least 4 points on GAD-7 score is required in order to assess a reliable improvement or deterioration (RCI).

Clinical Outcome for Routine Evaluation – Outcome Measure for global distress (CORE-OM) (Evans, Connell, Barkham, Margison, Mellor-Clark, McGrath, & Audin, 2002). Each of the 34 items is scored on a 5-point scale ranging from 0 ('not at all') to 4 ('most of the time'). Scores up to 5 are considered 'healthy', scores between 5 and up to 9 are considered 'low level' (sub-clinical), and scores of 10, 15, 20 and 25 are taken as the cut-off point for mild, moderate, moderately severe and severe distress, respectively. The cut-off of 10 yields a sensitivity (true positive rate) of 87% and a specificity (true negative rate) of 88% for discriminating between members of the clinical and general populations. CORE OM was used in assessment sessions, in sessions 8, 16 and follow-ups, whereas CORE short form A and B were used in all other sessions (Barkham, Margison, Leach, Lucock, Mellor-Clark, Evans, McGrath et al, 2001). A change of at least 5 points on CORE-OM score is required in order to assess a reliable improvement or deterioration (RCI).

The *Personal Questionnaire* (PQ) (Elliott, Shapiro, & Mack, 1999; Elliott, Wagner, Sales, Rodgers, Alves & Café, 2016) is a client-generated measure in which clients specify the problems they would like to address in their therapy and rate their problems according to how distressing they are finding each problem from 1 ('not at all') to 7 ('maximum possible'). Scores up to 3.25 are considered subclinical. In this case series, missing the Italian normative score, for the PQ we adopted a more conservative RCI of two points, rather than the RCI of 1.67 recently proposed by Elliott et al. (2016). The PQ procedure suggests including problems from five areas: symptoms, mood/emotions, specific performance or activity (e.g., work), relationships, and self-esteem/internal experience.

Qualitative Measure

The client was interviewed using the *Change Interview protocol* (CI) (Elliott, Slatick & Urman, 2001) one month

after the conclusion of the therapy. The CI is a semi-structured qualitative change measure which asks clients how they feel they have changed during the therapy and how they think these changes came about, what they felt was helpful or hindering in the therapy, and what changes they feel they still need to make. Clients are asked to identify key changes they made and to indicate on a five-point scale: 1) if they expected to change (1='very much expected'; 5='very much surprising'); 2) how likely these changes would have been without therapy (1='very unlikely'; 5='very likely'), and 3) how important they feel these changes to be (1='not at all'; 5='extremely').

The client also completed the *Helpful Aspects of Therapy form* (HAT) (Llewelyn, 1988) at the end of each session. The HAT allows the client to describe hindering or useful aspects of the session and to rate them on a nine-point scale (1='extremely hindering'; 9='extremely useful').

Furthermore, two qualitative measures have been implemented.

The representation of the *Script System* (O'Reilly-Knapp & Erskine, 2010) of the client has been created post hoc to: (a) detect areas of sufferance which might have not emerged as therapy goals or problems in the PQ and monitor any change in both depressive symptomatology and personality in the course of therapy, (b) focus on depressive personality aspects during the hermeneutic analysis, (c) monitor if changes in these areas are tied to therapeutic work, and (d) overcome incongruences between quantitative and qualitative data. To create a representation of the Script System the researcher makes a clinical evaluation of the most distressing problems presented by the client during sessions. The selection of the themes is based on: intensity of sufferance, recurrence of the theme, and pervasiveness within session and between sessions. The aspects the researcher is required to screen are similar to the areas of PQ (symptoms, mood/emotions, specific performance or activity, relationships, and self-esteem/internal experience) which have been rearranged according to the Script System structure (script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories). These themes have been selected in assessment sessions (Phase 1), and monitored during the first half of therapy (sessions 1-8, Phase 2), the second half of therapy (sessions 9-16, Phase 3), and in the Change Interview and follow-up period (Phase 4).

The *56 criteria of Bohart* (see Appendix 1) is a list of heuristics divided in to three groups. The first 11 items bring evidence that the client has changed; items from 12 to 39 help enlighten specific changes; and the last seventeen items (40-56) deal with evidence that it was therapy that helped the client change. These criteria have been transformed into structured grids by Widdowson for the case of "Alastair" (2014), to indicate the source and the evidence for each item. Reported evidence supporting a criterion is taken from the words of the client from session transcriptions, which additionally help with defining and describing quantitative data, and whether incongruent with qualitative data. For each of the 56 items, there are four possible evaluations: 'there is evidence', 'there is no evidence', 'there is some evidence' and 'not applicable', and for each group of items a 'plausible conclusion' is argued. It is possible to calculate a percentage of certainty of change (with 1-39 items) and a percentage of certainty of attribution to therapy (with 40-56 items). The proportion is calculated between the number of items 'with evidence' and the total number of items (39 including the first and second group, 17 for the third one). If there are not applicable criteria, these are not considered in the percentage calculation.

Therapist Notes

A structured session notes form (Widdowson, 2012a, Appendix 6, p. 50-52) was completed by the therapist at the end of each session. In this form, the therapist provides a brief description of the session in which they identified key aspects of the therapy process, the theories and interventions used, and an indication of how helpful the therapist felt the session was for the client.

Adherence

The therapist, the supervisor, and the main researcher were all Transactional Analysts and they each independently evaluated the therapist's adherence to TA treatment of depression using the "operationalised adherence checklist" proposed by Widdowson (2012a, Appendix 7, p. 53-55) and agreeing on a final consensus rating.

HSCED Analysis Procedure

HSCED analysis was conducted according to Elliott (2002) and Elliott et al. (2009) as described in previous publications of prior series.

Pragmatic Case Evaluation

After the hermeneutic analysis, the 56 criteria of Bohart have been applied to support both affirmative case and conclusions. In fact, the first 39 items of the criterion list mirror HSCED first affirmative point (specific changes for long standing problems), whereas the last 17 items reflect the second affirmative point (retrospective attribution). However, if there is little or no prof for a positive outcome case, Bohart's grid indirectly supports both sceptic case and conclusions. Therefore, a preponderance of evidence is more indicative of a positive change attributed to therapy. Moreover, the first 39 criteria correspond to the first two questions of the adjudication procedure (described in previous publications of prior series) ("how would you categorise this case" and "to what extent did the client change over

the course of therapy"), whereas the last 17 items represent the third question of the adjudication procedure ("to what extent is this change due to therapy").

Results

In earlier published HSCED's the rich case records, along with hermeneutic analysis and judges' opinions were often provided as online appendices (Benelli et al., 2015). Since all the material is in Italian language, we adopted here the solution of providing a summary of the main points, as proposed in MacLeod, Elliott and Rodger (2012). The complete material (session transcriptions, CI, affirmative and sceptic briefs and rebuttal, evidence in Bohart's criterion list and comments) is available from the first author on request.

Adherence to the manualised treatment

The conclusion of the three evaluators was that the treatment had been conducted coherently according to TA theory at a good to excellent level of application.

Quantitative Data

PHQ-9, GAD-7 and CORE were administered in the pre-treatment phase in order to obtain a five-point baseline, and during the two follow-ups, whereas PQ was generated during the assessment phase, are therefore administered from session 0E. Since the client expressed some discomfort in completing some items of the CORE, we chose to calculate the mean score considering only answered items.

Giovanni's quantitative data are presented in Table 1. The initial depressive score (PHQ-9, 12.6) indicated a moderate level of depression. The initial anxiety score (GAD-7, 10.6) indicated a moderate level of anxiety. The initial global distress score (CORE, 16.8) indicated a moderate level of distress. The initial severity score of personal problems (PQ, 4.7) indicated that the client perceived his problems as bothering him somewhere between 'moderately' and 'considerably'.

At session 8, (mid-therapy), his scores remained unchanged, showing a constant moderate depression (12), anxiety (10), and also global distress (17.3) showed no significant change. Instead, the severity of personal problems decreased to 'little' bothering (3.1), with a clinically significant change (CS).

By the end of the therapy, depression (8) and anxiety (9) scores passed into the mild range gaining clinical significance, and global distress score decreased to mild range too gaining a reliable and clinically significant improvement (RCSI), whereas personal problems (3.64) rose without reliable deterioration, bothering him somewhere between 'little' and 'moderately'.

At the 1-month follow up, depression scores remained in the 'mild' range (9) with clinical significance, whereas mild anxiety levels decreased (6), gaining RCSI, global distress decreased to a 'low level' (7.9) with a RCSI, and personal problems returned to be 'little' bothering (3.3).

Finally, at the 8-month follow up, depression remained in the 'mild' range, gaining RCSI, anxiety (5) and global distress (6.8) remained unaltered with RCSI, and personal problems became 'very little' bothering, gaining RCSI.

	Pre-Therapy[a]	Session 8 Middle	Session 16 End	1 month FU	8 months FU
PHQ-9	**12.6 Moderate**	**12 Moderate**	8 (+) Mild	9 (+) Mild	6 (+)(*) Mild
GAD-7	**10.6 Moderate**	**10 Moderate**	9 (+) Mild	6 (+)(*) Mild	5 (+)(*) Mild
CORE-OM	**16.8 Moderate**	**17.3 Moderate**	11.8 (*) Mild	7.9 (+)(*) Low level	6.8 (+)(*) Low level
PQ	**4.7[b] Moderately**	3.1 (+) Little	3.64 Little	3.3 Little	2.6 (+)(*) Very little

Note. Values in **bold** are within the clinical range; + indicates clinically significant change (CS). * indicates reliable change (RC). FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999). GAD-7 = Generalised Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006). CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002). PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off points: PHQ-9 ≥10; GAD-7 ≥10; CORE-OM ≥10; PQ ≥3.25. Reliable Change Index values: PHQ-9 variation of six points, GAD-7 variation of four points, CORE-OM variation of five points, PQ variation of two points.

[a]Mean score of pre-treatment measurements.
[b]First available score in assessment session 0E.

Table 1: Giovanni's Quantitative Outcome Measure

	PQ items	Duration	Pre-Therapy[a, b]	Session 8 (middle)	Session 16 (end)	1 month FU	8 months FU
1	I get scared when teachers yell at me	1-2y	**6 Very considerably**	1 (+)(*) Not at all	**4 (*) Moderately**	1 (+)(*) Not at all	2 (+)(*) Very little
2	I get depressed when I can't manage to do things on my own	6-10y	**6 Very considerably**	3 (+)(*) Little	3 (+)(*) Little	1 (+)(*) Not at all	2 (+)(*) Very little
3	I feel impotent when my anger is unheard	6-11m	**7 Maximum possible**	1 (+)(*) Not at all	**4 (*) Moderately**	3 (+)(*) Little	3 (+)(*) Little
4	I freeze when teachers insult me instead of answering them	1-2y	**5 Considerably**	2 (+)(*) Very little	**4 Moderately**	2 (+)(*) Very little	2 (+)(*) Very little
5	I'm afraid to make mistakes when I have to do important things because then these cannot be changed	1-2y	**4 Moderately**	**6 (*) Very considerably**	3 (+) Little	**4 Moderately**	**4 Moderately**
6	I'm afraid to make mistakes when others watch me correct my mistakes	6-10y	3 Little	**4 Moderately**	**5 (*) Considerably**	3 Little	**4 Moderately**
7	I feel anger because from the start I give up doing things that are important to me	6-11m	**5 Considerably**	2 (+)(*) Very little	**5 Considerably**	2 (+)(*) Very little	3 (+)(*) Little
8	I get sad because I feel I'm losing important occasions	6-10y	**4 Moderately**	**6 (*) Very considerably**	3 (+) Little	2 (+)(*) Very little	3 (+) Little
9	I get depressed when I can't manage to say what I think and feel	6-11m	**4 Moderately**	**4 Moderately**	2 (+)(*) Very little	**5 Considerably**	3 (+) Little
10	I feel sad because I can't manage to regulate and protect those relationships that are important to me	6-11m	3 Little	2 Very little	2 Very little	1 (*) Not at all	1 (*) Not at all
11	I don't feel accepted (negatively judged) when I'm with peers	1-2y	-	-	**5 Considerably**	2 (+)(*) Very little	1 (+)(*) Not at all
	Total		47	31	40	36	8
	Mean		**4.7 Moderately**	3.1 (+)(*) Little	3.6 Little	**3.3 Little**	2.6 (+)(*) Very little

Note. Values in **bold** are within clinical range. + = indicates clinically significant change (CS). * = indicates reliable change (RCI). m = months. y = year. FU = follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off point: PQ ≥3.25. Reliable Change: PQ variation of two points. The rating is on a scale from 1 to 7 and indicate how much each problem has bothered the client: 1 = 'not at all'; 7 = 'maximum'.

[a]Mean score of pre-treatment measurements.
[b]The first available score was in assessment session 0E.

Table 2: Giovanni's personal problems (PQ), duration and scores

Table 2 shows the 11 problems that the client identified in his PQ (10 at the beginning of therapy, 1 added from session 14) and their duration. One problem was rated as bothering him 'maximum possible', two as 'very considerably', two were rated 'considerably' bothering, three as 'moderately' and two as 'little' bothering. Two problems were initially rated under the clinical cut off, therefore cannot show clinical significance. Three problems lasted from 6 to 10 years, four from 1 to 2 years and four from 6 to 11 months, representing an almost stable and longstanding baseline. At the end of the therapy 4 out of the 8 problems above the clinical cut off showed clinical significance (CS), 2 showed a reliable improvement (RCI) and 2 gained RCSI. At the first follow up 8 items out of 11 showed a RCSI, whereas at the 8-month follow up, 2 problems showed a CS and 7 problems reached RCSI.

Problems are related to: mood/emotions (1 scared, 3 impotent when angry, 7 anger when giving up, 8 sadness), relationships (10 unable to protect relationships, 11 feel judged), self-esteem/inner experience (2 depressed when alone, 5 and 6 afraid to make mistakes, 9 incapacity to express thoughts and feelings), and symptoms (4 I freeze). The longer lasting problems were related to mood and self-esteemTable 3 shows the seven aspects of the Script System: (1) script beliefs about self, others and quality of life, (2) needs and feelings, (3) observable behaviours, (4) reported internal experiences, (5) fantasies, and reinforcing experiences through (6) current events and (7) old emotional memories. These aspects have been observed by the hermeneutic analyst during the assessment sessions (Phase 1), variations of these have been monitored in both the first part (Phase 2) and second part of therapy (Phase 3), and their maintenance and stability in the Change Interview (Phase 4).

In Phase 1, Giovanni's beliefs about himself were of low self-esteem and incapacity to express and make his parents respect his needs; beliefs about others were that others are better and fear that others will criticise him; beliefs about life is that he had no power in changing things with his teacher; needs and feelings, such as expressing and getting angry, were repressed and not considered in his family, making him feel impotent, and he felt scared in front of a teacher; as observable behaviours he could not defend his privacy between domestic walls, he isolated in his room, and he showed anxious symptoms; fantasies were about fear of rejections of girls and friends in going out and spend time together.

In Phase 2, beliefs about self were of fragility and absence of courage; however, he started speaking out his needs during therapy ("I would like"); about others remained the same ("they don't want to go out with me"); needs and feelings of anger were still repressed and devaluated, whereas insomnia due to anxiety ceased (S2 vs S6); as observable behaviours he made others respect his privacy; as reported internal experiences he says he felt ignored by his parents; fantasies were that if he went out, he would be alone; reinforcing experiences through current events were that friends ditched his invitations to go out, and that his father ignored his son unless it was about school grades; reinforcing experi-ences through old memories were an episode of a second-grade teacher who yelled at him.

In Phase 3, from Giovanni's beliefs about self emerged his desire and determination to go out with friends ("I will go"), whereas his parents kept ignoring his wishes; about others he reported that peers are not good people, fearing their judgment; needs and feelings changed from not enjoying and devaluing going out with friends (S13) to enjoying it without bringing up pretexts (S16); furthermore he does not feel scared by his teacher any more; as for observable behaviours he felt bullied, he protected other victims when involved cyberbullying; furthermore he started going out with friends; as for fantasies he reported fears of failing tests and of peers' rejections; moreover he believed his parents should know his needs and feelings even if he does not tell them; as for reinforcing experiences through current events he reported episodes of repression of enjoyable things, of fault, loneliness and of constant rejections; and reinforcing experiences through old memories were tied to happy events that today do not occur again.

In Phase 4, as a belief about self he reported to have gained self-confidence and to be shy no more; as for needs and feelings he reported that he did not suffer from insomnia anymore, and that he enjoyed going out with friends; observable behaviours were better relationships and going out with friends; and for reported internal experiences he did not feel depressed or stressed anymore.

Giovanni's script beliefs about self and others were representative of a dysphoric dependent victimised personality; script beliefs about life are representative of a dysphoric high functioning depressive personality; his repressed needs and feelings are typical of dysphoric high functioning depressive and dependent victimised personalities; observable behaviours were repre-sentative of a dysphoric avoidant personality; his fantasies reflect a dysphoric high functioning depressive personality; reinforcing experiences through current events were representative of dysphoric high functioning depressive and avoidant personalities.

Successively, these aspects have been compared with PQ items. Giovanni's Script System of script beliefs about self reflect item 2 (incapacity to do things alone), 7 (I don't try on my own) and 9 (I don't express my thoughts, feelings [needs]); script beliefs about others reflect item 4 (I freeze when I'm criticise d), 6 (I'm afraid of making mistakes) and 11 (I don't feel accepted). Needs and feelings reflect item 1 (I'm scared), 3 (I feel impotent), 4 and 9; observable behaviours reflect item 9; and fantasies reflect item 6, 9, 10 (I can't protect my relationships) and 11.

Furthermore, there is evidence that there is similar evolution between the Script System and PQ scores.

Qualitative Data

Giovanni compiled the HAT form at the end of every session (Table 4), reporting only positive/helpful events. All positive events were rated from 7 (moderately helpful) to 9 (extremely helpful). Giovanni also reported other useful events in session 2 ("The fact that my fear of aggressive teachers started when I was in second grade"), session 3 ("When we talked about the ego states model (GAB) which led me understand that my fear started long time ago through an old teacher"), session 5 ("I found a method to distract my mind from my sleeping phobia"), session 8 ("One of my classmates didn't show up in school, making others end in trouble (I vented)"), and session 13 ("Asking my parents to start playing the guitar"). He reported helpful aspects on: symptoms (HAT 4 "fear of falling asleep"), relationships (HAT 2 "got over the fight", 6 "my friend's brother's behaviour", 7 "conversation with dad", 11 "my friend's brother cyber-bullying", 12 "I want social interactions", 13 "fear of being judged", 14 "my friend's brother spoils my work", 15 "planning date", 16 "the date I went to"), and self-esteem/inner experience (HAT 1 "I opened up", 3 "importance of talking about sadness and anger", 5 "not wrong feeling interest", 8 "privacy parents don't give me", 9 "felt more tranquil and no anxiety", 10 "I vented").

Giovanni participated in a Change Interview (CI) 1-month after the conclusion of the therapy. In this interview he identified seven changes (Table 5) since he started therapy, three tied to his depressive and anxious symptoms (items 4, 6 and 7), two related to his relationships (items 1 and 2), and two connected with his self-esteem and inner experience (items 3 and 5). Four out of six rated changes are considered to be unlikely to happened without therapy, and two would have occurred even without therapy. Only item 1 (dating peers more often) was rated as 'very important' change (4), and item 1 and 3 were considered unexpected changes. However, according to Giovanni, all "changes occurred thanks to aspects of therapy, to the therapist's suggestions, she gave me courage, like asking friends to go out together, and I did… I don't think I would have ever managed to do this on my own" (Change Interview, Line 408-416), because "when I came here I reflected and this led to changes in my behaviour outside of therapy… it helped me think" (CI, L421-423). The client also reported that friends around him see he changed: "they tell me they see me different, I'm calmer, I'm more playful, I don't take offence for jokes" (CI, L216-232), in fact, "my relationships improved, before I didn't care about others' interests, now I do", (CI, L451-480), "they said that last year I was a pain in the neck, whereas now they say I'm not a pain in the neck anymore" (CI, L489-498). Giovanni also said that "therapy gave me self-esteem, self-confidence, which made me improve in my homework, because it gave me the strength to stay there and succeed, not giving up like I did before" (CI, L609-616). Finally, he reported that "therapy helped me in trying, being more myself" (CI, L433-452).

HSCED Analysis

Affirmative Case

The affirmative team identified four lines of evidence supporting the claim that Giovanni 1) changed and 2) therapy had a causal role in this change.

1. Change in stable problems

Quantitative data (Table 1) shows that from session 10, Giovanni's primary outcome measure (PHQ-9, depression) not also dropped in frequency during the last two weeks, but the intensity of the disturbance of these problems changed from being 'somewhat difficult' from assessment session 0A to session 5 and 'very difficult' from session 7 to session 9, to 'not difficult at all' from session 10 until the end of therapy and in the follow-ups. However, from session 10, the client's PHQ-9 score remained threshold until the end of therapy. Giovanni's anxiety (GAD-7) obtained clinical significance from session 10, with a RCSI maintained in the follow ups. Global distress (CORE) reached a reliable change in session 13, and a RCSI in the follow-ups.

In the PQ (Table 2), Giovanni identified 11 main problems that he was trying to solve. Two out of three long lasting problems (from 6 to 10 years) reached clinical significance at the end of therapy and one obtained RCSI. In the 1-month follow up eight out of eleven problems reached RCSI, whereas in the 8-month follow up nine problems showed a CS, seven of which obtained RCSI too. Overall, there is support for claiming a global reliable change.

Qualitative data supports these changes in stable problems. In his Change Interview (CI) Giovanni said: "I solved many of my problems" (CI, L64), "all the problems I brought out here I managed to solve them, so therapy worked" (CI, L579-580). About his symptoms, Giovanni reported that "I don't freeze

anymore" (CI, L740), "when my teacher yells at me, she doesn't scare me like before, this feeling diminished a lot" (S8, L21-26), "I'm not afraid of falling asleep anymore" (CI, L746-747) and "before therapy I bit my fingernails" (CI, 204). Giovanni also reported that he gained self-confidence and self-esteem: "I thought I was inept, unable to do many things, then I learnt to do things on my own, and I understood that it wasn't as I thought" (CI, L603-606). He explained that thanks to his better self-esteem, not only did he start going out with his friends, but also his relationships improved: "before I hated dating others because I felt embarrassed" (CI, L138-140), "I feared their judgment and I started to shiver, whereas now this problem ceased a lot" (CI, L650-654), "I try to understand others before judging them" (CI, L154-161). Finally, according to item 2 "I get depressed when I can't manage to do things on my own", he reported "I'm planning my summer vacations, I'm projecting some gameplays" (S10, L438-439), "I'm arranging a tournament of my favourite online game with some friends" (S13, L78-81).

2. Retrospective attribution

Giovanni identified in his Change Interview seven important changes, four of them rated "unlikely" or "somewhat unlikely" without therapy (Table 4). Giovanni described his therapy as "a place where I brought out my problems and we [the therapist and I] solved them together" (CI, L122-129), even if "at the beginning I didn't believe in it, then when I came here I talked about different problems and how to face them and I understood that talking was something positive" (CI, L33-36) and "I managed to solve all the problems I brought out in here" (CI, L579-580). "Having someone that listened to me and helped me face my problems and find solutions to them helped me a lot, and this is a rare thing for me, at home or with friends" (CI, L553-560). "I felt she [the therapist] listened to me, even friends can listen to you, but they don't care about helping you like she [the therapist] did" (CI, L562-563), "and I understood she cared about what I said because she didn't stay quiet all the time, she gave me advice, we were having a bidirectional conversation" (CI, L574-576). He recognised that therapy allowed him to find new strategies to solve his problems, like how to cope with his fear of falling asleep: "thanks to the therapist… I talked about my night paralysis and she helped me create a list of possible solutions I could do to solve this problem and it worked" (CI, L46-54). Giovanni also reported that the therapist helped him gain self-confidence and self-esteem (CI, L609-616) both in doing his homework and in going out with his peers (CI, L433-443). In fact, he believed that peers would have rejected his invitation to go out together and for this reason he did not want to go out (S13, 680-697), "but the therapist told me to try and to be myself, and I did, so now I go out" (CI, L433-443), and, "therapy helped me in being more confident and believe in myself" (CI, L451-452) and for this reason "my relationships improved" (CI, L461).

3. Association between outcome and process (outcome to process mapping)

The HAT completed at the end of each session provides us with regular and immediate reports of what Giovanni found helpful in each session. All reported events are considered from "moderately" to "extremely" useful and are coherent with the diagnosis, the treatment plan and the interventions reported in the therapist's notes. Changes in depression and anxiety symptoms (Table 1), in particular, feeling unable to be successful in doing something completely on his own, feeling lonely and unable to have social interactions, feeling he was not listened to by anyone, feeling scared of being judged, feeling afraid of teachers (and adults) that yelled at him, freezing when he had to face an exam, and fearing to fall asleep (PQ, Table 2) appear tied to interventions in almost all sessions, on changing his internal dialogue from Critical Parent to Nurturing Parent (reported in particular in the HAT, Table 4, in sessions 1, 5, 7, 13) and on his self-esteem (in particular in the HAT, sessions 9, 12, 13), and also on recovering the origin of his fears and how to cope with them (HAT, sessions 2, 3, 4), and on his relationships, especially on his fear of being judged by others (HAT, sessions 6, 10, 11, 14, 15, 16). Changes in his depressive symptoms seem more tied to interventions of decontamination (sessions 4, 5, 8, 13, 14) about his beliefs in his limits (I can't do anything alone), abilities (I'm not good enough), and peers (they all do drugs), and to the therapist's interventions to create a global concept of I'm OK, You're OK (sessions 1, 2, 5, 7, 8, 9, 12, 14).

4. Event-shift sequences (process to outcome mapping)

The greater effect on depressive symptoms appeared to be tied to interventions throughout the entire therapy, which focused on changing the client's self-critical internal dialogue associated with his feelings of incapacity and social estrangement. The therapist's interventions are mirrored in particular in Giovanni's words during his Change Interview "now I'm more self-confident, I have more self-esteem" (CI, L603-616), and in HAT Forms (Table 3, sessions 12, 15, 16). The therapist's intervention of decontamination and desensibilization in session 3 (S3, L209-350) regarding Giovanni's fear of his teacher, helped him feel more comfortable during the rest of the academic year and stopped him feeling scared by her (S8, L21-28). Moreover, the therapist worked on

	Script System	Phase 1	Phase 2	Phase 3	Phase 4
1	**Script beliefs: - about self**	"I'd like to go out with friends, but my parents won't let me" (0A) "I'm not good in doing this… I don't even try on my own" (0B) "I can't manage to do things on my own because I'm not capable" (0C) "I don't have self-esteem" (0D) "I'm insecure" (0D) "I feel impotent" (0D) "I'd like to learn playing the guitar, but dad doesn't want because he believes I'd give up" (0E)	"I'd like to go out with my friends… but I don't want my parents to worry" (S1) "I shouldn't get traumatised, I'm a grownup, but I'm fragile, I crack easily" (S2) "I'm not courageous" (S3)	"I'm unlucky" (S9) "This summer I'll go out with my friends" (S10) "My parents don't want me to learn to play the guitar, they won't take me to classes, they say that when I like something then I get bored and I give up" (S13)	"I'm shy but I solved it, I don't get angry easily, I'm funny" (CI) "I gained self-confidence" (CI)
	- about others	"I need mum's help" (0B) "Others are better than me in doing things" (0D) "I prefer to do homework in a couple or with others" (0D) "I fear how my teacher will correct my mistakes in front of the class" (0D)	"Friends don't ask me often to go out together" (S5)	"Peers smoke weed and swear all the time" (S13) "I fear others will criticise and judge me" (S13)	-
	- about quality of life	"I cannot change my teacher's point of view, I cannot tell him/her that he/she scares me" (0B)	-	-	-
2	**Needs and feelings**	"I feel terrified in front of a teacher" (0A) "I feel impotent when mum invades my privacy and she does not respect my anger" (0D) "When I'm angry my parents ignore me" (0E)	"I didn't sleep last night because the following day I had a test and I was scared" (S2) "I'm angry with my classmates that ditched class… anxious, couldn't stay still. I was scared the teacher would have examined my study level" (S3) "My moments of anger are ridiculous, I laugh about them" (S6) "I'm not nervous, I sleep well" (S6)	"The teacher doesn't scare me like before" (S8) "I cried because I won't see many of my classmates next year" (S10) "I didn't enjoy going out with my cousin and his friends" (S13) "I enjoyed going out with my friends" (S16)	"I'm not afraid of falling asleep and sleeping any more" (CI) "I like staying with friends and they like spending their time with me" (C)I)
3	**Observable behaviours**	"They [mother and father] forbid me to lock the bathroom door and they [family members] don't respect my privacy" (0A) "I isolate myself in my room playing videogames because it makes me feel more emotions" (0E) "I'm nervous, I bite my	"I lock the bathroom door, so others will respect my privacy" (S6)	"A classmate bullied me all year" (S10) "My classmates and I went out for an end-of-the-year pizza" (S10) "I get angry and defend victims when I get involved in cyberbullying" (S11) "I went out with my cousin and his friends" (S13)	"My relationships improved, I go out" (CI) "I go out now, before I hated it because I was embarrassed" (CI)

	Script System	Phase 1	Phase 2	Phase 3	Phase 4
		fingernails, I shake my leg, I sweat" (0E)		"I'm not asking some friends to go out for my birthday because dealing with rejections is too stressful… I fear their answer" (S15) "I went out with some friends" (S16)	
4	**Reported internal experiences**	-	"I get tired easily, I struggle to concentrate" (S1) "I feel like my dog that is considered only when he makes you angry" (S7)	-	"I'm not depressed anymore" (CI) "I'm not stressed anymore, only before oral examinations, before I got stressed for everything" (CI)
5	**Fantasies**	"I fear her [girl] rejection" (0A) "I'm afraid to make mistakes when others watch me doing things, I feel embarrassed" (0D)	"I don't know with whom to go out, I'd be alone" (S5)	"I failed two tests out of three… I think, I guess I failed them" (S9) "I'd like to ask my classmates to go out, but I don't want to be bothering during the summer break" (S10) "I don't ask this girl to go out because I'm scared I'll make a gaffe" (S12) "My parents don't understand my needs and wishes [I don't tell them, they should know]" (S13) "I don't go out because I'm afraid I'll make a gaffe with new people" (S13)	-
6	**Reinforcing experiences through current events**	-	"Middle school friends don't answer me when I ask them to go out" (S5) "The only thing dad wants to talk about with me is school and this makes me feel bad… or we talk about school or we fight" (S7)	"I don't play anymore, I study, all my energies are for studying" (S9) "If I fail the exam, every time dad says that it's my fault" (S9) "My friends stood me up four times" (S10) "I stopped asking my parents things I'd like to do because I'm used to receive rejections" (S13)	-
7	**Reinforcing experiences through old emotional memories**	-	"In second grade a teacher yelled at me" (S2)	"Happy memories of my childhood are when we went to the amusement park, now we don't go anymore" (S8)	-

Note: Phase 1 = assessment sessions. Phase 2 = 1-8 sessions. Phase 3 = 9-16 sessions. Phase 4 = Change Interview and follow-up session. 0A, 0B, 0C and 0D = assessment sessions. CI = Change Interview.

Table 3: How Giovanni's Script System changed from Phase 1 to Phase 4

loosening his script regarding fear of being judged by people he did not know, which prevented him going out with friends. By the end of the therapy, he reported having gone out on a date with his friends and new people, and to have liked it (HAT Form, session 16), which is confirmed in the CI: "now I go out, before I felt embarrassed" (CI, L138-13). Furthermore, according to the client statement "talking to someone that was genuinely interested in me really helped me, because this is rare" (CI, L553-560); hence the affirmative case includes that the strong therapeutic alliance and the space therapy gave Giovanni to share his passions (for the guitar, online games and creation of gameplays) and explaining his underestimated abilities (in game strategies and in editing videos) with a receptive and interested listener, helped him express his desires and needs, an aspect that he reported to be absent in his family (S14, L254-265). Finally, since the beginning of therapy, the therapist focused on giving strokes and recognitions when Giovanni spoke about his technological talent and about his desires of doing new things he liked (going out with friends, going on a trip with his family to a close place he wanted to visit, asking his parents to learn to play the guitar).

Sceptic Case

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

Four of the quantitative measures used (PHQ-9, GAD-7, CORE and PQ) are not validated for adolescence, thus should not be adopted in this case study. Furthermore, Giovanni's PQ scores did not improve significantly, and there is also no evidence that the therapist's interventions were tied to the different items of the PQ. For such reasons, we reject the claim of a global reliable change. In his CI, he also reported that since he started therapy, he began to act with more revenge if someone bothered him, "this thing got worse, one year ago I would have never done something similar" (CI, L303). He also said that "I don't see all these changes in me" (CI, L244), in fact, items 5, 7 and 11 of the PQ "didn't change, they are as before" (CI, L644, 663, 682). Moreover, in the course of therapy, there are many incongruences in Giovanni's words: i.e. wanting to start a sport but can't because parents won't let him (session 0A) versus not wanting to do any sport because he doesn't like sports (session 0C) versus "I wanted to start martial arts and my parents didn't allow me to go to the gym" (session 13); and also in the PQ's first item "I get scared when teachers yell at me", which is still from 'moderately' to 'considerably' bothering even after the end of the scholastic year. Therefore, positive changes at the end of therapy might be due to similar incongruences.

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

Even considering PHQ-9, GAD-7, CORE and PQ as valid measures for depression in adolescence, the visual inspection of the five-point baseline shows an unstable pattern in all measurements, making it difficult to calculate a reliable change. Furthermore, Giovanni did not fill in many different items of the CORE, highlighting a lack of attention in completing the questionnaires, which might have influenced quantitative data.

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

In his quantitative data, the client scores show a RCSI in the PHQ-9, GAD-7 and CORE in all four measures from the 8-month follow up. This could be tied to compliance effect, because he rated improvements also after the end of therapy. In fact, it seemed that Giovanni showed compliance towards the therapist because she listened to him, a rare thing for him (CI, L553-560). Moreover, in his CI, Giovanni reported only positive comments about the therapy and the therapist, and in his HAT forms he reported no hindering event.

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

The sceptic team was not able to find any proof of changes due to cultural or personal expectancy artefacts.

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

Even accepting that data from PHQ-9, GAD-7, CORE and PQ changes and widely fluctuating scores are normal in adolescence, all observed changes can be attributed to normal fluctuations associated with adolescence. Furthermore, Giovanni started therapy after a teacher yelled at him, an event that generated in him a strong feeling of fear every time he stood in front of that teacher. Therefore, the significant drop of depression and anxious scores in both PHQ-9 and GAD-7 between session 9 and 10, could be tied to the end of the academic year, which led Giovanni to an immediate recovery and return to the normal baseline.

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

As previously mentioned, improvements in Giovanni's quantitative data from session 10 may

have been due to the end of the academic year and to the beginning of summer vacations: "having finished school sent me like in to a coma, a state of calm" (S10, L9-11). Furthermore, in session 13 he received a diagnosis of dyscalculia, which "made me feel better, because now my bad grades in maths have a reason: I've been doing tests for normal people, that's why doing exercises was so difficult" (S13, L38-39), and solved his low self-esteem tied to his incapacities in exams. Furthermore, in his CI, Giovanni reported that "my behaviour changed even because I grew up, so I don't know whether this is due to therapy or me maturing" (CI, L189-190). Finally, in his HAT Form (Table 4, session 16) he reported that he managed to have a pleasant evening with new friends because they were friendly, therefore their tendency to be friendly might have positively influenced Giovanni's mood.

7. There is credible improvement, but it is due to psychobiological processes, such as psychopharma-cological mediations, herbal remedies, or recovery of hormonal balance following biological insult.

There is no evidence that Giovanni's improvements are due to psychobiological processes.

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

Participating in the research, talking about his problems and being recorded made Giovanni feel embarrassed and strange (CI, L567-568), which might have affected quantitative and qualitative data. In fact, during therapy, he did not want to say the names of his classmates nor friends "I don't want to say their names… so let's call this person Lorenzo" (S5, L75-76, 237).

Affirmative Rebuttal

1. A search for existing literature indicated that there are several studies which support the use of PHQ-9, GAD-7, CORE and PQ with adolescents. Studies indicate that disorder sensitivity and specificity in adolescence are similar to those of the adult population, suggesting only a slightly higher clinical cut off. Even if there is not a validated version for Italian adolescents, there is no reason to suppose a different result might occur in light of the other validations. Thus, we affirm the presence of a global reliable change. The therapist decided not to work directly on the patient's PQ items, because thanks to her clinical experience, she believed that to help Giovanni solve his problems, his self-esteem had to grow. Therapeutic interventions focused on improv-ing his self-confidence and his self-image. In his CI, Giovanni reported that all the problems he brought up during therapy were resolved; therefore, even if not all the items of the PQ reached a RCSI, the patient felt that what he desired to improve, did. Finally, the incongruences reported in the sceptic case could reflect a typical tendency of adolescents to change their mind about things they experience in order to create a congruent and stable self-image. As for the scores in the first item of the PQ, in session 13 the patient specified that "I'm not referring to teachers, but to people in general" (S13, L66-70).

2. Fluctuation in the PHQ-9 scores in the pre-treatment phase are inferior to the reliable change index, thus are not reliable and may reflect the error measure of the test. For the CORE items that were not filled in, Giovanni asked "some of these are stupid questions, for example 'I have achieved the things I wanted to'… what if I didn't plan any achievement? Because I didn't have a specific goal this week" (S12, L187-189) and the therapist answered that he could decide to answer if that event occurred, or leave it blank if he felt that the options for answering it did not mirror his feelings (S12, L202-203).

3. The creation of a friendly relationship is considered a necessity to engage adolescents in therapy, therefore, especially because he felt unheard between domestic walls, but listened to by the therapist, this helped Giovanni to express his desires and wishes. Furthermore, in his CI, the patient appeared able to describe the problems he did not solve during therapy, and about new emerging problems, like being unfriendly to people that bother him (CI, L290-291). Finally, after the end of therapy, the patient decided to continue his therapeutic journey with his therapist, discrediting the hypothesis of a compliant attitude with the therapist.

5. When Giovanni presented for therapy, his condition was worsening, which is mirrored in the intensity of the difficulties of the problems he marked in the PHQ-9, which rose from 'somewhat difficult' to 'very difficult', and to the slightly raising trendline of the GAD-7 and of the CORE in the pre-treatment phase. However, when school ended, his problems tied to teachers and exams ceased, but his self-esteem was still low, and his relational difficulties were also present. Therefore, finishing school has not been the event that triggered Giovanni's wellness, even because the duration of his problem tied to his low self-esteem lasted from '6 to 11 months' to 'from 6 to 10 years', which contradicts a 'reverse to normal baseline' hypothesis.

6. His improvements cannot be tied to the end of the academic year because the 8-month follow up took place exactly one year after session 9 (three weeks before the end of the academic year): in session 9 his scores represented a moderately severe depression (PHQ-9, 19), a moderate anxiety (GAD-7, 14), a moderate global distress (CORE, 18.8) and

moderately bothering problems (PQ, 4.2), whereas at 8-month follow up they showed a mild depression (PHQ-9, 6), a mild anxiety (GAD-7, 5), a 'low level' of global distress (CORE, 6.8) and his problems were 'very little' bothering (PQ, 2.6). If school's final exams made him feel so stressed, one year after he should have had a similar pattern; instead he maintained a higher self-esteem, which helped him cope with his daily life problems. Even when Giovanni received a diagnosis of dyscalculia, this did not improve his low self-esteem tied to his grades, because the resits he did in order to be promoted were not simplified for dyscalculic people. Giovanni reported to have studied hard throughout the summer: "I've already started taking private maths lessons, because I have the time, so why not use it?" (S15, L18-27).

7. The overall transcriptions of the sessions show that Giovanni expressed without censoring himself, furthermore in his CI Giovanni specified "after the first sessions I did not even remember about the recorder in the room, because you talk and you don't care about it" (CI, L570) and "during therapy I've said only what I truly felt" (CI, L242-246).

Sceptic Rebuttal

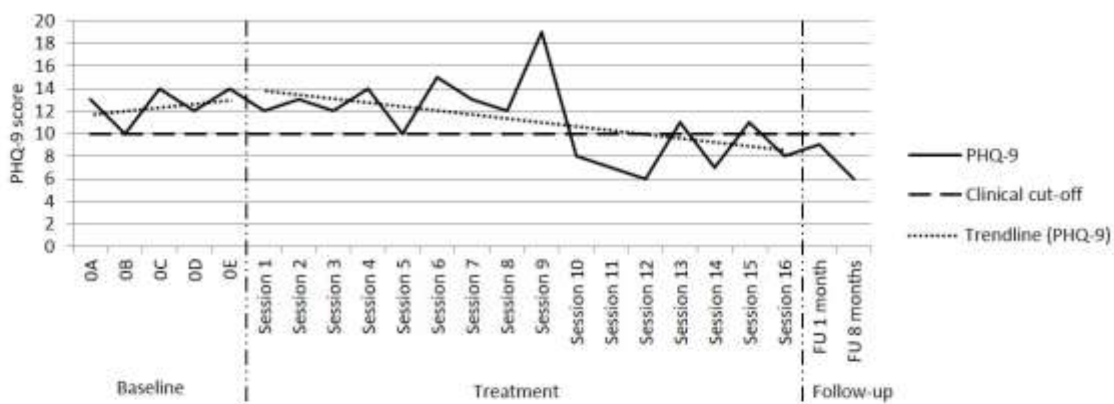
Even accepting the use of outcome measures not validated for adolescence, there still remain the difficulties in the use of questionnaires for adolescents. There are several indications that Giovanni found some difficulties, inconsistencies and confusion in completing the questionnaires. For example, during the CI, he forgot to score the last two items, and in session 16 the therapist pointed out that he missed filling in an item, asking him whether this was intentional or not, and he said he forgot about it. This shows an inattention to the questionnaires, so quantitative data is not only not valid, but it might also be unreliable. Finally, the end of the academic year, growing up and maturing, as he said, might have influenced Giovanni's attitude and self-esteem.

Affirmative Conclusion

Giovanni's depression, anxiety, personal and behavioural problems were related to difficulties in sustaining a self-nurturing internal dialogue, self-criticism and difficulty in solving problems. The therapist created a warm relationship where the client felt free to be open and experienced strong support for his low self-esteem. The focus on awareness of his internal dialogue, differentiation between internal dialogues from Critical and Nurturing Parent, loosening his script, helping him gain self-esteem and self-confidence, have been fundamental for Giovanni to create relationships with peers. The therapist gave the client permissions which contrasted with the constant injunctions he reported receiving, which led to a stable change in depressive and anxiety symptoms, especially worthlessness. These experiences were reflected in changes in depressive symptoms and depressive personality, internal dialogues, script beliefs about self and others, needs and feelings, behaviours, internal experiences, self-identity, and interpersonal relationships. The areas that have changed the most are self-esteem and relationships.

Sceptic conclusion

Giovanni's symptoms arose after a teacher yelled at him because he was not prepared for an exam, which made his anxiety rise and his self-esteem decrease. Some quantitative measures are not validated for adolescents and the tests also present several errors in their compilation. Several extra-therapeutic events may have had a prominent role in the reversal of symptomatology. The observed change could be due to a spontaneous remission.

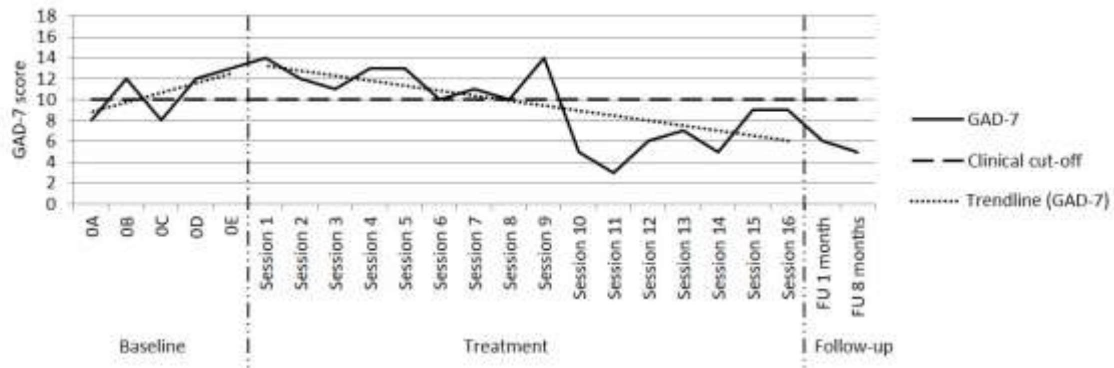


Note. 0A, 0B, 0C, 0D and 0E = assessment sessions. FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999).

Figure 1: Giovanni's weekly depressive (PHQ-9) score

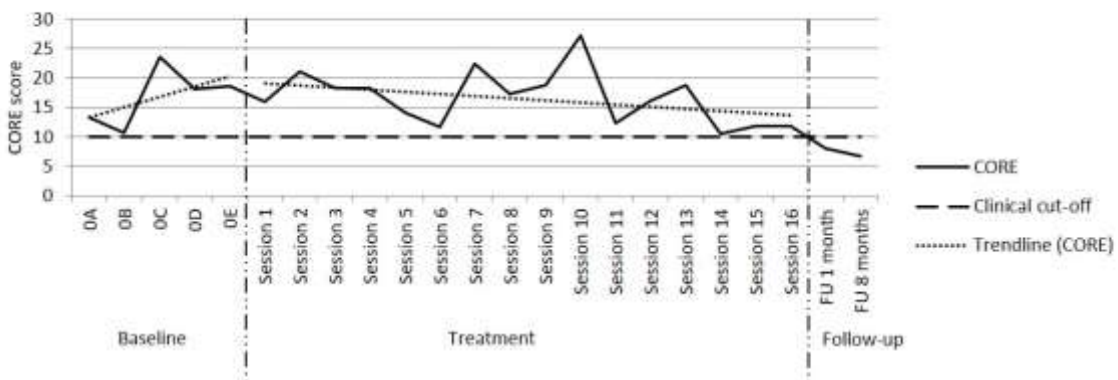
Figures 1 to 4 allow visual inspection of the time series of the weekly scores of primary (PHQ-9 and GAD-7) and secondary (CORE and PQ) outcome measures, with linear trendline.

Filling in the PHQ-9, at the question "If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?" in session 0A, 0B, 0C, 0D, 0E, 1, 2, 3, 4, 5 he rated those problems as 'somewhat difficult', in session 7, 8, 9 as 'very difficult' and in sessions 6, 10, 11, 12, 13, 14, 15, 16, FU1, FU2 as 'not difficult at all'.



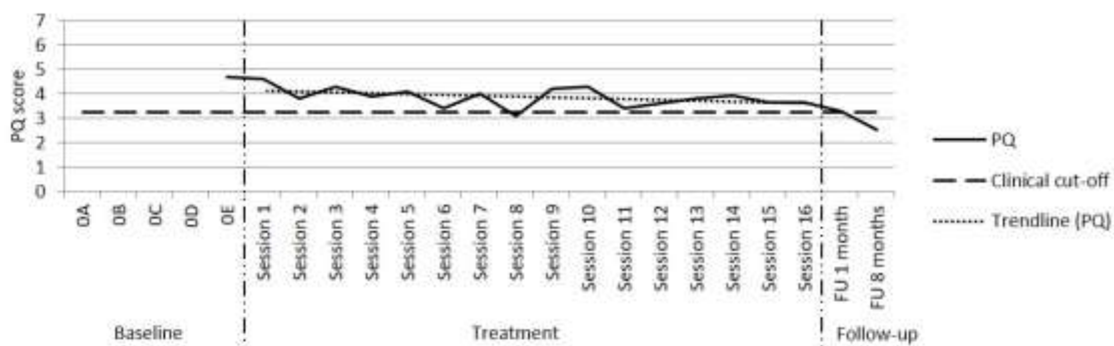
Note.0A, 0B, 0C, 0D and 0E = assessment sessions. FU = follow-up. GAD-7 = Generalised Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006).

Figure 2: Giovanni's weekly anxiety (GAD-7) score



Note. 0A, 0B, 0C, 0D and 0E = assessment sessions. FU = follow-up. CORE = Clinical Outcomes in Routine Evaluation (Evans et al., 2002).

Figure 3: Giovanni's weekly global distress (CORE) score



Note. The first available score was in session 0E. 0A, 0B, 0C, 0D and 0E = assessment sessions. FU = follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999

Figure 4: Giovanni's weekly personal problems (PQ) score

Session	Rating	Events	What made this event helpful/important
1	8 (greatly)	When we spoke about my passion for music and my desire to learn to play the guitar.	This event has been useful because I opened up to someone about this (I shared this passion).
2	7 (moderately	The fight with my classmate.	It's been like if I got over it, now it's not a problem anymore, it's not important.
3	9 (extremely)	It's been important to talk about my classmates who skipped class to ditch the oral exam.	The classmates I could trust left me alone with few people in class, making me risk an interrogation and feel that anger and sadness again.
4	9 (extremely)	The fear of falling asleep.	We looked for different strategies to fight my phobia of falling in a state of unconsciousness while I sleep.
5	8 (greatly)	When we spoke about a second girl I like.	The fact that I got to the conclusion that it's not wrong feeling interest for more girls.
6	9 (extremely)	The most useful event has been talking about my friend's younger brother and his behaviour.	It confirmed for me that I must keep making him feel like his own victims.
7	7 (moderately	Talking about the conversation with my dad.	Speaking or finding an excellent topic of conversation with my dad is difficult.
8	9 (extremely)	The privacy I don't have and that my parents don't give me.	-
9	9 (extremely)	Speaking about the two out of three exams in which I failed.	The fact that I felt more tranquil speaking about it with someone that listened to me instead of passing his anxiety on to me.
10	8 (greatly)	Talking about the classmate that doesn't respect others and that spent the whole academic year offending me.	I vented saying what I think about my classmate's behaviour.
11	8 (greatly)	When we spoke about my friend's younger brother's cyber-bulling against another friend of mine.	This kid dared to insult a friend of mine he didn't know, while we were playing online.
12	8 (greatly)	Speaking about the fact I want to have social interactions with peers.	When I'm home I frequently get bored, therefore I'd like to spend a part of my time with my peers.
13	9 (extremely)	Talking about my fear of being judged by people I don't know.	Going out with new people generates an embarrassing silence that could be interrupted with conversation. According to how you approach, you can be seen negatively.
14	8 (greatly)	Speaking of the constant problems that my friend's younger brother is creating in my videos.	This kid keeps spoiling my work when I'm editing a video.
15	9 (extremely)	Talking about planning to go out with peers.	I can't or I don't want to plan dates with my schoolmates or with my peers because I'm afraid that they won't consider me their friend and won't answer me.
16	8 (greatly)	Talking about the date I went to with peers I didn't know and the excellent consideration I had since the beginning.	I went out with people I didn't know and with some other friends of mine, and because they were friendly I bonded straight away, and I managed to spend a pleasant night.

Note. The rating is on a scale from 1 to 9: 1 = extremely hindering, 5 = neutral, 9 = extremely helpful. HAT = Helpful Aspect of Therapy (Llewelyn, 1988).

Table 4: Giovanni's helpful aspect of therapy (HAT forms)

	Change	How much expected change was (a)	How likely change would have been without therapy (b)	Importance of change (c)
1	I go out more often with my friends. I try to be more social	4 (somewhat surprised)	2 (somewhat unlikely)	4 (very)
2	I look at others with another perspective. I want to understand their intentions	2 (somewhat expected)	5 (very likely)	3 (moderately)
3	I try to think before I say something	5 (very much surprised)	2 (somewhat unlikely)	3 (moderately)
4	I'm more tranquil. Before I kept biting my fingernails and shaking my legs	2 (somewhat expected)	1 (very unlikely)	2 (slightly)
5	I don't take offence for the jokes on the bus anymore	3 (neither)	4 (somewhat likely)	3 (moderately)
6	I don't freeze any more	-	-	-
7	When I go to bed I'm not afraid to close my eyes any more	-	2 (somewhat unlikely)	-

Note. CI = Change Interview (Elliott et al., 2001).
[a]The rating is on a scale from 1 to 5; 1 = 'very much expected', 3 = 'neither', 5 = 'very much surprising'. [b]The rating is on a scale from 1 to 5; 1 = 'very unlikely', 3 = 'neither', 5 = 'very likely'. [c]The rating is on a scale from 1 to 5; 1 = 'not at all', 3 = 'moderately', 5 = 'extremely'.

Table 5: Giovanni's Changes identified in the Change Interview

Pragmatic case evaluation

The entire list of evidence reported for Bohart's grid is represented in Appendix 1.

In a preponderance of the evidence provided for specific changes with the first 39 considerations, there was clear evidence in 27 of the points. There was no evidence of these changes for 5 of the points, and 7 of the points were considered not applicable for this client. On balance, provided evidence shows that there has been a qualitative change in the client and that he reported clear and descriptive examples of the improvements in his life. Furthermore, in a preponderance of the evidence provided for the attribution of such changes to therapy with the last 17 considerations, there was clear evidence in 14 of the points. There was no evidence of these attributions in 2 points, and 1 was considered not applicable for this client.

To conclude, according to Bohart's grid, there is an 84% of certainty of change in the client and 88% of certainty that improvements were due to therapy.

Discussion

This case aimed to investigate the effectiveness of a manualised TA treatment for depression (Widdowson, 2016) in an adolescent client with moderate level of major depressive disorder in comorbidity with generalised anxiety disorder. Although the manual was originally designed for the treatment of depression in adulthood, this case demonstrates its utility and effectiveness both with adolescence and with comorbid anxiety. The primary outcome was improvement in depressive symptomatology, which showed a subthreshold level of depression from the tenth session till the end of therapy, maintained in the follow-ups; anxiety reached clinical significance in the tenth session, maintained until the 8-month follow up.

Secondary outcomes were improvements in global distress and personal problems: global distress reached reliable change in the fourteenth session, maintained throughout the follow-ups; personal problems show a little improvement thoughtout the entire therapy, reaching RCSI only in the 1-month follow up.

The therapist conducted the treatment with a good to excellent adherence to the manual. Hermeneutic analysis pointed out changes in stable problems, retrospectively attributed to the psychotherapy, highlighting connections between outcome and process. The treatment appears to be effective also for anxiety symptoms, suggesting that common mental health disorders such as depression and anxiety may share a common aetiopathogenetic mechanism. The therapeutic alliance appears to have been built on an active style, focused on personality traits associated to symptoms, transference and countertransference analysis. Specific TA techniques were: early sharing of the ego

state model, exploration of inner dialogue, developing of Nurturing Parent, exploration of drivers “Try Hard” and “Be Strong”, racket analysis of loneliness and sadness.

These conclusions provide a further support to the effectiveness of TA manualised treatment for depression for adolescents too, being the second evidence that TA was effective in the treatment of a male adolescent with comorbid depression and anxiety.

Furthermore, this case represents a variation of the hermeneutic analysis proposed by Elliott (2002, 2009). The adjudication procedure has been substituted with two qualitative measures: the Script System (O’Reilly-Knapp & Erskine, 2010) and Bohart’s grid for case evaluation. Using the structure of the Script System with script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories, allows to monitor these categories before, during and after treatment. In this way the Script System becomes a magnifying glass able to help the hermeneutic analyst select and classify the client’s sufferance, partially expressed in the items of the PQ, and then monitor how these aspects of depressive personalities change during therapy. If there are improvements in the Script System, this will probably be indicative of an efficacious therapy.

Limitations

The first author is a psychologist and is currently studying TA psychotherapy. Despite the reflective attitude adopted in this work, this may have influenced in subtle ways the hermeneutic analysis. Moreover, only one researcher was involved in the hermeneutic analysis, which might have had a potential impact on the briefs, rebuttals and conclusions. Furthermore, this new method to conduct a HSCED requires a training in the creation of the hermeneutic analysis, in the use of four quantitative measurements (in this case: PHQ-9 for depression, GAD-7 for anxiety, CORE for global distress and PQ for personal problems), in two qualitative measurements (CI, HAT), in the use of the Script System to conduct a structured analysis of the main changes in the course of therapy, and in the application of Bohart’s grids to support a more objective evaluation of the case. Although the simplified HSCED method reduces the quantity of resources and personnel for the analysis, the researcher must be well-formed. Even if the use of Bohart’s grid aims to support the final evaluation of the case, there is only one point of view, therefore validity problems could be consistent. Finally, quantitative measurements (PHQ-9, GAD-7, CORE and PQ) are not validated for adolescents.

Future Development

This variation the traditional HSCED method of Elliott (2002, 2009) has been proposed when a group for the hermeneutic analysis, or at least two judges for adjudication procedure, are not available, or when training a group of people becomes too time consuming. For future development we might suggest conducting the hermeneutic analysis by a person without or with little knowledge on the therapeutic model (i.e. TA), in order to decrease limitations regarding validity and allegiance. Furthermore, the use of the Script System is helpful both for the therapist and for the researcher to follow the therapeutic process and enlighten the deepest areas of sufferance of the client’s personality and monitor them during therapy. Therefore, if the therapist monitors the evolution of the Script System of the client, she/he will be more able to adjust the therapeutic work to specific personality problems. As for adolescent clients, future research could use quantitative measurements validated for adoles-cents.

Conclusion

This case study provides evidence that the specified manualised TA treatment for depression (Widdowson, 2016) has been effective in treating a major depressive disorder in an Italian adolescent client-therapist dyad, and provides evidence that hermeneutic analysis developed by a single researcher is possible with the use of the Script System (O’Reilly-Knapp & Erskine, 2010) for a deeper analysis and with Bohart’s grid for case evaluation. Despite results from a case study being difficult to generalise, this study add evidence to the growing body of research supporting the efficacy and effectiveness of TA psychotherapy for adolescents too, and notably supports the effectiveness of the manualised TA psychotherapy for depression as applied to major depressive disorder.

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APPENDIX 1

Evidence in Bohart's criterion list

Evidence that the Client Changed (item 1-39).

	Criterion	Source
1	Clients note themselves that they have changed	Changes reported in the CI
2	Client mentions things that make it clear that they either did something or experienced something different than what they normally do or experience in the course of their everyday lives	Changes reported in the CI
3	Clients are relatively specific about how they have changed	CI, 635-637; 650-654; 672-673; 676; 769-770
4	They provide supporting detail	CI, 64; 138; 194-196; 216-232; 461; 579-80; 609-616;
5	They show changes in behaviour in the therapy session plausibly related to the kinds of changes they should be making outside the session	CI, 579-580; 609-616
6	Plausible reports by the client that others have noted that the client has changed	CI, 216-232
7	Plausible indicators reported by the client: better grades, promotion at work, less use of medication, new activities such as jogging	CI, 138-143; 194-196; 609-616
8	They mentioned problems that didn't change	CI, 242; 322-328; 635-637; 644; 663; 682
9	They mention problems that did change	Changes reported in CI; 64; 138; 194-196; 216-232; 461; 579-80; 609-616; 635-637; 650-654; 672-673; 676; 769-770
10	The changes mentioned seem plausible given the degree of difficulty of the problem, degree of time in therapy	Changes reported in the CI
11	If there is a major change reported, it is described in rich enough detail to be plausible	CI, 609-616
12	If the client comes in depressed they show a reasonably consistent change in mood; more ups than downs as therapy goes on - i.e. they come to therapy less often depressed, seem less depressed, recover more quickly	CI, 672-673
13	If they report being anxious, they report either managing it better, or reductions in anxiety in key situations, and this shows a positive trend over therapy	CI, 194-207
14	If they report being unable to leave their house (agoraphobia) they report an example suggesting that they made a new and more concerted effort to go out and it met with at least some degree of success, and their affect about trying it is positive and hopeful (i.e. there is an increase in perceived possibility for them that they can do it)	S13, 122, S13, 221-233; S16, 13-20; CI, 138-143
15	If their problem is a habit problem (studying, overeating, drinking, smoking, etc.) they report concrete changes. With a habit problem ONE incident of change is not usually enough to say that a substantial change has occurred. We would want evidence that this one change was something new, or a new attempt after having been discouraged. But we would like it better if the person could report several successes; a pattern of success. But if a few fresh changes were made and the person seemed optimistic, that we could take as preliminary evidence of change.	Not applicable
16	If the problem is a demoralisation problem ("I can't"), or involves demoralisation, the person begins to show hope and optimism--a sense of possibility, a sense that it will be a challenge.	CI, 609-616

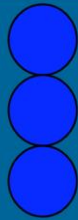
	Criterion	Source
	They become challenge oriented. If they fail they focus more on learning from the challenge than on what it means about them in terms of their inadequacy. In fact, they focus more on the difficulty of the task than on their inadequacies. In other words, when they fail they no longer see it as a complete sign of their inadequacy, or their failure. If they choose not to pursue it any further it is after a reasonable evaluation where they conclude reasonably that a shift in priorities is in order, or action plan.	
17	Evidence of new-found confidence in judgment.	CI, 154-161; 478-485; 489-498;
18	Evidence of greater competence in judgment - as the individual thinks out the problem he or she does it more proactively, considers alternatives, weighs them, uses good intuition. Does not seem driven by fear and jump to conclusions. They weight options aloud, think things out.	CI 154-161; 172-176
19	Evidence of greater proactive determination and persistence in relation to a reasonable goal.	Not applicable
20	If they make a risky choice, they seem to make it in a reasonable way.	Not applicable
21	Arriving at a major decision that the person was struggling with.	CI, 138-143
22	Coming up with a whole new plan which is innovative.	Not applicable
23	Getting a new perspective which brings greater coherence, reduces debilitating guilt, gives new positive behavioral options, helps the person let go of something from the past.	No
24	Gaining a new perspective where they seem to be acceptingly criticizing themselves, seeing their own limitations, but not in a defensive or overly critical way.	CI, 478-485
25	Gaining a perspective that "I am not my problem"	Not applicable
26	Identity work: clarifies fundamental goals and values. If no goals or values, begins to confront these issues. If has adopted goals and values from parents but is beginning to question them, begins to evaluate for self. If is in an "identity crisis," or moratorium, struggles with issues and makes progress in making commitments. Identity work can take place in any or all of the following areas: vocational goals, moral values, goals about relationships, goals about children, religious values, political values, values about what makes for a meaningful life, gender issues, sexuality, ethnicity and cultural background	No
27	Identity work: Real self-controversies--what is my real self, am I being untrue to my real self? Movement towards some kind of reconciliation or decision.	No
28	Traumatic experiences--signs of letting go of it, coming to terms with it, reductions in symptoms such as flashbacks or nightmares, or at least a greater sense that these can be handled and not so debilitating.	Not applicable
29	Achievement of specific goals--becoming more assertive, as evidence by self-report of concrete instances, perhaps seeming more assertive in the therapy session, rise in confidence.	CI, 609-616
30	Interpersonal changes--reported changes in a positive fashion in relationships--handling anger better, less dependence, greater problem solving, greater realistic acceptance of others (i.e., but NOT accepting certain things such as abuse), greater empathy as demonstrated towards others and towards the therapist (more careful listening, less confrontive). With therapist acts more proactively, dialogically, less dependent, less aggressive, less need for dominance.	CI, 138-143; 154-161; 172-174; 216-232; 461; 478-485; 489-498
31	Specific changes: finished a project, made attempts to protect daughter, exercising. Made a new friend. Got and kept a job.	CI, 461; 478-485
32	Greater realization that there may be some things that will take ongoing work.	No

	Criterion	Source
33	Changes in self-relationship. Greater realization and appreciation of accomplishments; more specific and concrete and accurate assessment of talents and effort; less global, negative self-attributions; greater self-empathy; greater self-listening to intuitions, felt experiencing; greater receptive internal dialogue; holding constructs more tentatively to evaluate them; more of an open, searching mentality; if overinflated self-esteem or self-confidence, taking a more careful look at how one might be doing, offending people, etc.	CI, 143; 154-161; 172-174; 478-485;
34	Reduction in any presenting symptoms, such as feeling weak, fearful, tiring quickly, feeling no interest in things, feeling stressed, blaming oneself, feeling suicidal, unfulfilling sex life, feeling lonely, frequent arguments, difficulty concentrating, feeling hopeless about the future, having disturbing thoughts come to mind, upset stomach, sweating, dizziness, heart pounding, trouble getting along with others, trouble sleeping, headaches.	CI, 194-207; 672-673
35	Increases in positive things: self-efficacy, enjoying spare time, feeling loved and wanted, greater happiness, greater sense of direction or optimism, greater acceptance of the injustices of life in a productive way.	CI, 769-770
36	Better ability to define goals in a proactive and functional way.	No
37	Prosocial changes--volunteering, involvement in productive activities, new projects.	S14, 9-10
38	Changes in physiology--less sweating, calmer and relaxed in therapy.	S10, 9-11; S11, 1-6
39	Changes in appearance in a positive fashion (if observed).	Not applicable

Evidence that it was therapy that helped (item 40-56).

	Criterion	Source
40	Clients themselves report that therapy helped.	CI, 33-36; 40-42; 64-66; 122-129; 408-416; 421-423; 433-443; 451-452; 512-529; 553-560; 562-563; 579-580; 609-616
41	Clients are relatively specific about how therapy helped, and it is described in a plausible way.	CI, 33-36; 40-42; 408-416; 421-423; 433-443; 451-452; 512-529; 553-560; 562-563; 579-580; 609-616
42	Outcomes are relatively specific and idiosyncratic to each client and vary from client to client (if comparing across clients).	Not applicable
43	In their reports, clients are discriminating about how much therapy helped, i.e. they do not in general give unabashedly positive testimonials.	CI, 242-246; 274-277; 290-291; 303; 322-328; 644; 663; 682
44	They describe plausible links to the therapy experience.	CI, 421-423; 433-443; 448; 504-529; 609-616
45	To the rater a plausible narrative case can be made linking therapy work to positive changes. This includes the following (#46-56):	HAT of all sessions and therapist's nots on sessions
46	Therapy provides a work space where clients have an opportunity to talk, think, express. The things the client talks about are the things that change, or if other things change, the client notes a relationship of them to the therapy experience. Client notes that this helped.	CI, 408-416; 421-423; 559-560; 553-560; 562-563

	Criterion	Source
47	Therapist's empathic understanding, warmth, acceptance, seems to relate to client's increased engagement, willingness to try new things, productive exploration.	CI, 408-416; 433-443; 553-560; 562-63
48	Therapist's encouragement, support, positive attitude seem to be related to client's overcoming demoralization, willingness to confront challenges, not be discouraged by failure. Therapist supports client productively when client fails. Keeps eye focused on productive behavior and this seems to relate to client's doing so also.	CI, 408-416; 421-423; 559-560; 553-560; 562-563
49	Therapist's warmth, empathic listening, seems to provide safe atmosphere for client to confront painful experiences, and these in turn change.	S2, 4-12; S7, 456-60; S9, 451-56; S10, 682-685; S16, 573-581; CI, 553-560
50	Therapist's in-tune questions, reflections, interpretations, or comments, seem to facilitate clients' exploration, gaining new perspectives, developing action plans, creativity. Client feels recognised.	CI, 408-416; 421-423; 559-560; 553-560; 562-563
51	Clients engage in concrete procedures in therapy and changes are congruent with what they are trying to achieve, and there is evidence of these changes. Examples: EMDR--clients work through a traumatic experience and then seem relieved afterwards, and at the next session; clients engage in chair work and either resolve an internal conflict, or come to terms with someone they have unresolved feelings towards; and this change persists or at least partially persists in subsequent sessions; clients challenge dysfunctional cognitions and show plausible changes in mood or behaviour.	CI, 138-143; 478-485; 609-616
52	Issues client struggles with in therapy change plausibly over time in accord with the trajectory of the client's working on them. E.g. client talks about them week after week, and has ups and downs, but gradually masters them, and the mastery seems related to their ongoing struggle with it in therapy. In other words, perhaps each week they talk about experiences related to resolving the problem, works on it, and gradually masters it.	CI, 138-143; 478-485; 609-616
53	Clients report changes in trajectory from their past life in the problem. Clients report something new in regard to coping with the problem, and relate it to therapy, or it seems related to therapy. Clients report a history of failed coping with the problem, and now it is changing. Even if client reports having tried some of these things before, now reports that therapy has helped have confidence in the effort and helps him or her persist.	CI, 33-36; 40-42; 64-66; 122-129; 408-416; 421-423; 433-443; 451-452; 512-529; 553-560; 562-563; 579-580; 609-616
54	There are no plausible life changes that could have assumed major responsibility for the change. Or, if there is a life change, it seems to be a result of therapist deliberative activity, or it gets incorporated into the therapy activity in a productive way	No
55	Topics not dealt with in therapy did not change, or, if they did change, there was a plausible reason why they changed from the therapy or from clearly independent reasons. In other words, they can be accounted for so that we can assume we are not talking about a global halo effect.	No
56	Clients' mastery experiences, problem actuation, and clarification and gaining of new perspectives that occurs in therapy are related to the changes.	Changes reported in the CI



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TA Treatment of Depression. A Simplified Hermeneutic Single-Case Efficacy Design Study - Margherita

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Abstract

This study is the seventh of a series of seven and belongs to the second Italian systematic replication of findings from previous series that investigated the effectiveness of a manualised transactional analysis treatment for depression through Hermeneutic Single-Case Efficacy Design. We address problems and difficulties that emerged in previous case series, such as: spending time in training a group of people to conduct the hermeneutic analysis, organising the involvement of external judges to give the final adjudication, and dealing with inconsistencies between quantitative and qualitative data. This study suggests a simplified method to conduct the hermeneutic analysis that require one person only, maintaining its validity. We integrated hermeneutic design with the pragmatic case evaluation methodology in order to follow pre-defined criteria in analysing qualitative material. Furthermore, we present a way to use the Script System to detect changes in depressive symptomatology and depressive personality. We tested this approach to HSCED in the case of 'Margherita', a 56-years old white Italian woman who attended 16 sessions of transactional analysis psychotherapy with a white Italian woman therapist with 5 years of clinical experience. The client satisfied DSM-5 criteria for moderately severe major depressive disorder with anxious distress, and SWAP 200 criteria for traits of depressive, dependent, avoidant and hostile personality types with a high level of functioning.

Key words

Systematic Case Study Research; Hermeneutic Single-Case Efficacy Design; Pragmatic Case Evaluation; Transactional Analysis Psychotherapy; Major Depressive Disorder; Anxious Distress; Depressive Personality Type; Dependent Personality Type.

Introduction

Recently, since the publication of the first Hermeneutic Single-Case Efficacy Design (HSCED) applied to transactional analysis (TA) treatment of depression (Widdowson, 2012a) there have been one direct replication of three single cases (Widdowson, 2012b, 2012c, 2013) and three Italian systematic replications of three single cases each (Benelli, Revello, Piccirillo, Mazzetti, Calvo, Palmieri, Sambin & Widdowson, 2016a; Benelli, Scottà, Barreca, Palmieri, Calvo, De Renoche, Colussi, Sambin, & Widdowson, 2016b; Benelli, Boschetti, Piccirillo, Quagliotti, Calvo, Palmieri, Sambin, & Widdowson, 2016c; Benelli, Moretti, Cavallero, Greco, Calvo, Mannarini, Palmieri & Widdowson, 2017a; Benelli, Filanti, Musso, Calvo, Mannarini, Palmieri & Widdowson, 2017b; Benelli, Bergamaschi, Capoferri, Morena, Calvo, Mannarini, Palmieri, Zanchetta & Widdowson, 2017c; Benelli, Procacci, Fornaro, Calvo, Mannarini, Palmieri & Zanchetta, 2018a; Benelli, Gentilesca, Boschetti, Piccirillo, Calvo, Mannarini, Palmieri & Zanchetta, 2018b; Benelli, Vulpiani, Cavallero, Calvo, Mannarini, Palmieri & Zanchetta, 2018c) aiming to recognise TA psychotherapy for depression as an Empirically Supported Treatment. Moreover, with the HSCED methodology Kerr (2013) evaluated TA treatment for emetophobia. However, even if HSCED has demonstrated to be an important and valid way to demonstrate the efficacy of TA, its application remained secluded in these three groups of research. A reason for this short-range application might be due to the onerous investment a hermeneutic design requires. We identified two main difficulties in conducting a HSCED: (a) involving a group of people and training them to conduct the hermeneutic analysis, which is time-consuming and probably possible only in an academic environment; and (b) including judges who have to read a substantial amount of qualitative data, interpret it, along with quantitative data, and who

must emit a verdict on the outcome of the case (good-, mixed-, or poor-outcome case), which is extremely demanding. Therefore, less expensive methods are necessary to evaluate the efficacy of a single-case in clinical practice.

In order to overcome these problems, in this simplified HSCED we decided to propose a variation of Elliott's (Elliott, 2002; Elliott, Partyka, Wagner, Alperin, Dobrenski, Messer, Watson and Castonguay, 2009) traditional method and of previous case series replications published in this journal. For problem (a) we suggest that the hermeneutic analysis can be conducted by one person only. However, leaving the analysis to a single person eliminates the multi perspective control, reducing internal validity. Therefore, to overcome this limitation, we decided to implement an additional method to analyse qualitative data in a more structured and systematic way, improving also internal validity: the 56 criteria of Bohart, hereinafter referred by us for ease of reference as 'Bohart's grid' (Bohart, Berry & Wicks, 2011; Bohart & Humphreys, 2000; Bohart, Tallman, Byock & Mackrill, 2011) for pragmatic case evaluation, already introduced in the case of 'Alastair' (Widdowson, 2014).

Bohart's grid allowed us also to solve problem (b). Involving judges to reach a final verdict on outcome was necessary to evaluate the efficacy of both treatment and hermeneutic analysis, which has been largely demonstrated with all previous case series in this journal. Therefore, for cases in which there are not substantial discordances between quantitative and qualitative data, the adjudication procedure can be left to the reader or to the researcher (Benelli, De Carlo, Biffi & McLeod, 2015), who can resort to Bohart grids for further matters.

Moreover, we identified another difficulty in some previous hermeneutic analyses: in fact, there have been cases (Benelli at al, 2016b, 2018a) in which hermeneutic teams have found difficulties in bringing evidence for both affirmative and sceptic briefs and rebuttals when significant incongruences emerged. Thanks to previous case series work, we have been able to pin-point these problematic aspects, and decided to shift the focus from evident changes in the client's behaviour to deeper and internal modifications. In an additional chapter in the Italian translation of *Transactional Analysis Treatment for Depression* (Widdowson, 2016), Benelli (2018) shows that it might be improbable for depression and depressive symptoms to exist outside of a structure of personality. Personality is a range of internal psychological processes (motivations, fantasies, peculiar patterns of thought and feeling, ways of experience of self and others, coping strategies, etc) which represents the individual in that circumstance (relationship, environment, culture, etc) (Lingiardi & McWilliams, 2018). Many clients are not aware of their personality disorder and are referred to the clinician by third parties, and others seek therapy for symptoms. However, even if dysfunctional aspects of personality are not clearly expressed as therapy goals, these are both directly and indirectly faced by the therapist and might inevitably undergo changes during therapeutic work. Therefore, it is sufficient for the researcher to keep in mind the client's pathological aspects of personality at the beginning of therapy and keep track of any modification in the course and at the end of therapy.

For these reasons, we decided to aim our attention also to pathological representations tied to depressive personalities using SWAP-200 (Westen & Shedler, 1999a, 1999b) taxonomy, which divides dysphoric (depressive) personality in five subtypes: avoidant, high functioning, dependent-victimised, emotionally dysregulated, and hostile-oppositional. A method to monitor deeper changes in depressive personalities is using the Racket System (Erskine & Zalcman, 1976), nowadays called Script System (O'Reilly-Knapp & Erskine, 2010), as suggested in Benelli's (2018) chapter.

The Script System is largely used in TA and its goals are listed in *Transactional Analysis: 100 Key Points and Techniques* (Widdowson, 2009).

The Script System helps both therapist and researcher to have a quick snapshot of the client's dynamics, identify script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories. The application of the analysis of the Script System in session transcriptions is innovative, because it allows focus not only on client's sufferance described in the Personal Questionnaire (PQ) (Elliott, Shapiro & Mack, 1999; Elliott, Wagner, Sales, Rodger, Alves & Cafè, 2016) but also monitors how different internal representations are established in the various phases of therapy. Moreover, using the Script System allows keeping track of possible incongruences between quantitative and qualitative data and resolve them by bringing evidence from the words of both client and therapist.

The general aim of this single case is to investigate the effectiveness of the manualised TA treatment of depression (Widdowson, 2016) with this simplified HSCED. Specifically, in this case we address the theme of focusing both on symptoms and personality disorders in diagnosis, treatment planning and treatment.

The present study is the seventh of a series of seven, and it analyses the treatment of 'Margherita', a 56-year-old Italian woman with a diagnosis of mild major

depressive disorder for more than ten years in comorbidity with anxious distress, worsening in the last month because she discovered that her husband could have cheated on her, and that she had no-one to talk to. The primary outcome is the depressive and anxious symptomatology and the secondary outcomes are global distress and severity of personal problems.

Ethical Considerations

The research protocol follows the requirements of the ethical code for Research in Psychotherapy of the Italian Association of Psychology, and the American Psychological Association guidelines on the rights and confidentiality of research participants. The research protocol has been approved by the Ethical Committee of the University of Padua. Before entering the treatment, clients received an information pack, including a detailed description of the research protocol, and they gave a signed informed consent and written permission to include segments of disguised transcripts of sessions or interviews within scientific articles or conference presentations. Clients were informed that they would have received therapy even if they decided not to participate in the research and that they were able to withdraw from the study at any point, without any negative impact on their therapy. All aspects of the case material were disguised, so that neither the client nor third parties are identifiable. All changes are made in such a way that does not lead the reader to draw false conclusions related to the described clinical phenomena. Finally, as a member checking procedure, the final article was presented to clients, who read the manuscript and confirmed that it was a true and accurate record of the therapy and gave their final written consent for its publication.

Method

Inclusion and exclusion criteria

Psychotherapists participating in this case series were invited to include in their studies the first new client with a disorder within the depressive spectrum as described in DSM-5 (Major, Persistent or Other Depressive Disorders) (American Psychiatric Association, 2013) who agreed to participate in the research. Other current psychotherapy, active psychosis, domestic violence, bipolar disorder, active current use of antidepressant medication, alcohol or drug abuse were all considered as exclusion criteria. As the overall aim of this project is to study the effectiveness of TA psychotherapy in routine clinical practice, comorbidity is normally accepted and both inclusion and exclusion criteria are evaluated on a case by case.

Client

Margherita is a 56-year-old white Italian woman who lives in a large metropolitan area in Italy. At the beginning of therapy she lives with her husband and their dog. Her husband has been in retirement for a few years. They have two children, one married a decade earlier and had children, whereas the second one left the family house a couple of years ago. Margherita is the first child of four daughters. When she was a little girl, her parents had a shop and while they both worked there, it was Margherita's duty to take care of her younger sisters. She feels she has never had a good relationship with her siblings: she refers to having always been called when they needed her help (dysphoric-high functioning depressive Script System, observable behaviours: take care of others), and never having the possibility to ask if she needed any help (dysphoric-high functioning depressive Script System, reinforcing experiences: ignore own needs). She feels betrayed by all of them: one flirted with her husband when they got married and still flirts with him nowadays; the other asked her for a big loan which she never paid back; and the last one, who suffered and suffers today from a very serious disease and tried to attempt suicide many times, mistreated her even when Margherita and their mother were the only ones to look after her (dysphoric-high functioning depressive Script System, observable behaviours: Saviour [Rescuer] and Victim). She has a very large family: all her sisters are married, with children and grandchildren too. She reports that the relationship her family members have between them is very good, but is not so with her, and she has the feeling they treat her like she is not doing enough for them (dysphoric-dependent victimised Script System, reinforcing experiences: abusive relationships). However, she explains she has never said "no" to anyone: when someone asks her something, she has always to do it, even if she does not want to, without complaining (dysphoric-dependent victimised Script System, observable behaviours: please others, be passive). Her mother is elderly and lives on her own with a dog, whereas the father of the client died many years before. At age 14, her parents did not allow her to go to high school, and made her work in their shop, whereas her siblings got the opportunity to study. Moreover, her parents arranged her engagement when she was underage and forced her to get married two years later, before turning eighteen (dysphoric-dependent victimised Script System, reinforcing experiences: no autonomy). Since she was "very young", Margherita worked on her own, in different shops and a coffee bar. At the beginning of therapy, she has been working in a shop for a "very long time", and feels that her boss always mistreats her, blaming her for everything (dysphoric with hostility externalization Script System, script beliefs about self: others take advantage of me). She has a depressed mood and is not able to express her feelings to sisters, mother, husband and boss, especially her anger, which she does not recognise (dysphoric with hostility externalization Script System,

repressed needs and feelings and reinforcing experiences: can't express anger, they taught me to keep my anger silent).

She starts therapy because she accidentally found out that a woman living in her neighbourhood was texting love messages to her husband. For this reason, she believed her husband was cheating on her, but he swore he did not even realise their neighbour was flirting with him, and never betrayed her. However, when she felt the urge to talk to someone about this situation, to ask for help or advice, she realised she had no one to talk to, because she knew she could not trust her sisters to keep the secret, and her only friend was facing a bad moment for the upcoming loss of a close relative, so she did not want to add to her problems. This friend went to therapy many years earlier, and for this reason, Margherita asked her if she recommended her ex-therapist to help her. After two sessions, the therapist proposed the client participate in the research and after a moment of embarrassment about recordings, she accepted.

She reported that when she found out about her sister's disease, she researched, reading not only scientific papers but also personal stories of similar experiences, and therefore expressed her willingness to share her story and help other people.

Therapist

The psychotherapist is a 42-year-old, white, Italian woman with 5 years of clinical experience and who has a certification as Certified Transactional Analyst (Psychotherapy) (CTA-P). For this case, she received monthly supervision by a Teaching & Supervising Transactional Analyst (Psychotherapy) (TSTA-P) with 15 years of experience.

Intake sessions

The client attended four pre-treatment sessions (0A, 0B, 0C, 0D), which were focused on explaining the research project, obtaining consensus, conducting a diagnostic evaluation according to DSM-5 criteria (American Psychiatric Association, 2013), developing a case formulation and a treatment plan, defining the problems she was seeking help for in therapy, as well as their duration and their severity (i.e., preparing the personal questionnaire, see later), and collecting a stable baseline of self-reported measure for primary (depression and anxiety) and secondary (global distress, personal problems) outcomes.

DSM 5 and SWAP-200 Diagnosis

During the diagnostic phase, Margherita was assessed as meeting DSM 5 diagnostic criteria of moderately severe major depressive disorder with mild anxious distress: she experienced depressed mood most of the day, nearly every day, for more than two weeks (criterion A1), decreased interest and pleasure in activities (A2), increase in appetite (A3), insomnia (A4), feelings of worthlessness (A7) and indecisiveness (A8). Margherita also met specifier for anxious distress, feeling keyed up (1) and that she might lose control of herself (5).

Knowing the level of an individual's personality functioning and personality traits, provides the therapist with fundamental information for treatment planning. According to the alternative model for personality disorder in DSM 5 Section III, a personality diagnosis was also conducted. This diagnosis allows for assessment of: 1) the level of impairment in personality functioning, and 2) personality traits. Margherita showed impairment ranging in the level of organization, and personality traits of identity, self-direction and intimacy, emotional lability, anxiousness, submissiveness, and depressivity.

Moreover, during the assessment phase, the therapist rated the computerised Shedler-Westen Assessment Procedure (SWAP-200) (Shedler, Westen & Lingiardi, 2014) that supported the diagnosis of high level of functioning, with traits of depressive, dependent, avoidant and hostile personality types.

Case formulation

TA Diagnosis

Case formulation was conducted according the TA diagnostic categories presented in the treatment manual. Margherita assumed a life position (Ernst, 1971; Berne 1972) of I'm Not OK, You're Not OK, that interacted with her stroke economy (Steiner, 1974), which was characterised by an absence of positive strokes and abundance of negative strokes. Furthermore, the underlying injunctions (Goulding & Goulding, 1976; McNeel, 2010): "Don't trust" (often I feel I am betrayed), "Don't be important" (I feel I must respond to everything), "Don't belong" (I feel as it no one likes me), "Don't be a child" (I'm always the caretaker, not the one cared for), "Don't want" (I give up easily and adapt to the desires of others), "Don't (be engaged with your life)" (whatever I do seems wrong), "Don't make it" (I feel a failure about my life), "Don't think" (I'm not very smart and feel inferior), and "Don't feel successful" (I always feel blamed) were also identified. This led to an internalisation of an under-functioning internal Nurturing Parent and an over-active internal Critical Parent, which activated intense self-critical internal dialogues (Kapur, 1987). In the drama triangle (Karpman, 1968) she assumes the role of Rescuer when taking care of everything and everyone, and Victim when her sibling did not show love to her and when she felt blamed for everything by her boss. Observable drivers (Kahler, 1975) of Be Strong, Try Hard and Please Others were also identified.

The Script System

In TA, the Script System (O'Reilly-Knapp & Erskine, 2010), previously called the Racket System (Erskine & Zalcman, 1979), allows to keep in mind all the associations of the client, like script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories. Margherita shows a dysphoric-depressive high functioning Script System (she takes cares of others for fear of being abandoned, she ignores her feelings), a dysphoric dependent victimised Script System (she stays in abusive relationships in which she pleases others and expresses anger in passive ways), and a dysphoric Script System with hostile externalization (she feels other mistreat and abuse her, she is not allowed to express anger which is manifested in passive ways). Moreover, the Script System involved all of the above-mentioned thoughts and behavioural manifestations, as well as repressed primary anger when she receives abuse or is not loved and considered by others, which was covered by secondary sadness, feelings of being unlovable. Finally, her script conclusions and decisions (Berne, 1961) were observable through script beliefs and contaminations (Berne, 1961; Stewart & Joines, 1987, 2012) such as: "I must take care of my sisters", "others are more important than me", "there is no time for me" and "I cannot get angry with others".

Treatment plan

Therapy followed the manualised protocol of Widdowson (2016). The treatment plan for Margherita's depression primarily focused on creating a therapeutic alliance, providing permissions (Crossman, 1966) congruent with the client's injunctions, namely: *trust*, *be important*, *belong*, *be a child*, *want*, *do*, *make it*, *think* and *feel successful*. Therapy was based on recognition and decontamination of script beliefs and emotion regulation, on changing internal dialogue from Critical to Nurturing Parent, on the creation of an I'm OK, You're OK relationship, and on problem solving strategies in daily situations with her sisters, her husband and her boss. The therapist offered Margherita empathic listening, supporting her to feel and express her emotions, needs and wishes.

Therapy process summary

Contract

Margherita asked to learn to find a balance for herself, to be able to express what she feels in her relationships, and to say "no" to others.

Sessions 1-8

In session 1 Margherita talks about being always compliant with her sisters and that this behaviour is not ok for her anymore, and when the therapist asks her "what do you want for yourself", Margherita realises she has subjugated her needs to those of others. In session 2 she explains how she has always been dependent on others' decisions and that her feelings were secondary. The therapist works on the importance of expressing emotions to stop feeling inferior. In session 3 the client is angry with herself because in her life she has always permitted others to take advantage of her. The therapist's aim has been to make Margherita realise that she does not have to be angry with herself, because this is what had been taught to her to do. In session 4 Margherita reports having been able to tell both her sister and her boss what she thought but having felt incompetent in doing it; therefore the therapist worked on the quality of anger expression. In session 5 client and therapist explore how Margherita's insomnia could be tied to the anger she feels against her sisters. Through an imaginative technique, she imagines what could happen if she spoke about her anger with her siblings. In session 6 Margherita speaks about her dependency from her family of origin (especially her mother) and how her mother's convalescence is reducing her time to spend with her husband, who she is not trusting. For this reason, the therapist suggests speaking with her husband to regain faith in him. In session 7 the client reports spending a lot of time house cleaning, and the therapist shows Margherita how she dedicates to things, moving her needs to the background, just like her husband does, and that they both ignore their couple needs. In session 8 Margherita refers to a family event in which her husband did not support her, so the therapist gives her permission to express herself in the couple, even if her feelings/wishes/needs are different from her husband's.

Sessions 9-16

In session 9 Margherita speaks about her lack of faith in her husband, so the therapist encourages her to find new ways to experience the relationship by doing things together. Furthermore, the client reports eating a lot of hazelnut cream when she is home alone and feeling angry when it happens. The therapist interprets it as an attempt to fill the emptiness and "sweetening the anger" of being alone. In session 10 Margherita talks about having enjoyed two daily trips she did with her husband, and how she feels reluctant to invest money for a new house. The therapist suggests this could be due to her need of finding place and time for herself, and not as a wish of ending their marriage. In session 11 the client reports feeling having changed since the beginning of therapy, and that her husband feels she is "terrorizing" him. The therapist explores this emotion and connects it with Margherita's lack of faith in her husband and encourages her to talk about it. In session 12 Margherita only reports improvements that happened from the beginning of therapy. In session 13 the client speaks about expressing anger

in an authoritarian way, so the therapist analyses the origin of this authoritarian expression, which could be arising from her anxiety and need to do things at her best. In session 14 Margherita reports that her anxiety is ancient, and the therapist helps her connect it with constant criticism by others due to her tendency of dispensing advice. In session 15 Margherita reports having re-established a balance with her husband, but she fears she has not been a good mother. The therapist works on this depreciation and underlines how this fear is not concrete, because she has proof of the contrary. In session 16 the therapist and the client make an evaluation of all progress Margherita has made and she attributes them to therapy.

Hermeneutic Analysis

Despite recent literature suggesting that hermeneutic analysis should be carried out by expert psychotherapists (Wall, Kwee, Hu & McDonald, 2016), in this case only one hermeneutic analyst was involved, a first-year TA psychotherapist student, who was taught the principles of hermeneutic analysis in a course on case study research at the University of Padua, by Professor John McLeod. Following the indications of Elliott et al. (2009), the researcher assumed both affirmative and sceptic positions, and created affirmative and sceptic briefs and rebuttals. The client's depressive personality was monitored from assessment phase throughout the entire therapy work and in the follow-up phase, to keep track of any change in the Script System. Furthermore, the hermeneutic analyst used Bohart's grid to enrich the evaluation of the case and solve slight incongruences between quantitative and qualitative data.

Measures

Statistical Analysis

All quantitative outcome measures were evaluated according to Reliable and Clinically Significant Change (RCSC) (Jacobson & Truax, 1991), where "change" stands for an improvement (RCSI) or for a deterioration (RCSD). Clinical significance (CS) is obtained when the observed score on an outcome measure drops under a cut-off score that discriminates clinical and non-clinical populations. For example, the PHQ-9 considers a score of ≥10 as an indicator of current moderate major depression (Kroenke, Spitzer & Williams, 2001). It is important to consider that even under the cut-off score there may be a subclinical disorder. For example, the PHQ-9 considers a score between 0 and 4 an indication of 'healthy' condition, and a score between 5 and 9 as an indicator of mild (subclinical) depression. Reliable Change Index (RCI) is a statistic that enables the determination of the magnitude of change score necessary to consider a statistically reliable change on an outcome measure (Jacobson and Truax, 1991). In particular, it is helpful in minimising Type I errors which occur when cases with no meaningful symptom change are assumed to have improved. For example, Richards and Borglin (2011) proposed that a reduction of at least 6 points in the PHQ-9 score would be indicative of a reliable improvement. Only when we observe the presence of both CS and RCI do we have a RCSC, which is considered a robust method for assessing recovery in psychological interventions (Evans, Margison & Barkham, 1998; Delgadillo, McMillan, Leach, Lucock, Gilbody & Wood, 2014). To control experiment-wise error which occurs when multiple significance tests are conducted on change measures, we consider that a RCSC is required in at least two out of three outcome measures, thus demonstrating a Global Reliable Change (GRC) (Elliott, 2015).

Quantitative Measures

Four standardised self-report outcome measures were selected to measure primary (depression and anxiety) and secondary outcomes (global distress and personal problems).

Patient Health Questionnaire 9-item for depression (PHQ-9) *(*Spitzer, Kroenke, Williams & Group, 1999) scores each of the nine DSM 5 criteria from 0 ('not at all') to 3 ('nearly every day'), providing a total score of depression. It has been validated for use in primary care (Cameron, Crawford, Lawton, et al, 2008). Scores up to 4 are considered 'healthy', scores of 5, 10, 15 and 20 are taken as the cut-off point for mild, moderate, moderately severe and severe depression, respectively. PHQ-9 score ≥10 has a sensitivity of 88% and a specificity of 88% for major depression (Kroenke, Spitzer, & Williams, 2001) and scores of <10 are considered subclinical. A change of at least 6 points on PHQ-9 score is considered to assess a reliable improvement or deterioration (RCI).

Generalised Anxiety Disorder 7-item for anxiety (*GAD-7) (*Spitzer, Kroenke, Williams, & Löwe, 2006), which scores each of the seven DSM 5 criteria as 0 ('not at all'), 1 ('several days'), 2 ('more than half the days'), and 3 ('nearly every day'), respectively, providing a total score for anxiety. Scores up to 4 are considered 'healthy', scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD and scores <10 are considered subclinical. It is moderately good at screening three other common anxiety disorders – panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%) (Kroenke, Spitzer, Williams, Monahan & Löwe, 2007). A change of at least 4 points on GAD-7 score is required in order to assess a reliable improvement or deterioration (RCI).

Clinical Outcome for Routine Evaluation – Outcome Measure for global distress (CORE-OM) (Evans, Connell, Barkham, Margison, Mellor-Clark, McGrath, & Audin, 2002). Each of the 34 items is scored on a 5-point scale ranging from 0 ('not at all') to 4 ('most of the time'). Scores up to 5 are considered 'healthy', scores between 5 and up to 9 are considered 'low level' (sub-clinical), and scores of 10, 15, 20 and 25 are taken as the cut-off point for mild, moderate, moderately severe and severe distress, respectively. The cut-off of 10 yields a sensitivity (true positive rate) of 87% and a specificity (true negative rate) of 88% for discriminating between members of the clinical and general populations. CORE OM was used in assessment sessions, in sessions 8, 16 and follow-ups, whereas CORE short form A and B were used in all other sessions (Barkham, Margison, Leach, Lucock, Mellor-Clark, Evans & McGrath, 2001). A change of at least 5 points on CORE-OM score is required in order to assess a reliable improvement or deterioration (RCI).

The *Personal Questionnaire* (PQ) (Elliott, Shapiro, & Mack, 1999; Elliott, Wagner, Sales, Rodgers, Alves & Café, 2016) is a client-generated measure in which clients specify the problems they would like to address in their therapy and rate their problems according to how distressing they are finding each problem from 1 ('not at all') to 7 ('maximum possible'). Scores up to 3.25 are considered subclinical. In this case series, missing the Italian normative score, for the PQ we adopted a more conservative RCI of two points, rather than the RCI of 1.67 recently proposed by Elliott et al. (2016). The PQ procedure suggests including problems from five areas: symptoms, mood/emotions, specific performance or activity (e.g., work), relationships, and self-esteem/internal experience.

Qualitative Measure

The client was interviewed using the *Change Interview protocol* (CI) (Elliott, Slatick & Urman, 2001) one month after the conclusion of the therapy. The CI is a semi-structured qualitative change measure which asks clients how they feel they have changed during the therapy and how they think these changes came about, what they felt was helpful or hindering in the therapy, and what changes they feel they still need to make. Clients are asked to identify key changes they made and to indicate on a five-point scale: 1) if they expected to change (1='very much expected'; 5='very much surprising'); 2) how likely these changes would have been without therapy (1='very unlikely'; 5='very likely'), and 3) how important they feel these changes to be (1='not at all'; 5='extremely').

The client also completed the *Helpful Aspects of Therapy form* (HAT) (Llewelyn, 1988) at the end of each session. The HAT allows the client to describe hindering or useful aspects of the session and to rate them on a nine-point scale (1='extremely hindering'; 9='extremely useful').

Furthermore, two qualitative measures have been implemented.

The representation of the *Script System* (O'Reilly-Knapp & Erskine, 2010) of the client has been created post hoc to: (a) detect areas of sufferance which might have not emerged as therapy goals or problems in the PQ and monitor any change in both depressive symptomatology and personality in the course of therapy, (b) focus on depressive personality aspects during the hermeneutic analysis, (c) monitor if changes in these areas are tied to therapeutic work, and (d) overcome incongruences between quantitative and qualitative data. To create a representation of the Script System the researcher makes a clinical evaluation of the most distressing problems presented by the client during sessions. The selection of the themes is based on: intensity of sufferance, recurrence of the theme, and pervasiveness within session and between sessions. The aspects the researcher is required to screen are similar to the areas of PQ (symptoms, mood/emotions, specific performance or activity, relationships, and self-esteem/internal experience) which have been rearranged according to the Script System structure (script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories). These themes have been selected in assessment sessions (Phase 1), and monitored during the first half of therapy (sessions 1-8, Phase 2), the second half of therapy (sessions 9-16, Phase 3), and in the Change Interview and follow-up period (Phase 4).

The *56 criteria of Bohart* (see Appendix 1) is a list of heuristics divided into three groups. The first 11 items bring evidence that the client has changed; items from 12 to 39 help enlighten specific changes; and the last 17 items (40-56) deal with evidence that it was therapy that helped the client change. These criteria have been transformed into structured grids by Widdowson (2014) for the case of 'Alastair', to indicate the source and the evidence for each item. Reported evidence supporting a criterion is taken from the words of the client from session transcriptions, which additionally helps with defining and describing quantitative data, and whether incongruent with qualitative data. For each of the 56 items, there are four possible evaluations: 'there is evidence', 'there is no evidence', 'there is some evidence' and 'not applicable', and for each group of items a 'plausible conclusion' is argued. It is possible to calculate a percentage of certainty of change (with 1-39 items) and a percentage of certainty of attribution to therapy (with 40-56 items). The proportion is calculated between the number of items 'with evidence' and the total number of items (39

including the first and second group, 17 for the third one). If there are not applicable criteria, these are not considered in the percentage calculation.

Therapist Notes

A structured session notes form (Widdowson, 2012a, Appendix 6, p. 50-52) was completed by the therapist at the end of each session. In this form, the therapist provides a brief description of the session in which they identified key aspects of the therapy process, the theories and interventions used, and an indication of how helpful the therapist felt the session was for the client.

Adherence

The therapist, the supervisor, and the main researcher were all Transactional Analysts and they each independently evaluated the therapist's adherence to TA treatment of depression using the "operationalised adherence checklist" proposed by Widdowson (2012a, Appendix 7, p. 53-55) and agreeing on a final consensus rating.

Pragmatic Case Evaluation

HSCED analysis was conducted according to Elliott (2002) and Elliott et al. (2009) as described in previous publications of prior series.

After the hermeneutic analysis, the 56 criteria of Bohart have been applied to support both affirmative case and conclusions. In fact, the first 39 items of the criterion list mirror HSCED first affirmative point (specific changes for long standing problems), whereas the last 17 items reflect the second affirmative point (retrospective attribution). However, if there is little or no prof for a positive outcome case, Bohart's grid indirectly supports both sceptic case and conclusions. Therefore, a preponderance of evidence is more indicative of a positive change attributed to therapy.

Moreover, the first 39 criteria correspond to the first two questions of the adjudication procedure (described in previous publications of prior series) ("how would you categorise this case" and "to what extent did the client change over the course of therapy"), whereas the last 17 items represent the third question of the adjudication procedure ("to what extent is this change due to therapy").

Results

In earlier published HSCED's the rich case records, along with hermeneutic analysis and judges' opinions, were often provided as online appendices (Benelli et al., 2015). Since all the material is in Italian, we adopted here the solution of providing a summary of the main points, as proposed in MacLeod, Elliott and Rodger (2012). The complete material (session transcriptions, CI, affirmative and sceptic briefs and rebuttal, evidence in Bohart's criterion list and comments) is available from the first author on request.

Adherence to the manualised treatment

The conclusion of the three evaluators was that the treatment had been conducted coherently according to TA theory at a good to excellent level of application.

Quantitative Data

PHQ-9 and GAD-7 were administered in the pre-treatment phase in order to obtain a four-point baseline, and during the three follow-ups, whereas CORE-OM was administered only from session 0D. PQ was generated during session 0B, therefore it has a three-point baseline.

Margherita's quantitative outcome data are presented in Table 1. The initial depressive score (PHQ-9, 15.5) indicated a moderately severe level of depression. The initial anxiety score (GAD-7, 11) indicated a moderate level of anxiety. The initial global distress score (CORE, 19.1) indicated a moderate level of global distress and functional impairment. The initial severity score of personal problems (PQ, 5.1) indicated that the client perceived her problems as bothering her more than 'considerably'.

At session 8, (mid-therapy), all scores obtained a clinically significant and reliable improvement (RCSI): depression and anxiety passed to a mild range (5), global distress passed to a 'low level' (8.8), and personal problems became 'little bothering' (3). By the end of the therapy, all scores maintained a RCSI: depression, (0), anxiety (0) and global distress (2.9) reached 'healthy' range, and her personal problems became 'very little bothering' (2).

At the 1-month follow-up: depressive scores remained in the 'healthy' range (1), anxiety remained unaltered (0), global distress level remained 'healthy' (0.9), and personal problems became 'not bothering at all' (1.8).

At the 3-month follow-up no significant change was present: depression (2), anxiety (1) and global distress (2.9) remained unchanged, whereas personal problems were considered 'very little' bothering (2.5).

At the 6-month follow-up all scores maintained RCSI: with a 'healthy' level in depression (1), anxiety (1) and global distress (2.1), and personal problems reached a 'not bothering at all' range (1.9).

Table 2 shows the 10 problems that the client identified in her PQ at the beginning of therapy and their duration. Two problems were rated as from 'maximum possible' to 'very considerably' bothering (6.5), four were rated from 'very considerably' to 'considerably' bothering (5.5), two were rated 'considerably' bothering, one was rated from 'moderately' to 'very little' bothering (3.5), and one was rated as 'very little' bothering. Three problems lasted from more than 10

	Pre-Therapy[a]	Session 8 Middle	Session 16 End	1-month FU	3 months FU	6 months FU
PHQ-9	**15.5 Moderately severe**	5 (+)(*) Mild	0 (+)(*) Healthy	1 (+)(*) Healthy	2 (+)(*) Healthy	1 (+)(*) Healthy
GAD-7	**11 Moderate**	5 (+)(*) Mild	0 (+)(*) Healthy	0 (+)(*) Healthy	1 (+)(*) Healthy	1 (+)(*) Healthy
CORE-OM	**19.1[b] Moderate**	8.8 (+)(*) Low level	2.9 (+)(*) Healthy	0.9 (+)(*) Healthy	2.9 (+)(*) Healthy	2.1 (+)(*) Healthy
PQ	**5.1[c] Considerably**	3 (+)(*) Little	2 (+)(*) Very little	1.8 (+)(*) Not at all	2.5 (+)(*) Very little	1.9 (+)(*) Not at all

Note. Values in **bold** are within the clinical range; + indicates clinically significant change (CS). * indicates reliable change (RC). FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999). GAD-7 = Generalised Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006). CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Measure (Evans et al., 2002). PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off points: PHQ-9 ≥10; GAD-7 ≥10; CORE-OM ≥10; PQ ≥3.25. Reliable Change Index values: PHQ-9 variation of six points, GAD-7 variation of four points, CORE-OM variation of five points, PQ variation of two points.

[a]Mean score of pre-treatment measurements.

[b]First available score in session 0D.

[c]First available score in session 0B.

Table 1: Margherita's Quantitative Outcome Measure

years, one lasting from 3 to 5 years, three lasting from 1 to 2 years, and three from 6 to 11 months. Eight out of ten problems showed a clinically significant and reliable improvement by the end of the therapy, maintained in the 1-month follow-up. In the 3-month follow-up, six problems had a RCSI, whereas in the 6-month follow-up eight problems out of ten reached a RCSI.

Problems are related to: symptoms (4 guilty, 5 mood swings, 9 insomnia), mood/emotions (3 difficulties in expressing, 6 control reactions, 8 emotional, 10 cry); and relationships (1 hurt people, 2 unable to say "no", 7 inadequate in relationships). The longer lasting problems were related to relationships.

Table 3 shows the seven aspects of the Script System: (1) script beliefs about self, others and quality of life, (2) needs and feelings, (3) observable behaviours, (4) reported internal experiences, (5) fantasies, and reinforcing experiences through (6) current events and (7) old emotional memories. These aspects have been observed by the hermeneutic analyst during the assessment sessions (Phase 1), variations of these have been monitored in both the first part (Phase 2) and second part of therapy (Phase 3), and their maintenance and stability in the follow-ups (Phase 4).

In Phase 1, Margherita's beliefs about herself were to be always available for others; beliefs about others was don't trust; needs and feelings, such as expressing and getting angry, were repressed; as observable behaviours she had always to please others; reported internal experiences consisted of feeling inadequate and ruminating; reinforcing experiences refer to please others and be neglected.

In Phase 2, beliefs about others moved from a general "don't trust anybody" to a more specific "I don't trust my sister"; she started to express needs and feelings such as resentment; as observable behaviour she stopped letting others exploit her; reported internal experiences changed allowing her to tell others when she is upset; she realised that reinforcing experiences of resentment was causing her insomnia.

In Phase 3, Margherita's beliefs about self were to worry about herself too; beliefs about her husband changed to trusting him again; she reported expressing needs and feelings, as rage and anger; as observable behaviours she spoke to her sisters and husband about her wishes and feelings; she reported internal experiences of adequacy and of long nights sleep without ruminations; reinforcing experiences of better relationships.

	PQ items	Duration	Pre-Therapy[a, b]	Session 8 (middle)	Session 16 (end)	1-month FU	3 months FU	6 months FU
1	I'm afraid I'll hurt people if I talk	>10 y	**3.5 Little**	2 Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	3 Little	2 Very little
2	I'm not able to say "no" to others	>10 y	**6.5 Very considerably**	4 (*) Moderately	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little
3	I've difficulties in expressing myself	3-5 y	**6.5 Very considerably**	4 (*) Moderately	3 (+)(*) Little	2 (+)(*) Very little	2 (+)(*) Very little	2 (+)(*) Very little
4	I feel guilty if I cause anger in other people	>10 y	**5.5 Considerably**	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
5	I've mood swings even for little things	6-11 m	**5.5 Considerably**	3 (+)(*) Little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
6	I control my reactions	1-2 y	**5.5 Considerably**	**4 Moderately**	**6 Very considerably**	**5 Considerably**	**6 Very considerably**	**6 Very considerably**
7	I feel inadequate in my relationships	1-2 y	**5 Considerably**	2 (+)(*) Very little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
8	I'm very emotional	6-11 m	**5 Considerably**	3 (+)(*) Little	2 (+)(*) Very little	2 (+)(*) Very little	**4 Moderately**	2 (+)(*) Very little
9	I suffer from insomnia	1-2 y	2 Very little	3 Little	2 Very little	2 Very little	**4 (*) Moderately**	1 (+)(*) Not at all
10	I easily cry	6-11 m	**5.5 Considerably**	3 (+)(*) Little	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all	1 (+)(*) Not at all
	Total		**50.5**	30	20	18	25	19
	Mean		**5.05 Considerably**	3 (+)(*) Little	2 (+)(*) Very little	1.8 (+)(*) Not at all	2.5 (+)(*) Very little	1.9 (+)(*) Not at all

Note. Values in **bold** are within clinical range. + = indicates clinically significant change (CS). * = indicates reliable change (RCI). m = months. y = year. FU = follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999). Clinical cut-off point: PQ ≥3.25. Reliable Change: PQ variation of two points. The rating is on a scale from 1 to 7 and indicate how much each problem has bothered the client: 1 = 'not at all'; 7 = 'maximum'.

[a]Mean score of pre-treatment measurements.
[b]The first available score was in session 0B.

Table 2: Margherita's personal problems (PQ), duration and scores

	Script System	Phase 1	Phase 2	Phase 3	Phase 4
1	**Script beliefs:** **- about self**	“I have to be available” (0A)	-	“Before I worried first about others, now there is me too” (S16)	-
	- about others	“I don’t trust my husband because he could have cheated on me” (0A)	“I still can’t trust him” (S6) “It’s not my husband I don’t trust, it’s my sister because she flirts with him, but he ignores her. I’m insecure” (S7)	“I trust him” (S16)	“I trust him, I feel more tranquil” (FU3)
	- about quality of life	-	-	-	-
2	**Needs and feelings**	“I get angry, but I remain quiet otherwise I will hurt others” (0A), “I have difficulties in expressing myself” (0B)	“I want to be free to express myself” (S1) “I feel resentment” (S5) “I have resentment, people must accept me” (S6)	“My anger towards him emerged” (S9) “I’m not afraid to express my feelings, even if I still have to learn how to do it best” (S11) “I manage to find the right words” (S13) “I don’t burst in rage, I control the way I express myself” (S16)	-
3	**Observable behaviours**	“I always please others, I never say no” (0A)	“I put some distance between us, I feel good” (S6) “If you hurt me, I hurt you; if you don’t help me, I don’t help you” (S7)	“Told sister we never had a healthy relationship” (S9) “I told them I’ve always felt put aside” (S9) “I told my husband he made me angry” (S10) “Asked to respect my needs” (S10) “I ask what I want too” (S11) “I talk when I want to” (S12)	“I count until ten before answering” (CI) “I feel considered, I say ‘no’ if I want” (FU1) “I learnt to say no” (FU3)

	Script System	Phase 1	Phase 2	Phase 3	Phase 4
4	**Reported internal experiences**	"I feel inadequate, inferior (with my boss and sisters) when I can't properly respond" (0A, 0B, 0D) "I can't sleep at night because I ruminate" (0B)	"I can't stay quiet anymore, everybody understands right away when I'm upset, but I don't want that others see my emotions, then I have to explain" (S5)	"I sleep all night long" (S9) "I don't feel inadequate" (S10) "I wouldn't want to wake up in the morning, I finally sleep" (S10) "I'm not their mother" (S11) "I don't even get angry, it slips through me" (S14) "It's really hot in these days, I have some difficulties, but not because I ruminate" (S15)	"I have some difficulties in falling asleep maybe because my sister tried to commit suicide, or because of my job" (FU2)
5	**Fantasies**	-	-	-	-
6	**Reinforcing experiences through current events**	The client refers of many episodes in which her siblings always contact her only when they need help (0C) and in which her husband repeatedly neglects her.	The client realised that her insomnia was due to the resentment she felt towards her sisters (S6) and thanks to this insight she successfully started sleeping all night long (S7)	The client reports a new feeling of strength, she feels able to have healthy relationships with both her sisters and her husband (S11), that she stopped running after her sisters (S11), that time with her husband improved qualitatively by enjoying each other's company (S15), and creating an equal relationship in which her needs have to be respected too (S15)	The client said to have found a balance with her sisters, to have stopped chasing them for their love (CI). She experienced a restored pleasure in her time with her husband (FU1), which she is able to maintain (FU3)
7	**Reinforcing experiences through old emotional memories**	The client explained she never had a sibling-relationship with her sisters, because her only duty since childhood has been to look after her sisters and help them whatever they needed (0D)	-	-	-

Note: Phase 1 = assessment sessions. Phase 2 = 1-8 sessions. Phase 3 = 9-16 sessions. Phase 4 = Change Interview and follow-up session. 0A, 0B, 0C and 0D = assessment sessions. CI = Change Interview. FU = follow-up

Table 3: How Margherita's Script System changed from Phase 1 to Phase 4

In Phase 4, her belief about her husband is that she still trusts him; in observable behaviour she explained she keeps the possibility to say "no" if she does not want to do something; her reported internal experiences focused on her sister's attempted suicide and on her job; reinforcing experiences of better relationships is maintained.

Margherita's script beliefs about self and others are representative of a dysphoric Script System with hostility externalization; both her repressed needs and feelings and observable behaviours are typical of dysphoric high functioning and dependent victimised Script System; her reinforcing experiences also reflect dysphoric high functioning and dependent victimised Script System.

Successively, these aspects have been compared with PQ items for any incongruence. Margherita's Script System of needs and emotions reflects item 1 (hurt people if I talk), 3 (difficulties in expressing) and 4 (guilt). Her observable behaviour of being unable to say "no" is mirrored in item 2 (not able to say "no"). Finally, her reported internal experiences of feeling inadequate is represented in item 7 (inadequate) and her difficulties in sleeping because of rumination in item 9 (insomnia).

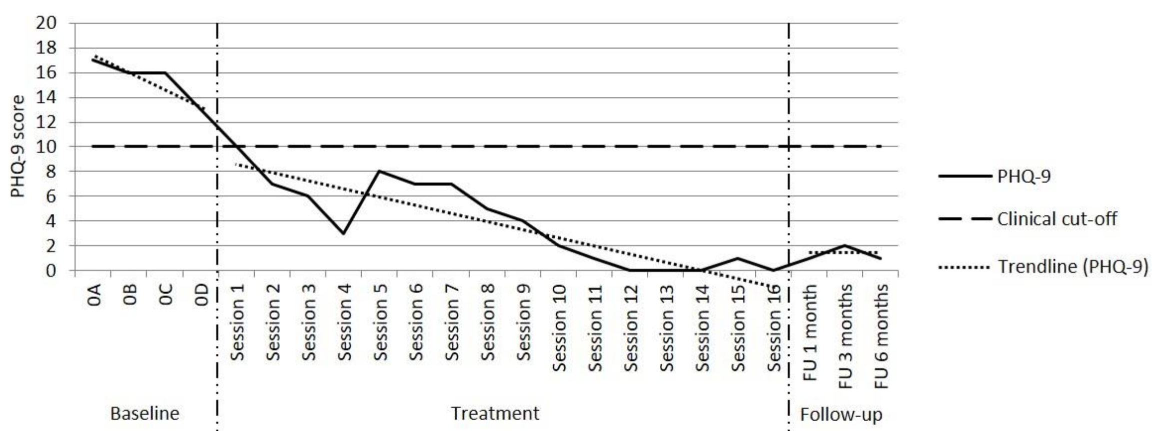
To conclude, there is evidence that there is an equal evolution of the Script System with scores in the PQ, except for item 9, regarding insomnia, which is rated from 'very little bothering' (3) to 'not bothering at all' (1) in all PQs, whereas in session transcripts of Phase 1 she reports being "unable to sleep" (0B) and in Phase 3 to "sleep all night long" (S9).

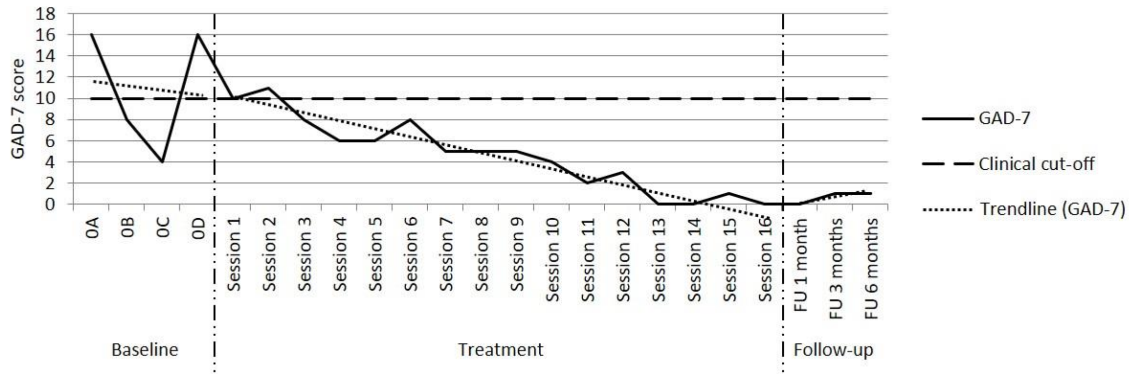
Figures 1 to 4 allow visual inspection of the time series of the weekly scores of primary (PHQ-9 and GAD-7) and secondary (CORE and PQ) outcome measures, with linear trendline.

Finally, Figure 5 and 6 represent Margherita's SWAP-200 scores at session 1, and Figures 7 and 8 scores at 6-month follow-up. Both PD-T and Q-T scores have been considered.

Note. 0A, 0B, 0C and 0D = assessment sessions. FU = follow-up. PHQ-9 = Patient Health Questionnaire 9-item for depression (Spitzer, Kroenke & Williams, 1999).

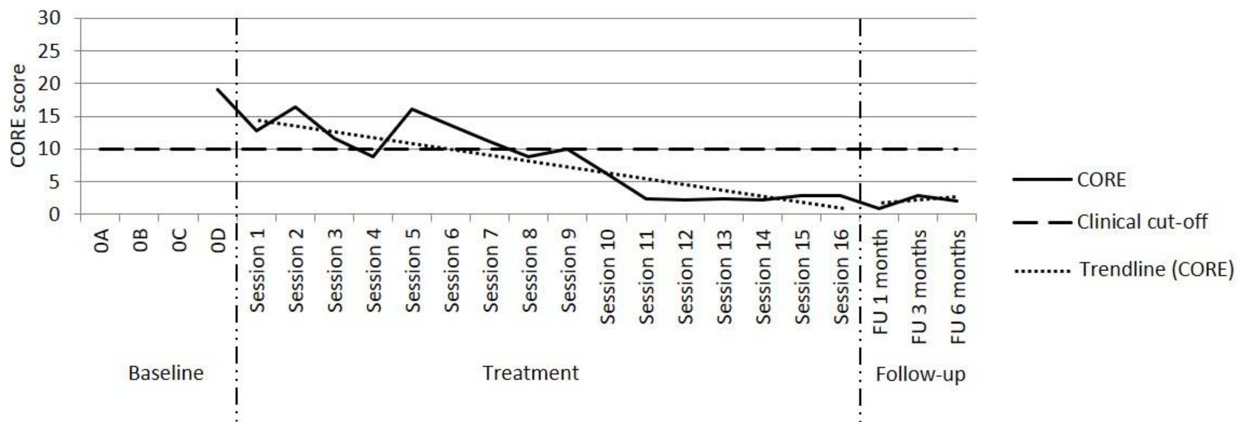
Figure 1: Margherita's weekly depressive (PHQ-9) score





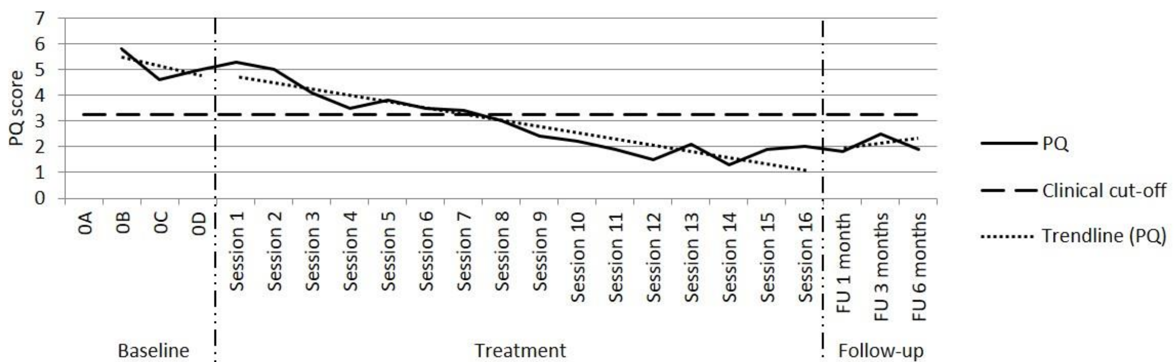
Note. *0A, 0B, 0C and 0D = assessment sessions. FU = follow-up. GAD-7 = Generalised Anxiety Disorder 7-item (Spitzer, Kroenke, Williams, & Löwe, 2006).*

Figure 2: Margherita's weekly anxiety (GAD-7) score



Note. The first available score was in assessment session 0D. 0A, 0B, 0C and 0D = assessment sessions. FU = follow-up. CORE = Clinical Outcomes in Routine Evaluation (Evans et al., 2002).

Figure 3: Margherita's weekly global distress (CORE) score



Note. The first available score was in assessment session 0B. 0A, 0B, 0C and 0D = assessment sessions. FU = follow-up. PQ = Personal Questionnaire (Elliott, Shapiro, & Mack, 1999).

Figure 4: Margherita's weekly personal problems (PQ) score

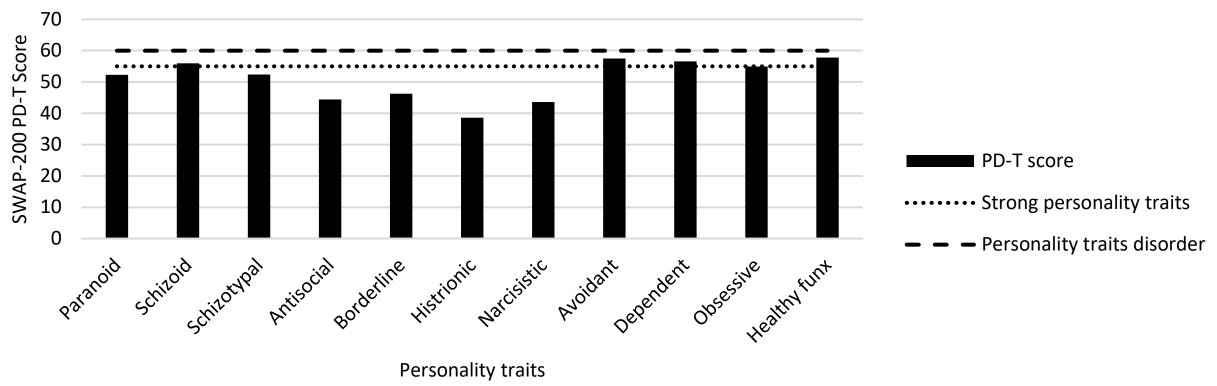


Figure 5: Margherita's SWAP-200 Session 1 PD-T score

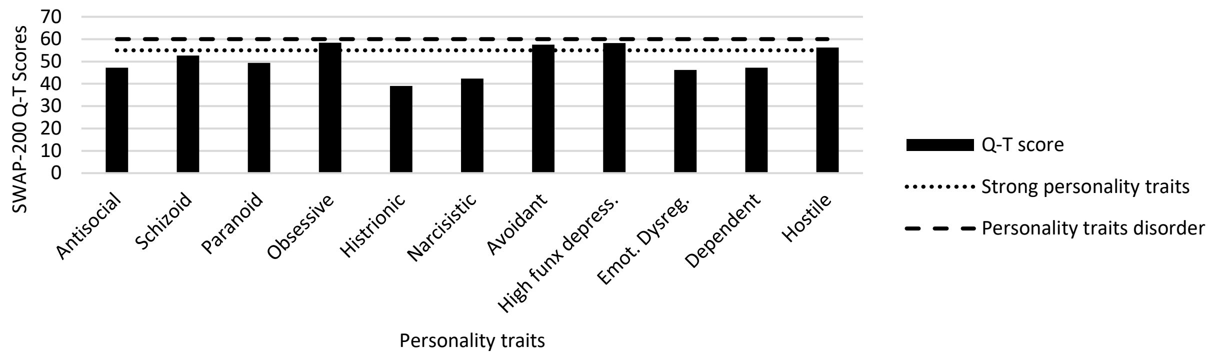


Figure 6: Margherita's SWAP-200 Session 1 Q-T score

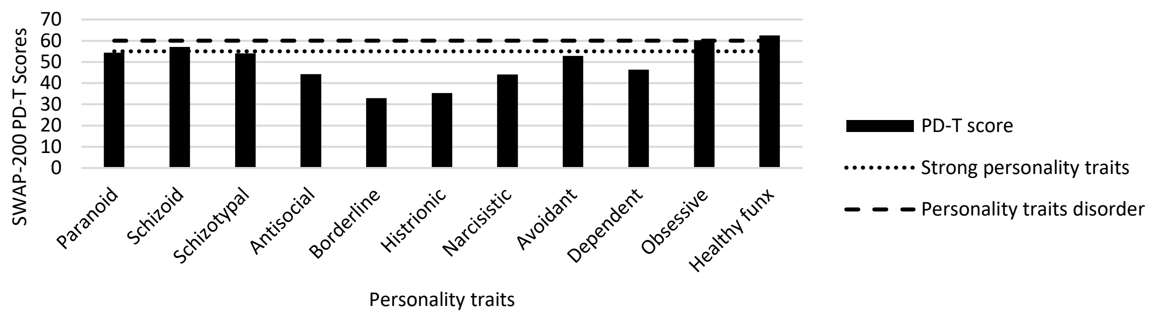


Figure 7: Margherita's SWAP-200 6-month follow-up PD-T score

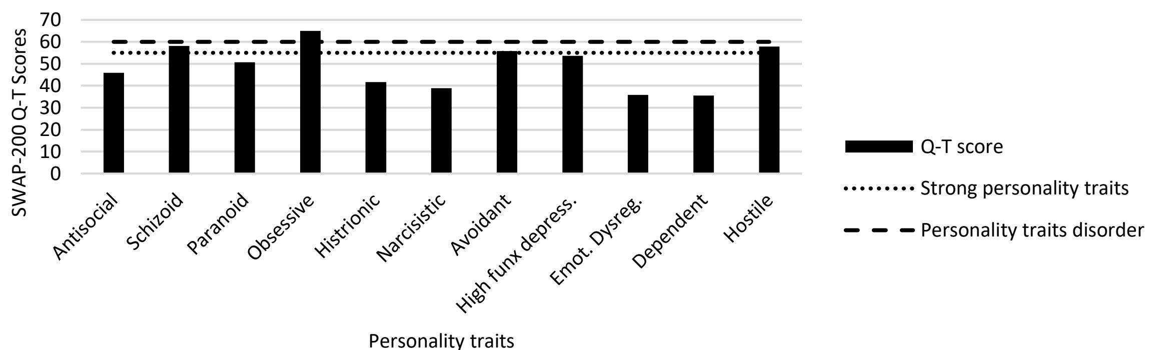


Figure 8: Margherita's SWAP-200 6-month follow-up 1 Q-T score

Session	Rating	Events
1	8 (greatly)	When I understood exactly why my distress began and I called into question my relationships with my relatives.
2	8 (greatly)	In this session, the therapist said that I should accept people like they are: I don't know why accepting my sisters for what they are is so difficult for me.
3	8 (greatly)	The most useful event has been when the therapist made me understand that it's me who decides what to say or do with "relatives".
4	8.5 (more than greatly)	In spite of my apparent calm, in this session the therapist made me notice the anger inside me towards my sisters.
5	7 (moderately)	The resentment and the anger which are latent in me are ready to explode, makes me live badly: this is what the therapist made me notice.
6	8 (greatly)	I don't know if it's useful or important, but the question of the therapist "Do you fear your sister?" is what made me reflect the most.
7	7.5 (more than moderately)	When the therapist said "there's always another choice" I was puzzled for its meaning, because I believe I've always done things "others" expected from me in all the different situations.
8	6.5 (more than slightly)	I participated in an event where all my family was present, and I felt isolated from them. The question is: do I isolate myself?
9	7 (moderately)	I and my husband should find a balance, now that we are a couple again… the therapist suggested.
10	7.5 (more than moderately)	We managed to find some time for ourselves…
11	7 (moderately)	We should talk to determine the right personal spaces…
12	8 (greatly)	I felt "lighter" after this session with the therapist…
13	8 (greatly)	"Are you an anxious person?" This is the question that made me reflect the most…
14	7.5 (more than moderately)	"Have you thought about the word 'sweetness'?" the therapist asked me…
15	8 (greatly)	I turned back to the starting point!!! It's true, it's not a euphemism…
16	8.5 (greatly)	Is faith 360-degree??

Note. The rating is on a scale from 1 to 9: 1 = extremely hindering, 5 = neutral, 9 = extremely helpful. HAT = Helpful Aspect of Therapy (Llewelyn, 1988).

Table 4: Margherita's helpful aspect of therapy (HAT forms) (Short version)

Qualitative Data

Margherita compiled the HAT form at the end of every session (Table 4, complete version in Appendix 2), reporting only positive/helpful events. All positive events were rated from 6.5 (more than slightly helpful) to 8.5 (more than greatly helpful). Margherita also reported other helpful events in session 1 ("I understood that my blood relatives involuntarily hurt me and that there are hidden wounds that I've never thought to exist"), and in session 4 ("The therapist suggested some advice on how to relate with my boss"). She reported aspects of symptoms (HAT 5 "can't sleep for my resentment and anger", 13 "am I anxious?"); mood/emotions (HAT 4 "the anger towards my sisters"; 10 "I listened to myself", 12 "work on the tone of my voice", 14 "sweetness"); relationships (HAT 1 "I've never had real relationships", 2 "accept people like they are", 3 "power to decide what to say to relatives", 6 "do I fear my sister?", 8 "do I isolate myself?", 9 "find balance now that we are a couple again", 11 "find a balance to trust him again", 15 "we are like newlyweds", 16 "faith is counting on someone when you need him"); and self-esteem and inner experience (HAT 7 "didn't know there is always another choice").

Margherita participated in a Change Interview 1-month after the conclusion of the therapy. In this interview, she identified seven changes since the beginning of therapy (Table 5), five were tied to self-esteem/inner experience (items 1, 3, 4, 6 and 7) and two were connected with relationships (items 2 and 5). She reported six changes to be 'very likely' (1) due to therapy. She was very much surprised (5) by being more present, saying what she thinks, being more herself, being aware that she exists too, and learning to give herself time. She rated the first two as 'very important' (4) and the others as 'extremely important' (5). Furthermore, she trusts herself more, rating it as 'somewhat surprised' (4) and 'extremely' important (5). Finally, she reported feeling lighter, which she is not sure if she expected or if she was surprised by it (3), however, 'somewhat unlikely' without therapy (2), but 'very' important (4).

	Change	How much expected change was [(a)]	How likely change would have been without therapy [(b)]	Importance of change [(c)]
1	I'm more present	5 (very much surprised)	1 (very unlikely)	4 (very)
2	I say what I think	5 (very much surprised)	1 (very unlikely)	4 (very)
3	I'm more myself	5 (very much surprised)	1 (very unlikely)	5 (extremely)
4	I trust myself	4 (somewhat surprised)	1 (very unlikely)	5 (extremely)
5	I exist too	5 (very much surprised)	1 (very unlikely)	5 (extremely)
6	I feel lighter	3 (neither)	2 (somewhat unlikely)	4 (very)
7	I learnt to give myself time	5 (very much surprised)	1 (very unlikely)	5 (extremely)

Note. CI = Change Interview (Elliott et al., 2001).

[a]The rating is on a scale from 1 to 5; 1 = 'very much expected', 3 = 'neither', 5 = 'very much surprising'.

[b]The rating is on a scale from 1 to 5; 1 = 'very unlikely', 3 = 'neither', 5 = 'very likely'.

[c]The rating is on a scale from 1 to 5; 1 = 'not at all', 3 = 'moderately', 5 = 'extremely'

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Table 5: Margherita's Changes identified in the Change Interview

HSCED Analysis

Affirmative Case

Four lines of evidence were identified supporting the claim that Margherita 1) changed and 2) therapy had a causal role in this change.

1. Change in stable problems

Quantitative data (Table 1) shows that there is an improvement in primary outcome measure (depression, PHQ-9) with a stable and solid clinically significant and reliable improvement (RCSI) with constant improvement from session 7, maintained throughout the entire therapy, and in the follow-ups; anxiety (GAD-7) reached a constant RCSI in session 9, maintained for the rest of the therapy and in the follow-up period. There is also a constant RCSI for global distress (CORE) from session 10, maintained until the 6-month follow-up.

In the PQ (Table 2), Margherita identified 10 main problems at the beginning of the therapy that she was trying to solve, two rated as bothering her almost "maximum possible" (6.5), four more than "considerably" (5.5), two "considerably" (5), one as more than "little" bothering (3.5) and one as "very little" bothering (2). Three problems lasted from more than 10 years and obtained a clinically significant and reliable change in the course of therapy, and two maintained the RCSI until the 6-month follow-up, showing an improvement in long standing problems. All the problems referred to issues with symptoms, mood/emotions and relationships. At session 8, Margherita's PQ reached a RCSI, maintained until the end of therapy and in the follow-ups. At the end of the therapy eight problems out of ten dropped under the clinical cut off reaching RCSI. At the 6-month follow-up seven problems maintained RCSI, and one remained under the clinical cut off, whereas no change was quantitatively present in item 6 ("I control my reactions") and 9 ("I suffer from insomnia"). Overall, there is support for a claim of global reliable change (reliable change in at least three out of four measures) for long standing problems.

Qualitative data supports this conclusion. Regarding Margherita's depressive symptoms she said: "I'm not falling back to depression, I don't cry anymore, I try to find the problem and solve it" (CI, Line 587-588), "the most important thing that happened is that when I came here the first times I was always crying, if I think how I felt and how I feel today, strong, happy, I regained my way of being, I smile, I laugh also with my customers, I'm never sad, I started to be what I thought I would have never been again" (CI, L591-600). As for her insomnia (item 9 of the PQ), since the first assessment session she rated an extremely low score, and specified "I'm suffering from insomnia, but I got used to it" (0B, L430-431) specifying she slept only four hours per night (S3, L532) and that when "I wake up, I stay in bed, my head starts running through my problems, and I'm unable to fall back asleep" (L533). During session 5 she connected her difficulty in falling asleep to feelings of resentment and latent anger towards her sisters, and from this realisation her insomnia stopped (S5, L4-6, L55-57). Therefore, with the support of the Script System (Table 3), we assume that there is a reliable and clinically significant improvement also for item 9 of the PQ.

About Margherita's mood/emotions, in session 11 she explained: "I feel good, I can't even recognise myself, life was dark, I was angry, sad, like in a black and white movie, and I don't like black and white movies. Now I'm a colour film, and I love life in colours" (S11, L373-380), and to "have finally regained the pleasure in doing things I like" (L268-276). She reported that "if someone gets angry, I want her/him to know my thoughts and feelings about it too" (S12, L282-291), and in her CI she added "feel freer to express myself, instead before I kept everything inside" (CI, L126-131). Moreover, regarding item 6 of the PQ ("I control my reactions"), Margherita reported that such a high score was associated with a new control of her emotions, and not as something bothering (S13, L2-28). Therefore, elevated ratings since session 13 represent an improvement: "Before I always yelled without realising, now I'm able to control my emotions (S16, L288-294). For this reason, this PQ item should be considered as a reliable and clinically significant improvement.

As for Margherita's problems with relationships, she explained "don't feel inadequate in relationships anymore, I'm not afraid to express myself" (S11, L148-151), "I learnt to say no" (FU3, L88) and "if something I don't like happens, I say it out loud" (FU3, L158-164). Regarding Margherita's relationship with her siblings she stated that she became aware that she had the power to decide what to do and say to her siblings, (S4, L4-9; S9, L134-138; S14, L317-320; S14, L328-355; S16, L167-179; S16, L190-204). With her husband she reported to have found faith in him (FU3, L284-285), to have finally managed to talk to him about things she desired (S10, L1-10; S12, L437-444) and that she found a different way to be with her husband (S15, L322-329; FU1, L6-13). Moreover, Margherita said that also the relationship with her mother improved (S16, L161-166). Thus, we claim that Margherita obtained a stable RCSI in Major Depressive Disorder, in anxiety, in global distress and in personal problems, claiming a Global Reliable Change.

2. Retrospective attribution

In her Change Interview, Margherita reported seven changes, which she believed were from somewhat unlikely due to therapy to very unlikely without therapy. She considered these changes from 'very important' to

‘extremely important’ and she was from ‘neither surprised nor expected’ to ‘very much surprised’ by them (Table 5). Margherita was very much surprised by “feeling more present”, “saying what I think”, “being more myself”, gaining the awareness that “I exist too”, and “learning to give myself time”, changes that very unlikely would have occurred without therapy, rating the first two as ‘very important’ for her, and the others as ‘extremely important’ for her. She also believed that another change is very likely due to therapy, which is “trusting myself”, being somewhat surprised by it, and an ‘extremely important’ change for her. Finally, she rated “feeling lighter” as a change that would have somewhat unlikely happened without therapy, feeling neither surprised nor expected about such a change, however rating it as ‘very important’ for her.

Furthermore, in her CI, Margherita also looked back at her PQ: regarding her symptoms she explained that “now I say things without feeling guilty, before therapy I never had the courage to do so” (CI, L783-789, 793) (item 4), and about her mood swings (item 5) she said: “I was becoming unpleasant, now I don’t keep things inside” (L802-805). About mood/emotion area, item 3 was about expressing herself, and she stated that “during therapy I realised that I was having difficulties in expressing myself because I had a big mess in my head” (L751-752). Furthermore, about items 8 and 10, she said “I’m sensitive only when I’m watching a touching movie, before I cried for nothing” (L826-832).

Finally, regarding her relationships, in particular item 1, she said “first I never talked, I feared to offend and to be offended, I thought people would get angry with me… but now it’s not like this” (L712-727). About item 2, she reported that thanks to the therapist she learnt to say no if she did not want to do something (CI, L735-741). Moreover, item 7 was about her feeling inadequate with others, and she stated she felt at the same level (L812-814). Margherita also added that “when my friend told me ‘go to a psychotherapist, he/she will help you’, I didn’t believe her, but sometimes you really need it” (L907-909). “Therapy helped me understand that if I need help I’ll not wait until the point of no return to go back and start again” (L911-912). When in the CI Margherita was asked for some evidence or examples of therapy usefulness, she reported “therapy has been useful because the therapist led me to reflect on things I did and said… I realised I was evolving every session” (CI, L8-17), “in fact, my husband always says: ‘when you come back from sessions, you change!’” (S16, L640). Finally, “the therapist helped me understand what was making me suffer” (CI, L548).

3. Association between outcome and process (outcome to process mapping)

The HAT completed at the end of each session provides us with regular and immediate reports of what Margherita found helpful in each session. All reported events are considered from ‘more than slightly’ to more than ‘greatly’ useful and are coherent with both the diagnosis and the interventions reported in the therapist's notes. One of the client's most important changes, reported in the CI and in the follow-ups, refers to being able to express and make herself valuable when with others (like sisters or husband), which improved her self-image. Margherita reported useful intervention and insight associated with the expression of her emotions in relationships, which was her therapeutic contract. In HAT forms (Table 4) 1 (“never had real relationships”), 3 (“accept people”), 4 (“anger”) 8 (“do I isolate myself?”), 9 (“find a balance”), 10 (“time for us”), 11 (“trust”), 12 (“the tone of my voice”), 15 (“like newlyweds”) and 16 (“faith”), Margherita explained the importance to have worked on healthy ways to relate with her siblings and with her husband.

In particular, in sessions’ HAT forms 1, 3, 4, 8 and 12, she reported aspects about her emotions related to her relationship with her sisters, whereas in HAT forms of sessions 9, 10, 11, 14 (“sweetness”), 15 and 16 were about her emotions and her husband. In those sessions, the therapist worked on the permission of free expression, analysed the possible consequences that her reactions could bring, and gave Margherita different point of views to examine her emotions in specific contexts. In the CI, Margherita said that she gained the awareness that she exists too and learnt to say what she thinks, thanks to the therapeutic work on relationships. The therapist used decontamination to help the client understand that past situations are not likely to happen again in the present if she acts differently, and that if she expresses her needs others will listen to her. Moreover, on session 10, Margherita reported having insisted with her husband to go on a daytrip to the seaside, and to have had a pleasant holiday with him even if he did not agree at first (S10, L1-10). When the therapist asked how she managed to win over all her husband’s objections (S10, L07-325), Margherita referred to the interventions of the therapist in the previous session (“If we need or want something, we can’t take it for granted, we have to express it if we want a direct and clear answer”, S9, L809-814), “it’s important how you are in the relationship, S9, L824): “it’s not fair he says ‘no’, there is me too, I have needs… I managed to open a new kind of dialogue with him” (S10, L341-379). In fact, in session 0C the therapist said: “let’s make some exercise here, because life is made of simple things, and if we don’t listen to simple things we want, then irritation comes out… ‘hey, there is me too here! Look up!’… so what do you want now?... ‘I want…?’” (0C, L412-432). In session 12, the client stated that she managed to find her own spaces inside the house and outside, and that she helped her husband find his own

spaces too (S12, L437-444), which is tied to previous therapist's interventions on her need to have her own personal space where she can do things she needs and want (S10, L466-468). During session 13, Margherita said that she learnt to control her actions and reactions thanks to the work she did in therapy (S13, L2-28): in fact, the therapist examined the origin of her anger, both toward her siblings and her husband and how to use it in a constructive way (S5, L353-377).

4. Event-shift sequences (process to outcome mapping)

The PQ mean score shows a progressive decrease in severity of her problems from the initial score (5.05, more than 'considerably') to the final score (1.9, 'not at all' bothering). Initially the therapist worked on the expression of Margherita's needs with her sisters: in HAT form (Table 4) of session 2, she wrote about the affirmation of the therapist "you have to accept people for what they are" and in session 6 she realised that "I can't change them, I have to accept them, and they have to accept me"; in session 3 she gained the awareness that she had the power to decide how to act with her sisters which she never thought possible, repeating it at the beginning of the next session (S4, L4-9). In session 4 they spoke about her anger and resentment, and in the following session she reported "I thought about what we said last week, and it's true, I feel resentment towards my sisters, and when I realised it, that night I slept all night without waking up" (S5, L4-6), "so insomnia could be due to anger" (S5, L55-57).

Furthermore, when the therapist told Margherita that there is not only one way to do things, but there are many (S7, L439-440), the client started to act differently according to her script, and in session 8 said she did not approach her ill sister as she would have done (and did) in the past, accepting her choice of getting distance from her (S8, L47). In session 9 she explained that she spoke with another sister about all her problems with her siblings, that she never had a sister-relationship with them but more a mother-relationship, that she feels being isolated from them, and found out that unlike what she believed, this discussion led to a positive and constructive share of opinions with her sister (S9, L94-138). Moreover, in session 9 the therapist worked on the expression of anger (S9, L232-240), and in the following sessions Margherita said that she does not feel the anger anymore, "I think before replying… I'm trying to give myself the time I need to think before speaking" (S11, L64-74).

From session 9, the therapist started working on Margherita's relational problems with her husband, suggesting finding new ways to spend time together, because they are a couple again (both children left the house) (S9, L490-566), and the following week Margherita said that she spent a lovely weekend with her husband at the seaside like they had not done in years (S10, L1-23): "I always remember your [therapist's] words 'you have to talk'" (S10, L179-182), "it works, I speak now!" (S10, L198).

Still in session 9, Margherita reported having started eating many sweet things after dinner, when her husband was going out to take the dog for a walk (S9, L574-588): the therapist hypothesised that her urge to fill her stomach with sweet things was probably due to her feeling of emptiness in the couple (S9, L597-601), and from the following week she started filling that emptiness with quality time spent with her husband. Finally, in the last session, when the therapist asked Margherita if she regained faith in her husband, and she answered "not completely", the therapist added "trust 360-degree is an ideal, faith is when the other person is there for us when we need him… knowing what he's doing outside home is control, not faith" (S16, L363-430). Margherita then realised that she never thought how that was the meaning of faith, and therefore corrected herself "then I do trust him" (S16, L435-436), "thinking about faith in these terms makes me feel good, because it's true" (S16, L460-464).

Sceptic Case

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

The client entered therapy with moderately severe depression (PHQ-9, score 15.5), which was already decreasing in the pre-therapy phase. In session 0A, while filling in the PHQ-9, Margherita pointed out "these problems are not bothering me at all because no one around me noticed them, I managed to hide them very well" (0A, L194-196). PHQ-9 shows a clinically significant improvement already in the first session of therapy and a RCSI in session 2; GAD-7 show a clinically significant improvement in session 3 with a RCSI in session 7; CORE gained reliable change in session 6 and a RCSI in session 8; and PQ obtained a RCSI in session 8. Furthermore, her SWAP scores tied to her schizoid traits increased (from 52.68 to 58.21), as did her obsessive traits (from 58.38 to 65.06) (Figures 5, 6, 7, 8).

Regarding Margherita's depressive symptomatology, in session 9 she reported having started eating sweet things (hazelnut, ice-cream) when her husband left her alone during the evenings, indicating a rise of a depressive symptom tied to her unsatisfying relationship with her husband (S9, L612). Also, insomnia is still present at the end of therapy: in sessions 11 and 15 Margherita reported having difficulties in sleeping all night long (S11, L487-488; S15, L865). About her mood/emotions area, in session 5, Margherita reported that her husband called her "mean" (S5, L22-23). Moreover, in the 3-month follow-

up the client reported feeling sad without any apparent reason (FU2, L3-4). Instead, regarding Margherita's relational problems, in the last sessions and in the follow-ups she explained having still different problematics with her sisters, especially with the sick one, with her husband, and in her job too, in particular with her boss and a younger and slacker attendant. Moreover, in the last session, Margherita said she was unable to trust her husband completely (S16, L363), a sign that their relationship did not improve as she pointed out, and in follow-ups she added that she was still feeling a bit neglected by him (FU2, L527-529), that the quality in their time spent together decreased (FU3, L112-120), and that she did not completely regain faith in him (FU2, L775-783, FU3, L284-285). Finally, also at work, things got uncomfortable, due to a new young slacker attendant, which made her angry, making Margherita stress out and eat every half hour, until she decided to do his duties instead of explaining to him how to do his job (FU3, L241-245). This led Margherita to fall back in the previous mechanism she adopted with her siblings and husband, i.e. to keep silence until she burst out.

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

All quantitative data baselines showed a decrease already in the assessment phase, gaining a RCSI already in session 2 in her depression scores (PHQ-9), and a clinically significant change in session 3 in anxiety scores (GAD-7), which could lead to the conclusion that change would have happened anyway, even without therapy. Furthermore, the baseline of her global distress (CORE) is missing. Finally, there is evidence that Margherita's scores are unreliable due to her paying little attention in filling in the forms; the therapist asked her in session 14: "I saw that in this test [CORE SHORT FORM A] you scored 'I've felt ok about myself', 'not at all'…", "no, no, I made a mistake, it's 'often'" (S14, L309-312).

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

Already in session 0B Margherita reported "feel better" (0B, L3) and that "talking to you [therapist] is different, it's like talking to a confidant, I have no difficulties in expressing myself with you" (0B, L444-449). In the CI she repeated different times that she felt the therapist was like a friend (CI, L94, L464, L632-634). Furthermore, Margherita's dependency traits and her tendency to be compliant and never say "no" might reflect a precocious decrease in all scores.

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

Margherita attended two sessions before being introduced to the research and agreeing to participate, and in session 0A (which was her third session), she stated that "since I've started to come here I've learnt to look inside me, reflect, think", which was what her friend told her about therapy, when suggesting her to start a therapeutic path. In fact, this friend of hers had been a client of Margherita's therapist too, and she knew her friend found therapy extremely useful to deal with her loss (therapist's notes). Therefore, personal expectancy artefacts might have influenced Margherita in feeling better already at the beginning of therapy. Furthermore, in session 12, she was speaking about her sick sister, who is following both medical and psychological treatments, and pointed out that "I read about psychological help and I found that psychotherapists are better than psychologists, my sister goes to a psychologist and the doctor said that she will never improve" (S12, L193-200), and in the CI she said "you therapists are so tranquil, you instil tranquillity, you are so calm" (CI, L632-634). For this reason, Margherita's scores might also be deformed by cultural and expectancy artefacts, and also by her readings.

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

Margherita sought therapy because she found out that her husband could have cheated on her, and in her second session (the last one before agreeing to participate in the research) she told the therapist that she had spoken with her husband about her fears, and that since that moment he became sweeter, he felt terribly sorry for not realizing that this woman was flirting with him, and stopped seeing her before therapy actually started (therapist's notes), making her feel "more reassured" (S3, L437-450). Therefore, Margherita might have improved without therapy.

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

In session 4 Margherita said that seeing her sisters and talking to them was one of the causes of her distress and she declared that she had stopped relating directly with them (S4, L3-4), which is mirrored in a decrease in all scores. As previously reported, Margherita explained that her depression decreased since she spoke to her husband about her fear of him cheating on her, and from that moment "he stopped seeing her and I feel reassured" (S3, L437-450). Moreover, between sessions 11 and 12, they gave

away their dog, therefore her husband did not have the opportunity to have his evening walks and stayed at home with his wife, making Margherita feel more reassured and less neglected. Therefore, talking about her fears and feeling to her husband might have been sufficient even without therapy.

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

For the sceptic case there was no evidence within the rich case record that would support a claim that Margherita's changes were associated with psychobiological processes.

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

For the sceptic case there was no evidence within the rich case record that would support a claim that Margherita's changes were associated with reactive effects of being in research.

Affirmative Rebuttal

1. For the affirmative case, all four measures support a claim in favour of Global Reliable Change. Margherita's SWAP scores on personality traits of high functioning depressive (Q-T score: from 58.25 to 53.65), emotional dysregulation (Q-T score: from 46.18 to 35.83) and dependency (PD-T score: from 56.54 to 46.35; Q-T score: from 47.16 to 35.58) dropped significantly under the clinical cut off, whereas healthy functioning level rose (PD-T score: from 57.84 to 62.50) (Figure 5, 6, 7, 8). Even if the sceptic case indicates that Margherita did not improve, quantitative scores' decrease is mirrored in qualitative data, in particular in the Script System. Furthermore, the client was very perceptive and has been able to obtain help since she first met the therapist.

Regarding Margherita's symptoms, since she and her husband went on their first trip together, their relationship started improving and that emptiness she felt started getting filled up. In fact, from session 11 in the PHQ-9 Margherita did not report feeling hungry for sweet things until the end of therapy. Furthermore, her depression did not decrease when she spoke to her husband about her fears, because first she had to learn to say "I" in their relationship, which she started expressing only from session 8. Therefore Margherita's depression decreased only when she started giving importance to herself and to her needs (between session 9 and 10). About the insomnia, she started to have difficulties in sleeping all night long "because of the weather, it's so hot" (SS11, L487-488; S15, L865), therefore insomnia is due to external factors.

Regarding Margherita's mood/emotions, when her husband said she was mean, she asked him why and he answered that he did not mean it (S14, L632-634). About her unexplained feeling of sadness in the 3-month follow-up, she said she had not realised until that moment that her feelings were due to her sister's last attempt of suicide the week earlier (FU2, L98-106). According to Margherita's words, her difficulties in relating with her siblings are now only tied to her sick sister, whereas with the one she had the worst relationship, it improved (FU1, L122).

2. A decrease in all her scores in the pre-treatment phase is firstly inferior to the reliable change index, thus is not reliable and may reflect the error measure of the test; second, the decreasing trend might be due to her strong intuition and openness to the therapist. Margherita has never been listened by anyone in her entire life, therefore finding receptive ears might have made her feel immediately positive about her therapeutic process. Furthermore, she attended two sessions before starting the pre-therapy phase, so an early improvement might also be reflected in having started therapy before filling in the questionnaires.

3. In her CI, Margherita reported "talking to the therapist is not like talking to a friend who is always on your side and doesn't give you advice, whereas the therapist listens to you and gives you those right tips you need" (CI, L640-643). Therefore, Margherita might not have improved without therapy. Second, unlike with others, the client was able to say "no" to any observation the therapist made that did not reflect her belief. Finally, her dependent trait decreased to subclinical levels (PD-T score: from 56.54 to 46.35; Q-T score: from 47.16 to 35.58) at the end of therapy, therefore her trend is not due to a compliance effect.

4. "Initially, when my friend told me to go to therapy I thought 'No, I don't need a therapist'" (CI, L907-909), so there were no personal expectancy artefacts. Furthermore, when she reported believing that psychotherapists are better than psychologists, the therapist explained that her sister's "doctor" must have been a psychotherapist too, therefore her cultural artefacts must have vanished (S12, L217).

5. Even if her husband stopped seeing that woman, Margherita would have not changed without therapy because her husband kept going out for a two-hours-walk every day with their dog (S9, L807-808; S10, L168-169). Only the therapist gave her the permission to tell her husband she was not happy about that situation (S9, 809-814). In fact, in session 10 she stated that she told her husband she did not like staying at home alone in the evenings (S10, L168-169).

6. Even if her husband stopped seeing the woman that sex-texted him, he kept going about with the dog during the evenings, and when they gave their dog away, he started taking out his mother-in-law's dog in the afternoons.

Sceptic Rebuttal

The sceptic case includes that Margherita's quantitative changes are not due to therapy but to a reverse to normal baseline due to a temporary state of distress, due to finding out that her husband was receiving sex-texts from another woman. Margherita's therapy contract consisted in learning to express herself, and in the follow-ups she reported that she was still keeping herself from answering to her sisters, which is a form of not expressing herself. Moreover, in the 3-month follow-up, the client reported having felt anxious and looking forward to her next session so she could ask the therapist how she could behave with her son who said she is not a present grandmother, unlike her husband, and what she should do about feeling neglected by her husband (FU2, L532-538). Finally, even if the relationship with her husband improved during therapy, in the 6-month follow-up Margherita reported to have lost quality in their time spent together, leading to a not stable change after the end of therapy.

Affirmative Conclusion

Margherita's depression, anxiety, global distress and personal problems were related to difficulties in mood/emotions and relationships, and interpersonal patterns, such as being unable to understand and address her anger and use it in a constructive way, feeling always sad, sensitive and tearful, being unable to stand up for her rights, needs and wishes (going on a daytrip holiday), being unable to say "no" to anyone's request, and feeling inferior to others (sisters and boss). She had structural problems since childhood and emotional dysregulation. Since the beginning of therapy, the therapist created a positive climate where the client felt free to express and feel her emotions and talk about her problems in her relationships, explored the possibility to appreciate herself and her emotions, learning to recognise them and apply them in relationships in a constructive way. Relational difficulties were present especially in her relationship with her siblings, behaving like a mother with them; with her husband, who she did not trust anymore; and with her oppressive boss.

The therapist taught her how to behave in a safer mode with her siblings, her husband and her boss. Margherita also had strong feelings of guilt when she thought of things on her own, and the therapist helped her get in contact with her needs and wishes and to express them. This step allowed Margherita's depression to decrease, and improved her relationship with her sisters and husband too. These experiences were reflected in changes in depressive symptoms and depressive personality, internal dialogues, script beliefs about self and others, needs and feelings, behaviours, internal experiences, self-identity, and interpersonal relationships. The areas that have changed for the most are mood/emotions and relationships.

Sceptic conclusion

Margherita asked for therapy with moderately severe depression, which reached a reliable and subclinical symptomatology already in session 2 after having spoken with her husband about the non-replied sex-texts he was receiving from another woman, which might suggest a reverse to a normal baseline of a temporary state of distress, therefore improvements might not be attributed to therapy. Changes in depressive symptoms might represent a self-correction due to extra-therapeutic factors, like when her husband stopped seeing that woman, and when they gave their dog away. Furthermore, Margherita's changes in relationships are not stable after the end of therapy; in fact, her relationship with her husband started losing quality, and she started to ignore her emotions and not expressing them in company of her siblings.

Pragmatic case evaluation

The entire list of evidence reported for the 56 criteria of Bohart is represented in Appendix 1.

In a preponderance of the evidence provided for specific changes with the first 39 considerations, there was clear evidence in 29 of the points. There was no evidence of these changes for 7 of the points, and 3 of the points were considered not applicable for this client. On balance, the evidence provided shows that: there has been a qualitative change in the client and that she reported clear and descriptive examples of the improvements in her life. Furthermore, in a preponderance of the evidence provided for the attribution of such changes to therapy with the last 17 considerations, there was clear evidence in 13 of the points. There was no evidence of these attributions in 1 point, and 3 were considered not applicable for this client.

To conclude, according to Bohart's grid, there is an 81% of certainty of change in the client and 93% of certainty that improvements were due to therapy.

Discussion

This case aimed to investigate the effectiveness of a manualised TA treatment for depression (Widdowson, 2016) in a client with moderately severe level of major depressive disorder with anxiety disorder. Although the manual was originally designed for the treatment of depression, this case demonstrates its utility and effectiveness where there is comorbid anxiety. The primary outcome was improvement in depressive and

anxious symptomatology, which showed a constant reliable clinically significant improvement (RCSI) from the seventh session till the end of therapy, maintained in the follow-ups; anxiety reached reliable and clinical significance in the ninth session, maintained until the 6-month follow-up.

Secondary outcomes were improvements in global distress and severity of personal problems: global distress reached reliable and clinical significance in the tenth session, maintained in the course of therapy and throughout the follow-ups; finally, also personal problems reached a stable reliable and clinically significant improvement from the eighth session, maintained throughout the entire therapy, until the 6-months follow-up.

The therapist conducted the treatment with a good to excellent adherence to the manual. Hermeneutic analysis pointed out changes in stable problems, retrospectively attributed to the psychotherapy, highlighting connections between outcome and process. The treatment appears to be effective also for anxiety symptoms, suggesting that common mental health disorders such as depression and anxiety may share a common aetiopathogenetic mechanism. The therapeutic alliance appears to have been built on an active style, focused on personality traits associated to symptoms, transference and countertransference analysis. Specific TA techniques were: early sharing of the ego state model, exploration of inner dialog, developing of Nurturing Parent, exploration of drivers Be Strong, Try Hard and Please Others, racket analysis of guilt and sadness.

Furthermore, this case represents a variation of the traditional hermeneutic analysis proposed by Elliott (2002; Elliott et al, 2009). The adjudication procedure has been substituted with two qualitative measures: the Script System (O'Reilly-Knapp & Erskine, 2010) and the 56 criteria of Bohart (Bohart et al, 2011) for case evaluation. Using the structure of the Script System with script beliefs about self, others and quality of life, needs and feelings, observable behaviours, reported internal experiences, fantasies, and reinforcing experiences through current events and old emotional memories, allows monitoring of these categories before, during and after treatment. In this way the Script System becomes a magnifying glass to help the hermeneutic analyst select and classify the client's sufferance, partially expressed in the items of the PQ, and then monitor how these aspects of depressive personalities change during therapy. If there are improvements in the Script System, this will probably be indicative of an efficacious therapy. Moreover, these areas of sufferance are connected with the SWAP diagnosis and are coherent with symptoms and pathological traits of personality.

Limitations

The first author is a psychologist and is currently studying TA psychotherapy. Despite the reflective attitude adopted in this work, this may have influenced in subtle ways the hermeneutic analysis. Moreover, only one researcher was involved in the hermeneutic analysis, which might have had a potential impact on the briefs, rebuttals and conclusions. Furthermore, this new method to conduct a HSCED requires a training in the creation of the hermeneutic analysis, in the use of four quantitative measurements (in this case: PHQ-9 for depression, GAD-7 for anxiety, CORE for global distress and PQ for personal problems), in two qualitative measurements (CI, HAT), in the use of the Script System to conduct a structured analysis of the main changes in the course of therapy, and in the application of Bohart's grids to support a more objective evaluation of the case. Although the simplified HSCED method reduces the quantity of resources and personnel for the analysis, the research must be well-formed. Even if the use of the 56 Bohart criteria aims to support the final evaluation of the case, there is only one point of view, so validity problems could be consistent.

Future Development

This variation of the traditional HSCED method has been proposed when a group for the hermeneutic analysis, or at least two judges for adjudication procedure are not available, or when training a group of people becomes too time consuming. For future development we might suggest conducting the hermeneutic analysis by a person without or with little knowledge on the therapeutic model (i.e. TA), in order to decrease limitations regarding validity and allegiance. Furthermore, the use of the Script System is helpful both for the therapist and for the researcher to follow the therapeutic process and enlighten the deepest areas of sufferance of the client's personality and monitor them during therapy. Therefore, if the therapist monitors the evolution of the Script System of the client, she/he will be more able to adjust the therapeutic work to specific personality problems.

Conclusion

This case study provides evidence that the specified manualised TA treatment for depression (Widdowson, 2016) has been effective in treating a major depressive disorder in an Italian client-therapist dyad, and provides evidence that hermeneutic analysis conducted by a single researcher, is possible with the use of the Script System (O'Reilly-Knapp & Erskine, 2010) for a deeper analysis and with the 56 criteria of Bohart (Bohart et al, 2011) for case evaluation. Despite results from a case study being difficult to generalise, this study adds evidence to the growing body of research supporting the efficacy and effective-

ness of TA psychotherapy, and notably supports the effectiveness of the manualised TA psychotherapy for depression as applied to major depressive disorder.

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APPENDIX 1: HAT Form Complete Version

Session	Rating	Events	What made this event helpful/important
1	8 (greatly)	When I understood exactly why my distresses began and I called into question my relationships with my relatives.	It has been important to understand that until today I've never had real relationships with my sisters, I guess like complicity, confidences, advices, I guess because I don't know what a familiar relationship is. I hope this awareness makes me stronger and more secure while with them.
2	8 (greatly)	In this session, the therapist said that I should accept people like they are: I don't know why accepting my sisters for what they are is so difficult for me.	This makes me reflect a lot: it's a thing I feel inside myself like a distress, but every time I meet one of them I'm defensive: why can't I let many things roll right off my back?
3	8 (greatly)	The most useful event has been when the therapist made me understand that it's me who decides what to say or do with "relatives".	It has been very useful in its simplicity because the power to decide what "to say", which means what you want to say to "relatives" it causes me many incomprehensions and "fits of anger".
4	8.5 (more than greatly)	Although my apparent calm, in this session the therapist made me notice the anger inside me towards my sisters.	All of this has been extremely useful because, even if I can decide what to say or do, the resentment that as accumulated with time and that is latent in me, induces me to be aggressive with them, and for this reason I prefer to avoid them.
5	7 (moderately)	The resentment and the anger which are latent in me are ready to explode, makes me live badly: this is what the therapist made me notice.	I probably can't sleep for more than few hours because of this anger inside, due to the many responsibilities I've always had. I don't remember being a little girl/adolescent and all of this is asking me to "pay up"…
6	8 (greatly)	I don't know if it's useful or important, but the question of the therapist "do you fear your sister?" is what made me reflect the most.	I don't know if this can be useful to me, but I've never asked myself if I do really fear my sister or not, but I can't give myself a clear answer. A part of me is self-convincing with the pros and the cons for those existing differences, which can't be, but rationally I'm not so sure, but I still can't understand the reason.
7	7.5 (more than moderately)	When the therapist said "there's always another choice" I was puzzled for its meaning, because I believe I've always done things "others" expected from me in all the different situations.	This event provoked in me a feeling of impotence. In the course of time I've always believed for certain that events had only one solution: for example when my mother is not feeling well, it's "me and my husband" who take care of her, and not doing it means not doing my duty and this generates guilt in me. When one of my sisters needed me, she always found me ready until a little time ago, today I feel I've become indifferent with them and I feel confused…
8	6.5 (more than slightly)	I participated in an event where all my family was present and I felt isolated from them. The question is: do I isolate myself?	I've asked this question for all the week, there are times in which I think I'd prefer to be alone, not only from those relatives I'm becoming indifferent to (probably it's this that keeps them away), but also alone without my husband, who I feel is not able to understand me, even if he's a bighearted person, and then I think that where he grew up didn't help him…

Session	Rating	Events	What made this event helpful/important
9	7 (moderately)	I and my husband should find a balance, now that we are a couple again… the therapist suggested.	Saying it is easy, but it's not like that. We spent many years facing our days independently and there has never been a great dialogue between us, and maybe it's for this reason we are having difficulties today. However, I have to be objective, I have difficulties in forgiving some recent things and what happened in the past, and probably I'm not able to give him faith, even if I'm learning that there is not only the absolute or everything or nothing.
10	7.5 (more than moderately)	We managed to find some time for ourselves…	It has been a long time since my husband and I spent a day alone out of our house. It has been a very pleasant trip for both of us. I experienced forgotten emotions, serenity, complicity, staying together like we haven't done from a long time. But I had the best feeling when the therapist made me understand that I managed to break down every objection my husband made, and listening to myself I feel stronger with him and with others.
11	7 (moderately)	We should talk to determine the right personal spaces…	The therapist believes that talking, my husband and I, we could manage to find the right balance in order for me to trust him again. I'm not doing it on purpose, but in spite of all the attention he's giving me, I can't still manage to trust my husband like before. Furthermore, I feel some possessiveness in him.
12	8 (greatly)	I felt "lighter" after this session with the therapist…	One simple question of the therapist and I realised having found again my positivity and the smile I once had, and all of this gives me a huge feeling of freedom, freedom to express myself with anyone without feeling guilty for having said or done something that could be bothering. But I realised I still have to work on the tone of my voice because I could still appear aggressive.
13	8 (greatly)	"Are you an anxious person?" This is the question that made me reflect the most…	We deepened the topic of my voice tone which could appear aggressive, but with the question "are you anxious?" the therapist astonished me. I've never considered myself an anxious person, however, reflecting, that's not entirely true.: I recall situations in which, without realizing it, my eyes seemed anxious because my interlocutor looked at me asking if something happened. I could ascribe all of this to my hurry in doing everything or am I really anxious and I've never realised it?
14	7.5 (more than moderately)	"Have you thought about the word 'sweetness'?" the therapist asked me…	Sweetness… I realised that I've learnt what it is thanks to my husband. My parents never told me "I love you", even if today I understand that they demonstrated in another way, in the past I felt imprisoned, and this is probably the reason I married at such a young age. However, today I realise that I haven't managed myself to demonstrate to my kids how much I love them, because even if this should be natural, I live it like a weakness moment. I've never seen my parents cuddle, and also today when my husband cuddles me in front of somebody else I feel a kind of shame.

Session	Rating	Events	What made this event helpful/important
15	8 (greatly)	I turned back to the starting point!!! It's true, it's not a euphemism…	I remember when I attended middle school, and a teacher told us that mankind arrives at a certain point in his evolution and then turns back to the starting point. This is what came up to my mind when the therapist made me notice that after many years, now that my children don't live with us anymore, my husband and I turned to be a couple again, like as soon as we got married, but it's not so easy because we were kids without any experience, instead now there's a new awareness and it's not easy to restore a balance. Certainly, we are more mature and so we see everything with a different perspective: it's like starting back over again with someone you have lived many years with, but you never actually ever knew…
16	8.5 (greatly)	Is faith 360-degree??	I've always thought that faith was believing blindly in your partner or to anyone who loves me, but today I understood that it's not like this because counting on someone, knowing that he is there when you need him is more important than the real faith, which is both with your husband and with your friends.

Note. The rating is on a scale from 1 to 9: 1 = extremely hindering, 5 = neutral, 9 = extremely helpful. HAT = Helpful Aspect of Therapy (Llewelyn, 1988).

APPENDIX 2: Evidence in Bohart's criterion list

Evidence that the Client Changed (item 1-39).

	Criterion	Source
1	Clients note themselves that they have changed	S11, 373-380; S16, 89-100, 160-162; FU3, 88; CI, 126-131
2	Client mentions things that make it clear that they either did something or experienced something different than what they normally do or experience in the course of their everyday lives	CI, 126-131; Changes reported in CI
3	Clients are relatively specific about how they have changed	S16, 89-100
4	They provide supporting detail	S16, 161-276; FU1, 748-753
5	They show changes in behaviour in the therapy session plausibly related to the kinds of changes they should be making outside the session	S10, 1-10; S8, 147
6	Plausible reports by the client that others have noted that the client has changed	S16, 640
7	Plausible indicators reported by the client: better grades, promotion at work, less use of medication, new activities such as jogging	S16 268-276; S10, 84-85; CI, 907-909
8	They mention problems that didn't change	CI, 525-598; Changes reported in CI
9	They mention problems that did change	S16, 624-628; S12, 297-306; Changes reported in CI
10	The changes mentioned seem plausible given the degree of difficulty of the problem, degree of time in therapy	-
11	If there is a major change reported, it is described in rich enough detail to be plausible	S11, 373-380, FU1, 748-753
12	If the client comes in depressed they show a reasonably consistent change in mood; more ups than downs as therapy goes on - i.e. they come to therapy less often depressed, seem less depressed, recover more quickly	From session 13 at the beginning of every session
13	If they report being anxious, they report either managing it better, or reductions in anxiety in key situations, and this shows a positive trend over therapy	FU3, 88; FU3, 46-48; FU3, 158-164
14	If they report being unable to leave their house (agoraphobia) they report an example suggesting that they made a new and more concerted effort to go out and it met with at least some degree of success, and their affect about trying it is positive and hopeful (i.e. there is an increase in perceived possibility for them that they can do it)	Not applicable
15	If their problem is a habit problem (studying, overeating, drinking, smoking, etc.) they report concrete changes. With a habit problem ONE incident of change is not usually enough to say that a substantial change has occurred. We would want evidence that this one change was something new, or a new attempt after having been discouraged. But we would like it better if the person could report several successes; a pattern of success. But if a few fresh changes were made and the person seemed optimistic, that we could take as preliminary evidence of change	S10, 1-13, 307-325; S6, 39-41, 65-70

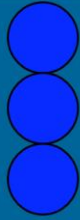
	Criterion	Source
16	If the problem is a demoralisation problem ("I can't"), or involves demoralisation, the person begins to show hope and optimism - a sense of possibility, a sense that it will be a challenge. They become challenge oriented. If they fail they focus more on learning from the challenge than on what it means about them in terms of their inadequacy. In fact, they focus more on the difficulty of the task than on their inadequacies. In other words, when they fail they no longer see it as a complete sign of their inadequacy, or their failure. If they choose not to pursue it any further it is after a reasonable evaluation where they conclude reasonably that a shift in priorities is in order, or action plan.	Changes reported in CI
17	Evidence of new-found confidence in judgment.	CI, 8-14, 17-27
18	Evidence of greater competence in judgment - as the individual thinks out the problem he or she does it more proactively, considers alternatives, weighs them, uses good intuition. Does not seem driven by fear and jump to conclusions. They weight options aloud, think things out.	S10, 1-13, 307-325; S6, 39-41, 65-70
19	Evidence of greater proactive determination and persistence in relation to a reasonable goal.	Not applicable
20	If they make a risky choice, they seem to make it in a reasonable way	S10, 1-13
21	Arriving at a major decision that the person was struggling with.	-
22	Coming up with a whole new plan which is innovative.	S14, 328-355
23	Getting a new perspective which brings greater coherence, reduces debilitating guilt, gives new positive behavioural options, helps the person let go of something from the past	-
24	Gaining a new perspective where they seem to be acceptingly criticizing themselves, seeing their own limitations, but not in a defensive or overly critical way.	S10, 341-343
25	Gaining a perspective that "I am not my problem"	S13, 684-835
26	Identity work: clarifies fundamental goals and values. If no goals or values, begins to confront these issues. If has adopted goals and values from parents but is beginning to question them, begins to evaluate for self. If is in an "identity crisis," or moratorium, struggles with issues and makes progress in making commitments. Identity work can take place in any or all of the following areas: vocational goals, moral values, goals about relationships, goals about children, religious values, political values, values about what makes for a meaningful life, gender issues, sexuality, ethnicity and cultural background	S14, 328-355
27	Identity work: Real self-controversies - what is my real self, am I being untrue to my real self? Movement towards some kind of reconciliation or decision.	Not applicable
28	Traumatic experiences - signs of letting go of it, coming to terms with it, reductions in symptoms such as flashbacks or nightmares, or at least a greater sense that these can be handled and are not so debilitating	All S2; S16, 332-338
29	Achievement of specific goals - becoming more assertive, as evidence by self-report of concrete instances, perhaps seeming more assertive in the therapy session, rise in confidence	S8, 147; CI, 96-99; FU3, 46-48; SWAP scores
30	Interpersonal changes - reported changes in a positive fashion in relationships - handling anger better, less dependence, greater problem solving, greater realistic acceptance of others (i.e., but NOT accepting certain things such as abuse), greater empathy as demonstrated towards others and towards the therapist (more careful listening, less confrontative). With therapist acts more proactively, dialogically, less dependent, less aggressive, less need for dominance.	CI, 893
31	Specific changes: finished a project, made attempts to protect daughter, exercising. Made a new friend. Got and kept a job	S16, 363-365, FU2, 775-78, FU3, 284-285
32	Greater realization that there may be some things that will take ongoing work	FU1, 131-132

	Criterion	Source
33	Changes in self-relationship. Greater realisation and appreciation of accomplishments; more specific and concrete and accurate assessment of talents and effort; less global, negative self-attributions; greater self-empathy; greater self-listening to intuitions, felt experiencing; greater receptive internal dialogue; holding constructs more tentatively to evaluate them; more of an open, searching mentality; if overinflated self-esteem or self-confidence, taking a more careful look at how one might be doing, offending people, etc.	FU3, 591-600; S16, 268-276, S11, 373-380
34	Reduction in any presenting symptoms, such as feeling weak, fearful, tiring quickly, feeling no interest in things, feeling stressed, blaming oneself, feeling suicidal, unfulfilling sex life, feeling lonely, frequent arguments, difficulty concentrating, feeling hopeless about the future, having disturbing thoughts come to mind, upset stomach, sweating, dizziness, heart pounding, trouble getting along with others, trouble sleeping, headaches.	S15, 322-326
35	Increases in positive things: self-efficacy, enjoying spare time, feeling loved and wanted, greater happiness, greater sense of direction or optimism, greater acceptance of the injustices of life in a productive way.	S15, 322-326; FU1, 204-214
36	Better ability to define goals in a proactive and functional way.	-
37	Prosocial changes - volunteering, involvement in productive activities, new projects.	-
38	Changes in physiology - less sweating, calmer and relaxed in therapy.	-
39	Changes in appearance in a positive fashion (if observed).	-

Evidence that it was therapy that helped (item 40-56)

	Criterion	Source
40	Clients themselves report that therapy helped	Changes reported in CI; S16, 624-628; FU3, 411-414
41	Clients are relatively specific about how therapy helped, and it is described in a plausible way	CI, 288, 907-909; Changes reported in CI
42	Outcomes are relatively specific and idiosyncratic to each client and vary from client to client (if comparing across clients)	Not applicable
43	In their reports, clients are discriminating about how much therapy helped, i.e. they do not in general give unabashedly positive testimonials	-
44	They describe plausible links to the therapy experience	CI, 525-598; Changes reported in CI
45	To the rater a plausible narrative case can be made linking therapy work to positive changes. This includes the following (#46-56):	Mostly all S16 and all CI
46	Therapy provides a workspace where clients have an opportunity to talk, think, express. The things the client talks about are the things that change, or if other things change, the client notes a relationship of them to the therapy experience. Client notes that this helped.	0B, 451-459; 0C, 426; S10, 482-485
47	Therapist's empathic understanding, warmth, acceptance, seems to relate to client's increased engagement, willingness to try new things, productive exploration.	S15, 171-173; S16, 624-634
48	Therapist's encouragement, support, positive attitude seem to be related to client's overcoming demoralization, willingness to confront challenges, not be discouraged by failure. Therapist supports client productively when client fails. Keeps eye focused on productive behaviour and this seems to relate to client's doing so also.	0B, 497-498; 0D, 383-387; S2, 135-137

	Criterion	Source
49	Therapist's warmth, empathic listening, seems to provide safe atmosphere for client to confront painful experiences, and these in turn change.	0B, 277; 0C, 412-422
50	Therapist's in-tune questions, reflections, interpretations, or comments, seem to facilitate clients' exploration, gaining new perspectives, developing action plans, creativity. Client feels recognised.	S12, 304-306
51	Clients engage in concrete procedures in therapy and changes are congruent with what they are trying to achieve, and there is evidence of these changes. Examples: EMDR - clients work through a traumatic experience and then seem relieved afterwards, and at the next session; clients engage in chair work and either resolve an internal conflict, or come to terms with someone they have unresolved feelings towards; and this change persists or at least partially persists in subsequent sessions; clients challenge dysfunctional cognitions and show plausible changes in mood or behaviour	S10, 1-13
52	Issues client struggles with in therapy change plausibly over time in accord with the trajectory of the client's working on them e.g. client talks about them week after week, and has ups and downs, but gradually masters them, and the mastery seems related to their ongoing struggle with it in therapy. In other words, perhaps each week they talk about experiences related to resolving the problem, work on it, and gradually master it.	HAT 6; CI, 525-529
53	Clients report changes in trajectory from their past life in the problem. Clients report something new in regard to coping with the problem, and relate it to therapy, or it seems related to therapy. Clients report a history of failed coping with the problem, and now it is changing. Even if client reports having tried some of these things before, now reports that therapy has helped have confidence in the effort and helps him or her persist.	CI, 8-14, 75-88
54	There are no plausible life changes that could have assumed major responsibility for the change. Or, if there is a life change, it seems to be a result of therapist deliberative activity, or it gets incorporated into the therapy activity in a productive way	Not applicable
55	Topics not dealt with in therapy did not change, or, if they did change, there was a plausible reason why they changed from the therapy or from clearly independent reasons. In other words, they can be accounted for so that we can assume we are not talking about a global halo effect.	Not applicable
56	Clients' mastery experiences, problem actuation, and clarification and gaining of new perspectives that occurs in therapy are related to the changes.	Changes reported in CI



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Research into the Relationship between Ego States and Neuroticism among Indian Males and Females

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Abstract

Results are shown of a research project exploring the relationship between the transactional analysis concepts of ego states and Neuroticism in the Big Five Factor model of personality, A sample of 192 Indian adults (37% male, 63% female) were administered the Ego State Questionnaire-Revised (ESQ-R) and the Big Five Inventory (BFI). Pearson Product-Moment Correlation indicated a small but positive correlation between Neuroticism and the ego states of Critical Parent and Adapted Child, and a small negative correlation between Neuroticism and Nurturing Parent, Adult and Free Child. (All correlations significant at 0.05 level using a two-tailed test.) There were differences between males and females and between different age groups. Though there are limitations to this research, the findings are in line with TA theory and may have implications for how TA therapy is applied.

Key words

Big Five, ego states, Neuroticism, Transactional Analysis (TA), Personality

Definitions and Key Terms

Ego states

Transactional analysis (TA) conceptualises the personality of an individual as a three-part model of ego states, which Berne (1972) defined as "coherent systems of thought and feeling, manifested by corresponding patterns of behaviour" (p. 11). These are set apart from each other in three distinct ways - which Berne (1961) called "exteropsyche (e.g., identificatory), neopsyche (e.g. data processing) and archaeopsyche (e.g. regressive) or colloquially as Parent, Adult and Child" (p. 3).

As explained by Stewart and Joines (1987), the above three-part ego state model is called the structural model of TA, which "we use when we want to examine the specific content of the ego states. It tells us what is there in each ego state. When we wish to study ego states in terms of how we use them, then we use a more detailed model of ego states called the functional model" (p. 21). The functional model divides the Parent and Child ego states into Critical Parent (CP) and Nurturing Parent (NP), and Adapted Child (AC) and Free Child (FC). These, with Adult (A), constitute the five-part functional model of ego states.

Given that each ego state has a positive and negative aspect to its functioning, (Kahler, 1977) it is helpful to think of each ego state as having a positive/ effective mode of operation and a negative/ ineffective mode of operation. This has been conceptualised by Susannah Temple (Temple, 2015) though her Temple Index of Functional Fluency (TIFF), the key concepts of which are:

- In the positive mode, CP is labelled Structuring and shows behaviour such as being inspiring, well-organised and firm. CP's negative mode is called Dominating and is characterised by being bossy, fault-finding and punitive.
- Similarly positive NP is called Nurturing and acts with compassion, understanding and acceptance. Negative mode of NP is called Marshmallowing and can be discerned when you see overindulgence, inconsistence and smothering.
- Positive AC shows friendly, considerate and assertive behaviour and is labelled Cooperative mode. Negative AC shows anxious, rebellious or submissive behaviour and is labelled Compliant/ Resistant mode.
- TIFF refers to positive FC as Spontaneous (creative, zestful, expressive) and negative FC as Immature (egocentric, selfish, reckless).
- Only the Adult ego state is not divided into negative or positive modes of operating. It is characterised as operating in an Accounting mode which is rational, evaluative, alert and aware.

According to Temple, all human behaviour will fall into one of the four positive modes (+NP, +CP, +AC & +FC) when the Adult is in the Accounting mode; and into one of the negative modes (-NP, -CP, -AC & -FC) when the Adult is not in the Accounting mode.

Personality and Five Factor Theory

The study of personality has had many approaches (Schultz and Schultz, 2013). This research relies on the trait approach to personality – a school of thought pioneered by Gordon Allport, Raymond Cattell and Hans Eysenck. McCrae and Costa (2008) define traits as "more-or-less consistent and recurrent patterns of acting and reacting that simultaneously characterise individuals and differentiates them from others, and they allow the discovery of empirical generalisation about how others with similar traits are likely to act and react" (p. 160).

Nettle (2007) points out that all of us have traits, although we differ in the degree to which each trait is manifested or expressed in our personalities. As he evocatively puts it "traits are continuous, like height is, rather than discrete, like being an apple versus pear" (p. 20).

John, Naumann and Soto (2008) show that the dominant model of personality is the Five-Factor Theory (FFT) personality system developed by Robert McCrae and Paul Costa. They provide a definition and explication of the Big Five domains as depicted in Table 1, and state "rather than replacing previous systems, the Big Five taxonomy serves as an integrative function because it can represent the various and diverse systems of personality desc-riptions in a common framework" (p. 116). Nettle (2007) also states that the "five-factor model looks to be the most comprehensive, reliable and useful framework for discussing human personality that we have ever had" (p. 9).

Neuroticism

Nolen-Hoeksema, Fredrickson, Loftus and Lutz (2014) define Neuroticism as "a dimension of emotionality, with moody, anxious, temperamental and maladjusted individuals at the neurotic or unstable end, and calm, well-adjusted individuals at the other" (p. 437). It is one of the five factors in the FFT and comprises six domains: Anxiety, Angry Hostility, Depression, Self-consciousness, Impuls-iveness and Vulnerability (Weiner & Greene, 2008, p. 316). Neuroticism, or traits similar to it, have been consistently identified historically by researchers such as Robert Cattell and Hans Eysenck (Schultz & Schultz, 2013, p. 217-228).

Factor	Verbal Labels	Conceptual definition
E (Factor I)	Extraversion. Energy, Enthusiasm	Implies an energetic approach toward the social and material world and includes traits such as sociability, activity, assertiveness and positive emotionality
A (Factor II)	Agreeableness. Altruism, Affection	Contrasts a prosocial and communal orientation toward others with antagonism, and includes traits such as tender-mindedness, trust and modesty
C (Factor III)	Conscientiousness. Constraint, Control of impulse	Describes socially prescribed impulse-control that facilitates task and goal-directed behaviour, such as thinking before acting, delaying gratification, following norms and rules, and planning, organising and prioritising tasks
N (Factor IV)	Neuroticism. Negative emotionality Nervousness	Contrasts emotional stability and even-temperedness with negative emotionality such as feeling anxious, nervous, sad and tense.
O (Factor V)	Openness to experience. Originality, Open-mindedness	Describes the breadth, depth, originality and complexity of an individual's mental and experiential life.

Note. The FFT is also informally called the Big Five factor model of personality.

Table 1: Big Five factor model of personality (John et al, 2008. p. 120)

Review of literature

Research on Ego States and Big Five Factor Model

A search for similar research on the relationship between ego states and the Big Five Factor model yielded only one pilot, exploratory research (Ciucur, 2013). This study covered 42 female school psychologists and counsellors in Timisoara, Romania. It used the DECAS Big Five Inventory (Sava, 2013) and the Ego States Questionnaire (correct title Personal Styles Questionnaire, Hay, 1992) to collect data and the Bravais-Pearson "r" correlation test to identify potential relationships. The key finding of this study that is relevant to us is "a significant negative correlation between Adapted Child and Emotional Stability" Ciucur (2013, p. 583). No other significant correlation was found between Emotional Stability (i.e. the term DECAS inventory uses as the opposite of Neuroticism) and other ego states. It is interesting to note "that Critical Parent was seen as negatively correlating with Agreeable-ness and not with Emotional Stability" (p. 584).

Ciucur (2013) has also listed the limitations of his research; a small sample size and exclusively female. Also, his research did not discriminate between positive and negative aspects of the ego states.

Research on relationships between ego states, locus of control and dogmatism

Loffredo (1998) studied the relationship between ego states and personality constructs such as locus of control and dogmatism. Locus of control was defined as "the perception of the extent to which positive and/or negative events are considered a con-sequence of one's own actions (internal locus of control) or not (external locus of control)" (p. 171). Dogmatism was defined as "the relatively closed cognitive organisation of beliefs about reality, focussed around a central set of beliefs about absolute authority which, in turn, provides a framework for patterns of intolerance and qualified tolerance towards others" (p. 171).

Using Pearson *r* correlation, Loffredo's research showed eleven significant correlations. The relevant ones are summarised below:

1. There was a significant negative correlation between the Adult ego state and external locus of control. This is consistent with TA ego state theory which states that those "with activated Adult ego states show good problem solving – a quality associated with those with high internal locus of control" (p. 172).
2. There was a significant positive correlation between the Adapted Child (AC) ego state scores and the external locus of control scores. Again, this finding was consistent with ego state theory as people with an activated AC "are frequently externally oriented…behave in ways that are considered best for getting along with others instead of autonomously and would therefore be expected to demonstrate a marked propensity to over-adapt to external locus of control" (p. 172).
3. There was a significant positive correlation between the Adapted Child (AC) and dogmatism again consistent with the theory of TA. This is because the AC "develops a response to significant, more powerful others…in whom the dogmatic individual seeks safety" (pp 172-173).

Research on ego states and application to drug abuse clients

Doelker and Griffiths (1984) developed an Ego State Energy Inventory by adapting Heyer's (1979) ego state profile. They developed a 75-item questionn-aire, with 15 statements for each of the five ego states. They administered the instrument to 57 social work undergraduate students and later to a group of 72 adults undergoing therapy in a residential drug abuse treatment program. They found that the social work students exhibited elevated scores on NP, FC and Adult ego states as compared to the CP and AC ego states. Among the drug abuse clients, the CP and AC ego states were less represented than the other ego states (p. 52).

Research on ego states and psychopathology

Thorne and Faro (1980) developed the Ego State Scale to measure ego states and explore their relationship with depression, schizophrenia, hysteria, etc. They studied eight ego states (+NP, -NP, +CP, -CP, A, +AC, -AC and FC), and developed an instrument with a total of 30 adjectives for each ego state. They analysed the relationship between individual ego state scales and MMPI (not referenced by Thorne & Faro but presumably Hathaway and McKinley, 1940) indices using a Pearson correlation coefficient. It was found that "as the number of extreme MMPI scale scores increased, indicating increased pathology, scores on -AC and -NP increased while scores on +FC and A decreased" (p. 51).

Essentially, they found "that FC, A, +NP and +CP were shown to be negatively correlated with pathology as measured on the MMPI, while -AC, -NP and -CP were positively correlated with pathology" (p. 51). Overall, the authors state that "high -AC scores were the best single indicator of pathology" (p. 51), and that "+AC is not necessarily indicative of psychological health" (p. 51).

Another interesting finding by the researchers was "that +NP was not found to be as highly negatively correlated with pathology as +CP" (p. 51). The authors say "while this would indicate that while both ego states are inversely related to pathology, the protective, limit-setting role of +CP is more central to psychological health than is the warm, supportive, permission-giving role of +NP" (p. 51). Equally interesting is that "-NP was shown to be more highly correlated with pathology than -CP…it is not unreasonable to assume that the overt expression of feelings consistent with -CP is less personally destructive than is the internalisation of feelings that occurs in -NP" (p. 52).

The overall conclusion by the authors was "that a significant relationship exists between ego state patterns and psychopathology" (p. 52).

Research on ego states and application to psychiatry

Robert Heyer (1979) developed an instrument called the Heyer Ego State Profile (ESP) and applied it to recovering alcoholics and prison inmates. The ESP is a fifty-item questionnaire that assessed individuals on the five ego states.

His research conclusions showed that the "CP correlates positively with dogmatism, negatively with acceptance of others and insignificantly with self-esteem" (p. 11). "The NP showed a positive correlation with both self-esteem and acceptance of others, with an insignificant correlation with dogmatism" (p.12). "The Adult ego state was most highly correlated with self-esteem, moderately associated with acceptance of others. There is no consistent relationship between the Adult ego state and dogmatism" (p. 12). The "FC was positively related to self-esteem and to acceptance of others, and is negatively correlated with dogmatism, and the AC was negatively correlated with self-esteem and with acceptance of others" (p. 12). These findings were consistent with what TA theory predicts and Heyer concluded that "the ESP lends empirical support to ego state concepts which TA theory developed from clinical observation" (p. 12).

He also found gender differences with the ESP noting that "Critical Parent (CP) is consistently higher among men than women and it tends to decrease with age. Nurturing Parent (NP) is significantly higher among women than among men and tends to increase with age" (p. 12).

His study of alcoholics showed that they had distinctly elevated AC ego states and markedly lower than average Adult when compared to general population norms (p.15). These findings were in line with what TA theory posits. However, there were deviations as well – for example, his study did not support the hypothesis that alcoholics have lower than average FC (p. 15).

Rationale of the study

Loffredo (1998) states that "few attempts have been made to integrate different measures of psychological constructs/traits with different theories of personality" (p. 171). The same picture is echoed by Ciucur (2013) when he reports that "no previous empirical researches approaching the relations between Transactional Analysis Ego States and the Big Five Personality Factors in the existing research literature were found" (p. 581). Therefore there is a need to bring TA up-to-date by relating classical theoretical concepts of TA to current developments in other branches of psychology. This research therefore assumes significance in the direction of bridging this gap.

In India, the World Health Organisation ([WHO], 2019) estimates that "the burden of mental health problems is of the tune of 2,443 Disability Adjusted Life Years (DALY) per 100,000 population. It is estimated that, in India, the economic loss, due to mental health conditions, between 2012 and 2030, is 1.03 trillions of 2010 dollars" (Mental health in India, para 8). Nettle (2007) states "Neuroticism is not just a risk factor of depression. It is so closely associated with it that it is hard to see them as completely distinct" (p. 114). He further states that "anxiety disorders, phobias, eating disorders, post-traumatic stress disorders, obsessive compulsive disorders - all these are characterised by heightened Neuroticism" (p. 117). He also describes the deleterious effect of heightened Neuroticism such as impaired immune systems, insomnia, schizophrenia, headaches, less satisfactory marriages and less satisfaction at work. Interestingly, he has also pointed out some of the potential positive spinoffs from managing Neuroticism healthily - such as using Neuroticism's capacity for sensitive insights into the human condition, realistic appraisal of danger, protective effects of vigilance and the opportunity for striving for achievement to mitigate suffering.

If TA therapists can gain a deeper insight into Neuroticism, through the research reported here, and thereby help clients buttress the strengths of Neuroticism and moderate its negative effects, this research will have contributed in its small way towards the cause of improving mental health.

Finally, the significance of this research stems from the possibility of extending this research to include other factors of personality. There were at least four other personality factors that could have been studied further: Openness to Experience, Conscientiousness, Extraversion and Agreeableness. A comprehensive understanding of the relationship

between TA ego states and all five factors of the Big Five can significantly enhance the state of TA theory and practices. It can equip TA practitioners with the rationale for leveraging ego state theory to enhance or moderate the effects of specific personality traits.

Research methodology

The study commenced in February 2019 and continued till April 2019. It was conducted primarily out of Mumbai but the participants in the study were drawn from across India.

Research objectives and hypotheses

To explore the relationship between the ego states of TA and Neuroticism of the Big Five model using correlational analysis, and draw inferences that may impact TA theory or practice.

This research tested five null hypotheses: that there is no correlation between each ego state i.e. NP, CP, A, AC, FC, and Neuroticism

Variables

The two sets of variables that were analysed for correlation were Neuroticism and the five ego states of TA: NP, CP, A, AC and FC.

For the purposes of the study, Neuroticism means the tendency to experience dysphoric affect such as sadness, hopelessness and guilt (McCrae & Costa, 2008). The following conceptual definitions of the five ego states are taken from Williams and Williams (1980, p. 120):

- CP: designates a set of feelings, attitudes and behaviour patterns which resembles those of a parental figure which criticises, finds fault, reflects the rules of society, and the values of the individual.
- NP: is a set of feelings, attitudes and behaviour patterns that represent a parental figure which nurtures and promotes growth.
- A: represents feelings, attitudes and behaviour patterns which are adapted to current reality, used for logical reasoning and precise predictions.
- FC: embraces feelings, attitudes and behaviour patterns which are relics of an individual's own childhood and characterised by fun, self-indulgence and natural, spontaneous feelings.
- AC: a set of feelings, attitudes and behaviour patterns manifested by compromising and conforming behaviours resulting from the domination of parental influence.

As described by John *et al* (2008), Neuroticism means the average score (after the raw score is ipsatized) of the eight items constituting the Neuroticism scale in the Big Five Inventory [BFI].

As described by Loffredo and Harrington (2012), the five ego states each mean the total score of the eight items constituting that particular ego state as defined in the Ego State Questionnaire- Revised [ESQ-R].

Instruments

The two instruments used were ESQ-R by Loffredo and Harrington (2012, pp. 94 – 96) and BFI by John, Naumann, Laura , Soto, Christopher (2008, pp. 157 - 158). MS-Excel and Google Forms were also used.

Study design

This research design was a descriptive research (Kothari & Garg 2014)). It did not attempt to determine causality between the independent and dependent variables, nor did it conduct an experiment between a control and experimental group. Rather, this research built on existing literature and used psychometric instruments to describe the existence of a relationship between ego states and Neuroticism. This will hopefully lay the basis for further – more precise – investigation, such as determining causality between shifts in ego states and personality, or the effect of TA therapy on personality.

Sampling technique

The respondents were selected through a process of convenience sampling and snowball sampling. They were contacted by email from a list of personal contacts of the primary author and by reaching out to members of the South Asian Association of Transactional Analysts (SAATA) headquartered out of Coimbatore, India. The respondents were also requested to forward the invitation to individuals they knew.

Sampling criteria and selection

The criteria for including subjects were that they should be:

1. Indian adults (male and female) in the age-group of 25-58
2. Willing to voluntarily participate in the survey
3. Familiar with English as a language

Sample size

A total of 198 respondents took the survey. Five of these indicated a nationality other than Indian and hence were excluded. One respondent responded to all questions with a 'Neutral' rating and hence was also excluded. The final sample size was therefore N = 192. As we can see in Table 2, the proportion of females in the sample (63%) was significantly more than the proportion of males in the sample (37%). A majority of the sample were in the age group of 25-40 years (62%), which is not representative of the Indian population in general. Hence, we need to be careful in making generalisations from this research to the entire population.

Gender / Age	Male	Female	Prefer Not to Say	Total	Percentage
Below 25 years	7	16	0	23	12%
25-40 years	48	71	0	119	62%
41-56 years	14	29	0	43	22%
> 56 years	2	4	0	6	3%
Prefer Not to Say	0	0	1	1	0%
Total	71	120	1	192	100%
Percentage	37%	63%	0%	100%	

Note. All percentages rounded.

Table 2: Age and gender distribution in sample

Data collection tools for ego states

A literature review based on a list compiled by Akkoyun (2014) of 15 ego state research instruments led us to consider the Ego State Scale (Thorne and Faro, 1980), the Ego State Energy Inventory (Doelker and Griffiths, 1984), the Ego State Profile (Heyer, 1979) and the Ego State Questionnaire – Revised [ESQ-R] (Loffredo, Harrington, Munoz & Knowles, 2004). Except for the ESQ-R, the other instruments were outdated and their authors were not contactable for any updates made to their instrument. The ESQ-R questionnaire with scoring key (Loffredo and Harrington, 2012, pp. 94 – 96) was finally selected for this research because it is relatively recently developed and it has been rigorously tested.

Data collection tools for Big Five

John *et al* (2008) have extensively described the history, concepts and measurement of the Big Five personality factors and compared three tools for measurement:

1. The NEO FFI: Neuroticism Extraversion Open ness Five Factor Inventory developed by Robert McCrae and Paul Costa in 1992.
2. The TDA: Trait Descriptive Adjectives developed by L. R. Goldberg in 1992
3. The BFI: Big Five Inventory developed by Oliver John in 1991

After considering all factors such as statistical rigour, cost of purchasing the instruments, access to literature and ease of administration, it was decided to use the BFI for measuring Neuroticism in this research.

Data collection procedure

The ESQ-R and BFI were administered online through Google Forms. The survey was tested in late January 2019 through a pilot survey across 10 respondents. Feedback was incorporated into the revised survey which was launched in late February 2019. The survey was finally closed in late April 2019.

Once the raw data was collected, the BFI data was ipsatized using the approach mentioned by John *et al* (2008, p. 158) and then scored for Neuroticism by taking the mean score of the items measuring

Neuroticism. For the ESQ-R data, the total scores for each of the five ego states were calculated as per the items mapped to each of the ego states.

The mean and standard deviations for each individual's set of responses were calculated. The sample mean and the sample standard deviation were used to convert the individual scores of ego states and Neuroticism into standardised scores. This was done to enable correlation of data within the normal range of the bell curve, to not have outliers skew the analysis.

Following this, Pearson Product Moment Correlation was calculated between the standardised scores of the ego states of the ESQ-R with that of the Neuroticism score of the BFI. The correlation was tested for significance at a 0.05 level (2-tailed). Conclusions about the five null hypotheses were then drawn as shown in Table 3.

Ethical considerations

The following ethical considerations were followed during the conduct of this research:

	Ego states				
Neuroticism	**NP**	**CP**	**A**	**AC**	**FC**
Males (N=71)	-.514	.622	-.627	.587	-.386
Females (N=120)	-.249	.463	-.625	.668	-.499
All Respondents (N=192)	-.347	.523	-.622	.638	-.466

Note. p < 0.05, two-tailed test. 'All Respondents' includes one participant who did not wish to identify his/her gender. (The significance testing for these correlations are shown in Tables 5-7 in Appendix A.)

Table 3: Correlations between ego states and Neuroticism (All respondents)

- Confidentiality: The survey did not ask for any information (such as name, email-id, phone number, IP-address) that would identify an individual respondent.
- Informed consent: The survey had a brief preamble that solicited participation, explained the rationale of the research (without naming the personality models being studied), assured confidentiality and offered the contact details of the author if respondents needed clarifications before they attempted the survey. All respondents were explicitly requested to confirm that their participation was voluntary and that they would provide their honest responses. In case respondents disagreed with any of these terms, they would automatically be prevented from participating in the survey.

Results and Discussion

Hypothesis testing

Each of the five null hypotheses was tested at 0.05 level of significance and the interpretation of each relationship is explained below.

H_0: There is no correlation between Nurturing Parent and Neuroticism

There is a weak negative relationship between NP and Neuroticism (*r*(190) = -.347, *p* = .00). Hence, the null hypothesis is rejected. The scatterplot for this is shown in Figure 1. For females, the relationship between NP and Neuroticism is negligible and negative (*r*(118) = -.249, *p* = .00) but for males there is a weak negative relationship (*r*(69) = -.514, *p* = .00). It can be inferred this difference between the genders indicates that within the Indian cultural context, where women are traditionally expected to frequently play nurturing roles, the NP ego state does not have a strong relationship when it comes to Neuroticism for females.

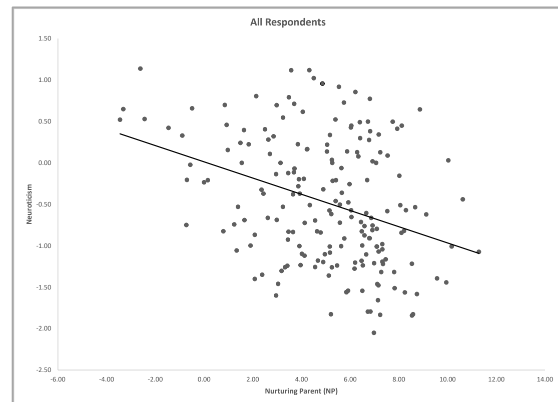

Figure 1. Weak negative r between Nurturing Parent (NP) and Neuroticism.

H_0: There is no correlation between Critical Parent and Neuroticism

There is a moderate, positive relationship between CP and Neuroticism (*r* (190) = .523, *p* = .00). Hence, the null hypothesis is rejected. The scatterplot for this is shown in Figure 2. For females, there is a weak positive correlation (*r* (118) = .463, *p* = .00) while for males it is a moderately positive correlation (*r* (69) = .622, *p* = .00). It can be inferred that across genders, the CP has a positive correlation with Neuroticism.

H_0: There is no correlation between Adult and Neuroticism

There is a moderately negative relationship between the Adult ego state and Neuroticism (*r* (190) = - .622, *p* = .00). Hence, the null hypothesis is rejected. The scatterplot for this is shown in Figure 3. This holds across genders - for males, (*r* (69) = -.627, *p* = .00); for females, (*r* (118) = -.625, *p* = .00). Among negative correlations, the relationship between the Adult ego state and Neuroticism is the strongest as compared to other ego states and Neuroticism. This is not surprising considering that every other ego

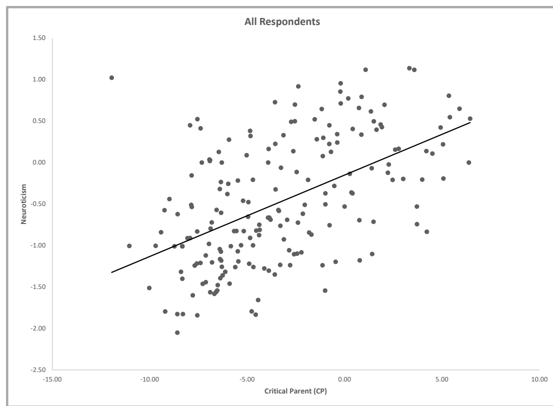

Figure 2. Moderately positive r between Critical Parent (CP) and Neuroticism.

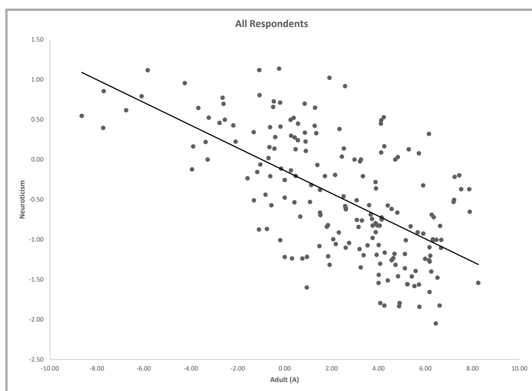

Figure 3. Moderately negative r between Adult (A) and Neuroticism.

state has its positive and negative modes of operation. The Adult alone does not have such dual modes of operation. Hence, it would be logical to surmise that the Adult ego state would have a stronger negative relationship than other ego states with Neuroticism.

H_o: There is no correlation between Adapted Child and Neuroticism

There is a moderately positive relationship between AC and Neuroticism (r (190) = .638, p = .00). Hence, the null hypothesis is rejected. The scatterplot for this is shown in Figure 4. Across genders too, there is a moderately positive relationship between AC and Neuroticism: for males (r (69) = .587, p = .00) and for females (r (118) = .668, p = .00).

H_o: There is no correlation between Free Child and Neuroticism

There is a weak negative relationship between FC and Neuroticism (r (190) = -.466, p = .00). Hence, the null hypothesis is rejected. The scatterplot is shown in Figure 5. Across genders too, this weak negative correlation persists: for males, (r(69) = -.386, p = .00) and for females (r (118) = -.499, p = .00).

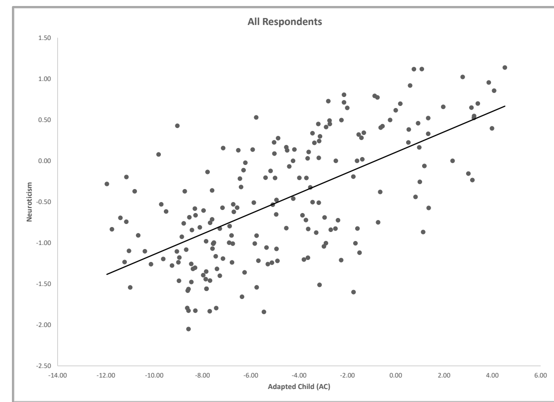

Figure 4. Moderately positive r between Adapted Child (AC) and Neuroticism.

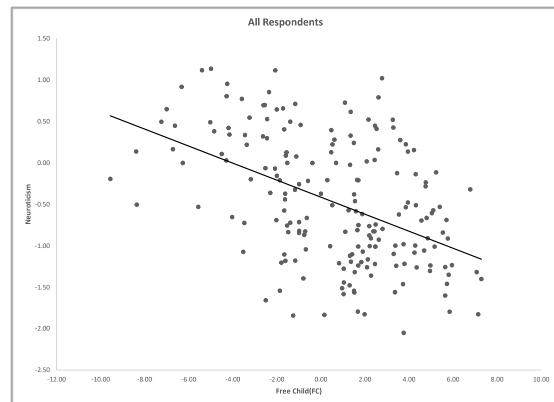

Figure 5. Weak negative r between Free Child (FC) and Neuroticism.

Age-related inferences

The data was also tested for different age groups. The age groups of Below 25 years and Above 56 years were not considered as the number of data points were less than 30. The results of the correlations between ego states and Neuroticism by the remaining two age groups (Between 25 and 40 years; and between 41 and 56 years) are summarised in Table 4. This analysis indicates that the direction of the correlations between Neuroticism and the ego states are the same as that of the correlational analysis seen at the aggregate level (Table 3). Further, it can be seen in Table 4 that the degree of correlation increases from the younger age group to the older age group with all ego states except FC.

Conclusions

From the observations, the following conclusions can be drawn:

1. At an aggregate level (Table 3), there is a positive correlation between Neuroticism with AC and CP. There is a negative correlation

between Neuroticism and FC, A and NP. This is consistent with TA theory – see Ciucur (2013), Loffredo (1998), Thorne and Faro (1980) and Robert Heyer (1979).

In the aggregate analysis (Table 3), the degree to which CP is correlated positively with Neuroticism (r (190) = .523, p = .00) is stronger than the degree to which NP is correlated negatively with Neuroticism (r (190) = -.347, p = .00). Similarly, the degree to which AC is correlated positively with Neuroticism (r (190) = .638, p = .00) is stronger than the degree to which FC is correlated negatively with Neuroticism (r (190) = -.466, p = .00). This trend holds true even when the data is analysed at the gender level or at different age groups. This makes for an unfortunate inference – namely that the strength of the deleterious relationships (positive correlations) between ego states with Neuroticism, are stronger than the strength of the benign relationships (negative correlations).

2. The potential implication for TA therapy is that strengthening the benign relationships will take more effort, compared to the effort that established the deleterious relationships in the first place.

3. Further, as seen in Table 3, among negatively correlated ego states, NP is most weakly correlated with Neuroticism for women (r (118) = -.249, p = .00) but for men it is stronger (r (69) = -.514, p = .00). Similarly, FC is most weakly correlated with Neuroticism for men (r (69) = -.386, p = .00), but for women the relationship is stronger (r (118) = -.499, p = .00). This indicates that therapy may need to be differentiated depending on gender.

4. When we see the trend in correlation between ego states and Neuroticism among different age groups (Table 4), then it indicates that proactive TA interventions need to be designed for young people in order to pre-empt issues later in life.

5. None of the relationships (Table 3 and Table 4) were strongly negative or strongly positive, i.e. none of the correlations were greater than +/- 0.75. One reason could be that the ESQ-R does not discriminate between the positive and negative modes of each ego state, and hence we cannot precisely discriminate the relationship between ego states with Neuroticism. Another potential reason could be the sample size and technique used. A much larger sample size and more rigorous techniques of sampling need to be used for arriving at a representative sample of the Indian population.

Implications for therapy

A correlational analysis cannot draw any conclusions about causality between ego states and Neuroticism. It is also a given that TA therapists can only work with the ego states of an individual and not directly on Neuroticism per se. Dusay (1972) proposed that the total psychic energy within an individual remains constant, and hence if one ego state is strengthened in intensity then another must correspondingly decrease in its intensity.

Keeping these aspects in mind, some inferences may be drawn to alleviate the ill-effects of Neuroticism:

- In general TA therapists may consider interventions that are aimed at increasing A, NP and FC of clients.
- When it comes to Indian women, TA therapists could focus on strengthening the A and FC in particular. For Indian men, TA therapists could consider strengthening A and NP in particular.
- It would help to introduce young adults (college-level students) to therapeutic or educational

Neuroticism	Ego states				
	NP	CP	A	AC	FC
Age between 25 and 40 years; (N=119)	-.316	.489	-.591	.607	-.505
Age between 41 and 56 years; (N=43)	-.388	.519	-.672	.735	-.382

Note. p < .05 levels, two-tailed test. (The significance testing for these correlations are presented in Tables 8-9 in Appendix A.)

Table 4: Correlations between ego states and Neuroticism (By age)

interventions that strengthen A, NP and FC to pre-empt the ill-effects of Neuroticism in later life. TA theory with its informal language, intuitive appeal and yet rigorous constructs can be an ideal vehicle to do so.

Limitations of the study and suggestions for further work

This study only measures the degree and direction of relationship between ego states and Neuroticism, and not causality. Experimental and control groups or longitudinal studies might help establish causality, and hence validate the impact of TA.

The ESQ-R does not differentiate between the positive and negative modes of the ego states; this may be why none of the correlations are strong. This points to a need for making a more nuanced instrument of ego states – one that differentiates between the positive and negative modes of ego states – to be made freely available for researchers.

Different models of ego states include an option for A to have negative modes (Schaefer, 1976; Hay, 1992) which might result in significantly different correlations.

This study has been based on models labelled functional ego states but which are in fact the descriptive model described by Berne, so the results refer to observable behaviours. In the case of Adult this may be significant because logical, problem-solving behaviour may not necessarily indicate that an individual is in the here-and-now in the same way that is implied by Berne's structural model and neopsyche.

The sample for this study has been restricted to adult Indian males and females. Hence, the findings cannot be generalised across cultures and other countries. Also, since the sample has been drawn from an English-speaking urban population, the findings cannot confidently be generalised to the non-English-speaking rural population of India. Future research studies will therefore need to cover a much wider sample of population, and for that the instruments would need to be translated.

The proportion of male respondents in the sample (37%) is significantly less than the proportion of female respondents in the sample (63%). This is not representative of the general Indian population, and hence findings based on gender should be further tested with more robust sampling procedures.

This research has focussed on one factor of the Big Five model – namely Neuroticism. The research could be extended to include other factors such as Conscientiousness, Agreeableness, Openness to Experience and Extra-version. Also, a similar study could be conducted to correlate the ego states with the HEXACO model of personality (Lee & Ashton, 2012). Such research could enrich TA theory and position it in the light of contemporary theories of personality.

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Appendix A: Significance testing of all correlations

Note. All correlations are significant at 0.05 level using a two-tailed test.

	Ego states				
	NP	**CP**	**A**	**AC**	**FC**
r	-0.347	0.523	-0.622	0.638	-0.466
n	192	192	192	192	192
df	190	190	190	190	190
p	8.146E-07	7.28509E-15	6.17863E-22	2.22162E-23	1.005E-11

Table 5: Significance testing of r: Ego states and Neuroticism (All respondents)

	Ego states				
	NP	**CP**	**A**	**AC**	**FC**
r	-0.514	0.622	-0.627	0.587	-0.386
n	71	71	71	71	71
df	69	69	69	69	69
p	4.4431E-06	7.07007E-09	4.91035E-09	7.38109E-08	0.000883284

Table 6: Significance testing of r: Ego states and Neuroticism (Males)

	Ego states				
	NP	**CP**	**A**	**AC**	**FC**
r	-0.249	0.463	-0.625	0.668	-0.499
n	120.00	120.00	120.00	120.00	120.00
df	118.00	118.00	118.00	118.00	118.00
p	0.00612395	9.90081E-08	2.27054E-14	8.19506E-17	6.66072E-09

Table 7: Significance testing of r: Ego states and Neuroticism (Females)

	Ego states				
	NP	**CP**	**A**	**AC**	**FC**
r	-0.316	0.489	-0.591	0.607	-0.505
n	119.00	119.00	119.00	119.00	119.00
df	117.00	117.00	117.00	117.00	117.00
p	0.00047268	1.67867E-08	1.42633E-12	2.43283E-13	4.79924E-09

Table 8: Significance testing of r: Ego states and Neuroticism (25-40 yrs of age)

	Ego states				
	NP	**CP**	**A**	**AC**	**FC**
r	-0.388	0.519	-0.672	0.735	-0.382
n	43	43	43	43	43
df	41	41	41	41	41
p	0.01014462	0.000367033	8.10424E-07	1.96523E-08	0.011487331

Table 9: Significance testing of r: Ego states and Neuroticism (41-56 yrs of age)

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The Little Professor: Reflection on the Structure, Development and Evolution of the Adult in the Child

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This paper appeared originally in Portuguese as O Pequeno Professor: Uma Reflexão Sobre a Estrutura, o Desenvolvimento e a Evolução do Adulto na Criança REBAT XXIII-OCTOBER 2014 PG 125-140 and is reproduced here by kind permission of UNAT-BRASIL - União Nacional de Analistas Transacionais – Brasil.

Where possible, quotations have been adjusted to reflect original English publications, particularly for TA publications which had been translated into Portuguese.

Abstract

According to the concept of the Life Script, developed by Eric Berne, the fate of each individual is sketched in the early years of life. The subdivision of Child Ego State, known as Adult in the Child or Little Professor, is responsible for decoding the world throughout intuition and analogical thought and, thus, in one way or another, having physical and emotional survival guaranteed. The purpose of this article is to qualify and recognise the Adult in the Child and its relevance in the construction of personality trait, by studying the anatomical, physiological and emotional scenario in which the Adult in the Child develops itself. The author suggests that the peculiar stamina and wisdom held in the Adult in the Child may be present in adult life in a positive manner, even if the events that structured it were dramatic.

Key words

Child Ego State, Adult in the Child, Little Professor, Generalised Representations, Evolutionary Development.

Introduction

"Look, the moon is flying" - David, 2 years

The observation of children has been a constant in my life for more than 30 years, initially as a paediatrician and later as a clinical transactional analyst. In all these years, both direct involvement with children and the Child ego states of adult patients has made my enchantment and admiration ever more consistent for the immense and courageous journey with which all human beings encounter their first years of life.

Like an alien on an unknown planet, the child at birth has the task of survival, to learn how to see, hear, walk and communicate in this new environment. Maybe they will not come across anything so complex and challenging again for the rest of their life. Therefore, an apparatus is required that not only can take care of the task but is able to constantly evolve throughout life.

The purpose of this work is to reflect, in terms of TA theory, on the subdivision of the Adult within the Child ego state, contextualising the scenario in which it develops and emphasising its task in the process of development.

The Child's Brain

According to Marta Pinheiro (2007) and Lewis and Wolkmar (1990), the development of the child's brain occurs as described below.

The brain begins to form between the third and fourth week of intrauterine life, in the so-called embryonic period, when the embryo measures approximately 0.5 cm. The nervous system originates from one of the three embryonic layers, the ectoderm, which is the structure that is in contact with the external environment.

From a longitudinal thickening of this ectoderm, neural plaque arises, which later in its development - 5th week - is rolled up, forming the so-called neural tube that remains inside the embryo, enveloped by the future epidermis that originates the primitive encephalic vesicles.

Neural stem cells, which are embryonic stem cells that specialise in the formation of the central nervous system, form precursor cells which, in turn, will form neurons and glia cells. The intense proliferation of these cells in this period, as well as the process of migration of the neuroblasts to the different regions of the nervous system, the selective aggregation of

the young affine neurons, the differentiation and maturation of the neurons and the formation of the synapses, are building a situation such that, with 24 weeks of gestation, the baby's brain is almost complete, made up of billions of neurons and trillions of connections.

At birth, the brain weighs an average of 350 grams, has several structures that are still immature, and the process of myelination is still unfinished. This still immature and flexible brain is bombarded with an endless stream of stimuli from both the external environment and the inner environment through the perception of new sensations that are not yet capable of being filtered or blocked.

Therefore, the evolution of the brain is dynamic and biological, developing through the responses it gives to the environment. The child's brain has hundreds of trillions of connections, more synapses than it can use - 50% more than that of the average adult - therefore, these experiences will determine which connections are left and which are lost.

Billions of neurons, trillions of connections, electrical and chemical energy, the child's brain, from birth or even before, is a system that is capable of learning from the external environment and that selects information which will be classified and recorded in the various neural networks. Each time the baby uses their senses as a way of perceiving their surroundings, a connection is formed. As these experiences repeat themselves, the brain connections intensify. We can say that the connections learned, or the paths that are recorded, build the way the child thinks, feels, speaks and does.

Eric Berne, based on the work of Penfield (1952), and Federn (1952), defined ego states as "coherent systems of thought and feeling manifested by corresponding patterns of behaviour" (Berne, 1972, p.11; 1988, p.25). Noting that patients could be seen moving from one mental state and one pattern of behaviour to another, Berne inferred the existence of three psychic organs: the Exteropsyche, Neopsyche and Archeopsyche, which manifest phenomeno-logically and operationally as the three ego states of Parent, Adult and Child (Berne, 1961).

In the same book, *Transactional Analysis in Psychotherapy*, Berne suggested the hypothesis that infantile ego states, existing as relics in the adult, could be re-lived through various circumstances that involved, one way or another, brain stimulation like "dreams, hypnosis, psychosis, pharmacological intoxicants, and direct electrical stimulation of the temporal cortex ... can exhibit spontaneous activity in the waking state as well." (Berne, 1961, p.31).

Several transactional analysts, including Jenni Hine and James Allen, have sought to understand where and how, neurologically speaking, the psychic organs manifest themselves as ego states.

Jenni Hine, both in her article *Mind Structure and Ego States* (Hine, 1997, 2003-4) and in the later publication *Brain Structures and Ego States* (Hine, 2005) proposes several considerations, many based on Joseph LeDoux's (2002) work on ego, self and mind, relating them to the Parent, Adult, and Child systems. Several of these considerations are especially interesting for this current reflection on the Child ego state:

About *Self* - Hine understands the formation of the *self* as, "our identity, our self, the essence of who we are ... arises bit by bit from the unique neural connections that our own participation in life experiences lead us to construct." (Hine, 2005, p.40).

In her study, Hine presents several considerations about self-understanding, highlighting the neuro-logical nature of the self, and quotes LeDoux (2002) as stating: "Given the importance of synaptic transmission in brain function, it should practically be a truism to say that the self is synaptic. What else can it be?" (p.2)" (Hine, 2005, p.40).

Another important consideration is the participation of memory in the composition of the self, both explicit and implicit memory, both building our identity and not just the contents of which we are aware.

On *Generalised Representations* – Hine describes a generalised representation as: "A GR can be understood as a cluster of perceptions that has acquired mental meaning because it has converged over time and through repetition to have become interconnected ... activated whenever a familiar signal stimulates any of their component parts" (Hine, 2005, p.42).)

According to Hine, a generalised representation of an event - meaning the occurrence of innumerable types of physical or mental experiences - is the knowledge and reactions to this knowledge that are constructed by the perceptions of different occurrences of similar facts until this becomes the expected stereotype for future occurrences of the same experiment. Hine also says that a generalised representation is constituted of a pattern of mental or neural connections that, over time, have been reinforced until they become available for activation through the appearance of a familiar stimulus.

Here is an example observed by the author illustrating this statement: A, before he was 2 years old, owned and knew a plush toy zebra like Zeze [http://keyframestudios.co.uk/Zeze/]. He could also recognise this same figure, with two eyes and dark

and clear stripes, when it appeared in books or other papers. The Zeze event was repeated in many ways, in the many experiences he had playing with the stuffed animal and with its images that were always named in the same way. One day, looking at a pine cabinet, he pointed and said Zeze. And yes, there was, in the drawing formed by the veins of the wood, a black dot and the outline of a body outlined with light and dark lines: obviously Zeze. A generalised representation.

On *ego states, self-states, and generalised representations* - for Hine, each ego state reflects a slightly different self-awareness from the others, so we have a *self*-state or a Parent awareness of self, an Adult awareness of self, and a Child awareness of self. For the author, these self-states or ego states are networks of generalised representations, and although each of them has slight differences in their awareness of self and personality, this does not preclude the existence of a global identity or personality.

It is important to emphasise that when we think about ego states with this understanding, it is implied that we are referring to brain areas, even though the areas related to each of these self-states or ego states are scattered in the brain and not concentrated in a single region, as follows: “The functioning of one of our PAC self-states is, therefore, the totality of a particular state of mental activation in response to signals from people around us or to internal signals from within us, formed and condensed over time as complex systems of interconnected GRs” (Hine, 2005, p.43).

For Hine, the different manifestations of ego states are because they were formed using different neural pathways that activate different patterns of neural networks when receiving external or internal stimuli**.**

Formation of Child Ego State

Between birth and five years of age, more or less, through the various experiences and trials of the person at this time, the Child ego state and its sub-structures are forming. Just as each ego state has its own characteristics, we can also, through Second and Third Order Structural Analysis, identify the subdivisions of the ego states, each with its own structure and content. The Adult in the Child is one of these substructures and, to better reflect on its constitution, it is necessary to contextualise it as part of the Child ego state.

Berne describes the Child ego state as "a set of feelings, attitudes and behaviour patterns which are relics of the individual's own childhood" (Berne, 1961, p.77; 1985, p.72). Some years later, Berne referred to the Child that "each person carries within a little boy or little girl, who feels, thinks, acts, talks, and responds just the way he or she did when he or she was a child of a certain age. " (Berne, 1972, p.12; 1988, p.25). According to him, this Child must be understood because, besides accompanying the person throughout life, it will also constitute the most precious part of personality.

Although we do not know exactly when the awareness of existence begins, we know that, even before birth, the baby is able to perceive stimuli coming from the environment, both internal and external, although in this period the child experiences himself and the environment as one. According to Schiff and Contributors (1975), the most decisive events during the intrauterine period are those that occur with the parents and how this is reflected in the physiology and health of the pregnant woman and, consequently, the baby. This is because, in addition to the experience of their own physical development, the first perceptions of rhythms occur in this stage. The unborn child already perceives “the rhythms of their own body and also those of their mother's body.” (p.24-35)

According to Hine (2004), the formation of generalised representations begins well before birth, arising from the experience of bodily sensations and continues to be constructed, more actively, in the first years of life, through early emotional experiences and interactions the infant has with those who provide care. At birth, the baby's vision is like a blurred photograph and the still immature brain cannot handle everything it sees. Due to the immaturity of nerve cells in the retina and cerebral cortex, visual acuity at birth is very low. New-borns are able to focus attention on strong contrast stimuli, seeing blurred shapes such as black and white and grayscale images.

This progresses so that at one month the baby's attention will be more directed towards the extremities and contours of the head and face, beginning at two to three months to observe the eyes and mouth, and at about five months, being able to perceive the face as a whole. Colour is perceived at the same time and visual acuity is estimated to evolve from very low in two-week-old infants to reach similarity with adult acuity at age five (Lewis and Wolkmar, 1990). Babies listen at birth and their auditory acuity improves rapidly in the first days of life, continuing to improve during the first two years. Within a week of birth, they can recognise the voice of their mother and at birth are able to identify the source of a sound. As for the senses of the palate, smell and touch, it is known that at birth new-borns discriminate sweet tastes as well as the other three basic tastes - salt, bitter and acid, and also possess good olfactory capacity and a developing tactile capacity.

Although it is estimated that only 40% of the hippocampus is mature at birth, infants soon recognise and are able to remember the mother's voice, face, smell and taste although initially the memory is short-term. With a month, a child can remember a mobile for about 24 hours, while at five or six months, they can remember for several weeks an object seen for a few minutes.

The fact that the baby is able to see, smell, hear and remember, even if not in a fully developed way, creates the possibility of experiencing non-rhythmic experiences and giving meaning to them. According to Schiff et al (1975), the perception of the mother's eyes, smell and smile is one of these non-rhythmic experiences that signal the beginning of symbiosis. This is the period of formation of Child in the Child (C1), composed of subdivisions C0, A0 and P0.

Jenni Hine (1997) refers to C1 as a specialised subsystem, very sensitive to internal stimulation, which forms at birth, or even in intrauterine life, through the creation of generalised representations of physical and emotional stimuli coming from the internal and external environment. C0 (Child Zero) is understood as the biological child, with the instinctive part and the reflex reactions to stimuli that are proper to humans. C0 is who we are when we are born, rudimentary instrumentalised beings for survival and sociability - the emerging self.

Not only are we born capable of seeing, hearing, sucking and grasping in a highly specific way, but also of bonding ourselves in our first hours of life (Lewis and Wolkmar, 1990).

According to Allen and Allen (2005) precocious ego states (C1, A1 and P1**)** develop basically in the right brain in the Sympathetic Vegetative Nervous System [nowadays called the autonomic nervous system (ANS)], which would explain the characteristics of excitement and joy of the child and analogical thinking. The substructure designated as A0 begins to develop around the time of birth. According to Schiff et al (1975), the onset of A0 (Adult Zero) would occur at the time that recognition of certain family stimuli begins, which results in a sufficiently significant somatic response by C0 to be recalled.

Note the similarity to the concept of generalised representations mentioned above. This substructure of C1 - A 0 will be responsible for learning through experience. Between two and four months, the baby begins to realise that there is a relationship between the inner sensation of hunger, the act of crying and sucking and the response of the external environment to it. The association of these situations will allow the child to create a relationship between these actions and the final result of the experience, which will be the ingestion of food.

This behavioural bridge - Hunger - Crying - Food - at this moment mediated by the Adult in the Child, still in formation, is, according to Schiff et al (1975), the beginning of learning to think.

The beginning of the development of P0 (Parent Zero) occurs when the baby begins to develop adaptive responses to the environment and represents the incorporation of the Parent that relates to the most basic needs of the child (Schiff, 1977). Messages related to P0 are usually somatic and nonverbal.

The forming structures of C1 (C0, A0 and P0) are the most primitive organised functions and, as they are elaborated and differentiated, will foster personality development. When the child is between five and six months old, the C1 substructure is formed and the two other substructures of the Child ego state begin to develop.

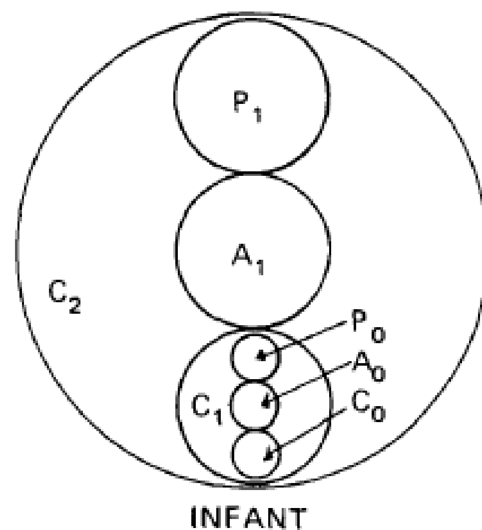

Figure 1: Development of the Child Ego State (Schiff, 1977, p.312)

P1- Parent in the Child- Although there are different opinions about when the P1 structure begins to develop, several authors who have dedicated themselves to the study of evolutionary development point to the period between 12 months and 3 years for the beginning of the formation of P1.

Schöfield (1992), who made a comparative study of child development in transactional analysis, cites Levin-Landheer (1982), Mavis Klein (1980), and Schiff et al (1975) among these authors. It is in this period, between 1 and 3 years, that the child is usually trained to control the sphincters and it is also the period in which the parental figures become more restrictive, NO being a word much used by both the child and the parents.

According to Schiff, at this time the child begins to conceptualise and the Parent, which is being

developed, is a fantasy of an external father who can be either negative or positive. This fantasised external parent, when incorporated, will serve as a repressive parental figure that will allow the child to be conditioned.

Berne (1972) called the Parent in the Child the Electrode. According to him, when the Parent in the head of Jeder – a character Berne created to designate any man - presses the button, Jeder's P1 jumps, whether its other parts want to or not.

Steiner (1974) refers to this subdivision of the Child as the Witch Mother or Ogre, and explains the name by saying that this Witch Mother has the function of forcing people to do things they do not want to do. According to Steiner, the Parent in the Child (P1) and the Parent (P2) present some characteristics in common such as the fact that both are parental structures, with parental behaviours learned from external figures. However, while Parent in the Child may behave in a seemingly protective manner, the real support and protection comes from P2. The power of subdivision P1 will be directed toward oppressive attitudes and conditioning.

According to Berne, the great difference between a trained animal and a domesticated animal is that "a trained animal will obey his master's voice when he hears it out loud; a tamed one doesn't need to hear the sound, because it carries it around in its brain" (Berne, 1972. p.64). We can close this topic by saying that the child is the most domesticated animal of all.

Another way of looking at this structure (P1) is the one proposed by Hargaden and Sills (2002). According to those authors, the child, when experiencing a negative experience related to the external environment, may perceive themself as unable to deal with the feelings arising from it. These feelings, not being processed properly, can be experienced as intolerable to the child. In order to manage them, the child keeps them as if they are separated from them, pushed into the P1 structure.

The usefulness of this is that, in this way, the child can coexist with feelings that would otherwise be threatening, making P1 therefore a space to contain introjections and denied parts of the self.

A1- Adult in the Child

Berne referred to Adult in Child as a keen and perceptive scholar of human nature whom he called Little Professor.

There are several opinions regarding the age at which the development of the Adult in the Child begins, and most of the authors who refer to this issue point to six months as the age from which the A1 is structured (Schofield, 1992). In the period of 6 to 12 months there is a significant change in the emotional meaning of relationships. Until then, many different people could meet the baby's need for attention. In this new phase, with the onset of individuation, the child perceives the mother as the other, a separate structure. It is the height of awareness of symbiosis. Between six and nine months the child expresses clearly and intensely that people other than the mother disturb them. The baby can already remember the mother's face and perceive the differences when comparing her memory with other faces. The Adult in the Child is involved in this internalization of the mother figure or adult caregiver, so that the memory of the mother's face can be used not only for comparison but to retain the image in the absence of the mother.

Hine (1997) refers to A1 as a pre-logical cognitive system very sensitive to the suggestion of urgency in both internal stimuli, such as hunger, and external stimuli, such as the perception of signs that the mother is about to leave the environment where the child is. The Little Professor presupposes purposeful learning experience and much of early life learning is related to survival issues. The baby needs someone to take care of it to survive. Therefore, A1's intuitive attention to urgency guides the child's attention to important stimuli, such as the mother moving away, by trying to learn ways to keep the separation from happening. Most babies cry when they see themselves separated from their mothers and welcome them on their return with clear signs of pleasure, although they can also utter complaining sounds amidst the shrieks and laughter.

Hargaden and Sills (2002) refer to A1 as representing the child's attempts to understand themself, others and the world. This understanding is based on the experiences of C1 and the patterns of later relationships. According to those authors, A1 is the basis of the child's personality and presents in two ways, A1 positive and A1 negative. The positive A1 is the self-image that is maintained by the messages of Counterscript, being the sense of OKness related to the retention of the bond with the other and to the successful adaptation of the child to these messages. The negative A1 is the appropriation, by the child, of those moments when she feels not OK and experiences negative injunctions. If the child's needs are met and her perception of herself is positive, these two A1 facets integrate, providing the child with a sense of OKness about herself.

Berne (1972) referred to the analogical way of thinking of the Little Professor as Martian thought. According to him, the Martian language translates the words to their real meaning in terms of results and allows the child to discover what their parents

really want. The task of the Adult in the Child is to intuit and think Martian in order to seek ways for survival. And they will do this as a small child can do - using intuition and magic.

It is important that we visualise the person we are talking about. Energy is directed towards the development of the A1 from about six months to about three or four years old. We are speaking, therefore, of a person who covers their eyes so that others will not see them, who knows how to read the subtle signs emitted by the adults who are important to them, and who, after reflecting and questioning, concludes that sea water originates from the spit of fish, is learning to speak and sing and control the sphincters, and who just learned to walk.

Berne (1972) suggested that the adult structure with which the child unravels the world at this time, the Little Professor, serves as a balance between two forms of behaviour, the Adapted Child and the Natural Child, deciding at every moment what kind of behaviour to use or repress in order to remain bonded to parents or caregivers. The behaviour of the Adapted Child is to avoid behaviours that are not adapted, while the behaviour of the Natural Child is spontaneous and expressive, dangerous for the A1, who seeks social adaptation. The defence mechanisms that the Little Professor uses to shape the Adapted Child and to contain the Natural Child are necessarily fanciful and limited.

Abreu and Lima (1988) addressed this theme and, according to, the Little Professor, through adverse environmental situations, organises powerful defence mechanisms, in a magical and fanciful way to hide the Free Child, the 'self' itself and shapes the Adapted Child as more adaptable and less authentic. According to this contribution, the Little Professor, when feeling threatened, structures and models without limitation, and represses and silences the Free Child's inclinations.

According to Lima, this uncontrolled defensive behaviour of the A1, in the face of the inhospitable environment, can become dangerous, as this defensive resistance creates a Sphinx child, cunning, destructive, enigmatic and perverse, whose purpose of existence is the repression of the Free Child. The A1 is smart, intuitive and devoid of ethics, fighting for survival in the way that seems most effective**.** The kind of thinking that the Child in the Adult does, which fascinates all of us, means that we find most small children to be cute and charming and does not reveal the inner process that occurs in the early years of life; which is not funny but instead is dramatic.

English (1969), in describing the Episcript or the Hot Potato Game, also refers to this determination of the Little Professor who, being instinctively committed to life, resorts to magical thinking, at the same time, to meet its priorities of obtaining parental strokes and defending itself from injunctions. But, however agile and firm the Adult in the Child may be, it cannot resist the force of the injunctions. To solve this, it sets up the episcript - "a secret plot based on the magic assumption that tragedy to the self can be avoided by passing it on to a sacrificial object, a victim or scapegoat" (English, 1969, p.77; 2005, p.306).).

Also according to English, there is a belief, a secret plan that the A1 adheres to or builds, which is to magically manipulate the script and pass it on to another person, in an attempt to avoid the final hamartic script ending. Thus, C2, the full Child ego state, is formed by these three vigorous and intense components, C1, A1 and P1.

And what is the fate of the Little Professor and the Child ego state as a whole, after childhood? Berne took a position on the Child ego state - C2 - in two different ways. In one of them, he saw C2 as an archaic and pathological ego state, composed of fixed content, resulting from related trauma, for example with unmet needs (Berne, 1961). In another, he saw the Child as the most valuable part of the individual's personality, which would accompany him throughout his life (Berne, 1972).

Transactional Analysts involved with this topic have positioned themselves one way or another according to their understanding of the issue. Stewart (2001) notes that these positions stem from the way transactional analysis professionals define Parent, Adult, and Child. If the Child is understood only as fixed material and unresolved issues of childhood, it will be seen as something from which we must rid ourselves of its pathological potential. He goes on to say that if instead the Child is understood to be all of our experience of the past, containing both the elements of script and autonomous childlike material, then we may perceive it as the source of energy and intuition in adult life. Other transactional analysts have a similar understanding, among them Clarkson (1988) and Goulding & Goulding (1978).

Blackstone (1993, trans 2005) states that: "In my opinion, any person's Child ego state(s) is inherently healthy. The more trauma someone dealt with in childhood, the healthier his or her C2 is because its structure and function show how the child successfully overcame significant hurdles in order to *have* a present." (1993, p.218; 2005, p.255). Hargaden and Sills (2002) suggest that when there was a sufficiently healthy childhood, C2 covers in its internal organisation the constituent elements of the earliest ego states, integrated so that the self can be

perceived as cohesive. Moreover, "... that the Child, although certainly being limited by the imperfections of parenting and environment, sits securely as the reliable core of the Adult" (p.27).

Final considerations

Humans are like patchwork quilts in their more or less successful attempt to tailor their good and bad experiences in the pursuit of a sense of self. From before birth our perceptions of the inner and outer environment are organised into generalised representations of the world that are activated when signs of the environment stimulate one of its parts. Ego states, such as Child, can be understood as networks of generalised representation networks, and therefore neural routes with an immense number of neurons and synaptic connections that can be activated by meaningful family stimuli.

The precocious ego states - C1, A1 and P1 - with their various contents coming from interaction with the environment, organise themselves with the pressing purpose of relating to one another, parents or adult caregivers, learning to decode what the parental figures really want and how to develop in the midst of child-caregiver interaction. The A1 subdivision, the Little Professor, is especially committed to survival, having to figure out the best way to maintain the bond with parental figures while trying to get rid of the injunctions given by these same figures. A1 is a naive and astute 'adult' who seeks to change reality to meet basic needs, with resources being intuition, Martian thinking and fantasy. While the child seeks to appropriate and metabolise the whole of its experiences, it encounters adverse situations in which the result of harmful and inappropriate interactions is defensively fixed and isolated, and this material is hardly accessible for change.

After childhood, the Child ego state, C2, formed by recording the events of a person's childhood, with their peculiar perceptions, basic decisions and conclusions, can be activated through networks of generalised representations that respond to bodily and emotional signals and also to transactional stimuli of figures that evoke parental figures.

If we can bear in mind that when children, armed with instinct, desire, and a handful of "slightly warped ego units (a set of pennies from a poor mold." (Berne, 1961, p.54; 1985, p.50), dare to sketch their future, perhaps we may feel more empowered to deal with the memories of these realities.

Finally, we can only reaffirm the desire that, as transactional analysts, we can recover and help others recover the energy and wisdom of the Child, so that we become adults who believe in magic.

"Fleas jump so much because they also have fleas" *(*Mário Quintana, 1983, when 77 years old)

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UK Council for Psychotherapy Position Statement on NICE Guideline for Depression in Adults

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Editor's Note

The following is reproduced here, with permission of the UK Council for Psychotherapy and their collaborators, because it makes interesting and generally applicable points about research methodologies.

The references are:

UKCP (2019) https://www.psychotherapy.org.uk/wp-content/uploads/2019/07/NICE-Depression-coalition-position-statement.pdf accessed 16 October 2019

UKCP (2019) https://cdn.ymaws.com/www.psychotherapyresearch.org/resource/resmgr/docs/downloads/StakeholderPositionStatement.pdf accessed 16 October 2019

The current NICE draft guideline on the Recognition and Management of Depression in Adults is not fit for purpose

According to the Mental Health Foundation, four in ten adults report experiencing depression at some time in their life. The sheer scale of depression in England and Wales should dictate that those charged with revising the 2009 guideline follow the most robust methodology in the most transparent way.

We have come together because we are extremely concerned about significant flaws in methodology, a lack of transparency and several inconsistencies we found in the first and second draft document NICE published in July 2017 and May 2018 respectively. NICE must address these issues in the third revision due for consultation in October 2019.

If the various concerns are not adequately addressed, the treatment recommendations cannot be relied on and will be misleading, invalid and impede the care of millions of people in the UK, significantly limit patient choice and potentially cause clinical harm.

In summary, our concerns are that:

- The draft guideline **fails to meet the NHS agenda of 'parity of esteem',** defined as valuing mental health equally with physical health. Despite depression often manifesting itself as a long-term condition, or becoming a long-term condition if immediate care is inadequate, the current draft recommendations are all made on the basis of very short-term outcomes (often 6-12 weeks). NICE guidelines for long term physical conditions would treat this evidence in question as inadequate, requiring at least 1 or 2 years follow-up data. Follow up data of 1-2 years has instead been completely ignored in the draft depression guideline.

- Ensuring that the **views and experiences of those who use the services** are properly taken account of, should be the *sine qua non* of a publicly funded body tasked with devising clinical guidelines, particularly as these services are fundamentally shaped by the guidance NICE produces. The current draft guideline has used **out-of-date evidence of service user experiences** mostly dating back to before 2004 and has failed even to incorporate this evidence into treatment recommendations.

- The current draft guideline is completely **out of step with US and European guideline methodologies.** The Guideline Committee has created its own method for categorising depression by longevity and severity – leading to **erroneous and unhelpful classification of research studies which do not match clinical, service user experiences or research outcomes.**

- The current draft guideline has used **inadequate methods for working out whether a treatment has shown itself to be effective** within a research study – ignoring the severity of depression at the start of the treatment. Much better methods exist for this and are widely used in the research community.

- The current draft guideline **used statistical analyses (network meta-analyses) that are associated with serious and unique risks**. These were inadequately reported and addressed (leading to violations of statistical assumptions in the approach adopted) and this therefore puts the resulting treatment recommendations into serious question.

- The current draft guideline has an **extremely narrow focus on symptom outcomes** and fails to take into account other aspects of service user experience which have long been called for such as quality of life, relationships and ability to participate in work, education or society.

- The current draft guideline poses a **serious threat to patient choice** and will result treatments being offered which may not have the best chance of relieving their suffering (which in turn will contribute to poor cost effectiveness in the long term).

Our position, therefore, is that a full and proper revision of the guideline must take place allowing sufficient time to properly address the concerns listed in this statement. These amendments must be made before the guideline is published.

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See full position statement here: https://www.psychotherapyresearch.org/news/452957/SPR-UK-Stakeholder-Campaign-against-the-NICE-draft-Guidelines-for-Depression-in-Adults.htm

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Stakeholder position statement on the NICE guideline for depression in adults

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Background

According to the Mental Health Foundation, four in ten adults report experiencing depression at some time in their life. The sheer scale of depression in England and Wales should dictate that those charged with revising the 2009 guideline follow the most robust methodology in the most transparent way.

In November 2017, the signatories to this position statement wrote to David Haslam, Chair of the National Institute for Health and Care Excellence (NICE), to formally request a second stakeholder consultation of the next revision of the guideline on the Recognition and Management of Depression in Adults, prior to its formal publication. We did this because, along with many other stakeholders, we were extremely concerned about significant flaws in methodology, lack of transparency and several inconsistencies we found in the draft document published in July 2017.

We briefed a number of peers and MPs who took seriously our concerns that the document was not fit for purpose. In February 2018, an Early Day Motion was tabled and a number of MPs signed a cross-party letter to NICE asking that they respond to our letter. A meeting took place between the members of this stakeholder coalition and NICE in April 2018, following which, the NICE executive opened a second four-week consultation on the revised draft.

Update March 2019: in July 2018, thirty-four MPs and Peers including a former Minister for Health, wrote to Sir Andrew Dillon, CEO of NICE, asking NICE to address our concerns. In October 2018, registered stakeholders received notification that the new guideline would undergo a third revision starting in December 2018. The planned publication date for the guideline is February 2020 with a consultation period from 2nd October to 13th November.

The scope for the third revision does not include any of the concerns detailed in this statement. Instead, NICE proposes to update the existing evidence review and to include new work on 'patient choice'. It is unclear what body of evidence 'patient choice' refers to, but NICE have specified that this does not refer to patient experience (of which there is a significant body of evidence).

Summary of Serious Concerns

The various methodological concerns we raised in our first response to the draft have not been addressed in the revised version.

Thus, we maintain our position that this guideline is not fit for purpose and if published will seriously impede the care of millions of people in the UK suffering from depression, potentially even causing clinical harm.

Under NICE's own rules, a second consultation can occur exceptionally if "information or data that would significantly alter the guideline were omitted from the first draft, or evidence was misinterpreted in the first draft and the amended interpretation significantly alters the draft recommendations"[1]. Both conditions have been met in this case. Stakeholders identified wide ranging and fundamental methodological flaws in the draft and offered recommendations for addressing these. In spite of acknowledging the serious omissions and misinterpretations through issuing a second consultation, these key issues have not been addressed in the new draft.

The quality assurance process in the stakeholder response document and in the overall process appear to fall short of acceptable scientific standards and lack scientific integrity. Our position, therefore, is that **a full and proper revision of the guideline must take place** allowing sufficient time for the guideline group to properly address the concerns listed in this statement. These issues relate both to the omission of large amounts of data as well as the potentially significant material impact on the recommendations that would arise from their inclusion. If these issues are not adequately addressed, the treatment recommendations cannot be relied on.

The draft guideline in its current form poses a serious threat to patient choice and will result in patients being offered a limited selection of treatments, which may not be the treatments that have the best chance of relieving their suffering (which in turn will contribute to poor cost effectiveness in the long term). **The following amendments must be made before the guideline is published:**

1. NICE should conduct a proper analysis of 1 and 2-year follow-up data from trials and prioritise treatment recommendations made on the basis of these data over and above recommendations which are made on the basis of short term outcomes (less than 1 year).
2. A full systematic review of primary studies of service user experience is required, employing formal methodology for qualitative synthesis; AND findings from such a review must be incorporated into the broader approach to quantitative review and treatment recommendations rather than being left as a stand-alone section.
3. Trials where the majority of the population is clinically complex, chronic or treatment resistant need to be grouped together as 'persistent depression' for the purposes of review, following the European Psychiatric Association[2].
4. The guideline review must look at the amount of clinical effect (e.g. partial recovery) from a severe baseline point and not ignore treatment effects because clients do not fully recover by the end of treatment. Moreover, categorisations of depression severity must be based on validated tools, not un-validated non-transparent functions of them.
5. Findings from indirect or mixed comparisons using Network Meta-Analysis (NMA) should only be used to supplement evidence derived from direct comparisons. NICE must reanalyse the data using standard meta-analyses and should NMA be used to supplement the findings a validated and reliable model for doing so should be employed.
6. NICE must run a reanalysis of studies using quality of life and/or functioning outcomes where these are available and prioritise recommendations based on these measures, given that these are the measures of greatest priority to service users.

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This position statement outlines in detail below the basis for each of these required amendments.

Methodological focus of concerns

This coalition of stakeholders is driven by and comes from a position of psychotherapeutic neutrality and scientific integrity, just as the development of the guideline should be. In other words, whilst some of the organisations involved may have a particular leaning towards one therapeutic approach or another, our concerns are directed towards the methodology adopted by the guideline development group and specifically their (a) selection, (b) grouping, and (c) analysis of the supporting evidence.

The evidence-based medicine paradigm has been shaped by medical science. This requires some adjustment when comparing and contrasting medical treatments with psychological treatments. The overall methodological approach in the guideline inherently favours (a) medical trials over psychological trials; and (b) particular psychological treatments over others. This is not an acceptable scientific stance and creates biases that are based on subjective choices rather than good scientific evidence of treatment effectiveness.

Moreover, we note that the guideline displays an over-reliance on one type of scientific method and fails to take account of the wide variety of good quality evidence available that uses a variety of methodologies and designs. Relying entirely on Randomized Controlled Trials (RCTs) represents a seriously restricted model of science. The various limitations of RCTs specifically in the field of mental health have been pointed out repeatedly by experts from many scientific disciplines and positions irrespective of therapeutic modality. Most psychotherapy trials are not sufficiently powered to detect true differences[3], and guidelines that ignore important evidence as they occur in clinical practice are concerning. Thus, there is a need to take account of large standardised routine outcome datasets, such as the Improving Access to Psychological Therapies (IAPT) dataset.

As the Health Foundation and Cochrane Collaboration have stressed[4,5], creating sound policy requires that we draw on a diverse range of evidence and that cohort studies as well as qualitative and case study research evidence maximizes the value of reviews to policy and practice decision-making. We recognise that some of these broader methodological matters should and will be addressed in our stakeholder responses to the NICE manual consultation currently ongoing. Nevertheless, serious methodological flaws in the current draft guideline for depression outlined below relate to the Guideline Committee's application of methodological practices set out in the current NICE manual.

1. The guideline must enable NHS services to deliver 'parity of esteem'

'Parity of esteem' refers to the legal requirement, set out in the Health and Social Care Act (2012), for NHS bodies to give equal priority to mental and physical health. Treatment recommendations set out in the draft guideline for depression will have a direct impact on the future commissioning of mental health care services and workforce planning (including IAPT and secondary care) and thus have an impact on the care of millions of people with depression and their families.

Depression often manifests as a long-term condition, or becomes a long-term condition if immediate care is inadequate. Depression can also be highly episodic and there is a high relapse rate. For example 38% of IAPT clients are repeat attenders[6]. It is imperative for research to demonstrate that treatment effects are long-lasting, or indeed to note where effects might appear over the long-term follow-up (sleeper effects).

NICE states that "the aim of [an] intervention is to restore health through the relief of symptoms and restoration of function, and in the longer term, to prevent relapse". NICE guidelines for long-term physical conditions such as epilepsy and asthma examine treatment outcome data over 1-10 years. The evaluation of treatments for depression must meet the same standards as guidelines for long term physical conditions. This requires the guideline to base recommendations on evidence concerning the long-term effectiveness of treatments.

The current draft recommendations are all made on the basis of very short-term outcomes (often 6-12 weeks) and always less than 1 year. This is inadequate as a basis for recommendations for long-term conditions (whether physical or mental). NICE guidelines for long-term physical conditions would treat this evidence as inadequate, requiring at least 1 or 2 years follow-up data. Follow up data of 1-2 years have been omitted in the draft depression guideline.

The Guideline Committee state that there are insufficient studies with long term follow up data to conduct such analyses. If this is the case then it is inappropriate for the guideline to make any firm recommendations for specific treatments based on (albeit large amounts of) short-term outcome data. Large amounts of poor evidence must not be used in place of small amounts of good evidence. **NICE should conduct a proper analysis of 1 and 2-year follow-up data where available and prioritise treatment recommendations made on the basis of this data over and above current recommendations made on the basis of short term outcomes (less than 1 year).** This is likely to alter the recommendations significantly, since, for example, where follow-up data is available these tend to be favourable to longer-term therapies over short-term therapies.

2. The guideline must review evidence on service user experience

Ensuring that the views and experiences of those who use the services are properly taken account of, should be the *sine qua non* of a publicly funded body tasked with devising clinical guidelines, particularly as these services are fundamentally shaped by the guidance NICE produces.

While the guideline committee has consulted service users as part of the guideline development process, it has largely ignored the voices of service users, using out-of-date evidence of service user and carer experiences mostly dating back to before 2004 and has failed even to incorporate this evidence into treatment recommendations.

The decision not to update this section is not justified given that evidence relating to service user experience has at least equal value to quantitative evidence of clinical outcomes. In omitting such a significant body of evidence, NICE has failed to follow its own stated approach to Patient and Public Involvement (PPI), which "reflects policy initiatives to involve patients, service users, carers and the public across the NHS and social care." In setting out its approach to PPI, NICE refers to policy contained in the Health and Social Care Act 2012; the NHS Constitution; Putting People at the Heart of Care 2009; and Essential Standards of Quality and Safety.

These policies collectively enshrine the right of service users to be fully involved in decisions affecting their care. The specific role of NICE within the planning of healthcare is to commission or conduct methodologically robust systematic reviews of evidence and to use findings from such reviews to inform a set of guidelines for the delivery and implementation of care. PPI must reflect this specific role and hence guidelines must include methodologically rigorous reviews concerning service user experience.

By not updating this section, the guideline fails to reflect the dynamic context in which people experience depression which is intertwined with the social and economic context in which people live. There is growing evidence of the impact of austerity on depression and many clients have been significantly affected by reductions in their benefits, loss of work or changes to employment conditions resulting from the economic downturn and political choices. There have been changes which may impact on the extent to which clients encounter stigma. Moreover, recent policy changes, such as the Care Act 2014 and benefits changes, mean that carers' experiences are unlikely to be the same as in 2004 or 2009. These changes in context are further justification for ensuring up to date evidence is reviewed and included in this guideline now.

The service user section copied over from the 2009 guideline was itself inadequate. The overall approach was methodologically weak, unsystematic and lacking the level of transparency and rigour expected in qualitative synthesis approaches as referred to in the NICE manual. A scoping search was carried out in March 2018 by Dr Susan McPherson to identify qualitative peer reviewed research published between 2009 and 2018. This scoping found 93 studies that included over 2500 participant voices that were not considered. In addition, a further qualitative systematic review examines the experiences of relatives and carers of people with depression using formal qualitative synthesis methods[7]. This recent literature extends client experience data to many under-represented groups (such as those listed in the scoping document as requiring 'special consideration'); and takes account of changes in socio-economic and cultural circumstances.

Given the purpose of a NICE review is to conduct methodologically sound reviews of evidence, **a full systematic review of primary studies is required, employing formal methodology for synthesis such as meta-ethnographic synthesis, meta-synthesis or formal grounded theory as recommended in the NICE manual**[8]. This would enhance understanding of service user experiences, a position held by several bodies including the American Psychiatric Association, the Cochrane Collaboration[9] and the Health Foundation. **Findings from such a review must also be incorporated into the broader approach to quantitative review and treatment recommendations rather than being left as a stand-alone section**. Updating this review and taking account of its findings when forming treatment recommendations would have a significant impact on the recommendations because, for example, service users often voice a preference for more rather than less choice and for longer-term rather than shorter-term therapies, as alluded to in the 2009 service user experience section.

3. Categorisation of persistent forms of depression must reflect good evidence

The current draft guideline is out of step with US and European guideline methodologies, leading to erroneous and unhelpful classification of research studies which do not match clinical or service user experiences. The adopted distinction between treatment resistant and chronic depression (as well as distinguishing both from complex depression) is particularly concerning. There is no evidence that warrants these distinctions and no appropriate sensitivity analyses were carried out. These distinctions cause confounds in treatment research, as many participants in the trials meet the guideline's definition of treatment resistant and chronic depression and in some cases also complex depression.

Trials where the majority of the population is clinically complex, chronic or treatment resistant need to be grouped together as 'persistent depression' for the purposes of review, following the European Psychiatric Association[10]. This would have a significant impact on the guideline. In the future NICE also needs to look at whether the overall categorical system of mental disorders really fits with service user experience or whether a more trauma-focused approach would fit service user experience better. In the meantime, the current guideline must at least be in line with the best clinical and research evidence.

4. The guideline must use appropriate methods for determining treatment effect

The current draft guideline has used inadequate methods for working out whether a trial has found a clinically significant treatment effect. The Guideline Committee devised a method for dichotomising study populations into 'More severe' or 'Less severe' in order to account for baseline severity when determining treatment effect. This approach has no scientific validity and overrides the categorisations of severity used by well-established measures as well as established methods of calculating the clinical significance of treatment effects. This dichotomy is also relied on for the Network Meta Analysis. Indeed the Guideline Committee admit that this dichotomisation was driven by their wish to conduct a Network Meta Analysis, which is an inappropriate form of reverse engineering, particularly as dichotomization inflates effect sizes[11]. The Guideline Committee claim that this dichotomization was supported by and will benefit General Practitioners but present no evidence or this claim.

This is of critical importance because persistent, severe and complex forms of depression represent a large component of the population of people with depression, yet there are very few treatments which have been found to help. Full remission from a severe baseline is difficult to achieve, whereas a treatment which helps some service users move from severe depression to mild or moderate depression (i.e. 'partial recovery'), for example, would be worth recommending. Service users with persistent depression are already doubly disadvantaged by their long-term mental illness because of the lack of parity of esteem reflected in the decision to omit long-term outcome data. In order to identify clinical practices which can relieve the severe and ongoing suffering within this population, **the guideline review must look at the amount of clinical effect from a severe baseline point and not ignore treatment effects simply because clients do not fully recover by the end of treatment. Examining partial recovery is therefore critical in order to identify treatments which can be of some benefit to people with severe and/or complex depression.**

5. The guideline must not base its primary recommendations on results of Network Meta-Analysis

The current draft guideline used statistical analyses (i.e. network meta-analysis, NMA) that are associated with serious and unique risks over and above that of standard meta-analyses that need careful addressing when employing it[12,13,14]. The Guideline Committee disagrees yet offers no scientific basis for their disagreement. NMA is an experimental technique with no formal expert consensus yet established on its appropriateness for this type of review. It relies on particular conditions, which, if not met, render the outcome unreliable. It is not the role of NICE to provide an experimental platform for methodological technicians. This type of methodology must first be subject to critical discussion and consensus forming within the scientific field through peer-reviewed publications and debate.

Use of the methodology in national guidelines should also be subject to formal stakeholder consultation, which has not yet taken place. NICE has over-reached its function in undertaking this experimental technique and making it the basis of a national guideline impacting on millions of people experiencing distress. This approach represents a serious deviation from accepted methodologies, is not supported by several experts in the field, has not been subject to a proper stakeholder consultation and should not be used.

The main assumption underpinning the validity of NMA is that the indirect and mixed comparisons are only valid when the studies included in the synthesis are similar in their distribution of effect modifiers[15]. These include not only severity at baseline, number of previous episodes and quality of study, which the draft guideline tried to address, but also sample size, age, sex, socio-economic

factors, therapist factors, as well as treatment dose and administration of treatment, which the draft did not address.

The NMA included 351 studies comparing 81 interventions and combinations of interventions, which differed considerably in all these variables, thus violating the transitivity or consistency assumption[16]. The variable distribution and thus contribution of the different treatments included in the NMA is highly problematic. It is evident that some treatments contributed very few studies (e.g. yoga and any AD contributed only two studies), whilst others (e.g. individual CBT contributed 35 and Amitriptyline contributed 43 studies). Thus, findings might not depict a representative range of treatment, thereby biasing an effect estimate compared with those with more studies[17].

It is our position, and in line with Canadian Agency for Drugs and Technologies in Health[18], that **findings from indirect or mixed comparisons (NMA) should only be used to supplement evidence derived from direct comparisons (standard meta-analysis). The evidence must be re-analysed accordingly.** Given that the recommendations for first episode depression rely on these analyses, this will have a significant impact on the recommendations.

6. The guideline must take proper account of non-symptom outcomes

The current draft guideline has an extremely narrow focus on symptom outcomes and fails to take into account other aspects of service user experience which have long been called for, such as quality of life, relationships and ability to participate in work, education or society. The guideline scope lists adaptive functioning, carer wellbeing and a range of other outcomes among the list of main outcomes to be considered, and yet the guideline takes no account of these outcomes.

Analysis of these outcomes would significantly impact the findings of the reviews. This is known because a re-analysis of the 2004 NICE guideline studies focusing on non-symptom outcomes (quality of life and functioning) found that the 'best' treatments were not the same as those deemed 'best' from the analysis of symptom outcomes[19]. This re-analysis demonstrates that such a review is both possible and useful. The Guideline Committee state, without foundation, that such an analysis is not possible because of the limited number of studies reporting such outcomes. Large amounts of inadequate evidence should not be used in place of small amounts of good evidence. Service users express a preference for improvements in quality of life over symptom change. The principle of patient-centred care, enshrined in the NHS Constitution and other NHS policies, demands that NICE take account of what service users actually want from treatment. **NICE must run a re-analysis of studies using quality of life and/or functioning outcomes where these are available and prioritise recommendations based on these measures, given that these are the measures of greatest priority to service users.**

Conclusion

If these serious methodological flaws are not adequately addressed in the guideline, the treatment recommendations cannot be relied on and will be misleading, invalid and impede the care of millions of people in the UK, potentially causing clinical harm. During the meeting between this coalition of stakeholders and NICE, NICE representatives suggested that some of these concerns could be addressed in the next revision of the guideline. Whilst we hope that NICE will indeed improve their methodological approach in future guidelines, we maintain that these issues need to be addressed now and not postponed. NICE guidelines have a significant influence on UK policy as well as

internationally and therefore, publishing this guideline in its current form would have a very damaging impact on service users, services, the health professional work-force and research practices.

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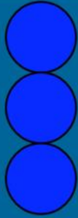
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TA Contributions from India

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Abstract

Produced originally as the content for an opening speech and associated workshop at the ITAA/SAATA Conference in Kochi, India in August 2018, the following contains a review of theoretical contributions from authors based in India between 1993 and 2018. In particular, the wide-ranging contributions of Os Summerton and Pearl Drego are described, along with a review of the activities of Father George Kandathil and of others on the subjects of the guru, ethics, universal consciousness and conflict strategies. Two themes are extracted: practical ideas and models, and the cultural and spiritual nature of Indian society, with an expansion of Berne's concept of autonomy into five components that are linked to Indian philosophy.

Key Words

autonomy, conflict strategies, cultural parent, cultural shadow, ethics, ethnic child, guru, India, transactional analysis, universal consciousness, Vipassana

Introduction

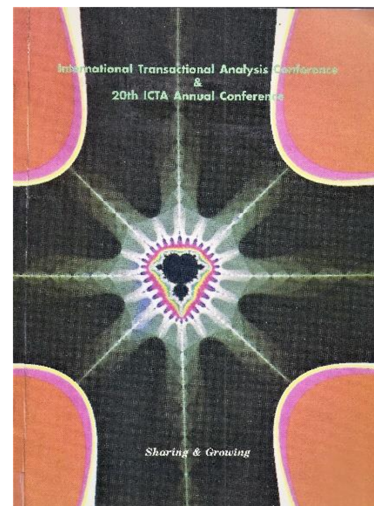
This material was prepared for the inaugural speech and a following workshop at the international Transactional Analysis Association (ITAA) and South Asian Association of Transactional Analysis (SAATA) joint conference in Kochi, India in August 2018. In the event, there were serious floods in the region and I was unable to proceed beyond Mumbai airport. Afterwards, I recorded the opening speech and made it available to the participants, and now generally, on YouTube at https://youtu.be/TVeLO8JIeTM.

I was invited to give the opening speech because I had been involved with the TA community in India since I had served as ITAA President 1990-1991. As President, I had received and presented an offer to the ITAA Board of Trustees to host the 1993 ITAA conference in India. Since then, I have visited India many times, running TA training in many locations, attending further conferences, taking part in multi-level learnings, and running Training Endorsement Workshops including one in January 2018.

In addition to professional activities, I have ridden astride an elephant in a parade, been taught to wear a sari, visited many varied places of worship, cooked dosas on a big griddle at a conference, engaged in numerous tourist activities, and made many friends within the TA community.

25 Years Ago

I began my preparation for the inaugural speech by looking back 25 years, when I realised that I still had my copy of the conference proceedings from 1993.



Conference Proceedings 1993

The theme was *Sharing and Growing*. Sr Annie Maria wrote about organising the conference, Fr George Kandathil about the conference theme, there were workshops on education, industry, management, rural women, cancer patients, P_1, and PK Saru (1993) wrote about *Vipassana*, explaining how this centuries old Buddhist meditation technique has striking similarities with TA. Learning to observe without identifying self with sensations builds awareness, especially once we recognise the universal truth of impermanence and the transitory nature of feelings. Vipassana encourages awareness at a deeper spiritual level, so that a higher order of intimacy becomes possible.

Dr George Kandathil

Oswald Summerton

Pearl Drego

Before 25 Years Ago

Of course, to be hosting an international conference in 1993 meant that TA had already been thriving in India over many years. Fr George Kandathil (1910-2011) had trained with Muriel James and Claude Steiner and returned to begin teaching in India in 1971. In 1973 he initiated the Institute for Counselling and TA (ICTA). Soon afterwards, Fr Os Summerton (1926-2012) returned to India after training with Martha and Bill Holloway and Bob and Mary Goulding and in 1976 set up the TA Society of India (TASI) followed in 1980 by the Transactional Analytic Centre for Education, Research and Training (TACET). Pearl Drego was already there, completing a master's thesis in 1976 on script and injunctions.

Father George

Fr George then concentrated on getting TA out there, such that many became TA qualified and there is now the thriving TA community that has formed SAATA. In 1995 he co-authored a book aimed at the layperson (Kandathil, Kandathil & Atthreya, 1995), and 2 years later Fr George and Sr Candida (Kandathil & Kandathil, 1997) wrote about autonomy as an open door to spirituality, which they described as "the process by which human beings transcend themselves. For those who believe in God, spirituality is their experience of this relationship with God. For a humanist, spirituality is a self-transcending experience with another person. For some it may be the experience of harmony or oneness with the universe or nature in whatever way we describe it." (p.28).

I have often thought that I'm OK, You're OK is the equivalent of the TA religious belief – can you claim to be a TA practitioner if you don't believe it? Yet constructivist TA, and neuroscience, tell us that we construct our world: the film *The Matrix,* and some scientists, claim that it is all constructed. Some of you may be familiar with the way in which I have extended life positions into windows on the world, with a metaphorical non-distorting open window for I and You. As I prepared this material, I was intrigued to realise as an atheist just how much my approach to TA has been influenced by Jesuits. The TA 101 I attended in the 1970s was run by Michael Reddy, who had left a Jesuit monastic order after learning TA. Fr George and Os Summerton were both Jesuit priests who created TA associations that emphasised they were for, respectively "different traditions of religion, race and region" (ICTA) and "Hindus, Christians, Muslims, Sikhs and Parsis" (TASI). Bearing in mind that the originator of TA was Jewish, I invite you to think about how much TA for you is intermingled with religion and how much it is captured in the Kandathil and Kandathil comment that "when autonomy and intimacy blend in a person, he or she transcends himself or herself and rises to a new level of experience. This level of experience is what we mean by spirituality. Human love is the seed from which spirituality grows, and it is the fruit of spirituality as well." (p.29).

Os Summerton

RANI

When I began to look at what Os Summerton had written, I was aware of his many papers about psychological games. However, before that I saw that he had written about RANI (Summerton, 1979), which he used as an acronym for Relationship Analysis Instrument. This was based on what he regarded as the most common stroking combinations between people, of Parents to Parent, Adult to Adult, Child to Child, Parent to Child, and Child to Parent. He described positive strokes as pleasant and supportive of the individual and negative strokes as unpleasant and destructive of the individual. He pointed out that in his experience strokes were rarely clearly conditional or unconditional, although he then used U and C to suggest four stroking combinations which he described colloquially as:

- + U + C = I like you and I like what you do.
- + U - C = I like you and I do not like what you do.

- U +C = I don't like you but I like the way you do things.
- U - C = I neither like you nor what you do.” (p.116) (bullets added).

He went on to relate these to Berne’s (1961) four relationship possibilities: Sympathy – get along well together; Antagonism – enjoy fighting or arguing with each other; Antipathy – cannot stand each other; and Indifference –have nothing to say to each other. He linked these with symbols to the stroking combinations as shown in Figure 1.

Relationship Type	Symbol	Stroking Combination
Sympathy		(+U+C)
Antagonism		(+U−C)
Antipathy		(−U+C)
Indifference		(−U−C)

Figure 1: Relationship Qualities (Summerton, 1979, p. 116)

Summerton went on to provide some examples of how clients have used the Instrument to identify where they wish to change their relationships, such as Santosh who decided to ask for and listen to his wife’s opinions in the Parent to Parent interaction. He recommended that weightings are applied so that clients concentrate on one change at a time. He suggested that partners complete the Instrument individually before comparing notes, and that sometimes it may be necessary to consider 2nd order functioning in terms of Nurturing or Controlling Parent, Adapted or Free Child.

Parental Flip

Following that, I found his material on the *Parental Flip* (Summerton, date unknown, 1986). In his papers on this, he described how individuals under stress would flip from their own Child into their Parent ego state, usually in a way that meant they then attacked another person. He also identified how there might be ‘complementary’ parental flips, as shown in Figure 2.

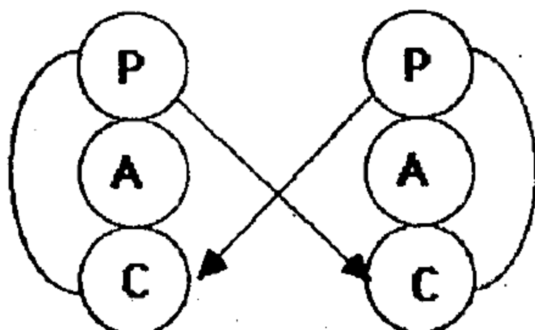


Figure 2: The Parental Flip in Action (Summerton, date unknown, p.109)

Rainbow Specs

Another early concept that I have found is Rainbow Specs (Summerton (1988, 1992a, 1993a). Prompted by the different colour thinking hats written about by Edward De Bono (1985), Summerton suggested that using the same metaphor for ego states might make the concept easier for clients to relate to, which is what he found. He emphasised that the colour indicates that each ego state has an attitude associated with it, to which the individual assigns a certain value. Changing colours then becomes an analogy for redistributing cathexis. Using Drego’s (1979) subdivision of Adult into Photographic and Combining, Summerton then suggested the following colour codes for seven ego states:

Red – Natural Child

Orange – Nurturing Parent

Yellow – Photographic Adult

Green – Combining Adult

Blue – Controlling Parent

Indigo – Rebellious Child

Violet – Adapted Child

It was fun to see a note in the 1993a article that a rainbow card had been distributed with the previous version of the article. The arc of a rainbow had been overlaid with the three circles for the ego states and two quotations had been included: “”I have set my bow in the clouds – a sign of the contract between me and earth” (Book of Genesis), and “Thou art a rainbow from the distant sky bending o’er the dust.” (Rabindranath Tagore).” (Summerton, 1993 a, p.33-34).

Models of Games

From 1992, Os Summerton contributed many papers on games to the TAJ, culminating with Figure 3 that summarised different models of games in terms of duplex transactions, the payoff, and parental strokes. In these he included Berne’s (1958) initial transactional model and (Berne, 1972) Formula G; the Goulding and Kupfer (Goulding, 1972) focus on inner perceptions; Kahler’s (Kahler & Capers, 1974) miniscript; Karpman’s (1968) drama triangle; Schiff & Contributors (1975) redefining hexagon; and English’s (1977) focus on strokes and psychological racketeering. He then added non-TA author Shaffer’s (1970) application of game dynamics to groups and communities rather than individuals, followed by his own game pentagon showing the five social roles.

Game Pentagon

For the Game Pentagon, Summerton (1992b) emphasised that the roles on this are social slots into which people can be expected to fit, and which may have negative or positive connotations.

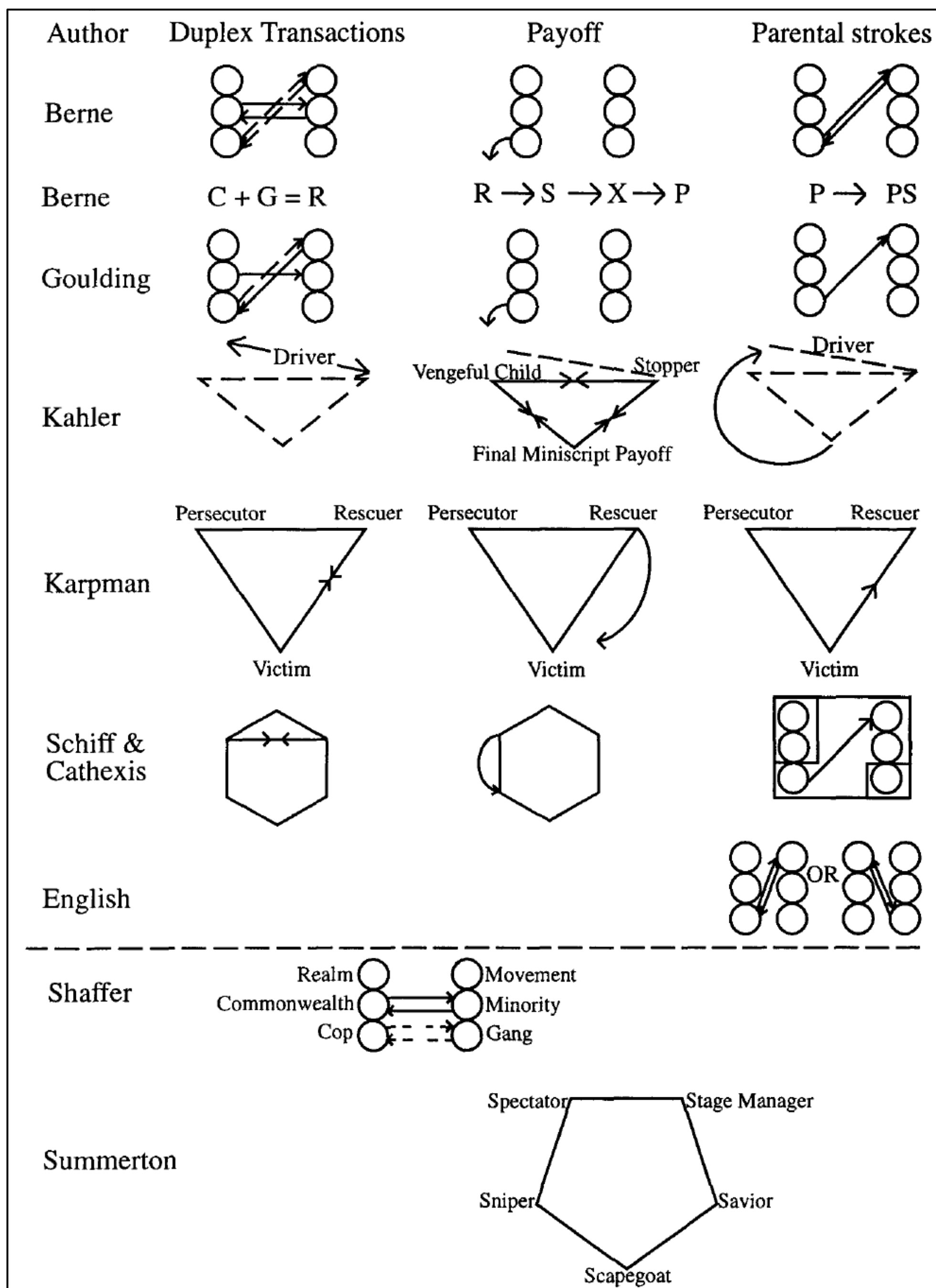


Figure 3: Summary of Game Models (Summerton, 2000, p.215)

See Figure 4 for the links between these roles:

- *Stage Manager* – the originator or source of an event, who unconsciously sets up the scenario or consciously masterminds it - such individuals may be forgotten because they do not appear on the scene of dramatic events.
- *Spectator* – the audience, the one who sits back and appears to be uninvolved but provides support by appearing interested in the event.
- *Sniper* – the openly decisive person, who may attack, defend, protect or prune, and offers critical comments and put-downs.
- *Saviour* – the ombudsman who brings justice, saves others from harm, takes up social causes.
- *Scapegoat* – who bears blame for others or suffers consequences on behalf or because of the group.

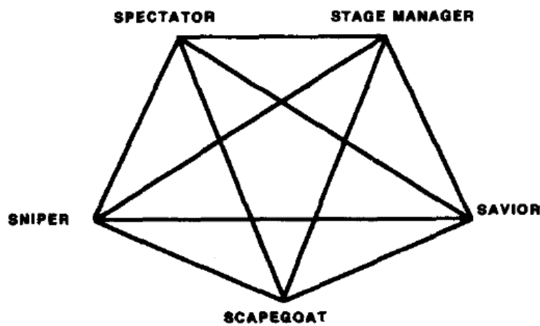


Figure 4: Game Pentagon (Summerton, 1992, p.69)

Soon after (Summerton, 1992c) he extended this to consider the two planes of intrapsychic and social, crediting Goulding and Kupfer (Goulding, 1972) with developing a way to analyse the intrapsychic processes of an individual and contrasting this with Berne's (1972) focus on the social situation. Summerton illustrated this as shown in Figure 5 by showing the Kupfer-Goulding model in a vertical plane alongside a horizontal plane containing Berne's Transactional Model.

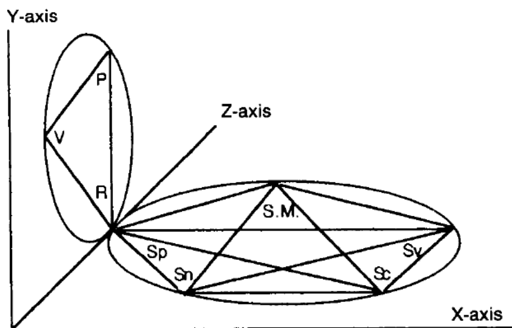


Figure 5: Two Planes of Game Analysis (Summerton, 1993b, p.31)

Not long after (Summerton, 1993b) he suggested a three-dimensional model using the drama triangle and the game pentagon, as shown as Figure 6. By now, he was also showing the game pentagon with drama triangles for each of the positions, indicating that we have four options: we are able to be in any of the roles on the game pentagon and behave competently, or we may do so in Persecutor, Rescuer or Victim role.

Summerton added that he saw Berne's "minor roles in script drama" (Berne, 1972, p.188) of Connection as merged with Stage Manager, Patsy with Saviour, Dummy with Spectator, and 'It' with Scapegoat. He added that rescuer, persecutor and victim without initial capitals are linked with Saviour, Sniper and Scapegoat, presumably in the positive version for that plane. In summary, the pentagon is of the positive or negative roles which are played in a group whereas the drama triangle roles relate to the individual – for instance, someone who ends as Victim within a psychological game may carry that position with them and end up being Scapegoated in a group.

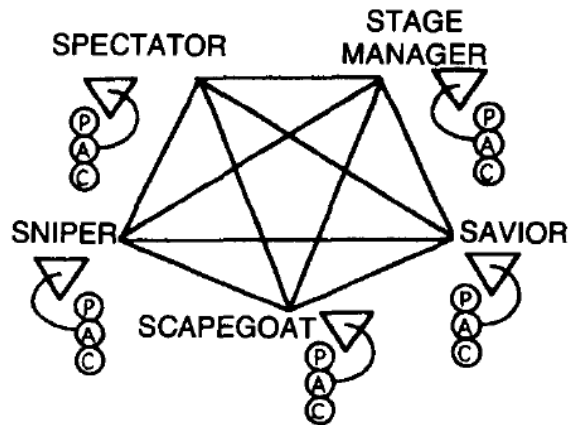


Figure 6: Diagram of the Individual on the Drama Triangle and the Game Pentagon (Summerton, 1993b, p.33)

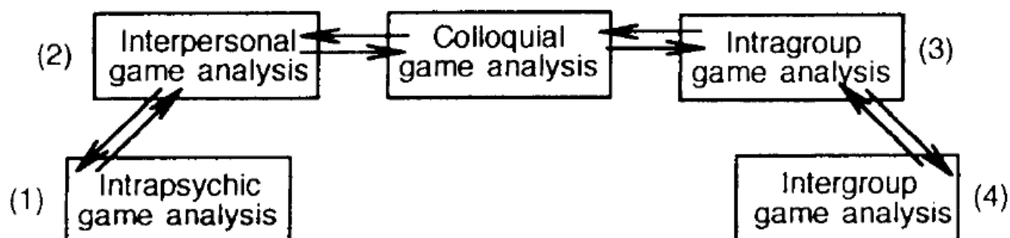


Figure 7: Game Spectrum (Summerton 1993c p. 88)

Game Spectrum

Summerton (1993c) also proposed that more attention be paid to analysing games within organisations on the basis of intragroup and intergroup dynamics rather than on interpersonal and intrapsychic factors. He suggested a 'game spectrum' (Figure 7) which showed how intrapsychic game analysis linked to interpersonal game analysis, which in turn linked to colloquial game analysis, with the mirror image of that leading to intragroup game analysis and hence to intergroup analysis. Summerton explained that the distinctions he was making were important to ensure that the organisational dynamics were considered and that individuals were not scapegoated by considering games only from the point of view of the individual player.

He went on to give a case study example of a joint family business with the husband as the chairman, the wife as the executive director, two sons were partners in the venture and several cousins were also involved. A psychological game of 'I'm Only Trying to Help/Poor Me' ensued (the game names are as they appear from the points of view of the two players). Having analysed the dynamics at an interpersonal and intrapersonal level, the two players then joined the rest of the family in order to complete the intragroup game analysis. This is "… the sum total of interpersonal analyses of group members with each other, together with analysis of what is happening in the group as an organism, that is, the analysis of members' transactions with each other as a unit." (p. 92). This is reminiscent of Berne's (1964) three-handed and four-handed games and is needed to avoid scapegoating. It also alerts people to the fact that different members of the group will often replace each other within the same game dynamics.

In the example, Summerton uses his Game Pentagon (Summerton 1992b) and identified that "Rex moved from Stage Manager to Saviour to Victim, Regina from Saviour to Spectator, John from Victim to Sniper, Bruce from Sniper to Victim, Rick from Victim to Sniper." (p. 93). This quotation is included here to demonstrate the number of moves that may be occurring in such games. In the same example, Summerton illustrates intergroup analysis because an uncle had been invited to join in the intragroup analysis; this uncle was therefore an outsider to the organisation but it seems that he too became engaged in a game when his comments about the game playing were perceived as a criticism of the family group.

To illustrate the intergroup game, Summerton refers to Shaffer's (1970) *Law and Order game*, which was based on analysis of riots in the USA during the late 1960s. For this analysis, Shaffer diagrammed cultural ego states as circles that did not touch, and representing two kinds of societies - the dominant one with a monopoly on force and the subordinate one with the advantage of natural cohesion. He showed how the dominant society indicates that every opinion is respected whilst at the equivalent of an ulterior level the police are telling people who are protesting that they must leave, and that the subordinate society is overtly making a reasoned protest but covertly resisting the police. In other words, both groups appear to be interacting on an Adult-Adult level but a different message is being conveyed Child-Child at the psychological level.

Summerton also shows how the group culture of the family business can be shown in terms of etiquette – we are the best; technicality – they award one plaque to one person, so that this person appears to be a favourite; and character – we are no good, we are fighting.

After some other examples, Summerton concluded by commenting that "the major difference between social psychiatry and social dynamics as understood by Berne (1963) is that the former focuses on managing unconscious manipulation, whereas the latter deals with the cultural matrices that support group games. In the effort to overcome group passivity, one important area would be to identify moral guidelines and alternatives in any society or organisation that can offset the impact of technicalities that are justifiable yet harmful." (p. 102).

Upside-Down Rackets

Summerton (1995) also developed a model of upside-down rackets, presenting these in terms of a ladder as shown in Figure 8. These represent the pathway between a real feeling and an old racket feeling, which occurs when a person "phenomenologically changes the real feeling and its energy into a racket feeling." (p.215). As an example, someone feeling genuine tiredness may 'confuse' this with the racket feeling of tiredness that they were allowed when feeling anger was forbidden. Hence the tiredness is then experienced as if it is a substitute, or racket, feeling and a familiar trading stamp payoff is taken. Within the ladder, this example would mean that the real feeling of tiredness is on Rung 1; in childhood this was allowed instead of feeling angry, which is the forbidden feeling on Rung 2; Rung 3 becomes the racket feeling of tiredness; and Rung 4 will be the familiar payoff that applied in childhood. Understanding the sequence can be very helpful to individuals as they learn about their rackets and begin to allow themselves to experience genuine versions of what they only previously experienced as substitute feelings.

Relationship and Group Analysis

One final mention – years earlier Summerton (1978) had also suggested some additions to the four types of analysis suggested by Berne (1961). Berne had ego

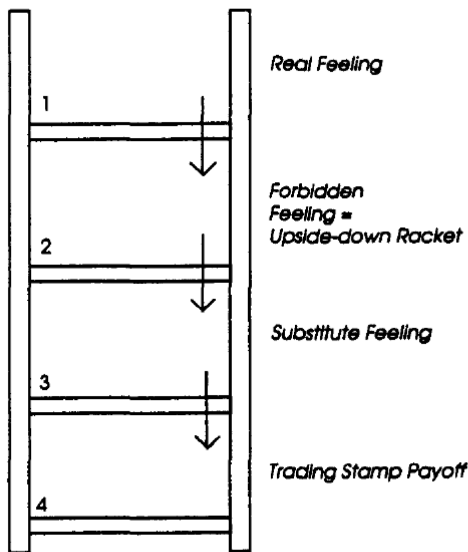


Figure 8: Upside-Down Racket Ladder (Summerton, 1995, p.219)

states, transactions, games and scripts. Summerton suggested we should add relationship analysis and the analysis of groups.

Pearl Drego

Paradigms

We can see the echoes of this when we look at Pearl Drego's work. Over the years, she has provided several articles about ego states. Referencing several prior publications (mainly conference presentations and books) Drego (1993) presented Berne's (1961, 1963) four principles of diagnosis to propose four corresponding paradigms, illustrating this with Berne's (1963) 'cowpoke story'. She provided a diagram to summarise Berne's models of phenomenological, historical, behavioural and social diagnosis, before presenting four more diagrams to illustrate how these become paradigms of experiential (for the phenomenological), biographical (for the historical), metaphorical (for behavioural) and relational (for social). Her diagrams for these paradigms are shown as Figures 9 – 13.

Different Perspectives

Whilst writing about the four paradigms later, Drego (2000) proposed that "Each ego state is an integration from past and recent experiences…" (p. 192). She suggested that there is a need to develop an integrated Parent, integrated Adult, and integrated Child [initial capitals for the second word of each only in original]. For this, she pointed out that ego states can be considered as metaphorical and as real; that they are both transactional and intrapsychic; and they are archaic and yet also contemporary.

She added that different models will lead to different perspectives, providing the worksheet in Figure 14 for problem-solving using those different perspectives. Phenomenological models help us to focus on who we can be in the here and now; historical models help us focus on who we were in the past and how we carry positive and negative influences from the past; behavioural models help us focus on improving the quality of our communication, both within ourselves and with others; and social models aid us in maintaining equity, partnership and dignity in our relationships.

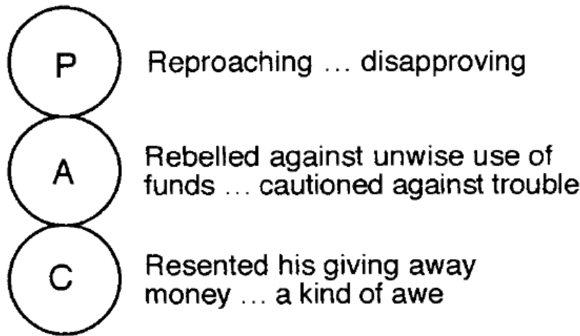
Adult Ego State

Within the 1993 paper, Drego also described the two aspects that had led her to label the two aspects for Adult ego state, referencing back to Drego (1979). She wrote that "the first aspect is called Photographic, which indicates the perceiving, appraising, representational, recording, categorising, and classifying ability of the Adult. The second is called Combining, which indicates the Adult's probability analysis, hypothesising, option-seeking, weighing of alternative courses of action, valuing, and decision-making abilities…. Berne (1970) mentioned two aspects of Adult: "taking in information from outside world, and deciding on the basis of reasonable probabilities what course of action to take" (p.105)." (Drego, 1983, p.20).

In 2000 she commented that she had found the "…dispassionate observer aspect of the Adult to be an ideal of harmony and self-actualisation that is consonant with mysticism and God-experience. The Indian spiritual ideal of being fully present in the here and now, without the effects of past karmas from this life or previous lives; the Buddhist ideal of self-awareness; the yogic ideal of dhyana or clear, unwavering attention; the classical Indian philosophical view of Being as consciousness and goodness; and the Christian experience of new life in Christ gives Berne's Adult ego state new dimensions of being and connectedness to deeper levels of reality." and "When transactional analysis supports the Adult in making a responsible choice based on a rational value, even though one is in the midst of emotional conflict from the Parent or Child, it seems to reinforce the values of the *Bhagavad Gita* of desireless actions or nishkarma karma. … The Photographic Adult… provides an additional spiritual dimension as the *witnessing self* or *see-er* in Indian spirituality and has the same sense of noninterpretive, even-toned response to both intrapsychic reality and external reality." (p. 204) (italics in original).

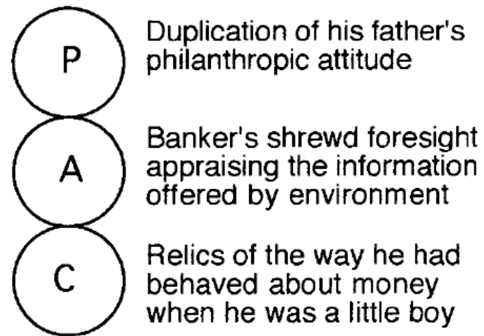
Writing in *The Script,* Drego (2004) referred in the title of her article to constructing the Lost Parent. Although she does not go on to mention this term specifically

Phenomenological Model of Cowpoke Story



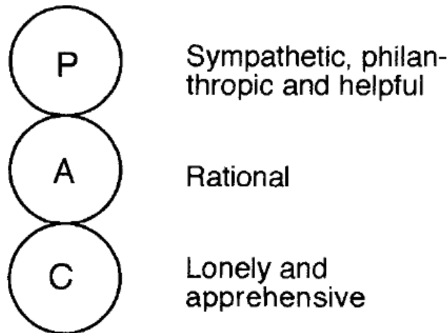
The subjective diagnosis is based on self-observation.

Historical Model of Cowpoke Story



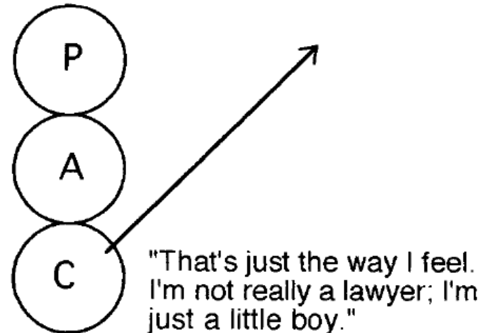
The historical diagnosis is made from factual information about the individual's past.

Behavioral Model of Cowpoke Story



The behavioral diagnosis is made by observation.

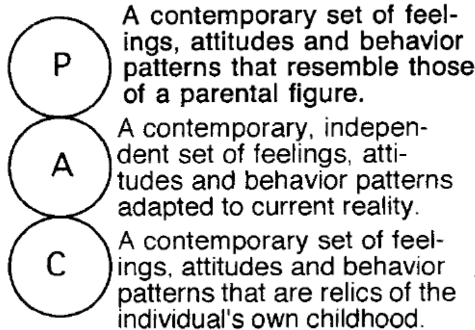
Social Model of Cowpoke Story



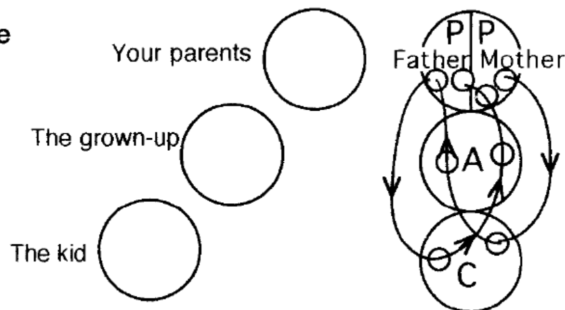
Those participating in transactions with the agent make the diagnosis on social grounds.

Figure 9: Ego State Models derived from the Four Paradigms of the Cowpoke Story (Drego, 1993, p.10)

Experiential Paradigm



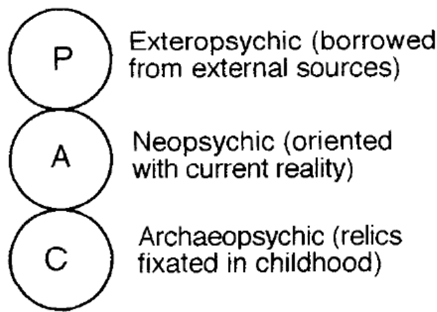
Phenomenological Models

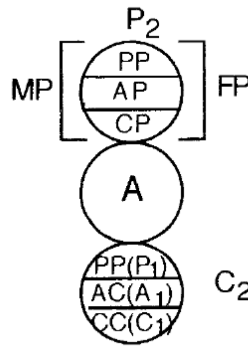


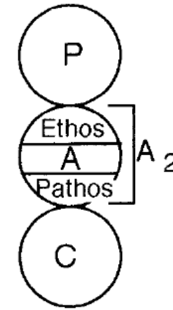
(Berne, 1963, pp. 136-137) (Berne, 1961, p. 174, Figure 16(a)) (Berne, 1972, p. 252)

Figure 10: From Experiential Paradigm to Phenomenological Models (Drego, 1993, p.12)

Biographical Paradigm **Historical Models**



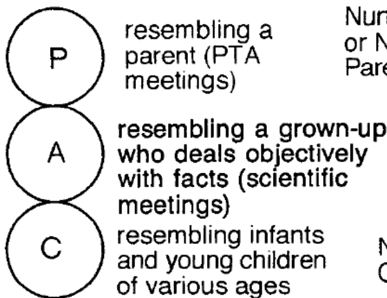


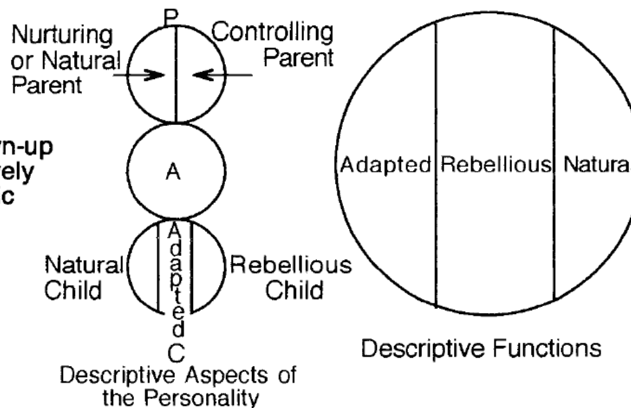


(Text : Berne, 1977, p. 146) (Berne, 1969, p. 111) (Berne, 1961, p. 193)

Figure 11: From Biographical Paradigm to Historical Models (Drego, 1993, p.14)

Metaphorical paradigm **Behavioral Models**

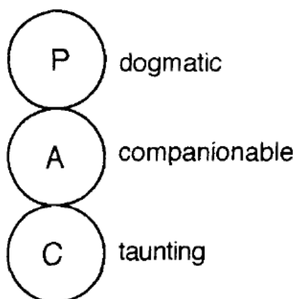


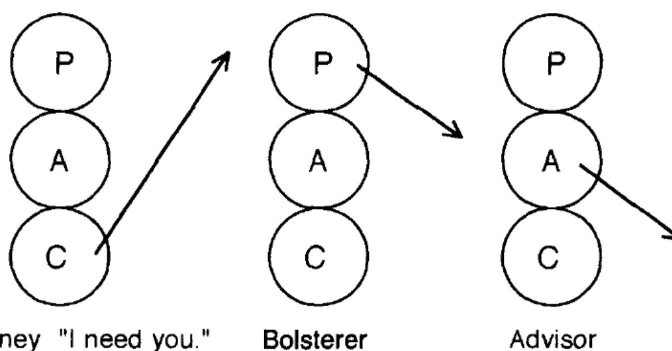


(Berne, 1963, p. 130, 1961, p. 71) (Berne, 1972, p. 13) (Berne, 1972, p. 412)

Figure 12: From Metaphorical Paradigm to Behavioural Models (Drego, 1993, p.17)

Relational Paradigm **Social Models**





(Berne, 1977, p. 147) (Berne, 1972, p. 384) (Berne, 1970, p. 272) (Berne, 1970, p. 274)

Figure 13: From Relational Paradigm to Social Models (Drego, 1993, p.21)

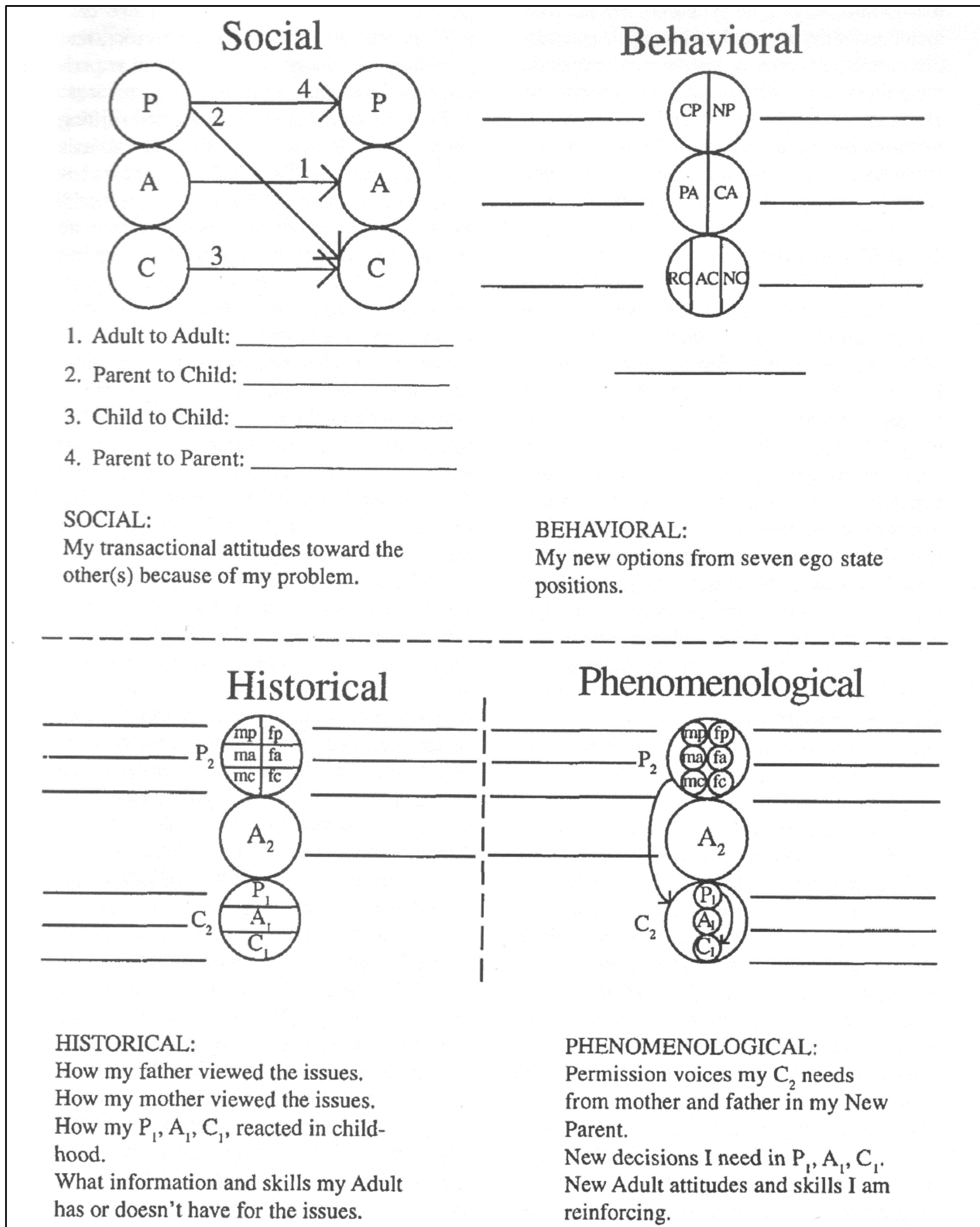


Figure 14: Ego State Models Worksheet for Problem Solving (Drego, 2000, p.200)

within the article, she writes that "The Parent ego state – the vehicle of hierarchies of autocratic power – has to submit to the reality-based lateral relationships of the Adult ego state. Commitment replaces domination, intimacy replaces predatory cultural relationships, strokes replace jealous competition and rivalry, and mutual planning replaces humiliating adaptations to authority." and "Hope is in the Adult ego state. When you have the facts and understand the scene, you can go beyond it." (p. 3).

Permissions

In her Acceptance Speech on receiving the 2004 Eric Berne Memorial Award, Drego (2005) drew together some of her material, including pointing out that relational/social and metaphorical/behavioural are

functional diagrams whereas those for biographical/ historical and experiential/phenomenological are structural. She added that "… permissions can be felt in the Child on the social model, heard behaviourally as an active voice from a Nurturing Parent, and becomes phenomenologically a re-experience of the positive history of therapy." (p. 18). She added that she was particularly pleased about the Award "because it includes recognition of two new permissions that I introduced and that are important to the Indian ethos: the experience of God as expressed in the permission to Be Holy and the experience of community as expressed in the permission to Fight for Justice" (p.8). She added that there are corresponding injunctions and that the first permission is a challenge to arrogance and the second a challenge to narcissism, casteism, and exclusivism in our societies. The first is particularly significant as a permission for girls in India and the second encourages bonding.

Drego concludes this 2005 article with "giving and receiving permission changes who we are. The development of updated ego states empowered by permissions represents a journey of the human spirit, with tremendous capabilities for family and groups, a journey that can infuse us to bring peace into our lives, our communities, and our networking between communities." (p.29).

Altruistic Model of Ego States

A year later, Drego (2006) went on to propose an altruistic model of ego states within the phenomenological paragon, as shown below. She referenced Harris's (1967) comments about updated validated Parent data, updated Adult data and updated appropriate Child data, before commenting that "the process of updating and integrating Parent, Adult, and Child ego states engages the total personality in capacity building, by which qualities such as helpfulness, responsibility, compassion and caring, self-denial, and service flow abundantly and easily. Phenomenologically, we experience a new updated integrated Parent that has potency, a new updated integrated Adult that has responsibility, and a new updated integrated Child that has the security of inner freedom. Furthermore, as the intrapsychic attraction between ego states deepens, so does interpersonal connectivity with others." (p. 99).

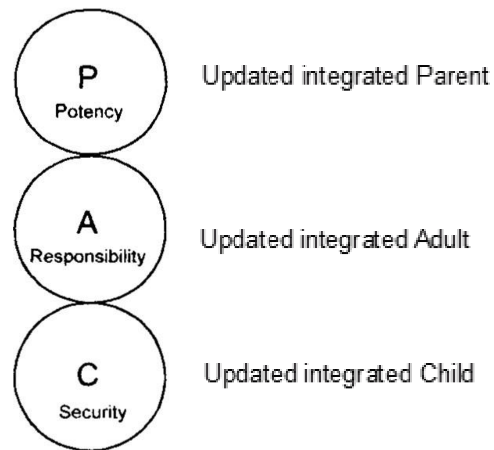


Figure 15: An Altruistic Model of Ego States (Drego, 2006, p.99)

Cultural Parent

Drego is of course known in particular for the introduction of the notion of the Cultural Parent, for which she suggested using ovals rather than circles to diagram the structure of the group culture, whilst using Berne's (1963) terms of etiquette related to Parent, technicalities related to Adult, and character related to Child, as shown in Figure 16. She (Drego, 1983) illustrated this with the example of the Indian dowry system, where the etiquette consists of beliefs about women and their status in the original and the husband's family, the technicalities are the procedures for accomplishing the handing over of money or assets, and the character consists of the feelings of those involved (e.g. worth or worthlessness felt by the bride, power felt by the husband's family). She reminded us that the Cultural Parent exists within the individual and also within a community; in the latter case it is that which justifies and maintains the given social order.

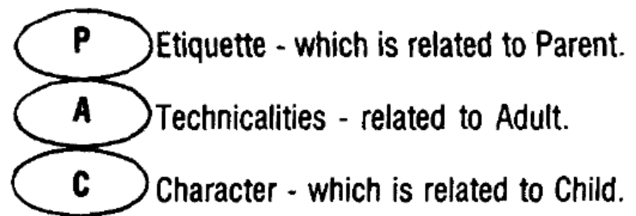


Figure 16: 'Personality' of a Culture (Drego, 1983, p.224)

Using similar examples from India, Drego went on to propose several examples that represent the Cultural Parent in action, including: children looking after younger siblings instead of going to school; wives been beaten by husbands; and believing oneself to be inferior because of the caste one is born into. She described the Cultural Parent as formed in the family and early sociocultural environment, and pointed out that the more closed the Parenting process, the fewer options allowed for the children. She also identified that movements to change the old structures may result in a reversal, quoting an example of China where children of farmers are encouraged to get a university education whereas the children of university graduates are denied this opportunity.

Drego proposed that an unhealthy Cultural Parent is one which:

- keeps things the way they are and repeats history;
- takes on responsibilities for others unnecessarily;
- punishes change and new behaviours;
- maintains power and control over others, whatever it may take.

Cultural Shadow

Some years later (Drego, 1996) she illustrated how the culture of the group is echoed within the Parent of the individual's Child. She had completed a five-year interdisciplinary study where she had interviewed 273 women about injunctions, and realised that it was through injunctions that the women cooperated with their own subjugation. They had their own internalised Cultural Parent and Drego suggested that we might think of it as a Cultural Shadow within P_1, just as Berne (1972) had referred to the negative electrode.

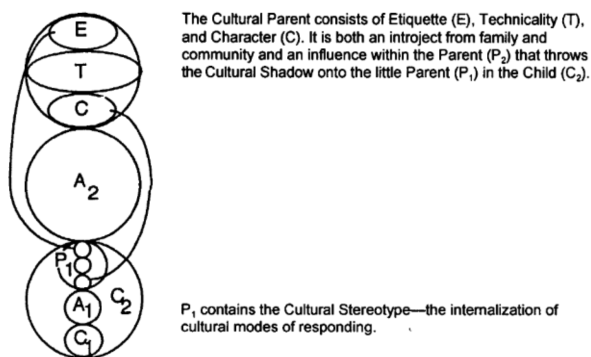


Figure 17: Cultural Parent and Cultural Shadow (Drego, 1996, p.67)

She also pointed out that elements of culture may be in harmony or conflict: social slogans in the etiquette such as Work Hard may be reinforcing script injunctions of Don't Feel; alternatively "Character, like the rebellious Child, may impel the group in a direction opposite to the group's etiquette. Character can therefore sabotage the etiquette." (p.61).

Providing detailed information about the myths around Sita, an ideal woman with a life of great suffering and rejection; Savitri, who appears to be invincible but only in order to challenge for the good of her family; and Draupadi, who is gambled away by her five husbands (brothers), Drego commented that such myths are powerful reinforcements of the injunctions within families and cultures. She also provided information about other mythical stories that are commonly told and which all serve to create a culture in which women are expected to sacrifice themselves for others, and especially for their sons. Drego wrote that, with enough information, it is possible to bring the cultural injunctions into consciousness, and the Cultural Shadow into awareness. However, "to bring about a change, the oppressive Cultural Parent and its injunctions, myths, and reinforcements must be cleansed at the individual level as well as at the group level. Therapy with individuals needs to be supported by group discussions among mothers, group support systems among women, retraining programs for families, and new kinds of relationships between mothers and their children – in short a form of cultural therapy similar to one Erikson (1963) described: "'group therapy'of the kind which would not aim at psychiatric improvement of the individual participant but at an improvement of the cultural relations of those assembled" (p. 127)" (p. 74-75).

In addition to the material about the Altruistic model of ego states referred to above, Drego (2006) provided further material that had been presented as the closing keynote speech at the World TA conference 2005 in Scotland, where she had praised what she regarded as the Scottish Cultural Parent:

"Etiquette: We are all equal and we have the right to be free.

Technicality: Each person is responsible to state an opinion and to participate.

Character: You can't force me." (p. 96).

She based this conclusion on factors in previous centuries such as that the first act of freeing a slave "came through an 18th century court order in Edinburgh that announced, "Nothing can change a rational creature into a piece of goods." (p. 90); the impact on women's emancipation and empowerment of the establishment of the first maternity hospital run by women; and the Covenanters' Bill of Rights which was ratified by all villages and counties and was sent to the king to demand people's self-determination.

Ethnic Child

Writing of yet another keynote speech, this time at the Transactional Analysis World Conference 2008 in South Africa, Drego (2009) extended her ideas about ego states and particularly the Cultural Parent, to propose an Ethnic Child. She began by describing four sources of inspiration: a march of over 20,000 women in 1956 to protest new laws requiring women to carry identity passes; the location of the conference in Africa with its amazing cultures and ecosystems; the contemporary ecological crises across the planet; and the vision of Eric Berne and other transactional analysts who work for societal change. She wrote that "I do not use "ethnic" to mean colored, first nation, or exotic. Every human child has ethnicity. We all have a biophysical ethnicity and a culturally conditioned ethnicity. It is the healthy parts of the latter that need to be identified, supported, and updated." and

elsewhere "The Child in us is shaped by constructed culture as well as by natural ecological supports that are fast losing their significance in our lives. We can restore the historical roots of eco-culture within the Child and harmonize these with a contemporary earth-centred ethos so that we are authentically ethnic and ecologically modern. On this foundation we can harmonise the ethnicity of our ego states with our commonalities as children of the universe. In ego state terms, we update the lost ethnic Child to create a new contemporary ethnic Child. The people in a land such as South Africa, which has suffered from so much human and ecological trauma, will surely have depleted Parent ego states and will need to increase their energies for nurturing, caretaking, and protection through community action." (p.195)

Drego went on to quote her personal experience with a 10-year-old Indian child who was being excluded from school. After Drego had worked with her using a daily routine of strokes and encouragement of Adult, the child was then very successful in school. However, Drego comments on her own dismay when she realised that the child has now become "… ready prey and promoter of the Parent of noninclusive, unequal globalization." (p. 196) when the child showed that her favourite food has become a pouch of Heinz Tomato Sauce with some Lays chips, slices of Kraft cheese, and Nestlé chocolate. On the basis of this, Drego concluded "This experience made me reflect that the task of the transactional analyst in this context is to heal and empower the Child in such way that the best of ancestral tradition is transformed into a buffer against global stereotypes. We need a new updated ethnic Child who is guided by a healthy transformed ancestral Parent who integrates updated universal Parent values and is monitored by an Adult who carries responsibility for self and society (see Figure 1). This updated Child must learn to identify with ancestral culture as well as with contemporary, eco-friendly culture." (p. 196). Later, she added "While the globalised Cultural Parent can create internal splits for the ethnic Child, it can also be a way of dissolving ethnic identities into one melting pot of false universality." (p. 199)". We need to be able to see the difference between true internationality and consumerist global culture, and a world of a united humankind rather than the world of multilayered corporate interests. We need a universal Parent based on an altruistic model of ego states and geared therefore to ecological regeneration, so that "The ethnic Child becomes transformed into the "Illumined Child" bonding with the divine Parent." (p. 204).

She also pointed out that "… injustices and oppression is perpetrated against a minority cannot be redressed by the members of that minority because they have lost the sense of collective identity from which to master the show of strength and political power." (p.199).

The Guru

There have of course been various mentions of the guru and the Indian culture.

Sashi Chandran (2007) wrote of the Guru within as she described how trainees in supervision move to empowerment even though overadaptation is strongly reinforced by Indian culture, and hierarchical processes and the existence of gurus is very common. Explaining that 'guru' includes spiritual guide or leader, one respected for their knowledge and who gives advice, the container of wisdom and dispeller of ignorance, she also comments that the guru is intrinsic in everyone and likens it to physis (Berne, 1961). The guru is about balancing using each ego state rather than existing within one of them; supervision and training aimed at developing the guru within the supervisee is challenging for supervisees and supervisors.

A similar theme was picked up by Saru (2011) when she wrote of the need for some form of professional licensing whilst stressing that becoming a psychotherapist should be "an evolutionary process wherein the person reaches a balance in feeling, thinking, and behaviour …. the secure base a psychotherapist needs in order to deal with transference and countertransference issues…" (p.152). She refers to "the wholistic (sic) development of the individual: cognitive, affective, empathic, and spiritual" (p.152). Hence, although licensing is needed, it is no guarantee of competence and should not be done at the risk of losing the way in which the guru models whatever they need to teach as well as imparting information.

This theme of the context of India and the guru was continued when Rosemary Napper interviewed Saru, Annie Cariapa and Sailaja Manacha (Saru, Cariapa, Manacha with Napper, 2009). Saru pointed out that "India is one of the most ancient civilisations in the world. It has a unique fabric of cultural, social, ethnic, religious, linguistic, and economic plurality and diversity. In this context, multiple relationships were very much a part of my training as an early Certified Transactional Analyst in the Pioneer group in South India." (p.326). Relevant wherever TA is beginning to grow elsewhere in the world, the multiple relationships work because of the plurality of the ethnic fabric; the guru models rather than teaches which means that this comes from a place of conviction, growth and integration. What is passed on is what has worked, meaning there is a high degree of authenticity and that leads to trust. There are sometimes challenges due to the multiple roles, which makes contracting particularly

important, but the key is integration – "in each of the roles… I bring certain aspects of my essence, of who I am, and all these aspects of who I am put together provide a powerful model to trainees when they see me as a trainer, a therapist, and a supervisor." (p.330).

Ethics

Continuing the theme of the Indian philosophical perspective, Suriyaprakash (2011) wrote of how his notion of ethics is influenced by *dharma* and *karma*. "Dharma has a wide spectrum of meaning, with basic duties on one end and the very nature of any being on the other. Between these two extremes are a range of meanings, including but not limited to righteousness, truthfulness, religion, code of conduct, morals, ethics, and values. Attempting to narrow the definition of dharma leads to oversimplification and hence defeats its purpose." (p.133). Suriya explained that karma is not fatalistic determinism; acting according to one's dharma earns good karma. He goes on to explain how the six paradigms shifts proposed by de Graaf and Levy (2011) are based on capitalism, democracy and individual development whilst Eastern cultures concentrate on collective well-being, respect for others and nature, and surrender to a larger force. Instead of moving from one polarity to another, we need to balance, whilst recognising that balancing is a continuous process.

Hence:

- the philosophy of "Vedanta emphasises the need to gain control and power over one's own senses and the importance of the means over the ends." (p.134)
- basing our decisions on dharma gives us "the power to shape our own destiny, which is intricately and inextricably interwoven with that of others around us, society at large, and the environment beyond." (p.134)
- The *Bhagavad Gita* "emphasises the need for us to transcend our narrow predicaments and act according to what is expected of us for the development of the larger system" (p.134)
- the Gita emphasises the need to act with the long-term in mind – and nature will find its own balance
- the Vedantic *Sanatana dharma* means "you are that" – self in its original form is the same in all of us and we are all parts of a larger whole, which in turn replenishes itself.
- The *Upanishads* (Roebuck, 2000) position ignorance as the result of attachment to material affairs and knowledge as the work of liberation from such attachment – this refers to the danger of believing we can know the right answer to an ethical dilemma.Universal Consciousness

This material was extended to include the Vedantic concepts of *bhaman, atma, yoga* and *satchidananda* (Suriyaprakash & Geetha, 2014) in a psychophilosophical exploration of death and embracing eternity. "Brahman is universal consciousness, which is all pervasive, and we are perceived as a part of that whole. Hence, while atma (the soul) inhabits the body, the body is not the atma. So, when death occurs, there is a transition in which the atma sheds one body and at some point enters another body." (p.336). Hence within the Yoga Sutras, among others, death is inevitable but the atma is eternal. The authors also explain that yoga means union and karma can loosely be defined as voluntary action, so karma yoga means recognising the repercussions that could result from an action and maintaining detached attachment in which our likes and dislikes are momentary.

Satchidananda is proposed as physis realised. "*Sat* is truth, *chid* is the awareness of the truth, and *ananda* is the bliss experienced through the awareness of the truth. … autonomy [therefore] could be understood as sat being the extension of spontaneity, as chid being the expansion of awareness, and as ananda being the experience of intimacy. …. this is how autonomy could be an "open door to spirituality"" (p.340) (italics in original).

Suriya and Geetha relate this to the Cultural Parent as shown in Figure 18. They also show, in Figure 19, how the process of spiritual contamination and fearing death is created, before giving some case examples of how this information can be useful within psychotherapy, educational and organisational practice.

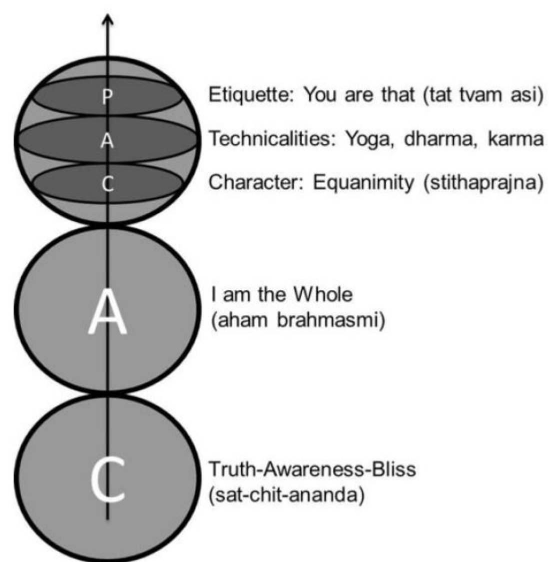


Figure 18: Spiritually Integrated Personality (Suriyaprakash & Geetha, 2014, p.338)

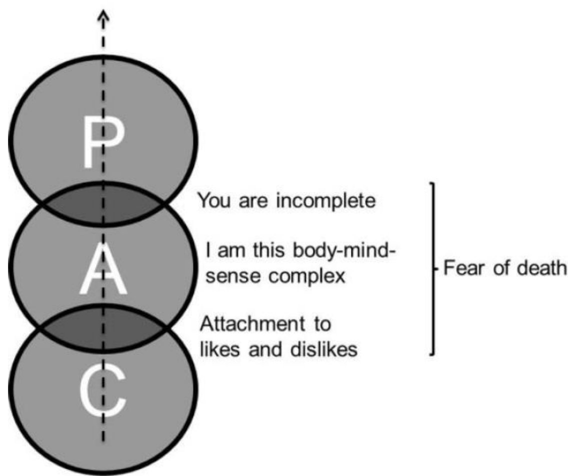


Figure 19: Spiritual Contamination and Fear of Death (Suriyaprakash & Geetha, 2014, p.342)

Conflict Strategies

Having written in response to an article by de Graaf and Levy (2011), Suriyaprakash joined with Susan George (Suriyaprakash & George, 2015) to respond to an article by de Graaf and Rosseau (2015) on the topic of how organisations respond to conflict. Commenting that they were inspired by de Graaf and Rosseau's comparison of the Thomas-Kilmann Conflict Mode Instrument (Thomas & Kilmann, 1974) with the OK Corral (Ernst, 1971), and Morrison's (1978) living encounter positions, Suriyaprakash and George presented a grid in which they divide each quadrant of the OK Corral with a horizontal axis that refers to 'my convictions about my idea (M+ or M-)' and a vertical axis referring to 'my convictions about your ideas (Y+ or Y-)', as shown in Figure 20.

They gave some examples from their own experiences, such as apparently irreconcilable differences between the ITAA and the erstwhile Training and Certification Council; training programs where trainees share their feedback on the learning process; people offering a TA 101 who are not qualified to do so; the Eric Berne Memorial Award selection process; and a lengthy conflict between an author and the TAJ editorial team. From these examples, they identify the need for cooperation, synergy, creativity and cooperation in order to arrive at consensus, which they then showed as in Figure 21.

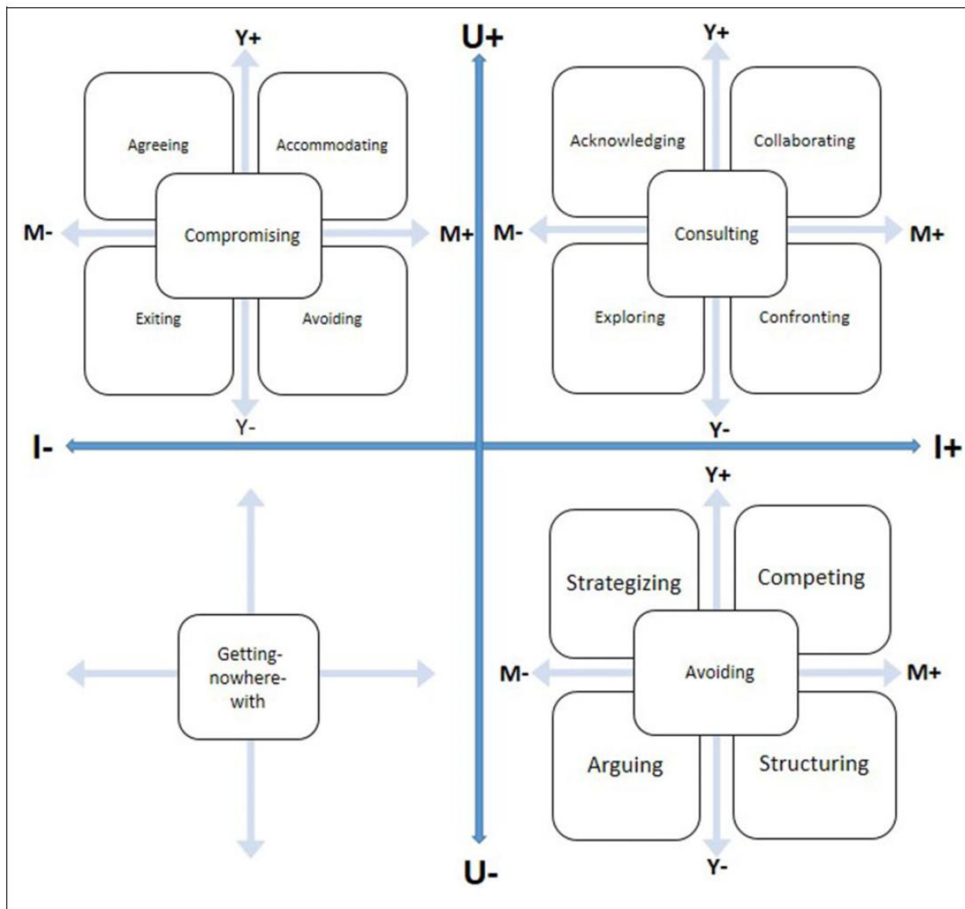


Figure 20: Conflict Strategies: Process (Suriyaprakash & George, 2015, p.273)

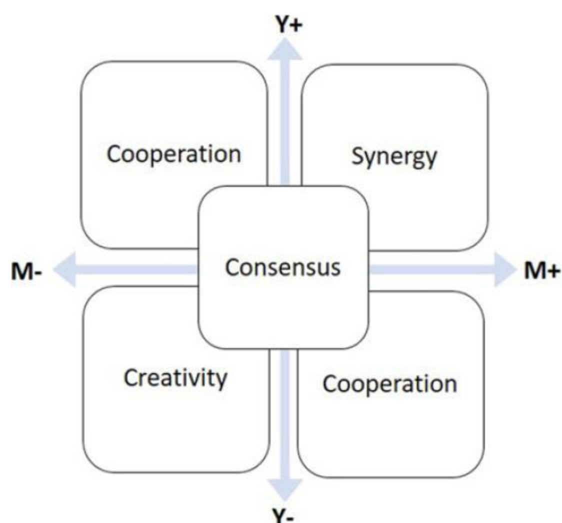


Figure 21: Conflict Strategies: Outcome for I'm OK, You're OK Life Position (Suriyaprakash & George, 2015, p.274)

A few more practical examples of what has been contributed.

Bhattacharya, Chatterjee and Mukherjee (1994) describe the application of basic transactional analysis principles in a participatory management program for forest officials which resulted in those officials being able to successfully involve local village people in managing the forest. They link this to the drama triangle, game pentagon, and cultural script.

Viswanathan (1995) provided an interesting comparison of how Kaizen in daily life compares to TA.

Uma Rajgopal (1999) described a study of the patterns of behaviour of cancer caregivers in terms of drivers (Kahler, 1975).

More recently, Marina Rajan Joseph (2012) has written about the use of Berne's (1966) therapeutic operations within an educational context, and specifically for teaching.

The 3Ps Wheel

Uma Priya (2007) described harnessing the mind to facilitate a healing process, for a case in which the client was able to live each day meaningfully beyond the time indicated by the doctor's prognosis. She presented the 3 Ps Wheel, in which the hub is the connecting point of mind and body, the circle represents the body, and the spokes represent the mind. The intervention therefore consisted of helping the client express pent-up emotions, using the 3 Ps Wheel to provide permissions, using progressive relaxation muscle technique alongside a visualisation of suppressed emotions being released, and using positive imagery about recovery alongside medical treatment.

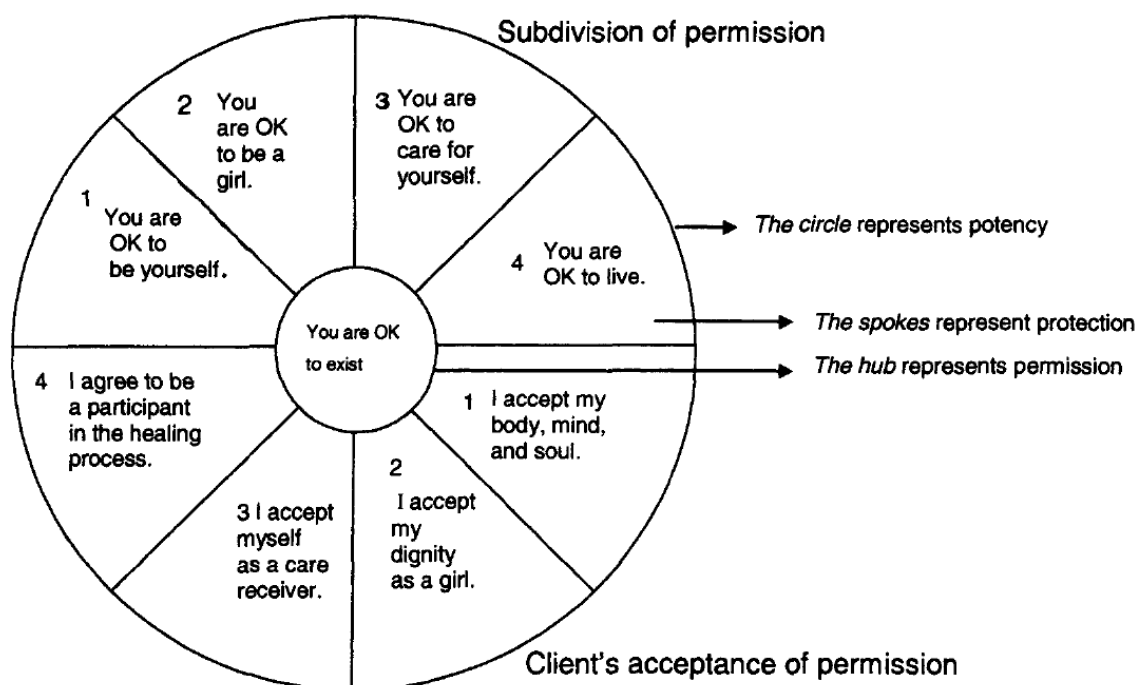


Figure 22: The 3 Ps Wheel (Priya, 2007, p.292)

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Imagoes

Suriyaprakash and Mohanraj (2008) developed the idea of a group transactional imago through the stages of:

1. A perceptual table, in which each group member checks for consistency between how I see myself, how I see you and how you see me.
2. The proportion of consistent to inconsistent perceptions is regarded as a measure of *Individual Functional Effectiveness*.
3. The Transactional Wheel represents this visually, with a participant in the middle and spokes indicating the strength of the relationship with each other person (thick lines for strong, thin for normal, dotted for weak or disrupted).
4. Scores of one for strong, half for normal and zero for weak or disrupted relationship yields a measure of *Individual Transactional Effectiveness*.
5. These can be combined into a functional matrix which then shows which ego states are being employed, so it can be seen who might be parenting the rest of the group, disrupting it through rebellion, or doing the logical thinking, or having the fun.

The use of ego states can be calculated to provide the *Group Functional Effectiveness* measure.

Suriyaprakash & Raj (2003) had published some of this material previously although at that time they referred only to the Transactional Wheel and a Group Ego Matrix.

Summary

in summary, we might think of the contribution from India as within two themes:

- there have been many practical ideas and models
- there has been much arising from the cultural and spiritual nature of Indian society, particularly with reference to autonomy.

I have expanded Berne's (1972) three components of autonomy into five and below is how I linked these in to Indian philosophy:

- Awareness – we are all part of the whole
- Alternatives – we are not limited by past or present, – that is within our Parent ego state
- Attachment – this can be with God, nature, or with another person
- Authenticity – the guru passes on the lessons by modelling so we have absorbed the lessons ourselves
- Accountability – the principles of gurudakshina and rin apply – the former is that we have a five-fold debt to the gods, the spirits, our ancestors and teachers, to all living beings, and to trees, plants, forests, rivers and seas. Rin refers more specifically to the debt we have to our teachers – which I am paying through how I pass on my TA knowledge as widely as possible, including many times pro bono.

India

I close with something prompted by Saroj Welch, who as a member of a conference panel about the role of permission (Allen, Allen, Barnes, Hibner, Krausz, Moiso, Welch & Welch, 1996) pointed out that "There is no such entity as "Indian culture"! The 1971 census listed 1,652 languages as "mother tongues" spoken in India. These languages represent distinct cultures that have emerged from six main ethnic groups that have from centuries past moved onto the Indian subcontinent.… Each of these languages represents a distinct cultural group. Through the past 3000 years, some common cultural features have emerged for about 65% of people, even though there are distinct differences in each of the cultural groups." (p.200). The commonalities mentioned included: male dominance; females defined in relation to males; joint family system; marriages arranged by elders; individual identity is corporate as family, cast, clan and linguistic group; sex as an appetite to be satisfied like hunger and thirst, particularly by males, and procreation and child rearing are religiously sanctioned duties; every moment and stage of life is rigidly defined by myth and belief and deviations lead to severe intrapsychic and interpersonal suffering.

Google now shows a census in 2001 that has a few more languages – 1721 - and another entry tells us that the population in 2018 is 1.35 billion, which means that it has doubled in size over the last 40 years. One in six people in the world now live in India. It is great to see my Indian TA colleagues being so successful at sharing the benefits of TA with such a significant proportion of the world's population.

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