Brief Transactional Analysis Psychotherapy for Depression:

A Pilot Controlled Trial with Block-randomization

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Acknowledgement

The authors express their profound gratitude to the European Association for Transactional Analysis for the research grant that made this study possible.

The authors declare that there is no conflict of interest.

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Abstract

Background: Transactional Analysis Psychotherapy has shown clinical benefits, but most manuals lack specificity and evidence-based interventions. This study tested a semi-structured 16-session Brief Transactional Analysis Psychotherapy (BTAP) manual for depression, developed with evidence-based components.

Methods: Individuals with mild to moderate depression were assigned to BTAP, Brief Cognitive Behaviour Therapy (BCBT), or Care As Usual (CAU) relational-humanistic therapies via block-randomization. Mental health outcomes were measured using depression/PHQ-9, anxiety/GAD-7, distress/CORE-10, and quality-of-life/WHOQOL-bref. BTAP-related skills were assessed with the Life Position Scale, Schema Mode Inventory, and Conceptual Well-Being Scale. TA-therapist competencies were measured with the Transactional Analysis Psychotherapy Self-Report Competencies Scale. Data were analyzed using Cohen's D and Cross-lagged Regression Analysis.

Findings: Of the participants, 28 completed BTAP, 10 BCBT, and 28 were matched to CAU. BTAP clients showed significant improvements in depression, anxiety, distress, and quality-of-life (Cohen's D: 5.67, 5.72, 4.99, .43), outperforming CAU (Cohen's D: .97, .81, .78, .69) and comparable to BCBT. Cross-lagged analyses showed unidirectional predictions of outcomes by clients' TA-related skills, and of clients' TA-related skills by TA-therapist skills.

Discussion: BTAP significantly enhances mental health and quality-of-life in depressed clients by improving TA-related skills and therapist competencies. Further validation is needed, but BTAP is a promising treatment for depression.

Keywords: clinical trial; humanistic; psychotherapy; integrative

Brief Transactional Analysis Psychotherapy for Depression: A Pilot Controlled Trial with Block-randomization

Transactional Analysis (TA), developed by Eric Berne in the 1950s, integrated psychodynamic and behavioural concepts underpinned by humanistic philosophy. It emphasized transparent communication and everyday language between the therapist and the client to describe complex processes. For example, the term "life script" signified an unconscious repetition of childhood experiences reinforced throughout life (Berne, 1957, 1972). This concept was later framed in relation to attachment theory research (Erskine, 2009). TA's therapeutic approach aimed to reduce a power imbalance between the therapist and the client, focusing on collaboration in understanding the client's difficulties and negotiating the therapeutic goals. TA was rooted in humanistic psychology, believing in humans' innate desire to grow and be responsible for their life decisions. TA may be described as a 'family framework' (Mahrer, 1989, p.29) of various subschools, such as later developments in classical-TA, integrative-TA, psychodynamic-TA and relational-TA that extended the original TA-model (Vos & Van Rijn, 2021a). However, research shows that TA therapies share a distinctive, coherent conceptual model (Vos & Van Rijn, 2021b).

Previous systematic literature reviews and meta-analyses have summarised the common conceptual model of the broad field of TA publications, in line with a survey suggesting a consensus amongst TA-practitioners, as follows (see Vos & Van Rijn, 2021a-c, 2022, 2024a-c, for details of single studies and differences between specific TA-schools). Etiological TA-models highlight the combination of factors potentially causing and influencing the development of clinical problems: early-life transactional-core-messages (e.g., parental or intergenerational messages, balance of strokes, developmental problems), life-events (e.g., life experiences, traumas), discounting of existential givens (e.g., insufficiently learned to cope with freedom, meaning, mortality, vulnerability),

genetics/temperament, and responses/decisions to these etiological factors. The central clinical phenomenon regards ego-states, which are distinct states/modes that an individual may experience; the ego-states which most evidence have been called Critical Parent, Nurturing Parent, Adult, Adapted Child, and Free Child. Psychopathology is associated with more dominant Critical Parent and Adapted Child, and less-dominant Nurturing Parent, Adult and Free Child. Furthermore, TA's clinical model focuses on the life-positions of I'm OK/not-OK which broader literature have described as self-efficacy, and Others are OK/not-OK which has been described as social functioning. Therapists help clients by analysing these etiological and clinical phenomena, offering a treatment structure (e.g., therapy goals, psychoeducation on the TA-model, therapy stages), working at experiential-depth in the here-and-now, and offering a positive client-therapist relationship. TA-therapy has been shown to improve psychopathology, distress, self-realisation (ability to live a meaningful and satisfying life), general well-being, behavioural well-being and quality of life.

There is an increasing demand for evidence-based therapies, requiring therapists to use the best available empirical research when working with clients (Vos, 2023). Therefore, TA therapists have also developed and tested treatment manuals. Meta-analyses of 41 clinical trials demonstrated that overall, TA seemed effective in improving clients' mental health, self-efficacy, social relationships, and general well-being (Vos & Van Rijn, 2023a). However, most of these treatment manuals only offered an ad hoc developed general guide and included interventions not supported by prior evidence, leading to application variations. Thus, although, overall TA-studies seem effective, it seems unclear what specific components of TA-therapy caused these positive effects. This is a common criticism f psychotherapy trials in general, in that the overall outcomes indicate positive effects, but due to a lack of specifics in the treatment manual, it is unclear which aspects of the therapy explain these effects (Kazdin, 2022). The lack of systematically developed TA treatment

manuals may impede the acceptance of TA as a bona-fide psychotherapy (Luborsky et al., 2002; Wampold & Imel, 2015).

To address this gap, Vos and Van Rijn (2024a) systematically developed a semi-structured 16-session treatment manual for Brief Transactional Analysis Psychotherapy (BTAP) for mild and moderate depression (see summary in online supplemental table 1). TAP was considered relevant, in line with previous TA-studies on depression (Fetsch, 1980, Benelli & Zanchetta, 2019; Vos & Van Rijn, 2023a; Widdowson, 2013); for example, research indicates that individuals with depression are more likely to report a 'I'm not OK' life-position, and a dominance of the Critical Parent and Adapted Child manual psychotherapy meta-analysis, and less-dominant Adult, Nurturing Parent and Free Child ego-states (Vos & Van Rijn, 2021c); according to TA-theory and an international survey amongst TA-therapists, TAP may alleviate depression by addressing these ego-states and life-position, address their aetiology, offer a therapeutic structure and constructive therapeutic relationship (Vos & Van Rijn, 2021a).

This BTAP-treatment manual could be considered a common foundation of TAP, as it was based on an international survey of TA therapists, a systematic literature review of TA psychometric instruments, and meta-analyses of TA clinical trials (Vos & Van Rijn, 2023, 2021a,c). Specifically, the manual was based on an evidence-based conceptual model of TA (Vos & Van Rijn, 2021b), helping clients to improve in a range of outcomes (mental health, self-realization, general well-being). In line with previous meta-analyses (Vos & Van Rijn, 2023), it was expected that these outcomes were the result of TA-specific therapeutic mechanisms. That is, clients were expected to have better outcomes because they improved on several essential TA-related skills, such as social functioning, self-efficacy, and 'ego-states', such as having a less dominant inner Critical Parent, more Nurturing Parent, more Adult, less Adapted Child, and more Free Child. The therapist aimed to help the clients

develop these TA-related skills via four TA-therapist competencies: analysis of clinical and etiological phenomena, experiential work in the present, treatment structure and positive therapeutic relationship. The aetiology analysis involved analyzing how the client's difficulties in their TA-related skills may have been caused by early life messages, decisions, life events, denial of existential givens, genetics and temperament. Thus, the TA-therapist competencies were expected to improve the client's TA-related skills and subsequently improve a range of outcomes.

BTAP was tested in a mixed-methods feasibility study on nine clients seen by three TA-trained therapists (Vos & Van Rijn, 2024b). The clients reported changes in their lives that they described as important, and they mainly attributed these changes to having received BTAP. Self-reported changes included, for instance, self-insight (e.g., understanding aetiological causes), better coping strategies (e.g., better ego-states such as stronger Adult and Nurturing Parent), self-efficacy (e.g., 'I am OK' life-position), and boundaries (e.g., 'Others are OK' life-position and social functioning). Psychometric instruments suggested significant improvements in symptoms of depression, anxiety, and general distress and no adverse side effects, bearing in mind the limitations of the small sample size. This study indicated that BTAP, as well as the research procedures in that study, were feasible, as clients and therapists seemed to accept BTAP, had all relevant resources, showed positive initial outcomes, described positive processes, were sensitive to a range of clients, and only suggested some minor adjustments to the manual and research procedures (Vos & Van Rijn, 2024).

Figure 1 shows the systematic development of this pilot study, following recommendations about how to develop and validate psychological therapies in multiple research stages (Carroll & Nuro, 2002; Rounsaville et al., 2001). As the systematic literature reviews and the phase-0 proof-of-concept study showed that BTAP could work in theory, and the phase-1 feasibility study demonstrated its feasibility, we aimed to conduct a phase-2 pilot

randomized controlled trial. We hypothesized that BTAP was equally or more effective than control groups, such as the gold standard therapy in the United Kingdom, Brief Cognitive Behaviour Therapy, and Care As Usual in a humanistic-oriented community clinic. We did not merely look at the outcomes of BTAP compared to BCBT, but we also looked at several mediators that may predict these outcomes; this decision reflects the broader trend in clinical-psychology/psychotherapy research to not merely look at outcomes but also mediators, such as improvements in client's TA-related skills and the therapists' TA-comptetencies. (Vos, 2023; Kazdin, 2020). We tested how improvements in the range of outcomes (mental health, self-realization, general well-being) were predicted by improvements in the client's TA-related skills (social functioning, self-efficacy, and ego-states). We also tested whether these improvements in the client's TA-related skills were predicted by the four therapeutic TA competencies (analysis of clinical and etiological phenomena, working at experiential in the here-and-now, treatment structure and positive therapeutic relationship). Therefore, this study answered the following questions:

Q1: What are the pre-post therapy effects of BTAP on the client's TA-related skills and outcomes?

Q2: What are the effects of BTAP compared with BCBT and CAU on the client's TA-related skills and outcomes?

Q3: Do changes in the client's TA-related skills over the course of BTAP/BCBT psychotherapy predict subsequent reductions in mental health symptoms? That is, do changes in TA-related skills on Time 1 predict changes in mental health outcomes at T2, etc.?

Q4: Do changes in therapeutic competencies over the course of BTAP-psychotherapy predict subsequent improvements in the client's TA-related skills and mental health symptoms?

[Insert Figure 1 about here]

Methods

Procedures

The study was conducted at a low-cost community clinic affiliated with a UK-based educational institution (everyone paid similar fees). This clinic receives referrals from the local National Health Service (NHS) and other community organizations. The clients were given information about the research study and the choice to participate or receive Care As Usual (CAU). The Metanoia Research Ethics Committee approved the study, participants gave written consent, could withdraw at any time, and their data were anonymized. Individuals interested in receiving therapy underwent an assessment by an independent clinical assessor before allocation to a therapist. This assessment acts as the gateway to the clinic. It serves as a screening tool to exclude clients with more severe symptoms such as psychosis, significant personality disorders, or severe learning difficulties. The study included block randomization for practical clinical and ethical reasons, as happens more often in trials in clinical settings, and has been described statistically as preferable over alternatives like small sample sizes (Feltz-Cornerlis & Ader, 2000; Friedman et al., 2015; Rosenberger & Lachin, 2015) All new clients who met the inclusion/exclusion criteria were offered BTAP or CAU during six months; after this, new clients were offered BCBT or CAU. To meet the requirements for participation, individuals with mild or moderate depression were considered eligible. However, we excluded individuals with severe anxiety as they may require different treatment focused on anxiety instead of depression; we also excluded individuals with

significant cognitive or linguistic impairments that could make it difficult for them to receive any talking therapy or complete questionnaires in English. A thorough clinical interview and assessment using the PHQ-9/GAD-7 tools were conducted to verify the criteria.

To ensure treatment fidelity, semi-structured treatment manuals were developed (see below), all therapists received two-day training in how to provide the treatment, received clinical supervision in which they brought cases and recordings. Furthermore, the therapists wrote a systematic evaluation after each session (generic case notes and topics discussed; what was helpful; what was not helpful; significant moments; aspects where the manual was not followed; session aspects that the therapist found challenging; recommendations to improve the manual); clients completed similar post-session questions about topics discussed; what was helpful; what was not helpful; significant moments, impact/outcomes; recommendations for therapists; TA-therapists also self-rated their skills on the four-item TAP Self-Report Competencies Scale (TAP-SRCS) (Vos & Van Rijn, 2024a). Analyses via thematic-analyses by senior TA/CBT-therapists indicated that, overall, therapists adhered well to the treatment manuals; due to limited space, we cannot detail these therapist evaluations in this article.

Readers can find this study's data in the research repository of the Metanoia Institute: https://mirep.metanoia.ac.uk/

BTAP

The therapists were in their last year of studying for an MSc in TAP. They had gained at least 100 hours of practical experience through clinical placements. Each therapist received an extensive BTAP-treatment manual (Vos & Van Rijn, 2024a) and two days of training on implementing and applying the manual effectively. Additionally, they participated in monthly clinical supervision sessions led by a TA-supervisor. The BTAP-manual occupied a middle

ground between a fully structured and an unstructured manual, providing structure and clinical flexibility. The 16-session treatment manual consisted of four stages: initial assessment and therapeutic agreement ('contract'), systematic assessment (which included, for example, a comprehensive assessment of the life history, presenting problems, social relationships, and broader socioeconomic/diversity factors), experiential processing, decision-making, and application of script changes (see summary in online supplemental table 1).

BCBT

As the control group, we chose Brief Cognitive Behaviour Therapy (BCBT) as this is the most frequently used therapy for depression in the United Kingdom. This 16-session treatment included the material from the BCBT training for Improved Access to Psychological Therapies (IAPT). Therapists were trainees of a doctorate in counselling psychology and had passed CBT-training as part of this. Each therapist received an extensive BCBT treatment manual and two days of additional training on implementing and applying the manual effectively. Additionally, they participated in monthly clinical supervision sessions led by a CBT-supervisor. In line with IAPT, the BCBT-manual included five stages: initial assessment (sessions 1-2), behavioural activation (3-4), cognitive restructuring (5-7), longitudinal case formulation (8-9), interventions and applications based on longitudinal case formulation (10-15), ending (16). There was flexibility to tailor and skip sessions depending on clients' needs, skills and preferences.

CAU

We selected the first 28 clients who had been offered CAU or BTAP but had decided to receive CAU but not BTAP. This clinic exclusively assigns clients to trainee therapists in their first year of training at the institution. The educational programs cover five theoretical orientations: Gestalt (Perls, 1969), integrative, humanistic, person-centred, and counselling

psychology (Rogers, 1951). All trainee therapists participate in clinical supervision at least once every two weeks. Trainee therapists have been found to achieve large, statistically significant effects similar to those achieved IAPT (Vos et al., 2022). CAU only included outcomes questionnaires and not other questionnaires.

Instruments measuring outcomes

The feasibility study (Vos & Van Rijn, 2024b) had shown that clients experienced too many questionnaires; therefore, this pilot study excluded questionnaires that replicated other questionnaires or did not measure key constructs.

Patient Health Questionnaire-9 (PHQ-9): This nine-item validated, reliable questionnaire measures depression symptoms (Kroenke et al., 2001; Richardson et al., 2017). Scores 0-4 indicate the absence of depression, 5-9 mild, 15-19 moderate, and above 20 severe depression.

Generalized Anxiety Disorder-7 (GAD-7): This seven-item validated, reliable questionnaire measures anxiety symptoms (Kroenke et al., 2007; Richardson et al., 2017; Spitzer et al., 2006). Scores 0-5 indicate mild anxiety, 6-10 moderate, 11-15 moderate, and 15-21 represent severe anxiety.

Clinical Outcomes in Routine Evaluation-10 (CORE-10): This ten-item validated, reliable questionnaire measures general distress (Barkham et al., 2006; Evans et al., 2002). For general psychological distress, a clinical cut-off score of 11.0, along with a reliable change index of 6, is recommended; for depression diagnosis, a score of 13 is suggested (Barkham et al., 2013).

WHOQOL-bref: This 26-item validated, reliable questionnaire measures quality-of-life regarding physical, psychological, social and environmental health (Ilic et al., 2019). Due to

significant correlations, lack of statistical differences across scales, exploratory factor analysis indicating one factor, and large overall reliability, we only used one total score.

Instruments measuring client TA-related skills

Ryff's Well-being Scale (RWBS): This validated, reliable 42-item questionnaire measures the well-being domains of autonomy, environmental mastery, personal growth, positive relationships, purpose in life, and self-acceptance on 6-point Likert-scales (Abbott et al., 2006).

Life Position Scale (LPS): Life positions encompass the fundamental stance one holds towards oneself and others, often shaped during childhood and establishing the basis for an unconscious framework of interpersonal connections. This validated, reliable 20-item questionnaire measures life positions on the subscales 'I am OK/not-OK' (LPS-Self) and 'others are OK/not-OK' (LPS-other) with low scores indicating not-OK'ness and high scores indicating OK'ness (Boholst, 2002; Vos & Van Rijn, 2021b).

Schema Mode Inventory (SMI): This validated, reliable 124-item questionnaire measures schema modes, a construct close to TAP's ego-states (Vos & Van Rijn, 2021b). The subscales include Vulnerable Child, Angry Child, Enraged Child, Impulsive Child, Undisciplined Child, Contented Child, Compliant Surrender, Detached Protector, Detached Self-Soother, Self-Aggrandizer, Bully and Attack, Punitive Parent, Demanding Parent, and Healthy Adult.

TA-therapist competencies

After every therapy session, therapists completed the four-item TAP Self-Report Competencies Scale (TAP-SRCS) (Vos & Van Rijn, 2024a). This scale required therapists to evaluate each session based on four categories of evidence-based TAP competencies (Vos &

Van Rijn, 2023, 2020b): analyzing clinical and etiological phenomena, providing structure, working at experiential depth in the present, and a constructive therapeutic relationship.

Sociodemographic questionnaire

We recorded the number of eligible clients and participants at the start and end of therapy, as well as the number of sessions attended, cancelled, and not attended. Following a previous study (Vos et al., 2022) and the British National Health Services, questions were asked at baseline about the following sociodemographic characteristics (treated as categorical/nominal variables, except if otherwise mentioned): gender (female/male/other); age (number); employment (employed/unemployed/retired-or-sick/student/other); ethnicity (standard ethnic groups/open answer option); living situation (alone/partner/children/family/other); marital status (single/married/divorced/widowed/living -together/other); children (number); medication (yes/no, if yes: open question); previous therapy (number of therapy round); religion (common religions/open answer option); sexual orientation (heterosexual/ homosexual/bisexual/other); receiving benefits (yes/no).

Analysis

Structural Equation Modelling and Cross-lagged Analysis in MPlus v.4.7. analyzed whether the groups differed in mental health and TA-related skills, and TA-related skills mediating the effects on outcomes.

Preliminary Analyses

Missing value analysis indicated less than 1% missing randomly; multiple regression imputed missing values. As Table 1 shows, McDonald's Omega was calculated for subscales/scales, indicating the reliability of all scales/subscales (Hayes & Coutes, 2020; McNeish, 2018). Exploratory factor analysis indicated the unidimensionality of the scales/subscales (number of dimensions based on eigenvalue<1, factor loadings>0.5)(Field, 2009; Vaske et al., 2017).

There were no extreme outliers, and all scales/subscales approximated normal distribution, confirmed by small skewness (<+/-.1) and small kurtosis (<+/-3), suggesting parametric tests were possible. We did not aim for a specific a priori sample size, as we had to use a convenience sample that depended on the number of interested participants within the given timeframe. A posteriori statistical power was conducted in G*Power based on the pre-post BTAP effects on PHQ-9 (t=5.67), indicating a good power of .81. Note that for readability purposes, detailed means/st.dev., t/p-statistics have been left out from this article's tables; the full data can be requested from the authors, and can be accessed from the research repository from the Metanoia Institute.

[insert table 1 about here]

Statistical analyses

Sample characteristics were described with frequencies, means and standard deviations. Pre-post therapy effects were calculated with t-tests, transformed into Cohen's d (.20 considered small, .50 medium, .80 large). We conducted mixed-factorial ANOVA with one between-groups factor (3 treatment groups: BTAP/BCBT/CAU) and one within-subjects factor (pre-post outcome variables), reported with eta-squared (η^2 was interpreted as: .01-small, .06, medium, >.14 large). We subsequently conducted post-hoc comparisons with t-test/Cohen's D for our specific research questions: pre-post effects within BTAP; BTAP-BCBT difference in pre-post effects; BTAP-CAU differences in pre-post effects.

We also calculated clinical change, i.e., the number of clients above the clinical cut-off point for each scale, and Reliable and Clinically Significant Improvement (RCSI) for the main outcome-measures PHQ-9, GAD-7 and CORE-10 (Jacobsen & Truax, 1991; Speer, 1992). We presumed that clients had attained RCSI if they commenced the therapy in a state of dysfunction and concluded the treatment in a state of normalcy. They also had a reliable

level of progress that was unlikely to be attributed solely to measurement inaccuracies. We used the previously mentioned threshold scores for PHQ-9, GAD-7, and CORE-10 to distinguish between the clinical and normal populations. We deemed reliable enhancement as a difference before and after, which, when divided by the standard deviation of the difference, was 1.96 or higher. We computed reliable change indices for each of the measures, utilizing the SD difference disclosed in the NHS IAPT in 2015 (digital.nhs.uk) and the previously provided information on the reliability of the scales.

We used cross-lagged regression analysis to examine reciprocal causal effects over time on client's TA-related skills and their outcomes (e.g. Hamaker et al., 2015). That is, we assessed associations over time (T0 baseline and 16 sessions T1-T16) between clients' TA-related skills (RWBS, LPS, SMI) and mental health outcomes (PHQ-9, GAD-7, CORE-10, WHOQOL-bref). Subsequently, we also used cross-lagged regression analysis to examine the associations between TA-therapist competencies (TAP-SRCS) and clients' TA-related skills (RWBS, LPS, SMI).

A cross-lagged regression aims to determine the causal direction of effects. In a basic lagged regression, one could conduct a regression analysis, such as regressing LPS-SELF at Tn+1 on PHQ-9 at Tn, to examine the potential connection between PHQ-9 at a specific time and LPS-SELF later. Although this provides the closest approximation to measuring causation (i.e., a strong relationship at Tn predicts a positive outcome at Tn+1), it does not offer strict proof. It is conceivable, however, that the relationship is stronger in the opposite direction, meaning that PHQ-9 at a certain point in time predicts LPS-SELF at a subsequent time. Cross-lagged regression aims to compare these two directions and assess which carries more weight. This answers the question: Does the strength of a relationship predict a positive outcome to a greater or lesser extent than a positive outcome predicts the strength of a relationship? The cross-lagged regressions were conducted as a path analysis. Outcome

measures were determined by summing their individual items instead of using a full structural equation modelling approach as reliability and exploratory factor analyses indicated the reliability and unidimensionality of the scales/subscales. Note that we initially intended to test a structural equation model with all outcomes, mediators and moderators; unfortunately, despite creating various models, the models did not seem to converge, possibly due to the small sample size; therefore, we decided to conduct cross-lagged analysis for only two instruments per analysis. We present the findings in one joint table to give an overview. Furthermore, the significance level was set at .05; trends between .05 and .10 were reported to compensate for possible type-II bias. The analysis used MPlus 8.6 (Muthén & Muthén, 1998-2017). Figure 2 visualizes an example using a lag of one session.

[insert figure 2 about here]

Findings

Sample characteristics

Thirty-eight clients were offered BTAP or CAU, and twenty-eight (73.7%) chose and completed BTAP. Twenty-eight clients were randomly selected from the CAU population. Thirty-three clients were offered BCBT or CAU, and twelve (36.36%) chose BCBT, but two dropped out, leaving a total BCBT sample of 10 (26.3%). The reason for dropout from BCBT was that the client expressed a change in preference in therapy; they were subsequently offered CAU. Sociodemographic details can be found in Table 2. No differences were found between the groups BTAP/BCBT/CAU in age (ANOVA $p(F)=.13$) and on the other variables ($p(X^2)>.05$).

[insert table 2 about here]

Q1: pre-post therapy effects

Table 1 shows several significant effects for time in the BTAP-group, i.e. symptom improvement between baseline and the last session. The outcomes showed very large effects on PHQ-9 (Cohen's =5.67), GAD-7(5.72), CORE-10(4.99), and medium effects on WHOQOL-brief (.43). The client's TA-related skills showed very large effects on SMI-Vulnerable Child(7.21), RWBS-autonomy(5.91), SMI-punitive parent (4.11), RWBS-personal growth(3.91), SMI-undisciplined child(3.35), SMI-enraged child (3.03), LPS-Self(2.45), RWBS-self-acceptance(2.21), SMI-angry child(2.23), SMI-demanding parent(1.85), large effects on SMI-contented child(.87) and RWBS-purpose(.78), and moderate effects on RWBS-relationships(.56). All 28 clients had mild to moderate depression before the start of therapy (PHQ-9), and after therapy 17 (60.7%) achieved RCSI, and 18 (64.3%) had reliably improved. At the start, 16 clients had clinical levels of anxiety (GAD-7), of whom 12 (75.0%) reached RCSI, and 19 (67.8%) had reliably improved. Of the 26 clients with clinical levels of general distress intensity (CORE-10), 18 (69.2%) showed RCSI, and 19 (73.1%) reported reliable improvement.

Q2: BTAP compared with BCBT and CAU

Table 1 shows the differences between BTAP/BCBT/CAU groups in terms of multiple outcomes. Post-hoc analyses showed that, compared with BCBT, BTAP did not differ in outcomes (PHQ9, GAD7, CORE10, WHOQOL-bref), but they did differ in the clients' TA-related skills with larger effects on LPS-Self(2.45), SMI-vulnerable child(2.34), RWBS-self acceptance(2.12), SMI-enraged child(1.66), SMI-angry child(1.21), RWBS-autonomy(1.21), RWBS-purpose(1.01), SMI-healthy parent(.95), and with moderate effects on RWBS-relationship(.65), SMI-punitive parent(.45), SMI-demanding parent(.49 BTAP had larger effects than CAU on all outcomes: PHQ-9(.97), WHOQOL-bref(.81), CORE-10(.78), and GAD-7(.69).

Q3: Cross-lagged analysis of client TA-related skills and outcomes

Table 3 shows the results for each direction of the cross-lagged regressions in BTAP and BCBT. This suggests that client TA-related skills significantly predicted larger improvements in outcomes, and none of the outcomes predict TA-related skills. A decrease in PHQ-9 depression scores was predicted by an increase in autonomy, relationships, self-acceptance, seeing self as OK, seeing others as OK, healthy adult, contented child, undisciplined child, compliant surrender, and a decrease in vulnerable child, bully and attack, punitive parent, and demanding parent. A decrease in GAD-7 anxiety scores was predicted by an increase in healthy adult, self-acceptance, mastery, personal growth, relationships, seeing self as OK, seeing others as OK, undisciplined child, detached protector, and a decrease in vulnerable child, impulsive child, and punitive parent. A decrease in CORE-10 general distress scores was predicted by an increase in self-acceptance, seeing self as OK, others as OK, undisciplined child, contented child, and healthy adult, and a decrease in the punitive parent. An increase in WHOQOL-brief quality-of-life scores was predicted by an increase in mastery, positive relationships, self-acceptance, seeing self as OK, seeing others as OK, healthy adult, impulsive child, undisciplined child, compliant surrender, detached protector, self-aggrandizer, and a decrease in punitive parent and vulnerable child. Across all outcomes, the most consistently significant predictors regarded an increase in self-acceptance, seeing self as OK, seeing others as OK, healthy adult, contented child, and undisciplined child, and a decrease in vulnerable child and punitive parent.

Q4: Cross-lagged analysis of therapist TA-competencies and client TA-related skills

Table 3 shows that in BTAP, all therapist TA-competencies significantly predicted most client TA-related skills. Client TA-related skills did not significantly predict therapist TA-competencies.

[insert table 3 about here]

Discussion

This study has found that Brief Transactional Analysis Psychotherapy (BTAP) improved symptoms of depression, anxiety, general distress, and quality of life in this sample of individuals with depression. BTAP was equally effective on these outcomes as Brief Cognitive Behaviour Therapy (BCBT) but more effective than Care As Usual (CAU), which included humanistic-relational therapies. These findings aligned with a previous feasibility study on BTAP (Vos & Van Rijn, 2024) and qualitative analyses of post-therapy interviews and weekly open questions in this study (Vos & Van Rijn, under review). The effect sizes were equivalent, and some were larger than a previous study on routine outcome monitoring in CAU in this same community clinic (Vos et al., 2021) and other clinical trials and qualitative studies on the depression-lowering effects of TA (see overview in Vos & Van Rijn, 2023; examples include Fetsch, 1980, Benelli & Zanchetta, 2019; Widdowson, 2013 and other humanistic therapies (Elliott, 2002; Elliott et al., 2002; Van Rijn & Wild, 2013; Vos, 2023). The equivalent effects were not surprising, as BTAP included many factors common to therapies that have previously been found to benefit clients (Wampold & Imel, 2015), such as working experientially in the present (Sachse & Elliott, 2002), fostering a supportive therapeutic relationship (Norcross & Lambert, 2019), offering a structure, systematic treatment manual and client-therapist agreement about clear therapy goals and methods (Sills, 2006), a systematic case formulation (Van Rijn, 2014), and well-defined therapeutic competencies (Norcross & Karpiac, 2017).

The findings indicate that BTAP clients developed a range of TA-specific skills and learned more and stronger TA-specific skills than BCBT clients. This difference between BTAP and BCBT was not surprising as TA focuses on improving TA-specific skills, such as

improving ego-states. BCBT does not focus on these but for example focus on improving cognitions and behaviour (i.e., different therapeutic mechanisms of change). Developing these TA-specific skills predicted the outcomes, particularly improving their self-acceptance, seeing themselves and others as OK, Healthy Adult, and Contented Child, and decreasing Vulnerable Child and Punitive Parent. The therapists' competencies of analyzing, offering structure, working in the present, and providing a good therapeutic relationship predicted the TA-specific skills. The outcomes did not predict the clients' TA-related skills, and the clients' TA-related skills did not predict the therapists' TA-related competencies. These findings suggest that the BTAP-therapists' use of their specific TA-competencies helped clients to develop skills that Transactional Analysts conceptualize as vital and that improve their outcomes (Vos & Van Rijn, 2021d), such as developing the life positions of 'I am OK' and 'Others are OK', accepting oneself, building positive relationships, and a more dominant Healthy Adult, Nurturing Parent (indicated by larger SMI-scores of surrender, protector, self-aggrandizer), Free Child (indicated by larger SMI-scores on the contented and undisciplined child), and less dominant Adjusted Child (indicated by smaller SMI-score of the vulnerable child), and less Critical Parent (indicated by smaller SMI-scores on punitive parent). Thus, these findings suggested that BTAP was effective and that the therapeutic mechanisms creating these changes were generally as expected.

Some of the effect sizes were remarkably large, which may have been caused by the Hawthorne Effect, as the clients knew they were taking part in a trial, whereas CAU participants completed questionnaires for routine outcome monitoring; some CAU-clients may also have experienced a nocebo effect, as they knew they actively choose for CAU instead of the experimental trial. It may be hypothesized that the effects were inflated as clients with comorbid disorders such as severe anxiety were excluded from the study, whereas in clinical practice, clients might have presented more complexities; however, the

effect of excluding these cases may be limited as the baseline sociodemographic characteristics and clinical scores were similar between the BTAP, BCBT and CAU. Compared to a previous study in the same community clinic (Vos et al., 2021), the sample was less ethnically diverse, which may have been due to the additional research procedures and limited the study's generalizability. There might have been a response shift, as clients had filled in the outcome questionnaires each week; however, this did not seem to thoroughly explain the huge effect sizes, as clients in CAU also completed questionnaires each week and showed smaller effect sizes. The self-report nature of most measures may inflate the findings; therefore, future studies should, for instance, include evaluations by therapists and partners, relatives, or friends.

Although the study has sufficient statistical power, the relatively small sample size may have contributed to elevated effect sizes; for example, as structural equation models in which we used all variables simultaneously did not converge, we had to conduct many individual analyses. While techniques like the Bonferroni adjustment typically tackle the number of estimations (Bland & Altman, 1995), we purposely opted not to use such a correction to strike a balance between Type-I and Type-II error risks. This choice aligns with Rothman (1990) and Feise's (2002) views, who propose that the cost of missing genuine effects may surpass that of false positives. However, it requires careful interpretation of results, particularly those with marginal significance.

There may hypothetically be a researchers' and inventors' effect, as studies conducted in the same clinic where an intervention initially was developed often show larger effect sizes. However, the same researchers with diverse expertise/training in both TAP and CBT developed the BTAP and BCBT treatment manuals, and therapists received similar training and supervision procedures; due to these similarities between both conditions, we intended to

reduce potential researcher-allegiance effects (Cuijpers & Cristea, 2016); consequently, there were no significant differences in outcomes between BCBT and BTAP.

Thus, the positive findings for BTAP align with previous studies, but the precise sizes of the effects need to be interpreted with caution, as some of the positive effects may have been elevated due to some of the before-mentioned factors. Therefore, validation in larger Phase 3 clinical trials is warranted, ideally with all variables tested in one structural equation model and using Bonferroni corrections for the number of estimations.

BTAP should be translated for further cross-cultural validation. Therapists should be trained in other languages (BTAP has been translated into Italian, and satisfactorily applied in two clients, but this needs to be tested in a larger trial; unpublished report). We recommend systematically addressing topics of diversity and social justice in the assessment, therapy-goal formulation, and therapeutic process, like in our treatment manual (Vos & Van Rijn, 2024a); this reflects recent TA publications indicating the importance of addressing diversity and social justice (e.g., Campos, 2010; Massey, 2007; Minikin, 2023; Rowland & Cornell,2021; Sedgwick,2020). Furthermore, the treatment manual was developed explicitly for depression. However, clients also reported improvements in anxiety and general distress, more research is needed to validate its applicability in other samples.

Future studies should also include larger and completely randomized and matched control groups. Despite using similar recruitment procedures for BTAP and BCBT, the BCBT sample was only one-third in size compared with BTAP; the clinical assessors have noted that most clients who rejected participation in the BCBT trial did so because they had specifically been referred to this community clinic to receive a different therapy than CBT, which several of them already had negative experiences with in previous health care services. The therapists providing BTAP had slightly more clinical expertise than those providing

BCBT; unfortunately, due to practical reasons related to therapist recruitment, we could not precisely match the therapist expertise between BTAP and BCBT. However, previous research in this clinic indicated no time or expertise differences in the effectiveness of therapists (Vos, Chryssafidou, Van Rijn, B., & Stiles, 2022); the positive BCBT findings in this study confirm the positive effects of therapists early in their training. Therefore, we carefully considered both therapist groups as comparable. However, future studies ideally include matched therapist characteristics across experimental/control conditions.

Furthermore, although the study's strength included its ecological validity as it was conducted in the reality of a community clinic, it was clinically impossible and unethical to blindly allocate clients to either BTAP, BCBT or CAU; block-randomization is a common strategy in ecologically-valid clinical settings where full-randomisation is not possible, is the preferred option over underpowered/small-sample studies, and may lead to more conservative/smaller effects (Feltz-Cornelis & Ader, 2000; Friedman et al., 2015; Rosenberger & Lachin, 2015). Furthermore, we aimed to reduce the risk of researcher bias by having independent assessors do the assessment and explain the study to possible participants, having a CBT-therapist and TA-therapist develop similar semi-structured treatment manuals, therapist training, and study design and analyses. Thus, these limitations in design seem to be the flip side of the ecological validity strength of the services provided in this community clinic (Golleman et al., 2020).

Despite these limitations, this study suggested that BTAP may be regarded as a bona fide therapy, as indicated by the definition of Wampold. BTAP is based on an evidence-based conceptual model (Vos & Van Rijn, 2021d), with therapists trained with a semi-structured treatment manual and an empirical confirmation of the hypothesized therapeutic mechanisms. Therefore, therapists may consider offering BTAP to clients with mild or moderate depression.

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Table and figures

Table 1. Effect sizes

Scale	Subscale	McDonald's Omega at T_0	Between groups effect sizes η^2	Within subjects pre-post p value	Pre-post effects BTAP (T0-T16) Cohen's D (95%-Confidence Interval)	BTAP – BCBT Cohen's D (95%-Confidence Interval)	BTAP -CAU Cohen's D (95%-Confidence Interval)
PHQ-9		.84	.237	<.001	5.67**** (4.65-6.69)	.35	.97** (.66-1.28)
GAD-7		.87	.194	<.001	5.72** (4.40-7.04)	.43	.69** (.46-.92)
CORE-10		.85	.163	<.001	4.99*** (4.02-5.96)	.37	.78** (.66-.90)
WHOQOL-bref		.80	.138	<.01	.43* (.40-.46)	.43	.81** (.62-1.00)
RWBS	Autonomy	.82	.146	<.001	5.91* (5.01-6.81)	1.21** (.89-1.53)	
	Mastery	.84	.008	.12	.46	.39	
	Growth	.88	.006	<.001	3.91** (3.21-4.61)	.36	
	Relationships	.79	.165	<.01	.56* (41-.71)	.65* (.53-.77)	
	Purpose	.82	.182	<.05	.78* (.66-.90)	1.01** (.78-1.24)	

	Self-acceptance	.80	.156	<.001	5.07** (3.84-6.3)	2.12*** (1.78-2.46)	
LPS	Self	.80	.119	<.001	4.56** (3.14-5.98)	2.45** (1.88-3.01)	
	Others	.82	.005	.16	3.12	0.98	
SMI	Vulnerable Child	.80	.118	<.001	7.21** (5.54-8.88)	2.34*** (1.91-2.77)	
	Angry Child	.79	.116	<.001	2.32** (1.77-2.87)	1.21** (.92-1.50)	
	Enraged Child	.81	.120	<.001	3.03** (2.75-3.95)	1.66** (1.34-1.98)	
	Impulsive Child	.82	.004	.13	.30	.12	
	Undisciplined Child	.85	.006	<.001	3.35** (2.92-3.87)	.56	
	Contented Child	.86	.005	<.005	0.87* (.66-1.08)	.66	
	Compliant Surrender	.80	.007	.25	.12	.23	

	Detached Protector	.81	.005	.27	.19	.09	
	Detached Self-soother	.83	.006	<.01	2.26** (1.5-3.02)	.21	
	Self-Aggrandizer	.84	.008	.13	.22	.31	
	Bully and Attack	.79	.002	.11	.56	.08	
	Punitive Parent	.83	.113	<.001	4.11** (3.24-4.98)	.45* (.33-.57)	
	Demanding Parent	.84	.109	<.01	1.85* (1.32-2.38)	.49* (.40-.58)	
	Healthy Adult	.84	.112	<.005	1.20** (.88-1.52)	.95** (.63-1.27)	
TAP-SRCS	Analyzing				2.21*** (1.76-2.66)		
	Structure				1.20** (.86-1.54)		
	Presence				.95** (.76-1.14)		
	Relationship				1.01** (.34-1.68)		

N for all scales and subscales was 28 (BTAP), 28 (CAU), 10 (BCBT). Means/Std.Dev. for PHQ9/GAD7/CORE10/WHOQOL regard su-scores; means/st.dev. for LPS/SMI/TAP-SRCS regard mean-scores; McDonald's Omega only presented for BTAP; similar omegas were found in CAU and BCBT. *p<.10, **p<.05, ***p<.01, ****p<.005, N/S Not Significant, Empty cells represent non-applicable tests.

Table 2. Client Demographics

Variable	**Categories**	**N = 66**	**Proportion of 66 (%)**
Employment status (%)	Employed Full-time	17	25.6
	Employed Part-time	12	17.9
	Sick	8	12.8
	Student	5	7.7
	Self-employed	3	5.1
		2	2.6
		2	2.6

	Unemployed Retired Not disclosed	17	25.7
Psychotropic drugs use (%)	Medication No medication Not disclosed	17 36 13	25.7 53.8 20.5
Age (mean, SD)			37.2(12.3)
Relationship (%)	Single Married Living together Divorced Not disclosed	27 12 3 3 21	41.0 17.9 5.1 5.1 30.9
Gender (%)	Female Man Other Not disclosed	34 19 2 11	51.3 28.2 2.6 17.9

Ethnic groups (%)	British/Irish	31	46.2
	White other	15	22.6
	Asian	5	7.8
	Not disclosed	15	23.4
Religion	Christianity	10	15.4
	Other	4	5.2
	Not disclosed	52	79.4
Disability (%)	Disability	5	7.4
	No disability	47	71.8
	Not disclosed	14	20.8
Sexual orientation (%)	Heterosexual	41	61.5
	Gay/lesbian	3	5.1
	Bisexual	2	2.6
	Not disclosed	20	30.8

Table 3. Average β (SE) values for cross-lagged regressions

WHOQOL-bref		PHQ-9 regressed on client TA-related skill	GAD-7 regressed on client TA-related skill	CORE-10 regressed on client TA-related skill	WHOQOL-bref regressed on client TA-related skill	Client TA-related skill regressed on TAP-SRCS Analysing	Client TA-related skill regressed on TAP-SRCS Structure	Client TA-related skill regressed on TAP-SRCS Presence	Client TA-related skill regressed on TAP-SRCS Relationship
RWBS	Autonomy	-.10(.05)**	-.01(.35)	-.07(.19)	-.13(.23)	.13(.03)****	.08(.02)*	.06(.01)***	.10(.02)****
	Mastery	-.01(.16)	-.06(.02)***	-.03(.21)	-.12(.03)*	-.05(.22)	-.02(.31)	-.05(.21)	.09(.01)**
	Growth	-.11(.21)	-.07(.04)**	.01(.52)	.03(.45)	.06(.02)***	.06(.02)*	.07(.03)***	.12(.04)**
	Relationships	-.06(.04)**	-.09(.05)*	-.04(.33)	.09(.02)****	.07(.02)****	.04(.23)	.06(.02)****	.07(.02)****
	Purpose	-.07(.43)	-.03(.36)	-.07(.45)	-.04(.29)	-.06(.31)	-.02(.32)	-.04(.37)	-.02(.29)
	Self-acceptance	-.16(.04)**	-.09(.02)***	-.07(.02)*	.11(.01)****	.07(.02)****	.06(.01)**	.10(.03)***	.08(.02)****
LPS	Self	-.07(.06)****	-.08(.01)**	-.06(.03)*	.12(.03)***	.08(.03)****	.09(.02)***	.12(.04)***	.07(.02)***

	Others	-.14(.03)****	-.13(.03)**	-.07(.01)**	.06(.05)***	.11(.02)****	.11(.03)**	.08(.02)***	.07(.01)****
SMI	Vulnerable Child	.16(.04)***	.12(.03)**	.13(.15)	-.08(.02)****	.13(.01)***	-.07(.11)	-.07(.02)***	-.12(.03)**
	Angry Child	-.15(.23)	-.20(.35)	-.17(.24)	-.20(.21)	.10(.02)***	.14(.04)*	-.13(.04)***	-.09(.02)**
	Enraged Child	-.17(.21)	-.09(.22)	-.12(.25)	-.12(.18)	.08(.02)**	.16(.06)**	-.15(.06)***	-.08(.01)**
	Impulsive Child	.09(15)	.12(.03)**	.11(.18)	-.10(.04)**	-.12(.21)	-.12(.03)**	-.08(.04)***	-.14(.06)*
	Undisciplined Child	-.14(.04)**	-.12(.06)***	-.06(.02)***	.10(.05)**	.08(.02)**	.10(.04)**	.09(.05)***	.17(.02)***
	Contented Child	-.07(.06)**	-.05(.02)**	-.11(.03)**	.08(.03)****	.07(.03)***	.09(.03)*	.08(.03)**	.09(.02)**
	Compliant Surrender	-.12(.05)****	-.14(.05)**	-.09(.23)	.10(.02)*	.13(.02)****	.07(.02)**	.06(.01)**	.12(.04)***

	Detached Protector	-.03(.21)	-.06(.02)**	.06(.22)	.08(.05)**	.08(.01)*	.06(.01)***	.05(.22)	.09(.24)
	Detached Self-soother	-.01(.22)	-.05(.27)	-.09(.29)	-.03(.31)	.03(.21)	.07(.34)	.09(.32)	.05(.27)
	Self-Aggrandizer	-.10(.18)	-.12(.22)	-.10(.21)	.13(.02)*	.16(.04)*	.09(.19)	.11(.20)	.07(.24)
	Bully and Attack	.06(.04)***	.08(.19)	.05(.21)	.07(.17)	-.05(.02)*	-.06(.01)*	-.14(.03)**	-.07(.03)***
	Punitive Parent	.07(.01)****	.07(.02)***	.12(.03)**	-.07(.03)***	-.07(.01)****	-.09(.03)***	-.10(.02)***	-.08(.01)****
	Demanding Parent	.09(.01)***	.07(.13)	.10(.19)	.11(.17)	-.08(.02)***	-.10(.02)***	-.08(.03)**	-.14(.04)***
	Healthy Adult	-.06(.07)****	-.08(.01)***	-.07(.02)****	.08(.02)*	.08(.03)****	.09(.01)****	.11(.04)****	.07(.02)****

*p<.10, **p<.05, ***p<.01, ****p<.005, N/S Not Significant.

Figure 1. Research background of this pilot study

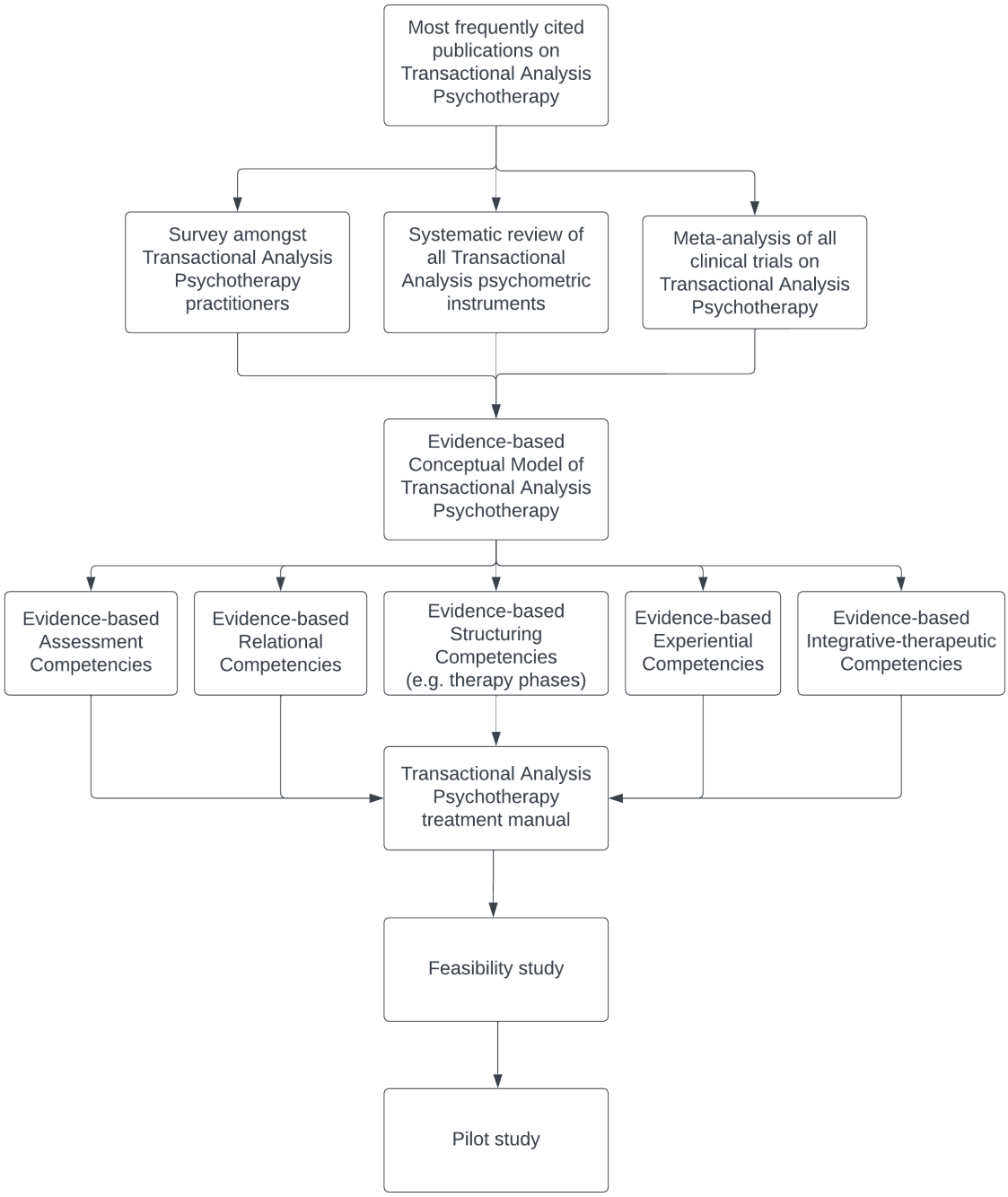
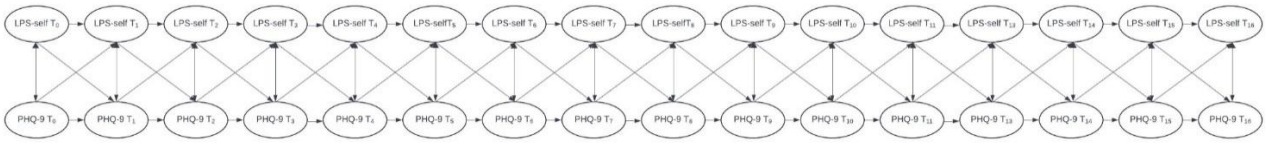
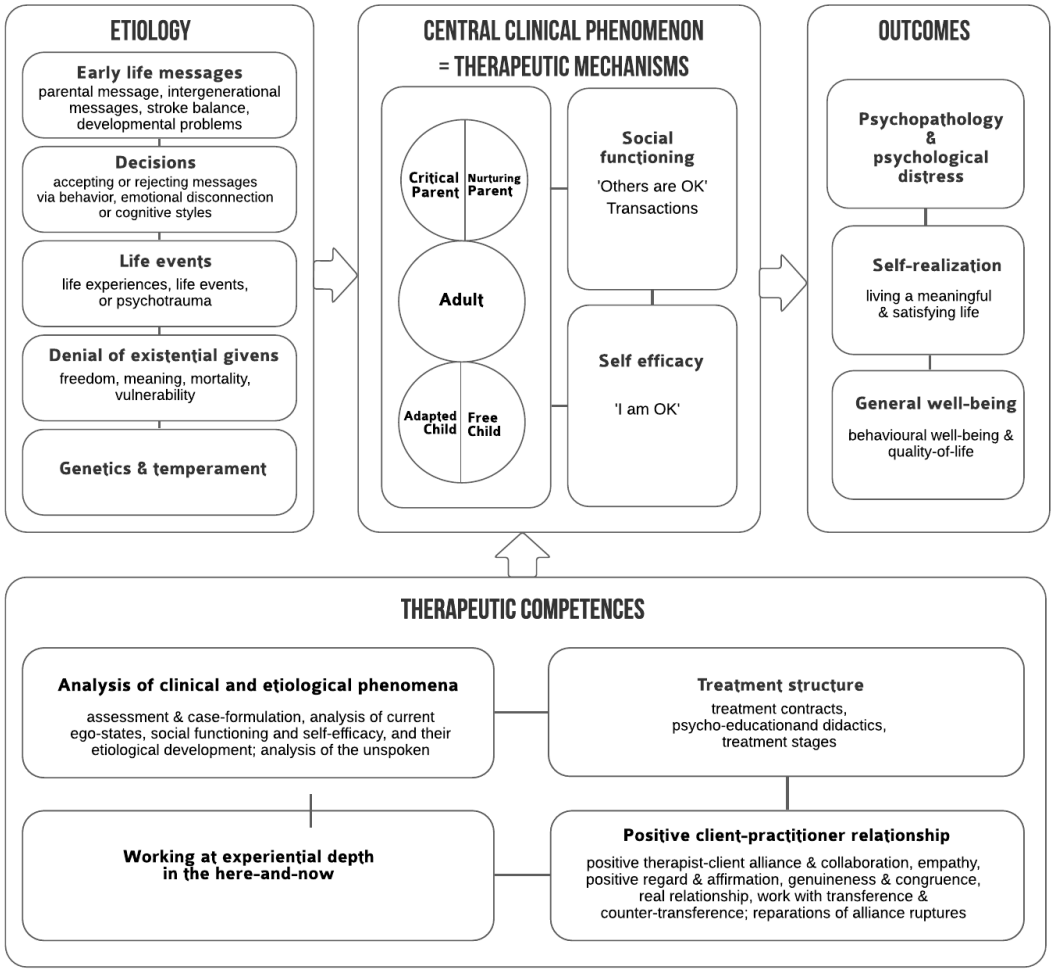


Figure 2. Example cross-lagged regression analysis between LPS-Self and PHQ-9



Supplemental material for online publication only

Online Figure 1. Conceptual model of Transactional Analysis Psychotherapy



Online table 1. Overview of BTAP

Name of treatment stage	**Aims of treatment stage**	**Treatment session**	**Name of session(s)**	**Aims of session**	**Steps in sessions**
1.ESTABLISHING RELATIONSHIP, INITIAL ASSESSMENT, AND INITIAL TREATMENT CONTRACT	1. offer the opportunity to the client to share their problems, needs and wishes in their own words. 2.lay the foundations for a positive therapeutic relationship. 3.inform the client about the general aims and methods of BTAP.	1-2	Establishing relationship, initial assessment, and initial treatment contract	Same as stage	1.Welcome 2.Agreeing session aim/method 3.Exploring client's motivation 4.Exploring context of problems 5.Exploring previous (un)successful coping with problems 6.Exploring broader context of problems 7.Identifying therapy goals 8.Informing about BTAP 9.Shared decsion-making (temporary treatment contract) 10.Ending

	4.develop a basic agreement about the aims of the treatment ('shared informed consent' or 'treatment contract').				
2.SYSTEMATIC ASSESSMENT	1.systematically assess the client's current problems. 2.systematically assess possible causes of the client's problems. 3.systematically develop a case formulation. 4.develop shared plan, aims and methods for the next stage in psychotherapy.	3	Assessment of clinical problem	1.Analysis of dominant ego states in difficult or problematic situations, e.g. via game analysis, drama triangle analysis, stroke analysis, analysis of non-verbal behaviour, and specification 2.Analysis of social functioning and underlying	1.Emotional check-in 2.Refresher/follow-up from previous sessions 3.Agreeing session aim/method 4.Discuss questionnaires 5.Systematic examination of ego states in difficult situations in general 6.Examine self-perception of Parent–Child–Adult

				position regarding others (others are OK/not OK) 3.Analysis of self-efficacy and underlying position regarding self (I am OK/not OK)	7.Examine social functioning & existential position 'others are OK/not-OK' 8.Examine self-efficacy & existential position 'I am OK/not OK' 9. Examine stroke balance 10.Summary of problems 11.Ending
		4-5	Assessment of aetiology	1.Examine the development of the problems in the subjective experience of the client ('phenomenological analysis') 2.Examine the general development of the client 3.Examine negative messages from their social	1.Emotional check-in 2.Refresher/follow-up from previous sessions 3.Agreeing session aim/method 4.Discuss questionnaires 5. Examine the development of the problems in the subjective experience of the client ('phenomenological analysis')

				context (negative parental messages in early life, lack of developing mature coping mechanisms, intergenerational messages, negative stroke balance) 4.Examine script decisions (accepting or rejecting negative messages via behaviour, emotional disconnection, cognitive styles) 5.Examine how life-events have influenced the development of their problems	6.Phenomenological life story 7.Examine the general development of the client (extended questions from Ohlsson, Bjork & Johnsson, 1992) 8. Examine unfavourable messages from their social context (based on previous questions, and/or systematic analysis of injunctions/counter-injunctions/drivers and stroking) 9.Examine how life-events have influenced the development of their problems (based on previous questions; focused questions about stressful life events, stressful life events questionnaire) 10. Crystallization, creating hope & challenging cognitions

					11.Ending
		NB: before the session, the therapist creates a systematic case formulation			
		6	Sharing case formulation & developing treatment plan		1.Emotional check-in 2.Refresher/follow-up from previous sessions 3.Agreeing session aim/method 4.Sharing case formulation 5.Agreement on treatment 'contract' 6. Crystallization, creating hope & challenging cognitions 7.Ending
3. EXPERIENTIAL PROCESSING IN THE HERE-AND-NOW	In session 6, the therapist and client have agreed on a unique treatment plan for the unique client. Within each of these five sessions,	7-12			1.Emotional check-in 2.Refresher/follow-up from previous sessions 3.Agreeing session aim/method 4.Identify relevant tool

	the therapist will use the tools in their 'TA toolkit' to achieve the specific goals for the client.				5.Apply tool 6.Evaluate application of tool 7.Summary and reflection 8. Crystallization, creating hope & challenging cognitions 9.Ending
4.DECIDING & APPLYING SCRIPT CHANGES	1.identify new goals in life (script change application). 2.create conditions and inner safety for structural change in life ('facilitating script change'). 3.experimenting and evaluating change in the session and trying in daily life.	13.	Setting new life goals & making plans		1.Emotional check-in 2.Refresher/follow-up from previous sessions 3.Agreeing session aim/method 4.Identify experiential learning and impasses 5.Identify new goals in life ('redicision') 6.Reflection on the conditions for structural change and creating a plan of action

					7.Creating the conditions for structural change in therapy ('facilitating script change') 8.Summarise/evaluate 9.Creation of safety 10.Homework 11.Ending
		14-15	Application in daily life		1.Emotional check-in 2.Refresher/follow-up from previous sessions 3.Evaluating homework 4.Identifying new problem 5.Experimenting within the session 6.Homework: experimenting in daily life 7.Summarise/evaluate 8.Creation of safety

					9.Homework 10.Ending
		16	Ending	1.evaluating and taking stock of lessons learned during BTAP. 2.identifying how the clients could continue their changes and developing contingency plans. 3.saying goodbye and coping with feelings of termination.	1.Emotional check-in 2.Refresher/follow-up from previous sessions 3.Evaluating homework 4.Identify learning & re-assess therapy goals 5.Develop contingency plans 6.Explore feelings of ending 7.Creation of safety 8.Evaluation & saying goodbye