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Brief Transactional Analysis Psychotherapy for Depression: The Systematic Development of a Treatment Manual

Joel Vos and Biljana van Rijn

Faculty of Research and Doctoral Programmes, Metanoia Institute

Since the birth of transactional analysis (TA) in the 1950s, many psychotherapists have provided and tested TA psychotherapy (TAP) in clinical trials. However, most descriptions of TA therapy within these trials offered a general guide rather than a systematic treatment manual. This makes it difficult to attribute their outcomes directly to TAP as the variations in the therapists' ways of working have not been sufficiently accounted for. The existing manuals are based on particular schools of TA and research-informed personal best practice, rather than systematic reviews and meta-analyses, which would ensure that they could be replicated. This article addresses that apparent gap by describing the systematic development of a semistructured treatment manual for Brief Transactional Analysis Psychotherapy for depression, in order to enable its use in practice and research. The manual was based on an international survey of TA therapists, a systematic literature review of TA psychometric instruments, and meta-analyses of TAP clinical trials, which fed into the development of the evidence-based integrated conceptual model. This model formed an operational definition of TAP and the basis of a 16-session treatment manual for mild to moderate depression. The manual consists of four stages: initial assessment and therapeutic agreement ("contract"), systematic assessment, experiential processing, decision-making and applying script changes. Two new instruments were also developed: Transactional Analysis Goal Attainment Form (TAGAF) and Transactional Analysis Psychotherapeutic Self Report Competencies Scale (TAP-SRCS).

Public Health Significance Statement

This article describes the development of a psychotherapy manual for clients with depression. This manual integrates the evidence-based components of the different schools within transactional analysis psychotherapy (TAP). TAP evolved from psychodynamic therapies and integrated ideas from other therapeutic approaches. This manual may be considered a common-denominator approach to TAP, as it is based on a survey among TAP practitioners and systematic reviews of research evidence. This manual can be used to treat depressed clients, for example, in clinical trials.

Keywords: humanistic, psychotherapy, treatment manual, randomized controlled trial, instrument development

Psychological therapies, like transactional analysis (TA), are usually developed and validated in multiple stages (Carroll & Nuro, 2002; Rounsaville et al., 2001). Eric Berne developed TA in the 1950s, as a therapeutic approach that integrated psychodynamics with behavioral concepts,

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Joel Vos https://orcid.org/0000-0002-7961-2354

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Correspondence concerning this article should be addressed to Joel Vos, Metanoia Institute, 13 North Common Road, Ealing, London W5 2QB, United Kingdom. Email: joel.vos@metanoia.ac.uk

and with an underlying humanistic philosophy. One of its recognizable characteristics is the use of everyday colloquial terms in describing what are sometimes complex processes. For example, the term "life script" described an unconscious attempt to repeat a transferential drama (Berne, 1957, 1972), originating in childhood and reinforced throughout the life span. This was deliberate and based on the notion that therapists needed to be able to communicate with their clients in a transparent and nonjargon-laden language. Using Mahrer's (1989) classification of approaches to integration, we note that the theory of psychotherapy developed by Eric Berne was influenced by Paul Federn and self-psychology. TA philosophy and theory of personality were rooted in humanistic psychology and embraced the notion that human beings had an innate desire to grow and develop, and were responsible for their life decisions. Within that therapeutic frame, transactional analysts sought to reduce the power imbalance within psychotherapy, develop their understanding of the therapeutic process collaboratively with their clients, and negotiate therapeutic aims and goals. There was a development of specific techniques, and the overt goal setting and emphasis on behavioral change, influenced both by the behavioral psychotherapy at the time, and the humanistic concepts of supporting clients in developing authenticity and self-actualization. Within Maher's criteria, we propose that TA is an integrative approach, developing a substantive new theory, as a strategy for integration. This is evident in its further development where it became a "family framework" (Mahrer, 1989, p. 29) for a range of TA approaches. The initial TA development was followed by several decades of lively theoretical and practice developments, embracing many differences in how TA therapists work and think (Vos & Van Rijn, 2021a). From a psychotherapy research perspective, this has sometimes led to a lack of emphasis on the distinctive nature of TA psychotherapy (TAP).

Our aim in the paper, as well as our previous publications, is to show that TAP is a distinctive model of psychotherapy based on a coherent, evidence-based conceptual model (Vos & Van Rijn, 2021b, 2021c). For example, in our previous meta-analysis, we reviewed 41 clinical trials of TAP (Vos & Van Rijn, 2022), showing that TAP improved the clients' mental health symptoms, social functioning, and general well-being with moderate and large effects. These effects were explained by the improvements in the clients' ego-states, self-efficacy, and social functioning, and by the positive client–therapist relationship, as hypothesized by the TA treatment model.

These clinical trials also triggered new questions. The meta-analysis showed large differences in the applications, possibly caused by a lack of semistandardized treatment manuals. The existing manuals tended to give generic guidance for treatment. Although giving leeway in using clinical judgment is a feature of all manuals, it is also important to define how and when it will be used during therapy, and give a range of techniques and interventions that can be used. That would support findings of causality between TAP and outcomes and conclusions about the efficacy.

There is currently an increasing demand for evidence-based therapies, asking therapists to work with clients using the best available empirical research (Norcross & Lambert, 2019). National health service guidelines use evidence-based research to decide which therapies will be funded, and this has been a challenge to transactional analysts in many countries. In the United Kingdom, between 60% and 90% of supported treatments in mental health care are brief Cognitive Behavior Therapy for specific disorders (O'Donohue et al., 2000). This might be due to political reasons, paradigmatic reasoning (Vos, Roberts & Davies, 2019), and the paucity of systematically developed treatment manuals supporting the claims that TA is a bonafide psychotherapy (Luborsky et al., 2002; Wampold & Imel, 2015).

In our previous meta-analysis, we found that some authors published the development of the treatment manual in the same article as their feasibility/pilot study; however, possibly due to the limited word count, the description of the manuals seemed to lack rigor and detail (Vos & Van Rijn, 2022). It was often unclear to which extent the manual was developed ad hoc during the clinical trials, due to which several studies had a large risk of bias. We see it as good research practice to publish a study on the development of the treatment manual before conducting the feasibility and pilot studies, to reduce bias, and to provide sufficient attention and detail to the rigorous development and content of the manual. The manual development is a separate step in the research process that forms the foundation of all next processes, and that should therefore not merely receive minimum attention in a clinical trial.

Therefore, our aim in this paper was to address this gap by describing the systematic development of a semistructured treatment manual for Brief Transactional Analysis Psychotherapy (BTAP).

Although we are mindful of the comorbidity of symptoms clients present with, we will follow a common practice among therapy researchers to first develop a treatment manual for specific symptoms before broadening this to other difficulties (Kazdin, 2022; Vos, 2023). For example, Cochrane reviews recommend to first focus on specific symptoms, such as depression, before broadening to other mental health issues, such as anxiety. The reason is that different symptoms may have different etiology, clinical characteristics, and mechanisms of change, requiring different treatment mechanisms. If these conceptual components overlap between symptoms, it may be preferred to develop a broad treatment manual that can be applied to these multiple symptoms, for reasons of efficiency and ethics. However, it may not be possible to develop a broad treatment manual merely with common therapy factors, as some disorders may require unique interventions, at least seen within some therapeutic paradigms. For example, TA studies indicate that depression is often associated with specific unfavorable messages in early life, which may give rise to the life position of "I am not OK," and subsequently the treatment often focuses on transforming this into "I am OK"; however, anxiety may not be associated with this life position (individuals can say "I am OK," while still feeling anxious, for example, due to the life position "Others are not OK"), and consequently the treatment for anxiety is often different (Vos & Van Rijn, 2021c, 2022). Seen from a research perspective, giving a treatment to a relatively homogeneous sample may also help to simplify the data analysis, and facilitate attributing research findings to the treatment manual, instead of having to differentiate the effects of the treatment manual from the differential effects in different samples (i.e., between-samples variation added to within-sample variation). Therefore, we decided to develop this manual for mild or moderate depression, as defined by DSM-5, as this is the most common mental health disorder and may therefore benefit the largest number of clients (Carroll & Nuro, 2002; Rounsaville et al., 2001). After clinical trials on this manual for clients with depression, we hope to extend and test the manual in clients presenting other symptoms.

Methodology

General Methodology

Although there are several common practices in the development of manuals, there are no authoritative guidelines about developing psychological treatment manuals (Carroll & Nuro, 2002; Rounsaville et al., 2001). In TA, as in other therapeutic schools, many manuals seem to evolve organically from the clinical experience from individual practitioners who simply write how they work with their clients, often based on crystallized expertise and clinical intuition. This inductive process may offer a unique treatment specific to the context in which it was developed, but it may not always be sensitive for broader contexts, and may risk subjective bias due to the lack of inclusion of systematic research. Consequently, several treatments have shown large effect sizes if studied in the original context, particularly if the treatment developer was the same as the therapist and the researcher, but they have smaller effects in replication studies ("research-allegiance bias"). The meta-analyses on TA studies indeed showed a large variety of manuals, usually based on the individual vision of individual practitioners, with few replication studies (a partial exception is Widdowson, 2013, who developed a treatment guideline with the help of multiple therapists). However, to develop a manual, grounded in systematic research and that may be broadly applicable, we decided to base our manual on the broadest evidence possible: a survey of common practices of TA therapists, a survey of evidence-based concepts in TA, and effective components of treatment manuals (Vos & Van Rijn, 2021a, 2021b, 2021c, 2022).

Thus, the development of this manual stands in the tradition that is known as "evidence-based psychological therapies," whereby therapists treat clients with the best available empirical research available, of course where possible tailored to the unique context of the client characteristics, culture and preferences (Barkham et al., 2010; Fisher & O'Donohue, 2006; Nathan & Gorman, 2015; Norcross & Lambert, 2019; Roth & Fonagy, 2006; Weisz & Kazdin, 2010). Meta-analysis indicates that studies using a treatment manual do not have significantly different outcomes in research studies (Crits-Christoph et al., 1991; Cuijpers

et al., 2010), and it may particularly benefit beginning therapists and may increase treatment adherence and fidelity (Miller & Binder, 2002). However, some authors have raised concerns about the effects on the therapeutic relationship, unmet client needs, treatment credibility, feasibility, and job satisfaction; however several of these concerns may be addressed by developing a semistructured manual with space for tailoring the treatment to the client (e.g., the later stage and "TA toolkit" in this manual; Addis et al., 1999). Therefore, this manual holds the middle ground between a fully structured and an unstructured manual, in order to offer both structure and clinical flexibility.

Specific Steps in Manual Development

The stages and specific content of the BTAP treatment manual were derived from the four previous systematic studies we conducted between 2018 and 2020 in the following steps (see Figure 1).

First, we integrated all components suggested by the global survey among 238 TAP therapists (Vos & Van Rijn, 2021a). Our aim was to use the common denominators of TA therapy that transcended many variations in the field ("schools of TA").

Second, we used TA concepts confirmed by research and evaluated with psychometric instruments (Vos & Van Rijn, 2021c; Figure 2).

Third, we used the findings from our meta-analyses of 41 clinical trials on TAP (Vos & Van Rijn, 2022) to identify the factors that impacted the effectiveness of TAP. These factors included: focus on the client's experiences; assessment and formulation; clear stages of therapy; psycho-education/didactics; focus on the present; analysis of life script (a framework of archaic unconscious patterns, formed in childhood, reinforced by subsequent life events and environment and unconsciously reenacted, Berne, 1972); analysis of injunctions/counter-injunctions relating to the components of these archaic unconscious patterns; therapeutic "contract" defined as an agreement about the aims of therapy; development of positive ego-state functioning related to the internal patterns of thought, feeling, and behavior formulated as the internal Adult, Child, and Parent; social functioning; self-efficacy; and a positive therapeutic relationship and working alliance. These factors are included in the manual.

Finally, we developed a treatment model explicitly based on the evidence-based conceptual model developed by these studies (Vos & Van Rijn, 2021b). As detailed in these publications, all four studies were based on systematic literature reviews and meta-analysis, and therefore may be regarded as representative of the broad field of TAP.

In addition to the above, the manual also included all therapeutic competencies recommended by the competencies framework of the British National Health Services of Counselling for Depression, based on systematic empirical research. These competencies for depression are common evidence-based and best-practice competencies that have been suggested to be effective in treating clients with depression; it may be argued that it would be scientific bad practice and unethical to exclude existing knowledge about what works best for this population. These competencies are very broad and overlap with the TA competencies for depression (which is not surprising as TA is an integrative therapy that has included widespread evidence-based and best-practice competencies); in addition to the NHS Competencies, TA adds several competencies as described in the treatment manual.

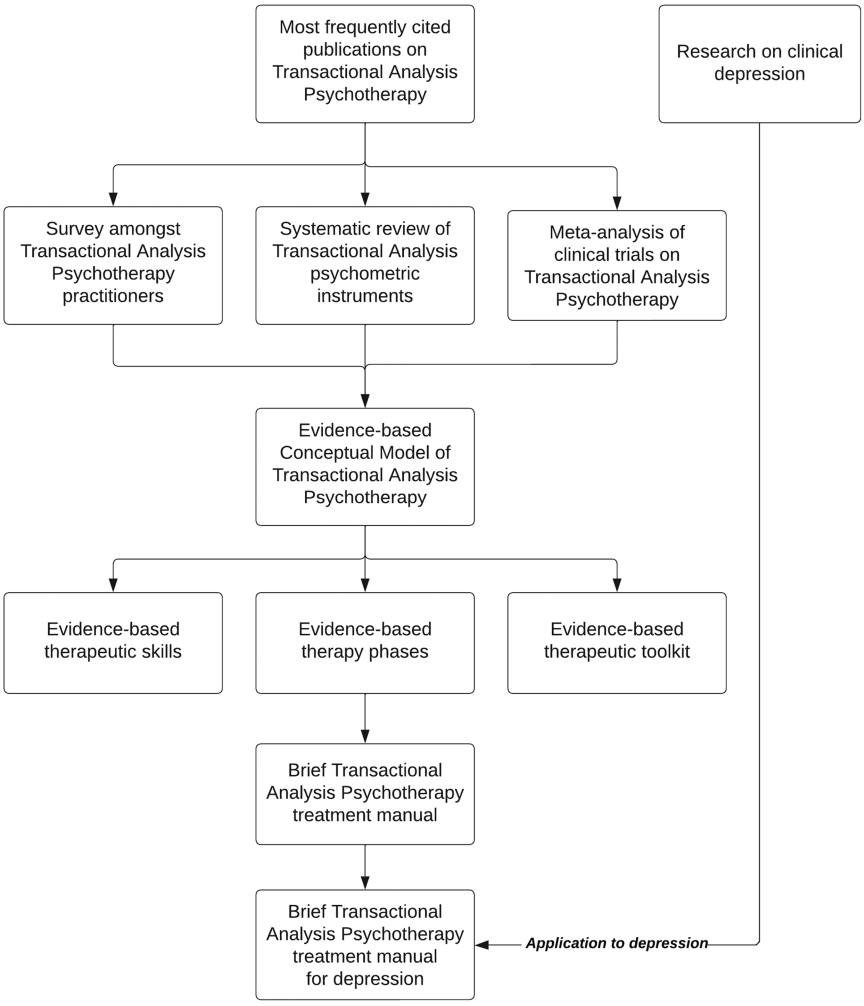
We decided to develop a manual for 16 sessions, as research on dose–response relationships indicates that more than 50% of all clients experienced significant change between 13th and 18th sessions (Vos, Roberts & Davies, 2019), and to enable a comparison with the British National Health Services that offers 16 sessions for mild/moderate depression.

Findings

The following findings sections will briefly summarize the conceptual model and highlight the role of systematic assessments, case formulations, and the use of questionnaires. This will be followed by a description of therapeutic skills, treatment stages, and a therapeutic toolkit, in line with a previously published systematically developed evidence-based treatment manual (Vos, 2017). This article describes the development and gives an overview of the BTAP treatment manual, but details are left out due to the limited word count. For readability purposes, we keep the explanation of concepts brief; readers are recommended to read Vos and Van Rijn (2021a, 2021b, 2021c,

Figure 1

Overview of the Systematic Development of BTAP Treatment Manual



Note. BTAP = Brief Transactional Analysis Psychotherapy.

2022) for detailed explanations. Readers may request the full manual from the authors (also in process of publication). Clinical trials will be published in future studies.

Treatment Philosophy: Conceptual Model

The evidence-based conceptual model could be summarized with clinical phenomena, etiology, therapeutic mechanisms, and outcomes (see chapter 3 in Vos, 2023 for an overview of conceptual models in psychological therapies, based on Kazdin, 2022; Vos, 2023)

Central Clinical Phenomenon

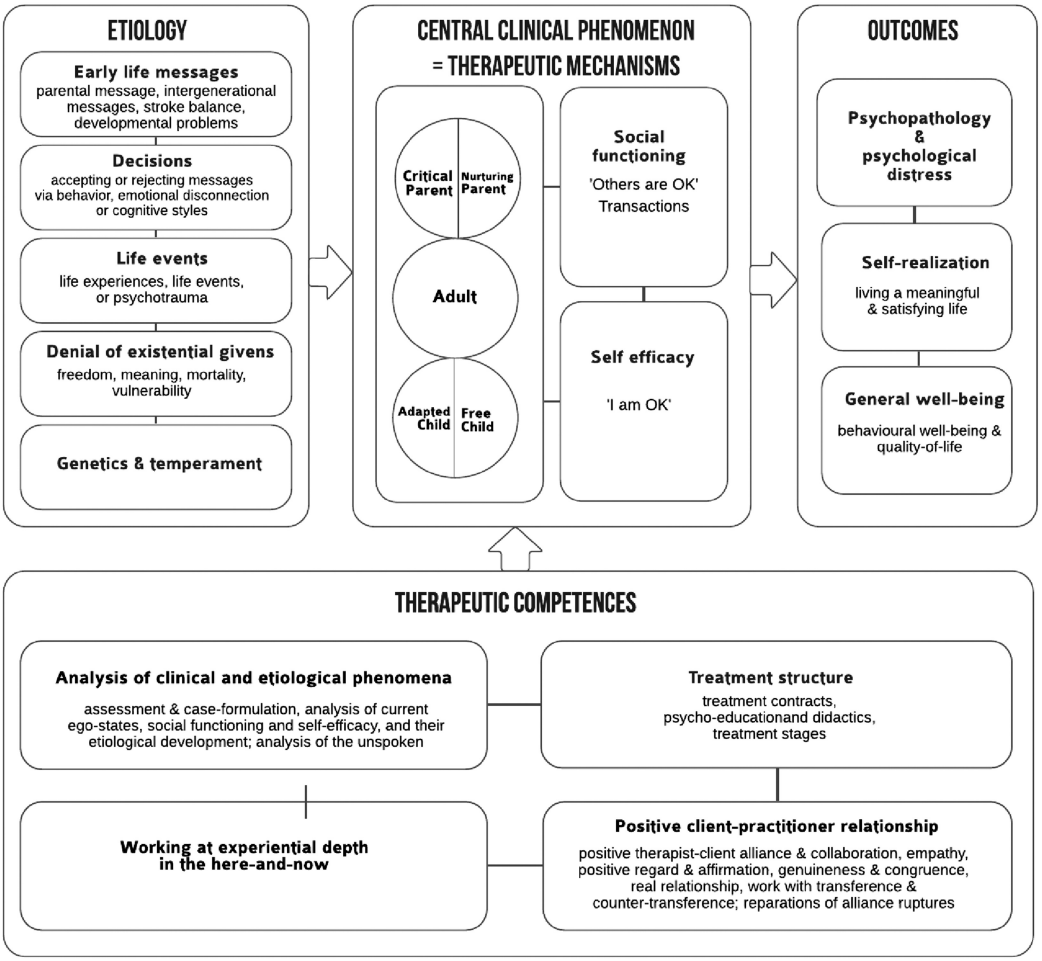
TA focused on problems in functional ego-states, which research has operationalized as Parent, Adult, and Child with distinctive behavioral functions of Critical Parent, Nurturing Parent, Adult, Adapted Child, and Free Child.

Etiological Component

Individuals could develop long-term problems in their ego-states, social functioning (i.e., respect and acceptance of others are OK) and self-efficacy (i.e., self-acceptance or "I am OK") as a result of

Figure 2

Conceptual Model of Transactional Analysis Psychotherapy (Vos & Van Rijn, 2022)



negative messages from their social context (e.g., negative parental messages or experiences in early life), lack of developing mature coping mechanisms, intergenerational messages, negative stimulation (stroking), script decisions (e.g., active, unconscious interaction with these negative messages evidenced in behavioral patterns, emotional disconnection, or cognitive styles), life events, and genetics/temperament.

Therapeutic Mechanisms

TAP aims to help clients develop constructive ego-states (both inter and intrapersonally), improve social functioning, and stimulate a sense of self-efficacy. Research confirms that TA improves mental health symptoms, behavior, and general well-being due to the improvement of ego-states, self-efficacy, and social functioning. Four evidence-based therapeutic competencies achieved these effects: a positive client–practitioner relationship, focus on current ex-periences, etiological analysis (e.g., life-scripts, injunctions, counter-injunctions), and therapeutic structure (e.g., treatment contracts, treatment stages, psycho-education/didactics). It is worth noting that although the etiological analysis involves reflection on the unconscious, developmental process, TAP also involves cognitive therapeutic strategies, such as overt agreement on therapeutic aims and psycho-education where the therapist shares theoretical concepts with a client,

using colloquial, easy-to-understand language (i.e., internal parent, adult, or child; life script; etc.).

Therapeutic Outcomes

The research evidence suggests the following outcomes: a meta-analysis of 41 clinical trials suggested that TA had moderate to large positive effects on mental health symptoms, self-efficacy, social functioning, and ego-states. Historically, clinicians hypothesized the following outcomes: Eric Berne stated that the aims of TAP (or "cure") were threefold: the attainment of autonomy, defined as the release or recovery of awareness, spontaneity, and intimacy. The attainment of awareness referred to not interpreting or filtering experience of the world to fit the early life messages. The attainment of spontaneity was regarded as the capacity to choose from a full range of options in thinking, feeling, and behavior (again unlimited by the historical content). The attainment of intimacy is related to the open sharing of authentic feelings and wants with another. Elsewhere, Berne (1961, 1972) identified that not every client could achieve the full "cure," and that individuals could achieve different levels of improvement, such as social control, symptomatic relief, leading to the transference or script cure. To summarize both the evidence-based and the hypothesized outcomes, the general aim of this brief psychotherapy treatment was to help individuals with mild or moderate depression according to their own circumstances and aims. Within the BTAP treatment manual, clients were asked to set their personal, specific goals for each of the following TA-specific outcomes (Vos & Van Rijn, 2021b). Progress on each was assessed during treatment (see Transactional Analysis Goal Attainment Form in Table 3):

1. specific psychological problems (e.g., symptoms of depression);
2. self-realization (e.g., living a meaningful and satisfying life despite life's challenges); and
3. behavioral well-being and social quality of life (e.g., satisfying social life and intimate relationships).

Treatment Philosophy: Focus on Systematic Assessment

Meta-analyses suggested that TAP was more effective if it included systematic assessment and case formulations (Vos & Van Rijn, 2021a). Broader research literature also indicated that treatments were more effective when based on a case formulation (Eells, 2022; Page et al., 2008). A good case formulation is as clear and brief as possible, holistic, precise, and empirically testable, and the hypothesized mechanisms of the etiology and the treatment are evidence based (Dawson & Moghaddam, 2015). Thus, the case formulation within the manual was based on the systematic assessment of the evidence-based clinical and etiological models (in the case of TA: ego-states, social functioning, and self-efficacy), and used to formulate a tailored case formulation, and it was in turn used for monitoring treatment progress and their adjustment (Van Rijn, 2015). In summary, the BTAP manual encompassed systematic assessment, based on a systematic analysis of the clinical and etiological components and hypotheses about the therapeutic mechanisms to develop a treatment plan consistent with a client's aims.

The case formulation can be found in Table 1. It translated the TA conceptual model (Vos & Van Rijn, 2021c) with the following components (note that not all may be relevant to each client):

i. The field-specific case formulation described the DSM/ICD or medical diagnosis and its impact on the client's daily life.
ii. The phenomenological description referred to the problems described in the client's words.
iii. The clinical model included problems in functional ego-states, behavioral functions, social functioning ("others are OK"), and self-efficacy ("I am OK").
iv. Etiological components included a description of early life messages, decisions, life events, denial of existential givens, genetics, and temperament.
v. Treatment indicators included reflections on whether BTAP could be relevant and helpful to the client at the current stage in their life; alternative treatments other than BTAP should be considered (therapists may want to clinically interpret these indicators and make a clinical judgment about the general potential helpfulness of BTAP,

Table 1

Systematic Case Formulation Form for Brief Transactional Analysis Psychotherapy (SCF-BTAP)

Component name	Include at least the following in the clinical model of this client (if known/relevant)	Tips and tricks
i. Field-specific case formulation	A. Formulation of DSM/ICD-diagnosis B. Physical diagnosis if relevant (consider psychosomatic symptoms) C. Impact of symptoms on daily life	For example, use questionnaires (PHQ-9, GAD-7, CORE-10, WSAS) as a hypothesis that needs to be examined in conversation
ii. Phenomenological description of concerns		This provides a comprehensive overview of the problem in the words of the client, with as little interpretation and theorizing from the therapist as possible (3–10 sentences)
iii. Description of clinical TA model	1. Possible problems in functional ego-states: Parent, Adult, or Child 2. Possible problems in behavioral functions of Critical Parent, Nurturing Parent, Adult, Adapted Child, and Free Child 3. Possible problems in social functioning or believing Others are OK 4. Possible problems in social functioning or believing self-efficacy or I am OK	Describe client's symptoms/concerns in TA terms. Justify the clinical model with specific examples. If you have no clear evidence, write explicitly that this is a hypothesisConsider the following clinical aspects often observed in depression: • Strong Critical, Punitive, or Demanding Parent • Strong Vulnerable Child • Weak Nurturing Parent • Weak Healthy Adult • Weak Free Child • Negative coping styles (e.g., avoidance and denial) • More likely to believe: I am not OK • More likely to believe: Others are not OK
iv. Description of etiology	A. Early life messages: • parental messages • intergenerational messages • stroke balance • developmental problems B. Decision to accept or reject messages via: • behavior • emotional disconnection • cognitive styles C. Life events: • life experiences • life events • psychotrauma D. Denial of existential givens • freedom, meaning, mortality, vulnerability E. Genetics and temperament	How has the client developed the clinical concerns in life? This includes a description of any life events which may have triggered the concerns, duration of the concerns, and specific situations in which the concerns are experienced as more present or less present, and whether anything has helped the client to deal with these concerns in the past. Explores the general development of the current problems in TA themes in the client's life

(*table continues*)

Table 1 (*continued*)

Component name	Include at least the following in the clinical model of this client (if known/relevant)	Tips and tricks
v. Treatment indicators	Reflect whether BTAP is indicated for the client	Consider the following points (not required to describe each point): • Inclusion/exclusion criteria from institution/service/researcher • Exclusion criteria • Curiosity and interest in developing self-understanding • Willingness to participate in therapy actively • Willingness to make reasonable sacrifices as part of the process of change • Realistic expectations of therapy and realistic goals • No urgent concerns that need to be addressed before starting BTAP • Sufficient social resources to start BTAP • Psychological mindedness • Capacity for reflection, introspection, and honesty • Level of self-awareness and self-insight • Adaptive coping styles • Other arguments pro offering BTAP • Other arguments contra offering BTAP
vi. Treatment aims	Formulate the aims of the treatment in the following ways: 1. Formulated by the client 2. Formulated in clinical-diagnostic terms 3. Formulated in TA terms	Examples: 1. Client: • For example, copy from BTAP Goal Attainment Form 2. Clinical-diagnostic terms: • For example, reduction in level of symptoms of depression and other mental health problems 3. Aims in TA terms such as: • Self-realization (e.g., living a meaningful and satisfying life despite life's challenges) • Behavioural well-being and social quality of life (e.g., satisfying social life and intimate relationships)
vii. Therapeutic mechanisms	A. Therapeutic mechanisms in TA terms: • analysis and change of dominant ego states • improving social functioning and developing a sense of OK-ness of others • improving self-efficacy and developing a sense of OK-ness of self B. Therapeutic mechanisms specific for the clinical diagnosis, for example, depression: • reducing the influence of the Critical, Punitive, or Demanding Parent over their Adult and Child • creating a sense of safety for the child, and allowing acceptance and expression of experiences related to the vulnerable child	Based on the therapeutic aims and the TA mechanisms, the therapist formulates how the client could benefit from the therapeutic process in BTAPAny specific benefits and concerns for the therapeutic alliance and dangers of ruptures in the relationship are described. This includes explicit reflection on processes of transference/countertransference in the sessions with the clientTherapists should not only describe WHAT therapeutic mechanisms or specific interventions they will use, but also justify HOW they expect that this can help the client achieve the treatment goalsUse psychotherapeutic relationship questionnaires to evaluate the relationship (e.g., PRQ may help identify transference/countertransference)

(*table continues*)

Table 1 (*continued*)

Component name	Include at least the following in the clinical model of this client (if known/relevant)	Tips and tricks
	• strengthening nurturing parent • strengthening healthy adult • strengthening free or happy child • developing more positive coping styles (e.g., less avoidance and denial) • Strengthening sense of: I am OK • Strengthening sense of: Others are OK C. Hypotheses about the use of how specific therapist skills could facilitate the client to achieve the treatment goals • assessment and etiological analysis • experiential work in the here-and-now • positive relationship • offering a structure in the treatment • transference/countertransference	
viii. Risk assessment	This should include any possible thoughts, plans, and actions regarding: A. Suicide B. Self-harm C. Harming others D. Harming the therapist E. Other risks Include plans to prevent or reduce risks, and what to do in case of emergency	
ix. Self-reflection and reflexivity	The therapists reflect on their own position and possible biases in the assessment process	This could include the following aspects: • reflection on own position and countertransference • embodied sensations and clinical intuitions in the therapeutic relationship • cultural and religious differences • reflections from third parties (e.g., supervisor)
x. Response from the client when sharing the case formulation		Describe response and how the case formulation was adjusted
xi. Comments and any other information		

Note. DSM/ICD = Diagnostic and Statistical Manual of Mental Disorders/International Statistical Classification of Diseases and Related Health Problems; PHQ-9 = Patient Health Questionnaire-9; GAD-7 = General Anxiety Disorder-7; CORE-10 = Clinical Outcomes in Routine Evaluation 10; WSAS = Work and Social Adjustment Scale; TA = transactional analysis; BTAP = Brief Transactional Analysis Psychotherapy; PRQ = Psychotherapy Relationship Questionnaire.

and not use these as rigid inclusion/exclusion criteria).

vi. Treatment aims included the aims of the treatment, as formulated and identified by the client (see below), clinical-diagnostic terms (e.g., "reduction of symptoms of depression"), and other TA outcomes.
vii. Therapists could reflect on the possible therapeutic mechanisms of using TA in helping clients achieve their goals.
viii. The risks of suicide, self-harm, harm of others, and other risks were essential considerations.
ix. The therapists were invited to critically reflect on their assessment and case formulation.

As described below, the therapists were expected to share their case formulation with the client as a hypothesis. The client input and feedback were used to improve the formulation and the basis for deciding on the steps in the treatment plan derived from this case formulation.

Questionnaires

Research has suggested that questionnaires were helpful in tailoring assessment and case formulations to inform treatment (feedback-informed therapies) and this impacted our decision to administer a battery of reliable, valid questionnaires during treatment (Prescott et al., 2017). Their aim was to support the therapists in developing an evidence-based formulation. The selection of questionnaires in Table 2 described the primary questionnaires used in the study and the alternative/additional questionnaires that therapists could consider. Therapists gave the questionnaires before or after the first session and examined them prior to case formulation.

We also developed two new questionnaires. As these were intended for practical–clinical purposes, we did not use formal steps for questionnaire development (Devellis, 2016; Vos, 2023):

i. *Transactional Analysis Goal Attainment Form (TAGAF).* This questionnaire (Table 3) invited clients to formulate therapy goals, in line with generic therapy goal attainment forms (Cooper & McLeod, 2007). The clients were asked to identify goals for each of the possible outcomes of TA, as described above (cf., Vos & Van Rijn, 2021c): emotional goals, goals about self-beliefs, social goals, goals about living in the present, life goals, and other goals. Clients were asked to formulate one goal for each (if possible) in the first stage of therapy, and evaluate the extent of achieving these goals at the end of therapy. They could formulate those goals during the session, or they could reflect on them at home. Goals in therapy should be im-portant (Austin & Vancouver, 1996; Moskowitz, 2012), specific and simple (Locke, 2002; Sheeran & Webb, 2016), not too far in the future (Locke & Latham, 2002), challenging (Locke & Latham, 2002), attainable (Emmons et al., 1986; Sheldon & Elliott, 1999; Wiese, 2007), mutually conducive in the case of multiple goals (Chun et al., 2011), and focused toward something positive ("approach") rather than negative ("avoidance"; Elliott & Friedman, 2017; Klein & Elliott, 2006). The TAGAF also enabled practitioners and researchers to examine to which extent clients achieve TA-specific therapy goals, beyond the generic therapy goals of reducing symptoms of depression.
ii. *Transactional Analysis Psychotherapeutic Self Report Competencies Scale (TAP-SRCS).* This scale (Table 4) asked therapists to assess their work in each session on the basis of the four groups of evidence-based TAP competencies (Vos & Van Rijn, 2021b): analyzing clinical and etiological phenomena; offering a structure; working at experiential depth in the here-and-now; creating and using a constructive therapeutic relationship. Similar to other competencies scales, TAP therapists assess their application of these competencies on a 6-point scale (e.g., Jacob et al., 2011).

Therapeutic Skills

The treatment manual elaborated on each of the following four groups of evidence-based competencies based on our previous systematic literature reviews and meta-analyses (Vos & Van Rijn, 2021a, 2021b, 2021c, 2022).

Table 2

Questionnaires to Consider in Transactional Analysis Psychotherapy (See Details in Vos & Van Rijn, 2021b)

Construct	Primary recommended questionnaires	Alternative or additional questionnaires
Depression	Patient Health Questionnaire-9 (PHQ-9)	Beck Depression Inventory (BDI)
Other mental health issues	General Anxiety Disorder (GAD-7)General Distress CORE-10	General Quality-of-Life WHOQOL-BREFWork and Social Adjustment Scale (WSAS)
Client interview	Extended version from Johnsson (2011)	
Ego states	Schema Mode Inventory (SMI)[a]	Tokyo University Egogram (Japanese only) Ego States[b] Adjective Check List[b] ANINT-A36[b] Less validated options: Daley Ego States Scale[b] Ego State Inventory[b]
Life position	Life Position Scale (LPS)[b]	ANINT-A36[b] Transactional Behavior Questionnaire[b]
Stroking	Stroking questionnaire (SQ)	Stroke balance (SB) Transactional Behavior Questionnaire[b]
Injunctions/counter-injunctions/ drivers		See systematic overview from McNeel (2010)[b] Drego Injunction Scale[b] ESPERO[b]
Therapeutic relationship (not specific TA)	Working Alliance Scale (WAS)	Agnew Relationship Measure (ARM-5) Psychotherapy Relationship Questionnaire (PRQ) Relational Depth Frequency Scale (RDFS)
Other TA questionnaires		Transgenerational Script Questionnaire[b] Joines Personality Adaptation Questionnaire[b]
Other questionnaires to consider		Stressful Life Events Screening Questionnaire (SLES-R) Coping Flexibility Scale (CFS) Acceptance & Action Questionnaire-II (AAQ-II) (experiential acceptance) Ryff's Well-being Scale (RWBS) Meaning Sextet Questionnaire (MSQ) Meaning Approach Scale (MAS) Vos Sociodemographics and Life Situation Questionnaire (VSLSQ)
Questionnaires to tailor transactional analysis psychotherapy (see other tables)	Systematic Case Formulation Form (SCFF-BTAP)Transactional Analysis Goal Attainment Form (TAGAF) Transactional Analysis Psychotherapy Competencies Scale (TAP-SRCS)	

Note. CORE-10 = Clinical Outcomes in Routine Evaluation 10; WHOQOL-BREF = World Health Organization Quality of Life Brief Version; TA = transactional analysis.
[a] That ego-states are called "modes" and slightly different ego-states/modes may be identified in line with Schema-Therapy. [b] Applicability, validation, and/or translation uncertain (see Vos & Van Rijn, 2021b).

Clinical/Etiological Analysis

We described previously how TAP therapists analyze clinical and etiological phenomena (Vos & Van Rijn, 2021c).

Relational Skills

Clients also benefit from relational skills, and TAP therapists referred to them in the survey (Vos & Van Rijn, 2021c), and in line with Norcross and Lambert's landmark publication "Psychotherapy relationships that work" (2019). The relational skills included: building a positive therapist–client alliance and collaboration; goal consensus; empathy, positive regard and affir-mation; genuineness/congruence; offering a real relationship; emotional expression; managing countertransference; and

Table 3

Transactional Analysis Goal Attainment Form (TAGAF)

Instruction:

Transactional analysis aims to help individuals achieve goals that they may have about their emotional well-being and reducing psychological distress, how they feel about themselves and others, their life in the here-and-now and living a meaningful and satisfying life despite life's challenges. These goals are of course formulated in a very broad way.

Therefore, we would like to ask you to *write down any specific personal goals that you may want to achieve in psychotherapy*, at the start of therapy. It is important to be *as specific as possible*, and to make sure that these goals are achievable. *Think about each possible goal, but you do NOT need to formulate each goal* (do not create artificial or inauthentic goals). During the final session, we will ask you to mark the extent to which you have achieved each goal.

Goal	Example	Write one of more goals at the start of therapy	Rate when evaluating progress or outcomes: 1 (goal not at all achieved)–7 (goal completely achieved)
Emotional goal	I would like to feel less sad, sleep better, feel less anxious, be better able to cope with stressful situations		1 2 3 4 5 6 7
Goals about my self-beliefs	I would like to feel more "OK" about myself, for example, by developing more self-esteem, being more independent from others, loving myself more, being more compassionate with myself, understanding my own motivations better, being able to plan activities and goals in life and to achieve these		1 2 3 4 5 6 7
Social goal	I would like to feel more "OK" with others, for example, by developing more friendships, trusting others more, having more intimate relationships, being more authentic in my relationships with others, and knowing how to deal with difficult people		1 2 3 4 5 6 7
Living in the present	I would like to live more in the here-and-now, understand better how I have become the person who I am now, understand how my experiences earlier in life influence my current thoughts feelings and behavior, be more authentic, become more honest with myself, feel more in control in how I respond to situations and people, feel more like an Adult in how I live my life, feel less pressure from my inner Critical Parent, develop self-care by my inner Nurturing Parent, give more attention to my inner Free Child, act less often like a Rebellious Child, less automatically conform to the expectations from others like an Adapted Child		1 2 3 4 5 6 7
Life goal	I would like to be able to feel more energy and flow in my life, find out what I find meaningful in life, learn how to achieve goals in life, be more spontaneous, experience the freedom to make my own independent decisions in life, live a meaningful and satisfying life despite life's challenges and limitations		1 2 3 4 5 6 7
Any other goal	Here, you can write any other goals		1 2 3 4 5 6 7

Table 4

Transactional Analysis Psychotherapeutic Self Report Competencies Scale (TAP-SRCS)

For the following TA core competence below, please rate how well you feel you applied them in this session:

1. Much improvement in application needed: I felt like a beginner, as if I did not have the concept
2. Moderate improvement needed: I felt like an advanced beginner, who is beginning to do this, but needs to work on the concept more
3. Slight improvement in application needed: I need to make a focused effort to do more of this
4. Adequate application of competence: I did enough of this, but need to keep working on improving how well I do it
5. Good application of competence: I did enough of this and did it skillfully
6. Excellent application of competence: I did this consistently and even applied it in a creative way

Competence	Description	
Analyzing clinical and etiological phenomena	For example, conducting an explicit and systematic assessment or case formulation; analyzing ego-states, social functioning, or self-efficacy; analyzing the etiological development of ego-states, social functioning, or self-efficacy; analyzing nonverbal communicationIn a later treatment stage, you may not focus much on analyzing clinical and etiological phenomena. In this situation, describe to which extent you have been using and applying any decisions made on the basis of your clinical or etiological analysis in previous sessions	1 2 3 4 5 6 7
Offering a structure in the session	For example, following the BTAP treatment manual, following the specific stage of the treatment manual, explicitly discussing the session structure with the client, explicitly discussing or following treatment contracts, using psycho-education and didactics	1 2 3 4 5 6 7
Working at experiential depth in the here-and-now	For example, examining how the current feelings of the client, examining or using emotions, deepening emotions, behavioral experiments triggering emotions, systematic desensitization, stimulating clients to tolerate and "sit with" emotions	1 2 3 4 5 6 7
Creating and using a constructive client–practitioner relationship	For example, a positive therapist–client alliance and collaboration; showing empathy, positive regard, affirmation, genuineness, and congruence; having a real relationship; working with transference and countertransference; appropriately responsive to the client; tailoring treatment; repairing alliance ruptures if needed	1 2 3 4 5 6 7
How do you think that can you improve your transactional analysis therapist competencies?	Based on the previous scores, what can you do to improve your skills and make future sessions better? What practical steps do you need to do to improve your skills and sessions (e.g., speak with clinical supervisor or colleagues, reading, personal therapy)?	Open question

Note. TA = transactional analysis; BTAP = Brief Transactional Analysis Psychotherapy.

repairing alliance ruptures. Working at experiential depth in the present implied that therapists stimulated clients to accept, express, and explore their experiences, such as freeing themselves from inhibitions, transcending self and developing self-insight, and a constructive relationship with the past. Research indica-ted that deeper and more internally focused analysis of experiences by the clients improved psychotherapy outcomes (Greenberg et al., 2007; Hendricks, 2002; Orlinsky et al., 2004; Pos et al., 2003; Sachse & Elliott, 2002), although experiential work should always be combined with other/rational-reflective work (Bohart, 1993; Mergenthaler, 1996; Mohr et al., 1990).

Structure

Developing explicit or implicit therapeutic agreements and aims has been a cornerstone of TA since its early development (Berne, 1972); its importance in impacting effectiveness has been confirmed by findings across different therapeutic schools (Sills, 2006). Research indicated that therapies were more effective if they offered treatment structure, and managed client expectations, for example, by explicating the aims, methods, and practical aspects of the treatment (Orlinsky et al., 2004). Treatment was more effective when the client and practitioner have assessed and agreed on the treatment goals and the methods to achieve those goals (Tryon & Winograd, 2011). However, treatment goals should not be conceptualized as rigid and unvarying targets. Instead, the emphasis should be on facilitating clients in clarifying and exploring the goals already implicitly present in their life (Cooper & McLeod, 2007). It has been recommended that goals should be set relatively early in treatment, preferably at the end of the assessment session, based on the meaning-centered case formulation, and adjusted after several sessions.

Psycho-Education/Didactics

Many TAP therapists offer psycho-education/didactics (Vos & Van Rijn, 2022), such as by explaining the TA models to clients and developing a mutual understanding and reflective language during therapy. Research across therapeutic schools indicated that didactics and psycho-education have some positive effects on clients in treatment (Donker et al., 2009; Lincoln et al., 2007).

Treatment Stages

Most psychological therapies have stages such as assessment, case formulation, intervention, application, and evaluation (Vos, 2023). They are supported by research indicating that individuals changed gradually and by going through multiple stages (Boswell et al., 2015). For example, the Transtheoretical Model of Behavior Change described "stages of change": from precontemplation to contemplation, preparation, action, maintenance, and termination (Prochaska & DiClemente, 2018). Similarly, the Health Action Process Approach Model (Schwarzer et al., 2003) describes motivational conditions of change. Several interventions could help improve client's expectations and motivations for change (e.g., motivational interviewing), relapse-prevention, and bridging to daily life. Applied to psychotherapy: clients often go through stages of different relationship with particular problematic experiences, such as painful memories, threatening feelings, or destructive relationships. Many clients seem to follow a regular developmental sequence of recognizing, reformulating, understanding, and eventually resolving the problematic experiences that brought them into treatment (Stiles, 2001). However, authors have not found clear evidence for the linearity of these stages (Riemsma et al., 2003), but they seem to agree that clients experience successive shifts in their frame of mind during therapy and that it could be helpful to offer distinctive therapy stages (Katakis, 1989; Kiesler, 1996).

Similarly, in clinical trials on TAP, clients seemed to go through stages of change. The TA Review Survey identified four stages of TA treatment that could be described as preparation, assessment, processing of the archaic material and resolution, and application/ending stages. In TA terms, they are referred to as preparation, decontamination, deconfusion and redecision, consolidation, and termination (Berne, 1961, 1966; Stewart & Joines, 1987; Woollams & Brown, 1979). We summarized this debate in TA with the help of systematic empirical literature (Vos & Van Rijn, 2021b). We concluded that, although there was a progression through stages of treatment (Pulleyblank & McCormick,

1985; Woollams & Brown, 1979), these stages of change often overlap during treatment and need to be tailored to the client (Clarkson, 2013; Hargaden & Sills, 2002). With that in mind, we have described the broad stages of TA treatment below.

The assessment (decontamination) stage involved therapeutic procedures to resolve the intrusion of the historical material into the current functioning. In TAP, this was formulated as contamination of the Adult ego state by the inner Parent or the inner Child ego state. For example, a client who was working to excess and struggling with anxiety and depression, was responding to internal messages about having to be strong (Parental contamination) and a fear of failing (Child contamination). The goal of decontamination is defined as the identification of inaccurate and unhelpful archaic beliefs and their intrusion into the current perceptions of reality, resulting in the strengthening of their current functioning (the Adult ego state). In this example, decontamination resulted in insight into the archaic material and attention to a need for self-care as well as a more realistic assessment of completing the tasks at work. In that sense, it was both a cognitive and an emotional process resulting in the development of meaningful insight and mentalization (Roth & Fonagy, 2006), leading to the beginnings of behavioral change. Exploring and expressing emotions have been shown to improve the effectiveness of therapy (Aldao et al., 2010; Norcross & Lambert, 2019) as have cognitive techniques (e.g., Hofmann et al., 2012), although it seems to be the combination of cognitive and emotional work that makes therapy effective (Bohart, 1993; Mergenthaler, 1996).

Research also suggested that individuals differentiated between experiences they associated with their "true self" beyond the influence of others and those associated with their "false self" influenced by others. Focusing on their true self improved their psychological well-being and life satisfaction (Schlegel et al., 2009, 2013). Furthermore, there was some empirical evidence that analyses and interpretations of the influences of one's past could improve the effectiveness of psychotherapy (Allen, 2000; Orlinsky et al., 2004; Williams et al., 2012). For example, systematic life reviews could improve someone's psychological well-being and quality of life (Westerhof et al., 2010). Indirect evidence for the effectiveness of strengthening the functioning of the Adult and the Nurturing Parent can be found in research that shows that improving self-compassion is associated with greater psychological well-being, increased life satisfaction, and resilience (Gilbert, 2009; MacBeth & Gumley, 2012; Neff, 2011).

The processing (deconfusion) stage involved working directly with the archaic, unconscious states and facilitating their expression and processing. This aimed at developing reflection and mentalization, instead of the previously unconscious/unreflected ways of being in the world (life script). In TA this process was described as the deconfusion of the Child ego state (Clarkson, 2013). The concept of Child ego state (Berne, 1957) encompassed the client's archaic and developmental experiences, emotions, and meaning-making. The insight gained through decontamination often challenges and uncovers an underlying conflict of archaic material. In the above example, a client whose father died, attempted to please her demanding mother by being the best at everything and not crying. Having realized that she was working excessively and not experiencing a sense of achievement during the decontamination stage, she began to reexperience the distress of her childhood, fueled by the attachment-based fear of losing her mother.

A good working alliance was a prerequisite for starting the deconfusion stage during therapy and also required a focus on developing an internal sense of safety (Clarkson, 2013; Woollams & Brown, 1979). It was understood that life script themes were the historically adaptive mechanisms in response to stress and trauma, and that the emotional processing during this stage could create distress for the client, requiring particular therapeutic vigilance in terms of the client's safety. Therapeutic interactions during this stage included empathic transactions and the cognitive analysis of the transference/countertransference matrix (Hargaden & Sills, 2002) within this primarily affective process (Widdowson, 2013). This process of combining affective processing with the development of cognition has been shown as effective in other therapies (Aldao et al., 2010; Bohart, 1993; Mergenthaler, 1996; Norcross & Lambert, 2019).

The decision-making and application (redecision) stage in TA referred to creating a therapeutic shift by changing an enduring pattern in the client's life script. In the wider literature, this

concept is akin to the Core Conflictual Relationship Theme (CCRT) developed by Luborsky in 1998 and preparation and action stages in the Transtheoretical model of therapeutic change (Prochaska & DiClemente, 1992; Prochaska & Norcross, 2001) Within TA, this stage was referred to as changing a script decision. It again combines an affective process in the deconfusion stage leading to finding alternative ways in meeting the individual's authentic needs and making thus changes to their life script. Integration of cognitive and affective processes is essential in this stage (Widdowson, 2013, p. 19), leading a client to make changes in their current environment. In our example, a script redecision led to a felt belief of the client's own value as a human being and self-empathy, leading to the development of internalized self-soothing. This supported her in putting external boundaries and, limiting a number of hours of work, as well as developing a more sustaining sense of achievement.

Therapeutic tasks involve setting concrete aims for daily life, including planning, experimenting, evaluating, and adjusting those aims and methods and making long-term commitments, further linked to action and maintenance stages of change ((Prochaska & DiClemente, 1992; Prochaska & Norcross, 2001). This aspect of the redecision stage of treatment has been well studied in the body of literature related to the effectiveness of setting goals and developing life projects in treatment (Arends et al., 2013; Lapierre et al., 2007). Goals were most effective when they were important (Austin & Vancouver, 1996; Moskowitz, 2012), specific, and simple (Locke, 2002; Webb et al., 2012), not too far in the future (Locke & Latham, 2002), challenging (Locke & Latham, 2002; Wiese, 2007), attainable (Emmons et al., 1986; Sheldon & Elliot, 1999; Wiese, 2007), mutually conducive (in the case of multiple goals; Chun et al., 2011), and focused on approaching something positive rather than avoiding something negative (Elliott & Friedman, 2017).

Thus, the broader sense of the stage of redecision meant that individuals developed new ways to live a meaningful and satisfying life while accepting life's limitations, which was a key to effective therapy (Vos, 2015, 2016a, 2016b, 2017). Research also showed that individuals benefited from developing a sense of hope by developing alternatives to what they considered a hopeless situation (Koehn & Cutcliffe, 2007; Schrank et al., 2008; 2012; Snyder et al., 2003). They particularly benefited from developing a sense of self-efficacy, a belief in their ability to produce desired outcomes through their own actions (Corrigan et al., 2006; Maddux & Kleiman, 2016; Marks & Allegrante, 2005; Schwarzer, 2014).

Based on this body of research and literature, we outlined the following four treatment stages: (a) establishing the therapeutic relationship, initial assessment, and initial treatment contract; (b) systematic assessment; (c) experiential processing in the here-and-now; and (d) deciding and applying script changes (Table 5).

Therapy Sessions

Table 5 shows an overview of the steps in the 16 therapy sessions across the four stages. Details can be found in the full treatment manual, which can be requested from the authors and will be published elsewhere.

Therapeutic Toolkit

In the application stage of TAP, therapists used a broad range of therapeutic tools. Table 6 summarizes the most frequently used TA tools, derived from the survey among TA therapists, and included as options in this treatment manual (Vos & Van Rijn, 2022).

Context and Training

The treatment should be provided in a professional context, following the law and guidelines from relevant professional bodies. There should be sufficient time and undisturbed space to offer 16 sessions. As described before, this manual is primarily aimed for individuals with mild/moderate depression, but may be extended in future studies with additional competences and exercises for other mental health issues.

For therapists to apply this treatment manual, they are expected to have been trained in each of the TA competences, at least at a basic level, for example, in a postgraduate level TAP training. They should receive clinical supervision by a Certified Transactional Analyst at the highest professional level of teaching and supervising

Table 5

Overview of BTAP Phases and Sessions

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 4. Develop a basic agreement about the aims of the treatment ("shared informed consent" or "treatment contract")	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 decision-making (temporary treatment contract) 10. Ending
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, for example, via game analysis, drama triangle analysis, stroke analysis, analysis of nonverbal behavior, and specification 2. Analysis of social functioning and underlying position regarding others (others are OK/not OK) 3. Analysis of self-efficacy and underlying position regarding self (I am OK/not OK)	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 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 etiology	1. Examine the development of the problems in the subjective experience of the client ("phenomenological analysis")	1. Emotional check-in 2. Refresher/follow-up from previous sessions 3. Agreeing session aim/method 4. Discuss questionnaires

			2. Examine the general development of the client 3. Examine negative messages from their social 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 behavior, emotional disconnection, cognitive styles) 5. Examine how life events have influenced the development of their problems	5. Examine the development of the problems in the subjective experience of the client ("phenomenological analysis") 6. Phenomenological life story 7. Examine the general development of the client (extended questions from Johnsson (2011)) 8. Examine unfavorable 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 and 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, the therapist will use the tools in their "TA toolkit" to achieve the specific goals for the client	7–12		1. Emotional check-in 2. Refresher/follow-up from previous sessions 3. Agreeing session aim/method 4. Identify relevant tool 5. Apply tool 6. Evaluate application of tool

(*table continues*)

Table 5 (*continued*)

Name of treatment stage	Aims of treatment stage	Treatment session	Name of session(s)	Aims of session	Steps in sessions
					7. Summary and reflection 8. Crystallization, creating hope & challenging cognitions 9. Ending
4. Deciding and 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 and 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 ("redecision") 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. Summarize/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 Summarize/evaluate 8. Creation of safety 9. Homework 10. Ending

			1. Emotional check-in 2. Refresher/follow-up from previous sessions 3. Evaluating homework 4. Identify learning and reassess therapy goals 5. Develop contingency plans 6. Explore feelings of ending 7. Creation of safety 8. Evaluation and saying goodbye
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	

Note. BTAP = Brief Transactional Analysis Psychotherapy; TA = transactional analysis.

transactional analyst. Therapists received a top-up training to work with this treatment manual. The first training day should consist of giving an overview of the general research evidence and stages, followed by in-depth explanation of each of the stages. At the end of the day, example questionnaires are used to practice questionnaire analysis and interpretation. Before the second training day, the therapists create a TA case formulation for a client/person they know well. The second training day starts with sharing of case formulations, with a focus on brainstorming on possible relevant therapeutic tools for the case, followed by training of specific competences via fishbowl exercises; the exercises should follow from the existing competences and needs of the therapists. To learn the new competence of working while developing a positive therapeutic relationship, the therapists could be asked to do a part of a session on each other (e.g., sessions 1–2); to learn how to share the case formulation, therapists could share their prepared formulation as if they are giving this to their client.

Discussion

This article described the systematic development of the evidence-based treatment manual for BTAP. The manual could be used in clinical trials and in the training of beginning TA therapists and a contribution to developing and evidence base to TA as a humanistic integrative therapeutic model.

This treatment manual differs from the previous TA manuals in several ways. It was based on a field-wide survey, systematic literature reviews, and meta-analyses, and represents the evidence-based common denominator of all TAP therapies combined with the latest insights from the field of psychotherapy research (Vos, 2023). This broadens the integrative base of TA theory and enriches it with the more current developments in cognitive-behavioral and existential therapies. A unique feature of TAP was the focus on the systematic assessment and case formulation. This followed the findings of meta-analysis (Vos & van Rijn, 2022), showing that TA is more effective when based on an assessment/case formulation (Vos & Van Rijn, 2022). This also followed other studies showing the importance of assessment/case formulations in psychological therapies in general (van Rijn, 2015).

Table 6
BTAP Therapeutic Toolkit

Name	Description
Further analysis	It could be that more information is needed, and the therapist and client may decide to do further analysis, for example, via functional analysis, life script analysis, drama triangle analysis, analysis of the dominant social positions and roles in groups (e.g., structural analysis of social behavior in line with Leary or Sciligo)
Decontamination	• Identifying the script beliefs • Exploring the contamination/contaminated beliefs • Facilitating reframing • Increasing cognitive dissonance • Empathic challenging of script belief • Behavioral disconfirmation (e.g., behavioral exercises)
Deconfusion	Empathic identification of needs and experiences of the Child, and differentiation from Adult, and experientially working through these needs (see next tool)
Exploring, expressing, and accepting archaic feelings or unmet needs ("catharsis")	
Deepening experiential processing	
Systematic experiential disconfirmation and empathic challenging of self-limiting script decisions	
Systematic exploration and exposure (in vivo or in vitro) to feared memories or imaginations to create systematic desensitization of the anxiety	
Using the therapeutic relationship	For example, explore games (in the previous example therapist might invite the client to reflect whether they have also felt angry with her/him)
Exploration of games	This would lead the client into the exploration of archaic enactment in the present to the archaic script process.
Didactics	Explanation, crystallization, illustration). At this stage they need to be only used sparingly (e.g., using Karpman's Drama Triangle to illustrate the game process), and not when the client is in Child
Dialoguing	Child–Parent, reducing pressure from inner Parent. This could be done through experiential exercises, for example, via empty chair exercise or Parent Interview or by inviting the client to reflect on different parts of themselves or different inner voices
Self-care exercises	

Note. BTAP = Brief Transactional Analysis Psychotherapy.

This brings us to one of the unique features of the manual in using questionnaires in case formulation, including the two new questionnaires to measure TA goals (TAGAF) and TAP therapist-competencies (TAP-CS). In the TA field, there is a long tradition of developing focus on clear goals and therapeutic agreements, or "contracts" (Sills, 2006) and therapeutic competencies such as the assessment criteria for accreditation and graduation by the European Association of Transactional Analysis (EATA). The use of questionnaires aids case formulation by supporting therapists in its systematic development. In order to avoid overly limiting and rigid interpretations, we recommend questionnaires as tools in developing treatment hypotheses, elaborated with clients and interpreted tentatively. Further research is needed to evaluate the therapists' and clients' experience of using questionnaires during case formulation.

Although this treatment manual was already based on empirical evidence, an outcome study is required to confirm its effectiveness as an evidence-based treatment. Bearing in mind the limitation, researchers and therapists may consider using this treatment manual with clients.

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