



Introduction

A depressive disorder is an illness that involves the body, mood, and thoughts. It interferes with daily life, normal functioning, and causes pain for both the person with the disorder and those who care about him or her. A depressive disorder is a syndrome (group of symptoms) that reflects a sad and/or irritable mood exceeding normal sadness or grief. More specifically, the sadness of depression is characterized by a greater intensity and duration and by more severe symptoms and functional disabilities than is normal. Some people experience only a mood change, transient and superficial. Others may be totally incapacitated by an oppressive, paralyzing sense of futility and unworthiness. No one is immune from the ravages of depression. The therapist is as much a potential victim as the patient receiving therapy. Therefore one must approach this problem personally and aggressively wherever it is met (*Dayringer, 1995*).

Depressive signs and symptoms are characterized not only by negative thoughts, moods, and behaviors but also by specific changes in bodily functions (for example, crying spells, body aches, low energy or libido, as well as problems with eating, weight, or sleeping). The functional changes of clinical depression are often called neurovegetative signs. This means that the nervous system changes in the brain cause many physical symptoms that result in diminished participation and a decreased or increased activity level (*Dryden-Edwards & Lee, 2012*).

One in 10 adults is affected by depression each year, nearly twice as many women as men. Moreover, the relapse rate for depression within the next year is 50% (*Zauszniewski & Rong 1999 and American Psychiatric Association, 2005*). On average, 15% of people with



recurrent depression (repeated attacks) have an increased risk of suicide. Although women are twice as likely to suffer from depression as men, men are far more likely to commit suicide. This may be because men are more reluctant to seek help for depression. Depression can affect people of any age, including children. Studies have shown that 2% of teenagers in the UK are affected by depression. People with a family history of depression are more likely to experience depression themselves. Depression affects people in many different ways and can cause a wide variety of physical, psychological (mental) and social symptoms (*the National Health Service (NHS), 2009*).

Depressive symptoms are linked to multiple factors including genetic, physiological, social, environmental and/or cognitive variables. In fact depression may be explained through five major theories namely the Psychodynamic, the Cognitive, the Behavioral, the Biological and the Transactional Analysis (TA) theories. The cognitive models for depressive symptoms are especially interesting from a clinical perspective because they focus on information processing as the core process, suggesting that depressive symptoms may be amenable to psychotherapy (*Ingram & Holle, 1992, Young et al., 2001 and Kessler et al., 2001 quoted by Greening et al., 2005*).

Beck, 1967 & 1979 quoted by Zauszniewski & Rong (1999) stated that depressive cognitions reflecting negative views of self, world, and future (the cognitive triad), are responsible for the onset, maintenance, and exacerbation of affective (sad mood), motivational (work inhibition), somatic (appetite and sleep), and behavioral (psychomotor retardation or agitation) symptoms of depression. Those people, who exhibit depressive symptoms, tend to show a cognitive bias toward interpreting life events



through negative schemas that they have acquired during their formative years of development (*Beck 1987 and Clark et al., 1999 quoted by Greening et al., 2005*). Such people can benefit from different types of psychotherapy.

Psychotherapy is a treatment of emotional distress with techniques that rely on verbal and emotional communication, most forms of psychotherapy are guided by a theory or a model about the psyche and the methods needed to solve problems within that framework, such as, the transactional analysis theory (TA) (*Buddle, 2000*). Transactional analysis does indeed offer a system of psychotherapy that is used to explore how clients develop their own Unhealthy Existential Positions, that reflect their views about themselves, others and the world. It also allows therapists to reflect on their experience, applying their treatment plan and offering a new experience that facilitate to the clients changing their existential positions.

Transactional analysis has various approaches; one of them (the one that will be adopted in this study) is the relational approach (*Hargaden and Sills, 2002*). The relational approach emphasizes that the therapist pays attention to and facilitate the client to realize and make sense of the dynamic of the unconscious processes in therapy. A relational TA therapist has to be mindful of his own process and how this impacts the relationship with his client, and has to be receptive to learning more about his own unconscious process in an ongoing and unfolding way (*Widdowson, 2010*).