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ATTITUDE TOWARDS ONESELF AND OTHERS IN NON-CLINICAL POPULATION, DEPRESSED AND PARANOID EXAMINEES

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SUMMARY

Background: *The theoretical concept of existential/life positions describes person's basic beliefs about oneself and others. Most of authors on TA postulated that every person has one of four possible basic life positions: I'm OK, you're OK; I'm not OK, you're OK; I'm OK, you're not OK and I'm not OK, you're not OK. The aim of this study was the authentication of Existential positions as theoretical concepts in Transaction Analysis, and it's potential to discriminate clinical from non-clinical examinees, and paranoid from depressive examinees within the clinical population.*

Subjects and methods: *The research conducted was co-relational. The sample belongs to the convenience sample type, and comprised 200 examinees, 100 from the non-clinical and 100 from the clinical population of adults.*

Results: *The results of the research confirm a statistically significant difference between the non-clinical and clinical part of the sample in the examined theoretical concept. The "I am not OK" existential position is more expressed in the clinical part of the sample. The differences between the examinees with depressive and paranoid disorders indicate that the examinees with the depressive disorder are more likely to express the "I am not OK, you are OK" and "I am not OK, you are not OK" Existential position.*

Conclusion: *In general, we can infer that the assumptions which the research was aimed at testing received partial validation. Examinees from the clinical part of the sample have a statistically significantly higher score at the position "I am not OK". Examinees with depressive characteristics have a more pronounced "I am not OK, you are not OK" position.*

Key words: *Transactional Analysis - existential positions - depressiveness - paranoidity*

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INTRODUCTION

The theoretical concept of existential/life positions describes a person's basic beliefs about oneself and others (Berne 1962, Fine & Poggio 1977). Life positions are the fundamental standpoint that a person takes in evaluating him or herself and other people (Stewart & Joines 1987).

It is assumed that it is typical of the position "I am worthy, you are worthy (I+, U+)" that the person is aware of his/her own and qualities of other people, so he/she accepts both him/herself and others. This position has been described as a position of self-respect and respect, i.e. self-love and love. It is considered that the person in this position is inventive and creative, spontaneous and capable of establishing intimate relationships, active in solving problems (Ernst 1971).

It is postulated that the position "I am not worthy, you are worthy (I-, U+)" develops if a child is exposed to neglect of its needs, child's worthiness, rejection.It occurs if expectations of the child are too low, or on the other hand too high, so that the parents tell the child that it is incapable of meeting those expectations. It is expected that these people diminish their value or exaggerate in assessing the value of others, as well as having feelings of insufficient worthiness, shame, anxiety, depression, even self-hatred. (Ernst 1971). This position is also called depressive (Kahler 1978).

The developmental hypothesis for "I am worthy, you are not worthy (I+, U-)" alludes to a child who was exposed to inadequate treatment (abuse etc), where the anger is a reaction to problems (regardless of whether the child is a witness or participant of that anger). It is believed develop according to the principle of social learning or can be developed as a reactive (revengeful) position, wherein the person behaves "on a high horse", arrogantly, humiliating, with depreciation, contempt etc. They expect others to assume a position of humility and servility. Common self-emotions are self-infatuation and self-admiration, while common emotions are contempt, hatred, envy, irritation (Ernst 1971). This position is also called paranoid (Kahler 1978).

The theoretical implication applying to the position "I am not worthy, you are not worthy (I-, U-)" is that a person is devaluating both him/herself and the other, and often feels senselessness, helplessness, hopelessness and different nihilisms. It is believed that different outcomes of strong affective conditions are possible exactly due to the person's negativism towards him/ herself and others. Also, there is a possibility of psychotic decom-

pensation in predisposed persons (Ernst 1971). This position is also called schizoid (Kahler 1978).

In an overview of literature, we have selected one research of existential positions in clinical population, specifically in persons with depressive disorder. That research ascertains that the depression is mostly related to the I-, U- position (Lester 1991). In research life positions and attachment, positive relationship has been founded between I+, U+ position and secure attachment, I+, U- position and rejecting attachment (attachment theory by Bartholomew & Horowitz 1991), while avoidant attachment correlated with I-, U- position. In the same study, no correlation has been determined between preoccupied attachment and I-, U+ position (Boholst et al. 2005). In a study of life positions according to the Berne's definition, results indicate that two factors are isolated, based on I and You items, which are defined by positive and negative attitude towards oneself and others (Boholst 2002).

Bearing in mind the relatively poor empirical support of concept in TA model, we will review findings of the research of similar concepts in other therapy schools. Research of implicit and explicit differences in self-esteem in depressive and paranoid examinees points out that depressive examinees have a lower level of self-esteem relative to the paranoid and non-clinical examinees (Valiente et al. 2011). It has also been confirmed that low self-esteem is a risk factor for the development of depressive and paranoid disorders (Ben-Zeev et al. 2009). Significance of the negative view of the self and others in the development of mental disorders is confirmed by the study of the relatedness of negative cognitions (low self-esteem, self-criticism , extreme negative view of the self and others), depression and paranoid disorders (Fowler et al. 2011). In a study which included depressive and persons with bipolar disorder (Jones 2005), negative self-esteem was best in discriminating persons with affective disorders from persons with no disorders. Concept of attributions can indirectly be related to the concept of life positions, in view of considering one's own role in the development of positive and negative events. Specificity of the attribution style has been confirmed by numerous sudies (Bentall 2001, Blackwood et al. 2001, Beck & Rector 2002, Humphreys & Barrowclough 2006), based on which it can be assumed that there is a difference in the attribution in depressive and paranoid patients and persons with no disorders.

The general aim of this research, which aims at testing the theoretical concept of life/existential positions to establish its potential to discriminate non-clinical from clinical, as well as paranoid from depressive examinees, within the clinical group, stems from the mentioned theoretical implications and the aforementioned significance of examining theoretical concepts in Transactional Analysis, especially in the context of its relation with non-clinical and clinical populations.

SUBJECTS AND METHODS

The research conducted was non-experimental and co-relational. Existential positions present as a dependant variable, and were operationalised through the examinees' answers on the Existential position Scale. The criterion for including examinees into the non-clinical group was the absence of previous or current psychiatric treatment, out or inpatient, which has been determined during the interview with the examinees. That the patients belonged to a diagnostic group from the range of depressive and paranoid disorders was established by relevant psychiatrists, who performed classification following the diagnostic interview and diagnostic criteria based on ICD-10 (World Health Organisation 1992). The Score from the MMPI-202 Pa Scale (Biro et al. 1995) and the LD Scale score (Novović et al. 2007) constitute control variables. We included them into research as a control of depressive and paranoid features present in the non-clinical group, as well as on the validity of the psychiatric diagnosis in the clinical group of examinees. Certain demographic variables (gender, age, marital status, education level, employment), which could potentially be helpful in the interpretation of the obtained results on the dependant variable, were also followed. It is important to emphasize that differences were expected between the non-clinical and clinical parts of the sample on the last two demographic variables, due to the professional deterioration of the clinical population.

Measures

- For examining life positions, we used the *Life positions Scale* (Boholst 2002). It consists of 20 items in statistically significant correlation with the four factors representing four life positions (Boholst 2002). Items are formulated in the form of attitudes that examinees rate the level of agreeing for on a five-point Lickert scale. Obtained reliability of this scale expressed by Crombach's alpha coefficient is 0.82 for I+/- factor and 0.61for U+/-.
- *LD Scale,* Scale of depressive personality (Novović et al. 2007), is comprised of 26 items and is based on Schneider's description of depressive personality, that Akiskal has formalised into seven traits: 1) calm, introverted, passive and non-assertive, 2) dreary, pessimistic, serious and incapable of humour, 3) self-critical, self-accusing and self-demeaning, 4) sceptical, hyper-critical and hard to please, 5) scrupulous, responsible and self-disciplined, 6) thoughtful and concerned, 7) preoccupied with negative events, feelings of inadequacy and own flaws (Novović 2007). This Scale is also five-point, Lickert type. Obtained reliability of this scale expressed by Crombach's alpha coefficient is 0.87.

- *MMPI-202 Pa Scale* (Biro et al. 1995), paranoid syndrome scale from the Multidimensional Personality Inventory, which needs not be introduced due to its wide application in clinical practice. Pa scale measures sensitivity, hostility and propensity towards paranoid interpretations (Biro 1995). Obtained reliability for this scale, expressed by Cronbach's alpha coefficient is 0.88.

Biographic data were given by examinees, who circled provided answers on the first page of the battery of questionnaires applied in our research.

The sample belongs to the convenience sample type, comprised of 200 examinees, 100 from the non-clinical and 100 from the clinical population of adults. In the clinical part of the sample, depressive and paranoid disorders are evenly represented. Examinees were divided into diagnostic groups based on psychiatric diagnosis, based on ICD-10 diagnostic criteria. The depressive disorders group include examinees with dominant depressive symptoms (F32.0, F32.1, F32.2, F32.8, F32.9, F33.0, F33.1, F33.2, F33.4, F33.8, F33.9) except from bipolar affective disorder, schizoaffective disorder, post-schizophrenic depression, cyclothymia, dysthymia and other unspecified mood disorders. The group with paranoid disorders includes examinees with predominant paranoid symptoms, from both paranoid personality disorder and compensated psychotic non-schizophrenic disorders (F22.0 in remission, F23.0 in remission, F23.3 in remission and F60.0).The patients with a given diagnosis were treated as ambulatory or as inpatients.

Study procedure

Research was conducted from November 2007 till August 2008. The non-clinical part of the sample was gathered in several institutions in Novi Sad and its region. The clinical part of the sample was gathered at the Institute for Psychiatry, Clinical Centre Vojvodina, Health centre Novi Sad, Special Psychiatric hospital "Dr Dragoslav Bakalović" Vrsac, General hospital "Djordje Jovanović" Zrenjanin, Psychiatric ward, General hospital "Dr Gere Istvan" in Senta, Psychiatric ward, Special Psychiatric hospital "Sveti Vraci" in Novi Knezevac.

Statistical analyses

Statistical data were processed with PC Software SPSS 15.0. Discriminative analysis was used to determine the difference between non-clinical and clinical groups and between depressive and paranoid examinees in the examined concept. Canonical correlation analysis was used to check the correlation between LD and Pa scale scores and the concept of Existential/Life positions. In addition to this, multivariate analyses of covariance is used to test the effects of demographic variables on the dependent variable.

RESULTS

Demographic characteristic of the sample

The total sample consisted of 38% men and 62% of women. The distribution by gender is not representative for the population. Examinees were an average age of 40, and a standard deviation of 10 years, where the youngest participant is 19 and the oldest 68 years.

Three groups are statistically significantly different by age, where a group of patients with depressive disorder is significantly "older" than non-clinical groups (F=7.502; DF=2; p=0.001).

The examinees are also significantly different by level of education. Subjects from the clinical part of the sample had a significantly lower level of education (Pearson's chi-square=30.959; DF=6; p=0.000).

Non-clinical and clinical groups are statistically different in employment status. The non-clinical group had significantly more employed examinees (Pearson's chi-square=92.425; DF=8; p=0.000).

Three groups are statistically different in marital status, in that the non-clinical group and the group of patients with depressive disorders have more examinees who are married, while in the group of paranoid patients are mostly "single" examinees (Pearson's chi-square=33.814; DF=6; p=0.000).

The possible impact of these demographic variables on the value of the dependent variable will be checked through statistical procedures.

Difference between non-clinical and clinical groups

Comparing the non-clinical and clinical populations on the concept of life/existential positions we obtained a statistically significant discriminative function (Table 1).

Reviewing the matrix of discriminative function structure, it is visible that it is entailed in a positive direction with I-, U- and I-, U+ positions, and in a negative direction with I+, U+ position (Table 2).

Table 2. Matrix of discriminative function structure

	Function 1
I-/others-	0.940
I+/others+	-0.533
I-/others+	0.511
I+/others-	0.044

Table 1. Parameters of isolated discriminative function

Func.	eigenvalue	variance %	cumulative %	Canonical correl.	Wilks' Lambda	χ-square	df	P
1	0.339(a)	100.0	100.0	0.503	0.747	57.195	4	0.000*

Table 3. Parameters of isolated discriminative function

Func.	eigenvalue	variance %	cumulative %	Canonical correl.	Wilks' Lambda	χ-square	df	P
1	0.190(a)	100.0	100.0	0.400	0.840	16.723	4	0.002*

Table 4. Matrix of isolated discriminative function structure

	Function 1
I-/others-	-0.689
I+/others+	-0.660
I-/others+	0.514
I+/others-	0.474

By the position of group centroids (Non-clinical: -0.579; Clinical: 0.579) and the structure of extracted discriminative dimension, one can infer that the clinical part of the sample differs with the statistical significance from the non-clinical part in representation of a negative attitude towards self. Previously obtained results are consistent with theoretical expectations. Surprisingly, clinical and non-clinical groups do not differ in the I+, U-position. Such a finding could be sequel of a culturally or "locally" accepted pattern of viewing oneself and others, which will be elaborated in the Discussion of results.

Difference between depressive and paranoid examinees

A statistically significant discriminative function (Table 3) was obtained between depressive and paranoid examinees regarding the difference in the concept of life positions.

It can be seen from Table 4 that the discriminative function is determined by positions I+, U+ and I+, U- in a negative direction, and in a positive direction by positions I-, U- and I-, U+. The group of depressed patients had a higher score on this function, which denotes that examinees with depressive characteristics have no I+, U+ and I+, U- positions, which is in compliance with the theoretical implications in TA (Berne 1972, Harris 1989, Kahler 1978, Woolams & Brown 1979), as well as with research findings (Allen 1973, Allen & Webb 1975, Lester 1991).

On the other hand, when differences between these two clinical groups on LD and Pa scales were examined, one statistically significant discriminative function was extracted, defined by the high score on the LD scale and the slightly less high score on the Pa scale (Table 5 and 6).

The group of depressive examinees has a higher score on the segregated function, which means that the depressed examinees also have a higher score on the LD and Pa scales (Depressive=0.451; Paranoid=-0.461).

Such a finding could be explained by the high sensitivity of the depressed examinees on the one hand, as well as by their tendency for aggravation, and by the possibility of the paranoid examinees minimizing their psychopathology, on the other hand, since the Pa scale is a standardized instrument whose discriminative properties has been proven repeatedly. This finding raises the question of the reliability of the diagnosis of the range of depressive disorders, which is more heterogeneous compared to the diagnosis of the spectrum of paranoid disorders. Depression often occurs as a secondary phenomenon in other psychopathological conditions, which in clinical practice very often remains unnoticed. All of the mentioned assumptions will be discussed in more detail in the discussion of the results.

In view of the results, we decided to subsequently check the relationship between the life/existential positions and the scores of the LD and Pa scales, in order to see what the nature of the differences between these two groups of examinees was, when the criterion for classifying examinees in these two groups of psychopathological disorders was not the psychiatric diagnosis, but an "objectified" approach. Two statistically significant correlations were isolated (Table 7).

Table 6. Matrix of discriminative function structure

	Function 1
Depression – total	0.978
Pa – total	0.384

Table 5. Parameters of isolated discriminative function

Func.	eigenvalue	variance %	cumulative %	Canonical correl.	Wilks' Lambda	χ-square	df	p
1	0.212(a)	100.0	100.0	0.418	0.825	18.481	2	0.000*

Table 7. Canonical correlation of LD and Pa Scales and life positions and test of canonical correlations significance

Canonical correlations		Wilk's	X -square	DF	P
1	0.759	0.332	214.387	8.000	0.000
2	0.465	0.783	47.476	3.000	0.000

The first canonical dimension within the first set is determined by the low score on both scales, and we shall thus call it 'absence of depressive and paranoid traits', and we called the second canonical dimension 'depressive traits', because of the negative correlation with the healthy and the remaining two unhealthy positions (Table 8). The first canonical dimension explains 81.6% of the variance of the first set, and the second canonical dimension 18.4% of the variance of the first set.

The first canonical dimension within the second set is determined by I+, U+ and I+, U- positions in a positive direction, and in a negative direction by I-, U- and I-, U+ positions. This canonical dimension was named as the I am OK position. The second canonical dimension is determined by I+, U-, I+, U+ and I-, U- in a negative direction and in a positive direction by I-, U+ position (Table 9). This dimension was named I am not OK position. The percentage of the explained variance for this set of variables by canonical dimensions is similar, the first dimension explains 40.8%, and the second 30.7% of the variance.

Table 8. Canonical loads for the set of LD and Pa Scales

	1	2
Pa – total	-0.865	-0.502
D – total	-0.940	0.341

Table 9. Canonical loads for the set of life positions

	1	2
I+/others+	0.674	-0.448
I+/others-	0.052	-0.986
I-/others+	-0.511	0.075
I-/others-	-0.956	-0.223

There is a statistically significant correlation between the absence of depressive and paranoid traits and the I am OK position, as well as between depressive traits and the I am not OK position. Both of these findings are in compliance with previously given theoretical assumptions and the results of previously conducted studies. The first canonical dimension explains 23.5% of the second set of variables, and the second only 6.7%. The first canonical dimension of the second set explains 47% of the variance of the first set of variables, and the second 4%.

Effects of demographic variables on the dependent variable

Finally, regarding the effect of demographic variables on the score on the scale of life positions,a statistically significant effect was identified for the variables group, education level, and joint effect of the variables gender and group, group and education level, working status and educational level, group, gender and education level (Table 10).

As far as the variable group is concerned, we obtained the expected results; the non-clinical group has the highest score on I+, U+ position, while the group of examinees with depressive disorder has the highest score on I-, U+ and I-, U- positions, and the group with paranoid disorders on the I+, U- position. Regarding the variable education level, examinees with high education level have the highest score on the I+, U+ position, and examinees with high school and primary school education on the remaining three positions. The joint effect of the group and gender indicates that the male examinees from the non-clinical group have the highest average score on the I+, U+ position, female examinees from the group of paranoid disorders on the I+, U-

Table 10. Multivariate test of demographic and control variables effects on existential positions in the non-clinical group and examinees with depressive and paranoid disorders

Effect		Value	F	Df hypothesis	df error	P
Age	Wilks' Lambda	0.968	1.193(a)	4.000	145.000	0.316
Group	Wilks' Lambda	0.810	4.023	8.000	290.000	0.000
Gender	Wilks' Lambda	0.944	2.144	4.000	145.000	0.078
Working status	Wilks' Lambda	0.850	1.513	16.000	443.620	0.091
Eduacation level	Wilks' Lambda	0.784	3.087	12.000	383.925	0.000
group*gender	Wilks' Lambda	0.898	2.009	8.000	290.000	0.045
group*working status	Wilks' Lambda	0.896	0.807	20.000	481.860	0.706
group*education level	Wilks' Lambda	0.776	1.596	24.000	507.055	0.037
gender*education level	Wilks' Lambda	0.886	1.497	12.000	383.925	0.122
gender*working status	Wilks' Lambda	0.941	0.739	12.000	383.925	0.713
working status*education level	Wilks' Lambda	0.697	1.533	36.000	545.119	0.026
group*gender*education level	Wilks' Lambda	0.886	2.266	8.000	290.000	0.023
group*gender*working status	Wilks' Lambda	0.970	1.135	4.000	145.000	0.342
group*education level*working status	Wilks' Lambda	0.895	1.369	12.000	383.925	0.178
gender * education level *working status	Wilks' Lambda	0.976	0.884	4.000	145.000	0.475
group*gender*education level*working status	Wilks' Lambda	1.000	0.744	0.000	146.500	0.675

position, and female examinees from the group of depressive disorders on the remaining two positions. Next, in the group and education level, where male examinees from the non-clinical group with academy or high education have the highest average score on I+, U+ position, male examinees from the group with paranoid disorders with primary school and high education on position I+, U-, and female examinees from the group with depressive disorders with secondary school or academy in the remaining two positions. Combination of working status and education level implies that students have the highest average score on the I+, U+ position, while pensioners, with academy or high education, have the highest scores on the other three positions. Jointly, group, gender and education level give the following picture: men from the non-clinical group with higher education have the highest average score on the I+, U+ position, female examinees with paranoid disorders on the I+, U-, and on the remaining two positions female examinees also, but from the group with depressive disorders, with academy or high school education.

We can assume that the impact of the variable education level is the consequence of the fact that there are statistically significantly more examinees with lower education level in the clinical groups, due to professional deterioration; that it is not an authentic influence of the variable education level on the values of the existential positions. In general, examinees from the clinical groups, examinees with a lower education level and the unemployed, who are, in turn, more represented in the clinical groups, have the highest average score in the "unhealthy" positions, most likely as a consequence of the negative effect of mental disorders on professional functioning.

DISSCUSION

The expectation that examinees from the clinical group of the sample have a more expressed negative attitude towards oneself and others has been confirmed. Berne, the founder of TA, claimed that I am OK, you are OK is the only position of health, wherein the person is active in problem solving (Allen 1973). It is expected that persons with a more pronounced negative attitude towards oneself will have a higher probability for the presence of psychopathological symptoms, both according to the TA model and according to other theoretical paradigms dealing with differentiating between normal and pathological in the mental health sphere (Ben-Zeev et al. 2009, Flower et al. 2011, Humphreys & Barrowclouqh 2006, Jones 2005).

We have mentioned that it is surprising that the non-clinical and clinical population do not differ in the position I am OK, you are not OK. We interpreted this finding as a possible consequence of culturally or "locally" accepted way of viewing oneself and others. Sociological research on the transition in Serbia, in the period 1991 to 2001 shows that approximately half of the families included in the study have closed up and lost contact with the environment, cut off friendly and other communications. The majority of those struck by the climate of bad interpersonal relations are found in the group of middle aged and even more among those older than 60, regardless of the education level of the examinees (Bolčić & Milić 2002). The above finding is in concord with Kramer's research from 1978, which has also shown that scores on You are OK position decline in earlier age compared with scores at the I am OK position (Kramer 1978). At this point, the above assumptions can only be inspiration for future research on existential positions in our areas.

The differences obtained between examinees with depressive and paranoid traits on the existential positions are in compliance with theoretical expectations. Examinees with depressive features have a more pronounced depressive and schizoid existential position, which is in accordance with TA implications in TA, as well as with findings of previous research. Also, the results of the canonical correlation analysis of existential positions and the scores on the LD and Pa scales implies that there is a statistically significant correlation between the absence of depressive and paranoid traits and the I am OK position, as well as between the depressive traits and the I am not OK position.

However, what has "messed up things" is an indicator that examinees from the group with depressive disorders have a higher score on the Pa scale than examinees from the group with paranoid disorders. If we exclude the possibility that examinees from the group with depressive disorders are more sensitive than those from the group with paranoid disorders, which is something we do not believe, it seems that the flaws of self descriptive techniques in clinical research have come to light in full extent at this point. It seems to be most likely that it is related to aggravation of examinees with depressive disorders and, at the same time, minimizing of examinees with paranoid disorders. Introducing a scale for the assessment of tendencies towards giving socially desirable answers and defensive responding could significantly decrease the above sources of jeopardising the validity of the obtained results. Also, suggestion for future research of similar type is the application of instruments that are equal in whether they measure personality traits and the current mental condition of the examinee, which would serve as authentication of psychiatric diagnosis validity. It would be even better to apply the so called "trait" vs. "state" scales, in order to improve the "objectified" assessment of the kind of psychopathological disorder as much as possible.

At this point, the question of the validity of psychiatric diagnosis imposes itself as a significant one. It has already been said that diagnoses from the group of depressive disorders are much more heterogeneous in comparison with diagnoses from paranoid disorders,

since depression as a secondary phenomenon can be found in the majority of psychopathological categories. We believe that, for the sake of improving the validity of the psychiatric diagnosis, it would be helpful to introduce diagnoses from both the first and the second axis, as by criteria from DSM-IV, in order to avoid overlapping of "states" and "traits", i.e. in order to separate these two aspects of psychological functioning, and know which phenomenon belongs to which aspect. Of course, we do not claim it is always possible. In addition, in order to improve the validity of the diagnosis, it would be useful to apply some of the "objectified" ways for the assessment of psychopathological disorders, e.g. standardised symptoms check-lists.

So far we can only assume which factor or which combination of factors has contributed to the obtained result. What we can claim with higher certainty is that those factors stem from the group of methodological flaws of either our research or clinical research in general, a special review of which should be made when creating future research designs, because they apparently jeopardise the obtaining of valid results.

CONCLUSION

In general, we can infer that the assumptions received the partially expected validation. Examinees from the clinical part of the sample have a statistically significantly higher score on the position "I am not OK". Examinees with depressive characteristics have a more pronounced "I am not OK, You are not OK" position. No specific unhealthy existential position has been demonstrated for examinees with paranoid disorders.

The non-clinical group of examinees has no clinically significant score on either of the control scales (LD and Pa). Examinees with depressive disorders have a clinically significant score on both the LD and Pa scales, while examinees with paranoid disorders have no clinically significant score on the Pa scale.

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REFERENCES

1. *Allen J: Existential position and adjustment in a college population. Transactional Analysis Journal 1973; 3:22-25.*
2. *Allen J & Webb D: Stroking, existential position and mood in college students. Transactional Analysis Journal 1975; 5: 227-234.*
3. *Andrews S, Fine M & Conrad D: Life positions: Stable or not? Transactional Analysis Journal 1977; 7: 357-361.*
4. *Beck AT & Rector NA: Delusions: A cognitive perspective. Journal of Cognitive Psychotherapy 2002; 16: 455-468.*
5. *Ben-Zeev D, Granholm E & Cafri G: Symptoms of depression and anxiety mediate the relationship between self-esteem and paranoia. Schizophr Res 2009; 115: 377-378.*
6. *Berne E: A Layman's guide to psychiatry and psychoanalysis. Ballantine Books, New York, 1957.*
7. *Berne E: Transactional analysis in psychotherapy. Grove Press, New York, 1961.*
8. *Berne E: Principles of group treatment. Grove press, New York, 1966.*
9. *Berne E: Sex in human loving. Simon and Schuster, New York, 1970.*
10. *Berne E: What do you say after you say hallo? Psychology of human destiny, Simon and Schuster, New York, 1972.*
11. *Bentall R. P, Corcoran R, Howard R, Blackwood N & Kinderman P: Persecutory delusions: A review and theoretical integration. Clinical Psychology Review 2001; 21:1143-92.*
12. *Biro M: Dijagnostička procena ličnosti MMPI-202. Futura publikacije, Filozofski fakultet, Novi Sad, 1995.*
13. *Blackwood N J, Howard RJ, Bentall R P, Murray R M. Cognitive Neuropsychiatric Models of Persecutory Delusions. American Journal of Psychiatry 2001; 158: 527-539.*
14. *Boholst F: Life position scale. Transactional Analysis Journal 1995; 32: 28-32.*
15. *Boholst F: Effects of transactional analysis group therapy on ego states and ego state perception. Transactional Analysis Journal 2003; 33: 254-261 .*
16. *Boholst F, Boholst G, Mende M: Life positions and attachment styles: A Canonical Correlation Analysis. Transactional Analysis Journal 2005; 35: 62-67.*
17. *Bolčić S & Milić A: Srbija krajem milenijuma: Razaranje društva, promene i svakodnevni život. Institut za sociološka istraživanja, Filozofski fakultet, Beograd, 2002.*
18. *Ernst J & Franklin H: The OK corral: the grid for get on with. Transactional Analysis Journal 1971; 1: 33-42.*
19. *Fine M & Poggio J: Behavioral attributes of the life positions. Transactional Analysis Journal 1977; 7: 350-357.*
20. *Fowler D, Hodgekins J, Garety P, Freeman D, Kulpers E, Dunn G, Smith B, & Bebbington P: Negative cognition, depressed mood, and paranoia: A longitudinal pathway analysis using structural equation modeling. Schizophrenia bulletin 2011, downloaded from: www.schizophreniabulletin.oxfordjournals.org*
21. *Harris T: Ja sam O.K., ti si O.K. Medicinska knjiga, Beograd, 1989.*
22. *Harris A & Harris T: Staying OK . Mono & Manana, Beograd, 1997.*
23. *Humphreys L & Barrowclouqh C. Attributional style, defensive functioning and persecutory delusions: symptom-specific or general coping strategy? Journal of Clinical Psychology 2006; 45: 231-46.*
24. *Jones L: Cognitive style in bipolar disorder. The British Journal of Psychiatry 2005; 187: 431-437.*
25. *Kahler T: Transactional analysis revisited. Human development publications, Little Rock Arkansas, 1978.*
26. *Kramer F: Transactional analysis life position survey: An Instrument for measuring life position. Transactional Analysis Journal 1978; 8: 166-169.*

27. Lester D: Depression and fears of individuation and attachment. Transactional Analysis Journal 1991; 21: 218-220.
28. Novović Z, Nedimović T & Biro M: Stanje depresivnosti: sindrom ili raspoloženje? Psihologija 2007; 40: 447-461.
29. Svetska zdravstvena organizacija: ICD-10 Klasifikacija mentalnih poremećaja i poremećaja ponašanja: Klinički opisi i dijagnostička uputstva. Zavod za izdavanje udžbenika, Beograd, 1992.
30. Valiente C, Cantero D, Vazquez C, Sanchez A, Provencio M & Espinosa R: Implicit and explicit self-esteem discrepancies in paranoia and depression. Journal of abnormal psychology 2011; 120: 691-699.
31. Woollams S & Brown M: TA: the Total Handbook of Transactional Analysis. Prentice-Hall, EnglSwood Cliffs, NJ, 1979.

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