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Depression, Psychotherapie und Veränderung: die ADI/TIP-Methode, Psychologie und Phänomenologie

Depression, psychotherapy and change: ADI/TIP method, psychology and phenomenology

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Kurzzusammenfassung

Depression (DP) stellt weltweit eine große Herausforderung für die psychische Gesundheit dar. Unter den verschiedenen Ansätzen hebt die multikulturelle und phänomenologische Methodik im Gegensatz zur rein biologischen Perspektive das psychologische Leiden ausgehend von primordialen affektiv-emotionalen Erfahrungen und seine Bedeutung für die Psychotherapie hervor. Ziel dieser Arbeit ist es daher, die ADI/TIP-Methode als evidenzbasierte Psychotherapie (EBPP) zur Linderung von depressiven Symptomen zu bewerten. Die spezifischen Ressourcen dieser Methodik ermöglichen den direkten Zugriff auf unbewusste psychische Inhalte (ADI) die auf eine Therapie der persönlichen Integration (TIP) abzielen. Zehn Personen mit Depression wurden entweder einer Experimental- oder Kontrollgruppe zugewiesen. Die Ergebnisse des BDI-II wurden gemäß SPSS im Intra-/ Intergruppenvergleich analysiert, und diejenigen der qualitativen Studie gemäß den generischen Veränderungsindikatoren (Generic Change Indicators - GCIs). Die Diskussion der Ergebnisse basierte auf der psychologisch-phänomenologischen Theorie. Die DP-Werte reduzierten sich signifikant mit einer prozentualen Variation von 81.9%. Darüber hinaus wurden die höchsten GCI-Werte erreicht. Die ADI/TIP-Methode kann als evidenzbasierte Psychotherapie betrachtet werden. Es werden Längsschnittuntersuchungen mit einer größeren Stichprobe vorgeschlagen, die die Ergebnisse bestätigen und zur Entwicklung der wissenschaftlichen Psychologie beitragen.

Schlüsselwörter

Depression, Psychotherapie, ADI/TIP Methode, mixed-method Forschung, phenomenologische Psychologie

Abstract

Depression (DP) is a mood disorder which, associated with comorbidities, is a major challenge for mental health worldwide. Among the approaches, the multicultural and phenomenological, in opposition to the biologist tendency, highlight the psychological suffering due to primordial affective-emotional experiences and its importance to psychotherapy. The objective of this paper is to evaluate the Direct Access to the Unconscious seeking Personal Integration Therapy (in Portuguese, ADI/TIP Method) as an evidence-based psychotherapeutic practice (EBPP) facing depressive symptoms. When directly working with unconscious content, this method allows for significant therapeutic changes. Ten individuals suffering from DP took part in the research, divided into two groups: experimental and control. The results of the BDI-II were analyzed according to SPSS in intra/intergroup comparison and those which were part of qualitative research followed Generic Change Indicators (GCIs). The discussion of the results was based on the psychological-phenomenological theory. It demonstrated a significant reduction in DP scores (81.9%) and reached the highest levels of GCIs, evincing shifts in the psychological and psychosocial scope. ADI/TIP Method is indicated as evidence-based psychotherapeutic practice. Longitudinal research with a wider range of samples is recommended, once it would allow for consistency in the result, contributing to the development of Scientific Psychology.

keywords

depression, psychotherapy, method ADI/TIP, mixed-method research, phenomenological psychology

Introduction

Depression (DP), a serious mood disorder, affects 20% of the world population, posing a major challenge to mental health (WHO, 2020). The prevalent biologist tendency states that it is a reactive and endogenous disorder associated with comorbidities, thus justifying the restriction to pharmacological treatment (ICD-10; WHO, 2020). However, Baztán (2008) and Alonzo-Fernández (2010) apply the structural-phenomenological method, considering DP an anthropological phenomenon, shaped in different symbolic universes, entwining biological, psychosocial, and cultural factors. DP is aggravated by the transformations and values imposed by contemporary culture.

The authors distinguish DP as a disorder marked by feelings of "detachment from life", "emptying of the self", lack of energy, interpersonal and spatial miscommunication, and rythmopathy. DP is a "vital sinking", where the "vital impulse" is interrupted. The patient's distorted impressions about himself result is a multifaceted suffering, starting as a psychic disorder, burying itself in the affective sphere and nestling in the somatic dimension. The authors evince a disorder which exposes the pain from the act of living, *Lebenschmerz*[1], (Baztán, 2008; Alonzo-Fernández, 2010), marking off a phenomenon which, to be understood, implies the consideration of the world of life (Lebenswelt) (Husserl, 1954/2012; Tatossian, 1979/2006). This is corroborated by studies highlighting the interconnection between the incidence or increase of DP and three other factors: sociocultural, negative experienced events and low self-esteem (Sarubin, et al, 2020; Honda, Yoshida, Krause, & La Parra, 2017).

Alonzo-Fernández (2010), Saloheimo et. al (2016) and Anders (2019) validate the importance of psychotherapies as a possibility of positive changes in self-narratives, alter-perspectives (intra and interpersonal), self-esteem and on the patient's ability to adapt. They point out the importance of creating evaluation methods for psychotherapies addressing these factors, answering questions arising from clinical practice (Krause et. al 2007).

These propositions must be up to date with the debates about the validation of research and therapeutical techniques, according to the concept of "Evidence-based Practice in Psychology" (EPPP), individualized decision-making process, integrating the best available evidence, clinical expertise, and the characteristics, culture, and preferences of the patient (Leonardi & Meyer, 2015; Monteleone & Witter, 2017). Honda and Yoshida (2013) and Krause et al. (2007) suggest that the evaluation of psychotherapeutic processes should consider the similarities and differences of the interventions and the psychological processes, and not only quantify results.

According to them and to others (De Smet et al. 2020; Sarubin et al., 2020), the notion of the modifications of the "therapeutic change", linked to "subjective theory" transformation, resulting in modification of the meanings given to symptoms and their correlations. Krause et al. (2006) and Krause et al. (2007), aiming to assess the degree of therapeutic changes and the psychological processes involved, created a theoretical list of Generic Indicators of Change (GCIs), it is an observer-rating instrument pointing to an ideal sequence of changes common to the various psychotherapies with

[1] The terms in German refer to specific phenomenological concepts, this is the reason why the authors chose to maintain the terms.

satisfactory results. Theoretical concepts and clinical observation are thus joined and evaluated through the analysis of psychotherapeutic sessions comparing the changes described by the patient: a) intra sessions, b) initial and final sessions and c) extra sessions (perspectives of the patient, therapist and/or observer).

Attention is needed on lack of research in such perspective, regarding especially DP and approaches envisaging the subject in its multiple dimensions and cultural insertions - a topic of a psychological clinic based on Phenomenological Psychology (Goto, 2008; Santiago & Holanda, 2013). This scarcity reduces the possibilities of understanding the problem and narrow the subject's ability to face psychic suffering.

ADI/TIP Method[2]- Direct Approach to the Unconscious Method (ADI) - based on Phenomenological Psychology and clinically applied in Personal Integration Therapy (TIP) - was identified as a possibility of theoretical and practical psychotherapeutic intervention concerning DP. This process of intuitive methodology was created and developed by Jost de Moraes (1936-2013), guided by data from clinical experience collated since 1975, with positive results: around 80% in longitudinal research regarding different symptomatology[3] for 140.000 patients (Jost de Moraes, 1985/2016).

Its therapeutic resources allow for the diagnosis and therapeutics of the pivotal roots of unconscious psychological suffering, linked to lived “events” and their respective senses, being the origin of the ways of being configurations that can fall ill. The phenomenological concept of “event” (Romano, 2009) refers to the mode of subjective implication that encompass the human capacity for self-configuration (Stein, 1922/2005a, 1919-1932/2005b, 1932-1933/2007). Therefore, if the contents held in the intentional conscience can be seized (Husserl, 1913/2006), intervention and change in the conformed subjective theories is allowed, as well as positive transformations linked to researched symptoms (Jost et al., 2009; Jost de Moraes, 1995/2008, 1985/2016).

This study is part of Psychology Post-graduate Program (Federal University of Uberlândia/MG, Brazil[4]), aiming to evaluate ADI/TIP Method as an evidence-based psychotherapeutic practice (EPPP) when coping with DP symptoms. To do so, it investigates the degree of therapeutic changes achieved, with ADI/TIP, in DP. Such is done in a double aspect: in terms of statistical significance and in relation to the quality of its results, highlighting the psychic-phenomenological processes which are the base for the therapeutic changes (Jost & Goto, 2019a, 2019b, in press).

[2] The acronym refers to the name of this methodology in Portuguese: Abordagem Direta do Inconsciente /Terapia de Integração Pessoal. The authors decided to keep the original acronym.

[3] ADI/TIP Method is conducted by a team of psychologists and doctors in different countries in Brazil and abroad (Germany, Austria, Portugal, Poland, and Italy), bound to the social clinic Fundação de Saúde Integral Humanistica (FUNDASINUM) Belo Horizonte/MG, Brazil. A research center continually generates data about the results of psychotherapy. From 2010 to 2019 an average of 2.300 patients was seen per year, meaning 61.400 annual sessions. We highlight the result of a longitudinal research carried out from June 2003 to March 2005, with 558 participants, 67% female and 33% male. A 5-point Likert scale was used to assess quantitative changes concerning complained symptoms. The result was 80.41% of symptomatic improvement, confirming results obtained throughout 45 years of the existence of this methodology (Jost, Jost de Moraes, Veloso, Alves, & Tróccoli, 2009).

[4] Certificate of Appreciation for Ethical Presentation (CAAE): 80587317.2.0000.5152.

Mixed-method research was employed, allows for (a) the identification of invariant elements and (b) the change process and the uniqueness of the subjects' experiences. Collated quantitative data was acquired by means of the Beck Depression Inventory (BDI-II), because it provides a descriptive image of the sample and allow generalizations, imparting more consistency to results. GCIs scale was employed for qualitative analysis, monitoring the individual process of change. Results discussion was based on the psychic-phenomenological theory. Thus, the phenomenon can be understood in a greater extent, obtaining more integrated knowledge when compared to unilateral approaches. Among the mixed-method methodologies, the explanatory sequential option was chosen, because it gives greater emphasis to the results of the qualitative analysis (Paranhos et al., 2016; Yin, 2010; Melo, Monteiro, & Rodrigues, 2013; Small, 2011; Shorten & Smith, 2017; Schoonenboom & Johnson, 2017; De Smet et al., 2020).

1. ADI/TIP Method: the psychotherapeutic process

Brazilian psychologist Renate Jost de Moraes started investigating the matter in the 1970s. Psychology, to ensure its scientific status, was disregarding the complexity of the human constitution, excluding specific characteristics demarcating the conditions which make possible the transformation of the being. In the development of her studies (Jost de Moraes 1985/2016; 1995/2008; Jost de Moraes & Jost, 1999) held theoretical discussions with several authors, such as V. Frankl (1905-1997), C. G. Jung (1875-1961), H. Bergson (1859-1941) and E. Husserl (1859-1938), the last two responsible for describing the intuitive character of the apprehension of consciousness and its specificities in relation to the time-consciousness (Jost & Goto, 2019b; Tourinho, 2016).

Jost de Moraes (2016, 2008) puts forward a therapeutic intervention with specific guidelines: "therapeutic questioning", referring to the ancient maieutics as proposed by Socrates (470-399 B.C.), applied to this particular context; and the "directional inversion", dynamic of inversion of the order in which the unconscious psychic contents are approached, directly and consciously, dismissing external resources (hypnosis, suggestion, or analyses). These procedures operationalize the capacity for intuitive apprehension (Bergson, 1889/2018) allowing access to original lived-experiences conformed to basic stages of the formation of subjectivity.

Identifying Husserl's criticism of psychologism and of naturalization of psychism, as well as the importance of a rigorous clarification of the concepts used by scientific psychology, Jost de Moraes (2016) realized its theoretical proximity with Phenomenology. The clinical research results have already demonstrated the consequences of the "reduction" of the human to a merely psychophysical being - she coined the term "psychonoosomatic[5]" to emphasize the need to consider the human holistically.

[5] The Greek term *noos* (spirit or meaning) highlights the centrality of the "noological" dimension and the articulation of the constitutive spheres of the human being: body itself (*Leib*), psychism and spirit (Stein, 2007; Jost de Moraes, 2016; Jost & Goto, 2019b). The body (*Leib*), which it is also known as the body itself, which indicates a living, animated body.

The psychotherapeutic process consists of two stages: first, there is a preparatory phase (PP), which consist of medical assistance and preparatory exercises, aiming to enable the subject to see internal images which are important from the affective point of view (Jost & Goto, 2019a; Nunes-Silva, Moreira, Rosa, Marra, & Valadares, 2016). The second phase is the Personal Integration Therapy (TIP, in Portuguese), comprising 10 to 15 sessions. TIP is an application of the ADI methodology to the "diagnostic-therapeutic" in order to intervene in the "psychonoosomatic" state of suffering. Every core of suffering addressed is marked as a "circular process", composed of the following moments: diagnostics, therapy, positivation, closure and verification.

The diagnosis' aim is to identify the origins of the psychic suffering, drawing near to the genetic phenomenology (Husserl, 1935/2017), starting from the genesis of the meaning configured to the lived event, since the intrauterine phase, marked by primitive affective-psychological lived-experiences, including the transgenerational contents. These contents of meaning, their layers of signification and their respective contexts of configuration can emerge into consciousness, just like an "inner movie" (Stein, 2005a), by way of specific stimuli. This dynamic occurs in a progressive way, considering the phenomenological possibility of the presentification of the lived-experienced (Almeida & Goto, 2019a, 2019b; Jost & Goto, 2019b; Osswald, 2018).

In this context, self-concepts (subjective theories), heteroconcepts (intersubjective theories) and conclusions about the environment (intra and interfamily) were identified. The self-concepts, expressed as "I am", are called register-phrase, and are constituted mainly of the apprehension of the primeval relationship models - marital and parenting (Almeida & Romagnoli, 2016; Jost de Moraes, 2016; Jost & Goto, 2019a, 2019b) when they can become personal convictions, crystallizations, and repetitions, composing patterns of non-constructive intersubjective and transgenerational relationships.

The corresponding therapy follows the diagnosis when the intervention in the negative meanings conferred to the original lived-experiences is consented, investigating the psycho-affective motivations that support the acts in relation to the subject and to his emotional surroundings. Thus, the subject can understand himself and those who made him suffer, not only from a rational-cognitive perspective, but through intuitive (unconscious) apprehension, authorizing the dismantling of the network of destructive sense configurations (decoding) settled on this emotional basis, adapting the paths of "decoding" to the contexts in question. The next step is to reinforce the emerging constructive content. The positive valence events ("positivation") are investigated, and the changes achieved are verified (Jost de Moraes, 2016, 2008). It is noteworthy that any "questioning" starts with "objectification", a resource that helps "focusing" on the problem situation and the emergence of unconscious memory, avoiding interpretations, the use of cognizant memories or imagination by the patient.

This clinical experience legitimizes aspects of the results of phenomenological descriptions (Husserl, 2012, 2017; Stein, 2005b), which distinguish intentional lived-experiences that constitute the human, demarcating contents "referred to the I" and which emerge from the "I", which is fulfilled with a certain "affective tone"- significant affective-emotional experiences. These are revealed to be connected to a certain way of constituting the world and the objects in it, mobilizing psycho-affective reactions that

reverberate in the body itself (Leib) in a healthy or non-healthy way, as in the case of depressed mood (Husserl, 2012, 2017; Alonzo-Fernández, 2010; Quepons, 2016a; 2016b; Jost & Goto, 2019b).

The specifics of this process are also grounded in the generative-phenomenology when considering that the child still "within the maternal flesh" (Husserl, 2017, p. 375) is already being formed in a primordial way. In this sense, an "original I" is created, affected as a first plenitude, becoming: "[...] the first theme while the first filled up [known]" (p. 375), demarcating the first existential predispositions. They are also close to the phenomenological descriptions of genetic lived-experiences, indicating the transgenerational link and the sharing of meanings that occur in the interrelation between the "I", the parental dyad and the total community of living "selves", immersed in a sociocultural and generative horizon in the temporality to which they belong (Josgrilberg, 2017; Jost & Goto, 2019b, in press).

Considering the psychic dimension linked to the level of resonance and reaction to what is received through the way of the sensitive and that their meanings remain registered in the psychic consciousness, one understands the possibility of apprehension and access to founding "affective-emotional registers" (gründende affektiv-emotionale Register) from the intentional lived-experiences, allowing the comprehension and the therapeutics of motives and motivations that are the core of psychological suffering. The notion of "unconscious", as empirically demonstrated by Jost de Moraes (2008, 2016), is thematically close to the Husserlian acknowledgments which describe it as one of the ways of apprehending consciousness - intuitive, integrative, founding, and anti-predicative. In this sphere, a total "horizon" of ways of appearing and non-current validity syntheses are delimited, operating in continuity of "retentions" and "protensions", demarcating temporal lived-experiences that synthesize in the present the past and future lived-experiences (Kretschel, 2012; Kretschel & Osswald, 2017; Osswald, 2018). Thus, it is possible to apprehend how the manifestation of an object of experience is revealed through a series of coherent appearances connected to each other, making explicit the correspondence of meaning which interweaves with different experiences, generating more and more complex associations and chains of meanings (Quepons, 2016a).

In this regard, reminiscent lived-experiences stand out, highlighting three modalities intrinsically related to attention: clear evocations (Intensive Selbsgebung); the not so clear-cut ones (Nebel der Unklarheit); and the empty ones (Leere Erinnerungen), these last referring to the possibility of the awakening (Wecken) of a remembrance which belongs to the "retention deposit" of memory, from an "affective stimulus" (HUA XI). It is shown that the intentional I can turn to the content of the memory, even if it is unconscious, and address the form of its presentification (Vergegenwärtigung), given the beneficial conditions (Osswald, 2018) favored by the specific resources of this psychotherapeutic process (Jost & Goto, 2019b).

The indications of Jost de Moraes (2016) describing a "noological unconscious", related to the sphere of opening to existence when covering the psychic dimension do have a ground. They are not, however, being restricted to this dimension when including the spiritual one (motivation, freedom, and rationality), constitutive of humans and encompassing the horizon of experiences, both those "noticed" and "not noticed" (Husserl, 1913/2006). Actions that emerge from a "personal-I" stand out (Jost de Moraes, 2016, p. 82), as similarly affirms Stein (2007, p. 100-103) are potentially complete,

free, and responsible for self-configuration, able to transform the psychic states that can lead to illnesses.

2. Method

2.1 Participants

Depressive patients (N= 10), 23 to 59 years old (M=44, SD=13, 89), male (n= 2), female (n= 8); single (n= 5), married (n= 3), divorced (n= 1), widowed (n =1), regardless how long the person has been ill. The participants level of education was Higher (n= 6), Medium (n= 3) and Elementary (n= 1). Employed (n= 8), unemployed (n = 1) and retired (n = 1). The limited sample considered the objective of qualitatively evaluating therapeutic changes; research with broad sampling and enumeration of frequencies is not encouraged (Small, 2011). Patients with comorbidities not indicated for this study were ruled out (ICD-10; Yoshida & Enéas, 2004).

Table 1. *Demographic characteristics of participants (N=10)*

Participant	Age	Gender	Level of Education	Profession	Marital Status
P1	56	Male	Bachelor	Teacher	Single
P2	25	Female	Bachelor*	Attendant	Single
P3	59	Female	Master*	Teacher	Married
P4	23	Female	High school	Unemployed	Married
P5	52	Male	Grade school	Musician	Single
P6	40	Female	Master	Bank	Divorced
P7	59	Female	High school	Merchant	Married
P8	32	Female	Bachelor	Doctor	Single
P9	40	Female	Bachelor*	Artist	Single
P10	54	Female	High school	Retired	Widow

* Incomplete

2.2 Data collection

Transcription of the descriptions of the changes: a) intra sessions; b) initial and final sessions; c) extra sessions according to the GCIs scale.

Beck Depression Inventory (BDI-II-): self-report inventory with 21 items, structured and validated to assess the level of depressive intensity according to the scores: minimum (0 to 11), mild (12 to 19), moderate (20 to 35) and severe (36 to 63) (Beck, Steer, & Brown, 1996).

Therapeutic sessions with ADI/TIP Method: recorded on video and transcribed in full (Honda & Yoshida, 2013). Conducted by the same psychotherapist, PhD in Psychology, 28 years of practice.

2.3 Procedures

The participants willingly sought the FUNDASINUM social clinic and signed the Informed Consent Form (ICF). They were randomly divided into groups: experimental (G1) and control (G2). The BDI-II was applied for all participants at the beginning, in the middle and at the end of the psychotherapeutic process. The GCIs[6] scale was applied to all participants throughout all sessions. Ten sessions of ADI/TIP Method were performed, lasting 50 minutes each, on ten consecutive business days for all participants (M=10, SD=O). All participant sessions were analyzed. The GCIs indicate 19 items related to the evolutions of change observed intra and extra sessions and at the beginning and end of the psychotherapeutic process. It uses verbal description of patients, session transcripts, and video recordings of all sessions.

The items are: Acceptance: 1) The problem; 2) The need for help; 3) The help of a professional; 4) Expressing hope; 5) Questioning the usual ways of feeling and acting; 6) Expressing the need for change; 7) Awareness of participation in your problems; 8) Discovering new aspects of yourself; 9) Manifestation of new behaviors and/or emotions; 10) Feelings of competence; 11) New characteristics between aspects of the self, the environment and elements of his or her history; 12) Reconceptualization of problems; 13) Transformation of values and emotions; 14) Formation of new constructs; 15) New constructs grow roots in the subject's history; 16) Autonomous understanding; 17) Recognition of the assistance obtained; 18) Decrease in asymmetry between patient and psychotherapist; 19) Reconstruction and re-reading of his or her history (Krause et al. 2006).

2.4 Research steps and evaluations

The procedures started with a medical assessment, and therefore were divided into three phases:

Phase 1: initial application of BDI-II for both G1 and G2;

Phase 2: While G1 went for the Preparatory Phase (PP), G2 waited, and there was a second application of BDI-II for G1 and G2;

Phase 3: While G1 went for therapeutic intervention ADI/TIP, G2 went for PP and there was a third application of BDI-II for both groups.

[6] As mentioned before, a GCIs scale it is an observer-rating instrument which points to an ideal sequence of changes common to the various psychotherapies with satisfactory results.

The results obtained in the BDI-II were tabulated and analyzed with the statistical software Statistical Package for Social Sciences (SPSS). The qualitative results obtained by the GCIs were interpreted according to the phenomenological theory.

3. Results

3.1 Quantitative analysis

The software *Statistical Package for Social Sciences* (SPSS) version 15.0 was used to analyze the data obtained with BDI-II. Non-parametric tests were performed with a significance level set at $p < 0.05$ for between and within-group analysis. Table 2 shows descriptive statistics for the BDI-II raw scores. BDI-II was employed to provide a descriptive image of the results and to allow generalizations showing the degree of change achieved through this psychotherapeutic process, responding to one of the research objectives.

Table 2. *Descriptive analysis of the BDI-II scores for both G1 and G2 groups (N=10).*

Condition	Mean	Median	SD	Minimum	Maximum
G1 - Baseline (Phase 1)	34.40	37.00	9.79	24.00	47.00
G1 - Preparatory (Phase 2)	14.80	12.00	7.05	8.00	26.00
G1 – Post-therapy (Phase 3)	5.40	5.00	3.51	.00	9.00
G2 - Baseline (Phase 1)	29.75	29.50	10.81	17.00	43.00
G2 - Waiting (Phase 2)	24.50	20.50	9.75	18.00	39.00
G2 - Preparatory (Phase 3)	15.25	16.00	10.28	3.00	26.00

Note. BDI-II level: no or minimal (0 to 11); mild (12 to 19); moderate (20 to 35); severe (36 to 63).

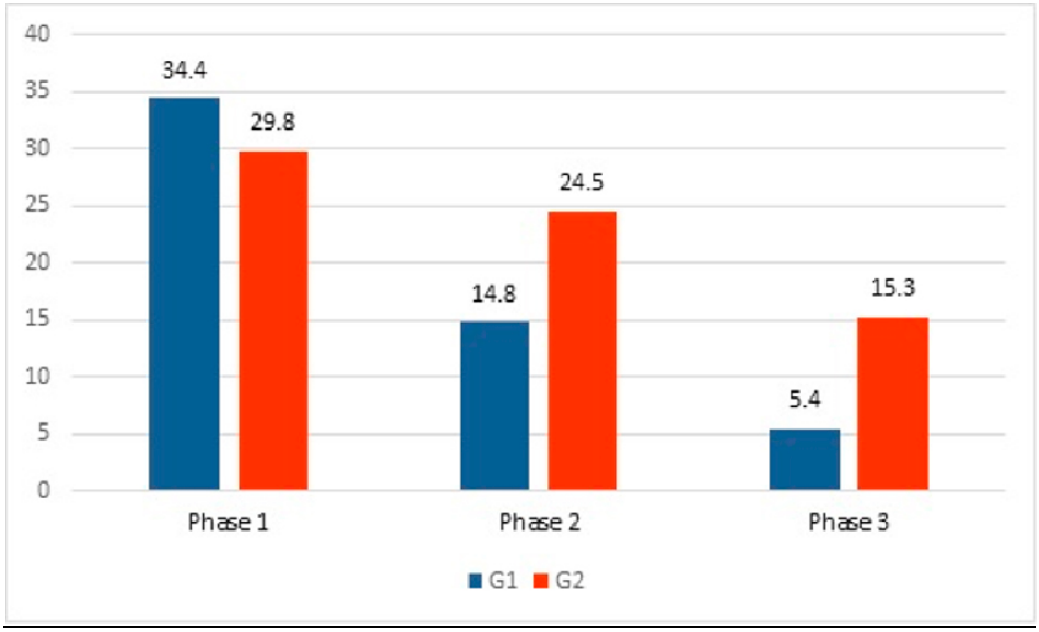
Table 3*. Mann-Whitney U test to verify between-groups differences for each condition*

	Mean rank		Sum of ranks					
Conditions (G1/G2)	G1	G2	G1	G2	Mann-Whitney U	Wilcoxon W	*Z* score	*p*-value
Baseline/ Baseline (1x1)	5.40	4.50	27.00	18.00	8.00	18.00	-0.49	0.62
Preparatory/ Waiting (2x2)	3.60	6.75	18.00	27.00	3.00	18.00	-1.71	0.09
Post-therapy/ Preparatory (3x3)	3.80	6.50	19.00	26.00	4.00	19.00	-1.48	0.14
Post-therapy/ Waiting (3x2)	3.00	7.50	15.00	30.00	0.00	15.00	-2.46	0.01*
Preparatory/ Preparatory (2x3)	5.00	5.00	25.00	20.00	10.00	20.00	0.00	1.00
Preparatory/ Baseline (2x1)	3.30	7.13	16.50	28.50	1.50	16.50	-2.09	0.04*

N=9, *p < .05.

For both groups, the mean score presented in the baseline corresponded to a moderate DP level. This moderate level was also observed for the G2 group in the waiting phase (W). After the preparatory phase (PP), the mean score indicated a mild DP level in both groups. Finally, for the G1 group in the post-therapy (PT) phase 3, the mean BDI-II score indicated a minimal DP level. Graph 1 shows the mean scores obtained in the BDI-II for both groups in each phase of the study.

Graph 1. *Mean BDI-II scores for both groups in each phase of the study.*



The non-parametric Mann-Whitney U test was employed to verify whether there were significant differences between the medians of the scores obtained in the BDI-II for each group (G1 = treatment, G2 = control), for each condition (phase 1, phase 2, phase 3). Table 3 shows the results of the Mann-Whitney U test.

The results obtained with the Mann-Whitney U test did not show significant differences between-groups for each phase of the study (1, 2, and 3). Nonetheless, results indicated significant differences between scores obtained by the G1 group on the post-therapy (PT) phase and the G2 group on the waiting phase ($p = 0.01$). Besides, there were significant differences between the G1 group after the PP and the baseline in the G2 group (phase 1).

A non-parametric Wilcoxon signed-rank test was performed to verify within-group differences between the results obtained by the participants of the BDI-II scores for each group on the three phases of the study. The results are shown in Table 4.

Table 4. *Wilcoxon signed-rank test to verify within-groups differences on BDI-II results for each phase (1, 2, and 3) of each group (G1 and G2)*

	Mean rank		Sum of Ranks			
Within groups conditions	NR	PR	NR	PR	*Z* score	*p*-value
G1 - Baseline/ Preparatory (1x2)	3.0	0.0	15.0	0.0	-2.02	0.043*
G1 - Baseline/ Post-therapy (1x2)	3.0	0.0	15.0	0.0	-2.02	0.043*
G1 - Preparatory/ Post-therapy (2x3)	3.0	0.0	15.0	0.0	-2.02	0.043*
G2 - Baseline/ Waiting (1x2)	3.0	1.0	9.0	1.0	-1.46	0.144
G2 - Baseline/ Preparatory (1x3)	2.5	0.0	10.0	0.0	-1.83	0.068
G2 - Waiting/ Preparatory (2x3)	2.0	0.0	6.0	0.0	-1.60	0.109

NR=Negative rank, PR=Positive rank; *N*=9, *p < .05, based on positive ranks.

Within-group differences on BDI-II scores were statistically significant for all conditions (p < 0.05) only for the G1 group. For the G2 group, there were no significant differences, comparing the results obtained in each phase of the study.

Regarding the percentage changes of the BDI-II raw scores, we could observe that there were significant changes for the G1 group, standing out the results obtained in phase 3, after the conclusion of the psychotherapeutic process. In phase 2, the G1 group showed a partial result with an average percentage change of 53.3%, against 14.8% for the G2 group on the waiting phase. Concerning phase 3, the G1 group presented an average percentage change of 81.9%, in total, against 55.7% for the G2 group. It should be highlighted that the result obtained in P2 occurred before the completion of the psychotherapy, with only five of ten sessions completed.

Thus, G1 patients showed a reduction in depressive symptoms from severe to minimal (P1, P5), or severe to no perceived symptoms (P3), and from moderate DP level to minimal (P2, P4). For the G2 patients, despite showing a reduction in BDI-II scores, they presented it in less intensity. The results of the percentage change analysis are shown in Table 5.

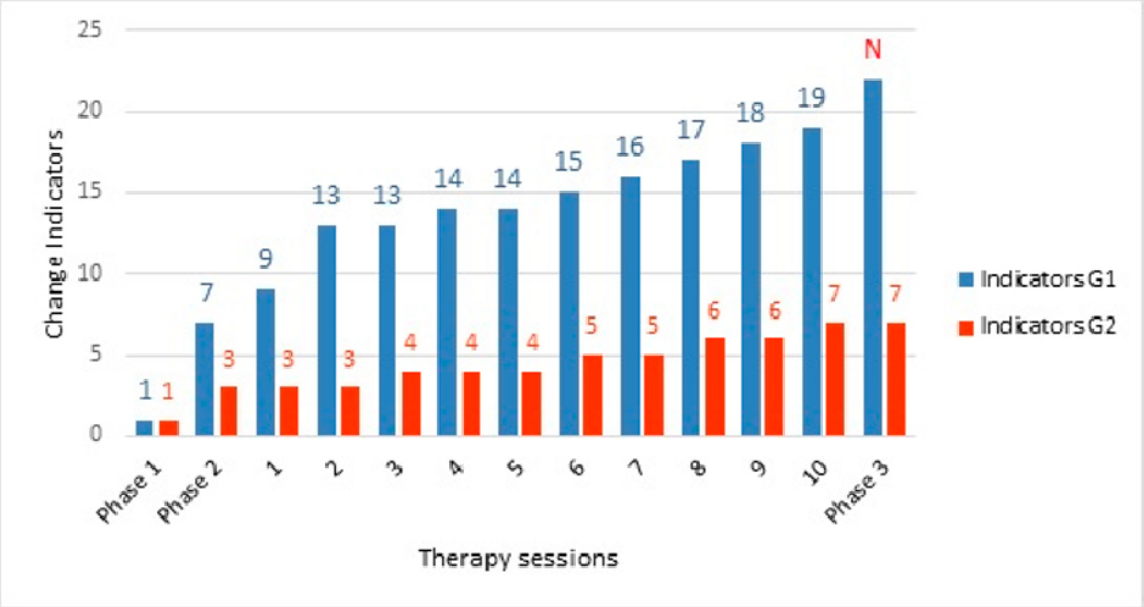
Table 5. *Percentage change analysis results*

Condition	**P1**	**P2**	**P3**	**P4**	**P5**	**Average**
G1 Phase 1	39	24	47	25	37	
G1 Phase 2	11	12	8	17	26	
G1 Partial	71.8%	50%	83.0%	32.0%	29.7%	53.3%
G1 Phase 3	5	8	0	5	9	
G1 - Final	**87.2%**	**66.7%**	**100%**	**80%**	**75.7%**	**81.9%**
Condition	**P6**	**P7**	**P8**	**P9**	**P10**	
G2 Phase 1	43	32	27	17	37	
G2 Phase 2	39	21	18	20		
G2 Partial	33.3%	34.4%	33.3%	+ 17.6%		14.8%
G2- Final	**39.5%**	**34.4%**	**66.7%**	**82.40%**	-	**55.7%**

Note. BDI-II level: no or minimal (0 to 11); mild (12 to 19); moderate (20 to 35); severe (36 to 63).

3.2 Qualitative analysis

Graph 2. Evolution of the change indicators over psychotherapy sessions of the ADI/TIP Method



During the first sessions, participants reported a family history of depression, complaints of multiple symptoms and said they were undergoing drug therapy. Important to highlight that P1 and P3 had severe DP, having been using antidepressants for several years (P1: 15 years; P3: 33 years). P10 (G2) indicates the reason for the continuity of the illness when he comments that his son started to pay him more attention after the worsening of DP, presumably the reason for the sample loss.

Deprecating narratives about oneself were observed. Descriptions were like: “my existence is a mistake” and being “a person without joy” (P1, P3, P6, P7) since childhood. Participants also reported feelings of failure and guilt, lack of meaning in life: “It seems that I am dead, and I don't know that I am” (P3), a subjective feeling comparing the apprehension of life to a “dark color” or even “without color” (P1, P2).

Regarding family relations, patients recounted feelings of bitterness towards the parents, linked to experiences of marital and interpersonal conflicts. The mother is described as “sad”, “non-affective” (P3) or “a victim” (P1); and the father as “distant” (P3), “cruel” (P1) and “one who forsakes” (P4). Intimate-affective relationships were linked to feelings of disbelief and frustration. However, at the beginning of the therapeutic process (TIP), participants expressed the need for help, their confidence in the therapist and in the possibility of change, corresponding to the initial indicators (1 to 3) of GCIs.

In the final sessions, G1 reported changes intra and extra session, as the decrease of depressive symptoms and improvements in other spheres, reaching the highest GCIs indicators (15 to 19). G1 describes changes regarding own-body perception: “before it was a dry body [...] now it is warm” (P3). He reports the emergence of new connections and meanings between aspects of the self and the environment, being interpersonal or intra-family relationships (ind. 11). The release of crystallized

negative emotions is also mentioned: “I feel less affected by bitterness and resentment” (P5). Feelings of competence were reported (ind. 10) and the transformation of values and emotions in relation to oneself and to others (ind. 11, 13.15): “I feel capable of conveying good things and to solve problems” (P3) (ind. 8 to 15). These movements caused changes in affectivity and habitual understandings, with affirmative descriptions about life as having “a new color” and the feelings of “fulfilling” the self and “joy, reliance and hope” (P1).

It is noteworthy that patients linked the changes in self-concept, alter-perspectives (intra and interpersonal), and changes in the feeling of chronic guilt (P1, P3, P4, P5) to the psychotherapeutic process. Thus, at the end of ADI/TIP, they described themselves not only “capable of adapting”, but also “to make a difference” in the surrounding environment. These results surpass the initial predictions.

Regarding the events that took place extra session (ind. 15 to 19), G1 confronts his current ability to cope with problematic situations with the previous feeling of incapacity, reporting changes in intimate-affective relationships and the planning of projects for the future. It is noted that the results of G1 are qualitatively superior (ind. 15 to 19) to those of G2, even though G2 has shown a higher-than-expected evolution (ind. 6-7).

4. Discussion

The descriptive analyzes have shown a reduction in BDI-II scores after PP (mild level) with a higher index post-therapy, PT (minimum level). The inferred analyzes have shown intergroup differences only between the PT (G1) and the baseline (G2). Intragroup differences appeared only between the phases of G1. The difference between G1 PT and G2 in W indicates that psychotherapy reduced BDI-II scores to those who undergone therapy. This happened even after the patients had received attention from the professionals (WP).

There were intra and intergroup differences in relation to PP and to the baseline (intergroup 2x1, intragroup G1 1x2). However, there was no statistically significant intergroup difference in PP in relation to WP for G2 (intergroup 2x2, intragroup G2, 2x3). The differences found in the Wilcoxon test along all the phases of G1 indicate significant decrease in BDI-II scores. G1 achieved significant lessening between baseline and PP, and between PP and PT. These results indicate that PP contributed to symptomatology reduction, qualitatively superior after performing ADI/TIP.

It was also noted that there was no significant difference between PP and G2’s baseline, even though the significance level has almost been reached ($p = 0.68$). It can be explained if one considers that in the context of ADI/TIP, PP is complementary to psychotherapy, which favors the appearance of positive expectations in relation to oneself, the therapist and the “motivation for therapy” (ind. 1 to 7), neutralizing the qualifiers in the depressive state (Alonzo-Fernández, 2010; Nunes-Silva et al., 2016). The “motivation for change” (Honda & Yoshida, 2013), in turn, implies a greater level of accountability, usually achieved in higher stages of GCIs. Concerning ADI/TIP, accountability was

already observed in G1 during the intermediate sessions. Another hypothesis may refer to the small sample (n= 10), indicating the need to replicate the study with a larger sampling.

However, the number of psychotherapy sessions held was relatively large (N= 230). Results were confirmed when previous studies, with a higher sample number (n= 27) and more psychotherapy sessions (N= 351). Of those, two showed significant changes in their scores: a) 91.6%, (n= 12) (Santos et al., 2016) and b) 83.6% (n= 15) (Duarte, Marra, Rosa, Fontes, & Coutinho, 2014), among other works with similar methodological design and objectives (Silva et al, 2016; Gomes et al 2016; Lopes, Jost, & Rosa, 2016; Silva et al, 2015). According to Easden & Fletcher (2020) the aggregation of this data offers greater consistency to the results of reduced sample studies. Improvements in self-esteem, interpersonal relationships, and other levels of personality (Krause et al., 2007; Alonzo-Fernández, 2010; Saloheimo et al., 2016; Sarubin et al., 2020) can be added to them.

The drug therapy routine was not altered, neither was the external factual context. Therapeutic changes must be attributed to transformations concerning the "contents of the sense" that fulfill fundamental psychic lived-experiences (Husserl, 2017; Jost & Goto, 2019b). Patients refer to the apprehension of primordial events connected to primary intersubjective relationships and to destructive self-configuration because the value attributed to them is one of disaffection. The genetic analyses of the lived-experiences show that the meanings given to the lived, when shaped in previous stages of subjectivity, become a "first affection" responsible for substantiating the comprehension of the subsequent lived. These primitive impressions, built from the first bonds established with the parents, may trigger reactive psychic-affective impulses and resentful feelings, as identified in the analysis regarding the sickening psychic movement of DP. The generative family nucleus, demarcated as a matrix of psychic life and intersubjective space for sharing and conveying cultural, social and intrafamily content meanings (Husserl, 2017; Stein, 2005b; Josgrilberg, 2017; Jost & Goto, 2019 b, in press), confirming conclusions of both traditional studies (Bowlby, 1990; Erikson, 1976; Winnicott, 1990) and recent ones (Almeida & Romagnoli, 2019; Jost et al., 2009; Jost & Almeida, 2020; Roncallo, Miguel, & Freijo, 2015; Silva, 2016).

The results are close to Husserl's observations (2006, 2012) when describing the dynamics of affects, differentiating the affective lived-experiences from the corporeal ones (Ales Bello, 2019) and characterizing the "sensitive feelings". The meanings which fill the feelings resonate within the innerness, affectively engraining the whole "world" of the person – being it with joy or sorrow. Moods are then distinguished as "a lasting and dominant feeling", constituting a background of emotional awareness even without original reference (Husserl, 2012, p.339).

Therefore, the psychic-phenomenological comprehension of the psychotherapeutic experiences refers to: a) affective lived-experiences, marked by a feeling of never-ending sorrow; b) the lived-experiences of the body (Leib) plunged in a depressed mood and without a vital impulse; c) remembering (Wiedererinnerung) lived-experiences, related to negative experiences; d) the lived-experiences of temporality, subjugated to the past. The patients, experience themselves self-cloistered in time and space, imersed in a darkened affective tone, regarding the symptomatologic scope, the subjective and intersubjective as well (Jost & Goto, 2019b). This meets the characteristics of DP (Alonzo-Fernández,

2010), demonstrating that, when primal lived-experiences are reached, the source of psychological suffering is identified as coming from an "I" that can configure its very own process of falling ill.

In the same way, the diagnostic-therapeutical work is allowed with events of a negative content and a wide perspective about what was lived. In this way, changes in feelings and affections are approved, linked to experiences of love and trustiness, expressed by a joyful mood. G1 patients describe the emergence of lived-experiences related to an "awakened I" that integrates the "I" and the "I itself" (Stein, 2005b, 2007), able to surpass the limits of the psychic sphere of the living body (Leib), and of socio-cultural ones. Diversely, G2 patients, despite reporting changes, refer especially to those feelings connected to suffering, such as symptom relief, revealing a positioning that is still self-referenced, with no changes in the way they place themselves and experience the affective-existential hue.

Thereby, if what motivates the "I" to a change can only succeed by means of a "new level of depth" and if this possibility is only available when the "I" is "awakened" by a person or event (Stein, 2005b), it is possible to apprehend that the therapeutic resources of this process, by emphasizing the "I" in its movement of "darkening" or of self-reconfiguration (Jost & Goto, 2019a; Jost & Almeida, 2020), allow the opening of the discovery of existence fulfilling meanings and the work with intrapsychic, interpersonal and transgenerational conflicts.

5. *Limitations of the study and future research*

The reduced sample, despite being indicated in qualitative analyses, can limit the scope of the study. In this aspect, there is a need for further longitudinal research with a greater number of patients, to reinforce the results enabling a contribution to the research and to the development of Clinical Psychology, increasing the range of scientifically based psychotherapeutic possibilities.

6. *Conclusion*

ADI/TIP Method results showed that its specific therapeutic resources led to changes that surpassed the predictions both in statistical (81.9%) and qualitative terms, indicating ADI/TIP as a psychotherapeutic possibility to confront DP symptoms, encompassed by scientifically based method. G1's results were 26.6% higher than the most positive expectations: 55.3%, (Fleck et al., 2003; Baptista, Berberian, Marín Rueda, & Mattos, 2007).

The following possibilities were demonstrated: a) apprehension of the experiences linked to primordial psychological suffering and its consequent "decoding"; b) discovery of positive valence meanings and c) alteration of internal dynamics: from self-centering to self-transcendence. One can note that the subjective/intersubjective changes and the alteration of depressed mood "way of being", by nestling in the somatic dimension and reducing the symptoms, allowing for biopsychosocial and existential improvements.

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