An Introduction to Transactional Analysis Psychotherapy

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Abstract

Introduction*: This paper presents a range of concepts from transactional analysis, an approach which shares many of the values of experiential psychotherapy. A short glossary is included at the end of the paper - terms are explained and referenced as they are described, and they are illustrated with practical examples.*

Objectives*: The article is provided to share useful TA concepts with those engaged in experiential psychotherapy, in a way that can be applied to consideration of therapeutic style, client diagnosis, contracting with clients, dealing with self, diversity, planning and making interventions, and dealing with ruptures to the relationship.*

Methods*: Hermeneutic, phenomenological reflections based on the professional experiences and theoretical learning of the author.*

Results*: Consideration of the application of a number of transactional analysis concepts within elements of case studies.*

Conclusions*: The paper demonstrates potential applications of various transactional analysis concepts in ways that align with the values of experiential psychotherapy; the author aims to stimulate further interest and possible application. Comprehensive referencing is included for those who wish to explore further.*

Keywords: transactional analysis, psychotherapy, TA glossary, philosophical assumptions, therapeutic processes

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Introduction

When I first saw the description of the journal, I was struck by the similarities with the transactional analysis approach. I noticed words such as: humanistic-experiential; transgenerational relationships, organizations and communities; holistic, unifying and integrative; spirituality, freedom, creativity, tolerance; individual and collective responsibility; ecological and transforming psychology; recovery and prevention of psychic and psycho-somatic dysfunctions and disorder; psycho-social integration and adjustment; and that it is for specialists from the humanistic fields (psychology, psychotherapy, counselling, medicine, social care, sociology, psycho-pedagogy), as well as those interested in the dynamics of health, experiential education and human transformation. I might as well have been reading a description of a transactional analysis journal!

It seemed, therefore, that the invitation to write about transactional analysis (TA) made sense. TA is described by the ITAA (International Transactional Analysis Association, 2011) as "a social psychology". I describe it as a set of interlocking theories, with accompanying techniques, and which rests on a number of philosophical assumptions. Developmental TA is a term I introduced several years ago (Hay, 1995) to refer to the non-psychotherapy fields of application of TA, which comprise organisational, educational and counselling (coaching) specialisms, each of which has its own version of the international examinations. After having been involved in the international TA community for many years, I added TA certification as a psychotherapist to the qualifications I already held in developmental TA. Much of my practice experience was in high security male prisons in the UK, working with clients who were typically suffering from personality disorders. This was for me a particularly inspiring experience as I saw how useful TA was for these clients, who so often needed to understand that their dreadful childhood experiences had been a function of environmental conditions (including how well and by whom they were 'parented') and not because they were born with something innately wrong with them. The focus was of course on explanation rather than excuse – they had still done things for which society expected to imprison them but increased psychological awareness provided them with options for different behaviours in the future (an important element when it came to being released).

Philosophical assumptions

The philosophical assumptions are the same whether we practise psychotherapeutic or developmental TA:

I'm OK, You're OK (Berne, 1962) implies that people have an innate worth and are selecting the best options they can.

Physis (the growth force) (Berne, 1968) - we all have an innate drive towards developing to our potential – I use the metaphor of the child having concrete poured over them and our role is to make the cracks that will allow the 'plant' to emerge towards the light. In some cases we may also need to move blocks of concrete but in many other cases, the plant, once released, will have enough energy to achieve this itself and may need only the provision of occasional fertiliser.

Autonomy (Berne, 1964) – we all seek and have the ability (unless physically brain-damaged) to be aware and, in the here-and-now, to know that we can choose from various options (Karpman, 1971) for how we behave from moment to moment, and to be in relationship (intimacy) with others. I add to this a fourth factor - authenticity, which links to knowing that we are OK even though we have characteristics which are not – colloquially, we are 'OK warts and all'.

I also add as a philosophy that we each have our own unique map of the world – several pre-suppositions can be subsumed into this factor (Hay, 2001): we all have our own unique maps - in TA, for example we have constructivism (Allen, 1997), *script* (Berne, 1961), etc.; the maps consist of thoughts, feelings, attitudes, beliefs, etc. and these are interconnected, as are *ego states*; we make the best decisions we can based on those maps e.g. *psychological games* are failed attempts at intimacy; we can change the mental maps but we cannot change history, as in the TA Redecision school (Goulding & Goulding, 1982) when we change the decisions/interpretations we made in the past; we need to change enough of our map to achieve change that is stable under stress – in other words , we need to create a wide enough path through the jungle to stop the jungle simply growing back – so *script* analysis is needed to support behavioural change.

Styles of psychotherapy

My personal style until now had been very much the classical school (Barnes, 1997). As a way of inviting clients into the here-and-now, I have converted many TA theories (Hay, 2009, 2012) into simplified versions that can more readily be understood by clients,

have changed the labels in many cases to normalise rather than pathologise, and have devised alternate models that explain health (e.g. *autonomy matrix*, Hay, 1997, *potency pyramid*, Hay, 2009).

In addition to utilising theories from the Redecision (Goulding & Goulding, 1982) and Cathexis (Schiff, 1975) Schools, I add, and explain to clients when appropriate, how we make meaning by constructing our worlds (Allen, 1997), how we cannot avoid being cocreative (Summers & Tudor, 2000) because any communication means that we influence each other's constructions, and that we also are relational (Hargaden & Sills, 2002) because humans naturally connect and seek to recreate the *imagoes* (Berne, 1978) of their family of origin. I also incorporate the nature/nurture dimension in line with research indicating the impact of genetics and I find it useful to give some clients *permissions* (Crossman, 1976) to accept their genetic inheritance and even to 'blame' it temporarily if this helps them to bring their issues into awareness. They can then be prompted to identify their own potency even when the problem is genetic such as an 'allergy' to alcohol.

Thus, I have tended to work to Berne's approach of contracting for interpersonal change and then engaging in a process of sharing specific aspects of TA and related theory with the client, as a way of giving *permission* to change childhood decisions that were made without the benefit of their grown-up knowledge of the world, and so that together we can *decontaminate Adult* through analysis of *transactions, games, script*, etc. In this respect I have resonated with English's (2007) comments about being Cognitive Transactional Analysts.

However, my training in NLP (neuro-linguistic programming) prompts me to consider also: how we unwittingly have an hypnotic effect on each other via the unconscious (Yapko, 1990), which I regard as a different way of explaining the phenomenon of the 'unthought known' (Bollas, 1987); how the language we use contributes to this (Bandler & Grinder, 1975); and how our values are implicit in our interactions. For example, my *Try Hard* tendency may lead me to interact in a *Natural Child* mode that implies enthusiastic is the right way to be, I might use words such as 'try' that convey an *ulterior transaction* about not succeeding, and my role as therapist might lead the client to symbiotically assign power over their own life to me.

As therapist, therefore, my style is to expect that clients are capable of being in the here-and-now, that they have the drive to be psychologically healthy and would be more so if they understood how they have been impacted upon by nature and nurture, and that my role is to join them in their map of the world, pick up the unconscious dynamics, share my 'reactions' and selected elements of the TA map with them so they can 'make sense' of their world, and stay alongside them while their own *physis* does the rest.

Diagnosis

Cornell (1986) proposed that the initial interview be used to 'engage the client in a mutual collaboration', 'establish the therapeutic canon' and pay attention to the 'client's strengths/competencies and difficulties' and he provided a useful list of questions for reviewing.

Diaz de la Vega and Gayol (1981) proposed using a series of forced choices to assist clients in defining the focus of the work when clients are unsure of their priorities. Allen (1992) provides a pictorial representation of Ware's (1983) doors to therapy and suggests how a treatment strategy might be developed based on initial diagnosis of personality adaptations (using labels from Kahler, 1980). Hoyt (1989) had extended the personality adaptations work to present ten personality disorders, including a table showing, inter alia, the 'watchwords' of clients, their common reactions to therapist and the therapist's common reactions to such clients.

I still felt the need for some structure about the information I would seek from the client and an internet search yielded a reference to Marquis and Holden (2008) and thence to Marquis (2008). Marquis has developed the Integral Intake based on Wilber's (1999) AQAL (all quadrants, all levels) model and had had the resulting questionnaire evaluated by 58 counselling/psychotherapy educators and experienced mental health professionals. I therefore 'borrowed' the headings as a basis for my intake interview, so that I would cover internal experience, external behaviour, culture and systems (within which the client is situated). This provides a framework for asking questions and I use it loosely so that the session is more one of encouraging the client to talk generally about their circumstances rather than an interrogation. It may take a few sessions to gather the data and be in a position to hypothesise a diagnosis and hence agree a contract with the client.

I supplement this, using audio recording where feasible, with self-reflection on transference/ countertransference indications, listening to language

patterns for *discounting* (Mellor & Schiff, 1975) and *drivers* (Kahler, 1975), and content analysis to pick up possible *games* and *rackets* (English, 1971), *injunctions* (Goulding & Goulding, 1982), *process scripts* (cross referenced to *drivers* and personality adaptations (Joines & Stewart, 2002), and DSM IV (American Psychiatric Association, 2000) indicators. I then check out my thinking in supervision.

To illustrate this, the following is an example of information obtained from a client (disguised for purposes of confidentiality), with my TA thinking in italics:

- Internal: issue stated as criticising self and wants to stop this *(rackets, injunctions, life position*); 39 yrs. old white professional female (*maybe 1 year old, Levin, re cycles of development, 1988)*; professional husband, 2 year old daughter *(maybe tracking her, Levin, op. cit.*); parents and sister (38) living; is a psychotherapist and thought she had solved the problem already during her training; is aware that is mother's voice she is hearing internally.
- External: good support networks *(sounded hesitant, what stroke patterns?)* supervisor, husband, support group, parents who also help with child care; no medication *(asked her to check and also could be hormonal)*; no drug, alcohol, diet issues, no recent changes to situation.
- Culture: East European ex-communist culture (*cultural script, low profile, anti intellectual*); traditional family values *(cultural AND family script re role of women*?), Catholic country: enjoys work; knows quite a lot of TA *(possible shared therapeutic cannon – what might we miss*).
- System: within professional community in own country (*professional role)*; own home *(can afford not live with parents; independent versus counter dependent?*); no neighbourhood concerns; able to pay for therapy *(at local, not UK rate)*.

My diagnosis after 3 sessions: some indications of Avoidant Personality Disorder; Schizoid survival personality adaptation and Passive-Aggressive performing personality adaptation; *drivers* of *Be Strong* and *Try Hard* with some *Please People*; a Never *process script* with Don't be Important, Don't Make It (succeed) and Don't be Close *injunctions; racket* feeling of incompetence covering anger covering sadness; *life position* of *I'm not OK, you're OK*.

Contracting

A contract is "an explicit bilateral commitment to a well-defined course of action" (Berne, 1978, p. 362) and proposes that we need the contract to exist at the administrative, professional and psychological levels. James & Jongeward (1996) define contract as "an *Adult* commitment to one's self and/or someone else to make a change" (p. 242). Steiner (1974) likens it to a legal contract, which must incorporate mutual consent, consideration, competency and lawful intent. Stewart (1966) writes that "the contract is a *present means* of achieving a desired *future outcome*" (p. 34). Holloway & Holloway (1973) caution against clients who seek "non-change with a hidden determination to undermine the efforts of the clinician so as to maintain the *script*" (p. 34).

Hence, when I contract with a client, I expect to cover (not all at once and some will be in writing):

Administrative contract - how often we will meet; dates when either of us cannot keep to schedules such as holidays booked; cancellation arrangements and who to contact about appointments (me or administrator); where we meet, location of toilets for client use, what are the boundaries e.g. arrive and wait in reception to be collected, session will last 50 minutes, I will see you out; fees, how they are paid, how frequently, notice period for cancellations; what information I will need about the client and why (name, address, medical contact etc.); where records are kept, who can access them, what happens to records afterwards; what is the legal situation about information held by a therapist, when would I be required to break confidentiality.

Plus – explain why we audio record and ask for signed permission; indicate how much flexibility for client to choose seat, room layout etc.

Consideration comprises therapist offering their time and skill, client paying fee.

Professional contract – this is where therapist and client agree what they will work on. Why has the client come, how do they want to be different (note – not how do they want to change someone else), and if they don't yet know their hope for outcome, then what is an approximation or interim goal? What does the therapist offer, what is their professional approach (i.e. TA), how does that work (client may need explanation, without jargon, of *decontamination, deconfusion*, or of cognitive behavioural or relational approach, etc.)

For this level, competence is relevant – client must be competent to understand what the therapist is offering and make the commitment, which means

therapist must be able to explain what is involved in layperson terms – and therapist must believe they are competent to work with this type of client and/or issue. Lawful intent is also relevant.

Psychological level – Berne (1978) said that the *ulterior* level will determine the outcome of an interaction so this is where we need to discuss with the client those aspects where their unspoken expectations or fears may interfere with the therapeutic process. It can be useful to talk about how clients often think that the therapist will work some kind of magic to solve the client's problems, or will give the client advice about what to do, or will be able to look inside the client and miraculously know what is going on internally. For clients with more awareness of therapeutic processes, it may be possible to ask about their previous experiences and then explore any areas where your own approach is likely to seem different.

This is the level at which we can expect to pick up indicators of a client's potential self-sabotage, such as through *driver* language patterns (I want to try ..., I want to sort of so x, you know). It is also the level at which we can begin tentatively to look out for transference and countertransference, get an idea of how the client may be seeking to re-enact archaic scenes, etc.

Mutual consent is relevant here – bringing the psychological level to the social level helps to make sure that the client really does understand the process they are committing themselves to. This includes them knowing that the TA therapist operates on the basis of the TA principles of okayness, *physis* and redecision being possible.

Working within a practice means that a three-corned contract applies (English, 1975). Clients may therefore need to be told about the role of the organisation, such as handling of administration, oversight/supervision of the professional work of the therapist, and reassurance perhaps about any 'big brother' worries.

With a referral, there may also be a three cornered contract or even four or more corners (Hay, 2009). An employer funded arrangement may require us to clarify the expectations of the employer, and particularly to check about confidentiality of the therapeutic process and that there are no unrealistic requirements that the person be 'sorted out' or helped to behave in a way chosen by the employer rather than the individual. Micholt's (1992) material on psychological distances prompts us to check that we avoid becoming too closely aligned with the client or with the person who is paying the fee.

Self-harm issues

I still recall the first client who told me in the first session that she was suicidal. I hurried to take this to supervision, during which I was prompted to take into account that:

- This was a work-based, intra-organisational counselling and it was likely that the client would not agree to be referred.
- There were no other indicators – she had no failed attempts, no plans.
- The counselling has arisen from interpersonal skills training I had provided so the client and I already had a working relationship of some kind, and she had presumably sensed that I could help her.
- She had felt able to tell me.
- It was important that I contracted clearly about the boundaries of our work together.

I subsequently invited the client to close her escape hatches (Holloway, 1973) by making a no suicide (and no-homicide) contract - "… a statement by the *Adult* of the client that he (sic) will monitor himself in order to stand guard successfully over his own self-murderous or other-murderous impulses." (Goulding & Goulding, 1982, p. 55). The contract was made each time for 8 days (we met weekly) at first, then for a month at a time, and finally without any time limit, using the wording "I will not harm myself or others, intentionally or accidentally..." This was a promise to herself that I witnessed and it was also a contract with me that she understood would allow me to concentrate on my professional role rather than worrying about her welfare, the emotional impact on me and my own situation if she were to kill herself and it became known I had been counselling her. It was also a part of her treatment plan as it required and reminded her to function in the here-and-now, confirmed that we would not be working directly on suicidality and reduced her anxiety in the short-term. We worked for several months on analysing *script* patterns, reducing *game* playing and *rackets*, and generally spending more time in the here-and-now so that she could establish more effective working (and personal) relationships. She was still alive several years after our contact had ended.

Another supervisor has suggested recently that we should include a no-harm to self, others or the therapy room ground rule in all contracts with new clients and this reflects the thinking of Boyd and Cowles-Boyd (1980) and Stewart (1989). However, this may conflict with the principle of self-determination (EATA, 2008) and also remove the

possibility for a potent intervention. Mountain (2000) points out that: there are different cultural views about death, that clients may need to explore their own views before making a decision, and that such a decision needs to be linked with hope. Clients have many ways to harm themselves that are seen as socially acceptable but are just as injurious, such as smoking, eating junk food, getting psychologically injured through how they interact, and we are unlikely to get them to agree to cease such passive (Glende, 1981) behaviours until we have established a therapeutic relationship. Then we might be able to use the 4th escape hatch decision of "I will not cooperate in my dying" (Boyd, 1986).

Reflecting upon and working with difference

"Therapies and therapists of all types are part of the political field which includes the identified problem." (Littlewood, 1992, p. 40). Hence we need to pay continuing attention to the ways in which we overlook difference.

As member of both the International and European TA Associations, I operate to their joint Code of Ethics (EATA, 2008) which includes acknowledging 'the dignity of all humanity regardless of physiological, psychological, sociological or economic status'. The code also refers to 'sex, social position, religious creed, ethnic origin, physical or mental health, political beliefs, sexual orientation, etc.' However, I am also conscious that much discrimination is out of awareness because we *discount* at various levels. I have completed an online questionnaire as part of research at Harvard University that measures prejudice using time to react, on the basis that stopping to think allows us to modify our initial reactions; to me this 'measures' *discounting* being overcome and is a useful concept to keep in mind as I respond to a client – am I filtering my reaction to 'eliminate' the impact of difference.

I have run TA workshops for students in all fields of TA in cultures as varied as India, Mexico, several Eastern European as well as several Western European countries, and Australia. I have worked with the police, prison, probation and health services, in small and large, public and private sector organisations, with manual workers, shop stewards and managers at all levels. I have counselled people working on their PhD's, those with disabilities and disfigurements, those who cannot find employment and those running businesses. Each has had their own set of cultures – as James (1983) points out, we must conceptualise with a conscious respect for the impact of cultures and subcultures such as national, religious, economic, ethnic etc. plus government, organisational, family, peer groups and so on.

I am very aware that I have grown up in a dominant white British culture when compared to 'foreigners' and yet within the non-dominant 'working class'; I grew up within the traditional two-parent family (albeit a gamey one) yet was a single parent to my own children; and I have trained originally in TA in the developmental field rather than the psychotherapy field. Einstein claimed that his brilliance was due to being taught by his mother to ask lots of questions; I thank a grandmother who said 'you learn something new every day' for my interest in differences.

I use a variation of Schiff (1975) frame of reference model (which I call FoRM) for thinking about how difference impacts within the therapeutic relationship. In addition to the concept of the FoRM 'screen' (p. 51) I take into account that they show *Natural Child* as the source of motivation with *Parent, Adult and Adapted Child* as "adaptive structures within the framework of reality definitions which have been learned out of social experience" (p. 51) – for me this indicates that the processing is even more complex and often bypasses what would in another *ego state* model be called *Integrated Adult*. It is as if all of the client's (and the therapist's) *ego states* will be working to maintain an existing frame of reference; they may *discount* whatever the other says or does that does not fit the preconceptions; they may also project elements from self into other; transference may be seen as an attempt to fill in gaps within a frame of reference so that the therapist will appear to complete the familiar frame. These misalignments will be exacerbated when the differences link to common stereotypes, such as different skin colour, sexual preferences, religion, etc.

Shivanath & Hireath's (2003) cultural *script matrix* indicates the cultural and religious script interposed between the dominant white society and the individual script. Roberts (1975) had previously suggested a model of several layers, or boundaries: culture, social class, provincial, ethnic, family, sexual and personal. I am not convinced that these are in the most logical order but they are more comprehensive. I think that economic might also be added at some level.

Economic status is a particular interest for me because I work in countries where the standard of living and incomes are much lower than in the UK. I agree with White (1994) when he points out that TA professionals in the financially advantaged countries should own to having two plusses for their *I'm OK* box

on the OK Corral (Ernst, 1971) and only one plus for the *You're OK* when this refers to those TA professionals (and people generally) in the financially disadvantaged countries – otherwise why are we not sharing the world's resources more fairly. I am particularly pleased with my achievement when, as ITAA President, I introduced the Talent. This policy, devised by Jennie and Mervyn Hine, states that ITAA fees will be pro-rated in line with differing economic circumstances. Likewise, when I work with individuals in economically-disadvantaged areas of the world, I charge fees at the rate for the country rather than the rate for the UK. This could be experienced as Rescuing (Karpman, 1968) rather than a positive outcome of my *script* character being Robin Hood. To counter this, I talk openly to the client about how I set my fees, how I operate as Robin Hood in the here-and-now to ensure that I earn enough money for my needs in 'richer' countries, and how I expect them to pay me based on their own level of income plus a 10-20% uplift. In this way we incorporate Steiner's (1974) contractual element of mutual consideration.

Planning and making interventions

There are some very interesting conceptual differences between TA authors when it comes to *ego states.* Functional is often confused with behavioural, even by Berne, and Stewart & Joines (1987) wrote that *Parent and Child* are respectively copies or replays from the past (p. 18) with only *Adult* being here-and-now (p. 12) but then suggest (p. 35) that we can go back into *Child* and access the intuition and creativity stored there, implying that we can use this now. They write "The functional model classifies observed behaviours, while the structural model classifies stored memories and strategies." (p. 36) and that 'constant *Adult*' (p. 54) means we function only as a data processor and can't join in the fun, which implies that this *Adult* is not in the here-and-now. I disagree with this and the way they use the metaphor of a heat pump; whilst structurally the pump may have a compressor, air ducts etc., we would do more than simply label them if we were interested in the structure of the pump – we would also want to know how old the parts are, whether there is any damage, etc. And functionally it would not be enough to talk about the pump heating or cooling the house – we want to know how well it is operating and when it goes wrong, we need to be able to speculate about which part may be causing the problem, and whether the various parts are working together as they were designed to, or are out of alignment, and so on. Hence I do not agree that we use functional model for interpersonal and structural model for intrapsychic; instead I believe that Berne's (1980) four elements of diagnosis apply to how we are functioning and models such as Levin's (1988) *cycles of development* are more relevant for understanding the content of structural *ego states* and how the parts became damaged.

For me, therefore, *decontamination* involves helping clients to become aware of: their behaviour (e.g. fidgeting, talking loudly); the social diagnosis or reactions of others , for which I may be relying for guidance on my own reaction in the moment, which is why I must be in the here-and-now and not regressing myself; the phenomenological or how they experience themselves to be, so what is happening for them, at this moment, within their own 'structure'; and the historical, as in can they recall when they were like this as a child or a parent figure was like it for them to copy? I sometimes add an additional 'diagnosis' of context as this can be a simpler way of raising their awareness of transference, by prompting them to realise that they may be responding to me (and others in daily life or the therapy group) as an authority figure, and/or a family member from the past.

To invite clients into here-and-now functioning, I might use the therapeutic operations (Berne, 1978), keeping in mind the need for these to be empathic transactions rather than something that is done to the client (Hargaden & Sills, 2002). With the client mentioned earlier, this has included, at various times: interrogation – "*Did you ever tell him how you felt about that?*"; specification – "*So you thought it was your fault that your father was not there?*"; confrontation – "*Can you imagine a positive intention behind your father wanting you to keep a low profile?*"; explanation – "*Perhaps that was your racket system going from not OK belief into resentful behaviour and stimulating the angry response.*"; illustration – "*So you're a clever kid at getting people to be angry with you?*"; confirmation – "*You've understood how you behaving like a victim is maintaining the pattern?*"*;* interpretation – "*So you now have the option of choosing a more positive feeling when someone reminds you of your father?*"*;* crystallisation - "*It sounds like you've understood the dynamic and you're ready to let it go.*"

Discounting provides a framework for problem solving that also invites clients into the here-and-now. I have taken the treatment levels in the *discount matrix* (Mellor & Schiff, 1975) and converted

them into a metaphorical set of '*steps to success'* (Hay, 2009). This makes it simple enough to share with clients so that I avoid the risk of appearing to solve their problems for them, as well as the risk of a *Yes but* game. I begin by explaining that discounting is a process that keeps us sane, as we tune out much incoming data so as not to be overloaded with stimuli. For example, we tune out background noise at a party in order to 'hear' what a companion is saying but we still notice if our name is spoken elsewhere in the room. This example implicitly gives the client *permission* to become aware of their discounting.

I then help the client review what they might be overlooking step by step through: the situation itself; the significance of it – why it's a problem – for the client; the possible solutions - there will always be some because *autonomy* brings options; the skills they need to make changes, or how they can acquire these; the strategy they can plan to implement chosen solutions; and finally how they might avoid sabotaging their own success, including acting to find support for change, both practically and in the form of changed stroking patterns. A variation of clean language (Tompkins & Lawley, 2003), without the strict syntax and voice tone, can be useful here – asking when, who, where, when, what, interspersed with occasional why and why not questions, helps me to avoid taking over the problem and 'solving' it for the client – or getting '*yes but'* responses.

Building on client strengths requires that I work within their frame of reference and also help them to expand it. Their strengths in terms of process will be their open doors to contact (Ware, 1983), for behaviour it will be the copies of parent figures and the recall of child states that are available to them to choose without regressing (whether we think of these as integrated or available for integration) plus psychological level modelling from therapist. Both sets of strengths also operate within their *working styles* (Hay, 2009), which comprise the useful elements of *drivers* (Clarkson, 1992).

Interpersonal process recall was devised by Kagan (Kagan & Kagan, 1980) and has much similarity to the way transactional analysts listen to recordings of their practice, although in the original IPR the focus would have been on how and what the subject was thinking and feeling rather than on analysis of the interactions, and it would be done immediately after the event. I have been listening to recordings of my practice since 1975. I may listen to a complete session and pick 'interesting' segments to analyse in depth or I may have identified 'interesting' interactions whilst with the client and will then find these afterwards. Much of my self awareness has been attained through analysing my recorded practice. Because we *discount*, I believe that this process is invaluable for identifying ways to increase competence. My original supervisor always asked for three options of how I might behave in a future similar situation – I still ask myself this, even for interactions that I think were effective.

Action research (Torbert, 2001) and especially critical ethnographies (Creswell, 1994) where the collection of observational data is analysed and provides the basis for challenges to the subjects in order to stimulate change, are in fact the normal way we practice – we collect data, form hypotheses, act on those (by our interventions with the client), observe the outcome, re-hypothesise, intervene again, and so until the contract is met. And of course listening to recordings is part of this process – and in a way we are also undertaking critical ethnographies of ourselves. Whilst doing this, I keep in mind that "… all research carries with it the ideological assumptions of the researcher, reflective of his or her time in history and position of power within a culture and subcultures." (Rowan, 2001).

Ruptures to the therapeutic relationship

I like to think that most ruptures in my practice arise because the client is 'telling' me what they need – although I do recognise that some will be due to my own lack of skill. Guistolise (1996) contends that "failures are *inevitable* during the course of any therapy, but that they are also *necessary* for the ultimate success of the therapeutic process." (p. 284, italics in original) I see that ruptures provide opportunities to identify what the client needs and is replaying from an early scene, and hence is a 'clue' for me about how I might respond in order to let the client know I have understood and that a different experience is possible. In other words, I will not repeat whatever the parental figures did in the early scene, or at least I will now stop repeating it if the rupture was due to me having accepted the invitation to begin with.

With the client already mentioned, for example, I felt invited to act as a mother (or grandmother) and to provide a corrective experience to meet a structural deficit (Stark, 2000). Instead, I prompted her to explore this and confronted her about what her mother's positive motivation might be for criticising. She recalled that her mother had been

traumatised as a small child when the communists turned the family out of their home and realised that the mother would have learned that maintaining a low profile was a survival issue.

With a different client, I became aware of a sequence of ruptures during the second session. Having started with an initial contract that she wished to develop a cognitive understanding of why she was exhibiting symptoms associated with anorexia after having been free of these for 4 years, we had completed an initial session during which she had exhibited interest and relief when I had explained how we would work with TA as a basis and given a brief description of how stroking patterns operate. In the second session she raised an issue about how some friends had verbally attacked her about her symptoms, apparently completely ignoring the progress she had been making in controlling her symptoms.

Having made what I thought was an empathic response, I then began to suggest ways in which she might understand what had happened. I 'suggested' she consider how the need for *strokes* – hers and theirs - might explain the dynamic; how she seemed to be oscillating between viewing the friends as all good before and now all bad and this might be what they were doing to her; and I invited her to think about why she had felt so upset by their behaviour and how she might be allowing them to define her identity. To each intervention, the client reacted with a polite, disguised *'yes, but'*. I was aware of increasing feelings of frustration and recognised (eventually!) the transference/ countertransference process. She responded to my final suggestion by telling me it was a great insight for her and a "wise" comment.

When reviewing the session, I considered first that the process can be interpreted as my own misattunement. My own *script* may be causing me to act as a *Rescuer* and try to make her feel better. Alternatively, the client may have been telling me something by her choice of story – perhaps she felt that I had not shown enough approval when she reported on her success at controlling her symptoms over the Christmas period. This could be a signal that her early experiences of nurturing was of the conditional, 'good girl to behave so well' *strokes*.

I can also interpret this sequence of ruptures followed by 'rapprochement' as the client attempting to contact me in the way she used in the past; concluding when that failed that it was her fault and something is wrong with her (Erskine 1994); reinforcing her need to control her eating because she cannot control much else; and finally changing from negation to total acceptance in order to feel there is still a good parent around.

Consideration of the next session prompts me to consider aspects such as:

- The need for me to take responsibility for my relational failure, and for the client to realise that it was not her fault – and to take this into the future and not be so ready to blame herself.
- The opportunity for the client to experience that there can still be relationship after rupture, and that this can occur without her having to apologise, which is what she usually does with friends and is struggling not to do on this occasion.
- That this is a breakdown in the communication system at number 2 (Lee 2008), where the client has reached out and I have failed to receive and hence need to redress an imbalance in power in the relationship.
- The likelihood that at some point the client will 'make' me the 'bad parent', and how I have unconsciously provided her with the necessary 'evidence' for that.

Closing Remarks

The above are some ideas about how transactional analysis can be applied. They are my personal thoughts and do not represent any 'official' statement about how it should be done. I hope that you will have found them thought-provoking and that you will want to learn more. I have given a range of references so feel sure there will be something there that will interest you.

I am happy to respond to questions and can be contacted on julie@juliehay.org or via www.juliehay.org, where there are other downloaded articles.

Glossary

(extracted and amended from Hay, J. (2009), *Working it Out at Work*, Hertford, UK: Sherwood Publishing)

Adult – one of the ego states, See also Integrated Adult

autonomy – script-free; being truly aware of the present, knowing you have alternative courses of action available to you, and that you can connect to other human beings

autonomy matrix – diagram showing impact of interactions between parent figures and child as basis for child's decisions about himself

Be Strong – one of five drivers; means that we are calm in a crisis but may appear unfeeling

Child – ego state: see Adapted Child, Natural Child

conditional stroke – unit of recognition that is only there 'on condition' that someone has done something; tends to be recognition for performance, appearance, etc.

Controlling Parent – one of the ego states we have available for interacting with others; used appropriately this style is firm; inappropriately and it becomes bossy and autocratic

cycles of development – cycle of stages in our development to adulthood, that then repeat throughout life; also repeated over shorter time spans related to significant changes in our lives

deconfusion – process of resolving unconscious conflicts within Child ego state

decontamination – process distinguishing when Parent or Child takes over but we think we are operating from here-and-now Adult; when we are affected by prejudices and fantasies but believe we are being rational

discount, discounting – process by which we unknowingly 'overlook' some aspect of the situation or people's abilities

discount matrix – chart showing how we discount e.g. at four levels: the stimulus (what is actually happening), the significance (that it is a problem), the solutions (that things could be resolved), and the skills (that someone is able to do something about it)

drivers – compulsive ways of behaving that become more evident when we are stressed; consist of Hurry Up, Be Perfect, Please People, Try Hard and Be Strong

ego states – states of being or behaving, typically referred to as structural – Parent, Adult, Child – and functional (behavioural) - Controlling Parent, Nurturing Parent, Adult, Adapted Child, Natural Child

games – more accurate label is 'psychological games': unconsciously programmed ways of behaving that result in repetitive interactions with others leading to negative payoffs

I'm OK, You're OK– belief about self and others that incorporates mutual respect, win/win approach; one of the life positions or windows on the world; each position can also be Not OK

imago, imagoes – mental image(s) we have in our heads, typically about groups and changing over time

Integrated Adult – label for Adult ego state that implies that useful material from Child and Parent ego states has been integrated into here-and-now functioning

life positions – set of ways in which we perceive the world, existential beliefs, typically expressed as I/You are OK or Not OK

Natural Child – one of the ego states we have available for interacting with others; used appropriately this style is friendly, creative and curious; used inappropriately it presents as immature and overly-emotional

Nurturing Parent – one of the ego states we have available for interacting with others; used appropriately this style is caring; used inappropriately it becomes smothering and stops other people developing their own skills

permission – belief that we need to have in order to fulfil our potential in life; 'antidote' to injunctions or attributions (e.g. it's OK to succeed, you can take your time)

physis – innate drive towards developing to our potential

Please People – one of five drivers; means that we want people to like us but may then be reluctant to challenge appropriately

Potency Pyramid – diagram which shows how we need to be to avoid psychological games: Powerful, Responsible, and Vulnerable

process scripts – themes of our unconscious life plans, and of short repetitive sequences of our behaviour; six themes are: never (get what you want); always (have to keep doing the same thing); until (can't have fun until all the work is done); after (you'll pay for pleasure later); over and over (keep on not quite getting there); open-ended (don't know what to do once the plan has been achieved)

psychological games –unconsciously programmed ways of behaving that result in repetitive interactions with others leading to negative payoffs

racket – behaviour that somehow manipulates people, as in protection rackets, but done outside our conscious awareness; substitute for genuine

emotions; familiar, habitual response that does not solve the problem

Rescuer – role we may adopt during psychological games: psychological role not to be confused with real rescuers

script – unconscious life plan, or story, that we 'choose' when young as a result of our interpretations of our interactions with the people around us, particularly our parents or other caregivers

script matrix – diagram that illustrates the processes whereby we form our scripts

Steps to success – metaphor for understanding the various levels of discounting and how to help someone overcome their own discounting

stroke – unit of human recognition, any way in which we let another person know we recognise their existence; may be positive or negative, conditional or unconditional, and vary in intensity

TA – abbreviation for transactional analysis

transaction – an interaction between people

transactional analysis (1) – body of theories and techniques, with unifying philosophy, for understanding human behaviour and developing autonomy and community

transactional analysis (2) – term originally used literally to mean analysing transactions in terms of ego states but this is now commonly referred to as transactional analysis proper

Try hard – one of five drivers; means that we put lots of enthusiasm into trying anything but may move on to new things before we finish our current project

ulterior transaction – an interaction between people in which there is another message being transmitted 'below the surface'

Victim – role on drama triangle; way we behave during psychological games: psychological role not to be confused with real victims

Yes, but - psychological game in which one party offers suggestions and the other rejects them, until one or other loses patience

working styles – developmental TA term to indicate the healthy, in awareness, application of drivers

* * *

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