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The International Journal of Psychotherapy is a leading professional and academic publication, which aims to inform, to stimulate debate, and to assist the profession of psychotherapy to develop throughout Europe and also internationally. It is properly peer-reviewed.

The Journal raises important issues in the field of European and international psychotherapy practice, professional development, and theory and research for psychotherapy practitioners, related professionals, academics & students.

The Journal is published by the European Association for Psychotherapy (EAP), 3 times p.a.

It is working towards obtaining a listing on Citation Indices and gaining an Impact Factor.

The focus of the *Journal* includes:

- Contributions from, and debates between, the different European methods and modalities in psychotherapy, and their respective traditions of theory, practice and research;
- Contemporary issues and new developments for individual, group and psychotherapy in specialist fields and settings;
- Matters related to the work of European professional psychotherapists in public, private and voluntary settings;
- Broad-ranging theoretical perspectives providing informed discussion and debate on a wide range of subjects in this fast-expanding field;
- Professional, administrative, training and educational issues that arise from developments in the provision of psychotherapy and related services in European health care settings;
- Contributing to the wider debate about the future of psychotherapy and reflecting the internal dialogue within European psychotherapy and its wider relations with the rest of the world;
- Current research and practice developments - ensuring that new information is brought to the attention of professionals in an informed and clear way;
- Interactions between the psychological and the physical, the philosophical and the political, the theoretical and the practical, the traditional and the developing status of the profession;
- Connections, communications, relationships and association between the related professions of psychotherapy, psychology, psychiatry, counselling and health care;
- Exploration and affirmation of the similarities, uniqueness and differences of psychotherapy in the different European regions and in different areas of the profession;
- Reviews of new publications: highlighting and reviewing books & films of particular importance in this field;
- Comment and discussion on all aspects and important issues related to the clinical practice and provision of services in this profession;
- A dedication to publishing in European 'mother-tongue' languages, as well as in English.

This Journal is therefore essential reading for informed psychological and psychotherapeutic academics, trainers, students and practitioners across these disciplines and geographic boundaries, who wish to develop a greater understanding of developments in psychotherapy in Europe and world-wide. We have recently developed new Editorial Policies that are available on the IJP website on the 'Ethos' page: **www.ijp.org.uk**

Editorial

Courtenay Young

Editor, International Journal of Psychotherapy

Dear Readers of – and Subscribers to – the International Journal of Psychotherapy (IJP). Over the years, we have had a number of 'Special Issues' of this Journal to date: There has already been: a Special Issue on '*Psychotherapy and the Internet*' (July 2006: Vol. 10, No. 2); a Special Issue on '*Different Approaches to Depression*' (July 2009: Vol. 13, No. 2); a Special Issue on '*R. D. Laing: 50 years after The Divided Self*' (July 2011: Vol. 15, No. 2), which was expanded into a published book by PCCS Books; a Special Issue on '*Roberto Assagioli & Psychosynthesis*' (July 2012: Vol. 16, No. 2); a Special Issue on '*Existential Psychotherapy*' (March 2015, Vol. 19, No. 1); an extra Special Issue on '*Mindfulness*' (July, 2016); a Special Issue on '*Psychodrama Psychotherapy*' (July 2017, Vol. 21, No. 2); and now, we are delighted to present you with another Special Issue: this time on '*Transactional Analysis Psychotherapy*'. We look forward to having many more of these Special Issues and we hope that you do too.

You will find out much more about this Special Issue in the Editorial that follows, from Biljana vanRijn & William Cornell: *Transactional Analysis Psychotherapy: A Humanistic Integrative Approach in the 21st Century.* This issue is 'sponsored' by the European Association for Transactional Analysis (EATA) and the International Transactional Analysis Association (ITAA).

We are also pushing forward to move the International Journal of Psychotherapy into 'modern times' so that it becomes much more of an Internet Journal, or an e-Journal: we have not yet found quite the right format and quite the right lay-out, but we are definitely moving ahead with this type of development. It will make it much more available. Printed copies will still be available to be ordered via the Internet. However, things might become easier as we are now cutting out quite a tortuous supply chain – even though it has worked for about 15 years – having the Journals printed in Lviv, Ukraine, then transported (somehow) to Budapest in Hungary, and then posted out from there. So, we are now trying to do something quite different. **Please watch this space!**

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Editorial to this Special Issue

Transactional Analysis Psychotherapy: An Integrative Humanistic Approach in the 21st Century

Biljana van Rijn & William F. Cornell

Transactional Analysis (TA) psychotherapy was developed in the 1950's by a psychiatrist, Eric Berne (E. Berne, 1958; Eric Berne, 1961), was one of the first integrative models for psychotherapy which combined a humanistic philosophy about the human nature and our innate drive towards growth and health with that of a psychoanalytic understanding of the internalised conflicts, conceptualised through his model of ego states (E. Berne, 1957). Furthermore, Berne developed an original theory and behavioural methodology for conducting treatment by defining observable outcomes for the treatment. Using humanistic sensibilities this way of working was transformed within the TA treatment into developing collaborative agreements about the direction and outcomes of psychotherapy.

From its inception, Transactional Analysis psychotherapy used deceptively simple terms to describe internal and intersubjective processes, such as Child, Adult and Parent ego states, life script and games. The simplicity of the language was intentional. Berne sought to develop psychotherapy where power and knowledge were shared between therapists and clients, working together on developing explicit aims for psychotherapy or therapeutic 'contracts'. The simplicity of the language had advantages in that it made some of these terms widely used in common parlance to the point where their origin is no longer recognised, and disadvantages, as it seemed to oversimplify the theory behind it and made the language jargonistic.

However, over the last 60 years or so, TA psychotherapy has continued to develop in both theory and application. It is practised internationally and has been facilitated by professional umbrella organisations. such as EATA (European Association for Transactional Analysis: eatanews.org) and ITAA (International Transactional Analysis Association: www.itaaworld.org).

Amongst the different schools of TA psychotherapy, the emphasis is placed on different aspects of the original theory: for example: 'Classical TA' is more focused on cognitive-behavioural outcomes and treatment; 'Relational TA' draws more on the psychoanalytic roots and is close to relational psychoanalysis; and 'Integrative TA' emphasises the humanistic and integrative nature of the early theory. These are not the only 'schools' of TA, as the international nature of the current TA treatment continues to foster a lively debate about

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both the theoretical concepts and ways of working as a therapist.

The theory of Transactional Analysis psychotherapy remains current. The concept of therapeutic agreements or 'contracts' is well supported by research on outcomes on psychotherapy and the importance of feedback and therapist responsiveness (Lambert, Whipple, & Kleinstäuber, 2018; Norcross & Lambert, 2018), as well as the current thinking on directionality (Cooper, 2019) and pluralism (Cooper & McLeod, 2011). The concept of working with ego states and the transferential enactments such as 'psychological game' and 'life script' is closely related to modern psychoanalytic approaches such as relational psychoanalysis (Aron, 2001; Mitchell, 1988; Orange, Atwood & Stolorow, 1997; Stolorow, Brandchaft & Atwood, 1987). Adding to the diversity of application, TA psychotherapy was practised as individual psychotherapy, as well as a group treatment (Berne, 1966), from its early development and it is being used in different settings and with different client groups.

Our aim in this issue was to present readers with a range of papers showing some of the diversity in modern thinking and working in Transactional Analysis psychotherapy, and some of its current research.

We start the issue with a paper on the mechanisms of change in Transactional Analysis psychotherapy: *"Why Transactional Analysis Works: Reasons for a Possible Explanation of Change in Psychotherapy"* from the perspective of socio-cognitive TA, developed originally by Pio Schiligo in Italy. This article is by **Laura Bastianelli, Maria Teresa Tosi, Rosanna Giacometto, Cinzia Messana** and **Davide Ceridono**, all from Rome, Italy.

We follow this article by revisiting the familiar concept of 'psychological games' from the perspectives of relational TA, *"Psychological Games in the Consulting Room"*, elaborating the theory and its application in therapeutic practice, which is written by **Jo Struthridge** (NZ) & **Charlotte Sills** (UK).

The following two papers: *"Relational Group Process: Developments on a Transactional Analysis Model of Group Psychotherapy"* by **Richard Erskine** (USA) and *"Working with Groups in TA: An Integrative Approach"* by **William Cornell** (USA) are in a dialogue with one another and show the current thinking about group-work, as well as the historical perspective and the approaches to group work. Both these papers were previously published in the Transactional Analysis Journal (2013) and are re-printed here with the kind permission of the authors, editor and publisher (Taylor & Francis).

The next two papers continue the theme of different forms of application: the first is focused on bodywork: *"A Psycho-Tactile Approach to Trauma"* by **Gerry Pyves** (UK): and *"Using Transactional Analysis to Treat Perinatal Mental Illness"* by **Emma Haynes** (UK).

Our final paper gives a meta-analytic review of case study research in TA psychotherapy, by **Enrico Benelli** and **Mariavittoria Zanchetta** from Padua, Italy. This article proposes a valid research tool for psychotherapy (much more appropriate than randomised controlled trials (RCT) using a manualised system of therapy, which is a systematic single-case design, supported by a meta-analytic review.

We recognise that, in this fairly small selection, these papers cannot – in any way – represent the full range of TA psychotherapy, its applications, research, or its diversity.

A much wider range of papers can be found in the annuals of (almost) 50 years of publication of the TA Journal (www.tandfonline.com/loi/rtaj20).

We really appreciate this collaboration with the International Journal of Psychotherapy and hope you enjoy this special issue.

Authors

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WILLIAM F. CORNELL, M.A., TSTA (P), maintains an independent private practice of psychotherapy and consultation in Pittsburgh, PA. Having studied behavioral psychology at Reed College in Portland, Oregon and phenomenological psychology at Duquesne University in Pittsburgh, Pennsylvania, he followed his graduate program with training in transactional analysis and body-centered psychotherapy and has studied with several mentors and consultants within diverse psychoanalytic perspectives. A co-editor of the Transactional Analysis Journal, Bill is also the author of '*Explorations in Transactional Analysis: The Meech Lake Papers, Somatic Experience in Psychoanalysis and Psychotherapy: In the Expressive Language of the Living (Routledge); 'Self-Examination in Psychoanalysis and Psychotherapy: Countertransference and Subjectivity in Clinical Practice'* (Routledge); *'At the Interface of Transactional Analysis, Psychoanalysis, and Body Psychotherapy: Theoretical and Clinical Perspectives'* (Routledge), *'Une Vie Pour Etre Soi'* (Payot), and a co-author and editor *'Into TA: A Comprehensive Textbook'* (Karnac), as well as numerous articles and book chapters. With Helena Hargaden, he co-edited *'From Transactions to Relations: The Emergence of a Relational Paradigm in Transactional Analysis' and 'The Evolution of Relational Paradigms in Transactional Analysis: What's the Relationship Got to Do with It?'*. Bill also edited and introduced '*The Healer's Bent: Solitude and Dialogue in the Clinical Encounter*', the collected papers of James T. McLaughlin; and *'Intimacy and Separateness in Psychoanalysis'*, the collected papers of Warren Poland. A co-editor of the Transactional Analysis Journal for fifteen years, Bill is now the Editor of the Routledge book series, "*Innovations in Transactional Analysis*". Bill is a recipient of the Eric Berne Memorial Award and the European Association for Transactional Analysis' Gold Medal, in recognition of his writing.

References

ARON, L. (2001). *A Meeting of the Minds: Mutuality in Psychoanalysis.* New York: Routledge.

BERNE, E. (1957). Ego States in Psychotherapy. *American journal of psychotherapy*, *11*(2), 293-309.

BERNE, E. (1958). Transactional Analysis: A New and Effective Method of Group Therapy. *American Journal of Psychotherapy*, *12*(4), 735-743.

BERNE, E. (1961). *Transactional Analysis in Psychotherapy; a Systematic Individual and Social Psychiatry*. New York: Grove Press.

BERNE, E. (1966). *Principles of Group Treatment*. Oxford: Oxford University Press.

COOPER, M. (2019). *Integrating Counselling & Psychotherapy: Directionality, Synergy and Social Change*. SAGE Publications.

COOPER, M. & MCLEOD, J. (2011). *Pluralistic Counselling and Psychotherapy*. Sage.

LAMBERT, M. J., WHIPPLE, J. L. & KLEINSTÄUBER, M. (2018). Collecting and Delivering Progress Feedback: A Meta-Analysis of Routine Outcome Monitoring. *Psychotherapy*, *55*(4), 520-537.

MITCHELL, S. A. (1988) *Relational Concepts in Psychoanalysis: An Integration*. Cambridge, MA: Harvard University Press.

NORCROSS, J. C. & LAMBERT, M. J. (2018). Psychotherapy Relationships that Work III. *Psychotherapy*, 55(4), 303-315.

ORANGE, D., ATWOOD, G. E. & STOLOROW, R. D. (1997). *Working Intersubjectively: Contextualism in Psychoanalytic Practice*. The Analytic Press.

STOLOROW, R.D., BRANDCHAFT, B. & ATWOOD, G.E. (1987). *Psychoanalytic Treatment: An Intersubjective Approach*. Hillsdale, NJ; Hove: Analytic Press.

Why Transactional Analysis Works: Reasons for a Possible Explanation of Change in Psychotherapy

Laura Bastianelli, Maria Teresa Tosi, Rosanna Giacometto, Cinzia Messana & Davide Ceridono

Abstract: The article presents a possible explanation for the efficacy of Transactional Analysis (TA) oriented psychotherapy, throughout the current dialogue between TA methodology and the reconsolidation process, discovered by neuroscientists at the end of last century. This hypothesis can enrich the debate between psychotherapy models about the issue of the common yet specific factor of change, promoting the integration of psychotherapies. Furthermore, the shift in the definition of ego states according to the theory of schema operated by Social-Cognitive Transactional Analysis is offered as a solid theoretical base to develop clinical research lines capable to integrate the analysis of quantitative and qualitative data, outcome and process studies, and verify the reconsolidation as specific ingredient of change hypothesis, for the benefit of clinicians, clients and trainees.

Key Words: social-cognitive transactional analysis, memory reconsolidation, ego states, schema, clinical research.

Introduction

We have come a long way since Eysenck published a provocative article in 1952, where he claimed that psychotherapy wasn't any more effective than the simple passage of time: (based on data that he collected), psychotherapy wasn't more effective than spontaneous remission without any treatment.

Although the methodology of that article has been strongly criticized (Bergin, 1971), it had the merit of stimulating the debate and more empirical research on the effectiveness of psychotherapy, instead of just settling for subjective interpretations of therapists and/or clients. From then, studies and publications have been increasing in this field and, in many quarters, the effectiveness of psychotherapy, or rather the effectiveness of various psychotherapies, has been confirmed and accepted. (e.g., Bergin, 1971; Lambert, 2013; Norcross, van den Boss & Freedheim, 2016a).

However, *"with isolated exceptions, we do not know why or how therapies achieve therapeutic*

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change" (Kazdin, 2009, 418). And again, *"We are still unable to explain completely their mechanism of change. In many ways, current knowledge on the outcome of psychotherapy can be viewed as correlational; that is a therapist performing a particular behavior, say, empathy or feedback or cognitive restructuring, correlates with and predicts a salubrious result, but its causal link cannot be conclusively demonstrated"* (Norcross *et al.*, 2016b, p. 481).

As a matter of fact, the frontier of research in psychotherapy focuses on the study of the mechanism behind the positive outcome of a psychotherapeutic treatment. *"Mechanism refers to the processes or events that are responsible for the change; the reasons why change occurred or how change came about [...] reflects the steps or processes through which therapy (or some independent variable) actually unfolds and produces the change. Mechanism explains how the intervention translates into events that lead to the outcome"* (Kazdin, 2009, p. 419).

To study and search for mechanisms behind the change in behaviour is important: to optimize results in psychotherapy; to make clear that a treatment can have both psychosocial and physical results; to go beyond the research area and also clarify the clinical practice; and to put in order and pare down the innumerable measures currently used: indeed, *"it is not likely that the different treatments produce change for different reasons"* (Kazdin, 2007, p. 4).

In this frame we found that the eye-opening work of Ecker (2018; Ecker *et al.*, 2012) about memory reconsolidation, can give the basis and an explanation of the deep and long-term process of change achieved in psychotherapy, no matter which approach is used, and it also perfectly combines with the strategical phases of Transactional Analysis (TA), and in particular of Social-Cognitive Transactional Analysis (SCTA) which favors the redecision model.

Basically, studying mechanisms behind the change in psychotherapy helps to bridge the gap between research and practice, which was a very important topic for Pio Scilligo (1990), SCTA founder, throughout his long career as researcher and clinical practitioner. His work that is still carried out by his colleagues in the Lab. for Research on the Self and Identity (LaRSI; De Luca & Tosi, 2011).

In fact, there is still some research on the outcome of TA psychotherapy and the importance of studying the effects of TA psychotherapy is underlined (Gelo, 2015; Ohlsson, 2010).

It is However, with a closer look, we can notice that there are some interesting and significant movements aimed at scientifically supporting the TA theoretical model and psychotherapy (see: Bastianelli, 2015-2016; Benelli *et al.*, 2017; Ceridono *et al.*, 2015; Ceridono *et al.*, 2018; Johnsson, 2011; Van Rijn, 2010; Widdowson, 2011).

In this article, we are going to show how referring to the rich empirical research on memory reconsolidation can contribute and scientifically confirm TA's clinical practice, which can take benefits from it, keeping pace and relevance within the actual psychotherapy scene, where many empirically validated operational protocols are increasing.

We think important to ride the challenge of researching those common factors that can explain psychotherapeutic change, highlighting the specific contribution of a specific theoretical model to it. At the same time, we also think that it is valuable to embrace the suggestions coming from clinical work that can motivate research, especially on personality and psychotherapy, in a circular process. In this sense, Transactional Analysis offers both interesting prompts to further research, considering its rich and multi-faceted practice, and attentive, pretty new research on it which needs to be fueled.

One of the core concepts of TA that has been discussed in order to consolidate its theoretical framework has been the concept of the 'ego

state'. Before addressing the issue of mechanisms of change, we therefore need to discuss this topic briefly, presenting the Social-cognitive Transactional Analysis perspective on it. Then, we will present the theory of change, according to Ecker, and its usefulness in enhancing the therapeutic process within a Transactional Analysis frame of reference. Finally, we will present the research work that is put forward by LaRSI on SCTA.

Ego States and Schema

The concept of 'ego states' is one of the main theoretical contributions by Eric Berne, the founder of Transactional Analysis. It has also inspired many authors who are not transactional analysts and who make use of it in their psychotherapeutic models (e.g., Young *et al.*, 2003), given their intuitive and yet profound capacity to explain personality.

This is not the place to present and debate the Bernian contribution, however we briefly want to give the Bernian definition of 'ego states' in order to present the development of that concept found in Social-Cognitive Transactional Analysis. For Berne, 'ego states' are coherent systems of feelings and experience that motivate a related coherent system of behavioural models (Berne, 1966). Child, Adult and Parent are three sets of 'ego states' that respectively refer to: the remnants of a person's early childhood; the capacity to analyse present reality; and the influence of real parents.

The 'ego states' concept represents a phenomenological advancement of the Freudian, Id, Ego and Super Ego, which means that they are 'mind states', with related behavioural models that can be observed in reality. They have a relational/interpersonal origin, and a potentially positive or negative function. When Berne described how 'ego states' function in relationship with self and others, he refers to affective and power dimensions in an implicit way (De Luca & Tosi, 2011). Important contributions to the concept of 'ego states' and a meta-analysis of its diverse models can be found in Trautmann & Erskine (1981), Erskine (1988, 1991), and Tudor (2010).

Scilligo (2009) redefines the concept of 'ego states', which is shown to be clinically effective in psychotherapeutic practice, having different goals in mind. Briefly, he wanted to: develop the concept of 'ego state' as a schema (a vision that we can find *"in nuce"* in the Bernian definition); overcome the distinction between structure and function, as referred to in 'ego states', which was plausible in Berne's age; give an operational definition of 'ego states', which allows one to make research *with* and *on* them; and to preserve and expand the rich interpersonal/relational root of Bernian theory, and its humanistic anthropological view (Scilligo, 2009; De Luca & Tosi, 2011; De Luca *et al.*, 2014; Tosi *et al.*, 2015).

This shift in the definition of 'ego states', according to the schema theory operated by Social-Cognitive Transactional Analysis, is one of the underlining aspects of this article. The concept of "schemas" appeared in the 1930's as a result of the effort to study the "structures of meaning".

A 'cognitive schema' referred to an internal structure or model of the external world by which individuals would make meaning of their experiences and decisions about living in the world. 'Ego states' are examples of schemas, which like the "person schema" (Horowitz, 1991), includes physical and psychological aspects, roles and transactions that can be described in terms of declarative and procedural knowledge (Anderson,1983; Kihlstrom, 1984, 1988). When a 'person schema' is activated neurologically and the individual acts according to its parameters, this is very similar to Bowlby's "internal working model" (Bowlby, 1980).

Until the early 80s, 'schemata' were seen

mainly as structures of the data 'stored' in memory. But it later became clear that this was not entirely accurate. Moreover, in the search for a concept capable of representing both the structural and flexible qualities of schemata, it was necessary to specify that they were not 'things', but 'emergent' processes evoked by the interaction of a great number of simple neural elements (McClelland *et al.*, 1986; Rumelhart *et al.*, 1986). That is to say, a 'cognitive schema' is activated or *instantiated* – brought into being – by an input or stimulus, either internal or external to the subject. And what is activated by this input is a group of connected 'units', which – physiologically – would be seen as a network of neural connections, regulated by the strength of their connections.

This radically different conception of memory, as an active process rather than a static entity, became part of what was called the "parallel distributed processing" (PDP) model. "Parallel" describes the way different activities within the neural network occur simultaneously rather than sequentially. "Distributed" describes how the representations of information, as connections, are spread throughout the network (McClelland *et al.*, 1986; Scilligo, 2005).

Learning is the result of experiences that gradually modify the strengths among the millions of neural connections that make up schemas. Contemporary neuroscience describes the way environmental stimuli or inputs, such as traumatic experiences, activate or 'teach' particular neural networks, strengthening their connections, which then tend to be reactivated by the interpretation of similar stimuli. Once a circuit has been activated, this increases the likelihood of its being reactivated again (Siegel, 1999).

We want to underscore one aspect of PDP models that seems important in relation to defining ego states. Nothing is 'stored' in memory; there is no huge library of ready-made schemas, or "tapes," as in the often-used technological metaphor of Berne's era. *"Rather, what is stored are the connection strengths between units that allow these patterns to be re-created"* (Rumelhart *et al.*, 1986, p. 31).

So, according to Norman (1986, p. 536) schemata are flexible configurations that: 1) reflect the regularity of experiences; 2) automatically fill in missing information; 3) automatically generalize from the past; and 4) are in ongoing transformation and adaptation to reflect the present situation of the organism and the environment (Scilligo, 2009, p. 61; Hine, 1997).

In other words, we can think of ego states as active social-cognitive processes, or schemas, continually being recreated in the dynamic interaction between the individual and her/his environment. Scilligo sustains that ego states are: *"complex schemas of emotional, cognitive and behavioural nature"* (Scilligo, 2009, p. 73) that define *"a cluster of mediation processes that build an interface between the external world and the behaviours acted by the individual in a circular process of adjustment and assimilation"* (Scilligo, 2009). Child, Adult and Parent are considered three prototypical ego states evolving during life. Readers interested in a description of SCTA framework and methodology, can consult: De Luca & Tosi, 2011; Scilligo, 2009; Tosi *et al.*, 2013; Tosi, 2016.

The Quest of the Specific Factor of Change in Psychotherapy: Incremental Change versus Transformational Change

As Transactional Analysts, we are loyal to Berne's idea that the purpose of our work is to cure the patient, rather than helping her making progress (Berne 1966). According to his ideas, we are trained to be capable to plan the treatment, knowing at each phase what we are doing and why we are doing it.

Transactional Analysis is a 'cure-oriented' therapy, which aims at effectiveness and healing, rather than to achieve a relief from the symptoms (even if this can be a first desirable goal). Berne reflected on the issue of cure and healing, putting together his humanistic philosophy with the view of the psychotherapist as a "real doctor", who has: "*to remove the obstruction for the patient to grow naturally in his own direction [...] to locate the healthy areas in each patient's personality so as to nurture them and strengthen their potential*" (Berne 1966, p. 63). After decades, these principles are still a point of reference and also a challenge, both as practitioners and researchers, even if the metaphors used by the TA founder to describe the psychotherapist sounds far from the actual view of the psychotherapy as a co-created, reciprocally transformative process. From this perspective, in SCTA "healing" is seen as a process that is realized in the protected space of the therapeutic relationship, where the schemas and the strategies of the ego states (connected to a discomfort, but expression of script dynamics perceived as protective and adaptive) can be safely updated. The question about the change process in psychotherapy, common factors and specific factors of change between different approaches is anyway something we are going to have to face, sooner or later.

It is useful now, for the purpose of this work, to focus briefly on a major discovery from neuroscience, capable of profoundly influencing the actual and future reflection on change and psychotherapy integration and that should stimulate a debate between, and inside, each methodological approach, including Transactional Analysis.

At the end of the 90's, several studies by neuroscientists have shown that the brain is capable of unlocking the synapses encoding a target of 'consolidated learning', that becomes labile, de-consolidating for a certain amount of time, before reconsolidating again (Nader, Schafe, & LeDoux, 2000; Przybyslawski *et al.*, 1999; Roullet & Sara, 1998; Sara, 2000).

In 2004, Pedreira, Pérez-Cuesta & Maldonado identified, more specifically, the human brain's built-in process for de-consolidating an emotional learning, allowing its unlearning, its erasure and substitution during the synaptic labile period: a sequence of two experiences is needed: memory reactivation, plus memory mismatch (a prediction error experience). This finding received confirmation by at least twenty-five studies, finally contrasting the acquired idea that problematic emotional learnings can't be dissolved, only over-ridden (see for example LeDoux, Romanski & Xagoraris, 1989; Roozendaal, McEwen, & Chattarji, 2009). Change strategies in psychotherapy can thus be divided into two distinct types: counteractive and transformational.

Counteractive methods, according to the well-known Hebb's law ("*Neurons that fire together, wire together*"), typically build a new preferred learning through extensive repetition over a prolonged period, that competes against and can regulate an unwanted emotional learning or schema (activating competing neural circuits). These contrasting strategies therefore rely on an *incremental* learning and imply frequent recurrences of the target dysfunctional schema, especially under stressful conditions. *Transformational* change through the reconsolidation sequence (named *Therapeutic Reconsolidation Process*, TRP) is profoundly different: it uses new learnings (vivid experiential knowledge) to *delete* or *update* problematic learnings, symptom cessation is fast and complete and not subject to relapse, and the client stays effortlessly symptom-free. In some cases, incremental strategies are necessary and transformational change can't be achieved due to the specific clinical situation (e.g., in cases of crisis, severe personality disorders, PTSD, dissociative states, etc.), and a "brain-wise" psychotherapist (Badenoch, 2008) should have a

wide range of skills to conduct efficiently and effectively the different kinds of clinic work. Quoting Ecker and colleagues (Ecker, Ticic and Hulley, 2012, p. 35):

> The prototype of counteractive, regulatory methods is (of course) 'extinction training', which is directly applied clinically in various forms of exposure therapy (e.g., Foa & Kozak, 1986; Foa & McNally, 1996; Tryon, 2005). However, there are many other regulatory approaches, which differ in the type of resources and experiences utilized for building up preferred new responses.
>
> The counteractive, regulatory strategy is predominant in the field of psychotherapy in such forms as cognitive-behavioural therapy (CBT) (e.g., Brewen, 2006; Dobson & Dobson, 2009; Hayes, Strosahl, & Wilson, 2003); solution-focused therapy (SFT) (e.g., Miller *et al.*, 1996), and systems of positive psychology (PP) (e.g., Gable & Haidt, 2005). Arden and Linford (2009) regard CBT as a form of emotional regulation and cite "brain science" to support that view; likewise, Brewen (2006, p. 765) reviews memory retrieval research indicating: *"that CBT does not directly modify negative information in memory but produces changes in the relative activation of positive and negative representations such that the positive ones are assisted to win the retrieval competition."*
>
> In-depth therapies, such as psychodynamic psychotherapy, also are usually conceptualized as regulatory. Therapy systems that concentrate on attachment disturbances, by using the client's experience of the therapist for new learning, are described by proponents as therapies of emotional regulation (e.g., Badenoch, 2008; Fosha, 2002; Della Selva, 2004).
>
> Methods used in this class of therapies tend to be richly experiential and emotionally deep and can yield either counteractive or transformational change, depending on how the methods are implemented by the individual practitioner.

The term 'regulatory' for the authors can therefore be used, both for counteractive and in-depth metodologies: these change approaches radically differ only when the latter achieve the erasure of an unwanted emotional learning.

> The erasure of an emotional learning is the dissolution of certain constructs in use by the emotional brain: this dissolution occurs only when these constructs receive such a direct and decisive disconfirmation through vivid new experience that the emotional brain itself recognizes and accepts the disconfirmation of its own constructs.
>
> In these moments of disconfirmation, what had seemed 'real' is finally recognized as being only one's own fallible constructs. Only upon their experiential disconfirmation are the constructs that make up emotional learnings recognized by the individual as constructs, rather than reality. The result of construct dissolution is a fundamental change in one's experience and perception of the world. Something that seemed self-evidently true about the world no longer seems true at all (Ibid, p. 55).

As Ecker and colleagues extensively describe, the transformational change in psychotherapy occurs when the client experiences the reactivation of the target learning (or schema), encoded into an emotional memory, together with the activation of a mismatch experience that destabilizes this 'old' knowledge that is motivating the problem/symptom; only then, the 'new' learning experience can nullify (or update) the target learning and reconsolidates itself differently using the same neural circuits.

These are the core steps of the 'erasure'/ transformational sequence:

1. Reactivation of target schema
2. Destabilization of target schema, via activation and mismatches using a contrary knowledge previously found (juxtaposition experience)
3. Nullification/updating of target schema: several repetitions of juxtaposition for target learning and disconfirming knowledge

The reconsolidation process can be verified observing three markers: (i) non-reactivation; (ii) symptom cessation; and (iii) effortless permanence. This is the '*specific'* treatment effect, differentiated from the 'therapeutic' effect, due to the relationship between the client and the psychotherapist, that is common to all the therapeutic methodologies.

Having identified the sequence that allows the re-consolidation process into the psycho-therapeutic setting, it seems now possible, accordingly to the actual knowledge of neuroscience, to identify *a common, yet specific factor*, the mechanism for profound and lasting change, which can be the subject of theoretical discussion and clinical research (for an in-depth discussion about incremental and transformational change, psychotherapy integration and the specific factor in common between therapies, see Toomey & Ecker, 2009; Ecker *et al.*, 2012; Ecker, 2018).

TA Methodology in Light of Incremental and Transformational Change

If we focus on Transactional Analysis, the new vision of 'ego states' as 'schemas' represents an important bridge between the psychotherapeutic practice and this theory of change. When an 'ego state' is instantiated, all its components are "active" and can be unlocked and updated. We could now say that these are feasible to pass in a deconsolidated state through the Therapeutic Reconsolidation Process. So, our hypothesis is that Transactional Analysis offers a methodology that allows to address different levels of change (incremental/counteractive or transformational) and Social-Cognitive Transactional Analysis offers a conceptual framework which enhances the therapeutic work and allows to make empirical research on it, as we will explain in the last part of this article.

Therapist and patient can address and clarify the different components and the origin of an ego state, explore the relationship among different ego states, build new adaptive competences through a counteractive strategy (de-contamination and re-learning stages), and/or work through the transformative change especially related to the affective/senso-motory component, deeply embedded in the affective/procedural memory (de-confusion stage). When the therapist and the patient want to explicitly address the transformational change, the therapeutic work takes on an experiential process, respecting the brain's rule which indicates that two opposite knowledge can't be true in the same time (Ecker, 2018).

Transactional Analysis psychotherapeutic methodology considers four stages in the treatment: alliance, de-contamination, de-confusion, re-learning (Berne 1961, Novellino, 1998). These four stages can be thought of as in a sequence, or in a circular process. As a matter of fact, they represent four different therapeutic processes which address different 'ego states' of the patient and different levels of change.

Broadly speaking, the alliance is a process which mainly involves the Adult and the Child 'ego states': the de-contamination's aim is to give power to the Adult; the de-confusion process deeply impacts on the Child; and the re-learning stage can be thought as a process,

which re-integrates the Parent, Child and Adult 'ego states'.

The alliance stage aims to co-create a collaborative therapeutic relationship both implicit (an affective, safe basis) and explicit (bilateral contract), ... *"which clearly defined the role (tasks and responsibilities) of the caregiver and the role (tasks and responsibilities) of the client. This emphasizes the equality of both parties and the fact that therapy [...] has a purpose that is stated at the beginning of the process"* (Cornell *et al.*, 2016, p. 190).

The decontamination is a process through which the patient becomes aware of the cognitive/affective/behavioural/somatic schemas connected with her symptoms or problems. The patient also understands the origin of the processes she suffers for, and how they pervade her experience of self, others and context. We think that this stage especially represents the incremental learning and change, insofar as it offers the possibility to expand the reflection on the nature of the patient's problems and the functional, present healthy options she can put in action. The implicit becomes explicit, the patient increases the consciousness of the underlying beliefs linked to her problems and intentionally begins to activate internal and external resources to follow alternative strategies to cope with life situations. The Adult ego state is taking charge in this kind of work, with the therapist acting from his/her Adult ego state to stimulate the patient towards the new awareness and learning (Berne, 1961).

Readers can find examples of simple, typical decontamination works, in Tudor (2003, pp. 212-213) or Mastromarino & Milizia, (1988, p. 201), translated here for readers.

C. I am in crisis because, when I stop working, I get depressed. It's like I must work all the time, and I don't want to do it anymore. *(Presentation of the problem and request.)*

T. What do you tell yourself to get depressed?

C. That I must work all the time, and there's nothing else that can make me feel right with myself.

T. Whom did you learn this idea of working all the time from?

C. From my dad, he worked day and night and he expected us to help him if we wanted to go ahead.

T. How many hours of work do you need now to go ahead?

C. I really don't have this kind of problem. I earn enough to afford even the unnecessary.

T. So, you keep doing something that before made sense but now it doesn't make sense anymore. *(This stresses the actual inadequacy of the script behaviour.)*

C. That's right!

T. So, what do you want to do?

C. I want to stop work myself to death. *(A new decision by Adult 'ego state'.)*

T. And how are you going to do that? *(This stimulates the concrete application of the new decision.)*

C. As other human beings do: I won't work more of eight hours per day.

In the de-confusion stage, the patient and the therapist are involved in an in-depth process, which can take the form of transformational learning. We underline "can" because different Transactional Analysis approaches help to determine a regulatory/counteractive change, or a transformational change.

In SCTA, we use the 'redecision' process as a transformational process that proposes an experience that is antithetic to the old, unwanted one, linked to script beliefs and emotional learnings. The Child and Adult 'ego states' are both involved into the process (Goulding and Goulding, 1979), and the Child 'ego state' a is

the most impacted by the process. In this stage the old schema is completely reprocessed in all its components and a new schema takes the place of the old one. Examples illustrating a redecision work that shows one of the options to create the mismatch experience can be found into Ecker, Ticic, Hulley and Bastianelli (2018a, pp. 8-9) and Mastromarino and Milizia (1988, pp. 201-202). As above, the latter is a didactic example that we translate here for readers.

C. I am sad.

T. What makes you sad?

C. It is not important to ask it to yourself and to figure it out, I am sad, I am just sad.

T. How do you make yourself sad?

C. I say to myself that I mean nothing here, it's like I am not even here. *(Shows the client's belief in the script.)*

T. So, you think you mean nothing, and this makes you sad.

C. I always knew it! *(Starts crying.)*

T. Where did you get this idea from?

C. At home, with my dad.

T. Stay with this and see what dad does or says. *(This encourages the re-enactment of an old experience.)*

C. He doesn't look at me, he doesn't say 'hi' to me, if I show myself too much, he gets angry and he kicks me out. *(Still crying.)*

T. What you decide to do for yourself?

C. That he will not see me.

T. Tell him! *(This encourages direct communication with the father and the contact with the 'script decision' linked to the emotion.)*

C. You will not see me! *(Cries and contracts the jaw.)*

T. Is that what you want? *(This enhances the consciousness of a genuine need.)*

C. No! *(Cries.)*

T. So, what you want from him?

C. I want him to see me!

T. Tell him! *(Enhances the direct manifestation of the need.)*

C. I want you to see me! *(Hit many times the arm of the chair.) (Directly expresses the genuine need.)*

T. Say: "I want to be seen!"

C. I want to be seen *(a little bit hesitant)*.

T. True or false?

C. True! ... Completely true. I want to be seen! I am here! Even though you don't see me *(talks to his father again)*.

T. How does it feel to be seen here?

C. *(laughs)* It feels good *(looks around)* and nothing bad happens to me! *(He verifies in the present the implementation of the redecision.)*

> *"First, the therapist enhances the consciousness of the script belief through the exploration of the sadness. Then he promotes the re-enactment of an old scene that helps the patient expressing, in contrast with the script decision, his genuine and actual need of being seen. The successful experience of being seen in the group, allows the implementation of the redecision."* (Mastromarino & Milizia, 1988)

In the re-learning stage, therapeutic attention is given to the consolidation of the new learning and the discovery of new behavioural options, and, eventually, to the separation process from the therapeutic relationship. All three ego states are involved in this process, because we think that therapeutic change influences the emotional experience of the Child, the development of an Adult capable to evaluate, and responsibly choose in the present reality, and the principles and norms of the Parent.

In Table 1, we summarize the four stages of the treatment according to SCTA methodology with a linkage to the TRP sequence proposed by Ecker, Ticic and Hulley (2012).

Table 1
Transactional Analysis strategic stages and TRP sequence proposed by Ecker *et al.* (2012)

TA treatment stages	TRP phases	TRP steps	NOTES
Alliance - Exploring the problem - Symptom identification - Questionnaires for pre-treatment evaluation - Empathic relationship - Collaboration - Explicit Psychotherapy contract	I. Accessing sequence	A. Symptom identification	
Decontamination *Discovery* and *Explicit* consciousness of: - Exploring the problem - Symptom identification - Questionnaires for pre-treatment evaluation - Empathic relationship - Collaboration - Explicit Psychotherapy contract		B. Retrieval of target learning	
- Antithetic experience retrieval/activation (Activation of antithetic relationship continues increasing the introjection of new knowledge about relationships)		C. Identification of disconfirming knowledge	The therapist can choose, according to the contract and the situation, to follow a counteractive, incremental strategy reinforcing the new, desired schema.
Deconfusion 1. Contact with the old "script decision" and activation of the involved Ego States 2. Individuation and expression of authentic emotions and need/s, "redecision" at the light of a new knowledge/experience. 3. Repetitions of the experience during redecision process and application to the present situation.	II. Transformation sequence	1. Reactivation of target learning 2. Activation of disconfirming knowledge, mismatching target learning 3. Repetitions of mismatched pairing	Different TA redecision techniques can achieve the goal of creating the juxtaposition of the two, competitive knowledges. Implicit juxtaposition experiences could occur even without an intentional intervention of the therapist nor awareness of the client, during/after decontamination stage.
Re-learning - Practicing and reinforcing new options in case of incremental change - Verification of schema nullification/updating in case of transformational change and validation of effortless permanence signs of schema nullification - Separation process from the therapeutic relationship	III. Verification phase	V. Verification of target learning erasure: - Symptom cessation - Non-reactivation of target learning - Effortless permanence	

A first confirmation of the validity of our hypothesis (that reconsolidation and TRP could be explicative of SCTA efficacy) came from Ecker and colleagues, who recently studied a clinical case conducted by a SCTA trainee to retrieve the steps of the TRP into the transcripts of the therapy sessions (Ecker *et al.*, 2018a; Ecker *et al.*, 2018b, pp. 184-197). This study represents – for us – the starting point to promote its solid validation through adequate clinical research protocols, and a demonstration that TRP and redecision *are not* mechanical processes, but emerge in the contest of a deeply empathic therapeutic relationship.

Reframing the TA Research Approach

As we have said, we consider SCTA as a useful and adequate framework that supports clinical research as it allows:

> *"to address different levels of change during the therapeutic process and offers operational definition of the concept to observe and describe ego states according to specific criteria which allow us to do empirical research and make direct clinical interventions. […] Child, Adult, Parent are the names given to prototypical ways of behaving, feeling and thinking with reference to the affiliation, interdependence and developmental dimensions, which can be manifested at interpersonal and intrapsychic levels. All three ego states are always present and each of them may be more prominent in different stages or contexts in life."* (Tosi *et al.*, 2013, p. 109)

Ecker, introduces his recent article (2018) referring to a passage written by Kazdin (2007, p. 1) and underlining the same issue that we mentioned in this article's introduction:

> *"After decades of psychotherapy research, we cannot provide an evidence-based explanation for how or why even our most well studied interventions produce change, that is, the mechanism(s) through which treatments operate"*

and then he proposes:

> *"that a fundamental breakthrough in that dilemma may be developing through the translation of memory reconsolidation neuroscience into clinical application"* (Ecker, 2018, p. 3).

Specifically, he highlights that:

> *"evaluating claims of methodology evidence by rigorously examining published clinical procedures in relation to reconsolidation research findings seems necessary and legitimate in support of the clinical field acquiring accurate, and thereby maximally effective, knowledge of the workings of reconsolidation"* (Ecker, 2018).

We consider it possible to accomplish this goal of studying outcomes and therapy processes in SCTA, referring to a reconsolidation of 'ego states' in terms of schema. SCTA and TRP actually have elements in common that can justify the predisposition and actualization of both quantitative and qualitative research plans for this purpose.

In our clinical centres, we have already collected a notable amount of data that:

> *"[…] allowed outcome studies that showed a pre- to post-treatment change in perception of Self ego states coherent with the aim of the treatment and related to the ego states activated in the therapeutic relationship (Ceridono & Viale, 2013). Also, another study found a change in perception of Self ego states coherent with the aim of the treatment, a post treatment recovery in 65% of client and improvement in 85%, with changes maintained at the six-month follow-up (Ceridono, et. al. 2015). In order to integrate the extensive research conducted on all cases of psychotherapy delivered in our training clinics we are developing a multi-perspective method for single case study."* (Ceridono et al., 2018).

In a restricted number of cases, the variation of physiological parameters during the psychotherapy treatment is also examined, with a

confirmation of positive outcome after treatment (Bastianelli, 2015-2016; Bastianelli & Tauriello, 2015).

LaRSI is conducting a wide range of studies, including a current research granted by EATA (European Association for Transactional Analysis) focused on: the efficacy of psychotherapy; the assessment of the construct validity of the theoretical model; and the study of the change processes and procedures.

Conclusions

In this article, we hope to have communicated our curiosity for what the basic mechanisms explaining change in the psychotherapeutic process are; our enthusiasm for research work in our field; and our wish to make Transactional Analysis well-known as a model that has much to offer to help with general well-being.

TA is a multi-faceted model, and SCTA wants to develop its humanistic, interpersonal and psychosocial frame of reference, favouring an attention to its scientific basis together with the effectiveness in its practice. The creation and development of SCTA is intertwined with an almost fifty years of experience in training psychotherapists, so we can say that it is the outcome of a long collaboration among students, trainers and colleagues, started by Pio Scilligo.

Supervision and training programs in our training institutes are impacted deeply by this model, and by the research that we put forward on clinical work, trainees' development and theoretical constructs (de Nitto *et al.*, 2013; Tauriello *et al.*, 2015).

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References

ANDERSON, J. R. (1983). *The Architecture of Cognition.* Cambridge, MA: Harvard University Press.

ARDEN, J. B. & LINFORD, L. (2009). *Brain-Based Therapy with Adults: Evidence-Based Treatment for Everyday Practice.* Hoboken, NJ: John Wiley & Sons.

BADENOCH, B. (2008). *Being a Brain-Wise Therapist: A Practical Guide to Interpersonal Neurobiology.* New York: W.W. Norton & Co.

BASTIANELLI, L. (2015-2016). Effetti neurovegetativi della psicoterapia analitico transazionale [Neuro-vegetative effects of transactional analytical psychotherapy]. *Psicologia, Psicoterapia e Salute*, Vol. 21, (3) – Vol. 22, (1), pp. 239-261.

BASTIANELLI, L. & TAURIELLO, S. (2015). TA Treatment in a Clinic Centre: Heart Rate Variability as Outcome Measure Related to Ego States Profile. In: K. Brajovc Car & Benelli, E. (Eds.), *Book of Abstract: Theory and Development Research Conference of EATA*, (pp. 19-20). Padova, CLEUP.

BENELLI, E., FILANTI, S., MUSSO R., CALVO, V., MANNARINI, S., PALMIERI, A. & WIDDOWSON, M. (2017). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study – 'Caterina'. *International Journal of Transactional Analysis Research*, Vol. 8 (1), pp. 21-38.

BERNE, E. (1961). *Transactional Analysis in Psychotherapy: A Systematic Individual and Social Psychiatry.* New York: Grove Press.

BERNE, E. (1966). *Principles of Group Treatment.* New York: Oxford University Press.

BOWLBY, J. (1980). *Loss: Vol. 3 of Attachment and Loss.* New York: Basic Books.

BREWIN, C. R. (2006). Understanding Cognitive-Behaviour Therapy: A Retrieval Competition Account. *Behaviour Research and Therapy*, Vol. 44, pp. 765-784.

CERIDONO, D., PEROTTO, N. L., BACA, E., BIANCHINI, S., MESSANA, C., RICCIOLI, E., MONTIXI, M. C. & LOI, E. (2015). The Outcome of TA Psychotherapy in Training Clinics according to the SCTA Model: Pre to Post Change and Six-Month Follow-up in Self Ego States and in CORE-OM Measures. *Paper at the 1st EATA TA Theory Development & Research Conference*, Rome: 9th-11th July 2015.

CERIDONO, D., TOSI, M. T., BASTIANELLI, L., BIANCHINI, S. & DE NITTO, C. (2018). A Multi-Perspective Method for Single Case Study of Social-Cognitive Transactional Analysis Psychotherapy Delivered in Training Clinics. *Paper at the EATA Theory Development and Research Conference*, London July 5th-6th, 2018.

CERIDONO, D. & VIALE, D. (2013). Ego States in the Therapeutic Relationship and Pre- to Post-Treatment Change in Self Ego States, *International Journal of Transactional Analysis Research*, Vol. 4, (1), pp. 49-58.

CORNELL, W. F., DE GRAAF, A., NEWTON, T. & THUNNIESSEN, M. (2016). *Into TA: A Comprehensive Textbook on Transactional Analysis.* London: Karnac Books.

DELLA SELVA, P. C. (2004). *Intensive Short-Term Dynamic Psychotherapy: Theory and Technique.* London: Karnac Books.

DE LUCA, M. L. & TOSI, M. T. (2011). Social-Cognitive TA: An Introduction to Scilligo's Model of Ego States. *Transactional Analysis Journal*, Vol. 41, pp. 206-220.

DE LUCA, M. L., GUBINELLI M. & TOSI M. T. (Eds.) (2014). International Colloquium about Social-Cognitive Transactional Analysis [Special Issue in Italian and English], *Psicologia Psicoterapia e Salute*, Vol. 20, (1/2/3).

DE NITTO, C., BIANCHINI, S. & TOSI, M. T. (2013). Theory, Research, Clinical Practice and Training: a Virtuous Circle through Social Cognitive Transactional Analysis. *International Journal of Transactional Analysis Research*, Vol. 4, (1), pp. 59-66.

DOBSON, D. & DOBSON, K. S. (2009). *Evidence-Based Practice of Cognitive-Behavioural Therapy.* New York: Guilford Press.

ECKER, B. (2018). Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production. *International Journal of Neuro-psychotherapy*, Vol. 6 (1), pp. 1-92.

ECKER, B., TICIC, R. & HULLEY, L. (2012). *Unlocking the Emotional Brain: Eliminating symptoms at their roots using memory reconsolidation.* New York: Routledge.

ECKER, B., TICIC, R., HULLEY, L. & BASTIANELLI, L. (2018a). *A Demonstration of Social-Cognitive Transactional Analysis Implementing the Therapeutic Reconsolidation Process.* Coherence Psychology Institute LLC.

ECKER, B., TICIC, R., HULLEY, L. (2018b). *Sbloccare il cervello emotivo. Eliminare i sintomi alla radice utilizzando il riconsolidamento della memoria.* [L. Bastianelli Ed; it. Transl. of *Unlocking the Emotional Brain: Eliminating Symptoms at their Roots Using Memory Reconsolidation*]. 2012, New York: Routledge) Milano: Franco Angeli.

ERSKINE, R. G. (1988). Ego Structure, Intrapsychic Function, and defense Mechanisms: A Commentary on Eric Berne's Original Theoretical Concepts. *Transactional Analysis Journal*, Vol. 18, pp. 15-19.

ERSKINE, R. G. (1991). Transference and Transactions: Critiques from an Intrapsychic and Integrative Perspective. *Transactional Analysis Journal*, Vol. 21, pp. 63-76.

EYSENCK, H. J. (1952). The Effects of Psychotherapy: An Evaluation. *Journal of Consulting Psychology*, Vol. 16, pp. 319-324.

FOA, E. B. & KOZAK, M. J. (1986). Emotional Processing of Fear: Exposure to Corrective Information. *Psychological Bulletin*, Vol. 99, pp. 20-35.

FOA, E. B. & MCNALLY, R. J. (1996). Mechanisms of Change in Exposure Therapy. In: R. M. Rapee (Ed.), *Current Controversies in the Anxiety Disorders,* (pp. 329-343). New York: Guilford Press.

FOSHA, D. (2002). The Activation of Affective Change Processes in AEDP (Accelerated Experiential-Dynamic Psychotherapy). In: J. J. Magnavita (Ed.), *Comprehensive Handbook of Psychotherapy*, Vol. 1, (pp. 309-344). New York: John Wiley & Sons Inc.

GABLE, S. L. & HAIDT, J. (2005). What (and Why) is Positive Psychology? *Review of General Psychology*, Vol. 9, pp. 103-110.

GELO, O. (2015). Scientific Validation of TA Theory – How Can Basic TA Concepts Be Empirically Validated to Reach Scientific Recognition? In: K. Brajovc Car & E. Benelli (Eds.), *Book of Abstract: Theory and Development Research Conference of EATA*, (pp. 11-12). Padova, CLEUP.

GOULDING, R. L. & GOULDING, M. M. (1979). *Changing Lives Through Re-Decision Therapy.* New York: Grove Press Inc.

HAYES, S. C., STROSAHL, K. D. & WILSON, K. C. (2003). *Acceptance and Commitment Therapy: An Experiential Approach to Behaviour Change.* New York: Guilford Press.

HINE, J. (1997). Mind Structure and Ego States. *Transactional Analysis Journal*, Vol. 4, pp. 278-289.

JOHNSSON, R. (2011). *Transactional Analysis Psychotherapy: Three Methods Describing a Transactional Analysis Group Therapy.* Department of Psychology, Lund University.

KARPIAK, C. P., NORCROSS, J. C. & WEDDING, D. (2016). Evolution of Theory in Clinical Psychology. In: J. C. Norcross, G. R., van den Boss & D. K. Freedheim (Eds.), *APA Handbook of Clinical Psychology (Vol. 2): Theory and research,* (pp. 3-17). Washington, DC: American Psychological Association.

KAZDIN, A. E. (2007). Mediators and Mechanisms of Change in Psychotherapy Research. *Annual Review of Clinical Psychology*, Vol. 3, pp. 1-27.

KAZDIN, A. E. (2009). Understanding How and Why Psychotherapy Leads to Change. *Psychotherapy Research*, Vol. 19 (4-5), pp. 418-428.

KIHLSTROM, J. F. (1984). Conscious, Subconscious: A Cognitive Perspective. In: K. S. Bower & D. Meichenbaum (Eds.), *The Unconscious Reconsidered,* (pp. 149-211). New York: Wiley.

KIHLSTROM, J. F. (1988). Personality. In: E.R. Hilgard (Ed.) *Fifty Years of Psychology: Essays in Honor of*

Floyd Ruch, (pp. 139-152). Glenview, IL: Scott, Foresman.

LAMBERT, M. J. (2013). The Efficacy and Effectiveness of Psychotherapy. In: M. J. Lambert (Ed.), *Bergin & Garfield's Handbook of Psychotherapy and Behaviour Change (6th Ed.)*, (pp. 169-218). New York: Wiley.

LEDOUX, J. E., ROMANSKI, L. & XAGORARIS, A. (1989). Indelibility of Subcortical Emotional Memories. *Journal of Cognitive Neuroscience*, Vol. 1, pp. 238-243.

MASTROMARINO, R. & MILIZIA, M. G. (1988). Per lavorare sulle impasse: un videonastro didattico [To work on the impasses: an educational videotape]. *Polarità*, Vol. 2, (1), pp. 199-205.

MCCLELLAND, J. L., RUMELHART, D. E. & THE PDP RESEARCH GROUP. (1986). *Parallel Distributed Processing: Explorations in the microstructure of cognition, (Vol. 2).* Cambridge, MA: MIT Press.

MILLER, S. D., HUBBLE, M. A. & DUNCAN, B. L. (1996). *Handbook of Solution-Focused Brief Therapy.* San Francisco: Jossey-Bass Publishers.

NORCROSS, J. C., VAN DEN BOSS, G. R. & FREEDHEIM, D. K. (Eds.) (2016a). *APA Handbook of Clinical Psychology: Vol. 2. Theory and Research*. Washington, DC: American Psychological Association.

NADER, K., SCHAFE, G. E. & LEDOUX, J. E. (2000). Fear Memories Require Protein Synthesis in the Amygdala for Reconsolidation after Retrieval. *Nature*, Vol. 406, pp. 722-726.

NORCROSS, J. C., VAN DEN BOSS, G. R. & FREEDHEIM, D. K. (2016b). Recent Developments and Future Directions in Clinical Psychology. In: J. C. Norcross, G. R. van den Boss & D. K. Freedheim (Eds.), *APA Handbook of Clinical Psychology: Vol. 5. Education and Profession*, (pp. 471-487). Washington, DC: American Psychological Association.

NORMAN, D. A. (1986). Reflection on Cognition and Parallel Distributed Processing. In: J. L. Mc Cleveland & D. E. Rumelhart (Eds.), Parallel Distributed Processing: *Explorations in the Microstructure of Cognition* (Vol. 2), (pp. 531-546). Cambridge, MA: MIT Press.

NOVELLINO, M. (2001) L'approccio clinico dell'analisi transazionale. *Milano. Franco Angeli.*

OHLSSON, T. (2010). Scientific Evidence Base for Transactional Analysis in the Year 2010. *International Journal of Transactional Analysis Research*, Vol. 1 (1), pp. 4-11.

PEDREIRA, M. E., PÉREZ-CUESTA, L. M. & MALDONADO, H. (2004). Mismatch between What Is Expected and What Actually Occurs Triggers Memory Reconsolidation or Extinction. *Learning & Memory*, Vol. 11, pp. 579-585.

PRZYBYSLAWSKI, J., ROULLET, P. & SARA, S. J. (1999). Attenuation of Emotional and Non-Emotional Memories after their Reactivation: Role of Beta-Adrenergic Receptors. *Journal of Neuroscience*, Vol. 19, pp. 6623-6628.

ROOZENDAAL, B., MCEWEN, B. S. & CHATTARJI, S. (2009). Stress, Memory and the Amygdala. *Nature Reviews Neuroscience*, Vol. 10, pp. 423-433.

ROULLET, P. & SARA, S. J. (1998). Consolidation of Memory after its Reactivation: Involvement of Beta Noradrenergic Receptors in the Late Phase. *Neural Plasticity*, Vol. 6, pp. 63-68.

RUMELHART, D. E., MC CELLAND, J. L. & THE PDP RESEARCH GROUP. (1986). *Parallel Distributed Processing: Explorations in the Microstructure of Cognition.* (Vol. 1). Cambridge, MA: MIT Press.

SARA, S. J. (2000). Retrieval and Reconsolidation: Toward a Neurobiology of Remembering. *Learning &*

Memory, Vol. 7, pp. 73-84.

SCILLIGO, P. (1990). La ricerca clinica e la prassi psicoterapeutica: una valle da colmare. *Rivista di Psicologia Clinica*, Vol. 2, pp. 104-125.

SCILLIGO, P. (2005). *La nuova sinfonia dei molti sé.* Rome, Italy: LAS

SCILLIGO, P. (2009). *Analisi Transazionale Socio-Cognitiva.* Roma. Ed. LAS.

SIEGEL, D. J. (1999). *The Developing Mind.* New York: Guilford Press.

TOOMEY, B. & ECKER, B. (2009). Competing Visions of the Implications of Neuroscience for Psychotherapy. *Journal of Constructivist Psychology*, Vol. 22, pp. 95-140.

TOSI, M. T. (2016). Social-Cognitive Transactional Analysis: From Theory to Practice. In: *R. G. Erskine (Ed.), Transactional Analysis in Contemporary Psychotherapy*, (pp. 229-255). London: Karnac Books.

TOSI, M. T., DE LUCA, M. L. & GUBINELLI, M. (2015). Researching in the Transactional Analysis Community. In: *K. Brajovc Car & E. Benelli (Eds.), Book of Abstract. Theory and Development Research Conference of EATA*, (pp. 73-74). Padova, CLEUP.

TOSI, M. T., DE NITTO, C. & BIANCHINI, S. (2013). A Social-Cognitive Definition of Ego States to Implement TA Research. *International Journal of Transactional Analysis Research*, Vol. 4, (1), pp. 107-112.

TRAUTMANN, R. L., & ERSKINE, R.G. (1981). Ego state analysis: A comparative view. *Transactional Analysis Journal*, Vol. 11, pp. 178-185.

TRYON, W. W. (2005). Possible Mechanisms for Why Desensitization and Exposure Therapy Work. *Clinical Psychology Review*, Vol. 25, pp. 67-95.

TUDOR, K. (2003). The Neopsyche: the Integrating Adult Ego State. In: Sills, C., Hargaden H. *Key Concepts in Transactional Analysis. Contemporary Views*. pp. 201-231.

TUDOR, K. (2010). The State of the Ego: Then and Now. *Transactional Analysis Journal*, Vol. 40, pp. 3-4, pp. 261-277.

VAN RIJN, B. (2010) Evaluating Our Practice. In: S. Bager-Charleson (Ed.), *Reflective Practice in Counselling and Psychotherapy*. Exter: UK. Learning Matters.

YOUNG, J. E., KLOSKO, J. S. & WEISHAAR, M. E. (2003). *Schema Therapy: A Practitioner's Guide.* New York, NY: Guilford Press.

WIDDOWSON, M. (2011). Case Study Research Methodology. *International Journal of Transactional Analysis Research*, Vol. 2 (1), pp. 25-34.

Psychological Games in the Consulting Room

Jo Stuthridge & Charlotte Sills

Abstract: In this article, we describe some of our thinking about working with the transferential dramas that Eric Berne referred to as *"psychological games"*. A game involves a repetitive sequence of interpersonal events, similar to the psychoanalytic concept of enactments. Berne understood these interpersonal dynamics as an unconscious attempt to reinforce defenses and therefore something to be avoided in the consulting room; however, in this paper we explore how the therapist's participation in a game can become an important avenue for "hearing" the client's unspoken communication. Drawing on the work of various psychoanalysts and relational thinkers alongside Berne's concept of 'degrees of games,' we elaborate a way that psychotherapists can think about and resolve games in a way that enhances the psychotherapeutic work, through analyzing counter-transferential responses.

Key Words: Berne, countertransference analysis, drama triangle, enactment, psychological game, relational transactional analysis, script.

Introduction

CA game is a relational interaction between two or more people which contains what Berne (1961) called ulterior (unconscious) messages. It is akin to what is called 'enactment' in psychoanalytic approaches in that both are an attempt to actualize a transference expectation through an exchange of unconscious nonverbal interactions (Jacobs, 1986; McLaughlin, 1987) In 1964, Berne articulated the defensive functions of games in terms of attempts to meet psychobiological needs while maintaining the limitations of *script* (a largely unconscious life plan based on past experiences, stored in *ego states* comprising the internalized experience of others: Parent ego state, and the experience of self – Child ego state. (Berne, 1961). These needs are such as recognition, predictability, avoidance of pain and relief of tension. His last description (published in 1974 some time after his death) states that games are "sets of ulterior transactions, repetitive in nature, with a well-defined psychological *payoff*" (our italics) (Berne, 1974, p. 23). The 'payoff' is a familiar feeling that confirms the transference expectation.

Like all therapists, we both spent many years in training and personal therapy learning how

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to reduce the impact of our personal proclivities and defenses on our professional lives. We learned how to avoid playing games with clients. However, clinical experience has led us to face the inescapable fact of the presence of *ourselves* in the therapy room; we accept that self-awareness is a lifelong task, that therapy is never complete, and that a therapist always arrives in the room with her vulnerabilities, blind spots and unconscious defenses – her script – in addition to her expertise. Indeed, we have become interested in how this mutuality of "flawedness" has the capacity to foster growth in a therapy relationship, especially in relation to those moments when two scripts collide in a game. We no longer view the therapist as a neutral, uninvolved observer, but rather a separate human subject who uniquely and unavoidably participates in a volatile interactive process, where shifts in the dyadic system invariably mean both client and therapist are changed. Further, we have reached a shared conviction that resolution of a game often requires a genuine internal shift within the therapist which can lead to growth for both parties.

Relational transactional analysis views the therapy relationship as an encounter between two psyches with each partner contributing consciously and unconsciously to this process. Patterns belonging to both client and therapist emerge in the consulting room and become the intersubjective vehicle for exploration and understanding. From this perspective, countertransference, mutual enactments, and games are no longer seen as unfortunate but rather as an important source of data.

Instead of viewing games as simply defensive we can think about these processes in broader terms. They can involve the replay of, or defence against early experiences which were in one way or another limiting to peoples' capacity to process and integrate what was happening to and inside them. Games contain both the deepest level of a person's relational expectation and unmet need, and also their attempts to avoid the pain of these early experiences. However, games can also be understood as the enactment of unworded experiences; the communication of something that has never been formulated in language and can therefore only be expressed through gesture, affect, and action.

When a game occurs in the therapy room, it is the most vital, vibrant, experience-near revelation of the client's unspoken truth – and often that of the therapist. Games allow for the possibility of reliving early experiences, bringing here and now reality to bear on them, and also weaving new meanings. In this light, games are not something to be avoided but to be welcomed by the therapist.

In this article we offer a framework for understanding and working with consulting room games.

How Does Unconscious Communication Occur between two Minds?

> *"It is a remarkable thing that the Ucs [unconscious] of one human being can react upon that of another without passing through the Cs [conscious]"* (Freud, 1915e, p. 194).

Freud's statement is quite remarkable for its time. The question of how unconscious communication occurs between two minds, as in a game, has puzzled psychotherapists ever since. The everyday bewilderment of how we engage others in repetitive patterns to confirm our worst nightmares often brings clients to therapy. Concepts like mutual enactment (Jacobs, 1986; McLaughlin, 1987, 2005), projective identification (Bion, 1962; Grotstein, 2005; Ogden, 1994), and theories concerning "thirdness" (Benjamin, 2004; Ogden, 1994) which have emerged from psychoanalysis are

attempts to explain these mysterious interpersonal phenomena by extending intrapsychic theories into the realm of interaction. These ideas have all made important contributions to the growing interpersonalisation of psychoanalysis (Aron, 1996; Brown, 2011).

In contrast, Berne's game theory is first and foremost an interpersonal theory – it describes what happens between people. Beginning with the assumption that there are often two conversations taking place side by side, one verbal (social level transactions) and one non-verbal (psychological level transactions), game theory attempts to explain the mechanics of how transference and countertransference are actualised in relationships.

Games, Script and Transference

Berne's game theory is embedded within his broader ideas about script and transference. Berne wrote:

> *"Games appear to be segments of larger, more complex sets of transactions called scripts. Scripts belong in the realm of transference phenomena, that is, they are derivatives, or more precisely, adaptations of infantile reactions and experiences. But a script does not deal with a mere transference reaction or transference situation; it is an attempt to repeat in derivative form a whole transference drama, often split up into acts, exactly like ... theatrical scripts"* (Berne, 1961, p. 117).

Thus, a script is a derivative of an early family drama that was never resolved and is then endlessly repeated in adult relationships. Berne noted that the idea is closely related to Freud's repetition compulsion and destiny compulsion (Berne, 1966, p. 302). A game can be understood as a pivotal act or scene in the overall life script. These scenes can take moments, days or years to replay.

Berne (1961) developed game theory working with therapy groups. He noticed how group participants acted like "a casting director" (ibid., p. 118), unconsciously choosing game partners, with "considerable intuitive acumen" (ibid., p. 119) to play the parts required by his script. "When his casting is complete he proceeds to try to elicit the required responses from the person cast for each role" (ibid., p. 119). We suggest that in individual therapy the client unconsciously scans the therapist as a possible game partner, intuitively looking for vulnerabilities that meet the character descriptions in his script.

One person unwittingly nudges the other into a particular feeling state employing a range of ulterior transactions, including verbal ploys, tone of voice, pitch, rhythm, syntax, actions, behaviours, and sensorimotor transactions such as breathing, posture, or facial expression. The game that emerges is a product of two intrapsychic worlds, only the storyline - the "currency" (Berne, 1964, p. 56) - tends to reflect the client's agenda. The client's ulterior transaction meets with the therapist's whole internal cast of characters (which might be affects, self-states, Parent and Child ego states, whole or part objects), which, to continue with Berne's theatrical metaphor, are "waiting in the wings for a director's call" (Stuthridge, 2015, p. 107). The client unerringly targets the particular quality in the therapist required by his script, often intuiting a complementary sensitivity in the therapist. Depending on the degree of game, the characters on stage may represent fully symbolised and repressed aspects of each player's psyche or more dissociated elements that have yet to find a name and costume. An aspect of the therapist's mind best suited for the part then steps forward to take centre stage. The therapist has unconsciously accepted a role and the drama begins. While there is some freedom to ad-lib, in each new scenario the roles are prescribed by the scripts of each player and lead inexorably to a replay of an old emotional conviction.

Client and therapist each become actors in the

other's script as the game is jointly constructed by the therapy couple. Every therapy couple is unique and while a client might play the same game with three therapists, with each, the familiar moves will take on a different flavour and specific nuance.

Three Degrees of Games

Berne described three degrees of games, which articulate three levels of progressively harmful behaviour. He defined a first degree game as "socially acceptable", a second degree game as one which causes "no permanent irremediable damage" although the players prefer to conceal these, while a third degree game is "played for keeps" and "ends in the surgery, the court room or the morgue" (Berne, 1964, p.57). Stuthridge (2015), Stuthridge and Sills (2016), Novak (2015) and Cornell (2016) have elaborated Berne's notion of three degrees and explored its relevance to working with games in the consulting room.

Cornell suggests that first degree games relate to the social level, "serving a "social" function [...] to make relationships more predictable". Second degree "serve defensive purposes that are often outside conscious awareness and control" and third degree refers to script which is "held in the body rather than the mind" (2016, p. 285).

Developing this idea further, we have suggested a link between these degrees of games and the levels of symbolic and sub-symbolic functioning described by Bion (1963) and Britton (2007). We paraphrase these levels here:

1) Action as the unconscious expression of organised thought (experiences that we can bring to awareness and think about)
2) Action as an alternative to thinking and feeling, and
3) Action as "evacuation of a psychic state" (Britton, 2007, p. 6) or ridding the mind of unbearable and unformulated affect.

In relation to games, we see the term "action" here as a relational gesture – something that is used to "do something" to another person in order unconsciously to extract a predictable reaction. These might include actual behaviour or concrete events like missing a session, but a range of non-verbal transactions such as silence, a movement, a subtle shift in tone, or words used to exert pressure on another person (Aron, 2003).

Each level or degree of game represents differing degrees of reflective capacity and abilities to symbolise experience in the moment. Thus, first degree games might be considered an externalisation of symbolised thought or the external manifestation of an internal dialogue that can be brought to awareness. They are, therefore, familiar patterns of gaining *strokes* (recognition) (English, 1976) and defending against uncomfortable experiences. Second and third degree games concern experience that has never been properly symbolised (felt, recognised, named) or contained as internal conflict (Stern, D. B., 2010). Second degree games defend against deeper unconscious levels of script that threaten to "break through" into unwanted awareness. Third degree games usually concern the parts of the self that have never been fully experienced, often due to trauma or deficit (represented by Hargaden and Sills's "the undeveloped self" (2002, p. 24)). In other words, first degree games are more likely to involve meanings we have known but would prefer not to, while second and third degree games can involve meanings we attempt to repress or have never known. These unlanguaged meanings are the "inarticulate speech of the heart" (Van Morrison, 1983, cited in Hargaden and Sills, 2002, p. 45) and might include a whole range of processes such as D. B. Stern's (2003) "unformulated" and Bucci's (2001) "unsymbolised" experiences or Bollas's (1987) "unthought known".

Each degree includes the two levels of conversation defined by Berne as an exchange of ulterior transactions. However, there are key differences between each degree, in terms of the extent to which the content of the communication is symbolised.

These different levels of symbolisation are experienced in the therapist's countertransference. In first degree games there is a reasonable degree of symbolic functioning present and countertransference is accessible at a conscious and cognitive level. We know what we are feeling. In addition, the meaning of what is being communicated can often be detected through verbal clues. For example, the infamous use of "Yes, but" (Berne, 1964), or verbal invitations (which Berne called cons) such as "If it weren't for you ..." (Berne, 1964).

In second degree games the experience evoked in both participants is likely to be unlinked to symbolic capacities. Ulterior transactions contain significant incongruities between the social and psychological level messages. According to Berne's (1966, p. 227) third rule of communication, the outcome of an ulterior transaction is determined at the psychological level. Thus, the non-verbal transaction induces the unwanted affect in the other person. This "action" becomes a substitute for thinking and feeling. Countertransference can usually be felt as an affective disturbance but it is difficult to decipher cognitively. That is, we can feel something is wrong without knowing what it is. The meaning of what is communicated is more often detected through the therapist's unconscious associations as images or daydreams.

Third degree games involve highly toxic affect and experience that has never been symbolised. The aim is to rid the psyche of feelings that are unbearable, not just unwanted, though "psychic evacuation" (Bion, 1963). Berne associated these tragic outcomes with "tissue scripts" and client histories of child abuse (1972, p. 111). The other person typically feels bombarded, invaded, disconcerted, and destabilised. Countertransference is felt viscerally and the therapist's reflective capacities are usually decommissioned in the moment.

Engaging with Games in the Consulting Room

Game theory itself is intrinsically relational – clearly requiring the involvement of at least two individuals. Despite that, it is only fairly recently that TA has engaged with their bi-directional nature as an inevitable feature of the consulting room.

Berne (1964) aimed to expose a game as soon as possible to prevent involvement in the dynamic and establish social control over the client's behaviour. The methods employed by early transactional analysts often used humour and confrontation (see Goulding & Goulding, 1979; Dusay, 1966).

During the 1970s and 80s game theory mostly focused on cataloguing and naming a plethora of new games. During the 1990's methods based on phenomenological enquiry, empathy and identification of the unmet need became popular (Bary & Hufford, 1990; Erskine & Trautman, 1996).

These strategies all rely on the premise that the therapist will recognise a game as it arises. However, we think that so much of our script is nonconscious that in any close relationship, there is a likelihood that script will emerge. The therapeutic relationship with its periods or moments of closeness and vulnerability can "open the edges of script pressures" (Cornell, personal communication). Indeed, we would go further and propose that some deeply held relational patterns are so embedded in our viscera, that they can *only* be brought to awareness in this way. Therefore, in a sense, being

available to play the game is essential.

This view of games has been gradually growing in the world of transactional analysis. In 1996, Woods cautioned the therapist not to cut short a game until she has 'grasped the full course of [it]' (p. 228) and is able to interpret its defensive function. More recently, transactional analysts (for example Hunt, 2011; Shadbolt, 2012; Stuthridge, 2015; Novak, 2015; Stuthridge & Sills, 2016; Cornell, 2016) have been developing a bidirectional perspective on games in the consulting room. These ideas have been enriched by relational analysts (Aron, 2003; Ellman & Moskowtz, 1998; Benjamin, 2004; Maroda, 1998; Stern, 2010) who have highlighted the value of involvement in and analysis of mutual enactments.

We have found Stern's (2010) ideas particularly useful in elucidating these complex relational dynamics. He argues that during a mutual enactment, conflicting roles in a relational drama exist as separate entities in two minds. Incongruent parts of the self that cannot be kept in one mind without risking affect dysregulation are instead enacted between two people. In transactional analytic terms, each player excludes the complementary role and provokes it in the other. We agree with Stern and suggest that when both parties are locked in their scripts, the game arises from the failure to contain internal conflict and resolution often requires one person to contain both game roles within one mind. This ability is viewed as a developmental achievement.

Typically, games revolve in what Benjamin (2004) called 'split complementarities' such as: accuser and accused, seducer and seduced, betrayer and betrayed. Karpman's (1968) early concept of the "drama triangle" can be usefully extended from a relational perspective to reveal ways of shedding light on and disentangling ourselves from these interpersonal knots. The model describes how games involve three psychological roles, Rescuer, Persecutor and Victim which each represent an attempted negotiation of love, power and vulnerability. A game emerges when an individual tries to maintain one (script driven) position in an intersubjective engagement, normally resulting in deadlocked complementarity (Benjamin, 2004) with another individual also in a script driven position. The symbiotic dyad might be Persecutor and Victim, Rescuer and Victim or Persecutor and Rescuer. The (sometimes temporary) end of the game is the moment when the tension cannot be maintained; it boils over, causing the players to switch roles and the repressed layer of underlying script emerges (called by Berne the 'pay-off').

In agreement with Benjamin, we think that it is the therapist's duty to "go first", and "surrender" (Benjamin, 2004, p. 8) to the truth of her own involvement. This usually means reclaiming a disowned aspect of her own experience before she can understand the game and risk making a different gesture.

We see the drama triangle contributing to the understanding of and resolution of these situations in its introduction of the third role which can reveal a broader field of play. Indeed, resolution, especially of a first degree game, maybe in the conscious adoption of the lost positive intent of the third position. For example, a therapist realises that his desperate attempts to support and reassure his client are a replay of his childhood attempts to heal his mother. They are locked in Rescuer and Victim. Thinking about the strength in the avoided Persecutor position, he decides to put a boundary on the client's e-mails.

In the following section we develop the idea that Berne's 'three degrees' can offer some additional insights about how a therapist can use countertransference to decipher nonconscious participation in games and enactments.

First Degree Games

As Berne (1964, p. 57) observed, first degree games can be played in public without much shame. Both therapist and client may recognise the sense of familiar discomfort and, if the game proceeds to a payoff, the accompanying wave of recognition: "How did I get here again?" The relational enactment, though not in awareness, is one that is amenable to thought and feeling.

With the support of the drama triangle, the therapist can become aware that she is caught in some form of rigid relational pattern, but is not able to free herself because of the pressure of her own script not to acknowledge certain parts of herself – often represented in the third position on the triangle. She is clinging to her social role and avoiding the 'unacceptable' position(s) in the drama triangle in order to maintain her 'preferred' image of herself and others.

Methods for working with first degree games therefore primarily rely on analysis of the conscious countertransference, unlike second and third degree games in which this experience is less accessible. This process can be thought of in three steps, beginning with identifying the feelings or thoughts which constitute the conscious countertransference experience (perhaps using the drama triangle to support understanding); secondly, reflecting on the implications for the therapist's script – for example, how do I want the client to see me?; and thirdly reflecting on the implications for the client's script. For example, why does the client want me (unconsciously) to feel what I'm feeling? Who have I become for this client? Following this reflective process and usually looking for corroboration from other aspects of the therapy, such as dream material or the client's history, we try to say something useful about what is happening unconsciously in the relational space. We attempt to put words to the exchange of non-verbal ulterior transactions.

The Persecutor-Victim and Victim-Rescuer binds are usually easier to recognize than the Persecutor-Rescuer one which is less common but can take various forms. In the example of Robert, a particularly malignant and unhelpful dance takes place, in which the therapist, Eddie, allowed himself to be attacked in the name of allowing the client to have his true feelings. In a sense, in his empathy he was "identifying with the persecutor" (Racker, 1968 p. 163).

One day, the attack was particularly vicious – with the client sneeringly asserting that therapy was a waste of time and that he didn't want to listen to someone asking him "How do you feel?" all the time. In that moment, Eddie felt as if a bucket of water had been thrown over him. Frozen, he simply agreed to Robert's demands, empathising with his need to take charge of the process and merely suggesting that they give each other feedback more regularly.

In supervision, with me, CS, Eddie reflected on what had happened. He knew that he wanted to be seen as the robust, understanding therapist. But he realised that he had actually felt hurt, frightened, and humiliated in the session and he recalled his school day experiences of having to show that he was tough in order to avoid being bullied. As Robert had taken the Persecutor role, Eddie had avoided feeling vulnerable by Rescuing, being understanding and interested in Robert's thoughts.

In the following session he said, "I was thinking about last session and what was happening between you and me. It brought to mind some of the stories you told me about your father. I wondered if your father made you feel scared and ashamed when you were little." Robert began to talk about his experience with his bullying father and his decision never to let anyone see him as vulnerable. The growing

closeness in the therapy relationship had begun to "open the edges" of his script.

It was only via the *'switch'* (the shift in game role that precipitates the payoff) and the final payoff that the therapist became aware of his participation in a game, when the feeling of shock and surprise, the "cross-up" as Berne (1974) called it, broke through the deadlock and introduced something different. At that moment, the whole field of play became clear to the therapist, who could then regain his capacity for mentalising and contribute to the development of meaning and thought.

We move now to thinking about the second and third degree games, whose provenance in recognisable script is harder to capture. The key question here, is how do we become aware of countertransference which is not conscious?

Second Degree Games

In second degree games, action functions as an alternative to thinking and feeling. The action takes the form of a psychological level transaction that is incongruent with the accompanying social level transaction and might include anything from overt behaviour such as arriving late at a session, a phone call at the weekend, to very subtle shifts in tone, facial expression, and posture or words with coded meanings. These actions all involve some element of symbolisation but there is usually no thinking subject present. That is, there is no connection between the action and the sense of "I". As one woman often exclaimed when she arrived late 'It wasn't me … It was (my husband/the traffic/the weather)"

The therapist's countertransference is neither as nameable as in the first degree game, nor as disconcerting, overwhelming, and destabilising as in the third degree. Frequently, there is simply a sense of unease, discomfort, and disorientation or a more powerful but unnamable feeling. The therapist's behaviour – anything that might veer from the norm - is often the first signal that a game is in progress (Renik, 1998).

Strategies that rely on conscious understanding, as outlined in the previous section, are not immediately available when working with second degree games. In exploring ways to work with these less conscious interpersonal dynamics we have found that the therapist's free floating associations, such as visual and auditory images, memories, or daydreams often provide important clues. Imagery, generated either by client or therapist can provide a link between conscious and unconscious realms and between client and therapist, thus forming a route to understanding what is being communicated.

Berne's early work on intuition and his concepts of the "primal image" (1955) and "ego image" (1957) focused on this realm of unconscious interpersonal communication. He described the primal image as "pre-symbolic representations of interpersonal transactions" (Berne, 1977, p. 96). Berne also refers to the ego symbol (pp. 113-115) which he describes as a picture, metaphor, or symbol, often offered by the patient himself, which indicates how he feels and is a guide in therapeutic technique. Clearly Berne was experimenting with spontaneous images as intuitive forms of induction between client and therapist.

Bucci, a cognitive scientist, offers another way to think about nonconscious interpersonal processes. Her theory of emotional communication argues that imagery provides a non-verbal yet symbolic halfway house between verbal symbolic and sub-symbolic communication, embedded in motoric sensory and somatic systems. In brief she describes (Bucci 2001, p. 54) a three-step process for working with the therapist's countertransference:

1. Arousal of experience dominated by sub-symbolic elements, the sensory, so-

matic, and motoric components of the affective core

2. Representation of experience in symbolic form as a visual or auditory image (non-verbal symbolic)
3. Conscious reflection on the meaning of the metaphor (verbal symbolic).

The therapist's capacity to symbolise experience and link incongruent affects then fosters the client's ability to integrate dissociated or split off experiences.

We are proposing that at moments in the work when the therapist senses that she might be embroiled in a second degree game, objective analysis, phenomenological enquiry, and conscious analysis of countertransference all risk being skewed by the therapist's unconscious participation. Instead, images that arrive in the therapist's mind, usually uninvited and unwilled, can offer possible pathways to deciphering the game. The therapist allows herself to notice any odd phenomena that pass through her, from images, to words, to snatches of song. She then associates to and feels with this experience, letting its meanings come to her.

I think you'll find ...

I, CS, enjoyed my conversations with Gail, an intelligent articulate client who was also a psychotherapist. I always felt stimulated by our interactions and believed that the script analysis we were doing was very effective – even though sometimes I wondered where the feelings were. One day, during a session with Gail I noticed my mind had drifted to a recent scene from the Houses of Parliament – something I had seen on the television news. It didn't seem related to anything Gail was saying but it engrossed me for a few moments. I visualised the politicians debating from either side of the house and I had a picture of a politician scoring a point and sitting down smugly to the cheers of his colleagues. In supervision, reflecting on this odd, intrusive fantasy, I mused on the feelings it aroused of besting someone intellectually – and felt the echo of the triumph I felt when I managed to score a point with my older brother. I began to wonder about competitive dynamics between Gail and me and then thought about Gail's history with a highly controlling mother.

More reluctantly, I recalled the humiliation and rage I used to feel as a child at those times when I *lost* an argument with my brother – and then I felt a noticeable shift toward compassion for Gail. Both roles were now held in mind. I realized that I had been caught in a subtle Victim-Persecutor complementarity, similar to what Racker, called "paranoid ping-pong" (Racker, 1968, p. 140), where there was a veiled competition between my client and me, under the subtle guise of interesting exploration. Both of us were vying to be in control. In the following session with Gail I found a way of saying, "It sometimes feels as if we are in a competition about who has the upper hand - as if being wrong or not knowing would be terrible... I am wondering whether it felt dangerous to be wrong with your mother."

Gail looked stunned for a moment and then began to get in touch with the experiences she had as a child – how vulnerable she felt when she was at the mercy of a rather cruel and competitive mother. With a start, she realized that the feelings were the same as the ones she often felt with her female manager, with whom she had had several difficult conversations.

Third Degree Games

Clients prone to third degree games often come from backgrounds of severe trauma and neglect. Concrete thinking and a poor capacity for reflective functioning can be part of the legacy that trauma leaves in its wake (Fonagy,

Gergely, Jurist, & Target, 2002). Traumatic experiences of overwhelming pain and intolerable stress combined with a lack of adequate mirroring from a caregiver can cause the mind to become fragmented. Experience that has never been thought about or symbolised remains as pockets of dysregulated and dissociated experience (Schore, 2003). Unintegrated experience is then endlessly re-enacted in the present rather than archived in the past, providing ongoing reinforcement of the rigid closed script system (Stuthridge, 2006).

In third degree games both therapist and client must often withstand replaying the parts of the abused child or the abuser, as this experience, internalised in Parent and Child ego states, is reactivated. The incongruity between these aspects of the self can be severe, and psychic stability often depends on keeping one aspect or other out of mind.

The function of a third degree game is to rid the mind of affect that is unbearable, unthinkable, and unspeakable – often in a moment when it threatens to become conscious. An exchange of ulterior transactions arouses an analogous affect in the other person.

In the midst of this interaction the therapist usually loses her ability to think or reflect on her experience. Cornell (2015) suggests that in a third degree game, client and therapist "live the problem together". The therapist's focus in the moment is often on simply surviving the game. After she has survived and regained a capacity to think, there is an opportunity to transform the raw sensory experience into symbolic thoughts and coherent self-narrative. Working with the countertransference of third degree games usually involves an attempt to translate visceral or somatic experience into symbolic meaning. Neither conscious thought, nor associations and imagery are generally available as in first and second degree games.

Dean

Dean was an ex-gang member with a long history of violence towards men and women. He relayed garish stories of his exploits, often with some pride. I (JS) felt nervous with him at times and made sure there was always someone else in the building during his sessions. He came to therapy because he knew his history of severe abuse had somehow "fucked up his life" and he wanted to keep custody of his daughter.

Over the first two years, Dean revealed that he was experiencing disabling panic attacks and periods of severe dissociation, in which he would lose hours of time, coming around to find himself in a foetal position under a bed or dangerously close to a heater. In broken snippets, devoid of feelings, he disclosed a horrific history of childhood sexual abuse and neglect. He had been fostered by a woman who tortured him by applying electric cattle prods to his genitals. She was also the only adult figure in his life who he felt had ever shown him affection and care, creating an attachment that was both needed and feared.

Dean's sessions were largely accounts of skirmishes with the police, his gang associates, and ex-partners. The stories were told as if he was always in the right and others were stupid and deserving of his contempt. He explained to me his various theories about life at length. Any response I made other than affirming his views would mostly be greeted with "You don't get it". I think he was right, I didn't really get what was happening between us but I had become fond of him and his growing trust in me felt precious. We had developed sufficient intimacy for a game (Berne, 1964).

This event began with Dean talking about an interaction with his six-year-old daughter the previous evening, in which he had severely disciplined her. The details were disturbing to hear and he told me he felt nothing when she cried. He was self-righteous and justified his harsh

approach, telling me she deserved to be punished. I heard in the transference a warning.

Cautiously I began to explore the moment with him and as we talked he began to feel less certain about what had happened. I sensed an opening in his rigid defences and probed further: "What did you see in your daughter's face?" Dean's words slowed, he became thoughtful, and very gradually a quiet sense of empathy for his daughter emerged, conveyed through a softening in his voice and body.

Then in quick succession, Dean recalled a memory of abuse from his own childhood, along with intense feelings. He realised with sickening insight that he had frightened and humiliated his daughter. Feelings of shame and childhood terror began to overwhelm him. He became anxious and agitated, squirming on the edge of his seat. Sweat appeared on his brow and his eyes darted towards the door. I was acutely aware of the rising tension in the room.

Suddenly he snapped. He looked up and glared. In a fast about-turn, he barked at me that it was different with his daughter and she deserved to be punished. "You don't get it," he repeated over and over, his voice rising steadily in volume. I began to feel afraid that the situation could get dangerously out of control. Dean jumped up from his seat, came towards me in a threatening manner, paused while he stood over me breathing heavily, then abruptly turned his back and walked out. I was left feeling severely shaken.

The image of my "probing" only appeared as I found myself using the word to write up notes, in an attempt to make sense of the session. The word pulsed with electricity on the page and connections between the incident and Dean's past suddenly fell into place in my mind. I realised that he may have felt my "probing" as a violation: too intrusive and too painful as it connected him to intolerable feelings. In this moment I became the terrifying sexual abuser; the trusted woman with the cattle prod. As feelings of terror and humiliation threatened to overwhelm him, he pulled a switch (in ego states) to evacuate the toxic affect, evoking terror in me. As I grasped the meaning of my notes, the emotional shift allowed me to hold both game roles in mind.

I decided to write him a brief note saying firstly that I wanted to see him again and secondly that he seemed to get stuck with me at times, either being frightened or frightening. He came back the next session and said, "Now you've got it." He told me that this was the story of his life; knowing terror as a child, then learning to frighten others. He said he had left because he was afraid he would hurt me. The incident marked a point at which we began to create shared meanings. He was able to symbolise his experience with me and link it to his past. As Dean began to contain split-off states of mind such as fear, rather than evoke it in others, the dissociative experiences lessened. He developed some ability to turn the horror of his childhood into a story that could be thought about and remembered rather than enacted in the present.

Conclusion

Games are essentially crucial scenes or acts in the drama of transference and counter-transference that take place in the consulting room theatre.

We are suggesting that, rather than aiming for the grail of neutrality, the therapist embraces her unique personality and uses this experience to understand the client. Having an acceptance of her own involvement is often key to freeing up the interpersonal knots that inevitably emerge in a therapy process. These knots in the interpersonal field may be repetitions of the past or clues to emergent new experiencing.

Berne's game theory, viewed though a con-

temporary relational lens, provides a strong model for understanding complex intersubjective dynamics and mutual enactments. His pithy observations about degrees of intensity, with further experimentation and thought, might contribute to thinking in the wider field about how to utilize countertransference effectively, in the heat of an impossible moment.

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References

ARON, L. (1996). *A Meeting of Minds: Mutuality in Psychoanalysis*. Hillsdale, NJ: The Analytic Press.

ARON, L. (2003). The Paradoxical Place of Enactment in Psychoanalysis. *Psychanalytic Dialogues*, 13(5), pp. 623-631.

BARY AND HUFFORD. (1990). The Six Advantages to Games and their Use in Treatment. *Transactional Analysis Journal*, 20 (4).

BENJAMIN, J. (2004). Beyond Doer and Done to: An Intersubjective view of Thirdness. *Psychoanalytic Quarterly*, 73, pp. 5-46.

BERNE, E. (1961). *Transactional Analysis in Psychotherapy*. New York: Grove Press.

BERNE, E. (1964). *Games People Play: The Psychology of Human Relationships.* (1996 ed.) New York: Ballantine Books.

BERNE, E. (1966). *Principles of Group Treatment.* New York: Grove Press.

BERNE, E. (1972). *What Do You Say after You Say Hello? The Psychology of Human Destiny.* New York: Grove Press.

BERNE, E. (1977). *Intuition and Ego States*. New York: Harper and Row.

BION, W. R. (1962a). *Learning from Experience.* London: Heinemann.

BION, W. R. (1963). *Elements of Psychoanalysis*. London: Karnac Books.

BOLLAS, C. (1987). *The Shadow of the Object. Psychoanalysis of the Unthought Known.* New York: Columbia University Press.

BRITTON, R. (2007). From Analysis of Children's Play to Enactment in Adult Psychoanalysis. *Paper presented at the International Psychoanalytical Association conference*, July 27th, Berlin.

BROWN, L. (2011). *Intersubjective Processes and the Unconscious*. East Sussex: Routledge.

BUCCI, W. (2001). Pathways of Emotional Comunication. *Psychonalytic Inquiry*, 21, pp. 40-70.

CORNELL, W., DE GRAAF, A., NEWTON, T, & THUNISSON, M., eds. (2016). *Into TA - a Comprehensive Textbook on Transactional Analysis*. London: Karnac.

CORNELL, W. (2015). Play at Your Own Risk: Games, Intimacy and Play. *Transactional Analysis Journal*, 45 (2), in press.

DUSAY, J. (1966). Response to Games in Therapy. *Transactional Analysis Bulletin, 5(18), pp. 136-137.*

ELLMAN, S. J. & MOSKOWITZ, M., eds. (1998). *Enactments: Toward a New Approach to the Theapeutic Relationship*. North Vale: Jason Aronson.

ENGLISH, F. (1976). Racketeering. *Transactional Analysis Journal*, 6(1): 78-81.

ERSKINE, R. & TRAUTMAN, R. (1996). Methods of an Integrative Psychotherapy. *Transactional Analysis Journal*, 26(4), pp. 316-328.

FONAGY, P., GERGELY, G., JURIST, E. & TARGET, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self.* New York: Other Press.

FREUD, S. (1915). *The Unconscious Standard Edition Complete Psychological Works of Sigmund Freud*, Volume XIV (1914-1916).

GOULDING, R. & GOULDING, M. (1979). *Changing Lives through Redecision Therapy.* New York: Brunner/Mazel.

GROTSTEIN, J. (2005). Projective Transidentification: An Extension of the Concept of Projective Identification. *International Journal of Psychoanalysis*.

HARGADEN, H. & SILLS, C. (2002). *Transactional Analysis: A Relational Perspective.* East Sussex: Brunner-Routledge.

HUNT, J. (2011). Exploring the Relational Meaning of Formulae G in Supervision and Self-Supervision. In: H. Fowlie & C. Sills (Eds.), *Relational Transactional Analysis - Principles in Practice* (pp. 287-303). London: Karnac.

JACOBS, T. (1986). On Countertransference Enactments. *Journal of American Psychoanalytic Association*, 34, pp. 289-307.

KARPMAN, S. (1968). Fairy Tales and Script Drama Analysis. *Transactional Analysis Bulletin*, 7(26), pp. 39-43.

MARODA, K. (1998). Enactment: When the Patient's and Analyst's Pasts Converge. *Psychoanalytic Psychology*, 15:517-535.

MCLAUGHLIN, J. (1987). The Play of Transference: Some Reflections on Enactment in the Therapeutic Situtation. *Journal of American Psychoanalytic Association*, 35, 557-582.

MCLAUGHLIN, J. (2005). *The Healer's Bent: Solitude and Dialogue in the Clinical Encounter.* Hillsdale, NJ: The Analytic Press.

NOVAK, E. (2015). Are Games, Enactments and Reenactments Similar? No, Yes, It Depends. *Transactional Analysis Journal*, Vol. 45(2) 117-127.

OGDEN, T. (1994). *Subjects of Analysis* (Rowman & Littlefield ed.). Lanham: Jason Aronson.

RACKER, H. (1968). *Transference and Countertransference.* London: Karnac.

RENIK, O. (1998). The Role of Countertransference Enactment in a Successful Clinical Psychoanalysis. In: S. Ellman & M. Moskowitz (Eds.), *Enactment: Toward a New Approach to the Therapeutic Relationship,* (pp. 111-128). Northvale: Jason Aronsen Inc.

SCHORE, A. (2003). Early Relational Trauma, Disorganised Attachment and the Development of a Predisposition to Violence. In: M. F. Solomon & D. J. Siegel (Eds.), *Healing Trauma, Attachment, Mind, Body and Brain.* New York & London: W.W. Norton & Co.

SHADBOLT, C. (2012). The Place of Failure and Rupture in Psychotherapy. *Transactional Analysis Journal*, 42(1), 5-16 .

STERN, D. B. (2003). *Unformulated Experience: From Dissociation to Imagination in Psychoanalysis.* New York and London: Taylor and Francis.

STERN, D. B. (2010). *Partners in Thought: Working with Unformulated Experience, Dissociation and Enactment.* New York, London: Routledge.

STUTHRIDGE, J. (2006). Inside out: A Transactional Analysis Model of Trauma. *Transactional Analysis Journal*, 36(4), pp. 270-283.

STUTHRIDGE, J. (2015). All the World's a Stage: Games, Enactment and Countertransference. *Transactional Analysis Journal*, 45(2), pp. 104-16.

STUTHRIDGE, J. & SILLS, C. (2016). Psychological Games and Intersubjective Processes. In: R. Erskine (Ed.), *Transactional Analysis in Contemporary Psychotherapy*, (pp. 185-208). London: Karnac.

WOODS, K. (1996). Projective Identification and Game Analysis. *Transactional Analysis Journal*, 26(3), 228-231.

Relational Group Process: Developments in a Transactional Analysis Model of Group Psychotherapy

Richard G. Erskine

Abstract: This article presents some of the principles of relational group psychotherapy. Several models have influenced the development of relational group psychotherapy, including therapy by the group, therapy by interpretation, therapy in the group, and therapy through the group. The dialectic between the feedback and the person-centred trends in group therapy is described, and an integration of models is proposed. Relational group psychotherapy emphasizes the healing power of relationships among group members, the importance of phenomenological inquiry, affective attunement, validation, respect, identification, and each individual's relational needs. The leader's tasks include stimulating the flow of contactful dialogue and teaching about human needs and healthy relationships.

Key Words: Relational group process, group therapy, group relationships, attunement, confrontation, person-centred, relational needs, respect, shame, Eric Berne, Martin Buber, phenomenological inquiry

In his (1961) book, *Transactional Analysis in Psychotherapy: A Systematic Individual and Social Psychiatry*, Eric Berne begins his chapter on "Group Therapy" by stating, *"Transactional analysis is offered as a method of group therapy because it is a rational, indigenous approach derived from the group situation itself"* (p. 165).

He wrote that a TA group is different from other groups that are based specifically on theoretical concepts of a group as a 'metaphysical entity' (such as psychodynamic group analysis), those designed to force growth (such as encounter groups), or those that use 'opportunistic' techniques (such as gestalt therapy groups).

Berne went on to describe what he meant by a rational approach: *"The objective of transactional analysis in group therapy is to carry each patient through the progressive stages of structural analysis, transactional analysis proper,*

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game analysis, and script analysis, until he attains social control" (p. 165).

Berne's rational perspective and structured approach make sense when we consider that his examples in Chapters 9 and 10 came from his experience with his borderline women's group or from the hospitalized patients described in Chapter 15 (D. Kupfer, personal communication, 16 September 1969). Rational understanding and social control are essential early therapy goals with such patient populations.

Berne (1961) provided a conceptual foundation for a transaction-by-transaction approach to group psychotherapy. He described how he made use of therapy by interpretation to analyse each group member's actual transactions, to identify life-script patterns, and to provide alternatives to psychological games. Berne's writings about group psychotherapy also illustrated a specific and useful model of therapy through the group members' interactions with each other. The central methods in his group therapy were his explanations of complementary, crossed, and ulterior transactions and his theoretical interpretations about the ego states involved in games, transference, and scripts. Berne's therapeutic effectiveness as a group psychotherapist seemed to lie in his integration of two models of group psychotherapy: therapy through the group and therapy by interpretation.

What I find significant in Berne's (1961) opening statement is the phrase ''indigenous approach derived from the group situation itself'' (p. 165). This intriguing phrase has led me to experiment with a number of ways to make use of the healing and growth-enhancing power that is indigenous in a secure and effective group situation. I have searched for models of group psychotherapy that are effective for clients suffering from prolonged stress, cumulative neglect, acute trauma, and/or repetitive humiliation. This article is written to describe various influences, experiments, and discoveries in searching for that indigenous, growth-enhancing group therapy experience and in developing a transactional analysis model of therapy through a relational group process.

Developments in Group Psychotherapy

The history of the development of group psychotherapy is a long and fascinating story comprising many contributions, concepts, and models (Bion, 1989; Ormont, 2003; Rutan & Stone, 1993; Yalom, 1995). The annals of both the American Group Psychotherapy Association and the International Group Psychotherapy Association are replete with rich examples of the effective use of various models. Rather than recounting this history in detail, I will describe just a few models that have influenced my professional practice as a transactional analyst. These models may be described as therapy by the group, therapy by interpretation, therapy through the group, and therapy in the group. My experimentation with and application of these models in psychotherapy, education, and organizational consulting have influenced the development of an integrated model that I refer to as relational group process.

Therapy by the Group

In the 1930s, Alcoholics Anonymous (AA) began as a leaderless group. AA is based on the theory that alcoholism is a disease and individuals need group support to stop drinking. The 12-step program shapes the methods of the group; every aspect of the group is determined by one of the 12 steps. Members are encouraged to practice one of the steps daily and to tell their story in meetings, often repeatedly, while others listen respectfully. Alcoholics

Anonymous is a prime example of therapy by the group.

In the early 1970s, O. Hobart Mowrer (1972) increased the scope of the Alcoholics Anonymous model to include the group treatment of depression and anxiety. Along with a focus on honesty and responsibility, he placed equal emphasis on integrity and the personal involvement of each group member in helping other group members live up to the 12-step program. Although Mowrer's integrity groups were originally designed for the treatment of acute depression and anxiety, his ideas and methods were also used in group therapy with a general adult population.

For two academic terms, Dr. Mowrer and I co-led a group of university graduate students in which we experimented with using a combination of integrity group concepts and transactional analysis theory. Each week, the 2-hour group would begin with a 20-minute introduction to a transactional analysis concept such as ego states, crossed and ulterior transactions, strokes, the OK Corral, time structure, games, or script. Although I taught a substantial amount of transactional analysis theory to the groups, we did not make use of interpretation in the way that Berne had.

Instead, we used a therapy-by-the-group model to explore how the TA and AA concepts could be used in the group members' lives to enhance each person's sense of honesty, responsibility, and integrity.

At the University of Chicago in 1945, Carl Rogers and Robert Neville developed non-directive group therapy to treat war neuroses. This form of therapy-by-the-group was influenced by the work of Harry Stack Sullivan and emphasized a democratic process of equality and encouraging group members to share their traumatic stories and feelings with each other. By telling these stories over and over again while receiving empathic responses, the traumas of war were healed (R. Neville, personal communication, 20 September 1967).

In non-directive group therapy, the leader's role is to model empathy, congruence, and unconditional positive regard for group members. He or she does not offer interpretations. The therapy is not determined by a theory of motivation, personality, or psychopathology but by the idea that people need to be authentic with each other about their emotional experiences (Rogers, 1951, 1961). In my first 2 years as a group psychotherapist, I used this model exclusively. Over the years, I have often returned to this model when 'shame' is a central issue, when the power of group members' empathy and identity are essential for the healing of trauma and neglect, or when other models seem too deterministic.

Therapy by Interpretation

The types of groups just described are different in principles, methods, and therapists' tasks from psychoanalytic group therapies that emphasize the importance of the therapist's interpretations. Several types of psychoanalytic groups began in the 1950s under the initial influence of Wilfred Bion at the Tavistock Clinic in England. The analyst's task was to interpret group members' behaviour according to the ideas of certain psychoanalytic theorists (particularly Sigmund Freud, Anna Freud, and Melanie Klein) and the basic assumptions proposed by Bion (1970). Group members were encouraged to talk to each other, and it was assumed that, in the course of the group's discussion, each member's childhood transferences and psychopathology would be disclosed through his or her interactions within the group.

In such groups, the leader spoke only to make theoretically based, authoritative interpretations of group members' pathological motivations for their behaviour (often in the last

few minutes of each session). For example, interpretations of an individual's behaviour might be attributed to unresolved aggression, envy, Oedipal sexual attraction, or infantile transference that was revealed behaviourally through dependency, fight or flight, pairing, and/or oneness (Banet & Hayden, 1997). In psychoanalytic groups, the authority of theory may, at times, appear to take precedence over group members' phenomenological experience.

In my experimentation with the therapy-by-interpretation model, I found that the use of authoritative interpretation may have the positive effect of arousing group members to think about their motivations, behaviours, and transference. It may even produce some adaptive changes in behaviour. However, such theory-determined interpretations may also have a negative effect in that they may be quite distant from the client's subjective experience (hence not so useful), are often shaming to an individual group member, and may also provoke other group members to either withdraw or conform to some theoretical expectation or norm. It has thus been my practice to abstain from using a therapy-by-interpretation model and instead focus on an intersubjective understanding of each client's motivations, affects, and behaviours as well as a co-constructive understanding among group members about their interpersonal relationships.

The 1960s were a rich time of development in group therapy. Three trends emerged, often over- lapped, and influenced each other: therapy by interpretation, therapy in the group, and therapy through the group. During this time, Berne made use of a modified psychoanalytic model to analyse group members' transactions to determine, which were transferential and which were not. He primarily focused on the transferences between group members that resulted in psychological games and reinforced life scripts. An example of his use of transactional analysis theory in group therapy can be found in his description of his weekly group of mothers of disturbed children at Atascadero State Hospital (Berne, 1961, p. 176).

In contrast to the psychoanalytically based group therapists of his time, Berne was active in the group's discussions, making theoretically based explanations, confrontations, and interpretations (Berne, 1966) during the process rather than waiting until the end as was done in most psychoanalytic groups. Even though he was active in the group's process and fostered a sense of equality by engaging group members in making contracts for behavioural change and in talking directly to each other, *"his primary methods were explanation, confrontation, and interpretation"* (B. Rosenfeld, personal communication, November 18th, 1976).

Although Berne did not make psychoanalytically-based interpretations about an individual's pathological motivations, focusing instead on group members' transactions with each other, both his transactional analysis groups and psychoanalytic groups can be seen as following the model of therapy by interpretation.

Therapy in the Group

Also during the 1960s and early 1970s, Fritz Perls (1967, 1973) developed a model of therapy in the group in which the psychotherapist did individual psychotherapy with one person in the group while other group members observed. Group members participated both vicariously and through their supportive statements at the end of the work, but there was little in the way of group interaction. The psychotherapist was highly directive of psychotherapy by encouraging the client to do psychological experiments, to be expressive, and to explore unfinished emotional experiences.

Perls's Gestalt therapy groups pioneered the idea of therapy in the group and had a large influence on how transactional analysis and other forms of group therapy were conducted during the 1970s. The use of a transactional analysis model of therapy in the group is illustrated in *"Changing Lives Through Re-decision Therapy"* (Goulding & Goulding, 1979) and *"Integrative Psychotherapy in Action"* (Erskine & Moursund, 1988/2011). I have often used such individualized in-the-group-therapy methods, particularly in therapy marathons, to stimulate profound change in a client's life script. Group members benefit by identification and through group discussion at the end of the work. However, in such groups there is a dearth of interpersonal contact unless the psychotherapist encourages whole-group interaction following the individual therapy.

Therapy Through the Group

Another trend in the 1960s was influenced by the emergence of 'encounter groups', which emphasized interpersonal growth and the development of human potential (Egan, 1970). Encounter groups began as a form of human relations training and were not originally proposed as a form of psychotherapy. Over time, however, the model of interpersonal growth was used in various clinical settings as a form of therapy through the group.

Encounter group theory was based on a cybernetic model that suggested that we all affect each other in a myriad of ways. This is articulated in the notion that one person's behaviour in the group directly influences the behaviour of the others. We are all constantly influencing each other both consciously and unconsciously.

Encounter groups focused on various group members describing the behaviour of each of the other group members and how that behaviour affected them. Each member in the group was encouraged to give feedback to other group members and to be highly vocal, confrontive, or even aggressive in describing others' behaviour. Direct confrontation was seen as a form of authenticity. Both individuals' behaviour and their possible lack of emotional expression were seen as their problem, which was to be fixed through group interaction. This theory is based on the idea that people are often out of touch with themselves and need an intense encounter with others to become authentic (Egan, 1971).

Unfortunately, the lack of respect that often characterized feedback among group members and a heavy focus on behaviour change made these groups shaming and traumatizing to some participants. They were not appropriate for clients with developmental neglect or acute trauma.

I have often experimented with the use of dyadic, small-group, and whole-group encounter exercises (as well as physical movement, dance, and psychodramatic enactments) to facilitate clients' discovery of their own potential and to heighten their awareness of how they have an impact on others. I found it essential when using this model of therapy through the group for the psychotherapist to maintain a protective environment that clearly communicates respect for each person's uniqueness.

The Feedback and Person-Centred Dialectic

By the 1980s, many group psychotherapists were influenced in some way by the various models I have just described as they experimented with different trends in interpersonal relations and group psychotherapy. I was influenced too and searched to find a form of group psychotherapy that was effective in changing the relational patterns of my clients' life scripts. I looked for a model that was re-

lational and co-constructive and that made full use of the therapeutic potential indigenous in group members' interactive processes. I experimented with transactional analysis in the styles of a feedback and a person-centred approach to group psychotherapy. These two trends reflect important developments in group psychotherapy and represent opposing poles on a continuum of therapy through the group.

In a similar vein, Kapur and Miller (1987) presented a research study comparing the therapeutic factors central in transactional analysis and psychodynamic therapy. They described how *"TA clinicians place strong emphasis on encouraging patients to achieve greater insight into their behaviour"* but place little emphasis on group interaction (p. 298). In contrast, psychodynamic group therapists emphasize a group process that facilitates universality, altruism, and cohesiveness.

According to Kapur and Miller, the aim of psychodynamic group therapists is "*to knit the group together and provide this as the therapeutic basis for personal change*" (p. 299). They surmised that the high value placed on interpersonal feedback in transactional analysis groups might account for the low level of altruism in them when compared to psychodynamic groups. They suggested that TA group therapists should integrate procedures that *"foster group cohesiveness and universality by varying therapeutic techniques, decentralizing leadership, and promoting free interaction among group members"* (p. 299).

Many current transactional analysis and other theoretically-oriented psychotherapy groups make use of a feedback approach to facilitate group interaction. Although such an approach is interactive, it often either reflects the leader's theoretical perspective or the opinion of a particular person or collection of people. Candour and bluntness are encouraged. The emphasis is on the speaker's perspective, which is considered bona fide and more significant than listening to and learning from others in the group.

The therapeutic intent of the feedback is to influence and modify group members' script-determined behaviours and relational patterns. The social message is, *"This is how you affect me"*, and the emphasis is on change.

Confrontation from the group leader, or from one group member, to another is considered essential to the therapy process. Such bluntness is often regarded as an expression of the speaker's genuineness and the *"reality of how I see you."* In a feedback-oriented group, the focus is on each member's perception and interpretation of other group members' behaviours.

The feedback may not accurately describe an individual's subjective and internal experience, but it reflects how another group member perceives him or her. Candour is often encouraged and is defined as speaking congruently of one's own feelings, interpretations, and opinions about another group member's behaviour. For example, one person might describe or interpret another with a statement such as, *"You are angry and withdrawn. You always feel superior."*

Theoretically, the advantage of the feedback model is that it provides the perspective and opinion of the group leader or of one group member to another. When someone makes a pronouncement, the recipient is expected to respond as though the original speaker is describing reality or the only truth (Banet & Hayden, 1997). Self-reflection, in accordance with the confrontation, is encouraged, whereas explaining one's subjective experience may be defined as being defensive (Bion, 1989).

One of the disadvantages of a feedback-oriented group is that little attention is given to

an individual's inner processes (such as fear, shame, uncertainty, etc.) that may be manifested in the expression of what may appear to be, for example, anger, withdrawal, or superior behaviour. Groups that rely on frequent use of a feedback model may change members' script-determined behaviour but may also increase members' sense of shame and being misunderstood within the group. Rather than inviting intersubjective connection and real interpersonal growth, the feedback approach may trigger compliance and/or withdrawal.

In contrast, a person-centred psychotherapy group attends to how each member's subjective experiences are manifested in the group (Rogers, 1961). It places the therapeutic focus on each individual's phenomenological process and the importance of sharing one's subjective experience with an interested and involved listener (Snygg & Combs, 1949). In a person-centred group, one's personal perspective, opinion, or interpretation is seen as inadequate for understanding other group members. There is, therefore, an emphasis on inquiry, understanding, and attunement with others' inner experience, a resonance with their affect, self-perspective, and how they make meaning. It is based on the leader and each group member assuming, *"I know nothing about the other person's inner process; my observation and interpretation are not enough to understand the experience of the other person."*

One of the principles of a person-centred group is to learn to see and experience the other as he or she experiences himself or herself, to enter vicariously into the other's subjective experience. Careful listening and respectful inquiry are viewed as essential for knowing the other (Rogers, 1970). Empathy with other group members' stories and attunement to others' affect, rhythm, and mode of cognition is given central importance. Confrontation is generally not part of person-centred groups. The assumption is that when people experience being truly known, without interpretation or ridicule, their levels of stress and shame decrease, and they can more freely express themselves and resolve psychological issues (Bozarth, 1986).

One disadvantage of the person-centred model is that it may overemphasize subjective experience and the importance of empathy. It may not sufficiently attend to the effects of a group member's behaviour on others. By emphasizing each member's internal, subjective experience, such groups may miss giving adequate attention to the person's behaviours, including the effect of crossed transactions, projections, and misinterpretations; the impact one member may have on another; or the behavioural dimensions of life scripts. Another disadvantage is that group members may be nice to each other rather than authentically expressing what they perceive. When the group is nice, significant aspects of group members' script-determined behaviours may not receive therapeutic atten- tion or the opportunity to be resolved.

My practice of group therapy has been influenced by a professional desire to resolve the dialectic between using a feedback and a person-centred approach, and I have experimented with bringing these perspectives into a therapeutically effective synthesis. In my view, clients need an approach that includes the central elements of both approaches. Such a synthesis provides the therapeutic environment in which clients can learn to relinquish their old life-script patterns; consistently engage in complementary transactions; live lives that are free from early survival reactions and parental introjections; avoid psychological games; be aware of themselves, others, and their environment; and have lives rich in intimacy. I think that the solution to the polemic between these approaches lies in the skilfull integration of the two modes. The goal is to develop an effective therapy that is co-con-

structive and relational, that is truly indigenous to the group.

Relational Group Process

Relational group process emphasizes transaction-by-transaction interpersonal contact, the processes of intersubjective relating, and the reciprocal and mutual influence of each group member on the other members. The focus of both the group therapist and group members is on the interplay between the present moment and the emergence of unconscious relational patterns that may be an expression of archaic experiences.

Group members learn to relate to each other through acknowledgment, phenomenological inquiry, validation, and normalization. The healing of anxiety, depression, cumulative neglect, and trauma becomes possible through group members' contactfull, caring relationships that attend to each person's subjective experience and relational needs (Erskine, Moursund, & Trautmann, 1999). Relational group process is an implementation of Buber's (1923/1958) 'I and Thou' philosophy.

The Therapist's Tasks

When using a relational group process model, my intention is to combine the best of both the feed- back and the person-centred models. One of the leader's responsibilities is to encourage all group members to attend to each person's phenomenological experience and to participate actively by providing respectful responses. An important focal point of the therapy is the creation of an intersubjective experience wherein each member is fully involved with each other member.

I often begin a relational group process by teaching the importance of a co-constructive mission within the group. This is accomplished by encouraging group members to be empathic, to listen, to inquire, and to resonate with others. Group members learn, and hopefully appreciate, others' perspectives and feelings. They are encouraged to be responsive and to speak about their perceptions of, feelings about, and reactions to each other.

When group members are attuned to each other's affects and relational needs and are respectful in their transactions with each other, the quality of feedback they provide becomes a valuable asset in promoting growth. An effective relationally oriented group will include some feedback, but it will be given in a way that is respectful and attuned to the recipient's affect. This respect is based on the awareness that one's comments may not accurately describe the other's experience. It is in integrating the person-centred and feedback trends of working in groups that we create a viable "*us*", a shared experience rather than just a "*you*" or a "*me*" perspective.

This reciprocal process of respectful involvement with other group members' perspectives enables everyone in the group to elaborate on and enrich the expression of their own experiences. Relational group psychotherapy provides group members with the opportunity to express themselves, to be understood, to grow in emotional attachment, to develop their unique identity, and to express their own integrity.

In relational group process, the therapist has several tasks, including introducing principles and practices that validate the individuality and importance of each person and the multiple relationships in the group; providing a sense of cohesion, continuity, and stability; and encouraging group members to question and challenge their own and others' beliefs, fantasies, and behaviours.

The therapeutic dialogue is built on honesty, responsibility, integrity, and courtesy. Truth telling, about one's self and how each person

experiences the other group members (and the leader), is an important characteristic of such groups.

Effective relational group process often provides a contrast between an individual's current relational experiences and his or her internal psychological processes of implicit and procedural memories, script conclusions and beliefs, projections and expectations, and archaic forms of self-regulation. It emphasizes the importance of phenomenological inquiry, each group member's relational needs, and the reparative power of people's genuine interest and involvement.

Another task for the relational group process leader involves teaching and emphasizing the importance of active-listening, acknowledgment, and normalization.

In these groups, normalization does not refer to placating or minimizing the significance of a problem but to recognizing that the psychological function of the person's affects, fantasies, self-protective processes, script beliefs, and modes of coping are normal and a means of self-stabilization within a historically stressful, neglecting, or traumatizing family or school context.

Relational group process also takes the psychotherapist out of the role of interpreting and out of the position of working individually with each person. Instead, the leader focuses on facilitating relationships between group members, teaching about human needs and relationships, and guiding and facilitating involved relationships among group members. The image I use is that of an orchestra conductor, who maintains the rhythm, adjusts the volume, gestures to various musicians when it is time for them to play their solos, and facilitates the orchestra members in playing in harmony with each other.

Healing relationships in groups are based on caring involvement while working together for the common benefit of all. An additional task of the group psychotherapist is to facilitate group members in inquiring about each other's phenomenological experience and to draw out those who are not actively participating or may be reluctant to talk about what they are feeling.

For example, in a group session, Charles spoke about how stressed he felt during the painfully protracted illness and eventual death of a dear friend. His grief was intense. He then thanked the group and the psychotherapists for encouraging and for supporting him in talking about it, even though he had hesitated to do so.

He described the relief he felt after talking and crying about his pain and how his feelings of grief had shifted to appreciating the way his life had been enriched by the friendship. With the group leader's encouragement, Charles then inquired about the experiences of two individuals who had not spoken in the group during this time and had recently experienced the death of loved ones. They said that they found it difficult to speak about death and their lost relationships because of the fear of being overwhelmed with intense sadness.

However, witnessing Charles's emotion-filled story helped them feel more able to express some of their own grief. This led to the whole group talking about the importance of interpersonal connections, loss, sadness, and how they each had a history of distracting themselves from the intensity of their feelings.

This illustrates one of the important tasks of the group psychotherapist, which is to help group members become aware of their own relational needs while being respectful and responsive to the needs of others in the group.

In this situation it seemed wiser to encourage Charles to inquire about the experiences of the other two group members. As the group therapist, I was building on the empathy and identification that existed between these three

people and wanted to strengthen the bonds between them. I was also focused on setting a model of involvement within the group. With other clients, I may be the one who initiates an inquiry rather than coaxing a group member to do so. That depends on the quality of connection that a person has with other group members and/or his or her need to rely on me to demonstrate my interest in his or her emotional experience. With someone else, I might inquire about his or her phenomenological experience of remaining silent, the importance of silence, and/or the quality of security that is needed.

In relational group process, I want to establish a cultural framework in which each member will be actively involved with other group members without a loss of anyone's individuality. Each therapeutic intervention is based on a split-second evaluation of the relational needs of each person and of the group as a whole. In the situation just described, the two group members who had not spoken did not require a challenge in order to express their silent grief. They needed another person, who was also acquainted with grief to reach out, ask about their feelings, and show an interest in their stories. It is through courteous and respectful transactions such as these that universality, cohesiveness, altruism, and intimacy are fostered.

Principles of the Model

A guiding principle of relational group psychotherapy is respect for each person's phenomenological experience. Through positive regard, understanding, kindness, and compassion, each group member establishes interpersonal relationships that provide affirmation of others' uniqueness and integrity. Integrity is perhaps best defined in Shakespeare's (1982) words in Hamlet: *"To thine own self be true, and it must follow, as the night the day, thou canst not then be false to any man"* (Act 1, Scene 3).

Interpersonal contact between group members is the therapeutic context in which each person explores his or her feelings, needs, memories, and perceptions. This does not mean that relational group process is all about being nice and superficial with one another. On the contrary, when we use the best of a feedback model, the result may be uncomfortable discussions, challenges to the other person's perspective, or confrontation of behaviour. Through the integration of the person-centred and feedback models, discussion, challenge, or confrontation done with honesty and respect for the other's perspective, in a nonhumiliating way, often builds trust in the relationship and fosters integrity.

Confrontation, when used in relational group process, is done with sensitivity to the potential shame it may cause and an awareness of potential re-traumatisation. As a group psychotherapist, I encourage members to obtain the other person's consent before making a confrontation, for example, *"I have something to say to you that may be uncomfortable. Do you want hear it and discuss your reactions?"*

I also lead group members to engage in phenomenological and relational inquiry following a confrontation with comments such as, *"How did you experience what was said to you? What meaning do you make of the fact that I said it now and not before? Is it possible that I have misperceived you and do not understand your experience?"*

When confrontation is accompanied by respectful, courteous inquiry into the current quality of an interpersonal relationship, the possibility of shame diminishes, and integrity is strengthened for each person involved in the exchange.

Confrontation is only useful in group psychotherapy when the person receiving it experi-

ences the confronter as being invested in the recipient's welfare. If that sense of interpersonal connection and collaboration is missing, then confrontation creates interpersonal conflict. The result may be resistance, resentment, and an interruption in the working alliance within the group. Therefore, it is essential that the group psychotherapist develop a relationally focused culture within the group, one that fosters attunement, understanding, acceptance, and interpersonal involvement among the members.

Developing a relationally focused culture occurs as the group therapist models and teaches about interpersonal contact and respect, focuses group members' attention on their own and other members' relational needs, explores possible breaches in relationships among members, and fosters group members' investment in resolving misunderstandings. Confrontations between group members are inevitable in therapy groups.

The effective therapist uses the perceptions of the whole group to work with the individuals involved: to help the person doing the confronting to discover the motivations underlying it and to help the person receiving the confrontation to explore his or her feeling, associations, and self-protective reactions. As a group builds experience together, it forms cohesion and intimacy. As that happens, confrontations can occur with sensitivity, respect, and inquiry. It should be noted that the traditional feedback and person-centred models are incompatible if used interchangeably and prematurely. It is only when a group has established mutual trust and a shared purpose that confrontation may be integrated effectively into a relational group process.

In a relationally focused therapy group, the therapist is not the only one to support and encourage group members to express what they are feeling and thinking. Group members' inquiry of and empathy with each other, and their encouragement for everyone to be heard, may constitute important psychologically supportive transactions when they express a shared experience of similar loss, stress, neglect, or trauma.

In an effectively conducted group, several elements occur synergistically:

- Group members talk authentically about their experiences, perceptions, and affect;
- Other group members fully listen and think about how the other's perceptions compare and contrast with their own;
- New experiences emerge in the form of communal experiences that are uniquely different from what each individual has previously known;
- New understandings come into view, script beliefs change and new emotional experiences occur as old relational memories are contrasted with what is transpiring relationally in the group.

These new experiences are uniquely individual and simultaneously uniquely relational. In creating a shared experience, the group constructs a place that belongs to no one in particular and yet to each and all, a creative place of relationship.

The Therapeutic Process

Relational group psychotherapy often begins with recognizing each person's needs and feelings. The leader often encourages group members to focus on each person's need for security, that is, the freedom to be as he or she is, without criticism, ridicule, or put-downs. One of the first steps in healing stress, undoing cumulative neglect, and resolving trauma is for each person to be assured that he or she will not be shamed in the group. This is often accompanied by encouraging group members to talk about past humiliating experiences and

how they were hurt, angry, or remain fearful in a group. Group members may be invited to remember emotionally laden experiences in which they did not feel secure with the goal of creating a safe space in which they can share their fantasies, attend to body sensations, and describe specific relational disruptions that occurred in their family, with friends, or at school. It is important to create the quality of relationships within the group that facilitates members talking about how they coped with fear, anger, relational disruptions, childhood neglect, a broken heart, or traumatic experiences. The goal is to foster understanding of how implicit memories and archaic ways of relating may be re-enacted within the group, in families, and in everyday life.

The group provides a safe place in which to experiment with new behaviours, attitudes, and relationships. The emphasis often shifts between what the person needed from significant others in original script-forming situations and what he or she currently needs from other group members. Such conversations may move from one group member to another with a focus on the type of security and interpersonal relationship each needs from the other.

For example, in a group that had met for several sessions, discussion among the members seemed to be rather superficial. I was disheartened when several group members avoided any emotionally charged topic. Some members repeated old stories, a few appeared to be shy, while a couple of members only talked about current events. Everyone avoided talking about early childhood script-forming experiences. Following one such session, I was quite troubled by the absence of any emotional expression or interpersonal contact in the group. I felt ashamed of my impoverished therapeutic work in the group and sought consultation with a colleague. She reminded me of the research I had done on shame. I realized that no one in the group had ever spoken about shame, even though most of the members were displaying symptoms of debilitating shame. Each person, including me, was living his or her distress in silence (Erskine, 1994/1997).

I began the next session by saying that I had realized that no-one had used the word "shame" in our previous sessions. I then described my sense of shame when I knew that I was not doing a competent job and expressed my fear of their potential ridicule. After my comments, there were several minutes of silence. Then the group members spoke of their own shame and how they often felt that there was something wrong with them. Over the next several sessions, each group member talked about how he or she had been blamed or humiliated in school, in previous groups, and in his or her family.

These discussions led them to recognize how each person needed safety in the group and the opportunity to express who he or she was, without ridicule. They then pledged to each other that there would be no shaming transactions and, if such transactions inadvertently occurred, the group would be committed to resolving the conflict. The group culture changed as they each talked about humiliating experiences, how they thought the others might reject them *"if you knew,"* and the painful childhood memories that had previously remained secret in the group. The group became lively and an interpersonally connecting, healing place.

Often discussions about security lead to someone's need for validation and affirmation by other group members. For many, behaviour or ways of making meaning were discounted, ignored, or in some way not validated in previous relationships. The lack of validation is often shaming and adds to stress. Validation is provided when we find value in what the other is saying.

As mentioned earlier, an important mission of

relational group psychotherapy is to provide each member with a sense of validation. A case in point: frequently a group member will say something that is full of emotion and others will remain silent. Although group members may think that they are being respectful, silence in such instances is often experienced by the speaker as a lack of validation of his or her affect and/or sense of self. The person may begin to doubt himself or herself and what he or she is saying; internal stress, shame, and withdrawal may result. It is the leader's responsibility to identify such moments when there is a lack of validation and to encourage members to speak about what they are feeling in response to the person. Such feeling-based responsiveness provides indispensable validation.

Each of us needs to rely on others who are stable, dependable, and protective, who provide under- standing, support, and guidance. An interpersonally contactful psychotherapy group can fulfil these needs when members consistently respect each person's affect, fantasies, and self-protective pro- cesses. The group provides a protective function when the setting is secure and offers the necessary attunement and involvement to understand the emotional expression or implicit memory that a member is experiencing. In some groups the significance of the larger unconscious story that a member is enacting in his or her behaviour and the importance of group members' patience and acceptance is a way to provide stability and dependability.

All of us need to have our personal experiences confirmed, which occurs when we are in dialogue with someone who understands because he or she has had a similar experience. The group leader watches for and encourages members to talk about how they identify with what a person may be saying that is similar to their own experience.

Frequently the conversation then flows between several group members, with each contributing the uniqueness of his or her own experience. It is in the shared experiences that people do not feel alone or worry that they are strange or crazy. Shared experiences are an important antidote to shame and an important way to reduce stress. The group's cohesiveness and the members' sense of belonging and universality are enhanced when members' personal experiences are confirmed.

Along with encouraging such confirmation, the group therapist supports each person in the group in expressing his or her uniqueness. People have the relational need to know and express their own self-definition, individuality, and distinctness while receiving acknowledgment and acceptance from others in the group. Self-definition is the communication of one's self-chosen identity through the expression of preferences, interests, and ideas without humiliation or rejection. The relational group psychotherapist encourages each person's expression of identity and integrity and the group's normalization of everyone's need for self-definition. In some family and school situations, children's attempts at self-definition are ridiculed or punished. When self-definition is thwarted, internal stress increases and a sense of one's self is lost. An effective group leader facilitates each individual in defining his or her self in relationship with others.

All people have the need to make an impact on others with whom they are involved. This need begins with an infant's first cry and continues throughout life. An individual's sense of competency in relationship emerges from attracting the other's attention and interest, influencing what may be talked about, and effecting a change of emotion or behaviour in others. Attunement to a group member's need to make an impact occurs when other group members allow themselves to be emotionally

impacted by the speaker and to respond with compassion when the speaker is sad, to provide an affect of security when the person is scared, to take the other seriously when he or she is angry, and to be excited when he or she is joyful.

Many people in group need others to initiate contact and reach out in a way that acknowledges their presence and demonstrates their importance in the relationship. The group psychotherapist models initiation, teaches about the importance of initiation, and encourages members to initiate with each other. So often people are hesitant to initiate because they think that they may be invasive or rescuing or they remember rules from school that prohibited children from talking to each other during class. Various initiations that group members make with each other often reduce group members' stress or sense of being alone. For example, a group member may say to another, *"I noticed that you have been silent for a while. I would like to know what you are experiencing."* This is an invitation to be fully involved together in the therapeutic process.

The need to express thankfulness, gratitude, and/or affection is also important in human relation- ships. When group members provide a sense of security, validation, stability, and dependability, when they have a shared experience, an opportunity for self-definition, a chance to make an impact, and show initiation with each other, individuals are often grateful and want to express their affection. The effective group leader facilitates expressions of thankfulness and gratitude as group members celebrate their accomplishments and successes together.

Conclusion

In my years of experimentation with group psychotherapy, I have found that a group based on the principles of relational group process is an effective venue in which to communicate transactional analysis concepts. It is through the development of trust, a shared relationship, validation, consistent reliability and security, and ongoing responses to each individual's relational needs that the indigenous healing and growth-enhancing power of the group is actualized in the lives of each member. Such respectful group involvement puts an end to group members' sense of shame, rectifies cumulative neglect, dissolves chronic stress, and heals trauma.

The development of this model of group therapy is not complete; it remains an active experiment. It must be continually refined according to the unique composition of each group, in response to the specific relational needs of its members and the cultural context of each group, and through the values and skills of the group leader.

I am intrigued by what other aspects of this model are yet to be developed: *"Are there more efficient and effective ways to resolve group therapy problems such as differentiation, inclusion, passivity, competition, envy, or confluence?" "What is the right balance between the therapist's attention to an individual member's script issues and the ongoing processes of the group?" "When is it appropriate to include experiential methods, supportive regression, body therapy, and/or re-decision therapy within a relationally focused group?" "What are the short- and long-term effects of being a member of a relationally focused group?"*

There is a plethora of research possibilities. I hope others will join me in experimenting with the various aspects of relational group process as a way to apply the theories of transactional analysis in group psychotherapy.

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References

BANET, A. G. & HAYDEN, C. (1997). A Tavistock Primer. In: J. E. Jones & W. Pfeiffer (Eds.), *The 1997 Annual Handbook for Group Facilitators*, (pp. 155-167). La Jolla, CA: University Associates.

BERNE, E. (1961). *Transactional Analysis in Psychotherapy: A Systematic Individual and Social Psychiatry.* New York: Grove Press.

BERNE, E. (1966). *Principles of Group Treatment.* New York: Grove Press.

BION, W. R. (1970). *Attention and Interpretation: A Scientific Approach to Insight in Psychoanalysis and Groups.* New York: Basic Books.

BION, W. R. (1989). *Experiences in Groups.* London: Tavistock Routledge.

BOZARTH, J. D. (1986). The Basic Encounter Group: An Alternative View. *The Journal for Specialists in Group Work*, 11(4), 228-232.

BUBER, M. (1958). *I and Thou.* (R. G. Smith, Trans.). New York: Scribner. (Original work published 1923)

EGAN, G. (1970). *Encounter: Groups for Interpersonal Growth.* Belmont, CA: Brooks/Cole.

EGAN, G. (1971). *Encounter Groups: Basic Readings.* Belmont, CA: Brooks/Cole.

ERSKINE, R. G. (1997). Shame and Self-Righteousness: Transactional Analysis Perspectives and Clin-

ical Interventions. In: R. G. Erskine, *Theories and Methods of an Integrative Transactional Analysis: A Volume of Selected Articles*, (pp. 46–67). San Francisco: TA Press. (Original work published 1994)

ERSKINE, R. G. & MOURSUND, J. P. (2011). *Integrative Psychotherapy in Action.* London: Karnac Books. (Original work published 1988)

ERSKINE, R. G., MOURSUND, J. P. & TRAUTMANN, R. L. (1999). *Beyond Empathy: A Therapy of Contact-in-Relationship.* New York: Brunner/Mazel.

GOULDING, M. M. & GOULDING, R. L. (1979). *Changing Lives through Re-decision Therapy.* New York: Brunner/Mazel.

KAPUR, R. & MILLER, K. (1987). A Comparison between Therapeutic Factors in TA and Psychodynamic Therapy Groups. *Transactional Analysis Journal*, 17, pp. 294-300.

MOWRER, O. H. (1972). Integrity Groups: Principles and Procedures. *The Counseling Psychologist*, 3, 7-33.

ORMONT, L. (2003). *Group Psychotherapy.* New York: Jason Aronson.

PERLS, F. S. (1967). Gestalt Therapy Verbatim. Lafayette, CA: Real People Press.

PERLS, F. S. (1973). *The Gestalt Approach and Eyewitness to Therapy.* Palo Alto, CA: Science & Behavior Books.

ROGERS, C. R. (1951). *Client-Centered Therapy.* Boston, MA: Houghton Mifflin.

ROGERS, C. R. (1961). *On Becoming a Person.* New York: Houghton Mifflin.

ROGERS, C. R. (1970). *Carl Rogers on Encounter Groups.* New York: Harper & Row.

RUTAN, J. S. & STONE, W. N. (1993). *Psychodynamic Group Psychotherapy (2nd ed.).* New York: Guilford Press.

SHAKESPEARE, W. (1982). *Hamlet (Arden edition)* (H. Jenkins, Ed.). New York: Methven.

SNYGG, D. & COMBS, A. W. (1949). *Individual Behavior: A New Frame of Reference for Psychology.* New York: Harper & Brothers.

YALOM, I. D. (1995). *The Theory and Practice of Group Psychotherapy.* New York: Basic Books.

Working with Groups in TA: An Integrative Approach

William Cornell

Abstract: In this article we want to make a contribution to the use of TA within the training and therapy groups by sharing the evolution of the work with the groups within the IFREP (Institute of Training and Research for Educators and Psychotherapists) founded by Pio Scilligo. This paper presents the theoretical foundations of the ATSC and explains how this model can be used within therapy and training groups with the aim to stimulate a relational climate that promotes the development of the individual's self, facilitating learning, personal and professional growth of all group members.

Key Words: Social-Cognitive Transactional Analysis, Development of the self, Relationships, Groups

Introduction

In this article, we want to share the evolution of the work with groups in the IFREP (Institute of Training and Research for Educators and Psychotherapists) founded by Pio Scilligo and give a contribution to the use of TA within training and therapy groups.

In the sixties, some authors who referred to Transactional Analysis (AT) theory proposed by Eric Berne (1961, 1966) began to integrate in his in-depth study on the theory and technique of therapeutic work with groups other therapeutic approaches, and while expanding and modifying some ways of intervening the reference theory remained the same.

This led to a "proliferation" of the various schools of thought in the various years up to the present day that, while maintaining their belonging to the basic model of Transactional Analysis, enriched it by integrating it with other therapeutic approaches.

Following that, we will report the evolution of the work with groups within the IFREP (Institute of Training and Research for Educators and Psychotherapists) school founded by Pio Scilligo.

In the seventies, Scilligo went to America to deepen his psychological studies attending several workshops and residential trainings. Among these, he attended a training organized by Bob and Mary Goulding that founded the school of the "Redecision therapy" putting together the TA model with the Gestalt therapy. In working with groups, this model modifies the methodology proposed by Berne passing from a "therapy with the group or through the

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group", characterized by the analysis of the transactions that occur between the different members of the group or between them and the therapist, to an intervention of "therapy in the group" characterized by individual therapy within the group.

Scilligo, becoming passionate about this model, after returning to Italy, first began to offer weekends, referring to this methodology of working with the groups, and following that, he organized and founded a training school for TA therapists where a therapeutic work that followed the model proposed by Gouldings (1983) was contemplated.

Within the educational path, the training involved also the study and deepening of other ways of intervening in group therapy proposed within the TA theoretical model. For this purpose, Carlo Moiso was invited several times to show how a classical Bernian group could be led and over the years, a group of IFREP collaborators, who had the opportunity to train in America at the Matrix (an institute specialized in working with Borderline patients using the working model with groups proposed by the Schiffs), joined to experiment this method of intervention with groups. This re-parenting intervention considers the group as the ideal structure that allows patients with "severe personality disorders" to overcome their symbiotic problem through, either the "containment" of the structure of the therapeutic group, or by means of the systematic regression technique. To deepen the procedure and the experience that was made, refer to chapters 11, 12 and 13 written by Maria Luisa De Luca (2009).

In the 1980s, Scilligo elaborated the interpersonal model proposed by Lorna Benjamin (1999) and began to integrate it with TA establishing the model of the Social-Cognitive Transactional Analysis (ATSC) (Scilligo 2009), (De Luca, Tosi, 2012). To illustrate how this model is used in the work with both therapy and training groups, we will report some concepts that distinguish it.

The ATSC is an integrated model of psychotherapy based on the principle that the "relationship" allows the change of the persons Self. This is in accordance with the object relations model (Mitchell, 1988; Mitchell-Aron, 1999), the interpersonal model (Benjamin, 2004) and the authors who are inspired by the relational TA model (Hargaden-Sills, 2002; Hargaden-Sills, 2003).

Scilligo (2009) defines the Self as the precipitate of all personal life experiences resulting from relational processes, even if in a non-exclusive way, as it is influenced by both genetic endowment and existential experiences of all kinds.

The Self is in continuous transformation according to the quality of the relationships that the person establishes, and it is the precipitate of the relationship between the person and the other important ones, as well as the impact one has on others and vice versa.

Figure 1 illustrates the process of structuring and continuous revision of the Self. It is possible to observe that the Self is structured in important relationships, for example between the parent and the child, in a process of an ongoing interdependence both for the child and for the parent. Both will also propose and respond, to "other important ones", starting from their Self and thanks to these new relationships the Self will be continually reinforced or restructured.

This process can explain the importance that the relationship with the therapist, the supervisor or the teacher as the "other important one", can have on the growth of the individual, both at the individual and group level, and therefore the necessity of the competence to promote a relational climate, which facilitates such development.

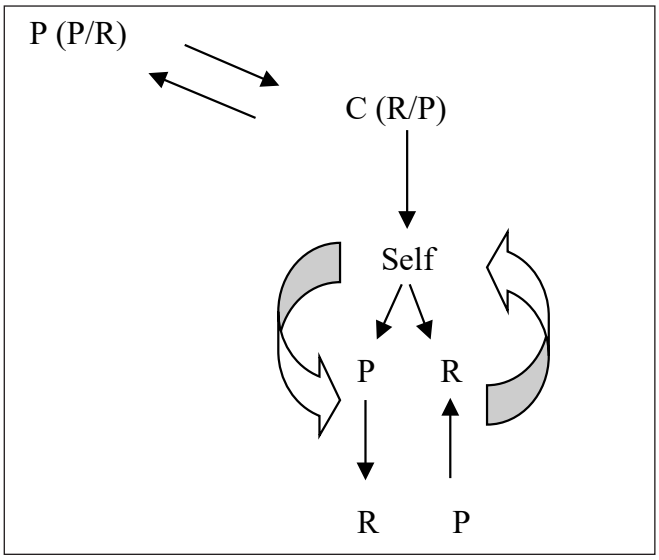

Fig. 1: *Process for structuring and continuous revision of the Self. The arrows that go from the parent (P) to the (Child), and alternate in the role of P (proponent) and R (Responder), indicate the relational process from which the Self arises.*

Scilligo (2009) through his research led at the Research Laboratory on the Self and on Identity (LARSI), has redefined the ego states, proposed by Berne (1961), referring to the model proposed by Lorna Benjamin (1999) and he identified specific ego states, indicators of well-being and pathology. Scilligo defines the ego states of the Social-Cognitive Transaction Analysis by considering:

1. The three dimensions referring to the evolutionary theory of man:
   - *Pain - Pleasure* are dimensions linked to existence and define the tendency of the human being to search pleasure and avoid pain;

     Active - Passive are dimensions linked to survival and define the tendency of the human being to react passively or actively to the changes in the environment;
   - *Relational Power* is a dimension linked to the capacity to provide for the maintenance of the species through relational interdependence, or else the tendency of the human being to give or take power away from the other and the self in passing on and transmitting to future generations the culture and values.

These three dimensions allow us to describe how the person works and structures itself, considering *how actively or passively he/she obtains pleasure or pain and gives or takes away power from himself/herself and others in carrying on his own values.*

2. The evolutionary dimension that describes the biological and psychological development of man, referring to the evolutionary phases proposed by Mahler, and which highlights the different abilities and functions of the child in the transition from an undifferentiated Self to a differentiated Self. This allows us to describe which evolutionary competence is activated by the person in the relationship with oneself and with others.

Through these dimensions Scilligo (2007) proposes a classification of 24 Relational ego states (12 linked to the way in which the person proposes him/herself to the other, called Pro-

ponent ego states, and 12 related to the way in which the person responds to the other, called Respondent ego states) and 12 Self ego states correlated with the relational models the person has experienced with the other significant ones. Both types of ego states, self and relational are distinguished in:

- Four Parent ego states (Free Parent FP, Protective Parent PP, Critical Parent CP, Rebellious Parent RP);
- Four Adult ego states (Free Adult FA, Protective Adult PA, Critical Adult CA, Rebellious Adult RA);
- Four Child ego states (Free Child FC, Protective Child PC, Critical Child CC, Rebellious Child RC). (Fig. 2a and 2b)

Research led by the LARSI has shown that the main indicators of well-being and pathology can be detected thanks to the configuration of specific profiles of ego states. The *typical profile of well-being and secure attachment is characterized by an activation of the FA, FC, PC, PA ego states that form the so-called "well-being system"* accompanied by a moderately high activation of the FP and PP, and a low activation of the remaining ego states (Scilligo-Bianchini, 2006).

Starting from these considerations, and referring to the concept of *Vis Medicatrix naturae* (the human being drive to the self-realization) elaborated by Berne (1966), it is fundamental that a therapist, a supervisor or a teacher structure a group in a way that models and stimulates the participants to activate relational positions imprinted on *loving interdependence*, in order to favour a constructive impact on the Self of the individual members of the group that facilitates personal growth and well-being. This means that the individual members of the group will be able to activate the protective and free ego states, typical of well-being and of secure attachment.

Therefore, to have an impact on this process, considering the context and a basic attitude characterized by positive affectivity, the therapist, supervisor and/or teacher in the role of the "Proponent" need to be able to "contain", or else:

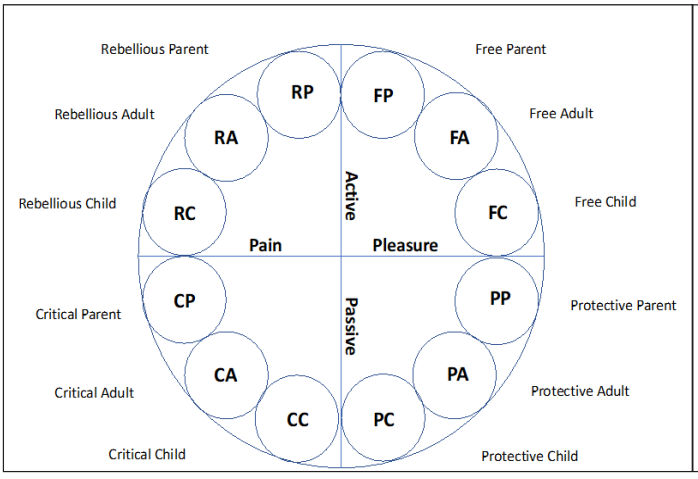

Fig. 2a: *The different Parent, Adult and Child ego states defined by the Social-Cognitive Transactional Analysis.*

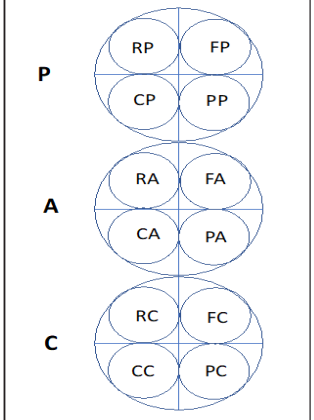

Fig. 2b: *The different Parent, Adult and Child ego states defined and represented by the Social-Cognitive Transactional Analysis.*

- Confront the other if he/she behaves inadequately, stimulate and encourage his/her ability to think and move with its own head favouring autonomy and differentiation.
- Activate the following attitudes and behaviours that characterize specific ego states:
  - let the freedom to do (FP);
  - let the other express own points view (FA);
  - accept the other as he is (FC);
  - support with affection (PC);
  - explain and make things understand (PA);
  - remember what must be done (PP).

In the role of the "Respondent" it is important that the therapist, supervisor and/or teacher can:

- Trust oneself in knowing how to accept what comes from the other and choose freely, according to the context, how to express oneself. To have a positive impact on the other, it is relevant to have a positive emotional connotation.
- Activate the following attitudes and behaviours characterizing specific ego states:
  - express oneself with a secure and distinct identity (FP),
  - express oneself with own thoughts and feelings (FA),
  - express oneself with joy and affection (FC);
  - accept affectionately help and attentions (PC);
  - listen and accept the proposals of the other (PA);
  - adapt to the another when necessary (PP).

The precipitate of the relationships linked to the activation of these ways of proposing and responding - that characterize the *well-being system* and the secure attachment- stimulate in the person who is in his personal or professional training, the development of an integrated Self that allows one to feel secure and capable of interdependence in the relationship, "to know how to dance between oneself and the other".

The person will be particularly stimulated in activating the following attitudes and behaviours that characterize specific ego states:

- take initiatives following rules that are respectful of oneself and the other (FP);
- reflect and accept oneself (FA);
- esteem oneself, and give oneself attention and affection (FC);
- accept attentions and affection (BP);
- reflect and protect oneself (PA);
- strive to do things properly (PP).

Summarizing, according to this approach, it is fundamental that the group therapist, the individual therapist, the supervisor or the teacher can create a relational environment that allows the promotion of a climate that facilitates the development of the Self and stimulate the person to experiment an antithetical relationship to his script process (Mastromarino, 2013).

Referring to this model in our clinical practice with groups, reflecting on the process, we pay attention to the quality of the relationship stimulating and promoting in the group members the activation of those ego states that characterize the well-being system, while at the level of the theory and technique, or else regarding the intervention in working with groups we refer both to the "therapy with the group and through the group" by Berne, and the one "in the group" by the Gouldings. Adapting the therapeutic intervention both to the needs of the group and to the phase of therapy in which the patients are located.

Specifically, in the phase of the alliance and decontamination we find it more useful to work by referring to the therapy with the group (Bernian group) to stimulate people to realize their script process or that they are acting in therapy with the other members of the group, or that they are acting in bringing back their experience.

In the deconfusion therapy phase, instead, we prefer to work individually in the group using the redecision; and in the relearning phase we find useful the support of the group using both working methods "with the group and in the group".

In 2008, Scilligo encouraged Emilio Riccioli to open a training school in clinical psychology in Palermo. This school began to the work with groups rediscovering the roots proposed by Berne.

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References

BENJAMIN, L. S. (1999). *Diagnosi interpersonale e trattamento di disturbi di personalità [Interpersonal Diagnosis and Treatment of Personality Disorders]*. Roma, LAS.

BERNE, E. (1961). *Analisi transazionale e psicoterapia [Transactional Analysis in Psichotherapy]*. Astrolabio, Roma.

BERNE, E. (1966). *Principi di terapia di gruppo [Principles of Group Treatment]*. Astrolabio, Roma.

DE LUCA, M. L. (2009). *Psicoterapia e ricerca: dalla teoria alla clinica [Psychotherapy and Research: from Theory to Clinic]*. Roma, Las.

DE LUCA, M. L. & TOSI, M. T. (2012). L'Analisi Transazionale Socio-Cognitiva: introduzione al modello di Pio Scilligo degli Stati dell'Io [Social-Cognitive Transactional Analysis: introduction to Pio Scilligo's model of ego states], *Psicologia Psicoterapia e Salute*, 17, pp. 9-44.

HARGADEN, H. & SILLS, C. (2002). *Transactional Analysis: A Relational Perspective*. Brunner-Routledge, London.

HARGADEN, H. & SILLS, C. (2003). *Key Concepts in Transactional Analysis. Contemporary Views*. Vol. 1: Ego States, London, Worth Publishing.

GOULDINGS, M. & GOULDINGS, R. L. (1983). *Il cambiamento di vita nella terapia ridecisionale [Changing Lives through Redecision Therapy]*. Roma, Astrolabio.x

MASTROMARINO, R.(2013). *La gestione dei gruppi. Le competenze per gestire e facilitare i processi di gruppo [Working with Groups. The Skills for Working and Facilitating Group Processes]*. Milano, Franco Angeli.

MITCHELL, S. (1988). *Gli orientamenti relazionali in psicoanalisi. Per un modello integrato [Relational Concepts in Psychoanalysis: An Integration]*. Torino, Bollati Boringhieri.

MITCHELL, S. A. & ARON, L. (1999). *Relational Psychoanalysis: the Emergence of a Tradition*. Hillsdale NJ, Analytic Press.

SCILLIGO, P. & BIANCHINI, S. (2006), L'Analisi Transazionale Socio-Cognitiva [Social-Cognitive Transactional Analysis], *Psicologia Psicoterapia e Salute*, 12, pp. 349-371.

SCILLIGO, P. (2007). Il dialogo tra Analisi Transazionale (tradizionale) e L'Analisi Transazionale socio cognitiva (ATSC) [The Dialogue between (Traditional) Transactional Analysis and Social-Cognitive Transactional Analysis (ATSC)], *Psicologia Psicoterapia e Salute*, 8.

SCILLIGO, P. (2009). *Analisi transazionale socio-cognitiva [Social-Cognitive Transactional Analysis]*. Roma, LAS, 2009.

A Psycho-Tactile Approach to Trauma

Gerry Pyves

Abstract: In this article, the author reviews some of the very latest neuroscience regarding the impact of touch on the limbic brain. In particular, he explores the relationship between gentle soothing touch and the role it may now have in dissolving traumatic triggers in the Amygdala. Transactional Analysis theory is used to integrate this exciting new science into psychotherapy, through a case study and the consideration of the role of the Adult Ego State, Script Protocol, Physis and 3rd Degree Impasse in working with trauma.

Key Words: Transactional Analysis, Massage & Bodywork, Neuroscience, Limbic Brain, Amygdala, Touch, AMPA receptors, Brain waves, Electrochemical, Trauma, Grief, Fight, Flight, Freeze, Child ego-state, Impasse, Psychotherapy, Psycho-Tactile, Adult Ego State, Script Protocol, 3rd Degree Impasse.

The Massage Client Who Did Not Want to be Touched

'Marion' (27-yrs old), walked into the treatment room looking nervous and without confidence. When I asked her why she had come for a massage, the first thing she said was that she "did not want to be touched". A little confused, I asked her why she had come and what did she want? She told me that she could not sleep and was having trouble making herself go outside the house. She avoided eye-contact whilst talking to me and said that she had lost all her confidence. Marion then went on to relate how she had recently been attacked and raped at knifepoint by a group of three men. She told me that she had come to me because she just knew that she needed to experience safe touch from a man. At this time, I had not even begun my psychotherapy training and only had the faintest inkling of trauma and its profound effects. A bit confused, I asked Marion what she thought I could do to help? She said that she knew "deep down" that this was what she needed to do, but that she felt too scared to receive touch right now. I re-assured Marion and suggested that perhaps we could start with me explaining to her how a session normally goes (remarkably, she had never had a massage before).

I showed Marion where people get undressed, how they lie on the table, what draping is used and what happens at the end of each session. When I explained that people decided how

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much clothing to keep on during the massage and that I was comfortable working with people anywhere from fully naked to fully clothed, her eyes lit up and she said, "So you can massage me fully clothed?" When I said that this could often be as effective as oil-on-skin massage, she asked if she could have that right now?

So, I agreed, and Marion got onto the table lying face down, fully clothed. Before I touched her, some instinct made me ask her how she felt just lying there with me standing so close. She said that she felt a lot tenser than before she got on the table. So, I asked her to direct me to a place in the room where her body felt more relaxed. Nothing made a difference as she suggested different places in the room and we even tried me sitting on the floor. I then asked her if I could open the door and stand in the corridor. As soon as I did this, she said that she could feel her body relax.

When I said that I thought I might struggle to massage her from out in the corridor, we both burst out laughing. I then gave complete control to her by inviting her to instruct me to move closer and closer at a pace that she felt comfortable with. It took about 20 minutes as she told me to move closer, one step at a time, and then away for one step, whenever she felt that it was 'too much". By the end of this first session, Marion had allowed me close enough to lightly place my hand on her back for about 5 minutes and she ended the session saying that she felt that this had helped. We booked another session for a week's time.

At the second session, I asked if she wanted me to start out in the corridor again. She agreed to this, but this time she brought me into the room much more quickly and I was touching her back within 5 minutes. I then explained the 5 different movements of massage and asked her which she wanted next. In that session. she chose gentle, light and slow stroking. Although receptive to the touch, there was a sense that she was 'watching and waiting'. A week later at the start of the third session, she asked me to start right away and not to waste any more time "mucking about in the corridor". During this session, she asked to experience the other strokes I used on my clients. I let her experience kneading, compression, rocking, swaying and tapping. She enjoyed this exploration and we spent quite a lot of the session discussing what she could feel with the different strokes and which ones she liked the most. At the fourth session, she asked for "just stroking", the same as in her second session.

On several occasions during this fourth (stroking) treatment, I noted that she sometimes sniffed or sobbed gently, often for just a few seconds. On these occasions, I asked her if she wished me to stop or to continue – and she always wanted me to continue touching her during these moments. At the beginning of the fifth session, she asked if I would use oil-on-skin strokes for her, which I did. This felt the most profound session of them all to me, as she seemed literally to drink the touch into her being, again with some gentle sobbing. I was deeply moved by the atmosphere of healing in the room. At the end of the session, she was smiling brightly and simply said, "Thank you - that's all I need. I am better now". I never saw her again.

In my work with Marion, I could call upon very little that I had learned whilst training as a massage therapist. I would like to say here, that I have spent the last thirty years working as both a psychotherapist and a Bodyworker trying to understand just what happened with Marion, and what role touch might play in my work with traumatised clients. Over the years, I have seen many massage clients make significant changes to their lives and to their general outlook without any psychological input from myself. Working with two separate practices, one as a psychotherapist and one as a massage

therapist, I was sometimes hard pressed to say which client group had made the most 'script' changes. How was it, I wondered, that clients who turned up with tight backs and necks and had simple touch, were making similarly profound script changes as those who came for psychotherapy?

I now firmly believe that the reason for this is that certain types of touch are able to reach the most traumatised parts of the brain. This article sets out to show how touch can literally soothe the amygdala, release procedurally-held trauma, and help clients to rebuild their overall resilience.

The First Human Transaction

It should not come as a surprise that touch may have profound psychological properties. Touch is the very first sensory system to develop in the embryo – the skin is highly developed by the time the embryo is still less than an inch long. In fact, both the skin and the brain arise from the same embryonic cell layer – the ectoderm. The fact that the brain and the skin share the same stem cells has been confirmed recently by scientists growing brain tissue from human skin cells (Yoo *et al.*, 2011). This suggests that the most direct way to reach directly into the brain may be to touch the skin.

At birth, we are subjected to massive compressive traumas to our tissues, as well as suffering the inevitable trauma of expulsion from a known and familiar environment. The only thing that soothes this distress is to be touched and held. Much has been written about the many traumas that have been (and often still are) inflicted upon babies and mothers at the time of birth through the denial of this reparative touch (LeBoyer, 1975). Most readers of this article will come from a generation in which such soothing touch was taken away from us by an ill-informed and essentially male-dominated medicalisation of birth.

What 'script protocols' are likely to have been laid down in all of us regarding touch and relationship through the denial of such a vital evolutionary and healing touch experience? Lacking a fully formed hippocampus, such experiences are not remembered in our declarative memory, yet they remain in our bodies through 'procedural memory' (Scaer, 2014). This is just one example of how most of us are carrying a level of early and unremembered trauma in our bodies that words may never reach. It is a fundamental tenet of Transactional Analysis that such early experiences form the 'script protocols' that will shape our future life scripts. Eric Berne illustrated this idea with the analogy of medieval palimpsests, where ancient documents are written over again and again with more recent material, yet still the original vellum remains (Berne, 1963/75).

The act of reaching out to be held, and the act of being held then, is the first and most primal of all human transactions. It is life's primal soothing transaction. In many ways, we could look at all other human transactions as simple developments (or palimpsests) of this first attachment protocol. Such early experiences will inevitably become the foundations for later variations of our attitude towards touch, relationships and the world:

> *"The first script programming takes place during the nursing period, in the form of short protocols which can be later worked into complicated dramas. Usually these are two-handed scenes between the baby and his mother, with little interference from the onlookers..."* (Berne, 1972, p. 83)

Berne links these early tactile experiences directly with our later adult life positions as he then goes on to write:

> *"Already the feeling of OK-ness or not-OK-ness, which separates the now and future 'princes' from the now and future 'frogs' is being implanted and several types of 'frogs and princes' are being set up."* (Ibid)

Berne is clearly writing about this pre-verbal stage of human development as laying down the foundations of our future 'life scripts'. As touch is the primary language of such early attachment protocols, if we wish to speak to this part of the psyche, we may need to consider conversing with our clients in this language, the language of touch.

Touch and the Amygdala

Traumatic Encoding

Over the last thirty years, great strides have been made in our understanding of the way that trauma actually affects the brain and what this means for psychotherapists. Much of this neuroscience has already been well summarised (Novak, 2008). More recently, new information has appeared about just how trauma becomes encoded within the amygdala and why this is so hard to change (Clem *et al.*, 2010; LeDoux, 2012). For an event – or a series of events – to be encoxded within the brain as "traumatic triggers", Ruden (2010) has proposed that *all four* of the following conditions are necessary:

1. There needs to be an event that carries an intense emotional component.
2. This event needs to carry attachment meaning, either to our own life or to a significant other.
3. The landscape or 'state' of the brain needs to be vulnerable to stress.
4. There needs to be an element of inescapability to the situation.

Ruden has also summarised the neuroscience into the following sequence of electrochemical events, taking place within the limbic area of the brain:

> *"Sensory information related to the threat passes electrically to the thalamus and then to the amygdala in the limbic brain. This takes place under the excitatory conditions of high frequency stress-induced Gamma brain waves (30-100 Hz). Under these conditions, the chemical neurotransmitters of glutamate, cortisol and noradrenalin are released in large amounts. Within the amygdala (specifically the lateral amygdala), glutamate receptors respond (or are raised) to these chemicals and this triggers an electrical impulse to the hypothalamus, where all of our fight, flight or freeze responses are initiated throughout the rest of the brain and the body. In addition to this, all the memories associated with the trauma are stored in the hippocampus for future reference. When the trauma is sufficiently extreme to fulfil the four conditions above, then the receptors within the amygdala (called AMPA receptors) are glued 'open' permanently in a process called 'phosphorylation'. It is this permanent availability of the AMPA receptors for traumatic re-triggering that explains the hyper-vigilance of traumatised individuals."*

This 'phosphorylation' process has an important survival function, namely that we can have a heightened awareness of such danger in the future. After the instance of the 2001 Twin Towers disaster, for example, many people reported being traumatised by the sound of aircraft flying anywhere near a building. When these 'trauma' receptors become 'cemented' open, it means that we are continuously on alert for these signals, even after the threat or trauma has long passed. This is an electro-chemical way for us to understand traumatic memory and PTSD and I have summarised it in Figure 1.

No matter how much common sense (or adult awareness) we might bring to a situation (i.e., "That plane is not necessarily a terrorist plane."), if the amygdala is sending "life threatening" signals to our hypothalamus, then we will react as if the threat is really present in the here-and-now. Basically,

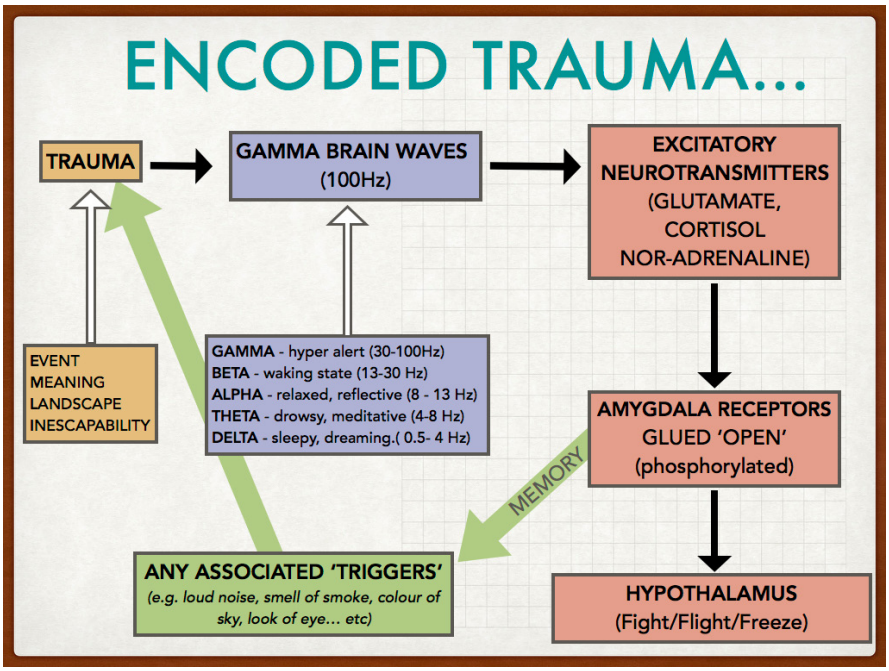

Fig. 1: *The Electrochemical Story of Trauma*

what the amygdala decides, nothing overrides. Neuro-chemically, we now know that this is because of these raised AMPA receptors (Kim *et al.*, 2008; Clem *et al.*, 2010; Hendler *et al.*, 2003).

By the time our higher brain functions in the cortex respond with a "Don't Be Silly" message (what LeDoux calls, "The High Road"), our limbic system has ensured that we are already running for cover. This is why it is almost impossible for the upper brain to contradict the limbic section of the mid-brain (LeDoux, 1996; Bromberg, 2006). Apart from anything else, the thalamus-amygdala "Low Road" travels much faster than anything that has to go through the higher part of the brain in the cortex.

This explains the inability of clients to distinguish the "there-and-then" from the "here-and-now", which is the very essence of PTSD. Research has also shown that repeated traumas actually erode our hippocampus, which is the part of the limbic brain where we lay down new and healthier associations and memories based on subsequent positive experiences (Bremner, 2006).

With respect to Transactional Analysis, this means that the more trauma that we have experienced, the harder it is to 'cathect' to our Adult Ego-State. Each trigger literally "rubber bands" us right back into the earlier Child Ego-State of the original trauma (Woollams & Brown, 1978). The more trauma that we have experienced, the more triggers lie cemented in the 'open' position in the amygdala. This means that we now have a clear neuro-scientific explanation for the observable process that we (in TA) have been calling 'ego-state contamination' and 'ego-state exclusion' for over 50 years (Berne, 1961).

Decoding Trauma

The good news is that neuroscientists are also

discovering that these raised levels in AMPA receptors are susceptible to extinction. In one study, researchers found that by simply stimulating the amygdala with slow electrical pulses, the alertness in these receptors was dissolved and the 'trigger' then re-absorbed into the neuronal body (Clem, 2010). This remarkable study was able to remove fear conditioning in rats through low frequency (Delta brain-wave-like) pulses. Research has also shown that, in the presence of touch, human brain waves drop into the slow Delta brain-wave state (Harper *et al.*, 2009).

In a tactile environment, a whole different chemical environment is created within the amygdala. The soothing or calming neurotransmitters of serotonin, GABA and oxytocin are all released in a calcium-rich 'soup' and this causes the encoded AMPA receptors to literally dissolve. When this 'de-phosphorylation' occurs, there is sometimes no longer any memory of the trauma at all, as the triggers have literally been dissolved (Ruden, 2010). This means that there is no future activation of the hypothalamus into our "Fight, Flight or Freeze" responses and there is no re-kindling of the trauma through repeated re-enactments. This decoding of trauma is captured in Figure 2.

This suggests that touch reaches directly into the amygdala and can set in motion a powerful change to the chemical environment of our limbic system, and that this change dissolves and removes our traumatically encoded triggers. This connection between touch and the amygdala is therefore a potential 'game changer' in the treatment of trauma.

C-Tactile Nerve fibres

Originally, it was thought that the only sense that could influence the amygdala directly was our sense of smell. However, with the recent discovery of what neuroscientists are now calling "C-Tactile afferent neurons", it seems

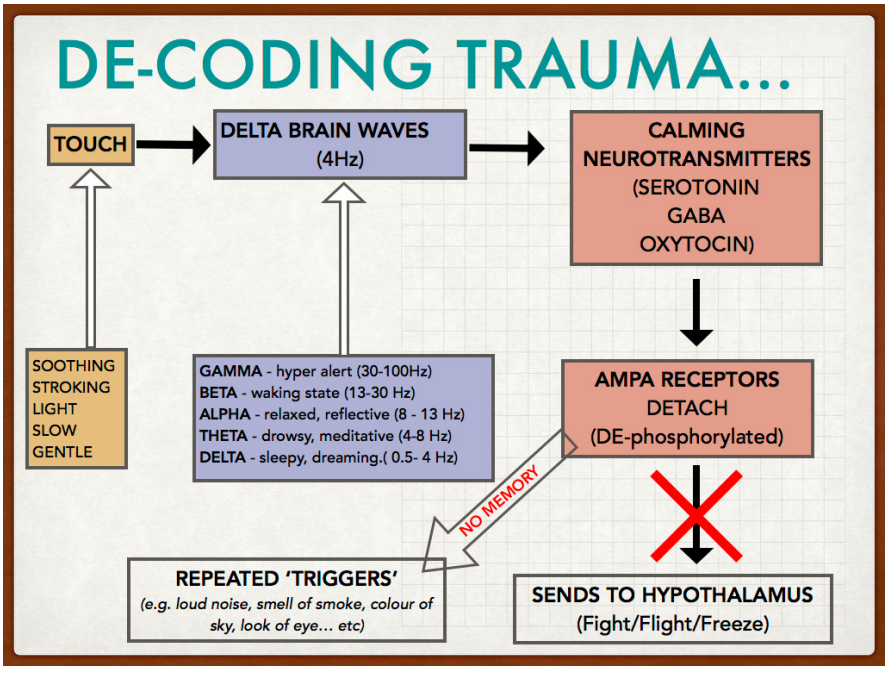

Fig. 2: *The Electrochemical Story of Decoding Trauma*

that we are beginning to discover just how touch can have an instant effect on the limbic system (McGlone *et al.*, 2007).

The many different types of nerves that innervate the skin generally inform us of where we are in our environment through proprioceptive nerves in our muscles, tendons and joints. Mechano-receptors in our skin inform us about our environment and whether it is safe or dangerous. These nerves all fire at very fast speeds (150-250 mph) and connect up to the sensorimotor regions of the cortex within milliseconds. The newly discovered C-Tactile neurons, however, send their signals at a leisurely 2 mph and end up in the limbic brain a lot later than the other sensory nerves (Linden, 2015). They are thus too slow to have any function for helping us assess the safety of our environment.

These nerve fibres do not seem to respond to heavy or fast movements, but they are only triggered by a gentle and light caressing touch, and the signal travels at 3-10 cm per second. It seems that these are our 'pleasure nerves' and our 'soothing nerves' (Morrison *et al.*, 2011). At the Liverpool Festival of Science, Professor McGlone (2008) stated that:

> *"...neuroimaging studies with fMRI and PET have corroborated both these findings [about CT-afferents], showing that the brain areas that respond to such pleasant forms of touch are those areas that are known to process emotions – of both pain and pleasure.*

When we provide a soothing touch, it seems we may be encoding pleasure into the emotional centres of the brain. Scientists are linking this soothing touch to mammalian grooming behaviours and now regard these CT afferents as our primary nerves of social interaction (Line et al., 2009). These nerves may well be the key that help us to understand, not only the healing power of gentle touch, but also the loss of resilience in people who have not had safe attachments in their early years. If we are not soothed, then it seems we are likely to interact with the world from a more vulnerable brain landscape. This is the stuff of hyper-arousal and hyper-alertness, as well as of frozen hypo-awareness (Siegal, 2011).

Soothing Touch

With the discovery that gentle soothing touch travels directly into our emotional brain, it seems that simple stroking may now be one of our most direct routes into the traumatised amygdala (Francis *et al.*, 1999; McGlone *et al.*, 2007). So, neuroscience is now pointing us towards the idea that gentle soothing touch may be one of the most powerful and direct therapeutic interventions that we can use in the treatment of trauma:

> *"The description of a 'new' touch modality in human skin, one that shares the same nerve type as pain, is seen as of potential relevance to not only a better understanding of the role of touch in human social behaviour and personal well-being but also to a better understanding of human pain mechanisms and their treatment. We have new evidence that stimuli that excite CT's, reduces activity in pain C-fibres. We are also interested in studying a range of clinical conditions, from depression to autism, that are also known to have links with touch – most autistic children hate being cuddled and stroked, and many depressed people show clear signs of lack of body care, such as lack of grooming behaviours, and a susceptibility to depression may have its roots in poor maternal care and early life experiences with touch starvation."* (McGlone, 2008)

McGlone shows how these findings in neuroscience take us right back to the issues of our early maternal care and our first attachment protocols. He also suggests that that the pleasure signals produced by touch actually reduce the pain signals in the limbic brain. The

role of touch in removing pain has long been documented and initially led to the 'gate theory of pain' within the spinal cord (Melzack & Wall, 1965). It seems that neuroscience is now offering us another 'gate theory', namely that touch replaces pain with pleasure in the limbic brain. This is consistent with the other neuroscientific findings that touch actually extinguishes traumatic triggers in the amygdala. It should come as no surprise then, that studies have shown that the very same 'touch aversive' autistic children mentioned by McGlone (as well as children suffering from ADHD and also abused children) have actually responded positively to the reparative experience of safe touch (Field, 2015).

All of this suggests that psychotherapists may be able to use simple human touch to affect the amygdala – almost surgically – and transform the electrochemical landscape of the traumatised brain. This takes place through the creation of Delta brain-wave patterns and the subsequent dissolution of raised AMPA receptors. It may also take place through the replacement of pain stimuli with pleasure stimuli from the actively stroked CT-afferent neurons.

In Marion's case, her instinctive choice of gentle soothing touch in a safe environment that did not re-trigger her traumatic response suggests that the depotentiation of her AMPA receptors was taking place and that painful triggers were being replaced by pleasurable ones. This is one way to understand her growing resilience over just five weeks of treatment.

Theoretical Considerations

1. The Adult Ego-State

Significantly, when Marion received touch, she remained in control of just *how the touch was given* throughout the process. Massage therapists working with veterans suffering from PTSD have found that – for touch to be beneficial – the client must be in total control of everything that happens in the session (McCafferty, 2016). Instinctively, I had repeatedly invited Marion to be in control and we both engaged our Adult Ego-States in the challenge of exploring what types of touch might work for her. This meant that the touch that she experienced was accompanied with a great deal of "here-and-now" discussion throughout. This means that she was repeatedly cathecting her Adult Ego-State in order to integrate her experiences of touch. This demonstrates graphically how touch can be used to actively strengthen the Adult Ego-State of our clients.

Dan Siegal (2011) would later call this *"staying within her window of tolerance"* and Peter Levine (1997) would later coin the phrase *"penduluming"* to describe this process of dipping in and out of Adult awareness – a process that had already been well documented in TA writings for more than half a century. Both writers believe that maintaining such "here-and-now" awareness is crucial for the medial pre-frontal cortex to stay sufficiently 'on-line'. This is what enables us to find new meaning and construct coherent narratives. These findings in neuroscience perhaps explain one of the main reasons why TA has proven itself to be such a popular and clinically effective approach to therapy, worldwide.

Without the ability to construct such narratives, clients struggle to process and move on from trauma. Marion's touch journey showed a gradual increase in her Adult Ego-State and consequently of her resilience to the point where she could finally receive oil-on-skin. It was also clear that her internal Parent Ego-State "watcher" now felt content that the massage was safe. This meant that she was able to "let in" the touch during a largely silent fifth session in which she clearly felt safe enough to sob gently. This would have simply been unimaginable at her first session.

2. Script Protocols

Another way to understand the neuroscience is to consider how touch may give us a unique form of access to our early 'script protocols'. Berne (1961) wrote: *"In script analysis, the household drama which is first played out to an unsatisfactory conclusion is called the protocol"* (p. 117). This suggests that protocol is essentially a response to traumatic events or surroundings. If encoded, then such trauma will reside as raised AMPA receptors in the amygdala. This should place the depotentiation of AMPA receptors in the amygdala (through touch) at the forefront of the future of the psychotherapy of trauma and changes to our 'script protocols'.

Cornell and Landaiche (2006) write of the unchangeable nature of experience at this pre-verbal level of early scripting: *"The most salient aspect of protocol, as distinct from script, is that it cannot be cognitively changed, re-decided, or re-scripted."* (p. 204). However, this does not fit with my own clinical experience when using touch. As a massage therapist, I am witnessing significant life transformations in many of my massage clients from simple touch on a regular basis. That early and somatic aspects of such scripts have been addressed is demonstrated by the physiological and postural shifts that accompany significant life changes, often characterised by growing affect and increased resilience. Such script protocol transformations are expressed by my clients across all three realms of cognition, affect and physiology – and often occur without any psychological contract or verbal input from myself.

Far from merely helping our clients to re-organise how they must live with such 'unchangeable' early script protocols, as Cornell and Landaich suggest, it seems that we can now use touch to remove these early traumatic triggers and create an environment where re-scripting occurs naturally across multiple ego states. My client, Marion demonstrated such a shift eloquently in her recovery from a recent trauma with a massage practitioner who had had absolutely no psychotherapy training or experience. Her physical difficulty in leaving her house after the rape suggests that her recent trauma may well have triggered earlier traumas held in her Child Ego-State. Bessel van der Kolk (2014) asserts that PTSD is almost always co-morbid with earlier traumatic experiences. This would mean that Marion's self-stated 'cure' involved her making *actual changes* at the level of her early script protocols.

3. 'Physis'

Such a natural re-scripting through simple touch brings us to one of Berne's (1947/86) most cherished and enduring of concepts, namely the concept of *'Physis'* or *"...the force of nature which eternally strives to make things grow and to make growing things more perfect"* (p. 98). Clarkson (1992) writes that, *"Physis is Berne's unique addition to the other two great, unconscious forces (Eros and Thanatos) in human life, and he sees all three as the background of psychological life."* Berne also described *'Physis'* as *"...the growth force of nature, which makes organisms evolve into higher forms, embryos develop into adults, sick people get better, and healthy people strive to attain their ideals"* (p. 11).

I believe that this essentially biological definition of change and growth brings us closest of all to the cellular and visceral structures of our 'script protocol'. Just as changing the alkalinity or acidity of the soil is sometimes needed in order to stimulate the innate *'Physis'* (or life force) of withering plants, I believe that changing our therapeutic 'soil' to that of human touch is sometimes needed to stimulate the innate *'Physis'* of traumatised human beings. In the same way that soil speaks to changing the primal language of alkalinity and acidity in plant biology, so I believe that touch

speaks to changing the primal language of 'alkalinity' and 'acidity' within the microscopic biology of the neuronal endings in our amygdala. This neuronal shift from a phosphorus environment (under traumatic circumstances) to the soothing calcium environment (that touch produces) actually mimics a similar acid-alkaline process in the soil: in acidic soil, phosphorus reacts with aluminium, iron and manganese, while in alkaline soils the dominant fixation is with calcium. It seems that the fragile eco-system of the internal neuronal workings of the human brain may well parallel the fragile eco-systems in the soil of our planet and link us right back to Berne's instinctive focus on the biological concept of '*Physis*'.

4. Impasse Resolution

At this 'script protocol' level, it is also possible to view such neurochemical transformations as biological expressions of the intra-psychic resolution of an early somatic impasse that occurred in the presence of relational trauma and ruptures. Mellor (1980) describes such third-degree impasses as occurring between the Parental and Child with any re-decision happening from the Adult. I interpret such non-verbal re-decisions as a direct consequence of the *somatic delivery* of a permission.

Gentle touch conveys that it is both OK to "feel" and to "be safe" in the only language that this somatic ego state actually understands, namely the language of touch. Far from declaring that *"we find it hard to conceive of a "re-decision" being made at a level of psychic experience and organization that has no real capacity to observe or think"* as Cornell & Landaiche do (Ibid), I believe that such resolutions can be seen happening daily through changes in physiology, affect and cognition as a consequence of simple and safe human touch.

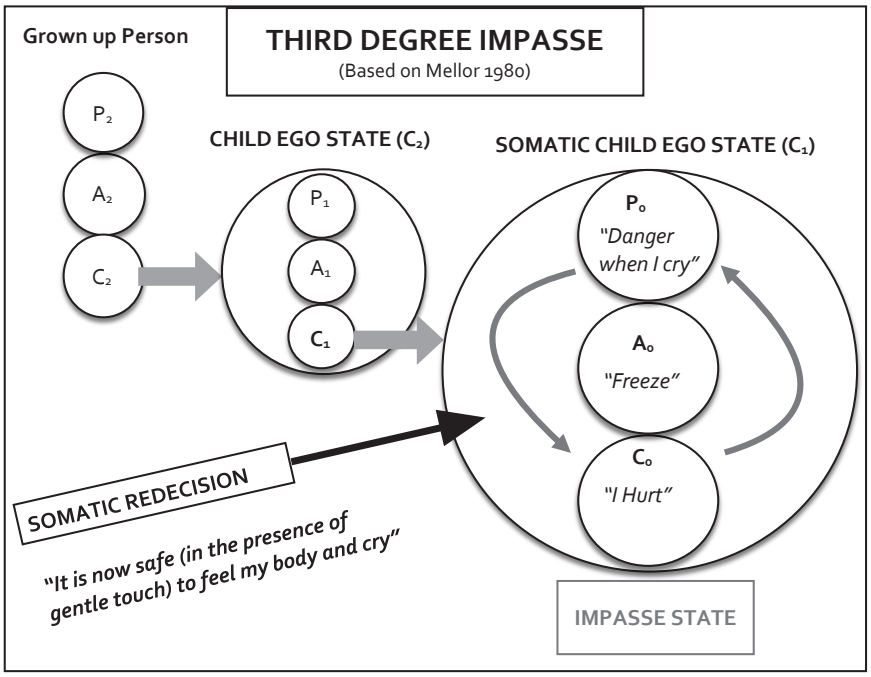

Fig. 3

Such a somatic re-decision can be understood as a 'Child' experience that goes something like: *"I hurt"* (from the rupture of neglect) and a 'Parent' experience that could be understood as *"I am shouted at when I cry"*, which results in a visceral 'freeze' solution of the 'Adult' that means *"I must numb my lungs and rigidify my arms in order to survive"*. This is shown in Figure 3 (below).

What I am proposing here is that touch provides a somatic permission that reaches deep into Child and it is this permission that facilitates the change of cathexis needed for a somatic re-decision. As the AMPA receptors are dissolved (de-phosphorylated) in the calcium rich environment that touch creates within the neuronal endings of the amygdala, so we can imagine the heavy weights of the somatic and visceral injunctions of our early 'script protocols' being gently dissolved, thereby releasing energy for a new cathexis and the appearance of new and more resilient behaviours. In Marion's case, such a visceral re-decision was visible in her gentle sobbing and also in her gradual change of posture from collapse and defeat into one of empowerment over just five sessions.

Summary

Neuroscience is now showing us that touch can reach into the mammalian limbic brain where deeply held emotional triggers are stored and that touch can extinguish these triggers. This de-phosphorylation of raised AMPA receptors could be happening due to a shift to delta brain-wave patterns or because painful signals are being replaced by pleasure signals, via our CT-afferent neurons, or both.

This means there are now compelling scientific and biological reasons for using touch in psychotherapy for the treatment of trauma and PTSD. Such touch can be used in helping clients to self-regulate and build resilience through decoding their traumatic triggers. Touch may also be a vital tool in helping us to access the preverbal decision making of our earliest Child ego-states and empowering our clients in resolving some of their earliest somatic impasses (namely those experienced at P_0 and C_0 levels).

The touch described in this article is most definitely not the touch of qualified massage therapists, nor professional bodyworkers, most of whom are only trained to fix and readjust the structural imbalances of the physical body. Very few bodyworkers have any training in how to deal with, or understand, this level of psychological release and processing. The touch described in this article is the gentle and soothing touch of normal human interaction. It is the universal language of all humans regardless of their spoken language or culture.

Quite how ethical touch is introduced into our work with clients, and what additional training is needed for psychotherapists to be competent and confident in using touch, is beyond the scope of this paper. However, I would suggest that – whilst years of training are needed to bring bodyworkers up to the level of psychological understanding and personal awareness necessary to understand the implications of their touch – only a short amount of additional training would be needed for qualified psychotherapists to learn how to introduce ethical touch safely into their practices.

Author

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References

BERNE, E. (1947). *A Layman's Guide to Psychiatry and Psychoanalysis.* (1986 Ed.) London: Penguin Books.

BERNE, E. (1961). *Transactional Analysis in Psychotherapy.* (1975 Ed.) London: Souvenir.

BERNE, E. (1972). *What Do You Say After You Say Hello?* (1992 Ed.) London: Corgi.

BERNE, E. (1975). *The Structure and Dynamics of Organisations and Groups'.* (Original work published 1963). New York: Grove Press.

BREMNER, J. D. (2006). Traumatic Stress: Effects on the Brain. *Dialogues Clinical Neuroscience*, 8 (4), pp. 445-461.

BROMBERG, P. (2006). *Awakening the Dreamer: Clinical Journeys.* Mahwah, NJ: The Analytic Press.

CLARKSON, P. (1992). *Transactional Analysis Psychotherapy: An Integrated Approach.* London: Routledge.

CLEM, R. L. & HUGANIR, R. L. (2010). Calcium-Permeable AMPA Receptor Dynamics Mediate Fear Memory Erasure. *Science*, 330 (6007), pp. 1108-1112.

CORNELL, W. F. & LANDAICHE, N. M. (2006). Impasse and Intimacy: Applying Berne's Concept of Script Protocol. *Transactional Analysis Journal*, 38, pp. 200-217.

FIELD, T. M. (2015). *Touch.* Cambridge, MA: M.I.T. Press.

FRANCIS, S., ROLLS, E., BOWTELL, R., MCGLONE, F., O'DOHERTY, J. & SMITH, E. (1999). The Representation of the Pleasantness of Touch in the Human Brain, and Its Relation to Taste and Olfactory Areas. *NeuroReport*, 10, pp. 453-459.

HARPER, M. L., RASOLKHANI-KALHORN, T. & DROZD, J. F. (2009). On the Neural Basis of EMDR Therapy: Insights From EEG Studies. *Traumatology*, (15) 2, pp. 81-95.

HENDLER, T., ROTSHTEIN, P., YESHURUN, Y., WEIZMANN, T., KAHN, I. BEN-BASHAT, D. *et al.* (2003). Sensing the Invisible: Differential Sensitivity of Visual Cortex and Amygdala to Traumatic Context. *Neuroimage*, 19 (3), pp. 587-600.

KIM, J. LEE, S. *et al.* (2008). Amygdala Depotentiation and Fear Extinction. *Proceedings of the National Academy of Sciences*, 104 (52), pp. 20955-60.

LEDOUX, J. (1996). *"Tracing Emotional Pathways"*. NY Times, Nov 5, 1996.

LEDOUX, J. (2012). Rethinking the Emotional Brain. *Neuron*, 73, No. 4, pp. 653-676.

LEBOYER, F. (1975). *Birth Without Violence.* New York: Alfred A. Knopf.

LEVINE, P. (1997). *Waking The Tiger: Healing Trauma.* Berkeley, CA: North Atlantic Books.

LINDEN, D. (2015). *Touch: The Science of Hand, Heart and Mind.* London: Viking.

LINE, S., LÖKEN, J. W., MORRISON, I., MCGLONE, F. & OLAUSSON, H. (2009). Coding of Pleasant Touch by Unmyelinated Afferents in Humans. *Nature Neuroscience*, 12, pp. 547-548.

MCCAFFERTY, I. (2016). In Safe Hands: Massage & PTSD. *Massage Therapy Journal.*

MCGLONE, F., OLAUSSON, H., VALLBO, A. & WESSBURG, J. (2007). Touch and Emotional Touch. *Canadian Journal of Experimental Psychology*, 61 (3), pp. 173-183.

MCGLONE, F. (2008). *The Guardian, 18 Sep 2008, www.theguardian.com/science/audio/2008/sep/16/pleasurable.stroking.francis.mcglone*

MELZACK, R. & WALL, P. D. (1965). Pain Mechanisms: A New Theory. *Science*, 19, 150 (3699), pp. 971-979.

MELLOR, K. (1980). Impasses: A Developmental and Structural Understanding. *Transactional Analysis Journal*, 10, pp. 213-220.

MORRISON, I., BJÖRNSDOTTER, M. & OLAUSSON, H. (2011). "Vicarious Responses to Social Touch in Posterior Insular Cortex Are Tuned to Pleasant Caressing Speeds". *Journal of Neuroscience*, 29, 31 (26): pp. 9554-9562.

NOVAK, E. T. (2008). Integrating Neurological Findings with Transactional Analysis in Trauma Work: Linking "There and Then" Self States with "Here and Now" Ego States". *Transactional Analysis Journal*, Vol. 38, No. 4, p. 303-319.

PYVES, G. (2015). *Transforming Lives with the Fairy Tale Process.* Shizen Publications.

RUDEN, R. (2010). *When the Past Is Always Present.* Hove, UK: Routledge.

SCAER, R. (2014). *The Body Bears the Burden.* Hove, UK: Routledge.

SIEGAL, D. J. (2011). *Mindsight: The New Science of Personal Transformation.* New York: Bantam Books.

VAN DER KOLK, B. (2014). *The Body Keeps the Score*. London: Penguin.

WOOLAMS, S. & BROWN, M. (1978). *Transactional Analysis.* Huron Valley Institute, MI: Institute Press.

YOO, A. S. ***et al.*** (2011). MicroRNA-Mediated Conversion of Human Fibroblasts to Neurons. *Nature*, 476: pp. 228-231.

Using Transactional Analysis to Treat Perinatal Mental Illness

Emma Haynes

Abstract: Perinatal mental illness is common, it affects the mother and child and is the leading cause of maternal mortality. It also has a monetary cost of about £6.6bn per annum in the UK. Gaps in knowledge remain, with disagreement between health professionals on its pathogenesis, causes, accurate diagnosis and treatment. Until recently, research was directed towards the postnatal period and depression only. However, research shows there is more to this illness, thus a more accurate description might be perinatal distress. Psychological treatment, in particular psychotherapy, is the treatment of choice for women, possibly due to the lack of risks associated, as opposed to risks of medication in pregnancy and during breast-feeding. Transactional Analysis (TA) psychotherapy provides a tangible means of treating women with this condition. This article focuses on four initial areas in which TA treatment has been found useful: (i) distress; (ii) perfectionism; (iii) grief; (iv) stigma and shame. All four address common difficulties and create barriers to treatment in the perinatal period. This highlights how TA can offer a plausible and practical treatment that may help to target the specificity of this distressing illness. There is a brief clinical vignette before the discussion and conclusion.

Key Words: Perinatal, mental illness, treatment, TA, psychotherapy, relational.

Introduction

Perinatal mental illness is common, affecting the mother and child (Murray *et al.*, 2010; Pawlby *et al.*, 2008; Stuart & Koleva, 2014) and is the leading cause of maternal mortality (Austin *et al.*, 2007; Lewis, 2007; Palladino *et al.*, 2011). Maternal suicide is the leading cause of death during pregnancy and the first-year post-birth period (MBRRACE Report – Knight *et al.*, 2017). The monetary cost (of around £6.6 billion per annum in the UK) is due to the long-term costs to the mother, the infant, the wider family and the economy (Bauer *et al.*, 2014; 2015). It also has an emotional cost to the infant, with long-term implications on infant development and mental health (Agnafors *et al.*, 2013; Deave *et al.*, 2008; Dunkel Schetter, 2009). At present, there is no consensus of agreement on aetiology, prevalence, longevity and the diagnosis of this illness (O'Hara

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& McCabe, 2013; Rallis *et al.*, 2014). There is little in the way of specific treatment – other than psychotropic medication. Research also acknowledges this illness is more than just a depression. It encapsulates any mental illness within this period – stress, anxiety, psychosis, distress, panic and depression (Grant *et al.*, 2008; Haynes, 2017; Rallis *et al.*, 2014)

When asked about treatment preferences, women say they would prefer psychological therapies than medication as a treatment (Battle *et al.*, 2013; Dennis & Chung-Lee, 2006). In particular, psychotherapy would be preferred, as it does not involve the risks of medication 'in utero', or when breast-feeding (Fitelson et al., 2011, Kim *et al.*, 2010). Yet, there is little research into suitable therapies. Psychotherapy is relational, the relationship between therapist and client is fundamental to the success of psychotherapeutic treatment. Maternal mental health also occurs within a relational paradigm, mother and foetus/infant.

What Can TA Offer?

TA psychotherapy offers a plausible psychotherapeutic treatment, suitable for women experiencing perinatal mental illness. The depth and breadth of TA and its diversity give it versatility (Widdowson, 2010, p. xiii) as a psychological therapy. It is this diversity and versatility that may be useful for women in the perinatal period, as TA has the ability within its theoretical model to be shaped towards the needs of the client. Relational psychotherapy is very much driven by the client, their experiences and their needs (De Young, 2003). Relational TA theory (Cornell & Hargaden, 2005; Fowlie & Sills, 2011; Hargaden & Sills, 2002) has shifted the focus onto exploring and engaging with the way in which the client relates to Self and others, placing the relationship at the centre of the work (Fowlie & Sills, 2011). Relational TA theory highlights several important factors: the value of a mother's bond with her infant; the conscious and non-conscious patterns of relating and experience; the significance of the relationship, and its co-creative nature; and the primacy of modelling of behaviour by the mother/father/caregiver both explicitly and implicitly within the infant/parent bond. Also, TA offers a philosophy of non-pathology, vital in treatment, as stigma and shame are significant barriers within this type of illness.

Relational theory is fundamental for treatment. From conception onwards, a woman is in relationship with her foetus. This relationship may even form prior to conception, if conception has been difficult, or if she has been through in vitro fertilisation (IVF). This relationship continues through birth and life, until there is a rupture. Perinatal mental illness can cause a woman to struggle with this relational aspect. Vice versa, some women's relationship difficulties with their infant may bring on mental illness through a sense of guilt, shame and frustration at not being the 'perfect mother'.

There is a societal romanticising of mothers as having to be the caring, selfless mother who sacrifices herself for her children, and indeed this is the portrayal of the 'good mother' (Benjamin, 1990). Mauthner (2002) highlights cultural pressure on motherhood as being the '*epitome of womanhood*' (Mauthner, 2002, p. 6). Any other style of mothering is demonized, with the mother at blame and seen as the likely cause of a child's emotional, psychological and social problems. Cultural myths continue to purport that women should instinctively know how to mother, and should bond with their babies at birth (Mauthner, 2002). However, this does not happen for many women, bringing a sense of failure, shame and guilt, and a re-defining of themselves as a 'bad mother'.

Relational TA provides a therapeutic framework by working with women through these difficult and disturbing myths and pressures,

and does not pathologise women. It provides an environment wherein a woman can explore her role, her expectations, her need to be the 'perfect mother' and enable her in what can be a difficult transition into motherhood. It highlights the importance of curiosity and creativity, as well as uncertainty and can help to enhance a woman's ability to engage, attach and bond with her baby.

Ethical Issues

Working with women in the perinatal period involves elements of ethics. Considerable consideration of these elements can be needed, dependent upon the situation and type of mental illness. Supportive clinical supervision with a supervisor with experience of working in this area would be a preference, although in TA this may be difficult at present as there are few therapists and supervisors working with these issues.

Women who struggle to let go or separate themselves from their infant due to extreme fear may even require the therapist to work with the baby in the therapy room. These issues – of lack of trust, and separation anxiety – are significant, and can often (but not always) be symptomatic of something underlying, such as trauma. Such work can be problematic, and requires careful thought about practicalities, depth and breadth of the work, as well as what is achievable. Yet it can provide useful opportunities to work in the moment, with what is occurring at the particular time, and provides an opportunity to watch the mother/infant dynamic. This can be helpful, particularly for women who find bonding with their baby a challenge, or who have a sense that their infant is 'doing' things on purpose, for example some women speak of their babies crying simply to antagonise them, and cause them stress and anxiety, even though the infant may only be a few weeks old.

As the baby gets older, and begins to become more adventurous, it can become more difficult. This often becomes a time of dialogue around value and trust. Can the mother value herself and trust herself enough to take the space for her own use, placing the care of the baby with another? However, such decisions should be left to the mother, who will decide when she is ready to initiate separation.

Another ethical issue is around the lack of research on TA psychotherapy to treat perinatal mental illness. As it is such an impactful and prevalent condition, it is important that treatment addresses the particular needs of the vulnerable women experiencing this condition. There is an existing small, yet growing and recent, body of research on the use of TA psychotherapy as a treatment option for depression (see: Benelli *et al.*, 2016; 2017; van Rijn, & Wild, 2013; 2016; van Rijn, Wild, & Moran 2011; Widdowson, 2012; 2013; 2014; 2015) and also for anxiety and depression (van Rijn & Wild, 2016; van Rijn, Wild & Moran, 2011; Widdowson, 2014) that give a prima facie case to suggest TA may also be effective for perinatal mental illness (Stillman, 2009).

As yet, no research or statistics exist to show how many women, experiencing perinatal mental illness, have either historic trauma or have experienced mental illness in their past. However, many women speak of a history of such experiences (Cohen *et al.*, 2006; Haynes, 2017; Patton *et al.*, 2015). Research does show a link between childhood trauma, and an increased susceptibility to postpartum depression within the first six months after childbirth (Choi *et al.*, 2017). As a therapist, it is important to understand that this type of illness can manifest itself in various ways, and does not necessarily fit specific diagnostic criteria. This can cause difficulties when using medical determinants to diagnose, as women will experience it in their own individual way. This is also why it can be unhelpful to call it

'postnatal depression', or 'perinatal anxiety'. For many women it might be this, but for others this will bear no correlation to their own experience of illness.

Finally, there may be an ethical issue in therapy around the position of the client's partner. This is not 'couples therapy'. However, it can be useful to bring the partner into therapy for a session, if the woman is in agreement or if requests it, although this can mean a single sessional contract that may not be in line with the overall therapeutic contract. Bringing the partner into the therapeutic space is often seen as inclusive, rather than isolating. As perinatal mental illness can cause a woman to withdraw, isolate and silence herself, which a partner may find confusing and damaging to their relationship, offering a space for open dialogue in which the partner is able to ask about parts of the illness and therapy they do not know about or understand often leads to the partner enquiring about how they can fulfil their role to promote help-seeking behaviours in their partner.

Using TA to Treat Perinatal Mental Illness

Prior to giving a clinical example, an overview of four of the most significant ways in which TA is useful for treating this illness are shown below:

1. Distress

Many women come into therapy with high levels of distress. This can manifest itself in different ways. Initially, it is important to listen and really hear the woman's experience. This helps to legitimise her sense of Self, and to address the woman's need for recognition. Berne (1961) highlighted how humans have a developmental need for recognition from birth, which he called recognition 'hunger'. This TA theory is a useful first tool to use with women with perinatal distress. This recognition hunger begins at birth with the infant's need for physical contact. Recognition is therefore a relational need and is relevant not only to a woman's need for recognition, but also to her infant's needs as well. As the infant is so reliant on the mother-infant bond, it will adjust itself accordingly to her distress. Gerhardt (2009) believes that babies of depressed mothers adjust themselves to the lack of positive stimulation they receive. In the same way, babies born to agitated mothers either attempt to switch off their feelings altogether in order to cope, ceasing to cry, or alternatively stay overaroused and distressed themselves (Gerhardt, 2009). Research from epigenetics, neuroscience and biochemistry offer a greater understanding of how a disturbed or malfunctioning relationship between mother and infant, due to illness either physically or mentally, can have an effect on the infant. Expanding recognition hunger theory to include the repercussions of negative recognition can be particularly useful for women who are struggling to bond with their infant and can be an opportunity to explore the mother-infant bond and its necessity to the survival of the infant (Bollas, 1987; Bowlby, 1979; Gerhardt, 2009; Piontelli, 1992; Stern, 1985). However, there is a need for caution. It is not helpful to highlight the detrimental effects of perinatal distress on an infant with a woman in therapy. She may already be feeling shame, guilt (Buultjens & Liamputtong, 2007; Bilzsta *et al.*, 2010), and stigma (Goodman, 2009; Mauthner, 2002; Staneva *et al.*, 2015), and have a fear of her baby being removed from her care if she admits to the way she feels (Boots Family Trust, 2013; Dennis & Chung-Lee, 2006).

During therapy, a dialogical, co-created relationship between therapist and client can model care-seeking behaviours (the clinical vignette gives an example of such a relationship). This helps to engender an understanding

of the client's Child ego-state, the thinking, feeling and behaviour of childhood, (Tilney, 1998). Often women with perinatal distress struggle with a lack of experience from their own childhood about how to self-regulate. Women who are extremely distressed may have no understanding of, or ability to, regulate their own emotions and will seek, often through creative means, this affect regulation. Schore's (2009) writings on the neurobiology of attachment can provide a theoretical context and understanding of the need for the 'good enough' Other, who can help with re-attunement and regulation of negative affect: *"The disruption of attachment transactions leads to a regulatory failure and an impaired autonomic homeostasis."* (Schore, 2009)

As is the case with any client who is unable to self-regulate, a woman with perinatal distress may need her therapist to attune to her. This is possible through the relational use of self in psychotherapy (Shmukler, 2010). This attunement can be possible, to some extent, by placing the therapeutic relationship at the core of the therapy. Such an attunement helps to soothe and calm the woman's Child ego-state, dissipating anxiety and regulating autonomic homeostasis. This also helps her infant, because it is so reliant on the mother-infant bond that it adjusts itself to its mother's distress or calm. Helping the mother to self-regulate therefore helps the infant to be more regulated too.

Co-construction of narrative within the therapeutic dyad allows the client to (re-)construct her identity, to fill a void, or to re-negotiate a part of her existence through a storied self (see clinical vignette). The story changes with each telling, evolving through interpretation and interaction, sometimes changing temporally as well as linguistically. As part of the therapy process, women may need to construct a story around what has happened to them. Narratives will often have a rupture, a break in the expected pattern of what should have been. Speaking her narrative, with the therapist as her audience, but also her co-interpreter, can help a woman to form a new identity as both child and mother, to fill the void with a level of knowledge. This can help in what is often a difficult transition from being someone's child, to someone's mother, with the responsibilities this brings. *"Identities are not expressed or represented by performance; they are made and remade by it"* (Squire *et al.*, 2014).

2. Perfectionism

Women can struggle with a need to be the perfect mother, and indeed in research by Mauthner (2002) into postpartum depression, the search for perfection was at the heart of each woman's story, perfection not only from themselves, but from their infant/child as well. In Western society, there is a paradox of motherhood. It is idealised and romanticised, yet it is also denigrated, with an expectation, particularly in the UK and the United States, for women to return to work after a baby is born, placing her infant in nursery care or with another care-giver. This can bring a discrepancy in the way a woman may want to be as a mother, and the way she actually is. Perfectionism, and in particular the drive to 'be perfect' (Kahler & Capers, 1974), is recognised in TA as a defence mechanism. A woman may use perfectionism to try to combat her internal stress or anxiety, with the childlike belief that if everything around her is perfect life will return to OK-ness. TA therapists would explore this drive to perfectionism, its roots in childhood, and the beliefs and myths surrounding it. This exploration can help to unlock a woman's need to continue with this often distressing and futile behaviour.

For women who have a coping strategy of perfectionism, this may manifest itself in compulsive behaviours, such as cleaning. If this is the case, it is not helpful to seek to pull apart these

coping strategies. Curiosity and understanding can be more potent, highlighting the creativity that has been used, allowing a woman to reflect and wonder at her ability to navigate the role she fulfils, even if at present it is not working for her positively. Learning about her anxiety and where it emanates from, being able to sit and be in the moment without charging off, both psychologically and physically, can be useful elements of the therapeutic work.

3. Grief

Qualitative studies on women's experiences of motherhood found that women's experiences after birth were mostly negative (Choi *et al.*, 2005; Mauthner, 1999). Dissonance between a mother's expectations of motherhood and the actual reality are highlighted in a study by Staneva & Wittkowski (2012). Grief can be a large part of therapy as a woman begins to recognise what has been lost from her life prior to motherhood, such as a negative change in body image, in partner relationships, in work practices, in multiple and conflicting roles, and with a fear of the future (Tseng *et al.*, 2008), amongst many other things. Usually, a TA therapist would work with the woman's Child ego-state until she felt supported enough to let the grief manifest itself (see clinical vignette for an example of such work). This part of the therapy can be intense and engulfing as she begins to realise those elements of life that she believes she has lost. TA encourages the exploration of all the elements of grief, validating a woman's feelings and providing a dialogical structure in which a woman is able to form a language around her grief experience. When working with women who are immigrants or refugees (some of whom may have experienced deleterious conditions due to war, economic privation, religion or cultural difficulties, and have had to adapt to possibly very different environments in first-world countries in Europe, Canada or Australia), their grief can also be about cultural dissonances (a difference in the cultural norms of childbirth and the woman's own beliefs and actions).

4. Stigma and Shame

Stigma and shame are also barriers within perinatal mental health. Women may feel the need to show they can cope with their new role, and may expect to feel positive fulfilment at becoming a mother (Mauthner, 2002). If those women then find themselves struggling and needing help, they can find it difficult to ask for it, instead self-silencing themselves and pretending to family, friends and medical practitioners that they are fine. Stigma and shame are primary factors in the low rates of detection and treatment of mental illness (Bates & Stickley, 2013), particularly in the perinatal period (Bultjens & Liamputtong, 2007; Mantle, 2002). Experiences of stigma are often familial (Bilzsta *et al.*, 2010), societal (Mauthner, 2002) and cross-cultural, (O'Mahoney et al., 2012).

Shame and stigma are both relational and are felt when there is a rupture or break of self in-relation to the 'other' and can cause a woman to withdraw, isolate and silence herself. De Young (2015) defines shame as *"the experience of one's felt sense of self disintegrating in relation to a dysregulating other"* (p. 18). TA provides a structure to explore and unlock stigma and shame. This is an area where Berne's philosophy of non-pathology is vital. It is all too easy for a therapist to re-initiate stigma and shame through a lack of understanding, by discounting or by dismissing them in some way. Berne's philosophy helps TA therapists to understand that coping strategies are often creative techniques to attempt to self-regulate, often from extreme anxiety. Recognising and highlighting the creativity of this action, with no expectation or need for the client to change, helps to open up the possibility to choose a more autonomous sense of agency, directing it towards helpful behaviours.

A Clinical Vignette: Transgenerational Trauma – Barbara

Barbara (from Eastern Europe) was in her 30s, with two boys aged 4 and 2. She had extreme anxiety, fear and serious perinatal mental illness that began in her first pregnancy. She was confused and frightened, yet could not understand why. She also had no memory of childhood before the age of five. No family photographs existed and her mother remained resolutely closed to talking about this time with her and often told her to *"stop going on about it"*. She came to therapy out of desperation because she was overwhelmed, feeling *"utterly terrified, totally unable to cope with anything"*. Her feelings were out of proportion to the behaviour of her two young sons, but she could not explain why and had intense shame and guilt. She described becoming out of control at the simplest of thing, wanting to scream and shout at the boys, unable to cope, and would shut down, isolating herself with a desperation to 'get away from' them. She was convinced she was the worst mother. Yet it was clear she really loved her boys.

At the start of therapy, Barbara's distress levels were high. She could not sit back in her chair and for many months sat wringing her hands, ready to leap up and run for the door. She emitted a palpable extreme fear but could not voice her distress and often remained silent, unable to speak. She had no understanding of or ability to self-regulate, instead finding creative ways such as obsessive cleaning to cope with her intense affect, or isolating herself if the cleaning was not enough. Barbara built her story in therapy through co-creation (Summers & Tudor, 2000), with different elements created with different people. She pieced it together, relying heavily on others to tell her about this period of her life, asking family members to help her.

At two years, she was admitted to hospital in what was then a communist, Eastern-bloc country. She had some form of hip dysplasia, although she is still unclear what the diagnosis was. The treatment was immobilisation, so she was strapped to a bed to stop her moving her hips. She remained in the hospital bed for over two years. Hospital policy – at that time – allowed parents to visit a child once a month for an hour. Although Barbara had no memory, it was clear that her body and mind held sensate memory.

It took months for Barbara to understand the enormity of those two years. At first, her defence mechanism was to discount it (Schiff *et al.*, 1975). However, the co-incidence of her sons' ages and the age she was at the time of her hospitalisation was significant, and she began to understand what that must have been like for her. We explored her feelings of utter desperation in the present and the parallel to how she might have been terrified in that hospital, and she realised the legacy of this time for her. Her sense of abandonment was: *"engulfing, utterly overwhelming and completely terrifying"* and triggered by many different, sometimes banal instances, that frustrated and angered her. She was also ashamed and guilty of not coping with her sons, abandoning them psychologically. She found it impossible to ask for help and would often smile and laugh after reaching a terrible realisation. Shame surfaced abruptly, a year into therapy, when she arrived distraught, saying she could not sleep for trying to work out how she had gone to the toilet in hospital. She seemed quite obsessed, totally confused, and transfixed like a small child. Once we unravelled her shame it finally made sense why her fear of being unable to find, or go to the toilet had been overwhelming and paralysing throughout her entire life, causing her extreme discomfort and irritable bowel syndrome. *The disruption of attachment transactions leads to a regulatory*

failure and an impaired autonomic homeostasis (Schore, 2009).

Barbara was searching for the 'good enough' other who could re-attune to her, helping her to regulate her negative affect. The relationship we built together was a much needed and yearned-for nurturing one, in which the aim was to model to her how to nurture herself. In turn, this nurtured and supported her Child ego state, allowing the anxiety to begin to dissipate and her overwhelming fear and need to flee to subside. Barbara manifested her distress in compulsively cleaning her house, her car, her garden, in fact anything she could possibly clean she would. In the beginning this spilled into therapy as she wanted to clean whilst she talked, sitting still was too difficult for her. Coping with her anxiety, and learning to sit and be in the moment without charging off psychologically and physically, were primary factors in the work. Whenever she was slipping away, dissociating from the here-and-now, ('withdrawal rupture' – Safran & Muran, 2000) which at first was the majority of the time, the aim was to bring her back as gently as possible. At first, she found this painful, but it was also helpful because she came to know how often she dissociated, not just from me, but from life itself, and it encouraged her to stay present. Once her Child ego state felt supported enough, Barbara went through intense, engulfing grief. This cycled through her abandonment, incredulity at the scale of her parent's abandonment of her and her realisation that this was still on-going, most notably by her mother, who *"was there, but yet never there, only superficially"*. Finally, Barbara realised how she abandoned herself, either by dissociation, or by using 'gallows laughter' (a TA term referring to incongruent laughter) to create a sense of OK-ness, when reality was too much for her. The final months of work centred on her guilt and profound shame. In Barbara's words, *"we [she and I] searched together for my traumatised child"*.

Barbara's 'do not exist' injunction (Goulding & Goulding, 1972, 1976), a TA concept referring to a negative parental message, was a constant throughout the therapy and, even towards the end, she found acknowledging her own value difficult. Her need was for me to remain her constant, not to abandon her, either within our relationship or without. She would often try and re-direct our time together, implicitly inviting abandonment in many different ways. It took time to realise just how powerful this was, and I initially stepped into the trap many times. This was possibly one of the most therapeutic parts of therapy. I often acknowledged to her that I recognised what I had done, and invited her to share her experience. There was no rupture through confrontation (Safran & Muran, 2000), almost certainly because Barbara unconsciously felt she needed me to remain in the idealised position for a proportion of her therapy.

Drawing from Shadbolt (2017), therapy was a process of 'acknowledgment'; 'space' in which to build dialogue around what had occurred; 'meaning-making' which helped to form a co-constructed narrative; and 'transformation' in which we both could notice the subtle invitations she gave. Her laughter at herself became one of authenticity, in which she could acknowledge how clever her Child ego state was and how creative she could be. Barbara constantly wanted to relinquish the power in our relationship. I constantly handed it back. Co-constructing a narrative was a difficult, but enriching process. Barbara recognised that she did exist, that she was attached to me as I was to her, that she held value, power and importance within our relationship (which she found a struggle to acknowledge), but more importantly within her own family relationship. This helped her take her position as the 'good enough' mother, something she yearned for, but believed would never happen. Her therapy lasted for 15 months.

Discussion

TA psychotherapy provides useful theories and methods to understand and work with women experiencing perinatal mental illness. It provides a non-pathologising therapeutic framework and may provide a woman with an understanding of her inter-psychic and intrapsychic processes that might negatively influence her mother/infant relationship. The co-constructive nature of relational TA and its theory of recognition hunger can be particularly helpful when working with women with high levels of distress who lack autonomic homeostasis, and seek attunement and regulation through recognition. The TA therapist provides curiosity and co-constructed interpretation, which may enable a woman to resolve difficulties within her transition to motherhood. It also promotes autonomy which can be helpful when a woman is flooded with, 'must, should, could' messages in many 'expert' guides to childrearing and parenthood.

However, there are ethical issues in working with women in this area. Competent supervision is needed, and this may involve ethical issues such as working with the parent/infant dyad, with the infant in the room and the inclusivity of partners. Knowing the possibilities and limits of psychotherapy is an important requirement.

Conclusion

Working with women with perinatal mental illness is an individual process, as most, if not all, psychotherapy is. Each woman comes with her unique experience, and listening to, hearing and understanding her experience and perceptions of her illness, without pathologising her, and dialogically enabling her to make sense of what is happening are of primary importance. TA offers the theoretical knowledge and methods, and relational TA offers the openness, the curiosity, the creativity and the possibility to work in a way that can help women with perinatal mental illness.

Author

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References

AGNAFORS, S., SYDSJÖ, G., DEKEYSER, L. & SVEDIN, C. G. (2013). Symptoms of Depression Postpartum and 12 Years Later – Associations to Child Mental Health at 12 Years of Age. *Maternal Child Health Journal*, 17, pp. 405-414.

AUSTIN, M. P., KILDEA, S. & SULLIVAN, E. (2007). Maternal Mortality and Psychiatric Morbidity in the Perinatal Period: Challenges and Opportunities for Prevention in the Australian Setting. *The Medical Journal of Australia*, 186, pp. 364-367.

BATS, L. & STICKLEY, T. (2013). Confronting Goffman: How Can Mental Health Nurses Effectively Challenge Stigma? A Critical Review of the Literature. *Journal of Psychiatric and Mental Health Nursing*, 20, pp. 269-575.

BATTLE, C. L., SALISBURY, A. L., SCHOFIELD, C. A. & ORTIZ-HERNANDEZ, S. (2013). Perinatal Antidepressant Use: Understanding Women's Preferences and Concerns. *Journal of Psychiatric Practice*, 19(6), pp. 443-453.

BAUER, A., PARSONAGE, M., KNAPP, M., IEMMI, V. & ADELAJA, B. (2014). *Costs of Perinatal Mental Health Problems.* London School of Economics and Political Science, London, UK.

BAUER, A., PAWLBY, S., PLANT, D. T., KING, D., PARIANTE, C. M. & KNAPP, M. (2015). Perinatal Depression and Child Development: Exploring the Economic Consequences from a South London Cohort. *Psychological Medicine*, 45, pp. 51-61.

BENELLI, E., BERGAMASCHI, M., CAPOFERRI, C., MORENA, S., CALVO, V., MANNARIN, S., PALMIERI, A., ZANCHETTA, M., SPINELLI, M. & WIDDOWSON, M. (2017). TA Treatment of Depression: a Hermeneutic Single-Case Efficacy Design Study – 'Deborah'. *International Journal of Transactional Analysis Research*, 8(1), pp. 39-58.

BENELLI, E., BOSCHETTI, D., PICCIRILLO, C., QUAGLIOTTI, L., CALVO, V., PALMIERI, A., SAMBIN, M. & WIDDOWSON, M. (2016). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - 'Luisa'. *International Journal of Transactional Analysis Research*, 7(1), pp. 35-50.

BENJAMIN, J. (1990). *The Bonds of Love.* London: Virago.

BERNE, E. (1961). *Transactional Analysis in Psychotherapy* (First published 1961). New York: Grove Press.

BILSZTA, J., ERICKSEN, J., BUIST, A. & MILGROM, J. (2010). Women's Experiences of Postnatal Depression – Beliefs and Attitudes as Barriers to Care. *Australian Journal of Advanced Nursing*, 27(3), pp. 44-54.

BOLLAS, C. (1987). *The Shadow of the Object: Psychoanalysis of the Unthought Known.* New York: Colombia University Press.

BOOTS FAMILY TRUST ALLIANCE, Netmums, Institute of Health Visiting, Tommy's, The Royal College of Midwives. (2013). *Perinatal Mental Health Experiences of Women and Health Professionals.* London: Boots Family Trust.

BOWLBY, J. (1979). *The Making and Breaking of Affectional Bonds.* Abingdon, UK: Routledge Classics.

BUULTJENS, M. & LIAMPUTTONG, P. (2007). When Giving Life Starts to Take the Life out of You: Women's Experiences of Depression after Childbirth. *Midwifery*, 23(1), pp. 77-91.

CHOI, K. W., SIKKEMA, K. J., VYTHILINGUM, B., GEERTS, L., FAURE, S. C., WATT, M. H., ROOS, A. & STEIN, D. J. (2017). Maternal Childhood Trauma, Postpartum Depression, and Infant Outcomes: Avoidant Affective Processing as a Potential Mechanism. *Journal of Affective Disorders*, 211, pp. 107-115.

CHOI, P., HENSHAW, C., BAKER, S., & TREE, J. (2005). Super-Mum, Super-Wife, Super-Everything: Performing Femininity in the Tansition to Motherhood. *Journal of Reproductive and Infant Psychology*, 23 (2), pp. 167-180.

COHEN, J., ALTSHULER, L. L., HARLOW, B. L., NONACS, R., NEWPORT, J., VIGUERA, A. C., SURI, R., BURT, V. K., HENDRICK, V., REMINICK, A. M., LOUGHEAD, A., VITONIS, A. F. & STOWE, Z. N.

(2006). Relapse of Major Depression during Pregnancy in Women Who Maintain or Discontinue Antidepressant Treatment. *JAMA*, 295, pp. 499-507.

CORNELL, W. F. & HARGADEN, H. (Eds.) (2005). *From Transactions to Relations: the Emergence of a Relational Tradition in Transactional Analysis.* Chadlingtpon, UK: Haddon Press.

DEAVE, T., HERON, J., EVANS, J. & EMOND, A. (2008). The Impact of Maternal Depression in Pregnancy on Early Child Development. *British Journal of Obstetrics & Gynecology*, 115, pp. 1043-1051.

DENNIS, C.-L. & CHUNG-LEE, L. (2006). Postpartum Depression Help-Seeking Barriers and Maternal Treatment Preferences: A Qualitative Systematic Review. *Birth*, 33, pp. 323-331.

DEYOUNG, P. (2015). *Understanding and Treating Chronic Shame – A Relational / Neurobiological Approach.* New York & Hove: Routledge.

DUNKEL SCHETTER, C. (2009). Stress Processes in Pregnancy and Preterm Birth. *Current Directions in Psychological Science*, 18 (4), pp. 205-209.

DUNKEL SCHETTER, C. & TANNER, L. (2012). Anxiety, Depression and Stress in Pregnancy: Implications for Mothers, Children, Research, and Practice. *Current Opinion in Psychiatry*, 25 (2), pp. 141-148.

FITELSON, E., KIM, S., SCOTT BAKER, A. & LEIGHT, K. (2011). Treatment of Postpartum Depression: Clinical, Psychological and Pharmacological Options. *International Journal of Women's Health*, 3, pp. 1-14.

FOWLIE, H. & SILLS, C. (2011). *Relational Transactional Analysis: Principles in Practice.* London: Karnac.

GERHARDT, S. (2009). *Why Love Matters – How Affection Shapes a Baby's Brain.* Hove, UK: Routledge.

GOODMAN, J. H. (2009). Women's Attitudes, Preferences, and Perceived Barriers to Treatment for Perinatal Depression. *Birth*, 36(1), pp. 60-69.

GOULDING, R. & GOULDING, M. (1972). New Directions in Transactional Analysis. In: C. Sager & H. Kaplan (Eds), *Progress in Group and Family Therapy*, (pp. 105-134). New York: Brunner/Mazel.

GOULDING, M. & GOULDING, R. (1979). *Changing Lives through Redecision Therapy.* New York: Grove Press.

GRANT, K. A., MCMAHON, C. & AUSTIN, M. P. (2008). Maternal Anxiety during the Transition to Parenthood: a Prospective Study. *Journal of Affective Disorders*, 108(1-2), pp.101-111.

HARGARDEN, H. & SILLS, C. (2002). *Transactional Analysis: A Relational Perspective.* Hove: Brunner-Routledge.

HAYNES, E. (2017). Listening to the Voices of Women Suffering Perinatal Psychological Distress, *Transactional Analysis Journal*, Vol. 47, (2), pp. 126-137.

KAHLER, T. & CAPERS, H. (1974). The Mini-Script. *Transactional Analysis Journal*, 4(1), pp. 26-42.

KIM, D. R., O'REARDON, J. P. & EPPERSON, C. N. (2010). Guidelines for the Management of Depression during Pregnancy. *Current Psychiatry Reports*, 12, pp. 279-281.

KNIGHT, M., NAIR, M., TUFFNELL, D., SHAKESPEARE, J., KENYON, S. & KURINCZUK, J. J. (Eds. on behalf of MBRRACE-UK). (2017). *Saving Lives, Improving Mothers' Care - Lessons Learned to inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15.* Oxford: National Perinatal Epidemiology Unit, University of Oxford.

LEWIS, G. (Ed). (2007). Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer – 2003-2005. *Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kindom. London, UK: The Confidential Enquiry into Maternal and Child Health, 2007.*

MANTLE, F. (2002). The Role of Alternative Medicine in Treating Postnatal Depression. *Complementary Therapies in Nursing and Midwifery*, 8, pp. 197-203.

MAUTHNER, N. S. (1999). Feeling Low and Feeling Really Bad about Feeling Low: Women's Experiences of Motherhood and Postpartum Depression. *Canadian Psychology*, 40, pp. 143-161.

MAUTHNER, N. S. (2002). *The Darkest Days of My Life: Stories of Postpartum Depression.* Cambridge, MA: Harvard University Press.

MURRAY, L., ARTECHE, A., FEARON, P., HALLIGAN, S., CROUDACE, T. & COOPER, P. (2010). The Effects of Maternal Postnatal Depression and Child Sex on Academic Performance at Age 16 Years: A Developmental Approach. *Journal of Child Psychology & Psychiatry*, 51, pp. 1150-1159.

NORIEGA-GAYOL, G. (2004). Codependence: A Transgenerational Script. *Transactional Analysis Journal*, 34(4), pp. 312-322.

O'HARA, M. W. & MCCABE, J. E. (2013). Postpartum Depression: Current Status and Future Directions. *Annual Review of Clinical Psychology*, 9, pp. 379-407.

O'MAHONY, J. M., DONNELLY, T. T., BOUCHAL, S. R. & EST, D. (2012). Barriers and Facilitators of Social Supports for Immigrant and Refugee Women Coping with Postpartum Depression. *Advances in Nursing Science*, 35(3), e42-56.

PALLADINO, C. L., SINGH, V., CAMPBELL, J., FLYNN, H. & GOLD, K. J. (2011). Homicide and Suicide during the Perinatal Period: Findings from the National Violent Death Reporting System. *Obstetrics & Gynecology*, 118(5), pp. 1056-1063.

PATTON, G. C., ROMANIUK, H., SPRY, E., COFFEY, C., OLSSON, C., DOYLE, L. W., OATS, J., HEARPS, S., CARLIN, J. B. & BROWN, S. (2015). Prediction of Perinatal Depression from Adolescence and before Conception (VIHCS): 20-Year Prospective Cohort Study. *Lancet*, 386, pp. 875-883.

PAWLBY, S., SHARP, D., HAY, D. & O'KEANE, V. (2008). Postnatal Depression and Child Outcome at 11 Years: The Importance of Accurate Diagnosis. *Journal of Affective Disorders*, 107, pp. 241-245.

PIONTELLI, A. (2004 [1992]). *From Foetus to Child – An Observational and Psychoanalytic Study.* Hove, UK: Routledge.

RALLIS, S., SKOUTERIS, H., MCCABE, M. & MILGROM, J. (2014). The Transition to Motherhood: Towards a Broader Understanding of Perinatal Distress. *Women and Birth*, 27, pp. 68-71.

SAFRAN, J. D. & MURAN, J. C. (2000). *Negotiating the Therapeutic Alliance: A Relational Treatment Guide.* New York: Guilford Press.

SCHORE, A. N. (2009). Relational Trauma and the Developing Right Brain – The Neurobiology of Broken Attachment Bonds. In: T. Baradon (Ed), *Relational Trauma in Infancy – Psychoanalytic, Attachment and Neuropsychological Contributions to Parent-Infant Psychotherapy.* London: Routledge.

SHADBOLT, C. (2017). Dancing in a Different Country. *Transactional Analysis Journal*, 47(4), pp. 264-275.

SHMUKLER, D. (2010). The Use of Self in Psychotherapy. In: H. Fowlie & C. Sills (Eds). *Relational Transactional Analysis – Principles in Practice.* (Published 2011). London: Karnac Books.

SQUIRE, C., DAVIS, M., ESIN, C., ANDREWS, M., HARRISON, B., HYDÉN, L.-C. & HYDÉN, M. (2014). *What is Narrative Research.* London & New York: Bloomsbury Academic.

STANEVA, A. A., BOGOSSIAN, F. & WITTKOWSKI, A. (2015). The Experience of Psychological Distress, Depression, and Anxiety during Pregnancy: A Meta-Synthesis of Qualitative Research. *Midwifery*, 31, pp. 563-573.

STANEVA, A. & WITTKOWSKI, A. (2012). Exploring Beliefs and Expectations about Motherhood in Bulgarian Mothers: A Qualitative Study. *Midwifery*, 29, 260-267.

STERN, D. N. (2000 [1985]). *The Interpersonal World of the Infant.* New York: Basic Books.

STILLMAN, R. (2009). Post-Natal Depression and the Implicit Client. *International Journal of Psychotherapy*, Vol. 13, No. 2, pp. 44-52.

STUART, S. (2012). Interpersonal Psychotherapy for Postpartum Depression. *Clinical Psychology and Psychotherapy*, 19, pp. 134-140.

STUART, S. & KOLEVA, H. (2014). Psychological Treatments for Perinatal Depression. *Best Practice & Research, Clinical Obstetrics & Gynaecology*, 28(1), pp. 61-70.

SUMMERS, G. & TUDOR, K. (2000). Co-Creative Transactional Analysis. *Transactional Analysis Journal*, 30(10), pp. 23-40.

TILNEY, T. (1998). *Dictionary of Transactional Analysis.* London: Whurr Publishers.

TSENG, Y., HSU, C., LIU, Y. & CHEN, C. (2008). The Experiences of Prenatal Depression among Taiwanese Women. *Journal of Advanced Nursing*, 64(5), pp. 495-503.

VAN RIJN, B. & WILD, C. (2013). Humanistic and Integrative Therapy for Anxiety and Depression. Practise-Based Evaluation of Transactional Analysis, Gestalt & Integrative Psychotherapy and Person-Centred Counselling. *Transactional Analysis Journal*, 43, pp. 150-163.

VAN RIJN, B. & WILD, C. (2016). Comparison of Transactional Analysis Group and Individual Psychotherapy in the Treatment of Depression and Anxiety: Routine Outcomes Evaluation in Community Clinics. *Transactional Analysis Journal*, 46(1), pp. 63-74.

VAN RIJN, B., WILD, C. & MORAN, P. (2011). Evaluating the Outcomes of Transactional Analysis and Integrative Counselling Psychology within UK Primary Care Settings. *International Journal of Transactional Analysis Research*, 2(2), pp. 34-43.

WIDDOWSON, M. (2010). *Transactional Analysis – 100 Key Points & Techniques.* London: Routledge.

WIDDOWSON, M. (2012). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study – Case Three: Tom. *International Journal of Transactional Analysis Research*, 3(2), pp. 15-27.

WIDDOWSON, M. (2013). TA Treatment of Depression – A Hermeneutic Single-Case Efficacy Design Study – Linda – a Mixed Outcome Case. *International Journal of Transactional Analysis Research*, 4(2), pp. 3-15.

WIDDOWSON, M. (2014). Transactional Analysis Psychotherapy for a Case of Mixed Anxiety & Depression: A Pragmatic Adjudicated Case Study: "Alastair". *International Journal of Transactional Analysis Research*, 5(2), pp. 66-76.

WIDDOWSON, M. (2015). *Transactional Analysis for Depression: A Step-by-Step Treatment Manual.* London: Routledge.

Single-Case Design Review and Meta-Analysis for Supporting the Method of Transactional Analysis towards Recognition as an Empirically Supported Treatment for Depression

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Abstract: Common Mental Disorders represent a severe burden for a country's health, society and economy. Several psychotherapies have shown their efficacy in treating such common mental disorders using randomized clinical trials (RCT). Psychotherapies that are not supported by this sort of research evidence are disenfranchised and marginalized. A way to obtain recognition as an 'Empirically Supported Treatment' relies on systematic replication of single-case designs and on the aggregation of results through a meta-analysis. The purpose of this meta-analytic review was to synthesize the single-case research on Transactional Analysis (TA) treatment for depression. Specifically, the effect of TA treatment for depression was examined in 11 studies, published between 2012 and 2017. Results indicated that, on average, TA psychotherapy for depression had a large effect on depressive symptoms: g = 0.89, 95% confidence interval (CI) [0.29-1.50]. Implication for future research on such TA manualized treatments for specific Common Mental Disorders is discussed.

Key Words: Transactional Analysis, Depressive disorders, Marginalized and Emerging Psychotherapy, Single-Case Meta-Analysis, Hermeneutic Single-Case Efficacy Design.

Introduction

In the last decade, epidemiological studies have drawn attention to the high prevalence of Common Mental Disorders (CMD; e.g., depression, anxiety, personality disorders) and their impact on health, society and economy (Steel *et al.*, 2014; Trautmann, Rehm & Wittchen, 2016; WHO, 2003). Research in psychotherapy grew exponentially to establish the efficacy

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and the effectiveness of psychological therapies for these CMD, progressively adopting the methodologies of Evidence-Based Practice (EBP), as used in medicine. EBP in psychology promotes effective psychological practice and enhances public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention, articulating a decision-making process for integrating multiple streams of information, encompassing: (a) research evidence on a treatment's efficacy and effectiveness; (b) clinical expertise; and (c) patient characteristics (APA Presidential Task Force on Evidence-Based Practice, 2006).

Research evidence on **efficacy** is generally supported by experimental designs such as Randomized Clinical Trials (RCTs), whereas **effectiveness** is generally supported by observational studies, such as cohort studies (Grimes & Schulz, 2002). However, Chambless & Hollon (1998) argued that efficacy may be supported, not only by RCTs, but also by a series of Single-Case Experimental Designs (SCED) with systematic replication by independent research groups.

Despite this, the last 25 years has seen the accumulation of ever-larger and more complex RCTs, with the widespread diffusion of the ideology of Empirically Supported Treatments (EST), that implicitly equates EBP as needing to be supported mostly by RCTs; this trend often discounts any (all) clinical expertise, different patient characteristics, and any evidence based on SCED, or equivalent designs.

As a result, in several countries, the mental health policy-makers only included methods of psychotherapy that had gained the status of EST in their national guidelines: thereby, implicitly delegitimizing any methods that cannot afford the costs of conducting RCTs. An example of this happened in the United Kingdom with the NICE clinical guideline for depression (National Collaborating Centre for Mental Health, 2009), that explicitly recommended doctors and mental health professionals discussing with the patient the uncertainty of the effectiveness of treatments, such as counselling or psychodynamic psychotherapy, and where a widespread, world-wide method, such as Transactional Analysis, was not even considered.

Methods of psychotherapy without EST status, because they were relatively new or were lacking in research support, were grouped under the label of Marginalized and Emerging Psychotherapies (MEPs). Stiles, Hill and Elliott (2015) proposed a four-step pathway that might enhance recognition: (1) publishing systematic single case studies by committed practitioners; (2) forming Practitioner Research Networks (PRN), with online data collection facilities, collecting substantial amounts of practice-based evidence that can be aggregated, analysed and compared with larger population benchmarks; (3) conducting small RCTs and practice-based randomized trials or pragmatic trial,s and high profile studies; and (4) developing political networking and pressure groups.

Supporting Marginalized and Emerging Psychotherapy with Single-Case Experimental Design

RCTs have become the 'gold standard' for supporting EST, thanks to their sound methodology based on: (a) registration of the trial in advance, to prevent publication biases related to publication of only good outcome trials; (b) randomization of population into cohorts under different conditions; (c) manualized treatments ensuring a common methodology that can be undertaken by different practitioners; (d) intention-to-treat (ITT) to avoid publica-

tion biases on dropouts; and (e) the possibility to compute meta-analyses and calculate valid effect sizes.

RCTs' rationale is similar to that of SCEDs. The 'gold standard' method evaluates effects of an intervention by comparing performances of a treated group with a control group, which does not receive the treatment, or receives a different one. On the other hand, SCEDs compares changes in the same person in diverse moments: i.e. during a baseline phase, where data is used to predict a level of performance for the immediate future if treatment is not provided; and then a therapy phase with the treatment (Kazdin, 1978).

Generally, case studies are considered biased by the author's assumptions, ethically problematic, difficult to summarize, unable to test causality, not generalizable, and their results are not relevant for policy-making (McLeod, 2010). This is not true for outcome-oriented case studies, able to support efficacy and effectiveness with SCED and the Hermeneutic Single-Case Efficacy Design (HSCED) (McLeod, 2010; Benelli *et al.*, 2015).

Results from well-conducted single-case studies can approximate the results of RCTs (Kazdin, 1981) when implying: (a) reliable and valid outcome measures; (b) continuous assessment of key outcome variables; (c) stability of the baseline before treatment; (d) marked effect of intervention on outcome variables supported by time-series analysis; and (e) replication of the same pattern over multiple cases.

Causality and generalizability may be further-ly enhanced by following some of the criteria used by an EST approach, and built into the guide for RCT (CONSORT, Schulz, Altman & Moher, 2010); meta-analysis (PRISMA, Moher, Liberati, Tetzlaff & Altman, 2009); and guideline production (GRADE, Guyatt *et al.*, 2011).

In particular, it is necessary to specify the dimensions grouped in the acronym PICO: Participant (eligibility criteria defining the target population, e.g., people with depressive disorders); Intervention (e.g., a manualized treatment); Comparison (e.g., the pre-post treatment, or time-series analysis); and Outcome (primary and secondary outcome measures and methods of assessment, e.g., a weekly questionnaire on depression).

Single Case Meta-Analysis

Thanks to methodological rigour, systematic outcome-oriented single case studies may be aggregated through meta-analysis (Shadish, Rindskopf & Hedges, 2008).

A meta-analysis is the statistical synthesis of results from a systematic review of original research related to a particular topic (Borenstein et al., 2009), and research syntheses whose aim is to integrate empirical research so as to generalize the data (Cooper & Hedges, 2009); evaluating the outcome through the effect size (Cohen, 1988); which measures the difference between control and treatment groups, in terms of standard deviation. The validity of conclusions drawn from such meta-analytic research is only as strong as the methods used within each original study (Burns, 2012).

SCEDs may be a valid and important contribution to evidence-based literature, but they are not largely used in reviews about evidence-practice because they lack of a widely accepted and formally-developed statistical method for analysis and meta-analysis (Shadish, 2014). There are many possible methods to conduct a meta-analysis with single-cases (e.g., see review by Allison & Gorman, 1993; Beretvas & Chung, 2008; Shadish, 2014).

For our meta-analysis, we selected a method that allows to use an effect size for SCEDs, with the same metrics as the one used in RCTs,

making possible the comparison between results of different designs and outcome measures. We adopted a standardized mean difference statistic (*d*), as suggested by Shadish, Hedges & Putejovsky (2014), because the d statistic allows us able: (a) to compare SCEDs and RCTs' effect sizes because they are based on the same metric; (b) to aggregate data from studies that used different quantitative outcome measures; (c) to use conventional statistical methods (like forest plots, diagnostic plots (such as radial plots and residual plots), cumulative meta-analysis, regression tests, or publication bias analysis; and (d) that the d statistic can be corrected for small sample bias with Hedges' 'g' (Hedges, 1981).

The Case of Transactional Analysis

Transactional Analysis (TA) psychotherapy is considered a MEP and is developing research strategies to be recognized as an EST, following the four-step pathway proposed by Stiles, Hill & Elliott (2015).

Efficacy of TA psychotherapy for the treatment of depression has been investigated through a particular SCED, the HSCED (Elliott, 2002, 2009) in a direct replication (Widdowson, 2012a, 2012b, 2012c, 2013, 2014), followed by systematic replications (Benelli *et al.*, 2016a, 2016b, 2016c, 2017a, 2017b, 2017c).

Nowadays, nine single cases demonstrated the efficacy of TA for mood disorders (Major Depressive Disorder, Persistent Depressive Disorder, Subthreshold Depression), all of them fulfilling the Chambless and Hollon criteria for claiming recognition as a well-established treatment.

The aim of this article is to conduct a review of SCEDs supporting Transactional Analysis treatment for depression and to conduct a meta-analysis.

Method

Review

A literature search was conducted using the following keywords: transactional analysis, psychotherapy, counselling, mood disorders, major depressive disorder, persistent depressive disorder (dysthymia), subthreshold depression. We identified 11 articles that focused on supporting efficacy of TA treatment for mood disorders (Major Depressive Disorder, Persistent Depressive Disorder, Subthreshold Depression). Each document was evaluated according to whether or not it met all of the following criteria according to the PICO strategy (see Table 1, below).

Table 1: The list of inclusion criteria for this meta-analysis

Population	Patient received mainly a DSM diagnosis of mood disorder
Intervention	Patient received a manualized treatment
Comparison	– The presence of a sound research design (e.g., SCED, HSCED); – The presence of a systematic case study research with at least AB phases (baseline, treatment)
Outcome	The presence of highly validated outcome measures (e.g., BDI-II, PHQ-9)

Meta-Analysis

In BSDs, Glass (1976) suggested to use Cohen's *d* statistic, which expresses treatments effects in terms of outcome standard deviations:

$$d = \frac{M_t - M_c}{S} \qquad (1)$$

where M_t is the mean of the treatment group, M_C is the mean of the comparison group, and S is an estimate of the standard deviation assumed to be common across treatment and control conditions.

The following equation (Shadish *et al.*, 2014) represents the effect size parameter as the standardized mean difference from BSDs:

$$\delta = \frac{\mu^T - \mu^C}{\sqrt{\sigma^2 + \tau^2}} \qquad (2)$$

where μ^T is the mean outcome treatment, μ^C denotes the mean outcome baseline, σ^2 is the variance of observations within cases, τ^2 is the variance of observations between cases, and $\sqrt{\sigma^2 + \tau^2}$ is the total variance. Cohen's *d* in BSDs is based on one observation per case, and for this reason σ^2 and τ^2 are not separately identified, so it is not possible to distinctly estimated them. Therefore, equations (1) and (2) overlap, leading to an effective comparison between BSDs and SCEDs. Moreover, as previously mentioned, this equation can be corrected for small sample bias using Hedges' *g* (Hedges, 1981).

To analyse these considered cases, we followed the indications of Shadish (2014) and used the SPSS macro with the software for meta-analysis of SCED (Shadish, DHPS version March 7, 2015). The variables that we considered for the analysis are the following:

- jid (journal identification number): 1 (International Journal of Transactional Analysis, IJTAR);
- SID (study identification number): 1 (Widdowson case series), 2 (Benelli *et al.*, 2016 case series), and 3 (Benelli *et al.*, 2017 case series);
- DVID (dependent variable identification number): 1 (for PHQ-9), and 2 (for BDI-II);
- DesType (0 = multiple baseline design, 1 = AB^k design, and 9 = mixture of both designs): 1;
- DesVar (design variable, required only when DesType = 9): not considered;
- PID (case identification number). We chronologically ordered the case series for each study, and numbered each single-case study from 1 to 5 for the cases of Widdowson and from 1 to 3 for each Benelli *et al.* case series;
- SessIDX (session number): as for AB phase, we considered 1 the first assessment score and 16+*n* the last treatment score (according to *n*-point baseline); for BC phase, we considered 1 the first treatment score, and 19 the last follow-up score;
- PhaseBTM (for AB comparison: 0 = baseline, 1 = treatment; for BC comparison: 0 = treatment, 1 = follow-up);
- NumPh (phase number): with AB: 1 = baseline, 2 = treatment; with BC: 1 = treatment, 2 = follow-up[1];
- DVDir (0 = outcome increases if treatment works, or 1 = outcome decreases if treatment works): 1;
- DVY (the outcome variable on the y-axis): the score of the BDI-II or PHQ-9;
- Detrend (optional detrending variable): not considered.

[1] *PhaseBTM and NumPh overlap because this study was an AB^1 design.*

The macro used in DHPS is illustrated in Appendix A. SPSS calculated for each study Hedges' *g*, the variance of *g* (VarG), the autocorrelation (PhiHat), and the intraclass correlation (Rho).

Finally, we used R (R Development Core Team, 2016) and the metafore package (Viechtbauer, 2010) to work on the analysis (the R metafore commands are illustrated in Appendix B), and we produced a forest plot to display the effect size and confidence interval for each study and the overall meta-analytic average.

Results

Review: This meta-analysis includes the analysis of 11 single-case studies. The cases that follow the PICO strategy above mentioned are described in the following tables (Table 2).

Population: The research recorded the therapist's first new patient that had received principally a DSM diagnosis of mood disorder (Major Depressive Disorder, MDD; and Persistent Depressive Disorder, PDD) and who also agreed to participate in the research project (see Table 3).

Intervention: All therapies followed (at first) the draft, lately, the manualised therapy protocol of Widdowson (2016). The therapists received supervision on a weekly to monthly basis from a Provisional Teaching and Supervising Transactional Analyst (Psychotherapy) (PTSTA-P), or from a Teaching and Supervising Transactional Analyst (Psychotherapy) (TSTA-P). and follow-ups outcome (see Table 4).

Outcome: In the Widdowson case series, the Beck Depression Inventory (BDI-II) (Beck, Steer & Brown, 1996; see Table 2) was administrated: a widely used 21-items self-report inventory. Scores for each item are representative of the gravity range and go from 0 (absent) to 3 (severe). Total scores up to 13 are considered healthy, scores of 14, 20, 29 are respectively cut-off points for mild, moderate and severe depression, scores above 63 consider an extremely severe depression, and its caseness cut-off is of 16 points. A change of at least 5.78 points on BDI-II is considered to assess a reliable improvement or deterioration (Reliable Change Index, RCI). Instead, in both the Benelli *et al.* (2016 & 2017) case series, the measure used to evaluate depression was the Patient Health Questionnaire 9-item for depression (PHQ-9) (Spitzer, Kroenke & Williams, 1999; see Table 2), which is a quantitative measure that scores each of the nine DSM-5 criteria from 0 (not at all) to 3 (nearly every day). Total scores up to 4 are considered healthy, scores of 5, 10, 15 and 20 are taken respectively as the cut-off points for mild, moderate, moderately severe and severe depression, and scores lower than 10 are considered sub-clinical. To reach RCI, there must be a change of at least 6 points on the PHQ-9 score.

The trial registration of the considered cases is reported in the table below (see Table 3).

The considered HSCEDs and the pragmatic case study used an ABA design, with baseline, treatment and follow-up. We considered only an AB comparison, between the baseline phase (A) and treatment (B). Table 4 summarizes the considered cases.

The three case series studies all have a large effect size, respectively: Widdowson series: g = 0.74 (95% CI [-0.06 to 1.53]); Benelli 2016 series: g = 0.77 (95% CI [-0.30 to 1.83]); and Benelli 2017 series: g = 1.16 (95% CI [0.31 to 2.02]). However, Widdowson (2012) and Benelli (2016) cannot be considered as representative because their lower CI is negative. Nevertheless, the average for all studies is 0.89 (95% CI [0.29 to 1.50]), which represents a significant and large effect-size. We can therefore observe the efficacy of Transactional Analysis on depression, with a large overall difference between assessment and treatment.

Table 2: The list of the considered cases for this meta-analysis on published data.

Case series	Case	Population (main diagnosis)	Intervention (treatment)	Comparison (design)	Outcome (measure)
Widdowson	"Peter" (Widdowson, 2012a)	MDD	Manualized TA treatment for depression	ABA[2] study	BDI-II
	"Denise" (Widdowson, 2012b)	MDD	Manualized TA treatment for depression	ABA study	BDI-II
	"Tom" (Widdowson, 2012c)	MDD	Manualized TA treatment for depression	ABA study	BDI-II
	"Linda" (Widdowson, 2013)	MDD	Manualized TA treatment for depression	ABA study	BDI-II
	"Alastair" (Widdowson, 2014)	PDD	Manualized TA treatment for depression	ABA study	PHQ-9
Benelli (2016)	"Sara" (Benelli *et al.*, 2016a)	MDD	Manualized TA treatment for depression	ABA study	PHQ-9
	"Penelope" (Benelli *et al.*, 2016b)	MDD	Manualized TA treatment for depression	ABA study	PHQ-9
	"Luisa" (Benelli *et al.*, 2016c)	PDD	Manualized TA treatment for depression	ABA study	PHQ-9
Benelli (2017)	"Anna" (Benelli *et al.*, 2017a)	PDD	Manualized TA treatment for depression	ABA study	PHQ-9
	"Caterina" (Benelli *et al.*, 2017b)	MDD	Manualized TA treatment for depression	ABA study	PHQ-9
	"Deborah" (Benelli *et al.*, 2017c)	MDD	Manualized TA treatment for depression	ABA study	PHQ-9

[2] *ABA study: A: baseline, B: treatment; A: follow-up*

Table 3: Trial registration of the considered cases for this meta-analysis.

Case series	Case	Started (month/year)		Ended (month/year)	
		Assessment	Treatment	Last follow up	End
Widdowson[3]	"Peter" (Widdowson, 2012a)				
	"Denise" (Widdowson, 2012b)				
	"Tom" (Widdowson, 2012c)				
	"Linda" (Widdowson, 2013)				
	"Alastair" (Widdowson, 2014)				
Benelli (2016)	"Sara" (Benelli *et al.*, 2016a)	11/2013	11/2013	04/2014	12/2014
	"Penelope" (Benelli *et al.*, 2016b)	10/2013	10/2013	03/2014	09/2014
	"Luisa" (Benelli *et al.*, 2016c)	10/2013	11/2013	06/2014	12/2014
Benelli (2017)	"Anna" (Benelli *et al.*, 2017a)	08/2014	10/2014	02/2015	09/2015
	"Caterina" (Benelli *et al.*, 2017b)	05/2014	06/2014	12/2014	06/2015
	"Deborah" (Benelli *et al.*, 2017c)	07/2014	10/2014	03/2015	11/2015

Discussions

The cases of Widdowson have a 1-point baseline. A baseline is conventionally defined as a minimum of three-data-points recorded before the beginning of a treatment, in order to compare absence of therapy with its effects (Kazdin, 2010), therefore a real baseline is missing. This is justifiable because research covered only a period of sixteen sessions (Widdowson, 2012a). Moreover, only three single-cases have 16 treatment session, whereas "Linda" dropped out attending only 9 and "Alastair" therapy considered only 14 sessions. All patients took part in 3 follow-ups, at 1-, 3- and 6-month after the end of therapy (Table 4).

The first two cases of Benelli (2016a, 2016b) have a 2-points baseline, however both pa-

[3] *Missing data: pending request*

tients attended a prior session, after which the therapist proposed to participate to the research, but quantitative data from that session is missing. The third case (2016c) has 3-point baseline (see Table 4).

The cases of "Anna" and "Caterina" (Benelli, 2017a, 2017b) extended the baseline to 4-points, whereas the first case with adolescents (Benelli, 2017c) has a 3-points baseline.

All cases in both Benelli case series had 16 sessions and 3 follow-ups, at 1-, 3- and 6-months after the end of therapy (see Table 4).

Overall, this meta-analysis indicates a significative global effect size for the efficacy of change in the comparison between assessment and treatment (AB), in particular for those case series with a more structured form and more data available. In fact, not all these considered cases were projected to conduct this meta-analysis, so some statistical artefacts have been made to calculate such effect sizes. Shadish *et al.* (2014) explained that both the number of observations (n) and the number of cases (m) are proportional to the estimated power, and higher these are, stronger will be the estimated power. Therefore, even if the number of observations ($1 \leq n \leq 4$) in the assessment phase is very poor, the high number of cases ($m = 9$) fills this gap. So, we can affirm that the more the cases were structured, thus fulfilling the criteria to compute a strong estimated power, the more significant the effect size was. This explains why the Widdowson series' and the Benelli 2016 series' effect-sizes were not significative in the first comparison.

As previously mentioned, SCEDs have generalization issues, but there are several ways to overcome this critical aspect: (a) creating a trial register, like the CONSORT, the International Standard Randomised Controlled Trial Number (ISRCTN) set out by the WHO International Clinical Trials Registry Platform (ICTRP) and the International Committee of Medical Journal Editors (ICMJE) guidelines to prevent selective reporting and publication bias; (b)

Table 4: The contingency table for the considered cases.

Case series	Case	Baseline (A)	Treatment (B)	Follow Up (A)
Widdowson (2012)	"Peter" (Widdowson, 2012a)	1	16	3
	"Denise" (Widdowson, 2012b)	1	16	3
	"Tom" (Widdowson, 2012c)	1	16	3
	"Linda" (Widdowson, 2013)	1	9	3
	"Alastair" (Widdowson, 2014)	1	14	3
Benelli (2016)	"Sara" (Benelli *et al.*, 2016a)	2	16	3
	"Penelope" (Benelli *et al.*, 2016b)	2	16	3
	"Luisa" (Benelli *et al.*, 2016c)	3	16	3
Benelli (2017)	"Anna" (Benelli *et al.*, 2017a)	4	16	3
	"Caterina" (Benelli et al., 2017b)	4	16	3
	"Deborah" (Benelli *et al.*, 2017c)	3	16	3

"randomly select" the first patient that askes therapy with the diagnosis that research aims to study; (c) avoid publication bias including drop outs (following the ITT criteria); (d) manualizing treatments; (d) making systematic replications of single-cases; and (e) calculating effect sizes with meta-analyses.

Limitations

This analysis is not free from limitations. Number of observations (n) in the assessment phase is: one in the Widdowson series and two in the Benelli (2016a & 2016b), leading to a poorly calculated effect size. It is an important limitation to this meta-analysis, but the case series that we considered were not structured to satisfy this requirement. We hope that further researchers that aim to support Transactional Analysis through SCEDs will make more assessment observations in order to make future meta-analysis statistically more powerful.

Another limitation to this study is due to missing data from the cases from the Widdowson series, and doing a linear interpolation created a straight trend, which not only lead to a non-significant effect size, but it's also poorly representative of real clinical change.

Finally, the DHPS program needed at least two baseline points to calculate 'g', VarG, PhiHat and Rho, therefore we had to duplicate the baseline score for Widdowson series, creating a 2-point stable baseline.

Future Directions

Future research should be considered – specially in order to obtain a stronger and more significative effect-size. Therefore, inspiring to Primary Registries in the World Health Organization (WHO) Registry Network, we suggest: (a) that future cases respected the definition of interventional clinical trial, which is "any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes" (WHO, 2012, pp 8), therefore researchers should follow the indications proposed by the WHO and CONSORT guidelines, and register studies in databases (such as clinicaltrials.gov for RCTs), as soon as any patients agree to participate to research; (b) the creation of a more structured therapy with at least three assessment sessions in order to obtain a stronger power analysis; and (c) to possess all sessions' scores and avoid linear interpolations that level trends. As to the first point, the inclusion in a register of the considered SCEDs was not planned, but indirectly happened thanks to the audio files, which have been archived.

We hope that future researchers will chose to conduct meta-analysis of SCEDs to support the acknowledgement of their therapy as EST, and specifically the efficacy and effectiveness of TA for Common Mental Disorders.

Conclusions

In the last decades, there have been many meta-analyses on SCEDs, especially in education, and these have been considered as a flexible and "*useful alternative to RCTs [...] for the goal of empirically demonstrating that an intervention is effective [...]. SCEDs are ideal for both researchers and clinicians working with small or very heterogeneous populations in the development and implementation of evidence-based practice*" (Byiers, Reichle & Symons, 2012, pp. 412), therefore, since Chambless *et al.* (1998) had defined that both RCTs and SCEDs can be used to demonstrate the efficacy of a treatment, so there is no reason why SCEDs shouldn't also become a valid substitute to traditional group designs in psychotherapy.

In fact, the considered SCEDs and this meta-analysis reflect some characteristics of RCTs', such as: (a) a prior registration of the cases; (b) a "randomization", meaning in-

cluding in the research the first patient that presented to therapy with a DSM diagnosis of mood disorder and agreed to participate; (c) the use of a manualized treatment; (d) the inclusion of cases of patients that dropped out to prevent biases (ITT); (e) the use of a d statistic (Shadish *et al.*, 2014) that uses the same metrics as the one used in BSD and that allows to compare different quantitative instruments (BDI-II and PHQ-9), that can also be corrected for small samples (Hedges' *g*; Hedges, 1981); and (f) follows the PICO strategy, where there is a Population with a DSM diagnosis (e.g. mood disorders), a manualized Intervention (e.g., AT for mood disorders), a Comparison between pre-therapy and post-therapy (instead of a control group like in RCTs), and a measured Outcome with highly validated quantitative instruments (e.g., BDI-II and PHQ-9).

This form of meta-analysis is the first step in supporting TA as an effective treatment for mood disorders, as an EST, and it showed how this form of psychotherapy is efficacious in treating depression in short-term therapies.

Since the first case of Widdowson (2012a), the methodology of these HSCEDs has improved throughout the years and via various publications, especially in extending the baseline from the 1-point baseline (Widdowson case series) to the 4-point baseline (Benelli, 2017a, 2017b). Moreover, the last case had included an adolescent in the research (Benelli, 2017c), which evaluated the efficacy of TA with mood disorders, also in adolescence. With the Italian's systematic replications, this type of hermeneutic analysis evolved, even focusing on the incongruences between quantitative and qualitative data. Furthermore, in order to keep pace with growing diagnosis, Widdowson (2015) manualized TA for depression and it has also been translated into Italian, published in 2018.

To conclude, systematic replications are an extremely important instrument in establishing external validity (Sidman, 1960), and conducting a meta-analysis is the via regia (Royal Road) for a systematic review of RCTs, whereas single-cases are left aside assuming they possessed a poor generality. Therefore, since the considered SCEDs for this meta-analysis are part of these systematic replications, they cannot lack in generalizability. Nevertheless, future research will be necessary to enhance the generality of TA psychotherapy's efficacy for mood disorders.

Appendix A

The following table is the obtained output from the macros used in DHPS for the AB comparison (see Table 5).

Table 5: DHPS output for AB comparison (for space issues only four decimals have been included)

jid	SID	DVID	St. Type	Err. Code	PhiHat	Rho	G	VarG	yi	vi
1	1	2	1	0	,8795	,4248	,7351	,1650	,7351	,1650
1	2	1	1	0	,7052	,1885	,7658	,2971	,7658	,2971
1	3	1	1	0	,2811	0	1,1627	,1912	1,1627	,1912

Appendix B

The following figure (Fig. 1) represents the AB (baseline-treatment) comparison of the three considered case series for the meta-analysis, with respective effect sizes and CIs 95%.

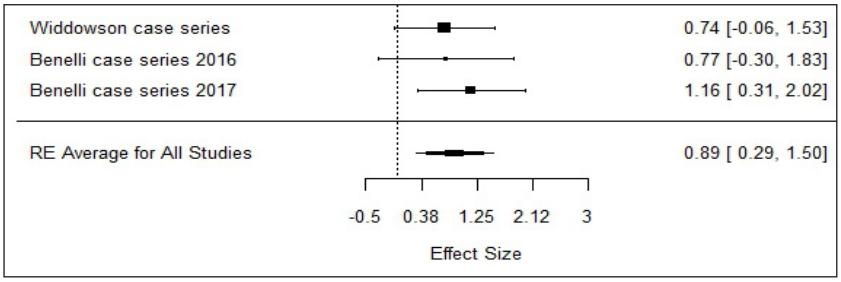

Fig. 1: *The forest plot of effect sizes and 95% confidence intervals of the three case series in the AB comparison and the average of all studies.*

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References

ALLISON, D. B. & GORMAN, B. S. (1993). Calculating Effect Sizes for Meta-Analysis: The Case of the Single Case. *Behaviour Research and Therapy*, 31(6), pp. 621-631.

APA PRESIDENTIAL TASK FORCE ON EVIDENCE-BASED PRACTICE. (2006). Evidence-Based Practice in Psychology. *The American Psychologist*, 61 (4), pp. 271-285.

BECK, A. T., STEER, R. A. & BROWN, G. K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.

BENELLI, E., DE CARLO, A., BIFFI, D. & MCLEOD, J. (2015). Hermeneutic Single Case Efficacy Design: A Systematic Review of Published Research and Current Standards. *Testing, Psychometrics, Methodology in Applied Psychology*, 22, pp. 97-133.

*** BENELLI, E., REVELLO, B., PICCIRILLO, C., MAZZETTI, M., CALVO, V., PALMIERI, A., SAMBIN, M. & WIDDOWSON, M.** (2016a). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study – 'Sara'. *International Journal of Transactional Analysis Research*, 7 (1), pp. 3-18.

*** BENELLI, E., SCOTTA, F., BARRECA, S., PALMIERI, A., CALVO, C., DE RENOCHE, G., COLUSSI, S., SAMBIN, M. & WIDDOWSON, M.** (2016b). TA treatment of depression: a hermeneutic single-case efficacy design study – 'Penelope'. *International Journal of Transactional Analysis Research, 7 (1), pp. 19-34.*

*** BENELLI, E., BOSCHETTI, D., PICCIRILLO, C., QUAGLIOTTI, L., CALVO, V., PALMIERI, A., SAMBIN, M.** & **WIDDOWSON, M.** (2016c). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study – 'Luisa', *International Journal of Transactional Analysis Research*, 7 (1), pp. 35-50.

*** BENELLI, E., MORETTI, E., CAVALLERO, G. C., GRECO, G., CALVO, V., MANNARINI, S., PALMIERI, A. & WIDDOWSON, M.** (2017a). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study – 'Anna'. *International Journal of Transactional Analysis Research*, 8 (1), pp. 3-20.

*** BENELLI, E., FILANTI, S., MUSSO, R., CALVO, V., MANNARINI, S., PALMIERI, A. & WIDDOWSON, M.** (2017b). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study – 'Caterina'. *International Journal of Transactional Analysis Research*

***BENELLI, E., BERGAMASCHI, M., CAPOFERRI, C., MORENA, S., CALVO, V., MANNARINI, S., PALMIERI, A., ZANCHETTA, M., SPINELLI, M. & WIDDOWSON, M.** (2017c). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study – 'Deborah'. *International Journal of Transactional Analysis Research*, 8 (1), pp. 39-58.

BERETVAS, S. N. & CHUNG, H. (2008). A Review of Meta-Analyses of Single-Subject Experimental Designs: Methodological Issues and Practice. ***Evidence**-Based Communication Assessment and Intervention*, 2 (3), pp. 129-141.

BORENSTEIN, M., COOPER, H., HEDGES, L. V. & VALENTINE, J. (2009). Effect Sizes for Continuous Data. *The Handbook of Research Synthesis and Meta-Analysis*, 2, pp. 221-235.

BURNS, M. K. (2012). Meta-Analysis of Single-Case Design Research: Introduction to the Special Issue. *Journal of Behavioral Education*, 21 (3), pp. 175-184.

BYIERS, B. J., REICHLE, J. & SYMONS, F. J. (2012). Single-Subject Experimental Design for Evidence-Based Practice. *American Journal of Speech-Language Pathology*, 21 (4), pp. 397-414.

CHAMBLESS, D. L., BAKER, M. J., BAUCOM, D. H., BEUTLER, L. E., CALHOUN, K. S., CRITS-CHRISTOPH, P., ... & WOODY, S. (1998). Update on Empirically Validated Therapies, II. *The Clinical Psychologist*, 51 (1), pp. 3-16.

CHAMBLESS, D. L. & HOLLON, S. D. (1998). Defining Empirically Supported Therapies. *Journal of consulting and clinical psychology*, 66 (1), pp. 7-18.

COHEN, J. (1988). *Statistical Power Analysis for the Behavioral Sciences.* London: Rutledge.

COOPER, H. & HEDGES, L. V. (2009). Potentials and Limitations. In: *The Hand. of Res. Synthesis and Meta-Analysis, 2nd Ed..* Russell Sage Foundation.

ELLIOTT, R. (2002). Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12 (1), pp. 1-21.

ELLIOTT, R., PARTYKA, R., ALPERIN, R., DOBRENSKI, R., WAGNER, J., MESSER, S. B., WATSON, J. C. & CASTONGUAY, L. G. (2009). An Adjudicated Hermeneutic Single-Case Efficacy Design Study of Experiential Therapy for Panic/Phobia. *Psychotherapy Research*, 19 (4-5), pp. 543-557.

GLASS, G. V. (1976). Primary, Secondary, and Meta-Analysis of Research. *Educational Researcher*, 5 (10), pp. 3-8.

GRIMES, D. A. & SCHULZ, K. F. (2002). An Overview of Clinical Research: The Lay of the Land. *The Lancet*, 359 (9300), pp. 57-61.

GUYATT, G., OXMAN, A. D., AKL, E. A., KUNZ, R., VIST, G., BROZEK, J., ... & RIND, D. (2011). GRADE Guidelines: 1. Introduction – GRADE Evidence Profiles and Summary of Findings Tables. *Journal of Clinical Epidemiology*, 64 (4), pp. 383-394.

HEDGES, L. V. (1981). Distribution Theory for Glass's Estimator of Effect Size and Related Estimators. *Journal of Educational Statistics*, 6 (2), pp. 107-128.

KAZDIN, A. E. (1978). Methodological and Interpretive Problems of Single-Case Experimental Designs. *Journal of Consulting and Clinical Psychology*, 46 (4), pp. 629-642.

KAZDIN, A. E. (1981). Drawing Valid Inferences from Case Studies. *Journal of Consulting and Clinical Psychology*, 49 (2), pp. 183-192.

KAZDIN, A. E. (2010). *Single-Case Research Designs: Methods for Clinical and Applied Settings* (2nd ed.). New

York. Oxford University Press

MCLEOD, J. (2010). *Case Study Research in Counselling and Psychotherapy*. London: Sage Publications.

MOHER, D., LIBERATI, A., TETZLAFF, J. & ALTMAN, D. G.: THE PRISMA GROUP. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med*, 6 (6): e1000097, pp. 1-6.

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH. (2009). *Depression: The Treatment and Management of Depression in Adults (Update)* (NICE clinical guideline 90). London: National Institute for Clinical Excellence. Retrieved from: www.nice.org.uk/CG90

SCHULZ, K. F., ALTMAN, D. G. & MOHER, D.: THE CONSORT GROUP. (2010). CONSORT 2010 Statement: Updated Guidelines for Reporting Parallel Group Randomised Trials. *PLoS Med*, 7 (3): e1000251, pp. 1-7.

SHADISH, W. R., RINDSKOPF, D. M. & HEDGES, L. V. (2008). The State of the Science in the Meta-Analysis of Single-Case Experimental Designs. *Evidence-Based Communication Assessment and Intervention*, 2 (3), pp. 188-196.

SHADISH, W. R. (2014). Analysis and Meta-Analysis of Single-Case Designs: An Introduction. *Journal of School Psychology*, 52 (2), pp. 109-122.

SHADISH, W. R., HEDGES, L. V. & PUSTEJOVSKY, J. E. (2014). Analysis and Meta-Analysis of Single-Case Designs with a Standardized Mean Difference Statistic: A Primer and Applications. *Journal of School Psychology*, 52 (2), pp. 123-147.

SIDMAN, M. (1960). *Tactics of Scientific Research: Evaluating Experimental Data in Psychology* (Vol. 5). New York: Basic Books.

SPITZER, R. L., KROENKE, K. & WILLIAMS, J. B. (1999). Validation and Utility of a Self-Report Version of PRIME-MD: The PHQ Primary Care Study. *Journal of the American Medical Association*, Nov 10; 282 (18), pp. 1737-44.

STEEL, Z., MARNANE, C., IRANPOUR, C., CHEY, T., JACKSON, J. W., PATEL, V. & SILOVE, D. (2014). The Global Prevalence of Common Mental Disorders: A Systematic Review and Meta-Analysis 1980–2013. *International Journal of Epidemiology*, 43 (2), pp. 476-493.

STILES, W. B., HILL, C. E. & ELLIOTT, R. (2015). Looking Both Ways. *Psychotherapy Research*, 25 (3), pp. 282-293.

TRAUTMANN, S., REHM, J. & WITTCHEN, H. (2016). The Economic Costs of Mental Disorders: Do Our Societies React Appropriately to the Burden of Mental Disorders? *EMBO Reports*, 17 (9), pp. 1245-1249.

VIECHTBAUER, W. (2010). Conducting Meta-Analyses in R with the Metafore Package. *J. of Statistical Software*, 36 (3), pp. 1-48.

WORLD HEALTH ORGANIZATION. (2003). *The Mental Health Context.* Geneva: Mental Health Policy & Service Guidance Package.

WORLD HEALTH ORGANIZATION. (2012). *International Standards for Clinical Trial Registries.*

*** WIDDOWSON, M.** (2012a). TA Treatment of Depression – A Hermeneutic Single-Case Efficacy Design Study – 'Peter'. *International Journal of Transactional Analysis Research*, 3(1), pp. 3-13.

*** WIDDOWSON, M.** (2012b). TA Treatment of Depression – A Hermeneutic Single-Case Efficacy Design Study – 'Denise'. *International Journal of Transactional Analysis Research*, 3(2), pp. 3-14.

*** WIDDOWSON, M.** (2012c). TA Treatment of Depression – A Hermeneutic Single-Case Efficacy Design Study – 'Tom'. *International Journal of Transactional Analysis Research*, 3(2), pp. 15-27.

*** WIDDOWSON, M.** (2013). TA Treatment of Depression – A Hermeneutic Single-Case Efficacy Design Study – 'Linda': A Mixed Outcome Case. *International Journal of Transactional Analysis Research*, 4:2, pp. 3-15.

*** WIDDOWSON, M.** (2014). Transactional Analysis Psychotherapy for a Case of Mixed Anxiety & Depression: A Pragmatic Adjudicated Case Study – 'Alastair'. *International Journal of Transactional Analysis Research*, 5:2, pp. 66-76.

WIDDOWSON, M. (2015). *Transactional Analysis for Depression: A Step-by-Step Treatment Manual.* Routledge.

WIDDOWSON, M, (2018). *Analisi transazionale per i disturbi depressivi. Manuale per il trattamento [Transactional Analysis for Depressive Disorders. A Manual for Treatment*]. Milano. Franco Angeli.

** Indicates articles included in meta-analysis (N=11).*

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