IJTARP
International Journal of Transactional Analysis Research & Practice

13 (2), 32-43
https://doi.org/10.29044/v13i2p32

The Client System: The Importance of the Client Support Group in the Area of Health Sciences

© 2022 Tânia Caetano Alves

Abstract

The author proposes in this phenomenological study the presentation of the Client System concept in the area of Health Sciences of Transactional Analysis, through a Narrative Study anchored in a literature review. It provides a basis for understanding the importance of knowledge and interaction of health professionals with client support groups - the Client System - when involved at some point in the health-disease continuum. It reflects on the impact that the loss of physical well-being can cause not only on the sick individual, but also on the groups to which they belong, including the health team involved in their search for recovery. It also proposes a more holistic and integrative view of health.

Keywords

Health. Disease. Health professionals. Transactional Analysis. Health Sciences.

Introduction

Margaret Mead was an American anthropologist who lived from 1901 to 1978 and contributed significantly to the understanding of the importance of the role of culture in the formation of values and social conduct. She is attributed a story about an answer given to a student who asked her about what she considered to be the first sign of civilization. Instead of citing the finding of clay pots, tools or religious symbols, the anthropologist chose as the first evidence of civilization the discovery of a fractured and healed femur, 15,000 years old, in an archaeological site. Her explanation for this statement was that, within a period of at least 6 months, someone must have taken care of the injured person, meeting their most basic needs for food, shelter and defence until the bone healed (Côrtes, 2021). For Margaret Mead, the measure of civilization is made in relation to the care we have for the other.

It is widely disseminated and accepted as fact that human is a gregarious animal and we can understand gregariousness as "a strategy for protection observed in several groups of animals that are grouped in more or less structured populations, permanent or temporary, aiming at the protection of individuals that compose it" (Wikipedia, in the entry Gregarismo, 2021). In his article entitled The importance of groups in health, culture and diversity, David Zimerman (2007) justifies the attribution of this importance to some factors, of which I cite the following three:

- the fact that human beings are gregarious by nature, participating in different groups from birth and only existing, according to the cited author, due to their group interrelationships.
- the fact that every individual spends most of their life living and interacting with these different groups, from the first natural group that exists in all cultures - the nuclear family - through the groups formed by day-care centres, nurseries and schools, even the groups that expand and renew themselves in adult life, with the constitution of new families and professional, sports, social, associative and other groups.
- the fact that, according to Zimerman, as the inner and the outer world are the continuity of each other, likewise the individual and the social do not exist separately. These two dimensions of the human interpenetrate, complement and confuse each other. Based on this, the author states that "every individual is a group (to the extent that, in their internal world, there is a group of characters who are introjected, such as parents, siblings, etc., and who live and interact with each other)" . (Zimerman, 2007, online).

When presenting his reflections on the innate drives that characterize physis, understanding physis as "the force that leads people to grow, progress and do better" (Berne, 1947, p. 98), Italian transactional analyst Piccinino (2018) identifies, acting within of

us, human beings, and motivating our behaviour the following impulses: Survival; Belonging to a group; Evolution and knowledge; and Self realization.

He goes on to say that in order to survive, human beings - especially given their relative physical helplessness - had to band together in groups and develop an innate tendency towards affection, group affiliation, altruism, empathy, mutual protection, mutuality and even a sense of justice within the world clan (de Waal, 2013; Ostaseski, 2017). We therefore 'invent' love and civility and the tendency to love another human being in order to address our pressing needs for affective and group attachments in order to survive from birth.

By understanding the importance of the impulse to belong to a group, especially in moments of greater challenge or fragility, such as those involving our physical health and the issues that revolve around the preservation of the integrity of our physical body, it is necessary that the various health professionals have as a highlight, in client service, the fact that whoever comes to them is not alone. On the contrary, the individual arrives accompanied by their own group of internal characters formed by the introjected figures in the formation of the Parent ego state, for example; arrives, bringing with them their support system, both in person and remotely, along with the culture, beliefs, rituals and values contained in such a context.

This work proposes the presentation of the Client System concept in the area of Health Sciences of Transactional Analysis, through a narrative study anchored in a literature review. It proposes reflection and understanding of groups that form the support system of people who are involved at some point in the health/disease continuum and how this system, the Client System, impacts the relationship between health professionals and clients. Having worked as a health professional for many years, I bring here, in addition to the narrative review of the literature, the vision I developed, on this topic, over 40 years of paediatric practice.

Systemic Thinking and Health

For the present reflection, health professionals are understood as the various professionals who are involved with people who are acutely or chronically ill, totally or partially incapacitated, temporarily or permanently or in search of preventive care for their health. Including therefore professionals working at any of the levels of health care: promotion, prevention and rehabilitation, including palliative care and monitoring in the process of death and dying.

Developing the perception of the client who seeks us out as someone belonging to a complex system of groups and subgroups that we will inevitably have to deal with, takes us back to the origins and evolution of systems thinking. Capra, in *The systemic view of life* (Capra and Luisi, 2014) sees the evolution of holistic thinking as a necessary paradigm shift, a new vision of life itself. In his words, it is "… an emerging new scientific conception of life, can be seen as part of a broader paradigm shift from a mechanistic worldview to a holistic and ecological worldview. At its very core, we find a shift in metaphors that today is becoming increasingly evident... - a shift in which the world is no longer seen as a machine and is understood as a network. (p.26).

According to Capra, there is a basic tension between the parts and the whole. The more mechanistic view of the world, also known as reductionist or atomistic, although it was essential for the emergence of science that took us away from a period of obscure knowledge, also diminished the vision of life and the human being. In contrast to this, there has been an evolution towards a more holistic, organismic or ecological view, where emphasis is placed on the whole and not on the parts. This perspective, known as 'systems' from the 20th century, is based on the so-called systems thinking, whose characteristics we will see below.

The cited author presents a detailed explanation of the evolution of thought and vision about life and the universe through the history of Western science. This evolution of thought through the centuries can be summarised as follows:

- During most of the Middle Ages, until the 13th century, the world view was an organic view, with people living in small cohesive communities and depending on nature and on each other in an intimate and communal way, under the system of feudalism. The Church exerted an important influence and there was a mixture of spiritual and material concerns. In the 13th century, there was a fusion of Aristotle's ideas about nature with Christian theology and ethics, placing the science of this time, based on faith and reason, around questions related to God, the human soul and ethics.
- In the 16th and 17th centuries there was a radical change in the prevailing perspective in the Middle Ages. According to Capra, "The notion of an organic, living, spiritual universe was replaced by that of the world as a machine, and the mechanistic conception of reality became the basis of the modern worldview." discoveries and postulations in the fields of Physics, Astronomy and Mathematics.

- The 18th century brought the application of Newton's Mechanics that deepened the shift in perspective by explaining the movements of planets, moons and comets down to the smallest details, as well as the flow of tides and various other phenomena related to gravity.
- During the 19th century, important investigations culminated in the presentation of the atomic hypothesis and electric and magnetic phenomena. In addition, there was the emergence of Mendel with the postulations that became the basis of modern genetics and evolutionary thinking, with the Theory of Evolution of Species by Lamarck (1744-1829) and Charles Darwin (1809-1882), which was a landmark of rupture with the "Cartesian conception of the world as a machine that emerged, already perfectly constructed from the hands of its creator" (p. 58).
- It was in the 20th century, which has just ended, that the Theory of Relativity and Quantum Theory emerged, questioning and shaking the main concepts of the Cartesian worldview and Newtonian mechanics. Capra places the beginning of systems thinking at the beginning of the 20th century, having as pioneers the biologists who emphasised the view of living organisms as integrated wholes. There was opposition to the reductionism of Biology, Physics and Chemistry. Schools such as Vitalism (19th century) and Organicism (early 20th century) maintained that, although applicable to living organisms, the laws of Physics and Chemistry were insufficient to fully understand the phenomenon of life.

Capra, referring to systems thinking, said that the behaviour of a living organism as an integrated whole cannot be understood from the study of its parts. As systems theorists would express themselves several decades later, the whole is more than the sum of its parts. From this perspective, "a system has come to mean an integrated totality, whose essential properties arise from the relationships between its parts, and "systems thinking" has come to indicate the understanding of a phenomenon within the context of a greater whole." (p. 94). According to Capra, understanding the world and beings in a systemic way means understanding them within a context, establishing the nature of their relationships and emphasising the fact that the essential properties of an organism arise from the relationships and interactions between the parts.

Systems thinking has several characteristics that constitute changes in perspectives that, if evaluated within the context of health and client/health professional relationships, greatly contribute to the understanding of another form of interaction with the client and their support system. Relating the various characteristics of systems thinking and linking them to a systemic view of health, we can reflect on some of them, such as those listed below.

- *Change of perspective from the parts to the whole*: the properties of living systems cannot be reduced to those of smaller parts. Essential, or systemic, properties are properties of the whole, which none of the parts have. The over-specialisation of many areas of health brings, as a side effect, the risk that the clients of professionals in these areas are often treated, not as João, the husband of Dona Maria, but as the 9:30 am surgery, heart failure of 304, the molar of 15h, the attendance of a dysphonia or the bath of 503.
- *Change of perspective from objects to relationships*: living beings are seen within the systemic view, as integrated wholes, both to their smaller components and to the larger whole to which they belong. According to Capra, there are no parts, only patterns in an "inseparable web of relationships." (p.113). Therefore, the perception of the client, by the health professional, without associating them with their context, without evaluating their past history, will inevitably lead to an incorrect view of them and, perhaps, to an erroneous or incomplete diagnosis and treatment.
- *Changing perspective from measurement to mapping*: when we think about the world and beings in a less reductionist way, we realise that these cannot be evaluated through measurements alone. In systems thinking, evaluation is based on the assumption that relationships cannot be measured and weighed, but rather mapped. The author in question says that "When we map relationships, we discover certain configurations that occur repeatedly." (p.114). Capra calls this a pattern. Perceiving people within their patterns of repetition brings us directly to the link with Berne's theory of script. It is extremely important that the health professional remember that the client who comes is a whole with a previous history, probably full of nuances and cycles full of meaning, even if the complaint is a stiff neck, hoarseness, caries or an ugly nose. And also that any of these cycles, stories or beliefs are closely related to the people who form the groups in their context.
- *Perspective shift from structures to processes:* systems science perceives structures as the manifestation of underlying processes, understanding the living structure through the

understanding of its metabolic and developmental processes. If we take some childhood complaints as an example, we can observe that many signs or symptoms are due both to the context-group to which they belong, and to the stage of development they go through.

- *Change of perspective from objective science to epistemic science*: this characteristic is highlighted by the fact that, when receiving a client, the health professional becomes part of their context, of their support group, in short, of their network and, for this also becomes an important influencer of their processes.

  For Cartesian science, scientific descriptions must be objective, independent of the human observer and the knowledge process. On the contrary, systems science postulates that the understanding of the knowledge process needs to be explicitly involved in the description of natural phenomena. Using, in a superficial way, a thought of the quantum physicist, Heisenberg: the observer changes what is observed by the simple fact of observing it.

- *Change of perspective from Cartesian certainty to approximate knowledge*: The mechanistic paradigm is based on the certainty of scientific knowledge. In the systemic paradigm, we will not find this complete certainty in belief as a single truth.

In relation to the health area, holding and concentrating the value of knowledge only on the health professional does not contribute to autonomy. The traditional view that people have of health professionals, in general, places the latter in a hierarchical role that tends to reinforce the status quo, which intensifies beliefs about power, passive behaviors on the part of clients and their support systems and makes people less autonomous than they could be in relation to their health. People in general have considerable knowledge about their physical matters, even if this knowledge may be interspersed with fanciful ideas. The qualification of lay knowledge about illness and health helps health professionals to have, in the client, the indispensable protagonist in their healing process.

The systemic proposal for health presupposes that we understand it in a broader way, capable of contemplating the human being as a being, which, gregarious by choice and aptitude, has its well-being related to the harmony between its many contexts of action. Relating this proposal with the various definitions of health, I bring some of them for comparison and reflection.

The current WHO (World Health Organization, 2006) definition of health states that it is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This definition of health, adopted by the World Health Organization in 1946, in a period immediately after the war, resulted from the current concern with the devastation that had occurred and from an optimism in relation to world peace. It has been as publicised as it has been criticised. It has been considered utopia because a state of complete physical well-being can be a beautiful goal to be achieved, but it has not been part of the reality of our planet, and therefore it is not a goal to be used by health services. Another criticism has to do with the lack of reference, in the text, to the environmental context in which the human being is immersed.

Also from the WHO, more specifically from the European Regional Office (2020), we have a broader reflection on the issue of health as the extent to which an individual or group is able, on the one hand, to fulfil aspirations and satisfy needs and, on the other hand, to deal with the environment.

In Brazil in 1986 at the 8th Natural Health Conference, the so-called Expanded Concept of Health emerged: in its broadest sense, health results from the conditions of food, housing, education, income, environment, work, transport, employment, leisure, freedom, access to and possession of land and access to health services. It is thus, above all, the result of the forms of social organisation of production, which can generate great inequalities in living standards. Health is not an abstract concept. It is defined in the historical context of a given society and at a given moment of its development, and must be conquered by the population in their daily struggles (Child Neurology Society, 1986).

This expanded concept of health was a reflection of the re-democratisation process that was taking place at the time and of a feeling of freedom to express ideas and ideals that had been repressed by the military dictatorship, which, having lasted 21 years, had ended just one year ago. The 8th Health Conference took place in five days of debates, with more than four thousand participants distributed in 135 working groups and with the participation of users. It was the first conference open to the people. In addition to the Expanded Concept of Health, this historic conference gave rise to important subsidies for the future Constituent Assembly and for the definition of the Unified Health System (SUS).

Another way of thinking about health has to do with the systems thinking that we discussed earlier. For Capra “Health is a state of well-being, resulting from a dynamic balance that involves the physical and

psychological aspects of the organism, as well as its interactions with its natural and social environment (CAPRA, 2014, p.323). For Capra, understanding health is and always will be linked to understanding life. In the systemic view, it would not be possible to define health as this is a subjective experience, intuitively known, but not possible to be described or quantified. According to the author, “Health is a state of well-being that arises when the organism functions in a certain way.” (p.403).

To end this topic, I bring a last definition, this one considered a holistic definition since, in addition to including the various contexts that other definitions include, it also includes the spiritual dimension. Health is the consciousness of well-being, resulting from a continuous process of harmonization between physical, psychic, social, environmental... and spiritual aspects... in all phases of human existence. (Pozatti, 2007). For Pozatti, human beings, in the search for their wholeness and quality of life, generate health. For him, to be healthy is to be whole again.

All these definitions, elaborated in different moments of life of different people and groups, serve to reinforce the idea of how the individual can change their vision about the well-being associated with the concept of health, depending on the context and the time in which the individual lives.

It seems essential that health professionals, regardless of their specialties and where and how they develop their profession, can welcome the client who seeks them having, as a reference, the notion that the person who arrives in front of them bringing a complaint, hope or despair has a history, a family, a socio-economic cultural situation of their own and, most likely, a faith. This welcoming movement brings, in its wake, several challenges involving the previous history of the professional and their current availability and completeness to be able to be the target of the transference and projection that the client will inevitably make in the bonding process. Not all professionals who care for sick people or in search of preventive health care have, at their disposal, time, equipment or place for care that meet all the needs of the client and the health professional. This is the acute Brazilian reality, sadly evidenced in the current pandemic that plagues us. However, I believe that if the client can be seen as a whole and unique person, the client and the professional will win, even in the worst conditions of service.

The Client System

By Client System, we understand the client's context and the various groups and subgroups with which they interact, considering the level of relational proximity e.g. family, extended family, work group, cultural, religious group and health professionals involved. (UNAT-BRAZIL, 2019). In principle, this system is the client support system. Its peculiarity is that it is made up of people, with all the elements that make up people's personalities, elements that make them unique and original.

When presenting his vision of the structure of personality, Berne (1961/1985), when describing the determinants, organised these various elements that determine the way a person as structured during neuropsychomotor development and called them Internal Programming, External Programming and Probability Programming.

Internal Programming comes from natural biological forces of the individual. We are born endowed with this organism that has a programme to respond according to instincts. These instincts are the survival instinct that has to do with the search for food and the preservation of life and the species preservation instinct that is related to sexuality. Furthermore, we are gregarious beings who, as biological organisms, need someone else to take care of us. Not only are we born capable of seeing, hearing, sucking, and grasping in a highly specific way, we are also able to bond in our first hours of life. (Lewis and Wolkmar, 1990).

Biological programming comes from beyond instincts, natural emotions and our biological baggage, our genetic inheritance.

Probability Programming comes from autonomous data processing, based on past experience. In other words, Probability Programming is the result of the experience and learning we had in meeting the characteristics of the organism that is born (Internal Programming) with the environment that welcomes it (External Programming).

The neural networks that will give rise to our ego states are constituted through this learning, through the result of what happens between the organism and the external environment. In the question at hand, we are interested in focusing on External Programming, one of the Determinants that comes from incorporated external canons. We were born in an external environment and due to this, external programming will be everything that comes from culture, society, family and parents. Therefore, we are talking about values, beliefs, imitated behaviours and rituals, including those that interfere, beneficially or not, with understanding and behaviour in the face of the signs and symptoms of diseases.

The Determinants, members of the Psychic Apparatus, were understood by Berne “as factors that determine the quality of the organization and phenomena” (Berne, 1985, p. 222); that is, they establish the programming of the Psychic Organs that manifest themselves through the Phenomena. or

ego states of Parent, Adult and Child. They are the elements that, different for each person, make us unique. We are original not only because of our fingerprints or our voice, but also because of the unique phenomenon that is the formation of neural networks that will emerge as a result of the dynamics that occur in the encounter between the individual and the external environment.

Hine, a transactional analyst who studied the relationship between neural networks and ego states, understands the formation of the Self, “our identity, the essence of who we are” (Hine, 2004. p. 60), as a gradual movement, starting from unique neural connections, built by experiences, also unique to each person. These elements of each person's internal environment, when in contact with the elements of another person's internal environment, through ego states, can give rise to various forms of social structuring of time, from rituals, through psychological games to intimacy. When, in addition to this, there is a threat to physical or emotional health, the risks of conflict become greater, being, therefore, an important focus of attention for the transactional analyst in the area of health sciences. Therefore, when a person seeks a health professional, they do so with all this complexity composed of instincts, emotions, beliefs, rituals, values, logical reasoning and experience.

The client that we receive arrives with one of the psychic organs (archeopsyche, exteropsyche or neopsyche) more cathected, and it is with this one that we will make the first contact. Even if whoever speaks to us is the Adult ego state, expressing the content organised by the neopsyche, this content can come with or without contamination from other psychic organs, which can make a difference in the way the contact will take place. Faced with the stress caused by a physical or mental illness, the patient and their support system may react to the stimulus (illness) with the neopsyche (Adult); in this case, the solutions for coping with the crisis will come from this psychic structure, whose characteristic is, according to Berne, to deal with the transformation of stimuli into pieces of information and the processing and archiving of this information based on previous experience.

However, the content of the exteropsyche (Parent) or of the archeopsyche (Child) can invade or contaminate the neopsyche, which configures a structural pathology, an anomaly of the psychic structure, named by Berne as contamination, which assumes the configuration of certain types of prejudices on the one hand and illusions on the other (Berne, 1961). in prejudice, part of exteropsyche is included in the borders of neopsyche, with its contamination by content of exteropsyche such as prejudices or stereotyped judgments. In the illusion, there is a contamination of the neopsyche, such as, for example, illusions or fears, originating from the archeopsyche. a double contamination can also occur, when the neopsyche is contaminated by both prejudices and illusions.

Each of the psychic organs perceives the environment differently, according to its function and, therefore, reacts differently to a different set of stimuli. Therefore, the reaction to the disease stimulus may come, not from the neopsyche but from the exteropsyche with its characteristics of immersion in the culture in which the individual lives, or from the archeopsyche based on pre-logical thinking and on poorly differentiated or distorted perceptions. This possible contamination of neopsyche, which can either affect the client or the client's system, including the health professional, tends to be harmful both for the relationship between those involved and for adherence to the treatment instituted for the various pathologies.

Now, let's multiply this situation by the number of people that make up the support system of the individual in question and we will have a sample of the mosaic to which we will be exposed as health professionals, involved in the various situations related to the health-disease process. Unfortunately, we currently have daily examples of this, regarding the way people have behaved in the face of the pandemic. The issue of wearing masks, social distancing, early treatment for COVID and vaccination, are vivid examples of how beliefs and prejudices stemming from the culture of individuals, as well as illusions and fears can interfere with adult, appropriate decision-making time and impacting the health of the client, the client system and the community at large.

Knowing how to theoretically contextualize these reactions and respond to them with interventions that can decontaminate the adult ego state of the client and/or the members of their support system (through the use of therapeutic operations, for example) can be the differential that will lead the client to a good evolution and better prognosis of his pathology. It is important to have the client and the groups to which they belong as allies in the treatment. Decontaminating the Adult ego state about wrong or harmful ideas and behaviours that may be occurring in relation to their health is both indispensable and challenging.

One of the frequent events in Medicine and, I imagine, in other areas of Health Sciences as well, is the action of the ‘patient’ and their support system (Client System) on the symptoms and signs of the disease that afflicts them. The popular saying that

“We all have a little bit of a doctor and a madman” refers to this. People act on their pathologies and on the pathologies of those they love, acting against the symptoms of the disease and, above all, being harassed by fantasies and beliefs arising from the interaction of individuals with the culture of which they are a part.

In the DSM 5- Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2014), there is a chapter whose title is Glossary of Cultural Concepts of Suffering, in which several syndromes related to beliefs of the cultures, from various parts of the world, in which the affected individual is immersed are described. For example, Dhat syndrome, a term created in South Asia, which refers to a set of symptoms such as anxiety, fatigue, weight loss and impotence that is attributed to the loss of semen, with a cultural disposition to explain problems of health and symptoms through reference to Dhat syndrome. Another example would be the Maladi Moun or sent disease, a cultural explanation present in Haitian communities for various psychiatric medical disorders; something similar to our ‘Evil Eye’ or ‘Breaking’ that would cause watery eyes, sluggishness, sadness, yawning, and sneezing. I have often come across reports of treatments based on my clients' cultural beliefs. I cite a few: blowing on the ‘soft spot’ (fontanelle) or on the baby’s face when choking, shaking hard when baby has colic, putting a small lint of wool moistened with saliva on the forehead to stop the hiccups, instilling drops of kerosene in the nostrils to treat sinusitis, put a coin in the belly button to treat umbilical hernias, blessings for shingles, and others.

Respecting the culture of the client and its support system and separating what is innocuous from what is beneficial or harmful is a constant challenge in serving clients, in any area of health. The health professional will always work with groups, since the client is accompanied, subjectively or concretely, by this support system, the Client System.

Berne (2011) defined group as “any social aggregate that has an external boundary and at least one internal boundary” (p.63), understanding it as a social aggregate, the one in which there are transactional stimuli and responses. The first social group to which we belong is the family. Sociologically, family is understood as an aggregation of individuals united by affective or kinship ties in which adults are responsible for caring for younger individuals. Despite having undergone important changes over time, the concept of family continues to have as its main characteristics the formation of a nucleus and the care with elements not yet fully developed. As it is the first group to which we belong, its importance is imposed and its influence acts on the other groups to which the individual integrates during their life.

Generally, the first contact that the health professional makes with the client's support system is with someone from their nuclear family or origin, whether this person is present at this first meeting or not. In medical consultations, this contact with family members, even in the first consultation, is very common, being mandatory in the paediatric clinic, in geriatrics and in emergency situations and serious conditions. In other health professions this also occurs, for example, dentistry, speech therapy, nursing, nutrition, occupational therapy, social work and others.

Berne (2011), when referring to the organising and disorganising forces that act in groups, cited group cohesion as an organising force and pressure and agitation as disorganising forces. According to him, groups can be constructive and destructive depending on which of these forces are more present. The activities of a constructive group increase the order of the external environment and those of a destructive group aim to promote disorder in the external environment. Generally speaking, “the family is a constructive group in which each member contributes to the cohesion of the group and promotes internal order” (p. 94), although it is not uncommon for internal or external disruptive forces to threaten the survival of the family group.

The Client System and Disease

When serving their clients, the various health professionals come into contact with the full range of emotions and feelings triggered when someone, in some way, gets involved with their health issues, at any of the levels of health care such as promotion, prevention. and rehabilitation, palliative care and also the process of death and dying. This range of feelings, of course, extends throughout the Client System, bringing, in each case, the nuances of the culture of that group. Fortunately, we do not always have to deal with death - with the definitive and ubiquitous death, but when it comes to the health-illness continuum, we will always be having to deal with the fear of losing something physical, and with the fear of threats to the integrity of this unique vehicle for being on this planet, which is our physical body.

Nurses, physiotherapists, dentists, physical educators, speech therapists, nutritionists, occupational therapists, doctors, social workers, those who work with the elderly and, probably others that I am not mentioning now, all of these face the issue of loss or expectation. of some kind of physical loss, with the various emotional demands these possible occurrences evoke. There are countless

situations in which the client comes to the health professional due to the loss of some capacity that implies in their quality of life, for example: loss of range of motion, strength, teeth, speech, ability to walk, the possibility of singing, sphincter control or youth.

Often, before reaching the health professional, the issue in question has already impacted several of the groups that are part of the Client System. If the individual has some type of discomfort or physical limitation, this may be reflected in their attendance and productivity at school or at work, they may have to change elements of the habits and routine of the family group, and, in many cases, they may already have been ingesting substances or undergoing some other type of treatment prescribed or advised by the various members of all the groups to which they belong, including groups that involve non-human, but spiritual entities.

There were several situations in which, as a paediatrician, I received children referred or already medicated by components of their support system who had no more formal knowledge about the disease or discomfort in question. While this does not mean that advice is always inadequate and unresolving, it often causes problems due to the misinformation and lack of objectivity that emotional involvement and lack of training can cause. Add to this the searches carried out on Google and we will have a very approximate view of what usually happens.

I think it is important to point out that the health team that, in one way or another, serves the client, is also part of the aforementioned Client System and is absolutely not exempt from emotions, feelings, transference and countertransference, nor from Google searches. Illness and fear of illness impact the group as a whole and this creates a very favourable context for less healthy forms of relationship to appear due to anxiety. Being able to identify and diagnose what is happening in the relationships between health professionals and the client, between caregivers and the being who is fragile, or among the members of the support system, can be an invaluable resource in these situations where emotions and expression of them may be harming the healing process and the maintenance of health.

The concepts and proposals of emotional education for understanding relationships and personal calibration, such as the concept of the Emotional Awareness Scale proposed by Steiner (Steiner and Perry, 1998), in the book about emotional literacy, can be valuable for us to understand where the client or their support system is located. in terms of awareness of emotions or feelings. This scale is a diagram that serves to delineate the different profiles constructed from the levels of emotional awareness that range from a minimum (Insensitivity) to a maximum (Interactivity) of Emotional Awareness. The levels of Emotional Awareness are, in ascending order, Insensitivity, Physical Sensations, Primitive Experience, Differentiation, Causality, Empathy, and Interactivity.

It is very common that when treating physically ill people, at the time we receive them, they are at the lowest levels of Emotional Consciousness, not aware of how their emotions may be moving and expressing inside and outside of themselves, or experiencing the physiological changes that emotions cause as symptoms, not of their emotions, but as if they were coming from some pathology (somatisation). And sometimes, although there may be awareness of the emotions in progress, the person cannot understand or control them, and there may be emotional outbursts or fits of impulsiveness, which only serve to upset those involved in the situation. Understanding and diagnosing these levels of Emotional Awareness in the Client/Client System and in ourselves (health staff) is an invaluable resource for knowing which approach is most convenient for each emotional moment. Even taking into account that the client's contacts with professionals in the Health Area may have a short duration, if we have awareness and basic knowledge about the intra and interpsychic process, this will undoubtedly be a differential in our way of welcoming people who look for us and the result of our work.

The Health Team and Disease

When the client and their support group look for a health professional, they usually look to that professional for maintenance or recovery of their well being. I want to focus, in this item of the present work, on the search for professionals for diagnosis, treatment and cure of some debilitating, disabling or potentially fatal aspect. As we all know, including from our own experience, when the physical complaint is presented to the doctor, nurse, nutritionist, physiotherapist or others, along with it, there is yearning, fear, hope and, sometimes, despair. I think it is important to reflect on how this impacts health team members who, like the client and their support system, think, feel and act according to their culture, emotions and experiences.

The current world situation involving the pandemic caused by COVID-19 has greatly intensified the drama that is usually hidden from the public and that has to do with the impact that illness, death and pain have on health professionals. Characterized by the World Health Organization as a pandemic in March 2020, COVID-19 has decimated families, greatly damaged the economy and consistently changed the

way people relate. This serious health condition, despite having already been considered, caught everyone unprepared to face it. People who work in essential services, as is the case with several health professionals, had to walk in the opposite direction of social distancing, exposing themselves, in the case of those on the 'front', to environments with a high risk of contamination.

Although users of health systems know that health professionals share their human condition with them, being also possible targets of the disease, this does not prevent them, in their fear and sadness, from directing to professionals their expectation that they, in some way, will save them and protect them from the evil that frightens them. The acquisition of knowledge about COVID-19, regarding its characteristics, possible treatments and forms of prevention, took place while people were getting sick and dying and health teams tried to avoid this experientially and, certainly, with great emotional tension. The risk of becoming infected and contaminating their families, the lack of personal protective equipment, the lack of medication (let us remember the crisis due to the lack of oxygen that occurred in Brazil) and the political polarisation surrounding all this and favouring the denial of the severity of the crisis has put many doctors and nurses in a situation of acute stress. Taken at times as the heroes of the crisis and, in others, as vectors to be avoided due to the risk of contamination, health professionals developed, during this period of pandemic that we are going through, conditions such as anxiety, depression, post-traumatic stress and others.

Although we are talking about these situations now, due to the event of the pandemic, this is not new nor unprecedented in relation to health professionals. In an article on the mental health of physicians during the COVID-19 Pandemic, Galbraith, Boyda, McFeeters and Hassan (2021) cite the following "Research from previous epidemics/pandemics (such as the 2003 SARS outbreak, the 2012 MERS epidemic, or Ebola outbreaks in West Africa) shows that healthcare workers can experience a wide range of psychological morbidities, including trauma, that can linger for many months after the outbreak. The relationship between traumatic life events and suicide is well documented and trauma from disaster events can increase suicidal ideation in emergency workers. Fear of health risk and social isolation contribute to psychological distress, as do community perceptions of the stigma of infection. However, negative effects on mental health can be found in physicians, whether or not they work directly with infected patients. While frontline health care stresses during an infectious outbreak can lead to sick leave and increased staff turnover, most evidence suggests that doctors and nurses feel a strong professional obligation to continue working despite danger. " (online). Still in the same article, the authors comment on the fact that having to balance one's own safety with the needs of patients, family members and employers, in addition to the lack of resources and long working hours, can lead to distressing and consequential ethical dilemmas. moral damages.

Lucia Cecilia da Silva, in her reflection on *The psychological suffering of health professionals in the care of cancer patients* (da Silva, 2009), brings considerations of some patients. health professionals such as doctors, nurses, psychologists, social workers and physical rehabilitators who can become risk factors for your mental health. These characteristics would be the intimate and frequent contact with pain and suffering; close and frequent contact with the prospect of death and dying; dealing with bodily and emotional intimacy; or dealing with difficult patients, for example, complainers, rebels and non-adherents to treatment; or dealing with the uncertainties and limitations of scientific knowledge that oppose the demands and expectations of patients who want certainty and guarantees.

One of the author's conclusions is that "… being constantly faced with human fragility and vulnerability, health professionals who work in cancer patient care are exposed more often and more intensely to their own fragility and vulnerability as existing beings. It is in contact with the other that the "I" is constructed, differentiated and recognized, and knowing the pain of the other, the finitude of the other is knowing one's own pain, one's own finitude. And in this human identification with the patient, the professional recognizes himself [or herself] as a being open to suffering because he [she] also recognizes himself [herself] as fragile and vulnerable, subject to all the possibilities that life presents, with death being the most certain possibility." (da Silva, 2009)

The emphasis of the text in bold is mine and I do so because these questions are relevant since, in the constant evidence of the fragility of life and in the clash between personal needs and those of the other, the information that everyone, clients, systems of client support and health professionals, are part of the same and broad system of the client, emitting stimuli and transactional responses, in an intense way, as well as signs of recognition and affection for each other.

As situations related to the health-disease process so powerfully impact patients and caregivers, including health professionals, building a space for open and generous listening for both people who are

sick and those who care for them is vital for maintaining the quality of health-promoting actions. The health team's contact with the other groups to which the client belongs can prove to be enlightening and useful, especially if we return to the idea that the whole may have more resources than its parts. Seeking curiosity and empathy for those who come to us with their pain and fear, expands the scenario of the encounter. What set of experiences, traumas, beliefs come to seek our guidance? And how will all this meet with our own set of experiences, traumas and beliefs?

The Health Team and the Client System

In addition to the topics covered so far, there is an interesting question about groups and how people relate to and within them. According to Berne (2011), individuals join groups with certain equipment necessary for this, namely: a biological need for stimulation, a psychological need for structuring time, a social need for intimacy, a nostalgic need to standardise transactions, and a provisional set of expectations based on past experiences. When entering a group, the individual needs to make an adjustment movement in order to adapt their needs and expectations to the reality they encounters.

Berne defined group imago as “any mental portrait, conscious, preconscious or unconscious, of what a group is or should be.” (p.236). Napper, referring to the vision of Imago from Berne, says that “the term Imago from Berne refers to the picture that we unconsciously carry in our head of what any group we enter or are a part of will be like. It is based on the past experience of our first family group, growing to more recent group experiences” (Napper and Newton, 2016, p. 204).

The group's Imago changes while the adjustment process takes place, going through four different phases, in which the social structuring of time, in the group in question, will be different for each of them, ranging from rituals to pastimes and activities, passing through psychological games until reaching intimacy. During this evolution, the way members perceive themselves and others within the group changes and, with this, also the way they relate to each other. Both the client and the Client System have prior impressions or impressions to be built on in the group in which they and the sought-after healthcare professional are included. Just as the health team will be the group about which the client and their support system will make fantasies and develop expectations based on past experiences, so health professionals, when included in the Client System, will be able to see or imagine themselves being seen according to their previous experiences.

Often the health professional is placed, in the group to which the client belongs, as a leader regarding health issues. This can go smoothly or there can be obstacles as the client belongs to other groups that also have authority figures recognised by the client. Recognising the existence of these other important and influential leaders in the client's support system and working with them in a cooperative way can encourage the client and their families to achieve autonomy in relation to their health. As the situations to which we are referring are related to the maintenance or recovery of physical well-being, we will have, as already mentioned, the issue of each person's physical vulnerability permeating this entire process.

Piccinino (2018) highlights a fundamental aspect of all this by bringing the following reflection “Let us not forget that the reflective capacity necessary to choose between various behavioral options implies, on the one hand, an awareness of our vulnerability to illness, our insecurity, our casual dependence on external events and the inevitability of death. But, on the other hand, it also implies an awareness of the beauty of creation, as well as the pleasure of living and being in the world. Anxiety and the joy of living have the same root and rationality; they are the consequence of the rise of awareness of ourselves as individuals. Anticipating threats, being prepared to face the unexpected, forming groups, giving meaning to our existence, and so on. These are the reactions that humanity has “selected” not only to survive, but also to overcome the anxiety of knowing our condition.” (p.275)

Conclusion

Based on the discussion and reflections above, the Client System - defined as the client's context and the various groups and subgroups with which it interacts - is also defined as a basic support element for the prevention, maintenance and recovery of health. The systemic view of health brings us a proposal for the perception of well-being and the wholeness of being, as something integrated in the culture, context and life stories that clients bring to the various health professionals they seek.

Since humans are gregarious beings, this defining characteristic will mark and influence our experiences from the simplest and most joyful to the most dramatic and challenging, such as those involving the issue of illness and finitude. By becoming the depository of the client's health complaint, the professional who assists them will also become the depositary of their affection, fears, pain, anger and expectations of cure. In addition, you will also be exposed to the various feelings and actions that your client's health issue causes in your

support group. Facing the signs of the client's vulnerability, their pain and the risk of, perhaps, not being able to avoid their losses, can trigger, in the health professional, due to the evidence of their own fragility, anxiety and depression.

It is a right and, perhaps, a duty of the individual who finds themself at some point in the health-disease continuum to be the protagonist of their own health, seeking the diagnosis, treatment, guidance and support they needs from professionals and, in the groups to which they belong, understanding and support. The healthcare professional, whatever their profession, will need to get involved in some way and, at some level, with the Client System and, if they know how to take advantage of the opportunity, they will be able to find allies that, in some situations, will prove to be of vital importance. for the good evolution of the treatment or for the reception of unresolved situations.

Understanding and accepting the characteristics of the client's culture and the Client's System can facilitate not only the anamnesis and diagnosis, but also the performance and effectiveness of the treatment. It is important for the health professional to know that, by saying yes to actions of prevention, rehabilitation, cure or adaptation to situations of loss, they will be saying yes to the cultural meaning of each of these elements.

Sometimes, what may seem like small actions bring important changes in the reference framework of the health professional and the client, providing space for those involved to function as interconnected and supportive groups where each respects the knowledge and culture of the other and can talk about the boundaries of each one in a clear and respectful way. The experiences that take us out of the comfort zone, that expand our consciousness, allow us to build new ways of acting due to new positive experiences. Having done it differently once, having faced the challenge of spontaneously feeling a new possibility of relationship with the client and their context, brings a differential that is worth seeking. This differential, which has to do with subtle nuances, is made up of small changes that have to do with decontaminating the way of thinking and reviewing ethical issues and beliefs.

Transactional Analysis, with its relational approach, becomes an important help for health professionals to move through this intricate of beliefs, emotions and expectations that the disease generates, not only in the client and in their context, but also in the team of the healthcare provider.

Finally, experiencing new forms of relationships with clients and their support systems, with an awareness of their meanings for a 'systemic life, can help us to place ourselves in this intricate world of limitations and fullness with our real size and, always, of holding hands.

The area of Health Sciences was validated after the formation of the first group in Brazil, in January 2021. In this way, this article is just the beginning of a vast area to be investigated and deepened. The limitation of this study is the isolated experience of the author. Field research will be useful to validate the empirical phenomenology of the Client System concept. This article is the suggestion and encouragement for such studies.

Tânia Caetano Alves is a Physician, and a Certified Transactional Analyst in the areas of Psychotherapy and Health Sciences, and a TA Trainer in Training in the area of Psychotherapy by UNAT-BRASIL. She can be contacted on taniaea2015@gmail.com

References

American Psychiatric Association. (2014). Manual diagnóstico e estatístico de transtornos mentais (Diagnostic and Statistical Manual of Mental Disorders) DSM 5. Artmed.

Berne, E. (1947). *The Mind in Action.* Simon and Schuster.

Berne, E. (1961/1985). Transactional Analysis in Psychotherapy/ Análise Transacional em Psicoterapia. Summus.

Berne, E. (2011). Structure and Dynamics of Organizations and Groups. UNAT BRASIL, restricted circulation for didactic purposes. Suliani Editografia Ltda,

Capra, F., & Luisi, P. L. (2014). *A visão sistêmica da vida: uma concepção unificada e suas implicações filosóficas, políticas. sociais e econômicas.The systemic view of life: a unified conception and its philosophical, political implications. social and economic.* Cultrix.

Child Neurology Society [Conselho Nacional de Saúde) (1986) Anais da 8ª Conferência Nacional de Saúde [Proceedings of the 8th National Health Conference]. Ministério da Saúde. www.conselho.saude.gov.br

Côrtes, D. A. (2021). A um fêmur de distância: a ligação da vida de Margaret Mead com a história das ciências. (A femur away: the connection of Margaret Mead's life with the history of science.) Biotecnologia, Blog do Profissão Biotec, 8. https://profissaobiotec.com.br/margaret-mead-historia-das-ciencias/

Da Silva, L. C. (2009). O sofrimento psicológico dos profissionais de saúde na atenção ao paciente de cancer. (The psychological suffering of health professionals in the care of cancer patients.) *Psicología para América Latina, 16* [online].

de Waal, F. (2013). *The bonobo and the atheist: In search of humanism among the primates.* W. W. Norton & Co.

Galbraith, N., Boyda, D., McFeeters, D., & Hassan, T. (2021). The mental health of doctors during the COVID-19 pandemic. *BJPsych Bulletin, 45*(2), 93-97. doi:10.1192/bjb.2020.44

Hine, J. (2004). Estruturas Cerebrais e Estados de Ego. (Brain Structures and Ego States.) *Brazilian Journal of Transactional Analysis,1,* 59-80.

Lewis, M., & Volkmar, F. (1990) *Clinical Aspects of Child and Adolescent Development*. Lea & Febiger. Published online by Cambridge University Press: 02 January 2018

Napper, R., & Newton, T. (2016). *Táticas: conceitos de análise transacional para treinadores, professores, facilitadores, coaches e mentores, mais insights para estratégias de aprendizagem colaborativa.* (*TACTICS Transactional analytics concepts for coaches, teachers, facilitators, coaches, and mentors, plus insights into collaborative learning strategies).* Medianitz.

Ostaseki, F. (2017) *The Five Invitations: Discovering What Death Can Teach Us About Living Fully*. MacMillan.

Piccinino, G. (2018). Reflections on Physis, Happiness, and Human Motivation. *Transactional Analysis Journal, 48*(3), 272-285.

Pozattl, M. L. (2007). *Buscando a inteireza do Ser / Proposições para o desenvolvimento sustentável da consciência humana (Seeking the wholeness of Being / Propositions for the sustainable development of human consciousness*.) Gênese Editora.

Steiner, C.; & Perry, P.(1998). *Educação Emocional (Achieving Emotional Literacy*.) Editora Objetiva Ltda.

UNAT-BRAZIL.(2019). *Manual de Certificação de Analista Transacional. (Transactional Analyst Certification Manual*.) UNAT.

WikipEdia (2021). Gregarism. https://pt.wikipedia.org/wiki/

World Health Organisation – Regional Office for Europe. (2020). Health 2020: A European Policy framework and strategy for the 21st-century. https://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf

World Health Organization. (2006). Constitution of the World Health Organization – *Basic Documents*, Forty-fifth edition, Supplement, https://www.who.int/about/governance/constitution

Zimerman, D. (2007). A importância dos grupos na saúde, cultura e diversidade, (The importance of groups in health, culture and diversity). *Vínculo, 4(*4), 1-16.