IJTARP

International Journal of Transactional Analysis Research & Practice

Volume 14 Issue 2 - December 2023

https://doi.org/10.29044/v14i2

ISSN 2218-3159

IJTARP is published under the auspices of the International Centre for Transactional Analysis Qualifications CIC. www.ictaq.org

IJTARP
International Journal of Transactional Analysis Research & Practice

14 (1), 2

Volume 14 Issue 2 December 2023

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https://doi.org/10.29044/v14i2p2

Editorial

Another great issue to read as we enter 2024. We have the full set - research, new theory, practice examples, and even plenty of diagrams.

We begin with a great research article from Carol Remfrey Foote, in which she sets out the initial stages of her project to investigate how transactional analysis practitioners use outcome measures in contracting, diagnosis and treatment planning. This is a very thorough introduction to her research, with masses of references for anyone who wants to follow up on how to set up their own research study. Plus the research is now happening so there is the opportunity to become involved.

This is followed by some very interesting material from a non-TA author, Zbigniew Wieczorek in Poland, who links how we characterise chronological time and neurolinguistic programming to several TA concepts, including ego states as well as script, personality adaptations, strokes and time structuring. This is based on an article originally published in Polish – and seen by a PTSTA who brought it to my attention because of its obvious relevance to us. An intriguing new perspective.

The third article is by Lena Kornyeyeva, who invites us to consider a different way of thinking about ego states when she introduces the idea of basing it on whether we value ourselves and others. Lena reminds us how significant attachment and self-esteem are, and the links to childhood development. In addition to illustrating how the theory helps us to understand client/practitioner dynamics, she also provides a helpful case study of working with a couple.

Next comes a case study from Szabolcs Lovas, this time about leadership within organisations. He provides us with much useful information about multi-party contracting and how he deals with the psychological level, plus how he fits TA concepts into a leadership development programme that is designed to encourage managers to develop others as well as themselves. He concludes with a detailed account of what happened in the third session of that programme.

The final article in this issue is by Steve Lankton. He has taken some material about states of consciousness that will appear in a book in 2024, and added extra TA to show how it can be linked to ego states. A thorough review of what has been written by many authors about states of consciousness and experiential resources is followed by some clear links to ideas on how we might work with the theory in practice as TA practitioners.

I have much stimulated by working with the contents of this issue, and I am sure you will find the the contents really useful. Happy reading – and hopefully we will have a more peaceful New Year.

The Abstracts of each article in each IJTARP issue appear at https://taresearch.org – and are translated by volunteers into several languages.

IJTARP
International Journal of Transactional Analysis Research & Practice

14 (2), 3-16

https://doi.org/10.29044/v14i2p3

Outcome Measures in Transactional Analysis Clinical Practice

Abstract

This article presents a review of the literature on the use of Outcome Measures (OMs) in counselling and psychotherapy, done by the author as part of her research (to be reported later) into how transactional analysis practitioners use OMs in TA contracting, diagnosis and treatment planning. A wide range of non-TA literature is presented, various OMs are described, practitioners' positive and negative perceptions of them are described as well what they tend to do instead of using OMs. It is reported how few counsellors and psychotherapists utilise OMs as part of their clinical practice. This article explores the issues and give more depth and detail into the 'pros and cons' of OM use within TA practice and is intended to initiate discussions of the topic alongside the research study.

Key Words

transactional analysis, outcome measures, outcome rating scale, session rating scale, clinical supervision

Introduction to a Research Study

This article is the first to appear about a research study that is being conducted as part of doctoral research. The author is a Certified Transactional Analyst (Psychotherapy) researching how TA practitioners (practitioners) use outcome measures (OMs) as part of their TA diagnosis, contracting and treatment planning process. There is a gap within the TA and wider research output, on how practitioners use the OM information from each therapeutic session, in their clinical decision making, to inform their client case formulation, and to adjust session by session components of the diagnosis, contract, or treatment planning in response to OM data. The research study has 12 participants who are qualified TA psychotherapists using OMs in their private practice. They have completed 60-minute semi-structured interviews that are being analysed using Interpretative Phenomenological Analysis (Smith, Flowers and Larkin, 2022), a hermeneutic, phenomenological and idiographic methodology well suited to the phenomenological basis of TA as it explores the intrapersonal and intrapsychic realm of the participants and their cognitive and affective lived experience in the clinical decision-making process.

As a trainee and then a qualified psychotherapist, the author has used OMs with clients for over 15 years to track clients' psychotherapeutic treatment trajectories to monitor their progress and intervene when there are indications of plateauing or deterioration and to adjust or ameliorate a client's TA diagnosis, contract or treatment plan. As such, OMs are a rich source of intrapersonal, interpersonal and extrapersonal information, immediately available to the practitioner at the start of the session. The client and therapist together can, in a few minutes, review levels of anxiety, depression, panic, somatic issues, interpersonal relationships, general health and well-being, trauma-related symptoms, mood disorders, and risk factors for self-harm and suicide. The OM scores and tracking data can then be utilised in session to inform TA counselling and psychotherapy. This author is therefore potentially biased – hence a research study to find out more about the process.

This means that OMs are a supportive tool for establishing the working alliance and holding the therapeutic container for the work together (Bordin, 1994; Bachelor and Horvath, 1999; Horvath, 2018). The use of OMs can help the client to gain a meta perspective of their therapeutic journey as they can track their progress over time and make informed decisions on the contract and goals for therapy. This is a partnership approach where the OM data is shared between client and therapist, promoting an OK-OK therapeutic relationship (Berne, 1975) and helps to focus the TA contract as exploratory, clarifying, behavioural or growth and discovery (Sills, 2006), using the OM data to inform this process. The use of OMs aids the development of the client's self-awareness of their intrapsychic dialogue through reflection on how Parent to Child messages impact on their anxiety, depression, self-esteem and self-confidence, and how changes in the intrapsychic

dialogue show up as improvements in their OM scores and aid in strengthening the Adult ego state (Berne, 1961, 1966). The OMs may also provide a framework for TA psychoeducation, in introducing the client to concepts and models by utilising the client's OM responses to address self-regulation, open communication and various TA concepts.

When clients fill in an outcome questionnaire at each appointment this positively affects the result of their therapy (van Rijn, Wild and Moran, 2011). Clients have used outcome measures to let therapists know how they experience the therapeutic relationship, and this can affect positively the client's outcome of therapy, meeting their goals and improving attendance (Miller, Duncan, Brown, Sorrel, and Chalk, 2006).

Finally, modern technology allows for OMs to be attached to email and sent ahead of the client's appointment, for completion and return prior to the session. This enables the OM to be reviewed, scored, charted and any improvement, plateauing or deterioration noted, and the trajectory of previous weeks OMs compared. This can take less than 5 minutes for the counsellor or psychotherapist to complete and after saying hello to the client the week's OM can be reviewed, discussed, and explored together with what emerges during the session.

The use of OMs in TA has begun to gain some traction among TA researchers and the wider TA community in recent years. This journal, *IJTARP*, has highlighted a plethora of research, primarily case studies, where OMs have been utilised in evaluating client's response to focussed interventions, such as anxiety and depression (van Rijn and Wild, 2013; Harford, 2013; Harford and Widdowson, 2014). Case study researches using OMs to track client responses to TA treatment have also made important contributions to the sound evidence base of TA clinical practice and effective treatment of mood disorders (Gentelet and Widdowson, 2016; Widdowson, 2011, 2012, 2013; Benelli, Revello, Piccirillo, Mazzetti, Calvo, Palmieri, Sambin, and Widdowson. 2016; Benelli, Scotta, Barreca, Palmieri, Calvo, de Renoche, Colussi, Sambin, and Widdowson, 2016; Benelli, Boschetti, Piccirillo, Quagliotti, Calvo, Palmieri, Sambin, and Widdowson, 2016; Benelli, Moretti, Cavallero, Greco, Calvo, Mannarini, Palmieri, and Widdowson, 2017; Benelli, Filanti, Musso, Calvo, Mannarini, Palmieri and Widdowson, 2017; Benelli, Procacci, Fornaro, Calvo, Mannarini, Palmieri, and Zanchetta, 2018; Zanchetta, Farina, Moreno and Benelli, 2019; Zanchetta, Picco, Revello, Piccirillo and Benelli, 2019).

Other articles have appeared in the *Transactional Analysis Journal* – such as Gentelet and Widdowson (2016) describing a case study in which they found TA psychotherapy to be "... an effective therapeutic approach for people with long-term health conditions, depression, and emetophobia …*" (*p.192). Recent research with 25 mild-to-moderate substance users who attended a 12-session TA programme and used validated OMs found strengthened Adult ego states, changed stroking patterns and life positions (Williams and Glarino, 2023). TA has also developed several concept-specific screening tools or psychometric TA instruments for use by therapists with their clients, and Vos and van Rijn (2021) completed a comprehensive search and review of 56 psychometric TA instruments, evaluated with Consensus-Based Standards for the selection of health Measurement Instruments (COSMIN). However, of these 56 instruments, only 5 were found to have met fair-to-good COSMIN standard: the Life Position Scale (Boholst, 2002), Schema Mode Inventory (Edwards and Arntz, 2012), Tokyo University Egogram (Oshima, Horie, Yoshiuchi, Shimura, Nomura, Wada, Tawara, Nakao, Kuboki and Suematsu, 1996), Adjective Checklist-TA Scales (Gough and Heilbron, 2007), and ANINT-A36 Questionnaire (Scilligo, 2000). These psychometric instruments are a more qualitative approach specific to TA whilst OMs can be seen as a generic quantitative method in measuring clients' symptoms and responses to counselling and psychotherapeutic treatment. Vos and van Rijn concluded *"*These findings may motivate psychotherapists to use the instruments … in their clinical practice to identify client's main problems and their root causes. Where they are used as sources of feedback and engagement with therapy, they strengthen the working alliance and prevent poor outcomes" (p.150-151).

Outcome Measures

For the purposes of this article, I will use the term Outcome Measures although other terms are used by various authors. The overarching aspect and key principles of OMs is to ask clients to self-report on how they experience their mental health and daily functioning, both at the first intake session, and throughout their therapeutic treatment. These frequent measurements detect progress and improvement as well as any levelling-off or plateauing, and the likelihood of early drop out from treatment when the client is not feeling any improvement in their mental health. When therapists use OM feedback systems, they can respond to any deterioration and work collaboratively with the client to improve their symptoms (Lambert and Harmon, 2018).

Note that there are OMs that are free to use whilst others require subscription payments. These may be aligned to a business model to generate income, to negatively evaluate existing competitors' OMs, or use a meta-analysis approach to test out the reliability and validity of OMs in routine use. There may be the issue of bias so care may need to be taken when choosing, especially as OMs become assimilated into daily use and their reliability and validity unquestioned and accepted.

Typical examples of OMs include:

- Clinical Outcomes in Routine Evaluation-Outcome Measure known as CORE-OM (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell and McGrath, 2000) which measures global distress.
- Generalized Anxiety Disorder version 7 (Spitzer, Kroenke Williams and Lowe, 2006) known as GAD-7 which measures levels of anxiety.
- Patient Health Questionnaire, known as the PHQ-9 (Kroenke, Spitzer and Williams, 1999) which monitors levels of depression, and the Hospital Anxiety and Depression Scale or HADS (Zigmond and Snaith, 1983).
- Outcome Rating Scale (ORS) (Miller, Duncan, Brown, Sparks and Claud, 2003) measures the client's perspective on change or improvement.
- Session Rating Scale (SRS) (Miller, Duncan, and Johnson, 2002; Duncan, Miller, Sparks, Claud, Reynolds, Brown and Johnson, 2003) monitors the practitioner and client working alliance parameters.

These OMs are free to use once registered on their website as a licenced user and have handbooks or instructions on how to present these to the client for their completion, how to score client responses, the score ranges (from within normal limits, moderate and severe impairment) and how to interpret and track the trajectories. The reader may be aware of or use other OMs which are not mentioned in this article.

There are also:

- Measurement-Based Care (MBC) is defined by Scott and Lewis (2015) as "the practice of basing clinical care on client data collected throughout treatment. MBC is considered a core component of numerous evidence-based practices" (p.49).
- Symptom Rating Scales are defined by Baer and Blais (2010) as "... designed to quantify the severity of a disorder ... the severity of depressive symptoms ... can inform treatment planning and monitor patient progress" (p.2).
- Routine Outcome Monitoring (ROM) is defined by Barkham, De Jong, Delgadillo and Lutz (2023) as "... a method that integrates data into the process of therapy and enables adjustments when patients are not on track ... thus enhancing the overall effectiveness of psychotherapy" (p. 841).
- Patient Reported Outcome Measures (PROMs) according to Roe, Slade and Jones (2022) *" ...* directly assess the lived experiences of service users, capturing their perspectives on their health status and essential subjective constructs such as goal attainment, quality of life and social inclusion" (p.56).
- Progress Monitoring (PM) is defined by Ionita, Ciquer and Fitpatrick (2020) as *" ...* measures which help ensure evidence-based practice, allow the tracking of client progress in psychotherapy treatment and even predict which clients will have negative outcomes" (p.245).

The use of handbooks, manuals, national and international standards, and guidelines for mental health practitioners have come into widespread use, as an attempt to make the delivery and measurement of mental health services formulaic. The Improving Access to Psychological Therapies (IAPT) (Holland, 2009) sets out case-identification tools for anxiety and depression and moves onto recommending 12 specific OMs for routine use in IAPT services, for 14 mental health problems. The National Institute for Health and Clinical Excellence (NICE) (2011), recommends that General Practitioners (GPs) ask the two Whooley (Whooley, Avins, Miranda and Browner, 1997) questions to screen for depression: "During the past month, have you often been bothered by feeling down, depressed, or hopeless? During the last month, have you often been bothered by having little interest or pleasure in doing things?" These are intended to incentivise GPs to measure the severity of depression to target antidepressant prescribing in line with NICE (2009) guidelines and to follow the UK GP contract (National Quality and Outcomes Framework, 2006/2007). GPs are then recommended to assess their patients with the PHQ-9 (Kroenke et al, 1999), the HADS (Zigmond and Snaith, 1983) or the BDI-II (Beck, Steer and Brown, 1996). The use of OMs as a reliable and valid measure of how unwell is the client, contrasts with a GP's clinical judgement alone, which may be flawed, and they may offer inappropriate medical treatment or mistake mild for severe cases (NICE, 2011).

This author finds the Session Rating Scale (SRS) useful as a framework that gives ample space and opportunity for the exploration of transferential and countertransferential factors in the therapeutic

relationship. This relates to the transference and countertransference matrix (Berne, 1964; Hargaden and Sills, 2002; Little, 2011) and in early intervention with therapeutic rupture and repair (Erskine, 1993). The SRS asks the client to rate the session (from 0-10) in how they experience: the therapeutic relationship, in feeling heard, understood and respected (Horvath, 2018); the sessional contract working on and talking about their topics and goals (Sills, 2006); the therapist's approach or method being a good enough fit for the client; and finally overall asks if there was something missing in the session.

The author has found that clients quickly become familiar with OMs and are able to identify how their OM scores show the impact of script limiting factors in their intrapersonal, interpersonal and extrapersonal aspects of their lives. This allows them to recover awareness, intimacy and spontaneity, resulting in their autonomy (Berne, 1968; Stewart and Joines, 1987). Moving next into specific areas of treatment planning which may be helpful in supporting counsellors and psychotherapists in clinical practice, I also consider the use of OMs in the exploration of the client's risk of harm to themself or others as being a key aspect of safeguarding the client and managing risk in psychotherapy and counselling. OMs such as CORE-OM, GAD 7 and PHQ 9, include statements or questions on thoughts of self-harm, suicidal ideation, and suicide planning. The risk factors listed in the outcome measures offer the client inherent permission to disclose, as well as safeguarding, proffering protection (Crossman, 1966) to the client, normalising the client's experience to enable them to explore their thoughts, feelings and behaviours involving self-harm and suicidality. Without the use of CORE, issues such as feelings of shame may well inhibit self-disclosure of such key information. Therapists have such a limited time with their clients each week and CORE can quickly show where and when clients are experiencing a decline in their mental health or an increase in their level of risk (van Rijn and Wild, 2016). A key question might be how does the TA practitioner then use the outcome data to manage risk in decision-making? The psychotherapist or counsellor may then consider concepts such as escape hatches (Haiberg, Sefness and Berne, 1963) with the client and assess if the client is at low, moderate or elevated risk of self-harm (and/or risk to others) and either monitor and track their responses or refer onto primary- or secondary-care providers. OMs offer a sliding scale or continuum of risk assessment to practitioners to support their decisions whether to refer on, and OMs can communicate to colleagues and fellow professionals areas of risk and the rationale for referral.

What do practitioners do instead of using OMs

Most practitioners use 'clinical judgement' rather than evidence-based sources in their treatment of clients (Bower and Gilbody, 2010). Counsellors and psychotherapists find it difficult to implement clinically relevant research in their decision-making. There has been important literature appearing from small, accumulated studies which explain this phenomenon, finding that psychologists ignore the research evidence, preferring to use clinical judgement and experience in making clinical decisions (Stewart, Stirman and Chambless 2012); Gyani, Shafran, Myles and Rose, 2014; due to time pressures and costs associated with training, rather than negativity towards research evidence (Stewart, Chambless and Baron, 2012).

Clinical judgements, based on 'gut feelings' or hunches without a robust evidence-base are prone to cognitive biases and heuristics. Heuristics are essentially shortcuts, a reductive, rapid, prioritising process in the clinical setting in response to time pressure and limitations within the professional environment (Bate, Hutchison, Maskrey and Underhill, 2012). Heuristics are outside the practitioner's direct awareness, held determinedly whilst adversely impacting on their clinical decision making and increasing risk to their clients (Tarescavage and Ben-Porath, 2017).

The three types of bias relevant to clinical decision making are those of confirmation, overconfidence, and blind spot (Lilienfeld and Lynn, 2015). Confirmation bias involves looking for information that fits the clinician's first impressions whilst simultaneously ignoring information that does not fit (Tarescavage and Ben-Porath, 2017). Over-confidence bias occurs when practitioners trust their clinical judgement when it is inaccurate. Blind spot bias occurs when they see other clinicians' decision-making bias and not their own (Tarescavage and Ben-Porath, 2017). These cognitive biases are important considerations, particularly confirmation bias which can be improved using OMs which are free of cognitive bias and invaluable as part of the evidence-based assessment process (Lilienfeld and Lynn, 2015; Tarescavage and Ben-Porath, 2017)).

Heuristics, or 'hunches' or 'gut feelings', can be useful to practitioners if applied with care and caution (Lilienfeld and Lynn, 2015) and rooted firmly in Evidence Based Practice (EBP). This may be likened to the Somatic Child response we experience in our bodies to a client talking about what has happened to them, our 'Little Professor' makes an interpretation or assumption, and if we check this out from Adult ego state by getting more information, asking questions or 'thinking Martian' (Berne, 1963) we can hone the heuristic and limit biases.

The Evidence Based movement originated in Paris in the mid 1800s but did not gain momentum until the 1990's (Rycroft-Malone, Seers, Titchen, Harvey, Kitson and McCormack, 2004), and can be seen as the original forerunner of EBP, initiated by medical practitioners and described as being the rigorous, precise, and considered use of the most recent evidence in the clinical decision-making of individualised client care (Sackett , Rosenberg, Gray, Haynes, and Richardson, 1996). These authors encourage practitioners to integrate and use their clinical expertise in how they apply the objective evidence, as one without the other may lead to inappropriate, obsolete, or inhumane clinical care.

The epistemological sources of evidence which can be used in clinical practice, known as the 'three-legged stool' (Figure 1) are sourced from research, clinical expertise, clients, and carers being involved in shared decision making about care and considering the culture and local environment (Rycroft-Malone et al., 2004; Stewart et al, 2012). There is rarely ontological certainty with even the gold standards of a Systematic Review or Randomised Controlled Trial (RCT), as research evidence shifts, changes and is updated as new knowledge emerges. As Rycroft-Malone et al (2004) point out, the axiological implications of the evidence base when focussed to specific aspects of treatment can hold diverse, competing sources of evidence open to a variety of explanations. The clinician's decision-making is always contextual and embedded in their organisation's attitudes and beliefs, priorities for the work, workload, management systems and what EBP senior professionals may have alighted upon. Private practice psychotherapists have other pressures and priorities, particularly financial; their incomes are dependent on attracting and retaining clients, advertising, paying practice-based utilities whilst complying with their professional organisations and insurers, managing their accountancy systems, and keeping abreast of the rules and regulations surrounding private practice. For counsellors and psychotherapists, the time pressures are acute. For those in organisations, access to Continuous Professional Development (CPD), necessitates time away from their clients, arranging cover for their caseload, and certain CPD may be mandatory and in line with short term/long term goals and priorities. This may leave practitioners with little choice in how they might widen and deepen their individual learning needs or interests. Private counsellors and psychotherapists experience barriers to accessing CPD or up-to-date research and this may impose limitations on how they might integrate new theory into practice. Professional journals have subscriptions and CPD courses cost time and financial resources, and are often 'fitted into' the working day or annual leave. There is also a plethora of new research on clinical practice coming on-stream and counsellors and psychotherapists can feel overwhelmed on where to look, what to choose, how and when to implement and integrate this new knowledge into clinical practice. This may be further complicated by modality specific publications which offer a particular philosophical perspective or stance on practice and leave the practitioner unsure on how to interpret and then implement EBP. The gap between research and clinical practice persists, and despite huge investment to promote EBP from organisations, clinicians appear to prefer their clinical judgement rather than the evidence gleaned from the research (Gabbay and Le May, 2011).

Practitioners may find it challenging to objectively assess the efficacy of their practice, and studies have shown they overestimate their effectiveness by up to 65% (Miller, Hubble, and Duncan, 2007). Therapists believed in one large scale survey that they helped 80% of their clients, whilst almost 25% of therapists felt confident that 90% of their clients, or more, improved, with very few deteriorating (Walfish, McAlister, O'Donnell and Lambert, 2012). Bickman (2005) conducted a study asking therapists to rate their performance from A+ to F, and 66% rated themselves A and above whilst no-one scored themselves below average. When it comes to keeping track of a client's trajectory in treatment, Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa and Sutton (2005) studied 550 clients seen by therapists who judged their deterioration in treatment, noting that on average 8% of clients show deterioration; sadly, in their study the therapists could only judge deterioration in one client out of 550 cases and were unable to detect the 39 clients who did deteriorate. A review of a meta-analysis in the research literature on the effectiveness of OMs in therapy has found them to be reliably consistent (Wampold and Imel, 2015) and yet psychotherapy outcomes have failed to improve in over 40 years (Prochaska, Norcross, and Saul, 2020; Thomas, 2013; Wampold and Imel, 2015). This has been despite the exponential growth in the number of psychotherapy modalities since the 1960s; an estimation of the number of actual modalities and techniques is well into several hundred (Lambert, 2013).

There is a belief amongst therapists that they improve and develop with professional training and working experience. Goussakovski and Sizikova's (2017) quantitative research tested the hypothesis that therapists became more empathic with experience; their research with more than 100 practitioners with experience ranging from 1 month to 15 years did not support this hypothesis. Instead,

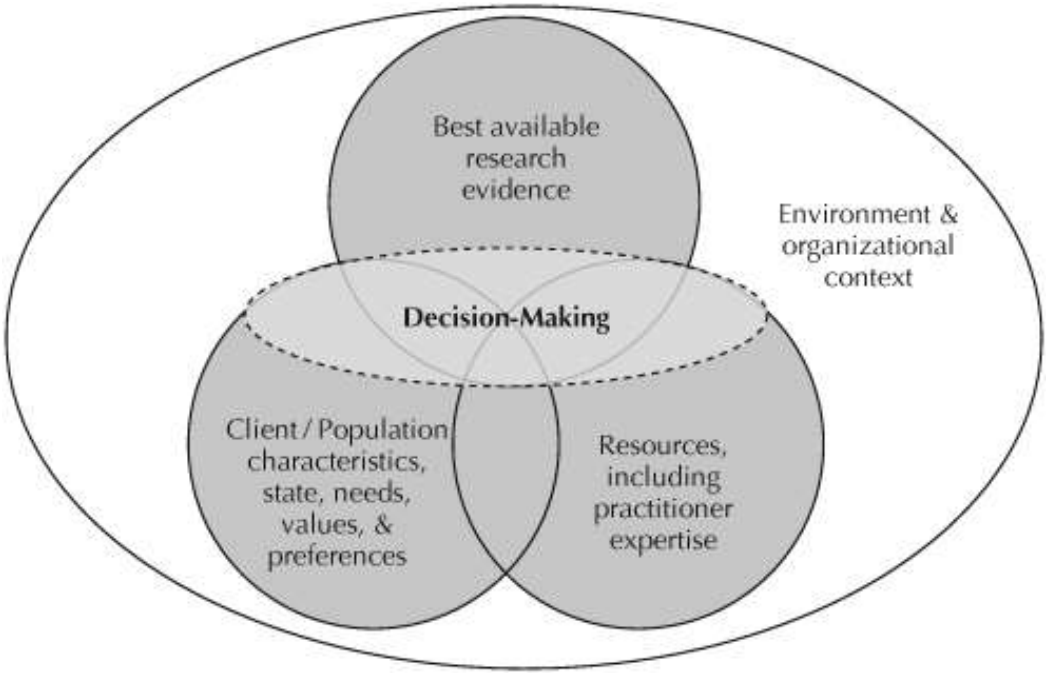

Figure 1: Elements that need to be integrated into EBP (Council for Evidence-Based Practice. (Spring and Hitchcock, 2010, online)

their findings showed that the TA therapist's level of empathy declined with experience, which led them to suggest that therapists develop 'professional empathy' as a tool, rather than use personal empathy, to protect against burnout. The assumptions made by practitioners as key in their professional growth and success in client work leading to positive outcomes includes the gender of the therapist, and the therapist's personal therapy (Duncan, 2010; Geller, Norcross and Orlinsky, 2005). Research has shown that counsellors and psychotherapists theoretical approach or professional discipline are found to be weak predictors of positive therapeutic outcomes with clients (Beutler, Malik, Alimohamed, Harwood, Talebi, Noble and Wong, 2004; Duncan, Miller, Wampold and Hubble, 2010). The research has shown that despite years of experience, qualified therapists perform no better than trainees in terms of positive, successful outcomes to therapy (Goldberg, Babins-Wagner, Rousmaniere, Berzins, Hoyt, Whipple, Miller and Lampold, 2016; Wampold and Brown, 2005; Boswell, Castonguay and Wasserman, 2010).

Positive and negative perceptions of OMs

There is currently much recent research supporting the use of OMs, and yet scepticism remains within the TA and wider counselling and psychotherapy community. Therapists continue to perceive that the use of OMs in some way interferes with or interrupts the therapeutic relationship and working alliance (Youn, Kraus and Castonguay, 2012).They also perceive that administering an OM delays or eats into the session time, or that OMs are not acceptable to clients (Hatfield and Ogles, 2004; Cooper, 2012; Tryon, Blackwell and Hammel, 2007; Green and Latchford, 2012; Boisvert and Faust, 2006; Macdonald and Mellor-Clark, 2014; McLeod, 2017). Researchers Miller, Duncan, Sorrel and Brown (2005) suggest that OMs with only four items, such as the Partners for Change Outcome Management System (PCOMS) take clients two minutes, five minutes for each of GAD 7 and PHQ9, and up to 10 minutes for CORE-OM; can be completed online sent ahead of the planned appointment time; and takes the counsellor or psychotherapist a few moments to calculate the score and then share this with the client.

Van Wert, Malik, Memel, Moore, Buccino, Hackerman and Narrow (2020) surveyed 138 practitioners on their attitudes towards OMs and identified the following barriers to implementation: time pressures (50%); uncertainty around which OMs to use (35%); OM findings being difficult to locate (34%); insufficient training on understanding the data (29%); workplaces being unsupportive of OMs (19%); the use of OMs not seen as important (14%); incorrect selection of OMs (18%); and incompatibilities with the therapeutic work (18%) . Practitioners may feel a sense of control from managers or organisations who have the power to affect and determine their professional judgement

and clinical decision making (Rousmaniere, Goodyear, Miller and Wampold, 2017). For those practitioners in private practice there may be other considerations.

There is a sense of 'big brother' overseeing psychotherapists' work with clients, and a threat that they will be compared to their peers and colleagues and found lacking in some way (Hatfield and Ogles, 2004; Youn et al., 2012). Practitioners may believe that clinical work is under such time pressures that to squeeze in another task, that they believe is of dubious therapeutic value, would be wasteful. (McLeod, 2017). Practitioners can rely on their 'clinical judgement' to monitor the client's response to therapeutic work even though the research suggests this intuiting method can be an unreliable method to find how well their client is responding to therapy (Hatfield and Ogles, 2004; Hatfield, McCullough, Frantz, and Krieger, 2010; Hall, Taylor, Moldavsky, Marriott, Pass, Newell and Hollis, 2014;). Practitioners have competing demands on their time and added administration to fill in more forms is added pressure (Chapman, Winklejohn Black, Drinane, Bach, Kuo and Owen, 2017). Research has shown that a five minute time slot, at the start of the session, can be allocated to complete OMs. Research has shown that a five minute time slot, at the start of the session, can be allocated to complete OMs (Meier, 2008).

A recent estimation, from data provided from the UK Association for Transactional Analysis) (UKATA) (A. Davey, personal communication, February 2nd, 2021) and the UK Council for Psychotherapy (UKCP) (E. Dunn, personal communication, February 25, 2021), of TA practitioners using OMs who are registered in the UK is between 7% to 36%. This figure does need to be viewed with caution as TA therapists may be registered with other professional bodies, not included in the estimation, or may be counted twice as therapists can hold membership of more than one registering organisation. A search of the wider research literature from the USA shows a range of results for therapists who use outcome measures: 37% (Hatfield and Ogles, 2004); 29% (Phelps, Eisman and Kohout, 1998); 23% (Bickman, Rosof-Williams, Salzer, Summerfelt, Noser, Wilson and Karver, 2000); under 20% (Lewis, Boyd, Puspitasari, Navarro, Howard, Kassab and Kroenke, 2019); and 13.9% (Jensen-Doss, Haimes, Smith, Lyon, Lewis, Stanick and Hawley, 2018). Across the USA border, only 12% of Canadian psychotherapists use OMs (Ionita and Fitzpatrick, 2014; Tasca, Angus, Bonli, Drapeau, Fitpatrick, Hunsley and Knoll, 2019). The low uptake of OMs by counsellors and psychotherapists seems to be a widespread phenomenon not confined to the UK.

Hatfield and Ogles (2007), in their survey of therapists, found similar issues about the adverse practicalities of administering OMs: more paperwork, time taken, burdening clients, OMs not being supportive of the therapeutic process and a negative effect on client treatment. Garland, Hurlbert and Hawley (2006) concurred, with their research on why therapists do not use OMs, showing: 90% of respondents cited time issues; 55% felt OMs were not of use with their clients; and 15% found the interpretation of OMs scores to be challenging. Ionita and Fitzpatrick (2014) add that 67% of practitioners were not aware that OMs existed, and the 33% who did know about OMs felt they did not have enough knowledge or training and that OMs intruded into time with and they felt this burdened the client. Boswell, Kraus, Miller and Lambert (2013) summarised the obstacles and challenges to OM uptake into practical obstacles such as financial and time burden, multiple stakeholders with diverse needs and staff turnover. The philosophical obstacles relate to the belief that OM is different from other assessments; fear and mistrust over who has access to the data and therapist performance; and finally privacy and ethical issues around confidentiality and information sharing. Ionita et al (2020) reported on the results of an online survey of 533 psychologists in Canada about the barriers to using outcomes measures, citing a lack of understanding, training, impact on clients, an increase in workload and time spent administering the OMs.

The facilitative factors on the use of OMs reported by psychotherapists included: that OMs are convenient (Hall et al., 2014; Perry, Barkham and Evans, 2013); improve the treatment process (Perry et al, 2013); enable clients to see their progress (Omer, Golden and Priebe, 2016); express themselves (Omer et al., 2016; Perry et al., 2013); and support the development of service provision (Wolpert, Curtis-Tyler, and Edbrooke-Childs 2016). Therapists did find them useful when they felt they had adequate training and could use OMs in a flexible and creative way with their clients (Unsworth, Cowie and Green, 2012). Hatfield and Ogles (2004) survey of therapists found that 37% used some form of OM to track their clients' progress, to watch treatment trajectories, to implement ethical practice and to discover the clients' strengths and vulnerabilities. Hatfield and Ogles reported that the most useful clinical information for practitioners was being able to check the clients progress since work began, the client's global ability to function at work, support close long-term relationships, and name indicators of difficulty for the client.

Rye, Rognmo, Aarons and Skre (2019) discovered that therapists who were in stable employment situations utilised OMs more often and recognised the importance of the information as a standard of their expertise and ability as a therapist. Van Wert et al (2020) recent research on the barriers and facilitators to OM use found: most clinicians (86%), of the 138 surveyed, would increase their use of OMs if there was ease of access to OM data; 77% would be willing to spend 3-5 minutes of the session in the client completion of the OM; therapists felt OMs would increase their accountability; they needed training and support to implement OMs; 74% responded affirmatively that OMs would supply meaningful and accurate measurements of their work.

Ionita et al (2020) make differentiation between OMs and Progress Monitoring (PM), the former being used towards aiming to work towards a successful termination of treatment in short term therapy, and the latter to continuously assess the client's progress by using the PM data to inform the clinical case management process and monitor the client response to therapeutic treatment. They suggest that the PM measures which perform this integrative function are the Outcome Questionnaire-45 (OQ-45; Lambert, Burlingame and Hansen, 1996), the Partners for Change Outcome Management System (PCOMS; Miller et al., 2005) and the Treatment Outcome Package (TOP; Kraus, Seligman and Jordan, 2005). There may be a useful discussion to be had about whether there is a need to differentiate between PMs and OMs and whether this difference is significant. Is this discussion less about either OMs or PMs or more about how these measures are used in the clinical decision-making process by therapists?

What next?

The positive outcomes of treatment that clients receive in therapy and the research in the literature indicate that it is the working alliance and developing therapeutic relationship which make the difference (Prusinski, 2022; Bordin, 1994). In today's climate of value for money and evidence-based psychotherapeutic practice, professionals can no longer rely completely on established 'custom-and-practice' ways of delivering mental health services. The drive to supply evidence and research-based interventions has become clear, as is the need to shed light on what happens in the therapy room between client and therapist. This is where OMs, such as the Session Rating Scale (SRS), can offer direct client feedback on their experience of counselling and psychotherapy (Miller, Duncan, and Johnson, 2002). Practitioners need clients to give session-based feedback on the therapeutic alliance to improve treatment and recovery trajectories and reduce client drop-out rates. Duncan (2010) recommends the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) for psychotherapy practice. Two independent Randomised Controlled Trials (RCTs) found that clients who completed feedback about their experience were up to four times more likely to improve clinically than those who were not asked for feedback (Reese, Norsworthy and Rowlands, 2009; Reese, Toland, Slone and Norsworthy, 2010). Feedback Informed Treatment (FIT), using ORS and SRS, improved client's outcomes by 27% and reduced deterioration rates by 50% (Miller, Duncan, Brown, and Sorrel, 2005; Lambert and Shimokawa, 2011).

Clients are becoming more aware of what they want from therapy in terms of outcomes and are likely to drop-out from therapy if they do not feel connected to the therapist or the therapy process. Medicine and other health professions have seen the rise of the 'expert patient' who has gained 'expertise-by-experience' through living with a mental illness (Swift and Parkin, 2017; Noorani, 2013). These expert seekers of services, who do their research increasingly via the internet (Kaluzeviciute, 2020; Knox, Connelly, Rochlen, Clinton, Butler and Lineback, 2020), know a lot about their psychological issue or mental health problem. Clients looking for a psychotherapist can be attracted by specific details, such as their professional experience, area of specialisation, and where they are situated geographically (Pomerantz and Dever, 2021). The Covid-19 pandemic has enabled the delivery of counselling and psychotherapy via online platforms so clients can choose from much further afield. The expert client, armed with this level of detail, can discuss with their mental health professional what treatment options might be available to them. If we gaze into the horizon of psychotherapy's future, we may expect to see clients who want much more in the way of involvement and consultation in their psychological care (Swift and Parkin, 2017; Black, Owen, Chapman, Lavin, Drinane and Kuo, 2017). Clients are less likely to accept that the psychotherapist knows best (Swift and Parkin, 2017). Clients will also look for individual tailoring of their needs "characteristics, culture, and preferences" (American Psychological Association, 2006, p.273), and a therapist who is able to synthesise and apply outcome data to inform their TA diagnosis, treatment plan and together formulate a mutual contract for the work. Clients will also want to be able to give the therapist feedback on how they are responding to their needs for contact, connection, relationship building, personalised treatment methods and approach to working in partnership (Black et al, 2017).

Psychotherapists and counsellors care passionately about the future of practice and the retention of

clients in therapy, and a reduction in drop-out and no-show rates, whether this is for short- or long-term work (Whipple, Lambert, Vermeersch, Smart, Nielsen and Hawkins, 2003). The use of OMs helps the treatment planning process, the beginning stages of building the working alliance, and paying attention to the client's day-to-day functioning. The therapist can offer psychoeducational support with issues such as sleep hygiene, nutritional needs, and aspects of physical health and wellbeing, which tend to be the most disruptive aspects of clients' lives; they can offer social control and symptomatic relief. This integrated approach builds the therapeutic relationship and the client's confidence in the therapist's ability and interest in their lives. Clients may also begin to develop insight and reflection on what brought them to therapy, and the therapist can gauge their psychological awareness and understanding. OMs give both an objectivity of what is measured, and the client and therapist can notice the subjective elements and the impact on their daily life, internal world, and relationships.

Clinical supervision is an important part of all TA practice and OMs may be a useful adjunct. There are several studies which support the use of OMs to enable supervisors and supervisees to have discussions based on the client's clinical data rather than solely upon the supervisee's assessment of the client (Swift. Callahan, Rousmaniere, Whipple, Dexter and Wrape, 2014). The client OMs can support a supervisee's decision-making as to which clients to bring to supervision, making more use of supervision sessions (Reese, Usher, Bowman, Norsworthy, Halstead, Rowlands and Chisholm, 2009), and for supervisors to see any emerging patterns with clients over time or suggest specific OMs to add into the client work (Swift et al. 2014). OMs in supervision can also help in the identification of the client's presenting problem or issue, level of risk to themselves or others, Adult ego state functioning, interpersonal relationships, psych-ological awareness, and the tracking of the client's treatment response trajectory. The supervisor and supervisee can monitor together the client's improvement, plateauing, deterioration, ruptures in the therapeutic relationship, unplanned ending of treatment (Lambert, 2010; Swift et al., 2014) and therefore focus on and prioritise areas of difficulty encountered by the client and supervisee. The OMs in supervision would not replace the other important aspects of clinical supervision but offer an enhanced dimension to the process of both qualitative and quantitative data. The OMs offer the supervisee opportunities to assimilate data into the TA diagnosis, contracting and treatment planning process. This is an area of research the author is exploring in the forthcoming research.

Conclusion

This article seeks to begin a conversation with counsellors and psychotherapists who may be considering using OMs in their clinical practice to improve treatment outcomes and client retention, and reduce drop-out rates and no-show appointments (Lambert, Whipple, Hawkins, Vermeersch, Nielsen and Smart, 2003; Bohanske and Franczak, 2010; Ionita, Fitzpatrick, Tomaro, Chen and Overington, 2016). This discussion will offer the practitioner the current and available research and evidence and practice-based data on both the positive benefits and challenges to using OMs in private practice.

Research continues to show that OMs have high validity and reliability and can be used across different modalities as a rapid assessment tool supplying data on a client's progress, plateauing and deterioration. OM data supplements clinical judgment and provides an opportunity for the counsellor or psychotherapist to intervene and review the client's treatment plan and direction. The use of OMs, such as CORE, PHQ 9 and GAD 7 in private practice and beyond show utility in ongoing client risk assessment and screening for self-harm. Finally, supervisors and supervisees using OMs as an adjunct to clinical judgment in supervision may offer clinical data which supplements the early client assessment process, presenting issues, TA diagnosis, contracting and treatment planning approaches.

Carol Remfrey Foote MPhil, CTA (Psychotherapy), BSc(Hons), Dip. TA Practice, RHV, SRN, is a Post Graduate Researcher in the School of Health & Society in the University of Salford and can be contacted on c.remfreyfoote@edu.salford.ac.uk

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IJTARP
International Journal of Transactional Analysis Research & Practice
14 (2), 17-23
https://doi.org/10.29044/v14i2p17

The Ego State Timeline Model

Editor's Note

This is a translated and edited version in an article that appeared in Polish as Wieczorek, Z. (2017). Język zmiany w analizie transakcyjnej. *Edukacyjna Analiza Transakcyjna*, *6*, 145–156. http://dx.doi.org/10.16926/eat.2017.06.09.
It was therefore written for a non-TA audience so some amendments have been made, including referencing back to originators rather than authors who were describing concepts in the language of the author.

Abstract

The author presents another way to think about personality adaptations and the communication process based on a framework drawn from neurolinguistic programming about how we characterise chronological time in the space around us. It presents a model in which ego states might be diagnosed and worked with in terms of whether they are considered as in the past, the current or the future.

Keywords

transactional analysis, ego states, timeline, personality adaptations, interpersonal communication, personal change, NLP

Introduction

Transactional analysis (TA) is a theoretical approach that is relatively consistent and transparent. The simple language and the division of theory into specific areas means that it can be used both to work on change and to describe other theoretical approaches in order to better understand them. It also happens that within TA there are borrowings from other theoretical areas. One example of such an approach is the concept of personality adaptation, initiated by Paul Ware (1983). This concept presents six dominant personality disorders described in DSM III (American Psychiatric Association, 1980), which can be described in a model way on a continuum: activity-passivity, community- disconnection, haste-patience in action (Joines and Stewart, 2002). Ware also points out that each person has a dominant tendency to invest energy in a specific behaviour, thinking or feeling, which is something that opens us to contact so we willingly enter into communication if our open door is used. Another important consideration is our target door and trap door; where we need to move to and the way in which we might become trapped.

The concept of personality adaptation can be considered in terms of neuro linguistic programming (NLP), such that the doors can be compared to the preferred sensory representation systems of auditory, visual, and feeling. The doors can also be linked to the dominant ego state in that thinking in terms of knowledge and cognitive judgments might be Parent, behaviour as specific actions or practice might be Adult, and feelings or experiencing emotions might be Child.

The concept of personality adaptation is intended to help in working with the client: "by knowing a person's personality adaptation, we also get a hint on how best to establish and maintain contact with them. To do this, we make a methodical choice in what order to address a person's three contact fields – thinking, feeling, or behaviour" (Stewart and Joines, 2016, p. 215). Here another problem arises, because we introduce a whole range of new concepts, not necessarily the same as the terminology of TA, which may limit the declared effectiveness of the concept. The starting point of the concept of personality adaptation (in DSM III) were analytically understood types of disorders of obsessive-compulsive, paranoid, schizoid, passive-aggressive, histrionic and antisocial. Getting to know personality adaptations in practice means that you need to quickly diagnose the person you are working with. If we fail to do so, we can only rely on intuition or trial and error. One can also ask why six and not more adaptations (White, 2004).

This study is an attempt to present a different version of personality adaptation using the classical TA language. Assuming that it is not always possible to quickly diagnose the person we work with, a work model based on the analysis of the current situation

would be useful, which would also allow us to plan our work and systematically invite change. What we can use for analysis is the construction of a message, which should reflect the structure of a person's personality and way of functioning. It is an attempt at an integrative approach, combining different points of view and different theories from the point of view of TA theory. Various ways of working with clients will be used as examples. To sum up, the area of analysis will be the way of building change from the perspective of conscious action towards oneself or other people in the communication process.

It is difficult to overestimate the importance of interpersonal communication; it is the basis of social life, socialisation and the functioning of society. In TA, the communication component is strongly exposed in transaction analysis or time structuring. It remains an open question whether communication is a factor that constantly and actively constructs reality, and to what extent it is already formed by people. Jessie Delia's research (as described by Griffin, 2003) shows that people with cognitive complexity achieve better career outcomes; similar descriptions can be found in Basil Bernstein's (2000) description of linguistic codes. We cannot omit the research on communication of Watzlawick, Beavin Bavelas and Jackson (1967), who, together with co-researchers, created an interactive concept of communication that explained the emergence of mental disorders as a result of disorders in the communication process. These concepts allow us to look at the process of communication not only as an exchange of information, but as a process of creating a specific social reality. Communication in this area will be related to the process of change, and it will be indicated how modifying the communication process can contribute to change and personal development. By changing, we change the way we communicate, and by changing the way we communicate, we change internally. This topic will be expanded on later in the text.

On the one hand, personal change is an element of socialisation and something that is natural and simple for a person, but on the other hand, it is a huge problem when we reach the limit of our abilities, e.g. not being able to lose excess weight or eliminate a dysfunctional habit. It is difficult to determine which model of work will be the most effective then, and in a wide range of theoretical approaches it is difficult to determine the only right one. It seems that a reasonable decision, like in other areas of life, is that each of us will need slightly different stimuli to act. It is also a good idea to combine different approaches, of course in an eclectic rather than chaotic way. TA provides a theoretical language that allows such a process to be carried out efficiently.

In TA, the human being is seen as a system striving for internal autonomy, consisting of a specific structure, spread over time and actively reacting with the environment. This is due to the key elements of the theory and the basic philosophy, which is based on the assumption that: people are OK, able to think, decide about their destiny and can change it, which takes place in the process of communication and making specific decisions. The key elements of TA discussed in this study are the ones that define the process of assigning meanings and determine the effectiveness of certain modes of action, and I will discuss them briefly.

Personality structure – in TA, it is assumed that we have three more or less dependent states of self, the so-called PAC model: I-Parent, I-Adult and I-Child. This means that in the process of change, each of our states of self requires separate signals, a separate language, and that these ego states communicating with each other can support or block a particular change. On the one hand, this opens the way to personalisation of the operation and increases the effectiveness, but it also complicates the theoretical description. The dynamics of the 'I' states make us strive for balance and autonomy, and, at some point in our lives, one of the ego states becomes our inner leader and sets the tone for our actions. Currently, in most TA literature it is shown that the correct direction of development is the development of the Adult state. Adult autonomy requires awareness, spontaneity, and the ability to be intimate and is realised, among other things, in the process of intrapsychic communication of individual ego states. The problem can be both excessive connectivity between the states i.e. contamination, and the lack of contact, i.e. too rigid a boundary between the states. An analogy can be made here with the structure of systems and boundaries in the system, as their flexibility determines the functionality of the whole (Ludewig, 1995).

Transactions, strokes and time structuring. The PAC model leads to the breakdown of interpersonal relationships at the level of different ego states. In addition to communicating with ourselves, we communicate with the environment, but always from the level of one of the ego states. In the process of change, this is particularly important, as it is necessary to adapt the language and methods of action to the state with which we communicate. The natural tendency of people is to self-define; the eternal question is "Who am I and where am I going?". We hunger for signals that are conducive to this self-definition, i.e. signs of recognition or strokes. We see ourselves in a certain social mirror and define ourselves based on the reflection in others. Hunger for stimuli sometimes leads to a situation

where we prefer negative signs of recognition to their absence; the child prefers to be punished rather than ignored, and this of course also applies to adults. In the process of change, this means that it is often necessary to modify one's self-definitions, especially those that are destructive to our functioning. This is a pretty big threat to our internal cohesion, and not everyone is ready to face it. In order for a new self to come into being, something has to happen to the old. Kazimierz Dąbrowski's (1996; Limont, 2011) theory of positive disintegration describes this process quite well. The choice of certain signs of recognition as a habit leads to a certain structuring of time; we enter into certain habitual cycles of communication which, according to our experience, will provide us with what we need. In the case of intimacy, it will be something developmental, and in the case of, for example, psychological games, something that reinforces the dysfunction. The result of the dominant structuring of time is the adoption of a specific attitude to life, which is perceived as between the feeling of OK and the feeling of being not OK, of oneself and of others. This is another element that requires attention in the change process.

A life script is a specific life scenario that we adopt in childhood based on behaviours of our parents. A child, who is not yet an autonomous being, accepts as facts the messages they receive in the course of their upbringing. Sometimes parents do not realise that they are programming their child and do not care too much about what they say in front of them, and sometimes they consciously communicate their expectations. Regardless of the motives, we are presented with a certain life script that has an introduction, development and end that is not always happy. We usually reinforce the received script according to the principle of a self-fulfilling prophecy, so we unconsciously choose actions that confirm our role in life. Awareness of the script gives us the ability to change, whereas lack of awareness explains the recurrent problems of life and the inability to make a change. Role and place in the script introduces a new variable, which is location in time. It can be defined as the contamination between the present and the past or future. This topic is better developed in the theoretical area of NLP (O'Connor and Seymour, 2013). From the point of view of change, we have to deal with both the situation when we are not able to distinguish, for example, the past from the present, and the situation when we are blocked at a certain time. The assumption of the existence of a life script allows for the introduction of a new variable to the description of personality, i.e. location in time. Seeing yourself in the perspective of time allows you to realistically plan your actions, including internal change.

To sum up, when facing the challenge of change or working with a client, we should take into account the map of the internal structure of the personality, the level of permeability of boundaries between the ego states, the degree of development of individual states and which ego state is introductory and which dominates during the usual activities (structuring of time). It seems necessary to define the contamination and barriers between the states, both within the structure of the self and in the time perspective. The formula should be applied depending on the social structure in which we function. There may also be barriers to communication or symbiotic relationships with broken boundaries in our relationships with others. This allows us to create certain communication models that are useful in building change at both the intrapsychic and interpersonal levels.

I will present here only selected descriptions of the communicative process in the following cases: stiffening of boundaries in the areas of personality, relationships and time, as well as contamination in the areas of personality, relationships and time. A well-functioning person is in touch with his or her past, anticipates the future, has access to his or her states, which he or she can smoothly switch. We can illustrate such an arrangement as a diagram – Figure 1. The dotted line here is meant to signify the fluid boundaries between the states, which allows information to flow between states and easily move from the one state to another. If we have problems with acting, making changes, we can assume that our person does not have a fully correct structure. Some ego states may be separated from others, some may overlap (lack of boundaries, contamination). Examples of irregularities can be seen in Figure 2.

A functional personality communicates correctly both at the intra- and interpersonal stages. Therapeutic experiences allow us to assume that change can begin at the stage of the person and manifest itself in the process of communication, and vice versa. When we change the process of communication, we change internally. This phenomenon is presented in the Sapir-Whorf hypothesis, (Sapir, 1978) of how the language used influences the way of thinking. It is both about the way of speaking within one language and the phenomenon of differences in personality disorders in multilingual individuals. The concept was revised by Nairan Ramirez-Esparza (Ramirez-Esparza and Garcia-Sierra, 2006; Ramirez-Esparza, Gosling, Benet-Martinez, Potter and Pennebaker, 2014; Garcia-Sierra, Ramirez-Esparza, Silva-Pereyra, Siard and Champlin, 2012) when bilingual students were asked to complete personality tests twice in two languages.

Past	Present	Future
P	P	P
A	A	A
C	C	C

Figure 1. The functional self, the flexible boundaries between the ego states, the awareness of self, the awareness of the location in time.

Past	Present	Future
P - separated	**P** - contaminated	**P**- barrier present/future
A	**A**	**A**
C - blocked	**C** – contaminated present/future	

Figure 2. Examples of selected dysfunctions

The results of the test performed in English showed the subjects as more extroverted, agreeable and open-minded than when they used Spanish. A similar experiment was conducted by Boaz Keysar (Hayakawa, Tannenbaum, Costa, Corey and Keysar, 2017; Liberman, Woodward, Kaysar and Kinzler, 2016) when subjects were asked to make a hypothetical decision about sacrificing someone else's life in an emergency. The problem was presented to different groups in the mother tongue and in the learned language. It turned out that people considering a problem in a foreign language were more likely to make a decision that meant the death of another person. If we assume that language not only diagnoses our personality, but can change it through appropriate use, let us see how TA can be useful in this regard.

According to Bernstein (2000), a properly communicating person communicates at different levels of abstraction, uses subtle verbal distinctions, is convinced of their own views and grants others the right to their point of view, easily uses abstract material, captures events from a distant perspective, and is able to postpone gratification. According to Delia (Griffin, 2003), a properly communicating person has cognitive complexity, i.e. they are able to perceive many different aspects of reality and realize knowledge at the same time as different purposes in the communication process. According to Watzlawick et al (1967), proper communication is logically coherent, devoid of paradoxes. By creating communicative axioms, they emphasize that we cannot avoid communication, we should be aware of the content and relational aspect, be aware that assigning meanings is a rather random process, separate symmetrical roles from complementary ones, and be aware of the non-verbal aspects of our communication. All the presented approaches draw attention to the awareness of the spread of reality in time and show the importance of many different perspectives and ways of seeing reality.

Limitations in time, perspective or number of points of view, in turn, translate into less effectiveness in action and less autonomy. Going back to Figure 1, we can imagine our consciousness as a queen on a chessboard that can move to any square in any way. For example, the bishop has a limited ability due to the nature of the move, and the pawn moves only in one direction, square by square. The specificity of communication can be easily seen in the following example describing constructivist cognitive complexity (Griffin, 2003). Three different ways of reacting to a violation of the norm of behaviour between a boss and an employee:

- *Expressive communication:* "You're the most disgusting guy I've ever had the misfortune to meet. You have sticky paws and sticky thoughts. How did you even think I could have an affair with you? It makes me sick just thinking about it..."
- *Conventional communication:* "Please absolutely do not count on any affair with me. And if you thought of firing me. I will certainly not remain silent about what happened here. This behaviour in the workplace is not right. And what's more, you are still married. Give me peace of mind... "
- *Cognitively complex (rhetorical) approach*: "So far, our cooperation has been excellent and I would like to see it continue to be so. That's why we should talk. You are a smart and sensible guy. I would like to see you not only as a boss, but also as a friend. You have probably had too many stressful responsibilities lately. Otherwise, it would be difficult for me to understand why you told me what I have just heard. I know what it means to work under pressure. You can go crazy from all of this. I think it would probably be good for you to take a short vacation..." (141-143) (bullets added).

We can see that expressive communication takes place from the position of the Child ego state, there is indignation at mistreatment, the emotional reaction takes place here and now, regardless of the moral side of the issue, it does not really solve the problem.

In the statement, it can be seen that there is no reference to the past, a blockade against the future. Conventional communication takes place from the position of the Parent ego state. We have a reference to the norms of behaviours, there is a threat of using legal aid, so the response refers to possible future behaviour.

In the case of rhetorical communication, there are more elements. We see a reference to the past and a wish for the future and a plan of action (conversation). We can see an analysis from the Adult state, which concerns the explanation of the behaviour of the other person (an attempt to understand), we see an exploration of the states of Parent and Child manifested in relation to two social roles, the boss (norm) and the friend (emotions). The reaction is more empathetic than defensive, but despite this, there is an assertive defence of one's boundaries. On the basis of the diagrams presented above, you can try to create graphics representing individual reactions, as shown in Figure 3.

Unlike in personality adaptations, there are a number of combinations of the pattern of communication. Without the need for additional nomenclature, we can attempt to determine from which ego state the communication is initiated, and which ego state is touched during the communication. Similarly, to the description of the partnership style of communication, Lidia Grzesiuk (1994) referred to the determination of the extent to which communication begins, maintains and ends together (in partnership, taking into account the perspective of both parties). It is worth noting that the language of change requires what Delia calls sophisticated communication (cognitively complex, allowing you to achieve multiple goals at the same time). In TA terminology, the language of change will be a process in which we explore different ego states, similar to the development and integration of personality.

An example of such an approach is Marshall B. Rosenberg's (2016) Nonviolent Communication (NVC). In this model, communication is broken down into four stages: perception (as objective as possible); feelings (important to distinguish between feelings and judgments); needs (which result from feelings); and requests (to the other person to do something to satisfy our need). This model quite schematically allows us to explore the ego states in each of the stages of communication. The same applies to motivational dialogue. Recommended open-ended questions in William Miller's (Miller and Rollnick, 2014) study are: "How does the problem affect your daily life? How different a life you would like to lead in five years' time? Where do you think the path you are now taking is going? What do you think are the five most valuable things in your life?" (p.97). The TA theory allows us to explain quite precisely the mechanism of operation styles of communication appearing in other concepts.

Adopting the model of personality adaptations requires a lot of experience when making the first diagnosis, although the model allows, at least in theory, to improve work with the client. A small mistake can cause us to go the wrong way. On the other hand, the lack of diagnosis makes it practically impossible to apply this concept of work. The communication model, presented in a nutshell, allows you to build the area of work and the direction of change on an ongoing basis. The starting point is to identify which ego states in the client's statements dominates at the beginning of the utterance, and into which the next state passes or in which it has become stuck. Indicators can be, as in the concept of personality adaptation, statements related to the statements of what we think, feel, do, plan, remember, etc. The direction of the statement seems to be important. A different path is followed by someone who first feels something and then plans to act about it. The initiating state is then the Child, and then the Adult comes to the fore. This is where the action for the future will come in. If we hear that the client is going to do something (Adult) because he felt somehow (Child), we guess that the course of action was initiated in the past and there is no certainty that it will turn into practical actions.

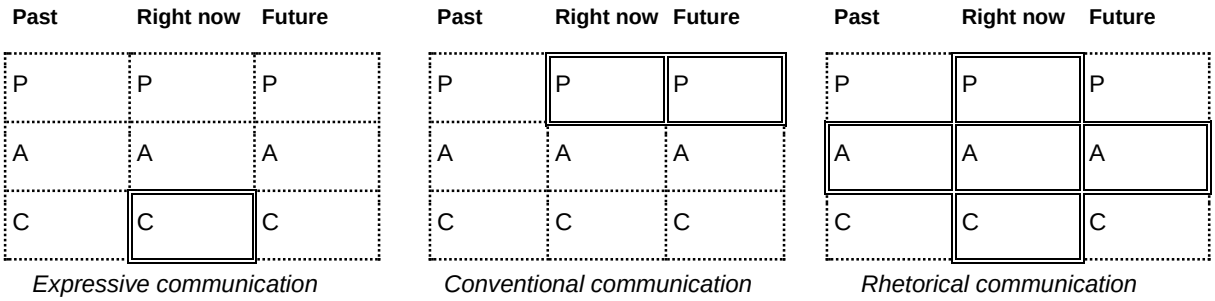

Figure 3: Examples of reaction diagrams

If we hear that the client is going to do something (Adult) because he felt somehow (Child), we guess that the course of action was initiated in the past and there is no certainty that it will turn into practical actions. A similar pattern occurs in the case of ineffective work on the diet. I'm going to go on a diet (future) because I've neglected myself too much (past). This direction, as practice shows, is not very effective, there is no transition to the future, there is no link in the present, which looks like we are not doing anything about the diet for now. Finding indicators of such a location in time in the statement leads us to fill the gap and ask what the customer is doing now, today. This can fill the empty space and allow for greater efficiency in operation. After all, all ineffective diets start 'from tomorrow', where tomorrow is usually a permanent state. For example, if the statements refer only to the here and now, e.g. to emotions, it is difficult to expect action and change. We can initiate the transition to the Adult state with a question such as "What are you going to do with this?" and into the future, "What are you going to do with it next?" If only the future tense appears in the statement, e.g. "I'll show him, he'll remember me!" we expect impulsive action or inaction, a statement suspended in the future may never go beyond constant shifting. Questions we can ask include "How do you feel about it now? What can you do about it now?" or anchor the client in the past with questions such as "What do you think is the cause of this situation? Where did it come from? How is it developing?". We can imagine our behaviour as a chessboard (Figures 1 and 2) on which we move to fill in the missing squares. If it is difficult to write down the client's initial statement, we can always 'fill in the fields' quite mechanically, asking about thoughts, actions and feelings, past, present and future. Sooner or later, the client will indicate in their behaviour a tendency to stick to a certain field, which will allow them to make an initial diagnosis and determine the direction of work.

Zbigniew Wieczorek PhD, Assistant Professor, Lecturer, Court Mediator, Trainer. In his professional work, he uses theoretical models: TA, NLP, SFBT and POP. Affiliation - Jan Dlugosz University in Czestochowa, https://wns.ujd.edu.pl/ and he can be contacted at z.wieczorek@ujd.edu.pl

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IJTARP
International Journal of Transactional Analysis Research & Practice

14 (2), 24-32
https://doi.org/10.29044/v14i2p24

Rethinking the Parent: A Valuing-Based Ego State Model

Abstract

The two integrative components of the Parent ego state in the original functional model are reconsidered in the context of psychotherapeutic work and its effectiveness. An alternative interpretation of the functional model is presented and argued, based both on theoretical considerations widely accepted in the profession and on a practical implementation of the reconsidered functional model. The present elaboration is based on the value principle, i.e. the premise that the need for self-worth is a core social need and that the experience of being devalued by a significant parental figure causes psychological trauma and correlated deficits and compensations. The importance of self-esteem in the context of attachment, "narcissistic wounding" and vulnerability, and empirical findings and therapeutic responses in psychotherapeutic practice are discussed. A case study of couple therapy is presented to illustrate the application of the model.

Keywords

value-based approach, ego state model, Valuing Parent, Devaluing Parent, strokes, value principle, couples therapy

Introduction

The re-consideration of the Parent ego state described in this article was motivated by the aim to enhance the effectiveness of psychotherapeutic work. The models presented here, incorporating a valuing-based approach, has been in use since 2016. It has been implemented in individual psychotherapy within a therapeutic group and in couples' therapy; a case study is given below. TA colleagues in psychotherapy and educational TA who are familiar with the approach have given their positive and encouraging feedback.

Ego State Models

Ego state is one of the core concepts of TA, and over the years there have been various ways of describing the difference between structural and functional models. Although Berne presented the structural model as a representation of intrapsychic composition and the functional model to help us analyse how differently the three ego states can function and cause effects within transactions, he only described the latter model in terms of the behaviours that could be seen. We are therefore left to assume how the behaviours emerge from the structure – as Hay (2009) describes, we have internal ego states that function inside and then produce behaviours.

When we consider the Parent ego states, in either model, the labels used have included several negatives such as Critical Parent, Prejudicial Parent, Witch Mother, Pig Parent. Furthermore, Steiner (1990) described a separation in terms of strokes, proposing that positive strokes are only produced by the Nurturing Parent and negative strokes by the Critical Parent. He even wrote that the so-called Pig Parent attack is one of the acute manifestations of the Critical Parent, which is "an intense, accusatory, damning, emotional attack on the OKness of the person" (Steiner, 1979, p. 34); that the Critical Parent causes difficulties in relationships, plays a role in the formation of a script, and is totally counterproductive in cooperative human affairs.

This negativity then gets associated with the label of Controlling Parent and this is misleading as control is one of the most important functions of caregivers. This is especially true when young children are not yet able to assess possible risks or dangers. Parental control can be exercised in either a caring, respectful and supportive way or in an abusive, restrictive, oppressive and disempowering way. The first type of control implies a valuing attitude on the part of the caregiver and invites a child to feel good; the second is devaluing in character and evokes unwanted emotions. The vague term 'controlling' for the parental function is not descriptive enough when we are trying to identify the counterproductive transactions and patterns of behaviour in order to replace them with the harmonious ones. Over the

years, alternative models have emerged, including ones where plus and minus signs are added to the behavioural ego state labels to indicate each may be positive or negative.

Self Esteem, Attachment, and Childhood Experiences

The liberating, empowering and revolutionary aspect of Berne's approach was that transactional analysis recognised and emphasised the individual value of each client. Berne was one of the first to insist that psychiatrists should speak an understandable language to patients and treat them as individuals of value. In this context it is useful to briefly review how the understanding of value developed.

Alfred Adler introduced the concept of the inferiority complex as a sense of one's inferiority in relation to the perceived superiority of others over oneself and saw this as playing a key role in personality development (Hergenhahn and Olson, 2006). Donald Winnicott (1973) claimed that a mother's attentive holding of her child is central to health. Self-esteem was considered a fundamental human need and so part of motivation by Abraham Maslow (1968) who included it in his hierarchy of needs. John Bowlby (1969) suggested that all humans develop an internal working model of other and an internal working model of the self which determines how the individual perceives him-/herself and which then will impact his/her self-confidence, self-esteem, and dependency. He outlines the personality development literally as follows: "A young child's experience of an encouraging, supportive and co-operative mother, and a little later father, gives him a sense of worth, a belief in the helpfulness of others, and a favorable model on which to build future relationships. Furthermore, by enabling him to explore his environment with confidence and to deal with it effectively, such experience also promotes his sense of competence. … Other types of early childhood and later experience have effects of other kinds, leading usually to personality structures of lowered resilience and defective control, vulnerable structures which also are apt to persist" (p.378). Mary Ainsworth (Ainsworth and Bowlby, 1965) also focused on the importance of maternal sensitivity for the development of infant attachment security. Carl Rogers (1961) saw the origin of many people's difficulties in a tendency to consider themselves worthless and incapable of being loved and emphasised the importance of showing unconditional acceptance to a client, with such an attitude as a source of the desirable positive changes.

The interconnections between narcissism (its impact) and attachment, and attachment and self-esteem, are also well elaborated by psychologists and researchers. Baker and Baker (1987) emphasise such an aspect as the ability of an individual to soothe and comfort self (i.e. regulate self-esteem internally), if the individual has a well-patterned or solid intrapsychic structure. Patton and Robbins (1982) suggested that such an individual is able to effectively achieve goals and relationships. From the value-focused perspective it is interesting that empirical studies confirmed the presumptions of attachment theory: secure attachment was found to be associated with more positive views of others (Collins and Read, 1990; Hazan and Shaver, 1987), an ability to establish trust (Feeney and Noller, 1990; Hazan and Shaver, 1987) and intimacy (Bartholomew and Horowitz, 1991; Levy and Davis, 1988). The understanding of a secure attachment encompasses an appreciation of both self and other as well as a capacity for cooperativeness and openness (Pistole, 1995) and these findings are entirely consistent with Berne's conception of the positive life position I'm OK, You're OK, where the value and worth are perceived as equally distributed between self and other(s).

Our need to be recognised is observable; by nature, we are sensitive to an attitude significant others show towards us, and any attitude may be either valuing or the opposite. We 'monitor' intuitively the changes in the others' attitudes towards us from day one of our life, as Edward Tronick (Weinberg and Tronick, 1996), demonstrated in his famous 'still face' experiments. Tronick found that a few-weeks-old baby begins to worry if the face of a significant parental figure suddenly freezes without facial expressions; that is, ceases to give signals of attitude towards him. "Infants reacted to the still-face with negative affect, a drop in vagal tone, and an increase in heart rate. By contrast, they reacted to the reunion episode with a mixed pattern of positive and negative affect" (p.905). It may be suggested that this inborn sensitivity is the external manifestation of our natural need for value-acknowledgement.

The more recent empirical studies conducted by Beatrice Beebe (Beebe and Lachmann, 2020) examined self- and interactive-contingency processes in relation to one another in a mother–infant face-to-face communication. The study showed that interactive regulation is never the sole organising process; it exists intertwined with self-organising processes and individual self-rhythms that are partially influenced by individual response to the partner, hence partially dyadic. The infant experience of trauma in the parental relationship has been a focus of many researchers during the last decades. Relational trauma occurs within the infant's relationships with primary love objects and can negatively affect the individual attachment organisation and also have other adverse effects on

the child's development (Baradon, 2009; Schore, 2003). A traumatic earlier experience causes an 'unresolvable paradox' for the infant, as his/her attachment figure is also perceived as the source of threat to survival and to psychic integrity (Liotti, 2004; Main and Hesse, 1990). Blanck and Blanck (1979) and Moore and Fine (1990) noted an even more significant and relevant aspect in the context of transactional analysis - that an individual without trauma shows the ability to value both self and significant others, i.e. there is an even distribution of self-esteem and other-esteem. Baker and Baker (1987) and Patton and Robbins (1982) reported the opposite effect with regard to the individuals with a less patterned or more nondifferentiated self-structure. The positive valuing of the self and management of esteem functions depend more on others' attitude and acting in ways that support the self - that is, provide valuing, confirming, or comforting functions. Thus, with a more fragile self-structure, an individual experiences more difficulties within maintaining an inner sense of comfort and esteem and so is more easily wounded or hurt, i.e. more vulnerable.

The Need to be Valued

This concise overview of relevant psychological theories and empirical research emphasises the significance of the need to be valued - both within the parent-child relationships as well as within adult ones. An analysis of the attitudes that correspondingly affect the subjective perception of value is essential. Thus, when defining the functional components of the Parent ego state, it may be beneficial to consider the value principle, which bears resemblance to the old saying "Treat others as you would like to be treated.", commonly known as the Golden Rule in various religious teachings and ethical systems. In more precise psychological terminology, demonstrating a valuing parental attitude involves exhibiting considerate and respectful conduct towards another's needs, emotions, and perceptions during interactions. Conversely, an attitude that is devaluing shows disregard and disrespect towards another's needs, emotions, and views. The perception of a child can vary depending on their age, ranging from less developed to highly developed perspectives and opinions. However, regardless of age, parental readiness to treat and discuss their child's perceptions as equally valuable to their own is crucial. All aspects of parenting, including setting boundaries and exercising control, can be carried out in a way that confirms value rather than devalues.

A devaluing parental attitude can manifest in numerous ways, but its impact is clear: there is nothing more hurtful than being devalued by those we love and depend on. This may entail feeling unwanted or neglected by one's parents, or perceived as a burden or an unwilling rival to a sibling or parent. Examples of parental devaluation include disengagement, emotional detachment, and a lack of respect for a child's needs, interests, and vulnerabilities. A subtle and non-violent devaluing attitude by parents can lead to not less harmful effects than physical violence. Neuroscientists Eisenberger, Lieberman and Williams *(*2003) have empirically confirmed that being rejected hurts; social exclusion activates the same areas of the brain as when we experience physical pain and was positively correlated with self-reported distress.

"You are ugly" (less beautiful than others), "You are dumb" (less intelligent than others), "You are insane" (less normal than others) — these are common messages an individual reports during therapy when discussing their parents' attitude, which has become a part of their inner (self-) devaluing voice. "…It is a voice or an image in the mind saying that the person is bad, stupid, ugly, crazy or doomed - in short, not okay" wrote Steiner (2003, p.161). The devaluing messages cause a disempowering effect; I (Kornyeyeva, *2*022) hypothesise that the individual power as capacity and ability to act is correlated with and manifested through the individual value. The inclination of parents to treat a child in a devaluing way is not necessarily intentionally harmful but could simply be an attempt to make the child more compliant and manageable, as such a devaluation lowers the child's confidence and assertiveness.

Ray Little (1999) provided further evidence for the interrelation between value and power in his article on shame and the shame loop. He describes how humiliation-shame transactions can lead to a subjective feeling of worthlessness and unlovability, as well as the resulting behavioural effects. Shaming is the antithesis to the attribution of dignity, which according to Sulmasy's (2012) exploration of human dignity within the philosophy of bioethics, is confirmed or "created value" (p.938). Therefore, shaming, like any other act of devaluation, has a disempowering impact: a self-perception based on the premise of 'something is wrong with me' encourages the avoidance of any activity that could lead to the re-experience of shame. It explains the use of devaluation as a 'weapon' in parent-child relationships, which is then replicated in adult and couple relationships as part of power dynamics and power abuse.

Valuing and Devaluing Parent

Following these considerations, the terms Valuing Parent and Devaluing Parent were utilised during individual and group psychotherapeutic sessions instead of the corresponding Nurturing and Critical Parent. This was done to assist clients, who are not

acquainted with transactional analysis, to recognise their psychological challenges, experienced individually or within relationships. This, in turn, enables them to consciously correct their own thinking and behaviour patterns and to design transactions without any form of devaluation. Hence, although there was no need to have clients learn the TA models, they learned to think about valuing and devaluing as how they are shown in the diagrams below.

The structural model, or internal ego states, can be shown as Figure 1 and only contains positive elements. The Free Child (also called the Natural Child in some sources) is understood not only as the source of our feelings, desires, spontaneity, and childlike behaviour, but also as the 'hot spot' of our natural needs. The need to be valued is the crucial need for all human relationships; the less valued, or less treated with care and respect, one feels in relationships, the more frustrated and dissatisfied one can feel, and the more counterproductive one's response can be.

The Devaluing Parent contradicts our need to be valued; this ego state is about making the recipient less adaptive and self-sufficient, and less capable in general, less aware of one's own needs and feelings, i.e. dependent on parental figures of all kinds and thus prone to symbiotic relationships. Submissiveness as the opposite of individual independence, autonomy and healthy adaptability is therefore a more accurate description of the phenomenon. A counterproductive rebelliousness is an essential and 'pre-programmed' part of submissiveness; a lack of adult-like coping strategies leads to various forms of non-cooperative behaviour - non-compliance, passive-aggressiveness, etc.

Figure 2 shows the functional or behavioural model, with devaluation-related ego states shaded and the healthy and productive capacities as clear. Instead of Adapted, the adjective Submissive is suggested here, as the ability to adapt is neither counterproductive nor pathological: the problem is not being adaptable or adapted to certain conditions, and feeling and acting constrained because of the experience of being devalued and so disempowered.

Value Based Couples Therapy

There are several approaches to family/couple therapy in transactional analysis that are useful in working with family systems. Robert Massey (1989a) gave a systemic perspective and described how script analysis and structural and functional analysis of ego states can be used in family/couple therapy. He also offers techniques and interventions in a later article (Massey, 1989b), mentioning passivity, symbiosis and rebelliousness, as prominent symptoms of unhealthy relationships.

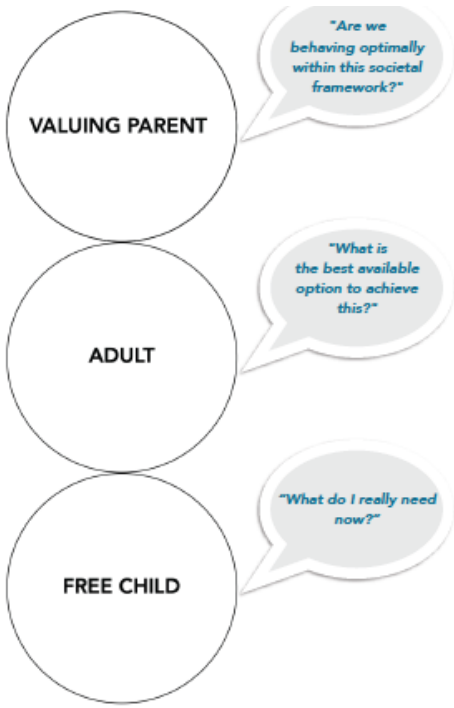

Figure 1: A Valuing Structural Model

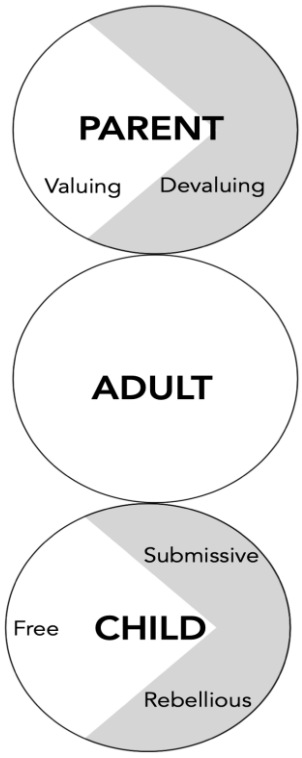

Figure 2. Value-Based Behavioural Ego States (Personal Styles)

Passivity, symbiosis and rebelliousness reflect the relationship between value and power as an individual's ability to make a difference and achieve a desirable outcome in relationships; the more

devaluing and self-devaluing tendencies an individual shows, the more passivity, symbiosis and counterproductive rebelliousness will be manifested in a relationship. Erskine and Trautmann (1996) state that the sense of self and self-esteem emerge out of contact-in-relationship, which is inevitably rooted in the child development - i.e. the influence of parental figures. “Contact refers to the quality of the transactions between two people: the awareness of both one's self and the other, a sensitive meeting of the other, and an authentic acknowledgment of one's self” (p.317). One of Little's above-mentioned contributions (the interplay between feeling ashamed and a sense of worthlessness and unlovability) is also an insightful contribution to the theory and practice of couple’s therapy.

In the relational context, value is crucial; behind destructiveness, gaming and escapism in a relationship, there is always an unfulfilled need to be and to feel genuinely valued by the partner. The interrelationship between a meaningful self-worth and an ability to have a fulfilling relationship and affect management is well known (Basch, 1988). One study found that unhappy lovers, compared to happy lovers, manifested clinical depressive symptoms, and reduced blood oxygen level-dependent changes in a brain network described as involved in major depression; those who felt happy in love showed no such symptoms (Stoessel, Stiller, Bleich, Bönsch, Doerfler, Garcia, Richter-Schmidinger, Kornhuber and Forster, 2011).

Work with couples needs a framework that establishes the equal value of all the parts involved and the impartiality of the practitioner who emphasises the equal value of both sides. This framework makes it possible for both parties to replace any devaluing and self-devaluing actions with valuing (value-affirming) ones. It is indeed a challenge to communicate without devaluation during a conflict, but it can be done within a safe framework offered by a professional during sessions, and can be continued by the couple at home as an important prerequisite for positive change. A very helpful tool in this context is what Steiner (1990) called the cooperative contract. The cooperative contract means that everyone involved takes responsibility for their actions and statements and consciously excludes power plays, lies and rescues from their own interactions In addition, the contract about a desirable change in terms of TA is agreed on the basis of expectations that both parts of a couple declare.

Couples Therapy: Mary and John

The contract with Mary (35 years old) and John (37 years old; both names changed) was part of my work in 2020. Six sessions were held in which the contract was successfully fulfilled, and a few months later positive feedback came in about the impact of our working together on their lives and relationships.

Mary and John had been living together for about 18 months and were planning to get married and have children. John initiated the first session with me after an ongoing conflict with Mary about his relationship with his teenage son from his first marriage. This was the reason for their sudden separation; Mary left him while he was at work. There were further difficulties in John's relationship with the mother of the child, his ex-wife. Mary moved out and left a note saying she wanted to end the relationship. John felt abandoned, hurt and misunderstood as he thought he was doing his best to make the relationship work. The aim of our therapeutic contract was to bring some peace to the relationship, to encourage non-escalating communication and mutual understanding between them.

Once the contract was agreed, I invited Mary and John to be more self-reflective about their own strokes and actions and whether they were perceived as valuing or devaluing. They considered the impact in terms of emotional reactions they were having. To facilitate this process, the Value-Based Model was explained and a handout with the model was given. They both had the task of becoming more aware of their own inner processes (tendency to self-devalue, lack of adult thinking and behaviour patterns) and how these were manifested in their interactions. It was also agreed to consciously exclude the Devaluing Parent from both internal and external dialogue and to rely on the Valuing Parent instead.

The internal processes and trauma management of each party plays a very important role here. The transactions are the key to better understanding these processes and consciously contributing to a desired outcome. Given that we reproduce script fragments and trauma in the strokes we give and in our reactions to the strokes we receive, the aim is to learn to act free from the counterproductive patterns. To support this, my suggestion was to keep the focus on the strokes and the emotions they lead to, and to experience the self with more gentleness, care and respect. For example, asking your partner for support and understanding rather than continuing to feel left alone, misunderstood and helpless.

Mary and John's current feelings were analysed and named. In a safe therapeutic space, it became possible for both to recognise and openly express their own emotions, together with their causes, as subjectively perceived (“When you did that, I felt angry”, “I felt sad when you left my phone call unanswered”, etc.). Each partner began to be more aware of how his/her emotional reactions were

subjectively perceived by the other. This led to better mutual understanding and acceptance. The tendency to devalue and hide emotions was openly discussed, as was the family script each brought to the relationship. Mary and John agreed to be more aware of their own emotions and their true origins and to express them openly to each other without (self-)devaluation.

At the end of the first session, I asked them to find something (an action or an individual quality) that each of them valued in the other and would like to acknowledge. John expressed his gratitude to Mary for her patience, as his time-consuming job leaves him much less time than he would like to spend with her; Mary gave a positive (appreciative) stroke to John for being such a good father to his son. The condition for the exchange of strokes was that both of them had to be completely honest and non-devaluing towards themselves and their partner; initially the negative emotions of both Mary and John were an obstacle to this. Also, the feeling of insecurity and the lack of experience of being completely honest with one's own feelings was at first observable, and I carefully addressed this with a question. When they confirmed my intuition, I gave them a good stroke for their braveness and openness, and this careful facilitation helped them to continue to talk honestly about their own painful wounds and expectations. They then felt good, which helped them to work on rebuilding trust in each other.

Subsequent sessions focused on sensitivity to wording to help Mary and John recognise devaluing elements in their communication and to reframe statements so that they were both non-devaluing and sincere. The value-based model was used during each session and helped to identify whether the stroking was perceived as devaluing by each partner. In order to facilitate their awareness of the behavioural ego state manifestations, I sometimes had to stop the interaction and ask: “Can you now reflect and identify which of the ego states this statement/question sounds like?” and sometimes it would be about where it came from. The more we referred to the model, the easier and quicker they could reformulate their statements. By managing to exclude the Devaluing Parent they could observe how the desired effect was achieved.

Many devaluing transactions from the past needed to be talked about, as the pain, anger and sadness caused by previous communication hindered the process of mutual rapprochement. We talked about the emotional pain and the relationship between the pain and the unmet need to be valued. Mary's feelings were hurt because she felt that she was being treated as less valuable than John's ex-wife, but she could not talk about it earlier (“I felt that I was not as important to you or less important than your ex-wife and her expectations”). This subjective perception of Mary's was not obvious to John, and it was an important insight for him to hear her express her perception openly without devaluations.

Mary was initially not open enough to talk about the intense emotions she was experiencing; she kept the emotions hidden from John because she was afraid he would not accept her vulnerability or think she was “overreacting”. The script analysis revealed that Mary's self-devaluing tendency had been present in her childhood and in her previous relationships, so she was afraid of “ruining this relationship too”, which reinforced her self-devaluing attitude and negatively affected her communication with John. John realised that his old fear of abandonment was reactivated when Mary left him and that he was suffering more than he was prepared to admit and could not find proper words. Mary interpreted John's behaviour based on her own perception and fear of not being important enough for John.

John, with his tendency to feel “more responsible for his son” and his need to have a functioning relationship with his ex-wife, tended to overlook Mary's desire to be consulted and involved in decision making. She perceived this as a devaluation of her importance in John's eyes. On one or two previous occasions, Mary had tried to give him her views on this but felt that she was not being listened to, as John was focused only on the views of his ex-wife and son. John was not aware that Mary felt hurt by this, and he interpreted Mary's behaviour as an intention to make him feel bad, as his ex-wife had “tried to do before”.

In the fourth session, both reported that John's ex-wife was no longer an “explosive focus” in their relationship; Mary no longer felt excluded and devalued. This was due to their willingness to act in the here-and-now without letting the past come into play. The next step was to learn to express their expectations, intentions, desires, emotions, wishes and opinions openly and without any devaluation. This devaluation-free openness is particularly necessary because of the complexity of the family system - the need to communicate with the ex-wife and the partial presence of John's son.

As they both told me the next time, it was not perfect at first, but the more they relied on the value-based model, the easier it was to communicate and the more satisfied they were with the results. Mary learned to say “I want to be heard, understood and valued by you” instead of escaping and punishing John in a passive-aggressive way; John learned to say “I need you” instead of hiding his vulnerability. Both realised that they were devaluing their needs, and both now learned to meet their needs without

devaluation. As I helped John to understand the background to Mary's reactions and the real motives behind them, John's focus was no longer on his own feelings of abandonment and trauma, but on the compassion and empathy he felt for Mary.

When John realised that Mary still wanted to be valued by him, he realised his own value in her eyes, rather than feeling abandoned, hurt and so devalued by her as he had before. He asked Mary's forgiveness for his actions as the cause of her distress. Mary responded very positively and also asked for an apology for not being sincere before. By not being aware of their own need to be valued by the other, each had tried to punish the other through devaluation.

In the fifth session John said that he now understood much more clearly “how relationships work” and that he felt much more emotionally stable and secure because now he was using his awareness and responsibility for his own actions and statements. They both said that since they weren't repressing their anger, they were experiencing much more tenderness towards each other. The less feelings and needs are devalued in relationships, the more comfort and honesty there can be.

The final session showed that both had gained a capacity for self-reflection, autonomy, responsibility and individual power, and that they had become closer and much more comfortable with each other. Mary reported that her emotional reactions were “no longer disturbing” and that her self-awareness and self-esteem helped her to harmonise her relationships at work as well.

The result in the psychotherapeutic setting was that it was easy to establish a mutual understanding with the clients; everyone can easily see whether valuing or devaluing strokes are being used in communication and the (emotional) effects they cause. It also helps to ‘locate’ the intrapsychic source of behavioural difficulties and to learn to entrust all the executive power to its opposite - the Valuing Parent with the positive impact on communication and relationships. This clarity is a prerequisite for further positive changes on the way to desirable authentic autonomy and fulfilling relationships.

Discussion of the Approach

In implementing this approach, the focus has been on the three Ps: Permission, Protection (Crossman, 1966) and Potency (Steiner, 1968), as prerequisites for positive change in line with the value principle. In order to be sufficiently permissive and protective, a practitioner should manifest a potent Valuing Parent that is more powerful than the client's Devaluing Parent, especially in cases such as confronting games and injunctions and related impasses of the client.

It is worth noting that it is not uncommon for a client to try to ‘test’ the practitioner - whether the practitioner's Valuing Parent would endure as more powerful than the client's Devaluing Parent, i.e. whether the practitioner is able to provide sufficient protection, acceptance, and respectful and careful treatment. Such an attempt to test is based on the common perception that the (soft) power of the Valuing Parent is less effective than the (destructive) power of the Devaluing Parent. The practitioner’s conscious and constant value-affirming attitude in both 'directions' (to self and to the client) provides a good remedy against such tests and makes it possible to recognise and openly analyse them with the client, which plays an important empowering role in the therapeutic alliance.

Berne argued that the task of therapy is to liberate the individual from the compulsion to repeat reliving the early script-bound scenes and thus start a new, independently chosen way in life. The desired liberation and autonomy are unthinkable without the psychotherapeutic restoration of the sense of OKness, which is about perceived individual value and worth. The value-based ego state model can contribute to the practice of transactional analysis in a way that makes it easier to distinguish between the structural, functional and behavioural manifestations of ego states and thus to achieve the desired positive changes.

The value-based approach reflects the zeitgeist of modern social reality in many cultures; there is a strong public demand for non-discriminatory policies, inclusiveness and equality - being treated with respect means being valued. It can work well in developmental applications of TA, especially in relation to highly sensitive individuals (and their parents) as conceptualised by Aron (2016), helping to create and maintain a bullying- and mobbing-free environment, of safety and cooperation rather than power plays between children and school staff. A study showed that highly sensitive boys were less victimised and less depressed or anxious after a so-called school-based anti-bullying intervention (Nocentini, Menesini and Pluess, 2018).

The value-based approach can also be developed into a measurable methodology. Future research could examine a possible correlation between subjectively-perceived individual value and the ability to use positive (non-manipulative) individual power, and also their opposites – the tendency to self-devaluation and to manipulate. Quantitative (based on Likert-scale questionnaires) or qualitative studies could investigate how the value-based approach can

be of use in psychotherapeutic, counselling, educational and organisational TA.

As modern technical equipment allows neuroscientists to study the effects of different types of interaction in the human brain, it may be instructive to study the processes in the amygdala and the whole limbic system during exposure to valuing and devaluing strokes. It might also be interesting to explore how individual self-worth is constructed and perceived within cultural scripts in different cultures, and whether and how exactly the cultural context influences parental valuing or devaluing attitudes in different cultures.

It may be useful for professionals working with couples, families and groups to look at Bowlby's theory of attachment as a primary need through the lens of the value-based approach. It seems that it is not attachment per se, but the need to be valued by the desirable object of attachment that defines relationships and their quality for those involved. An awareness of this need and the vulnerabilities it entails may enhance the ability to meet it delicately and openly, without the usual counterproductive defences of withdrawal, avoidance or attack on self or other.

Conclusions

Psychotherapeutic thinking and understanding of the developmental and relational phenomena of human psychology has made impressive progress since the beginning of the 20th century. We now have a clearer picture of the causal relationships between psychological trauma and its origins, and this knowledge helps to treat them more effectively in practice. The knowledge we have gained about the effects of devaluation trauma and how it increases vulnerability in adult relationships can have a positive impact on child rearing as well as on relationships between parents and their (adult) children.

The presented model of ego states is an attempt to 'sharpen' the existing tool by reducing its complexity in order to reach a core understanding of interpersonal and intersubjective phenomena. This would also be useful for beginners to facilitate health within a reasonable period of time.

Berne (1972) wrote about us being born princes and princesses and how the scripting process makes us frogs. The value-based ego state model reflects this astute observation: it is not a part of our nature, but something we internalise from the outside under the influence of others, that makes us generally feel less capable and less happy than we actually are and would like to be. It is the devaluing and thus disempowering manifestations of the Parent that cause us to act in conflict with, or even directly against, our own natural needs; the need to feel valued by those who are valuable to us is our innate need. Berne's understanding of how our psyche works was perhaps the core idea that made TA so significant and liberating among many other psychotherapeutic approaches.

Lena Kornyeyeva PhD, clinical psychologist at a rehabilitation clinic and counselling psychologist and couple's therapist in private practice. She has conducted empirical research on the negative life position as a predictor of individual authoritarian traits. Several of her books are published in German, Ukrainian and Russian. She can be contacted on dr.kornyeyeva@gmail.com

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IJTARP
International Journal of Transactional Analysis Research & Practice

14 (2), 33-41
https://doi.org/10.29044/v14i2p33

Leadership Development: Supporting And Developing Colleagues

Abstract

A description is given of an leadership development programme designed and run within an organisation, including how the multi-party contracting was conducted, and how the psychological, professional and administrative levels were addressed. In addition to an overview of the programme, details are given of the content and process of the third session, as well as the reactions of the participants who shared what they had learned.

Key Words

leadership, transactional analysis, ego states, multi-party contracting, cycles of development, supporting colleagues, organisational culture

Introduction

I was given the task of doing a complex development program for leaders of a big company. The organisation was struggling with the inability of its managers to retain their new recruits so the aim of the development was to help them sort this problem out. Whereas I had been working with organisations for several years and knew about contextual TA (Sedgwick, 2020), I was aware that sometimes we need to change the culture to be different and the company was working on that (thinking about the renewing of the recruiting process, benefits etc.) However, at the same time they wanted to give personal support for their leaders to be better managers, and for those leaders to be more able to use their behaviour consciously in order to make better relationships to help their colleagues. That was the part of the project I was invited to do.

Please note that, although I am a member of different TA and non TA professional associations and I know their Codes of Ethics, for the ethical considerations I used the Code of Ethics of the International Centre for TA Qualifications (ICTAQ) (2023) in this case study as a reference. I know these are similar to other TA Codes and based on the same values and I wanted to be consistent in the work by using one source. The ICTAQ Handbook says: “In establishing a professional relationship, members of ICTAQ assume responsibility for providing a suitable structure, including but not limited to such things as specifying the nature and limitations of confidentiality to be observed, particularly when other parties are involved, and obtaining informed consent from all parties to the processes to be utilised.” (p.2) and “the ICTAQ member shall resolve the relationship in such a way as to minimise harm to (any of) the parties to the contract”. (p.1). Hence, in this article I will not give the name of the company nor any information that would identify the specific company (it could be any I worked with in my career as an organisational development consultant) and I do not use the real names of the participants in order to give protection to the participants and any other stakeholders.

Multiparty contracting

In this part of the case study I would like to present my thinking about contracting for the whole project. The ICTAQ Code states “the ethical practice of transactional analysis involves entering an informed contractual relationship” (p.1) so every time we are working we have to think about this and of course it is the base of being a TA professional.

As I was an employee of the company at that time, I knew I needed to be very aware of the dependencies and relationships in terms of organisational hierarchy. To analyse this during the contracting I identified the stakeholders first. After this, I used Hay's (2009) model of the multiparty contract, which is a further development of English's (1975) three-cornered contract. In this, the solid lines represent the open, stated or written contractual elements, and the dashed lines those where no direct agreement can be made (Figure 1) but we have to be aware that there is a psychological level contract too.

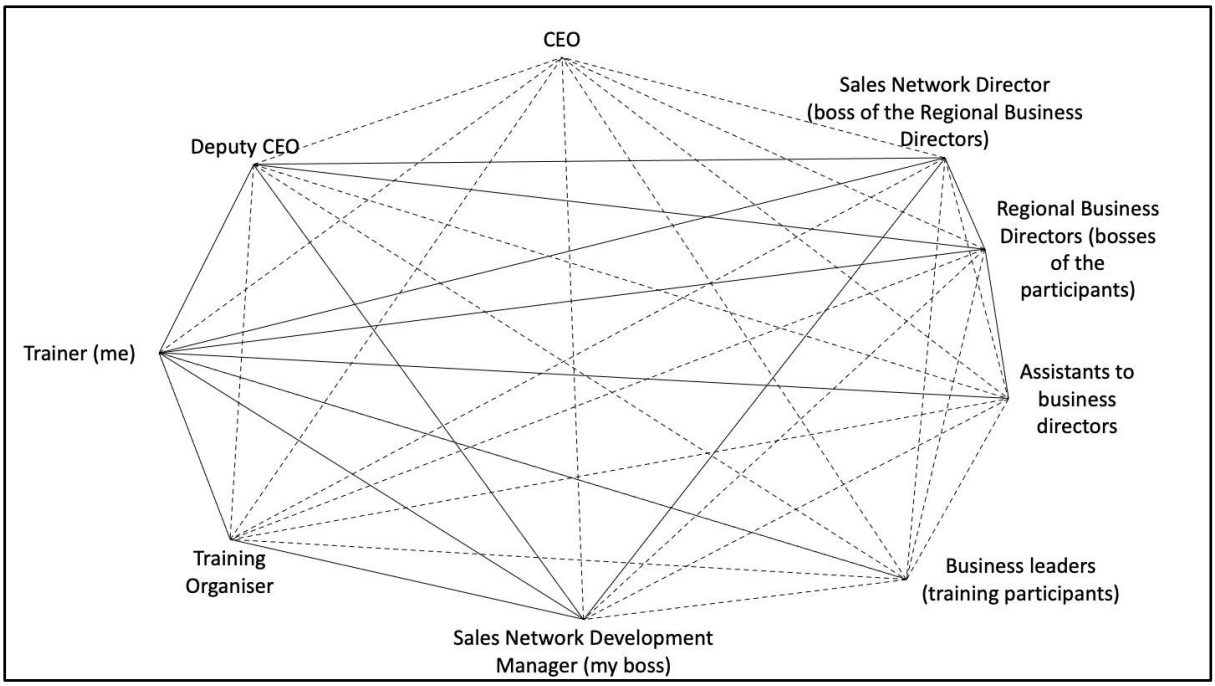

Figure 1: Multiparty Contract with Stakeholders

I spent 1.5 months getting to know the company, the culture, the managers and the staff. I attended trainings and had one-to-one meetings with a lot of colleagues. During this time, I also gathered information on the opportunities and risks that our leadership development project would bring. After thinking about these, I defined the elements of the contract, which I thought through based on Berne's (1966) three levels of contract.

Psychological level

- Because of a multiparty contract, I was concerned that there was a risk that the Sales Network Director and Deputy CEO would want to have too much say in the content, even though they are not professionals in training and people development. I knew this from my colleagues, based on their experience of prior development, and it required increased attention on my part.
- Discretion with training participants can be guaranteed in cases where the business is not compromised by what we see and hear; otherwise we have a reporting obligation to the director and this is transparent to the participants - this may involve them not sharing certain information with us.
- We had no experience of what people liked and disliked about previous developments, or whether there were any negative events that could undermine the success of the current project, because the people who worked with them before were no longer there.
- Business leaders interest in the scheme did not include an assessment of the people in leader roles, and motivation to implement changes may therefore be mixed.
- There was no leadership competency and roles model in the organisation and this might imply that different images of the leadership role live in people's minds - in addition, it invites more of the patterns of 'leader' experienced in our original family and first group experiences, which may make it difficult to develop them (group imago theory based on Berne, 1966).
- Participants may fear that they need development because something is wrong with them, which invites more of the Internal Child ego state instead of the Adult.
- Perhaps business directors are not supportive or make it impossible to put this development into practice because of competition; fear may appear on their part in Internal Child (labels used for internal and behavioural ego states are from Hay, 2009).
- There are different levels of leadership competencies (none, potential, do it well instinctively, do it well based on learning) in the organisation.
- There was no culture of leadership skill development, so it may be unexpected, or maybe it will be surprising, unusual for participants.

- Part of the organisational culture is that business leaders are perceived at headquarters as “they are not fit to lead, they don't want to work" - so as a professional I have to be able to keep the faith that they can develop, because what I have in my head later functions as a self-fulfilling prophecy. Perhaps this was something that previous trainers had not considered enough - the impact of this on a psychological level. But of course maybe it is true and we have to think about how to change the organisation to be more motivating instead of helping them to change themselves.
- Relational embeddedness - those who are not fit but are there, for example, because of good connections or their established business portfolio.
- In areas where family members are co-workers, confusion may arise and the manager-worker and parent-child roles may be confused. By role I use Schmid's (1994) definition, where role is a feeling, thought and behaviour and a perception of reality and a pattern of relationships in an interrelated, consistent co-existence and pattern. This is an extended definition of ego-states. It means when we are in a situation, at the moment we are in the role and we perceive reality differently from that role and different relational patterns are activated in each of the roles. We are almost always living and acting in some role, and the role we are in has a great influence on what we see. The potential danger in this regard can come from the way in which, for example, professional and private roles are mixed up in these areas, because for example family members do not let people go, family does not monitor performance, family does not pay for performance as managers do with their staff. Equally true from the staff side: you do not leave your family and find another one, as staff may do with managers. So role confusion occurs as private roles and professional roles get mixed up.

Professional level

The aim is to develop the leadership skills of managers, so that they can retain their staff. Business leaders need to have the basic leadership skills, the tools to effectively manage their staff throughout their careers. We support this through training, group coaching and interim tasks.

Because of ethical considerations, I included thinking about discretion and the information flow direction; we agreed on discretion, with the exception of when we learn of a factor that could jeopardise the business.

Except in such cases, the trainer does not disclose information about individuals, but if a topic arises that has been mentioned by at least two people, it may be shared anonymously by the trainer with the professionals in the HQ and business directors. It was important because without this we cannot behave ethically. The quotation I have given above from the ICTAQ Code of Ethics about specifying the nature and limitations of confidentiality is relevant here.

The structure of the overall development process was:

1. Conduct a focus group (I considered this important because I identified at the psychological level of the contract that we did not have information about what had happened to participants in previous development sessions) ;
2. Leadership role training (non TA);
3. Leadership communication training, based on Working Styles (Hay, 2009);
4. Supporting and developing colleagues - training, based on cycles of development (Levin, 1982) and strokes (Steiner, 1971);
5. Performance evaluation and objectives training, including Internal ego states and M&M’s (Hay, 2009);
6. Interview techniques training (non TA);
7. Closing ceremony.

I planned to do reflective consultation with business directors between training sessions, and included this in the professional contract because I had identified a potential danger at a psychological level that if they become competitive or feel left out, it may make it difficult to do the project successfully.

All training sessions are followed by optional individual coaching opportunities for participants.

To prevent problems at the psychological level, I have included and shared a three-cornered contract in the professional contract section, which I presented to the participants in the first session (Figure 2).

Administrative level

- Number of training days: 5 days, including 2-3 weeks break among them;
- Time frames - 9:00 - 16:30, lunch break from 12:00 to 13:00 each day;
- Location – the offices of the directorates;
- Flipchart board and paper, moderation card, markers - tools are in trainer's bag, our colleague can order others if required, we carry flipchart to the trainings;
- Lunch will be funded by the company for the training, arranged by the assistants of the business directorates;
- Attendance - Adult learning data request is done by the central team in HQ;

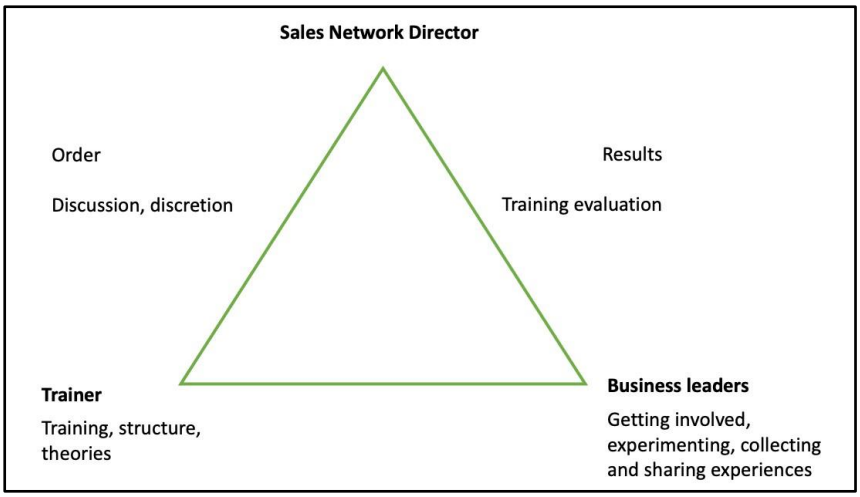

Figure 2: Our Contract for Development

- Required attendance of participation 85%;
- Training evaluation form in digital form at the end of the day, per training, prepared by me and delivered to the Sales Network Development Manager;
- Contact with participants (uploading of preliminary, intermediate and follow-up material): I do it by e-mail;
- Approximately 11 participants in the first round, then all managers in the country will be involved later;
- It is possible for the trainer to travel to the training location the evening before the training and the cost of this is financed by the company and it is organised by the trainer himself;

All of the above has been shared and agreed with the Sales Network Development Manager (my immediate boss at that time I was working there). I considered it important that this person should be made aware of the risks (psychological contract level) that we will maybe face during our project, as it is in our mutual interest to be aware of and to address them. In an organisational context, I think it is particularly important to help my manager to be aware of the potential threats that I can identify as a TA student, so that they can focus their awareness, and in this way I support my manager's development and growth as well.

We also agreed on the administrative and professional part of the contract with the Sales Network Director and Deputy CEO. It was an interesting phenomenon that during the conclusion of the contract, the latter two did not want to have too much say in the content (as I had expected and therefore included in the psychological contract). I realised afterwards that perhaps the professionals themselves (who had previously had this project) had blamed too much involvement by not having the necessary competence themselves (which is probably why they hired me to fill the missing competence).

What happened before the 3rd session

On the first training session, we contracted with the group. They then learned about the leadership role and understood what elements of leadership matter in today's modern organisations and what they need to be able to do to remain competitive. They recognised the risks of not paying attention to the role. Most of them had learned that as leaders you need to be aware of psychology to some extent in order to better manage your people. Another useful lesson for them was that they need to invest in all 'relationships' in order to get results from their team members and that not all performance problems can be solved by strongly indicating that more and more performance is needed. Many people started new things in their teams by the end of this training, which was noticeable from the fact that at the beginning of the second session, more than an hour was spent sharing experiences from the time between the two trainings.

In the second session, they learned about working styles, ego states and communication channels. They identified their own strengths and weaknesses. They were able to identify themselves and their colleagues and figure out some options about what to with them to have better relationships. They experimented with it and by the third time they were telling me about more 'clues' they had discovered about their colleagues.

I now present part of the third session of the training, which focused on supporting and developing colleagues and was implemented using a transactional analysis model.

Contract for the 3rd session

As the different topics I work with in leadership development can provoke different difficulties, and as I work with groups in the above-mentioned process, I also have new insights into what dangers might be present at a psychological level, I revisit this contract between each training session. I did so before the 3rd training module, where I came to the following conclusions.

Psychological level

I anticipated that someone might be at the same stage of development as me at the time when the project happened, which could trigger a parallel process, so I thought it important to include this in the psychological contract. I sensed that I was in a recycling phase myself, as I had changed jobs, which was a really big change in my life. Even mathematically it comes down to what Levin said, every 13 years or so a recycling starts. This means that even if a parallel process occurs, I will be able to be very empathic with the person, because I am at that stage myself, but I have to be careful that it does not stop me from helping them, because what is happening to them is not exactly the same as what I am going through.

Alongside this big cycle, I had also started a small cycle of settling into my new job. Here I was currently in the identity formation phase as I found myself searching for my role in the organisation. This was helped by my experience of always being able to develop my identity and clarify my roles. My parents have typically responded to this with support, love, patience and acceptance. So I could easily draw on this experience at this stage of my life.

I know for myself that my biggest gap is in the thinking stage, perhaps because my mother's overprotective attitude ignored encouraging me to form my own thoughts and opinions and instead told me what to think. This caused problems later in my life and now, learning TA and in supervision, I get the support to help me form and believe my own thoughts.

Professional level

I did not change the professional contract much; I used the three cornered contract as the first time (Figure 2). The only thing I added was the content of this particular training. I found Pam Levin's (1982) model, cycles of development very useful for the topic of developing and supporting colleagues. Based on Levin's clinical experience, the model describes what a child goes through in his or her development, what developmental tasks they have to do and what needs they have to meet to do so. We also learn from Levin that the cycle plays out over and over again throughout our lives and that areas where there have been deficiencies cause difficulties later in life.

I have chosen this model to help managers identify as many options as possible to support and develop colleagues and to be able to choose their behaviour based on what their colleagues need at that stage. So, at a professional level, this is what I have included in the professional contract.

In terms of approaches, I have basically chosen Classical TA, so I teach the clients models that describe complex human behaviours and internal processes and then let the clients analyse themselves. I do this so that the client can generate increased Adult options (Widdowson, 2010). I have combined this approach with the Developmental TA approach (Hay, 2016), where the focus is not on healing past hurts but on people's development and focuses more on the present and the future, which has proved more useful to me in working in organisations, as through this we help clients to help themselves to develop rather than 'heal'. This is also important because in an organisation we are most often working with healthy people who can usually cope with their tasks, so they are not pathological enough to need to be cured by a psychotherapist or in a psychiatric hospital.

Administrative level

The administrative level of the contract was not changed.

Events during the 3rd session

In the morning, I invited participants to choose a picture (I printed these out) that best expresses how they are feeling now. This was a transactional stimulus

from my Nurturing Parent ego state, which appealed to their Natural Child ego state. They responded well to this. Some said they felt bad (Natural Child). I responded to this with Nurturing Parent by expressing "I understand, with that said I am glad you are here". There was also an expression that was clearly from Natural Child, but it was directed at my Natural Child (he chose a funny picture, spiced with humorous thoughts and there was no particular point to what he was saying, just fun), so I responded with Natural Child ego state instead (laughed).

In addition to this, I asked them to share their experiences from the previous session. I projected this instruction to them as a PowerPoint. The need to project the instruction as well as verbally was necessary because working with the same group before I realised the pattern was that they were easily distracted a lot. When I analysed why it is happening, I realised there are several participants in the group whose working style (Hay, 2009) is Try Hard and they tend to digress and quickly take the conversation to a different focus than what it was originally. On the one hand, this is a very likeable way of working, but on the

other hand, I found myself at times getting too attached to the Natural Child way of working which is very typical of Try Hards and losing focus myself. Weighing my options, I decided to go with a different one this time and structure the group better with my Structuring Parent mode (I would select the instruction differently from before and if someone did not answer a question, I would redirect their attention back). I found that this was a useful choice as the kick-off round went more smoothly and more useful content and experiences related to the training topic were shared. I needed to use this later on, for example for group formation. I appreciated that it proved to be a useful intervention on my part and I noted to keep it for the future.

Then, in Structuring Parent ego state, I asked them to think about who in their lives had been a supportive role model and write it down on a post-it. I gave them a permission to do the task, but this can only go with protection (Crossmann, 1966), so I told them to choose someone they would like to talk about later, but they could also give them a nickname so they would not be identifiable if they wanted. The potency (Steiner, 1968) was manifested in the form of my confidence in their ability to deliver this and their ability to think. Their Adapted Child ego state responded when they performed the task.

I then asked them to think about the five qualities that made them choose this individual and to write this down on a post it and share it with each other by putting it on the flipchart. In this I addressed their Functional Adult ego state as I asked them to analyse and draw logical conclusions as to why they chose this individual.

This was done by all participants without exception, confirming my experience with this group on previous occasions that participants are able to function flexibly in different communication channels (FF-FF, SP-AC, NP-NC, NC-NC). There were no problems with this in the group.

I intended this as a sensitising exercise, drawing attention to how much they themselves had gained by having someone who supported them in the right way and also drawing attention to the fact that they themselves could be good role models for their colleagues. I told them that we would now work on how they could do this consciously - I addressed their Functional Adult ego state as I talked to them about the logic of why we were doing this exercise.

I then showed them Pam Levin's cycles of development model. I did this using creative tools (string, ribbons) and while I was doing it, I told them about children's development and what developmental tasks they have at a given stage (blue moderation card) and what they needed to do well to complete them (green moderation card) (Figure 3). In addition to this, I also shared with the participants the difficulties of not getting the support they need at a given stage and the difficulties this can cause in adulthood.

Then, on a slide (Figure 4), I showed them the cycles in the loops and gave an example. This helped them to understand why it is sometimes stressful when otherwise positive changes happen to us (e.g. marriage, birth of a child, buying a new house).

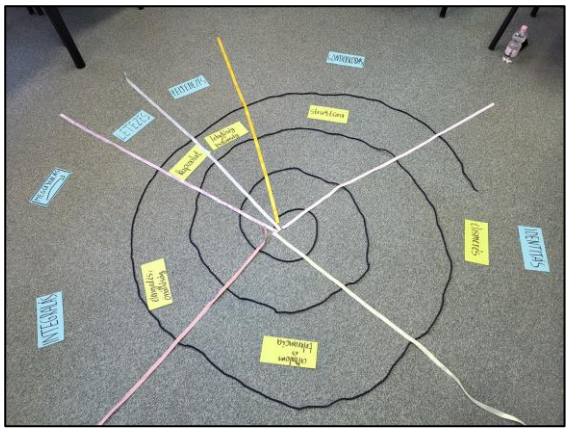

Figure 3: Illustration of the Cycle

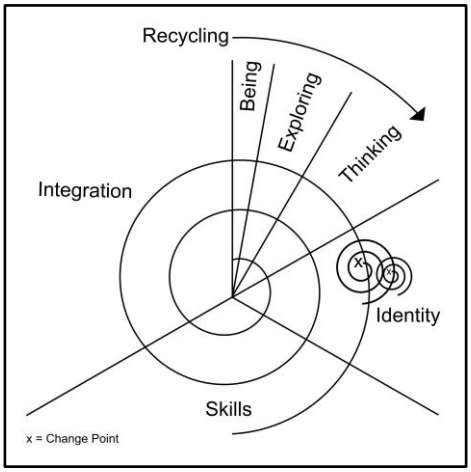

Figure 4: Spirals within Spirals (Hay, 2009, p.206)

I then asked them what questions they had. One of the participants, asked me about how old are we in the identity stage and I said about 3-6 years old.

I then asked the participants where they thought they were in the cycle and what insights they had (Functional Adult to their Functional Adult) We went around the circle and everyone shared their thoughts logically.

Tom: he is about 60 years old and has realised how many times he has gone through the cycles. He said "I've been through a good few of them". He said that as a leader you need to be constantly renewed, and he has experienced this in his career.

Adam: he recognised why it was difficult for him when his 3 young children were born, he no longer feels guilty for not having experienced joy at that time. His wife is starting a new job in January, Adam realises what they will be going through. So, on the one hand, he has become more aware and able to analyse what s happening using the cycles of development, and on the other hand, he will be able to change his behaviour accordingly, so that he can be as close as possible to his partner in this change.

James: he recognised what he was going through now that he had joined the organisation 3 months ago. He identified that this is his small circle in the big circle. He recognised that he is in the renewal stage in the big circle (that's why he changed jobs) and in the discovery stage in the small circle, as he is discovering things about the company. The change I have seen in him is that instead of frustration, he has become more understanding of himself, as he now understands what he is going through. Although we did not go into it in the training, it would bring him important insights on an individual level if he would consider what causes him to experience frustration when he has to discover new things. I think it is possible that some of his needs were not met in this regard in his childhood. I will monitor this in the future and, if necessary, I will be the one to give him what he was lacking before (perhaps not enough support, freedom and protection to explore).

Logan: he joined James because he is also fresh in the organisation. He had similar insights as James. He had an "aha!" experience when he saw the model and realised what stage he was at.

Noah: very logical in his thinking, Be Perfect in his working style. He was interested in the numbers.

Monica: asked whether the fact that a new IT system is coming into the company, that has not been used before, mean that you are starting to recycle? I replied that it's more like being somewhere in the big circle in your life and within that phase you start a small circle - it becomes a small circle of IT system, but it goes through much faster than the big circle. She recognised how interesting it is that we go through the same thing every time we change. She said that this now made her very thoughtful and touched her. She did not say more and it was probably a private issue. It was very touching to see and hear her talk about this realisation.

Mia: she realised how many times her identity has changed in the 20 years she has been working here; for example when she first started working here, then when she went from being a staff member to a leader. Now she feels she is in a recycling phase. She has recognised that this leadership development training series can provide her useful support to do it. She told me how this was an important realisation for her. At that point I understood why she just "was" in the previous trainings with us and realising this, I encouraged her to explore new things, I gave her a positive conditional stroke (Steiner, 1971) when I told "That is so good you realised it, so now you can do some exploring, it's fantastic!" I gave her this because I felt that she was really at the stage she recognised and she needed more opportunity to explore and I wanted to encourage her to do so. So I gave her a permission, and of course protection at the same time as I told her that in this leadership development process we meet again and again, so she will always have somewhere to bring her new experiences, she will not be alone, even if it is difficult. To make her aware of this, I referred to the model and told her that if she was thinking about it, the opportunity was there because the company had created this programme, and also she could bring back her questions, her stumbling blocks, her experiences, so she could experiment safely like when we are children - if we have something to talk about it is good if we can always go back to parents to talk about it.

Evelyn: was already thinking further about the model when it came to her and she started thinking about how she could use this to develop her staff and what stage they could be at. I redirected the question back to where she perceives herself to be (my Structuring Parent) and complimented her on her great thinking (my Nurturing Parent) and how we will work with that further.

I then gave them an example of how this model can be used in management to analyse colleagues. As integrating and retaining new colleagues is the biggest challenge in the organisation and our professional contract is about showing managers opportunities that support them in this, I used this as the basis for my example: the arrival of a new entrant. Together, we went through what happens to a new entry colleague and how they can be supported by leaders at that stage.

I then invited the participants to work in pairs for 20 minutes, where they could reflect on how they themselves could use their new knowledge to develop their colleagues.

I gave them the instructions below, to support them to make their own decisions about how they would like to use their new knowledge and to help them make decisions about their behaviour with their colleagues.

As there had been no signs of danger so far in the training, I had confidence in the participants, and knew they would be able to do this as they were all in the here and now, Internal Adult, at this stage of the training.

Small group work briefing:

- Choose 1 team member from your team.
- Where do you think he/she is now in the development cycle? Where is he/she in the big circle? Is there a small circle, and if so, where is he/she in it?
- How can you help your team member move to the next stage of the cycle? Help each other with ideas! - This will be one of your homework assignments!
- Write down the questions that arise and bring them back to the big circle.

After the small group work, there was one person who said that she now understood why one of her colleagues had left after 13 years and started something completely different, and that she feels she can be more understanding with him now. Here I reflected that yes, it is probably about his recycling, but I also pointed out the many ways in which you can renew yourself, even within a workplace, because they have done it, especially those who have been here for more than 20 years.

The question was raised of how best to support their group members when they do not know what stage of life they are at? I replied that, of course, as leaders they have less information about this and therefore often find it harder to influence. However, when they talk to their colleagues many of these issues come to the surface and they know the ages so they can calculate as well as guess. But I also said that they could easily see how a change in the company could trigger a small cycle and how they could provide useful support to their colleagues.

The dilemma also arose of what to do if, at a particular stage, their colleague had suffered a gap in their growing up. I told them that if they perceive this, it means that they can be very empathic with the person and understand what their problem is, so they will be able to develop and help them effectively. I gave an example of when I was not very confident in representing and sharing my own thoughts because my mother was overprotective and never encouraged me to formulate my own thoughts and develop them and this caused difficulties later in my life. That applied until a professional came along who constantly challenged me and refused to keep telling me what to do and how to do it, but encouraged me to formulate my own thoughts on the subject. This was very unpleasant at the time, but I know now that in this way that professional made up for a shortcoming I did not recognise at the time.

In this group there were staff from two directorates. Both directorates had new directors in the past year.

Some members of the group reflected on who experienced what during the change. They used the model well for this and I perceived that they used their Functional Adult ego state to analyse logically what happened to them and was still happening.

The change in most participants' behaviour was that instead of lack of understanding, they turned to their colleagues with greater understanding and curiosity, as they already had a model for this. Once they understand what is happening to their colleagues, they can consciously choose their leadership behaviour to best support them. Just as we discussed several options with the leaders in the training itself, they will be able to choose their behaviour based on these options in their everyday life, thus creating more autonomy for themselves.

There were managers who, in the light of this knowledge, made themselves aware of what they would need to do to help their team when they moved office to make this change go smoothly.

One explained that initially he needed to let the team just exist, just "be" with the idea of newness, and then, when they started to explore the newness of it, he needed to both facilitate it and let them do so freely. But you also need to provide security during this time, so you invite anyone who is finding it harder to experience change to a one-to-one meeting to help them move on to the next stage: reflection, so that they can then make the new place, the new office part of their identity and use the skills they have already acquired here.

Another manager discussed how he would support his staff to discover the system, to think about it, to make it part of their identity, to acquire the skills to use it and then integrate it into their operations, in the context of the introduction of a new IT system.

Although we did not listen to everyone, I did ask and the group gave feedback that everyone could formulate one-to-one action for themselves, what they planned to do with their colleague and I know they can use their own resources, so I did not ask them individually what they chose to do.

Evaluation

My assumption is that the training was effective in terms of giving the managers the opportunity to have a framework for thinking, and on the other hand, this framework supported them to explore more options for possible behaviours, thus becoming more autonomous. Classical TA approach combined with Developmental TA proved to be practical and useful with this group. This required the participants and my internal Adult ego state to be available so this meant during the training most of the time we were in the here and now.

Szabolcs Lovas is an organisational consultant who has worked with 4,000 employees in 26 workplaces, for over 3,000 hours, delivering individual and group development. He has also voluntarily translated the full set of Abstracts of this journal into Hungarian. He can be contacted on hello@lovasszabolcs.hu

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IJTARP
International Journal of Transactional Analysis Research & Practice

14 (2), 42-53

https://doi.org/10.29044/v14i2p42

States of Consciousness and Ego States

Abstract

A theory of consciousness is presented and linked to ego states. Different levels of consciousness are described and how states of consciousness (SoCs) contain within them different collections of experiential resources, leading to limitations on how individuals can access different resources when they are in specific states. Examples are given related to everyday life, followed by ideas on how practitioners can use empathy with clients so that the clients become able to change the contents of problematic SoCs.

Key Words

consciousness, experiential resources, intuition, empathy, expectancy, unconscious communication, ego states

Introduction

Consciousness has been a popular matter of scientific investigation for contemporary psychology for years (Hilgard, 1980). Attempts to understand, inventory, or investigate consciousness from various frames of reference are numerous: structural states of consciousness (Tart, 1969, 1972); stimulus conditions (Pekala & Wenger (1983); neo-dissociation (Hilgard, 1986), phenomenologically (Pekala, 1991, 1995a, 1995b; Terhune & Cardeña,

2010); shamanic practices (Harner, 1990; Rock, Wilson, Johnston and Levesque, 2008); spiritual awakening (Bucke, 1991); altered higher consciousness (Lilly, 1972); mystical awareness (Assagioli, 1965); acts of fire-walking (Hillig & Holroyd, 1997/1998); and more. This article concentrates on the more common, down-to-earth states of day-to-day consciousness, and is concerned with those states which can conceivably be a part and parcel of most peoples' daily experience, It also considers how consciousness can be considered as an element of ego states.

Levels of Consciousness

In the science of consciousness, the notion of *levels of* consciousness is a common construct. It seems reasonable that we all intuitively understand that consciousness is different as we move from experiences of being comatose or vegetative, under anesthesia, deeply asleep, lightly asleep, feeling hypnogogic drowsiness, wakefulness, alert, having heightened concentration, and so on. Just like orbital shells of electrons around atomic nuclei, the observable and phenomenological difference between these colloquial experiences lends us to regard them as different states of consciousness. However, this apparent gradient does not convincingly suggest that each state is free from experiential components which may also be shared with other states. This paper in not concerned with nor does it discuss levels or stages of consciousness but rather states of consciousness. However, the point of the analogy is that some common experiential elements, such as physiological monitors for temperature, hunger, etc., are shared between otherwise discrete states.

Additionally, the colloquial idea of *levels* of consciousness brings a certain, almost spiritual, baggage with it. This term is sometimes associated with Eastern concepts of satori, sasmitanir bija, sanande, vicara, vitarka (Lilly, 1972); or, śūnyatā, turīya, kevalatva, sāyujyatva, braman, and svātantrya (Govinda, 1973). Each of these are altered states of consciousness denoting aspects such as of deep concentration, mental void, divine grace, and so on, within Sanskrit that do not translate easily to English. While these states may function in a similar manner or have similar composition to those being addressed here, they may differ greatly in function, and nevertheless are outside the scope of this paper. However, with the increasing interest in spirituality within the transactional analysis community, others might wish to further investigate that notion.

States of Consciousness

The foundations for understanding a state of consciousness (SoC) were well expressed by Charles Tart (1975). Tart described the contents or 'stuff' of the SoC as psychological structures with active subsystems. He writes, "Our ordinary or 'normal' state of consciousness is a tool, a structure, a coping mechanism for dealing with a certain agreed-upon social reality – a consensus reality" (Tart, 1975, p.vii). He further explains that a discrete state is "…a unique, dynamic pattern or configuration of psychological structures, an active system of psychological subsystems" (Tart, 1975, p.5). The state is induced by the stimulation provided by sensory and chemical input and once induced, it is maintained or stabilised by feedback created by "mental monitoring". For Tart, the channels for induction and stabilisation of a SoC are the sounds, sights, feelings, smells, tastes, and reactions to internalise chemical substances for the duration of time during which the continuance of those stimuli prevail.

Using Tart's ideas of structures and sub-systems, the model presented in this article looks at sets of experiences and how they interact within and between SoCs. In this writing, the term SoC, always refers to an awareness within a grouping of experiences which are subtly monitored, usually without distracting consciousness, so as to ensure they remain within an acceptable range of variance. All of the individual's learned experiential resources are not included in any single SoC. In differing contexts, each person will have differing 'ordinary' SoC and each state will have its own unique (and perhaps sometimes overlapping) experiential resources.

Experiential Resources and Ego States

Before discussing the more complex mental frames of reference I am calling SoCs, I want to introduce a way to discuss parts of the composition of each. Tart proposed that each discrete SoC was a pattern of what he described as "energy / awareness flow interrelating various human potentials" (Tart, 1975, p.56). Emphasising the concept of a unique amalgam of "human potentials," he equates his concept of discrete States of Consciousness (d- SOC) with the more familiar term "ego state" (p.60-61). This is an appropriate definition for use here, but with one crucially important caveat: Certain so-called, higher states of consciousness identified by many authors, including Lilly, Govinda, Assagioli and others, do not have a sense of self or ego as part of their make-up. While many aspects of this discussion may apply to those 'higher' states of consciousness, however, this writing is concerned with SoCs commonly associated with daily life and TA practice.

Berne (1961) stated "The term 'ego state' is intended merely to denote states of mind and their related patterns of behavior…" (p.30). And similarly, as "a coherent system of feelings, and operationally as a set of coherent behavior patterns" (Berne, 1964, p.23). Citing Penfield and Jasper (1954) and Penfield and Roberts (1959), Berne (1961) also clarified that an ego state is more than just the stimulated auditory and visual cortex that comprises the memory or speech and words; an ego state includes the potential re-experiencing of the complete memory.

In a collection of his materials published later, Berne (1977) defined ego states "*phenomenologically* as a coherent system of feelings, and *operationally* as a set of feelings which motivates a related set of behavior patterns; or *pragmatically*, as a system of feelings which motivates a related set of behavior patterns" (p. 123) (italics added). While that definition is vague regarding experiences which are outside of those classified as 'feelings,' it appears that Berne's view of an ego state is most compatible with the grouping of experience-sets which Tart and I are referring to as a SoC. This is further supported by James Allen's (2011) summary "Berne described ego states as coherent ways of thinking, feeling, and behaving that occur together. Today, we can also conceptualise them as the manifestations of specific neural networks in the brain" (p.12). A useful working model, then, is that the phenomena of ego states referred to by Berne are complex neural net bundles of perceiving, thinking, feeling, and behaving.

[Editor's note: This is similar to when Jenni Hine (1997, 2005) wrote of 'generalised representations' (GR) and referenced, among others, Stern (1985) who originated the concept of RIGs - Representations of Interactions that have been Generalised. Hine proposed that "… ego states form progressively out of the generalised representations that develop as the individual interacts with the environment and with his or her perceptions of self and others through the period of infancy and childhood." (p.278). Figure 2 below is somewhat similar to the diagram that Hine (1997, p. 281) provided. Great minds …. !]

Other non-TA theorists also use the term 'ego state' to embrace complex psychological phenomena which have operational characteristics or preferences. William James dealt with this concept of sub-personalities - which he called 'the various selves.' The functions of an individual, in whom various

psychological traits are not integrated, form what we consider to be sub-personalities. Assagioli (1965) suggested the word 'roles' instead of 'functions' to avoid semantic confusion, commenting that ordinary people shift from one to the other without clear awareness, and only a thin thread of memory connects them; but for all practical purposes they are different beings – they act differently, they show very different traits.

In his writing, Assagioli is not speaking about the rare cases of dissociative personality disorders but rather the day-to-day or minute-to-minute shifting of consciousness that Berne would call changing ego states. In some situations, these may be seen as mental programs of a defensive or survival nature as if the group of experiences are sub-personalities, and complex processes with various protective (even if maladaptive) motives (Frederick, 1996, 2005, 2016; Frederick and McNeal, 1999; Lowen, 1967; Watkins, 1978; Watkins and Watkins, 1979, 1984, 1988, 1997). To emphasise her position, for instance, Frederick states "Malevolent ego states (also known variously as destructive, perpetrator, demonic, and protector ego states or alters) are aspects of the personality that preside over a number of self-destructive behaviors such as suicide and homicide attempts, disturbances of mood and of cognition, somatic and somatoform illnesses, and disabling flashbacks" (p.332).

While the phenomenon behind those above characterisations provides a dramatic view of dynamic consciousness, they are only one focus of this discussion. Yet, they illustrate an observed repetitive pattern of complex behaviour and ego states or state of consciousness. Of course, not all ego states should be considered defensive or malevolent. Most ego states account for acts of daily living, creativity, and general survival in society.

That is, each ego state or SoC is comprised of experiential resources. By way of definition, an experiential resource is a named (labelled, or symbolised) set of monitored experiences associated with one or more memories of historical events during which it occurred. As a point of reference, Bandura's (1969) research on learning and modelling illustrates that symbolised or coded image representations (auditory, visual, olfactory, etc.) or words function as mediators for subsequent response retrieval and reproduction. He writes, "If perceptual sequences are repeatedly elicited a constituent stimulus acquires the capacity to evoke images (i.e., centrally aroused perceptions) of the associated stimulus event…" (p.133). He further adds, "Concise labeling and imaginal coding were equally effective in aiding immediate reproduction of modeled responses and both systems proved superior in this respect to the concrete verbal form" (p.134).

As with any experience, one's awareness of an experiential resource fluctuates over time. Memory of, and conscious access to, the experiences may have faded or been suppressed over time, rendering it an unconscious resource. That is, we experience more or less courage, hunger, confidence, tension, fatigue, etc., throughout time. The neurobiological mechanisms for monitoring these events and alerting one to attend to them are complex and beyond the scope of this paper. However, the pragmatic operation of monitoring experiences and alerting consciousness can be referred to as an experience monitoring process and will be designated only as "experience monitors." These experience monitors may be shared with, or isolated from, other ego states/SoCs.

The following should help clarify these smaller components which provide experience monitoring - but be reminded that these represent complex and expansive neural networks within the brain. Consider how most individuals monitor the high and low limits (represented as horizontal bars) of common physical experience - in this example, muscle relaxation or tonus shown here in the form of thermometers, as in Figure 1.

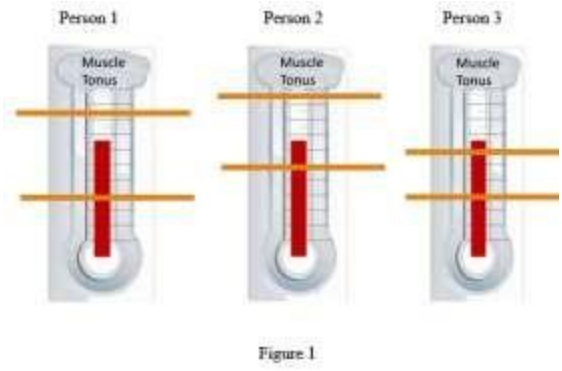

Figure 1: Differing Assessment for the same stimulus for three individuals

Assume these are monitoring the same physiological experience for 3 individuals. The same measurable level of muscle tonus (the vertical red 'temperature' bar) measuring relaxation or tension is judged differently by each person (the high and low thresholds indicated by the horizontal bars). That is, it is about mid-range for the left person's monitor, becoming low for the middle person's monitor, and beyond the highest comfort level

for the person alerted by the third monitor. Each person will have a unique tolerance for their experience. Such differences are created from genetics, social learning, modelling, trial and error, conditioning, and deliberate training, etc. When an experience rises above or drops below a learned threshold, experience monitoring brings it into consciousness.

Various experience monitors are the building blocks of each ego state – some ego states have access to shared experience monitors, and some do not. For instance, in TA language, a person who may be in any of the three major groupings of ego states - archeopsyche (Child), neopsyche (Adult), or exteropsyche (Parent) - may have access to the *set* of experience monitors that he or she labels 'daydreaming' (that is, non-deliberate or less intentional and directed frontal lobe cognition). As a result, the person could use the experience of daydreaming to shift from one ego state to another. The example for this would be that in one moment the person might chuckle at the content of the daydream (a connection to shift to a Child ego state), then in self-talk say "That's interesting and explains a lot." (a connection to shift to an Adult ego state), and the next moment emphasise "It's a damn shame more people don't realise this." (a connection to shift to a Parent ego state). Experience monitors, shared within other SoCs, provide avenues for switching states and recombining with other sets of experiences contained within them.

It is important to recognise that many, maybe most, monitored experiences are associated with still other monitored experiences and make up a *set* of experience monitors. It is convenient to refer to these *sets* of monitored experiences as 'experiential resources' (ERs). When, for instance, I witnessed Dr. Milton Erickson help a client elicit what he referred to as 'pride' or 'joy' or 'confidence' from childhood efforts learning to tie his shoes, he considered 'pride' or 'confidence' to be an experiential resource (personal communication, July 1977). But the client, as a child, would have had to monitor and execute several experiences to accomplish tying his shoes. For instance, a client, as a child, would have to have monitored gripping, hand position, balance, eye-focus, breathing, and so on, to accomplish the learning. In short, an experiential resource is a named (labelled) *set* of monitored experiences associated with one or more memories of historical events during which it occurred.

Each person learns labels for these combined sets of experience monitors and those labelled sets remain fairly constant throughout life. Even though ERs are comprised of complex sets of experience monitors for affects, cognitions, perceptions, etc., on a daily basis people only refer to them by names such as 'confident,' 'weary,' 'happy,' frightened,' 'affectionate,' 'angry,' and 'focused.' It is easy to refer to such a label and yet the vast set of mixed component experiences that comprise each are often indistinct. That is, they are indistinct until awareness is directed to it by means of a sensory-based memory, interpersonally offered suggestions, or a monitored process goes beyond the limits of the learned thresholds and involuntarily intrudes on awareness.

If some external or internal stimulus triggers an ER beyond the customary limits, it may involuntarily and suddenly provide a signal that it is out of bounds and the person may shift ego states. For instance, when a person is happily running on a beach and becomes aware that they stepped on something that cut their foot, the person suddenly shifts from a state of carefree exercising SoC to a concerned and cautious set of experiences triggered by pain. If those experiences are not among the components of their exercising SoC, they will suddenly shift to another SoC. In so doing, the previous ERs may no longer be available. Thus, the avenue back to the carefree jogging in the previous SoC is temporarily impossible. These concepts illustrate what is meant by SoCs. They consist of shared experience monitors and limits of recombining experience.

In summary, SoCs are identifiably different collections of *sets* of perceptions, thoughts, feelings, behaviours, monitoring processes, and the capacity for consciousness. It is important to note four factors in defining a SoC:

1. There must be consciousness or sensory awareness at some level;
2. The SoC will contain sets of experience monitors for motor skills, perceptions, cognitions, bodily function monitors, affects, etc.;
3. Many or most of the sets of experience monitors will have labels (that is, they are ERs);
4. There are limits or rules for connectivity that delimit traversing from one ER to another.

Phenomenological observation indicates that within a given customary (or normal) waking state, some experiences can be accessed immediately with little willful effort, and some cannot be so easily brought into awareness. For instance, in their customary waking state, the behaviour of chuckling at something

humorous may come more easily for some individuals than for others. Furthermore, there is varying difficulty for the same individual to chuckle at different times and in different circumstances. This example is an indication of what can be called the person's 'rules-of-connectivity' that govern switching from one set of experience to another.

Rules may be, in most cases, biologically based but, in many cases, they are learned. The learnings are, of course, a reflection of each individual's unique history. This, basically, gives rise to the problems that bring people to psychotherapy. That is, therapeutic or developmental opportunities exist when people cannot acquire the experiences needed in the context in which they are required.

As Erickson explained it, "psychological problems exist precisely because the conscious mind does not know how to initiate psychological experience and behavior change to the degree that one would like" (Erickson and Rossi, 1979, p.18). As previously explained, people recognise *sets* (i.e., grouping, or patterns) of experience monitoring processes and give them labels and thus they become ERs.

Simplified examples of four SoCs with ERs are illustrated in Figure 2. Each egg-shaped ellipse represents a different SoC and for the purpose of simplified discussion, there are only a few circled numbers within each. The numbered circles within the SoCs represent an experiential resource. Each of these ERs will have a label that is familiar to the individual.

Some of the experiential resources are connected to one another, and some are not. The highly connected ones share some commonality, usually established by a unique learning history. Or they may be related by containing a common experience monitor, etc. Hence, moving between those is easy. Each SoC has several ERs that are similar or even shared with another SoC. But for the sake of simplicity Figure 2 does not show any overlapping geometry to illustrate that. Table 1, which is based on several hypothetical illustrative examples of various experiential resources, shows how:

1. Each SoC is represented as an enclosure with a dotted line as its boundary.
2. Within each SoC there are many experience monitors.

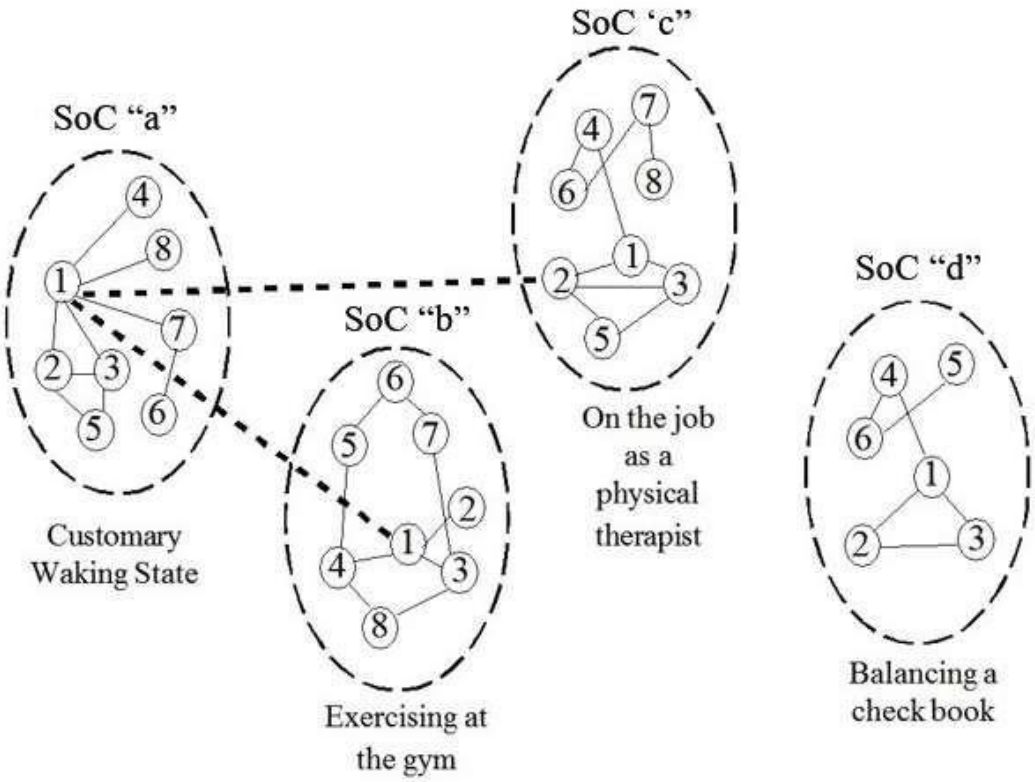

Figure 2: Various Sets of Experiential Resources Distributed within States of Consciousness

Description of the contents of SoC “a:” This is the individual’s hypothetical SoC that we’ll call her customary waking state. a1 is “feeling alert and awake.” a2 is “withdrawn and thinking.” a3 is “ignoring stimuli - dissociating.” a4 is “being able to explain”. a5 is “scanning surroundings.” a6 is “seeking attention.” a7 is “fatigued.” a8 is “evaluating.”
Description of the contents of SoC “b:” This is the individual’s hypothetical SoC that exists when she is exercising at the gym. b1 is “determination.” b2 is “self pep-talk.” b3 is “relaxing.” b4 is “hopeful.” b5 is “exhausted.” b6 is “feeling in the zone.” b7 is “feeling rushed.” b8 is “comparing self to others.”
Description of the contents of SoC “c:” This is the individual’s hypothetical SoC that exists when on the job as a physical therapist. c1 is “observing” - subject’s motion. c2 is “planning” – for a prescribed therapy. c3 is “explaining” –giving assignments. c4 is “confidence” – delivering plan to a subject. c5 is “ignoring” – sounds of activity. c6 is “worrying” – checking paperwork. c7 is “satisfaction” –seeing subject’s progress. c8 is “being firm” – insisting on assignments.
Description of the contents of SoC “d:” In this illustration “d” is shown to represent any other distinct SoC, but it could possibly be named the SoC used when balancing a check book. d1 is “committed, determined.” d2 is “curiosity.” d3 is “focussed.” d4 is “forgetting.” d5 is “confusion.” d6 is “frustration.” d7 is “distracted.” d8 is “angry.”

Table 1: Experiential Resources in the SoCs of Figure 2

3. Eventually, sets of experience monitors will be labelled in the process of socialisation (e.g., strong, confident, helpless, brave, cautious, competent, smart, etc.).

4. The set of experience monitors constitute experiential resources.

5. Some experiential resources cannot be reached from other experiential resources.

6. Some experiential resources will be pathways to other experiential resources, and some may be potential pathways to other SoCs.

An important reminder is that these representations of SoCs are meant to help explain the concepts of discrete states of consciousness, experiential resources, stabilised boundaries, and connectivity between them. As illustrations, they are not representative of complete states: a SoC would have hundreds more ERs. They should, however, help convey and clarify the major components needed for using psychotherapeutic transactions for co-creating a therapeutic state and the relationship between those components.

The SoC model illustrates that some ERs cannot be directly reached within a SoC and that some needed resources may be even more difficult to elicit due to their relationship to more unfamiliar or lesser used SoCs. This has to do with the learned channels or pathways that connect them. These learned channels are what I referred to already as 'rules-of-connectivity.' Many rules of connectivity are learned and can be changed. In Figure 2, for example, it is possible to move from experience a1 to several other experiences - a2, a3, a4, a7, or a8. But, as the diagram shows, it's not possible to move directly from a1 to a6 or to move from a6 to a8 or to a4, etc. That is, the person in this example cannot directly move from feeling awake and alert to daydreaming or falling asleep. This is, of course, not a big revelation in the real world, but it illustrates the concept that movement between experiences is governed by certain learned rules of connection.

More interestingly, if the person in this example is in a therapy office and having the experience of a1 (feeling awake and alert) they cannot directly move to b6 (dissociation). The experience b6 (dissociation) is part of an entirely different SoC. But it can be most easily achieved by the association of a1 shifting to b1 (preparing) – a key part of a different SoC. Then from b1 (preparing) to b3 (relaxing), to b7 (determination), and finally to b6 (dissociation). When these shifts happen in everyday life to our hypothetical subject, that person is unaware of the complexity that is involved – it just happens. But movements to other ERs which the combining rules will not allow – do not 'just happen'.

Changing circumstances to a real person outside of this hypothetical set of SoCs - what happens when the subject needs a feeling of confidence to ask for a promotion while at their place of employment and in the associated SoC? If that confidence is not a part of that SoC and they do not have experience getting from point A to point B, so to speak, the person cannot consciously evoke the needed confidence. Therein lies the simple analogy that brings people to therapy or maybe coaching - one cannot get the resources that one needs in their customary waking state from some other particular state of consciousness. The rules of connectivity are often inadvertently learned and can be relearned. Some of that learning may be simple socialisation, and in other cases that learning may be the result of trauma or inappropriate psychosocial development. One effect of trauma is to create *pervasive* oversensitive experience monitors, or several experiences being over-monitored from multiple SoCs.

This short example includes a reminder to not generalise the specifics it contains. For instance, debilitating anxiety related to test taking can be due to a variety of individual circumstances. However, to illustrate this point of hyper-sensitive monitoring, consider a student who, as a child was verbally berated and physically assaulted (e.g., struck in the face with a parent's hand) when making a mistake on a homework assignment or when reciting the multiplication table. Such an event, especially if repeated, would sensitise the child to increase his/her level of hesitancy to answer a question or his/her inability to formulate a mental image of an answer. While these types of learning might not be an ordinary component of a person's customary waking state, they nonetheless may remain as hyper-sensitive monitoring process in other SoCs.

Consequently, the context of taking an exam on material about which he/she has some doubt could be a context in which the over-sensitive monitoring triggers anticipated pain (even when that is irrational, of course). And, as those mechanisms flood consciousness with that irrational anticipation (fear or anxiety), his/her ability to deliberately evoke the resource of confidence would be increasingly blocked. Since the fear or anxiety would not likely be a component of his/her customary waking state, the monitoring mechanisms that led to it would be

considered a connecting route into a different SoC. And, once in that SoC, he/she would not be able to quickly shift out of it and back to a relaxed and confident frame of reference for continuing the exam.

These experience monitors which are meant to protect the person from the reoccurrence of an unpleasant or painful situation may be easily triggered by environmental cues which approximate the trauma that created them. As such, they are common examples of why the conscious mind may be unable to retrieve needed experiences from other states of consciousness due to trauma.

Apropos to the concept of pervasive experience monitoring, two research studies using fMRI (functional Magnetic Resonance Imaging) to compare the neuroimaging of hypnotically induced and physically induced pain responses, illustrate the point. Derbyshire, Whalley, Stenger, and Oakley (2004) studied several highly suggestible subjects with findings replicated in subsequent research by Raij, Numminen, Narvarnen, Hiltunen, and Hari (2005).

Oakley cited these studies, sharing that they found "widespread activation throughout the brain circuitry associated with the mediation of pain" [that is, in the thalamus, anterior cingulate, insula, prefrontal and parietal cortices]. Adding, "with the additional observation that source monitoring by medial prefrontal cortex may contribute to the subjective reality of pain in both cases" (Oakley, 2008, p.369). Such widespread brain excitement is not confirmation that multiple SoCs learn pervasive hyper-sensitive monitoring of critical experiences. However, to the extent that the pain in these studies can be compared to physical or emotional pain from life's traumas, the feasibility of such a phenomenon does exist.

The excitability of hyper-sensitive experience monitoring can be seen in the way phobic avoidance can generalise in a person. Imagine the person who feels excessive fear during a car accident on a stormy night and subsequently finds that fear has become nearly debilitating. As time progresses the fear may inhibit the person from driving in a storm. Then the fear may further generalise to hearing or seeing any storm, and over time, generalises to a fear of wind - and even a fear of hearing weather forecasts. In such a case, the person becomes increasingly unable to feel safe in their home, at work, or even watching a movie that involves a windy day. This is to say, the person has fewer and fewer routes to connect to a feeling of safety despite any SoC they can achieve.

Expectancy and Empathy

The next questions concern how it is possible to move experiences from within SoCs that have rules for transiting from one experience to another and assemble a state that contains several of them. The best answer, as it pertains to professional interaction, is empathy and empathic rapport.

To understand the role of empathy we need to define it. Empathy refers to a *felt* understanding of another person's situation, feelings, thoughts, and desires (Rogers, 1961). Empathy does not refer to merely having a cognitive understanding of the other person's situation and feelings. Empathic rapport refers to the situation in which the subject or client also believes that the practitioner has a shared sense of his or her situation. It should go without saying that a client may incorrectly believe that an understanding exists. Rogers makes the poignant observation that "When the therapist is sensing the feelings and personal meanings which the client is experiencing in each moment, when he [sic] can perceive these from "inside," as they seem to the client, and when he can successfully communicate something of that understanding to his client, then this third condition [empathic understanding] is fulfilled" (p. 62). Successful empathic blending has an effect on clients that is nearly essential for creating new states of consciousness in treatment, such as an impartial Adult ego state with connection to several empowering ERs.

To a new client, the practitioner is a stranger, an outsider. As the two converse, the practitioner's communicated empathic sensings have an effect on the client's perception of the other as *other.* The more the practitioner's contributions to the "conversation capture essential elements of, and resonates with, the client's experience, the more the client finds the differences between themself and the practitioner to be irrelevant — undifferentiated. The borders of the client's self are able, for the time being, to become unremarkable, making it possible for the practitioner to become accepted as an insider" (Flemons, 2020, p.349).

Perhaps Gregory Bateson (1979) best identified those factors that explain how people blend their sense of identity with another. He explains "perception operates only upon difference. … all perception of difference is limited by threshold. Differences that are too slight or too slowly presented are not perceivable" (p.29). He goes on to say, "information consists of differences that make a difference" (p.99).

The important question becomes what creates such sufficient empathic rapport that the distinction between which individual has initiated a thought becomes blurred. The subtle nuance of interpersonal communication has been elusive and difficult to measure. Thus, it seems to have often been brushed aside in psychology. Notable exceptions, whose work to codify communication greatly influenced me, include the operant interpersonal communication research by Richard Stuart (1969), the work from the Mental Research Institute of Palo Alto (Bateson, Jackson, Haley and Weakland, 1974), the unique approach to hypnosis by Milton Erickson (1948, 1958, 1970, etc.), and the advanced theories that developed from TA (Berne, 1961, 1964, 1967). Yet, these works still fall short of codifying an acknowledged, but more subtle, feature of communication often summarised by phrases synonymous with the word 'intuition" which may play an even more important role.

A perceptive observation came from Kempt (1921) who may have correctly observed that intuition is reflex imitation through similar brief muscle tensions. That imitation was derived partially through subliminal cues according to Jung (1946) who later posited that intuition "is that psychological function which transmits perceptions in an unconscious way" (p.567-569). Two years later, Reik (1948) wrote that intuition is listening with the third ear. But, despite that being a poetic definition, it fell on deaf ears, as it left little for science to measure. Kempt and Jung introduced what we now suspect to be the transactional aspect of conscious and unconsciously perceiving muscle (and other subtle) activity driven by mirror neurons. In my estimation, mirror neuron driven behaviour and its transactional detection and response most certainly account for a large part of what is experienced as empathy.

Berne (1961) addressed this when writing of communications that stimulate an ulterior involvement by appealing to a vulnerability or 'gimmick' in the listener. Later, (Berne, 1964) identified this type of communication and labelled it an 'angular transaction'. Angular transactions involve multiple ego states. They are communications that stimulate activity in a SoC outside of the ostensible state being used by the respondent. This category of transactions may subsume empathic communication but also includes a great number of other seductive communications. For example, "Drivers look younger in that car. " "When you open your eyes, you'll be like the strongest man anyone has ever met." "In trance you are going to know how it feels to never be wrong." The defining aspect is that they result in stimulating or evoking expectancy outside of immediate awareness and encourage its emergence.

What is referred to in some therapies as 'expectancy' or a placebo effect is evoked by angular transactions. This is because they include, in addition to language, alluring social factors such as perceived prestige of the practitioner, symbolic iconography, the popularity of the approach being used, peer pressure, and demand characteristics of the environment. Specifically, expectancy is the result of a cognitive and unconscious transderivational search for previous perceptions, experiences, imagination, or memories that might help frame an event and give it meaning (Goffman, 1969). The search process has a similar mental (possibly, yet to be discovered, neurological) activation effect on clients. It requires relaxing the boundaries of the customary waking state (or the current SoC) and increasing receptivity for experiences customarily residing in the associational patterns of other SoCs.

This is the situation at play whether the stimulus is presented legitimately or fraudulently and, when received, it stimulates a type of broad mental search (or fuzzy search) across possible favourable meanings. The phenomenological affect of this search can be named as 'enchantment' (Lankton and Lankton, 1986, 1989). This phenomenon and what theorists and researchers refer to as expectancy should be conceptualised as transactional events stimulating searches for favourable past experiences including those residing and monitored in various different states of consciousness. Thinking of it in this way means that expectancy is not a trait but it is a transactional event.

Working with SOCs

While the specific content of a state cannot be delineated, the process can be. It begins with the steps to establish an empathic relationship. That is primarily done to help the practitioner gain as accurate an understanding of the client's situation as possible. Figure 3 uses a wavey line to highlight the 2-way communication that occurs at both the conscious and the mirror neuron level of exchange.

Fortunately, the outcome of such a relationship is creating a lack of 'difference' and therefore a lack of boundary. As discussed, this allows for more easy movement of experiences within the SoC as well as the elicitation of experiences found outside of the current SoC.

Figure 4 illustrates how the practitioner might prompt the client to recall ERs that will help them move into a

positive SoC. These might be curiosity or hopefulness, or others that are relevant to whatever the client wishes to achieve.

Figure 5 shows the practitioner increasing the elicitation by the client of appropriate ERs through a process where the client recognises that the practitioner really understands them, again via communication at conscious and psychological levels.

Figure 6 illustrates how the practitioner invites the client to associate ERs in new ways, and Figure 7 shows how the client finishes up with a newly created SOC comprising a new set of ERs. This final temporary therapeutic state can be a hybid Adult state containing the needed resources for the contracted therapy goals such as overcoming a traumatic and limiting childhood experience, stop substituting an adapted feeling and empower the self to own a previously abandoned feeling, or envision and embrace a successful and desired life script.

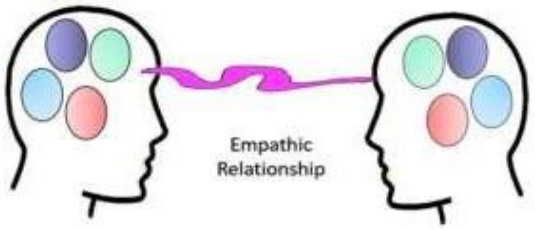

Figure 3: Conscious and Unconscious Communication Establish Empathic Rapport (Lankton, 2023, presentation)

Figure 4: Experiences Desired Usually Reside in Differing SoCs (Lankton, 2023, presentation)

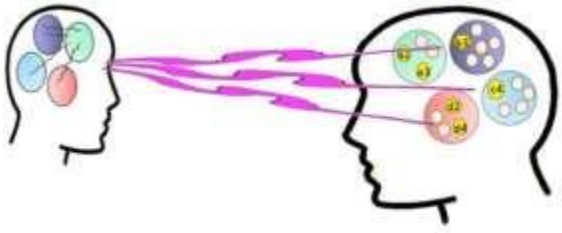

Figure 5: Eliciting Experience within Other SoCs with Relaxed Boundaries (Lankton, 2023, presentation)

Figure 6: Assembled Experiences Begin to Connect by Repeated Association (Lankton, 2023, presentation)

Figure 7: The Set of Experiences becomes an Independent SOC (Lankton, 2023, presentation)

Stephen Lankton, Licensed Clinical Social Worker, Diplomate American Hypnosis Board, Fellow American Society of Clinical Hypnosis, is an Emeritus Clinical Member of ITAA due to having been involved with TA for so many years. He can be contacted on steve@lankton.com.

Similar material, with less focus on TA, can be seen when a new book is published – the reference is Lankton, Stephen. (2024). States of Consciousness Model and Ericksonian Approaches to Therapy. In J. H. Linden, G. De Benedittis, L. I. Sugarman, K. Varga. (Eds). *Routledge International Handbook of Clinical Hypnosis*. Chapter 8. Routledge.

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