descendants which has been evident for some time. 1] On the one hand there is the growing army of those who 'use or practice transactional analysis in their work, sometimes with more and sometimes with less concern whether their version of it coincides with anyone else's. 2] And on the other hand there is the comparatively tiny number of those who have gained official recognition, and who are often concerned to raise standards even higher, particularly in the clinical area. The last is reflected in the high proportion of those who do not pass exams the first time.

There are reflections too of the same divisions at an organisational level within ITAA which do not matter much here.

My conclusion is that the very language of transactional analysis is an ulterior transaction. It conveys a message at two levels: the obvious invitation to the general public to enjoy learning and to savour knowledge which has been unavailable (wickedly withheld?) from them; and the hidden request to be taken very seriously.

Hence I pick up a revue one week which dismisses TA as 'superficial', and another the next which warns its readers that TA is 'dangerous' and that TA practitioners are a particularly virulent specimen of a species which should be proscribed.

Good luck to readers of this special issue on TA.

Roger Kreitman

Transactional Analysis - What is it?

Origins and current status

T. A. was developed in the 1950's by Eric Berne, a psychoanalytically trained psychiatrist dissatisfied with the limitations of orthodox Freudian psychotherapies. Berne remained the most influential T.A. theorist up until his death in 1970; though since then many important theoretical and technical contributions have been made by other T.A. practitioners. T.A. now has a clearly defined institutional structure; the International Transactional Analysis Association regulates the teaching of T.A. and the training of therapists. Currently the I.T.A.A. membership directory lists more than 10,000 Regular Members and more than 600 accredited T.A. therapists (Clinical Membership category). Although developed in the context of psychiatry and psychotherapy, T.A. is finding applications in a wide variety of other settings, e.g. schools, welfare agencies, management consultancy, prisons, children's homes.

Distinctive features of T.A. as a therapeutic system

1. T.A. offers a simple and clear theoretical framework within which the therapist and patient operate. Most T.A. therapists introduce their patients very early on to the terminology of ego-states, games, life-positions, etc. and encourage them to apply these ideas to themselves and their dealings with other people. Not only does this commom frame of reference simplify communication about psychopathology and patterns of interpersonal behaviour; the patient is from the very beginning invited to share the therapist's perspective on treatment, using the same language that the therapist uses to think about cases or discuss them with colleagues.

This educational/didactic emphasis has given T.A. a reputation for being over-intellectual in its approach to therapy. However, the basic concepts can be understood and used by most people; attesting to this is T.A.'s increasing use in mental-handicap settings (Cheney 1970).

2. T.A. treatment is contractual; client and therapist negotiate and specify the changes at which treatment is aimed . A viable treatment contract should simply and clearly state what the client wants to achieve; these goals should be of a concrete and operational verifiable nature, e.g. 'I want to enjoy sex', 'I want to be happy most of the.time', 'I want to loose three stone in weight', I want to stop rowing with my wife'. Examples of unacceptable vague contracts are 'To become more mature', 'To improve my relationships' and so on.

The cotract will also specify the conditions the therapist thinks will be necessary in order that the client achieve his goals, e.g. that he attend group sessions regularly for six months, say; that he undertake homework assignments given by the group; that he refrain from certain behaviours detrimental to his progress in treatment.

T.A. therapists vary in the rigour or detail with which they frame therapeutic contracts. However, the contract is designed to protect the therapist against becoming involved in vague attempts at 'help' to which the client is uncommitted, and the client against intrusion by the therapist into areas of his life unconnected with the desired changes. *See 'Scripts People Live' Chapter 20 for a fuller discussion of contracts.)*

3. As its name implies, T.A. concerns itself largely - though not exclusively - with the social realm of transactions between people; so inevitably attention is focussed on the client's relations with his family, his workmates, etc. (T.A. therapists are very aware of the importance of involving the client's intimates in the therapy process).

It follows from this emphasis on interpersonal phenomena that the ideal setting for treatment is the therapy group. Though one-to-one is perfectly feasible, most T.A. therapists would regard the therapy group as the more effective vehicle for change.

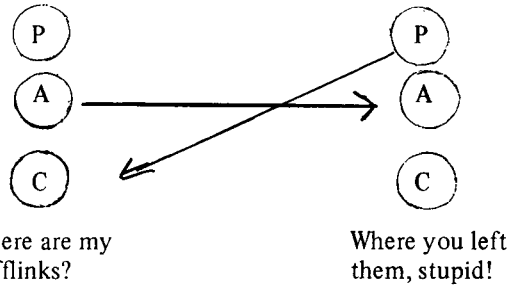
4. T.A. is an actionistic therapy. The influence of the past is acknowledged and explored; yet the client is regarded as an *agent* who always retains the capacity to

transcend his conditioning. Having decided in the past to live a certain way, he is free to re-evaluate this decision and, if he so chooses, re-decide.

Eric Berne went to some trouble to describe the relationship of T.A. to other psychotherapy systems - see *'Principles of Group Treatment'* for a full discussion. There are clear links, for example, with psychoanalysis, existential therapy and behaviourism. Furthermore, T.A. can be combined with *any* rational form of therapy if so desired.

Concepts

1. Ego-states - Parents, Adult and Child. This assignment of motives, perceptions and behaviours to ego-states allows for the drawing of the distinctive T.A. diagrams, e.g.



Berne (1961) writes 'An ego-state may be discribed phenomenologically as a coherent system of feeling related to a given subject; operationally as a set of coherent behaviour patterns; or pragmatically, as a system of feelings which motivates a related set of behaviour patterns.'

Ego-states are sub-systems of the personality between which we shift from moment to moment. In adult, we objectively appraise situations, collect information, use our past experience to predict the likely outcome of various courses of action, and so on. In Child, we react more abruptly, often on the basis of pre-logical thingkings and distorted perceptions; the Child is the source of most strong feelings, happy as well as sad. In Parent, we are judgmental and evaluative (of others or ourselves) in a dogmatic manner. The Parent is the source of criticism, values and 'standards'. The Parent is also responsible for nurturing and comforting behaviour.

Note that ego-states are not roles; they are experienced and observed psychological realities. Note also that ego-states refer historically to people who once existed. We all retain archaic perceptions and emotional responses deriving from the children we once were. We also all incorporate an internal representation of the parents we once had. (As they appeared to us as children.)

Shifts in ego-states are apparent through observation of people's gestures, appearance,

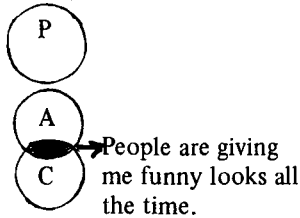
manner and choice of words; each ego-state has its repertoire of mannerisms, vocabulary, etc.

Some implications of ego-states for therapy are as follows:-

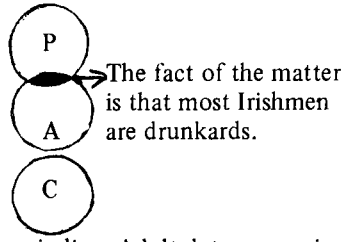
(a) In any problematical situation, a person has to contend with with three sets of input, one from each ego-state. (The examination of these internal messages and their allocation to ego-states is known as structural analysis).

(b) Communication between people takes place ego-state to ego-state, as in the example at the beginning of this section. Communicative behaviour is governed by various rules, e.g. 'Communication proceeds smoothly as long as the transactions are complementary (vectors parallel)'. (Examination of these interpersonal phenomena is sometimes referred to 'Transactional Analysis proper').

(c) The main pathologies of personality-structure are *contamination* (overlap of ego-states, as in the case of a delusion or strongly-held prejudce) and *exclusion*, where one or more ego-states are more or less completely de-commissioned.



A delusion: Adult perception contaminated by Child-based fear



A prejudice: Adult data-processing contaminated by Parent dogma

In the case of a contamination, the first task of therapy is to re-align the ego-boundaries by a process of clarification and reality-testing. (For symptomatic relief and social control this may be all that is required; however, if circumstances permit, resolution of conflicts and deconfusion of the Child may then be undertaken.)

2. Life positions

A life-position is a deep-seated - and usually unspoken - belief about oneself and where one stands in relation to other people. There are many possible life-positiosn, but these are all variations of four basic patterns.

Fundamentally, I can believe one of two things about myself.

I'M OK (intelligent, successful handsome, powerful, lovable worthwhile, etc., etc., etc.)	*OR*	*I'M NOT OK (I am stupid inadequate, ugly, feeble, hateful, worthless, etc., etc., etc.)*

Similarly, You (which here means any other person I come into contact with) can be either OK or NOT OK - again for any number of reasons. It follows therefore that I can have any one of *four* basic attitudes about myself-and-the-world:-

I'M OK and YOU'RE OK I'M OK and YOU'RE NOT OK I'M NOT OK and YOU'RE OK I'M NOT OK and YOU'RE NOT OK

We tend to shift from one position to another over time; the importance of the life-position is that all the time we *work* to *justify* the stance we have adopted - *to prove to ourselves that things really are that way.*

	I'M OK	I'M NOT OK
YOU'RE OK	*I'M OK, YOU'RE OK* The healthy position, I respect myself and others. Even when things get painful or difficult I am confident that we can get things sorted out. Colloquially, the 'Get On With ..' (Other people) position. No need to play games.	*I'M NOT OK, YOU'RE OK* The one-down, (Often depressive) position. 'Everything's my fault. I'm just a nuisance and a burden to others, who would be better off without me.' People in this position work to get rejected or humiliated. Colloquially, the 'Get Lost' position. Games: 'Kick Me', 'Stupid', etc.
YOU'RE NOT OK	*I'M OK, YOU'RE NOT OK* The one-up (often self-righteous) position. 'It's not my fault, it's yours. I'm better than you and I'll prove it.' People in this position look for faults in others to make themselves feel better. They also look for 'good reasons' for getting angry with others. Colloquially 'Get Rid Of ...' (other people). Games: 'Blemish', 'Now-I've Got-You-You-Sonofabitch.	*I'M NOT OK, YOU'RE NOT OK* The futility position, there's No point in trying anything, because nobody is worth much and there's no goodness to be found anywhere. Colloquially 'Give Up.'

One of the tasks of therapy is to examine which life-positions people habitually adopt and how this affects their behaviour; also to look at what difficult situations are liable to shift people from 'healthy' into 'unhealthy' life-positions.

3. Strokes, time-structuring and games

T.A. regards human activity as directed towards meeting a set of universal needs.

These include:

- stroke-hunger *The stroke is the unit of recognition. Strokes include both pleasant and unpleasant stimulation; physical contact; insults, criticism, compliments and expressions of affection; non-verbal communications of various kinds. 'Stroking' is conceptually somewhat similar to 'reinforcement', with the important proviso that T.A. theory says that under some circumstances some people will work to obtain negative strokes ('punishment')*

- position-hunger. *This can be regarded as a need for existential security or validation - see the previous section on life-positions. Hence 'pathological' or self-defeating behaviour may be satisfying to a person because it provides just this security.*

- structure-hunger. *How to pattern time, preferably in stimulating and exciting ways. Most people, once having obtained the necessities of life and fulfilled basic biological functions, have surplus time which they must fill somehow.*

Modes of time-structuring are classified according to their stimulation value - ('Stroke value') and the opportunities afforded for intimate social contact. At one extreme is withdrawal *from others e.g. into autistic fantasy. Next there are* rituals *(e.g. 'Good morning.' 'Good morning.' 'Nice day isn't it?' etc.) which have some stroke-value, but little opportunity for individual variation.* Pastimes *and* activity *(goal-directed purposeful behaviour, e.g. 'work') allow us to structure longer periods of time and select partners for more enduring relationships.* Games *are repetitive sequence of transaction, conducted largely out of awareness, whose function is to limit intimacy: we can get close to other people; but not* too *close. Games allow us to structure time and acquire strokes whilst maintaining our preferred life-position. In his popular 'Games People Play', Eric Berne describes over 90 games and analyses the psychological and social advantages which maintain a wide range of apparently destructive behaviours.*

Beyond games is intimacy, *a rare state of honest and open communication which is undefined by Berne. One description that has been offered of an intimate relationship between two people is a state in which each ego-state in each person is fully available to each ego-state in the other person. The capacity for such relationships is, of course, the ultimate aim of treatment.*

4. **Scripts**

A script is a life-plan, based on decisions made prematurely under parental pressure, which sets limits upon the development of the individual and governs important aspects of his or her life, e.g. whether the person will be a success or failiure, what kind of marriage he will have, often even how long he will live.

The ingredients of the script are *injunctions* - restrictive messages from one's parents indicating the kind of person they want/expect one to be - and *decisions* taken in response to these injunctions. These decisions in turn govern one's preferred games. Injunctions are rarely given to the young person explicitly. Rather, the parent may frown or subtly express displeasure whenever the child expresses some forbidden emotion - sadness or distress, for example. Under the pressure of which a 'Don't be sad' injunction, the child makes a decision which is at that time necessary for pschological survival in that family - a decision which may remain unexamined until the person seeks therapy. Or under different circumatances, a child may come to understand that his role is to be stupid or clumsy in order to please his parents; under this 'Don't succeed' injunction, he may learn to acquire strokes and relate to others through games of the 'Kick Me' variety. For two first-class accounts of script theory, see 'What do you say After You Say Hello?' (Ernie Berne 1972) and 'Scripts People Live', (Claude Steiner 1974). The most ambitious goal of T.A. therapy is to enable the patient to give up the script and regain autonomy.

Technique

There are a wide variety of styles of T.A. therapy. Some therapists rely on a largely intellectual, analytic approach with their clients, whilst others augment the T.A. theoretical framework with a host of actionistic techniques borrowed from Gestalt, Psychodrama, Encounter and body therapies. The Gestalt 'empty chair' exercise can be adapted to explore the internal conflict between ego-states; encounter exercises can help the over-intellectual patient 'get in touch with his Child' and so on.

Distinctive T.A. exercises have been devised around the concepts of the 'stroke economy'; in the group, patients practise asking for strokes, giving them to others or refusing to give strokes when they don't want to. Other distinctive T.A. procedures have been developed around the concepts of Permission, whereby the patient is encouraged in the protected group setting to behave in ways forbidden by his own Parent programming. However, at present much therapeutic technique is borrowed from elsewhere.

T.A. therapy is normally conducted in the group setting, though individual consultation is perfectly feasible. As many theoretical points are best illustrated diagrammatically, a blackboard is very useful; so is a tape- recorder, to provide patients with instant feedback about their transactions in the group.

Applications and developments

In addition to general psychiatric problems there are four areas in which T.A. has made important contributions to treatment. These are alchololism (e.g. Steiner 1971), delinquency and criminal behaviour (Frazier 1971), mental handicap (Cheney 1970) and schizophrenia (Schiff 1970 and 1975). In this last area Jacqui Schiff and others have successfully treated a number of extremely disturbed people using regressive techniques accompanied by 're-parenting' - a wholesale replacement of the Patient's Parent ego-state.

Outside rehabilitation settings, T.A. concepts have been fruitfully applied to institutions and organisations; groups of people can thus be seen to be engaged in the same manipulative games as are individuals, and with the same unsatisfactory outcomes. (Berne 1963, Jongeward 1976).

Not only has T.A. proved its therapeutic effectiveness in a wide variety of treatment areas; it has succeeded with some patient populations usually regarded as virtually unsuitable for psychotherapy. Its therapeutic aims are highly ambitious; the achievement of autonomy, spontaneity and the capacity for intimacy, no matter how malignant the effects of past conditioning. At the same time, as a therapy system it is both straightforward and highly accessible to its clients. T.A. therapists have always opposed the mystification inherent in much traditional psychiatry and psychotherapy; they strive wherever possible to communicate their understanding and their skills to those seeking help. This egalitarian philosophy of treatment does much to explain the growing popularity of T.A. both among professionals and the general public.

Reading List

There are a number of good introductory texts: Harris' 'I'm O.K., You're O.K.' and Berne's 'What do You Say After You Say Hello?' are my preferences. The two most thorough accounts of therapy *techniques* are found in 'Transactional Analysis in Psychotherapy' and 'Principles of Group Treatment' both by Berne. The following bibliography is only a selection from a rapidly-growing literature.

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