# LUND UNIVERSITY

**Transactional Analysis Psychotherapy**

**Three Methods Describing a Transactional Analysis Group Therapy**

Johnsson, Roland

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# TRANSACTIONAL ANALYSIS PSYCHOTHERAPY

## Three Methods Describing a Transactional Analysis Group Therapy

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Department of Psychology 2011

Cover picture: I am sailing my boat Blue Pram II in the Sound (Öresund).

Photo taken by my son in law Martin Bergström in early autumn 2011.

A sailing boat symbolizes freedom. You loosen the moorings, set your sails, decide the course, and check weather and navigation and then you go where you want to go.
Jean Paul Sartre says, "Freedom is what you do with what has been done to you"
Psychotherapy is to help people get emotional and cognitive awareness about themselves so they can free themselves from their self-limiting patterns and bonds, leave their unsecure harbour and set new course in life.

# LIST OF STUDIES

This doctoral dissertation is based on the following three studies, which will be referred to in the text by their Roman numerals:

Study I    Johnsson, R. Client Assessment in Transactional Analysis – A Study of the Reliability and Validity of the Ohlsson, Björk and Johnsson Script Questionnaire. *International Journal for Transactional Analysis Research*, Vol. 2, No. 2, July 2011
Electronic version at http://www.ijtar.org/article/view/8943

Study II    Johnsson, R. Transactional Analysis as psychotherapy method – A Discourse Analytic study. *International Journal for Transactional Analysis Research*, Vol. 2, No 2, July 2011
Electronic version at http://www.ijtar.org/article/view/8942

Study III    Johnsson, R. and Stenlund, G. The affective dimension of alliance in Transactional Analysis psychotherapy, *International Journal for Transactional Analysis Research*, Vol. 1, No. 1, July 2010
Electronic version at http://www.ijtar.org/article/view/8943

## Abstract

The overall aim of the present thesis was to enhance and revive the practical understanding of the active ingredients in Transactional Analysis Psychotherapy (TA) and to define and lay down elements of TA, which makes it a distinct and replicable method of treatment.

The thesis includes three empirical studies of a videotaped one-year long TA Group Therapy with 10 clients. Three different key areas of Transactional Analysis have been investigated with support of three different approaches. These are: Diagnosis/ Client assessment with TA´s Script Analysis made as a reliability study (Study I), Identification of different components in TA´s psychotherapy method with the use of Discourse Analysis (Study II) and the Therapeutic Alliance studied with a psychodynamic approach, using the CCRT method (Luborsky, 1990, 1998) and the Plan – Diagnosis method (Weiss and Sampson, 1986) (Study III).

The average result in **Study I** shows a "moderate" reliability in analysing central conflict motives (the overall Script) in the client's life situation. More specific Script components were given a "fair" reliability, like "primary injunction from father", "racket feeling", "escape-hatch", "driver from father" and "driver from mother". Conflictual motives with fixed alternatives showed higher reliability than those formulated freely by the assessors. There was no clear stability over time.

The results in **Study II** indicate that with "certain" reliability the studied therapy contains the categories that have been identified as parts of TA psychotherapy. In ranking the seven main categories you can find "moderate" reliability for the two categories "feeling contact" and "contract". Six of the 42 sub-categories gave similar result where the techniques "talk to the parent projection" and "active use of TA terminology" has the highest value. The other four were "making feeling statements", "mutual negotiation", "refer to contract" and "discrepancy in body language". One intervention, "mutual negotiation", with moderate reliability could be identified as "TA typical"

The result in **Study III** showed, both through quantitative and qualitative analysis that the affective dimension was given larger space than you can expect from what the TA method prescribes, where contract and other rational techniques and attitudes are stressed.

# ACKNOWLEDGEMENTS

# CONTENTS

# INTRODUCTION

Transactional Analysis Psychotherapy (TA) is an integrative, relational, psychodynamic therapy grounded in humanistic psychology. TA is described in the International Transactional Analysis Association, ITAA´s training and examinations handbook (ITAA website, 2011) as "a theory of human personality, a theory of social behaviour, and a comprehensive system of psychotherapy".

TA was introduced in the late 1950´s by the Canadian/American psychiatrist Eric Berne (1910 – 1970), who founded the basic ideas of the theory and method. From Berne's conceptualisation and form of therapy, TA has developed and changed in different directions. One direction is the Redecision Therapy, created by Bob and Mary Goulding (1976, 1979). The one-year long Transactional Analysis group therapy studied in this dissertation has its main reference in this with Gestalt Therapy (Perl's, 1969, 1973) integrated form.

Three different parts of Transactional Analysis have been investigated with support of three different approaches. These are:

Diagnosis/ Client assessment with TA´s Script Analysis as a reliability study (Study I), Identification of different components in TA´s psychotherapy method with Discourse Analysis (Study II) and Study III investigating the therapeutic alliance with a psychodynamic approach, the CCRT method (Luborsky, 1990, 1998) and the Plan – Diagnosis method according to Weiss and Sampson (1986)

The overall aim has been, based in TA´s theoretical concepts, to increase and renew the practical understanding of the active ingredients of TA. Additionally to define and establish elements in TA that makes it a distinct and replicable treatment method.

## TA´s theory, method and history.

### An overview.

From his clinical experiences Eric Berne (1953, 1954, 1955, 1957, 1958, 1961,1963, 1964, 1966, 1970, 1972) step by step created a coherent theory and systematic psychotherapy that generally can be described with the following analytical models (TA concepts will be written with initial capital letter):

1. A *personality model* named Structural Analysis, which starts from the dynamics between three different states in the ego (Ego states). The analysis describes normal changes and psychopathological problems (Contamination and Exclusion) in the inner dialogue between the Ego states.

2. A *communication model* that Berne called Transactional Analysis Proper. From the Ego state theory the social psychological interaction between the individuals is

analysed in the form of different types of social exchanges (Transactions) and the individuals motivating forces (Hungers) in the form of social recognition (Strokes) and social time structuring (Time Structure).

3.  A relational *game model,* where Berne (1964) described negative childhood related interactional patterns that repeat themselves in current relations (Games) with accompanying bad feelings (Racket feelings).

4.  A *script model* (Script Analysis), where Berne (1970) describes a historical analysis of unconscious patterns that develops in the child's early interaction with the parents. The child's life plan or survival decision (Early Decision) is based on the parent's different verbal and non-verbal messages (Counter-injunctions, Drivers, Injunctions, Program).

All four TA analyses, which were influenced from different psychoanalytic approaches and predecessors, were designed by Berne to construct a coherent theory and therapy. Besides the work from Freud he has references in the ego psychology (Federn, 1953; Weiss, 1950) and the object-relational theory (Fairbairn, 1952; Sullivan, 1953; Klein, 1959). His ambition was to unite an intrapsychic perspective with an inter-personal.

His emphasis of what was useful for the client and the therapist gave the therapy a tendency of pragmatism with an interest of the observable and immediately experienced (phenomenological). Berne meant that the urges were difficult to change, but the manner they appeared in could be controlled by the ego. The theory followed an eclectic approach where therapeutic challenges, techniques and interventions took precedence over theoretical clarity and consequence.

> He was a doctor and pragmatist, and he prided himself on taking a scientific approach. He was no doubt influenced also by the growth of cognitive behavioural methods in the U.S. at the time, methods that stressed the factual and the observable. (Hargaden & Sills, 2003)

Berne's action-oriented and rational approach was supplemented with values and cultural influences from after-war U.S. An optimistic belief in the individual with references in humanistic principles and humanistic psychotherapy (Johnsson & Ohlsson, 1974, 1977), where change, growth and health stood for a force, *physis* (Berne, 1964) that could be a counterforce to pathology. The clients unique experience was protected in the therapeutic relationship built on mutual trust and responsibility.

With a concrete, illustrative and lively everyday language Berne described, with assistance of pedagogical diagrams, the human psychology in terms that were attractive for the public. TA had a boom in the 60 – 70´s and different TA books, as Berne's *Games People Play* from 1964, were sold in many million copies. The strength of TA´s multidimensional, accessible and useful theory, retrospectively, also became a trap. The risk of simplification and stagna-

tion came true and TA´s reputation was diminished, especially in the academic world. Ian Stewart described this phenomenon as TA´s "frozen image" (1992, p. 121).

TA literature after Berne's death 1970 has been extensive and many new developing directions and schools have been presented, where their theories were integrated with other directions. Besides through books, most of the material has been published as articles in ITAA´s since 1971 released, *Transactional Analysis Journal (TAJ)*. TA´s mixture of literature with self-help character and scientific depth has been confusing. Prochaska and Norcross (2010) have pointed out, that concepts and experiences from the clinical work have been transferred to scientific evidence too easily before their validity has been scientifically tested. They also think that an everyday language is an obstacle when it comes to producing a theory with depth.

Because of this, many TA practitioners during the 2000´s have had the ambition to combine scientific consistency and depth with simplicity and clarity in theory and practice. One of the consequences is the, in 2010, started Internet based scientific journal for research, *the International Journal of Transactional Analysis Research* (www.ijtar.org).

For a complete overview of the TA theory and practice the *Transactional Analysis in Psychotherapy* by Berne (1961) and the Swedish book (also available in Chinese) *Transaktionsanalytisk Psykoterapi* (Ohlsson, Björk & Johnsson, 1992) is recommended. An additional reference is Prochaska and Norcross (2010) scientific review of TA in *Systems of Psychotherapy – A Transtheoretical Analysis.*

The theoretical focus in this dissertation is mainly connected to the TA concept Script. The concept comes last in Berne's theoretical construct, so to get a coherent understanding, a short introduction is given of the other concepts Ego states, Transactions and Games. Furthermore TA is described as a treatment method, especially the direction called Redecision Therapy.

## Ego states

Eric Berne developed TA as an alternative to psychoanalytic theory and psychotherapy. He created the ideas from his interest of the concept intuition. Instead of psychiatric diagnosis he started to use his discoveries about intuition in his psychotherapeutic work. Steiner, an early practitioner in the circuit around Berne, writes:

> For instance, a man whom he would have diagnosed as a "severe latent homosexual" was seen by Berne's intuition as a man who felt "as though he were a young child standing naked and sexually excited before a group of his elders, blushing furiously and writing with almost unbearable embarrassment" He called this latter description of the man an "ego image" (Berne 1957, s. 611-627), that is, the therapist's intuitive image of the person which in some way describes his ego (1974, p.11)

Berne wrote a series of six articles from 1949 to 1962 (Berne, 1977), which ended up with the idea of three Ego states (Fig.1a + 1b). These three observable ego functions, which he

called Parent, Adult and Child, became the foundation on which he built the TA theory. On an international group therapy conference 1968 he said:

> […] First of all, ego states are the key to Transactional Analysis, if you can´t break it down to ego states, it is not Transactional Analysis, and this distinction is well worth making. […](1973, p.71)

Berne defined Ego states as "coherent systems of thought and feeling manifested by corresponding patterns of behaviour" (1972, p. 11).

He had found the concept from his own educational analyst Paul Federn (1953), who in turn was a pupil of Freud. Federn looked at ego states as a wholeness of a person's mental and bodily experience of himself and the surroundings caught in every moment. Numerous such previously experienced archaic ego states were stored in memory as entities and formed a large part of the individual's psychic structure.

Federn suggested, in contrast to Freud and contemporary psychoanalysts (Hartman, Kris and Rappaport), that the ego and the different states of the ego were real emotional experiences, specific and limited, and not just theoretical constructs. This view of ego states was similar to what Berne called "Ego Image". He wrote the "ego's image is an image of the patient´s Ego state" (Berne 1957, p.103). Berne developed the concept's usefulness by highlighting two important aspects namely:

1. There are three groupings of Ego states, Parent, Adult and Child, in all individuals
2. It is possible to make conclusions about internal processes by directly observable behaviour of the client.

Using a clinical example of lawyer Segundo, "the cowpoke story", Berne showed that Ego states includes four different dimensions. These can be used as a diagnosis of the Ego states and forms the basis for the original validation criteria of the Ego state model. The dimensions are the phenomenological, historical, behavioural and social.

> An eight-year-old boy, vacationing at a ranch in his cowboy suit, helped the hired man unsaddle a horse. When they finished, the hired man said: "Thanks cowpoke!" To which his assistant answered: "I'm not really a cowpoke, I'm just a little boy". That's the way I feel. Sometimes I feel that I'm not really a lawyer, I'm just a little boy (Berne, 1961).

Segundo describes two conscious aspects of his personality, the adult rational lawyer and the little boy. During the therapy process these states were examined in depth, leading to an additional part of the personality, which was under strong influence from Segundos parents. Segundo connects the past Ego states Child and Parent to the current reality and separates them from his functioning in the here-and-now (Adult). Because these conditions are clearly observable, it will be possible to draw conclusions about his internal mental processes.

The phenomenological dimension is clear when he says: "Sometimes I feel that I'm not really a lawyer, I'm just a little boy". This is his inner experience. The historical dimension is expressed when he remembers the scene from when he is 8 years old. Berne´s observation of how he or others were influenced to answer the "adult lawyer" or the "little boy" displays the social dimension. The behavioural dimension was shown by the different ways that the primitive child and the mature adult were expressed through tone of voice, body posture, choice of words and gestures.

Berne describes Ego states both from structural and functional aspects, but expresses a clear interest to emphasize the manifest and observable functioning. The three Ego states differs from Freud's structural model on three points:

1) They are not hypothetical abstracts but observable and identifiable in the different patterns of behaviour.

2) They are not general but individual notions of personal development and history.

3) Finally, they are not considered static but possible to change.

Berne's structural analysis (Fig. 1) was classified into three systems:

1. That which originates from parent figures, in everyday language called Parent. In this state, one feels, thinks and behaves in a similar way as parents or other significant parent figures did when you were little.

2. When a person's behaviour, thoughts and feelings are neither re-plays from childhood or borrowed copies from parent figures, but are direct, appropriate responses to the current reality, they are manifested as Adult.

3. Finally, each individual carries with him the relics of childhood where he feels, thinks and acts the same way as he did as a child of a certain age. This condition is called Child.

Berne described coherent systems, from which you could draw conclusions about the individual's internal mental processes from the observed Ego states. The expressions "to be in his Child-ego state" or only Child (Fig. 1a), abbreviated to C (Fig. 1b) are concise, useful clinical metaphors rather than theoretically correct names. They can thus be understood as reifications instead of names on coherent dynamical systems. Berne (1961) claims that the Parent, Adult and Child are "phenomenological realities" (p. 24) but not that the model and its diagram are real.

Berne´s further breakdown of the Child Ego state in the subsystems (Fig. 1c) had object relational theory references (Fairbairn, 1952, Bowlby, 1969). He shared the view that the need and importance of interactions in early relationships formed structures, Ego states, which affected important relationships in later life. In Berne´s second-order structural model the structural aspect is emphasized where the individual's emotional experiences and memories are classified and systematized in content order. The model provides a historical explanation and a deeper understanding of the individual's personal development.

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a) Structural
diagram of the
personality

b) Informal
structural
diagram

c) Second order
structural
diagram
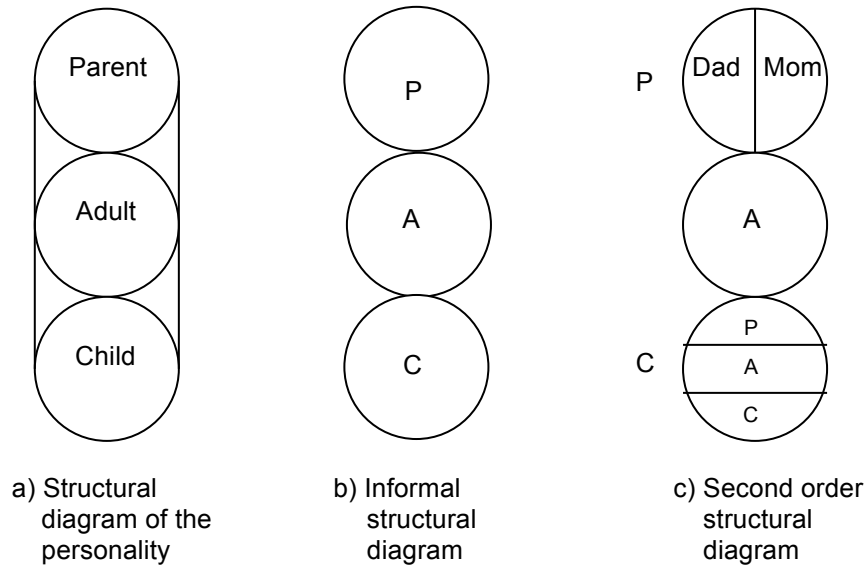
*Figure 1*. Berne´s (1972) different structural diagrams of the Ego states

With emphasis on the functional aspect Berne created a model called Functional Analysis (Berne, 1963). Ego states are described in five different behavioural functions. In addition to the Adult expression The Parent can be controlling (CP) and nurturing (NP) and the Child adapted (AC) and free (FC).

Adult was given a special place in Berne´s therapy model, called the classical school. The therapist invites the client to more effectively use and strengthen his Adult to become an autonomous person, freed from negative childhood-related survival patterns, Script. Such pathological influence of Parent and Child as "overlapping" Adult is described in TA as a Contamination. Sometimes Ego state problems can be described as Exclusion of an Ego state. A good dynamic in which the individual has access to all of his Ego states is regarded as a good state of health. The therapy method focuses on decision based behavioural changes in the now rather than insight. Personal change is achieved by the completion of the, between client and therapist, mutually agreed treatment contract. The contract is central in TA and the method can therefore be described briefly as a contractual therapy.

## Transactional Analysis Proper

The transaction analytical diagram ((Fig. 2) illustrates the essence of Berne´s socialpsychological therapy theory. The transaction brings together the intrapsychic processes, the Ego states, with the interpersonal exchange, a major integration, which gave name to the whole method. Transactions are about the individual's different ways to exchange recognition with others. Social recognition, which Berne (1964) called Strokes, is a basic human need for mutual confirmation (recognition hunger), which can be expressed in various positive, negative, verbal, nonverbal, conditional and unconditional forms of attention. Berne described this interpersonal activity as "a unit of recognition" (p.15). The underlying idea of mental and physical stimulation, Stimulus hunger, as the basis for normal and healthy psychological development in all mammals, Berne had adopted from Spitz (1945), Harlow and Zimmerman

(1959) Bowlby (1958) and Eriksson (1963). This motivating factor was complemented by the individuals need for structure, which Berne named Structure hunger.
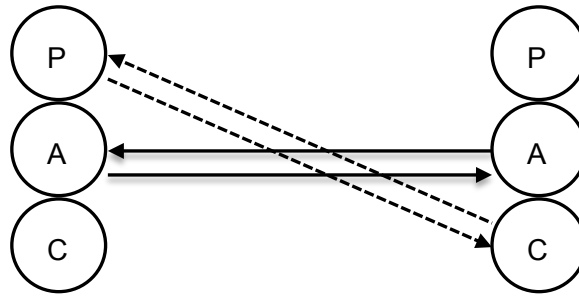


*Figure 2*. An ulterior transaction according to Berne (1961)

*Note*. The fully dashed arrows are the social open message,
while the dotted arrows are the psychological hidden message.

TA describes three types of transactions: Complementary, Crossed and Ulterior. These exchanges, or "units of social intercourse" (Berne, 1961), all consists of a transactional stimulus from a person followed by a transactional response from the other. The communication expressed in a series of these operations can lead to positive and / or negative recognition. Based on the human need to structure time, these exchanges of recognition can be connected to a special context. Berne mentioned Withdrawal, Rituals, Pastime, Activities, Games and Intimacy as linked to various recognition-intensive levels of social interaction.

The Ulterior transaction is the most complex, as two messages are exchanged simultaneously, where one message is open (social level) and one is hidden (psychological level). When the levels are incongruent, it can lead to confusion and bad feelings in the interaction. This relationship pattern in TA is called a Game.

## Game Analysis

Berne (1964) described Games as "an on-going series of complementary ulterior transactions, progressing to a well-defined, predictable outcome". In a final definition Berne (1972) adds "repetitive in nature" (p. 122). He had a turnover of Freud's concept of repetition compulsion and described how numerous repeatable transactional sequences later confirms, deepens and strengthens the individual's childhood patterns, the Script, The main purpose is to satisfy the need of recognition, even if the outcome (payoff) leads to negative feelings. The Game sequence could be expressed in a formula according to Berne (1972), named the Formula G (Fig. 4).

Con + Gimmick = Response $\longrightarrow$ Switch $\longrightarrow$ Cross-up $\longrightarrow$ Payoff
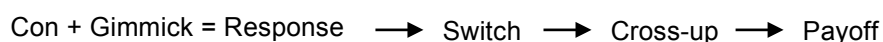
*Figure.4.* Berne´s Formula G (1972).

In Games People Play Berne (1964) describes 36 different game variations, that he gives witty and descriptive names, such as "Kick Me", "Now I´ve Got You, You Son of a Bitch", "I´m Only Trying to Help You". These have a high recognition factor, but a limited value in clinical diagnostic work, as they contain a huge number of specific details.

The dramatic meaning of Game theory was clarified by S. Karpman's introduction of the Drama Triangle (1968), where the Switch of the three drama positions Persecutor, Rescuer, Victim became an essential part of the Game's dynamics. A person's primary position in the various Games has become a way to generally diagnose that person's Game.

The negative feelings in the Game's pay-off may often be the individual's Racket feelings. Holloway (1973, p.32) says, "The aim of the game is mainly in the pain". He expresses Berne´s (1964) and Steiners (1971) view, that the main motivation for playing is to ensure the emotional sickness benefits. Berne talked early about how in Games and Scripts you express bad feelings known as Racket feelings, and how to aggregate these feelings known as Trading Stamps. These bad feelings are learned in early childhood and are used for manipulative and exploitative purposes says Berne (1966, s.127). He suggests that there is a quality of emotional expression, which is not authentic. English (1971) underlined this. She writes that behind every Racket feeling there is a genuine feeling (Real feeling) that a person will not allow himself to feel because it was forbidden in his childhood. Racket feelings are therefore "substitute feelings" of the genuine ones. They are considered stereotypical, repetitive, and learned in their expressions compared with the liberating, communicative and adequate expressions of the Real feelings.

A similar reasoning can be found with the originator of the affect theory, Tomkins (1995a). He assumes the nine biologically innate affects are the foundation of our motivation for survival. When the baby is communicating often infectious, intense and intrusive affects to his surroundings, the parents take it upon themselves to modulate it to an "acceptable" level (Nathanson, 1992). The child may, according to Tomkins (1995 a), by his will (*voluntary response*) change its natural and innate affective expression to modify, withheld, or opposite forms of "backed-up affects". The difference is that Tomkins (1995 b) talks about affects, which he differs from the emotions and feelings. He writes, "Whereas affect is biology, emotion is biography". Emotions and feelings are tied to historical development and are linked to the individual's unique thoughts and memories. This organization of emotional experiences, integrated with cognitive and symbolic levels, is also named script by Tomkins (1978).

Although the Racket feelings are often associated with the pay-off in the interpersonal Games, you can see them as an expression of an internal psychological process associated with the Script. It was this system Berne called "Racket" and that was further developed by Erskine & Zalcman (1979) to the so-called Racket system. Racket feelings are seen here as one of the rackety displays. Together with rackety thoughts and actions the behaviours of an interconnected, self-sufficient and distorted system of Script belief and reinforcing memories

is kept. This system shows how a person stays in his Script and is consequently, in a later version of Erskine and Moursund (1988), called the Script System.

## Script Analysis

Client Assessment or diagnosis is mainly based on TA's conceptual world in which, besides Ego states, Games and Script theory has a central place. The Script was defined by Berne (1972) as: "A life plan based on a decision made in childhood, reinforced by parents, justified by subsequent events, and culminating in the chosen alternative" (p. 445).

In the early stages of Transaction Analysis development, Eric Berne considered Script theory as central in TA theory building. "The ultimate goal of Transactional Analysis is the analysis of scripts, since the script determines the destiny and identity of the individual" (Berne, 1958, p. 57). Scripts were defined in relation to the Freudian concept of transference. The client's early unmet needs for care were transferred, re-established and directed against the therapist. Berne was also influenced by Freud's ideas about repetition compulsion and destiny compulsion, and the importance of how early traumatic experiences affects an individual's adult life. He writes:

> A script is an attempt to repeat in derivative form not a transference reaction or a transference situation but a transference drama, often split up into acts, exactly like the theatrical scripts which are intuitive artistic derivate of these primal dramas of childhood. Operationally, a script is a complex set of transactions, by nature recurrent, but not necessarily recurring, since a complete performance may require a whole lifetime (Berne, 1958, p.102).

Berne (1961) highlights how scenes and experiences from early family drama are played out in everyday life in a specific and concrete way that is similar to dramaturgy in a theatre. There is in the individual's life a prologue, a climax and an end just like in a script for a play. The current life drama can be traced to an original dramatic experience, an original manuscript, and the protocol, written by the individual in early childhood.

The reasoning is linked to psychoanalytic approach to neurosis as an intrapsychic conflict (Fenichel, 1945, Haak, 1982). The child gets into conflict with the environment when it is frustrated in getting its drives and needs satisfied. The conflict is pushed away, becomes unconscious and is fixed in terms of needs to the time of the conflict. When the individual later in life, in times of crisis, wants to regain his inner balance he regresses to the fixation point. The ego resolves the conflict by creating a symbolic designed compromise formation, the neurotic symptom. This is the solution Berne termed Early Decision, which is the basis of the Script formation. He sums up as follows:

> In script analysis, the household drama, which is first played out to an unsatisfactory conclusion in the earliest years of life, is called the *Protocol*. This is classically an archaic version of the Oedipus drama and is repressed in later years. Its precipitates re-appear as the *Script proper*, which is a preconscious derivative of the protocol. In any given social

situation, however, the script proper must be compromised in accordance with the possible realities. This compromise is technically called the *adaptation*, and the adaptation is what the patient actually tries to play out in the real life by the manipulation of the people around him. In practice protocol, script proper and adaptation are all subsumed under the term "script". (Berne, 1961, s. 118).

According to the theory, the individual will search for people who more or less fulfil the various roles that match the Script. Intuitively the individual selects who will be "playing" mother, father and / or any of the siblings. He also tries to encourage them to give replicas and responses that fit into the role. Berne (1961) argued that therapy's task was to liberate the individual from the compulsion to repeat reliving of the early script-bound scenes and thus start a new independently chosen way in life.

He understood the value of the theory in therapeutic change, but also the difficulty for clients to make Script changes. In spite of the TA-therapy´s here and-now orientation, he considered, that the underlying Script had a dominant influence on human social interaction. Behaviour in the present, "Transactional disturbances" (Steiner, 1971, p. 158) was the apparent result of the early Script's impact on the individual.

Various forms of clarification, "therapeutic operations" (Berne, 1963, p.167), played an important role to adapt the client to reality. Berne called this procedure Decontamination of Ego states to strengthen the Adult. The therapist's task was to confront the clients Script and invite the client directly in the moment to be independent from the influence of The Script (Script Cure). Techniques used were a sense of humour, imagination, fun, creative exercises, positive stroking, the use of TA-specific vocabulary and permissive, protective and powerful operations, "permission transactions" (Crossman, 1966). Berne's technique and approach was pragmatic and reminds to some extent of some aspects of cognitive behavioural therapy (CBT). He gave his clients clear and concise information about Ego states, Transactions, Games and Scripts, facilitated conscious understanding and invited to clients own responsibility to change.

He described the early Script, the protocol, as an unconscious life plan, but regarded the later variants, palimpsest (Berne, 1963, p.167), as preconscious. Although he basically defined Script as an "unconscious life plan" (Berne, 1966, p. 300), he was not interested in therapies with long processing of transference and counter-transference in order to raise the awareness of unconscious material. His Adult-oriented rational approach was questioned by some of his followers (Goulding and Goulding, 1976, 1979; Moiso, 1985; Novellino, 1984, Erskine, 1991; Clarkson, 1992; Cornell, 2000; Hargaden & Sills, 2002;). The earliest critics were Goulding and Goulding (1976, 1979) who developed the TA-school called Redecision therapy. They were influenced by humanistic psychotherapy and especially the Gestalt therapy's emphasis on emotional contact and expressions in therapy (Perls, 1969, 1973). They argued that a fundamental change of the Script can be achieved only if you make change work in the Child, something they called Redecision. They developed in accordance with this a short-term oriented psycho-dramatic technique, with "Double-chair work", where they in the now staged and helped the client to re-experience and find new solutions and decisions to

early scenes.

They emphasized the client's emotional anchor in the therapy work through those "contracted regressions," but minimized the "direct regression" in the transference process. The other critics wanted to return to a psychoanalytic approach in which the unconscious and the transference relation got a renaissance in therapy.

It took about 10 years before Berne had developed the knowledge of Script. The in-depth knowledge he obtained, according to Steiner (1976, p.123), came more from his individual therapeutic work than from his work in groups. Berne (1961) writes: "Since the scripts are so complex and full of idiosyncrasy, however, it is not possible to do adequate script analysis in group therapy alone, and it remained to find an opportunity in her individual sessions to elucidate what have been learned so far" (p.120).

His new thinking about Script was published in 1972, two years after his death, in the book *What Do You Say After You Say Hello?* Berne then defined the Script as "an on-going program, developed in early childhood under parental influence, which directs the individuals behaviour in the most important aspects of his life" (p.418). The terminology of the definition is according to him as follows:

- On-going = to irrevocably and continually move forward on a one-way road to death.
- Program = an action plan, a schedule, a "project" to be followed.
- Parental Influence = a real exchange with parents, where the influence is imposed in a specific observable way at a specific time.
- Direct = directives that must be followed and that may mean to adapt well or to revolt.
- Important Aspects = important events as marriage, child rearing, divorce and death.

In the 70's the interest in Script was strong and a large number of books and articles on the subject were published. Claude Steiner's diagram of the Script matrix (1966, p.133-135) based on Berne's concept was of great importance.
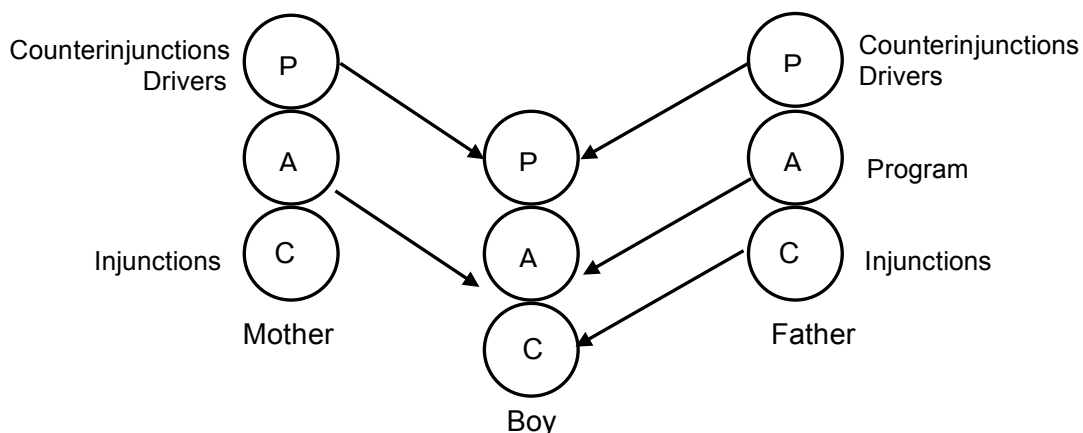


*Figure 3.* A Script matrix according to Steiner (1966)

Steiner's Script matrix (Fig. 3) is a diagram that describes different Script components and illustrates how the child is influenced by parents' different script messages. He named the messages Injunction, Counterinjunctions, Drivers and Program. The messages come from the parents Ego states Parent (P), Adult (A) and Child (C) and are directed to the Ego states in the child.

### Injunctions.

Injunctions represent underlying unprocessed psychological material, in the parent. These have been formulated and sent as limiting, negative, non-verbal, ulterior messages from the Child in the parent and received in the Child by the child in early childhood. These messages are considered most essential for creating the actual Script (Script proper) and in causing varying degrees of pathology.

Goulding and Goulding (1976) formulated the 12 most common injunctions expressed in practical, general terms. These were: 1. Don't exist, 2. Don't be you, 3. Don't be a child, 4. Don't grow, 5. Don't make it, 6. Don't, 7. Don't be important, 8. Don't belong, 9. Don't be close, 10. Don't be well/sane, 11. Don't feel and 12. Don't think.

### Counterinjunctions and Drivers.

The behaviours that the individual defensively build up against the Injunctions and the actual impact of the Script are called Counterscript. These are important in how the Script is lived out, as they rely on the child's perception of what gives recognition and love from his parents. The child bases his position on the moral messages and mottos, as shown in Figure 3, which are transmitted from parents Parent ($P_2$) and received in the child's Parent ($P_1$). These Counter injunctions, given in later childhood are mostly verbal, involving both constructive regulations, prescriptions, on how to survive in the world in a positive way and inappropriate messages that are associated with a Driver.

A Driver is based on the child's perception of what creates conditional recognition. This is an observable behaviour that is expressed as a way of dealing with the internal stress created by the injunctions. Kahler and Capers (1974) identified five common Drivers. These are: Be Strong, Be Perfect, Please others, Try hard and Hurry up.

### Program.

Adult-to-Adult message, the program shows how the child should behave in order to fulfil the Script. Usually, the program comes from the parent of the same sex as the child.

### Other Script matrixes.

Steiner's stripped matrix emphasizes the functional clinical usefulness. You can fill in the client's messages directly in the matrix. Other diagrams are constructed by Berne (1966, p.171), Goulding and Goulding (1979) and Woollams and Brown (1978). Woollams and Brown (1978) clarified the developmental psychological aspect, where early forms of the Ego states ($P_1$, $A_1$ and $C_1$) were put against later forms $P_2$, $A_2$ and $C_2$.
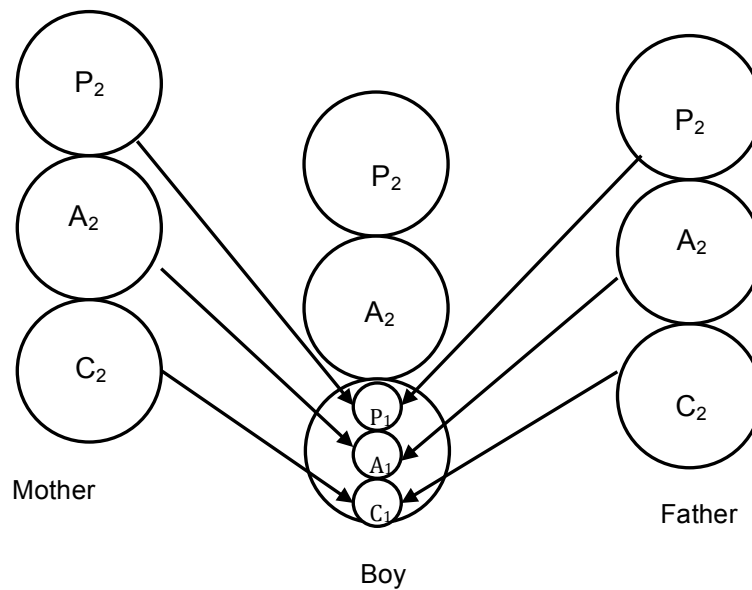
*Figure 4*. A Script matrix according to Woollams and Brown (1978)

These structural models clearly expresses the view that the essence of the Script formation occurs in Child ego state which is also shown in their Script matrix (Fig. 4). Berne (1972) earlier had described the contents of a similar diagram in the following clarifying way:

> The most important principle of script theory could then be stated as follows: "The parents Child forms the child's Parent" or "The child´s Parent is the parent´s Child". This should be easy to understand with the aid of a diagram, remembering that the "Child" and "Parent" with capital letters refer to Ego states in the head, while "parent" with a small "p" and "child" with a small "c" refer to actual people (p.180).

Following an idea by Karpman (1966) Steiner supplemented his visual matrix with a form, in which other scripting components were listed, known as a Script checklist (1967, p. 38-39). This was a development of Berne's thinking about the Script Apparatus (1972, pp.107-109), containing seven different aspects of the script. In addition to the three components in the matrix, Steiner added six more components (Table 1).

> Because of the various meanings given to the word "script", it is suggested that "script" properly *refers to all of the items in this checklist* (my italics) and that ideally, when talking about a persons script, the observer is referring to the whole checklist rather than to one or a few of the items (Steiner, 1967, p.38).

In the table, besides Berne's and Steiner's Script checklist, a list of Ohlsson, Björk and Johnsson (1992) is also described containing eight different script components. This Script Analysis has been the starting point for the client assessment in Study I.

## *Early Decision.*

Injunctions, Counterinjunctions and Drivers are regarded as primary concepts in Script Analysis. Another core concept is the Early Decision. Generally the Script is seen as a life plan or a scenario in which each individual is based when he shapes his life. It is mostly unconscious and has evolved in the interaction between parents and children in the individual's childhood. The Script matrix clearly shows the importance of the parents' messages to the child, but not the child's receiving part in the process. The Script is an unconscious pattern of life, which is "based on early decision", says Berne. He believes that this early decision about ourselves, others and reality forms the basis for the formation of the Script.

"The Decision" is taken in early childhood with its limitations in mental and emotional functions and reality testing, but despite this vulnerability, always from the child's optimal creative ability. The aim is to survive and get basic needs met. In line with Freud, Berne considered that the forming of personality took place at 5-7 years of age, in contrast to M. Klein (1975) and D. Stern (2000), who think that it happens during the first year.

Transactional analysis is rooted in humanistic and existential humanistic psychology (Rogers, 1961; Buber, 1958; Maslow, 1968; Perls, 1969, 1973; Sartre, 1971; May, 1983) a treatment philosophical approach, which is entitled "the Responsibility Model" by Johnsson & Ohlsson (1974,1977). It emphasizes man's responsibility for his life and his ability to move from the non-functioning early decision to make a Redecision. A Redecision on an emotional and intellectual level is considered by Goulding and Goulding (1979) to be the basis for personal change work in TA therapy.

Table 1. *A comparison between different Script checklists*.

| Script components | Berne (1972) | Steiner (1975) | Ohlsson, Björk and Johnsson (1991) |
| Swedish terminology | Script Apparatus | Script Check List | Script Analysis form |
| | Own terminology | Own terminology | Own terminology |
| --- | --- | --- | --- |
| Påbud | Prescription Counterscript slogans | Counterscript Counterinjunction | Påbud |
| Pådrivare | Prescription Counterscript slogans | Counteriscript Counterinjunction | Pådrivare |
| Förbud | Injunction Stopper | Injunction Attribution | Förbud |
| Tidiga Beslut | Script Decision | Decision | Tidiga Beslut |
| Program | Parental Pattern | Program | - |
| Favoritkänsla/ genuina känslor | - | Racket | Favoritkänsla/ genuina känslor |
| Spel | - | Game | Spel (Dramatriangeln) |
| Livsposition | - | Position | Livsposition |
| Skriptutdelning | Script Payoff | Tragical Ending | Destruktiv flyktväg |
| Destruktiv flyktväg | Curse | | |
| Demonen Antiskript | Demon | - | - |
| Livskurs | - | Life Course | - |
| Tidsfördriv | - | Pastime | - |
| Utdelning | - | Payoff (Stamp Sweatshirt, Racket) | - |
| Psykosomatik | - | Somatic Component | - |
| Terapeutens roll | - | Therapist's role | - |
| Hjältefigur | - | Mythical Hero | - |
| Inre Befrielse | Internal Release | - | - |
| Provokation | Come-On | - | - |
| Förförelse | Seduction | - | - |
| Tillåtelse | Permission | - | - |
| Antites | - | Antithesis | - |

19

### Life position.

Life position is the basic existential view, which the infant (0-2 years), has obtained about his and others' value. There are four approaches: I'm OK - You're OK, I'm not OK - You're OK, I'm OK - You're not OK and I'm not OK - You're not OK. Berne (1972) argues that these positions are universal, and that although a person may have traits of all of them, there is usually a dominant position. The first position leads to a life-affirming Script (Winner Script), while the other three involve a life-denying Script (Non-Winner and Looser Script). A winner is defined as a person who fulfils his contract with the world and with himself. That is, he sets out to do something, says that he is committed to doing it, and in the long run does it (Berne, 1972, p. 204).

### Escape Hatch.

A Looser Script is a Script where the Script payoff in the final scene is painful and destructive. The individual feels that he failed to do what he was committed to do in life. A tragic harmatic Script leads to death, mental and physical illness or criminality. The pay-off in a Non-winning script is neither gain nor loss. Holloway (1973), based on the three negative Life positions, said that when the situation becomes unbearable for one individual, there is a possibility that he chooses to flee, either, by killing himself (I $^-$ - You $^+$), kill the other (I $^+$ - you $^-$) or going crazy (I$^-$- you$^-$). These ways out, he called Escape Hatches. In TA psychotherapy it is considered important to shut these ways down. Goulding & Goulding (1979) developed a procedure with protection contracts to help the client to gain social control over these impulses.

### Script questionnaire.

There are many ways to determine a person's Script. Berne (1972, p. 315-348) writes about various signs of the Script that indicates that a person is in his Script. It can manifest itself in characteristic breathing sounds, choice of words, laughter, physical symptoms, fantasies and stories in response to direct questions. The therapist's ability to switch between different levels, like verbal and nonverbal, thought and feeling and observation and intuition, forms the basis of a good client assessment. As a basis for diagnosing the Script's various aspects, a Script questionnaire was developed. The Scripts questionnaire consisted of a number of questions that were designed to obtain specific information. Berne (1972, pp. 425-439) included 220 questions in his form while other authors such as James, (1977, pp. 84-85), McCormick, (1971) and Holloway (1973) constructed forms with a smaller number of questions. In the study (Study I) a reduced form by Ohlsson, Björk and Johnson (1992) is used.

### Comparison with other scripts theories.

The similarities are significant between the cognitive theory's concept Schema (Perris, 1996), Sterns (2000) concept RIG's (Representations of Interactions that have been Generalized) and Tomkins (1978) script concepts. They all concern individual-specific structures and patterns formed in childhood, which then, for better or worse, guided the individual through life. One

difference is that Perris emphasizes cognition, while Berne, Stern and Tomkins underlines the emotional interplay in early relationships and the ability to create and develop an internal object world.

Tomkins, like Berne, uses concepts and metaphors from the theatre. According to Tomkins, emotions are organized on two levels, as scenes and as script. The scene is the basal unit, where the feeling is tied to an object (person) or a theme and to an event with a start and an end. The script refers to the guiding principles (rules) for how the scenes are organized and thus how specific emotions or emotional experiences are predicted, interpreted and verified. Similar to TA theory, scripts can be appropriate winning scripts or destructive loosing scripts. The innate nuclear script has a tragic connection while the latter script structures can be healthy and / or personally limiting.

The practical, content-related and emotionally charged scenes are gradually transferred into abstract, generalized and non-context-bound schemas, scripts, which affect the individual's ability to cope with future similar scenes. This unconscious influence in people's lives can be compared with TA's description of the script. The difference is that the actual scenes may be more important in TA's script definition, and the more abstract framework dominates in Tomkins definition. In psychotherapeutic practice Berne's definition means that the direction in therapy and client change responsibilities becomes clearer, while Tomkins focuses on awareness and change of the elusive negatively regulated sequences of feelings.

## Treatment

### *Treatment Philosophy.*

The interest in the Transactional Analysis approach has partly focused on its core values in the humanistic-existential and phenomenological traditions.

Berne's psychodynamic therapy is primarily influenced by the ego psychology, but is very similar to the basical view of man in the humanistic psychotherapy. Johnsson and Ohlsson´s (1977) comparison of TA and the "Responsibility Model" points to the following similarities.

1. The emphasis on positive social recognition (Strokes) and unconditional regard (I'm OK You're OK) as the basic needs of human's psychological development.

2. An emphasis on change through personal responsibility, decision-making and wilful actions, which are established in the contract-oriented therapeutic relationship and in the therapy´s focus on freedom (Autonomy) and experiential challenges in the here-and-now.

### *Treatment goals.*

Berne stressed that psychotherapy should not be only about gaining insight and making progress without curing people. Today Transactional Analysts connect "cure" to completing the treatment contract and describes the goal in terms of change. The contracts are initially mostly focused on the social control of dysfunctional behaviours and changes over time to autonomy in relation to the Script. Berne (1961, 1972) originally classified curing the client

based to four different progressive levels:

1. *Social control:* The client's first step to recovery was to control the dysfunctional behaviour in a social context even if he still felt bad about his problems.
2. *Symptomatic relief:* The next step was not only to control his behaviour, but also to feel relief of confusion and anxiety.
3. *Transference cure*: In this step, the client can free himself from his script as long as he has the therapist as support in his consciousness. He uses the therapist as a supportive Parent ego state.
4. *Script cure:* Finally, the client owns his integrated Adult, who can take over the internalized therapist from the transference cure. He can now permanently move away from the Script and improve the skilled and personally responsible person that can feel, think and act autonomously in relation to the current reality.

## *Treatment Contract.*

If you want to describe the TA method with one word, it would be "contract therapy". Therapy work is done on the basis of mutually agreed upon contracts to achieve specific goals. The contract describes an approach between client and therapist where the approach and success in therapy is linked to how well their working alliance functions. Berne (1966, p. 362) defined the contract as "an explicit bilateral commitment to a well defined course of action" and suggested three types of contracts related to various aspects of the therapy: administrative, professional and psychological contracts.

The administrative contract deals with practical elements such as time, frequency, payment, and confidentiality. Its function is to provide a clear structuring of the therapy that clarifies therapy options and limitations. The professional contract defines the goal of therapy and the means to get a positive result. The contract process rests on an approach between client and therapist, where the equal dignity and responsibility are key ingredients. Clients will contract with himself in negotiations with the therapist, who acts as a helping resource and witness for the client to set realistic goals and reach success in achieving them. The contracts are negotiable and are changing as the achievements of various levels of treatment goals are completed. The psychological contract deals with the unspoken and unconscious expectations of the bond that arises in the therapeutic relationship. Awareness of this "affective dimension" of the contract (Bordin, 1979) is necessary to obtain consistency with the other two "rational dimensions" of the contract. Berne (1961) suggested that the therapeutic outcome was depending on the implicit psychological level (Ulterior transactions) in human communication and that constructive binding or alliance in therapy, based on trust, hope and optimism, was necessary for a successful outcome.

The benefits of contracts according to Stewart (2007) are as follows: 1. The client is actively involved in the therapy process. 2. The contract provides a mental approach focused on change. 3. Therapist and client know clearly when the therapy is finished. 4. The contract protects against the therapist's own misguided ambitions to determine the goal for the client. 5. The contract prevents the development of hidden agendas. A good contract is feasible, safe,

positively worded and observable and supports the client through the therapy process from Script bondage to autonomy.

*Treatment Techniques.*

There are a number of different techniques or skills that the therapist makes use of in the various phases of therapy. The most common are Decontamination, Deconfusion and Re-decision. Decontamination work is based on an unhealthy mixing of the client's historic Child and Parent Ego states with the here and now-oriented Adult. The goal is, with the help of clarification and confrontation, to identify inappropriate beliefs from past and present per-ceptions of reality. This may increase the client's awareness of differences and boundaries be-tween Ego states, strengthen Adult influence and control and expand resources for problem solving in everyday life.

When therapy focuses on emotional conflicts in the Child the therapist is working on making the client whole (Deconfusion). Clarkson (1992) argued that the child is confused because of repressed feelings and thoughts. Deconfusion means to allow the Child to express the feelings, thoughts and behaviours that were prohibited to express in childhood and to clarify the confusion that arose in connection with this repression. Using catharsis techniques as double-chair work, the Child with words and body expressions can ventilate feelings to be released from the contamination with the Adult. With Adult means the client can re-discover the lost real feelings and understand how the innate conflict occurred. Berne (1972) pointed out that Redecision is necessary to achieve Script autonomy. As stated earlier, the child's early decisions were made from limited survival capacity and strong parental influence. Non-satisfied needs and feelings were repressed from the conscious adult life. The Redecision implies that the adult, while he / she is in her Child, becomes fully aware of alternative opportunities and existing resources to get needs met and then can decide, on thinking and feeling foundation, to change the Early Decision.

Goulding and Goulding (1979) argued that the solution of the so-called Impasse is necessary for a successful Redecision therapy. They defined an Impasse as a point where two or more opposing forces meet - a locked place, an internal conflict between self-satisfaction of needs and adaptation to the parents' needs and requirements. The conflict raises the tension and anxiety and drains the client's energy, which creates immobility, splitting and confusion.

Impasses can be classified into three types (see Fig. 5) or degrees, related to when in the child's development the early decision was made (Mellor, 1980). First-degree impasse is about a conflict in the preoperative (verbal) stage after 2 years of age. The conflict is between a Driver ($P_2$) and a natural need ($C_2$). Second-degree Impasse is a serious conflict that occurs in the sensorimotor (preverbal) stage between 4 months and 4 years of age and is related to Injunctions ($P_1$) and natural needs ($C_1$). Third degree Impasse is about the establishment of the client's life position prenatally and around birth. The conflict is linked to the attributions which the client feels are innate qualities and consistent patterns of life. These attributes ($P_0$) are set against the client's natural needs ($C_0$).

First degree Impasse   Second degree Impasse   Third degree Impasse
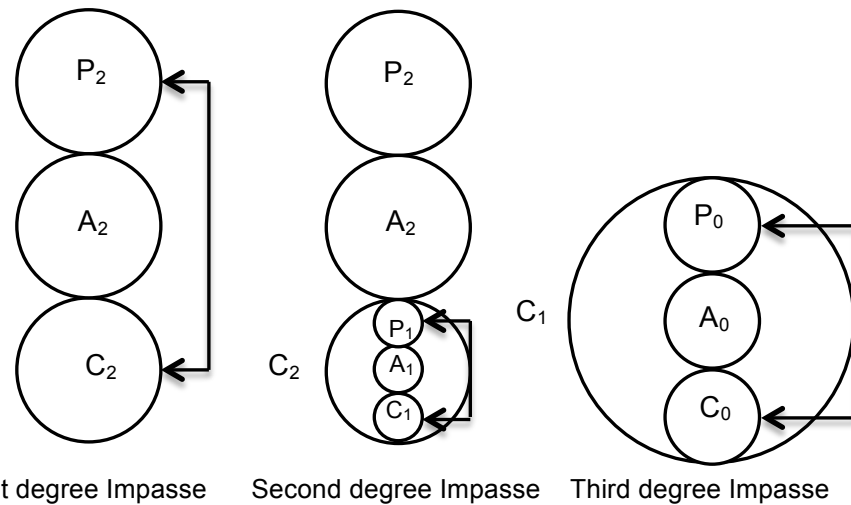
*Figure 5.* Structural diagrams of Mellors (1980) three different degrees of impasse.

# Psychotherapy Research

## Effectiveness and Process Research

According to Armelius (2002), psychotherapy research has undergone three different phases during the past 25 years. Interest has shifted from psychotherapy theories to research and methods of integration of knowledge today. Results from systematic reviews, known as meta-analysis of psychotherapy effects, suggest that all well-developed therapeutic methods give approximately the same effect (Andersson & Lambert, 1995, Bergin & Garfield, 1994, Lambert & Ogles, 2004, Leichsenring, 2003, Lipsey & Wilson, 1993, Smith, Glass & Miller, 1980, Wampold, 2001).

In Smith, Glass and Miller´s (1980) meta-study, TA was one of 18 forms of therapy that was analysed. Of the nine controlled studies that examined TA there was an average effect size (d) of 0.67. The effect size was defined as the mean difference between treatment and control groups divided by the control group standard deviation and used as a comparison measurements for the different therapies. The results for TA ranged from medium (d = 0:56) to high power (d = 0.85). In a later study by Graw, Donati, and Bernauer (1998) with four studies and 226 clients it was found that there were too few controlled studies that could provide a reliable answer to TA's effectiveness.

Comparison of different therapy studies did not show any significant difference between methods, which has created a growing interest in finding empirically validated treatments with randomized controlled design (randomized controlled trial, RCT) and the ability to draw causal conclusions about effectiveness. Researchers were looking for a specific method that would fit into a specific client's diagnosed problems (Snyder & Ingram, 2000).

Empirical Supported Therapies (EST) has been listed since 1995 by a group within the APA (American Psychological Association, Division 12 Task Force), which assessed the evidence strength of therapies. Transactional Analysis, along with most psychoanalytic and humanistic oriented therapies, has been studied less often compared to cognitive and behavioural methods. These are considered more "empirically supported" (Arkowitz & Lilienfeld, 2006). The reason for this is that many dynamic therapies do not emphasize behavioural correlations as outcome criteria, which sometimes is because they are not as strongly focusing on a diagnostic tradition.

Westen and Morrison (2001), Seligman (1995), Arkowitz and Lilienfeld (2006) and Messer and Wampold (2002) have all expressed critic of EST. They have especially highlighted the difference between EST´s experimental approach and the practical clinical reality. 1) The client is not seen as quite a complex human being and is limited to fit into tight "pure" diagnostic criteria or simplified outcome criteria, which limits the usability of a complex practical experience. 2) The therapist's openness and flexibility is limited in favour of a manualised treatment, which is a disadvantage for the "process oriented" therapies. The discussion of evidence-based practice (Wampold & Bahti, 2004) has led to a need for the clinician to secure the quality of treatments and to distinguish therapies and interventions, which have good or less good scientific support.

Rules for classification and measurement require, to some extent, that you have to ignore the reality of a diverse and chaotic variability in reality. It allows a certain simplification and you may risk not describing the individual as a whole. APA (The APA Presidential Task Force on Evidence-Based Practice, 2006) has recognized this dilemma and clarifies that in practical application, there is often interaction effects between the method, psychotherapist, client, context and the treatment relationship. This has often concerned the unique and complex encounter between therapist and client, and the effects of the therapeutic alliance itself.

The difficulties in finding those specific factors of change for different therapies, has meant a growing interest in what is effective in the therapies non-specific factors or common factors. Of the various common factors mentioned (the placebo effect, working alliance, loyalty, experience), the therapeutic relationship or alliance between client and therapist has been emphasised as the most important (Lambert & Ogles, 2004; Johansson, 2006). Lambert and Barley (2002) gathered over 100 studies and concluded, showed in Figure 6, that common factors accounted for 30 % of psychotherapy outcome, while techniques accounted for only 15 %. Expectations (placebo effect) accounted for 15 %, while the remaining 40 % consisted of additional therapeutic changes (e.g., spontaneous healing, and social support).
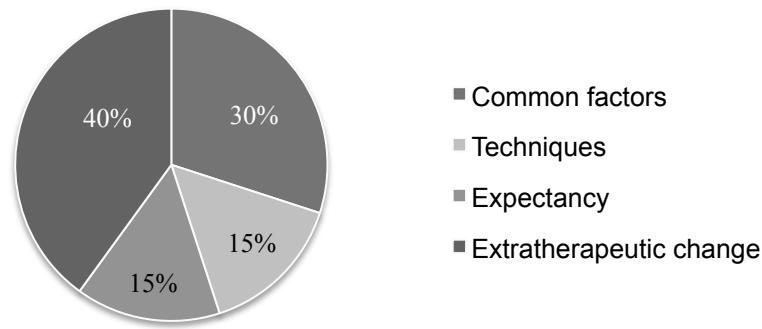
*Figure 6.* Outcome factors in psychotherapy (Lambert & Berley, 2002).

Norcross and Lambert (2011) shows (Fig. 7) the variance in psychotherapy outcome in which 40 % is attributed to unexplained variance. Therapeutic relationship (12 %), therapist (7 %) and client (30 %) account for over half of all factors, while treatment method accounts for 8 %. They note that individual characteristics and qualities of the therapist, client and their relationship are the key effective factors before techniques and methods. They argue that even the practice of the method is related to the person, where timing, context and client adaptation plays a significant role.
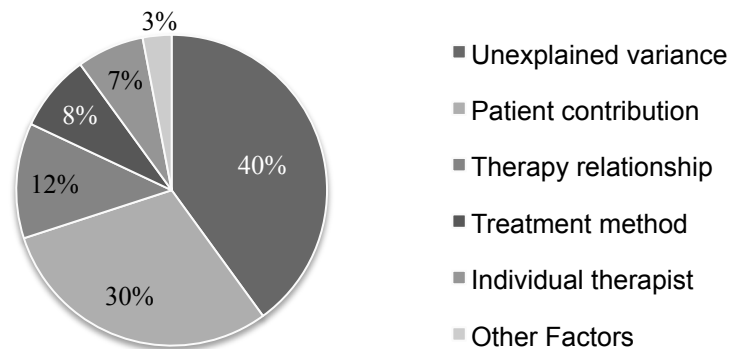


*Figure 7.* Outcome variance in psychotherapy (Norcross & Lambert, 2011)

Lundh (2006) points out that the common factor, to a large extent, can be specific, as the different therapeutic approaches advocate different attitudes based on their theories, techniques and philosophies. The non-specific in the alliance describes primarily specific contact qualities that are considered to be beneficial in human interaction, such as support, warmth, empathy, trust, understanding, respect, appreciation and consideration. Johansson (2006) expressed that this emotional, relational aspect is complemented by most researchers with a rational goal-oriented working alliance e.g. Luborsky (1976), Bordin (1979), Gaston (1990) and Horvath and Bedi (2002). The latter aspect can be identified in the contract concept in TA (Berne, 1961). A contractual relationship is fundamental in transaction

analysis, but it includes both aspects of the alliance in the message "no contract without contact" (Ohlsson, Björk & Johnsson, 1992)

Lambert and Norcross (2011) argues that the contrast between researchers and practitioner's world sometimes is expressed in polar reasoning. This is understandable, given that the evidence-based efficacy research is mainly quantitative, has scientific, deductive logic, and uses statistical analysis, measurement, while the qualitative process of research is descriptive, inductive, humanistic and hermeneutically grounded and interpretative.

However, there should be a common interest in finding a balance and a consensus between the final outcome (effect) of therapy and the factors involved that leads to the result (process). The relationship between process and effect is relevant in each phase of a therapy from the intervention and therapy session to the end. With qualitative process-oriented methods we can, for example by transcribed therapy sessions, have advanced knowledge of the outcome in the immediate encounter between therapist and client. The new findings can then be validated by quantitative impact studies.

There is an on-going interest in finding alternatives or additions to EST, which takes into account the qualities of the therapeutic relationship as well as individual-specific characteristics. Wampold (2002) and Norcross (2002) refer to this work in the APA (The APA Division of Psychotherapy, 2006) as "Empirically Supported (Therapy) Relationships", which focuses on the relationship process linked to outcome. Zuroff and Blatt (2006) show a clear association between relationship quality and outcome. Other studies that emphasize the therapeutic alliance's importance for the outcome is Martin, Garske & David (2000), Horvath and Bedi (2002), Lebow, Kelly, Knobloch-Fedders, and Moos (2005) and Lambert and Barley (2002).

In the current work of the APA's Interdivisional Task Force on "Evidence-Based Psychotherapy Relationships", according to Norcross and Lambert (2011), you want to identify evidence based elements of the therapeutic relationship and simultaneously determine effective methods to tailor the therapy to the client's needs. The ambition is to unify the dichotomy between research and practice, between the therapy relationship and the treatment method so that the client can benefit from the most effective relationship and treatment.

## Effectiveness studies in the Transactional Analysis psychotherapy.

The Swedish National Board of Health and Welfare (Socialstyrelsen) in the late 80´s used RCT studies as criterion when they examined TA for recognition and licensing as a therapy method. In connection with this evaluation a research review of Transactional Analysis effectiveness studies was produced, with mainly control-group procedures (RCT and CT studies), but also with quasi-experimental design and case studies. Ohlsson (2010 c) developed this list further. Elbing (2007) and Khalil (2007) separately also have made reviews.

Ohlsson (2010 c) shows that, of 82 potential effectiveness studies, 60 studies met the evidence-based criteria and 50 of them verified a positive outcome of Transactional Analysis treatment. Khalil (2007) examines 34 studies and includes 19 studies as evidence-based studies, 12 of which yield a positive outcome for TA. Elbings (2007) search for EBS criteria

(Evidence Based Medicine) gives approval to only seven studies, 3 of which are RCTs. Strategies for literature search and criteria for assessment are crucial to the differences in the results between the different statements. The conclusions from the three statements are as follows:

- Elbing believes that it is possible to make successful RCT studies in TA, but there are not enough of them. An important factor is TA´s goal and contract orientation, which should be measurable.
- Khalil notes that TA is most effective as a group therapy compared with individual therapy, and probably is as effective as other psychotherapies for many kinds of problems. She also believes that the evidence base remains scanty and isolated from the academic research community.
- Ohlsson (2010 a) believes that TA's research pool in 2010 is substantial with 326 trials of professional quality. In TA's evidence-based psychotherapy research there is one study showing a negative effect, and he finds that "positive effects were frequent and negative effects were absent" (p.8). There is a base for further development of the existing research including major new evidence-based projects.

There is a recurring debate among Transactional Analysts about why TA as psychotherapy has problems being academically acceptable. Although there are some 50 studies with positive outcomes, there seems to be differing opinions of the assessments of the scientific quality of these studies. Many of the studies were carried out in the 70-80's when TA was most popular and would need to be supplemented and updated today. In addition, TA's easily accessible language and pragmatic content led to a practical / clinical presentation. This has resulted in more published books and articles of self-help character, than of acceptable research literature.

TA´s integrative approach has also meant, that the method is difficult to classify under any broader school culture as PDT or CBT. In England, where TA is a member of the self-regulatory body UK Council of Psychotherapy, UKCP (2011), TA falls under HIPS (Humanistic Integrative Psychotherapy Section).

Furthermore, TA´s width in applications where in addition to psychotherapy, also the fields of education, counselling and organization are included has created difficulties in deepening the knowledge in the therapeutic field. Only 30 % of the scientific studies are in the psychotherapy field (Ohlsson, 2010 a). Of these the 17 RCT or CT studies with positive outcomes can be considered relevant to the study's psychotherapeutic orientation (Table 2).

TA's overall impact research is to the extent that a future meta-analytical study would be fully possible. There is also a large number of TA studies, like this study, that mainly focuses on process research in the psychotherapy field where Kahn, 1973; Kapur and Miller, 1987; Shaskan, Moran and Moran, 1981; Shaskan and Moran, 1986; Scilligio and De Luca, 1997 can be mentioned.

In addition, much of the TA research that is not directly linked to psychotherapy has a value, since a lot of knowledge overlap, such as validation of TA's concepts. In summary

Ohlsson (Ohlsson 2010 b) found 59 studies in which various TA concepts have been tested. Most frequently the concept Ego state (41 studies) and then Script with its various components (12 studies) appear.

Table 2.

*RCT- or CT studies on Transactional Analysis psychotherapy relevant to this dissertation.*

| Author | Year | Title | Publication |
|---|---|---|---|
| Bader | 1976 | Redecisions in family therapy: A study of change in an intensive family therapy workshop | PhD-dissertation |
| Baker | 1984 | Evaluating treatment changes that occur during psychotherapy as measured by the T-JTA (effectiveness, treatment) | PhD-dissertation |
| Boholst | 2003 | Effects of transactional analysis group therapy on ego states and ego state perception | Scientific journal |
| Brown | 1973 | Change of self-concept with an intact group by a transactional analysis approach | PhD-dissertation |
| Fetsch and Sprinkle | 1979 | Stroking treatment effects on depressed males | Scientific journal |
| Goodstein | 1971 | A comparison of Gestalt and Transactional Analysis therapies in marathons | PhD-dissertation |
| Jesness | 1975 | Comparative effectiveness of behavioral modification and transactional analysis programs for delinquents | Scientific journal |
| Lieberman Yalom and Miles. | 1973 | Encounter groups: First Facts | Meta-analysis |
| McNeel | 1975 | A study of the effects of an intensive weekend group workshop | PhD-dissertation |
| Novey | 1999 | The effectiveness of transactional analysis | Scientific journal |
| Novey | 2002 | Measuring the effectiveness of transactional analysis: An international study | Scientific journal |
| Ohlsson | 2001 | Effects of transactional analysis psychotherapy in therapeutic community treatment of drug addicts | PhD-dissertation |
| Olson, Ganley, Devine and Dorsey | 1981 | Long-term effects of behavioral versus insight-oriented therapy with inpatient alcoholics | Scientific journal |
| Scilligo and Coratti | 1987 | Effetti della psicoterapia di gruppo sulla percezione di sé nella formazione degli psicoterapeuti (Effects of group therapy on self-concept in the training of psychotherapist) | Scientific journal |
| Sinclair-Brown | 1982 | A TA redecision group psychotherapy treatment program for mothers who physically abuse and/or seriously neglect their children | Scientific journal |
| Smith, Glass and Miller | 1980 | The benefits of psychotherapy | Meta-analysis |
| Steere, Tucker and Worth | 1981 | Change in two settings | Scientific journal |

# PROJECT STRUCTURE AND AIM

The dissertation is based on a one-year Transactional Analytic group therapy. Using three different approaches, three different parts of TA are investigated. The areas studied were:

- Diagnosis / Client assessment (Study I). The assessment of the 10 clients in the group therapy has been made with TA diagnostics (Script Analysis). The author and two independent observers have performed these analyses, on two occasions, from a Script questionnaire. The analyses have been compared in a reliability study. The aim was to examine the reliability of making diagnostic Script analyses from a Script questionnaire.
- Psychotherapy Approach (Study II). Categorization and identification of TA as a psychotherapy method, where the method of investigation was a modified discourse analytic approach, combined with reliability testing. The aim was to study whether the therapy conducted was consistent with what TA as a method prescribes.
- Therapeutic alliance (Study III). The affective dimension of the therapeutic alliance, where the CCRT method and the Plan-Diagnosis method were used. The aim was to develop the TA method by investigating the affective dimension of the therapeutic alliance.

These three projects do not provide the whole answer to what Transactional Analysis psychotherapy is, but discusses the major therapeutic areas of diagnosis, treatment and therapeutic relationship. Overall it provides a better overview of TA's content, approach and form.

The overall aim of the examination of the three selected aspects has been, with relation to the theoretical concepts of TA, to improve and renew the practical understanding of the active ingredients in TA. In addition, there has been an aim to define and determine elements in TA, as to make it a distinct and replicable method of treatment.

*Roland Johnsson*

# METHOD

# Selection

## Study Materials

The basic data collection for the three projects was based on a video recorded TA group therapy with 10 clients and the author as psychotherapist. The therapy lasted over 24 sessions during the years 1984-85, and each session lasted three hours with a half-hour break in the middle. A professional documentary filmmaker did the recording with a variable camera and a sound engineer with a microphone on a rod.

The therapy sessions were transmitted from the original professional U-matic format to the more accessible VHS format. In total there were 66 sixty-minute tapes available of the therapy´s total of 75 tapes. The shortfall was due to technical problems and loss of tapes (see Table 3, on the next page, p.34). The project's ethical starting points have been examined and approved by the Research Ethics Committee at Lund University (2002).

A strategic selection of 13 sessions was made according to the phases in therapy, where the beginning was represented by sessions 1-8, middle by 9 - 16 and the end by 17 - 24. The purpose to choose a strategic selection was to investigate whether different results could be linked to different phases of the therapy process. In each phase a random sample was then made. These sessions then became the basis for two of the studies (Study II and III) and they were recorded over to audiotapes. Based on the audiotapes the sessions were transcribed entirely to a word program (Word) and were roughly transcribed from a transcription key (Appendix A). The total transcription of the material was 813 pages.

Ten of the 13 strategically selected sessions constituted the basic data material in the studies II and III (ordinary study). These were the sessions 2, 4, 6, 9, 11, 12, 16, 19, 23 and 24. Of the other three sessions 5, 15 and 21 the first two formed the basis for a reliability test in Study III and the last one as a pilot study in Study II.

Table 3.

*The basic study material from the TA group therapy 1984-85.*

| Ses-sion | Date | Tape no. | Number | Comments | U-matic | V-HS | Audio tape | Word pages | Excel |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 24/9-84 | 2-5 | 4 | No. 2-5 lost | | | | | |
| 2 | 3/10-84 | 6-8 | 3 | Ordinary study | Yes | Yes | Yes | 60 | Yes |
| 3 | 8/10-84 | 9-11 | 2(3) | No 10 lost | Yes | Yes | Yes | | |
| 4 | 15/10-84 | 12-14 | 3 | Ordinary study | Yes | Yes | Yes | 66 | Yes |
| 5 | 22/10-84 | 15-17/18 | 3(4) | Reliability test Study III | Yes | Yes | Yes | 66 | Yes |
| 6 | 29/10-84 | 18-21 | 4 | Ordinary study | Yes | Yes | Yes | 72 | Yes |
| 7 | 5/11-84 | 22-24 | 3 | | Yes | Yes | Yes | | Yes |
| 8 | 12/11-84 | 25-27 | 3 | | Yes | Yes | Yes | | Yes |
| 9 | 19/11-84 | 28-30 | 3 | Ordinary study | Yes | Yes | Yes | 71 | Yes |
| 10 | 26/11-84 | 30 | 1 | No. 31-33 lost | Yes | Yes | Yes | | Yes |
| 11 | 21/1-85 | 34-36 | 3 | Ordinary study | Yes | Yes | Yes | 60 | Yes |
| 12 | 28/1-85 | 37-39/40 | 3 | Ordinary study | Yes | Yes | Yes | 78 | Yes |
| 13 | 4/2-85 | 40-42/43 | 3 | | Yes | Yes | Yes | | |
| 14 | 11/2-85 | 43-45 | 3 | | Yes | Yes | Yes | | |
| 15 | 18/2-85 | 46-48 | 3 | Reliability test Study II | Yes | Yes | Yes | 64 | |
| 16 | 25/2-85 | 49-51 | 3 | Ordinary study | Yes | Yes | Yes | 69 | Yes |
| 17 | 4/3-85 | 53-54 | 2 | No. 52 lost | Yes | Yes | Yes | | Yes |
| 18 | 11/3-85 | 55-57 | 3 | | Yes | Yes | Yes | | Yes |
| 19 | 18/3-85 | 58-60 | 3 | Ordinary study | Yes | Yes | Yes | 62 | Yes |
| 20 | 23/5-85 | 61-63 | 3 | | Yes | Yes | Yes | | Yes |
| 21 | 1/4-85 | 64-66 | 3 | Pilot study Study II | Yes | Yes | Yes | 65 | Yes |
| 22 | 15/4-85 | 67-69 | 3 | | Yes | Yes | Yes | | Yes |
| 23 | 22/4-85 | 70-72 | 3 | Ordinary study | Yes | Yes | Yes | 52 | Yes |
| 24 | 6/5-85 | 73-75 | 3 | Ordinary study | Yes | Yes | Yes | 28 | Yes |

*Note.* Ordinary study marks the strategically selected sessions that were the basic data basis of the Studies II and III.

## Therapist

The therapist was the author and no selection of therapist had been made. The therapist was at the time of the therapy, 1984-85, thirty-seven years old and since 1979 a licensed psychologist and had graduated in 1977 as a Transactional Analyst (Certified Transactional Analyst, CTA, in the psychotherapy field) authorised by ITAA, the International Transactional Analysis Association. From 1975, he was a full-time practitioner as a psychologist in private practice. At the beginning of therapy, 1984, he was recently graduated through ITAA as a supervisor and trainer in transactional analysis (Teaching and Supervising Transactional Analyst, TSTA).

The official TA training covers all directions in Transactional Analysis. The therapist had his main reference in the Redecision therapy approach in TA and was trained in the U.S. by prominent figures in this approach, Bob and Mary Goulding and Ruth McClendon.

## Clients

The therapy group consisted of 10 clients. Recruitment to the group therapy was done through the client's volunteer request of therapy to a private practice in Malmo (Institute of Life Therapy - IFL). The selection of clients was based on the temporal order of registration (waiting list). A secretary managed written and verbal information about the therapy and applications to the group. Before the beginning of therapy clients were contacted by the therapist over telephone. The call was a brief check that the conditions for therapy were Ok. Concerning the conditions from a diagnostic perspective, only clients with severe disorders like schizophrenia and manic-depression would have been denied. All of the 10 clients who were first on the waiting list were accepted. Their therapy was self-funded and they had in writing consented to the therapy being recorded on video for research purposes. All of them participated for the entire process of therapy except for Janet, who completed the therapy after half the time.

Prior to the third study (Study III) a random sample was done with five clients, consisting of Amanda, Barbara, Daniel, Eric and Harriet.

## Description of the client group

Based on a compilation of clients' social background variables (see Tables 23 and 24), one can conclude that the group has a heterogeneous profile in terms of variables such as gender, age, parenting, siblings, education, housing and employment.

Table 23.

*Current background variables for 10 clients participating in a TA group therapy.*

| Client no | Clients name | Age | Gender | Marital status | Children | Current housing | Education/ employment |
|---|---|---|---|---|---|---|---|
| 1 | Agneta | 25-30 | F | Married | 1 | House Countryside | Cook/ nurse |
| 2 | Barbro | 25-30 | F | Single | None | Apartment Town | University student/ maid |
| 3 | Carolin | 30-35 | F | Single | None | Apartment Town | Master of Engineering / civil engineer |
| 4 | Daniel | 30-35 | M | Partner | 1 | Apartment Town | Lic. Psychologist/ counsellor |
| 5 | Erik | 30-35 | M | Single | None | Apartment Town | Social worker/ treatment ass. |
| 6 | Fanny | 20-25 | F | Single | None | Apartment Town | Nursery nurse/ Juvenile ass. |
| 7 | Greta | 35-40 | F | Married | 3 | Apartment Town | Sports coach/ nurse |
| 8 | Harriet | 30-35 | F | Partner | None | Apartment Town | Social Worker/ Arts secretary |
| 9 | Ingegerd | 30-35 | F | Single | None | Apartment Town | Social worker/ treatment ass. |
| 10 | Janet | 55-60 | F | Single | 3 | Apartment Town | Social worker/ nurse |

Table 24.

*Background variables related to childhood environment of 10 clients participating in a TA group therapy*

| Client no | Clients name | Parents/ Custodians | Parents employment | Siblings | Current housing |
|---|---|---|---|---|---|
| 1 | Agneta | Biological grandparents | Waitress and mechanic | One older sister | House, countryside |
| 2 | Barbro | Biological | Housewife and caregiver | Two older sisters | Apartment, town |
| 3 | Carolin | Biological | Housewife and Engineering | One older sister | House, town |
| 4 | Daniel | Biological | Housewife and captain | No siblings | House, small town |
| 5 | Erik | Biological | Housewife, utility workers | Two younger brothers, one older sister | Apartment, town |
| 6 | Fanny | Biological | Housewife and small business owners | One younger brother, one older brother | Apartment, town |
| 7 | Greta | Adoptive | Housewife and workers | No siblings | House, small town |
| 8 | Harriet | Biological | Housewife and small business owners | No siblings | Houses, town |
| 9 | Ingegerd | Biological | Housewife and farmer | No siblings | House, countryside |
| 10 | Janet | Biological | Housewife and farmer | One older brother | House, countryside |

Summarizing the 11 variables in Tables 23 and 24, the following can be noted:

- Gender: Of the 10 clients in the group 8 are women and 2 are men.

- Age: Half of the group is between 30-35 years. Three clients are younger and two are older.
  The median age is 34 years.

- Marital status: 6 persons are single and four are married or living together with a partner.

- Children: 6 clients have no children, while four have one or more children.

- Current housing: 9 clients live in an apartment in the city. One client is living in a house in the countryside.

- Education: 6 persons have an academic education. Of all clients nine are in human service programs. One client has a technical education (engineering)

- Employment: 7 persons are working in the caring professions. One person works as a maid, one as an arts secretary and one as a civil engineer.

- Parents: 9 clients grew up with both biological parents and one client with adoptive parents.

- Parental employment: 8 clients had mothers who were housewives. Fathers have had various non-academic professions (9 of 10)

- Siblings: 7 clients have had 1-2 siblings while three clients have grown up without siblings.

- Childhood Environment: 7 clients have grown up in a house or a villa, while 3 persons have grown up in the countryside and four in urban areas. Three clients have grown up in an apartment in a city.

The significance of the group's profile has not been investigated in this study. The clients' social conditions seem generally, however, to be "safe" but that it is not about high status or high material standard. From an individual perspective, these different background data about the clients gives a special and particular meaning for each of them in their individual therapeutic work.

From the information in the videotaped follow-up interview it appeared, that six of the clients had received help with their problems by a psychiatrist or a psychologist. Four did not receive any help earlier. Three clients had been medicated for their problems, but, at the time of therapy, all clients were medication-free. All of the clients had had their problems for a long time (> 5 years).

At the beginning of therapy, all of the clients together with the therapist formulated therapeutic goals in the form of a treatment contract (Appendix B), which formed the basis for the therapy work. They were evaluated at the end of therapy and in the follow-up interviews six years after the end of the therapy. All but one expressed that they had fulfilled their contracts.

# Instruments, codings and statistical processing

## Study I

In the study material of the first study one of Ohlsson, Björk and Johnsson (1992, pp.178-184) designed Script questionnaire was included. This consisted of 43 questions with the possibility of open responses (Appendix A in Study I). The questionnaire was based on similar structures done by Berne (1972), James (1977), McCormick, (1971) and Holloway (1973). Response Data from this form were collected on two occasions from all 10 clients. The first time was before the beginning of therapy and this consisted of written answers. The second time, six years after completion of the therapy, the material consisted of individual video recorded follow-up interviews. The author instructed the clients and coordinated the collection of data on both occasions and also served as an interviewer during the video recording.

As an analytical instrument, connected to the Script questionnaire, a Script checklist (Appendix B in Study I) was used. This form, made up by Ohlsson, Björk and Johnsson (1992), was based on Script checklists like Berne's "Script Apparatus" (1972) and Steiner's "Script Matrix" (1966, 1975) and described the various major components of the Script.
In the comparison in Table 1, you can see that the Script component "Program" is not included in the form used. Experience in clinical work has shown that this component has been of minor use.

The author and two independent observers made the analysis of the Script questionnaire. Inter-assessor reliability and intra-assessor reliability was calculated statistically where the agreements in percentage and kappa values (Fleiss, 1971) were determined.

## Study II

In the second study a coding key (Appendix A in Study II) was designed from McNeel´s (1975) categorization of the structural elements in the Redecisional approach of TA group therapy. McNeel´s dissertation was primarily an effectiveness study using Shostroms (1964) personality test, the Personal Orientation Inventory (POI) and interviews. He noted that the intensive therapy over a weekend (marathon) resulted in measurable personal changes of the clients. McNeel´s secondary interest was to see what factors in the therapy led to changes in the client. It is this part that is the starting point of this study. In an article in Transactional Analysis Journal (1982), where his dissertation is summarized, McNeel writes:

> One aim of this research was to establish how workshops such as these provided benefits to those   involved. In pursuing this goal the researcher and an assistant studied the transcript with an eye toward discerning repeated types of questions, theoretical points of view, confrontations, instructions and techniques. Various components were consistently noted and labelled. At the end of this process the researcher had isolated 42 of these components, which were then divided into seven categories (p. 45).

McNeel´s seven main categories with 42 sub-categories (components) are described in his dissertation (McNeel, 1975), in the article *The Seven Components of Redecision Therapy*

(McNeel, 1977) and in TAJ (1982).

A revised version of McNeels categorization was developed for this study and it was tested in the pilot study to provide the two assessors with a common understanding of the basic content of the different category definitions. In this revision process principles for the coding emerged and also classification and operationalization of the main and sub categories. The definitions of all these categories can be found in the coding key in Appendix A in Study II.

The descriptions of the main and sub categories were given TA headlines, but were defined in general psychological terms in order to be used by an independent observer, who was not trained in Transactional Analysis. The coding key was designed with the categories classified and defined in seven major categories and 42 subcategories.

The transcribed text from the 11 strategically selected sessions was put into a calculation program (Excel) simultaneously with the code key headlines for the 42 sub-categories in the form of a so-called "Pop-up menu". With access to both the transcribed text and the 42 coding categories the assessors could code the therapist's interventions. After a pilot study of one therapy session, the assessors developed a joint assessment of the classification of categories and a common understanding of the existing coding principles:

- The coding is based on 42 sub-categories, which are, grouped under seven main categories. The main categories serve as general headings and are not coded
- Only the therapist's statements or interventions are coded.
- Up to three of the individual narratives relevant to the categories are coded for each intervention.
- Unclear (not heard) statements are excluded from coding.

The author and an independent assessor performed the codings. Inter-assessor reliability for the main and sub categories were calculated statistically both from percentage agreement (Araujo & Dearborn 1985), Kappa ratio (Cohen, 1960) and Odds Ratio (Viera, 2008).

## Study III

In the third study the affective dimension of the alliance between therapist and client was examined. The study was carried through using the CCRT method, Core Conflictual Relational Theme method, (Luborsky & Crits-Christoph, 1990) and Plan-Diagnosis Method (Weiss & Sampson, 1986) - methods specifically developed within the psychodynamic therapy.

The CCRT method was applied to the transcribed therapy sessions with the aim to formulate the client's core conflictual theme (individual CCRT). In the therapy transcripts first shorter or longer sequences that were expressions of the client's spontaneous "stories" about the interaction with others, including the therapist, were identified. These stories are named Relational Episodes (RE). The RE´s where the client interacts with the therapist are referred to as "enactments". Based on various RE´s the client's CCRT is described by identifying three components. These are the client's "Wish" (W) in relation to others, the client's

expectation of the response to this request (Response from Others = RO) and the client's own response to RO and his Wish (Response from Self = RS). First tailor-made components were described, which are variants close to the language used by the client. They were then transformed into so-called standard categories (Barber, Crits-Christoph & Luborsky: Expanded Standard Categories Edition 2, 1990). These include 35 W, 30 RO and 31 RS categories. A coding sheet for each client and session was constructed, where all the CCRT data was inserted. The client's two or three most frequent combinations of W, RO, and RS determined his individual CCRT.

The next step was to use the Plan-Diagnosis Method according to Weiss and Sampson (1986). The basis for this method, is that the client's perspective is rooted in negative experiences of encounters with significant others, which has led to the foundation of feelings of guilt, shame, fear and helplessness (= anxiety). This, in turn, has led to the client developing, as Weiss and Sampson puts it, pathogenic expectations, which in adult life affects and limits his interaction with others. According to the authors, the client "tests" the negative expectations in the therapy situation with the hope that they will not be proved or confirmed (Confirmation). The client really has an "unconscious plan" for how his pathogenic expectations must be rebutted or refuted (Refuting)

Using this method the RE´s in the coding sheets, coded as interactions with the therapist (enactments), and which also corresponded to the client's individual CCRT, were examined. These were called "tests". Finally, how the therapist challenged these "tests" was coded, and in accordance with the method it was marked when he was able to confirm (= "failed") or refute (= "was successful") the clients "test".

Assessors coding's in the study consistently followed the principal to first conduct an individual reading and coding of the transcribed sessions, and then jointly discuss, interpret and assess the codings up until a common consensus decision was made.

A reliability test from two separate sessions was made, by calculating the percentage of agreement in the evaluators' codings.

# SUMMARY OF RESULTS

## Study I

### Client Assessment in Transactional Analysis – A Study of the Reliability and Validity of the Ohlsson, Björk and Johnsson Script Questionnaire. (R. Johnsson)

Script analysis, as described in a number of categorized conflictual themes from childhood, is used by Transactional Analysts to make client assessments as a basis for treatment contracts and treatment planning.

Based on a standardized questionnaire, three experienced psychotherapists and trainers in the TA method have independently analysed the clients Scripts on two different occasions, first at the initiation of therapy and then at the follow-up interview six years after the termination of the therapy.

The results of the survey were calculated and reported by a number of correlational analyses of the similarity between assessor's analysis (inter-assessor reliability) of the clients overall script, and also by their individual scripting components on the two occasions. Furthermore, in a comparison between the two occasions, a study was made if the initial assessments were stable over time (intra-assessor reliability).

Different assessors show (at least 2 of 3) with an agreement of 67 % that they can define the central conflictual motives (the total Script) in the client's life situation. Focusing on the 11 primary components increases the percentage of agreement to 78 %. With compensation for the chance factor, reliability was assessed, according to Fleiss method (1971), to an average Kappa coefficient of 0.48, which corresponds to a "moderate" reliability (Landis & Koch, 1977). More specific Scripts (individual Script components) did not show equally high agreements. In a ranking of the Kappa ratios and percentage agreements of the Script components, the categories "primary Injunction from father", "Racket feeling", "Escape hatch", "Driver from father" and "Driver from mother" have values corresponding to a "moderate" reliability.

Conflict motifs with fixed alternatives were generally more consistent than those formulated freely by the assessors. No clear stability over time could be found. The therapist's own assessments were more consistent over time than the two independent assessors.

## Study II

## Transactional Analysis as Psychotherapy Method - A Discourse Analytic Study. (R. Johnsson)

The results show, that the therapist used 41.7 % of the discourse space. Of the remaining space of 59.3% the 10 clients used between 3.8 and 8.3 % each.

Based on a previous study of McNeel (1975), a revised categorization of seven main categories and 42 subcategories was used that were considered relevant to describe the method. Based on this model, codings were made by an assessor who was not familiar with transactional analysis (TA) and by the author, independently of each other. Reliability was compared from the assessor's codings of the subcategories. The results showed an agreement of all 42 sub-categories in an average of 33.4 %. A limited comparison of the seven main categories increased the agreement to an average of 46.2 % (Araujo & Dearborn 1985). The average Kappa ratio (Cohen, 1960) was calculated to 0.32. All Odds Ratio (OR) ratios are > 1, which strengthens the connection between the assessors matching codings (Viera, 2008). The results indicate, according to Landis and Koch (1977) estimates of "fair" reliability. The conclusion is that the therapy contains the components that are specific in Transactional Analysis group therapy. In a ranking of the main categories, one finds a variation in which "moderate" reliability is measured for categories "Feeling Contact" ($\kappa = 0.48$) and "Contract" ($\kappa = 0.44$). This also applies to six of the subcategories where the techniques "Talking to parent projection" ($\kappa = 0.55$) and "Active use of TA-terminology" ($\kappa = 0.55$) has the highest value. The others are "Make feeling statements" ($\kappa = 0.52$), "Mutual negotiation" ($\kappa = 0.47$), "Refer to contracts" ($\kappa = 0.46$) and "Discrepancies in body language" ($\kappa = 0, 44$).

The results also show a clear variation in the frequency of the various category codings, where certain categories with a high frequency could be identified as more "TA specific". One such specific intervention with "moderate" agreement, could be distinguished, namely "Mutual negotiation".

# Study III

## The Affective Dimension of Alliance in Transactional Analysis Psychotherapy. (R. Johnsson och G. Stenlund).

According to Bordin (1979), there are two aspects of the alliance, one agreement between client and therapist on therapy goals and tasks, and one special emotional or affective bond. Some therapies emphasize the first, more rational aspect of the alliance, while others emphasize the second. Freud (1912/1958) argued that the irrational, unconscious, positive transference was the strongest motive for the client's cooperation with the therapist, but later added the importance of alliance with the client's conscious and rational reality-based ego. Sterba (1934) termed this observing part "ego alliance". Greenson (1965, 1967) termed it "working alliance" and regarded it as more important than the emotional "therapeutic alliance". In Bordin's definition, alliance is a pan-theoretical, general umbrella term, both in

relation to the transference, countertransference, the real relationship and the technology with which the characteristics, qualities and aspects of the therapy relationship can be empirically examined. According to Paul and Haugh (2008), most effect studies of the alliance after 1990 is in accordance with Bordin´s conceptualisation. As Sterba and Greenson, Transactional Analysis is coming from the ego-psychological tradition. In this, usually the rational aspect is emphasized, as a contract-oriented approach is an indicative of the therapy. The aim is to reduce the time-consuming affective transference processes, and to accelerate change through a conscious and goal focused alliance with the client. Rational here is not to be understood as emotionally withdrawn. On the contrary, much of the emotional expressions of the real "normal" relationship are intense and genuine.

This study is focusing on "emotional" aspects important for the alliance between client and therapist. The client's affective relationship patterns have been identified with the help of the psychodynamically oriented CCRT method, Core Conflictual Relationship Theme method (Luborsky and Chrits-Christoph, 1990, 1998). How the therapist is responding to the client's affective messages ("test") have been estimated according to the Plan-Diagnosis method (Weiss & Sampson, 1986).

The quantitative results show to what extent the therapist "fail" (confirm) and "manage" (refute) the clients "test". Overall, the therapist "managed" most tests (70 %), where the proportion of positive responses to Daniel's and Eric's test is higher (82 % and 100 %). compared to the therapist response to Agneta, Barbro and Harriet's test (63 %, 60 % and 62 %).

These results have been complemented by a qualitative analysis of the therapeutic process in which the interpretation procedure was clarified. Overall, the results show that the "emotional" aspect is given more space than can be expected, based on what the TA method prescribes, where contracts and other "rational" techniques and approaches are emphasized.

# DISCUSSION

## Main results

The three key therapeutic areas diagnosis / client assessment, psychotherapy methodology and therapeutic alliance has been studied with the following main results:

- *Diagnosis / Client Assessment (Study I).* A qualified Transactional Analysts can make an overall assessment of a client's basic conflictual themes with a "moderate" reliability. The result can be achieved by using the TA method Script Analysis, based on the primary elements of the script (Script Components) and made from a Script questionnaire. You cannot just rely on the individual Script components being assessed correctly, except for a few, which have good reliability. The non-verbal information does not appear to significantly affect the analytical results. Validity is not examined and thus the result doesn´t give information about Script questionnaires or Script concept's validity.

- *Psychotherapy Method (Study II).* It is possible to identify what in general terms represent a TA group therapy with "fair" reliability. Two individual major categories of the seven, namely the techniques "Feeling Contact" and "Contract" had a slightly higher "moderate" reliability than the other five. This also applies to six techniques of the 42 sub-categories, "Talk to the parent projection", "Active use of TA-terminology", "Make feeling statements", "Mutual negotiation", "Refer to contracts" and "Discrepancy in body language".
  Only one of these interventions could be identified as "TA-specific", namely "Mutual negotiation".

- *Therapeutic alliance (Study III).* The "affective" aspect is given more space than can be expected, based on what the "rational" Redecisional TA method prescribes.

The results from the three studies reflect both the general and the specific nature of the TA approach, where both consistency and deviation from the therapy's expected treatment methodology is apparent. The results indicate that TA therapists can use their standard TA terminology "Script" for client assessments. The expected main elements of the TA method can be identified. The affective dimension of the therapeutic alliance was emphasized more in practical work than the TA method prescribes.

The results points to and deepens our understanding of the relationship between the theoretical conceptual descriptions, the use of empirical material and the pedagogical functional skills. By gaining a theoretical overview, categorize and empirically examine the different parts of the TA method, the results of these studies give both a more complex and more accurate picture of TAs approach, which can form the basis for further modifications and research.

# Methodological considerations

All three studies have their starting point in the TA therapy that was video-filmed 25 years ago with the author as therapist. The disadvantage with such a long time perspective is that a recent development in the psychotherapy field, influencing the TA method, has not been included in the study. One such example is influences from Bucci (2008) on how to work and understand the client's Script based on its non-verbal and somatic level (Cornell, 2008). The advantage is that a clear distance to the material has occurred, which can reduce any "allegiance" problems that the author may have, in form of loyalty and trust to his psychotherapy method and therefore a desire for positive outcomes. "Allegiance" is a manifestation of systematic biases in comparisons between the effects of different psychotherapy methods. One may have a preference for one method (positive allegiance) and one can be opposed (negative allegiance). Luborsky et al. (1999) showed that the results of a therapy were in the expected direction that the effect size was higher for positive and lower for negative allegiance. The most important actions to control a positive allegiance have been the use of independent observers in all the studies (research triangulation). In study I, however, all the analysts and colleagues were linked to the TA method, although the assessor's analyses were completely independent. In Study III, the independent assessor had a positive allegiance to "alliance research", even if she wasn´t linked to the TA method.

The recording was done with two professional filmmakers present, which guaranteed a good technical management. But their presence also constituted a variable with a possible group dynamic influence. This, as well as how the video recording influenced the therapist and the clients, has not been investigated.

In all of the studies the analytical method, triangulation, has been used. The dissertation in itself is an example of triangulation, both theoretically and methodologically; three different methods are used to study the different parts of TA. In Study III the methodological triangulation of quantitative and qualitative interpretive methods were used to document the clients studied. In Study II a combination of discourse analysis and statistical reliability calculations was used. In study I data triangulation, where both questionnaires (list of Script questions) and interviews, was used.

In studies II and III video material has been transcribed from audiotapes, which has given material based only on verbal printed transcripts. A transcription key has been used where auditory but not visual impressions could be shared, which limits the interpretation of process variables. In study I these visual components were used when observing the videotaped follow-up material. This was not interpreted to have any significant effect compared with the analysis of the written answers to the interview questions. Based on what has been learned by Tomkins (1962, 1963, 1991, 1992), the expression in the eyes is important to affective communication and attachment, and therefore a review of the video material was expected to strengthen and complement the set view of the variables. Although the assessors agreed on the non-verbal significance for the analysis, this didn´t result in any significant difference. This may be because the interviews were well structured and didn´t invite to any direct

emotional expression.

In study II a strategic selection to study if different phenomena could be linked to different stages of the therapy process was used. The motive was to study if the distribution of the therapist's interventions shifted over time, as the clients' needs were changing. One may expect that the professional progress of the change process follow certain generally predictable steps, even if individual differences in the therapist and client (the therapeutic relationship) is essential. Berne (1961, 1972), Erskine (1973), Woollams and Brown (1978), Ohlsson, Björk and Johnson (1992), Goulding and Goulding (1979) and Hewitt (1995) have described these phases of TA therapy. It can also be found in contemporary research e.g. Prochaska and Norcross (2010). The result in the study confirmed this thinking.

## Reliability and validity.

Reliability and validity are concepts, which in their original definition, are designed for studies with quantitative approach, but which later have been applied in studies with qualitative approach. The dissertations naturalistic studies are basically qualitative with additional quantitative elements. The data collection in study I consisted of questionnaires, interviews and video observations. In studies II and III independent assessments of the transcribed video sessions have served as the base material. In study II, assessors used a classification of the TA categories according to McNeel (1975) as an instrument for their coding, while assessors in Study III has coded from a psychodynamically oriented categorization, according to Luborsky and Chrits-Christoph (1990, 1998). The quantification has consistently been based on pre-specified categories (script components, TA-therapy categories, CCRT standard categories), which systematically has been coded by different observers, been compared and statistically calculated. These quantifications of qualitative material brings with it known methodological problems, because the qualitative research method wants to find the essence and aims to provide qualitative empirical evidence, while the quantitative method is primarily looking for statistical and quantifiable results.

The study's naturalistic approach in combination with a limited number of clients partly reduces the possibility to generalize the results to other therapies. The ambition has generally not been to determine the outcome, but to qualitatively distinguish the categories that best describe the phenomena that are studied, and to determine the key categories in a TA-therapy. Using distinct statistical analysis while maintaining the authentic connection to a complex reality is a delicate balance between taking into account both the external and partly internal validity.

### *Reliability problems.*

In study I raw data have consisted of responses from the Script interviews partly in the form of written responses, and partly in the form of observations of videotaped interviews. Three specially trained assessors carried out the assessments and interpretations, which consisted of Script Analysis. Sources of error with human beings as measuring instruments are many and create known reliability problems (Armelius & Armelius, 1985, p. 23-26). By using multiple assessors (inter-assessor reliability), making independent assessments on several occasions

(test-retest reliability or intra-assessor reliability) and using assessors who are well trained and experienced Transactional Analysts, the ambition has been to increase the scientific consistency in terms of both reliability and validity.

By having the therapist leading the video interviews himself you can have a clear, confident and trusting situation created for the client. In addition, the same questionnaire is used on both occasions. The time interval between the two sessions is 6 years, which means that the result has probably been influenced by the client's maturation, development, and possibly other treatments. At the same time the client's memory of previous measurement responses have diminished, which stabilises the reliability in a classical sense. Perhaps stability is a better term than reliability.

This is not a reliability study in which the therapist is largely responsive to a specific manualised treatment procedure (adherence). The therapist's adherence to his methodology has been linked to positive outcomes by particularly Luborsky et al (1985), but his research also demonstrated that the therapist more easily was responsive to his techniques, when the client is motivated and cooperative and develops a "working alliance" with the therapist. The theoretical and operational definitions of the script and its various components are qualitative and diverse, which creates adherence problems related to the therapist's way of practicing the therapy. As it is based on clinical practice, it requires a clinical and constantly modified observation of the process. Consequently, the concepts will be less well defined to allow the inter-assessor reliability to be expressed in simple statistical terms (coefficients). The logical-deductive model has been used to quantify Script impressions, well aware of the subjective and qualitative elements of the definitions and observations. The aim has been to not let the assessors prior understanding colour the final assessment results, but at best it will be a reliable measure of inter-subjectivity where the analysis in principle is the same, no matter who makes them.

In study II the therapist's adherence to his method is an important part of the result, since the therapist's interventions are connected to a categorized method. It becomes critical how "purely" the therapist can stay with the "official" school training. That said, with the risk that it will be the therapist's adherence to the method that will be studied and not the TA method. Canestri (2006) argues that there is a possibility that therapists develop, through further education, practical applications and personal experiences, "private" adaptations of the "official" method. Despite this, it may nevertheless be claimed that probably the "official" method forms the basis for any new development that can be observed and identified. In all the studies analytical data has been used to make correlational analyses of the assessors agreements (inter-assessor reliability). Primarily, percentage agreement has been calculated, but in Study II and III Kappa coefficients has been set to compensate for the chance. In Study III, the assessors have used an individual interpretation procedure followed by a consensus discussion and a mutual agreed upon decision. The reliability of the coding has been supplemented by a simple percentage reliability assessment and with a qualitative analysis to emphasize the quantitative result.

### *Validity problems.*

Cook and Campbell (1979) discuss problems that may occur with different types of validity. High reliability does not guarantee that the study has high relevance (validity). The validity in study I is about to which extent the questions and answers in the interview are relevant to make an assessment of the Script, its components and its significance. The operationalization of the theoretical definitions of the concepts are not precisely described but rooted in clinical practice. This means that the concepts validity (construct validity), i.e. how well the Script questionnaire leads to the Script concepts is complex. The content validity (content validity), how well the script questionnaire covers the different script components, has never been tested empirically, but has been assessed from face validity by different TA therapists. The interviews and assessments indicate that the "face validity" was good, since the motivation, confidence and knowledge about the interview was high among the interviewers and interviewees. The therapy room where the interviews are made and the direct contact between the therapist / interviewer and the client, may in this context be regarded as an authentic environment with good ecological validity (Shadish, Cook & Campbell, 2002). The video observations can be assessed to see how clients react and respond to the interview questions. This online validation is built into the interview dialogue, and has been used in other studies such as family therapy (Gustl et al, 2007; Sundell, Hansson, Andree Lofholm et al., 2006).

In a predominantly qualitative study, it becomes important to describe how to collect and process data in a systematic way (internal validity). The Script interview in the study is compiled by the assessors and has been used in a clinical context during a 25-year period. It can be considered relevant and reliable for its intended purpose.

Through a careful and detailed description of how this and other important parts of the research have been carried out, communicative validity (Malterud, 1998), and in the final results and changes in the Scripts, the reader is provided with good opportunities to determine how transferable this approach is to other similar situations (external validity). My assessment is that the reader is given good opportunities to determine the level of generalization.

The Script questionnaire is not standardized and there is no study in the literature in which the form has been validated against an independent standardized and statistically assured personality interview. Two effectiveness studies, MacNeel (1975) and Bader (1976) have been made, where the Script changes were compared with assessments based on POI, Personal Orientation Inventory (Shostrom, 1977). Script Analysis has here been made from the various Script components, although no direct use of Script questionnaires has been reported. The results were based on measurements before and 3 months after therapy, and showed measureable changes in the clients' personality orientation, for example in self-acceptance and spontaneity.

The difficulty in the clinical research method, to use the criteria for validity that follows the positivistic science approach has been discussed. In the clinical research method, the "truth" is, to a large extent, linked to the practical consequences. A widening of the validity concept, which takes into account the therapeutic movement or process, may therefore be

appropriate. Kvale (1987) and Polkinghorne (1983) have presented two validity criteria that are relevant in a clinical context, namely the communicative and pragmatic validity.

The communicative validity is about scientific reasoning where you continually reflect and logically weaves together theory and practical implications to a discourse that gives a credible and relevant impression. The Script theory´s different components are tested partly internally (how they are logically linked) and partly externally (how they are related to other theories). The internal rationale has been put forward in the section about the Script and its components and the external has been examined in several studies in which TA was compared with other treatments (Goodstein, 1971; Ohlsson, 2002; Novey, 1999; Shaskan, Moran & Moran, 1981), where Script application of TA therapy gave a positive outcome. The pragmatic validity is linked to the prolonged use of the method and an experience that it has been effective in clinical work.

Finally, it should be mentioned, that the internal validity of this study is strengthened through triangulation, where three different non-TA-related methods have been used to study different aspects of TA- therapy.

## Discussion of results.

By studying Transactional Analysis therapy with three different research methods, the combined results from the investigated areas (diagnosis, treatment method and therapeutic relationship) provide an overall view of the Transactional Analytical psychotherapy.

The conclusion (Study II) is that the psychotherapy under study follows what generally constitutes TA psychotherapy. Of the 42 subcategories coded, "Mutual negotiation" is clearly the most frequent one and was assessed to be a TA-specific category. It is included under the main category of "Contract". TA is consistently described as a contract therapy in which the mutual negotiation is an important ingredient in the therapeutic collaboration. The idea of contract is also referred to in the cognitive behaviour therapy (Beck, 1976, 1995), but is not pervading the therapy and the therapist's attitude in such a profound way as in TA. Even if this TA-specific intervention is shared with other therapies it is practiced in a TA-specific way. Another common category in the study is "Specification-clarification". This category tends to be represented, more or less, in all therapies and therefor it can be assessed as a non-specific or common factor. Holmqvist (2006) and Lundh (2006) have discussed the difficulties in distinguishing theory related characteristic ingredients from common and temporary ones. Messer and Wampold (2002) and Luborsky et al (2002) showed that the differences between methods were small and that many "psychotherapy-interventions" are shared by most therapies. The TA method also has an integrated or eclectic focus, which complicates the realignment from other therapies.

Methodologically, the study demonstrated, that several of the 42 categories could be deleted. In future research, such a reduction of non-relevant TA categories can function as a basis for specification and development of TA-specific elements in the theory and method.

 The qualities of the therapeutic alliance are usually mentioned as an important common

mechanism of effect. In study III, one can conclude, that the affective dimension of the alliance has received more space than is ascribed to the TA method. The result is interesting, because the specific design of the treatment method is less important and the focus is directed to the psychotherapist and the client. Rönnestad (2006), Sandell (2004, 2009) and Armelius (2002) have shown that the variance in the therapist factor is more important than the method. The therapist's relational approach is partly given through his studies of the methods literature, training and supervision, but also by the therapist's personality and personal development. There is a conflict between different therapeutic approaches that can be linked to the Lundh (2006) discussion of "relationship as technology". He concludes that the relationship as a technique always is included in therapy, but it can have different meanings. He contrasts an "empathic-validating" approach to a "steering-influencing" approach. The first attitude is focused more on the inner world of the client's by emphasizing empathy and listening, as compared to the latter method, which is more encouraging concrete behaviours and thinking. It appears that the therapist in the study has some difficulty in balancing these different approaches, where the TA technique is more in line with the steering-influencing approach, compared to the empathic-validating. The therapist applies the techniques as a strategy to push the process forward, but instead it sometimes generates setbacks and lockups in the process. In connection with the resulting conflicts, it seems that the therapist follows a general methodological factor that repairs or balances the situation and that may rather be linked to the therapist than to the method.

Based on Bordin´s definition of alliance (1976) the affective part of the alliance has been focused, to contrast it to the rational part. In line with psychodynamic tradition (Luborsky, 1976) the affective level is seen as following an irrational and unconscious process, while the rational level stands for the conscious and the reality-based one. In both parts, there are expressions of feeling and thinking. The use of the Plan-Diagnosis method according to Weiss and Sampson (1986) examines the client's affective "plan" to confirm his "pathological expectations". The study shows that the affective level is important in a TA therapy, even if the rational level is emphasized. To open up for the affective level, TA needs to develop both its theory and its method. TA's conceptualization is mainly rooted in a useful "methodology theory", that is close to practice. TA theory is based on the Ego state theory that focuses on the conscious ego, which leads to rational treatment content. A practical method theory is not available in psychoanalysis, but there is a consistent theory that opens up for further speculation and depth, without the direct need to be linked to clinical usefulness. Johnsson and Ohlsson (1977) described in a model four different scientific levels, from a meta-perspective of the therapy´s underlying view of man and society, via theory I (psychology theory), theory II (psychotherapy theory) to practice (psychotherapy). All levels are essential, and it seems like TA needs to deepen its "psychology theory" in the future without abandoning its "psychotherapy theory". Treatment wise, knowledge of the affective level should lead to an approach where the use of techniques is put in its relational context.

In study I a "moderate" high inter-assessor reliability (78% and $\kappa = 0.48$) was given to client diagnoses, based on the primary components of Script Analysis. The reliability is lower

than what practitioners averagely reach when diagnoses in the DSM axes are used. According to Hägglöf (2008) the reliability varies between Kappa values (κ) 0.65 to 0.85. The problem with TA diagnoses is that there is no standardization, or precision in the concepts, and because of this you don´t know for sure if the Script diagnosis is valid in relation to its treatment method. TA diagnoses are not regularly tested to achieve consistency between the TA and non-TA practitioners, which, can be added, is often not the case in other therapies either.

On the other hand communicability to the client and usefulness is considered to be satisfactory, even if this is not confirmed in a research context. Widdowson (2010) has shown that many TA therapists uses the diagnostic system DSM-IV or ICD 10 as a supplement to their TA diagnoses. ICD has a vague classification, while DSM has clear behavioural criteria and may serve as a symptom-sorting instrument. In addition, TA uses many different diagnostic concepts and systems as for example analysis of Ego states, Transactions, Games, Racket feelings, Life positions and Impasses, which are not represented in other diagnostic systems.

Stewart (1996) concluded that the DSM and ICD classifications are not appropriate for TA practitioners, because of contrasting views on how to describe health problems and the tight focus on the client's symptoms. The diagnoses are usually not only following a formally structured method, but the therapist also draws his conclusions from the informal process-oriented dialogue he has with his client (Cornell, 2008). This is a dialogue in which the therapist emphasizes the observation of himself, his feelings, memories and thoughts, also known as his countertransference. (Novellino, 1984; Hargaden & Sills, 2002). The diagnosis is then initially used in a wider sense. The psychodynamically developed OPD-2, Operationalized Psychodynamic Diagnostics (2008), has been identified as a suitable well-developed diagnostic instrument, which has become well tested in a series of reliability and validity studies.

Also PDM, the Psychodynamic Diagnostic Manual (PDM Task Force, 2006), prepared by the five major psychoanalytic organizations in collaboration with leading researchers in neuroscience and effectiveness research, emphasizes the whole by linking the subjective inner experience to the externally observable symptom. PDM is considered a good complement to DSM and ICD diagnosis. It would be important for TA practitioners to link to other systematic classifications, and pragmatically create congruence between systems. The knowledge that it is possible to describe bad health in several ways is basically fertile. It can weigh up the risk that the diagnosis has a negative effect of becoming a self-fulfilling prophecy, especially for those who believe that a diagnosis always has an organic base and is a disease. Stewart and Joines (2002) have made an attempt to combine the diagnostic descriptions based on TA and DSM where they have made classifications of different personality adaptations. It has been widely spread among TA practitioners, but has not been researched closer.

There seems to be a need for an official standardized diagnostic system that can increase the reliability in the psychotherapy assessments made. There is a legal security aspect in that

people can get the same assessment regardless of analysts. Different analysts cannot have different criteria. With explicit criteria it becomes easier to design and evaluate tools that facilitate problem formulating diagnosis (like estimates and structured Script interviews) and treatment follow-ups (contract fulfilment). Explicit criteria also facilitate communication between researchers, psychotherapists and clients. Finally, a clear categorical system functions as a decision support for mutual contracts, interventions, and a well planned therapy. Hopefully, the TA method will increase its research and based on specific descriptions and evaluation measurements, you can gradually develop an alternative diagnostic classification system that builds on DSM / ICD or PDM and OPD and where TA's pragmatic concepts becomes meaningful.

TA has to meet many challenges in the future if it is going to survive as a theory and psychotherapy. There is a lot of creativity linked to observations from clinical practice. Theories are created which are directly related to an observable reality, which are useful for both therapist and client. These "methodological theories" are unique to TA and ought to be described in terms where it is fully possible to test their scientific validity. Moreover, the therapy needs to specify with which clients and which conditions it works best. The need for a constant current empirical research is crucial to complement the wide number of literature studying articles that explain and revise various TA concepts. In addition, the previous TA research could be summarized in different meta-analyses.

A strength in TA is its integrative and multi-dimensional approach, as pointed out by Prochanska and Norcross (2010). Unlike the therapies that are "faithful" to their method, this opens up for variety, flexibility and an ability to stay with the therapeutic relationship process. There is an outspoken interest in combining different directions and perspectives, and thereby develop and enriches the therapy and the therapist's skills. The additions from other directions should be supplemented together with a deepening of the theory. This can be a depth study that could lead to a simplification in clarifying TA's basic concepts in verifiable stringent theoretical postulates.

Berne (1971) wrote, "…there is only one paper to write which is called "How to Cure Patients" – that´s the only paper that´s worth writing if you´re going to do your job". This book can hardly be written without roots in empirical academic research. It is therefore a delicate task for TA, in various ways, to ensure that the research is stimulated and maintained. Then TA's survival as a psychodynamic, integrative and relational methodology to humanistic foundation can be secured.

## Concluding remarks

By discussing the three areas of diagnosis, method and therapeutic alliance with the use of three different approaches, the following aims have been achieved:

- A better understanding of TA's strengths and weaknesses in terms of diagnosis, treatment method and therapeutic relational attitude.
- A clearer view of what is TA-specific and what is common to all psychotherapies.

- To add and provide the benefits of academic research for practicing TA psychotherapists.

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# SWEDISH SUMMARY/SVENSK SAMMANFATTNING

## Transaktionsanalytisk psykoterapi – Tre metoder som beskriver en transaktionsanalytisk gruppterapi.

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Avhandlingen är baserad på en ett årig Transaktionsanalytisk gruppterapi. Transaktionsanalysen (TA) är en integrerad, relationell psykodynamisk terapi med rötter i den humanistiska psykologin. Den beskrivs i den internationella TA föreningen, ITAA:s utbildningsmanual (ITAA hemsida, 2011) som "en personlighetsteori, en teori om socialt beteende och en systematisk psykoterapimetod."

   TA introducerades i slutet av 50-talet av den kanadensisk/amerikanska psykiatern Eric Berne (1910-1970), som lade grunden för TA:s teori och praktik. Baserat på Berns begreppsbildning och terapeutiska metod har TA utvecklats och förändrats i olika riktningar. En riktning, som är den viktigaste referensen i denna studie, är Nybeslutsterapin (Redecision Therapy), utvecklad av Bob och Mary Goulding (1976, 1979) De assimilerade idéer från gestaltterapin (Perls, 1969,1973) som integrerades med TA.

   I studien används tre olika metoder för att undersöka tre olika delar av Transaktionsanalysen. Dessa områden är:

- *Diagnos / klientbedömning (Studie I).* Bedömningen av de 10 klienterna i gruppterapin har gjorts med ett TA diagnostiskt tillvägagångssätt (Skriptanalys). Tre oberoende bedömare har utfört dessa analyser vid två tillfällen, baserat på ett Skriptfrågeformulär. Analyser har jämförts i en reliabilitetsstudie. Syftet har varit att undersöka reliabiliteten i klientbedömningarna, genom att göra diagnostiska Skriptanalyser utifrån Skriptfrågeformulär. Det genomsnittliga kapparesultatet ($\kappa = 0.48$) visar på en "moderat" tillförlitlighet (Landis & Koch, 1977) i bedömarnas analyser av de centrala konfliktmotiven i klientens livssituation (det totala Skriptet). Mer specifika Skript komponenter fick inte lika hög reliabilitet, utom "primärt förbud från far", "favoritkänsla", "destruktiv flyktväg", "pådrivare från far" och "pådrivare från mor" som hade "moderat" reliabilitet. Konfliktmotiv med fasta alternativ visade högre tillförlitlighet än de som formulerats fritt av bedömarna. Det fanns ingen tydlig stabilitet över tiden.

- *Psykoterapimetoden (Studie II).* Det gjordes en kategorisering och identifiering av TA som psykoterapimetod, där undersökningsmetoden som användes var en modifierad diskursanalytisk ansats, i kombination med reliabilitetstestning. Syftet var att undersöka om den terapi som bedrivs är i enlighet med vad TA-metoden föreskriver. Resultatet visar enligt Landis och Koch (1977) att med "fair" tillförlitlighet ($\kappa = 0.32$) innehåller den studerade terapin de kategorier som har identifierats som delar av TA psykoterapi. I

en rangordning av de sju huvudkategorierna finns en "moderate" tillförlitlighet för de två kategorierna "känslokontakt" och "kontrakt". Sex av de 42 underkategorier gav liknande resultat där teknikerna "tala till förälderprojektion" och "aktiv användning av TA terminologi" har det högsta värdet. De övriga fyra var "göra känslouttalanden", "ömsesidig förhandling", "referera till kontrakt" och "diskrepans i kroppsspråk". Resultaten visade också att vissa kategorier med hög frekvens kunde identifieras som "TA-specifika". En sådan intervention med "moderat" tillförlitlighet var "ömsesidig förhandling".

- *Den terapeutiska alliansen (studie III).* Den affektiva dimensionen av terapeutisk allians undersöktes, där CCRT metoden (Luborsky & Crits-Christoph, 1998) och Plan-Diagnos metoden (Weiss & Sampson, 1986) användes. Syftet var att utveckla TA-metoden genom att undersöka den affektiva dimensionen av terapeutisk allians. Resultatet visade, både genom kvantitativa och kvalitativa analyser att den affektiva dimensionen gavs större utrymme än man kan förvänta sig från vad TA-metoden föreskriver, där kontrakt och andra rationella metoder och attityder är betonade.

Dessa tre projekt behandlar de viktiga terapiområdena diagnos, behandlingsmetod och terapeutisk relation och tillsammans ger de en övergripande bild av TA: s innehåll, metod och form. Baserat på teoretiska TA begrepp, har syftet varit att öka den praktisk förståelse av de aktiva ingredienserna i TA och att definiera och fastställa element i TA, som gör den till en distinkt och reproducerbara behandlingsmetod.

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*Roland Johnsson*

# APPENDIX
## Appendix A

### Transcription key

| | |
|---|---|
| : · | Prolonged vowel (e.g. "yes" or "yes :::::::") |
| | Restart ("we-we will talk more about this") (.) (.) |
| - | |
| (.) | Audible pause. (Short and distinct) |
| (pause) | Pause. (Marked and longer) |
| Capitalization | Increased volume (e.g. "ABSOLUTELY NOT!) |
| ° ° | Significantly lower volume |
| X | Inaudible words |
| > < | Compressed, rapid speech |
| < > | Extracted, slow speech |
| Strong bold | Marked emotional stress |
| [ | Indicates that overlapping speech begins |
| ] | Indicates that overlapping talk ends |
| ( ) | Comments on non-verbal communication (e.g. "crying," "cough" "sigh") |

# Appendix B

## Treatment contracts

The treatment contracts of 10 clients who participated in transactional analysis group therapy.

Agneta
- Use my time here in the therapy group, which is at least 1/10 of total time.
- Express my anger and direct it outwards rather than being submissive.
- Put my raincoat on and go out in to the wood with my daughter, rather than washing clothes.

Barbro
- To receive recognition from others without feeling guilty.
- Assert myself and express my feelings spontaneously
- Stop taking care of others to protect them from the problems they're faced with, saying "No" to all of this instead.

Carolin
- Check which patterns I have that belongs to my mother
- Embrace my femininity.
- Be liked without performing

Daniel
- I want to participate in this group without being an observer.
- Find out what my real emotional needs are rather than being busy with my ambitions, my duties and my work.

Erik
- I want to lead my own life rather than simply showing allegiance to my father and the culture he represents.
- Express my feelings and my views on things to my boss and to my work colleagues rather than to simply withdraw.

Fanny
- Tell my dad that he can be sober when I get home or I will not come.
- Be able to go to a party and have fun even if others are drinking
- To be independent and live my own life but still has a good relationship with my mother.

Greta
- Be spontaneous in my sex life instead of clinical
- Get angry instead of scared when men withdraw and walks away.

Harriet
- Feel relaxed and satisfied rather than being tense and being afraid of everything imaginable.
- Be conscious of when I'm angry, and express my anger.

Ingegerd
- I want to feel joy and satisfaction in what I do.

Janet
- To be assertive and angry instead of analysing and backing off.

# APPENDED STUDIES