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ABSTRACT

This article presents a focused review of the research literature in transactional analysis (TA). TA was developed in the 1950s as a theory of human personality and social behavior and as a comprehensive form of psychotherapy, but there has not been any systematic research to test the empirical evidence for the efficacy of TA theory and practice. The aim of this study was to develop the conceptual model of transactional analysis on the basis of a systematic review of the actual, self-reported practice of international TA psychotherapists and on the evidence found in research. The article systematically reviews common conceptual components of TA and their empirical evidence by examining the common denominator and the empirical evidence for the central clinical phenomenon, etiology, therapeutic mechanisms, therapeutic competencies, outcomes, and synthesis. TA focuses on problems in ego states (operationalized as Parent, Adult, and Child) with distinctive behavioral functions of Controlling Parent, Nurturing Parent, Adult, Adapted Child, and Free Child. Individuals can develop long-term problems in their ego states, social functioning, and self-efficacy as the result of unfavorable messages from their social context (negative parental messages in early life, lack of developing mature coping mechanisms, intergenerational messages, negative stroke balance), script decisions (accepting or rejecting unfavorable messages via behavior, emotional disconnection, or cognitive styles), life events, and genetics/temperament. TA treatment intends to help clients by developing constructive ego states, improving social functioning, and stimulating a sense of self-efficacy. Research confirms that TA improves psychopathology, behavior, and general well-being thanks to improvement in ego states, self-efficacy, and social functioning. These effects are achieved by four evidence-based therapist competencies: creating a positive client-practitioner relationship, working with experiences in the present, etiological analysis (life scripts, injunctions, counterinjunctions), and therapeutic structure (treatment contracts, treatment stages, psychoeducation/didactics). Meta-analysis of 41 studies shows that TA has moderate to large positive effects on psychopathology, self-efficacy, social functioning, and ego states. This conceptual model shows that TA can be considered a bona fide and evidence-based treatment for a wide range of clients.

KEYWORDS

Transactional analysis; psychology; research; evidence based; effectiveness; model; psychotherapy development; theory; Berne; psychotherapy

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Transactional analysis (TA) was originally developed by psychiatrist Eric Berne in the late 1950s as a theory of human personality and social behavior and as a comprehensive form of psychotherapy that emphasizes the open and equal dialogue between client and therapist. Berne integrated his psychodynamic understanding of the personality structure with the newly emerging cognitive-behavioral techniques within a humanistic philosophical framework. This was one of the first approaches to psychotherapy integration by developing a substantive new therapeutic theory (Mahrer, 1989). The field of TA psychotherapy continued to develop as an integrative approach by integrating developments in other fields, such as neopsychoanalytic theory, behaviorism, and neuropsychological research. As a result, TA has become a frequently used approach in various fields such as psychotherapy, counseling, coaching, education, and organizational development, with systems of certification, training institutions, journals, and books (e.g., https://www.eatanews.org/ and https://www.itaaworld.org/).

However, this development of TA did not lead to a research focus reflected in the emergence of a relatively broad field of studies into specific TA topics. For example, we found in our TA instruments review that over the years 647 studies have used 56 different instruments related to TA concepts, such as ego states and life scripts. Twenty studies reinvented the wheel by developing a new instrument to measure ego states (Vos & van Rijn, 2021a). This lack of collaboration and a unified evidence-based framework for TA may have been one reason that TA has received relatively limited statutory recognition. Therefore, this article sets out to describe a systematic review of the empirical evidence for the core concepts in TA in order to help practitioners to justify offering TA to clients, mental health services, and health insurers.

In the medical field, justifications for interventions are usually based on positivist research, such as randomized controlled trials or instrument validations. An intervention is deemed justified when it delivers the outcome desired by the patient and/or the professional. Elsewhere, our TA meta-analysis of 41 clinical trials showed that TA has large effects on reducing psychological stress and improving well-being (Vos & van Rijn, 2020). It could be argued that achieving the desirable outcomes might not be enough to justify an approach, but there is also a need to focus on the process of the therapy and mechanisms of change. Many studies have examined the relational process in therapies, as summarized in handbooks by authors such as Norcross and Lambert (2019) and Cain (2016). A specific focus has been on the relationship between the practitioner and client because research indicates that the deeper the relationship, the more effective the therapy (Cooper & McLeod, 2007).

The definition of psychotherapy offered by the American Psychotherapy Association (APA) adopted the following definition by Norcross (as cited in APA, 2013, pp. 218–220):

> Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviours, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable.

It also recognizes that psychotherapy is rooted in the therapeutic relationship, which involves a bond between the therapist and the client and agreement about the aims of treatment. These elements are clearly recognizable in TA theories and practice.

As with many other psychotherapeutic approaches, in transactional analysis there are a considerable number of publications on clinical theories and clinicians' experiences but relatively few on research. Thus, there is a gap in the systematic research evidence needed to bring this approach more clearly in line with the APA definitions of effective psychotherapy. The aim of this article, therefore, is to examine the extent to which TA is a bona fide therapy by identifying its conceptual model and searching for empirical evidence for the components of that model.

There are several scoping literature reviews of TA concepts and treatments, but they are either not systematic, outdated, or focused only on specific aspects of TA instead of the overall conceptual framework (Baumeister & Leary, 1995; Elbing, 2007; Khalil et al., 2007; Miller & Capuzzi, 1984; Ohlsson, 2010; Widdowson, 2013; Wilson, 1981). Furthermore, O'Reilly-Knapp and Erskine (2010) published an example of a conceptual framework for integrative TA, but the methodology for the development of this framework was unclear. Clarkson (1992, 2013) published a book on integrative TA that provided a theoretical overview. Thunnissen (2015), Stewart (1996, 2013), and Widdowson (2013, 2016) published book chapters or books that introduce TA theory and practice.

In contrast to these texts, our aim is to base this conceptual model on a systematic review of the actual international practice of practitioners and on the evidence found in research. A systematic review is defined as a review of the evidence on a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant primary research and to extract and analyze data from the studies that are included in the review. We will also show the similarities ("common components") and unintegratable dissimilarities between different TA approaches.

Method

This review follows the conceptual components approach of psychotherapies (Vos, 2014a). This approach assumes that the conceptual model of a therapy consists of multiple, logically connected conceptual components (Kazdin, 2015; Vos, 2014a). In this study we will focus on six core components and search for empirical evidence supporting these components: central clinical phenomenon, etiology, therapeutic mechanisms, therapeutic competencies, outcomes, and synthesis. This sextet is based on the systematic review of the conceptual components of the 100 most frequently cited articles in psychotherapy, clinical psychology, and counseling (Vos, 2014a). The conceptual components approach has been applied to other therapies (e.g. Vos, 2017; Vos et al., 2015).

The central clinical phenomenon component answers the question what is the central (psychological, clinical, or experiential) phenomenon in this therapy? This may include a definition or diagnostic criteria, such as behavioral exposure therapy focusing on anxiety or phobia. The etiological component answers the question how did this central phenomenon originally develop? This could include specific life events, natural change, and sociodemographic and other influences on the development of the central clinical phenomenon, such as trauma or attachment. For example, in exposure therapy this could be a traumatic experience that gave rise to a phobia. This

could also involve mechanisms that feed the problem, for example, the avoidance of dogs could reinforce cynophobia due to a lack of exposure and experiential habituation. The therapeutic mechanism component answers the question how can the central phenomenon be changed by providing this therapy? This could include information about the nature of therapeutic change. For example, in exposure therapy, exposure to the feared object could lead to experiential habituation and preventing avoidance behavior. The therapeutic competencies component describes the therapeutic methods, techniques, and processes of change that a therapist might use to stimulate change. For example, a behavior therapist could use in vitro or in vivo exposure to create gradual desensitization of the anxiety. The outcomes component answers the question what are the outcomes of providing this therapy? This could be described in terms of effectiveness or efficacy in clinical trials or interview studies, for example, on the subjective experience of the outcomes, the attribution of life changes, and the identification of helpful and unhelpful factors in therapy. For instance, exposure therapy has been shown to have large effects on reducing anxiety in clinical trials. The synthesis component summarizes all of the conceptual components and shows their logical connections and coherence. For example, exposure therapy offers a coherent model that shows how an individual could develop a phobia of dogs as a result of having been bitten by a dog and subsequent reinforcing avoidance behavior. This phobia could be treated by exposure to stop the avoidance and create experiential habituation.

In a bona fide therapy, each of the conceptual components is supported by systematic, empirical evidence from quantitative and/or qualitative research. The evidence for the conceptual model of TA was collected in the following systematic ways. A Transactional Analysis Review Survey was used to identify the common conceptual components that were mentioned by 238 TA practitioners (Vos & van Rijn, 2021b). The TA instruments review summarizes 647 studies on 56 TA-specific instruments and was used as evidence (Vos & van Rijn, 2021a). The TA meta-analysis included 41 studies and was used to describe the outcomes (Vos & van Rijn, 2020). A new, focused review was conducted to identify further empirical evidence for each conceptual component. Finally, we developed a coherent synthesis and visualization of these components. The result of this methodology is the formulation of a coherent, evidence-based, common-denominator model of TA and an indication of the extent to which TA could be considered a bona fide therapy. Concepts excluded from this model may be beneficial for certain clients, but there may not yet be sufficient research evidence to demonstrate this convincingly.

Results

Conceptual Component I: Central Clinical Phenomenon

Transactional Analysis Survey Results

In the survey, 238 TA practitioners internationally were asked what they regarded as the central clinical phenomenon of TA (Vos & van Rijn, 2021b). Factor analyses revealed five factors underlying their answers: ego states, social functioning, self-efficacy, psychopathology and general well-being, and self-realization. Theory in TA seems to hypothesize that ego states, social functioning, and self-efficacy (the central clinical

phenomenon as well as the main therapeutic mechanism) can lead to a decrease in psychopathology as well as an increase in general well-being and self-realization (outcomes). Our meta-analysis seems to confirm this, as will be described in the TA outcome section.

Ego states. Ego states are coherent systems of thought and feeling manifested by corresponding patterns of behavior. Eric Berne developed the idea that people could be in different ego states, or, more specifically, he described how we could experience differences between our inner Adult, inner Parent, and inner Child. Berne did not believe that ego states were hidden but that they were observable in patterns of behavior. Ego states are individual and reflect one's personal development and life story. Therefore, ego states within an individual frame of reference represent the structure of personality, and ego state functions describe patterns in how that structure might be expressed. They were originally described as Free Child and Adapted Child, Critical Parent and Nurturing Parent, and Adult.

In the Transactional Analysis Review survey we did, TA practitioners described a wide range of models of ego states that they use in their practice. Factor analyses of the frequency of the use of different ego state models showed two factors: classical TA ego state models (first-, second- and third-order models) and later, more complex models. The classical ego state models of Parent, Adult, and Child were supported by most practitioners, used most frequently, and experienced as easy to explain to clients. The later complex models were used less often, had less support, and were seen as more difficult to explain to clients. The classical ego state model differentiates an inner Parent, Adult, and Child as well as their different functions within the ego states, although practitioners differ in the formulation of these different functions. All ego state models describe how certain ego states can dominate within a personality structure and behaviors and the impact of the intrapsychic dialogue between those different aspects of personality.

Social functioning. Social functioning includes two aspects. First, it includes the fundamental life position of trust and respect for self and others: that other people are OK, that we can trust others and feel connected, that we are capable of intimate relationships, and that we are able to authentically express ourselves. Second, it includes transactions between people. The survey participants agreed that there can be a difference between verbal and nonverbal messages in a transaction and used the theoretical understanding of how these transactions impacted communication (Berne, 1964).

Self-efficacy. Self-efficacy describes a fundamental life position of "I'm OK." This includes self-love (from the relational Parent, Child, or self), autonomy, self-esteem, a sense of control over one's life, emotional self-regulation, self-protection, psychological resilience in the face of future shocks, problem-solving skills, and taking responsibility for oneself.

Psychopathology and general well-being. Survey participants described that ego states, social functioning, and self-efficacy can predict psychopathology and general

well-being, and thus they expect that TA is effective in ameliorating psychopathology and increasing general well-being. Psychopathology includes common mental health problems such as anxiety, depression, and trauma. General well-being describes behavioral aspects of well-being such as first- and second-degree games and enactment/reenactment of life scripts.

Self-realization. This consists of two aspects. First, it is about the authentic identification and acceptance of feelings and needs in the present instead of feeling hindered by the past. Second, it includes the free flowing of drives, energy, and spontaneity within the bounds of the context and individual circumstances. Thus, individuals feel that they are able to fulfill their potential and live a meaningful and satisfying life.

Instruments Review Results

The review of psychometric TA instruments provided empirical support for the central clinical phenomenon and the relationships with the outcomes.

Ego states. Dusay (1972) developed the egogram as a way to visualize ego states. Several instruments have further developed this. Twenty-three studies operationalized ego states, most often with five concepts: Critical Parent, Nurturing Parent, Adult, Adapted Child, and Free Child. For example, the Tokyo University Egogram was used in 281 studies and had high psychometric quality, and the Adjective Check List–TA Scales was used in 22 studies and had high psychometric quality. The Schema Mode Inventory included more ego states, was validated in 281 studies, and had high psychometric quality (Adapted Child modes: vulnerable, angry, impulsive/undisciplined, contented; dysfunctional coping modes: overcompensation, avoidance, surrender; dysfunctional Parent modes: punitive, demanding/critical; healthy Adult mode). The strongest evidence exists for the five ego states model, although other ego states could be identified in individual clients.

Social functioning. Life position questionnaires include the Life Position Scale, the Life Position Questionnaire, the Personal Orientation Scale, and the Transactional Analysis Life Position Survey (as described in Vos & van Rijn, 2021a). This included Boholst's Life Position Scale, which was used in 24 studies and showed a significant difference between the fundamental positions of "others are OK" and "others are not OK." Social functioning was correlated with strong Adult and weak Adaptive Child and Critical Parent modes. Furthermore, the drama triangle was operationalized with fair psychometric quality by the Drama Triangle Test (Vos & van Rijn, 2021a), which differentiated between Persecutor, Victim, and Rescuer.

Self-efficacy. As just described, the life position questionnaires differentiated between the fundamental life positions of "I'm OK" and "I'm not OK." Self-efficacy correlated with strong Adult, Nurturing Parent, and Free Child.

Psychopathology and general well-being. A greater level of psychopathology had strong correlations with Maladaptive Child and Dysfunctional Parent modes of schema therapy and a life position of "Others are not OK" and "I am not OK."

Self-realization. The level of self-realization had strong correlations with Adult, Nurturing Parent, and Free Child modes and with a life position of "Others are OK" and "I am OK."

Literature Review of Related Research-Evidenced Concepts

Ego states. The concept of ego states, and the derived concept of *schema modes* in schema therapy, has been criticized for conceptual reasons (Lobbestael et al., 2007). There may not be one universal model of ego states/schema modes: It seems that different psychological problems are associated with different ego states/schema modes and that certain psychopathology is associated with specific ego states/schema modes (Arntz & Bögels, 2000; Lobbestael et al., 2007; Young et al., 2006). Although overall therapists seem to have a relatively good understanding of the client's schema modes, in some cases of severe personality disorders—particularly antisocial personality disorder—there seems to be a large discrepancy between the therapist's and the client's perspectives on the client's modes (Lobbestael et al., 2007). Despite these drawbacks, many therapists seem to have integrated the ego state or schema mode model into their practice (Rafaeli et al., 2014). Twelve studies have shown that psychotherapy that focuses on changing modes can reduce the impact of early maladaptive schema (Ata, 2016; Taylor et., 2017) with implications for the effectiveness of using the concept of ego states in TA theory (Vos & van Rijn, 2020). Some studies indicate that therapists may not be accurate in assessing clients' ego states. It might, therefore, be helpful to include questionnaires in treatment as a systematic, reliable, and valid way to assess ego states (Lobbestael et al., 2007).

Further indirect evidence for the Free Child seems to come from research in positive psychology, which shows that individuals can experience a state of *flow* that contributes to positive mental well-being (Csikszentmihalyi et al., 2014). Interview studies indicate that individuals can experience flow with and without rationally taking into account the reality of the situation and possible consequences (e.g., Csikszentmihalyi, 1986). This seems to indicate a difference between flow that is related to the Free Child and flow that combines the Free Child with the Adult. Indirect evidence for the Nurturing Parent may be found in research on self-compassion, which has been described as compassion turned toward oneself and seems to associate self-compassion more with the Nurturing Parent than with the Adult ego state (Neff, 2012). Self-compassion includes explicit nurturing activities such as kindness to oneself, self-care, and understanding for one's own vulnerability and suffering. Research indicates that self-compassion is important for mental health (MacBeth & Gumley, 2012; Neff, 2011).

Social functioning. There have been several observational studies of social functioning (Chung, 2018; Lovejoy, 1991; McGovern et al., 2014; Shustov et al., 2016; Strain & Ezzell, 1978; Williams et al., 2012), some of which indicate the difference between complementary and crossed transactions. However, these studies seem to have a large risk of bias. Many studies have confirmed the difference between nonverbal/implicit messages and verbal/explicit messages in communication and its role in therapeutic effectiveness (Hall et al., 2005; Henry et al., 2012; Manusov, 2014).

Self-efficacy. Research indicates that self-esteem, locus of control, emotional self-regulation, psychological resilience, and problem-solving skills correlate strongly with level of psychopathology (Greenspoon & Saklofske, 2001; Werner et al., 2019; Zeigler-Hill, 2011).

Self-realization. Research indicates that experiential acceptance and authenticity correlate with one's level of psychopathology (Chawla & Ostafin, 2007). Ego states and self-realization are also correlated (Arndt et al., 2002; Schimel et al., 2001; Schlegel & Hicks, 2011; Vos, 2017). Individuals who feel that they are able to live a meaningful and satisfying life experience less psychopathology and better overall well-being (Vos, 2016a, 2016b, 2017).

Summary

TA practitioners focus on ego states and their functioning, which research has specified as Nurturing Parent, Critical Parent, Adult, Adapted Child, and Free Child. However, other ego state classifications may also be identified for specific individuals in the deeper analysis of the personality structure. These ego state functions are related to social functioning and self-efficacy. Research indicates that ego states, social functioning, and self-efficacy are strong predictors of an individual's levels of psychopathology, general well-being, and self-realization.

Conceptual Component II: Etiology of Problematic Experiences

Theory

Eric Berne (1972) used the term *life script* to describe "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). Later he added that the life script is a repetitive pattern of a complex set of transactions. A script is an attempt to repeat the past in derivative form in the here and now. This is a transference drama created by the interaction of the child within their environment. Berne (1961) described how patterns from early family dramas are reenacted in everyday life. The current life script is developed over time, with the basic dynamics and conflicts developed preverbally. Berne called the unconscious life script developed in early life the *protocol* and the preconscious script in later life a *palimpsest*. TA theory suggests that in their current life, individuals may search for others who unconsciously fulfill the various roles in their life script (protocol and/or palimpsest). In his expressive writing, Berne described the transferential drama as a theater set.

In early TA writings by Berne and Steiner, the development of the life script was more explicitly connected to the ego state model, and new terms were introduced to explain the different influences. The concept of *injunctions* was developed to define unprocessed psychological material. These were seen as negative, controlling, nonverbal psychological messages given unconsciously by the parent to the child in early childhood. Injunctions were usually experienced as prohibitions or negative commands. The concept of *counterinjunctions* referred to messages about how to be loved, recognized, and OK while avoiding internal and external conflict. Some of those

messages become compulsive and were termed *drivers* (Goulding & Goulding, 1976). They enable the enactment of the unconscious script process (e.g., a "Be perfect" driver leading to perfectionism and an internal experience of shame and failure). The "program" was related through learning from a caregiver's example rather than intention. In terms of ego states, the Adult material became contaminated (or flooded) by the unconscious and/or historical material of the Child or Parent.

Over the years, this theory became more refined and led to a more nuanced understanding of the process of developing script decisions and patterns through complex interactions between the child and their environment, sociopolitical context, and genetic influences. However, the description of the full development of this theory is beyond the scope of this paper.

The concept of life position relates to a stance toward oneself, others, and the world that an infant often develops very early in life. This life position underlies the individual's life script.

Transactional Analysis Review Survey Results

Participants in the Transactional Analysis Review Survey were asked to describe the cause of problems in the central clinical phenomena in TA (i.e., ego states, social functioning, and self-efficacy). Most TA practitioners believe that a combination of factors can lead to the development of problems. Factor analyses of their answers revealed four factors.

Unfavorable messages. According to factor analysis, individuals can receive four types of unfavorable messages. First, negative messages in early life include negative protocol, injunctions, and insufficient psychosocial holding; negative stroking (stimulation); nonverbal psychological transactions; explicit unfavorable messages; and insecure attachment. Second, individuals may insufficiently develop mature coping mechanisms because of a negative palimpsest, defensiveness, and/or a lack of separation-individuation, psychological integration, or holding. Third, individuals may be psychologically impacted by previous generations, for example, via episcripts, family secrets, and ambiguous family communication. Fourth, individuals can also experience a negative stroke (stimulation) balance of negative and conditional strokes, may not accept or seek strokes (positive social stimulation by others) or self-strokes (self-soothing), and/or may lack positive key permissions (e.g., "You are OK," "You can be close," etc.).

Decisions. Responses indicated an understanding that the development of self-limiting patterns is an interactive process, although not necessarily a conscious one. Individuals contribute to the development and continuation of their problems in multiple ways. Factor analyses indicated three underlying dimensions understood by the practitioners. Individuals could accept behaviors and reject injunctions via emotional disconnection, avoidance, denial, dysfunctional emotion regulation, and dissociation of experiences and memories. Individuals could also accept injunctions via cognitive styles (e.g., learned helplessness and cognitive biases).

Life events. Individuals are also influenced by life events, such as childhood trauma, neglect, abuse, and traumas later in life.

Denial of existential givens. Some individuals also mentioned that an existential given may be discounted in early life by others, for example, freedom and responsibility/lack of freedom, meaning/meaninglessness, connection/isolation, death/life, and vulnerability/health.

Genetics/temperament. Although some TA practitioners mentioned the role of luck, genetics, and temperament, these were regarded as relatively unimportant in therapeutic practice and will therefore not be examined further in this review.

Instruments Review Results

These concepts were operationalized on six scales, all of which had poor to fair psychometric quality: ESPERO, ANINT, Drivers Checklist, Drego Injunctions Scale, Driver Questionnaire, and Script Injunctions Scale (as reviewed in Vos & van Rijn, 2021a). Life scripts were operationalized on seven scales, all of which had poor to fair psychometric quality: Comprehensive Life Script Interview; Decision Scale; Developmental Script Questionnaire; Berne's Script Check List; Steiner's Script Check List; Ohlsson, Björk, and Johnsson's Script Questionnaire; and Script Questionnaire (Vos & van Rijn, 2021a). The relatively poor psychometric quality of these instruments is mainly due to a lack of research.

However, other psychometric instruments with strong psychometric quality indicated correlations between unfavorable messages and the central clinical phenomenon. Several studies showed strong correlations between childhood trauma and ego states and life positions (Anne & Boholst, 2020; Blizard, 2001; Boholst et al., 2005; Novak, 2008; Van der Kolk et al., 1994). No TA-specific instruments have been developed for script decisions, life events, denial of existential givens, and genetics/temperament.

Literature Review of Related Research-Evidenced Concepts

Unfavorable messages. The idea that individuals may develop a life script early in life (programs and episcripts) has also been formulated and studied outside of the TA field, including concepts such as schema in schema therapy (Perris, 2009), representations of interactions that have been generalized (RIGs) (Stern, 1985/2000), and Tomkin's script (1978). In general, research indicates that mental health problems in later life can have their origins in the early development of an insecure attachment (Morley & Moran, 2011). The following is an overview of studies on the impact of four types of unfavorable messages (parental and intergenerational messages, early development, lack of key permissions) on ego states, social functioning, self-efficacy, and psychopathology over the long term.

Parental messages. There have been 386 studies on the relationship between parenting style, ego states/schemas, and psychopathology as measured with the Young Parenting Inventory (e.g, Sheffield et al., 2005; Young, 1994). Systematic literature

reviews clearly indicate that parental messages have a moderately large impact on the development of a child's ego states/schemas and on psychopathology later in life. For example, research has shown how individuals with psychopathology are more likely to have had unpredictable, invalidating, and critical caregivers in a home that lacked warmth, safety, and nurturing and in which there were conflicts, childhood trauma, and abuse (Harold & Sellers, 2018; Toth et al., 1992).

Examples include the effect of toxic early childhood experiences on depression, including such factors as physical abuse, emotional abuse, emotional neglect, low care, high rejection, high overprotection and/or control, and maladaptive parenting styles (Lim & Barlas, 2019). Many studies have focused particularly on the impact of attachment style on later psychopathology (Chauhan et al., 2014; Gorrese & Ruggieri, 2012; Jalali et al., 2011; Körük et al., 2016; Mallinckrodt & Wei, 2005; Ranson & Urichuk, 2008). Insecure attachment was associated with poor social functioning and a low sense of self-efficacy (Caldwell et al., 2011; Wei et al., 2005; Wolfe & Betz, 2004).

Furthermore, research shows that early-life parental messages influence later psychopathology due to the development of negative ego states/schemas. That is, ego states mediate the impact of early-life experiences on later psychopathology. Research shows that these impacts can be explained by the fact that early environmental factors have influenced a child to develop a poor self-image, a self-critical internal dialogue, and negative feelings such as guilt and shame (Hammen, 1992; Sachs-Ericsson et al., 2006). Negative child-rearing styles lead to the development of early maladaptive ego states/schemas, which can subsequently influence the development of psychopathology later in life (Basso et al., 2019; Fischer et al., 2016; Unal, 2012). Studies have confirmed that the impact of early-life experiences on later psychopathology is mediated by the development of negative ego states/schemas in conditions such as depression and anxiety (DeLorme, 2013; Haugh et al., 2017; Nia et al., 2014), eating disorders (Sheffield et al., 2009), gender identity problems (Hinrichsen et al., 2007; Simon et al., 2011), obsessive compulsive disorder (Rejtô et al., 2017), antisocial behavior (Van Vlierberghe et al., 2007), partner problems (Besharat et al., 2014; Monajem, 2013; Taskale & Soygüt, 2017); sleep problems (Rodrigues et al., 2019), and attention deficit hyperactivity disorder (ADHD) (Evinç et al., 2014). Furthermore, some studies indicate how negative parental messages can influence the neurodevelopment of children (Allen, 2000).

Transgenerational transmission. Research on transgenerational transmission of psychological messages has mainly focused on the children of traumatized parents, particularly those who suffered during the Holocaust. This shows that traumas can impact future generations (Baranowsky et al., 1998; Goodman & West-Olatunji, 2008; Pearrow & Cosgrove, 2009; Roth et al., 2014). Although more empirical evidence is needed, it has been suggested that even after several generations, the offspring of slaves still suffer from worse health (posttraumatic slave syndrome), possibly due to epigenetics (Degruy-Leary, 1994; Sullivan, 1953/2013). The hypothesized mechanisms behind this transmission in these studies regard problems in parenting styles and attachment. Furthermore, some small studies indicate that family secrets may lead to a long-term impact on the well-being of children and grandchildren (Dalzell, 2000; Vangelisti,

1994), with particular attention to the emotional impact of disclosure of family secrets (Pennebaker et al., 1988; Vangelisti et al., 2001).

Early development. Research on a failure to develop sufficient coping mechanisms shows how a lack of separation-individuation increases the likelihood of mental health problems (a selection from many studies: Kins et al., 2013; Lopez & Gover, 1993; Rice et al., 1995). Recent developments in theory and research also indicate that separation-individuation is not confined to adolesence but extends into later adulthood (Colarusso, 1990). Coping mechanisms and emotion regulation seem disturbed in individuals with mental health problems (Carl et al., 2013; Ehring et al., 2008; Fehlinger et al., 2013; Gross & Thompson, 2007), and a dominance of avoidance and denial as dominant coping strategies in life is common (Beblo et al., 2012; Campbell-Sills et al., 2006; Ehring et al., 2010). Psychological integration is a broad, ill-defined concept that usually means that an individual does not suppress or avoid important parts of their self, that is, they are "congruent" (Sollarova & Sollar, 2010). Research suggests that mental health is impacted by a lack of congruence and coherence in life (Sheldon & Kasser, 1995); inauthenticity (Goldman & Kernis, 2002; Schlegel et al., 2009; Schlegel et al., 2013;); and repression and dissociation of emotions and body experiences, particularly in the case of psychotrauma (Bremner & Marmar, 2002; Nijenhuis, 2001; Singer et al., 1995).

There has been much criticism from researchers of the concepts of symbiosis or relational merger and projective identification in early relationships (Blass & Blatt, 1996; Weinberger & Stoycheva, 2019). A review of the research literature found few reliable empirical studies on the existence of these phenomena and none on their impact on mental health. Experimental research seems to suggest that some individuals may have a wish for oneness or merger with others, which may be associated with some mental health problems (Weinberger & Smith, 2011). However, the specific psychodynamic ideas about the concept of symbiosis may need to be replaced with more evidence-based concepts closely associated with these phenomena, such as the psychological importance of secure attachment (Morley & Moran, 2011) and separation-individuation (Kins et al., 2013; Lopez & Gover, 1993; Rice et al., 1995). Furthermore, there is little evidence for the associated concept of the *double bind*, which is a complex theory and includes the idea that conflicting messages from parents—either conflicts between nonverbal and verbal or conflicts between the messages from both parents—can lead to severe psychopathology such as schizophrenia (Koopmans, 2001). What research seems to confirm is that any type of transactional ambiguity in families may lead to mental health problems, although there may not be a direct relationship because other causes and interacting factors need to be taken into account (Koopmans, 2001). A more holistic assessment is needed to understand what was once called a double bind, such as the scenario that pathogenic patterns in family interactions (e.g., power discrepancies between spouses, ill-defined parental roles, etc.) are exacerbated by life events (e.g., death of a family member, moving house, unemployment, etc.) and can lead to children turning to address their parents' adult needs (Koopmans, 2001).

Strokes. Strokes are the human need for social recognition and stimulus in many forms. There is little research on the specific relationship between the TA concept of strokes and mental health. However, indirect evidence comes from the overwhelmingly large number of research studies on the important role of social support in maintaining mental as well as physical health (e.g. Almquist et al., 2017; Buchanan, 1995; Cohen et al., 2004; Uchino, 2006; Wang et al., 2017). Family ties, particularly in early life, are important for mental health (Shor et al., 2013). Social support can reduce depression, perhaps because it fosters more positive coping styles (Joiner, 1997; Marroquin, 2011), whereas relational problems can lead to feelings of loneliness and isolation that worsen a person's mood (Barrett & Barber, 2007; Cacioppo et al., 2006; Perlman & Peplau, 1984; Segrin & Passalacqua, 2010; Weeks et al., 1980). Individuals with mental health problems often struggle with relational problems for a long time—even before the onset of the mental health issues—and may have been the victim of relational bullying (Brown et al., 1995). The relationship between mental health problems and social isolation seems to be a vicious cycle—or even a tautology—as mental health problems are often associated with social withdrawal and inhibition that can exacerbate those problems (Alfano & Perry, 1994; Hames et al., 2013). This includes more negative communication styles (Kazdin et al., 1985; Segrin, 2000), such as seeking negative feedback or excessive reassurance, interpersonal conflict avoidance, and blame maintenance (Joiner, 2000; Joiner et al., 1993).

There is little research on strokes such as appreciation and compliments, but there are some indications that both can improve mood and self-esteem as well as the sharing of positive emotions between individuals (Fredrickson, 2004; Gable et al., 2006; Gable et al., 2004; Singh, 2017). However, it appears that people do not often give compliments or engage in other prosocial behavior because they underestimate the impact that they can have on others (Zhao & Epley, 2019). Research indicates that positive strokes often meet a complementary transaction. In fact, individuals often respond in complementary ways to others. For example, if a person is withdrawn in a relationship, the other will also withdraw (Kiesler, 1996; Ravitz et al., 2008). An important aspect of positive strokes seems to be the feeling that one matters and belongs to a community (Prilleltensky, 2014). Giving and receiving positive strokes confirms the social meaning of one's life, and research shows that focusing on social types of meaning in life—instead of merely focusing on materialistic or self-oriented types of meaning—is important for positive mental health (Vos, 2016a, 2016b, 2017, 2020).

There is more research on self-stroking, in the sense of the role of self-acceptance and self-criticism for mental well-being. Mental health problems are often associated with negative self-esteem, negative self-schema, and self-criticism (Bagby et al., 1992; Beck et al., 1979; Blass & Blatt, 1996; Cox et al., 2004; Wisco, 2009). In contrast, self-compassion predicts better mental health (MacBeth & Gumley, 2012; Neff, 2011; Zessin et al., 2015). Finally, the idea of life positions has been empirically confirmed by countless research studies on attachment (e.g., summarized by Morley & Moran, 2011).

Script decisions. According to the TA practitioners in the survey, individuals are not passive victims of their generic circumstances and their early-life experiences but

make choices and develop coping mechanisms, some of which can be behavioral, emotional, or cognitive.

Behavioral coping strategies. Many research studies show that individuals can externalize problems. In particular, young men may act out in response to stressful situations such as verbal or physical aggression (e.g., Enstad & Kjeldsen, 2018; Kjeldsen et al., 2020; Zilanawala et al., 2017). Individuals are more likely to show externalizing behavioral coping strategies because of their genetics (Bakermans-Kranenburg & Van Ijzendoorn, 2011); temperament, which includes self-regulation and reactivity (Rothbart et al., 2006); hyperactivity (Shaw et al., 2005); lack of social competence (Bornstein et al., 2010; Burt et al., 2008); and being male (Dodge et al., 2006). Furthermore, externalization is more likely when someone has experienced harsh, negative parenting such as physical aggression or low warmth (Odgers et al., 2008; Shaw et al., 2003; Wiggins et al., 2015).

In particular, it seems that the authoritarian combination of lack of warmth and high levels of control by parents can lead to externalizing behavior (Baumrind, 1991; Thompson et al., 2003). Parental depression and other mental health issues can also increase the likelihood of externalization (Shaw et al., 2005) as can marital dissatisfaction and conflict (Campbell, 1995; Katz & Gottman, 1993) and other family stressors such as loss of a relative (Campbell et al., 1996). There is overwhelming evidence that externalizing behavior can also be caused by lack of social support and socioeconomic problems of the family (Bøe et al., 2012; Côté et al., 2006; Nagin & Tremblay, 2001). Large families and having younger siblings may also increase the risk (Farrington, 1995). Peer pressure and peer cultures can be an additional factor in creating externalizing behavior (Dishion et al., 1999; Hanish et al., 2005). Thus, a complex combination and dynamic interaction of multiple factors over time can lead to a trajectory of externalization. It appears for individuals who later externalize, these factors remain relatively consistent during early life until adulthood, and there is not a specific sensitive period that leads to externalizing behavior as some TA theorists have proposed (Kjeldsen et al., 2020; Roberts & DelVecchio, 2000; Skipstein et al., 2010). Furthermore, there is some evidence that early maladaptive modes—similar to the concept of ego states—predict internalizing and externalizing behavior (Van Wijk-Herbrink et al., 2018).

Emotional coping strategies. In classical TA, the term *racket* was initially used to broadly describe inauthentic feelings, thoughts, and behaviors learned in childhood through the familial socializing process (e.g., in a family where it is not acceptable for girls to be angry, a girl might learn to cry when angry). Erskine and Zalcman (1979) and O'Reily-Knapp and Erskine (2010) developed the understanding of this term as a cyclical enactment of the script dynamic in the present, usually at times of stress. This frequently resulted in predictable but self-limiting interactions with others (psychological *games*). The script process becomes observable through a recognizable set of behaviors (e.g., irritability); a related internal experience (e.g., feeling weighed down); and a cognitive process that contains self-limiting beliefs about self, others, and the quality of life (e.g., I am on my own, no one will help, life is pointless); and a habitual

repetitive emotion (e.g., hopelessness). This cyclical experience is reinforced by the memory of similar past experiences.

Cognitive coping strategies. TA psychotherapists have argued that individuals may accept injunctions via a despairing or defiant decision. As mentioned earlier, there is little evidence that people have well-defined alternative options for rejecting the impact of their early-life situation. However, there is much evidence that in response to difficult life situations, individuals may develop a sense of hopelessness (Liu et al., 2015), demoralization (Robinson et al., 2016), and a schema mode or ego state of surrender. From a behaviorist perspective, there is considerable evidence that in response to repeated failure, individuals can develop learned helplessness, which is associated with symptoms of passivity and depression and can be explained by neurobiological mechanisms (Maier & Seligman, 2016). Children can also copy the helplessness of their parents, possibly due to parental modeling and negative parental responses (River et al., 2018). People can also redefine experiences according to their own frame of reference or, more generally formulated, because of cognitive biases. Biased interpretations, processing, and memory retrieval are associated with mental health problems such as depression, anxiety, and rumination (Everaert et al., 2012; Gotlib & Joorman, 2010; Mathews & MacLeod, 2005; Nolen-Hoeksema et al., 2008). Greenberg and Watson (2006) identified four maladaptive (inauthentic or racket) emotions in depression that have shifted from a more realistic and nuanced perspective on life, the world, and the self: shame and guilt, fear and anxiety, sadness, and anger. Research has identified many cognitive biases (Manoogian & Benson, 2017), of which the following seem the most common and most psychologically problematic for clients (Widdowson, 2016): black-or-white thinking, catastrophizing, fortune telling, mind reading, taking things personally, overgeneralization, overdetailing, and tunnel vision.

What can prevent individuals from developing learned helplessness or cognitive biases? Many researchers have studied a wide range of resilience factors that can prevent stressful life events from triggering mental health problems (Galatzer-Levy et al., 2018). Resilience means, among other things, that individuals are able to rise above their situation, adapt, and adjust dynamically to their stressful situation (Aburn et al., 2016). Several factors have already been mentioned in this article, such as social connectedness, self-compassion, and a sense of meaning in life (Vos, 2016b, 2017). Meta-analyses show that the strongest factors for resilience in situations of failure are higher self-esteem, more positive attributional style, and lower socially described perfectionism as well as, to some extent, lower attribution to one's own traits, lower self-oriented perfectionism, and higher emotional intelligence (Johnson et al., 2017). Thus, there are several factors that can protect individuals from developing mental health problems.

How free are individuals to change their attitude toward their situation? Can individuals decide their response? The empirical literature does not seem to support the traditional TA concept of *decision* in the narrow sense as a clear point in time when the individual had multiple options and chose consciously or unconsciously one specific behavioral, emotional, or cognitive response to their life situation. Often under the influence of the complex interaction of their circumstances, individuals did not

have another option. Thus, there are so many complex factors at play that the question of freedom needs to be regarded as a metaphysical question that may not be operationalized and validated at all. One might argue that the question of freedom should not be investigated because it is a nonscientific, nonverifiable construct (Popper, 1990). The use of the term decision may even be criticized for blaming the victim, which may exacerbate feelings of guilt and shame and thereby psychopathology (Verhaeghe, 2017; Vos et al., 2019). Therefore, therapists need to be careful and sensitive in how they assess and address the role of the self as a hypothetical factor in the etiology of mental health problems. However, the belief in freedom seems to be beneficial for individuals in various situations. Research suggests, for example, that a sense of hope can improve mental health (Koehn & Cutcliffe, 2007; Schrank et al., 2008; Snyder et al., 2003). Consequently, instilling hope during therapy can be beneficial (Schrank et al., 2012). Individuals can also benefit from a sense of self-efficacy, which is their belief in their ability to produce desired outcomes through their own actions (Maddux & Kleiman, 2016; Schwarzer, 2014). This seems particularly the case for individuals with mental health problems, who seem to benefit from interventions that increase a sense of self-efficacy and control (Corrigon et al., 2006; Marks & Allegrante, 2005).

Thus, although it seems impossible to conclude that individuals can totally decide or redecide their situation or life script, they seem to have some scope in determining their own attitude toward their situation. This has been described as a "dual attitude" (Vos, 2014b, p. 885). On the one hand, individuals accept the limitations that their situation puts on their freedom, and on the other, they try to develop a meaningful attitude toward their situation. This idea was developed by Viktor Frankl (1949/1985), who described in his book *Man's Search for Meaning* how concentration camp prisoners could not decide to completely transcend their situation—it was realistic that they suffered from hopelessness and mental health problems—but within their limited options, some were able to focus on meaningful moments, such as sharing a gaze with another inmate or holding on to the past. Thus, individuals have some freedom to decide a more beneficial attitude toward their situation, even though it may be understandable if they feel unable to do so.

Role of life events. Individuals are also influenced by life events, such as childhood trauma, neglect, abuse, and trauma later in life. For example, the environment in a home impacts the mental health of children, including such factors as a parent's felt burdens, needs, and psychopathology; whether it is a single-parent household; and being from an ethnic minority group (Ryan et al., 2015). Research seems to indicate a particularly important role for transmission of parental burdens to children and the direct impact of a parent's mental health, possibly as children are implicitly or explicitly expected to take up parental tasks (which is called *parentification*) (Boszormenyi-Nagy, 2013). Research indicates that several groups experience significant oppression in society: women, individuals with lower socioeconomic status; Black, Asian, and people from other ethnic minorities; LGBTQI + individuals; and those with chronic physical and mental health problems. Such factors are associated with feelings of stigma, fear, distrust, humiliation, shame, instability, and insecurity; social isolation; and feeling

trapped and helpless (Vos et al., 2019). Furthermore, traumatic life events can severely impact one's fundamental assumptions about life, the world, and the self, such as the benevolence, understandability, and explainability of such events (Janoff-Bulman, 2010; see also Vos, 2016b, 2019).

Denial of existential givens. Some individuals also mentioned that an existential given may be discounted in early life by others. There are no studies on the specific discounting by parents, but in general research indicates that denial or avoidance of existential givens can be detrimental for social and psychological well-being (Vos, 2014b, 2016a, 2016b, 2019).

Summary

This review shows that unfavorable messages and stressful life events early in life can have a long-lasting effect. These may include negative parental or transgenerational messages or other developmental problems in attachment development and separation-individuation. Although empirical literature does not support the narrow meaning of the term *script decision*, individuals seem to experience some freedom to accept or reject these unfavorable messages through their behavioral, emotional, or cognitive coping styles. These unfavorable messages, life events, and decisions can influence ego states, social functioning, and self-efficacy later in life and subsequently influence the individual's psychological well-being and psychopathology. More research is needed on the role of discounting existential givens and genetics/temperament.

Conceptual Component III: Therapeutic Mechanisms

Transactional Analysis Review Survey

The therapeutic mechanisms describe the internal changes within the client that explain the improvement during therapy. Most TA practitioners believe that clients improve because of the following mechanisms of change: They develop freedom to develop themselves; remove obstruction to natural growth; rise above circumstances, past history, inner drives, and impulses; learn to live in the moment; develop self-insight; resolve structural conflicts; have a positive corrective experience; feel validated in their experiences; develop greater movement between ego states; learn to risk intimacy; learn from mistakes; learn to fulfill their potential; grieve for losses; forgive; and remember but not repeat the past.

Optimal scaling indicated three categories underlying these mechanisms of change: ego state development (e.g., development of self-insight, rising above the past by having a stronger Adult, and more freedom in moving between ego states), improved social functioning (e.g., daring to take social risks in the present), and increased self-efficacy (e.g., trusting one's experiences; developing self-insight, a sense of freedom, and control).

TA Meta-Analysis

TA had significantly larger effects on psychopathology and general well-being when large changes were reported in the positive functioning of ego states ($R^2 = .43$, $p < .01$), social functioning ($R^2 = .34$, $p < .01$), and self-efficacy ($R^2 = .33$, $p < .01$) (Vos & van Rijn, 2020).

Literature Review of Related Research-Evidenced Concepts

There is relatively little empirical research into therapeutic mechanisms. One review of 75 existential therapies showed that clients' psychological well-being improved thanks to an improvement of their skills in living a meaningful and satisfying life while acknowledging life's challenges (Vos & Vitali, 2018). This means that they learn to hold the paradoxes and complexities in life, which in TA terminology can be explained as the ability to shift between different ego states instead of being stuck in one or that a decontaminated Adult ego state has a capacity to hold complexity and paradox.

Summary

TA treatment intends to help clients by developing constructive ego states, improving social functioning, and stimulating self-efficacy. Research confirms that TA improves clients' psychopathology and general well-being thanks to improvement in their ego states, self-efficacy, and social functioning.

Conceptual Component IV. Therapeutic Competencies

Transactional Analysis Survey Results

Survey participants described that TA practitioners use a range of therapeutic competencies; factor analysis identified four groups of competencies.

Etiological analysis. Participants described that they use the following types of assessment (in order of importance): relational needs, transference and countertransference, stroking behavior, the drama triangle, clinical intuition, historical inquiry, phenomenological inquiry, analysis of ego state contamination, linguistic and body analysis, script and/or racket analysis, and social and behavioral diagnosis of ego states. Other assessment styles include analyzing unmet archaic needs, coping with disruptions in the past, listening for unconscious stories, analyzing racket systems (e.g., what is feared and avoided), being aware of reenactments of scripts from childhood, looking at existential life position (e.g., war versus peace, famine versus plenty, pestilence versus health, death versus life), considering modes of passivity, and analyzing time structure.

Factor analysis indicates the following underlying dimensions: analysis of current ego states and their development over time (e.g., life scripts, injunctions and counter-injunctions/drivers); analysis of current social functioning and its development over time (life position, permissions, stroking behavior, time structure, modes of passivity; archaic relational needs in the here and now, including in the therapeutic relationship); analysis of self-efficacy and its development over time (inauthenticity, script

feelings and behavior, reported fantasies, reinforcing experiences); and analysis of the unspoken (body language, phenomenological analysis, clinical intuition).

Working at experiential depth in the here-and-now. Therapists stimulate clients to accept, express, and explore their experiences. This involves using mechanisms to help clients become free from inhibitions and transcend the self as well as to develop self-insight and a constructive relationship with the past. Clients are also stimulated to focus on their experiences in the here and now and not merely on the past and to take risks to fulfill their potential in the present.

Treatment structure. TA practitioners described that they use several ways to structure the treatment via contracts, psychoeducation/didactics, and treatment stages. Survey participants described how often and when they used specific techniques in the treatment. Factor analysis of their answers indicated that there are four treatment stages: a preparation stage (building a therapeutic alliance, creating a contract, an initial assessment of strengths and difficulties); assessment (clinical and etiological analysis, strengthening the inner Adult; this seems to overlap with what has been called the decontamination stage); processing (learning to accept and express experiences, working through past emotions and memories, developing insight and awareness, challenging unhelpful messages); and decision making, application (making decisions and applying them in daily life), and an ending stage.

Positive client-practitioner relationship. This includes stimulating a positive relationship between the client and the therapist and using the relationship as a tool in the therapeutic process. Factor analyses showed the following underlying dimensions: validation of the client as an autonomous individual (openness, autonomy, respect, stimulating responsibility, belief in change) and actions to facilitate the therapeutic relationship (cooperative, emotionally literate, clear contracts, avoiding games). Specific techniques to stimulate the relationship include expressing positive emotions (empathy, attunement, kindness, validation, normalization), accepting and validating the client's autonomy, working with transference and countertransference, being non-judgmental (asymmetric mutuality, neutrality, objectivity), following the client (patience, rapport, using the client's language), and stimulating the development of insight (theorizing, clarifying, using clinical intuition). When a transactional game emerges in the therapy setting, therapists put the game aside (not playing along but also not exposing the game), expose it and offer insight into the game, and/or use self-reflection.

TA Meta-Analysis

TA is more effective when practitioners focus on creating a positive client-practitioner relationship, include work at experiential depth in the present, use etiological analysis (life script analysis, analysis of injunctions and counterinjunctions), and offer a strong structure (clear treatment stages, psychoeducation/didactics, treatment contracts) (Vos & van Rijn, 2020).

Literature Review of Related Research-Evidenced Concepts

Case formulation. Research indicates that treatments are more effective when based on a case formulation (Kendjelic & Eells, 2007; Page et al., 2008). Case formulations are used to examine which treatment and interventions suit the client and which effects can be expected. When problems arise during treatment, the case formulation may be used as a guide to resolve them. A good case formulation is as clear and brief as possible, holistic, precise, and empirically testable. In addition, the hypothesized mechanisms of the etiology and treatment are evidence based (Dawson & Moghaddam, 2105). Although the term *case formulation* is not used in the TA literature—which often refers to assessment and TA diagnosis—a case formulation describes a systematic assessment of the evidence-based clinical and etiological models of the treatment (in TA the ego states, social functioning, and self-efficacy). This is then used to formulate a tailored treatment. The case formulation can be used to monitor treatment progress and adjust treatment goals or methods when needed (van Rijn, 2014).

Research also indicates that assessment does not merely involve analyzing the verbal content of the client's communication but also what is unspoken. Research indicates that explicit analysis and use of nonverbal communication is associated with better treatment outcomes (De Roten et al., 1999; Hassan et al., 2007; Pally, 2001; Pinto et al., 2012; Sherer & Rogers, 1980; Tepper & Haase, 1978). For example, a study in which counseling psychology trainees were trained to accurately identify nonverbal behavior improved their level of empathy, which is an important aspect of effective therapies (Eyles, 2016). Few studies investigated the existence, accuracy, and effectiveness of clinical intuition in psychotherapy, although several authors have reported that clinical intuition may improve the assessment and tailoring of interventions in therapy. They also mention the dangers of inaccurate intuitions and biases (Herbert et al., 2007; Jeffrey & Fish, 2011; Rea, 2001).

Working with experiences in the present. Research shows that experiential processing skills that help clients to accept, express, and deepen their levels of experiencing and emotional processing are a key ingredient of effective psychotherapy (Norcross & Lambert, 2019). The deeper and more internally clients analyze their experiences, the more effective psychotherapy becomes (Greenberg et al., 2007; Hendricks, 2002; Orlinsky et al., 2004; Pos et al., 2003; Sachse & Elliott, 2002). However, some research suggests that emotional processing alone is not effective or could even be detrimental (Mohr et al., 1990), but it can be effective when combined with cognitive processing of the emotion (Bohart, 1993). For example, Mergenthaler (1996) found that therapy is most effective when there are both high levels of emotion and high levels of cognitive abstraction in a session.

Treatment structure. The survey showed that TA practitioners use multiple ways to structure treatment via treatment contracts, psychoeducation/didactics, and clear treatment stages.

Treatment contracts can have many forms in TA (Sills, 2006). Research indicates that it is important to manage the expectations of clients in therapy, for example, by explicating the aims, methods, and practical aspects of the treatment (Orlinsky et al.,

2004). Treatment is more effective when the client and practitioner have assessed and agreed on the treatment goals and the methods to achieve those goals (Tryon & Winograd, 2011). Treatment goals should not be conceptualized as rigid and unvarying targets that clients are pressured to construct and pursue. Rather, the emphasis should be on helping clients clarify and explore the goals that are already there in terms of being implicit in the structure of the person's engagement with his or her life (Cooper & McLeod, 2007). It has been recommended that goals be set relatively early in the treatment process, preferably at the end of the assessment session, and that they be based on the meaning-centered case formulation and adjusted after several sessions.

Compared with other treatments, TA includes psychoeducation or didactics in the treatment, for example, by explaining the structural and functional models to clients. In some clinical trials, it is even difficult to differentiate treatment from educational training (Vos & van Rijn, 2020). Research indicates that didactics and psychoeducation have some positive effects on clients in treatment (Donker et al., 2009; Lincoln et al., 2007).

The Transactional Analysis Review Survey identified four stages in TA treatment: preparation, assessment, processing decision making, and application/ending stages. However, within the TA field, these are called preparation, decontamination, deconfusion, redecision, and consolidation and termination (Berne, 1961, 1966; Stewart & Joines, 1987; Woollams & Brown, 1979). Many TA psychotherapists assume that decontamination, deconfusion, and redecision take place in a linear progression, starting with decontamination and moving through deconfusion to the final stages of redecision followed by consolidation and termination (Pulleyblank & McCormick, 1985; Woollams & Brown, 1979). However, several authors have argued that deconfusion already starts in the first session when the therapist responds empathically to the client (Hargaden & Sills, 2002) because there needs to be an empathic, supportive therapeutic relationship before the client's irrational thoughts can be challenged (Clarkson, 1992; Hargaden & Sills, 2002).

Research indicates that the process of change occurs in stages as individuals move from precontemplation to contemplation, preparation, action, maintenance, and termination (Prochaska & Norcross, 2001). Also, in psychotherapy, clients seem to go through stages of change, and starting treatment at a higher stage leads to better and greater outcomes (Krebs et al., 2018). However, some authors did not find clear evidence for the linearity of these stages and argued that clients may not follow a rigid path. Rather, they may return to previous stages, and those need to be tailored to each individual (Riemsma et al., 2003). Regardless of the specific stages that clients go through, researchers seem to agree that clients experience successive shifts in their frame of mind during therapy (Katakis, 1989; Kiesler, 1996). Thus, stages need to be tailored to the client, implying that aspects of decontamination and deconfusion may be used at any moment in treatment as long as it facilitates the client in undergoing a shift in their frame of mind.

The decontamination (assessment) stage involves therapeutic procedures to resolve contamination of the Adult ego state by the inner Parent or the inner Child. The goal of decontamination is to identify inaccurate and unhelpful beliefs from the past and

current perceptions of reality. This can make the client aware of differences between ego states and strengthen the Adult ego state. Although the therapist aims to strengthen the Adult ego state, deconfusion includes both cognitive and emotional processes related to identifying and reflecting on archaic material. As described earlier, exploring and expressing emotions have shown to improve the effectiveness of therapy (Aldao et al., 2010; Norcross & Lambert, 2019) as have cognitive techniques (e.g. Hofmann et al., 2012), although it seems to be the combination of cognitive and emotional work that makes therapy effective (Bohart, 1993; Mergenthaler, 1996). Research suggests that individuals are able to differentiate experiences that they associate with their "true self" beyond the influence of others and those associated with their "false self" influenced by others. Focusing on their true self improves their psychological well-being and life satisfaction (Schlegel et al., 2009; Schlegel et al., 2013). Furthermore, there is some empirical evidence that analysis and interpretations of the influences of one's past can improve the effectiveness of psychotherapy (Allen, 2000; Orlinsky et al., 2004; Williams et al., 2012). For example, systematic life reviews can improve someone's psychological well-being and quality of life (Westerhof et al., 2010). Indirect evidence for the effectiveness of strengthening the functioning of the Adult and the Nurturing Parent can be found in research that shows that improving self-compassion is associated with greater psychological well-being, increased life satisfaction, and resilience (Gilbert, 2009; MacBeth & Gumley, 2012; Neff, 2011, 2012).

The deconfusion (processing) stage addresses the confusion of the Child ego state related to repressed feelings, thoughts, or memories (Clarkson, 1992). Such work with the Child ego state relates to acceptance, expression, and deepening of feelings, thoughts, and behaviors that were prohibited in the person's childhood and related to script enactments and problematic experiences in the present. This processing results in new meaning making, reflection, and script changes. It also involves developing an internal sense of safety (Clarkson, 1992; Woollams & Brown, 1979). As a process, deconfusion relies on empathic transactions and analysis of the transference/countertransference matrix (Hargaden & Sills, 2002) and is primarily an affective process (Widdowson, 2016) that has been shown to be effective in many therapies, particularly when combined with cognitive understanding (Aldao et al., 2010; Bohart, 1993; Mergenthaler, 1996; Norcross & Lambert, 2019).

The redecision (decision making and application) stage in TA means that the client changes their script. Within TA, this is referred to as changing a script decision, although this process does not always relate to the narrow, cognitive meaning of the term decision. The redecision stage in TA treatment refers to the process whereby the client, while they are in the Child state, becomes aware of alternative options and resources to get their needs met and to make changes to their early script decision. This engages both the Child and the Adult ego states (Goulding & Goulding, 1979; Stewart, 2013). "For example, an individual is encouraged to let go of limiting script beliefs and make a new personal decision and commitment regarding how he will conduct his life from now on. The process of redecision combines cognitive and affective processes" (Widdowson, 2016, p. 19). It includes stimulating clients to set concrete aims for daily life, including planning, experimenting, evaluating, and adjusting those aims and methods and making long-term commitments. This aspect of the

redecision stage of treatment has been well studied in the body of literature related to the effectiveness of setting goals and developing life projects in treatment (Arends et al., 2013; Lapierre et al., 2007; Little et al., 2017). Goals are most effective when they are important (Austin & Vancouver, 1996; Moskowitz, 2012), specific, simple (Locke, 2002; Webb et al., 2012), not too far in the future (Locke & Latham, 2002), challenging (Locke & Latham, 2002; Wiese, 2007), attainable (Emmons et al., 1986), Sheldon & Elliot, 1999; Wiese, 2007), mutually conducive (in the case of multiple goals) (Chun et al., 2011), and focused on approaching something positive rather than avoiding something negative (Elliott & Friedman, 2017). Thus, the broader sense of the stage of redecision means that the individual develops new ways to live a meaningful and satisfying life while accepting life's limitations, which is key to effective therapy (Vos, 2014b, 2016a, 2016b, 2017). Research also shows that individuals benefit from developing a sense of hope by seeing alternatives to what they had thought was a hopeless situation (Koehn & Cutcliffe, 2007; Schrank et al., 2008; Schrank et al., 2012; Snyder et al., 2003). Individuals can particularly benefit from developing a sense of self-efficacy, which is their belief in their ability to produce desired outcomes through their own actions (Corrigon et al., 2006; Maddux & Kleiman, 2016; Marks & Allegrante, 2005; Schwarzer, 2014).

Creating a positive client-practitioner relationship. Norcross and Lambert's (2019) third edition of *Psychotherapy Relationships That Work* summarized research on the effectiveness of the client-therapist relationship. Their meta-analyses showed that therapy is more effective if the treatment offers a positive therapist-client alliance and collaboration; empathy, positive regard, and affirmation; genuineness/congruence; a real relationship; work with transference and countertransference; and reparations of alliance ruptures. This is closely linked to the emphasis in TA theory on equality, respect, and empathy as well as work on script and games within the therapeutic relationship.

Summary

Research shows how clients improve by analyzing the clinical and etiological models (assessment and case formulation; analysis of current ego states; social functioning, self-efficacy, and their etiological development; and analysis of the unspoken), working at experiential depth in the here and now, offering a structured treatment (treatment contracts, psychoeducation and didactics, clear treatment stages), and a positive client-practitioner relationship (positive therapist-client alliance and collaboration; empathy, positive regard, and affirmation; genuineness and congruence; a real relationship; work with transference and countertransference; and reparations of alliance ruptures).

Conceptual Component V: Therapeutic Outcomes

Review of TA Theory in Relation to Therapeutic Outcomes

Eric Berne saw the aim of TA psychotherapy as the attainment of autonomy, which he defined as the release or recovery of three capacities: awareness, spontaneity, and

intimacy. Awareness related to not interpreting or filtering our experience of the world to fit our early-life messages; spontaneity was the capacity to choose from a full range of options in thinking, feeling, and behavior; and intimacy meant open sharing of authentic feelings and wants with another. Elsewhere, Berne (1961, 1972) identified that not every client could achieve full "cure" and that individuals can achieve different levels of improvement. Social control was the lowest treatment goal and referred to the client learning to control dysfunctional behavior in social contexts. Symptomatic relief related to the experience of relief of the person's inner conflict and confusion, pressures, or mental health problems. The next level of cure was transference, which is related to gaining freedom from the constraints of one's life script with the therapist's support. The final level was script cure, which referred to when the Adult ego state has been integrated and the individual can structurally move away from their script and live with full awareness, spontaneity, and intimacy. The systematic empirical evidence for these levels of cure are unclear, but they may be used as a metaphorical rule of thumb.

Transactional Analysis Review Survey Results

The Transactional Analysis Review Survey asked detailed questions about the specific aims of TA using open and multiple choice questions and categorized via statistical factor analyses. This resulted in the following aims, which can be interpreted as a specification of the generic aims that Berne formulated.

Constructive ego states. This includes the ability to be in the here and now, insight (awareness of how the past influences the present), expressing or experiencing authentic feelings, and flexible movement between ego states.

Social functioning. This includes feeling socially connected with others (instead of feeling the world is a cold, lonely place), trusting others ("You are OK"), respecting and acknowledging other people as individuals, intimacy, and sharing authentic expression with others.

Self-efficacy and self-love. In general, self-efficacy describes how individuals conduct "effective actions in daily life (setting specific activities or goals, planning, organising, discipline, evaluating and adjusting daily life activities or goals), and being in control" (Vos, 2017, p. 156). In the survey, self-efficacy included the ability of individuals to understand and transform dysfunctional script systems that intervene with daily life and to regulate themselves, their thoughts, and behavior. It also means

> they can control their motivation and commitment and stick to these but are also able to adjust flexibly to changing circumstances. This implies the sense of progress, being in control, knowing how to work towards attaining goals in daily life, overcoming challenges and realising meaning in daily life. (p. 156)

Self-efficacy also includes self-protection in order to protect oneself psychologically from the harmful influence and actions of others, themselves, and their past. Individuals experience resilience as insurance against future shocks, which means that they have developed the skills and resources to cope with future challenging situations. Such people have adequate problem-solving skills that involve using internal

and external resources to resolve current problems in life. This includes an Adult ego state analysis of problems aided by the intuitive powers of the Child ego state. Finally, the category of self-efficacy also includes self-love, which includes autonomy, self-love ("I am OK," a sense of integrity, self-esteem, and self-compassion), being honest and authentic toward oneself, and feeling a sense of responsibility for one's own life.

Self-realization. This means that individuals feel that their drives and energies are not blocked and that they can try to fulfill their personal potential. It includes a sense of vitality and energy, spontaneity, not feeling hindered by the past, and taking risks in social and professional life in an attempt to fulfill one's potential.

Psychopathology and general well-being. TA practitioners report that they also aim to alleviate psychopathology and increase general well-being, including addressing psychological distress, anxiety, depression, personality disorders, and anti-social behavior.

Results of TA Meta-Analysis

Vos and van Rijn (2020) conducted a meta-analysis of 41 clinical trials on TA, of which 13 were randomized controlled trials. Nine studies described TA for individuals, seven for groups, ten for families, seven for school classes, and eight for prison inmates. TA for individuals, in groups, in families, and in prisons created large improvements in psychopathology and self-efficacy, both measured as pre/post effects and compared with control groups. Additionally, TA in groups and prisons improved social functioning. The only findings with enough statistical power in schools was that TA increased self-efficacy. TA had significantly larger effects on psychopathology and general well-being when large changes were reported in the positive functioning of ego states, social functioning, and self-efficacy.

Literature Review of Related Research-Evidenced Concepts

The large effect sizes in the outcomes of TA treatment are similar to meta-analyses of other humanistic therapies (Cain, 2016; Elliott, 2002; Vos & Vitali, 2018; Vos et al., 2015). With some specific exceptions, these findings also seem in line with other evidence-based psychotherapies (Goodheart et al., 2006).

Summary

TA improves healthy ego state functioning, social functioning, and self-efficacy in clients, and via this improvement, it also improves self-realization, psychopathology, psychological distress, and general well-being.

Synthesis of Findings

This review has provided the following evidence-based conceptual model of TA as visualized in Figure 1. TA practitioners focus on the individual's ego states (Parent, Adult, and Child) and their functions, which consist of Nurturing Parent, Controlling Parent, Adult, Adapted Child, and Free Child. These ego states are related to social

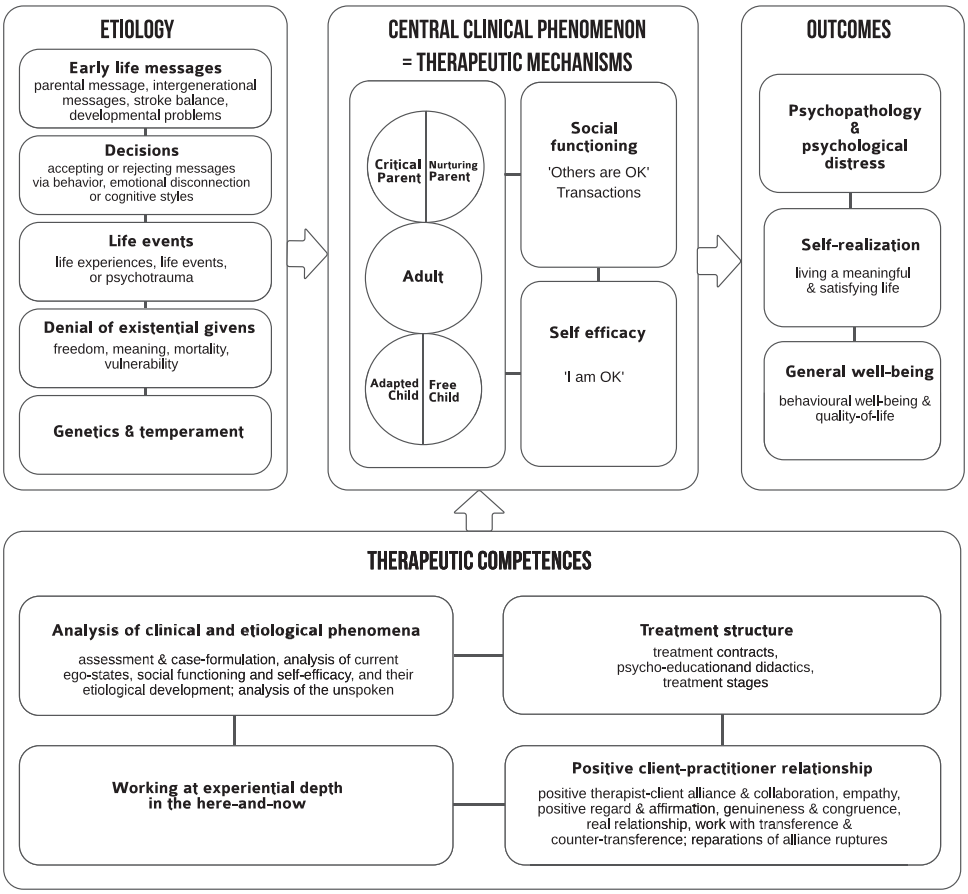

Figure 1. Conceptual Model of Transactional Analysis

functioning and self-efficacy and are strong predictors of an individual's levels of psychopathology, general well-being, and self-realization. The ego states, social functioning, and self-efficacy are influenced by negative social messages and stressful life events, although individuals seem to experience some freedom to accept or reject these unfavorable messages via behavior, emotional disconnection, or cognitive styles. TA practitioners help clients by assessing the clinical and etiological situation of the client, working at experiential depth in the here and now, offering a structured treatment, and developing a positive client-practitioner relationship. TA improves the ego states, social functioning, and self-efficacy in clients, and via this improvement, TA also improves self-realization, psychopathology, psychological distress, and general well-being.

Discussion

This is the first study to review all the literature on the conceptual model and its empirical evidence on TA. These findings indicate that TA may be regarded as a bona fide therapy, as it is delivered by trained therapists, based on psychological principles,

following professional books and manuals, and containing specified components (APA, 2013; Wampold et al., 1997). The effects are similar to other psychotherapies and psychological treatments, which seems to confirm the so-called "dodo-bird effect" that explains that most therapeutic treatments are effective because they use similar common therapeutic factors (Cain, 2016; Fonagy, 2010; Norcross & Lambert, 2019). Not only does TA have positive outcomes for many clients, but the underlying therapeutic mechanisms and etiological and clinical assumptions are coherent and supported by a strong body of empirical evidence. These findings are in line with previous, less systematic reviews on the evidence basis of TA (Baumeister & Leary, 1995; Clarkson, 1992, 2013; Elbing, 2007; Khalil et al., 2007; Miller & Capuzzi, 1984; Ohlsson, 2010; O'Reilly-Knapp & Erskine, 2010; Stewart, 2013; Thunnissen, 2015; Widdowson, 2013; Wilson, 1981). Therefore, TA can be recommended as an evidence-based psychotherapy to national mental health services and health insurances.

This review is limited by the fact that there was wide variety in the included studies because they used different terminologies, psychometric instruments, and treatment manuals. Therefore, we recommend translating and validating instruments with the largest empirical-evidence support and developing and testing a semistandardized treatment manual on the basis of this evidence-based conceptual review. More studies are also needed on the therapeutic mechanisms.

This review can be used in the training of TA practitioners. We recommend focusing training on four core competencies: clinical and etiological analysis, working with experiences in the here and now, providing structured treatment, and developing a positive client-practitioner relationship. Although there seems to be a large variety of clinical and etiological theories, we recommend that practitioners focus on the evidence-based concepts as described in this review.

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