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ARTICLE

The Transactional Analysis Review Survey: An Investigation Into Self-Reported Practices and Philosophies of Psychotherapists

Joel Vos and Biljana van Rijn

ABSTRACT

Since the creation of transactional analysis (TA) in the 1950s, almost 50,000 handbooks, theoretical articles, and personal perspectives have been published about it. However, the application of TA has not been systematically studied. The research described in this article involved an online survey titled the Transactional Analysis Review Survey (TARS), which consisted of ten open and 45 closed questions. Items were derived from the most frequently cited TA publications and focused on the psychotherapist's perspective on metalevel reflection, a central clinical phenomenon, etiology of psychological problems, therapeutic mechanisms, and therapist competencies. Data were analyzed with thematic analysis, principal component analysis, and latent class analysis. The survey was filled out by 238 TA therapists, and most reported seeing TA as a therapeutic approach, a general attitude and view of the world, and their preferred model in their practice. According to their reports, TA focused on the client's ego states and transactions, social functioning, and self-efficacy, which helped improve their psychological health, self-realization, and general and behavioral well-being. Clients' most frequently reported problems were seen as caused by negative messages early in life (scripts), lack of development of mature coping mechanisms, transgenerational messages, life events, denial of existential givens, and genetics/temperament. Individuals were understood to have some choice in accepting or rejecting the negative impact of these messages and life events via behavior, emotions, and cognitive styles. TA was viewed as helping clients via the therapeutic work with their ego states, social functioning, and self-efficacy. The changes were facilitated by the therapist competencies of positive client-practitioner relationship, working at experiential depth in the here and now, etiological analysis, and providing treatment structure. Thus, TA seems to offer a coherent conceptual framework for psychotherapeutic practice. Further empirical validation of this framework is required.

KEYWORDS

Transactional analysis; survey; questionnaire; psychotherapy; counseling; experiences; evaluation; theory; clinical practice; change

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Transactional analysis (TA) was developed by Eric Berne in the 1950s. He was a prolific writer who authored many articles and books. With further development and many subsequent authors, at the time of this study, there are approximately 50,000 scientific publications on TA.

As researchers, we wanted to establish to what extent these publications reflected the actual practices of TA therapists. Studies on other psychotherapeutic approaches indicate that there is frequently a large gap between the theory and training in a therapeutic modality and the actual practices of individual therapists using it. Researchers have questioned how important it is for practitioners to adhere to a formally prescribed psychotherapeutic model. For example, some studies suggest that therapist adherence to a therapeutic modality seems to play a relatively small role in determining the improvement of symptoms in clients (Atkins & Christensen, 2001; Miller & Binder, 2002; Webb et al., 2010). In fact, such lack of adherence may not hinder the experience and effectiveness of psychotherapeutic practice, and several studies have indicated the importance of tailoring therapy to the individual client (Norcross & Wampold, 2011). In general, the effectiveness of psychotherapy practice can be explained to a large extent by common factors among psychotherapeutic approaches, such as the relationship between therapist and client (Norcross & Lambert, 2019), agreement on aims and goals, shared understanding, and empathy (Wampold & Imel, 2015).

We can thus hypothesize that TA publications and training may not fully reflect the actual practices and effectiveness of individual TA psychotherapists. To gain further understanding of how TA therapists actually work, this study aims to describe their self-reported practices and personal theories. This might help us to understand the experiences and effectiveness of TA and develop future research studies and psychotherapy training. We use these self-reported psychotherapeutic practices and theories in a follow-up study (Vos & van Rijn, 2020) in which we searched for specific research evidence for their effectiveness. We use those results to build an evidence-based model of TA practice that can be used to train therapists as well as to justify coverage for TA in national health services and insurance to fund TA psychotherapy.

Methodology

Underlying Philosophy

There are multiple ways to examine the self-reported practices and theories of psychotherapists. A bottom-up approach would consist of open, nonleading questions asking practitioners to describe their practices (Cooper et al., 2015). The strength of this approach is that the researchers limit their bias in the formulation of the questions. A weakness is that without a clear structure to the interview or survey, therapists may overlook certain aspects of their practice, for example, due to availability bias or recency effects in their memory retrieval processes. Furthermore, an open approach might leave it unclear how their practices precisely relate to the theories and research in their psychotherapy field. Therefore, other researchers into the self-reported practices and theories of practitioners have combined open-ended questions with specific questions about the extent to which individual therapists theoretically agree with and

practically adhere to common theories and models in their field (e.g., Correia et al., 2014; Correia et al., 2017). Keeping these considerations in mind, our Transactional Analysis Review Study (TARS) begins with open questions followed by questions about the extent to which the participants theoretically agree with and practically adhere to key ideas from common TA theories.

Open Questions

To examine how survey participants perceived the strengths, weaknesses, and controversies in the TA field in general, we added the following questions: What do you feel are the three biggest strengths of TA? What do you feel are the three biggest weaknesses of TA? What do you feel are the most contested topics in TA? By asking about three specific examples for each of these questions, we hoped to stimulate participants to generate multiple answers.

We started by asking participants what they perceived as key components of their practices. Whereas the multiple-choice questions examined prestructured components (as will be described in the next paragraph), we wanted to give participants the opportunity to mention any components, including those that we might not have considered. Thus we asked: What do you see as key ingredients in your TA practice?

In line with client helpfulness studies (Cooper et al., 2015), we asked multiple questions to elicit their perceptions of helpful and unhelpful components of change: What aspects of your TA practice are helpful for your clients? For example, think about the best therapy you may have offered to a client: What do you think made that case so good? What aspects of your TA practice are less helpful for your clients? For example, think about the least helpful therapy that you may have offered to a client: What do you think made this case so unhelpful, and what could you have done better? How do you think your TA practice can help clients? What changes do you see in clients?

Whereas the previous questions focused on TA in general or the impact on the client, we also wanted to understand how the participants saw themselves with the following questions: What makes you a good TA practitioner? How could you become a better transactional analysis practitioner?

At the end of the survey, we also offered space for any additional comments or suggestions. In the multiple-choice part of the survey, the participants could also add their own answers to any questions.

Multiple-Choice Questions

To focus our multiple-choice questions on the most crucial aspects of TA, we developed the questions in line with the conceptual framework called the conceptual components approach of psychotherapies. This framework is based on a systematic review of the conceptual components of the 100 most frequently cited articles in psychotherapy, clinical psychology, and counseling (Vos, 2014). This model has been used to develop the conceptual framework of existential and meaning-oriented psychotherapies (Vos, 2017, 2019). This framework assumes that any type of psychotherapy consists of multiple, logically connected conceptual components (Kazdin, 2016; Vos, 2014).

In the study described in this article, we focused on the following five core components: metalevel reflection, central clinical phenomenon, etiology, therapeutic mechanisms, and therapist competencies. *Metalevel reflection* includes questions about the status of the approach, for example, is TA a generic approach, an attitude, or a specific set of techniques? This also includes reflections on the differences and overlap with other therapeutic approaches and adherence to TA theories in practice. *Central clinical phenomenon* describes the central psychological, clinical, or experiential problems that are addressed in psychotherapy, including questions about psychotherapy aims. *Etiology* describes how the central clinical phenomenon originally developed and how it evolved over time. *Therapeutic mechanisms* describe how TA can change the central clinical phenomenon, for example, via learning to accept one's own experiences, developing better social skills, and so on. *Therapist competencies* describe all activities that the therapist does, including the therapeutic relationship, specific techniques, and so on.

The first practical step in developing multiple-choice questions was to identify key theories and models in TA. We used the search term *transactional analysis* in Web of Science and scholar.google.com to identify the most frequently cited books and articles on TA. We have included the following most frequently cited books and articles: Berne (1964/2011, 1961/2016), Clarkson (1992), Cornell et al. (2016/2019), De Luca and Tosi (2011), Erskine (2018, 2010/2019), Erskine and Zalcman (1979), Fowlie and Sills (2018), Goulding and Goulding (1997), Hargaden and Sills (2002), Horn (2016), James and Jongeward (1971), Karpman (1968), Law (2006), Lister-Ford (2002), O'Reilly-Knapp and Erskine (2003), Sills (2006), Steiner (1974/1990, 2003), Stewart (1996, 2013), Stewart and Joines (1987), Thunnissen (2007), Tilney (1998), Tudor (2002), Tudor and Summers (2014), Widdowson (2009, 2013), and Woollams and Brown (1979). We also included the following reviews of research on TA: Baumeister and Leary (1995), Elbing (2007), Khalil et al. (2007), Ohlsson (2010), Miller and Capuzzi (1984), Widdowson (2013), and Wilson (1981). In the second step, we derived possible answers from all different TA theories and models to the five core components in our framework: metalevel reflection, central clinical phenomenon, etiology, therapeutic mechanisms, and therapist competencies. In the third step, we created items for the questions, with tick boxes and 1-7 Likert scales. The answer possibilities reflected the breadth of all TA theories and models.

Procedures

The Transactional Analysis Review Survey had a total of 45 multiple-choice questions and 10 open questions, which took on average 25.19 minutes for participants to fill in as measured online. Part I, "Questions About Yourself," consisted of questions about the participant's sociodemographic and training characteristics. Part II, "General Questions," contained the open questions and metalevel questions. Part III, "Clinical Relevance," included questions about the central clinical phenomenon; Part IV, "Development," questions about etiology; and Part V, "Process," questions about therapeutic mechanisms. (The items can be found in the research repository of the Metanoia Institute at metanoia.ac.uk/research.) The survey was developed by the first

author, who is an expert on psychotherapy development and evaluation but not on TA; this facilitated the independence of the survey. Additional answer possibilities to several questions were developed by four TA therapists and researchers.

The survey was created online using Hostinger, Wordpress, and Formidable Forms in line with the General Data Protection Regulation (GDPR) of the European Union and the British Data Protection Acts. Individuals were given information, including pros and cons of participating in the study, and were asked to give informed consent. Any personally identifying information was deleted from the analysis and publication, and participants were able to withdraw their survey until the point when all the data were analyzed. This study received approval from the Research Ethics Board of Metanoia Institute. The survey was promoted in social media of the European Association for Transactional Analysis (EATA), which sent two emails to all members with a request to participate in the study. An announcement and an interview on the research were also included in the *EATA Newsletter*.

Analyses

We systematically analyzed the open and closed answers to the survey questions to identify the main themes across participants and to come to evidence-based conclusions on the research findings. The open questions were analyzed with thematic analyses in line with the steps from Braun and Clarke (2012). The answers to the closed questions were inserted into statistical software "R" and were analyzed with descriptive statistics (frequencies, means, standard deviations). Missing values were not replaced because that could have created a false description of the average opinion of the participants.

Because the survey included a large number of answer options—including overlapping answers—the result was a large amount of data. To simplify the findings and identify underlying categories, we used statistical data reduction techniques. Principle component analysis was used to analyze continuous variables on Likert scales, with varimax rotation to improve interpretation. A factor was identified on the basis of the scree plot, eigenvalues (EV) larger than 1, interpretability of the factors, and total variance accounted for (VAF) larger than 40%. We used latent class analysis (LCA) to find trends in the answers to categorical questions in tick-box format (Agresti, 2003). LCA was used to classify cases according to their maximum likelihood of class membership (Collins & Lanza, 2010; Lazarsfeld & Henry, 1968). To perform LCA, the package poLCA for R software was used (Linzer & Lewis, 2011, 2013), which uses expectation-maximization and Newton-Raphson algorithms to find maximum likelihood estimates of the parameters of the latent class and latent class regression models. The new categories that emerged from these data reduction techniques often received new names because these categories did not always precisely overlap with any existing TA terms, and some existing TA terms have different connotations for different participants. As is common practice in factor analysis research, we gave these types new names in the most neutral and simple ways possible, except when an existing term precisely described all items in a category and was clear and unambiguous. To facilitate

differentiating categories from the items that constituted the categories, category names are not put in quote marks but items on the questionnaire are.

Results

Sample

In total, 238 TA practitioners filled in the Transactional Analysis Review Survey. Most participants were from Germany (10%), the United Kingdom (10%), the Benelux (8%), or Italy (5%). The average age was 41.2 (SD = 10.7). Sixty percent self-identified as female, 35% as male, and 5% as nonbinary. One-third were senior trainees, and almost two-thirds had completed advanced TA training. Eighty-three percent had additional degrees in other fields, such as coaching (20%), psychology (10%), or child and educational studies (10%). These individuals worked in a wide variety of contexts, with a third working in private mental health care (32%) and a third in public mental health care (31%). The problems that clients presented with in the practices of survey participants varied widely, from mild to moderate mental health problems (42%) to relational or marital issues (36%), self-development (31%), work problems (21%), and other (11%). There was a large variety in the TA schools that participants identified with, but most considered themselves integrative (19%), relational (16%), psychodynamic (14%), or cognitive-behavioral (11%).

Metalevel Reflection

Almost all participants saw TA as a therapeutic approach (92%) as well as a general attitude (81%) and view of the world (67%) and less often as a psychological tool kit (44%), theory (32%), or educational approach (21%). Approximately 85% of participants use TA together with other therapeutic approaches (M = 5.8, SD = 1.1), and two-thirds feel that they usually apply their most ideal TA model in practice (M = 5.1, SD = 1.7).

Analyses of the open answers revealed that participants thought that the biggest strengths of TA are that it is easy to share with and be understood by clients; is systematic/structured and comprehensive/holistic; promotes an "I'm OK, You're OK" life position; focuses on relationships, life scripts, autonomy, and flexibility; and is easy to integrate with other approaches. The biggest challenges of TA include a lack of research; lack of acceptance in academic and national health services; is sometimes too simplistic and reductionistic; presents conceptual confusion (e.g., structural and functional models); uses jargon; has old, stuffy language and theories; is too cognitive (less focus on emotions, body, and the unconscious); has a rigid, hierarchical training system; exhibits self-righteousness about the TA field; is difficult to apply with severe pathology; and has a lack of serious attention for other academic and research fields. The most contested topics were Cathexis, competition between and tribalism of different TA schools (particularly the dominance of the relational school), ego state models, contracts, escape hatches, and rigidity of training structure.

Central Clinical Phenomenon

Outcomes

Survey participants rated the following outcomes of TA as important: autonomy (88%), awareness of how the past influences the present (85%), spontaneity (77%), living in the present moment (73%), intimacy (73%), insight (72%), developing greater movement between ego states (69%), facilitating Adult analysis of problems while stimulating intuitive powers of the Child to aid in problem solution (65%), validation of self (64%), resolution of internal conflicts (61%), redecision (60%), developing a position of "I am OK" and "You are OK" (60%), understanding and transforming homeostasis functions of the script system that intervene with daily life (57%), self-regulation (56%), self-protection (54%), insurance against future shocks (53%), and sense of integrity (51%). Latent class analysis indicated the following underlying classes: psychopathology (e.g., anxiety, depression, trauma), general and behavioral well-being (e.g., first-degree games, second-degree games, life scripts) and self-realization (identification and acceptance of feelings and needs in the present instead of feeling hindered by the past; free flowing of drives, energy, and spontaneity).

Focus

According to survey participants, TA focuses "much" on the following topics in clients: daily life problems (66%), trauma (56%), depression (45%), and anxiety (41%). It focuses less on psychosis (11%) or other issues (13%). The main problems of clients in order of importance were enactment/reenactment of life scripts ($M = 5.4$, $SD = 1.2$), racket/inauthentic feelings ($M = 5.3$, $SD = 0.9$), second-degree games ($M = 4.9$, $SD = 1.3$), defensive Child-Parent relational unit ($M = 4.8$, $SD = 1.4$), the relational Parent/Child/self is not loving ($M = 4.6.$, $SD = 1.4$), avoidance of problems ($M = 4.5$, $SD = 1.5$), first-degree games ($M = 4.5$, $SD = 1.2$), loneliness ($M = 4.4$, $SD = 1.5$), and existential problems ($M = 4.2$, $SD = 1.6$). The following underlying factors were identified: ego states (relationship between Parent, Adult, and Child), social functioning (this included items such as other people are OK, trust, feeling connected, intimacy, and authentic expression), self-efficacy (I am OK, self-love, autonomy, self-esteem, sense of control over one's life, emotional self-regulation, self-protection, psychological resilience against future shocks, problem-solving skills, and taking responsibility for oneself).

Exclusion

Participants reported that TA is not suited for individuals who are unwilling or unable to self-reflect (88%); unwilling or unable to face psychological pain (75%); wanting to be a passive recipient of help (33%); unable to contain feelings (21%); or lacking Adult ego state functioning such as in the case of active psychosis, influence of psychoactive substances, severe learning disabilities (19%), and other (11%).

Models

Almost half of all participants (47%) believed that ego states are clearly distinct psychological phenomena, comparable with the status of a concept such as attachment or personality. One-third reported that ego states are multiple phenomena or experiences that often go hand in hand (34%), ego states are not a thing (32%), or they

mentioned that the concept of ego states is coconstructed between therapist and client (27%). The only model that most participants agreed with much or totally (65%), which they often or always used (56%) and that they found much or totally easy to explain (52%), was the basic ego state model of Parent, Adult, and Child. Less than half of participants agreed with and frequently used other models. Factor analyses of the frequency of use of different ego state models showed two factors: classical TA ego state models (first-, second-, and third-order models) and the later, more complex models.

In Sum

TA seems to focus on the client's ego states and transactions (as reflected in the traditional structural and functional models), social functioning, and self-efficacy, which can help clients ameliorate their psychopathology and improve their self-realization and general and behavioral well-being.

Etiology

When we conducted factor analysis on all the items about etiology, a large number of factors were identified. To make the factors easier to interpret, we decided to do separate factor analyses for the items on negative messages, life events, decisions, denial of existential givens, and genetics/temperament.

Negative Messages

Individuals can receive four types of negative messages in life that can cause psychological and social problems later. The categorization of these four types of negative messages follow from statistical factor analysis. As these types did not precisely overlap with any existing TA terms, and existing terms may have different connotations for different participants, we gave these types new names in the most neutral and simple ways possible, which is common practice in factor analysis research. First, negative messages in early life (EV = 1.7, VAF = 30%) included the questionnaire items negative protocol (M = 6.2, SD = 1.1), injunctions (M = 6.1, SD = 0.9), insufficient psychosocial holding (M = 5.2, SD = 2.1), nonverbal psychological transactions (M = 5.1, SD = 0.8), explicit negative messages (M = 5.0, SD = 1.2), and insecure attachment (M = 4.9, SD = 0.9). Second, individuals may insufficiently develop mature coping mechanisms (EV = 1.5, VAF = 22%) due to a lack of separation-individuation (M = 4.6, SD = 2.1), a negative palimpsest (M = 4.4, SD = 2.5), or lack of psychological integration (M = 4.2, SD = 1.7). Third, individuals may be psychologically impacted by previous generations (EV = 1.4, VAF = 21%), for example, via episcripts (M = 4.3, SD = 2.1), family secrets (M = 4.2, SD = 1.7), and ambiguous family communication (M = 4.2, SD = 1.5). Fourth, individuals may also experience an unfavorable stroke balance (EV = 1.2, VAF = 14%) as a result of negative and conditional strokes (M = 5.4, SD = 1.7), not accepting or seeking strokes (M = 4.6, SD = 1.3), a lack of self-stroking (M = 4.1, SD = 1.6), or a lack of positive key permissions (M = 4.0, SD = 2.1).

Life Events

One underlying factor was found (EV = 1.8, VAF = 56%) describing the etiological influence from life events, including childhood trauma (M = 5.6, SD = 2.1), neglect (M = 5.4, SD = 1.8), abuse (M = 5.3, SD = 1.9), and trauma later in life (M = 4.7, SD = 1.8).

Denial of Existential Givens

Participants also mentioned that "an existential given may be discounted in early life by others, such as freedom and responsibility/lack of freedom, meaning/meaninglessness, connection/isolation, death/life, and vulnerability/health" (M = 3.9, SD = 1.6).

Genetics/Temperament

On average, the following factors were considered to have a small impact on etiology: genetics (M = 2.1, SD = 0.6), temperament (M = 2.0, SD = 0.7), and luck (M = 1.6, SD = 0.3).

Decisions

According to the participants, individuals have some choice in accepting or rejecting the negative impact of messages, life events, denial of existential givens, or genetics/temperament: Individuals have neither no freedom at all to accept or reject these nor total freedom (M = 4.1, SD = 0.8). The following individual decisions contribute to the etiology of an individual's problems: substituting feelings (rackets) (M= 5.3, SD = 2.1), habits (M = 5.1, SD = 1.8), accepting negative injunctions (despairing or defiant decision) (M = 5.1, SD = 1.8), redefining experiences according to one's own frame of reference (M = 5.0, SD = 1.8), acting instead of thinking and feeling via second-degree games (M = 4.6, SD = 2.3), dissociating experiences and memories to cope with difficult experiences (M = 4.5, SD = 1.8), and preventing the pain and stress from trauma and neglect to become conscious via third-degree games (M = 4.4, SD = 2.6). Factor analyses indicated three underlying factors. Individuals could accept messages in their behavior (e.g. habits; EV = 1.5, VAF = 23%), emotionally reject these (e.g., emotional disconnection, avoidance, denial, dysfunctional emotion regulation, and dissociation of experiences and memories; EV = 1.3, VAF = 21%), or cognitively accept these (e.g., cognitive biases; EV = 1.4, VAF = 19%).

Therapeutic Mechanisms

The therapeutic mechanisms describe the internal changes within the client that explain improvement during therapy. Most TA practitioners believe that clients improve because of the following mechanisms of change: developing freedom to develop themselves (88%); removing obstruction to natural growth (86%); rising above circumstances, past history, inner drives, and impulses (85%); learning to live in the moment (84%); developing self-insight (82%); resolving structural conflicts (80%); having a positive corrective experience (74%); feeling validated in their experiences (72%); developing greater movement between ego states (69%); learning to risk intimacy (65%); learning from mistakes (63%); learning to fulfill their potential (61%); grieving

for losses (60%); forgiving (55%); and remembering but not repeating the past (52%). The following latent classes were identified: improvement of ego states (e.g., develop self-insight, rising above the past by having a stronger Adult, and more freedom in moving between ego states), social functioning (e.g., daring to take social risks in the present), and self-efficacy (e.g., trusting one's own experiences, developing self-insight, and having a sense of freedom and control).

Therapist Competencies

When we conducted factor analysis on all the items about therapist competencies, a large number of factors could be identified. To make the factors easier to interpret, we decided to conduct separate factor analyses for the items about creating a positive client-practitioner relationship, working at experiential depth in the here and now, etiological analysis, and offering treatment structure.

Positive Client-Practitioner Relationship

The following characteristics of the therapeutic relationships are described as important: respectful (97%), accepting (95%), secure (94%), rapport (92%), nonpathologizing (92%), kind (92%), attunement (90%), empathic (90%), space for developing interpersonal agency and efficacy (85%), being in the here and now (84%), coconstructed (82%), stimulating autonomy for self and others (81%), unconditional positive regard (80%), open communication (80%), stimulating personal responsibility (79%), holding the therapeutic frame (76%), asymmetrical mutuality (75%), clarifying (74%), validating (74%), normalizing (72%), working with transference and countertransference (62%), avoiding psychological games (60%), and having clear contracts (56%).

Factor analyses showed the following underlying dimensions: validation of the client as an autonomous individual (open, autonomy, respect, stimulating responsibility, believe in change), actions to facilitate the therapeutic relationship (cooperative, emotionally literate, clear contracts, avoiding games), expression of positive emotions (empathy, attuning, kind, validating, normalizing), working with transference and countertransference, being nonjudgmental (asymmetrical mutuality, neutrality, objectivity), following the client (patience, rapport, using the client's language), and stimulating the development of insight (theorizing, clarifying, clinical intuition).

Furthermore, when a game emerges in the therapy setting, therapists usually reflect on their own part in the game and use this to decide how to address it with the client (62%), try to help clients to understand the game (56%), or use humor to shift the game (52%). Seldom used are playing along (32%) or ignoring the game (22%). Latent class analyses indicated three dimensions: putting the game aside (not playing along but also not exposing the game), exposing and offering insight into the game, and personal process (self-reflection, playing along).

Working at Experiential Depth in the Here and Now

One factor was found describing therapists stimulating clients to accept, express, and explore their experiences. This included helping clients to become free from inhibitions and transcend oneself ($M = 6.1$, $SD = 1.1$), develop self-insight ($M = 5.7$, $SD =$

0.8), staying with physical sensations (M = 5.4, SD = 1.2), and observing and differentiating emotions (M = 4.1, SD = 1.1). Clients are also stimulated to focus on their experiences in the here and now (M = 6.3, SD = 0.7) and to take risks to fulfill their potential in the present (M = 5.7, SD = 1.3).

Assessment

Survey participants described that they use the following types of assessment: relational needs (88%), transference and countertransference (84%), stroking behavior (82%), the drama triangle (80%), clinical intuition (79%), historical inquiry (78%), phenomenological inquiry (76%), analysis of contamination of ego states (75%), linguistic and body language analysis (75%), script or racket analysis (75%), and social and behavioral diagnosis of ego states (72%). Other assessment styles included: analyzing unrequited archaic needs (50%), coping with disruptions in the past (42%), unconscious story (41%), racket system analysis (e.g., what is feared and avoided?) (40%), reenactment of scripts from childhood (40%), existential life position (e.g., war versus peace, famine versus plenty, pestilence versus health, death versus life) (39%), modes of passivity (35%), and time structure (32%). Latent class analysis indicated the following underlying dimensions: analyses of ego states in the context of one's life story; current fundamental position in life (permissions, existential life position, stroking behavior, time structure, modes of passivity); archaic relational needs in the here and now, including in the therapeutic relationship; and analysis of the unspoken (body language, phenomenological analysis, clinical intuition).

Furthermore, survey participants said of transactions that there can be a difference between verbal and nonverbal messages in a transaction (99%), each transaction has an expectation about a complementary response (90%), complementary transactions can continue endlessly (82%), when a transaction is crossed the partner is likely to answer from a new ego state (81%), and transactions can contain implicit messages (80%).

Treatment Structure

TA practitioners described that they use several ways to structure the treatment: via contracts, treatment stages, and using explicit psychoeducation/didactics. That is, most participants rarely use written contracts (M = 3.4, SD = 1.2), but most of them often use explicit verbal and negotiated contracts with the client regarding the aims and methods of therapy (M = 6.2, SD = 1.8). Practitioners experienced the following phases in therapy as important: building a therapeutic alliance (M = 5.6, SD = 2.1); creating a contract (M = 4.2, SD = 0.9); assessment of strengths and difficulties (M = 4.3, SD = 0.8); learning to accept experiences (M = 4.3, SD = 1.3); developing insight and awareness (M = 4.2, SD = 1.7); working through, including the emergence of buried emotions and memories (M = 4.1, SD = 2.0); changing script (M = 4.0, SD = 2.1); practicing new behavior and making changes in daily life (M = 3.7, SD = 1.8); and ending (M = 3.2, SD = 2.3). Latent class analysis indicated that there were four treatment stages: preparation stage (building a therapeutic alliance, contract creation, initial assessment of strengths and difficulties), assessment (clinical analysis, etiological analysis, strengthening of the inner Adult), processing (learning to accept and express experiences, working through past emotions and memories, developing insight and

awareness, challenging unhelpful messages), decision making and application stage (making decisions and applying in daily life), and ending stage. Explicit psychoeducation/didactics are used often (M = 5.6, SD = 1.6).

Discussion

The Transactional Analysis Review Survey is the first systematic survey into the practices and theories of TA therapists. Most participants see TA as a therapeutic approach as well as a general attitude and view of the world. They feel that they usually apply their most ideal TA model in their practice, although sometimes combined with other therapeutic approaches. TA seems to focus on the client's ego states and transactions (as reflected in traditional structural and functional models), social functioning, and self-efficacy. The common use of the first-order structural and functional models of TA, despite participants' reflection that different theoretical definitions of ego states are also the most contested, is interesting. It points to a unifying practice base as well as, and perhaps despite, the conceptual differences and rivalries. This practice base and focus could help clients ameliorate their psychopathology and improve their self-realization and general and behavioral well-being. According to participants, the client's problems are often caused by unfavorable messages (e.g., unfavorable messages early in life, lack of development of mature coping mechanisms, and transgenerational messages), life events, denial of existential givens, and genetics/temperament. Individuals may have some choice in accepting or rejecting the negative impact of these messages and life events via behavior, emotions, and cognitive styles. TA can help clients via therapeutic work with their ego states, social functioning, and self-efficacy. This change can be stimulated by four groups of therapist competencies: a strong working alliance, working at experiential depth in the here and now, etiological analysis, and offering treatment structure. (A visual figure summarizing these findings can be found in Vos & van Rijn, 2021a, p. 185).

We have focused on the most frequent answers given by survey participants and used statistical techniques to reduce the data. Consequently, some individual variation and uniqueness in practitioners' experiences may have been lost. The final model and visualization should therefore not be perceived as a rigid template. In contrast, the TA practitioners in our study seemed to emphasize developing a unique approach for the unique needs and unique situation of the unique client.

Some of the names that we have given to categories and typologies (e.g., unfavorable messages) may not be what an individual TA practitioner prefers to use. However, we felt that it was important to stay as close as possible to the statistical data, particularly where overarching categories included more than a standard TA term or where a TA term seemed ambiguous or contested. When this model is, for example, used in training therapists, trainers may want to present our model in combination with an explanation of the frequently used terms in the TA field.

This study is limited by the lack of participants outside of Europe, by the use of the English language, and by the length of the survey. As with any survey, participants may have had a self-preserving bias because they may have given answers that were more positive and more in line with the ideal TA models than what they do in actual

practice. Future studies could overcome these limitations by observing therapeutic practice and including multiple languages and countries.

In our next studies, we will systematically search for research evidence for the effectiveness of each of the practices and theories that the participants reported in this survey. These studies will also include more in-depth reflection on each of the components that we have identified in this current study (Vos & van Rijn, 2020, 2021a, 2021b). Although further empirical validation is needed, the findings of this study seem to suggest that TA offers a relatively coherent conceptual framework for psychotherapy. This framework may be used in the training of therapists and in the justification for national health services and insurance to fund TA psychotherapists.

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