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Transactional Analysis in the service of the mentalisation capacity

Abstract

Conceptualization of language of Transactional Analysis is being discussed in this article. It seems that Transactional Analysis deliver tools, which allow mentalizing in patient-therapist relationship. In this article basic TA concepts describing internalizing relationship will be presented.

This process is fundamental to mentalizing and this will be described in second part of the text. This article shows part of case study in which TA strengthened therapeutic relationship and at the end healed the patient.

Keywords: therapeutic relationship, mentalizing, Transactional Analysis.

Introduction

This paper is an attempt to use the conceptualisation of mental functioning coming from the language of Transactional Analysis – TA (Berne, 1998; Jagieła, 2012) to comprehend the capacity of mentalisation in the patient-therapist relation. It seems that Transactional Analysis with its rich mental equipment – its language, on the one hand, simple and colourful, on the other hand, non-reductionist and allowing to describe very complicated phenomena in a relation between individuals, might constitute an inspiring area that lets the therapist be with their patient and at the same time broaden their insight and reflection. The article discusses basic TA terms describing the process of internalizing object relations

(Gabbard, 2015, pp. 55–73), which constitutes the foundation of the capacity of mentalisation discussed in the second part of this text. Everything is illustrated with a fragment of description showing therapeutic work in the clinical context, revealing the complexity of relations and the importance of mentalisation while using the language of Transactional Analysis.

Transactional Analysis as the language of mentalisation

During therapeutic work, there is a clear need to use a comprehensible language, consistent with the patient's internal world, so that adaptation is accompanied by an opportunity to broaden one's insight and reflect on the discovered world (Gabbard, 2015, pp. 125–132; Czabała, 2006). The language in question should also cover the complexity of phenomena occurring in the therapeutic relation – creating models for the describing aforesaid phenomena. The world mentioned above emerges from introjections, internalizing external early-childhood relations with objects – important individuals. That is how the content of the *Adult, Child or Parent ego states* is created. Their mechanics is based on strokes creating script decisions consolidated in the patient's life positions (Oller-Vallejo, 2003, pp. 162–167; Muriel, Jongeward, 1999; Hay, 2010, p. 185).

Therefore, to find a language that would properly describe both early-childhood attachment relations and the patient's current situation – their frequently forced and stiff replaying of scripts, one would have to look for a map of words referring to both these areas. Models of Transactional Analysis used in conceptualization offer tools to describe both these areas (Hay, 2010, pp. 78–84):

— on the one hand, early-childhood transactions – overt, crossed and hidden together with strokes (Grzesiuk, 2006, p. 498,) create the frame of relations with the minder;
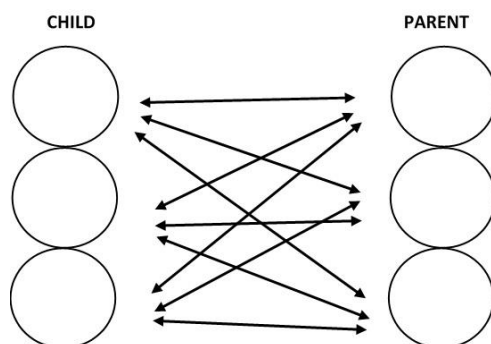

Fig. 1
Representation of I – You relations of the external world

Source: own materials based on: Jagieła, 2012.

— on the other hand, a model describing internal relations between different ego states *I* Adult-Child-Parent (Cierpiałkowska, 1992) allows for describing the richness of relations between the external and the internal world.
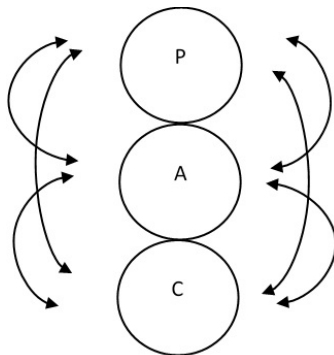

Fig. 2

Representation of relations between various ego states and the internal world

Source: own materials based on: Jagieła, 2012.

It seems that TA constitutes a perfect foundation for this map – an area with its constructs of the ego states structure as life positions and ways of creating transactions that reconstruct early-childhood relations. Therefore, TA could be used to better understand these relations between the layout of what constitutes the representation of an individual's external environment, and the area of internal experiences, thoughts and emotions. In Transactional Analysis (after: Berne, 1998, pp. 115–127) these layouts are called life positions between *I* and *You*, which are worth completing with distinctions introduced by Fonagy, Allen, Bateman (2014, pp. 142–144). We deal with three modes of introjected object relations. They describe relations between the external world and internal representations:

— equivalence mode in which the internal world would be identified one to one with the external world. The patient so strongly identifies with their intrapsychic feelings that through them they project everything that surrounds them in the real world.

— "as if" mode – both worlds (internal and external) remain separated. The external world does not have its internal representation. The mechanisms of dissociation and fission so intensively separate both realities that the patient does not have any opportunity to function in both areas, integrating experiences from reality with these from the internal world.

— and finally, the most mature reflection mode, in which the internal world is not a simple calque of the external reality, but an individual notices their relationship and interdependence. In that way, an individual creates both the representations of their ego state and the representations of external objects together with their references to each other. An individual is aware of the fact

that each of these objects is only their subjective, emotionally marked experience, and, at the same time, thanks to an intellectual component, they can have an insight into it and look at it from a distance. This allows for the so-called affect regulation (after: Fonagy, Allen, Bateman, 2014, p. 104), where the reflection component is able to impact emerging emotional agitation. In this situation, it is possible to container the emotions of another person and reflect them.
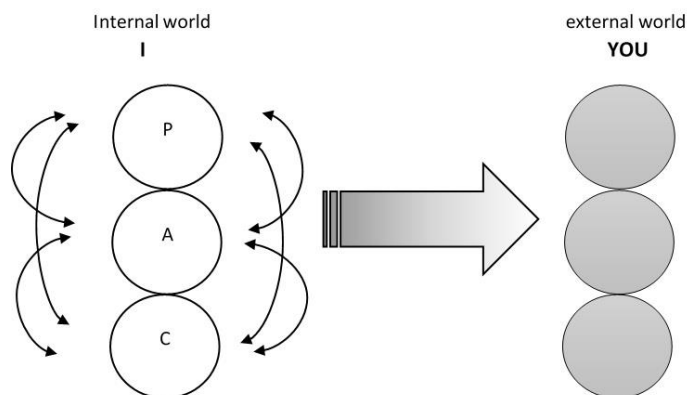
Fig. 3
Equivalence mode – relation between the external world being the projection/ reflection of the internal world

Source: own materials based on Fonagy, Allen, Bateman (2014, pp. 142–144) and Jagieła (2012).
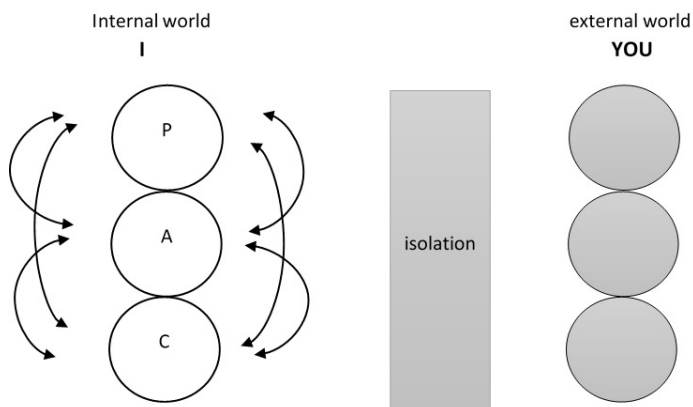
Fig. 4
"As if" mode – the external world is isolated from the internal world

Source: own materials based on Fonagy, Allen, Bateman (2014, pp. 142–144) and Jagieła (2012).

This mode does not, of course, emerge in the void. It is created while building the attachment relationship with the parent (Wallin, 2011, pp. 33–58) – a signifi-

cant object, and constitutes, in fact, the crowning of internal processes of relationship maturity. This situation takes place when the parent is capable of separating themselves from the affect of the child they look after, at the same time adjusting to them in order to support them. In such situations, the child's despair becomes reflected and, at the same time, the parent creates a safe base to contain this despair and comfort the child. It seems that the reflection mode (Fonagy, Allen, Bateman, 2014) of *I – You* relationship (Jagieła, 2006/2007, pp. 365–374) between the internal and the xternal world, emerging thanks to safe attachment to the minder, protects an individual against self-destruction and constitutes the foundation of their mental health in the future.

It is clearly seen that the reflection mode occurs in two areas. According to L.S. Vygotsky's genetic law (2002, pp. 330–336), each mental function occurs in one's development twice. Once, in its interpersonal form, the second time it is internalized as the world of internal experiences, representations of ego states. Thus, in the first stage, we have parents bringing up their children – they container their strong affects; in the second stage there is the inter-object relationship creating relations between particular ego states. This exceptional combination of two worlds is created as a result of multiple repetitions called by Schaffer (2000) Episodes of Interpersonal Engagement – EIE. These EIE constitute a kind of conveyor belt for internalising processes.

Schaffer (2000, pp. 72–96) noticed that the so-called anticipating behaviours influence human development. In this case, mothers treated a child as if it was at a higher developmental level than in reality. Supporting something more than expected creates a certain type of tension, non-specific agitation, providing an area for development for both persons. It does not happen constantly but rather irregularly, episodically, and is interlaced with a sleep mode and withdrawal from contact (Kuźnik, 2013, p. 145). Thanks to this, the child's mental world becomes more and more diverse – soaked with cultural meanings transferred with the help of its mother's behaviour. On the other hand, there is still enough mental space to create individual meanings of internal representations.
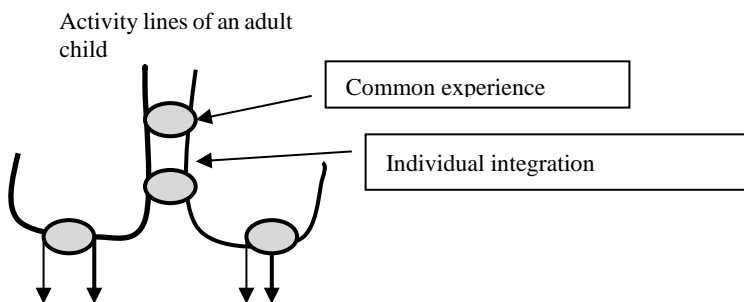

Fig. 5
The Model of Episodes of Interpersonal Engagement in the mother-child relationship

Source: Kuźnik, 2013, based on: Brzezińska, 2007.

Episodes of Interpersonal Engagement are such situations in which both sides, respecting their uniqueness, meet and experience their worlds. There is a certain interaction between them, an exchange thanks to which they learn from each other, make some experiences common, and then they separate fully respecting each other's rights to act the way they choose.

Conceptualisation of the therapist-patient relationship

If the conceptualisation of human psyche with the help of TA offers that language of reflection-introjection of internal and external worlds, there arises a question: how a therapist can approach these worlds and create corrective experiences within their framework. It seems that it is nothing else but creating opportunities to function in the patient-therapist relationship in the reflection mode. To make it possible, it is necessary to be able to mentalise the world of the patient's experiences and the external world, both in the intrapersonal area and the interpersonal area – the patient-therapist relationship. Transference and countertransference emerging in this way obtain a new reference and – one might say – space in which they are not only interpreted in the equivalence mode or the as if isolation mode, but with the help of the reflection mode (after: Fonagy, Allen, Bateman, 2014, pp. 142–144).
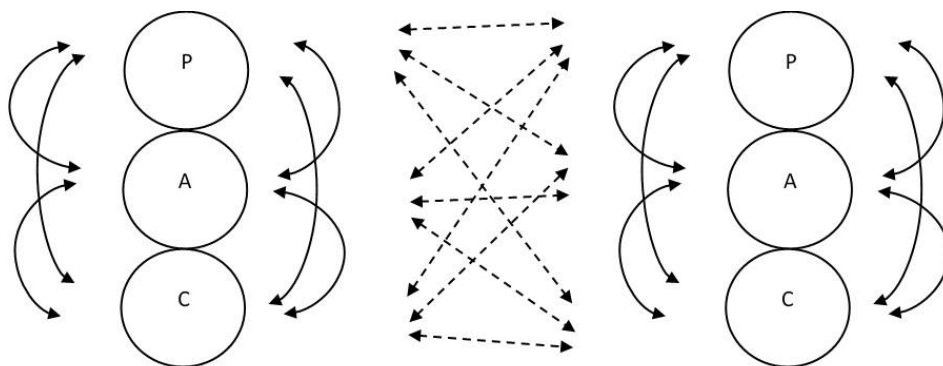
Fig. 6
Conceptualisation of the reflection mode in the therapeutic relation

Source: own materials based on Fonagy, Allen, Bateman (2014) and Jagieła (2012).

With such an interpretation, the therapist becomes the third one in the dryad, which has shaped the relations with the patient's internal and external world so far. The third one who has the power to container and reflect, and, at the same time, to accompany, remaining in their relation to themselves (relation of particular ego states to each other). And again TA with its analysis of transactions oc-

curring between ego states of both persons constitutes a priceless matrix for comprehending such interactions in the therapeutic process. Figure 6 presents the whole complexity of this conceptualization of both areas. On the one hand, there are relations between ego states, being the reflection of early-childhood world of relations depending on the mode (cf. Fonagy, Allen, Bateman, 2014), or 1:1, or constituting the representation of the internal and external world. On the other hand (marked with a dotted line), there is a complex world of transactions, constituting the description of wealth of exchange with the external world of particular ego states (Oller-Vallejo, 2003, pp. 162–167). All of them mutually stimulate and influence each other.

The Capacity of Mentalisation

Only when we apply the reflection mode and use the conceptualisation of transactional analysis models, is it possible to use the capacity of mentalisation effectively (Cierpiałkowska, Górska, 2016).

There arises a question: what is the aforesaid mentalisation? Its creators (Fonagy, Allen, Bateman, 2014) describe this competence as the ability to realise that an individual's thinking is of a representative nature, and motivation to act is their internal state. In other words, it would be self-awareness in reflecting on relations with another person, in our case – with a patient. Baron-Cohen (after Fonagy, Allen, Bateman, 2014, p. 223) talks about a way of thinking like *empathizing*, contrary to the so-called scientific way of thinking.

The text below presents an analysis of mentalising components and dimensions that lets us assess the usefulness of conceptualization with the help of TA language.

The dimensions of mentalisation (after Fonagy, Allen, Bateman, 2014, pp. 6–69):

1. content of mental states – here the conceptualisation of the Child, Adult and Parent ego states and their content: messages, needs, etc., constitute an undeniable value of this conceptualization (Muriel, Jongeward 1999);
2. level of representation – overt – narrative or covert (intuitive) – which would fit the framework of the model discussed as far as possibilities of discussing life positions and scripts in TA are concerned (Hay, 2010, pp. 78–84);
3. object – I and You – subjects of transaction undergoing analysis (Fonagy, Allen, Bateman, 2014, pp. 165);

4. time brackets – past, future, present, referring the model both to **here and now** relations between the patient and the therapist as well as reconstructions of relations/transactions from the world of the patient's experiences, often from distant past. It seems to be compatible with the so-called analysis of temporal structure dealing with the ways of psychological use of time by people. It contains: withdrawal, rituals, activity, leisure, games and intimacy (after: Jagieła, 2012, p. 22).

These dimensions allow for emphasising the components of mentalisation (Fonagy, Allen, Bateman, 2014, p. 27):

— storing the image of the patient's mind in the therapist's mind (is Fig. 6 above not the best proof that it is possible?),
— paying attention to own mental states and mental states of the person one is in relation with. It would mean maintaining the context of reality of the patient's life together with its references to other people (when it comes to the figure above, it would mean taking the arrows into account),
— understanding misunderstandings (the author, drawing arrows a few times was wrong or had to look for a counterpart in his experience to make sure that it exists),
— looking at oneself from the outside and at others from the inside (possibility of changing observation points from one's particular ego states and another person's ego states). It means relativity: who is analysed *I* and who is *You*,
— attributing mental dimension (acknowledging that the model presented by the picture can correspond to the representation of complex mental capacity of mentalising),
— immersion in emotions (it would mean to constantly experience significant emotional content introduced by particular ego states of the patient into a therapeutic relation (Cierpiałkowska, Górska, 2016; Jańczak, 2018, pp. 5–17).

Mentalising also contains an important component of enlarging the insight and undertaking reflection, but, what is even more important, it lets us container emotions. To make it possible, the mentalising person should (Fonagy, Allen, Bateman, 2014, pp. 102–103; 109):

1. Recognise the patient's emotions. Nor only from the Adult ego state, but also allowing to explore them, taking interest by a positive response of the Protective Parent ego state. This message, often non-verbal, transaction addressed to the patient's Child ego state lets them recognize this agitation in their body and get used to it.
2. In this situation, the therapist, reflecting emotions and adjusting to them, de facto, modulates them so that in the next step
3. the patient, used to their strength and size, can express them, in safe intra- and interpersonal conditions of the therapeutic relation, getting emotional support. To make it possible, on the one hand, the therapist has to use their so-called Little Professor ego state (Cierpiałkowska, 1992) triggered by the aforesaid adjustment, being part of the Natural Child ego state, and on the other hand, create safe framework conditions by activating the normative Parent ego state, i.e. friendly rules that facilitate expressing emotions, and the Nurturing Parent ego state addressed to the patient's Child ego state.

What Stern (2004, p. 55) describes as the so-called moment of meeting concept seems to be an important aspect of mentalisation. It focuses the capacity in

question on the *here and now* situation experienced as a spontaneous one, not subject to any planning. Stern says "I feel that you feel that I feel" (after Fonagy, Allen, Bateman, 2014, p. 229). And again the richness of TA lets us conceptualise such a situation. The Little Professor ego state on the one hand invites to spontaneous activities staying in appropriate contact – an overt transaction with another person, and on the other hand, it does not turn off other ego states that help to comprehend and container strong emotions deriving from mutual interest in each other. This meeting of the therapist's Child ego state with the patient's Child ego state creates a special opportunity for exchange – transactions abounding in corrective emotional experiences. Similarly, when the Parent ego state is activated, it creates a safe space for uncertainty, shyness expressed in the transaction by the Child ego state of a submissive patient. What is equally important, if such experiences are immersed in TA language, they can be reflected on and described later on, both from the therapist's and the patient's perspective. In this way, there emerges a space for the development of the reflection mode – that is the patient recovers, gaining a perspective to their internal experiences by getting used to them in their relation with the therapist. The language that was used for this interpersonal meeting allows for creating a representation structure for the mental world.

Neurobiology of trauma and its consequences for ego states' functioning

Current neuropsychological research (Gazzaniga, 2017) seems to confirm the presence of such areas of mental functioning and offer very interesting inclinations for working with traumatized patients, i.e. those who suffer from dissociation – separating the world of internal experiences and external events, relations. At the psychological level, this isolation (see Fig. 4) occurs due to defence mechanisms protecting the patient against unpleasant stimuli maintaining traumatic reactions: cognitive, emotional or behavioural. Hence events passing into oblivion, distorted memories, somatic symptoms, etc. At the biological level, relations between an early-childhood trauma and hypoplasia of corpus calossum Gazzaing 2017; Fisher, 2019, p. 55) were discovered. It would mean that experiencing a trauma triggers the process of separation, cutting off, lack of cooperation between impulses coming from the left and right hemisphere. Impaired communication between the two hemispheres has to, in turn, influence difficulties in integration, which the authors describe as the effect of owning two brains: one, which is strongly traumatized, emotional, containing script messages founded on traumas, and the other one, which is linear, logical, but does not cover verbally the record of those dramatic events. These languages of patients seem to be impenetrable, and attempts undertaken by therapists to recall traumatic events did not

bring any relief and only deepened the gap between the two ways of their brain's neurological functioning. It would mean that the right hemisphere codes non-verbal aspects of experiences but does not interpret them, constantly remains on high alert, ready to escape or fight. Emotionality processed by both hemispheres cannot be verbalized as it is the function of the left hemisphere. Therefore, a childhood drama neurologically remains under cover of lack of naming possibilities, and, at the same time, is subject to a state of considerable agitation when trigger stimuli are provided, e.g. encouragement to take a trip down memory lane. Without information exchange through corpus calossum, the left hemisphere might not remember actions driven by emotions and reactions managed by the right hemisphere (Fisher, 2019, p. 55).

Fisher (2019, p. 57) writes that patients remain so to speak imprisoned between two colliding types of instincts. On the one hand, the attachment instinct drives a child towards closeness and comfort found with their minder, parent. On the other hand, that primitive alert makes it react with freezing, fight or flight. The patient is in a stalemate, where only acting out can bring a momentary relief. Thus, at the biological level, we would have anatomical foundations to distinguish isolation between particular ego states – a desperate Natural Child ego state and reactions from the Adapted Child ego state (freezing, submission) and/ or the Rebellious Child ego state (fight and flight). It seems that in therapeutic practice we witness such situations quite frequently among patients with deep early childhood traumas.

And here TA conceptualisation lets us use the capacity of mentalisation to seal this gap, this cracking and additionally strengthen the weakened structures of the Protective Parent ego state negatively used. TA language gives us an opportunity to show the patient particular parts of their ego states and how they are experienced differently, especially in the area of traumas. What in traditional therapeutic work has caused frustration and suffering so far (Fisher, 2019, pp. 225–230) can be an opportunity to meet and to use a therapeutic reaction which:
— explains these two instincts – the Adapted and Natural Child ego states from the perspective of the Adult ego state,
— creates a safe framework for frequently non-verbal meeting the patient's Adapted and Natural Child ego states from the perspective of the Protective Parent ego state – the spontaneity of the meeting *here and now*;
— introduces new rules for taking care of weakened Child ego states from the perspective of the Normative Parent ego state,
— finally, from the perspective of the Child ego state, frequently offers the psychotherapist an opportunity to approach their patient and empathise with their suffering, which lets them offer more appropriate help and protection and build elements constituting the foundations for reconstructing the patient's Protective Parent ego state. In this way, the therapist's voice becomes a missing element integrating this gap between the patient's ego states.

Clinical illustration of the conceptualisation in question

The case of Mrs M. shall illustrate the aforesaid discussion. The 38 year-old patient reported the symptoms of rage attacks alternated with the feeling of strong fear, especially of a social nature. Her way of functioning clearly pointed to personality disorders at the borderline level of organisation (McWilliams, 2019, pp. 53–60).

The patient had a few unsuccessful relationships, where she did not feel understood and accepted with her emotionality and needs of dependence, when, at the same time, she wanted to feel exceptional and unique in her partner's eyes. It was her dream to become an ideal wife and mother, which was to be a solution to all her problems. She declared herself to be a deeply believing person, unconsciously using her faith as an area of projective identification with religion as the cause of her misfortune and a way to free herself from it by further suffering inflicted on herself as a kind of formation, mortification, etc. In her eyes, God was a capricious and cruel object, at the same time omnipotent and depriving her of any influence. The patient used strong primitive mechanisms of dissociation and split-off, isolating these parts of herself responsible for the need of dependency, merging with her partner, at the same time demonstrating a high level of fear and rage addressed at him as the one not providing support and understanding. Getting involved into this relationship, she divided the internal object into a good confessor and a bad, seductive, corrupted therapist. During her sessions, many times, the patient projected the material threatening her onto the therapist, depriving herself of any responsibility for being aggressive. She regularly tried to disturb a therapeutic setting, and any attempts at initiating a conversation about it were treated by her as an attack.

In her life story, the patient talked very positively about her relationship with her father as the only parent who had adored her, had been warm and tender. She perceived her mother as addicted to alcohol and aggressive. As her memories more and more drifted from reality in which she functioned (in fact, her father had not hesitated to put his family into debt, cheat on his wife and the patient's siblings), going back to the past was accompanied with considerable suffering and strong resistance.

As the first stage of mentalisation, working with unwanted aspects of the patient's ego states was suggested. The patient was asked to draw her inner child. The drawing presented a huddled figure, with a face hidden behind her knees, and the grey colour dominating. To her surprise, the patient easily made contact with that part of herself, when asked about her feelings and thoughts, she gave answers while pointing to a high level of incomprehensible aversion to that aspect of herself: "it's not worth listening to her," "she's stupid," "why do we talk about her?, she doesn't understand anything." After a few sessions, the patient got used to this part thanks to the drawing and undertaking a dialogue with it: – she external-

ized her unwanted impulses. It turned out that this childhood part was quite ne-
glected, yet it knew what it needed: it wanted to be able to feel, be finally safe,
well looked after. The patient saw that when she talked to this part, she calmed
down and soothed her strong emotions of fear. Meanwhile, the part controlling
the Child ego state – a girl who was protesting, throwing numerous accusations
and being aggressive – became more and more noticeable. As it resembled mum-
bling of an alcoholic, one day the patient called this part the Mother – strict and
critical towards herself. In this way, both ego states, *the Child and the Normative
Parent* negatively used, were not only recognized but from session to session, the
patient deepened her insight in comprehending their mutual relations. There was
a distinct lack of language that would reconcile both parts, become a mediator:
and that was often the therapist's role. One day, the patient said herself that the
therapist became a voice that she recalled when mother in her (the Normative
Parent ego state) got frantic again. This voice was soothing for her, yet meaningful.
In the therapeutic process, there was an attempt to strengthen the relation of the Child-
girl ego state with the therapist. Due to that fact, there were new, previously denied
memories arousing strong emotions at every attempt to approach them.

Initially, before she got used to this child part of her ego state, the patient
experienced strong resistance, saying that these were not memories. She said she
did not remember anything and that one would need proofs. At the same time, the
patient's general condition was getting better as the process of strengthening the
Protective Parent ego state and caring for herself got more effective. Having con-
sulted her doctor, she stopped taking her medication. There appeared good mem-
ories from her childhood – doing sport, swimming, till a clear temporal dividing line
after which there was no energy in her memories and she did not like herself – her
body. A memory of fear of someone entering and calming down when it turned out
it was her mother, experience of being fondled, touched in intimate parts.

These memories referred to a strong trauma of sexual abuse by her father and
lack of support from her mother in this situation. The only way of dealing with
this situation was dissociating the trauma experiences and idealizing her father's
image. Thanks to the introjection of the Child-girl from the picture ego state, it
was possible to learn how to express strong emotions experienced because of that
state while omitting the resistance of the Normative Parent ego state. Interest-
ingly, the memories of abuse occurred first as somatic experiences, strong emo-
tional experiences, and only thanks to mentalisation used during sessions it was
possible to verbalise them – to integrate these two dissociated trauma languages.

One day, the patient described a picture in which the bliss of carefree swim-
ming in water was brutally disturbed by crashing into an iceberg and her body
falling apart. She was terrified and at the same time ready to confront the memory,
in which her father came at night, lay down next to her and aroused rubbed his
penis against her back and crotch. For the first time her despair, sadness and rage
was joined with the desire to protect herself and prevent from this happening

again. The patient could integrate the pictures and memories, acknowledge their reality, experience emotional support. Care for herself in the therapeutic relation slowly but systematically rebuilt broken relations with her ego states. From the therapist's perspective, these sessions were both exceptionally emotionally intense and provoked tenderness and sympathizing with the patient's suffering. During this adjustment, there was a need to care about safety and learn how to take responsibility for caring about herself.

Conclusion

In conclusion, it seems that mentalisation supported with conceptualisation originating from Transactional Analysis allows not only for comprehending the client's reality, especially in the situation of strong emotional traumatic experiences, but also offers a space for verbalizing what has not been named and understood so far. Thus, classical understanding of ego states and transactions can be discovered in a new way in the context of the capacity of mentalising the process of the patient-therapist relation. It provides both the patient and the therapist with language, creating paths of understanding and opportunities for closeness necessary for creating corrective experiences.

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Analiza transakcyjna w służbie kompetencji mentalizowania

Tekst stanowi próbę użycia konceptualizacji języka analizy transakcyjnej – dla rozumienia kompetencji mentalizacji w relacji pacjent–terapeuta. Wydaje się, że analiza transakcyjna dostarcza prostego, barwnego, ale i nieredukcjonistycznego języka (przestrzeni) pozwalającego opisywać złożone zjawiska w relacji pomiędzy pacjentem i jego terapeutą. W artykule omówione zostaną podstawowe pojęcia AT, opisujące proces uwewnętrzniania się relacji. Proces ten stanowi podstawę kompetencji mentalizowania omówiony w drugiej części tekstu. Całość ilustruje fragment opisu klinicznego pracy terapeutycznej, w której użycie elementów analizy transakcyjnej pozwoliło na istotne wzmocnienie relacji terapeutycznej, co przełożyło się na proces zdrowienia pacjenta.

Słowa kluczowe: mentalizacja, analiza transakcyjna, relacja terapeutyczna.