https://doi.org/10.16926/eat.2026.15.03.en

eLocator/Article ID: eat-2026-rb-02

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Integration of Transactional Analysis and Monodrama in the Psychotherapy of Adult Autistic Women: A Narrative Case Study of the Therapeutic Process

How to cite [jak cytować]: Zwolska-Płusa K. (2026). Integration of Transactional Analysis and Monodrama in the Psychotherapy of Adult Autistic Women: A Narrative Case Study of the Therapeutic Process. *Edukacyjna Analiza Transakcyjna*, *15*, Article eat-2026-rb-02. https://doi.org/10.16926/eat.2026.15.03.en

Abstract

Autistic women are often diagnosed in adulthood, following many years of functioning under conditions of extensive camouflaging, overadaptation, and secondary relational trauma. In clinical practice, this is associated with high levels of anxiety and depression, difficulties in emotional regulation, and fragmentation of the sense of self. The aim of this article is to present monodrama and transactional analysis as a cognitively accessible and clinically useful therapeutic approach in working with adult autistic women. The paper adopts a narrative-clinical format and is based on a detailed description of the therapeutic process of an autistic patient with a history of relational trauma. Monodrama and transactional analysis are presented as complementary frameworks for organising the patient's internal experience, while integrating parts work and somatic regulation.

Over the course of therapy, clinically meaningful improvements in functioning were observed. The patient reported a substantial reduction in anxiety symptoms, particularly in crowded environments, and developed greater capacity for emotional self-regulation within her window of tolerance. Eating behaviours became more organised and balanced, shifting toward nutritionally adequate and health-supportive patterns appropriate for an adult working woman. The patient also gained increased insight into her relationships with both parents and began to reconsider previously rigid and generalised negative beliefs about men, which became noticeably less pervasive. Importantly, therapeutic progress was reflected not only in symptom reduction but also in growing self-agency – the patient increasingly developed the ability to care for herself and rely less exclusively on external sources of support. These changes suggest that approaches emphasizing experiential processing, relational meaning-making, and accessible symbolic work may support psychological integration and autonomy in autistic women with histories of relational trauma.

Keywords: autism, autistic women, transactional analysis, monodrama, psychodrama, psychotherapy, camouflaging.

Introduction

In recent years, there has been a growing interest in the specific characteristics of autistic women's functioning, reflecting a response to their longstanding underrepresentation in both scientific research and clinical practice. For decades, autism research has been heavily based on male samples, leaving key questions about sex/gender differences insufficiently addressed (Lai et al., 2015).

As a result, many autistic women receive their diagnosis only in adulthood, often after years of ineffective therapeutic interventions and misdiagnoses, such as anxiety disorders, depression, or personality disorders.

The experience of autism in women is characterized by a range of features that may mask developmental difficulties during childhood and adolescence. The literature highlights that autistic women more often demonstrate high levels of reflectivity, an ability to observe and imitate social behaviours, and a strong motivation for relational belonging (Hull et al., 2017). However, this relational engagement is often based not on spontaneity but on cognitive analysis and imitation, requiring significant psychological effort and leading to chronic overload.

One of the key concepts describing the female autistic experience is social camouflaging, understood as a set of strategies aimed at concealing autistic traits and adapting to social norms. These strategies may include regulating emotional expression, suppressing self-stimulatory behaviours, preparing conversational "scripts," and excessive monitoring of others' reactions (Hull et al., 2017). While such strategies may facilitate short-term social functioning, research indicates that in the long term they are associated with poorer mental health, increased anxiety and depressive symptoms, and a sense of loss of authenticity (Cage & Troxell-Whitman, 2019).

Another important aspect of autism in women is the high prevalence of co-occurring mental health conditions. Empirical studies indicate that autistic women are at increased risk of internalizing difficulties, particularly anxiety and depressive disorders, and are more likely than autistic men to receive multiple psychiatric diagnoses (Belcher et al., 2022; Rødgaard et al., 2019). There is also growing evidence suggesting elevated rates of eating disorders and trauma-related symptoms among autistic women, although these associations may vary depending on the sample and methodology (Hull et al., 2017; Westwood & Tchanturia, 2017).

Elevated levels of anxiety are frequently accompanied by somatic complaints, including gastrointestinal difficulties and sleep disturbances, which further contribute to the complexity of the clinical presentation (Croen et al., 2015).

The literature increasingly emphasizes that the elevated risk of mental health difficulties in autistic women reflects not only neurodivergence itself, but also its interaction with environmental and relational factors. Autistic women appear to be at increased risk of interpersonal and sexual victimization compared to non-autistic women, which may contribute to higher rates of trauma-related symptoms (Weiss & Fardella, 2018). At the same time, social camouflaging, combined with gendered expectations regarding femininity, empathy, and caregiving, may lead to the systematic neglect of one's own boundaries and needs (Hull et al., 2017).

Qualitative studies on the psychological well-being of autistic women indicate that their experience often involves a sense of "falling through the cracks," being misunderstood, and the constant pressure to meet others' expectations (Yau et al., 2023). At the same time, factors such as mutual acceptance, a sense of belonging, and relationships based on safety and predictability serve protective functions and support mental health.

These findings highlight the need to develop therapeutic approaches that take into account the specific characteristics of the female autism phenotype, including regulatory needs, experiences of camouflaging, and the high prevalence of relational trauma. Psychotherapy with this group requires not only knowledge of autism but also flexibility, process transparency, and a language that helps organize experience without pathologizing it.

In this context, transactional analysis – with its structural and relational model of understanding psychological functioning – offers a promising framework for working with adult autistic women.

A key assumption of the therapeutic approach presented in this paper was the integration of transactional analysis with experiential parts work conducted in the form of monodrama. This integration emerged both from the specific characteristics of autistic women's functioning and from the clinical need to reduce abstraction and enhance the safety of the therapeutic process.

Theoretical Framework: Transactional Analysis and Monodrama

Transactional analysis (TA) is a humanistic-existential theory of personality and communication developed by Eric Berne (1961). It conceptualizes human functioning through the framework of ego states (Parent, Adult, Child), interpersonal transactions, and life scripts – early, often unconscious decisions about the self and relationships.

TA assumes that individuals are capable of thinking and change, and that patterns formed in childhood can be revised within a safe therapeutic relationship. In clinical practice, this approach enables the organization of internal experience, the identification of internalized critical messages, the strengthening of the Adult ego state as a centre of reflection and regulation, and the modification of maladaptive scripts.

Monodrama is an individual form of psychodrama derived from the work of Jacob L. Moreno. It is experiential in nature and is based on working with roles and parts of the self within the therapeutic space. Unlike classical group psychodrama, all roles are enacted by one person, while the therapist takes on the role of a director – structuring the process and ensuring emotional safety.

Monodrama allows internal conflicts to be seen and embodied, and through action and shifts in perspective, it facilitates the integration of split or polarized aspects of experience (Moreno, 1946).

In monodramatic work, three main types of roles can be distinguished: somatic roles, expressed through the body (e.g., “Frozen,” “Alert,” “Collapsing”), which serve as an entry point to pre-narrative experience; psychodramatic (internal) roles, representing parts of the self and affective states (e.g., Inner Critic, Wounded Child, Masking Self); social roles, referring to ways of functioning in relationships and systems (e.g., “Good girl,” “Invisible student,” “Expert”), co-constructed within familial and cultural contexts.

The monodrama process unfolds in stages. It begins with entering through the body – observing and naming somatic sensations without interpretation. Next, a role or part is identified, separated from the “whole self,” and named. The role is then placed in space (e.g., using a chair or object), which supports the concretization and mentalization of experience.

This is followed by a controlled enactment of the role and a brief dialogue between roles, allowing recognition of both their protective functions and the costs associated with their operation. The final stages involve integration, transferring insights into real-life social roles, and closing the process through regulation and grounding in the present moment.

Monodrama enables individual work using roles, space, and symbolism without requiring spontaneous social interaction, making it particularly accessible for autistic individuals. In combination with transactional analysis, it allows for embodied and concrete experiencing of ego states, scripts, and internal conflicts, rather than relying solely on verbal analysis.

In clinical practice, monodrama was used as a tool to support contact with somatic, psychodramatic, and social parts, while maintaining the structure and regulatory framework provided by transactional analysis. Ego states described in TA could thus not only be named but also “seen” and experienced within the therapeutic space, supporting both mentalization and integration.

This is particularly important in work with autistic women, in whom high levels of camouflaging, alexithymia (Bird & Cook, 2013), and histories of relational trauma often limit access to narrative descriptions of internal states. Monodrama allows the process to begin at the level of body and role, gradually leading to reflection and insight.

Such integration of transactional analysis with parts work in monodrama enables the simultaneous organization of experience, strengthening of the Adult as a regulatory centre, and safe exploration of scripts and psychological games – without the risk of retraumatization or increased masking. This approach aligns with integrative psychotherapy tailored to the female autism phenotype.

The decision to integrate transactional analysis and monodrama was based on both clinical observation and the specific characteristics of the patient’s presentation. The patient demonstrated high levels of alexithymia, chronic camouflaging, difficulties with emotional identification, and a tendency toward intellectualization and dissociative responses under stress. These characteristics limited the effectiveness of purely insight-oriented or verbally focused interventions.

Transactional analysis was selected because of its structured and cognitively accessible language, which supported the organization of internal experience through clearly differentiated ego states, scripts, and relational patterns. The model was considered particularly suitable due to the patient's preference for explicit structures and psychoeducational frameworks.

Monodrama was introduced because it offered a more concrete and embodied way of working with internal experience. The use of symbolic representation, spatial organization, and role differentiation reduced the level of abstraction typically required in psychotherapeutic work and created opportunities for accessing experiences that were difficult to verbalize directly. Importantly, monodramatic interventions were introduced only after sufficient stabilization had been achieved and were consistently embedded within a regulatory framework focused on maintaining work within the patient's window of tolerance.

Case Description and Conceptualization

The patient described in this article was a 27-year-old woman who entered psychotherapy shortly after receiving a diagnosis of autism spectrum condition requiring support. She was employed in the hospitality industry, in a highly sensory-demanding environment characterized by a fast pace, multitasking, and time pressure.

Previously, she had participated in various forms of psychotherapy, during which she had been diagnosed with anxiety and depressive disorders, as well as borderline personality disorder – later excluded through differential diagnosis.

The autism diagnosis was comprehensive and took into account the developmental nature of her symptoms, which had been present since early childhood. Already in preschool years, she exhibited minimal eye contact, difficulties initiating relationships spontaneously, and pronounced food selectivity, suggesting early sensory processing differences.

She demonstrated strong sensory hypersensitivity, particularly to auditory stimuli – noise, sudden sounds, and multi-stimulus environments led to overload and withdrawal. In the domain of social communication, she experienced difficulties understanding non-literal language, irony, and indirect cues, which resulted in frequent interpersonal misunderstandings.

At the same time, from an early age she developed intense and highly detailed interests, including drawing and Japanese culture, which functioned both as passions and as regulatory strategies.

The diagnostic process included a comprehensive developmental interview (ADI-R), clinical observation using ADOS-2, questionnaires targeting the female autism phenotype (e.g., the Girls Questionnaire; Attwood & Garnett, n.d.), as well as differential diagnosis with personality disorders and trauma-related conditions using the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and standardized trauma assessment tools.

The clinical picture indicated a pervasive neurodevelopmental condition, co-occurring with significant relational adversity.

The patient came from a two-parent family but experienced significant environmental burdens during childhood and adolescence. Her father abused alcohol and was violent within the family. Her mother was largely focused on caring for the patient's younger brother, who had a heart condition and required increased attention and support.

From an early age, the patient was involved in caregiving for her brother, which resulted in premature assumption of caregiving roles and limited access to adequate emotional support for her own needs. During secondary school, she developed anorexia; despite severe emaciation, she did not receive appropriate help or support from her family. The illness was experienced in a context of loneliness and lack of protection from adults.

In the domain of interpersonal relationships, she had previously engaged in abusive relationships, reflecting a pattern of relational imbalance and lack of safety. At the time of therapy, she was married.

Her current emotional and relational difficulties should be understood in the context of long-term developmental burden, experiences of violence, parentification, and lack of adequate support at key life stages.

The clinical presentation included high sensory reactivity, difficulties in recognising and naming emotional states, frequent shifts into protective modes such as freezing, overcontrol, and dissociation, as well as somatization of tension.

One of the key areas of difficulty was her relationship with food, which served both regulatory and controlling functions. She would refuse to eat if food was not prepared by someone else. She experienced resistance toward preparing meals independently and often resorted to eating sweets, which did not require preparation.

Access to a stable Adult – understood both in terms of transactional analysis and the concept of Self in parts work – was unstable and easily disrupted under conditions of overload.

In summary, the case conceptualization included the interaction of three main factors: (1) neurodevelopmental differences associated with autism, (2) experiences of relational trauma, and (3) insufficient external regulation during development.

The patient's internal system was dominated by protective strategies that enabled functioning at the cost of contact with needs and emotions.

From a transactional analysis perspective, her psychological functioning can be understood as a system organised around survival strategies developed in response to early experiences of overload and the absence of a sufficiently regulating caregiving relationship.

A prominent feature of her ego structure was a strong Critical Parent, internalized through experiences of violence, emotional neglect, and premature responsibility for others. This part communicated through pressure toward self-control, minimization of needs, and the belief that expressing vulnerability or dependency is unsafe.

In response, the Adapted Child ego state became dominant, organising functioning around strategies of overcontrol, withdrawal, and freezing.

In situations of sensory or relational overload, access to the Adult – understood as the capacity for reflective monitoring and appropriate emotional regulation – became rapidly disorganised. The Adult was present but unstable and easily "taken over" by protective strategies.

From a script perspective, it can be assumed that early decisions were formed around the necessity of self-reliance, restriction of needs, and maintaining control as a condition of safety.

From a monodramatic perspective, this system can be understood as an internal structure composed of parts fulfilling specific protective functions. Particularly salient were roles such as the Controller (responsible for maintaining order and limiting needs), the Frozen Child (associated with helplessness and overload), the Caretaker (linked to parentification and responsibility for others).

These roles formed a dynamic system in which spontaneous, vital aspects of the self had limited space for expression. The internal "stage" was dominated by protective roles organising functioning around avoidance of threat rather than exploration of needs and emotions.

As a result, access to the observer role – corresponding to the reflective Adult in transactional analysis – remained limited and easily destabilized.

Course of the Therapeutic Process

The therapeutic process lasted approximately two years and consisted of around 100 individual sessions conducted on a weekly basis. The treatment followed a phased and integrative structure, with goals evolving over time according to the patient's regulatory capacity and clinical needs.

The initial phase focused on stabilization, sensory regulation, strengthening therapeutic safety, and increasing awareness of bodily signals associated with overload and dissociation. A secondary goal involved developing access to the Adult ego state as a foundation for reflective functioning.

The middle phase concentrated on identifying internalized relational patterns, differentiating ego states and protective parts, strengthening self-regulatory skills, and improving recognition of emo-

tional and sensory states. Work during this period also targeted eating-related difficulties, interpersonal boundaries, and reduction of masking behaviours.

The later phase focused primarily on integration, including exploration of traumatic relational experiences, increasing self-agency, strengthening self-care capacities, and developing more flexible relational patterns. Monodramatic interventions were introduced gradually during this phase after sufficient stabilization had been achieved.

Treatment outcomes included substantial reduction of anxiety symptoms, improved functioning in crowded and sensory-demanding environments, increased ability to remain within the window of tolerance, greater emotional awareness, improved eating behaviours, enhanced insight into family relationships, and reduced reliance on external regulation.

The initial phase of therapy, following the establishment of a safe therapeutic alliance, focused on the regulation and stabilization of the nervous system, understood as a prerequisite for further insight-oriented work. Regulation was not conceptualized as the suppression of emotions, but rather as the development of the capacity to recognize bodily signals, maintain arousal within a tolerable range, and return to relative equilibrium following activation of the threat system.

In working with an autistic patient with a history of relational trauma, it was assumed that the process of regulation begins in the body, stabilizes within the therapeutic relationship, and only subsequently can be supported by cognitive reflection. A key conceptual framework was the notion of the window of tolerance (Ogden & Fisher, 2015), understood as the range of arousal within which it is possible to simultaneously experience emotions, maintain orientation in time and space, and access reflective thinking and relational engagement.

When this range was exceeded, the patient experienced hyperarousal (e.g., anxiety, tension) or hypoarousal (e.g., freezing, shutdown, derealization). Consequently, the pace of therapeutic work was continuously adjusted to the patient's current level of arousal. When the body signaled overload, the process was slowed down, and attention returned to somatic grounding.

Interventions included mapping sensory stressors – particularly in the work environment – recognising early signals of transitions into protective modes, working with breath and rhythm, and normalizing the need for sensory stimulation as a form of self-regulation.

Regulation also functioned as a prerequisite for strengthening access to the Adult ego state as the centre of reflective management of the internal system. Without sufficient stabilization, attempts at deeper insight could have intensified masking, shame, or dissociation. Thus, the stabilization phase was not merely a preparation for "proper" trauma therapy, but its foundation – a space in which the patient gradually learned to experience emotions in a tolerable way, regaining a sense of agency and flexibility within her window of tolerance.

In subsequent months, as therapy entered a more stable phase, interventions were primarily somatic-reflective and closely attuned to ongoing monitoring of the window of tolerance. Sessions often began with a brief body scan, in which the patient was invited to name the quality of sensations – such as pressure, heaviness, trembling, or numbness – without immediate interpretation.

An arousal scale (0–10) was introduced to support the Adult ego state in recognising when tension approached the regulatory threshold and in making decisions about appropriate responses, such as taking a break, changing posture, engaging in rhythmic movement, or reducing sensory input.

In situations of increasing activation, micro-movements, conscious lengthening of the exhalation, and brief grounding exercises were used to help the body return to a tolerable range before automatic transitions into protective modes (freezing, overcontrol, dissociation) occurred.

At the same time, the Adult ego state was strengthened as a monitoring and organising instance. Structured reflections in the form of three columns (fact – reaction – choice) were used to organize experience and differentiate sensory data from interpretation.

The therapist modeled Adult language by pausing the process and asking questions such as "What is the observable fact right now?", "What is your current level of arousal?", "What does your body need at this moment?"

Within the framework of transactional analysis, particular attention was given to distinguishing messages of the Critical Parent (e.g., “you’re overreacting,” “others can manage”) from actual signals of physiological overload.

The critical voice was externalized – given a name, its protective function was explored, and boundaries were subsequently established by the Adult. In place of critical messages, a more nurturing internal dialogue was introduced “You have the right to feel tired.”, “This is a lot of stimulation.”, “Let’s focus on regulation right now.”

Gradually, an internal structure was developed in which the Adult could recognize activation, differentiate evaluation from need, and consciously select regulatory strategies rather than defaulting to automatic protective responses.

As therapy progressed, it became possible to deepen work with wounded parts and traumatic experiences. This work followed a phased approach and remained strictly aligned with principles of emotional regulation and the window of tolerance.

Transactional analysis provided a structuring and normalizing function, enabling the patient to understand her reactions as the activation of specific ego states rather than as a “lack of control” or a “personality defect.” It also introduced a relational perspective, allowing experiences to be understood not only as internal conflicts but as patterns shaped within significant relationships.

From this perspective, emotional difficulties and impulsive reactions were seen as responses emerging within specific interpersonal contexts – particularly those involving lack of safety, excessive responsibility, or experiences of violence.

Therapeutic work focused on gradually strengthening the Adult ego state, enabling more conscious regulation of responses, recognition of personal boundaries, and the selection of more adaptive forms of interpersonal contact.

In this context, assertiveness was conceptualized as the ability to communicate needs and boundaries from the Adult state, while work on impulsivity involved recognising moments of Child activation and introducing a brief reflective pause to support more regulated responses.

At a later stage, when a sufficient sense of safety had been established, elements of monodramatic work were introduced. This work was conducted with the active involvement of the Adult state, which maintained an observing and regulating function, ensuring grounding in the present moment and preventing emotional flooding.

Monodramatic interventions involved naming and differentiating internal parts, as well as their symbolic representation – for example, through drawings depicting the patient’s internal landscape and relationships between parts.

The patient gradually gave voice to different parts, which facilitated their expression while simultaneously supporting processes of mentalization and integration. This allowed for a deeper understanding of internal conflicts while maintaining regulatory stability and integration of the self.

An important area of therapeutic work was the patient’s relationship with food, which was conceptualized not merely as problematic behavior but as part of a regulatory system linked to early experiences of caregiving deprivation.

In the patient’s history, food was strongly associated with relationships. During her experience of anorexia, she did not receive symbolic “nurturance” from her mother, who was unable to respond adequately to her needs. At the same time, one of the few positive childhood memories involved her father bringing her sweets after work – an act that briefly conveyed care and recognition.

As a result, in adulthood, eating remained closely linked to the presence of another person and was experienced more as something “received” from others than as an act of self-care. The patient had difficulty preparing meals independently and often waited for a “caregiver figure,” most often her husband, to provide food.

In therapy, a confrontational approach to eating behaviours was deliberately avoided. Instead, the relationship with food was explored as an expression of protective parts that had historically helped the patient cope with emotional deprivation, lack of care, and helplessness.

From a transactional analysis perspective, the difficulty in “feeding oneself” was understood as limited access to a nurturing Adult and the absence of an internalized Nurturing Parent.

Therapeutic work therefore focused on developing a more compassionate relationship between the Adult and the parts representing hunger, dependency, and helplessness.

In monodramatic work, these experiences were explored through symbolic roles introduced into the internal “stage,” including the Hungry part (representing the need for care and regulation), the Helpless part (associated with abandonment and lack of support), and the Caring part (capable of providing support).

Monodramatic work was introduced gradually after approximately several months of stabilization work, when the patient demonstrated more consistent access to the Adult ego state and improved capacity to remain within her window of tolerance during emotionally activating material.

The primary function of monodrama was not catharsis or emotional exposure, but concretization, differentiation of internal experiences, and strengthening reflective functioning. Sessions typically followed a structured sequence: grounding, identification of activation, role differentiation, brief experiential work, reflection, and regulation before closure.

For example, during work related to eating difficulties, the patient identified three symbolic roles: the Hungry part, the Helpless part, and the Caring part. These roles were represented spatially using chairs placed at different distances from one another. The patient was invited to move between positions and describe bodily sensations, thoughts, and impulses emerging from each role. Initially, the Hungry part was experienced as demanding and shameful, whereas the Helpless part expressed expectations that care should come exclusively from others. Through Adult-guided dialogue between roles, the patient gradually explored alternative responses and experimented with the perspective of the Caring part, which was later integrated into everyday self-care practices.

The therapist maintained an active directing role throughout the process by monitoring arousal levels, slowing down activation when necessary, and frequently reorienting attention toward bodily sensations and present-moment safety. Experiential work was deliberately brief and followed by reflective integration in order to minimize overload and dissociative responses.

Over time, the patient developed the capacity to assume the role of a host of her internal space. The metaphor of the home became central to the therapeutic process: the patient began to perceive herself as someone capable of creating a safe environment for her own needs and emotions.

Within this framework, “feeding oneself” ceased to be merely a behavioral act and became a symbolic expression of self-care and responsibility for one’s well-being.

Gradually, it became possible to establish an internal experience in which the Adult – as the host of the inner home – could notice the hungry part, invite it “to the table,” and respond in a regulating and supportive manner.

Discussion

The presented description of the therapeutic process confirms the validity of using transactional analysis and monodrama as a conceptual framework in the psychotherapy of adult autistic women, particularly in the context of co-occurring relational trauma and long-term camouflaging.

Transactional analysis proved useful not only as a model for understanding relationships and communication, but above all as a structural language for organising the patient’s internal experience, enabling her to gradually regain a sense of agency over her emotional and relational functioning.

Monodrama, as a form of parts work, deepened the process by allowing a shift from the narrative level to the experiential level, which was of particular importance in working with a patient with a high level of alexithymia and a tendency toward intellectualization.

The embodied representation of ego states, protective parts, and social roles made it possible to mentalize and integrate them without the need for immediate verbalization of emotions. In this sense, monodrama functioned as a bridge between somatic regulation and Adult reflection.

From a clinical perspective, it is also important to emphasize the significance of pacing and the extended stabilization phase in therapy with autistic women. The described process confirms observations indicating that an emphasis on rapid insight or intensive trauma exploration may increase overload and secondarily reinforce masking strategies.

Transactional analysis, due to its structural nature and focus on the "here and now," supported maintaining the process within the window of tolerance and allowed the patient to retain a sense of control over the course of therapy.

A limitation of the present study is that it is based on a single case, which does not allow for generalizable conclusions. Nevertheless, the detailed, narrative description of the therapeutic process contributes meaningfully to the developing field of research on psychotherapy for adult autistic women, particularly in the context of transactional analysis and monodrama – approaches that remain underrepresented in this population.

Despite its clinical usefulness, the integration of transactional analysis and monodrama was associated with several challenges and limitations. Monodramatic work, even in an individual format, may increase emotional activation and requires careful pacing, particularly in autistic individuals with trauma histories and difficulties in interoceptive awareness. The symbolic and experiential elements of monodrama may also be experienced as confusing, overly abstract, or emotionally overwhelming for some autistic patients, especially during periods of sensory overload or dissociation.

Another limitation concerns the strong individualization of the therapeutic process. The interventions were continuously adapted to the patient's sensory profile, arousal level, and regulatory capacities, which limits direct transferability of this model to other autistic women. Furthermore, because the presented approach combines multiple modalities – including somatic regulation, parts work, transactional analysis, and monodrama – it is difficult to determine which components contributed most strongly to therapeutic change.

The approach presented in this article differs from many interventions commonly used with autistic adults because it combines structured cognitive organization with embodied experiential work while maintaining a strong emphasis on regulation and pacing. Rather than relying primarily on verbal insight, cognitive restructuring, or exposure-based mechanisms, this model prioritizes concretization of internal experiences and uses sensory-informed regulation as a prerequisite for deeper therapeutic work.

Compared with approaches that depend heavily on abstract emotional language, monodrama may provide greater accessibility for autistic individuals with alexithymia, high levels of camouflaging, or difficulties identifying internal states. Transactional analysis contributes a structured framework that organizes experience into recognizable patterns and states, whereas monodrama allows these experiences to become observable, embodied, and relationally meaningful.

The potential advantage of this integration lies not in superiority over existing approaches, but in its suitability for autistic women whose difficulties involve a combination of sensory overload, relational trauma, fragmented self-experience, and limited access to emotions through language alone.

Future research could include the analysis of a larger number of cases, comparison of different therapeutic modalities, or qualitative studies exploring the experiences of autistic women participating in therapy based on transactional analysis and monodrama.

Conclusion

The integration of transactional analysis and monodrama may be understood as a complementary combination of a structural-cognitive approach with an experiential approach.

Transactional analysis provides a clear model for conceptualizing psychological functioning through ego states, life scripts, and internal messages, enabling the patient to organize her experience and strengthen the reflective function of the Adult as a centre of regulation.

In the presented case, this model allowed for the identification of the dominance of the Critical Parent and the Adapted Child, which manifested, among other things, in strong camouflaging, overcontrol, and self-deprecating internal messages (e.g., "others can manage," "I shouldn't be so sensitive").

At the same time, monodrama introduced a dimension of action and embodiment, enabling these parts to be experienced directly within the therapeutic space. For example, one of the protective roles was named by the patient as the "Masking part," and its function was explored through symbolic placement in space and dialogue from the perspective of the Adult.

At other moments, somatic roles such as "Frozen" or "Alert" served as entry points into the work, particularly in situations of sensory overload in the workplace. This made it possible to move from pre-narrative bodily experience to mentalization and reflection.

As a result, transactional analysis functioned as an organising framework for experience, while monodrama enabled its direct experiencing and integration.

Such integration supported the deepening of insight while maintaining regulatory safety within the therapeutic process, which was particularly important in working with an autistic patient with initially high levels of alexithymia and a history of relational trauma, for whom the experiential nature of interventions increased both accessibility and effectiveness of psychotherapy.

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