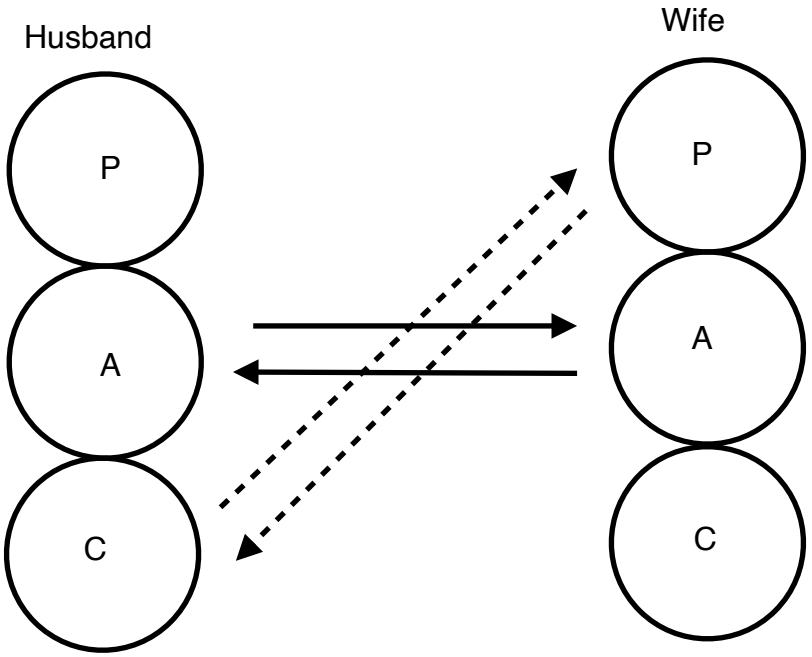
The Book of Transactions:

Part two

The Monograph Series:
Monograph One



Tony White

The Book of Transactions:

Part two

The Monograph Series:
Monograph One

By

TONY WHITE

TA Books
Perth, Australia

Published by:

TA Books
136 Loftus Street,
North Perth, 6006.
Perth.
Western Australia.
Australia.

Email: agbw@bigpond.com
Website: http://tony-white.com

Published July 2023.

Type, design and format done on MacIntosh
using macOS Monterey Version 12.6.1
Pages version 11.2

This may be referenced as: White, T. July 2023. The Book of Transactions: Part Two. Monograph Series: Monograph One. TA Books: Perth Australia.

Table of contents

The smile transaction

In the Book of Transactions 1 the gallows transaction was discussed and that included an explanation of the gallows smile by the client. The psychological meaning and purpose of a smiling transaction will now be examined in much more detail.

Smiles can be voluntary, non voluntary, unconscious or conscious. Research shows that a smile may be connected to a feeling of happiness but it can also be as a response of disgust, discomfort, sadness. There can be true smiles to convey positive affect and false smiles to communicate positive emotion when it is not there. At this stage I will only talk about Free Child smiles. One can also have Adapted Child or fake smiles. In this case the person is smiling for some other reason. To manipulate the other or as a happy racket where they are adapting to a rule in their head which says they must smile to please the parents.

This will be a discussion of enjoyment smiles or Free Child smiles. Smiles are consistent with positive feelings that are found in primates and are often initially produced involuntarily. The perceiver feels positive feelings and they tend to be infectious. When one person sees another person smiling as an expression of good feelings they will often smile back, Rothschild (2023). One reason for this is because when a smile is observed the reward system in the brain is stimulated so the person gets the experience of a reward. A smile can be experienced as a social reward for the observer, “I am being smiled at which says something good about me”. The social reward areas of the brain like the basal ganglia get stimulated when observing another person smile.

In addition to this, facial mimicry is a common occurrence in human communication and can be accompanied by self reports of corresponding emotions to the other person which is called emotional contagion, Tomkins (1963). These contagious feelings are natural, sometimes involuntary and often unconscious for one person to smile after seeing another person smile. Research has shown that on observing another smile within less than one second the observer will also smile. This can also occur on observing animated characters smile as well. However the smile by the observer does not necessarily have to include a change in emotion to go with the smile. Sometimes it does and sometimes it doesn’t.

The smile transaction in figure 1. shows how the observer responds. Firstly there is stimulation of the basal ganglia and the person experiences a sense of social reward. This will increase the likelihood of a smiling response as the person has pleasant feelings in response to the reward. Unconscious facial mimicry also may occur which also increases the likelihood of a smiling response. The observer is then likely to respond quickly, often unconsciously, with a smile in return. There may or may not be a positive feeling response in the observer as a result of the smile occurring.

This creates a difficult set of circumstances for the therapist when a client does the gallows transaction with a gallows smile. The smile transaction highlights the rapid nature with which a therapist can respond with a smile and that it can easily be unconscious for the therapist so they don't even realise they are smiling. To not engage in a smile response to a client's gallows smile requires the therapist to be vigilant about the gallows transaction occurring and be ready to respond without a smile. Not an easy thing to do at times also because therapist's as a group tend to have higher than average levels of empathy and as Niedenthal et al (2010) note, people with high facial mimicry tend to have high empathy as well. Meaning the empathic therapist is even more likely to mimic the client's smile compared to the average individual.

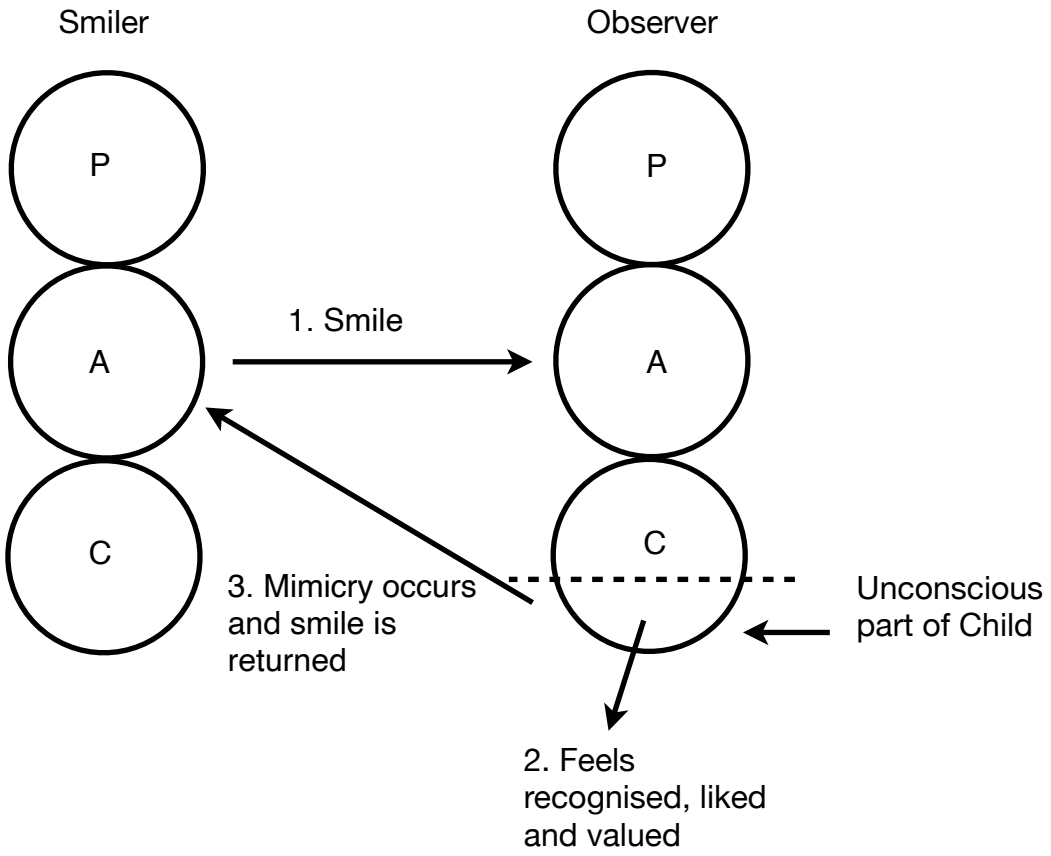


Figure 1. Smile transaction

1. First person smiles
2. The basal ganglia is stimulated and person feels a sense of social reward. "I am liked, I am valuable". Leading to increase in likelihood of smiling in return.
3. Facial mimicry occurs unconsciously so person is more likely to smile in return.

Chapter two

The smile transaction as stroking

The idea of the stroke is at the very core of what Eric Berne proposed. He discussed stimulation hunger as one of the most basic human drives. Each person has a relentless drive to acquire strokes and stimulation to keep their psychological functioning alive. The other aspect to strokes which he highlighted is the idea of behavioural reinforcement. This is the whole basis of behavioural psychology, as Berne put it, “What you stroke is what you get”. When you stroke or reinforce a piece of behaviour that will increase the likelihood of that same behaviour occurring in the future.

A smile is one way to stroke another person and show that you like the behaviour they are currently doing. As shown in chapter one this can be done consciously our unconsciously. It easy to do and the effect of the stroke can be quite powerful especially if the two people are known to each other such as with a therapist and client or a parent and child. When a therapist smiles at the client she is stroking that behaviour, it is saying: “At least part of me agrees and likes what you are doing.” The client feels the stroke and will be more likely to repeat that behaviour in the future. See figure 2.

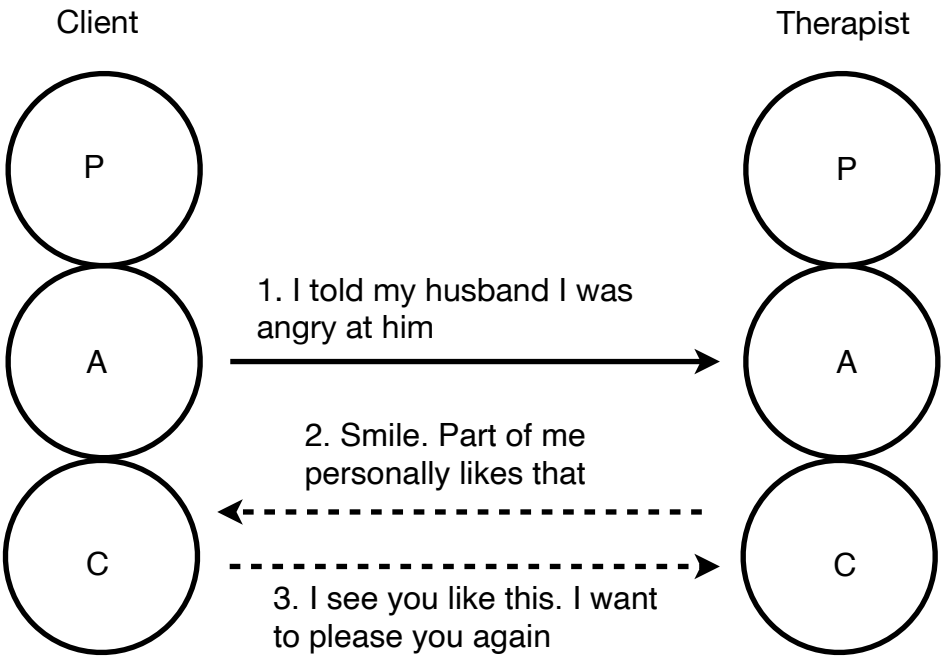


Figure 2. The smile and stroking

The thing about a smile is it’s personal. It’s a statement from the Child ego state of the person. When a person smiles at you, or in response to you, then you know that their Child ego state has been personally touched by what you have just done or said. They like it personally, especially if the smile is spontaneous and probably unconscious. In other words it comes across as a real Free Child smile. It is this personal nature of the smile that gives it, its extra potency. As figure 2 shows if this

happens in the therapy setting it is a potent way for the therapist to communicate counter transference attitudes to the client. Thus it's important for therapists to be aware of their smiling when working with clients.

A smile can be subtle, fleeting, unconscious and it tells the other person that part of them likes the behaviour they are doing. This can happen sometimes in school refusal or school phobia. See figure 3. The mother may be aware she is smiling or not and it may only be a small, fleeting smile that the child observes. So others may not notice it at all and it becomes a secret communication between mother and child which gives it an extra special quality for their relationship.

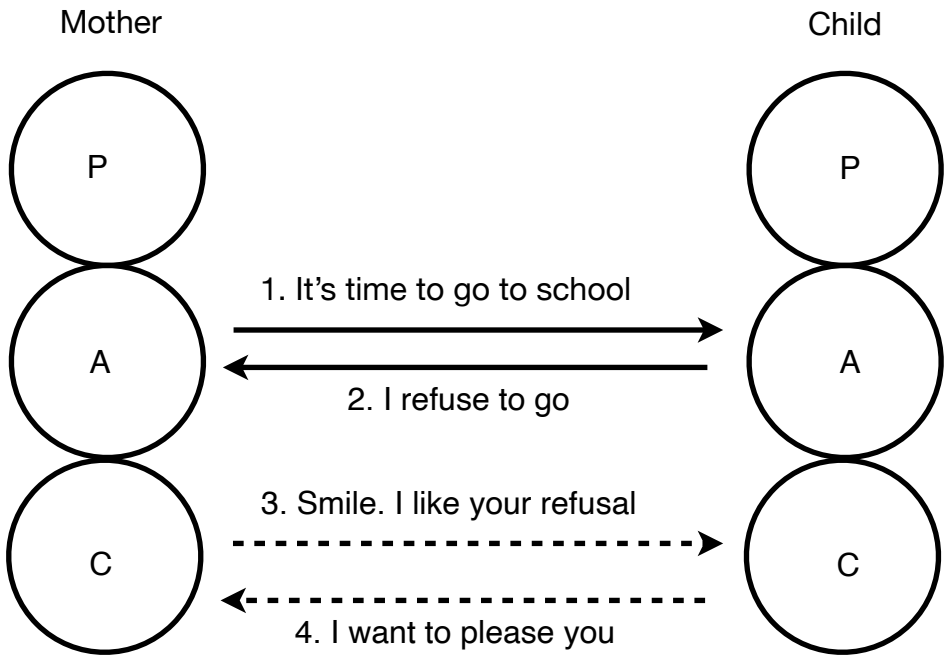


Figure 3. School refusal transaction

When working with teenagers or children who present to therapy with problem behaviour, one must be alert to the idea of at least one parent secretly liking the problem behaviour which they say they don't want. A teenage girl who is very defiant and rebellious towards father. When she is doing this she notices a slight smile on mother's face that comes and goes. She knows that mother secretly likes her defiance of father. Mother is stroking the girl's rebellion so it will increase in frequency. Again that spontaneous Free Child smile is a very potent type of stroke as the person seeing it knows this is personal for the parent or other person. They know mother is liking this at a 'deep' psychological level.

Chapter three

The smile and attachment

Smiling between two people has been acknowledged as important in attachment formation and relationship maintenance, Levenson and Ruef (1997). Smiling between two people shows to both parties that both their Free Child ego states are involved in this relationship. Niedenthal et al (2010) say that when perceiving a smile people can also experience feelings of affiliation and attachment. In particular between a mother and her young child. Studies on brain activation have shown that when a mother observes the smile from her own child then her orbitofrontal cortex is stimulated. However when she observes a smile from a baby unknown to her then no orbitofrontal cortex activity occurs.

Such smiling is associated with attachment formation. If one has a pre existing relationship with the other and the other smiles that will add to and reinforce the attachment between the two people. If a client has a transference relationship with the therapist and the therapist smiles that will be taken by the client as further reinforcement of the the attachment and the transference will deepen.

At a psychological level it shows to both parties that they are liked by the other one. That the Free Child ego state is invested in this relationship and this will result in a sense of more connection and hence attachment. If you know the other person has Free Child investment in the relationship then you also know this person will be driven to maintain the relationship. This person will have a strong motivation to maintain the relationship in some form. This allows for more of a sense of security and both parties can think, “I can allow myself to attach because they are attaching to me.” See figure 4.

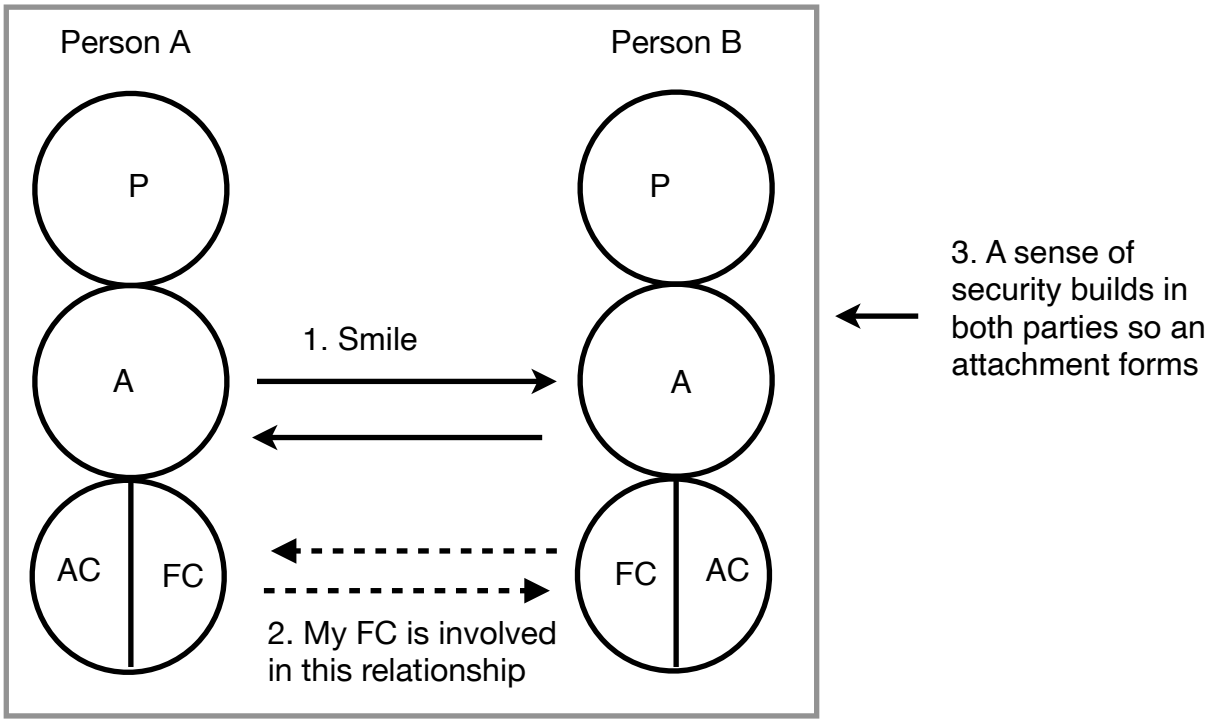


Figure 4. Smile and attachment

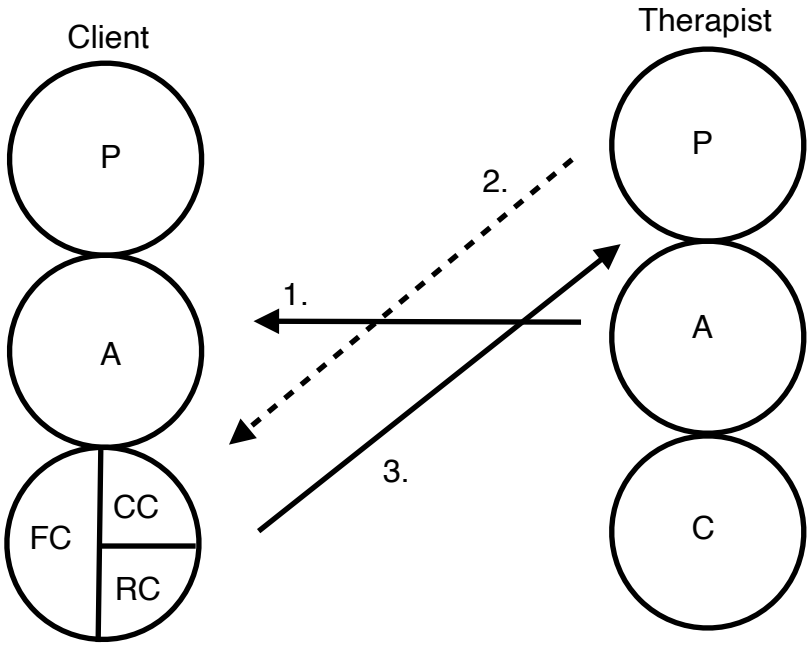
Both parties see the other smiling and take it is a Free Child enjoyment smile. This allows both to see that the Free Child of the other person is invested in this relationship. This provides more of a sense of security in the relationship and then an attachment can begin to form on both sides.

When people enter into an attachment they immediately become vulnerable and dependent on the other person because they can use the attachment to harm you if they are so inclined. The most obvious example is with threats of abandonment. If the other person chooses to end the relationship then you know you are going to suffer considerable pain with a period, sometimes a long period, of grief. We all know that to form an attachment is psychologically dangerous. If one can get some sign that the other person's Free Child ego state is involved in the relationship then one feels safer about entering into the relationship attachment. Of course a true Free Child smile gives that sign.

This has been shown to be especially true with the mother and young baby. Above it was shown that the mother has a neuropsychological response to her young baby smiling. This may help in her attachment formation because the child will only attach to her if it believes she is attaching to them. If a child does not feel the mother attaching to them then their own attachment process will be disrupted. The child needs to get some indication that mother's Free Child is invested in this relationship. For example a mother with post natal depression may simply not have the emotional energy to invest in an attachment with the child, so she tries to 'fake' it. She smiles because she knows that is the right thing to do. However the relationship is so intense and intimate that a 'fake' Free Child smile is likely to be recognised as such. The child gets a sense of mother not being invested in this relationship and the attachment process is disrupted.

The transference transaction

Eric Berne, being a transactional analyst, when he approached the idea of transference he of course endeavoured to explain it as a transaction and created the transference transaction. See figure 5.



1. I need to change the appointment
2. He is trying to get rid of me, or
He prefers his other client's to me
3. The client will respond from either Conforming Child or Rebellious Child

Figure 5. Transference transaction

Berne says that the therapist firstly delivers Adult information but the client then transfers mother's or father's face onto the therapist. This means the client does not hear the Adult information but usually hears a Critical Parent accusation as shown in the transference transaction. Transaction 1 shows the Adult transaction, then two examples are given for the accusation that the client may hear (transaction 2). The client may hear the therapist saying, "He is trying to get rid of me" or "He prefers his other client's to me". Therefore the client is less likely to respond from Adult and is more likely to respond from their Child ego state, usually the Conforming Child (CC) or the Rebellious Child (RC) ego states as shown in transaction 3.

As a result you can get confusion or miscommunication between the two people. After the transactions both parties do not understand what has happened especially if this occurs out side the therapy room such as between husband and wife, two co workers, teacher and student and so forth. This can and does happen

in any relationship. In the therapeutic relationship the therapist is supposed to be alert to such transference occurring and therefore the confusion on the therapist's side is not meant to occur so often. He then deals with it appropriately at that time. An indication that transference is occurring is when the client gives a response that is more emotionally charged than one would normally expect for that situation. Thus indicating a Child ego response (emotional), rather than an Adult ego state response (Intellectual).

Two theories of transference
The whole relationship theory - This theory says that all reactions from the client to the therapist are the result of transference, Little (2013). That every transaction between the two people will always be influenced by a person's transference issues, or their past issues from childhood. It is not possible to have a transaction that is free from the person's past conflicts or life script. Therefore the whole relationship between the two people is transferential. It is not possible to have a part of the relationship that is not influenced by past childhood issues.

The bit of repetition theory - Others such as Silverberg (1948) say that transference is only a bit of repetition in the overall relationship. Others like Thompson (2014) say that people are quite capable of having rational judgement unaffected by the past and only parts of the relationship are based on transference. Unlike the previous theory there can be substantial parts of a relationship that are not based on transference, influenced by the life script or a result of early childhood traumas. This is a rebuttal of the position by others, such as Little.

If you accept the whole relationship theory of transference that creates some problems for integrative transactional analysis. That theory states that it is not possible to have here and now contact with another person. One can never have a here and now relationship with another person which as we know is a central premise of integrative therapy and the idea of the integrated Adult ego state. The Parent and Child ego states are influenced by the past and the Adult ego state operates in the here and now unencumbered by the past.

Furthermore the whole relationship theory annihilates the Free Child ego state. It is the Adapted Child ego state that is influenced by the past. Expressions of that ego state are 'adaptions' to past parental figures who gave the little child messages or directives of some kind. The Free Child is not effected by such past parental messages and is that part of the personality that can be spontaneous and operate in the here and now in such a 'free' fashion.

Three different ways to respond to transference
Transference is seen as irrational reactions that a client has to a therapist - their thoughts, feelings and behaviours. Different schools of transactional analysis have different ways of dealing with these irrational responses

Classical transactional analysis as used by Eric Berne. In classical TA the therapist would draw and explain to the client the transaction as shown above in figure 5. This is presented to the client so they understand what is happening. They

become aware of their transference transactions and then they can avoid it in the future. Awareness is seen to result in cure.

Reparenting or relational TA. Instead of explaining the transactions to the client the therapist thinks in terms of what is called the feared relationship and the needed relationship. With the therapist's help the client usually becomes aware of these two relationships and then they are given a choice of which they will do. All clients have experienced problem relationships in their past where their needs were not met by the parents. For example a child may have felt that mother never showed it much love so it feels unloved as an adult. This is the feared relationship because as an adult when it has transference it will again establish a relationship with the other where it ends up feeling unloved. See figure 6.

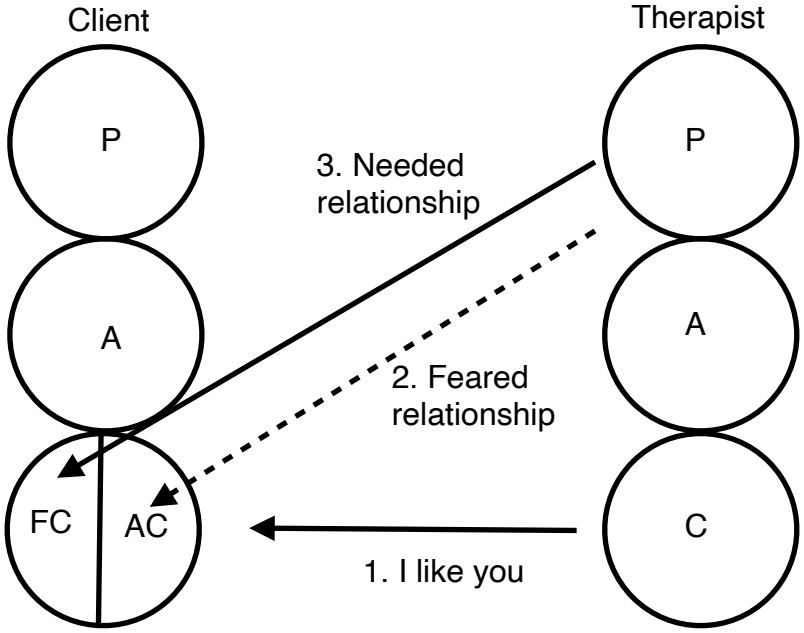


Figure 6. Relational TA solution to transference

The therapist may express a liking for the client (transaction 1). This gives the client two options. They can see this transaction as part of the feared relationship where she discounts the therapist's initial transaction of liking and uses some technique to reconstruct in her mind the feared relationship again. For example she may do reinforcing memories with the therapist, where she suddenly starts remembering all the times in the past when the therapist seemed distant and cold with her. In her mind she recreates the transference relationship with mother where she again feels unloved with the therapist in the present. This is seen as transaction 2 where the client experiences the relationship as an adaption to the original unloving relationship.

The therapist is then meant to help the client avoid this and experience the 'needed' relationship which is where she feels loved. The original relationship that the client

needed with mother. This is transaction 3 where the client experiences the therapist's liking in the present and then feels loved. This happens with the Free Child as it is not influenced by the past damaging experiences in childhood.

If transaction 3 happens repeatedly and becomes the norm in the relationship with the therapist then one can say that transference cure has occurred, which usually means a deep level of cure in the client. Through the transference relationship the client has managed to experience the unmet needs of childhood (in this case feeling unloved), and this often results in a deep and new form of feelings in the client. This is the type of transference cure that is needed with a third degree impasse. These relationship based therapies are best suited to treat personality disorders and third degree impasses. The relationship is seen to result in cure.

Redecision transactional analysis. Instead of the client responding through the relationship to the therapist, the therapist offers the empty chair to the client. She can then visualise mother in the empty chair and express the unresolved emotions at her with the therapist's guidance. The transference gets redirected away from the therapist towards the empty chair and the client then makes a redecision to the projected transference image in the chair. See figure 7.

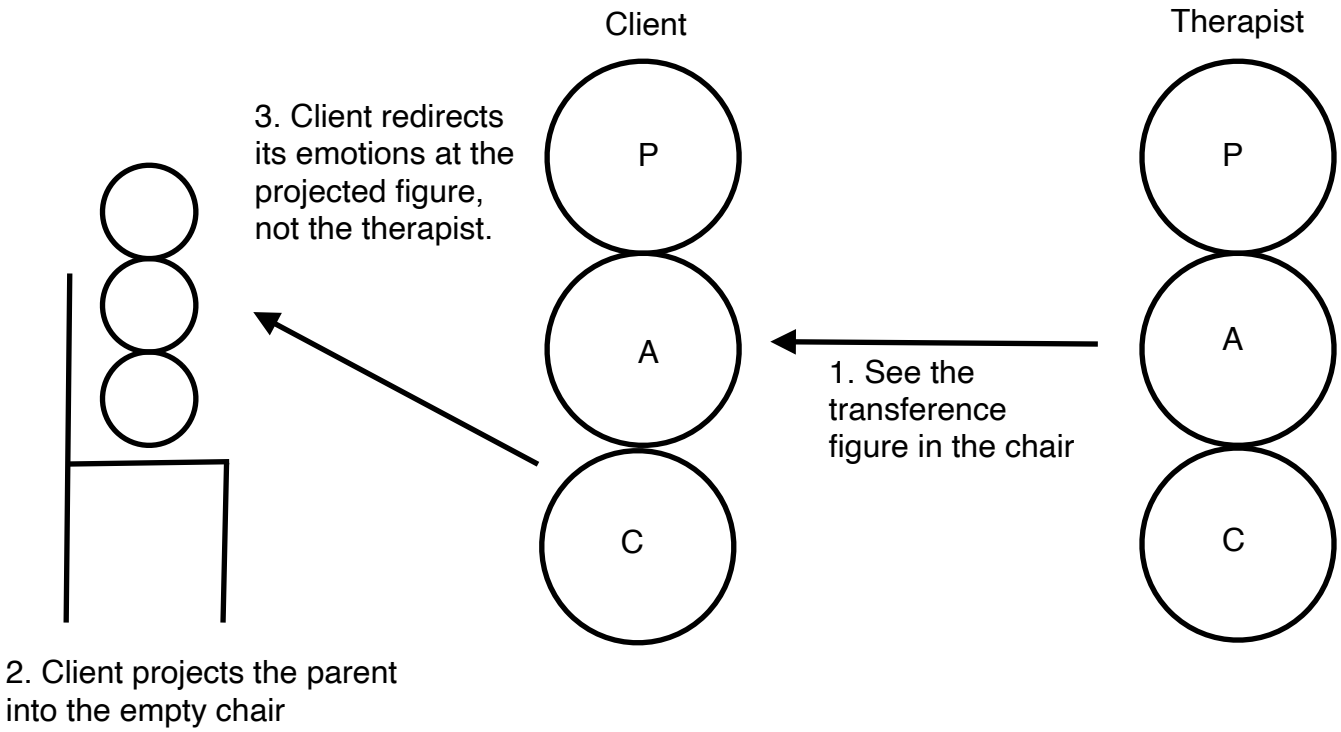


Figure 7. Redecision TA approach to transference

This is also a way of managing the transference relationship. To reduce the transference to the therapist the client can be invited to redirect it elsewhere. Or to increase the transference the client is invited to direct it at the therapist. Figure 7 also shows what Martha Stark (1999) calls a one person psychology as compared to the two person psychology shown in figure 6. In the two person approach it is both the client and the therapist that are seen as the means to achieve cure. The therapist is deeply involved in how change in the client occurs, indeed in relational TA they propose that the therapist is also transformed by the therapy process.

In the one person approach of redecision it is ultimately the client who drives the change in themselves. The therapist is there to guide the client to the right place (point of redecision) but then it is all up to the client to cause the actual change in self. This has the side effect of developing more autonomy in the client. Change, or not, occurs from the client and of course the client gains a sense of that. “This change has come from me”, is what the client experiences. Whereas in figure 6, the two person approach, the client realises, “The change has come from us”.

The redecision approach is most useful with first and second degree impasses but struggles with treating third degree impasses where the relational approaches are at their best. These are of course not mutually exclusive and one can use a combination of them at different times, for different reasons. Indeed this is what White (2021) has done with what he calls a, Redecision relational approach to transactional analysis.

Chapter five

The counter transference transaction

The counter transference transaction is when the therapist's own Child ego state interferes in the therapy process. See figure 8. Often this is unconscious in the therapist but it does not have to be. In this case the client has stated they want to stop therapy which personally impacts on the therapist's Child ego state and they have a feeling about the client's statement. Usually that will be the therapist's racket feeling, such as anger, shame, sadness and so on. The therapist may or may not be aware of this feeling they are experiencing. In this case the therapist feels rejected by the client and then uses some irrational therapeutic response to deal with their own feeling reaction.

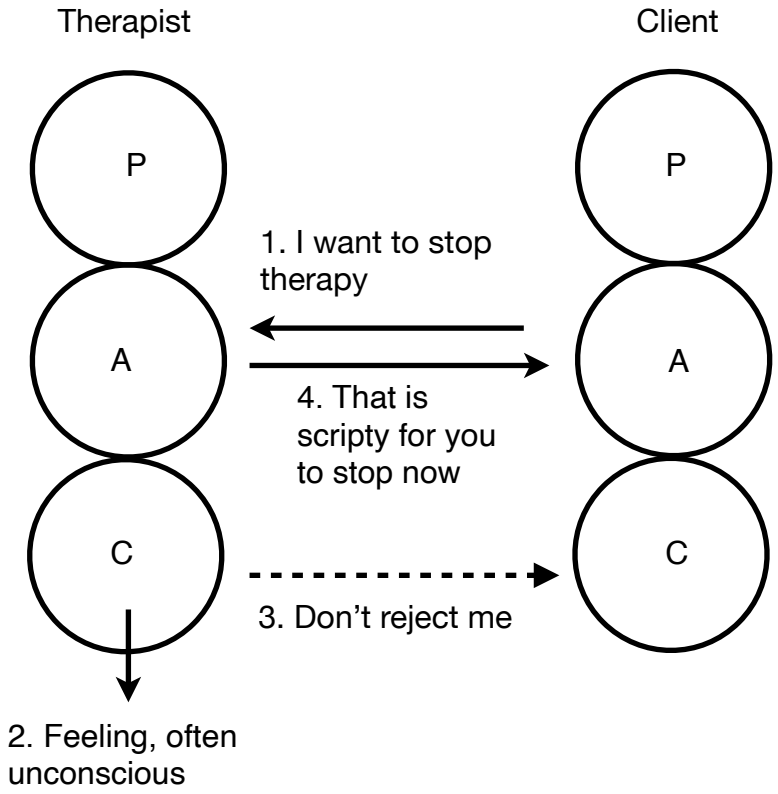


Figure 8. Counter transference transaction

This leaves the client in a very difficult situation because the therapy relationship is an asymmetrical one when it comes to power. The therapist is usually in the powerful position in the relationship. So the therapist can convince the client this is their problem when it is not. In figure 8 the therapist is telling the client that her desire to terminate therapy is an unhealthy thing to do as it will be advancing her life script. In reality this is not the case and the therapist is saying it to deal with their own script feelings of rejection which they developed from their own childhood. The therapist is doing 'incorrect' interventions which is to the detriment of the client.

This often will lead to a game or enactment of some kind and the progress of therapy stops. In this way the counter transference transaction is seen as something to be avoided but the alternate view would see this transaction as a positive for therapy. This transaction is occurring because the therapist's own unconscious urges are coming up which creates the opportunity for the therapist to become aware of their own issues, to be understood and resolved. Furthermore as these issues are coming up in reaction to the client that also gives us information about the client that they may not have been aware of before. Often with the assistance of some supervision of the therapist, the client and therapist work through the enactment and in this way the client gets therapeutic gains from it.

Which approach one uses depends on the way the therapist wants to conduct therapy. I mentioned in the previous chapter about the one person and two person psychology. The one person approach as shown in the redecision figure 7 transaction one seeks to identify and avoid counter transference transactions. The two person relational TA figure 6 approach would see such counter transference and the resultant enactments as 'good' things which the therapist and client can work thorough in their relationship together. However as White (2021) notes many, if not most long term therapy relationships do not have serious counter transference difficulties. Difficulties from the therapist's side of the relationship most often do not occur in longer therapy relationships. Therefore using the working through of enactments between the client and therapist for therapeutic gains is going to be limited use with most clients.

Identification and counter transference

Identification occurs when one person confuses their own identity with someone else's. Identification is a psychological process that we all engage in, some more than others. Probably all parents identity with their own children to some degree. In their biological children all mothers to some degree see their own Child ego state. The son or daughter is seen to some extent as an extension of self. People with poor personal boundaries or with a fragile sense of self can do identification a lot. For example in the dependent and borderline personality types. Also White (2021) discusses the topic of munchausen syndrome by proxy (MSBP) where in some cases the mother probably has identified with the son or daughter. She sees her own Child ego state in the offspring. Some mothers with MSBP report hating their biological child whilst at the same time hating their own Child ego state. This could be identification where the mother is vicariously expressing hate though causing pain and suffering in the son or daughter when her true motivation for these actions is to express it at her own Child ego state.

In figure 9 we see that the therapist has extended their own identity onto the client. The therapist unconsciously believes, "I see myself in you". Their own Child ego state is seen as existing in the client. When this is achieved the therapist can experience vicarious enjoyment or satisfaction through the client. The magical thinking is, "When something happens to the other it is also happening to me".

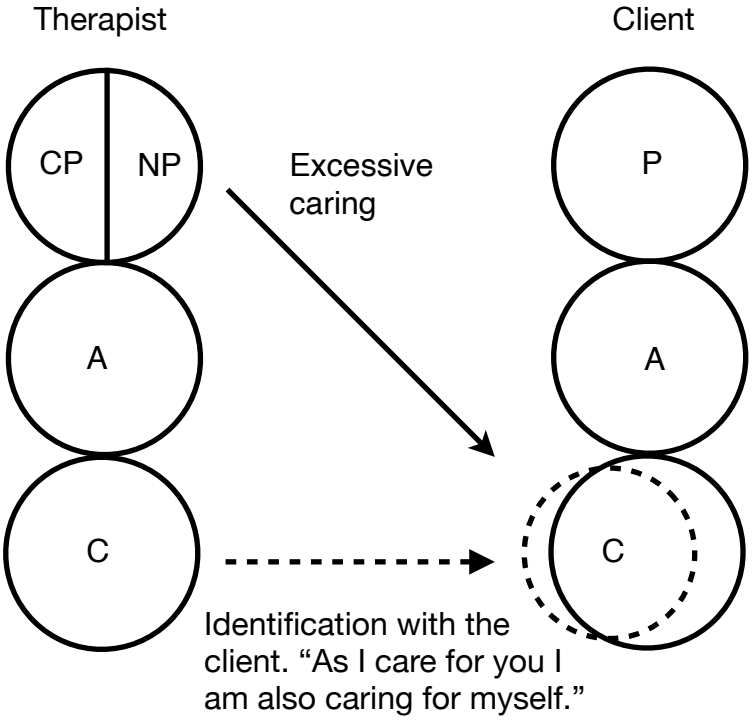


Figure 9. Identification as counter transference

Hence we have a counter transference problem for the therapist. Firstly they are going to start seeing things in the client that are not there. If the therapist came from a stroke deprived background then they may start to see the same stroke deprivation in the client when it is not there. Hence the therapist can develop an overly caring relationship with the client because that meets their own stroke deprivation needs which they are satisfying vicariously. The therapist starts to see unmet needs in the client that are not unmet and is using the client to vicariously satisfy their own unmet needs. Indeed in one sense this is a form of munchausen syndrome by proxy in the therapeutic relationship. The client is perceived as having forms of ‘sickness’ that are not there and exist in the mind of the therapist to meet their own Child ego state needs.

Sometimes therapists will gravitate to working with clients who have had the same experiences and problems that the therapist had in the past. For instance some people who have suffered domestic violence themselves will begin to work therapeutically with others who are currently involved in domestic violence situations. Sometimes people who had their own drug or alcohol abuse and addiction problems will gravitate to working in clients in drug rehabilitation or with alcoholics anonymous. This not necessarily a bad thing and can in fact be a big positive. The therapist who has experienced their own domestic violence knows the client at a much deeper level than the therapist who has not had that in their own life. They can understand the client in that extra way which can help the therapist in their work. However there is always the possibility of the therapist identifying with the client in these situations, so one must remain alert to this type of counter transference occurring.

Chapter six

Communication transaction

The vast majority of human communication is unconscious and involuntary so we are not aware we are communicating it. Significant research has demonstrated that in most situations people are only aware of about 7% of what is being communicated. That is their Adult is only aware of about 7% of what they are saying and 7% of what the other is communicating to them. The breakdown is usually as follows:

Percentages of human communication
7% - verbal words
38% - paralanguage
55% - body language
(Nyoni (2021), Altun (2019) & Mehrabian (1972))

Verbal words are those that are actually spoken. Paralanguage refers to the vocal component of speech which includes pitch, resonance, articulation, tempo, volume and rhythm. Whereas the body language refers to body movements such as facial expressions, gestures and posture.

There is actually one other form of communication that occurs between people known as spatial language. There are two types of spatial language and this refers to how the person places themselves spatially in relation to the other person

Spatial language (1) - In one to one communication how much physical distance is put between self and the other.

Spatial language (2) - In groups of three or more how the individual physically positions themselves in relation to the others. In the middle of the group, on the edge, addressing an audience, creating a sub group and so forth.

As we know Eric Berne explained these different types of communication using the idea of the social level transaction and the psychological level transaction. This is shown in figure 10.

He said that most often people were unaware of their psychological level transactions, especially when playing games. This shows us that we are unaware of the vast majority of what we are communicating to others (93%) and unaware of the communication we are taking in from others (93%). Clearly the unconscious (Child ego state) is playing a huge role in how we communicate with others each and everyday. Indeed researchers like Birdwhistle (1970) estimates that the average person only speaks for about 10 or 11 minutes each day and the average sentence takes about 2.5 seconds. The vast majority of our communications do not involve any words.

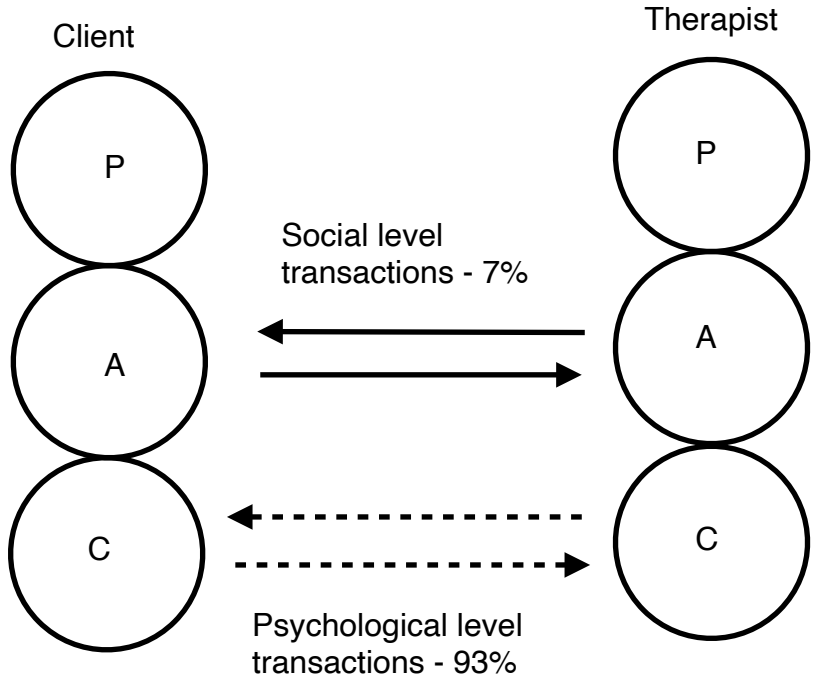


Figure 10. Communication transaction

Psychotherapy of course is all about human communication. The psychotherapist could be seen as a professional observer of people's communications. Obviously it is advantageous for the therapist to become aware of some of these non verbal communications by the client. To begin to understand the 93% of communication that is occurring mainly unconsciously.

How do you do such a thing? There is a saying in psychotherapy, that one hears from time to time, especially as advice to trainee psychotherapists, "Turn down the audio and turn up the video". Or as I say sometimes, stop listening to the client with your ears and start listening with your eyes. Don't listen to what they say instead watch what they say. This will force the therapist to focus more on the psychological level transactions occurring, the 93%.

There is nothing new in this emphasis on the psychological level of communication. McNeel (1975) did his doctoral thesis where he observed the Gouldings' do a weekend marathon therapy group. He identified many of the techniques they used including, "5. Confrontation of incongruity. In psychotherapy the client will often offer two communications at one time, one verbal and one non-verbal. It is important for the therapist to see both of these forms of communication as equally important. These incongruities are seen as head shakes that go with a 'yes' answer, smiles that go with tragic stories, and decisions which lack action."(p124). The Goulding's are focussing a lot on the 93% of communication.

As figure 10 shows it is the unconscious and involuntary Child communications that carry by far the most information about the client. The vital information for a therapist to have. The therapist needs to develop communication between their own unconscious (Child ego state) and their conscious (Adult ego state) so that it

can begin to understand some of the unconscious communication that is happening.

Detection of unconscious information

There are at least three possibilities for ways in which the Adult can begin to listen for and understand the Child unconscious communication. Or at least three ways how one can understand the therapist's Child ego state reactions to the client

Counter transference

The first and most obvious one is by the therapist understanding their own counter transference. The majority of the literature will say that Child ego state unconscious responses to the client are representative of counter transference issues in the therapist, Stuthridge and Sills (2016). The therapist's unconscious is reacting to the the client based on past unresolved issues in the therapist. This gives insight into the therapist's own issues and also provides insight into what the therapist maybe reacting to in the client, thus informing about the client as well. Or as Allen and Allen (1978) put it, "The physician may react to the patient as if he were some one from his past. This is called counter transference."(p335). Counter transference is occurring in the therapist when they become involved in a game or enactment with a client. Then the past unresolved issues of the therapist are involved with the client. Whilst this does occur there are two other ways the therapist's unconscious Child ego state can react to the client that have nothing to do with his past script issues.

Mirroring

Second, there is the idea of mirroring which is presented in depth by Rothschild (2023). People naturally and unconsciously mirror each other in both their psychological states and in their physical postures. For example she states, "Muscle patterns also can be (and often are) imitated unconsciously. During normal situations of interpersonal contact, it is common for people to mirror one another's breathing, facial and postural patterns."(pp 55-56). She goes onto cite further research which, "..found that subjects noticed changes in their own moods that corresponded to the expression they were unconsciously mimicking."(p57)

The Child ego state in the therapist is being effected by the client because it is unconsciously mirroring the client which is a natural thing for all people to do. This is not counter transference in the sense that it results from unresolved past issues in the therapist. However mirroring does result in the therapist's Child ego state being impacted emotionally by the client.

Free Child reactions

It is proposed that a lot of what is called counter transference, is not. Instead it is simply the Free Child ego state in each of us reacting to the world and others in it. As we go about our daily lives our Free Child is constantly responding to what we encounter and what we see and do. If we are hiking we feel the cool air, if we are at the beach we feel the warmth, if we are stuck in a traffic jam, if we are walking and see lots of rubbish laying around, if we see someone give a homeless person some money, if we see a mother smack a child in the supermarket and so on endlessly.

All our ego states are responding constantly to events such as these that we encounter everyday in our daily lives. Our responses are most often not responses that are based on, or influenced by, our past unresolved trauma or issues. The Free Child in all of us will simply react to these events which we encounter each day.

In chapter four I talked about the two theories of transference - the whole relationship theory and the bit of repetition theory. Of course the same applies for counter transference. Here I reject the whole relationship theory and contend that it is quite possible for a therapist to have a here and now, rational Free Child response to a client. Where the Free Child reactions are not based on past unresolved issues. The person has simply observed a mother smack a child in a supermarket and their Free Child responds with some kind of feeling response that is in the here and now and not effected by their own life script. The therapist listens to a client report how he bashed his wife. It is quite plausible for the therapist to have a quite strong emotional reaction to that, which is a here and now response and not based on historical traumas in their own childhood. This is not a counter transference reaction whilst it is a strong emotional response by the therapist to the client.

One may need a bit of time to consider this as it goes counter to what most therapists have been told since the beginning of their training and what they have been practicing and believing for years. They have been told that when you have an emotional or physical reaction to a client then that is your counter transference reaction to the client. That is, your reaction is based on irrational and unresolved issues from the therapist's past. I am proposing here that that is most often not so. It definitely can happen but most often it isn't and instead it is simply the therapist's natural Free Child reaction to some one they are currently talking with, that is rational and in the here and now. This is shown in figure 11.

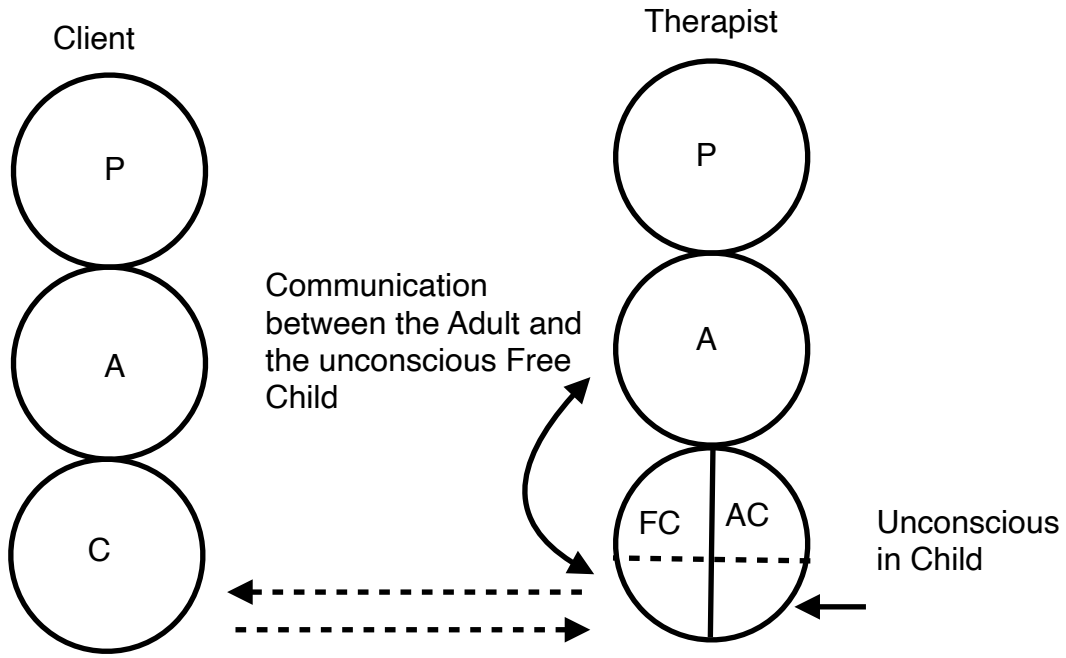


Figure 11. Free Child reaction transaction

The unconscious part of the Free Child is simply reacting to the interactions with the client. What the therapist needs to develop is communication between their Adult and the unconscious Free Child which is having these reactions. If one can develop this communication then the therapist is beginning to tap into 93% of the communication that is occurring between them. Obviously very desirable thing to do.

Interpretation of Free Child reactions
How does one do this? Fortunately others have already provided some insight into answering this question. It is best to begin with some kind of understanding of what the unconscious is and how it functions, I suggest reading White's (2022) article, "Hard contracts, soft contracts and the unconscious".

In that article he calls on three observations made by Stuthridge and Sills (2016) where they cite reactions that a therapist can have to the unconscious communications of the client:

1. A therapist may begin to feel a sense of discomfort and disorientation, or any behaviour of the therapist that deviates from the norm.
2. The therapist may begin to feel free floating associations such as visual and auditory memories, images and daydreams coming up as they work with a client.
3. Images that occur in the therapist's mind, especially when they are uninvited and unwilled, including odd phenomena such as images, words or parts of songs.

In addition Rothschild (2023) has done the same and come up with a list that she says are counter transference indicators. Again it is suggested that most of these are not counter transference indicators but simply here and now Free Child reactions to the client.

1. Sensations you feel in your body
(Hot, cold, achy, prickles)
2. Visual or auditory images that arise in your mind
(Pictures, colours, sounds, songs)
3. Movement or muscular impulses in your body
(Head turning, sitting back, legs tensing, clenched fists)
4. What you feel
(Angry, irritated, sad, happy, scared)
5. Changes in level of arousal (Breathing, heart rate, temperature of hands and feet.)
6. Any thoughts that occur to you

These are a good place to start when developing the Adult and unconscious Free Child communication in the therapist as shown in figure 11. The therapist begins by heightening their Adult observation of their Free Child reactions such as the ones just described. When working with a client the Adult is alert to any odd occurrence in the psyche as listed above. As one becomes more practiced at this it becomes easier to pick up the odd, unexpected reactions in the therapist's Free Child.

Once you have noticed them what does one do with them? Unfortunately the writers above who made the lists do not tell you that. Be wary of taking this material to some kind of supervisor as it is highly likely they will immediately assume that your reaction is a counter transference one and begin looking at your unresolved issues from childhood. Most often it wont be this and can be either simple mirroring of the client or that your Free Child is having some kind of here and now, rational reaction to the client (ie it is not counter transferential).

The problem is the reactions listed above are metaphors. They don't give you the answer. Instead you have to examine them and find the answer your self but this usually is not too hard. One solution is to do what Fritz Perls did with dreams. Isolate each part of the dream and then be that part and talk. Essentially you place the reaction in an empty chair and talk as if you were that reaction. To assist with this you can draw a picture of the reaction, then write what it feels and write what it thinks. Secondly one can free associate the reaction. Let it float around in your mind and see what comes up, any words or any thoughts. Ponder it with no expectations and see what comes up.

Booth, Trimble and Egan (2010) conducted research on the frequency of therapist's Free Child reactions to clients. Some of there more common ones were sleepiness, numbness, stomach disturbance, nausea, headaches and so on. With each of these the therapist could do the exercises just discussed. Once done the therapist has extra information about what the reaction means to them and then that will also tell you something about the client. The therapist is beginning to tap into that huge amount of information being given to them by the client that they don't normally use.

Chapter seven

Competitive transactions

Competing for the Parent ego state position
In some relationships both parties can compete for a particular ego state or position in the relationship, see figure 12.

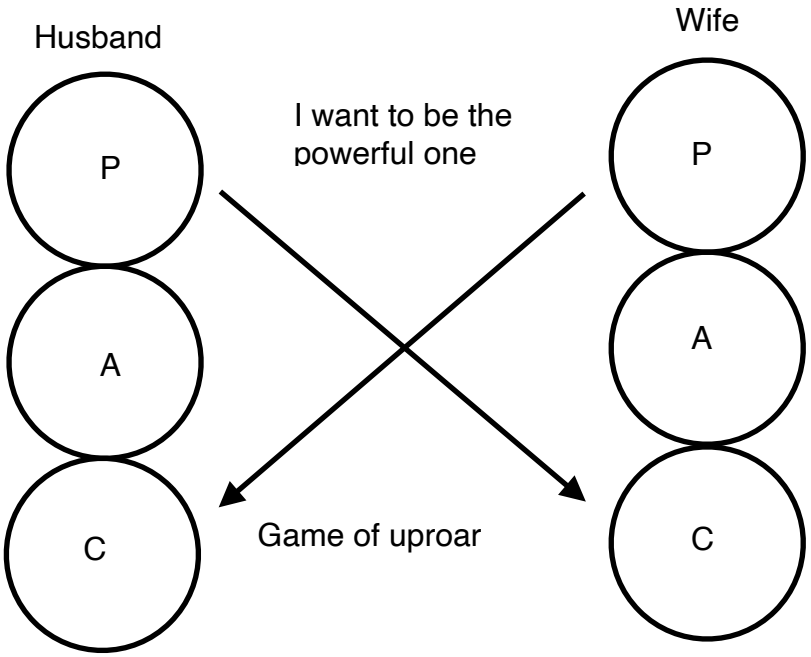


Figure 12. Competing for the Parent position

Competing for the Parent ego state position is a power struggle for the powerful position in the relationship. This type of situation can often lead to the game of Uproar and often happens after the first two or three years of marriage. The honeymoon period is over, they are beginning to realise that what they thought they could 'train' the spouse out of or into, is not going to happen. So there can be a period of disharmony or uproar about who is going to 'be in charge' or who is really going to wear the pants in the relationship.

Such a couple tend to come to counselling because they are often arguing about the big four issues - child management, money, the in-laws or sex. These are the four most common issues that couples will repetitively argue over. But the real reason is a power struggle for the top dog position, they are wanting to establish the basis of the relationship for the next twenty or thirty years

One will hear lots of "shoulds", finger pointing, "you are..." statements, raised voices, "Ain't men/women awful" games with their peers, and so on. In the extreme this type of relationship can lead to domestic violence as indeed all uproar games have the potential to do. Of course the ego state that is missing is the Adult, so in the arguing neither party is really listening to what the other is saying. They are just waiting for the other party to give a brief break so they can then start in on their Critical Parent comments

This can also occur in the counselling relationship with the client. Typically it is the type of client who is used to being the one in charge in relationships. In the counselling setting they are in the less powerful position. The power difference between the client and the therapist is clear and obvious. If the challenge for power in the therapeutic relationship is to come from the Parent position then the client in some way will express anger at the therapist. The hope is that the therapist will be frightened or intimidated by this. If that does happen then the therapist becomes in some ways the less powerful one in the relationship. They may also attempt to take charge of the therapy situation. They are the one that watches the clock and announces the end of the session, they may rearrange some furniture in the room, or make suggestions how the therapist could add to the room or even things like their clothing and presentation.

When I was working in a prison this type of transaction by the client is not uncommon. Some prisoners will seek to establish themselves as the psychologically dominant one in the relationship with the prison staff member. If achieved they can intimidate that person to do favours which they are not meant to do. In the prison environment it is all about power and control in the relationships and this is as much between staff members as between the prisoner and staff member.

However in the everyday counselling setting this does occur from time to time. It is most important that the therapist does not get personally caught into it and this can happen because people with power issues can be attracted to being a therapist. As I said before, the therapy setting is structured such that the therapist is the more powerful one in the relationship and hence people with power issues can be attracted to this kind of occupation.

If the power play from the client disturbs the therapist's own Child ego state, then there is a problem indeed and counter transference issues can cause all sorts of problems. Of course the therapist is meant to personally stay out of the client's power play and see that the client's young inner child is just struggling with the personal resources it has. Don't take it personally is the key.

With your average marital couple, anger is the most common emotion used to obtain the power position, but it is not the only way. Another way which is most often used by females is the sexual relationship. She communicates to him in some way "Do as I want or sexual favours will be withdrawn". If couples are arguing over sex then a therapist would certainly be looking to see if there is a power play underneath the disharmony presented in counselling.

It should be noted that an asymmetry of power in a relationship is the norm, not the exception and it is constantly changing as relationships change and develop. It is rare that both parties will sense equal power in a relationship for an extended period of time. Sometimes the power differential is small and some times it is large and it is constantly changing. When the man and wife were getting married he may have been the powerful one in the relationship. After five years of marriage that

may have changed and she is then the powerful one in the relationship. What this means is on the important issues the powerful one will tend to get their way, such as with money, children, in-laws and sex.

This raises the issue of consent. On some issues the less powerful one will consent to things which they do not really want to consent to. They will say ‘yes’ when they really want to say, “no”. That can be to minor things like what movie to watch or where to go for a holiday. Or it can be on more serious matters like how to manage the money or the sexual relationship. The more powerful one will manage the money and the sexual relationship how they want it to be and the less powerful one will consent to that at times when they do not want to.

Competing for the Child ego state position
In this instance both parties are wanting to take the Child position where they are taken care of by the other party. They do not want to do the looking after of the other, instead they want to be looked after. See figure 13

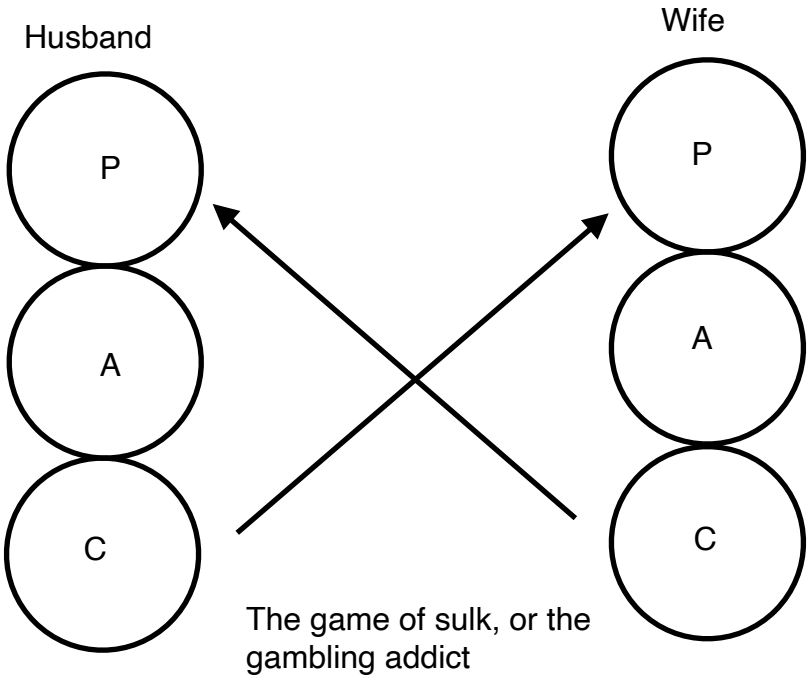


Figure 13. Competing for the Child position

In this instance you do not tend to get uproar or shouting, rather you have two people who are tending to be passive and doing nothing. Maybe playing the psychological games of Helpless, Poor me, Yes but, I’m only trying to help, and so on. The resultant feelings are not likely to be anger (at least not openly), but more likely to be disappointment, frustration, sadness and depression.

This can lead to games of sulk which is a childish thing to do, where one party sulks around the household. Or the person may do ‘no speaks’ where they don’t speak to the other party and ignores them. These are child like behaviours so the person is imposing their childlike part into the relationship with the other person. They are wanting to take the Child ego state position in the relationship and in one

sense control the relationship from that position. The other party is pressured to take the grown up responsible parent like position in the relationship and give into the demands of the child in the relationship. This person can also do other behaviours like being unemployed or drinking alcohol to excess which again are the child position in the relationship.

The gambling addict can be trying to take the child position in the relationship as well. This person adopts the child position by mismanaging their money. If you give a 4 year old child 10 euros and take it to a candy store the child will go into the store and spend all 10 euros there in that one time. Even if you say to the child, “If you only spend 5 euros this time then you will have 5 euros saved for the next time”. It will still spend the 10 euros in that one time. It does not have foresight or the ability to stop itself. So the parent manages the child’s money for it.

A gambling addict is the same. They will spend all the money they have at that time (at the ‘candy’ store) in the casino. They can’t stop self until all the money is gone. Which eventually means sooner or later some other person will end up managing the gambling addict’s money for them. For example the wife may demand that her husband’s weekly pay goes directly into her account and then she gives him money as she sees fit to control his gambling. Or the wife may take control of all the credit cards they have and so on. She takes the parent position and manages his money for him and he takes the child position by repeatedly mismanaging his money.

References

Allen, J.R. and Allen, B.A. 1978. Guide to Psychiatry: A Handbook on Psychiatry for Health Professionals. Medical Examination Publishing: New York.

Altun, M. 2019. An underestimated tool: Body language in classroom during teaching and learning, International Journal of Social Sciences & Educational Studies. 6(1), 155-170.

Birdwhistell, R. 1970. Kinesics and Context. University of Pennsylvania Press: Philadelphia.

Booth, A., Trimble, T. and Egan, J. 2010. Body-centered counter-transference in a sample of Irish clinical psychologists, The Irish Psychologist. 36(12), 284-289.

Levenson, R.W. and Ruef, A.M. 1997. Physiological aspects of emotional knowledge and rapport. In W.J. Ickes (Ed.) Empathic Accuracy (pp. 44-72). Guilford Press: New York.

Little, R. 2013. The new emerges out of the old, Transactional Analysis Journal. 43(2), 106-121.

McNeel, J.R. 1975. Redecisions in Psychotherapy: A Study of the Effects of an Intensive Weekend Group Workshop (Doctoral dissertation). The California School of Professional Psychology.

Mehrabian, A. 1972. Non-verbal Communication. Aldine Transaction: New Brunswick.

Niedenthal, P.M., Mermillod, M., Maringer, M. and Hess, U. 2010. The simulation of smiles (SIMS) model: Embodied simulation and the meaning of facial expression, Behavioural and Brain Sciences, 33, 417-480.

Nyoni, J. 2021. Criticalities of non-verbal reading competencies: An afrocentric ethnological approach to qualitative research, KOERS - Bulletin for Christian Scholarship. 86(1), 1-12.

Rothschild, B. 2023. Help for the Helper. Norton Professional Books: New York

Silverberg, W.V. 1948. The concept of transference, Psychoanalytic Quarterly. 17, 303-321.

Stark, M. 1999. Modes of Therapeutic action. Jason Aronson Inc.: London.

Stuthridge, J. and Sills, C. (2016). Psychological Games and Intersubjective Space. In Erskine, R.G. (Ed). Transactional Analysis in Contemporary Psychotherapy. Karnac: London. 185-208.

Thompson, C. 2014. Transference as a therapeutic instrument, Psychiatry. 77(1), 1-7.

Tomkins, S.S. 1963. Affect, Imagery, Consciousness. (2 Vols.) Springer: New York.

White, T. 2021. Redecision Therapy Today: A Redecision Relational Approach to Transactional Analysis. Deonis Plus: Kyiv.

White, T. 2022. Hard contracts, soft contracts and the unconscious. International Journal of Transactional Analysis Research and Practice, 13(2), 25-31.