Controlling the Consultation III - Transactional analysis

First published on Onmedica.com

Dr Ian Wyer, MRCGP, a GP and Course Organiser for the Dorset GP Vocational Training Scheme

Tuesday, 3 October 2006

This is the third in a series of three articles on controlling the consultation. They are aimed at Registrars but may be of use to others.

- The first addresses setting an agenda in patient centred consulting, and helping the patient understand and stick to it.
- The second article discusses what to do with new information that arises during the consultation and disrupts the agenda.
- This last one in this series will look at how interpersonal relationships can affect the doctor's control over the consultation.

Some scenarios

Mr White comes to see you on a regular basis. He seems to be very precise about everything and wants you to define and guarantee what you will do for him. This seems okay at first, but suddenly there is a misunderstanding or perhaps you don't send a referral letter until a week after you see him. He makes an official complaint. You write apologetic letters. Perhaps you see him and explain yourself. He is initially verbally abusive towards you and questions your professional competence, then accepts your apology grudgingly.

To your surprise he is back to see you three weeks later with a new problem. Why has he come back to you, whose competence he doubts? You feel he is watching your every move and that he is controlling the situation.

Miss White (no relation) comes to see you for some minor ailment. She asks for solutions. You give her some suggestions. She comes back next week and it becomes evident that she has given only a fleeting trial of each of your suggestions before rejecting them as too impractical or kept forgetting to take the tablets or the side effects were unacceptable.

You suggest some other ideas. Next week, back she comes with more objections and failures. After a while you start to feel as if you are failing her as your patient. You cannot find a solution that will work for her. Perhaps you try referring her on for a second opinion. Soon she is back; the second opinion has been unable to help her. You have failed her again.

What is going on here? Why can patients do this to us? One way of looking at these situations is to use 'transactional analysis' (TA). TA is complex and has developed into a variety of different branches since it was conceived of in the 1950s by Eric Berne and colleagues. Although perhaps better known as a basis for psychotherapy, a basic summary some aspects of TA can be useful for understanding how interpersonal relationships can affect medical consultations (a more comprehensive but still very readable introduction can be found in Stewart and Joines' book).

The basis of TA

Everybody is born with a need for social stimuli. Initially these stimuli take the form of cuddles and caresses from their parents - 'strokes'. Over time we learn to receive these strokes through the proxy of social interaction, attention or recognition. Such is our hunger for these strokes that we will look for good strokes first, but failing this will take bad strokes (e.g. being told off) in preference to none at all.

Over time we learn behaviours and attitudes under the influence of our social environment. Some aspects will be through imitation of our parents. Sometimes we will adapt our 'natural child' reactions to those that gain our parents' approval, or failing that, attention. At about the same time, we form a view of the world and of ourselves. These deeply held views, learned reactions

and behaviours form a substantial part of our personality and although they are refined during our teenage years and adulthood, rarely change much.

In TA thinking, by the time we are adults we have three 'ego states' from which we can think/speak/emote: The 'Parent', 'Adult' and 'Child'. Each may act internally - to influence the way we think, or externally - in the way we talk to others. The Adult is the logical, rational part of us, which tries to act on the basis of the best evidence. The Parent may be critical (CP) or nurturing (NP) and its influence may be helpful in many situations but harmful in others. The Child may be natural/free (NC) or adapted (AC); its influence may be the source of much of the joy and fun in our lives, but may also lead to maladapted behaviour that causes us trouble.

In theory of human behaviour'. all interactions between people constitute 'transactions' (hence TA). These transactions use strokes as their currency. Transactions occur between people's ego states. Most commonly these are parallel (complimentary) transactions (Adult to Adult, Parent to Child, Child to Parent).

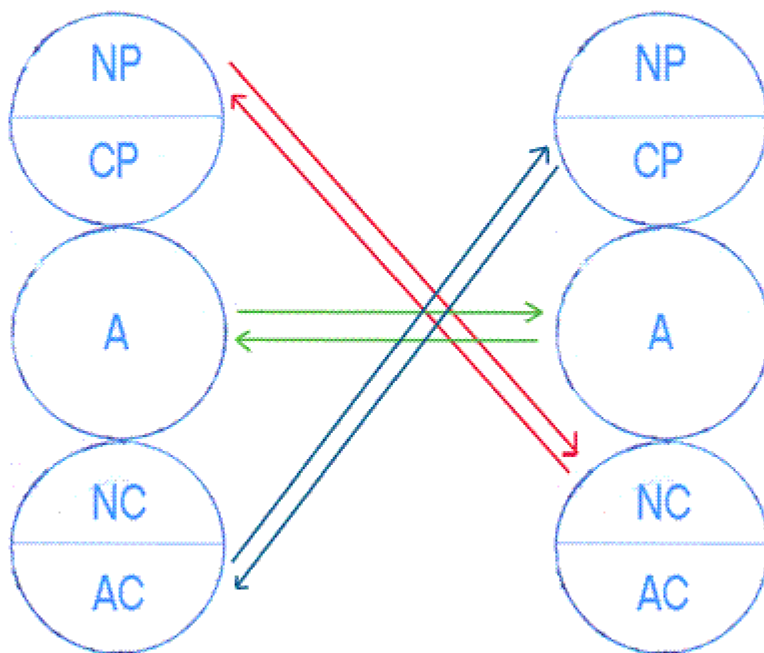

Figure 1.

In the consulting room, it is sometimes appropriate to be a 'nurturing Parent' to a patient acting as a 'hurt Child', but most of the time we wish our interactions to be on an Adult to Adult basis. For example:

Doctor: "I've been through the various options for contraception, which do you think would suit you best?" (A)

Patient:: "Well, life is pretty busy at the moment and I don't have a set routine because of my job, so I think I'd better try the injection and see if it suits me." (A)

Only the Adult can make the best decision, 'uncontaminated' by maladapted emotions. However, a patient may try to operate from the Child position. Often, the instinctive response is to reply from the nurturing or critical Parent position:

Doctor:: "How have things been?" (A)

Patient: "I'm sorry doctor, I'm terrible - I keep forgetting my pills." (C)

Doctor: "How many times must I tell you - if you don't take them you won't get better?" (CP)

Or

Doctor: "Never mind, I know its hard for you, why don't you try this instead." (NP)

Or the patient may operate from the Parent position:

Patient: "You seem to just keep sending me for investigations. Haven't you got any idea what's wrong with me yet?" (CP)

Of course in reality the transactions are often more subtle and Child or Parent messages are often hidden in apparently Adult transactions. These are known as ulterior transactions and are common in situations where polite discourse is the norm.

People are comfortable with those whose Parent and Child speak some of the same language, so patients who want to play Child will seek out doctors whose Parent understands and responds to their subtle Child cues. Equally patients who enjoy the Critical Parent role may keep going back to a doctor who they can brow-beat into a timid Child position.

It is helpful to learn to recognise the ego states from which patients are operating. Becoming self-aware in this regard can help with recognition and defence. Ask yourself: "Why do I feel I need to look after this patient?" "Why do I feel defensive/guilty/scared with this patient?"

Because the natural response to a transaction from one ego state is to reciprocate with a complimentary transaction, by persistently operating from the Adult one can often persuade the patient to doing the same:

Patient: "You seem to just keep sending me for investigations. Haven't you got any idea what's wrong with me yet?" (CP)

Doctor: "I can see you are getting quite frustrated with this, but medicine is often complicated and until I have more information from these tests I can't recommend the right treatment." (A)

Patient: "So you don't know what's wrong with me?" (CP)

Doctor: "No, I don't yet. There are quite a few things this could be and its important that I find out which it is so you and I can decide what the best treatment will be for you" (A)

Patient: "Well, okay, I'll have the tests, but I'm getting quite worried about it." (A)

From ego states to games

But why do adults choose non-Adult roles? TA suggests that the emotions associated with childhood strokes are re-assuring (even once the stroke no longer follows). In contrast, when Adult information about reality challenges our world view it feels threatening. We set ourselves up to get the comforting strokes we need. And we want to protect ourselves so we set ourselves up to have our preconceptions about the world re-affirmed.

At a simple level, we play a Parent role to get the self-stroke of having helped or chastised someone, or play the Child role to receive Strokes of help or chastisement from someone else. The next level is use a 'racket' where we set ourselves up to experience a certain type of familiar emotion. An example might be leaving a task until the last minute in order to experience the thrill of trying to hit the deadline (there may also be fringe benefits, such as excusing the submission of less-than perfect work, or being reassured that we are "not good enough" just as we had always believed). At a more complex level, people play (psychological) 'games', oten unwittingly.

Games are distinguished by having several 'moves' which may be enjoyable in themselves, but also by having a 'payoff'. Eric Berne provided an extensive 'taxonomy of games' in the book 'Games People Play'. More have been identified since.

The society as described in 'Games People Play' seem antiquated and sometimes Berne's attitudes seem a little ruthless, but the principles still apply. The important thing is to get a feel for 'gamey-ness'. In Berne's convention for describing games the prime mover is called White and the other players Black, Green, etc.

The first patient described at the start of the article is playing a variant of Berne's "Now I've Got You, You Son of a Bitch" (NIGYSOB) game. The patient, Mr White negotiates carefully from the

Adult to establish contracts and expectations. He then gets to enjoy the suspense/thrill of watching Dr Black carefully for a mistake. When Mr White spots one, he pounces and can play Critical Parent with what he sees as full justification. Subconsciously, he has an excuse for abusive Critical Parent behaviour and also gets the pleasant stroke of receiving an apology. His existential view "People can't be trusted" is re-enforced. Having found a willing player of his game, he comes back for another round in which he may gain the added strokes of the clinician's 'special care'.

Doctors are particularly vulnerable to NIGYSOB as they can't easily escape. If they try to throw the patient off their list they will have transgressed the contract and be in for another round of chastisement. If they do not, they are in for the long haul. Berne suggests extreme care as the only answer. It is particularly important to establish APPROPRIATE contracts explicitly and to ensure that they are ones you are willing and able to adhere to.

Berne does not say so, but playing carefully from the Adult when it comes to apologising, should also reduce the payoff in such a game. For example you could say: *"I am sorry that the letter took a long time to send. I can see why you are upset and I apologise. I'm afraid that there are sometimes unavoidable delays, but we will look at our procedures and see if there are ways we can reduce the chances of this happening again."*

The second patient is playing a variation of "Why Don't You... Yes But" (WDYB) or perhaps "Look How Hard I've Tried" (LHHT). In this case Miss White presents a problem from the Child, but sequentially rejects each suggestion of ways she might solve it (also from the Child). In the process the patient gets the doctor's attention and Nurturing Parent strokes. She may also be playing the 'sick role' with friends and family, gaining all sorts of benefits including extra attention, and being excused from various demands made by society (e,g. to go to work) or by her own internal Parent (eg. To be sociable, keep the house tidy, be the perfect mother, etc..)

In LHHT the eventual payoff is that Miss White is able to say to herself, friends, relatives and society "I am blameless - Look how hard I've tried. I have gone through the motions of seeking help and to help myself, but I'm not cured so we must accept the situation". In WDYB the payoff is Doctor Black's eventual disconcertion/helplessness.

Having identified the game, one can start to look for a solution. WDYB and LHHT are played from the Child and as usual, the answer lies in the Adult.

Doctor: "We've tried all the available options for treating this problem. How will you make one of them work for you?" (A)

Patient: "But I can't." (C)

Docotor: "Well, you can decide to put up with the problem or you can find a way to use one of the solutions I've suggested, but that choice is yours to make." (A)

The doctor is no longer helpless and the patient does not have the option of blamelessness. The payoffs have been subverted.

As mentioned earlier, people seek others who respond to their cues. They also seek those who are willing to play their games. In the situation above, the doctor has played the game long enough to establish the alternatives and call the patient's bluff.

Unfortunately at this point the patient will often move on to another partner with whom they can continue their preferred game. The danger is that the doctor either feels that they have failed the patient and been rejected by them, or anger that the patient plays these silly games. Once the game is recognised for what it is, however, we can be less hard on ourselves and them. The patient has been offered all the options and an opportunity to behave in an Adult manner. The doctor has done their duty. The healthy response is probably to shrug and move on.

Choosing to play the game
People play all sorts of games with GPs. In therapy, Berne suggests it is often necessary to play the game to maintain the patient's involvement until a point where a challenge can be made and the patient can learn not to play it. GPs are rarely in a position to offer a psychotherapeutic cure for game playing. Sometimes they will have to play the game in order to keep the patient coming and achieve satisfactory management of their medical problem.

It is also worth asking yourself "What games do I play?". Does your preference to play a particular Parental role attract 'Child-ish' patients? Do you find yourself in a Child ego state when any suggestion of criticism arises - and how does this make your patient behave?

Summary

To maintain control of the consultation and retain ones own equilibrium it is useful to recognise when a game is being played. One can then make an informed decision whether to play it. Boundaries can be set, and if necessary one can choose to stop playing. When in doubt, keep returning to the Adult.

SUMMARY POINTS FOR TRANSACTIONAL ANALYSIS

- People learn maladaptive behaviours in childhood.
- Transactions can take place from the Adult, Parent or Child ego state.
- In most cases consultations should be on an Adult - Adult basis.
- Staying in the Adult can take a conscious effort.
- Helping the patient stay in the Adult can help them make the right decisions.
- Patients will resist interventions that challenge their world view.
- There are often benefits to be gained from learning to recognise games; it helps to avoid being sucked into them.
- Sometimes it is necessary to play the patient's game.

References:

This work is based on the author's own experience and ideas, combined with concepts from the following works.

Berne E. The Games People Play: The Psychology of Human Relationships. Penguin Books. 1970

Stewart I, and Joines V. TA Today: A New Introduction to transactional Analysis" Lifespace Publishing. 1987.

Houghton A. Using transactional analysis in clinical consultations" BMJ Career Focus 2006: 333, 8-9.

Thanks is given to Onmedica.com for permission to reproduce this article