

Mapping transactional analysis to clinical leadership models

ABSTRACT

Leaders in today's NHS face the unenviable task of reconciling rising demand, frozen resource allocation and increasing accountability. As the NHS itself stands at the nexus of an unstable political and socioeconomic landscape, its future success relies largely on its ability to nurture excellence, to encourage open communication within and across health-care teams, and to inspire its workforce through exemplary leadership and followership. Key to these endeavours are clinicians on the 'shop floor', whose daily interactions with patients and staff help to shape prevailing culture and drive progress through quality improvement and leadership initiatives. This article considers how transactional analysis can be incorporated into professional development to help doctors develop insight into and optimize the use of different communication styles. The authors propose that a working knowledge of the transactional analysis ego state model can enhance effective communication, leadership and followership within and across health-care teams, with a view to optimizing patient outcomes and workforce interactions.

Leaders in the NHS in 2019 face unprecedented challenges. Navigating the choppy waters of soaring service demands, austerity-driven budget cuts and increasing scrutiny from national bodies, many health service leaders have found themselves divested of autonomy and forced to 'do more with less'. This is reflected in the high turnover of executive level jobs witnessed since 2015. According to a survey by the King's Fund, 37% of trusts have at least one vacant board-level executive post, with the most poorly performing trusts having shorter tenures and higher vacancy rates (Anandaciva et al, 2018). This 'leadership churn' has severe consequences for stability, productivity and progress. Framed by a tumultuous political landscape, the future and sustainability of the NHS has never been less certain. Leading amid relentless and mounting pressures requires high-quality, effective leadership at all levels, but there are huge challenges in empowering such leaders to flourish so that they can improve service delivery and patient care.

The NHS Leadership Academy (2013) reinforces that:

1. A range of leadership styles and behaviours is necessary to effectively implement lasting change in the NHS

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2. Engaging and empowering staff translates directly into better patient care.

This paradigm shift builds on a King's Fund report, which embraces modern philosophies of shared and distributed leadership, and rejects more traditional styles of hierarchical and 'heroic' leadership models which have traditionally dominated health care in the UK (The King's Fund, 2011).

The key position of doctors in 'delivering the service' means that they are uniquely placed to engage with clinical and non-clinical staff, patients and other stakeholders to implement change, with a view to improving the standard and quality of health care. A range of leadership development activities supports the closer involvement of doctors in leadership roles, aiming to provide theoretical and practical tools to help them engage others to develop positive working cultures and effect lasting change. Empowered clinical leaders can use several strategies, according to the context in which they work, to engage followers and achieve desired outcomes. Key to leading successfully in a large, dynamic and complex environment such as the NHS is connectivity (McKimm and Held, 2009). This involves actively engaging stakeholders in order to minimize disenchantment and maximize overall participation in delivering change. The successful clinical leader therefore needs to be a highly effective communicator in a wide range of situations and contexts.

While communication skills are acknowledged as vital for all doctors, medical schools mainly focus on strengthening doctor-patient communications, with little formal training in how to communicate effectively with other doctors, managers and health professionals. Furthermore, the influence of leadership and followership styles on communication (and vice versa) has rarely been considered in the clinical management literature to date. Gaining insight into the power of one's own responses to others, situational awareness and anticipated outcomes is crucial if doctors are to successfully collaborate with colleagues and patients, and use transformational leadership strategies across boundaries.

This article explores how one model (the 'ego state' model) from transactional analysis – an approach commonly used in psychotherapy and counselling – can be used to analyse and develop more appropriate communication, leadership and followership approaches and positively influence one's own and others' behaviours and outcomes in a clinical context.

What is transactional analysis?

Dr Eric Berne's theory of transactional analysis was developed during the late 1950s and 1960s. It built on psychoanalysis and Sigmund Freud's proposition that our inner states

govern and can predict behaviours. While transactional analysis has elements in common with psychoanalysis and its models seem deceptively simple, it is widely used in psychotherapy and counselling to help clients with a range of issues including addiction and managing relationships, as well as in education, training and supervision (McKimm and Forrest, 2010; Siva et al, 2011).

The philosophy of transactional analysis revolves around a number of key concepts (Stewart and Joines, 1987; McKimm and Forrest, 2010):

1. People are essentially 'OK' – this means that I accept myself as I am and you as you are, although people can learn maladaptive behaviours which undermine this belief
2. Everyone has the capacity to think for themselves (with some exceptions)
3. People decide their own destiny, therefore decisions can be changed
4. The basic unit of interaction and communication is a 'transaction', which can be verbal or non-verbal
5. People need 'strokes' – social stimuli, recognition or attention – and positive strokes are essential for psychological wellbeing.

This article takes one of the fundamental models of transactional analysis, the ego state model, and explores how this might help and hinder communication in the clinical setting, specifically focussing on leader–follower interactions and relationships.

The ego state model

In considering how people interact with one another, themselves and the world, the ego state model suggests that every individual's personality comprises three ego states: 'parent', 'adult' and 'child' (Figure 1). At any given time, people may operate in any of the states, often without conscious awareness.

The most helpful and productive interactions (particularly in the workplace) are those in which both parties are operating in the adult state, using all resources available to them, being able to objectively analyse a situation, and function in the 'here and now' (i.e. they are fully present). While the adult state is in the here and now, both the parent and child ego states are archaic and involve replaying behaviour, thinking or feelings from the past.

The parent state is about replaying things (behaviours, values, beliefs and opinions) we have learned from others in the past, whereas in the child ego state, we replay needs, wants and feelings that we ourselves have experienced in the past. An example might be if we are crossing a road and a car comes out of a side street and we have to step back suddenly to avoid it (adult). While we processed the information quickly and rationally and decided what to do, we also feel shaky and shocked (in the child state) as it reminded us of a similar event we have experienced or seen. At the same time, a parental message might play in our head, e.g. 'you must always pay attention when you're crossing the road'.

The effectiveness of a particular interaction depends on whether transactions are parallel or complementary (e.g.

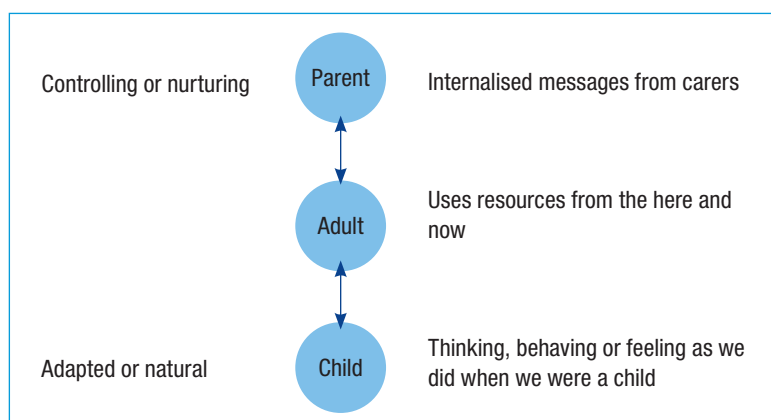


Figure 1. The parent–adult–child diagram demonstrating the three transactional analysis ego states.

adult to adult, parent to child) (Table 1). If one party directs a statement to the other operating from either parent or child mode, the recipient may answer in kind, rather than maintaining an effective adult character. What happens when such transactions occur is that if we feel that someone is operating from (for example) 'controlling parent', we start to feel like we did when we were a child. So if we feel someone is critical of us or they are trying to boss us about, then we may start functioning from an 'adapted child' ego state and find ourselves becoming over-compliant, rebellious or argumentative.

Another example is if we feel lacking in confidence or that we do not belong to a team, we might appear to others that we are operating from the child state and they might go into the parent state. This might be positive in that they start helping us or giving us hints and tips about the team, but it could be negative and they might start over-protecting us or criticising us.

These parent–child transactions could continue indefinitely, but in most situations (and certainly in the workplace), it is much better to recognize this and for both parties to move into the adult ego state. This is done primarily by recognizing how we feel and what we are thinking: often just starting to think about what is going on helps us make the transition into the adult state as we are moving from a 'feeling' to 'thinking' state. Strengthening the ability of a person to operate primarily in the adult state and to draw from the other ego states appropriately is one of the main goals of transactional analysis.

A final point to make is that, when we are structurally operating from the adult ego state, we can choose to function as if we are in either the parent or child state, but we are not actually in those ego states even if the other person responds to us as if we are. From the adult state, we can help people (but we will not take over their problem solving), give negative feedback (but constructively, not in a punishing way) and be assertive (e.g. say no to things we do not want to do). So even if the other person goes into the child state (e.g. becomes upset or argumentative), from the adult state, we can make sure that they are psychologically safe, as we are operating with all our resources in the here and now.

Table 1. Summary of key features of the ego states

Ego state	Positive features	Negative features	Verbal signs or behaviours	Non-verbal signs or behaviours
Controlling parent Seeks to make the child do what it wants them to do	Protective, gives helpful rules and boundaries to keep people safe, e.g. transferring beliefs and values, helping the child to live in their society, good in a crisis when authoritative leadership is required	Critical and controlling, may have negative intent and seek to punish the child in some way, may be seen as bossy and overbearing, coercive leadership is negative for organizational cultures	'Should', 'must', 'don't', 'good', 'bad', harsh, abrupt, authoritative tones	Finger pointing, wagging finger, arms crossed, over-staring, serious or stern face, rolling eyes, furrowed brow, scowling, standing over someone
Nurturing parent Seeks to keep the child contented and calm their fears	Displays caring behaviours, is helpful, offers safety and care, useful for affiliative, developmental and coaching leadership	Overprotective, smothering, takes over, does not allow risk taking or others to develop their own skills	'Don't worry', 'let me help you', 'I'll do it for you', soothing, consoling	Pat on arms, hugs, nodding encouragingly, active listening, smiling, proud eyes
Adult Our 'ideal self' behaves the way our 'best self' would behave	Functions in the here and now, is present, relies on objective factual data to make rational decisions, using logical practical thinking, communicates clearly, able to respond appropriately in difficult interactions, uses feedback from the parent and child ego states, can tap into and use a wide range of relevant leadership approaches	None really although might be seen as boring and pedantic. However, the adult ego state seeks balance and can handle fierce conversations	'How', 'when', 'I understand', tell me more', calm, clear even tones	Level eye contact, absence of fidgeting, open and thoughtful facial expressions
Natural child – free child Unencumbered by rules and what you 'should do'	Responds with natural emotions to the world around you, likes playing, displays genuine feelings – positive if appropriate to the situation (e.g. crying when someone dies), can offer spontaneity to the team and shows authentic leadership	Displays genuine feelings – negative if inappropriate to situation (e.g. crying in a formal meeting), may be seen as over-emotional, naïve or immature, open and potentially vulnerable	'I wish', 'I want', 'wow', 'love', 'hate', makes non-speech noises, joyful, noisy, energetic tones	Exaggerated movements, uninhibited, bright-eyed, smiling freely, joking
Natural child – little professor Has natural curiosity in order to solve problems	Curiosity, creativity and source of ideas, always trying new things, creativity and openness to experience are valuable leadership and followership skills	May get distracted and be seen as being unable to focus or stick to one thing, uses resources and problem-solving mechanisms from the past rather than the here and now	'I wonder why', 'I wonder how', 'I wonder what if ...'	Uses words, diagrams and models to explain the world, appears quick-thinking
Adapted child – compliant child Learned to do what they were told, to be accepted and fit in	Reacts to the world around them and is very aware of social rules and norms, tries hard to please others and compromise, when leaders are respected will be a good follower	Might try to change themselves to fit in (e.g. gender stereotypes) and become inauthentic, might feel criticised or left out, or try to over-please, can seem under-confident, unable to accept responsibility, unassertive and become a 'victim'	'Yes of course', 'Please', 'sorry', 'may I?', 'I'll try'	Avoids eye contact, appears hyper-aware of what everyone is doing and saying, appeasing smile, nodding, downcast expression
Adapted child – rebellious child Fights back as a protective device to avoid being hurt or ignored	Able to gain attention from others, can be used when strong, competitive, forceful leadership is required	Can appear attention-seeking, argumentative, aggressive or rebellious – an 'alienated' follower, can be disruptive	'I can't', 'I won't', complaining, surly or aggressive tones, non-speech noises, e.g. huffing, sighing, rustling papers	Fidgeting, slouching, pouting expression, withdrawal (with 'noises off'), acts out for attention

Gradually, through staying in the adult state (using calm tones, acknowledging their feelings, staying rational and logical, and maintaining eye contact), we can help the person move back into their adult state and become re-engaged.

When practising transactional analysis, a contract is usually established which is rooted in open communication and in which both parties are fully aware of their tasks,

taking joint responsibility towards achieving their goals. Transactional analysis highlights the importance of effective communication in achieving any goal, and facilitates the development of both emotional and intellectual insight. However, very few doctors have formal training in transactional analysis or its impact on communication styles and leadership philosophies.

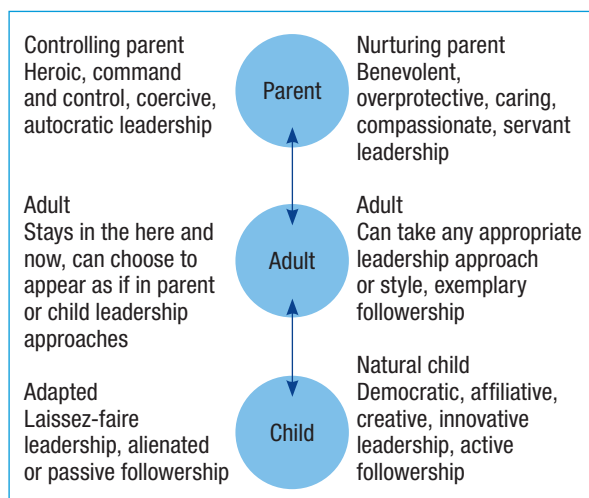


Figure 2. Mapping transactional analysis ego states to leadership and followership approaches and styles.

Leadership lessons

This section draws on Weirich's (1979) and the authors' own work (McKimm and Forrest, 2010) to consider the ego state model in relation to leadership and followership styles, and explore how a working knowledge of the ego states can enable the leader and follower to use a range of strategies according to the demands of a particular situation, individual or group. *Figure 2* sets out some of the predominant leadership and followership approaches and relates them to the ego states. For reasons of space this article cannot go into detail of all these approaches, but these range from the traditional 'hero leader' to the more contemporary approaches suggested as appropriate for health care, such as compassionate and caring leadership (see for example The King's Fund, 2011; West et al, 2017).

In the emergency department, while many clinicians undertake leadership of various situations, medical leadership falls mainly to consultants and registrars, who guide more junior doctors in training in their decision making, and oversee safe management of patients. In the following scenarios (*Case studies 1* and *2*), two doctors in training reflect on real-life interactions with senior colleagues, and these communications and leadership approaches are mapped onto the ego state model.

Both an autocratic ('command and control') and a benevolent leadership style can be seen as operating primarily from the parent ego state, reflecting the controlling and nurturing parent ego states respectively.

In contrast, individuals functioning from the adult ego state are able to provide productive leadership, through encouraging collaboration, inviting questions and considering the opinions of followers within the organization. The adult leader is democratic (consultative) and affiliative (aligning people to achieve goals), and can gather information to accurately assess a particular situation. They would facilitate good communication through empowering team members, demonstrating individualised consideration (Bass and Avolio, 1994), and

CASE STUDY 1: THE ADULT EGO STATE AND LEADERSHIP STYLES

One doctor in training (Dr S) recounts her experience of leadership from the adult ego state during a trauma scenario in the emergency department resuscitation room. Dr S was on a night shift with Dr J, a registrar, when a trauma call was received about a 27-year-old man who had sustained multiple traumatic injuries in a motorcycle accident.

Dr S recalls: 'The patient was wheeled in on a spinal board, and was drowsy, with evidence of facial trauma. My registrar took care of the airway and ventilation, and I concentrated on obtaining large-bore intravenous access and drawing bloods. A full examination was conducted by my registrar, who asked me to re-examine the patient 5 minutes later and confirm her initial thoughts. She described a scalp haematoma and a compound fracture of the patient's left tibia, which orthopaedic surgeons were dealing with. I had arranged for the patient to have a computed tomography (CT) scan of the brain, to exclude any intracerebral bleeding. My registrar arranged for the anaesthetics team to review the patient in the emergency department.

While I was assessing the patient, he abruptly stopped talking, and began to lose his airway. I immediately provided a temporary airway adjunct and applied an oxygen mask. His left pupil was far larger than the right, and did not react to light. The patient's observations chart showed a rising blood pressure and falling heart rate: in short, all the signs of rapidly rising intracranial pressure. I called my registrar immediately, who confirmed my findings. I told her that I was concerned about the possibility of an extradural haematoma compressing the patient's brain, with which she agreed. We rushed the patient to the CT scanner, where an accelerated CT head scan showed a left-sided extradural haematoma.

We contacted the nearest neurosurgical service immediately, and the patient was accepted for transfer. My registrar intubated the patient and organized an anaesthetist for transfer. We stabilized the patient in resus, and he was taken by blue-light ambulance to the local neurosurgery centre. At every step, my registrar asked for my opinion and considered it carefully. Despite being far more senior than I

was, she treated my concerns with credibility and respect. She effectively involved nursing staff and relevant medical teams through constant and respectful communication, asking for ideas and taking charge effectively but not enforcing her authority.'

In this scenario, the registrar and junior doctor worked collaboratively and with compassion to ensure all steps were taken to maximally stabilize the patient, and involve the correct medical teams.

There was also distributed leadership, where power was spread across teams, e.g. nursing staff, anaesthetists, neurosurgeons and emergency department physicians. There is evidence of good communication, with relevant services being involved early in the patient's journey to secure the best possible outcome. The registrar appears to take a democratic view on leadership, as she takes the junior doctor's viewpoint into account, treating her with credibility and respect, and encouraging active, engaged followership (Kellerman, 2008; Kelley, 2008).

Operating in adult ego state, Dr S and Dr J were able to engage in mutually beneficial interactions, working collaboratively to confirm each other's findings and ensure the highest possible level of patient care. In the adult state, leaders are able to select appropriate leadership styles. Here Dr J chose democratic, affiliative, collective and person-centred styles as her main approaches, but she could also take an authoritative approach when a serious decision had to be made. Through giving followers the freedom to identify problems and participate in delivering a solution, the democratic, inclusive leader uses adult-style communication strategies, asking probing questions and giving credence to new ideas. Encouraging participation can forge consensus among followers and engage them in contributing towards a shared vision, as the organization is seen as interlocking and interdependent. This also reflects Bass and Avolio's (1994) transformational leadership philosophy which focuses on raising followers' aspirations and achievements through idealised influence (role modelling) and inspiring and motivating others.

KEY POINTS

- Effective communication is central to the provision of high quality health care and maintaining good relationships.
- Transactional analysis models can provide insight into communication difficulties.
- Both leaders and followers can learn to communicate more appropriately when they understand how ego states operate in practice.
- Being able to operate in 'adult' ego state aligns with the most effective leadership styles for the workplace.

CASE STUDY 2: THE PARENT EGO STATE AND LEADERSHIP STYLES

Dr Y is a consultant emergency physician in a large teaching hospital in the UK. With several years of experience in a range of medical specialties, he is regarded as one of the most senior doctors in the department. However, when giving advice to junior doctors, his style is often abrupt, authoritative and dismissive, such that the general level of trust in him is less than might be expected for someone of his status, knowledge and clinical acumen.

The following is an example of a dialogue between Dr Y and Dr Z, a doctor in training working in the emergency department.

Dr Z: Dr Y, I wondered if you could help me to confirm my X-ray findings for an 89-year-old woman who fell over today and is non-weight bearing?

Dr Y agrees to look at the X-rays, and after a few seconds, points out: *Dr Z – don't tell me you can't see that pubic ramus fracture, it's blindingly obvious! A medical student would be able to diagnose this, and you've been working in my department for 6 months.*

Dr Z: But I knew-

Dr Y: Do some homework before you present to me next time and don't interrupt when I'm talking to you.

The consultant, via his use of the parent state, had perhaps unknowingly set the stage for a child-like response from the junior doctor. Dr Y, through his critical parental response, did not permit Dr Z to cross his transaction and move them both into adult, where they could have a meaningful, productive discussion and work together for the good of the patient. When people are stressed and busy, they often move into parent (becoming abrupt and critical in this case) or child (feeling 'told off', overwhelmed or a passive follower).

The leadership in this case was autocratic, commanding and pace-setting (setting high standards for self and others), as the consultant gave orders and implied that Dr Z had not met his standards for X-ray interpretation. There was little opportunity given for a participative or inclusive approach in this case. Had the consultant offered the trainee a chance to interpret the X-ray himself, Dr Z may have arrived at the correct diagnosis without being criticised, which would have resulted in a more satisfactory interaction, even a learning experience.

hence encouraging both vertical and horizontal discussion, i.e. between seniors (leaders) and subordinates (followers), and between the followers themselves. Ultimately, this leadership style is integrated and conducive to improved performance as it 'encourages problem solving and decisions based on objective facts' (Wehrich, 1979). Finally, permissive or 'laissez-faire' leaders operate predominantly from a child ego state in which freedom but little authority is afforded to their followers. While this may engender an environment in which creative ideas can flourish, the lack of authority, stimulus and direction from such a leader means that these ideas fail to be implemented effectively (Wehrich, 1979).

Conclusions

A working knowledge of models of transactional analysis can significantly enhance communications between doctors and other health-care professionals, with practical applications on the shop floor. Understanding the way that ego states affect interactions can help us identify why some interactions work well and others do not. Mapping transactional analysis to various leadership styles is a novel concept which aims to enhance the applicability of transactional analysis to various clinical situations.

These examples highlight that leaders are most effective when in the adult state, where they can select an appropriate leadership approach, and the consequences for followers (and ultimately for patient care) when leaders operate in the parent state. There is a big difference between the leader who is operating in the adult state and chooses to take an authoritative or 'command and control' approach when needed, to one who is in the controlling parent state and takes a 'heroic' autocratic stance, which is inappropriate for most clinical situations. However, being able to draw from the nurturing parent state and display compassion, care and empathy (for patients and colleagues) is vital. The NHS is in the midst of a febrile political, social and economic climate in which doctors must embrace democratic, compassionate and collaborative leadership approaches if they are to steer the organization towards future success. **BJHM**

Conflict of interest: none.

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