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The Global Psychotherapist (JGP) is an interdisciplinary digital journal devoted to Positive and Transcultural Psychotherapy (PPT after Peseschkian, since 1977)[™]. This peer-reviewed semi-annual journal publishes articles on experiences with and the application of the humanistic-psychodynamic method of Positive and Transcultural Psychotherapy. Topics range from research articles on theoretical and clinical issues, systematic reviews, innovations, case management articles, different aspects of psychotherapeutic training and education, applications of PPT in counselling, education, and management, letters to the editors, book reviews, etc. There is a special section devoted to young professionals that aims to encourage young colleagues to publish. The Journal welcomes manuscripts from different cultures and countries.

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WELCOME BY THE EDITORIAL BOARD OF THE PPT JOURNAL “THE GLOBAL PSYCHOTHERAPIST”

Dear Reader,

It is with great pride and delight we are able to present to you the second issue of *“The Global Psychotherapist” – the International Journal of Positive Psychotherapy*. The efforts of the editorial board of *The Global Psychotherapist* as well as the referees of the blind peer review system contributed to the emergence of this issue. First, we would like to thank the researchers, referees and individuals on the editorial board of the journal who contributed to this issue.

As is the purpose of *The Global Psychotherapist – the International Journal of Positive Psychotherapy*, this issue also includes practical material and research in the field of psychotherapy with a universal perspective. As Positive Psychotherapy, which is an intercultural approach that focuses on the positum (whole person), can include eclectic approaches, and is based on analytical therapies, these various techniques are reflected in the studies included in the second issue of this journal. During the Covid-19 pandemic, the world is going through extraordinary processes, and we found that **Prof. Dr. Nossrat Peseschkian's** perspective on the principal of hope in Positive Psychotherapy offers us a skill most significant at the time of this second issue. Developed by Prof. Dr. Peseschkian during the 1960s and confirmed by the Positive Psychological movement in the early 2000s, the importance and power of Positive Psychotherapy is shown in these articles. In the same way, **Röder** examines hope and its importance for mental health with proverbs and carries this tradition to the present in this second issue.

The increase in the number of studies on the effectiveness of Positive Psychotherapy can be seen in this second issue. Here **Christ et al.** impressively demonstrates, from the points of view of psychotherapists and patients, that Positive Psychotherapy is an important therapy method in terms of motivational clarification, active help in solving problems and therapeutic support and relationships. The concept of hardiness, used in today's psychology is Examined here by **Chykhantsova and Kuprieieva** in terms of Positive Psychotherapy, which provides important information to the literature. **Chykhantsova and Kuprieieva** show us that capabilities such as contact, trust, hope, love, achievement, and reliability can be important tools in increasing hardiness. Additionally, **Tomcheva and Arabazhiev** examine the frustration and the general level of aggressive tendencies of adolescents and remind us of the importance of “egocentrism”, which is an important concept in adolescent development. One of the important concepts of Positive Psychotherapy is intrapersonal differentiation. **Ivanova** shows us the importance of authenticity and openness, which are important tools of intrapersonal differentiation in the psychotherapy process, with an interesting and important research in terms of Positive Psychotherapy.

Positive Psychotherapy sees the body as an important source of coping with conflict and an important area where people's abilities and capacities are reflected. **Remmers** deals with the body's messages in the psychotherapy process in a theoretical and practical way. As there are special people in our lives, there are also special clients in the psychotherapy process. **Dobiata et al.** discuss in detail the nature of the disorder experienced by individuals with adult autism, its effects on the psychotherapy process, and what needs to be done. One of the applications of Positive Psychotherapy is positive group psychotherapy. **Perebeynosov** broadens our perspective with his study on group practices. Finally, **Fortunatova** evaluates and examines the issue of ethics in the psychotherapy process from a different perspective.

When the content of the second issue is summarized, it is seen that Positive Psychotherapy has been scientifically examined by researchers at micro and macro levels. An interesting aspect of this issue is the examination of the relations between the concepts dealt with in positive psychology studies and the structures of Positive Psychotherapy. As stated at the beginning of our second issue, the principles, concepts, and structures of Positive Psychotherapy protect individuals and societies from crises. As a result, providing significant support to bio-medical, psycho-social, and biopsychosocial perspectives; with the hope that **The Global Psychotherapist - International Journal of Positive Psychotherapy**, which offers an important perspective to different help professional groups such as psychological counselors, psychologists, psychiatrists, educators, social workers, and psychiatric nurses, will be beneficial to humanity.

The Editorial Board

"The Global Psychotherapist",
Journal of Positive and Transcultural Psychotherapy



DEALING POSITIVELY WITH WORLD CRISES: OUR CONTRIBUTION TO WORLD PEACE

by PROF. DR. NOSSRAT PEESCHKIAN †
M.D., WIESBADEN, GERMANY

First published in
Hessisches Ärzteblatt Journal. Issue 3 (2002) in German
Translated by Dr. Dorothea Martin

Dostoyevsky said that life is like a paradise to which we have lost the key. -"The Brothers Karamazov", Book VI, Ch. 1 This talk will show us a way to find this lost key.

On 11 September 2001 a world order that we had taken for granted was completely and unexpectedly turned upside down.

This article will not discuss the facts of this event or the political reasons underlying it. Instead it will try to shed light on its psychological and psychotherapeutic aspects.

"If you want to put the country in order, first put the province in order.

If you want to put the province in order, you have to bring first order to the cities.

To bring order to the cities, you must bring order to the family.

If you want to bring order to the family, you must first bring order to your own family.

If you want to bring order to your own family, you must bring order to yourself." (Oriental Stories)

This ancient oriental wisdom traces the interrelationships in which we live. We must assume that even small changes in one area of life have an impact on the entire system. According to Confucius, each person is responsible for the rise and fall of humanity.

“One can only recognize the value of persons and diamonds when they are taken out of their settings.
-Word of Wisdom

From a therapist's report:

" ... In addition to these fears of war, images came from the television which showed hundreds of unsuspecting people burning up in a ball of fire within seconds or being torn into a thousand pieces. Thoughts of death, which we are usually so good at repressing in our society, were omnipresent during those days. The fact that it all could be over in seconds was always on the table."

We will limit ourselves to a few factors here:

To ask about the meaning of human life also means that we must ask about its origin and about its goal. Further questions arise in this context as to what is the nature of man? Is he good or evil? Is he free to make his own decisions? Is there fulfillment for his longing for happiness? Does he have any influence on the fate of humanity? Does everything end with his death?

An important motivation for the approach known as positive psychotherapy may well be that I find myself in a transcultural situation. I am Persian (Iranian) but have been living in Europe since 1954. From this vantage point I have become aware that many behaviors, habits and attitudes are valued differently between these two cultures. This is an experience which I had already had during my childhood in Tehran. It concerned prejudices about religion, which I was able to observe quite closely.

As Bahà'is, we always found ourselves caught in the tension between our Islamic, Christian and Jewish classmates and teachers.

This stimulated me to think about the relationships

between the religions and about the relationships between people. I had experience with the families of my classmates and came to understand their behavior as coming from their world views and family concepts. Later I was witness to similar confrontations during my specialization when I experienced how tense the relationship between psychiatrists, neurologists, internists and psychotherapists was and the vehemence with which these positions clashed.



Only the Seed

In a dream a young man entered a shop where an older man stood behind the counter. The young man asked him: "What do you sell, dear sir?"

The wise man answered: "Everything you want."

The young man began to list them: "Then I would like world unity and world peace, the abolition of prejudice, the elimination of poverty, more unity and love between the religions, equal rights for man and women and ..."

Then the wise man interrupted him: "Excuse me, young man, you have misunderstood me. We don't sell fruit, we only sell the seeds."

- after N. Peseschkian

These experiences and my reflections led me to understand people not only as isolated individuals (even in psychotherapy); rather, to consider their relationships between one another and, because of my own development, their transcultural situations, which makes a person what he or she is.

Commonality and differences in different cultures (the transcultural approach)

We must consider the transcultural approach, which offers not only material for understanding individual conflicts, but also carries an extraordinary social significance as we face Problems of guest workers and of development aid, difficulties that arise in dealing with members of other cultural systems, problems of transcultural marriages, prejudices and overcoming them, and alternative models that come from another cultural framework. In this context political themes can also be discussed which arise out of a transcultural situation.

For interpersonal relationships, this means bringing prejudices into question by relativizing one's own values, loosening fixations and removing communication blocks.

This is linked to a further process, namely the dismantling of emotional barriers and prejudices that exist towards foreign ways of thinking and feeling. These cause whatever is foreign to be perceived as something aggressive and threatening where understanding would be initially appropriate.

Perplexity and hope

- The fact is, that we can perceive a worldwide crisis in our communication today which is assuming the proportions of an epidemic. In marital communication, partners are experiencing the pain of mutual misunderstanding and disregard. Families suffer from an almost total lack of communication between parents and children or from communication that is merely superficial. Similarly, communication between governments and their peoples exhibit a state of mutual distrust, abuse, deceit and hostility. Finally, there has been an unprecedented crisis of communication between the superpowers - a state which could easily have ended with the destruction of all life on this planet. According to a 1997 UN report, we had wars in 59 places throughout the world. These facts make it clear that our efforts to analyze the reasons for inadequate communication are no more sufficient than our efforts to develop new methods of problem solving or fact-finding.
 - In the whole world there are a great number of people - I would say it is the majority - who are in favor of world peace and view it as the only way of resolving questions about the meaning of our human existence. However, many people maintain an unmistakable skepticism toward the realization of this idea, a mistrust and even an inner resistance against it.
- At the outset I would like to share some experiences which have been particularly important for me. The following four areas are of special interest to me:
- **The contribution of the politician to world peace** (the transcultural encounter)
 - **The contribution of the religious leader to world peace** (concepts of religion or world view)
 - **The contribution of the scientist to world peace**
 - **The contribution of the individual to world peace**

Three examples:

Behavior/Concept	West	East
Illness	When someone is sick, he/she wants to get some rest. He/she is visited by only a few people. These visits are also seen as a social control.	Here, if someone is ill, the bed is placed in the living room, as with a broken leg. The sick person is the focus of attention and is visited by numerous family members, relatives and friends. A lack of visitors would be considered an insult and a deprivation.
Death	We ask people to refrain from condolence visits. I must come to grips with my fate alone. I must bear such great suffering alone.	Relatives, friends, acquaintances and other sympathetic people visit the bereaved for 8-40 days and give them a feeling of security. A shared sorrow is half a sorrow.
Depression	Central Europeans and North Americans develop depression because they lack contact, are isolated and lack emotional warmth.	In the Orient people develop depression because they feel overwhelmed by the narrowness of their social obligations and relationships from which they cannot escape.

1. The contribution of the politician

The actions of the politician are determined by the time and culture in which he/she grew up, the degree of emotional warmth and the examples their families gave them, the relationships they have been able to develop with their fellow human beings and the significance which other people have for them. Furthermore, the ideas of meaning that they receive from their religions and world views and which instruments of science and technology are available to them are also decisive. The considerations paired with the example of the politicians, are not limited to them. Because man, as a social being, can only shape his life together with other people, each of us has a political mandate. We can delegate our tasks but not our responsibilities:

Transfer to language:

It is important for all of us to maintain our mother tongues but we should also be able to speak a language which will help us communicate with others. Such a "language" is what transcultural psychotherapy attempts to provide - a metacommunication - communication beyond conflicts.

“Many little people in many little places who do many little things will change the face of the earth.”
- African Proverb

2. Contribution of religious leaders

Though there is a tendency to ignore religion, there is no argument that religion, in a moral context and also in the context of providing an active creed, influences

the life of the individual even into its most private and intimate areas. Without going into a deeper content analysis of the religions, we can say that their basic principles are the same despite the differences between them. The functional theory of sociology and psychology teaches that the institutional structures built in the contexts of the religions fulfill a function. The institution must fulfill a practical need of its society and its individuals. If it has no meaning and no function, it ceases to exist, or as is unfortunately so often the case, it attempts to save itself over time through fixation and dogmatism. Here also, the dimension of time can be seen as a basic principle of its development.

Religion is like a remedy that is measured according to the nature of the human being. It can only be meaningful when it is appropriate to the requirements, needs and demands of the human being and when it takes into account the concepts of development (the principle of time), relativity and unity. When a falsely-understood religion leads to disturbance, fixations, limitations to development, rigidity of intellectual defenses, then it becomes meaningless. Thus Feuerbach typed it as pathology rather than theology, Marx and Engels called it the opium of the people and Freud caricatured it as an insurance company.

“Learn to tell the difference between a religious belief and an institution”

3. The contribution of the scientist

The task of religion is to give the human being values, goals and meaning (giving meaning), whereas

science seeks for explanations and presents descriptive laws (finding meaning). There are a great number of sciences and they approach reality from different perspectives. Here, too, we find competition between individual sciences with their claims of the absoluteness of their particular systems and their rivalry with other systems.

These connections show us that a science's preliminary decisions, the subjects it investigates, the questions it presents and its methods depend on historical, societal, ideological and religious preconditions. It is not only through geographical connections that humanity has achieved functional unity. This is much more due to the interdependence of the elements of the structure of its civilization. Thus, fields such as politics, business, education, science, philosophy, psychology and religion are interlinked by a whole network of connections. The practical facts of the case are then that the economy is no longer the business of economists and education is no longer in the hands of parents alone. All the fields of endeavor have come to be interrelated in some way ("globalization").

Our current situation, with its non-human technological independence, necessitates working together.



Thoughts without content are empty, intuitions without concepts are blind.

- Immanuel Kant

4. The contribution of the individual

When we ask where a person got his/her idiosyncrasies, views and value judgments, we most likely come back to the environment in which he or she grew up, namely, his/her family. The continuity of society is maintained by the rules of the game that a person has acquired in the family and by the common values which, as group goals, hold the society together. The individual stands in the midst of these contending, culturally specific, ideological-religious and scientific concepts, which are all trying to offer meaning. The individual will be ground down between these competing millstones if none of them seems to be something he or she could identify with.

The result is that the human being him/herself is integrated into this unity and must accede to certain orders, laws of nature and unavoidable regulations. At

the same time the individual possesses the capacity of differentiation and the responsibility that goes with it. Thus he or she is not passively subordinated to nature but actively determines his or her own destiny within the range of the available possibilities.

Practical Approach

In this sense, the relationship of a politician, a religious leader, a scientist or an individual can be seen as disturbed if his/her emotionality is made desolate. One therefore asks the person about the relationships within the following five categories:

How is my relationship as a politician/scientist to my own self?

Do I take time for my own needs such as sleep, food, free time and further education?

How is my relationship with my partner?

Is there good contact with my wife/husband, and with the children? Do I take time for them, trust them? Do I only demand obedience and politeness from them or do I place value on an open exchange of opinions with them? Do I take the family into consideration?

How is my relationship with my social environment?

How is my relationship with relatives, friends, colleagues, compatriots or any other person at all? Am I ready for such relationships, sociable, or do I have prejudices, fears or aggressiveness toward specific individuals or groups?

How is my relationship with my profession?

Did I choose this profession voluntarily or was I forced into it? Was there no other work that I could have done? Does the work that I do interest me? Do I only work for the money or to afford the things I want? Or has my work become meaningful to me, an inner need? Do I have conflicts in my job? Am I overtaxed or under-challenged? Do I find the work fulfilling but not get along with my colleagues? How can I make a contribution to social development?



No future can make up for what is neglected in the present.

-Attributed to Albert Schweitzer

How is my relationship to the future?

Am I satisfied or unsatisfied with the present? Do I see possibilities for development or just being stuck? Can I expect my needs to be appropriately satisfied in the future? What are my goals and what are the principles underlying my system of orientation? Did I work out my system of orientation for myself or did I just get it from others? What does life really mean for me? How do I work through difficulties which appear in various situations? Am I willing to experiment? Am I willing to state my opinion openly and be judged on it, even risking the danger of losing the good opinion of others?

Consequences

Humanity's search for a new and effective orientation will bring with it a changing relationship between cause and effect. Individuals disillusioned by culture, society, politics and religion, who seek refuge and help in their private worlds, will in turn multiply the collective problems because of these shifting relations.

This shows us once again that none of these cultural systems is good in itself. Their qualities only reveal themselves in the ways in which they are effective for the people who live within them and to the extent to which the rules of their games allow for constructive encounters with other sociocultural systems and their members. So, there is much that the members of various cultural systems could learn from each other - even if they only learn to understand one another.

RECOVER YOUR BALANCE: EFFECTIVENESS RESEARCH OF POSITIVE PSYCHOTHERAPY



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Abstract

The present study examines whether Positive Psychotherapy (PPT) fulfills the three common efficacy factors of psychotherapy postulated by Grawe et al. (1994) and in doing so takes the therapists' assessment of the common factors, the length of professional experience of therapists and multiple times of measurement into account. 207 outpatients (66 males, 41 females) and their therapists - who were trained in PPT - evaluated the fulfillment of the three common factors after an individual therapy session. Results provide support for the effectiveness of PPT: patients and therapists both assessed PPT to fulfill the three common efficacy factors. However, patients perceived all three factors to be fulfilled to an even higher degree than therapists did. Additionally, two of the common factors were judged to be more fulfilled when the treating therapist had more rather than less professional experience. Lastly, patients experienced therapy as even more effective over time. The verification of the effectiveness of Positive Psychotherapy via an explicit measurement of the common efficacy factors leads to a gain of knowledge and has important implications for psychotherapists practicing and teaching PPT alike. Furthermore, the present study provides new and interesting approaches for future research.

Keywords: psychotherapy research, Positive Psychotherapy, effectiveness research, common efficacy factors, outpatient treatment

Introduction

Psychotherapy research is considered by many authors as a "fundamental aspect of psychotherapeutic

services" (e.g. Lambert, 1991, p. 1) and is held to be necessary to improve treatment outcomes and treatment guidelines of psychotherapy (Angus et al., 2014). Its relevance results from the contribution that

psychotherapy research makes in extending the knowledge of psychotherapeutic processes and outcomes (Strauss et al., 2015) and the important benefits and implications it has for practicing psychotherapists (Grawe, 1992; McLeod, 2001; Safran et al., 2011; Taubner et al., 2014) as well as for the training of ongoing psychotherapists (Elkins, 2012; Grawe, 1992). Additionally, psychotherapy research is also of interest to patients (McLeod, 2001), as patients' positive valuation of therapy – including the belief that psychotherapy is efficacious and likely to be of help to them – goes along with increased motivation for therapy (Rosenbaum & Horowitz, 1983). On top of that, there has been increasing pressure from health insurances, funding bodies and other stakeholders to demonstrate effectiveness of psychotherapeutic services (McLeod, 2001; Peseschkian et al., 1999; Presslich-Titscher & Datler, 1994).

All of the above led to a rise of research on psychotherapy over the past 70 years (Fuertes & Nutt Williams, 2017). This research can generally be divided into four phases, depending on the particular research question under investigation (Grawe, 1992). During the first phase research concentrated on demonstrating the effectiveness of psychotherapy in general, while the second phase centered on comparing psychotherapy directions and thus on identifying the most effective one. The third phase, on the other hand, took a more prescriptive approach by examining which form of therapy was indicated for which patient. In the 1990s, process research came more and more into focus, and with it the question of how psychotherapy works and what exactly makes psychotherapy effective (Grawe, 1997; Hank & Krampen, 2008; Mattejat, 2011).

Concerning that last research question, Grawe, Donati and Bernauer (1994) - based on a large empirical examination of psychotherapy effectiveness - postulated that three common efficacy factors were crucial for the effectiveness of every psychotherapy: *motivational clarification*, *active help to solve problems* and *therapeutic support and relationship*. According to them, *motivational clarification* refers to fathoming the threatening meaning of a particular situation or event or the implications of a patient's goal. The second common factor of *active help to solve problems* refers to the patient's concrete experience of learning how to deal with situations previously experienced as difficult or anxiety-provoking (Grawe, 1997). Finally, Grawe et al. (1994) defined the third common factor of

psychotherapy as the extent to which the patient feels understood by the therapist and can accept the therapist's support. According to the model, the effectiveness of psychotherapy depends on the extent to which these three common factors are activated by concrete therapeutic procedures (Grawe et al., 1994).

These common efficacy factors sensu Grawe et al. (1994) have found general acceptance in the psychotherapy research field (Mattejat, 2011) and thus, have been used in order to demonstrate or compare the effectiveness of various psychotherapeutic approaches and treatments (e.g. Sander et al., 2012; Schramm et al., 2004; Stangier et al., 2010). In that sense, Nossrat Peseschkian and colleagues conducted a wide-ranging effectiveness study between 1994 and 1997 in order to show that Positive Psychotherapy (PPT) fulfills the three common efficacy factors defined by Grawe et al. (1994; Peseschkian & Remmers, 2020). Their study was undertaken under conditions of daily clinical practice and examined 402 patients with different psychiatric and psychosomatic disorders that were treated by therapists trained in PPT (Peseschkian & Tritt, 1998; Peseschkian et al., 1999). Using a battery of psychometric test that was decided on in consultation with Grawe, Peseschkian and colleagues were able to show that "PPT fulfills the [...] principles postulated by Grawe [et al. (1994)] for the effectiveness of psychotherapy" (Peseschkian & Remmers, 2020, p. 29). The importance and impact of that effectiveness study is highlighted by the award for outstanding work in the field of medical quality assurance it received (Peseschkian et al., 1999). Yet, it should be noted that the researchers at that time could only infer the fulfillment of the three common efficacy factors from the patients' results on various psychometric tests since there was no instrument available to specifically measure the common efficacy factors postulated by Grawe et al. (1994).

Now, over 20 years later, this has changed as Krampen (2002) developed the Session Questionnaire for General and Differential Individual Psychotherapy (STEP). This instrument was designed in order to allow for an economic measurement of the three common efficacy factors according to Grawe et al. (1994). The STEP questionnaire refers to the patient's experience of an individual therapy session as well as the associated external perception and evaluation of his or her therapist (Krampen, 2002). The items form three subscales, namely *motivational clarification*, *active help*

to solve problems and therapeutic relationship, therefore covering the three common factors defined by Grawe et al. (1994). As the good psychometric quality of the STEP questionnaire has been attested multiple times (Beutel & Brähler, 2004; Krampen, 2016; Krampen & Wald, 2001), this instrument can be used to reliably and explicitly survey the three common efficacy factors.

Therefore, the present study aims at examining whether PPT fulfills the three common efficacy factors postulated by Grawe et al. (1994) when explicitly surveyed via the STEP questionnaire. Additionally, the present research also takes the therapists' evaluation of the common efficacy factors, differences in the professional experience of therapists and multiple times of measurement into account, allowing for a more sophisticated exploration of the activation pattern of common efficacy factors in PPT. Following the work of Peseschkian and colleagues, in order to maximize generalizability of results, a naturalistic setting was chosen in that the STEP questionnaire was administered to 210 outpatients that were treated by therapists trained in PPT. Thus, this study poses a continuation of the research conducted by Peseschkian and colleagues in 1998 and 1999 and provides further evidence for the effectiveness of PPT.

Methodology

2.1 Subjects and study design

The study sample consisted of outpatients treated at the psychotherapy practice *Akademie an den Quellen* in Wiesbaden, Germany, between 2014 and 2019. Patients were asked to fill out the STEP questionnaire directly following a regular therapy session. They completed the STEP questionnaire at different stages of therapy, consequently, the sample was a mixture of patients at the beginning of therapy as well as at advanced stages of therapy. Sessions to be evaluated were selected randomly and patients were not told about the planned evaluation in advance in order to prevent biases.

In total, 210 patients participated in the study of whom 54 completed the questionnaire twice, 17 filled it out thrice and 5 answered it four times. The average time between two measurements was 7 months. The present study poses a clinical study in which no control group was planned (quasi-experimental study or non-randomised design; Schramm et al., 2004).

After scanning the data for potential outliers, 207 patients were included in the statistical analysis for the first time of measurement. Thus, this sample included 66 males and 41 females between 18 and 78 years (average age = 44). The outlier analysis of the sample with two measures resulted in 52 patients (11 males, 41 females, average age = 43). As the sizes of the samples with three and four measures are both very small, these samples were not analyzed separately.

For the statistical analyses of the general effectiveness of psychotherapy in the practice, all measures were analyzed together as the STEP questionnaire is designed specifically to evaluate the therapy session just conducted and, therefore, multiple measurements by the same person should also be considered for assessing the general effectiveness of a form of psychotherapy. After having excluded statistical outliers, the resulting sample, including multiple measures of the same person, consisted of 282 patients (86 male, 196 female, average age = 44). On average, patients had been treated in the practice for 9.9 months when they completed the STEP questionnaire. Diagnoses of patients included depression (52.9%), stress disorders (26.8%), anxiety disorders (14.3%), psychological and behavioral factors associated with disorders or diseases classified elsewhere (15.0%), somatoform disorders (7.5%), personality disorders (6.8%), and others (22.1%).

2.2 Therapists

A total of 21 psychotherapists participated in the present study, all of whom worked at the psychotherapy practice *Akademie an den Quellen* in Wiesbaden, Germany, throughout the time of the study. All therapists were trained in psychodynamic psychotherapy and PPT. 19 of them were psychotherapists in training at *Wiesbadener Akademie für Psychotherapie* (WIAP) where psychotherapeutic training based on PPT is provided. The other two psychotherapists both are lecturers at WIAP: one is certified as master trainer in PPT, while the other is qualified in Integrative Therapy sensu Petzold (1993), an approach very similar to PPT concerning the fundamental structure and conception of human beings.

2.3 Therapy Sessions

All patients included in the present study received weekly 50 minute-sessions of PPT. PPT is 'a form of

humanistic psychodynamic psychotherapy' (Peseschkian & Remmers, 2020, p. 11). It was developed by Nossrat Peseschkian during the 1970s and 1980s (ebd.). PPT is characterized by conflict-centeredness and resource-orientation as well as the integration of approaches from the main psychotherapy directions (ebd.). PPT focuses on the capacities of the patient and wants to help the patient to discover his or her potential for self-help. Disorders, conflicts and symptoms are seen as 'a capacity to react to conflicts' (ebd., p. 12), and are considered to be part of the wholeness of the patient just like his or her resources, capacities and potentials.

2.4 Measures

The *Session Questionnaire for General and Differential Individual Psychotherapy* [Stundenbogen für die Allgemeine und Differentielle Psychotherapie] (STEP; Krampen, 2002) constitutes an economic and standardized questionnaire to assess the common efficacy factors of psychotherapeutic processes distinguished by Grawe et al. (1994) from the perspective of patients and their therapists. The items of the questionnaire directly relate to the experience of an individual therapy session by the patient, constituting the patient version (STEPP), as well as his or her therapist's external perception of the session and of the patient's experience, forming the therapist version (STEPT).

Both versions are designed as parallel in terms of content and comprise 12 complementary items each. Five items measure the experienced (patient version STEPP) or perceived (therapist version STEPT) *motivational clarification* of the patient (STEP-C), four items assess the experienced or perceived *active help to solve problems* (STEP-P) and three items evaluate the *therapeutic relationship* (STEP-R), respectively for the specific therapy session.

For the STEPP the patients use a 7-step answer scale to rate how applicable the respective statements are to their experiences. The reliabilities for the three scales of the patient version lie between Cronbach's $\alpha = 0.76$ and Cronbach's $\alpha = 0.89$. For the STEPT the therapists assess content-analogous questions related to their perception of the patients' experience and behavior on a 7-step answer scale. The reliabilities for the three scales of the therapist version range from Cronbach's $\alpha = 0.78$ to Cronbach's $\alpha = 0.91$. Thus, all scales show good internal consistencies (Field, 2013).

Because of the different amounts of items of the three scales, the maximally achievable values vary. For the STEP-C a total score of 35 can be reached, for the STEP-P a maximal assessment of 28 is possible and for the STEP-R the maximal score is 21.

Results

3.1 PPT fulfills the three common efficacy factors

The statistical analysis of the dataset including all measures revealed that in comparison to the norms published by Krampen (2002) the mean values of all subscales were in the average range (see Table 1).

When taking into account random fluctuations, however, the mean values of STEPP-P and STEPT-P tended to be in the below average to average range. As the deviations from the average range are rather small (see Table 1), overall, both scales can still be considered to be lower average. It is noteworthy though that both scales concern the *active help to solve problems* – from the patients' and the therapists' point of view. Therefore, this could imply that therapists practicing and teaching PPT should pay special attention to this common factor in order to ensure its fulfillment.

Additionally, in consideration of random fluctuations, the mean value of STEPP-R tended to be average to above average, suggesting that patients perceive the common factor *therapeutic relationship* to be especially strongly fulfilled by PPT (see Table 1).

All things considered, it can be stated that PPT activates the three common efficacy factors distinguished by Grawe et al. (1994), both from the patients' point of view and according to the therapists' assessment, and is thus perceived to be effective.

Table 1.

T norm values, Cronbach's α , standard deviations (SD) and confidence intervals (CI) for all STEP scales.

Scale	T	α	SD	90% CI	Classification
STEPP-C	50	.89	10	[44.56, 55.44]	a
STEPT-C	45	.85	10	[40.08, 49.92]	a
STEPP-P	45	.76	10	[38.64, 51.35]	ba to a
STEPT-P	45	.91	10	[38.44, 51.56]	ba to a
STEPP-R	60	.84	10	[51.97, 68.03]	a to aa
STEPT-R	50	.78	10	[42.31, 57.69]	a

Notes. N = 282, STEPP-C/STEPT-C = patient/therapist version of motivational clarification scale, STEPP-P/STEPT-P = patient/therapist version of active help to solve problems scale, STEPP-R/STEPT-R = patient/therapist version of therapeutic relationship scale, a = average, ba = below average, aa = above average.

3.2 Patients experience therapy as more effective than their therapists think

Interestingly, patients' evaluations differed significantly from the therapists' assessments on all subscales and at all times of measurement (see Table 2 and Figure 1). Thus, on average, the patients experienced all three common efficacy factors as significantly more fulfilled than their therapists perceived them to do.

Although divergence in patients' and therapists' evaluation of a therapy session is neither alarming nor unusual and is described as a generic problem of process research by Hartmann et al. (2013), the differences in the assessments of the STEP questionnaire are generally not as uniform and consistent across all scales as was the case in the present survey. Usually, it can be observed that at times the patients and at other times the therapists perceive the common efficacy factors as more fulfilled and that the direction of divergence between the scales also differs within the same sample (Krampen, 2002).

One possible explanation for this unusually uniform divergence in terms of higher values of the patients' assessments evident in the present study is that the therapists have a more advanced understanding of the three common factors and base their assessments of them on their professional knowledge of how they should be fulfilled in a psychotherapy, leading to higher expectations and, thus, a more critical evaluation. The patients on the other hand compare the psychotherapy situation to their past personal experiences resulting in more positive assessment. A similar explanation was suggested by Horvath (2000) concerning the divergence of patients' and therapists' assessment of the therapeutic alliance. Fitzpatrick et al. (2005) applied Horvath's assumption to the three dimensions of task collaboration, goal collaboration and patient-therapist bond. Therefore, it seems plausible that this pattern may also be applicable to the three common factors of psychotherapy defined by Grawe et al. (1994).

Table 2.

Means (M), standard deviations (SD), t- and p-values of t-tests for comparison of patients' and therapists' assessment of the STEP scales.

Scale	Patients' assessment		Therapists' assessment		t(280)	p
	M	SD	M	SD		
STEP-C	25.06	6.04	21.67	5.49	8.53	<.001
STEP-P	19.20	5.23	14.43	6.06	13.13	<.001
STEP-R	18.86	2.36	16.56	2.63	12.90	<.001

Notes. N = 282. STEP-C = motivational clarification scale (score range = 5-35), STEP-P = active help to solve problems scale (score range = 4-28), STEP-R = therapeutic relationship scale (score range = 3-21).

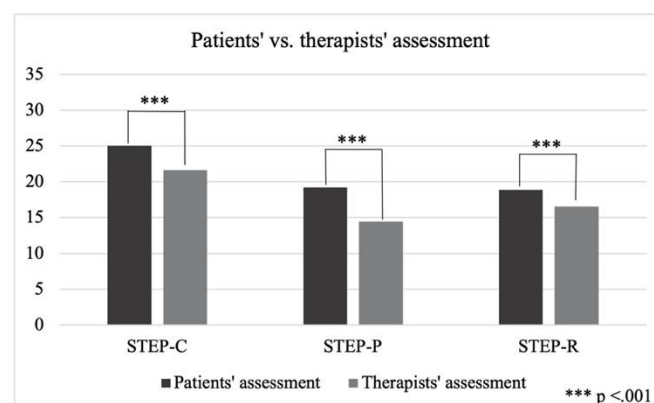


Figure 1. Comparison of mean scores of patients' vs. therapists' assessment on STEP scales motivational clarification (STEP-C), active help to solve problems (STEP-P) and therapeutic relationship (STEP-R).

3.3 Therapists' professional experience plays a role

As two therapists with many years of professional experience (average professional experience = 20.56 years) as well as 19 psychotherapists in training (average professional experience = 3.50 years) participated in the present study, the influence of professional experience of the treating therapist on the assessment of the common efficacy factors could also be examined. The statistical analysis of the dataset including all measures showed that the common factor *problem solving* was perceived by both patients and therapists as being significantly more fulfilled if the treating therapist had more rather than less professional experience. As it had been those two scales (STEPP-P and STEPT-P) that tended to be in the below average to average range when compared to the norm values, another norm comparison was conducted for therapists with much and for therapists with little professional experience, *separately*. This analysis

revealed that the patients' and therapists' assessment for experienced therapists was in the average range, even when taking into account random fluctuations. The mean values for therapists with less professional experience, on the contrary, tended to be below average to average. As the analyzed dataset includes 248 measures from therapists with little professional experience, but only 34 measures of more experienced therapists, it seems plausible that the effect of therapists' professional experience led to the overall classification of STEPP-P and STEPT-P as below average to average, that was reported earlier.

In addition, patients of therapists with many years of professional experience rated the *therapeutic relationship* to be significantly more fulfilled than patients of less experienced therapists. The therapists themselves, however, showed no significant difference in their assessment of this common factor. With regard to *motivational clarification*, therapists and patients agreed that no difference was seen in the fulfillment of this common factor depending on the therapist's amount of professional experience (see Table 3 and Figure 2).

Table 3.

Means (*M*), Standard deviations (*SD*), *t*- and *p*-values of *t*-tests for comparison of much versus little professional experience of the treating therapist.

Scale	Much professional experience		Little professional experience		<i>t</i> (280)	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
STEPP-C	26.59	5.57	24.86	6.07	1.57	.117
STEPT-C	22.71	5.37	21.54	5.49	1.16	.247
STEPP-P	21.12	4.75	18.93	5.70	2.14	.033
STEPT-P	17.94	5.06	13.92	6.07	3.70	<.001
STEPP-R	19.74	1.69	18.70	2.53	3.11	.003
STEPT-R	16.68	3.36	16.59	2.60	0.36	.721

Notes. *N* = 282. STEP-C = patient/therapist version of motivational clarification scale (score range = 5-35), STEP-P = patient/therapist version of active help to solve problems scale (score range = 4-28), STEP-R = patient/therapist version of therapeutic relationship scale (score range = 3-21).

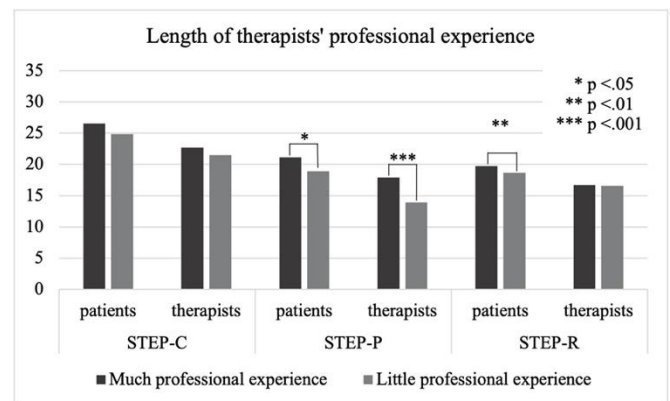


Figure 2. Comparison of patients' and therapists' mean scores of STEP scales motivational clarification (STEP-C), active help to solve problems (STEP-P) and therapeutic relationship (STEP-R) for therapists with much vs. little professional experience.

When comparing the results of the present study with the comparative results reported in the manual of the STEP questionnaire (Krampen, 2002), the findings are only partially corresponding.

Coinciding with the present findings, Krampen's (2002) analyses also revealed significantly higher values regarding *problem solving* for therapists with more professional experience, both from the therapists' and the patient's point of view. However, the patients' and therapists' ratings of *motivational clarification* were also higher for more experienced therapists, which was not true for the present survey. Moreover, in the comparative analyses the patients' assessment of the *therapeutic relationship* showed no significant differences depending on the professional experience of the therapist, whereas this was the case in the present survey. Although it should be considered that the comparative analyses reported in the manual are based on rather small samples only, a more differentiated and in-depth exploration of the influence of therapists' professional experience on each of the three common factors seems desirable and germane. The agreement on the direction of the effects – always in the sense of better ratings of the common factors for therapists with more professional experience – however, indicates that therapeutical work can be taught and learned.

3.4 Patients experience therapy as even more effective over time

Since for 52 patients two measurements were conducted, it was also possible to investigate whether and how the patients' and therapists' assessment of the three common efficacy factors of psychotherapy developed over time. It was noteworthy that the patients' evaluation changed significantly in that they perceived all three common factors to be even more strongly fulfilled over time. Thus, patients perceived therapy to be even more effective over time. However, no such effect was observed among the therapists: they always perceived therapy as equally effective for the patients (see Table 4 and Figure 3).

Table 4.

Means (*M*), Standard deviations (*SD*), *t*- and *p*-values of *t*-tests for comparison of first versus second time of measurement.

Scale	First time of measurement		Second time of measurement		<i>t</i> (280)	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
STEPP-C	24.83	6.25	26.04	5.61	-2.15	.036
STEPT-C	21.57	5.00	21.65	5.34	-0.41	.682
STEPP-P	17.87	5.78	20.19	4.92	-3.65	.001
STEPT-P	13.14	5.99	13.92	6.05	-1.29	.204
STEPP-R	18.06	2.93	18.97	2.04	-2.36	.022
STEPT-R	16.33	2.39	16.25	2.65	0.23	.816

Notes. *N* = 282. STEP-C = patient/therapist version of motivational clarification scale (score range = 5-35), STEP-P = patient/therapist version of active help to solve problems scale (score range = 4-28), STEP-R = patient/therapist version of therapeutic relationship scale (score range = 3-21).

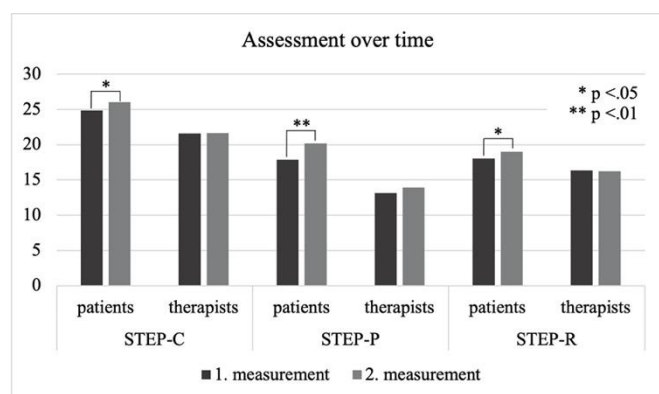


Figure 3. Comparison of patients' and therapists' mean scores of STEP scales motivational clarification (STEP-C), active help to solve problems (STEP-P) and therapeutical relationship (STEP-R) for first vs. second measurement.

Conclusions

The aim of the present study was to examine the fulfillment of the three common efficacy factors of psychotherapy by PPT. Using the STEP questionnaire (Krampen, 2002) to explicitly measure the common factors postulated by Grawe et al. (1994), the results at hand provide support for the effectiveness of PPT in the sense that patients as well as therapists perceived PPT to fulfill the three common efficacy factors. The finding that patients and therapists assessed *active help to solve problems* to be fulfilled only at a lower average could be resolved by taking into account the professional experience of the treating therapist which was identified as especially relevant for the fulfillment of this common efficacy factor. The professional experience also played a role for patients' evaluation of the *therapeutic relationship*. This provides evidence for the teachability and learnability of therapeutic work, especially concerning the *active help to solve problems* and the *therapeutic relationship*. Furthermore, patients judged all three common factors to be fulfilled to an even higher degree than therapists did. Lastly, it could be found that patients experienced therapy as even more effective over time while no such trend was detected in therapists' assessments.

To the authors' knowledge this paper poses the first examination of the fulfillment of the three common efficacy factors as measured by the STEP questionnaire in PPT. Therefore, it provides important and new support for the effectiveness of PPT. Additionally, because of taking into account the therapist's assessment, the length of the therapist's professional experience and multiple times of measurement, it allows for deeper insights into the patterns of activation and makes it possible to identify relevant aspects of the fulfillment of the common factors. A particularly important finding in this context is the influence of professional experience on the fulfillment of *active help to solve problems* as this highlights the importance of giving special consideration to this common factor in the training of ongoing psychotherapists.

In addition to providing meaningful answers concerning the effectiveness of PPT, the present findings also open up further questions and thus provide important and interesting approaches for future research. For one thing, there should be closer examination of what factors play a role for the differences in assessment between patients and therapists and whether the potential explanation

suggested by the authors proves to be true. Moreover, future research should try to illuminate how the growing professional experience of psychotherapists translates into increased fulfillment of two of the common factors. Lastly, it seems interesting to explore how and to what extent patients' assessment of the three common factors increases over time.

The present results should always be interpreted by taking into account that this study is also not without limitations. Therefore, it should be noted that the absence of a control group limits the causal conclusions that can be drawn from the study on the effectiveness of PPT. In addition, the chosen naturalistic design reduces the internal validity of the study (Howard et al., 1996). However, this limitation was accepted as the study aimed at examining the effectiveness of PPT under naturalistic conditions emphasizing external validity and generalizability of the findings (Howard et al., 1996; Leichsenring & Rüger, 2004). Nonetheless, due to the abovementioned reasons a replication of the study under more controlled conditions seems desirable for future research.

All in all, the present paper provides important evidence for, as well as further insights into, the effectiveness of PPT as measured by the common efficacy factors sensu Grawe et al. (1994). It can thus be seen as a continuation of the research of Peseschkian and colleagues (1998; 1999). The present findings are highly relevant for future psychotherapy research as well as for psychotherapists practicing and teaching PPT all around the globe.

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POSSIBILITIES OF POSITIVE PSYCHOTHERAPY IN THE FORMATION OF HARDINESS



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Abstract

The main goal of this study was to explore the possibilities of Positive psychotherapy in the formation of hardiness and to delve deeper into the relationship between hardiness and actual capabilities of the person. Data were collected from 380 people from Ukraine, aged between 19 and 62. The respondents completed the Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF 2.0), which was developed by N. Peseschkian in collaboration with H. Deidenbach and the Maddi Hardiness Scale. We used Pearson's correlation coefficient to measure the statistical relationship between hardiness and personal capabilities. Also, we used regression analysis to determine the prognostic indicators for hardiness. As a result of our research, we found that the capabilities of contact, trust, hope, love, achievement, and reliability have the greatest influence on hardiness.

Keywords: hardiness, Positive Psychotherapy, personality features, primary and secondary capabilities

Introduction

In the modern scientific world, the concept of personal hardiness is attracting increasing attention of researchers. The problems of loss of meaning of life, coping with stressful factors, especially in activity, prompts exploration for means of psychological and psychotherapeutic support.

The concept of "hardiness" was first presented by Suzanne C. Kobasa (1979) as a personality style or pattern associated with continued good health and

performance under stress (Mund, 2016). This concept is defined as a basic characteristic of a personality, the system of an individual's attitudes and beliefs that mediate the impact of adverse life situations on human consciousness and behavior (Maddi, 2013).

So, S. Kobasa and S. Maddi (2002) characterized hardiness as being comprised of three components, known as the 3C's: 1) Commitment, 2) Control, and 3) Challenge. 'Commitment' is an important characteristic of a person's attitude to him/herself, the surrounding world and interactions with it, which gives strength and

motivates him/her to self-realization, leadership, healthy thoughts and behavior; it allows the person to feel important and sufficiently valuable to be fully engaged in solving life's problems without paying attention to stress factors and changes. 'Control' over circumstances helps to find ways to influence the outcome of changes from stress rather than falling into a state of helplessness and passivity. 'Challenge' helps a person to be open to the surrounding world, other people and society. Its essence lies in the perception by a person of his/her life events and problems as a challenge and test for his/herself. The applied aspect of hardiness is determined by the role that its personal parameters play in tolerance to stressful situations (Baranauskienė, Serdiuk, Chykhantsova, 2016).

D. Leontiev believes that hardiness is a kind of psychological analogue of a person's life core that reflects the extent of his/her overcoming of certain stressful situations and adapting to given circumstances, as well as a measure of applied efforts for self-improvement and overcoming unfavorable circumstances in life (Leontev, 2002). According to S. Maddi 'hardiness emerged as a set of attitudes or beliefs about yourself in interaction with the world around you that provides the courage and motivation to do the hard work of turning stress changes from potential disasters into opportunities instead' (Maddi, 2004, p. 286).

An important factor for hardiness is an individual's fundamental assumptions (Janoff-Bulman, 1992), which are the basis of his/her picture of the world, they are included in the acts of internal human choice, so they are the basis for self-determination, purposefulness and self-development. These fundamental assumptions, as a unit of worldview, are a criterion for value choices made by an individual in different life circumstances and a base for certain personal meanings (Kuprieieva et al., 2020).

The important fact is that not only hardiness as human potential, but also Positive Psychotherapy (PPT) as a therapeutic approach is among the resources that ensure a person's ability to overcome stress. According to E. Messias (2020) the feature of Positive Psychotherapy is a change in the focus of approaches to a person from an orientation to symptoms and deficits, to the development and support of his/her internal resources. In other words, Positive Psychotherapy is one such therapeutic model that has aimed to reorient the therapeutic approach to be more focused on

supporting clients to use their inner resources to overcome challenges, understand and recognize areas of growth, and focus instead on working towards hardiness (Mead, 2021). Positive psychotherapy, with the help of reflection and self-assessment, allows people to come to the awareness of their resources, the content of the conflict, the characteristics of conflict reactions and their psychodynamic origin. The basic conflict is described by primary and secondary capabilities and during therapy the personal meaning and development of every capability are reflected upon, differentiated, compiled by the human (Dobiła, Winkler, 2016).

According to PPT theory, everyone has two core capabilities: the Capability of Perception and the Capability of Love. N. Pesechian (1987) concluded that these two core capabilities are what lies behind our further abilities. PPT seeks to explore an individual's two core capabilities to understand better and, where appropriate, address imbalances to create additional positive outcomes. Positive Psychotherapy sees human beings as capable of helping the person, who wants to lead a meaningful and fulfilling life, to grow, mature and flourish (Dobiła, Winkler, 2016).

Consequently, in our study we try to investigate the role of Positive Psychotherapy in the development of a person's hardiness.

The object of the research – personal features of hardiness.

The aim of the research – to investigate the importance of primary and secondary capacities in the formation of a person's hardiness.

Methodology

2.1. Methods and organization of the research

The study was conducted on the basis of the Laboratory of Personality Psychology of Kostyuk Institute of Psychology of the National Academy of Educational Science of Ukraine.

In the empirical study we used the following methods:

1. Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF 2.0), which was developed by N. Pesechian in collaboration with H. Deidenbach (Pesechian, & Deidenbach, 1988), translated and adapted for the Ukrainian sample by L. Serdiuk and S. Otenko (Serdiuk, Otenko, 2021). The questionnaire consists of 27 scales that allow us to assess the subjective significance of one's personality

traits in the following three sections: 1) actual capacities (secondary in relation to one's own behavior; primary in relation to oneself); 2) manifested conflict reactions in four areas of the balance model; 3) subjectively perceived parameters of the relationship model. All questions were rated on a four-point scale, ranging from strongly agree to strongly disagree. Cronbach's alpha ranged according to the different WIPPF scales in the Ukrainian version from 0.73 to 0.86 (Serdiuk, Otenko, 2021).

2. Maddi Hardiness Scale, adapted version by D. Leontev and E. Rasskasova (Leontev, & Rasskasova, 2006). It was designed to determine personal ability and willingness to act actively and flexibly in situations of stress and difficulties. The Scale contains a general indicator of hardiness and three scales: commitment, control, and challenge. It has 45 statements and 4 answer options from 1 (*completely disagree*) to 4 (*completely agree*). Cronbach's alpha was 0.81.

For statistical analysis of the obtained data, the following methods of mathematical statistics were used: correlation, regression analysis. The processing of the obtained empirical data was carried out using the statistical software package SPSS 21.0 for Windows.

2.2. Participants in the research

The sample of our study consisted of 380 people, including 96 men (25,26%) and 284 women (74,74%) from different regions of Ukraine, aged 19 to 62 years. Average age 37.7 ± 11.1 . According to the way of selection, the sample is random to avoid unintentional or deliberate distortion of the facts.

Results

Table 1 reports the correlations among the study variables. Pearson's correlation coefficient results obtained indicate that there are more correlations between primary capacities. Therefore, we can say that the following primary capacities have relationships with hardiness as: hope ($r = 0,533$; $p < 0,01$), trust ($r = 0,451$; $p < 0,01$), contact ($r = 0,439$; $p < 0,01$), and love ($r = 0,419$; $p < 0,01$). This indicates that hardiness can be developed through the individual's example through relationships. Faith correlates with challenge as a component of hardiness ($r = 0,325$; $p < 0,01$). Sexuality correlates with general hardiness ($r = 0,330$; $p < 0,01$) and control ($r = 0,335$; $p < 0,01$). This means that the respondents are aware of their capabilities and

characteristics, self-reflect and show self-understanding. Primary capacities influence the corresponding experiences on mood and physical condition, which is important in stressful situations.

Among the secondary capacities, the influence on hardiness have: punctuality ($r = 0,383$; $p < 0,01$), reliability ($r = 0,381$; $p < 0,01$) and achievement ($r = 0,358$; $p < 0,05$). With the help of these secondary capacities, a person tries to control a stressful situation and demonstrates hardiness-s.

As a result of our research, we found that people tend to express themselves in terms of socially acceptable qualities, at the same time, real behavior often turns out to be the opposite. Through awareness of the poles, it becomes possible to increase acceptance and understanding of oneself.

Table 1.

The relationships of hardiness with personal capabilities

		Hardiness			
		commitment	control	challenge	general indicator of hardiness
Secondary capacities	Orderliness	.265	.277	-.105	.331
	Cleanliness	-.223	.253	-.157*	.334**
	Punctuality	.358*	.029*	.390*	.383**
	Politeness	-.023	.163*	-.133	-.103
	Openness	.141*	.096	.046	.115
	Achievement	.388**	.364*	.347	.358*
	Reliability	.311**	.245*	.298	.381**
	Thrift	.229	.294	.370**	.328*
	Obedience	-.035	.011	.216**	-.071
	Justice	.139*	.125	.037	.122
	Exactitude	.223**	.158*	.115	.196**
Primary capacities	Patience	.158*	.126	.140*	.159*
	Time	.164**	.273**	.252**	.242**
	Contact	.483**	.474**	.341**	.439**
	Trust	.423**	.432**	.368**	.451**
	Hope	.514**	.507**	.387**	.533**
	Sexuality	.250**	.335**	.283**	.330**
	Love	.420**	.385**	.443**	.419**
	Faith	.201	.259	.325**	.264

Note: **. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed).

It is interesting to note that all three components of hardiness (commitment, control and challenge) have correlations to primary capabilities as contact, trust, hope and love. This means that emotions take the first

place and they are very important for the development of hardiness. This can be explained by the fact that, in essence, primary capacities refer to life experience that was acquired in connection with secondary capacities. So, the development of hardiness through positive psychotherapy will mean that the person can increase acceptance and understanding of himself.

We used regression analysis to determine the prognostic indicators for hardiness. Table 2 presents the calculation of results for hardiness predictors.

Table 2.

Prognostic model of hardiness

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	,654 ^a	,527	,410	12,9694

Note: Predictors: (const) love, reliability, contact, achievement, hope, trust.

Dependent variable: hardiness

As we see, the primary capacity of love is in the first place in the formation of hardiness. Basic settings are formed on the basis of primary capacities and we need to pay attention because they are the basis of human screening and the development of hardiness. Thus, the predictors that have a positive impact on hardiness are primary and secondary capacities: reliability, contact, achievement, hope, trust.

Actual capabilities are the main tool for work in Positive Psychotherapy, because they are the content of the conflict, and they are the kind of value norms that help us build hardiness.

Conclusions

This study represents one of the first attempts to examine the role of actual capabilities (primary and secondary capacities) with hardiness. This result confirms the definition of hardiness as an individual resource that can be enhanced when people develop their capacities through Positive psychotherapy.

The Wiesbaden Inventory for Positive Psychotherapy and Family Therapy is an original tool for the study of personality traits, primary and Secondary Capacities. Using this Inventory we studied an impact of personal capabilities on the development of hardiness.

In our study, we found that such components of hardiness as commitment, control and challenge

involve personal capabilities in interaction with the parameters of an existentially difficult situation.

As actual capabilities are the content of upbringing, they are formed in individuals in accordance with the needs of society. They are socialization variables, so some abilities prevail over others. This was demonstrated in our study. A person forms and develops his/her abilities depending on the micro and macro society. As a result, our sample is characterized by the following indicators. The strongest correlations were found between the hardiness and primary capacities: contact, trust, hope, and love and secondary capacities: achievement and reliability. We also demonstrated, that primary and secondary capacities as predictors have a positive impact on hardiness. The primary capacity of love is in the first place of hardiness' predictors. Depending on the physical condition, environment and time in which a person lives, these abilities are differentiated and form an unchangeable structure of essential traits. These abilities are constantly featured in everyday life in various situations.

The primary abilities ensure the development of viability as internal resources of the individual. Depending on the physical condition, environment and time in which a person lives, these capabilities are differentiated and affect the formation of hardiness.

Our research has confirmed that PPT helps individuals better understand the skills and abilities they have, and ones they might need to develop, to achieve a greater sense of inner balance, which is important for the formation and development of hardiness.

As the aim of the research was to investigate the importance of primary and secondary capacities as actual capabilities in the formation of a person's hardiness, so we did not set differences between primary and secondary capacities in this process. But this is in the plans for future research. Also, the further research should use a longitudinal research plan that will unequivocally prove that the development of actual abilities can consistently influence people's resilience, which, as a result, will be reflected in their general state of both physical and mental health.

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FRUSTRATION REACTIONS SPECTRUM DURING THE CRISIS OF PUBERTY

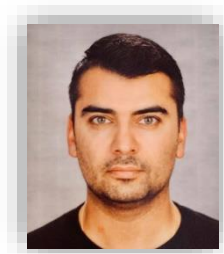


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Abstract

In every sphere of life, whether it is education, academic or personal, adolescents feel lots of obstacles on the way to their goals in life. Sometimes they are able to deal with them rationally but sometimes they deal with them emotionally. If they are incapable of dealing with these obstacles, they become frustrated. To cope with frustration, the adolescents need time to develop their social and emotional skills. This means that they should have flexibility, optimistic thoughts and skills to control impulses. The present study will examine the reactions of adolescents in situations of frustration and the general level of aggressive tendencies, as well as the presence of a link between reactions of frustration and aggressive behavior. During the period of 2018-2020 we have consulted with 212 adolescents and their parents in our practice. Informed agreement for inclusion in the study of the characteristics and dynamics of reactions in situations of frustration was obtained from the parents of 109 adolescents, who were all male - 57 (52.3%) aged 12-14 years and 52 (47.7%) aged 15-17 years. The results showed that the adolescents are focused on their inner world and believe that the world should be what they want it to be. They lack enough experience to judge and accept opinions that differ from their own. They try to hide the uncertainty in their abilities and skills, relying on protective mechanisms.

Keywords: frustration, adolescents, aggression, crisis, Positive Psychotherapy

Introduction

During one's individual development, one goes through different periods. Through each of them one faces the solution of various "psychological tasks", which require a certain resource in order to pass

"successfully". If this happens, the individual resolves the corresponding crisis, "accumulates" new "psychological experience" and moves to a higher level of personal functioning. Adequate role models and new coping strategies are being developed (Boncheva, 2013). In each normative crisis there are: objective

factors, most often changes coming from the environment or physiological processes and a subjective factor - deficit, ways of surviving and resolving the crisis.

Puberty is rightly called a crisis. During this period there are significant changes in the formation of personality, which lead to a radical change in the behavior, interests and attitudes of adolescents.

During the crisis of puberty, one of the most complex and controversial stages of every person's life begins and ends. L.S. Vygotsky (1984) identifies three phases during the crisis of puberty:

- Negative phase (pre-crisis) – Starts around the 10th - 11th year. The value system begins to rearrange themselves, stereotypes are broken. Problems begin in the relationship between parents and children.
- Real crisis - 12 - 14/13 - 15 years. This phase can go through several different ways: from expressed negativism towards all spheres of life, to a smooth transition to mastering new skills. The field of interests and way of thinking expands, new opportunities appear. The adolescent defends his individuality and struggles to separate from his parents.
- Positive phase (post-crisis). It marks the end of the crisis, a rather calm period, characterized by an already-expanded horizon (prognostic thinking), a changed worldview, formed life values and a certain further path of development.

Intense physical and physiological development causes adolescents to look at themselves differently. According to I. Boncheva (2013, p. 102), “while in earlier ages their main task was to adapt to the world outside of them, now the conscious attempt to adapt the world to their increased personal needs begins. The main conflict is the struggle between the relatively low level of psychosocial maturation and the increased need for sexual identity”. And if in the beginning the challenges that the adolescents face are the changes that the body undergoes, then the next, much more complex challenge is how to build their social relations in a new way (figures 1, 2, 3, 4).

Body

Beginning of puberty, the appearance of secondary sexual characteristics, rapid growth and change in the body, sudden changes in mood, accompanied by a feeling of influx of strength and energy to helplessness.

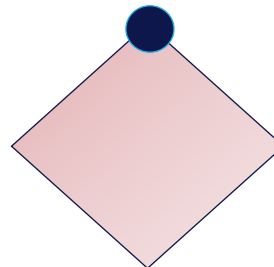


Fig. 1. Body

Achievement

Deficiencies: Loss of interest in previous/old activities, decreased productivity of cognitive functions and reduced performance. Striving to prove their uniqueness by any means, incl. problematic behavior and rejection of norms

Resources: Differentiated attitude towards the learning content, expanded volume and selectivity of knowledge, preferences and abilities. Development of volitional qualities: from the basic dynamic - strength, speed and speed of reaction, through qualitative - the ability to withstand greater and longer load - endurance, perseverance, patience, to complex and differentiated volitional qualities - concentration, consistency, concentration and perseverance.

The need for self-determination gives impetus to increased cognitive and creative activity - curiosity, experimenting with different activities, participation in different clubs and schools

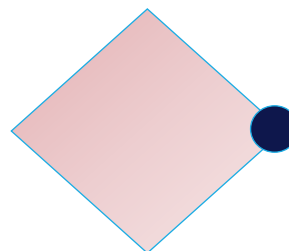


Fig. 2. Achievement

Contact

Deficiencies: Stubbornness, rudeness, disobedience, arbitrariness, devaluation, ignoring and / or sharp opposition to the authority of the adult. Frequent mood swings – from irritability, "explosiveness", aggression and negativism, to tearfulness, indifference, indifference and apathy. The relationship with the adults is strongly conflictual, with an active pursuit of separation, expressed in disregard for norms, contesting rules, rejecting and not respecting restrictions, rebellion against sanctions.

Resources: Expansion of communication skills, formation and development of organizational skills, business skills, entrepreneurship, discipline, responsibility, expanding the range of strategies for dealing with conflict situations.

Contrary to the content of contact with adults, the desire for contact with peers develops - the circle of friends is the place to learn new models and practice them. In the group of friends, everyone experiences and shares the same thing. Reflection.

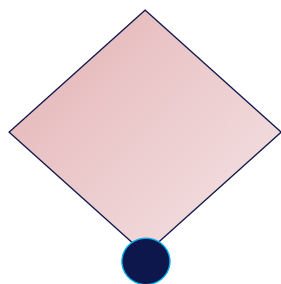


Fig. 3. Contact

Future / meaning

Deficiencies: Feeling a lack of meaning in life, fear of the future, insecurity, helplessness, hopelessness. Strong internal contradictions between desire and possibilities.

Resources: Broadening the horizons and enriching and restructuring the system of values - in the field of communication - selective attitude and evaluation of others, and self-esteem.

During the "crisis of puberty", the susceptibility of adolescents to frustration is very strong. Young people are faced with many challenges, on the one hand there is the flourishing of creative, cognitive and intellectual abilities, and logical approaches to solving problem

situations, and on the other hand, the period is characterized by emotional instability, stressful and frustrating situations related to difficulties with psychological growth.

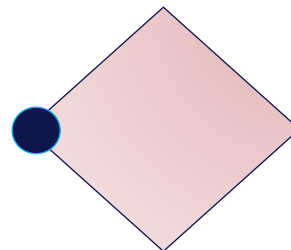


Fig. 4. Future/meaning

The key to growing with minimal emotional damage is the formation of psychological resilience of young people, based on confidence in their own strengths and skills, ability to accept and cope with challenges, flexibility in approaches to solving problems and overcoming difficult situations. In other words, it is a matter of forming tolerance against frustration.

Frustration tolerance is defined as psychological resilience to a frustrator, which is based on the ability to adequately assess the frustrating situation and predict a way out of it (L. S. Aseikina, 2005).

J. Wilde (2012) identifies some contradictory traits of adolescence that influence the formation of frustrating tolerance:

- Young people are focused on their inner world and believe that the world should be what they want it to be.
- They lack enough experience to judge and accept opinions that differ from their own.
- They try to hide the uncertainty in their abilities and skills, relying on protective mechanisms.
- Adolescence is a period of high sensitivity and frequent mood swings.

They show a tendency to quickly orient themselves to how it "should be" and not how it really is.

Methodology

2.1. Participants

During the period of 2018-2020, we consulted with 212 adolescents and their parents in our practice.

Informed agreement for inclusion in the study of the characteristics and dynamics of reactions in situations of frustration was obtained from the parents of 109 adolescents, all male - 57 (52.3%) aged 12-14 years and 52 (47.7%) aged 15-17 years.

Aim of the study: To study the reactions of adolescents in situations of frustration and the general level of aggressive tendencies, as well as the presence of a link between reactions of frustration and aggressive behavior.

2.2. Instruments

Primary psychotherapeutic interview – 5-steps model of Method of Positive and Transcultural Psychotherapy (Peseschkian H., 2000).

Rosenzweig Picture Frustration test (Rosenzweig S., 1945; Bulgarian standardization K. Мечков, 1979). A projective test, designed to measure characteristic modes of responding to frustration, in which the respondent is presented with 24 cartoon drawings, each depicting one person saying something frustrating to the other, the second person being shown with a blank speech bubble. The respondent's task is to fill in each of the 24 blank speech bubbles with the first response that comes to mind. The score is based on nine factors, derived from combinations of three types of aggression (obstacle-dominance, ego-defense, and need-persistence) and three directions of aggression (extraggression, imaggression, and intraggression).

Aggression questionnaire (Buss and Perry, 1992). The Buss–Perry Aggression Questionnaire (BP-AQ) is a 29-item, four-factor instrument that measures physical aggression, verbal aggression, anger, and hostility.

Results

During the first psychotherapeutic interview shared information with the parents, the conflict content was found:

- High anxiety (*"Things in contact with my/our son depend on me, I can't handle it - I'm helpless and that's a problem!"*) - in 60.5% of the parents, with a minimal difference in age - 31.2% for parents of young adolescents (12-14 years) and 29.3% for parents of adolescents (15-18 years).

- Disappointment, dissatisfaction, discouragement (*"I/we can't do it; We are supposed to be good parents, but it doesn't work! I don't understand what's going on!"*) is the experiences of 82.5% of parents, more for parents of young adolescents - 47.7 %, for parents of adolescents this is 34.8%.

- Outrage, irritation, accusations (*"He/she is not what we expected!; "He/she behaves childishly and none of our efforts work!"*) showed 63.3% of the parents, respectively 22.1% of those of young adolescents and 41.3% from the parents of the examined adolescents.

- Insult, aggression (*"I/we give him / her everything that a good parent is supposed to and we expect to get good behavior !;" He/she tries to overcome with his/her behavior, but it will not happen - with punishments and restrictions we will "cure" his/her stubbornness!"*) is observed in 38.6% of parents - less in young adolescents (15, 5%) and about 8% more in parents of older adolescents (22.9%).

On the opposite side are the experiences of young adolescents and older adolescents. The content of the problems they share could be conditionally divided into several main groups: Relationships with adults; peer relationships; problems at school; dissatisfaction with oneself and dissatisfaction with others (table 1):

Table 1.

Problems through the perspective of young adolescents and adolescents.

Problems	Age group 12 – 14-years old	Age group 15 – 17-years old
Relationships with adults (parents and significant adults)	Conflicts with parents: "They forbid me to go out!"; "They don't like my friends and we have fights over them!"; "They threaten me with punishment!"; "They constantly scold me and insult me!" "They accuse me of being disobedient, lazy and	Conflicts with parents: "They only demand and oblige!" "They don't understand me!"; "They argue with me and limit me"; They are always dissatisfied - with my style, with the music I listen to, with my friends ..., with

	irresponsible!"; "They want things to happen just their way - They don't understand me!"; "I have no right to want or to do anything – because I am young!"; "They don't buy what I want, but what they have decided!"; "They don't love me!"	myself! "" They accuse me of being lazy and irresponsible! "" According to them, I'm not good for anything if I don't do it the way they want it! "; "I have no say!"; "They don't believe me!"
Relationships with peers	Rejection, isolation, harassment, aggression, ridicule	Complex relationships with peers - betrayal, treason, rejection, harassment, aggression. Unrequited love.
Problems at school	Lack of interest and resistance - "My parents chose the school, let them study!"; bad grades - "They deliberately give me bad grades!"; punishments; Rebellion against the rules: "The rules are designed to be broken!"	Lack of interest, boredom; problems with teachers, injustice in assessment, a lot of requirements, a lot of homework, heavy workload; not understanding, not accepting, forcibly imposing "dumb" rules.
Dissatisfaction with themselves	Body; appearance; abilities	Irritability, resentment, anger towards oneself: "Everything is out of control!"; "Everything slips away from me!" "I'm not good for anything!"
Dissatisfaction with others	Others are evil, dissatisfied, vindictive, hate me, insult me and gossip.	"They're always outraged, they annoy me, I'm disappointed, they're not fair."

To track the age specifics of frustration reactions in young adolescents and older adolescents, we used the Rosenzweig Picture - Frustration Test.

The reliability of the results (Cronbach's Alpha) - 0.77 in the age group 12 - 14 years and 0.86 in the age group 15 - 17 years.

Both groups showed the highest values in external accusatory reactions as a way to deal with frustration

(category "E"). With regard to the object to which the reaction is directed, the highest values are observed in the reactions fixed to self-defense (category "ED"). (Table 3).

Compared to the normative range (K. Mechkov, 1979) the reactions of both groups are normal (Code 3).

Table 3.

Values of the mean values in both groups

Age		E	I	M	OD	ED	NP
12 – 14 years	Mean	11,17	4,833	7,684	5,99	10,92	6,77
	N	57	57	57	57	57	57
	Std. Deviation	3,853	1,9419	2,9725	2,304	2,904	2,591
15 – 17 years	Mean	9,53	5,442	8,683	4,27	11,88	7,51
	N	52	52	52	52	52	52
	Std. Deviation	3,884	2,1343	2,6972	1,708	2,646	2,500

Significant differences between the two groups were found in Rosenzweig's *Picture Frustration test* In 61.3% of 12 - 14 year olds (compared to 38.7% of 15 - 17 year olds), anxiety, tendency to rely on rigid stereotypes of activity and inability to assess the situation are found. Adolescents fixate on the conflict as an event / obstacle (factor E – extrapunitive responses) and through vulnerability, a desire to impose themselves and "have a say" try to attract

attention to themselves. Not without significance are the other participants in the frustrating situation, 58.0% of young adolescents, compared to 42.0% of older adolescents tend to react with acute rejection of what is happening, a desire to subordinate reality to their needs, striving for dominance and intolerance to "Foreign will" (factor E - extrapunitive responses). The other factor with a greater emphasis on young adolescents is the impulsive response to circumstances

(factor M – impunitive responses), respectively 61.1% of 12-14 year olds react with carelessness, frivolity, irresponsibility and / or underestimate the situation. Such behavior is subject to emotional breakdowns, and frequent change of values and asthenic states.

In the characteristic of frustration reactions in adolescents (15-17 years) compared to young adolescents (12-14 years) with a strong statistical significance (60, 1% in adolescents, compared to 39.9% in adolescents) proved factor "e", which on the one hand is an indicator of claims and expectations towards the other in order to remove frustration, on the other hand means activity, tendency to delegate responsibility and leadership. In the young people we examined, the factor "e" shows significance in combination with the factors:

- "I" (intropunitive responses) – a sign of self-criticism, focus on one's own inferiority, sense of guilt, remorse, sometimes self-blame and self-discreditation with the characteristic behavior of politeness and irrational conformism.
- "M" (impunitive responses) – tendency to be indifferent in situations of frustration, devaluation or demonstrated indifference, which is probably the selective use of psychological defence "reaction's formation" in order to deal with the fear of new frustration or to contain a repressed aggressive impulse built in the adolescent's perceptions of subjective unacceptability of aggressive behavior - 53.7% in young adolescents, compared to 46.3% in older adolescents).

Table 4.

Significance of the differences in the two groups by factors of the Rosenzweig P -F Study

	E'	E	e	I	M'	M
Mann-Whitney U test	1028,5	1105,0	740,5	957,0	1030,5	740,5
Wilcoxon W	2406,5	2483,0	2393,5	2610,0	2408,5	2393,5
Z	2,770	2,293	4,527	3,21	2,762	4,527
Asymp. Sig. (2-tailed)	,006	,002	,001	,001	,006	,001

Buss and Perry Aggression Questionnaire (AQ)
Results:

The questionnaire reliability (Cronbach's Alpha) for the individual subscales varies between 0.73 and 0.79, reaching 0.77 for the overall score of aggression.

The average values of the studied variables are higher in the group of adolescents, and significant differences between the two groups are found in all components of aggression, except for the scale "Hostility". (Tab. 5 and Tab. 6).

Table 5.

Average value for the components of aggression

Age		OA	FA	VA	A	H
12 – 14 years	Mean	98,74	34,49	22,77	22,89	18,84
	N	57	57	57	57	57
	Std. Deviation	13,915	6,596	6,921	5,554	3,895
15 – 17 years	Mean	76,17	23,52	20,46	16,50	15,69
	N	52	52	52	52	52
	Std. Deviation	12,269	6,210	5,465	3,739	3,644

Table 6.

Significant differences between groups on scales of aggression

	OA	FA	VA	A	H
Mann-Whitney U test	337,0	362,5	803,0	518,5	1184,5
Wilcoxon W	1715,0	1740,5	2181,0	1896,5	2562,5
Z	-6,948	-6,797	-4,132	-5,855	-1,808
Asymp. Sig. (2-tailed)	,001	,001	,001	,001	,071

2-14 year olds show a willingness to use these two forms of aggression to achieve their own. Young adolescents openly show their irritability, dissatisfaction, anger and irritability. Still limited cognitive abilities affect the meaning of behavior, and the lack of tolerance in achieving the desired and the strength of the impulse that guides the actions of adolescents gives aggression a more protective character. Limited self-control and the emerging self-esteem, expressed mainly in sensitivity to negative evaluation and the accompanying emotions and experiences, predispose to aggressive actions.

The low values in both groups on the scale "Hostility" are an indicator that the actions of young adolescents and older adolescents are not determined by prolonged and persistent negative attitudes towards the surrounding reality (people and events), but rather are the result of an emotional state of a provocative nature, such as anger.

By definition, hostility is an antagonistic attitude towards people, which includes a cognitive, affective and behavioral component. The affective component is represented by a number of interconnected emotions such as: anger, irritation, resentment, disgust, contempt and others. The cognitive component contains negative beliefs about the world and others - mistrust, suspicion, contempt, prejudice and cynicism, The behavioral component includes a diverse repertoire of actions, most often hidden - passive-aggressive actions, unwillingness to cooperate and compromise, avoid contact (communication), cold attitude towards others, etc. (Barrett et al., 2007).

Passive - aggressive behavior is, perhaps the worst way to show anger - as opposed to the open and spontaneous way, to strongly relieve the tension that usually follows the trajectory: dissatisfaction - irritation - anger - rage. The adolescents and the young adults are not yet able to understand their insidious and destructive ability, and they do not realize that their resistance and perseverance prevent the imprisoned anger from being released. Examples of such behavior are: procrastination, stubbornness, suspicion, resentment, anger, deliberate "inability" to make the expected or repeated failure to perform the required tasks. On a conscious level, the young man believes that in this rank he defends himself and "lets them understand." On an unconscious level, such behavior is

aimed at infuriating and / or upsetting authorities (parents, teachers, educators).

"There is no smoke without fire!" - what is the spark that ignites the aggressive behavior of a growing person?

Discussion

The summarized information from the primary psychotherapeutic interview shows that in order to establish himself in his new social position, the young man tries to go beyond his current style of contacts. His efforts are focused on finding ways to realize his "growing" opportunities, the pursuit of autonomy and independence (experienced as freedom), to develop his individuality and to receive recognition from adults, whose model he repeats, and to whom he wants to show his readiness to take a place in the "world of the great."

The sphere of communication with peers is very emotionally charged. And if in the second normative crisis (of the first grader) the successful outcome is the good contact with just one person – "My friend! Peace in the group" (I. Bontcheva, p.101), then in the crisis of puberty the leading motive in the behavior of the young man is to consolidate his place and to establish himself in the group of peers. Friendship during the period is complex and controversial, and friends are a source of social and emotional significance. The assessment that he expects and receives from his peers acquires paramount importance and displaces from the adolescent's field of vision the relationship with the significant adult, but the content of the contact retains its strong emotional charge. The inner struggle of the growing person is, on the one hand, a strong desire for autonomy, independence and freedom, and on the other hand the need to feel and receive love, patience, attention, trust and time (primary capabilities) to feel secure and stable and to experience himself as significant and valuable.

This is where the "cornerstone" in the contact between parents and young/older adolescents is found. Shared problems show where the discrepancy is - parents have **expectations** for success, achievement, order, accuracy, courtesy, discipline, responsibility (secondary capabilities), and the young adolescent and adolescents have **needs** for support, help, cooperation and partnership. Parents demand and blame, and / or helplessly withdraw from active contact with their

children, while adolescents either protest violently or remain grimly silent and act in their own way.

Unmet needs cause frustration. The rapid pace of physical and cognitive development leads to the formation of new needs, and the narrowed psychological horizon of "Here and now!" determines the framework in which the adolescent insists on getting what he wants.

Based on the psychological features of the crisis during puberty, it is evident that adolescents, due to their vulnerability and not-strengthened self-image, choose demonstrative behavior - from open aggression, active-offensive position, striving for dominance and intolerance to requirements, to impulsiveness and poorly judged action decisions. Successful self-defense in their experience is the activity through accusations, demands / expectations of the other to take responsibility for what is happening, rejecting and denying their own guilt and / or participation trying to "equalize forces".

The comparative analysis allowed the demonstration of the characteristics of the frustrating reactions of young adolescents and older adolescents in the field of motivational needs: *destruction of the authority of the adults, orientation towards affirmation in the peer group, need for self-affirmation, self-expression, defending one's own position, gaining recognition from the others, need of autonomy and independence*. In terms of the emotional sphere and behavior: *irritation, resentment, anger, suspicion vulnerability, frustration, impulsivity, resistance, desire to resolve this situation oneself, stubbornness, disobedience and fighting, ego-protective behavior and demonstrativeness*.

Taking into account the age characteristics, it can be said that in general the reactions of frustration are normal, but non-constructive frustration reactions prevail, which are the probable barrier that creates another reality in young people and determines their reactions and experiences - resentment, suspicion, isolation and aggression. In general, in both groups the ego-protective type of reactions dominates, followed by the reactions fixed to the satisfaction of needs, and the influence of the obstacle is the weakest.

The adolescents sends messages to his parents through his behavior, sometimes in the form of unpleasant, aggressive attacks, outbursts of anger, and / or oppositional behavior. Parents need to respond to the message hidden in the behavior, not the way it is

conveyed. In many cases, adolescent anger is an attempt (sometimes consciously, more often not) to declare that some basic needs have not been met or have been unfairly ignored.

Young people are filled with indignation and anger when they feel they do not receive:

- **Respect** - Adolescents may be outraged because in talking to their parents they feel that their parents think they do not deserve respect. They are often considered more capable than their parents are willing to admit.
- **Space** - they need physical and emotional space for curiosity and experimentation and expect their parents to provide it. A space in which to explore life, themselves, without obeying parental rules, guidelines and imposed images. They need space to form their own self-image.
- **Recognition** - entering the lives of adults, adolescents do not yet have life experience. They experience for the first time what their parents have experienced many times. This makes it difficult for parents to understand the severity of their reactions to situations that seem common. This misunderstanding leads to conflicts: the parent does not recognize their emotions as appropriate to the situation, and young people simply have not yet learned to respond to the fluctuations (rise and fall) of life in the way the parent already knows how. It is good for the parent to remember that the growing person is still learning to live in a difficult period, and it is very important for him to know that his parents recognize and accept the reality and adequacy of his experiences.

Conclusions

1. In general, in both groups the ego-protective type of reactions dominates, followed by the reactions fixed to the satisfaction of needs.
2. In the group of 12 - 14 year-olds, anxiety, the tendency to rely on rigid stereotypes of activity and the inability to assess the situation are found. Young adolescents fixate on the conflict as an event / obstacle and through vulnerability, a desire to impose themselves and "have a say", they try to attract attention to themselves. Young adolescents tend to react with acute rejection of what is happening, a

desire to subordinate reality to their needs, striving for dominance and intolerance to "Foreign will"

3. In the characteristic of frustration reactions in adolescents (15-17 years) with a strong statistical significance proved factor "e", which on the one hand is an indicator of claims and expectations towards the other in order to remove frustration, on the other hand, this means activity, the tendency to delegate responsibility and leadership.
4. Young people are focused on their inner world and believe that the world should be what they want it to be. They lack enough experience to judge and accept opinions that differ from their own. They try to hide the uncertainty in their abilities and skills, relying on protective mechanisms.
5. The crisis of puberty is characterized by the fact that the adolescent acquires new opportunities and strengths that were previously absent or were a process of development. Moving to a higher stage of development, the young person feels that he already has much more strength, independence and will to solve the problems that until recently were solved by adults.

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THE ABILITY TO AUTHENTIC PRESENCE OF THE THERAPIST AS A METHOD OF QUALITY FOLLOW UP THE EFFECTIVENESS OF PSYCHOTHERAPY



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Abstract

There are disputes and a large number of methods that claim to measure efficacy in psychotherapy. Most studies focus on the personality and skills of the therapist, fewer which examine the process of psychotherapy and how interconnections between the therapist and the client change this process. In this study we present a method of assessing the authenticity and the level of communication inspired by the theory of Budgatal (Budgendhal), examining the authenticity of the client's contact after each session, together with two therapist-related factors: expression and openness (Reflectiveness according to Peseschkian). In the semantics of positive psychotherapy, these are the abilities of the therapist, the ability of openness, emotional expression, and so on. The results are determined through the correlation analysis of the authentic presence and communication scale (Alpha of Cronbach Alfa 0.6) which presents the correlation relationship between abilities of Expression and accessibility of the therapist and the level of authenticity in the therapeutic sharing of the client. The results show that there is a statistically significant positive correlation (Spearman's Correlation .748 and .511, $p=0,01$) between the ability of openness and high levels of authenticity in therapeutic communication and a negative correlation with the emotional expression of the therapist. In conclusion, we can say that the level of authenticity in therapeutic communication depends on the ability of openness (frankness according to Peseschkian) and needs the opposite of expressiveness, namely the introverted function of the emotion capable of "the contents of the other's experiences, without taking space with excessive expression of their emotions.

Keywords: effectiveness, authentic presence, Positive Psychotherapy

Introduction

If we track the development of research methods in psychotherapy, three major dimensions stand out, representing research interest, efficacy, efficiency and the research proces. Psychotherapeutic communication is qualitatively different from communication outside the therapy room but what is contained in this concept is a common, complex issue. Due to our insufficient knowledge of the mechanisms of psychotherapy, the relationship between the

theoretical concepts of the model and the actual behaviour of the psychotherapist conducting psychotherapy is still not understood. Studies in psychotherapy show that the therapist's profile and knowledge are what determines the effect of psychotherapy, rather than the therapist's training and the school to which it belongs. In this sense, to avoid asking psychotherapy to justify scientific concepts about its action, it is possible if the focus is on speculative structures but the principle of activity, in the different environmental and different profile of

patients. The parameters are optimally objectified according to The behaviour in the course of communication of patients as, in the conditions of a particular social group, personal qualities exist in the form of phenomena of interpersonal relations.

Empirical studies of psychotherapy are increasingly requiring differentiated objectivization of patients, the role of the personality of the therapist and process levels. The latter is recognized as particularly important as pure pre-measurements, i. Studies of patient parameters before and after treatment, as well as any one-dimensional studies of the physician's and patient's parameters, are insufficiently reliable. With no data on the psychotherapy process, it remains inaccurate and the specifics of the model cannot be understood (Beebe, 1998). That is why the different types of psychotherapy based on pre-measurements can give similar results (Berríos & Lucca, 2006).

The transition from the preliminary measurements of efficacy to diagnose the psychotherapeutic process at the level of the dual quality units - the exact specification of the psychotherapeutic procedure, the study of individual interventions from psychotherapist and patient responses to them - is seen as a major achievement in evaluating research (Chattor & Krupnick 2001, Del Prette, Zap, & Del Prette 2008, Elliot, Shapiro, Firth-Cozens, Stiles, Hardy, Lewelin et al., 1994). The specifications for the procedure also contribute significantly to the objective of the mechanism and complex psychotherapeutic approaches.

Reaching objective psychotherapeutic goals, such as adaptation and mitigation of symptoms, can only be focused on process subjectivity. The inability of the patient to show a complete presence is the most obvious, effective way to avoids importing his/her subjectivity into group therapy work. The inexperienced and unskilled therapist, according to Bugental, 1990, may not notice that during the sharing of facts, contents and symptoms,, the patient has avoided presenting him/herself as a complete person in the process of therapy. (Peseschkian & Remmers, 2020) In this situation, even the most significant therapeutic interpretations risk the abstract therapeutic communication, intellectual accumulation of volume of new knowledge but without authenticity

and ultimately without a true therapeutic Process, which yields almost no psychotherapeutic benefit. Therefore, a study of levels of "presence", the degree of authentic communication, as the role of the therapist is by showing expressiveness and transparency, to help the group reach a more in-depth level of "presence". The simple transmission of information is not psychotherapy, Bugental, *The Art of Psychotherapy*, 1990), as a result, the patient knows a lot about him/herself, but almost does not achieve sustainable changes in the most important area of his/her relationship with others. Presence, expressiveness, authenticity are incompatible with the psychoanalytic principles of the therapist as an interpreter, side observer and critic. The effect of psychotherapy depends very much on what level of presence in the patient.

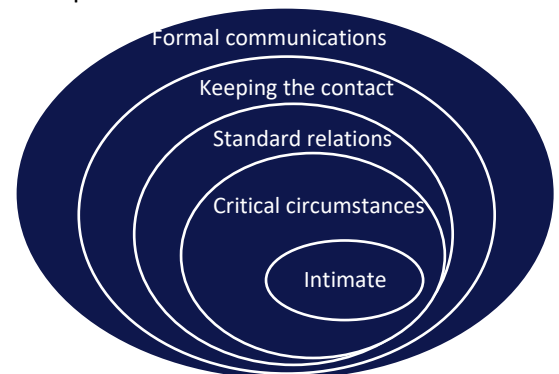


Fig.1 Five degrees of authentic presence and levels of communication on the Budget

1. Formal communication
2. Keeping the contact
3. Standard relations
4. Critical Circumstances
5. Intimacy

Each item is estimated at a 5-point-scale, the group indicators are compared to the factors:

- Expression of therapist
- Accessibility of the therapist - ability to open

The levels of communication or as it calls them a "presence" budget, are related to the abilities of authentic accessibility and adequate expression of the therapist. The main hypothesis of the study is related to the assumption that the accessibility and expression of the therapist are associated with the degrees of the authentic presence of patients during the group process (Bugental, 1965).

The first level is a level of formal communication. When coming to a new person in the group who has no psychotherapeutic experience, he/she is inclined to use customs adapted from his/her culture of communication. Such behaviour we use in communicating with authority. Formal communication focuses on the objective characteristics of people. A key sign of formal communication is that accessibility and expression are restrained to limit human involvement in communication with the other and are a type of resistance. The patient holds everything under control until he has assured the security of the middle. This control is focused on his image. As a result, the speeches are more objective, superficial and banal, above all impersonal. Spontaneity is minimal and practically absent (Budjental, 1990).

The second level is the level of maintenance of the socket. Some patients can miss this level and pass straight on to level 3, standard relationships, but others, especially in stationary conditions, need an intermediate stage. They may look allocated***, ready to share but often restrained. Communication is in the form of superior participation, sharing contains only facts. At this level of communication, there is a lot of factual information, and the psychotherapist observed emotional responses and signalling readiness to pass on to a deeper level of communication. The therapist directs the discussion to such topics having psychotherapeutic importance (Budjental, 1990).

The third level is the level of a stood talk, as "standard" is used in the sense of common, expected. Psychotherapeutic communication, in the most effective part there is little dependence on standard, customary conditions. This is a transitional moment, between the care of the image and internal experiences. Sincere but limited personality inclusion. As a rule, such communication does not contain a conflict (Budjental, 1990).

The fourth level, called "critical circumstances", under which it is significant, meaningful to man, having a crucial meaning. Talk at this level leads to prolonged changes in the thoughts, feelings, words and actions of one or more of the participants. Typical for this level are the strong up-to-date emotions, not so many memories of them. A sign of profound input is the sincere descriptions of the past and current internal experiences and issues that the patient is experiencing. The patient is more disturbed by its internal experiences than the external circumstances as they

seem to others, social desirability is reduced at the expense of sincerity. The experiences become more immediate. The patient begins to use more adjective names, adverbs, in his experience to transmit the quality of his experiences. Slug, exclamation, obscene words. The posture becomes more relaxed and unprotective, with the body language corresponding to the feelings. Here we have a strong expression and limited accessibility (that is, the man is swallowed by his experiences and is not so accessible to understand it).

The fifth level is an intimacy level. The word has been cleared by its meaning of sexual proximity. Means intensity and emotional proximity, suggests sharing personal, secret experiences. Maximum accessibility and expression, crying, laughter, deep fear, enthusiasm, suffering from conscious loneliness and despair, rising anger. The subjective existence of the client is energetically involved in the process of inland awareness. (Budjental, 1990)

Objective of the study: a positive and significant correlation is expected between the ability of a therapist for openness and expression and the two high levels of authenticity of therapeutic contact - "critical circumstances" and "intimacy" and low or negative in the other three levels of authenticity. It is assumed that the more open and expressive the therapist is, the more likely the client is to reach the "intimate" level of sharing.

Methodology

This study describes data for 30 participants, all adolescents. ($X = 6.16$, $SD = 3.06$). The following clinical methods were used: observation, psychotherapy sessions with adolescents with methods of the PPT, inpatient and ambulatory. Statistical methods include data processing with the SPSS program. For data analysis, there were used descriptive statistics, correlation analysis, a frequency distribution of data and reliability statistic.

Results

The results were processed with the statistical program SPSS 19. The standard methods for this type of data presentation were used - descriptive statistics, correlation analysis. The research includes 30 sessions of psychotherapy. 18 women and 12 men.

Table 1

Description of the sample

	N	Mean	Std. Deviation
Formal	30	1.7000	.70221
Contact	30	2.0667	.86834
Standard	30	2.7000	1.26355
Critical	30	2.8000	1.15669
Intimate	30	4.2333	.67891
Accessibility	30	4.0333	.71840
Expressiveness	30	4.3667	.55605
Valid N (listwise)	30		

Table 2

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.626	.635	30

Correlation analysis

Correlations between the therapist related factors (Expression of therapist Accessibility of the therapist) and the level of authenticity of therapeutic communication.

Table 3

Correlation analysis

		Formal	Contact	Standard	Critical	Intimate
Accessibility	Spearman's correlation	.031	-.436	.271*	.748**	.511**
	Sig. (2-tailed)	.871	.016	.147	.000	.004
	N	30	30	30	30	30
Expressiveness	Spearman's correlation	-.271	-.062	-.054	-.312	.283
	Sig. (2-tailed)	.746	.763	.757	.093	.129
	N	30	30	30	30	30

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

It is seen from the table that the openness or ability to honesty the therapist correlates significantly positive with the two most important levels of authenticity of therapeutic communication (.748 and .511).

The expression of the therapist have low correlates with all the rocks and low and insignificant with the highest level of authenticity 5-intimacy.

The objective of the study was set in the correlational study of the study was not fully confirmed. The expected positive correlation between the therapist openness and the critical level of authenticity of therapeutic contact and customer sharing is confirmed. This means that the theories of the distant, passive and wrapped psychotherapist are not justified, it is the openness that is the ability to self-disassemble, accessibility, trust to the client is the basis for creating a safe and secure space in which the level of Authenticity of therapeutic sharing which allows them to get to intimacy and intimate moments. What is interesting is the result of interconnections between the emotional expressiveness of the therapist and the reported negative correlation with most levels of sharing except with the intimacy, but it is negligible. An analysis of this result is important in terms of balance between openness and expression, the expressive therapist occupies more space in the consulting room,

but at the same time, does not predispose to low levels of authenticity, but also supports intimacy. This can be explained by the fact that the fifth level of authenticity, as Bugental describes it, is a client closure, sinking into experiences whose power requires a calm, open but not so expensive therapist who will be able to "contain the" anxiety of the client. Probably empathy to a client whose sharing is intimate, requires more concentration, calm silence and non-verbal support that is not highly emotionally coloured.

The negative correlation between the accessibility of the therapist and the contact level of communication is an unanticipated result. In practice, contact level 2 is when the client uses words to hide the real emotions, the level when the client talks and talks but has not said important things. In the early sessions, some clients talk a lot out of fear or fear of rejection from the therapist. When accessibility is emphasized, when the therapist is sincere and open, the time of the second level in therapy is reduced, the words become less, but more authentic.

In Positive Psychotherapy (Peseschkian, & Remmers, 2020) the primary abilities to which they relate both the openness (frankness) and the expression of emotion are related to the emotional capacity of the therapist.

Thus, their relationship with the level of authenticity of therapeutic contact are not surprising.

In Jung's understanding of the personality typology (Jung, 2020), the extravagant emotion (expressiveness) is more directed out, to show, to say, to say itself similar to the actors game while the other, introverted emotion function (the opposite of expression In this study) is the one that is necessary for therapeutic communication because it is aimed at relations and process, to understand the emotions of the other and their peaceful admission. Thus, we would explain the negative correlations that are received with the "Expression" factor.

Conclusions

There are many types of research with the focus on the qualities of the therapist as an authentic person, its ability to contact, preparation and experience are available (Ablon & Marci, 2004; Nathan, 2003). Most researchers are unanimous that the relevance of the working union, including, the dedication of dialogue and creating conditions that facilitate it is the basis of good therapeutic practice.

The level of presence depends on the accessibility of the therapist, which is authentic accessible and adequately expressive, allocating its attention to the content and on the process of psychotherapy. (Budjental, 1990).

Practice-based evidence is characterized as a "bottom-up" process to collect data that relies on the experience of clinicians to inform therapy. (Dupree, 2007).

The future direction of the study is to make a comparative study on the role of the ability to the empathy of the therapist, as well as the various capabilities of the inventory of positive psychotherapy, with the factors inherent in the approach that help define those from them that support the effectiveness of psychotherapy.

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WHAT DOES OUR BODY TELL US IN THERAPY?



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Abstract

Verbal interaction seems to be the main instrument of treatment. In this article the the unconscious language of the body interaction will be looked at, as it seems to be not only an important transmitter of an emotional therapeutic atmosphere, but also valid to find out the conflict contents, relation pattern, and helps to work with structural problems. Results about early parent-child interaction show like a mirror the specific needs of a successful therapy relation especially in personality disorder treatment. Counter transference is based mainly on the awareness for the own body reactions and feelings, mirroring the unconscious themes of the client. To look as a therapist how the own body reacts with specific impulses, feelings and emotions can help to discover the associated psychodynamic terms of conflict contents and structural needs. The interpretation of the own body sensations can be helpful in the application of positive and psychodynamic therapies as well as in cognitive approaches to see the body interaction like an instrument to understand the hidden agenda.

Keywords: Positive Psychotherapy, counter transference, protective factors, prevention, body language

*We do not shiver because we are scared of the lion,
but we shiver, and this is what we feel as our fear.
In other words, emotions are feelings of bodily changes."
James, 1884*

Introduction

Impact of the body language, interaction, and initiative in early childhood

Physical interactions between persons start as early as in pregnancy between mother and child, influenced by the interaction of the mother with her environment: Some researchers have even found that the prenatal influence of the mother's stress during pregnancy causes more emotional and behavior problems in the child later in school (overview in Talge et al., 2007). O'Connor et al. (2002) showed this prenatal influence

even if the mother had better control of her anxiety and depression after giving birth to her child (Schmid-Hagenmeyer, 2008). The mother - child body language interaction, as a protective factor for mental health, was found as "the touch from the mother in the interaction with the baby, the mother's supportiveness..., smiling in the interaction with mother, expressive language during the child's infancy." This was found in research to be a strong influence on mental health even 19 years later in adulthood, as compared to the interaction with the mother during the baby's childhood. Early active interaction can prevent depression, nearly independent of genetic factors. "The less initiative the mother showed in the contact with the three-month-old child, the more depressive the children noted themselves to be at the age of 19, and

the worse this became., resulting in diagnoses of depression or dysthymia". These children also had more behavior symptoms between the ages of 2 and 15. The social support for the pregnant women and new mothers plays an important role; the more support they had, the more responsive they are usually with their children. "Emotional support is the offering of empathy, concern, affection, love, trust, acceptance, intimacy, encouragement, or caring. It is the warmth and nurturance provided by sources of social support." All these capacities and attachment are expressed by body language, and are similarly to feel in therapy sessions.

Methodology

Body language, personality, and therapeutic relations

Different ways of body language are to find, related to the specific personalities with their style of perception, and the specific evaluation of the perceived body language. Fuchs and Koch (2014) describe it clearly: „We regard emotions as resulting from the circular interaction between affective qualities or affordances in the environment and the subject's bodily resonance, be it in the form of sensations, postures, expressive movements or movement tendencies. Motion and emotion are thus intrinsically connected: one is moved by movement (perception; impression; affection) and moved to move (action; expression; emotion). Through its resonance, the body functions as a medium of emotional perception: it colors or charges self-experience and the environment with affective valences while it remains itself in the background of one's own awareness. This model is then applied to emotional social understanding or interaffectivity which is regarded as an intertwinement of two cycles of embodied affectivity, thus continuously modifying each partner's affective affordances and bodily resonance. We conclude with considerations of how embodied affectivity is altered in psychopathology and can be addressed in psychotherapy of the embodied self...

"The special thing about feelings is that they ... affect all areas: experience, expression, instrumental behavior and physiology. Feelings are the litmus test for the state of discussion of the body-soul problem. The heritability of feelings, of temperament, even of empathy will have to be reopened and we will probably have to concede a far greater share to it than was usual in psychoanalytic circles (Zahn-Waxler et al., 1992)."

The physical basis and mediation of emotions is in the process of increasing enlightenment: "The emotions are not only experiential representations of physiological processes, but function as organizers and integrators for important physiological processes and especially for our immunological defense potentials. "...Neuropeptides (are) the main molecular mediators for emotions (Pert, 1986)... Neuropeptides are most densely localized in the limbic system. This region of the brain is particularly significant for emotional neurological analogues. ...This neuropeptide network (forms) a biochemical basis for this... ...that emotional stimuli can modulate the emergence and development or regression of biological diseases." "Displacement of aggressive feelings ($p < 0.001$), humorous moods... an active defensive or coping style, increased general emotionality... are highly correlated with immune competence versus immune failure..."

Application

How can we address body interaction in therapy?

As a therapist I may feel very angry or even contemptuous, but I will not give it back directly affectively, but rather as a "container" to take up the projections, transform them and place them in my interventions in a curative way. If this is correct, then the opposite is also true: as a therapist you may have the feeling inside you to react very empathetically and lovingly to the patient's offers and at the same time to act quite differently in the affective microexpression behavior. This is also verifiable and more frequent than we think." (Krause, 1996). Krause (1996) describes the paramount importance of recognizing the type of feelings in psychotherapy for the success of therapy, even as a prognosis factor within the first sessions. In addition, an active interaction with the client using the awareness for the own feelings becomes a model for the clients to be aware of their own feelings and impulses.

The unconscious manifests itself as often between the lines, is interpreted in a subordinate clause, an inappropriate break to speak, a slip of the tongue or in accompanying body language characters. As the patient speaks, we can observe his non-verbal communication: Does he grasp your hand, or does he approach you, demanding your greeting? Is his hand stretched far away from himself to keep distance from you, to quickly retract his hand after the handshake? Language pictures like: "There the ground breaks away under my

feet", or "I lose the hold" contain the body language quite clearly. Non-verbal communication is groundbreaking for the unconscious process that unfolds between you and your patient from the very first minute. The body communicates not only through facial expressions and gestures, but also through the skin's blood circulation (the patient turns red or gets warm), body odor (e.g. anxiety sweat that likes to be masked with a lot of perfume), wet hands, changes in breathing and pupil reactions. Even if your conscious observation misses one or the other detail of body language, your unconscious systems of perception will implicitly grasp it. In this respect, the self-observation of the therapist also belongs to the observation in a very special way. Do not only collect data, but also feel your patient: What do people trigger in you in feelings, vegetative reactions, prejudices, value judgements, fears, desires, fantasies, memories?

Discussion

For depression, the subconscious basic conflict of anxiety of separation and loss was described by Gerd Rudolf (Küchenhoff, 2017) in a way that later the anxiety of losing the attachment and relation become a reason for depressive reactions. The emotionally meaningful, active and physically-interactive therapeutic relation can here have a healing quality, that means how we are, how our attitude towards the client is of a higher impact than what we "do" or which method we apply. Chebotareva, I. S. (2001) described the importance of the emotionality and personality of pregnant women in the therapeutic interaction and the changing dynamic in the process of positive psychotherapy treatment in Kazan, Russia. In the textbook "Positive Psychotherapy", on the other hand, the term "emotion" cannot be found in the index, nor can references to "feeling" or "affect" be found. In the comparison between differentiation analysis and the very affectively emphasized primary therapy according to A. Janov, Peseschkian assigns the emotional area with the search for love and recognition to the primary actual abilities. However, he deals with emotions and affects in stories without making the emotion itself the subject; he sees them rather as the physical counterpart to a content-definable micro-conflict, which a mature person can control cognitively.

Conclusions

The process of therapy works unconsciously and later consciously with feelings as body sensations: Feeling, sensing, perceiving, naming and writing down feelings and bodily functions - this is the first step of observation and distancing in a positive psychotherapy process. To differentiate the feelings and body reactions in the next step we can translate them into the underlying contents of capacities, values, conflict contents, and relationship patterns in relation to the patient's experience and history. To name the feelings missing from the patient, are they covered by defense mechanisms or not able to feel, becomes an encouragement in the situation of the patient and his environment. Feelings signalize conflicts - their resolution is possible by understanding the language of the body as an expression of inner conflicts, which can also be felt in the countertransference. To enable the patient to experience sensations consciously and to differentiate their content into relationships broadens the possibilities of the client.

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CHALLENGES OF PSYCHOLOGICAL THERAPY WORK WITH AUTISTIC ADULTS



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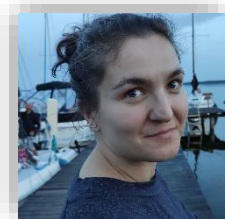
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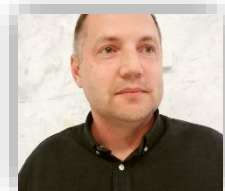
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Abstract

Autism spectrum disorder (ASD), as a neurodiverse developmental pattern, affects between one and two individuals in every 100 people. Autistic individuals experience different challenges in every decade of their lives. The difficulties in sensorimotor functioning, emotional codes, communication and cognition, albeit causing emotional distress, form a basis for developing a unique culture. Knowledge, understanding, respect and openness to neurodiversity are the fundamental prerequisites for Transcultural and Positive Psychotherapists and any professional who intends to deliver psychological therapy to autistic individuals. In this paper, we discuss the medical, psychological and sociocultural aspects of the autistic spectrum and present the basic goals of therapeutic work with autistic adults.

Keywords: adults, autism spectrum disorder, recommendations, Positive Psychotherapy

Introduction

Due to their different developmental pattern, autistic individuals often experience lack of understanding of their unique needs by others, including psychological therapists. In the current medical and psychological sciences, there is no "gold standard" for therapeutic intervention in autistic individuals. At the same time, our understanding of the autistic spectrum changes and becomes outdated very quickly. Whereas there is a plethora of therapeutic interventions intended for autistic children and adolescents (Greenspan & Wieder, 2014), there are only a few interventions intended for autistic adults, making the available assistance on offer insufficient. The number of autistic adults worldwide is difficult to estimate. Epidemiological studies are usually conducted in children and their results are extrapolated onto the general population, which does not seem entirely legitimate. One of the few studies conducted in adults (Brugha et al., 2007) showed that in the UK, the prevalence of autism spectrum disorder was 1%. Clinical experience suggests that the number of autistic adults, who receive their diagnosis of autism very late, e.g. after a long-term search and numerous visits to different professionals, or having discovered their own neurodiversity through the diagnosis of their own children, increases every year. This increase is particularly noticeable in women whose diagnostic assessment requires distinct knowledge and attention from professionals who are only beginning to learn how to effectively recognise the subtle manifestations of the female autism phenotype (Rynkiewicz et al., 2019). As shown later in this paper, the need for psychological and therapeutic support is already great in the autistic

population for a number of reasons, and it will become even greater with the growth of that population. Where professionals are not sensitive to the specificity of the autism spectrum, this work may, however, be ineffective and a source of frustration for all parties involved.

1.1 General overview of adulthood

Adulthood is the longest developmental stage in human life, spanning across several decades between adolescence and old age, the boundaries of which are determined by biological, demographic, social and cultural factors. This is because the lifespan itself as well as the ageing rate and legal norms and regulations of different age-related matters affect who is considered to be at the age of consent to e.g. a marriage, who is subject to criminal liability or who is entitled to retire. Developmental psychology has come up with many developmental stage classifications, which are often discrepant in age range boundaries of adulthood. For instance, E. Erikson or R. Havighurst considered the age of 18 as the beginning of adulthood, further subdivided into: early adulthood (18-35 years of age), middle adulthood (aka midlife, 35-60 years of age), and late adulthood (over 60 years of age). D. Levinson considerably extends early adulthood, placing it between 17 and 45 years of age, with each five-year period marking its respective beginning and end seen as a transitional phase (Brzezinska et al., 2015).

Contemporary research data indicates the increasingly "delayed onset of adulthood" in modern young people, which is reflected by their staying in full time education for longer, having a full time, permanent career later, as well as starting a family or giving birth to the first child after the age of 30 years (Brzezińska &

Syska, 2016). Therefore, the divisions of adulthood proposed by contemporary authors need to account for it, although it is not clear whether the key issue should be termed the 'postponement' of adulthood rather than its 'delayed onset'. Accordingly, Bee (2004) suggests that early adulthood begins at the age of 20 and lasts until the age of 40, midlife falls between 40 and 60 years of age, after which the late adulthood follows. This shift of the age at onset affects subsequent age ranges, blurring their limits. In line with the above, Brzezińska et al. (2015) divide human life into 4 distinct stages: early and late childhood (from birth to 10-12 years of age), adolescence (from 10-12 to 20-25 years of age) and adulthood (from 20-25 years of age to the end of life).

Oleś (2015), on the other hand, postulated four criteria which - if met - confirm that an individual progressed to adulthood. The first criterion (1) is accepting and carrying out adult life tasks. Traditionally, those would include having a job and starting a family. Nowadays, however, the extent of social and mental transformations within our culture, as well as changes to the conditions in which those life roles are fulfilled, warrant a revision of adult-like life roles and tasks. Hence, at the moment, adults would be persons who have determined the directions of their life pursuits, have chosen their predominant activity (not necessarily of a professional nature), have identified their aspirations for the subsequent 10-20 years and are capable of active and persistent attempt to live their chosen lives. Regarding starting a family, this expectation is increasingly more often replaced now by considering themselves ready and able to build long-term relationships or abide by their choice to live alone. The second criterion (2) is the ability to take responsibility for oneself and others. The third criterion (3) is achieving independence, in particular emotional independence, from one's parents (carers/ protectors). This does not necessarily mean leaving the family home, which - Oleś postulates - is not the most important thing. Instead, he argues, the ability to make autonomous choices and decisions without the need for the decision-making process to be supported or approved by "an adult". The fourth criterion (4) is the freedom of choice and the accompanying drive to fulfil one's desires and aspirations. This takes courage (to live an independent life), perseverance (to tackle adult life roles), and endurance (in the face of hardships and

obstacles) to continuously strive to achieve one's goals despite difficulties and setbacks.

Thinking of these criteria, it becomes clear that adulthood is not about one's age. Instead, the factors related to individuals and the degree of their personal development, as well as contextual factors creating the field of possibility, necessity and acceptability of one's actions play the key role.

1.2. *Adulthood on the autistic spectrum*

When assessing psychosocial function of autistic adults with the view to determine their needs in order to provide sufficient support, a number of factors which affect their daily lives, beyond those typically associated with their current stage of life, need to be considered. These are all biological/ medical, psychological and social consequences of neurodiversity, that is, of the autistic pattern of development, which need to be explored beyond the usual psychopathological perspective (Stefańska-Klar, 2017a; Stefańska-Klar, 2017b).

1.3 *Medical aspects of autism*

Contemporary understanding of the autism spectrum assumes its neurobiological nature, underpinned by both genetic (Sandin et al., 2014; Risch et al., 2014) and environmental factors, which affect both prenatal and postnatal brain development. The research to date failed to identify any isolated causal factors. Hence, autism spectrum disorder is considered one of the most heterogeneous neuropsychiatric disorders. Numerous cohort studies (e.g. Hviid et al., 2019) have excluded the link between autism and vaccinations, which was suggested in 1998 and has since become popular. On the other hand, variations in over 700 genes have been confirmed in autistic individuals. However, these include only few *de novo* mutations (Ruzzo et al., 2019). Hence, even though the genes clearly play a role in autism, their phenotypic expression in autistic individuals remains highly variable (Veenstra-Vanderweele et al., 2004), affected by a number of prenatal, perinatal and postnatal factors (Wang et al., 2017).

The specificity of autistic cognition, sensory and motor function as well as communication pose a medical challenge throughout the lifespan of an autistic adult alongside comorbidities, both physical and mental, including primary and secondary disorders. Highly prevalent, those comorbidities contribute to the

high variability of clinical presentations in autistic adults.

Recent studies show that 50% of autistic individuals have at least four confirmed comorbidities (psychiatric, neurological, endocrine, rheumatologic, gastrointestinal, etc.) and that over 95% of autistic children have at least one additional diagnosed condition (Baron-Cohen, 2020). In clinical practice, 83% of autistic children have another neurodevelopmental condition, 10% have at least one mental health condition (anxiety disorder, depressive disorder, eating disorder, etc.), and 16% have a concomitant neurological disorder. Sleep problems affect 50% to 73% of autistic individuals, with prevalence depending on the assumed definition of sleep or the assessment tool used in a study (Hodges et al., 2020).

The prevalence of mental illness and disorder increases significantly with age in the autistic population, which is believed to be attributable to childhood and adolescence microtraumas and traumas. Approximately 50-70% of autistic adults have at least one diagnosed mental health condition. The risks of depression and schizophrenia in autistic individuals are 3 times and 22 times higher than in the non-autistic population, respectively. Even though the risk of a suicidal attempt is 5-fold higher in autistic individuals, only 50% of those who attempt suicide have been previously diagnosed with depression. The prevalence of autoimmune, endocrine or rheumatologic diseases is also significantly higher in autistic individuals compared to the general population. A single population-based prospective study indicated that the mortality risk in autistic population is nearly twice that of the general population (Mouridsen et al., 2008).

1.4 Psychological difficulties of autistic adults

Individuals with autistic traits (whether formally diagnosed or not) experience a range of psychological difficulties, both specific to their condition and those commonly affecting other adults for a number of reasons. The developmental, clinical and health psychology provides tools to group those difficulties translating into different counselling approaches (Czabała & Kluczyńska, 2020). Some of those problems result from internal and external barriers to one's progression through consecutive developmental stages and/ or fulfilling their respective developmental tasks, positive resolution of normative life crises. These may as well be difficulties in maintaining optimum mental

health and associated psychological wellbeing, which stems from satisfaction from a life which one perceives as meaningful, fruitful and conducive to their further personal development.

The World Health Organisation (2004) defines mental health as *"a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"*. Therefore, from a psychological perspective, mental health is a by-product of reaching one's full potential in terms of meeting one's needs, achieving one's aspirations, plans and goals, undertaking tasks which mobilise one's internal and external resources, as well as positive coping with stress and difficult life events. What follows is acknowledgement of mental health as a *sine qua non* prerequisite for achieving everything that wellbeing depends upon i.e. good and fruitful human functioning, positive adjustment to life changes and self-fulfilment in terms of achieving one's aspirations.

Research into psychological functioning of autistic adults supports the conclusion that it is a group particularly vulnerable to stress and its consequences, as well as to experiencing emotional crises of various origins. Environmental maladjustment, related to the situational stimuli or challenges and difficulties of social life, seems an important factor (Hirvikoski & Blomqvist, 2015). The inherent autistic specificity of receiving and processing sensory and semantic information, as well as interpersonal and social difficulties (encompassing cognitive, emotional and practical aspects), means that many situations that most neurotypical people find to be usual and manageable become considerably difficult to cope with for the autistic individual. Some situations may even put one on the verge of mental and physical safety, being exceptionally energy-consuming and demanding significantly intense activity across different domains, in order to meet the expectations, achieve the goal or just survive until the conclusion of a situation. It should be noted that the emotional and energy expenditures in question are considerably higher compared to those of a neurotypical individual. When such experience becomes regular or even permanent, one lives in a state of chronic fatigue, leading to periods of exhaustion and even a subjective sense of 'life burnout' (Stefańska-Klar, 2020). One's inability to cope with the situation may lead to atypical consequences, sometimes perceived as shocking by the environment.

These can be sudden affective-behavioural outbursts (meltdowns) or energetic breakdown, manifesting as a prolonged inability to move, detachment from the stimuli, or even falling into a deep sleep, regardless of one's physical location (shutdown). In the absence of support and access to personal resources, exhaustion results in what has been termed 'autistic burnout', which is a state threatening to health or even life itself.

A distinctive group of psychological difficulties experienced by autistic individuals are those resulting from the untimely (i.e. accelerated or delayed) achievement of subsequent stages of psychosocial and personality development. They stem from the mismatch between one's intellectual ability, readiness to undertake specific developmental tasks, and one's social, communication or emotional skills. Alternatively, they may originate from one's not being ready to assume certain roles, despite societal norms and expectations expressed, explicitly or implicitly, by those important to an individual (Stefańska-Klar, 2017). The society may "push" an autistic person to assume roles and tasks considered age-appropriate, status-appropriate, or expected by socio-cultural norms. Alternatively, fuelled by fear, concern or prejudice, it may create barriers, hinder his/her activity or prevent him/her from taking certain actions. What follows, as psychological consequence, is the lack or loss of autonomy, emotional crises, depression and/or learned helplessness. On the other hand, the effect of autism may cause difficulties in achieving one's goals and meeting one's own needs even for an individual who is successfully fulfilling his/her personal life plan, in the absence of, or despite barriers or obstacles. Whereas such effect may be confined to an individual (personal problems, personality difficulties, etc.), it often affects the person's closer and more distant social environment, such as relationships with loved ones, within the family system, workplace, neighbourhood etc. The autistic individuals who are in relationships, have started families and have children, experience problems typical of couples or families where a member of a family is autistic, be it an adult, a child/ children or both. In these circumstances, the autistic traits of one or both spouses/ partners affect the issues typically addressed in couple counselling, family therapy and psychological support for parents of autistic children, which should always be taken into account when working with this client group. For example, autistic parents may fear that they are not competent enough

to raise their non-autistic child, feeling unable to understand the child or to appropriately respond to the child's needs.

Another group of psychological difficulties is linked to self-image and self-acceptance, the subjective meaning of life and perceived life satisfaction, which form the basis of psychological wellbeing across the lifespan. This includes all issues associated with autism awareness, understanding its impact, accepting the diagnosis, self-contentment as well as a positive appraisal of one's place in the world and the quality of their relationships with others. As reasonably expected, the needs of young adults will differ from the needs of those in their midlife or old age. Hence, it is important to identify the stage of adult life affected by the personality and existential difficulties of an autistic person (Stefańska-Klar, 2017).

1.5 Social and cultural dimensions of autism: the issue of autistic self-identity

Autistic self-identity, defined as a cognitive self-perception of an autistic individual in all possible relationships with oneself and the outside world, can only start to develop once autism has become known. Building self-identity requires grounding in society and culture, followed by a construct of awareness and self-awareness, the ability to identify oneself with others and compare one's own traits with those of others. A. Giddens (2012) defines self-identity as "*a reflexive project of the self, which consists in sustaining consistent, yet continuously revised, biographical narratives, and takes place in the context of multiple choice as filtered through abstract systems*". Autistic self-identity, as the collective identity of a social movement, cognitive self-perception common to and shared by groups of people with similar characteristics, defined as autistic traits, is a new and dynamic reality, yet deeply rooted in culture, created by, and typical of, society. It fits into the model of resistance identity with projective characteristics, as defined by Boksanski (2005), because the social actors are marginalised by the logic of domination, which leaves them feeling stigmatised. They are often excluded from full participation in social life, which additionally grounds them in resistance leading to adopting rules different from those upheld by the part of the society which is excluding them. The activities aimed at a comprehensive transformation of the social structure and its underpinning principles (Boksanski, 2005),

being one of the key objectives of autistic self-advocacy, demonstrate features in keeping with the projective model of identity. Such activities bring about qualitative changes in the level of autism awareness and understanding. Thus, as such, they are significant from the praxeology perspective. This is largely a credit to self-advocacy movements, which aim to empower groups and individuals, help them regain their agency, and ensure that human and civil rights are duly granted. Self-advocacy is therefore centred on such sociological categories as trust, agency, social identity, care, dignity and respect, representation, cooperation, and subjectivity (Raław & Trawkowska, 2017).

The history of autistic self-advocacy movements dates back to 1990, when the first such identity movement of individuals diagnosed with autism, the Autism National Committee (AUTCOM), was founded *"... to protect and advance the human rights and civil rights of all persons with autism and related differences of communication and behaviour. In the face of social policies of devaluation, which are expressed in the practices of segregation, medicalization, and aversive conditioning, we assert that all individuals are created equal and endowed with certain inalienable rights, and that among these are life, liberty, and the pursuit of happiness"* (<https://www.autcom.org/about.html> [accessed on: 30.08.2020]).

Another such organisation, the Autism Network International (ANI) is an autistic-run self-help and advocacy organization for autistic people created in 1992 by Jim Sinclair, Kathy Grant and Donna Williams. The organisation objectives are to help autistic people identify positive ways of living with autism and about functioning as autistic people in a neurotypical world, to give them a sense of belonging to the shared autistic culture and, since 1996, to share and expand knowledge based on first-hand accounts of autistic people during Autreat conferences (https://www.autreat.com/History_of_ANI.html [accessed on: 30.08.2020]).

In 2006, Ari Ne'eman and Scott Michael Robertson founded the Autistic Self Advocacy Network (ASAN), an international organisation whose motto is: Nothing about us without us. It was founded in response to the US legislation as well as inaccurate media portrayals of autistic people as lacking independence, dangerous and in need of intensive aversion therapy. ASAN voiced their opposition to Autism Speaks - an organisation claiming to support autistic people and their families, on the

grounds of their systemic, strategic disregard of autistic people their contribution to autistic stigmatisation and excluding autistic people from the public debate on issues which directly affected them. The ASAN initiated the campaign to introduce legal changes in a bid to prevent the Judge Rotenberg Educational Center from using the graduated electronic decelerator (GED), an electrical stimulation device designed by the centre's founder, Matthew Israel. The American Food and Drug Administration (FDA) only banned the GED in 2020, after the United Nations had twice condemned the device as torture. However, the JRC still use other aversive treatments on their students and residents (<https://www.masslive.com/news/2020/03/after-fda-bans-judge-rotenberg-center-from-using-electric-shock-devices-advocates-seek-public-apology-reparations.html> [accessed on: 01.09.2020]).

The grassroots initiatives appear essential for the discourse on the place of autistic individuals in the society. Therefore, such autistic self-advocacy movements and third sector organisations working with and on behalf of autistic people and their allies have been set up in Poland, too. These are the Bright Side of the Spectrum [Polish: Jasna Strona Spektrum] autistic self-advocacy organisation and autistic self-advocates centred around the Mary and Max Association [Polish: Stowarzyszenie Mary i Max]. Furthermore, the Autism Team Foundation, an organisation for autistic people, their families, friends and allies, has the "Conscious Youth Club", a grassroots initiative started by Jan Gawroński, a young autistic self-advocate. All these groups provide psychoeducation for autistic people, their families, teachers/ educators and other professionals. Some of those initiatives additionally aim at promoting positive changes in law and infrastructure in order to reduce social disability of autistic individuals.

The ASAN website reads: *Autism (...) is not a disease. It is a neurological, developmental condition; it is considered a disorder, and it is disabling in many and varied ways. It is lifelong. It does not harm or kill of its own accord. It is an edifying and meaningful component of a person's identity, and it defines the ways in which an individual experiences and understands the world around him or her. It is all-pervasive"* (<https://autisticadvocacy.org/about-asan/identity-first-language/> [accessed on: 04.09.2020]). This definition is quintessential for autistic self-advocacy. While it does not rule out the coexistence of autism and disability, it points out that such coexistence is not a

commonplace. Autism is not a functional deficit or deficiency, which can and should be corrected. An autistic individual growing and developing in a friendly environment will build his/her self-identity based on their personal resources and those obtained from the environment; hence autism cannot be seen as an “addition” to an individual. Furthermore, as Sabina Pawlik points out, autistic self-advocates, whose activity contributes to shaping the autism discourse in a public domain, win increasingly more control of categories that they are defined by, exposing such dark sides as eugenics, institutional abuse and stigmatisation that have been an experience of many autistic individuals (Pawlik, 2015). A pursuit to define normality based on what is common, homogeneous and uniform by means of rejecting what is different, is deeply rooted in our culture. Whatever causes upset, anxiety or surprise should be investigated and explained (Brauner & Brauner, 1988). As the investigation is limited by the resources and tools, uneducated communities developed their own folk stories, myths and legends. In those, developmentally different individuals were labelled as “foundlings” (in Polish: *podrzutki*, *podciepy*, *niańduchy*, *zamienoki*, *znajdy*, cf. Kojder-Demska, 2020), that is, children dropped off in their families by goddesses, elves, good people or other characters of the world of magic. This emic notion of disability still significantly affects the level of social acceptance of disability or developmental differences. It is reflected in numerous superstitions regarding, for instance, pregnant women and babies. Babies still wear red ribbons as a protection against evil and the motif of a “bad eye” is omnipresent across cultures. Some people still believe that disability can be a punishment from God for the sins of one’s ancestors, or a result of substandard upbringing.

The perception of autism has also been affected by the development of social sciences, starting from L. Kanner and H. Asperger whose work encompassed the concept and diagnostic criteria of autism. Later, Bettelheim’s psychogenic theory of autism with its central ‘refrigerator mother’ concept caused significant irreversible harm to autistic people and their families (Rosmalen & Veer, 2020). Unfortunately, that is also true about the applied behavioural analysis using aversive treatments developed by Lovaas (Kirkham, 2017). Finally, contemporary authors such as T. Attwood, T. Gałkowski or S. Baron-Cohen, undisputed autism research experts, have also contributed to the

current perception and understanding of the autistic spectrum.

In the project discussed, we have been guided by the motto: “*The person comes first*” from the inception of our work, with the primary aim of putting the patient/client, his/her emotions and needs first in all therapeutic support, regardless of his/her cognitive and social potential, self-awareness, emotional regulation, health or independence. Hence, the humanistic therapy paradigm, in which the perception of a person as a subject rather than object is central to all activities building on one’s strengths and protecting their vulnerabilities, regardless of one’s (neuro)diversity or disability, has become central to the recommendations postulated herein. This paradigm is consistent with the social definition of disability, and the perception of disability in terms of normalisation, integration and emancipation (Krauze, 2010). Defining autism as neurodiversity rather than a disorder is a significant aspect of autistic self-identity and a factor in promoting and maintaining good mental health of autistic individuals.

Methodology

These recommendations were written as part of the “Awareness and Relationships. Improving Access to Psychological Therapies for Adults on the Autism Spectrum” project carried out by the Centre for Supporting Relationships as a part of the “Accessibility Generator: Social Innovation Incubator” under the Operational Programme “Knowledge Education Development”, Priority Axis IV Social Innovation and Transnational Cooperation, Action 4.1 Social Innovation, co-financed by the European Union under the European Social Fund. The aim was to inspire reflection on the specificity and distinctness of (psycho)therapeutic work with neurodiverse persons. The author team, all being members of the project working team, represent various domains of science and clinical practice. We decided to present different perspectives on and modes of understanding of the autism spectrum in adulthood. The descriptive language of this paper was intended to be supraparadigmatic, hence the terms patient/client were used interchangeably to denote an autistic individual seeking therapeutic support, leaving behind the discussion of the meanings attached to those terms. We firmly believe that, whether termed a client or a patient, individuals and their needs should always be at

the heart of design and delivery of any support services. Accordingly, the overarching aim of such services should always be to promote their optimum wellbeing - both physical and mental - with the possibility of achieving their full potential in good relationships with their important ones. The target audience of this paper are researchers and clinicians of various professions, who encounter or may encounter neurodiverse adults as a part of their respective roles. We are convinced that therapeutic encounter of an autistic individual differs from that of a neurotypical individual and, as such, it requires a separate, in-depth discussion. In line with project limitations, an autistic person is denoted herein as an autistic adult without concomitant intellectual disability (aka learning disability, LD). The issues of psychological therapy with autistic adults with concomitant LD are relevant and significant enough to warrant a separate project followed by a separate article or even a book. Being aware of the need for such recommendations, it is our intention to develop them as a part of subsequent social innovation projects.

Results

The following recommendations are the sum of the conclusions of the working team and then of three groups of reviewers:

- three independent psychotherapists experienced in working with autistic patients
- three independent autistic people with experience of psychotherapeutic process
- three independent psychotherapists implementing the developed by authors recommendations in daily psychotherapeutic work within three months.

3.1 Therapy goals in autistic adults

Highly vulnerable and with a unique psychosocial profile, autistic adults and children can undoubtedly benefit from therapeutic support, which should aim at:

- (1) identification of one's own physiological and emotional states with their subsequent self-regulation,
- (2) increasing self-awareness,
- (3) understanding one's own needs and wellbeing and learning how to meet/ promote them,
- (4) coping with sensory hypersensitivities, and
- (5) acceptance of one's neurodiversity. Autistic people are at high risk of developing mental health problems - depression, anxiety, strong psychosomatic response to stress - which are typically secondary to

their needs being unmet throughout the lifetime, as they are exposed to high levels of stress from an early age - in education, peer relationships, developmental crises, professional career and/or family life (if one chooses to have a family). This highlights the urgent and vital need to build awareness and broaden the understanding of unique cognitive, emotional and social aspects of autism in professionals (including therapists) and to teach them how to effectively support autistic adults. Whatever shape or form such awareness-building takes, it is always worth the effort.

The "Awareness and Relationships: Improving Access to Psychological Therapies for Adults on the Autism Spectrum" project carried out by the Centre for Supporting Relationships as a part of the "Accessibility Generator: Social Innovation Incubator" under the Operational Programme "Knowledge Education Development", Priority Axis IV Social Innovation and Transnational Cooperation, Action 4.1 Social Innovation, co-financed by the European Union under the European Social Fund was an attempt to fill the gap in the support offered to autistic adults. The aim of the project was to draw particular attention to the psychosocial situation of autistic adults without learning disability and to inspire debate and reflection on the quality of available support. The outcomes of the project included, alongside the current article, an educational brochure containing detailed clinical recommendations for professionals working with autistic adults, as well as an instructional video which present the recommendations in an enriched, more dynamic manner (all resources will be available at www.wspieranielerelacji.pl and can be directly requested from the authors). Using the opportunities of the social innovation projects, the resources developed by the project working group were reviewed by both experts according to knowledge (psychological therapists) and experts according to experience (autistic patients/clients). This ensured that the developed content was evidence-based and well-suited to the needs of its recipients, both direct (therapists) and indirect (autistic adults). The project was carried out between September 2020 and May 2021.

The project working group developed a number of recommendations for professionals who work (or intend to work) with autistic patients/ clients. One of those recommendations includes primary therapeutic goals which can/ should be considered when working

with autistic adults in an effective, respectful and dignified manner. These goals can specifically include:

- Developing the SELF, that is improving ones awareness, building identity, strengthening self-esteem, developing the philosophy of acceptance and/or affirmation of their autism spectrum condition whilst developing acceptance (and/or affirmation) or other people's uniqueness, thus promoting positive regard for human diversity.

These four elements (self-awareness, coherent self-identity, healthy self-esteem regardless of one's ability levels, and accepting neurodiversity, both one's own and that of other people) are the most important therapeutic goals when working with autistic people of any age - children, adolescents, and adults.

- Enhancing self-regulation and coping skills, especially in highly emotive situations or during a sensory overload;
- Developing emotional literacy and awareness (starting from identifying emotions based on bodily symptoms) and working towards emotional maturity;
- Building understanding of one's own needs followed by understanding the needs and emotions of others;
- Identifying relaxation techniques and activities (massage, osteopathy, manual therapy, medication, physical activity - individual or in a group setting), as well as self-regulation and self-soothing strategies (stimming, acupressure mat, weighted blanket, etc.);
- Developing the ability to maintain a dynamic psychoemotional balance and to return to it following the short-term highs/ lows;
- Developing the motivation and competence to build relationships, become a part of a wider community and positively contribute to it in a number of accessible and mutually beneficial ways, while feeling the satisfaction from said contribution and attending to the emotional needs of others;
- Building on one's strengths - exploring their special interests and passions, while moving away from a harmful, negative view of autistic special interests/ passions as manifestations of disorder ("fixations" or "stereotyped behaviours").
- Supporting individuals to identify their strengths and talents and to set suitable SMART goals.

- Building assertiveness, especially in those who have been exposed to 'therapeutic interventions' which disregarded their needs and their right to autonomy (such individuals are exceptional patients; sometimes a professional can also encounter an adult completely dependent on other adults - their carers - despite a clear potential and capacity for more independent living).

We emphasize those particular goals, as they have been disregarded in many other proposed interventions for autistic people (despite having a clear role in promoting and maintaining optimum mental health) in favour of interventions focused on eliminating autism or fixing what is "autistically broken". Supported by the reasoning of Polish and international researchers and organisations, we encourage the shift of perspective towards a more humanistically-oriented view based on respect for each person's uniqueness.

The strategies that may help achieve the goals described earlier which can be used by professionals, include primarily

- (1) a therapeutic relationship based on trust and positive regard,
- (2) creating the sense of safety, by means of understanding and acceptance shown to the client by the therapist, their consistent responses, attitude, and a stable, predictable setting, that a client considers important.

For many autistic people, this will also include the therapist's appearance (e.g. hairstyle, hair colour, attire, etc.), the therapy room layout (also important in online therapy). Any significant changes may cause upset, uncertainty or distraction causing difficulty focusing on the actual conversation;

- (3) session continuity and regularity (session frequency can be changed as long as regular intervals are kept) avoiding sudden, abrupt changes.

Most autistic patients prefer more frequent sessions to discuss ongoing changes in themselves, their environment and the relationship between themselves and the environment, especially if these discussions seem to be helping in their daily lives. However, where the therapy is not a part of the public healthcare system or subsidized by external funding with the third sector provider, financial constraints will likely determine therapy duration and session frequency;

- (4) therapists' open-mindedness and willingness to explore new ideas, solutions, and techniques to meet

the needs of a patient whose needs evolve throughout the relationship and who may need different activities or challenges.

This requires flexibility and creativity, but also the therapists' ability to learn from their patients, their motivation to be led by their clients and accompany them, while encouraging changes;

(5) providing ample opportunities for the client to test out the newly acquired skills and to put them into practice, first in the therapy room and then in life;

(6) considering one's personal development as the overarching principle for everything that takes place as a part of therapy.

This means that, alongside the immediate or short-term goals, there should be some long-term goals which determine the direction of change in the clients' behaviour and personality as well as provide the general direction in their ongoing work on their own lives. Obviously, the clients still remain the principal architects and creators of themselves and their lives. The therapist is their conscious companion, sometimes taking on the role of a guide or adviser, but never making the choices/ decisions for an individual.

Conclusions

The growing awareness of neurodiversity in society creates the need to be both attentive in a diagnostic setting and aware of potential challenges in a therapeutic setting when working with autistic people.

Positive Psychotherapy (PPT after Peseschkian, since 1977), owing to its humanistic-psychodynamic nature and a deep reflection on transcultural dynamics (Dobiala & Winkler, 2016), is one of the promising approaches in psychological therapy for autistic individuals (Dobiala, 2020). We remain aware of the need for further research and publications to enable a debate and reflection on the neurodiverse specificity across various aspects of psychological therapy for autistic people, including the therapeutic covenant, relationship and process.

It should also be noted that being an autistic adult is not a condition which requires an urgent psychological or psychiatric intervention per se, as autism itself is not a condition to be treated or fixed. However, psychological therapy, especially for those who have grown in an environment not embracing their neurodiversity and not promoting their autonomy and independence, can prove an important, powerful driver for a change understood as developing a good, healthy

autistic life. This paper is one of the outcomes of the "Awareness and Relationships: Improving Access to Psychological Therapies for Adults on the Autism Spectrum" project carried out by the Centre for Supporting Relationships as a part of the "Accessibility Generator: Social Innovation Incubator" under the Operational Programme "Knowledge Education Development", Priority Axis IV Social Innovation and Transnational Cooperation, Action 4.1 Social Innovation, co-financed by the European Union under the European Social Fund. As the project team members we hope that the content of this publication, the brochure and the instructional video, which aim at changing the perception of autism and improving the quality and relevance of support services to enable comprehensive, holistic development of autistic people will inspire reflection, promoting updated and improved understanding of autism by researchers and practitioners working with autistic adults.

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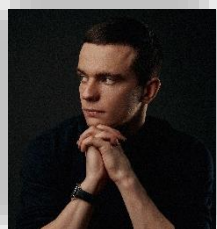
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ГРУППОВЫЕ ФОРМЫ РАБОТЫ В ПСИХИАТРИЧЕСКОМ СТАЦИОНАРЕ И ОТНОШЕНИЕ К ПАЦИЕНТУ

THERAPEUTIC GROUP IN PSYCHIATRIC HOSPITALS AND THE ATTITUDE TO THE PATIENT



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Аннотация

Ирвин Ялом называл психотерапевтические группы «социальным микрокосмом» (Ялом, 2007). Группы психологической поддержки и закрытые психотерапевтические группы особенно важны для пациентов психиатрических учреждений. В статье обосновывается ценность групповой работы в психиатрических учреждениях; описываются основные формы группового взаимодействия; разбираются особенности взаимодействия с пациентами в российских психиатрических стационарах. Предлагаемая концепция помощи и работы с пациентами основана на идеях Позитивной и Транскультуральной Психотерапии Носсрата Пезешкиана. Цель этой статьи: актуализировать для специалистов помогающих профессий важность групповых форм работы с пациентами.

Ключевые слова: групповая психотерапия, медицинская психология, психиатрия, социализация, Позитивная Психотерапия

Abstract

Irwin Yalom called psychotherapy groups a "social microcosm" (Yalom, 2007). Psychological support groups and closed psychotherapy groups are particularly important for patients in psychiatric institutions. The article substantiates the value of group work in psychiatric institutions; describes the main forms of group interaction; analyzes the features of interaction with patients in Russian psychiatric hospitals. The proposed concept of patient care and work is based on the ideas of Positive and Transcultural Psychotherapy by Nossrat Peseschkian. The purpose of this article is to update the importance of group forms of work with patients for specialists of helping professions.

Keywords: group psychotherapy, medical psychology, psychiatry, socialization, Positive Psychotherapy.

Вступление

Актуальность данной темы обусловлена растущим интересом общества к психологическим формам работы с пациентами психиатрических учреждений.

Психоневрологические стационары повышают количество рабочих мест для медицинских психологов, а также, увеличивается количество специалистов, проходящих обучение в психотерапевтических методах. На момент написания статьи, в условиях пандемии, в большинстве медицинских учреждений запрещены посещения пациентов; что оставляет людей в ещё большей изоляции без непосредственной поддержки близких людей. Исходя из этого, повышается важность групповой работы с пациентами.

К сожалению, многим медицинским психологам приходится сталкиваться с отсутствием вовлеченности врачей-психиатров, заведующих отделений, среднего и младшего медицинского персонала к глубокому сотрудничеству. По мнению автора, это связано с отсутствием заинтересованности и понимания ценности внутреннего мира пациентов. Зачастую, процесс лечения сводится лишь к купированию имеющейся симптоматики; а отношение к пациентам, местами, антитерапевтично.

Методология

Написание данной статьи основывается на опыте работы в психиатрическом учреждении и изучении опыта европейских стран. В статье «Реформирование психиатрической службы. Опыт США и Европы» (Цыганок, 2007) обозревается и анализируется опыт психиатрического движения в странах Европы и США. В статье было проведено подробное изучение предписаний ВОЗ, касающихся психиатрической помощи.

Анализ теоретического и исторического материала до и после реформ, введенных французским врачом Филиппом Пинелем, позволяет проследить важность гуманного и гибкого подхода к лечению пациентов.

Анализ и теоретическая разработка эффективного способа помощи пациентам внутри стационаров были основаны на наблюдении,

собственном опыте работы в психоневрологическом стационаре и взаимодействии со специалистами различного профиля. Большое внимание уделялось идеям Позитивной и Транскультуральной Психотерапии. Труды Ирвина Ялома и его художественное описание процесса психотерапевтической работы, также, внесли большой вклад в написание данной статьи.

Результаты

С точки зрения современных представлений о гуманности и лечении, изначальная цель функционирования психиатрических больниц была неверно поставлена. Первые психиатрические «лечебницы» ставили перед собой стремились «изолировать» пациента; а не «вылечить» или «помочь». Как мы помним, Филипп Пинель, французский психиатр больницы Сальпетриер, в 1795 г. принимает решения снять цепи и оковы с душевнобольных, что уже приводило некоторых пациентов к выздоровлению. Мы не можем констатировать, что к пациентам современных психиатрических больниц проявляют открытое насилие. Однако его пассивные формы, мешающие выздоровлению, в виде стигматизации, ограничении прав и свобод, изоляции, грубости в российской психиатрической практике встречаются повсеместно.

Высокие нагрузки на медицинский персонал, жёсткие протоколы, нехватка кадров усугубляют незаинтересованность медицинского персонала к внутреннему миру пациентов.

Как следствие незаинтересованности, появляется привычка "клеймить". То есть пытаться подогнать состояние человека под определённые рамки, четко и понятно описывающие происходящее с ним. В какой-то мере это помогает врачам и учреждению, поскольку упрощает документацию и фармакотерапию. Однако, не приносит пользы самим пациентам. У врачей встречаются диагнозы, основанные на быстрой диагностике, - что особенно часто наблюдается на врачебных комиссиях (т.н. гипердиагностика). У психологов – это попытка «вставить» человека в определенные шаблоны, якобы описывающие то, как устроен внутренний мир того или иного пациента, например: "истеричный", "эпилептоид", "шизоид", "демонстративный", "нарциссичный" и т.д. Однако, использование данных понятий, с точки зрения

пользы для пациента, практически не имеет смысла без вовлеченности во внутренний мир и интереса к индивидуальности каждой отдельной личности.

По вышеперечисленным причинам, пациенты и их родственники, за последние годы, повышают внимание именно к негосударственным учреждениям психиатрической помощи. По статистике частной психиатрической клиники «Клиника Роса», темп роста обращаемости пациентов с психическими расстройствами в негосударственную психиатрическую службу г. Москвы ежегодно возрастает, увеличиваясь за последние 7 лет в среднем на 20% в год (на 24%, 81%, 28%, 4%, 7%, 20%, соответственно) (Филашихин и Аведисова, 2010).

Неоспоримой является важность повышения уровня образования среди врачей, а также младшего и среднего медицинского персонала. В особенности это касается изучения психологических аспектов психических больных. По мнению автора, очень важна организация помощи медицинскому персоналу в понимании собственного стиля взаимодействия с пациентами; возможности получения своевременной психологической помощи и профилактики эмоционального выгорания.

3.1 Подходы к оказанию психиатрической помощи

Подходы к оказанию психиатрической помощи в разных странах Европы различаются, однако не слишком критично. Все европейские государства следуют предписаниям Всемирной организации здравоохранения (ВОЗ). Соответственно, можно проследить общие направления развития (Колпакова и Тарасова, 2019).

1. *Деинституционализация.* Подразумевает закрытие государственных психиатрических больниц или уменьшение их стационарных отделений, путем сокращения количества койко-мест и финансирования. Такой подход позволяет частному сектору и неправительственным организациям (НПО) создавать учреждения интернатного типа, где лечение проходит в более домашней обстановке и атмосфере.

2. *Децентрализация оказания психиатрической помощи.* Означает перевод стационарных отделений для душевнобольных из специализированных больниц в общегородские. Эта политика, прежде всего, направлена на включение

психиатрии в общую систему здравоохранения, интеграцию психического здоровья с первичной медицинской помощью, развитие учреждений интернатного типа.

3. *Рост заботы со стороны сообщества (community care).* Этот подход призывает делегировать часть полномочий по оказанию помощи на социальные группы и организации, находящиеся в зоне проживания душевнобольного. К ним могут относиться сообщества пациентов или их родственников, а также НПО.

4. *Увеличение внимания к немедикаментозной терапии.* Психотерапией стали заниматься не только врачи-психиатры, но и другие специалисты. В том числе, немедицинского профиля.

5. *Проведение законодательных реформ для обеспечения гражданских прав пациентов.* То есть формирование правовой основы политики в области психического здоровья. В частности, в задачи входят: регулирование принудительной госпитализации, предоставление адекватных условий лечения, борьба за свободные от дискриминации рабочие места и образование, развитие социальной поддержки, обеспечение права на неприкосновенность частной и семейной жизни.

6. *Дестигматизация.* Психические больные подвергаются сильной стигматизации, что приводит к потере социального статуса, дискриминации, безработице, изоляции, сокращению жизненных возможностей. Для уменьшения негативных последствий, в рамках работы по развитию заботы со стороны сообществ, создаются программы и стратегии по снижению стигмы и изменению стереотипов, ассоциирующихся с психиатрией.

7. *Ориентация на повышение качества жизни пациентов.* Со временем этот принцип стал важной концепцией современной модели медицинской помощи. На первый план, вышли психологическое и физическое благополучие и социальное участие, а не просто уменьшение симптомов или выживание.

8. *Вовлечение членов семьи и близких людей в процесс лечения пациентов.* Важно, что вместе с вовлечением, рядом идет осознание бремени, которое ложится на плечи заботящихся родственников. Им, также, стараются обеспечить поддержку.

В российской практике стремятся следовать Европейскому видению и предписаниям ВОЗ.

Однако данные предписания, зачастую, являются формальными. Изменения, которые внедряются в действующие системы, проходят без должного обучения специалистов. Помимо этого, существует проблема отдаленных регионов, которые тоже должны попадать под влияние изменений, но зачастую, остаются без должного внимания.

«Закон, прежде всего, заботится об уменьшении негативных последствий для государства — имеется в виду сокращение случаев инвалидности и нетрудоспособности, преступности, непригодности к военной службе и т.п.» (Колпакова и Тарасова, 2019) Права пациентов, в основном, учитываются в нормативных документах о стационарном лечении, а вот что же происходит с людьми за пределами и внутри больницы — зачастую противоречит изначальным целям созданных предписаний.

3.2 Ценность групповой работы с пациентами в психиатрических стационарах

Анализируя собственный опыт работы в психоневрологическом стационаре, в данной статье была выведена схема наиболее эффективного взаимодействия членов терапевтического процесса для помощи пациентам. Данная схема основывается на единстве специалистов помогающих профессий между собой, с больным и с его близким окружением.

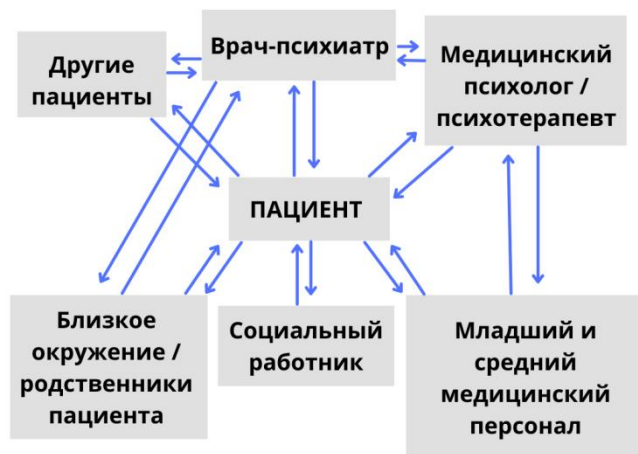


Рис. 1. Эффективное взаимодействие персонала и пациентов в медицинских учреждениях

Как видно из схемы (рис. 1), практически все элементы системы должны взаимодействовать друг

с другом для комплексной и полноценной помощи пациенту. К сожалению, в российских реалиях медицинских учреждений наблюдается отсутствие подобного взаимодействия. Звенья помощи либо разобщены друг с другом, либо медицинский персонал, а особенно врач и психолог, говорят «на разных языках».

Также, как видно из предложенной схемы, достаточно значимым элементом является взаимодействие пациентов между собой. Именно поэтому, одними из самых важных и эффективных форм лечения, являются психотерапевтические группы.

В психиатрических учреждениях, психологу приходится собирать психотерапевтические группы «из того, что есть». Учитывая различный срок нахождения в стационаре, диагнозы, стадии, состояние больного - приходится приспосабливать группу к тем пациентам, которые уже находятся на стационарном лечении.

По наблюдениям автора, нахождение в атмосфере принятия и поддержки — это основной фактор улучшения самочувствия «здесь и сейчас» среди пациентов стационара. Но, к сожалению, приходится сталкиваться с тем, что практически любые эмоциональные проявления пациентов, будь то плач или раздражение, стремление к конфронтации, настойчивость в отстаивании собственных интересов — воспринимаются медицинским персоналом как «ненормальные». Будто непослушание, даже то, которое никак не вредит благополучию самого пациента и людей его окружающих, нужно срочно лечить. Дается посыл: «тебе нельзя проявляться и быть самим собой - ты патологичен». Бывает так, что слова или действия пациентов принимаются медицинским персоналом «на свой счет», что влечет за собой злоупотребление властью. А зачастую, сами действия медицинского персонала провоцируют у пациентов различные эмоциональные и поведенческие реакции.

В качестве выхода из подобного рода трудностей, предлагается организация семинаров и групп психологической подготовки для медицинского персонала по развитию понимания важности гуманного отношения к пациентам и создания атмосферы заботы и принятия внутри стен медицинского учреждения. Такие обучающее и психологические группы, в которых медицинский персонал мог бы понять свой способ

взаимодействия с пациентами, получить информацию и обратную связь; найти и проработать внутри себя причину, которая влияет на способ взаимодействия с пациентами и перестроить собственные формы коммуникации.

3.3 Классификация групп в условиях стационара

Как известно, по составу участников группы могут быть:

- Гомогенные. То есть, собранные по каким-либо признакам (пол, возраст, диагноз, запрос и т.д.)

- Гетерогенные. Группа, в которой встречаются различные вышеперечисленные признаки.

Предлагается выделить две основные используемые формы работы с пациентами психиатрического стационара:

1. *Группы психологической поддержки.* Могут быть использованы для пациентов, чей период нахождения в стационаре менее двух месяцев. То есть тот период, которого недостаточно для развития постепенного близкого и стабильного контакта с другими участниками группы. Данные группы могут создаваться и на более длительный срок, для создания атмосферы групповой поддержки и сопровождения пациентов на весь период лечения.

Самое главное, что формируется в группах психологической поддержки, – это ощущение, что ты не один. На протяжении длительного времени приходилось наблюдать, как между несколькими десятками пациентов, находящихся в одном отделении и общих палатах, не формируется близкий контакт. Пациенты практически не общаются между собой, а при взаимодействии не позволяют говорить открыто о своих переживаниях. Открытое выражение эмоций, медицинским персоналом, чаще всего, расценивается как усиление симптомов.

Группа является отличной возможностью для пациентов приблизиться друг к другу в безопасной и принимающей атмосфере. Практически все пациенты, уже после первой встречи группы, становятся более сплоченными в отделении. К ним будто приходит понимание, что остальные пациенты здесь «такие же, как и я», то есть страдающие люди, попавшие в тяжелое положение. Пациенты начинают коммуницировать друг с другом, помогать в решении проблем в отделении

или советами в обществе. Они начинают выслушивать друг друга и делиться опытом схожих переживаний.

Так как внутриличностные конфликты формируются вследствие нарушения отношений человека с миром, а прежде всего с людьми; то я периодически привношу в процесс поддерживающих групп интервенции о групповой динамике и взаимоотношениях между участниками группы. Это делается для того, чтобы наряду с получением и проявлением поддержки, пациенты имели возможность обращать внимание на способы своего взаимодействия в группе и постепенно перестраивать сложившиеся шаблоны поведения и взаимодействия.

2. *Закрытые динамические группы.* Собрать в условиях стационара полноценную динамическую группу, в которой пациенты были бы мотивированы, могли просить о помощи, были бы критичны к своему состоянию, имели примерно одинаковый срок нахождения в стационаре – очень сложно. Но при удаче собрать такую группу, взаимодействие получается очень и очень продуктивным.

3.4 Факторы эффективности стационарных терапевтических групп

Выделим несколько факторов большой эффективности динамических и поддерживающих групп в условиях стационара:

а) *Уровень критических переживаний.* Согласно постулату позитивной психотерапии о развитии первичных актуальных способностей, они могут развиваться двумя основными способами: через пример или через отчаяние (через прикосновение к пиковым переживаниям). Как правило, пациенты, которые по своим способностям, могут допускаться к участию в динамической группе – это люди, дошедшие до очень острого уровня переживаний (вследствие чего они и попали в психиатрическое учреждение) и при этом способные постепенно к этому прикасаться. Пациенты, например, с психотическими эпизодами или тяжелыми депрессиями проходят через отчаяние. Одновременно с этим участвуют в группе, получая пример людей и отношений, через которые можно более полноценно развивать в себе недостающие способности. Именно это и является очень большим движущим механизмом развития. Есть вероятность,

что в стационарной динамической группе будут задействованы оба способа развития актуальных способностей.

б) Наличие времени. Как известно, для рефлексии и контакта с собой нужно достаточно много временного ресурса. Подразумевается время на обдумывание, проживание, нахождение со своими чувствами и эмоциями, чему потенциально способно научить откровенное групповое взаимодействие.

в) Ощущение, что «Я не один». Пациентка, после своего первого группового занятия по арт-терапии, на индивидуальной сессии сказала, что она и не подозревала что переживают и думают другие пациенты. Хотя, ей всегда хотелось об этом узнать.

г) Купирование продуктивной симптоматики лекарствами. Обеспечение медицинскими препаратами и контроль их приема позволяет человеку, прикасающемуся к тяжелым переживаниям, оставаться в контакте с самим собой. Однако, зачастую, лекарственные препараты мешают разговорной психотерапевтической работе.

Одна из основных причин, по которой специалистам не удается собрать психотерапевтические группы в условиях стационара, является постановка чрезмерного акцента на критериях отбора в группу. Очень интересными выдаются критерии Ирвина Ялома для работы со стационарными больными, описанные в книге «Теория и практика групповой психотерапии» (Ялом, 2007):

1. Способность говорить.
2. Способность удерживать свое внимание на протяжении 80 минут.
3. Признание своей потребности в помощи.

Очевидно, критерии достаточно просты. Отбирая участников для стационарных групп и руководствуясь данными критериями, взаимодействие было действительно продуктивным. Ирвин Ялом не делает акцента на диагнозе. Например, во многих источниках говорят о том, что не нужно брать в группу пациентов с диагнозом «умственная отсталость» (или «расстройство интеллектуального развития» по МКБ-11). В наших группах были случаи, когда пациенты с расстройством интеллектуального развития сами проявляли желание присоединиться к группе и вносили вклад в процесс групповой работы. Однако, с такими пациентами также были и

трудности, которые приводили к острым групповым конфликтам. Поэтому, каждый случай и каждого пациента, с точки зрения его возможности находиться в группе, необходимо рассматривать индивидуально.

Недостаток теплоты, заботы и поддержки со стороны медицинского персонала блокирует способность к Контакт у пациентов, вследствие ощущения недоверия. Группа, здесь, является тем «спасающим» для пациентов местом, в котором есть возможность ощущать, проявлять и развивать Доверие. Также, в группе большой акцент делается на Надежде. Так как учитывая тяжесть состояния больных, Надежда является важным звеном в процессе помощи. Пациентам, находящимся в отчаянии, бывает очень полезно понять причины, которые привели к тому, что происходит в жизни на данный момент. Понимание причин дает возможность сделать выбор. «Нами управляет то, что мы не осознаем». Дает возможность проанализировать и сделать шаг в другом направлении; что добавляет Надежды на изменения в будущем. Также, группа отлично развивает Контакт и Открытость. А как известно, одна из основных причин формирования психопатологии и фактор, сильно усугубляющий состояние – это неспособность пациента к выражению чувств и их блокирование. Принятие, также, является одной из важнейших способностей, развивающихся в отношениях в группе.

Как видно из выделенных выше актуальных способностей, большинство из них – это первичные способности. Акцент сделан именно на них, поскольку наличие психопатологии, в большинстве случаев, предполагает глубокий дефицит в структуре эмоциональных потребностей (например, в принятии). И именно в психотерапевтической группе возможно внести вклад в их развитие.

Карл Роджерс говорил о трех основных принципах взаимодействия между людьми, лежащих в основе лечения (Роджерс, 2001):

1. Безусловное принятие. Которое совпадает со способностями к принятию и терпению в позитивной психотерапии.
2. Конгруэнтность. Что схоже со способностью к открытости и доверию в позитивной психотерапии.
3. Эмпатия. Эмпатия предполагает способность к контакту.

Неоспоримые принципы Карла Роджерса подтверждают важность именно первичных актуальных способностей. Это можно сравнить с фундаментом, на котором строится лечение и адаптация пациента.

Способность к открытости, в условиях стационара, имеет первостепенную важность среди вторичных АС. Если возможно её развивать у пациентов стационара, то вероятно и освобождение множества лежащих внутри переживаний и чувств, которые и привели человека к психопатологии. Однако, очень важно соблюдать баланс вежливости и открытости, в условиях стационарного лечения. Зачастую приходилось наблюдать, как открытое выражение эмоций (например, плача) воспринималось медицинским персоналом как ухудшение состояния человека и ему лишь добавляли дозу лекарств. Поэтому, очень важно помочь человеку найти тот способ и место выражение эмоций, которое будет безопасным для самого пациента и будет давать ему чувство облегчения. Например, в психотерапевтических группах или на индивидуальных психологических сеансах.

Стоит отметить, что через развитие контакта и первичных способностей, у пациентов стационара, происходит развитие способности к Любви. Под развитием способности к любви, в данном случае, я понимаю рост теплого, принимающего и эмпатичного отношения к себе и другим.

Особенность стадий взаимодействия (слияние, дифференциация и отделение), в данном случае заключается в том, что пациентам стационара крайне сложно их отслеживать и понимать степень отношений с другими людьми. Некоторым пациентам сложно войти в стадию слияния, так как она автоматически ассоциируется у них с опасностью. Таким пациентам требуется больше времени. На стадии дифференциации может наблюдаться некоторое сопротивление к отделению; попытки зацепиться за слияние с группой. Что может выражаться в частом возникновении чувства обиды, протеста и даже усиление остроты симптомов. Важно отметить, что в условиях стационарного лечения, где в среднем срок нахождения пациентов не принудительного лечения составляет 2–6 месяцев, нужны группы психологической поддержки, нежели полноценные закрытые группы. В группах поддержки основное

взаимодействие происходит на стадии слияния; однако оно не настолько глубокое, как в закрытых динамических группах. Группа поддержки проводит человека на этапе переживания глубокого психического и эмоционального кризиса.

3.5 Примеры из практики ведения групп в условиях стационара

Предлагается кейс одной из пациенток. Елена (имя изменено). 31 год. Наблюдается с диагнозом «Параноидная шизофрения» (F20.0). Госпитализация, во время прохождения групповой психотерапии, 14-я. На индивидуальных терапевтических встречах, а также на первом групповом занятии, пациентка была отгорожена, а ее высказывания касались сверхценных идей отношения других к Елене. Всю первую группу она просидела отодвинутой от всех, в небольшом углу. На протяжении первых встреч она вела себя схожим образом, что и на индивидуальной психотерапии: говоря о себе и пытаясь показать всю тяжесть своего положения, пациентка практически полностью отгораживалась от возможности получения поддержки, заботы и теплого отношения от других участников группы. Постепенно, у участников группы начала возникать злость и желание исправить восприятие Елены. Некоторые участники открыто выразили свою критику. Постепенно, автор вносил интервенции по поводу ощущения беспомощности, возникающего в группе и вызывающего злость и желание исправить человека. А также о том, что мы периодически сами бываем в настолько тяжелом положении, что отрицаем любую возможность помощи и поддержки со стороны. Группа достаточно быстро ушла от попыток критики Елены. Участники стали больше доверять и делиться собственным опытом. Постепенно, по истечении 5–8 встреч, Елена понемногу стала доверять участникам группы. Да, она всё еще не умела принимать заботу и поддержку, но, даже несмотря на короткий промежуток времени нахождения в группе, она перестала выставлять жесткие стены в ответ на теплую обратную связь. Вместо этого она начинала смеяться и пытаться перевести тему. Но она перестала реагировать враждебностью на желание другим ей помочь.

Столкновение между глубокой потребностью в помощи и поддержке, вместе со стойкой убежденностью в невозможности получить это для себя создает внутриличностный конфликт, в котором актуальные способности к открытости, доверию, принятию, контакту могут быть развиты во взаимодействии в психотерапевтической группе. Постепенно, приводя к возможности сближения с другими и формированию эмоционально значимых отношений.

Другая пациентка настолько полюбила группы поддержки, что ходила в них на протяжении всего срока принудительного лечения (1,5 года). Каждую встречу она ждала с нетерпением, говоря о том, что это единственное, что приносит ей помощь, интерес, чувство общности во время нахождения в стационаре. Она с глубоким интересом анализировала себя, собственное прошлое, слушала опыт других пациентов и делилась собственным.

Был опыт, когда пациенты, устанавливающие близкий доверительный контакт на групповой психотерапии, продолжали поддерживать друг друга вне стен больницы, обмениваясь личными контактами и помогая решать возникающие социальные проблемы.



Рис. 2. Основные актуальные способности, развивающиеся в стационарной групповой психотерапии и группах психологической поддержки

Как видно из схемы (рис. 2), способность и потребность в контакте размещена в центре, как самая значимая и необходимая во время нахождения на стационарном лечении. Именно близкий открытый контакт с другими пациентами и специалистами, способен развить те актуальные способности, которые помогут пациенту повысить его реабилитационный потенциал.

Заключение

1. В российской психиатрической практике необходим кардинальный пересмотр как целей функционирования психиатрических учреждений, так и их условий. Важно, чтобы основной целью была не изоляция пациентов, а помощь им, переход к более гуманному отношению. А условия должны удовлетворять потребности пациента в заботе, в теплом отношении, в надежде и помощи.

2. Психологическая служба психиатрических учреждений, в первую очередь, должна дать человеку возможность выстраивать новый способ отношений с окружающими людьми и самим собой: через индивидуальную и групповую психотерапию пациентов, заинтересованное взаимодействие с врачами и родственниками. Это развивает способности человека к дальнейшей социализации, адаптации и интеграции в общество.

3. Для многих пациентов стационарного лечения, особенно в период пандемии и изоляции, важны групповые формы работы с соблюдением необходимых защитных мер.

Таким образом, ведение групповой работы с пациентами, с точки зрения метода Позитивной и Транскультуральной Психотерапии, позволяет достаточно комплексно и осознанно подойти к руководству группой. В стационарных условиях есть возможность для развития как первичных, так и вторичных актуальных способностей. Позитивная концепция человека позволяет разглядеть в каждом пациенте его ресурсы и способности.

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Ограничения исследования

Пандемия коронавирусной инфекции существенно затруднила возможность проведения как терапевтических групп, так и групп психологической поддержки. Однако, с другой стороны, пандемия помогла понять важность группового взаимодействия для пациентов. В период обострения инфекции, групповой работы с пациентами не проводилось, в периоды спада заболеваемости, группы были только в некоторых отделениях с очень ограниченным количеством пациентов и применением защитных мер.

INTERNATIONAL PROVERBS ABOUT HOPE



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Abstract

The base for every treatment is hope. To understand the concept of a patient about the future and to stimulate a process of widening the horizon proverbs about hope can be used. As a help for a therapist to use this tool a paper seized DIN A 4 was created which offers a collection of international proverbs. Some practical hints are given how to use the paper. Also, the paper can be used by the patient afterwards to transmute the role within the family from a source of trouble into a source of encouragement.

Keywords: hope, fantasy, proverb, transmutation, Positive Psychotherapy

Introduction

Due to their different developmental pattern, The emotional and motivational base for every treatment is hope [Peseschkian, Aziz 2009, p. 64]. Hoping is the combination of two abilities. On one side there is the abilities to remember well doing experiences in the past. On the other side there is the ability to imagine new well doing experiences in the future. The imagination might be similar as the previous ones or even totally different.

Treatment is a cooperation between a therapist and a patient for the benefit of the patient following rules which make sense to both, even if the basic ideas behind this vision may differ from each other. As first common step they must talk about their visions of hope. Doing this they start with the relaxing part of the complicated emotional situation, causing the wish or the need for treatment. Thus, the danger of a failing start of the first meeting is averted. Doing this the chances for a positive start of the meeting rise at once. And this positive experience encourages the

imaginations of further positive experiences with each other. The more desperate a patient is, the more important is to direct the attention on positive aspects of life. And talking about hope is a subject everybody understands at once. And hope is a subject each of the members of the patient's social system have an attitude to, which is mostly known by the patient. So, the therapist can ask the patient about their concept of hope. Thus, it is possible to understand the social position of the patient and to discover chances to change it.

Talking about hope is not only important at the beginning of a therapy, but also in every situation a crisis is raising or has already overwhelmed the patient with the unsolved problems. Then talking about hope is an important way to stabilize the slackened emotional status and identity. And as the treatment goes on, the concepts of hope sometimes change. Because of this it might be usefull to return to the earlier attitude of hope and to compare it with the actual result of the latest development.

Hope is the ability to calculate with possibilities, which are not known in the presence. So, hope is closely

related with fantasy. To make talking about hope more sufficient the abilities of fantasy on side of the patient and of the therapist must be encouraged. For that purpose, the Positive and Transcultural Psychotherapy uses the technique of telling stories or proverbs. The* method of offering the patient a great variety of international proverbs about hope is an invitation to enlarge the horizon of fantasy [Peseschkian 1979, p. 7]. For this purpose I developed a DIN A 4-sized paper containing proverbs about hope from many places and cultures [Personal comments 2009-2013; Özcan, Seuß 2013; www.sprueche-liste.com; www.sprueche.woxikon.de; www.sprichworte-der-welt.de]. Some of the proverbs in this collection can be exchanged with a few from the cultural background of the patient which are familiar to him or her

Application

Handout with international proverbs about hope:

What kind of hope do you have when facing your problems?

“Actually, it is not difficult to reach the top of a mountain. You only have to walk slowly enough.”

“It is better to stumble while going new ways than to just run in place on the ways you know.”

But how do you find your way and your speed? Without hope, nothing will be possible.

But: Which hope guides to which aim? Therefore: Which kind of hope do you have?

International proverbs:

If hope didn't exist, I wouldn't be alive now. (Germany)

On one hand, I still hope, but on the other hand, I still doubt. (Germany)

Hope is something you don't have to buy. (Germany)

Is the way ahead of you in darkness? Remember: the curtain is only before your eyes, but not in your way. (Turkey)

No matter how much snow is falling, it will not remain until summer. (Turkey)

When God closes the silver door, he opens the golden one. (Turkey)

If you don't know how to go on, there are still four solutions left. (Bulgaria)

Hope is just a swimming vest, but not a lifeboat. (Poland)

Hope without strain is like a sea voyage without a ship. (Wales)

He who harnesses the hope before his cart, will drive twice as fast as before. (Poland)

Even the stake hopes that it will become green again when next spring returns. (Finland)

Hope is the anchor of the world. (Bantu)

The smaller the lizard, the bigger its hope to become a crocodile one day. (Abyssinia)

Hope and courage are two bright diamonds in the crown of success. (India)

If you lose a hope which was in vain, you will gain a lot. (Italy)

- Which proverb encourages you?
- What is the next step that this proverb encourages you to take?

Practical hints:

Print this handout and give it to the patient.

Ask the patient to read this handout aloud. It usually takes between two or three minutes to read it. This allows to check the measure of the patient's ability to read, which may give information about the intellectual status, and discover psychotic disorders of thinking. By listening to the patient's reading, it is possible to watch the patient's spontaneous reactions.

After the patient has read the handout, you may begin to talk with the patient about these proverbs.

At the end of this therapeutic session, you may encourage the patient to take the handout home, for him/herself and for presentation to the family. Thus, you help the patient to change his or her role at home. Very often a patient is defined by the family mainly as a cause for troubles and the family hopes that his visit to a psychiatrist or psychotherapist will bring release for him/herself and for them. If the patient presents them with this handout, the family members learn at once that they are included in the therapy and that they shall be encouraged also. The patient thus transmutes his or her role from a cause for troubles into a cause for hope and the patient can read the handout together with the family members and talk about their situation in a new and simple way. Their discussion can unbolt various blockades that have existed within and between them.

Conclusions

The base for every treatment is hope. To understand the concept of a patient about the future and to stimulate a process of widening the horizon proverbs about hope can be used.

As the therapy progresses, it is possible to return to this collection of proverbs and see whether the process of learning has caused the patient to change his or her favorite proverb.

As a help for a therapist to use this tool a paper sized DIN A 4 was created which offers a collection of international proverbs. Some practical hints are given how to use the paper. Also, the paper can be used by the patient afterwards to transmute the role within the family from a source of trouble into a source of encouragement.

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ХАОС VS ПРОДВИЖЕНИЕ: КАК НЕ ИСЧЕЗНУТЬ В ИНФОРМАЦИОННОМ ПРОСТРАНСТВЕ

CHAOS VS PROMOTION: HOW NOT TO DISAPPEAR IN THE INFORMATION SPACE



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Аннотация

Данная статья посвящена тонкому и сложному вопросу конкуренции методов психотерапии, этике и стратегии их продвижения, задачам и цели популяризации метода, а также роли в этом каждого из нас, как носителей метода Позитивной Психотерапии. Целью статьи является привлечение внимания коллег к такому важному и ценному делу, как проявление себя в информационном пространстве и последствия отказа от такового.

Ключевые слова: Позитивная Психотерапия, популяризация, социальные сети, ключевой конфликт, баланс

Abstract

This article is devoted to the delicate and complex issue of competition between methods of psychotherapy, ethics and strategies for their promotion, the objectives and goals of popularizing the method, as well as the role in this of each of us as carriers of the method of Positive Psychotherapy. The purpose of the article is to draw the attention of colleagues to such an important and valuable matter as manifesting oneself in the information space and the consequences of refusing it.

Keywords: Positive Psychotherapy, popularization, social networks, key conflict, balance.

Вступление

«Мы не добиваемся правды, мы добиваемся эффекта» - говорил апологет пропаганды, не брезговавший ни серой, ни черной информацией в деле завоевания умов. Апологета сожгли, а вот его

приемы остались, въевшись в коллективное бессознательное настолько, что уже не воспринимаются, как нечто, противоположное правде.

Причем тут мы, мирная профессия, помогающая людям стать счастливее, успешнее, здоровее? Ответ

в нашем профессиональном пространстве, где рекламные трюки, попсовые переработки сложных теорий, противостояние и информационный мусор преобладают. И не просто наводняют пространство, а создают серьезное препятствие человеку в выборе способа преодоления проблемы.

Для специалиста, решившего стать психотерапевтом, вопрос какой же метод выбрать – это не только о личном совмещении с уровнем интеллекта, философией и инструментарием метода. Это еще и вопрос – насколько метод привлекателен для клиентов и уважаем в профессиональной среде.

И мы неминуемо столкнемся с качеством информационной среды. Ключевым станет, насколько она отражает реальность и дает возможность сделать объективный и свободный выбор как специалисту, так и потенциальному клиенту. Главный вопрос насколько все это зависит от каждого из нас предлагается рассмотреть предметно далее.

Процесс цифровой трансформации общества – данность, которой не избежать. И именно в мировом интернет-пространстве, социальных сетях формируется сейчас отношение к психологии, психотерапии, как инструментам исцеления и роста. Только на Facebook около сотни тематических групп, где люди пытаются найти ответы и рекомендации.

Крайне важно учитывать особенность постсоветского пространства и развивающихся стран, где психологическая просвещенность невелика, а лояльность к психотерапии еще меньше. Потому люди преимущественно обращаются к соцсетям за рецептом от душевной боли и от того, что они там прочтут, зависит очень многое.

И на сегодня большое количество ответов – это непрофессиональные рецепты от экстрасенсов, распространителей БАДов, психологов-самоучек, и воодушевленных собственной терапией клиентов. Но плотность этих рекомендаций преобладает настолько, что создает впечатление истины. Именно потому, так много людей долгие годы следуют им.

С одной стороны, эти советы не на пользу клиентам, но с другой стороны, они – хорошее поле работы с невежеством и непросвещенностью людей, отличный повод психотерапевту заявить и о возможностях метода, и о себе.

Но голос психотерапевтов слаб и не звонок, и люди вынуждены выбирать из того, что предлагается, а возложить всю ответственность за выбор на клиента опасно. «Ослабление когнитивных процессов и переход на «детское» правополушарное мышление – результат стресса, приводящий к принятию иррациональных решений» (Сандомирский, 2005). Таким образом, сотни тысяч людей, находящихся в тяжелых жизненных обстоятельствах, просто доверятся информационному пространству.

Но является ли сегодня информационная среда сбалансированной, объективной о методах помощи в душевных страданиях? Достаточно ли мы, как представители научного метода психотерапии, проявляемся в ней? И как мы участвуем в противостоянии?

Но противостоянием «псевдоцелители VS специалисты в области психических процессов» дело не ограничивается. Специалисты не улучшают шансы клиентов на получение эффективной помощи.

Первое, что привлекает внимание неправильностью, это оспаривание психиатрами, психотерапевтами с медицинским образованием, психотерапевтами без медицинского образования и психологами прав друг друга на психологические интервенции. Обычному человеку в этом споре почти невозможно разобраться.

Таким образом, второй уровень противостояния, в которое мы втянуты, это «психотерапевт метода VS иные специалисты в области психических процессов».

Но даже там, где сталкиваются только психотерапевты, возникает не менее яркое противостояние – противостояние методов.

Давайте проследим, в какое информационное пространство вариантов попадет современный клиент, если попытается разобраться в методах психотерапии.

«Окей, Google!»

Запрос: «лучшие методы психотерапии». Результатов: примерно 2 640 000 (0,52 сек.)

И первый выделенный фрагмент поиска категоричен: «Эффективные методы психотерапии:

- Психоанализ
- Аналитическая психология
- Когнитивно-поведенческая терапия
- Гештальт-терапия

- Экзистенциальная терапия
- Десенсибилизация и переработка движением глаз»

Среди ссылок первых двух страниц поисковой выдачи представлены эти же методы, и увы, отсутствуют упоминание о методе ППТ.

Специалисты знают, что подобные утверждения беспочвенны, а такие заявления не этичны. Но об этом не знают и не подозревают клиенты, в чьих умах прочно поселяется мысль о том, к кому же можно обращаться.

Как обычному человеку разобраться в вопросе, какой метод психотерапии эффективен, если путаница начинается на самом высшем уровне? Так, Всемирная организация здравоохранения в «Руководстве mhGAP-IG по оказанию помощи в связи с психическими и неврологическими расстройствами, а также расстройствами, связанными с употреблением психоактивных веществ, в неспециализированных учреждениях здравоохранения», говоря о способах психологического лечения дает двусмысленный перечень. Среди приемов интервенции упоминаются несколько методов психотерапии:

«Рекомендуется: Поведенческая активация, Обучение приемам релаксации, Терапия, направленная на решение проблем, Когнитивно-поведенческая терапия, Лечение методом управления непредвиденными обстоятельствами, Семейное психологическое консультирование или психотерапия, Интерперсональная психотерапия, Психотерапия, направленная на активизацию мотивации».

Не удивительно, что страны дублируют подобные рекомендации в своих протоколах лечения. Так, например, Украина ввела Унифицированный клинический протокол первичной, вторичной и третичной медицинской помощи. Реакция на тяжелый стресс и расстройства адаптации, ПТСР; или Унифицированный клинический протокол первичной, вторичной и третичной медицинской помощи. Депрессия, в утвержденном приказом МОЗ Украины 23.02.2016 № 121, обязывает врача: «предложить пациенту и координировать с ним специализированные и высокотехнологичные виды психотерапии (терапия решения проблем, короткая когнитивно-поведенческая психотерапия (КПТ) и консультирование – в течение 6-8 сеансов около 10-

12 недель). Решение о месте проведения и специалисте, который будет проводить определенный вид психотерапии, принимается вместе с пациентом».

Таким образом, люди, страдающие депрессией, соматоформными расстройствами и психосоматическими заболеваниями, неврозами, ПТСР и стрессовыми расстройствами должны согласовывать с врачом психотерапевта, с которым будут работать, и он может быть только в методе КПТ.

Дискуссия о возможности научно доказать и подтвердить эффективность метода на сегодня не закрыта, и однозначный ответ не получен. Более того, сегодня идет горячая дискуссия о том, как вообще оценить эффективность психотерапии валидно (Чушке, 2015).

Таким образом, мы, как представители Позитивной психотерапии, уже втянуты (и не по своей воле) в несколько уровней противостояния.

Обсуждение

Важно помнить, что психотерапевты постсоветского пространства и развивающихся стран, в отличие от европейских, американских коллег, на стадии «грязных» работ в деле строительства рынка психотерапевтических услуг: разгребания мусора и закладки фундамента. Этот факт напрочь лишает нас возможности почивать на лаврах победы разума над невежеством. Нам предстоит еще много работы.

Начинать нужно с освоения маркетинга, а именно азов продвижения (promotion). Основа продвижения – информирование. Это база, на которой возможна вся последующая надстройка: формирование престижности, поддержание популярности, изменение стереотипа восприятия, лояльность методу.

Давайте посмотрим, с какой плотностью информации столкнется клиент, захотев подробнее ознакомиться с методами психотерапии из вышеупомянутого перечня:

«Окей, Google!»

«Транзактный анализ» Результатов: примерно 220000 (0,54 сек.)

«Когнитивно-поведенческая терапия» Результатов: примерно 1820000 (0,58 сек.)

«Гештальт терапия» Результатов: примерно 1210000 (0,57 сек.)

«Телесно-ориентированная психотерапия»
Результатов: примерно 1470000 (0,59 сек.)

«Психоанализ» Результаты: примерно 3100000
(0,70 сек.)

Теперь рассмотрим результат для ППТ:

«Позитивная психотерапия» Результаты:
примерно 193 000

«Позитивная кросс-культурная психотерапия»
Результатов: примерно 49 800 (0,46 сек.)

Очевидно, что такая структура – вовсе не результат количества психотерапевтов в том или ином методе. Это результат активности.

Очень важно помнить, что продвижение метода психотерапии – это совсем иной феномен, нежели продвижение товаров. По сути, мы меняем взгляд на устройство человека. Согласитесь, это о науке более, нежели об услуге. И тут важно понимать, что просто информировать не получится.

«Переход к новой парадигме не может основываться на чисто рациональных доводах, хотя этот элемент значителен. Здесь необходимы волевые факторы – убеждение и вера» (Кун, 2002).

Убеждение и вера: Верим ли мы в наш метод? Верим ли мы в себя? Знаем ли мы тонкости настолько, чтобы убеждать других в эффективности метода? Убеждаем ли?

В сегодняшних реалиях информирование – это даже не инструмент заявления о себе. Это инструмент противостояния отрицанию метода и его возможностей. Это отстаивание права быть.

Но важно учитывать, что мы не только в атмосфере научной среды, мы в реалиях конкуренции. И то, что происходит в информационном пространстве сегодня, добавляет еще один признак – конфликт. Мы часто оперируем этим понятием, ведь оно ключевое для динамического направления.

«Конфликт – серьезное разногласие, столкновение противоположных сторон, мнений, сил» (Ефремова, 2002).

Что как не конфликт, принятие акта, который навязывает пациенту определённый метод психотерапии, значительно ограничивая права и возможности пациента?

Что как не конфликт, многочисленные и столь категоричные заявления коллег из других методов: «единственный метод, который может помочь вам – это метод ХХХХ».

И тут уместно вспомнить о центральном понятии позитивной психотерапии – ключевом конфликте. В понимании ППТ метода, «имея что сказать – нужно сказать», в противном случае эта энергия становится разрушающей.

Обратимся к четырем вариантам сочетания искренности и вежливости, которым соответствует четыре типа нашего поведения (Кириченко, 2007) и адаптируем их к обсуждаемой проблеме.

«Искренняя вежливость»: мы спокойно реагируем на утверждение о том, что некий метод «единственно действенный», просто игнорируя это.

«Неискренняя вежливость»: уступаем из страха, вяло отделиваясь общими формулировками. Возможная причина – неверие либо не знание силы собственного метода.

«Невежливая искренность»: агрессивно отстаиваем свое мнение, не заботясь об аргументах, упоывая на эмоциональный напор. «Вежливая искренность»: открыто, но вежливо вступаем в диалог, запрашивая аргументы, источники, выражаем свое несогласие и предоставляем свои аргументы.

Немаловажно задуматься, как каждый из нас сегодня преимущественно реагирует на ситуацию научной и деятельной конкуренции направлений, вернее конфликт. Если это молчание, игнорирование или уходом, важно понять почему так происходит. Ведь с точки зрения ППТ метода – это не эффективно. Что мы, как психотерапевты, будем предлагать клиенту, реагирующему на конфликт таким образом? Возвращать вежливую искренность, поскольку у иных вариантов реакции есть негативные последствия.

Нельзя не коснуться еще одного уровня противостояния: психотерапевт против самого себя. Сегодня многие коллеги, пытаясь выиграть в гонке, присваивают себе знания уровня «могу все». Например, заявляя о своей специализации во всех известных психологии расстройствах и проблемах. Или гарантируя применение всех популярных методов. Специалист 27 лет от роду заявляет о работе в 11 методах психотерапии. Некоторые «для надежности» еще и добавляют такие способности, как «энерготерапевт», «нумеролог», «астролог». *«У семи нянек дитя без глазу» (Too many cooks spoil the broth).* Глубокое изучение одного метода и специализация в определенной тематике – это лучшая ли гарантия эффективности и узнаваемости.

Заключение

Таким образом, для усиления своей бытности в информационном пространстве предложены следующие шаги.

Если многие коллеги уже пришли к необходимости иметь сайт и размещать статьи в онлайн изданиях, то активность в соцсетях все еще остается на очень низком уровне. Максимум предпринимаемых усилий заключаются в создании статического контента. Но большой поток запросов и обмен информацией сегодня происходит в объединениях по интересам: группах. Сегодня стоит относиться к работе с ними, как к части своей профессии: ответы на вопросы, разъяснения, отсылка к своим статьям, или статьям коллег. Достаточно найти несколько групп по своей специализации, где люди ищут ответы.

Создание своей группы или аудитории – это более продвинутый уровень, который дает возможность целенаправленно заявлять о себе и методе. И что самое важное в группе: это регулируемое столкновение мнений и взглядов. На сегодня Фейсбук не выдал и десятка групп по запросу «Позитивная психотерапия», как в русскоязычном так и в англоязычном варианте запроса.

У каждого, кто проходил обучение на базовом и мастер курсах есть сотни страниц готовой к публикации информации. Это контрольные работы. Они могут как сразу писаться в формате статьи, так и переделываться позднее. Это полезная и творчески переработанная информация внесет весомый вклад в дело уплотнения информационного поля о нашем методе. Как в виде статей, так и постов или разъяснений.

Люди очень любят истории про людей. Каждая встреча с клиентом – это сокровищница. Короткие заметки об интересном случае (с соблюдением требования конфиденциальности) вызывают живой интерес и дают возможность привлечь внимание как к проблеме, так и к методу ее разрешения.

Но если совсем не хочется писать – информационное поле предлагает говорить. Подкасты – сегодня очень востребованный сектор, и дает не меньшую возможность заявить о методе и о себе.

Сегодня как никогда важно не просто владеть информацией, а загружать ее в пространство. И не просто загружать, а помочь ей стать видимой.

Реклама – не менее важный способ в деле продвижения и метода и себя. Впечатляюще масштабную работу по изучению запретов на рекламу в этических кодексах психотерапевтических обществ разных стран провел психиатр, психотерапевт Кирилл Кошкин, в результате которой сделал однозначный вывод: запрет для психотерапевтов на рекламу – это миф. Реклама должна соответствовать этическим нормам, но она должна быть.

Подводя итог, хочется отметить самое главное – без всех этих мер в современном мире обойтись нельзя. Мы уже втянуты в информационную битву, и возможно нам не выиграть. Но есть такие битвы, где важнее не победа, а противостояние.

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BOOK REVIEW



подготовил Максим Чекмарев

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HELLO CHILDREN! by Amonishvili, S.

ЗДРАВСТВУЙТЕ, ДЕТИ! Ш. А. АМОНИШВИЛИ

Учебное пособие
«Просвещение», 1983
208 стр.

Работая в Дальневосточном Федеральном Университете во Владивостоке, я часто ездил на поездах в Благовещенск. Это почти сутки пути, в которые я брал с собой книгу. Однажды я провёл эти сутки неотрывно за книгой, часто начиная плакать. Соседи по купе оглядывались, но сохраняли вежливую дистанцию. Этой книгой была «Здравствуйте, дети!» Шалвы Амонашвили издания 1983 года - документальные записи педагога о большом эксперименте в грузинских школах. Над следующей его книгой - монографией 1984 года «Воспитательная и образовательная функция оценки учения школьников» я тоже нашёл, где заплакать.

Шалва Амонашвили - грузинский педагог и психолог, создатель концепции гуманной педагогики, в этом году ему исполнилось 90 лет. С 1980-х годов его труды успели получить международное признание. Моя мотивация рассказать об одной из книг Амонашвили в научном журнале, посвящённом Позитивной и Транскультуральной Психотерапии продиктована близостью двух концепций. Много из того, о чём говорил и писал Пезешкиан в области психотерапии перекликается с идеями Амонашвили в педагогике и наоборот. В нашем методе только происходит формирование методологии позитивной педагогики, складывается понимание специфики концепции ребёнка в образовании. В гуманной педагогики эти философские основания хорошо описаны.

В качестве объекта рецензии я возьму книгу Шалвы Амонашвили 2000 года «Школа жизни», которая вышла с подзаголовком «Трактат о начальной ступени образования, основанной на принципах гуманно-личностной педагогики». Она, пожалуй, наиболее лаконично и полно описывает не

только философию, но и практику подхода, затрагивает учебный и воспитательный процесса в школе как в организации.

Книга написана уже в новом тысячелетии и вдруг - «трактат». В языке автора присутствуют намеренные архаизмы. Во-первых, Амонашвили признаётся, что они служат для передачи пафоса и даже романтики педагогики. Ему чужда тенденция восприятия образования как услуги, оно непременно только служение, особая деятельность, не имеющая права потерять ощущение себя как чего-то сакрального. Во-вторых, архаизмы помогают понять, что перед нами неоклассика. После модернистского и постмодернистского подхода к образованию, то есть становления его как массового и стандартизированного явления, а затем имеющего право на плюрализм, автор предлагает задуматься о возвращении к истокам. Что такое педагогическая классика? Какие ценности утверждали в образовании Квинтиллиан, Коменский, Песталоцци, Ушинский, Корчак и Макаренко? Каждый из них предполагал, что ученик - субъект обучения, личность, раскрывающая свой потенциал.

Далее я предложу краткий обзор основных положений гуманной педагогики. Вы легко сможете оценить их близость с позитивным видением человека, что открывает возможность для транскультурального плодотворного обмена между двумя школами.

Описывая свой подход, опираясь на педагогическую классику, Амонашвили предлагает три допущения, три постулата и формулирует три движущих силы.

Три допущения связывают педагогику и духовную традицию. Вот они:

- душа человека есть реальная сущность;
- она устремлена к вечному восхождению и совершенствованию;
- земная жизнь есть отрезок пути восхождения. Здесь автор напоминает нам, что слово «школа» происходит от латинского «scale» - лестница.

Три постулата описывают наше отношение к

ребёнку в гуманной педагогике.

1. Ребёнок есть **явление** (феномен). Феноменологический подход призывает к восприятию ребёнка как уникального человека, который уже живёт, а не готовится к жизни.
2. Ребёнок несёт в себе жизненную **миссию**. В нём скрыт потенциал для прохождения уникального жизненного пути, который должен быть раскрыт и актуализирован образованием.
3. Ребёнок несёт в себе **энергию духа**. Библия говорит о том, что «Дух дышит, где хочет», таким образом и ребёнок не видит границ для своей реализации, способен и стремится выйти за пределы мира, очерченного старшими поколениями.

Три движущих силы обосновывают бессмысленность авторитарного педагогического мышления и постулируют компоненты природосообразного воспитания, которое способно учесть наличие следующих стремлений в душе ребёнка:

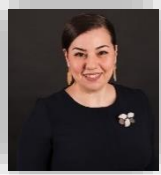
1. Стремление к развитию. Ребёнок не может не развиваться, развитие происходит через преодоление трудностей. Это естественный врождённый процесс, который требует создания условий, а не постоянного мотивирования извне. Он нарушается только при воздействии агрессивной социальной среды, которой может стать и семья, и школа.
2. Стремление к взрослению. Ребёнок рождается не для того, чтобы остаться ребёнком, а для того, чтобы стать взрослым. Поэтому его жизнь - каждодневный выход за пределы себя. Амонашвили предлагает возвести исполнение педагогических процессов до искусства, что поможет чувствовать себя взрослым там, где он вовсе ещё не взрослый, а ребёнок.
3. Стремление к свободе. Оно означает движение к самостоятельности и автономности, которое может превратиться из возможности в реальность при содействии взрослого, через общение и совместную деятельность как с ним, так и самостоятельно.

Вне всякого сомнения, такой взгляд на ребёнка требует новое устройство школы. Современные тенденции стремятся сделать её максимально соответствующей текущим ценностям общества. Гуманная педагогика предлагает сосредоточиться на непреходящих истинах и раскрытии личностного потенциала, который включает физическое, интеллектуальное, эмоциональное и духовное развитие.

Даже беглый анализ основных положений гуманной педагогики позволяет определить этот подход как родственный позитивной психотерапии. В силу интереса у многих наших коллег к формированию нового направления - позитивной педагогики, я настоятельно советую ознакомиться как с трактатом «Школа жизни», так и с иными работами Шалвы Амонашвили.



BOOK REVIEW



by Diana Pop

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**Învățăm împărtășind. Ghid de
experiențe scrise de și pentru
specialistii L&D, Editor: Gabriela
Hum**



**WE LEARN BY SHARING - A GUIDE
WRITTEN BY AND FOR L&D
SPECIALISTS [in Romanian]**

TREI publishing, 2021
348 pages
ISBN: 9786064010124

During the pandemic of 2020, eighteen specialists in learning and development from different companies in Cluj-Napoca (Romania) coordinated by Gabriela Hum started to write a book.

The result?

"We learn by sharing - a guide written by and for L&D specialists" - A great 347 pages book about their personal experience about training and the rules to follow in order to create a good learning experience, how to deliver training and sustain the changes induced by trainings in organizations.

The volume contains five chapters, divided in twenty sections created around the word "learning" and organizational development. The main accent is on the importance of learning and development as part of the Human Resources functions and the importance of learning and development specialists as business partners, points out technical aspects that are part of the need analysis and the design of the interventions, delivery programs, post-delivery learning, careers one could have in learning and development department and exciting possibilities in this area.

It is a new entry book in the HR field and should become the "bible" for each organization and for everyone interested in training area.

What I've noticed when started to read the book was the easy accessible language used, although is a technical book, the language used allowed me - a non-learning and development specialist to understand and to immerse myself into this world. From the first chapter it made me curious about how long the process of creating a training is and how many details are taking into consideration from the first point: the need of training analysis.

It is a book of details but not in a boring,

excessive way. Are those details needed to make a difference and those details who can capture attendance's attention in order the learning process occurs.

The feeling you get while reading this book is not a heavy, tired one, but a feeling of curiosity mixed with enthusiasm, that "Ok, tell me more about it feeling.

I particularly enjoyed Chapter three – "*Training delivery*" and from the title you would expect a "How to" section, but no, imagine this book as a maze, you know where you enter to, you learn how to get out and you will receive all the tools in order to find the way out, but the process will amaze you. And this is the correct word for this Chapter: amazing! When you start to read this chapter the first sentence is: "*When we prepare a training, we start thinking about it as a journey. IT has a starting point where we meet our trip partners, we warm up and we look on the map to see where we need to arrive. Then we start the journey, and we follow some rules to make sure everybody is with us, the guides. And at the end, we say goodbye to each other and take with us the things we learned during the journey, in order to share them and practice them further.*"

The reader will be amazed how good this sentence summarizes the entire chapter: the opening, the group rules, the warm up for the training and the warm up for the specific subject, expectations, everybody's learning style - to make sure "*everybody is with us, the guides*", training delivery and techniques of delivery, group dynamics and visual facilitation.

Another thing I enjoyed is the accent from the last Chapter – "*Possibilities and perspectives in L&D*" on section - *How to train a trainer* – an important aspect and rarely taken into consideration when a training is delivered. And the author Calin Grigorovici points out: "*The training is about the participants not about the trainer*" and the chapter is dedicated to trainer's preparation around three pillars: background, pedagogy and shape.

The entire book focuses not just on information, methods and exercises but on people as well: from the trainer to participants and the organization – which in Romania are timidly beginning to have a culture of learning.

At the end of each chapter, the reader can find a References section, examples of exercises, tools to be used in trainings and a practice area where the reader is invited to be part of the journey.

If you are not a learning and development specialist like me, maybe your question will be: "Why to buy this book?"

My answer to you will be: you should buy it for your own personal development, because we learn something each day and with each experience we encounter in live we can easily become trainers for our children, clients, students etc. And most of the exercises and information found in this book can be easily used in day to day practice.

The learning process is not just for organizations, is for everybody, every day in our life.

WAPP NEWS

- July 2021

Dear WAPP members,

Dear friends and supporters of Positive Psychotherapy worldwide,

Over the past six months, the WAPP Board of Directors and the Head Office – with much support of our members – have implemented many innovative ideas and developed existing projects:

- ✓ WAPP has launched a course monitoring system.
- ✓ The WAPP Board has developed an information leaflet on self-discovery.
- ✓ An international edition of a Textbook on “Psychodynamic Positive Psychotherapy” is in the process of being published, and will soon be translated into many languages.
- ✓ The WAPP Board of Directors has developed criteria for the admittance of Master Course participants.
- ✓ WAPP president Dr. Hamid Peseschkian has been appointed to the Council of the International Federation of Psychotherapy (IFP).
- ✓ Two online meetings with trainers, one of them was dedicated to self-discovery.
- ✓ One online meeting with centers and organizers of PPT courses.
- ✓ Monthly online meetings of the WAPP Board of Directors.
- ✓ Preparation of international online and offline conferences.

As well as other significant news, please find below.

WAPP establishment of Committees

The World Association for Positive and Transcultural Psychotherapy (WAPP) has formed 4 Committees to discuss and work on the following four main topics of our organization: Governance; Membership; Training; Publications.

Our Association has grown to about 1,900 members in 36 countries this year. The topics become more complex and wider. The WAPP Board of Directors meets once a month by video conference to discuss a constantly enlarging number of issues. Still, many subjects need a closer look and research – and most important – different views and opinions.

Therefore, the Board has appointed some colleagues among our members to help us bring our Association to the next level. 19 of the nominated members volunteered to join the Committees. Together with the Board members they form the following groups of 27 persons from 12 countries:

Governance Committee	Membership Committee	Training Committee	Publications Committee
Strategy, plans, headoffice, staff, agenda, board issues, annual meetings, elections, legal affairs	Membership, finance, budget, events (World Congress, ITS, conferences)	Trainers and trainings, evaluation, training standards, specialized courses, centers, associations, EAP/ECP	Publications, Journal supervision, translations, Social Media, Website, Internet
governance-committee@positum.org	membership-committee@positum.org	training-committee@positum.org	publication-committee@positum.org
Hamid Peseschkian	Ewa Dobiala	Gabi Hum	Olga Lytvynenko
Raluca Ursica	Tinia Tober	Ivan Kirillov	Stefanka Tomcheva
Daria Krebs	Anna Wyszadko	Maxim Goncharov	Irina Kuklina
Fariba Karamloo	Ekaterina Dokunova	Natalia Khanetska	Erick Messias
Liudmyla Moskalenko	Adela Moldovan	Polina Efremova	Ovidiu Damian
	Denys Lavrynenko	Oana Bodor	Klaudia Sujecka
		Ocean Liu Yang	Oana Cuesdeanu
		Oleksandra Nizdran-Fedorovych	Maksim Chekmarev

There will be more committees, subgroups of the committees, or working groups for which we will be happy to find volunteers in the future.

The new possibility of meeting online over continents and time zones enables us to consult and meet more frequently and to finally get things started.

A first meeting of all Committees took place in May, subsequent meetings of the Committees are now frequently taking place and are very fruitful and inspiring. Their ideas and suggestions are presented to the WAPP Board and, if approved, are realized in close cooperation of Committees, Board, and Head Office.

We very much look forward to the new developments the work of our new Committees will bring.

Many thanks to all of you who fill this organization with life and experience – and special thanks to our new Committee members for your readiness and for adding your ideas!

WAPP by-elections

Due to the resignation of a Board member a by-election was needed. The Board was calling for an extraordinary (online) assembly meeting, which was held by Zoom on 29 of April 2021.



Altogether we had 11 nominations for members from 8 countries, of who 7 were ready to candidate for the WAPP Board. Thank you for nominating them and showing them your trust and respect. The election was only possible by electronic vote and took place in April. 311 members eligible to vote participated in the election.

The newly elected member is Dr. Stefanka Tomcheva from Bulgaria. More than 50 members from 3 continents participated in the extraordinary (online) assembly on 29 April, in which the by-election results were announced.

Brand new website launching

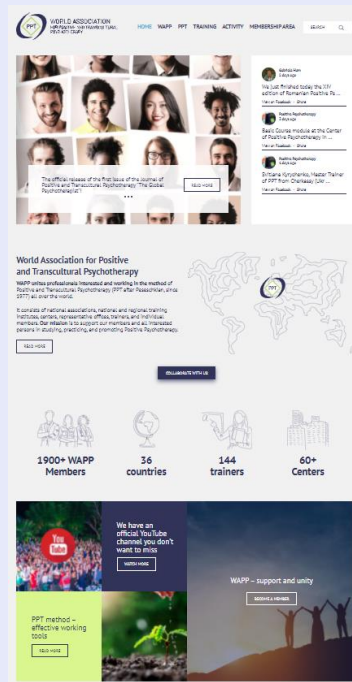
WAPP has released a brand new website (www.positum.org). It is more contemporary, easy to navigate, and full of useful information.

There is a special section "Publications" where we've collected all available PPT publications: books, articles, presentations, training and promo materials.

You can filter it by type and language.

Of course, the new website again has the member list sorted by countries and other features you were used to on the old website.

It also has a member login that allows WAPP members to get more information than other users of the site. It offers more news, training materials, details on publications and articles.



International Training Seminar (ITS) 2021 – Registration is open



We are happy to announce the next International Online Conference on PPT: 9-10 October 2021. Due to the pandemic the ITS will again take place online via Zoom.

Registration is open – [Register>>](#)

9 October 2021 – Trainers day: only for trainers and candidate trainers - plenary meetings, seminars, workshops on trainer and training related topics and self-discovery groups.

10 October 2021 – Open day: plenary meetings and workshops - open for everyone.

Seminar language will be English and partly Russian, translation for individual presentations needs to be organized by presenter, translation to other languages please also organize yourself. More information about the scientific program is on our website.

We are delighted to see the growth of the WAPP community as well as the increase of the quality of PPT trainings all over the world. Despite the COVID-19 pandemic, WAPP remains continually active thanks to members contributing time and expertise.

*With deep gratitude
WAPP Board of Directors and Head Office*

World Association for Positive and Transcultural Psychotherapy (WAPP)

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THE GLOBAL PSYCHOTHERAPIST

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INFORMATION AND GUIDELINES FOR AUTHORS

Full and up-to-date "Information and Guidelines for Authors" are on the JGP website:

<https://www.positum.org/ppt-journal/>

The Global Psychotherapist (JGP) is an interdisciplinary digital journal devoted to Positive Psychotherapy (PPT after Peseschkian, since 1977)[™]. This peer-reviewed semi-annual journal publishes articles on experiences with and the application of the humanistic-psychodynamic method of Positive and Transcultural Psychotherapy. Topics range from research articles on theoretical and clinical issues, systematic reviews, innovations, case management articles, different aspects of psychotherapeutic training and education, applications of PPT in counselling, education, and management, letters to the editors, book reviews, etc. There is a special section devoted to young professionals that aims to encourage young colleagues to publish. The Journal welcomes manuscripts from different cultures and countries.

The languages of articles are: English and Russian. Each article must have abstracts in English and for Russian articles – in English and Russian. For English language editing, authors may ask our English language editor, Dr. Dorothea Martin (USA/Albania), for assistance. This service is free-of-charge for authors. But, this is only for editing, not for translation – email via journal@positum.org.

Review Process: All manuscript submissions - except for short book reviews - will be anonymised and sent to at least 2 independent referees for 'double-blind' peer-reviews. Their reviews (also anonymised) will then be submitted back to the author. Submitted articles are checked in the "Antiplagiat" system and are accepted in case of a satisfactory result (determined for each of the articles on an individual basis by the ratio of the original text fragments, borrowed fragments and the presence of formalized links).

Submissions can only be sent by an email attachment in DOC, DOCX, RTF format to journal@positum.org.

For article's formatting, including information about the authors, the Editorials ask authors to use special templates.

- For scientific sections: [Template for scientific articles](#)
- For practical sections: [Template for practical articles](#)
- Book reviews and letters are accepted in free form.

An author can publish only one paper per issue.

In exceptional circumstances, longer articles (or variations on these guidelines) may be considered by the editors, however, authors will need a specific approval from the Editors in advance of their submission. (We usually allow a 10%+/- margin of error on word counts.)

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References: The author must list references alphabetically at the end of the article, or on a separate sheet(s), using a basic Harvard-APA Style. The list of references should refer only to those references that appear in the text e.g. (Fairbairn, 1941) or (Grostein, 1981; Ryle & Cowmeadow, 1992): literature reviews and wider bibliographies are not accepted. Details of the common Harvard-APA style can be sent to you on request or are available on various websites.

In essence, the following format is used, with exact capitalisation, italics and punctuation.

Here are three basic examples:

[1] For journal / periodical articles (titles of journals should not be abbreviated):

FAIRBAIRN, W.R.D. (1941). A revised psychopathology of the psychoses and neuro-psychoses. *International Journal of Psychoanalysis*, Vol. 22, pp. 250-279.

[2] For books:

PESESCHKIAN, N. (2016). *Positive Psychosomatics: Clinical Manual of Positive Psychotherapy*, Bloomington, USA: AuthorHouse UK.

[3] For non-English resources:

ШПИГЕЛЬБЕРГ, Г. М. [SPIEGELBERG, H. M.] (2002). *Феноменологическое движение. Историческое введение* [Phenomenological movement. Historical introduction]. М.: "Логос". 608 с.

[4] For chapters within multi-authored books:

PESESCHKIAN H., REMMERS A. (2020) *Positive Psychotherapy: An Introduction*. In: Messias E., Peseschkian H., Cagande C. (eds), *Positive Psychiatry, Psychotherapy and Psychology*, (pp. 3-9). Springer, Cham.

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<https://www.positum.org/ppt-journal/>