

THE GLOBAL PSYCHOTHERAPIST

July 2023
Number 2
Volume 3

JOURNAL OF POSITIVE AND TRANSCULTURAL PSYCHOTHERAPY



WORLD ASSOCIATION FOR POSITIVE
AND TRANSCULTURAL PSYCHOTHERAPY

ISSN: 2710-1460
Published by WAPP
www.positum.org

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The Global Psychotherapist (JGP) is an interdisciplinary digital journal devoted to Positive and Transcultural Psychotherapy (PPT after Peseschkian, since 1977)TM. 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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Published by: World Association for Positive and Transcultural Psychotherapy (WAPP)
Luisenstrasse 28, 65185 Wiesbaden, Germany

Email: wapp@positum.org

Website: www.positum.org

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ISSN: 2710-1460 (Online)

WAPP as a publisher is a member of **Crossref** registration agency.

All peer-reviewed articles published in *The Global Psychotherapist Journal* (JGP) have a **DOI**.



The Journal (JGP) is currently **archived** on WAPP's official website and **indexed** in:



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Welcome Letter by the Editorial Board

Dear Readers,

Welcome to the new issue of "The Global Psychotherapist" PPT Journal, Volume 3, Number 2, for July 2023. As we embark on this new edition, we find ourselves in a world grappling with numerous challenges and complexities. The evolving nature of our society, marked by war, migration issues, religious conflicts, and diverse cultural perspectives, necessitates a deeper understanding of the transcultural aspects of psychotherapy. Furthermore, the increasing prevalence of mental health disorders calls for innovative approaches and comprehensive solutions. Psychotherapists play a vital role in providing support and guidance to individuals facing diverse diagnoses and illnesses, bridging the gap between cultural differences and the universal need for healing.

Within this issue, we aim to shed light on the multifaceted issues faced by psychotherapists around the globe and showcase the innovative approaches and research being conducted in the field. We have curated a diverse collection of articles that delve into the realms of mental health, therapy techniques, and emerging trends, all aimed at providing valuable insights and practical guidance for professionals in the field.

We begin with the section on *"Research and Innovation in Positive Psychotherapy"*, **Ali Eryilmaz and Dilay Batum** contribute with their article "Examination of Impulsivity in Positive Psychotherapy Structures." Focusing on impulse control problems among adolescents, the authors explore the predictive role of primary and secondary capabilities in impulsive behavior. Through a study involving 225 male adolescents, they find that both primary and secondary capabilities significantly predict impulsivity. Notably, hope from the primary capabilities and orderliness, diligence, reliability, and obedience from the secondary capabilities emerge as significant predictors. The colleagues, **Ivan Kirillov, Polina Efremova, Ewa Dobiala, and Ivan Pleshakov**, present a thought-provoking article titled "Primary Capacities as a Predictor of Perceived Stress, Anxiety, and Depression in the Pandemic Crisis of COVID-19. Through an international survey of 1165 respondents, they discover a significant correlation between lower levels of integration of specific primary capacities and higher levels of perceived depression, anxiety, and stress. These findings not only contribute to our understanding of the impact of primary capacities but also emphasize their relevance in times of crisis. Furthermore, we feature an article by **Aleksandra Zarek**, which conducts a correlational analysis among concepts used in positive psychotherapy, social competences, attachment styles, and stress-coping strategies in a sample of 93 female students of psychotherapy. The results reveal interesting correlations between social competences and secondary capabilities, as well as attachment styles and primary capabilities and model dimensions.

In the realm of interdisciplinary and multidisciplinary approaches, **Fabio Galli** presents an article titled "An Interdisciplinary and Multidisciplinary Approach between Medical Education and Positive Transcultural Psychotherapy to Lead to a Suicide-Prevention Strategy for Healthcare Students and Healthcare Workers." Galli emphasizes the importance of addressing suicidal ideation, suicide attempts, and completed suicides through collaborative interventions involving medical education, counseling/psychotherapy, and Positive and Transcultural Psychotherapy (PPT).

In the section *"PPT Training"*, we explore the power of traditional games as instruments in Positive Group Therapy. **Etion Parruca** in the article "Positive Group Therapy Through Traditional Games with a Positum MGS Approach for Building Resilience Against Trauma in Times of Pandemics, War and Earthquakes: Theoretical Considerations and Practical Applications of "The Witches" Game" demonstrates how these games can be transformed into psycho-social tools, fostering resilience and promoting healing in groups affected by trauma resulting from pandemics, wars, and natural disasters.

Continuing our journey, we move to the section *"Modern PPT Practice"*, where we explore cutting-edge advancements in positive psychotherapy. One article by **Ivan Kirillov** introduces the "Evaluation Criteria for Psychosomatic Practice", which provides clinicians with a comprehensive list of criteria to diagnose and treat somatic disorders, taking into account psychosocial factors. By incorporating significant psychodynamic factors and offering a balanced framework for assessment, treatment planning, and outcome monitoring, the ECPP enhances clinical understanding and facilitates improved treatment outcomes. Another article from **Arno Remmers** focuses on the application of positive psychodynamic therapy in addressing attachment, trauma, and inner confidence. It highlights the structured treatment process, starting with stabilization and leading to integration, to restore confidence and balance in individuals who have experienced traumatic events. This approach aims to address the profound impact of trauma on health, relational patterns, and conflict reactions. The section also presents a novel conflict model for operationalizing and visualizing psychodynamics within the context of positive psychotherapy, presented in the article by **Richard-Christian Werringloer**. By considering different inner conflicts simultaneously or sequentially, this model provides a comprehensive understanding of a patient's motivations and psychodynamic responses, further enhancing the practice of Positive Psychotherapy. **Igor Olenichenko** explores the application of VR-technology methods in psychology and psychotherapy. The article discusses the potential of virtual reality (VR) technologies in treating phobias, psychosomatic disorders, and other psychophysical conditions. This emerging field offers deep immersion in virtual reality, providing new avenues for working with psychosomatics and phobias. Georg Franzen delves into the relationship between positive psychotherapy and art. While art therapy and PPT have distinct theoretical and practical concepts, they intersect when psychological conflicts are expressed through artistic means or stories. The article explores how art therapy can be integrated into the resource-oriented practice of Positive Psychotherapy, offering a unique approach to self-expression and healing.

In the section *"Psychotherapeutic Work during Wartime"*, **Svitlana Kyrychenko** explores the existential aspects of PPT and its unique ability to provide answers to the challenges faced during times of war and presents the author's perspective on various levels of psychological assistance that can be provided in crisis situations. The second article by **Tetiana Kitchak** focuses on the phenomenological aspects of psychotherapeutic work specifically related to the actual ability of "hope" during wartime. It highlights the dynamic and unpredictable nature of war and the crucial role of hope in the psychotherapeutic process.

The *"Special Articles"* section delves into specific topics related to positive psychotherapy and explores their implications for therapeutic practice. The article of **Vanda Drozhzhyna** examines the concept of microaggressions, which are subtle forms of hostility experienced by marginalized individuals. It discusses the interconnectedness of aggression and microaggressions in contemporary society, considering power dynamics and critical social theories. The article emphasizes how PPT uniquely addresses microaggressions by transforming negative experiences into opportunities for personal growth. Turning our attention to mental health services, **Raluca Ursica** presents an overview of the current landscape in England and the vital role of psychotherapists within this context. The author addresses concerns regarding the reliance on psychotropic medication and advocates for a comprehensive approach that integrates both pharmacotherapy and psychotherapy. The article of the colleagues **Svetlana Chebarykova, Irina Kuklina and Anna Gardner** focuses on building professional relationships between psychologists and clients with visible differences in appearance. It justifies the use of the concept of "visible difference" to accurately describe individuals with distinctive physical features related to health conditions. The article advocates for a transcultural approach in establishing professional relationships, leveraging differences as resources to assist clients. The next unique article by **Anahit Haykazuni** explores the primary actual capacities of individuals as illustrated in the Bible. It presents N. Peseschkian's proposed primary actual capacities, as demonstrated through the behavior, actions, and relationships of biblical characters and suggests that biblical stories and parables can be utilized as tools for the development of primary abilities, aiding clients in visualizing their situations and finding solutions to their problems.

The “PPT Cases” section presents real-practice case studies that highlight the application of positive psychotherapy in diverse clinical scenarios. **John Okoro’s** article explores patients' encounters with diagnoses from a transcultural perspective. The author presents three cases to illustrate how different traditions approach patients with various illnesses and establish diagnoses for organic and psychological problems. Drawing from the author's extensive experience working with individuals from different cultural backgrounds, the article adopts an analytic and descriptive approach, offering valuable illustrations and emphasizing the need to expand our understanding beyond our own perspectives. The article by **Hamid Peseschkian** focuses on the treatment of a patient with Borderline Personality Disorder (BPD) using Positive Psychotherapy. The article concludes with the therapist's comments, offering insight into the countertransference experienced during the treatment. Furthermore, it discusses the therapeutic techniques employed, such as writing, homework assignments, storytelling, and bibliotherapy. The article calls for more innovative approaches to treating borderline disorders.

Lastly, we explore the *latest news from the World Association for Positive and Transcultural Psychotherapy*. The WAPP Board shares exciting implementations and inspiring plans for the development of the “positum” community and the method of positive psychotherapy.

Nossrat Peseschkian had the conviction that every individual possesses unique strengths, resources, and capacities, akin to a precious pearl hidden within a protective shell. This concept underlies the essence of positive psychotherapy, which seeks to uncover and nurture these inner potentials to promote personal growth and resilience.

We hope that this collection of articles expands your knowledge, stimulates further exploration, and sparks meaningful discussions within the field of psychology and psychotherapy. Each article presents a unique perspective and valuable insights from distinguished authors. We extend our deepest gratitude to these authors for their valuable contributions as well as the whole team Editorial Board, International Scientific and Advisory Boards and well as secretaries and language editors!

In conclusion, let us remember the importance of research in positive psychotherapy. It is through rigorous investigation and continuous exploration that we can further advance our understanding and refine our practices. We invite you, dear readers, colleagues to contribute to our journal: share your thoughts, ideas, reflections and experiences in your articles. See you in new issues!

Sincerely,

The Editorial Board

The Global Psychotherapist,
Journal of Positive and Transcultural Psychotherapy

Section: Research and innovations in PPT

EXAMINATION OF IMPULSIVITY IN POSITIVE PSYCHOTHERAPY STRUCTURES



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Received 20.04.2023
Accepted for publication 15.06.2023
Published 01.07.2023
DOI: [10.52982/lkj194](https://doi.org/10.52982/lkj194)

Abstract

When the common features of the problems encountered in adolescence are examined, impulse control problems draw our attention. At this point, preventive and developmental studies are needed to help adolescents control impulses. It is important to examine the structures that can be used to explain impulsive behavior in order to transform impulsivity into a functional form. This study aims to examine whether primary and secondary capabilities, which are the basic concepts of positive psychotherapy, predict the impulsive behaviors of adolescents. The dependent variable in this research is impulsivity, its independent variables are primary and secondary capabilities. The participant group of the research is 225 male adolescent individuals between the ages of 14-19 who continue their secondary education. The Personal Information Form, the Barrat Impulsivity Scale (BIS-11), and the Wiesbaden Positive Psychotherapy and Family Therapy Inventory were used as data collection tools in the study. The data were analyzed by multiple regression analysis. As a result of the analysis, primary capabilities ($R=0.376$; $R^2=0.141$; $F=4.305$; $p<.01$) and secondary capabilities ($R=0.488$; $R^2=0.238$; $F=5.841$; $p<.01$) were found to significantly predict impulsivity. It was revealed that hope, from the primary capabilities, and orderliness, diligence, reliability and obedience, from the secondary capabilities, predict impulsivity.

Keywords: impulsivity, positive psychotherapy, adolescents

Introduction

Adolescence, defined as the period of transition from childhood to adulthood, is a crucial stage in a person's development (Arnett, 2000). If this stage is not navigated successfully, it can lead to a multitude of problems. These problems can manifest in various ways, such as engaging in risky behavior, substance abuse, criminal activity, suicidal thoughts or actions,

and behavioral disorders (Adcock and Parkin, 2016). Upon closer examination of these issues, it becomes evident that impulse control problems are a common thread (Casey et al., 2011). Therefore, it is crucial to implement preventive and developmental measures aimed at helping adolescents gain better control over their impulses (Steinberg, 2010). Such efforts can significantly contribute to the healthy development of adolescents and reduce the

likelihood of long-term negative consequences (Biehl et al., 2019).

Although impulsivity is explained as the lack of ability to delay or postpone pleasure (Neto & True, 2011) and the tendency to act spontaneously without deliberation (Carver, 2005), there is no consensus on a clear definition of impulsivity in the literature (Winstanley, Eagle, & Robbins, 2006). However, there is agreement that impulsivity is a multidimensional and complex construct (Neto & True, 2011). Similarly, the definition of impulsivity is not clear in the DSM-V. According to the DSM-V, impulsivity includes tendencies to act without thinking, inability to concentrate, and a tendency to become easily distracted (APA, 2013). Although there is no general definition of impulsivity, some accepted elements of being impulsive include making quick decisions and responses, inability to cope with negative emotions, inability to delay gratification, and acting without thinking about the future (Neto & True, 2011). Thus, impulsivity is generally associated with pathological problems such as attention deficit and hyperactivity disorder, eating disorders, behavioral addictions (e.g., gambling, shopping), aggressive behavior, and borderline personality disorder (Morrell & Burton, 2014). Studies on impulsivity rely mainly on biological and genetic origins, where impulsivity is often explained by brain damage and low serotonin levels; however, the relationship between impulsivity and environmental factors and personality traits has been neglected in most of these studies (Neto & True, 2011; Royuela-Colomer et al., 2021).

The concept of impulsivity has been a fundamental concept in child, adolescent, and adult psychopathology for many years. Particularly, impulsive behaviors during adolescence have been the subject of numerous studies. Adolescence is a critical developmental period in terms of cognitive problems and difficulties (Polanczyk et al., 2015). Physiological, psychological, and social changes during adolescence are considered as risk factors for adolescents to experience anxiety, depression, and stress, as well as to develop psychopathology (Romeo, 2013). Impulsivity can be seen as a dimension of normal personality and a characteristic of adolescence (Eysenck & Eysenck, 1977; Winstanley, Eagle & Robbins, 2006). However, impulsive behaviors during adolescence have been associated with

undesirable situations and behaviors, such as adolescent psychopathology (Vitacco & Rogers, 2001), substance addiction (Soloff et al., 2000), attention deficit hyperactivity disorder (Schachar, Tannock & Logan, 1993), aggressive behaviors (Hollander, Posner & Cherkasky, 2002), and internet addiction (Luijten et al., 2015). These types of behaviors are also known to occur frequently during adolescence (Moffitt, 1993). In addition, impulsivity is related to depression, anxiety, stress (Moustafa et al., 2017), emotion regulation (Cheung & Ng, 2019), and rumination (Hasegawa et al., 2018). It is also found that males exhibit more impulsive behavior than females during adolescence (Regan et al., 2019). Considering that both cognitive and psychological health problems encountered during adolescence are related to problems which present in adulthood, attention to situations that predict, increase or decrease problems that arise during adolescence is seen as socially important (Johnson et al., 2018).

In general, there are two categories of treatment for impulsivity: pharmacological treatment and psychotherapy. One of these approaches is positive psychotherapy, which is an approach that emphasizes the importance of individuals' capabilities in their lives and their functional use (Peseschkian, 2002). Within this approach, capabilities are described in two main groups as primary and secondary capabilities (Peseschkian & Walker, 1987; Sari, 2015). Primary capabilities express the emotional aspect and the individual's capacity for love, while secondary capabilities cover the behavioral aspect and the capacity for knowledge. Primary capabilities include patience, time, hope, contact, trust, faith/sense, sexuality/tenderness, and love, while secondary capabilities include orderliness, cleanliness, punctuality, politeness, openness, diligence, reliability, thriftiness, obedience, justice, and faithfulness (Sari, 2015).

According to the positive psychotherapy approach, all individuals have innate abilities to love and know from birth (Eryilmaz, 2017, 2019). However, both groups of capabilities are shaped and developed over time and by the environment. The shaped and developed capabilities form the character structures of individuals in adulthood. Adolescence is also a critical period during which capabilities develop and character structure begins to form. Problems that arise during this period due to

undeveloped or excessively developed capabilities can contribute to some adolescent problems and psychopathological patterns. Underdeveloped capabilities can prevent individuals from fully demonstrating their capacities, while excessively developed capabilities can cause them to use their energy in imbalanced and excessive ways (Peseschkian, 2000; Sari, 2015). Therefore, examining the development and use of capabilities is critically important to assist adolescents to lead balanced and healthy lives (Peseschkian, 2002). Thus, for adolescents, examining the relationships between their structures in terms of these capabilities and impulsivity through positive psychotherapy can provide support for their positive development. As a result, positive psychotherapy can serve as a means for adolescents to have more hope (Eryilmaz, 2012), high levels of motivation (Eryilmaz & Aypay, 2011), increased attendance in classes (Eryilmaz, 2014), can assist them to become more peaceful (Eryilmaz, 2009), and overall more happy.

Impulsivity can be approached in two dimensions, functional and dysfunctional, according to Eysenck (1993), who describes impulsivity as extraverted and psychotic (excessive) impulsivity. Extraverted impulsivity refers to a decision-making process that takes into account outcomes and risks, while psychotic (excessive) impulsivity means not considering the risks of a decision. Similarly, Dickson (cited in Coles, 1997) describes impulsivity under the concepts of functional and dysfunctional impulsivity. From this explanation, it can be seen that both types of impulsivity mean "acting without thinking or being influenced," with the difference being that functional impulsivity refers to the action being beneficial or optimal, whereas dysfunctional impulsivity means the action causes problems or harm to oneself or others. Eryilmaz (2019) states that primary and secondary skills, which are addressed in positive psychotherapy, are important indicators in explaining individuals' personality patterns. At this point, impulsivity is explained in a direction that reflects positive and negative meanings.

Positive psychotherapy defines impulsivity as a result of individuals' skills (such as obedience, hope, and orderliness) not developing (Peseschkian 1996, 1997, 2002). Positive psychotherapy also explains impulsivity as using the body dimension more in coping with conflict (Peseschkian, 2002). Empirical studies have been

conducted on sample groups such as substance-dependent adolescents (Eryilmaz, 2014) and delinquent adolescents (Eryilmaz 2018) to confirm these theoretical explanations. However, there are no studies directly examining the relationships between impulsivity and positive psychotherapy structures. Positive psychotherapy has been found to be effective in treating many mental disorders (Eryilmaz, 2012, 2015; Peseschkian, 1996, 2000, 2009). Therefore, positive psychotherapy can be an important psychotherapeutic approach in explaining adolescents' impulsivity. In line with these explanations, it is thought that examining the structures that can be used to explain impulsive behavior is important for transforming impulsivity into functional forms of behavior. The purpose of this study is to investigate whether primary and secondary skills, which are fundamental concepts of positive psychotherapy, predict adolescents' impulsive behavior.

Methodology

2.1. Model of the Research

This study used the relational scanning model, which is one of the general scanning models. The relational scanning model aims to determine whether there is a simultaneous change between two or more variables and/or the degree of change (Fraenkel and Norman, 2006). In this study, the relationship between impulsivity and positive psychotherapy structures was investigated. The dependent variable of the research was impulsivity, and the independent variables were the primary and secondary capabilities of positive psychotherapy structures. Multiple regression analysis was used to analyze the data.

The participants in the study are male adolescent individuals who are continuing their secondary education between the ages of 14-19. The exclusion criteria for the study were determined as the absence of a diagnosis of behavioral disorder in adolescents. Adolescents with a diagnosis of behavioral disorder were not included in the study. A total of 225 male individuals continuing their vocational and technical secondary education participated in the study. Of these, 83 individuals (36.9%) were 9th grade students, 62 individuals (27.6%) were 10th grade students, and 80 individuals (35.5%) were 11th grade students. Of the participants, 46 (20.4%) reported having a low socioeconomic

status, 159 (70.7%) reported having a moderate socioeconomic status, and 20 (8.9%) reported having a high socioeconomic status.

2.2. Data Collection Tools

In this study, researchers used a personal information form prepared by the researchers themselves, the short form of the Barratt Impulsiveness Scale (BIS-11), and the Wiesbaden Positive Psychotherapy and Family Therapy Inventory as data collection tools.

Personal Information Form: The personal information form was prepared by the researchers to determine demographic variables such as gender, age, class, socio-economic level, level of liking school, and frequency of school absenteeism among the participants.

Barratt Impulsiveness Scale (BIS-11): The Barratt Impulsiveness Scale, consisting of thirty items and developed by Barratt in 1959 to assess impulsiveness, has undergone many revisions over the years. The latest version, BIS-11, was developed in 1995 by Patton, Stanford, and Barratt. The Turkish adaptation and validity and reliability study of the scale were conducted by Güleç and colleagues in 2008, and it has been used in many studies with adolescents in Türkiye. The higher the total score obtained from the scale, the higher the person's impulsivity level. In this study, the 15-item short form developed by Tamam and colleagues to increase the widespread use of the scale was used. In the adaptation study of this form, the Cronbach's alpha internal consistency coefficient of the scale was found to be .82. In this research, the Cronbach's alpha internal consistency coefficient of the scale was found to be .77.

Wiesbaden Positive Psychotherapy and Family Therapy Inventory: The Wiesbaden Positive Psychotherapy and Family Therapy Inventory was created by Peseschkian and Deidenbach in 1988 to assess positive psychotherapy structures. It consists of 88 items and respondents use a four-point Likert scale to answer. In 2010, Sarı, Eryılmaz, and Varlıklı conducted a study to adapt the scale to Turkish and identified four important dimensions: primary skills, secondary skills, coping resources for conflict, and models. The reliability of the sub-scales was evaluated using the Cronbach's alpha technique, which showed that the secondary capabilities had a reliability of .77 and primary capabilities had a reliability of .75. In this

study, the Cronbach's alpha reliability for primary capabilities was found to be .83 and for secondary capabilities, it was .84.

2.3. Data Analysis

IBM SPSS 22 package program was used with a significance level of .05 in conducting data analysis. Multiple regression analysis was performed to examine the relationship between impulsivity and positive psychotherapy structures in line with the research objectives. Necessary inspections were conducted to prepare the data for multiple regression analysis. First, an outlier examination was conducted by checking the skewness and kurtosis values of the variables. Skewness and kurtosis values should be between +1 and -1 to ensure a normal distribution (Field, 2009). Accordingly, box plots were examined for each scale and subscale total score, and 3 data were excluded from the analysis to approach the distribution to normal. In addition, a normal Q-Q plot was examined, and it was determined that the points on the graph were on or close to the 45-degree line (Field, 2009), indicating that the data were normally distributed.

Multivariate outliers were examined with the Mahalanobis distance test for regression analysis where impulsivity was the dependent variable and primary capabilities, secondary capabilities, and coping resources of positive psychotherapy structures were the independent variables. In the chi-square analysis, 4 data points with a value less than .001 were excluded to meet the multivariate normality assumption. The presence of multicollinearity problems among the independent variables was examined by VIF and tolerance values in the regression analysis. The tolerance values being greater than .10 and VIF values being less than 10 indicate that there is no multicollinearity problem (Pallant, 2011). The analysis showed that the VIF and tolerance values met the desired conditions. Durbin-Watson test value for autocorrelation examination was found to be between 1.5 and 2.5, indicating no autocorrelation between the variables (Field, 2009). In addition, the correlation coefficient between the variables was between -.02 and .51. As the correlation coefficients were less than .90, it was observed that the variables were unrelated and there was no multicollinearity problem (Pallant, 2011). Based on all these results, it was assumed that the assumptions necessary for multiple

regression analysis were met, and multiple regression analysis was performed with 218 data.

Results

To determine the relationship between impulsivity and primary capabilities, a Pearson product-moment correlation analysis was conducted and the analysis results are presented in Table 1.

Table 1. Pearson correlation results for relations between primary abilities and impulsivity

Variables	1	2	3	4	5	6	7	8	9
1. Impulsivity	1.00								
2. Patience	-.23**	1.00							
3. Time	-.24**	.39**	1.00						
4. Contact	-.08	.37**	.43**	1.00					
5. Trust	-.24**	.26**	.44**	.32**	1.00				
6. Hope	-.33**	.40**	.50**	.31**	.51**	1.00			
7. Sexuality/Tenderness	-.09	.29**	.34**	.34**	.38**	.37**	1.00		
8. Love	-.16*	.25**	.36**	.51**	.42**	.43**	.34*	1.00	
9. Faith/Sense	-.20**	.39**	.46**	.35**	.37**	.49**	.35**	.37**	1.00

**p<.01, *p<.05

When Table 1 is examined, relationships between primary capabilities and impulsivity are observed. According to the results of the analysis, there were significant, low-level, and negative correlations between impulsivity and hope ($r=-.33$; $p<.01$), trust ($r=-.24$; $p<.01$), time ($r=-.24$; $p<.01$), patience ($r=-.23$; $p<.01$), faith ($r=-.20$; $p<.01$), and love ($r=-.16$; $p<.05$).

Pearson product-moment correlation analysis was conducted to determine the relationship between impulsivity and secondary capabilities, and the analysis results are presented in Table 2.

Table 2. Pearson correlation results for relations between secondary abilities and impulsivity

Değişkenler	1	2	3	4	5	6	7	8	9	10	11	12
1. Impulsivity	1.00											
2. Orderliness	-.29**	1.00										
3. Cleanliness	-.17**	.32**	1.00									
4. Punctuality	-.13	.31**	.30**	1.00								
5. Politeness	-.31**	.35**	.41**	.33**	1.00							
6. Openness	-.16*	.40**	.36**	.37**	.36**	1.00						
7. Diligence	-.03	.38**	.28**	.43**	.28**	.28**	1.00					
8. Reliability	-.34**	.38**	.30**	.24**	.40**	.43**	.30**	1.00				
9. Thriftiness	-.11	.29**	.31**	.28**	.30**	.17*	.20**	.16**	1.00			
10. Obedience	-.31**	.32**	.43**	.40**	.48**	.45**	.44**	.40**	.24**	1.00		
11. Justice	-.11	.34**	.34*	.24**	.32**	.33**	.33**	.31**	.29**	.38**	1.00	
12. Faithfulness	-.31**	.38**	.26*	.33**	.40**	.49**	.28**	.48**	.17*	.47**	.28**	1.00

**p<.01, *p<.05

When Table 2 is examined, relationships between secondary capabilities and impulsivity can be observed. According to the results of the analysis, there are low-level and negative significant relationships between impulsivity and

reliability ($r=-.34$; $p<.01$), obedience ($r=-.31$; $p<.01$), politeness ($r=-.31$; $p<.01$), faithfulness ($r=-.31$; $p<.01$), orderliness ($r=-.29$; $p<.01$), cleanliness ($r=-.17$; $p<.01$), and openness ($r=-.16$; $p<.05$).

Multiple linear regression analysis was conducted to determine the extent to which primary capabilities predicted impulsivity, and the results of the analysis are presented in Table 3.

Table 3. Impulsivity of primary capabilities predict levels

	B	Std. Error	β	t	p	Part r	Partial r
Constant	43.247	3.113		13.895	.000		
Patience	-.402	.252	-.120	-1.595	.112	-.110	-.226
Time	-.318	.282	-.093	-1.124	.262	-.078	-.243
Contact	.371	.286	.105	1.297	.196	.083	.089
Trust	-.368	.303	-.097	-1.216	.225	-.084	-.242
Hope*	-.842	.319	-.227	-2.640	.009	-.180	-.331
Sexuality/Tenderness	.288	.282	.076	1.020	.309	.070	-.093
Love	-.134	.323	-.034	-.413	.680	-.029	-.160
Faith/Sense	-.053	.309	-.014	-.173	.863	-.012	-.199

R=0.376; R²=0.141; F=4.305; p<.01

When Table 3 is examined, it is seen that primary capabilities significantly explain impulsivity in multiple regression analysis ($R=.38$, $R^2=.14$; $F=4.305$; $p<.01$). When the relationships of the variables with impulsivity are examined individually, it is concluded that the capability of hope predicts impulsivity. Primary capabilities account for 14% of the variance in impulsivity.

To determine how much secondary capabilities predict impulsivity, multiple linear regression analysis was conducted, and the results of the analysis are presented in Table 4.

As seen in Table 4, multiple regression analysis reveals that secondary capabilities significantly explain impulsivity ($R=.49$, $R^2=.24$; $F=5.841$; $p<.01$). When looking at the relationships between variables and impulsivity individually, it is found that the capabilities of orderliness, diligence, reliability, and obedience predict impulsivity. Secondary capabilities account for 24% of the variance in impulsivity. According to the standardized regression coefficients (β), the relative importance of independent variables on impulsivity is as follows: obedience ($-.22$), diligence ($.22$), orderliness ($-.21$), and reliability ($-.20$).

Table 4. Impulsivity of secondary capabilities predict levels

	B	Std. Error	β	t	p	Part r	Partial r
Constant	47.079	3.383		13.915	.000		
Orderliness*	-.798	.280	-.211	-2.846	.005	-.195	-.290
Cleanliness	.002	.270	.001	.008	.993	.001	-.175
Punctuality	-.024	.261	-.007	-.091	.928	-.006	-.130
Politeness	-.485	.280	-.132	-1.730	.085	-.120	-.308
Openness	.510	.300	.132	1.700	.091	.118	-.163
Diligence*	.830	.280	.219	2.970	.003	.203	-.031
Reliability*	-.878	.333	-.199	-2.635	.009	-.181	-.336
Thriftness	.050	.249	.014	.202	.840	.014	-.111
Obedience*	-.789	.290	-.224	-2.719	.007	-.186	-.311
Justice	.218	.254	.061	.859	.391	.060	-.115
Faithfulness	-.447	.300	-.117	-1.489	.138	-.103	-.306

R=0.488; R²=0.238; F=5.841; p<.01

Discussion

This study examined the relationship between primary and secondary capabilities of positive psychotherapy and impulsivity skills of male adolescents. The analysis results revealed that hope from primary capabilities and orderliness, diligence, reliability, and obedience from secondary capabilities were significant predictors of impulsivity. To the best of our knowledge, no study has been found in the literature that examines impulsivity skills in terms of positive psychotherapy structures. However, impulsivity is considered as an extension of personality, especially in adolescence (Eysenck and Eysenck, 1977; Winstanley, Eagle, and Robbins, 2006). At this point, the explanation based on the capabilities of positive psychotherapy structures is in line with the literature.

The results of the study indicated that the capability of hope was a significant predictor of impulsivity among male adolescents. This suggests that limited use of hope can be an important factor in explaining their impulsivity. Hope refers to the belief that there is always a way out of difficult situations, positive thinking about oneself and one's family, and having a good plan for the future (Peseschkian, 2002). The study findings suggest that increasing the use of hope can help to reduce the impulsivity levels of adolescents. The literature suggests that hope plays an active role in changing people's basic reactions and is functional in ensuring that individuals maintain a determined attitude to achieve their goals (De Ridder et al., 2012; Li et

al., 2021). Hope is thought to contribute to individuals' impulsivity by creating a control mechanism for the individual. However, hope may also contribute to making individuals goal-oriented by providing planning and motivation, which are lacking in impulsive individuals. Impulsive individuals experience a lack of both capability and motivation to plan for the future. They are more focused on the present moment than the future (Patton et al., 1995). Nevertheless, through hope, individuals can plan for the future and move away from the pleasures of the present moment (Snyder, 1994). Therefore, hope can support adolescents in planning for the future by shifting their focus from the present moment.

One characteristic of impulsive individuals is their impatience in reaching their goals and their preference for pursuing small pleasures and quickly achieving pleasure (Bechara and Damasio, 2002). Strengthening the capability of hope may encourage adolescents to set difficult and long-term goals and make efforts to achieve them (Snyder, 2002).

The research results revealed that the capabilities of orderliness, diligence, reliability, and obedience significantly predicted impulsivity. In other words, it can be said that the low level of openness, reliability, and obedience and the high level of diligence of male adolescents play an important role in explaining their impulsivity.

Orderliness is explained in the context of positive psychotherapy as the individual's "always keeping and leaving their workplace/office/home organized, ", "going crazy if everything is in a mess", and "believing that a person always needs to look tidy" (Eryilmaz, 2020). The capability of orderliness is also evaluated as an extension of the personality trait of responsibility. At this point, the organized and disorganized aspects of people, both in terms of orderliness and responsibility are evaluated as a common point (Roberts et al., 2009). Characteristics such as being planned, organized, and prepared are also included in the capability of orderliness. On the other hand, unplannedness, chaos, and disorder are not seen in individuals who use their organizational skills at a high level (Roberts et al., 2014). As can be seen, the characteristics that emerge as a result of low use of the capability of orderliness also reflect the characteristics of impulsive individuals. When the literature is examined, it is

seen that the low level of orderliness is related to impulsivity (Simms, 2007; Widiger, 2005). At this point, improving the capability of orderliness may contribute to reducing adolescents' impulsivity. Conducting studies that involve self-control can be helpful in this regard (Eryilmaz, 2018).

It has been found in the study that adolescents with high levels of reliability have less impulsive behavior. It is believed that developing reliability can be effective in controlling adolescents' impulsive behavior. Reliability is explained as individuals thinking and behaving in the context of positive psychotherapy as: "reliability is very important in business and society", "a person whom you cannot fully trust can never be your friend", and "I always keep my promises" (Eryilmaz, 2020). At this point, reliability is thought to create a control system for individuals. Studies show that a low level of reliability is associated with lack of empathy, disrespectful behavior, selfishness, and impulsivity (Gordon and Platek, 2009). Increasing the use of reliability to reduce adolescents' impulsivity levels appears to be important. In this context, empathy, respect, selflessness, and self-control exercises are critical (Eryilmaz, 2020).

The study found that individuals with high levels of impulsivity tend to use their capability of obedience less frequently. This suggests that developing obedience could be an effective strategy for reducing impulsivity among adolescents. Obedience refers to changes in behavior or beliefs that occur as a result of real or imagined pressure from a group. It involves not only behaving like others, but also being influenced by their behavior (Eryilmaz, 2020). Low or high use of obedience can have negative effects on individuals' lives. However, the study results suggest that increasing compliant behavior can reduce impulsivity. An examination of the relevant literature clearly shows that there is a significant relationship between a low level of obedience and antisocial and impulsive behavior (Coid and Ullrich, 2010). Therefore, Eryilmaz (2020) suggests that individuals who are less obedient frequently tend to have active impulsive systems. It is important to activate the control system in individuals in order to increase the use of obedience. Goals should be set to increase individuals' use of obedience, standards should be established, and principles should be

created. These strategies can contribute to reducing impulsive behavior.

The latest finding from the research indicates that a high level of the capability of diligence (persistence) increases impulsive behavior. This finding is quite interesting. The reason for this finding may be that the teenagers in the study group who attend vocational high school, which does not require a relatively high level of success and comprehension, have a high level of success. Studies have shown that academically successful students have high levels of self-control (Hong et al., 2009; Souvignier and Mokhlesgerami, 2006). At this point, this finding of the study differs from the literature. This is because this research was conducted in a vocational high school where the majority of students have medium to low achievement levels. Therefore, successful students easily achieve success. Examination of the relevant literature shows that individuals may experience a feeling of boredom when dealing with tasks or activities that are below their skill level (Csikszentmihalyi, 1997). The increase in impulsivity of the teenagers participating in the study as their diligence increases can be evaluated in this direction.

In addition, diligence can have a negative impact on behavioral control mechanisms, especially for vocational high school students. It is also thought that as the diligence of teenagers studying in vocational high schools increase, they may exhibit a tendency towards impulsive behavior by feeling stronger. This situation may also be due to the school system. Since the number of successful students in vocational high schools is low, their negative behaviors are generally tolerated and often ignored. This situation may also increase the tendency towards impulsive behavior.

Conclusions

Based on the findings obtained from this research, it is considered important to increase the abilities of hope, orderliness, reliability, and obedience to control impulsive behavior in male teenagers with high levels of impulsivity, while controlling their capability to achieve success through undesirable behaviors. In this regard, psychotherapists can support teenagers who exhibit impulsive behavior by activating their control system, organizing their learning experiences, setting goals, establishing standards, creating principles, and regulating

their emotions through self-control and self-regulation.

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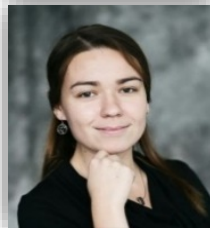
Section: Research and innovations in PPT

PRIMARY CAPACITIES AS A PREDICTOR OF PERCEIVED STRESS, ANXIETY, AND DEPRESSION IN THE PANDEMIC CRISIS OF COVID-19



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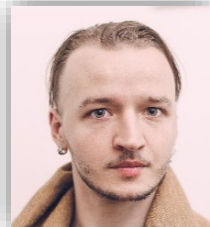
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Received 12.03.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj195](https://doi.org/10.52982/lkj195)

Abstract

Fifty years of worldwide success of Positive Psychotherapy practice suggested that primary capacities, postulated by prof. Nossrat Peseschkian, are reliable criteria to diagnose the integration level of personal psychological functioning. If this assumption is correct, then the higher level of integration of primary capacities should correlate with better adaptability, and inversely the lower level of integration should correlate with a higher level of perceived stress, anxiety and depression under the pressure of crisis, such as the COVID-19 pandemic. To test this hypothesis, we surveyed internationally 1165 respondents, collecting data on emotional reactions and coping strategies engaging primary capacities of personality structure. As a result of this research, we discovered that a lower integration level of 4 out of 8 primary capacities, namely: ideal, trust, love, and time significantly correlate with a higher level of perceived depression, anxiety and stress. Those results support our initial hypothesis that the lower level of primary capacities would allow a higher level of depression and anxiety.

Keywords: structure of personality, stress, anxiety, depression, COVID-19, positive psychotherapy, primary capacities

Introduction

Any structure is an arrangement of parts, interacting with each other under historically developed rules and thereby forming the functional whole.

In psychology, the term "structure" refers to the integration of mental dispositions and "to the availability of mental functions for the regulation of the self, and its relationships to internal and external objects" (OPD Task Force (Eds.), 2008), for processing "internal conflicts and external stressful events" (OPD Task Force (Eds.), 2008).

The level of integration of the specific structural function defines its availability and vulnerability under the stress of internal or external conflicts or physical illness and therefore determines the "personal style (Shapiro, 1965) in which the individual time and time again re-establishes his intrapsychic and interpersonal balance" (OPD-2).

As the structure is not directly observable, it can only be evaluated by visible reactions and behaviors. Therefore, the function, organization, and history of structures are always hypothetical and incomplete. Understandably, such explanations and models are unavoidably constructed in line with the theory and formulated in specific terms.

The infant's inborn, object-seeking activity evolves into the capacity "to involve the adult caregiver in social interactions" of pleasurable bodily care and feeding, in these early interested, active and emotional interactions with the non-ego objects, the Ego begins to organize its intentional communicative function (Rudolf, 1977).

The structural functions (primary capacities) are "imprinted on the child by the direct behavior of the parents and through their modelling" (Remmers, 2020) in repetitive interactions, and in the "experience of being emphatically understood and appropriately treated" (OPD Task Force (Eds.), 2008). Such self-object experience (Kohut, 1973) develops the self- and object-representation (Fonagy P, 1993)" (H. Peseschkian, 2020).

Approximately, by the age of 18 months, the Ego develops the capability to perceive "itself as an object and thus reflexively refer to itself" as a

certain mental space filled with an early symbolic and semantic representation of experiences. Such an increasingly mentalized affectivity "finally finds expression in the availability of the self-reflexive function (Fonagy et al., 2002)".

The objects that are experienced as separate from the self are recognized and named. In ongoing emotionally-charged interactions with such objects, the Ego internalizes them and forms their inner representations by their importance and emotional meaning. At the same time, the Ego integrates its representation and self-worth and learns to organize and regulate itself.

Thereby the experience of object relations forms the personality structure until the development of the autonomous self with the increasing mentalization, integrated sense of identity and capacity to regulate its self-image and self-worth as well as its capability for control in ever-new ways.

Psychological structure develops through the continuous integration of new information, forming new, more adaptive rules that, sooner or later will be challenged by more recent information. Yet, this process is so slow that one perceives the self as a personality with consistent identity and character.

The attempts to describe the structure of personality started from S. Freud's topographical model (Freud, 1923) and K. Abraham's character structure (Abraham, 1925), H. Schultz-Hencke's drive-based structure of neuroses (H. Schultz-Hencke, 1951) and H. Hartmann's Ego structure (Hartmann, 1960). In 1969 L. Bellak and M. Hurvish were able to systematize the ego functions (Bellak, 1969).

In 1974 Nossrat Peseschkian defined (Peseschkian, 1974) the "psycho-dynamically operative" (Peseschkian, 2013, 1988) "related to psychoanalytic categories" (Peseschkian, 1977) actual capacities, secondary and primary. The secondary capabilities are referring to as norms and behaviors. The primary capacities, that are the subject of our interest in this research, reflect:

the primary emotional needs (Kirillov, 2015b); (Goncharov, 2020) the "emotional ties" and "resonance" (Peseschkian, 1977) charging one's expectations regarding the secondary capabilities with "the pronounced affective

response” based on individual life emotional experience.

the primary capacities to deal “with the predominantly emotional domain”, which is “close to the self” (Peseschkian, 1977), “such as feelings of self-worth and inferiority complex” (Peseschkian, 1977). Thereby, the primary capacities describe the functions of the Ego (Kirillov, 2015b) in its relationships with self and objects. The list of those functions initially included: *contact, sexuality, love, time, patience, trust, hope, confidence, doubt, certitude, unity, faith and model*.

In parallel with this, the OPD Working Group (OPD Task Force (Eds.), 2008) integrated the heritage of psychodynamics thinking with the (at that time) recent idea of the structure of object relations (Kernberg, 1976, 1977, 1980, 1984) “in line with the work of Rudolf (Rudolf G., 1993.)”. Just as as Nossrat Peseschkian described the primary capacities (N. Peseschkian 1974, 1977), the Group instead of using traditional psychoanalytic terms addressed to functions (OPD Task Force (Eds.), 2008) of personality structure in its relation to objects (Rudolf, 2002; Rudolf et al., 1995) to “determine the behaviour and experience of the patient as close to observation as possible”.

In intensive testing of OPD, the structure axis showed good clinical practicability, and inter-rater reliability (Freyberger et al., 1998; Rudolf, 1996, 1999; Rudolf et al., 1997; Rudolf et al., 2000). It appears that less integrated structural functions correlate with a lower ability to express emotional resonance (-0.41 ; $p<0.01$), to rely on others (-0.43 ; $p<0.01$) (Rudolf/Grande, 1999); to benefit from therapy (Strauß, 1997), and with longer duration of psychogenic illness (-0.38 , $p=0.06$) (Rudolf G., 1996). As well, the level of structural integration correlates with conflicts

and relationship patterns (Heidelberg working group):” The lower the level of structural integration, the more difficult it becomes to identify stable conflict patterns. In a disintegrated level of structural functioning, unequivocally identifiable conflicts are largely absent. (OPD Task Force” (Eds.), 2008). The level of structural integration correlates also with the ICD-10 diagnoses: patients diagnosed with the spectrum of neurotic disorders (mean=1.97) proved to be better structured than patients with personality disorders (mean=2.37, $p<0.01$) (Nitzgen, 2000).

Considering sound proofs of the practical usefulness of OPD’s structural functions, their descriptive similarity with primary capacities of Positive Psychotherapy after N. Peseschkian, the latter was optimized (Kirillov I., 2015a) to increase the theoretical and practical understanding between specialists practising both approaches and to enrich both systems with new ideas (Table 1).

Primary capacities are differentiated from the basic inborn capacity to love: “to establish active emotional ties” with external objects (active mode) (Peseschkian, 1977) and “to accept and bear emotional affection” (Peseschkian, 1977) of external objects (reactive mode) (Kirillov, 2015a). Therefore, primary capacities, as well as structural functions of OPD-2, describe the “mental processes” in two modes: 1) active – directed to object (Rudolf, 2002; Rudolf et al., 1995) and 2) reactive – directed at self (Peseschkian, 1977; Kirillov I., 2015a).

A well-integrated structure allows One even in stressful situations to avail oneself of one’s mental space and to regulate it via intrapsychic processes in such a way that she/he can also establish and maintain satisfactory relationships with external objects.

Table 1. Comparison of structural functions of OPD-2 and primary capacities

OPD-2: functions/abilities		PPT: primary capacities	
Self and object perception	Self-reflection	Contact with self Pleasure (self)	Self and others' perception and mentalization
	Perception of others (realistic and as a whole)	Contact with others Pleasure (others)	
Control of self and of relationships	Regulation of own impulses, affects, and self-worth	Time for self Trust to self	Regulation of own affects and productivity, and those in relations
	Regulation of relation to another	Time for others Trust to others	
Emotional internal and external communication	Internal communication via affects and phantasies	Love to oneself Care for self	Bonds, bounds and relationships with self and others
	Communication with others	Love to others Care for others	
Internal attachment and external relationship	Usage of good internal objects for self-regulation	Meaning (own) Ideal self	Regulation of symbolic structures, concepts, and narratives
	Attachment and detachment	Meaning (others) Ideal others	

Disintegrated structural capacity is unavailable for usage because of its insufficient development or vulnerability under the pressure of internal or external stresses. For diagnostic and prognostic purposes, one must differentiate long-existing structural disintegrations (at least 1-2 years) from situational structural vulnerabilities.

Following the OPD-2 pattern we differentiate 4 levels of structural integration: 1) High, 2) Moderate, 3) Low and 4) Disintegrated. Those levels can be assessed by the “interactional behaviour experienced by the patient’s social surrounding (including the interviewer) and described by the patient in patterns of his/her daily life and life history”.

Our survey is based on the primary capabilities as described by I. Kirillov (2015a, b), let us define them in ontogenetical order:

Contact is the capacity to focus, maintain and switch attention from one object to another, differentiating and naming one's own characteristics: such as feelings, needs, actions and states and the same for others, finding similarities and distinctions to further integrate them for a holistic view of Self and objects.

Pleasure is the capacity to notice the connection between stimuli and responsive emotion, and to prolong those which are pleasant; to consider and avoid/discontinue the possible dissatisfaction and (or) pain.

Love is the capacity to integrate an emotionally charged experience motivating relationship, to cherish pleasing healthy

interactions, and to optimize the attitude toward harmful and unpleasant objects. To love – is the capacity to enjoy (oneself, others, or life) again and again; to merge oneself emotionally with loved ones and to experience empathy towards them.

Care is the capacity to support pleasant emotional relationships by distinguishing the needs of self and others, knowing how to meet them, and doing or helping to do so; it also is an ability to ask for help and accept it with gratitude.

Time is the capacity to sense (notice) understand, structure, remember and use the sequences and rhythms of occurring events, emotions, thoughts, impulses, actions and their outcomes; to reproduce, build up and modify them efficiently; to provide oneself, others and external events with enough time to unfold in their unique rhythms.

Trust is the capacity to expect good and to accept such expectations from others: to notice successful and predictable acts of care towards oneself or others; to reproduce the learned sequences of actions trusting that they will predictably meet one's actual needs; to trust predictable results of one's own and another's actions, external events, and objects.

Meaning is a capacity to find causality in observed events and objects (including self). It uses fantasy to see the invisible connections and forces to figure out the metaphysical events (such as a relation between people) and to create new insights and ideas.

The ideal is the capacity to differentiate and choose preferable examples of optimal satisfaction of one's needs. Its function is to motivate oneself and others to reproduce optimal strategies and to stabilize intrapersonal and interpersonal relationships when faced with frustration.

COVID-19 appeared to be a major stress, thus had an undoubtful impact on mental health, such as short-term increase of anxiety and long-term increase of depression, as described in meta-analysis of 65 studies (Robinson et al., 2022). Other meta-analysis, which gathered 36 studies, showed the significant increase of depression, anxiety and eating disorders among population, despite their age, gender, race, social and marital status (Schafer et al., 2022). While a lot of studies mention social support (Dobiala et al., 2022) and specific actions as coping mechanisms (Finstad et al., 2021), it is especially interesting to observe psychological resilience factors built on personality structure and capacities. Some of the studies mention inner resources used to cope with stress, anxiety and depression (Finstad et al., 2021; Rahman, 2022; Swami et al., 2021; Oli'E, 2022). The authors of this article are interested in conceptualizing inner resources in terms of primary capacities in positive psychotherapy.

Methodology

The results presented in this article have been obtained within research designed to study the strategies of coping with the stress of the COVID-19 pandemic, related quarantine and the effectiveness of psychoeducational "stress-surfing" (Kirillov, I., 2019) protocol based on the principles of transcultural positive psychotherapy.

We used a web-based (Zoho Survey) questionnaire and online survey formula (CAWI) to reach as many respondents as possible despite pandemic isolations. We have sent the link to the survey by e-mail to the selected respondents. The applied exclusion criteria were hospitalization, incapacitation, conscripts, deprivation of liberty, completing the course of psychiatric outpatient treatment and minors. As a result, we surveyed 1165 respondents with different backgrounds (Poland - 836, Russia - 183, Türkiye - 31, Ukraine - 25, China - 18, Romania - 16, Kosovo - 16 and other countries -

40). Their age varies from 18 to 78, $m=39,9$, $st.d=11,95$.

The survey form included information for the subjects about the purpose and course of the study, a form of voluntary and informed consent of the study participants. Participants were also informed about the possibility of withdrawing their answers after they were sent to the survey system via email contact with each of the researchers.

Completed surveys were recorded in the survey system and available only to the respondents. At the end of this step, the data was anonymized by deleting the email addresses. The study lasted from 30.04.2020 to 31.07.2020.

The survey battery included the Beck Depression Inventory (BDI) (Beck, 1961), the State-Trait Anxiety Inventory (STAI) (Spielberger, 1983) and the author's Self-Reflection Survey (collecting data on emotional reactions, triggers in terms of secondary capabilities (behaviours/norms) and coping strategies (physical, social, behavioural and psychological (imagination)) engaging primary capacities of personality structure).

State-Trait Anxiety Inventory (STAI) (Spielberger, 1983) was not used in Poland. This fact and some incomplete responses affected the number of respondents included in the analysis of the correlation of the integration level of primary capacities and depression ($N=1167$), anxiety (as a state ($N=330$), as a trait ($N=331$)) and stress ($N=836$) (table 2).

The self-Reflection Survey was designed for this study in March 2020 by an international team (I. Kirillov, P. Efremova, E. Dobiała). Stress levels have been evaluated by the reported strength of the emotional reaction rated as: "Very Strong", "Quite Strong", "Moderate", "Weak" and "None". Each of the primary capacities (contact, pleasure, love, care, time, trust, meaning, ideal) was evaluated based on subjective estimation of 4 statements regarding the behaviors, attitudes, and expectations specific to those capacities (2 for active mode and 2 for reactive mode).

Respondents rated the relevance of those statements for their experience as: „too much" [relevant], „more than usual", „not relevant", „less than usual" and „not enough". Those answers were rated from 5 to 1 point, respectively. For a particular area, the arithmetic mean was calculated from the scoring of the respective answers. The cut-off point for the

occurrence of depressive disorders according to Beck's Depression Test was ≥ 14 points (Jackson-Koku, 2016).

Due to the skewed distribution of the variables, we used mainly non-parametric methods for the analysis. Data were presented as median (interquartile range) or number (per cent). Differences among groups were tested with the Kruskal-Wallis test (and post hoc two-way test) or Pearson's chi-square test. The correlation strength of the two variables was expressed with Spearman's correlation coefficient. The logistic regression analysis and determination of the odds ratio were also performed. A P-value <0.05 was considered

statistically significant. Calculations were performed using Statistica version 13, TIBCO Software Inc.

Results

As a result of this research, we discovered (table 2) that lower integration levels of 4 out of 8 primary capacities, namely *ideal*, *trust*, *love* and *time* are significantly correlating with a higher level of perceived depression, anxiety, and stress. Those results support our initial hypothesis that the lower level of primary capacities would allow a higher level of depression and anxiety.

Table 2. The correlation for 1AC and psychological symptoms

Correlations Spearman		Contact	Pleasure	Love	Care	Time	Trust	Meaning	Ideal
Depression N 1167	Coef.corr	-,033	-,019	-,233*	,046	-,175*	-,247*	,022	-,334*
	Sign. (2-tailed)	,258	,525	,000	,119	,000	,000	,455	,000
Anx. State N 330	Coef.corr	-,093	-,028	-,255*	-,069	-,287*	-,310*	,035	-,263*
	Sign. (2-tailed)	,090	,614	,000	,214	,000	,000	,523	,000
Anx. Trait N 331	Coef.corr	-,024	-,052	-,221*	-,059	-,152*	-,221*	,071	-,229*
	Sign. (2-tailed)	,661	,346	,000	,285	,006	,000	,197	,000
Stress N 836	Coef.corr	-,020	-,026	-,239*	,018	-,205*	-,256*	,003	-,345*
	Sign. (2-tailed)	,562	,451	,000	,597	,000	,000	,937	,000

* Correlation is significant on a level of 0,01 (bilateral)

The lack of capacity to *idealize* (Kirillov I, 2015a) significantly correlates with higher levels of subjectively-perceived stress (-,345) depression (-,334), and anxiety as a state (-,263) and trait (-,229).

The lack of capacity to *trust* (Kirillov I, 2015a) significantly correlates with a higher level of subjectively perceived anxiety as a state (-,310) and trait (-,221), stress (-,256) and depression (-,247).

The lack of capacity to *understand and manage time* (Kirillov I, 2015a) significantly correlates with a higher level of subjectively perceived anxiety as a state (-,287) and trait (-,152), stress (-,205) and depression (-,175).

The lack of capacity to *love* (Kirillov I, 2015a) significantly correlates with a higher level of subjectively perceived anxiety as a state (-,255) and trait (-,221), stress (-,239) and depression (-,233).

Discussion

The results obtained partially support our hypothesis about connection of the lower level

of integration of primary capacities and the higher level of subjectively perceived stress, depression, and anxiety in dealing with a crisis such as the COVID-19 pandemic. Though correlation cannot predict the casual relationship, the theory of actual capacities in positive psychotherapy claims that it takes a long time to develop primary capacities and that most of them are developed in the childhood or develop slowly. Therefore, one could assume that primary capacities tend to be developed to some level before the pandemic and then either help or hinder the coping process depending on their integration level.

The lack of capacity to *idealize* ("useful models for optimized satisfaction of [primary] needs to reproduce and learn them" and to adjust those ideals to ever-changing reality (Kirillov I, 2015a)) significantly correlates with a higher level of subjectively perceived stress (-,345) depression (-,334), and anxiety as a state (-,263) and trait (-,229).

The COVID-19 pandemic and following isolation significantly changed habitual lifestyle

and daily expectations, challenging one's capacity to give up the old and to find the new ideals "to motivate oneself; and others and to stabilize one's own inner world in case of frustration". The limited ability to adjust ideals for changing reality and to find clear guiding ideas and models for life prompt one to perceive the crisis as a strong and more stressful disappointment and to respond to it with depressive reactions, and high situational anxiety "as a state" and even highest risk to activate the anxiety "as a trait" in the situation of long-lasting crisis. It corresponds with the finding (Ofir Ben-Yaakov, 2022) that psychological inflexibility "mediates the association between health anxiety and poorer mental health" and (Rahman, 2022) that a positive professional attitude empowered the coping strategy of nurses dealing with COVID-19.

The lack of capacity **to trust** ("to process one's life experiences", to recognise "one's own and other's needs and patterns of their satisfaction; to rely on those predictable causal successions promising security and satisfaction of need" (Kirillov I, 2015a)) significantly correlates with a higher level of subjectively perceived anxiety as a state (-,310) and trait (-,221), perceived stress (-,256) and depression (-,247). One can say that people who cannot rely on the world and don't feel trustworthy often have higher depression levels. This is in line with the data of (Ofir Ben-Yaakov, 2022) that "Intolerance of uncertainty mediates the association between health anxiety and poorer mental health".

The lack of capacity **to understand and manage the time** ("to grasp succession of events, emotions, thoughts, actions and conditions with their natural rhythm and to create one's own intentional rhythms putting events, emotions, thoughts and actions in optimal sequence" (Kirillov I, 2015a)) significantly correlates with a higher level of subjectively-perceived anxiety as a state (-,287) and trait (-,152), stress (-,205) and depression (-,175). It can be described from two different perspectives: 1) those who feel that time is never enough experience higher stress, depression and anxiety when chronically and largely disturbed by the challenges of the crisis (this corresponds

with (Sh.L. Johnson, 2022) finding that "emotion-related impulsivity could predict heightened vulnerability" to stress; 2) those who have difficulties in rearranging their daily sequences and algorithms to adjust to crises are more likely to meet stress, depression, and anxiety (this is in line with (E.Oli', 2022) assumption that a high level of boredom is an independent risk factor.

The lack of capacity **to love** ("to utilize life experiences of primary needs satisfaction in the form of attitudes [and bonds in order] to optimize interaction with the environment by avoiding and preventing what is perceived as harmful, or by cultivating what promises pleasure of satisfaction; to sustain attitudes with memories and fantasies" (Kirillov I, 2015a)) significantly correlates with a higher level of subjectively perceived anxiety as a state (-,255) and trait (-,221), stress (-,239) and depression (-,233). In other words, lonely people experiencing a deficit of healthy attachment are also more vulnerable to subjectively-perceived anxiety as a state and trait, stress and depression. That corresponds with findings showing that, on one hand, high levels of loneliness (E.Oli', 2022) and social isolation (Hans Oh, 2021) are independent risk factors for depressive reaction to lockdown and that Covid 19-related stress is associated with lower self-compassion (Viren Swami, 2021), and that, on the other hand, family, friends and colleagues support (Rahman, 2022) (S.E. Badon, 2022) are effective coping strategies to deal with the stress of COVID-19.

The other primary capacities, namely Contact, Pleasure, Care and Meaning did not show such a strong correlation. This fact can lead us to the following hypotheses:

- those capacities are not significant for coping (this suggestion seems highly doubtful, yet should be considered unless proved otherwise);
- the questions of inventory do not reflect the nature of those capacities clearly enough;
- respondents are less able to notice manifestations of those capacities due to the lack of differentiation of those functions in contemporary culture and thereby in semantic structures;
- those coping capacities are activated in different stages of adaptation.

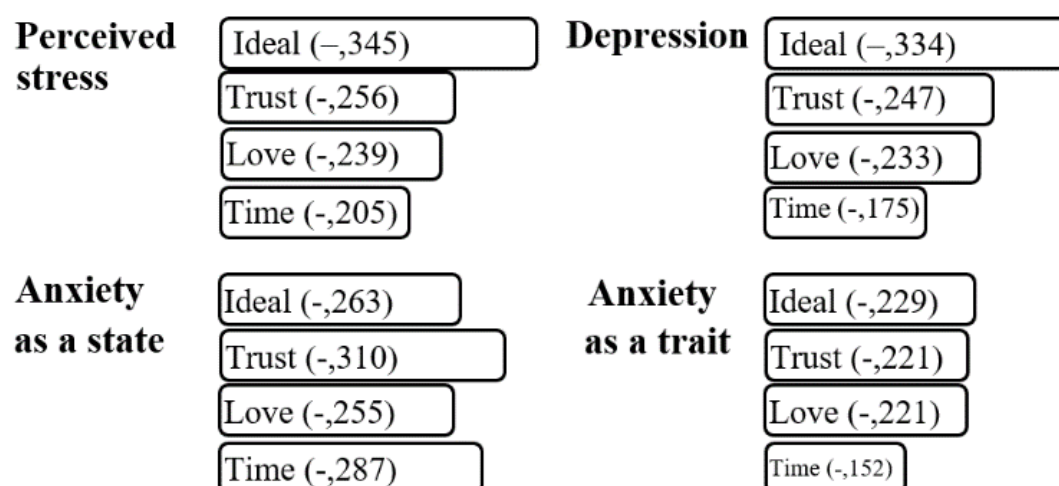


Fig. 1. Correlating primary capacities and symptoms

Conclusions

The view researches are mainly focused on the external copings and resources to detect the possible intensity of anxiety, depression and stress. They conclude that social interaction and physical activity boost mental health during challenging times, such as the COVID-19 pandemic. However, it is rarely included that inner coping capacities contribute to stress resilience as well.

As shown in the above discussion, the primary capacities of ideal, trust, love, and time, postulated by prof. Nossrat Peseschkian can be used as reliable criteria to describe, diagnose, and predict the integration level of personality functioning (I. Kirillov, 2021) in terms of adaptation as an ability to cope with such a strong and long-lasting crisis as the COVID-19 pandemic.

There was no correlation found in this research between the integration level of primary capacities of *contact, pleasure, care and meaning* and quality of coping with the pandemic of COVID-19. There are hypothetical explanations to be further tested:

- those capacities are not significant for coping (this suggestion seems highly doubtful, yet should be considered unless proved otherwise);
- the questions of inventory do not reflect the nature of those capacities clearly enough;
- respondents are less able to notice manifestations of those capacities due to the lack of differentiation of those constructs in contemporary culture and thereby in semantic structures;

- those coping capacities are activated in different (earlier or later) stages of adaptation.

This brings up the importance of continuing the research to identify the adaptive capacities of personality structure and to discover the psychodynamic algorithms allowing to adjust to a long-term crisis such as the COVID-19 pandemic and isolation.

Limitations: 1. The self-reflection survey was conducted for this particular study and was not approbated before. 2. The level of understanding of PPT concepts, computer skills, age, gender, educational and social status were not included as factors for these article. It should be taken into consideration, that some of the might influence the results.

Author Contributions: Conceptualization: I.K., methodology: E.D. & P.E., writing: I.K., E.D., P.E. and I.P.

Funding: This research received no external funding.

Conflicts of Interest: The authors declare no conflict of interest.

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Section: Research and innovations in PPT

CORRELATES OF THE WIESBADEN SCALE FOR POSITIVE PSYCHOTHERAPY AND FAMILY THERAPY 2.0 IN 93 POLISH FEMALE STUDENTS OF PSYCHOTHERAPY



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Received 15.05.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj196](https://doi.org/10.52982/lkj196)

Abstract

The article presents correlational analysis of the concepts used in PPT in the context of social competences, attachment styles and stress-coping strategies in 93 female students of psychotherapy. Polish translation of WIPPF2.0, together with Profile of Social Competencies (PROKOS), Questionnaire of Attachment Styles (KSP) and Polish adaptation of the COPE Inventory were used as measuring tools. Minor to moderate correlations were found between social competences and four Secondary capabilities (Openness, Politeness, Orderliness, Cleanliness) as well as attachment styles and two Primary capabilities (Trust, Sexuality/Tenderness) and three Model dimensions (I-mother, I-father, YOU). Social Contact was moderately (and positively) correlated with Seeking of Instrumental Social Support and Seeking of Emotional Social Support, whereas Body/Senses, Activity/Achievement and Future/Fantasy were positively correlated with Mental Disengagement.

Keywords positive psychotherapy, transcultural psychotherapy, Wiesbaden Scale for Positive Psychotherapy and Family Therapy 2.0, students of psychotherapy, females, quantitative research

Introduction

The contemporary literature concerning Positive Psychotherapy shows that from the very beginning of his therapeutic work Nossrat Peseschkian hoped to find a method that would be understandable and practicable for patients and at the same time function as an agent of mediation for different schools of psychotherapy (Peseschkian, Remmers, 2020). One way to achieve that was to search for similarities between the constructs of PPT and other theoretical approaches, embracing their specific value and practical implication, but also trying to overcome their one-sidedness. Another way was for Peseschkian to care for the simplicity of language used to describe psychological

constructs in his theory. In that process he always had in mind the point of view of the patient. He explained that openly: "Over 300 different schools, orientations, and psychotherapeutic convictions offer him (the patient) their services, and this number is raised to some higher power by the fact that practically every psychotherapist nurtures his own psychotherapy (p. 366). If we postulate that each of these psychotherapeutic orientations contains at least a partial truth, and has proven valid in a practical way with certain groups of ailments, the situation for the potential patient becomes hazy (...). They speak different languages and emphasize different points (367). Positive Psychotherapy is in a position to provide therapy to all patients, independently of their social strata. The expressions employed in

Positive Psychotherapy, especially the actual capacities, meet the various linguistic styles of the different social strata half way (p. 374). (...) Positive Psychotherapy itself is not to be understood as an exclusive system, but rather attributes a particular value to each of the various psychotherapeutic methods. (...) (It) represents an integral method, in the sense of a multidimensional therapy (p. 400) (Peseschkian, 1987).

As Remmers points out, although inspired by many psychotherapeutic orientations and ideas, from the scientific point of view, Positive Psychotherapy is rooted in humanistic psychology and in psychodynamic therapy. However, PPT is more structured – with the semi-structured First Interview (being one of the first such tools in psychodynamic psychotherapy) used to gather necessary information for diagnosis, the three stages of interaction proposed to organize each session, the five stages implemented to organise the whole process of the therapy and self-help, and finally the use of visualizations such as the balance model, modelling dimensions, stories, proverbs and questionnaires such as the Differentiation Analytic Inventory (DAI) and Wiesbaden Scale for Positive Psychotherapy and Family Therapy (WIPPF) (Remmers, 2020).

According to Remmers and Peseschkian the most important use of the WIPPF is in individual therapy, but it can be applied also in couple and family and in other settings. It provides a complete summary of the psychological characteristics described as the actual capacities, conflict reactions and role models (Remmers, Peseschkian, 2020). Additionally, the questionnaire has been also used in scientific research in various languages and populations (Sinici, Sari, Maden, 2014; Zarek, Wyszadko, 2018; Serdiuk, Otenko, 2022; Zarek, 2023).

WIPPF is an instrument of special interest for the author of this article because it is the only one in PPT that was created for a quantitative measurement and by that enables comparing the theoretical concepts of PPT with other constructs using quantitative methods, e.g. correlational studies.

The aim of this work is to analyze the concepts used in Transcultural Positive Psychotherapy and measured by the Wiesbaden Scale for Positive Psychotherapy and Family Therapy (WIPPF 2.0) in the context of corresponding theoretical constructs.

Specifically, it was assumed that Secondary capabilities and social behaviors scales will correspond with social competences, Primary capabilities and Model dimensions scales will be related to attachment styles and that Conflict reactions scales will be related to stress-coping strategies. The study was exploratory and a correlational approach was used.

As the therapist's role is to model the patient's perceptions and behaviors, students of psychotherapy were chosen as the group under study.

Methodology

The study was realized between September 2017 and February 2018 in Polish training centers (Wrocław, Katowice, Sopot) among students of psychotherapy (Basic Course and Master Course, Accredited Course).

The students of psychotherapy were approached by the author during their training, informed about the aim of the study and requested to participate in it anonymously. They were asked to give some demographic data (gender, age, education, profession, occupation, marital status, number of children, years of therapeutic work) and fill in 4 self-descriptive measuring tools:

1. The Wiesbaden Scale for Positive Psychotherapy and Family Therapy (WIPPF2.0) in Polish translation;
2. Profile of Social Competencies (PROKOS) measuring five types of competencies (assertive, cooperational, social, socially resourceful and community-oriented);
3. The Questionnaire of Attachment Styles (KSP) measuring three attachment styles (secure, anxious-ambivalent and avoidant);
4. The Polish adaptation of the COPE Inventory, measuring 15 different strategies of coping with stress, characterized as active, avoidant and emotion-centered.

Data were collected from 104 students (96 females and 8 males). Due to the limited number of male participants and incomplete data, ultimately 93 females aged 24-58 were included in the analysis.

As was mentioned in the introduction, the aim of the study was to compare the concepts used in PPT and measured by the WIPPF 2.0 with other theoretical constructs that might be seen as similar.

First, the WIPPF profile for the group under study was estimated. Results of that part of the research have been presented in the separate paper (Zarek, 2023).

Then, the Scales of the WIPPF 2.0 were correlated with the corresponding scales of three self-descriptive psychological test: 1) Secondary capabilities and Social behaviors with the scales of the Profile of Social Competencies (PROKOS) measuring five types of competencies and a total result; 2) Primary capabilities and Model dimensions with scales of the Questionnaire of Attachment Styles (KSP) measuring three attachment styles; 3) Conflict reactions with scales of multidimensional questionnaire COPE measuring 15 different strategies of coping with stress, characterized as active, avoidant and emotion-centered.

The Spearman rang correlation was used to estimate the relationship between scales of the WIPPF 2.0 and corresponding scales of PROKOS, KSP and COPE.

As social competencies are supposed to be influenced by training (Martowska, 2012), additionally age, therapeutic experience, partnership status and number of children (being a parent) of participants were correlated with PROKOS scales.

2.1. Description of applied measuring tools

The Wiesbaden Scale for Positive Psychotherapy and Family Therapy (WIPPF)

The Wiesbaden Scale for Positive Psychotherapy and Family Therapy (WIPPF) was developed first in the German language by Nossrat Peseschkian and Hans Deidenbach (Peseschkian, Deidenbach, 1988). Its further development and adaptation in English was realized by Arno Remmers, who modified the name of the Scale into WIPPF2.0 (Remmers, 1996). WIPPF2.0 has been translated into the Polish language from the German by Mariusz Hewczuk in 2014 and this translation was used in the present work, as the WIPPF has not been adapted for the Polish population yet.

The WIPPF2.0 questionnaire includes 88 statements and the task of the subject is to estimate to which degree the content of each statement is descriptive of him/herself using a 4-point scale (yes, rather yes, rather no, no). The WIPPF2.0 consists of 35 independent scales, from which 11 scales are indicators of secondary capacities, 8 scales are indicators of primary capacities, another 4 scales describe conflict

reactions, 6 scales are indicators of Model Dimensions and the remaining 6 scales are abstract measures of social behaviors (concerning secondary and primary capacities in their active, reactive and ideal form) and emotional reactions (with ego, others and ideals).

The Profile of Social Competencies (PROKOS)

As the measuring tool for social competencies, the Profile of Social Competencies (Profil Kompetencji Społecznych, PROKOS), authored by Anna Matczak and Katarzyna Martowska, was used. This self-descriptive questionnaire was developed in the Polish population in 2013. It enables us to estimate the adult person's general level of social competencies as well as his/her profile in five various types of competencies: assertive, cooperational, social, socially resourceful and community-oriented. The test consists of 90 items presenting various activities, and the task of the subject is to indicate how well he/she would manage them, using 4-point scale (definitely well, rather well, rather poorly, definitely badly). While calculating the test results, only diagnostic items are taken into account, which are 60 items. They form 6 scales, which are 5 profile scales of competences and the total result scale. Higher results indicates higher levels of the given competence (Matczak, Martowska, 2013).

The Questionnaire of Attachment Styles (KSP)

The Questionnaire of Attachment Styles (Kwestionariusz Stylów Przywiązaniowych, KSP), developed by Mieczysław Płopa in 2008, was used to estimate the participants' way to build partnership relations in their adult lives. The theoretical basis for the construction of the test is the concept of attachment in romantic relationships described by Hazan i Shaver, in which four such styles are proposed: secure, anxious-ambivalent and avoidant. This self-descriptive tool enables us to discriminate between them. The KSP consists of 24 statements describing behaviors, beliefs, expectations and feelings usually experienced in a close, engaged relationship with a partner. It evaluates the person's tendency to follow a certain attachment style in partnership. The task of the subject is to indicate on a 7-point scale (from "I definitely agree" to "I definitely disagree") to what degree the presented

statements describe him/herself on the basis of his/her general experience in partnership relationships. A higher result indicates a higher level of the given attachment style (Plopa, 2012).

The Polish adaptation of the COPE Inventory

The Polish adaptation of the multidimensional questionnaire COPE developed by C. Carver, M.F. Scheier and J.K. Wienstraub, authored by Zygfryd Juczyński and Nina Ogińska-Bulik in 2012, was used to estimate the typical ways in which the individuals deal with stress. In COPE there are 15 different strategies named, which are characterized as active, avoidant and emotion-centered. COPE consists of 60 statements, which describe 15 strategies (each strategy is described by 4 items) and is most often used to measure dispositional coping with stress (typical for the subject's ways of reacting in stressful situations). The subject's task is to evaluate how he/she usually acts when being confronted with a difficult or stressful life situation and then indicate how often he/she uses coping strategies presented in the statements using a 4-point scale (1 – "I almost never do it", 2 – "I rarely do it", 3 – "I often do it", 4 – "I almost always do it").

In the Polish adaptation, COPE has a three-factor structure:

- I. Factor – *Active coping* – is constituted by 5 scales: Active coping, Planning, Suppression of competing activities, Positive reinterpretation and development and Restraint coping.
- II. Factor – *Avoidant behaviors* – is constituted by 6 scales: Denial, Behavioral disengagement, Humor, Mental disengagement, Using alcohol and other intoxicants and Acceptance.
- III. Factor – *Seeking support and focus on emotions* – is constituted by 4 scales: Seeking of instrumental social support, Seeking of emotional social support,

Turning to religion, Focus on and venting of emotions (Juczyński, Ogińska-Bulik, 2012).

Results

3.1. Demographic characteristics of the group under study

The mean age of the group was 36,83 years (min=24; max=56, standard deviation SD=8,43), so the participants were relatively young, considering the fact that they all had high level of education.

What is more, the participants in the study were not very experienced in their therapeutic work. They have worked with patients on average for 3,09 years (min=0; max=30; SD=5,19), but about 43% had no therapeutic experience and another 23% had worked with patients no more than 2 years.

Although most participants declared having a partner in life – 52 (55,91%) were married, 34 (36,56%) in partnership and 7 were single (7,53%) – almost half of the female students of psychotherapy (48,4%) did not have any children, 24,7% had one child, another 20% had 2 children, 5% had 3 children and one student (1,1%) had 4 children.

3.2. Secondary capabilities versus Social competences

All eleven Secondary capability scales of the WIPPF2.0 were correlated with the six scales of the PROKOS (5 profile scales of competences and the total result scale). Additionally, age, therapeutic experience, partnership status and number of children of participants were correlated with the PROKOS scales. In Table 1. are presented only those paired variables, for which the relationship was statistically significant (p-value < 0,050).

Table 1. Relationships between WIPPF 2.0 Secondary capability scales and PROKOS social competencies scales

Paired variables	N	R Spearman	t (N-2)	p<0,050
Orderliness & PROKOS Assertive	93	-0,239	-2,349	0,021
Politeness & PROKOS Assertive	93	-0,316	-3,175	0,002
Openness & PROKOS Assertive	93	0,445	4,747	0,000
therapeutic experience & PROKOS Socially resourceful	93	0,227	2,220	0,029
Orderliness & PROKOS Socially resourceful	93	-0,210	-2,047	0,044
Openness & PROKOS Socially resourceful	93	0,315	3,167	0,002
Cleanliness & PROKOS Community-oriented	93	0,223	2,183	0,032
Openness & PROKOS Community-oriented	93	0,233	2,284	0,025

Openness & PROKOS total	93	0,300	2,996	0,004
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In the group under study, Spearman's rank coefficients were minor to moderate and they were found between three social competencies (assertive, socially resourceful, community-oriented) and the total score and four secondary capabilities (Openness, Politeness, Orderliness, Cleanliness) and also therapeutic experience.

Openness was positively correlated with assertive, socially resourceful and community-oriented competencies, as well as with total score of PROKOS. The highest correlation ($r=0,445$) was found for the assertive competence, which is described as an ability to efficiently influence others and at the same time to resist their influence, to direct and delegate tasks, to refuse, to act in accordance with one's will. On the other hand, being socially resourceful means that a person is able to obtain something from others, ask for help or a special treatment, which partially is realized because a person knows what he or she is entitled to get. Finally, the community-oriented competence is described as the ability to recognize social needs and purposes and to organize actions that lead to their fulfillment, involving others [Matczak, Martowska, 2013]. Interestingly, this competence was the only one that was positively correlated with the subjects' therapeutic experience.

All these above-mentioned results suggest that a crucial aspect of Openness is connected with the ability to care for personal needs and goals and directly express them, as in "being on your own side". However, this is not done against others.

Politeness was negatively correlated with assertive competence. Although this correlation was minor, it might suggest that this quality describes individuals who find it difficult to carry out their will, to speak for themselves.

Minor and negative correlations were also found between Orderliness and assertive, as well as the socially resourceful competence. One hypothesis concerning the interpretation of this result is that Orderliness is associated with difficulty to take action or with some inhibition, as undertaking action characterizes both assertive and socially resourceful individuals.

Attachment styles versus Primary capabilities and Model Dimensions

For this part of the analysis, eight Primary capability scales and six Model Dimensions scales of the WIPPF2.0 were correlated with three scales of the Questionnaire of Attachment Styles (KSP) indicating Secure, Anxious-ambivalent or Avoidant styles. Again, in Table 2. are presented only those paired variables, for which the relationship was statistically significant ($p\text{-value} < 0,050$).

Table 2. Relationships between WIPPF2.0 Primary capabilities and Model dimension scales and KSP attachment styles

Paired variables	N	R Spearman	t (N-2)	p<0,050
Trust & Secure Attachment	92	0,262	2,578	0,012
Sexuality/Tenderness & Secure Attachment	92	0,329	3,308	0,001
I-mother & Secure Attachment	92	0,257	2,527	0,013
I-father & Secure Attachment	92	0,230	2,241	0,028
YOU - parent's partnership & Secure Attachment	92	0,352	3,568	0,001
I-mother & Anxious-Ambivalent Attachment	92	-0,260	-2,552	0,012
YOU - parent's partnership & Anxious-Ambivalent Attachment	92	-0,313	-3,131	0,002
Sexuality/Tenderness & Avoidant Attachment	92	-0,299	-2,975	0,004
I-mother & Avoidant Attachment	92	-0,253	-2,482	0,015
YOU - parent's partnership & Avoidant Attachment	92	-0,253	-2,486	0,015

Minor Spearman's rank coefficients were found between attachment styles and two Primary capabilities (Trust, Sexuality/Tenderness) and two Model dimensions (I-mother, I-father, YOU).

The secure attachment style was positively correlated with Trust, Sexuality/Tenderness, two aspects of I Model dimension (I-mother, I-father) and YOU Model dimension. This is not surprising, as the Secure style in KSP characterizes individuals who experience high satisfaction with a relationship with their partner, which is based on the belief that the partner will be accessible in difficult, important, stressful situations. Partners often react with tenderness and are often close to each other. They are ready to reveal themselves. Communication is based on mutual trust, openness and support [Plopa, 2008].

On the other hand, the insecure attachment styles (Anxious-ambivalent and Avoidant) were negatively correlated with I-mother and YOU Model dimension. Additionally, the Avoiding attachment style was negatively correlated with Sexuality/Tenderness, which might suggest that individuals who experienced little closeness and

physical contact with their parents – it is usually so in children who formed avoidant attachment (Wallin, 2011) – develop negative attitude toward tender touch in partnership.

The results suggest that primary capabilities, such as Trust, Sexuality/Tenderness and the Model dimensions of I and YOU could be understood as indicators of attachment styles, however the Spearman's rank coefficients are minor. This can partly be explained by the fact that the KSP was created to measure attachment in romantic relationship and not with parents. It was used in this research simply because there was no other self-descriptive tool measuring attachment style known to the author at the time of conducting the research. Further research in this field with the use of the WIPPF is needed.

3.3. Stress coping strategies versus Conflict reactions

In the last part of the analysis, four Conflict reactions scales of WIPPF2.0 were correlated with fifteen stress coping strategies of the COPE questionnaire. Only those paired variables, for which the relationship was statistically significant (p -value < 0,050) are presented in Table 3.

Table 3. Relationships between WIPPF2.0 Conflict reactions scales and COPE stress coping strategies

Paired variables	N	R Spearman	t (N-2)	p<0,050
Mental disengagement & Body/Senses	89	0,212	2,020	0,047
Mental disengagement & Activity/Achievement	89	0,267	2,586	0,011
Using alcohol and other intoxicants & Activity/Achievement	89	0,247	2,374	0,020
Seeking of instrumental social support & Social contact	89	0,406	4,147	0,000
Seeking of emotional social support & Social Contact	89	0,557	6,255	0,000
Focus on and venting of emotions & Future/Fantasy	89	0,249	2,396	0,019
Mental disengagement & Future/Fantasy	89	0,259	2,502	0,014

Minor to moderate Spearman's rank coefficients were found between Conflict reactions and five stress coping strategies. Interestingly, all obtained correlations were positive, which means that higher levels of results in those stress coping scales corresponded with a tendency to respond with

psychosomatic reactions in Body and a tendency to “fly into” in the remaining Conflict reaction scales.

Social Contact was moderately correlated with Seeking of instrumental social support ($r=0,406$) and Seeking of emotional social

support ($r=0,557$), which were the highest correlations obtained.

Body/Senses correlated only with Mental disengagement, Activity/Achievement correlated with Mental disengagement and Using alcohol and other intoxicants, Future/Fantasy correlated with Mental disengagement and Focus on and venting of emotions, but all those Spearman's rank coefficients were minor. Because the Mental disengagement stress coping strategy is described as "avoiding thinking about consequences of the event by engaging in other activities such as sleeping, watching TV", it is possible that the common aspect apparent in all three conflict reactions is avoiding the confrontation instead of taking an active attitude toward the problem (Juczyński, Ogińska-Bulik, 2012).

It is difficult to estimate to what degree these results are expected, as there is no other study known to the author that aimed at comparing the Conflict reactions and stress coping strategies.

However, the results obtained in the group studied might suggest that the concept of flying into Contact as a conflict reaction is similar to the stress coping strategies described as Seeking emotional social support ("seeking moral support, liking or understanding") and instrumental social support ("seeking advice, help or information"), which both are more often used by women than men in the Polish population (Juczyński, Ogińska-Bulik, 2012).

Further research is needed to investigate similarities between WIPPF2.0 constructs and other theoretical constructs.

Conclusions

1. Minor to moderate correlations were found between social competences and four secondary capabilities (Openness, Politeness, Orderliness, Cleanliness). The highest positive correlation was found for assertive competence and Openness ($r=0,445$), which also correlated positively with socially resourceful and community-oriented competencies, as well as with total score of PROKOS.
2. Minor correlations were found between attachment styles and two Primary capabilities (Trust, Sexuality/Tenderness)

and two Model dimensions (I-mother, I-father, YOU).

3. Social Contact was moderately and positively correlated with two of the stress coping strategies: Seeking emotional social support ($r=0,557$) understood as seeking moral support, liking or understanding and Seeking instrumental social support ($r=0,406$), that is seeking advice, help or information.
4. Body/Senses, Activity/Achievement and Future/Fantasy were positively correlated with Mental Disengagement, though the correlation coefficients were minor.

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Additional important info

1 Declarations

1.1 Study Limitations

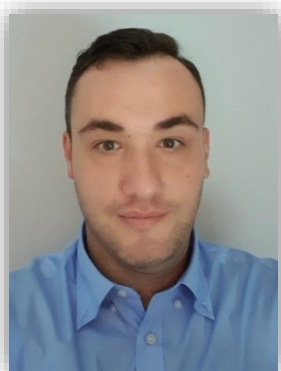
One limitation of the study is the use of the WIPPF2.0 in translation, however WIPPF has not been adapted in Polish population yet. Another limitation of the study is the sample size. The study's results cannot be generalized to Polish population of female students of psychotherapy.

1.2 Funding source

Presented research results have been realized within the subject about the number SUB.A150.20.001 according to the records of Simple system.

Section: Preliminary studies in PPT

AN INTERDISCIPLINARY AND MULTIDISCIPLINARY APPROACH BETWEEN MEDICAL EDUCATION AND POSITIVE TRANSCULTURAL PSYCHOTHERAPY TO LEAD SUICIDE PREVENTION STRATEGY FOR HEALTHCARE STUDENTS AND HEALTHCARE WORKERS



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Received 15.03.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj197](https://doi.org/10.52982/lkj197)

Abstract

Suicidal ideation (SI), suicide attempts (SA), and completed suicides (CS), seem to be phenomena present globally and in heterogeneous growth. The objectives of this manuscript are to offer an overview of these phenomena related to mental health and mental well-being, focusing on the prevention of SI, SA, and CS, with multidisciplinary team (MDT) and interdisciplinary team (IDT) interventions that can be integrated into the daily activities of healthcare workers (HWs) and medical/healthcare students (MHSs). The role of medical education (MedEd) and counselling/psychotherapy, with particular interest in the PPT (Positive and Transcultural Psychotherapy), can become fundamental in intervention, identification, prevention activities, for MHSs and HWs.

Keywords: medical education, suicide, positive psychotherapy, mental wellbeing, prevention

Introduction

Globally, approximately 800000 suicides were estimated in 2012, around 11.4 suicides/100000 people, and this number appears to have grown by 6.7% between 1990 and 2016 reaching an average of 817000 suicides in 2016, an increase of 60% in the last 45 years. SAs are globally about 20 times higher than CSs (around 16 million), and SIs are about 100 times more frequent than CSs (Wasserman, 2016; Naghavi, 2019; Chehil, 2012; Falcone, 2018). Regarding the MHSs in the first year of study, a rate like that of the previously mentioned general population of 11.4 / 100000 is given and a worsening of the state of mental health during subsequent years of study is indicated (Coentre, 2018). Furthermore, the prevalence of SIs appear to be between 6% and 43% in medical students, and for university students in general, an annual rate of CSs between 6.5 and 7.5/ 100000 is estimated over 20 years (Yusoff et

al., 2012; Carson et al., 2000; Iarovic, 2014); regarding HWs, the suicide rate is 1.41 times higher for men and

2.27 times higher for women, compared to the general population (Latifi, 2019). While data relating to CSs, SAs, and SIs may be influenced by cultural, religious, ethnic, educational, or other biases related to personal belief (Mehmet Eskin, 2018), it is necessary to intervene through prevention systems that can be considered inclusive, and that avoid generating socio-cultural barriers, and stigmatization.

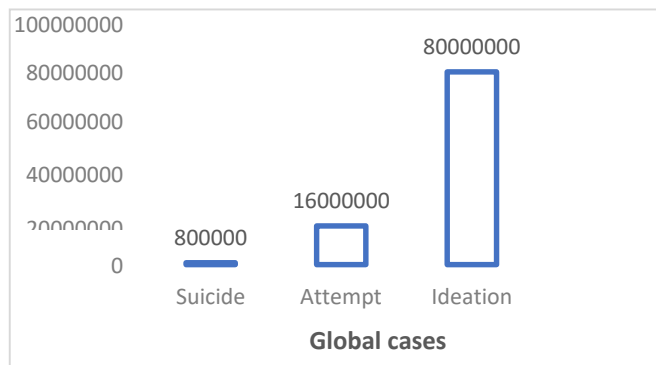


Fig. 1: Comparison between CSs, SAs, and Sis

1.1. Risk factors

The main risk factors in reference to MHSs and HWs are depression, burnout, excessive workload, occupation, dissatisfaction, lack of sense of belonging, alcohol consumption, stress, comorbid mental illness, post-traumatic stress disorder, feeling of isolation, previous SIs or SAs, anxiety, stressful personal events, gender, and race. With reference to the prevention of suicidality, there are wide-ranging difficulties that can compromise the necessary actions. Stigma of suicidal ideation and attempted suicide are a cultural factor that leads to isolation and discrimination (*and self-isolation, self-discrimination, and self-stigmatisation*) which makes it difficult to track down people in need of support. Poor awareness of possible support paths, poor knowledge of risk factors, behavioural signs, and symptoms make it difficult for the subject to be aware of the need for support, as well as lack of knowledge and awareness of suicidality as a multifactorial product, and perception of suicidality as a cultural taboo, due to possible communication and multidisciplinary/interdisciplinary activity deficiencies (Wasserman, 2016; Wasserman, 2021; Soper 2018).

Methodology

2.1. The role of medical education

The primary role of MedEd relates to curriculum development and intervention, organization, leadership, assessment, of academic programs defined undergraduate, postgraduate, and continuing professional development. Deepening the role does not exclusively concern what is defined as “teaching and learning” but appears to have an important role in the development of well-being for MHSs and HWs, which will become well-being and safety for patients. The well-

being of MHSs and HWs impact on their performance, on the acquisition of skills and competences, on personal and professional development, and on healthcare and educational providers. In this regard, medical education acts by planning and organizing support and monitoring systems for learners (*MHSs, and HWs in lifelong learning*), thus influencing the area concerning welfare and well-being (Meeks et al., 2019; Bishop et al., 2018), the pillar of education, and the pillar of community involvement and interaction, as visible from diagram 1.

2.2. The role of Positive and Transcultural Psychotherapy

The university and the healthcare workplaces are subject to high migration flows, which allow the structuring of multicultural, transcultural, and dynamic environments, in which it is necessary to understand and face the challenges deriving from the encounters and interactions of different cultures, habits, backgrounds, and relational modalities (Peseschkian, 1990; Kirmayer, 2022). In connection with the migratory dynamics and in line with the objectives of suicide prevention among MHSs and HWs, PPT describes characteristics and methods in line with the challenge. PPT turns out to be a humanistic psychodynamic modality, conflict-centred and resource-oriented, in which cognitive-behavioural aspects are integrated, based on a positive and transcultural approach. Among the objectives of PPT are the promotion and development of well-being and physical, mental, social health, awareness of human potential in its complexity. The PPT modality follows different objectives and can be applied in different areas, such as the treatment of psychosomatic and mental health disorders (*therapeutic*), counselling-prevention-education (*preventative and pedagogical*), dissemination of transcultural understanding (*Transcultural-societal approach*), and use of different integrated modalities of therapeutic methodologies (*interdisciplinary approach*) (Peseschkian & Remmers, 2020; Cyrous, 2020), visible in Fig. 2.

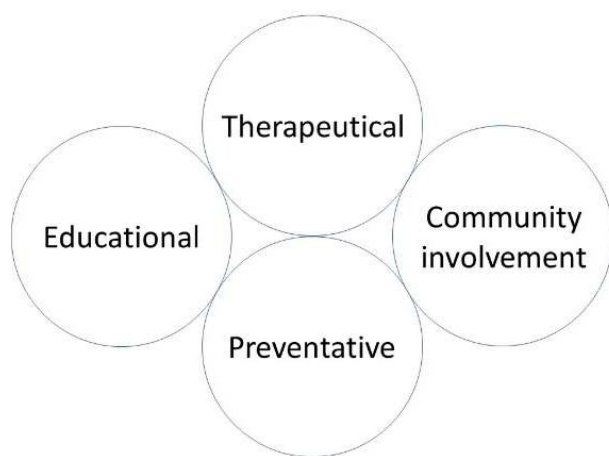


Fig. 2: interdisciplinary and multidisciplinary role of MedEd and PPT

Discussion

3.1. Multidisciplinary and Interdisciplinary mindset

As schematized in Fig. 2, it is possible by summarizing the main characteristics of MedEd and PPT to understand the importance of interdisciplinary and multidisciplinary activities and interventions, which can be planned on the centrality of the four pillars of interaction between MedEd and PPT:

- Education/pedagogy.
- Therapy/intervention.
- Prevention.
- Interaction with the community/society.

By multidisciplinary we mean the interaction between different disciplines simultaneously, and by interdisciplinarity (*or interprofessionalism*) we mean the transfer of skills, abilities, knowledge, between different disciplines (Nima Rezaei & Amene Saghadzadeh, 2022). Cooperation between MedEd and PPT can be considered through the establishment of multidisciplinary (*MDT*) and interdisciplinary teams (*IDT*), which can play active roles in suicide prevention, further interacting with different environments, stakeholders, and subjects (*universities, educational providers, hospitals/clinics, communities*).

Table 1. Simplification of multidisciplinary and interdisciplinarity team

Team Modality	Function
Multidisciplinary	Interaction between professions
Interdisciplinary	Transfer of skills/abilities between professions

3.2. Preventative interventions and activities

Curriculum intervention and workload organization, programming a compulsory personal therapy (*counselling/psychotherapy*) for MHSs and HWs, constant over time (*personal therapy cyclic sessions and supervision*), which allows the development of self-awareness, emotional development, self-reflexivity, as well as direct monitoring of mental well-being, and it can also find its application in favour of students who decide to opt for study paths offered with distance learning / online modality with the possibility of carrying out personal therapy in the same methodology (Gentile & Roman, 2009; Søvold et al., 2021). In addition, peer support activities should be organised with supervised mental well-being monitoring activities carried out by counselling / psychotherapy students (Moe 2020; Chester, 2006). These activities involve supervision by expert personnel, MDT, and IDT, with reference to the therapies carried out by counselling / psychotherapy trainees towards MHSs and HWs. These activities may offer many advantages:

- Cost reduction for MHSs and HWs for mandatory personal therapy, delivered as a supervised internship.
- Distance counselling / psychotherapy activities, also in support of distance learning students, organized through university structures or providers (*monthly or three- month evaluation*).
- Establishment of MDTs and IDTs involving MHSs and HWs in the cooperation of MedEd and PPT.
- Generation of the awareness of the real existence of the practitioner-patient.
- Increase in the number of peers (MHSs and HWS) available for the training in counselling/psychotherapy for students (*with and without supervision*).
- Increase in the number of mental well-being practitioners (*in departments or areas at risk, and in university departments*).
- Increase in the use of PPT in environments with a high migratory flow or multicultural environments.
- Increased use of technology and monitoring and self-monitoring tools (*artificial intelligence, face/emotions analysis, performance analysis, reflective journal*).

- Integration intervention of counselling/psychotherapy skills training for all programs of the health professions (*medical and non-medical*).
- Support to MHSs and HWs in the monitoring phase and support of mental wellbeing and suicide prevention.

A further step in suicide prevention is to train and educate HWs and MHSs on epidemiological data, on the prevention supports present in institutions and workplaces, on education to recognise the possible signs of stress or mental illness, education on emotions and feelings, and to educate on the challenge against the stigmatization of mental disease due to social and cultural barriers. MHSs and HWs must thus be informed of the absence of possible disputes or participate in their study path and career path (Klein, 2022; Kusumadewi et al., 2021; Hrovat et al., 2012). Academic and workplace activities useful for the prevention of suicide are identifiable in the following activities:

- Reflective journal.
- Performance analysis.
- Surveillance survey.
- Formal and informal feedback.
- PPT (counselling/psychotherapy).

The reflective journal (*reflective practice*) is a monitoring tool mainly used in the development of professional practice, knowledge, and skills, in the planning of corrective actions or improvement of the professional / academic path and is a useful tool to increase the level of self-awareness and self- knowledge, which thus allows constant monitoring of oneself also in relation to sensations and emotions (Richard et al., 2010; Cooper, 2019). Peer feedback (*formal and informal*), survey, and performance analysis (*academic and professional*), in the context of suicide prevention, can be useful tools for monitoring suicidality, both in MHSs and HWs (Bowersox et al., 2021; Andreotti et al., 2020; Chadha, 2021). MedEd in cooperation with universities and the managerial areas of the workplaces have the task of supporting the organization and methods of using feedback and surveys, making them clear, executable, and interpretable; in support of these three tools that may be used in suicide prevention, artificial Intelligence and facial/emotions analyser software could be proposed (Bernert et al., 2020; Laksana et al., 2017).

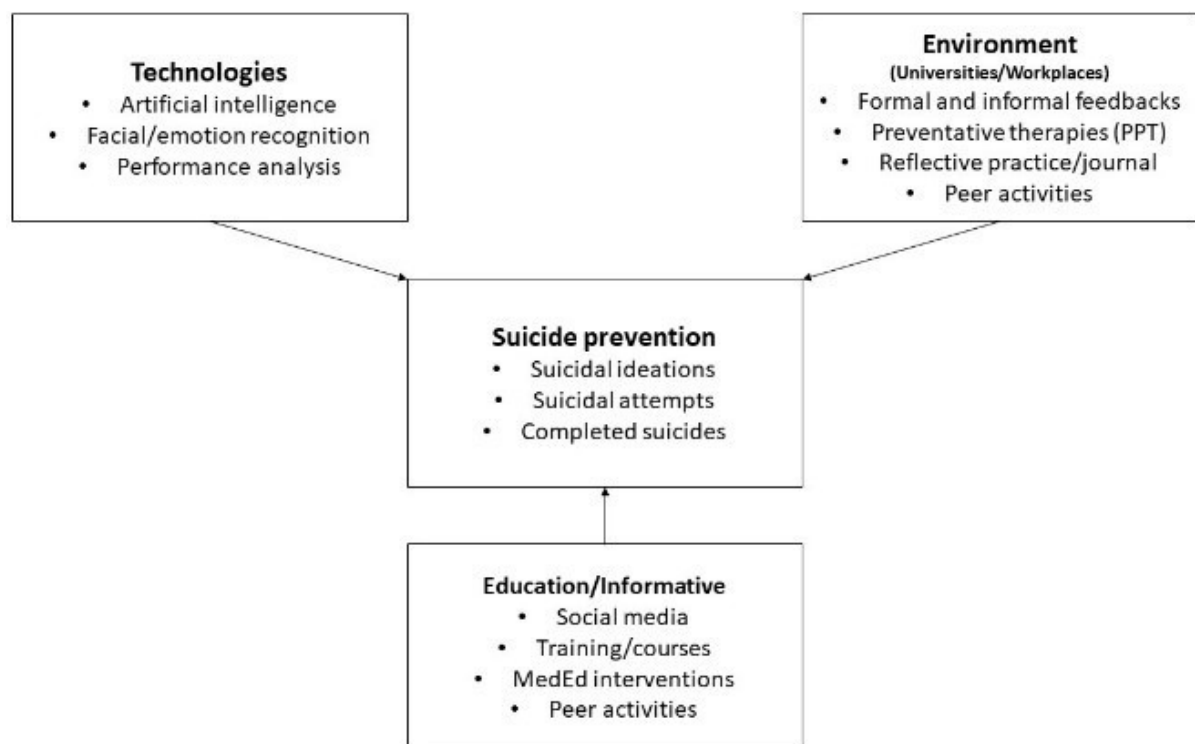


Fig. 3. Outline of the prevention activities

Conclusion

In the objective of the prevention of CSs, SAs, and SIs, MDTs and IDTs based on MedEd and PPT, fit a fundamental role in identifying the best monitoring and preventative systems in a high-risk group such as MHSs and HWs (Hoppen & Morina, 2021; Birni & Eryilmaz, 2022). From what has been described, the mental health of subjects at risk can be monitored to prevent the risk of suicide through the integration of different areas as illustrated in diagram 2:

- Technologies.
- Environment.
- Education/dissemination activities.
- Preventative counselling/psychotherapy modalities.
- Peer activities.

The aims of the interventions and of the organization of support to the MHS and HW, in addition to prevention as a primary objective, are also the generation and monitoring of mental health, interdisciplinary and multidisciplinary support, training, dissemination, and information on mental health and emotions, and against discrimination and stigmatization of mental illness and suicide.

Limits of the manuscript

What is proposed in the manuscript does not evaluate the possible cost-effectiveness ratio, ROI, and the peculiarity of the different academic and health systems, their legislation, their financing, and any preventive pathways already active.

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Section: PPT training

POSITIVE GROUP THERAPY THROUGH TRADITIONAL GAMES WITH A POSITUM MGS APPROACH FOR BUILDING RESILIENCE AGAINST TRAUMA IN TIMES OF PANDEMICS, WAR AND EARTHQUAKES: THEORETICAL CONSIDERATIONS AND PRACTICAL APPLICATIONS OF “THE WITCHES” GAME



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Received 08.05.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj198](https://doi.org/10.52982/lkj198)

Abstract

Why traditional games and how to transform them into powerful psycho-social and holistic instruments in Positive Group Therapy? The paper aims at looking at the space that Positive Transcultural Psychotherapy [PPT after N. Peseschkian, since 1977]TM can provide for the Positum MGS approach in utilizing traditional and transcultural games with a psycho-social aim in groups. Pandemics, wars and natural disasters such as earthquakes – among many other traumatic events – can result in forced displacement and migration for masses of populations, including children, and have severe consequences in the holistic health of affected people. The paper looks at the foundations of Positive Group Therapy, its interaction with the Positum MGS approach within it, and the value they can create for healing trauma in groups when integrating such tools as traditional games. The paper analysed the research and practice in the field, demonstrating the great value of traditional and transcultural games in strengthening the identity and sense of belonging, as key resources for building resilience for individuals in groups and through group work sparked by traditional games transformed into psycho-social ones. The features, principles and strategies of the Positum MGS approach within the framework of PPT are further explained, and cases of practical application from recent years are discussed in the light of theoretical concepts of Positum MGS and PPT.

Keywords: positive group therapy, positive psychotherapy, transcultural, traditional games, Positum MGS, identity, resilience, neurodiversity, pandemic, war, earthquake

“Consultation bestoweth greater awareness and transmuteth conjecture into certitude. It is a shining light which, in a dark world, leadeth the way and guideth. For everything there is and will continue to be a station of perfection and maturity. The maturity of the gift of understanding is made manifest through consultation... it is and will always be a cause of awareness and of awakening and a source of good and well-being.”

- Mírzá Ḥusayn-‘Alí Núrí (Bahá’u’lláh, 1817-1892)

Introduction

Consultation is a process of sharing ideas in a state of openness that leads to a greater awareness on the reality and, in therapeutic settings, of self-awareness or self-discovery. 'Consultation' is one of the three principles of Positive Transcultural Psychotherapy [PPT after N. Peseschkian, since 1977]TM and it is essential also in Positive Group Therapy (PGT). The original conceptual framework for the theory and practice of Positive Group Therapy (or Psychotherapy) can be found thoroughly discussed in at least two key works of prof. dr. Nossrat Peseschkian, the founder of PPT. Thus, according to Peseschkian (1986, 2013), the main focus of the consultations in Positive Group Therapy is on the primary and secondary actual capacities, which become central themes for differentiation and consultation in the group. The therapist's role is to help the members of the group become more aware of the conflict dynamics, symptoms, and disorders experienced by the group members, generated by the dysfunctions and insufficient differentiation on actual and basic concepts at the basis of those psycho-social capacities. In the same time, the therapist's role is to raise awareness and encourage the group members to see the functions of the dysfunctions, to re-interpret, to mobilize internal and external resources, to create counter-concepts, and broaden the goals. Similar to the practice of individual and family therapy, Peseschkian (1986) suggests the 5-stage strategy of consultation for groups as well, namely, (1) Observation and Distancing), (2) Inventory, (3) Situational Encouragement, (4) Verbalization, and (5) Broadening of the Goals.

1.1. *Positum MGS approach within Positive Group Therapy*

In addition to the above, Peseschkian (2013) lists the ninth thesis of PPT, stating: "Through its content-related procedure, Positive Psychotherapy offers conceptual framework within which the different methods and disciplines can meaningfully complement one another (meta-theoretical and meta-practical aspects)". It is on this foundational ground that the Positum MGS approach within Positive Group Therapy, which is largely discussed by Parruca (2013, 2022), brings its technical tools and methodological principles for therapeutic

work with groups of children and adults affected by the traumas related to pandemics, war, earthquakes and other related trauma-generating events and factors, resulting also in complex trauma. According to Parruca (2022), the Positum MGS approach uses several therapeutic instruments, and most of them are adopted and adapted from the MGS Methodology, which was developed and conceptualized by Heiniger, Meuwly, et al. between 2005 and 2011 in countries affected by war, conflict, violence and natural disasters. The MGS Methodology, in its unique form without Positum elements, is currently being applied in different regions and countries of the world. As Parruca (2013, 2022) argues, one of those tools for group therapeutic work is any traditional game that is played with a 'Positum' approach, because Positum MGS, in its technical aspects, is largely inspired by the rich repertoire of such games in every country and culture. Although traditional or folk games are originally played interactively with elements of competition and exclusion in a group of 4-20 people or more, resulting in uncomfortable emotions and feelings for "the losers", the Positum MGS approach, being in essence a psycho-social methodology, transforms the games into more co-operative, participatory and inclusive. As such, these games generate more laughter, joy, enthusiasm and other pleasant sensations, emotions and feelings, resulting in a cascade of positive neurotransmitters and hormones. These, in turn, lead to a more relaxed physical and cognitive state, which ultimately serves to differentiate with more awareness during the closing consultation and debriefing on the actual capacities of acceptance, safety, affection, contact, hope, trust, self-confidence, unity, honesty, politeness, achievement, obedience, responsibility, etc.

The participants in a Positum MGS training session (mainly PPT trainers, therapists and consultants, as well as mental health specialists from other methods) can learn through interactive and experiential activities in the training group how to work with groups of children, adolescents and mixed groups between them and adults through the Positum MGS tools. The approach helps to build the personal, social, technical and methodological capacities of professionals who want to facilitate group sessions that contain psycho-social transcultural games, played through the principles of the MGS

Methodology and Positum MGS approach, followed by “positum feedback” and debriefing, as largely discussed by Parruca (2013, 2022), which is based on the 5-stage consultation of Positive Psychotherapy (Peseschkian, 1987). The post-game feedback reflects deeper on emotions and feelings that emerged during the game, on actual primary and secondary capacities – either in the form of emotional needs or social expectations – as well as on concepts at their bases and new reflections on what can and needs to be changed.

The traditional games, when transformed into ‘Positum’ ones, become more psycho-social and transcultural, and have similar functions to stories in PPT, because they are like fairytales being played through movement and other tools, playing with the fantasy and paradoxical situations. As such, they have resulted to be powerful instruments in group psychotherapy for prevention and treatment of micro- and macro-trauma, traumatic stress, PTSD and complex trauma, including in the work with groups of children and adults with special needs, and who are neuroatypical and neurodiverse, as the groups are encouraged to establish comfortable and acceptable contact through active physical games, in which they would otherwise not be able to fully participate, if the game was played in its original traditional form. Positum MGS sessions, being part of a therapeutic process that is embedded within the psychodynamic and systemic facets of Positive Group Therapy, address also simultaneously these four dimensions: (1) intrapersonal; (2) interpersonal; (3) group; and (4) systemic aspects (Dobiała, 2020), as participants are engaged continuously in a process of entering and exiting one or another dimension with the support of the facilitator-therapist and the group. Dobiała (2020) discusses also the principles that should guide psychotherapists when considering the needs of distinct transcultural groups such as people on the Autism Spectrum.

1.2. Research on benefits of traditional games for building overall skills and holistic resilience

From 2013 to nowadays, observations by the author in the field practice of the Positum MGS approach with groups of whether mental health specialists under training or groups of children, adolescents and adults under support in Albania,

Kosovo, Hungary, Poland, Türkiye and other countries where trained specialists reside, are confirming of the findings of the study of Lester & Russell (2010). In the study, the resilience-building effects of playing in groups and the beneficial use of traditional games have been researched and largely demonstrated:

“Playing is a mechanism of survival and protection, because while children play, they create their own well-being, according to Bradshaw et al. (2007). Indeed, through playing, children externalise their impulsions and inner world in a safe environment that helps them to reconstruct themselves and develop their resilience. Thanks to new situations ‘beyond the real world’, specific to games, the children are forced to adapt and adopt original behavior because ‘everything is possible’. “This external behavior is matched with an internal connection process; a novelty of wiring potential in brain circuits (Gordon et al. 2003; van Praag et al., 2005).” [...] Play supports novel neural connections and changes the architectural structure of brain regions through its own value and fabulations (pleasurable and ‘as if’ behavior); ‘the brain not only shapes play ... play also shapes the brain’ (Pellis and Pellis, 2009:94).” [...] “Feelings of joy and pleasure are associated with more flexible and open responses to situations and with effective problem-solving, self-control, forward-looking thinking and caution in dangerous situations (Isen and Reeve, 2006).” [...] Research suggests that experience of pleasurable situations may have benefits for dealing with stress and negative experiences (Silk et al. 2007; Cohn and Frederickson, 2009).” Bonding reveals itself to be another primordial factor while playing, because friendship and positive relations between peers have protective effects, according to Abou-ezzedine et al.’s (2007). “Play becomes an important medium for establishing peer friendships, learning about social dynamics and the rules of engagement (Fantuzzo et al. 2004; Panskepp, 2007).”

Moreover, based on research and practice, Meuwly (2012) states:

“[...] playing is fundamental to stay healthy, as well as for well-being, development and child protection. Certain immediate benefits that are already recognised are, the fact of

“providing important physical exercise that develops endurance, control of body movement and perceptual-motor integration; testing aspects of the environment to deduce their value; establishing social roles and alliances that may contribute to current survival; enhancing psychological and physiological well-being and resilience (Burghard, 2005).” Beyond the topics exposed in the study on the children's right to play, playing allows children to develop a certain number of life skills for better protecting themselves: better self-confidence and self-knowledge helps them assert themselves, be more responsible, make choices, make decisions, evaluate when people are safe or not, etc. “Playing with others requires constant maintenance, reading and differentiating the intentions of others and adjusting behaviours in response. It is evident that these interrelated components enhance children's repertoire of social, emotional and cognitive abilities (Pellis and Pellis, 2009).” Playing, therefore, allow general skills (mental, emotional and physical) to be developed, which helps to acquire or modify certain attitudes and behaviours in order to improve the capacity of long-term resilience: self-esteem, self-confidence, feeling of security, cohesion in a group, etc. [...] Through their cultural links, the traditional games also have an impact in reinforcing identity – a factor of resilience. They actively [contribute] in the children's well-being by making them feel they belong to a group, a community and a collective history. This is even more important when working with displaced people, migrants or refugees for example.”

In such considerations, any PPT therapist or consultant can identify a wide range of actual capacities being outlined. And they, in addition to other mental health practitioner or other methods, may undertake the use of play therapy in groups with enough self-confidence, after receiving some core training, coaching and supervision in the Positum MGS approach. It helps to further build the required competences at personal, social, technical and methodological levels to facilitate groups through the concepts of the MGS Methodology and Positive Psychotherapy (Parruca, 2013). The results of the MGS Methodology's implementation with

groups of children in Albania, Moldova and Rumania, compared to control groups, during 2009-2010, have been satisfactory and encouraging, indicating of increased resilience, as already discussed by Lasku & Lopari (2012) and reiterated by Parruca (2022).

Methodology

Transforming a traditional game into a Positum MGS game is not difficult. However, from the author's experience of some 10 years in the approach, it requires an awareness of the features, learning stages, intensity curve along the PPT interaction stages, and guiding methodological principles of Positum MGS, and then to start implementing them during and after a 4-5-day core training under coaching and supervision. Let's see them one by one.

2.1. Theoretical considerations for transforming traditional games into Positum MGS ones

Firstly, a facilitator needs to have an awareness of the features of Positum MGS games, as summarized in Figure 1.

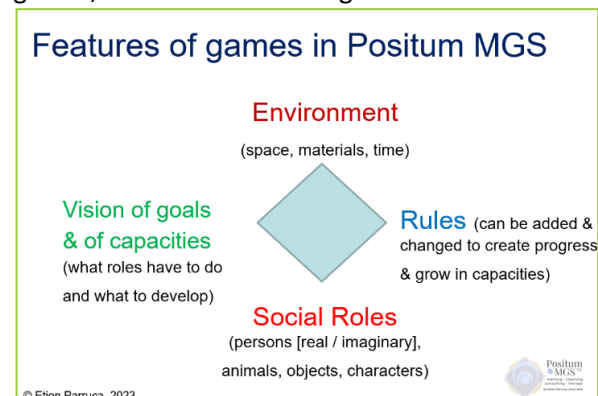


Fig. 1: Features of Positum MGS games

During training, a facilitator of Positum MGS learns how to combine and change these features in order to transform a traditional game characterized by exclusion and strong competition into a psycho-social game that gives participants a feeling of inclusion and achievement in unity. This is especially important for children and adults who have experienced exclusion and loss during traditional games. Any of the features can be changed and the game can immediately become a 'Positum' one, highlighting the primary capacities of acceptance, hope, trust, patience, contact, unity, etc.

Secondly, it requires the undertaking of a process of “experiential learning” inspired by the learning theory of Kolb et al. (Meuwly 2011) that happens within the areas of the Balance Model of PPT. Both models are harmonic in essence and process.

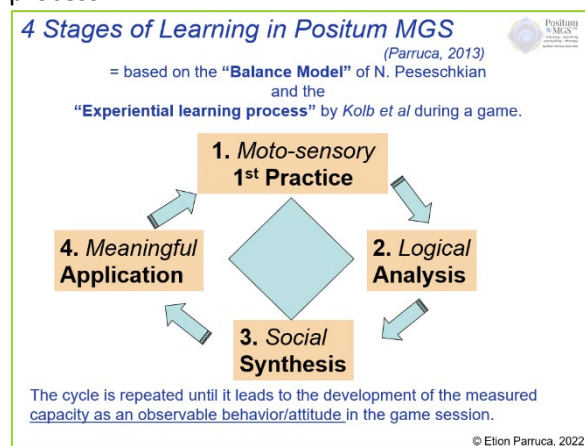


Fig. 2: Learning process in Positum MGS

Figure 2 summarizes this process. Practically, it means that after a traditional game is played with its usual rules of exclusion and competition for a few minutes, the 1st moto-sensory practice has taken place; then there is a stop of 1-2 minutes for a logical analysis in the group to discuss on what happened and what was difficult; followed by social synthesis in the group of how the participants experienced it in terms of emotions and feelings towards one another and within the group, making then a decision about the change of rules they want, in order to interact within their social roles (imaginary

people, animals, objects, phenomena, etc.) and the actual capacities that need to be engaged in the game; to then finalize the learning process through a re-application that is infused with a new vision on what needs to be done and meaning on what needs to be developed. This cycle is repeated several times during the game, to give each group participant the opportunity to experience the learning through the four modes of perception: senses, logic, tradition and intuition (Peseschkian, 1987), and when the capacities in focus are observed as desired behaviors and attitudes within the group (Heiniger & Meuwly, 2007).

Thirdly, after the session facilitator notices that there has been enough physical, emotional, logical and social engagement through several rounds, the game is stopped for relaxation and a 15-60 minutes reflection in the group, depending on the age of the participants and need for differentiation. Practice has demonstrated that adults need more time, and facilitator need to consider it when planning the stages and steps in a Positum MGS session, as demonstrated in Figure 3. Some key elements of the four integral and cohesive parts of a Positum MGS session and how they are connected with the three steps of interaction in PPT and also its five-stage strategy were explained by the author (2022). It is noteworthy to reiterate that the reflection part that follows the cool-down entails elements of both the differentiation and detachment steps of interaction in PPT.

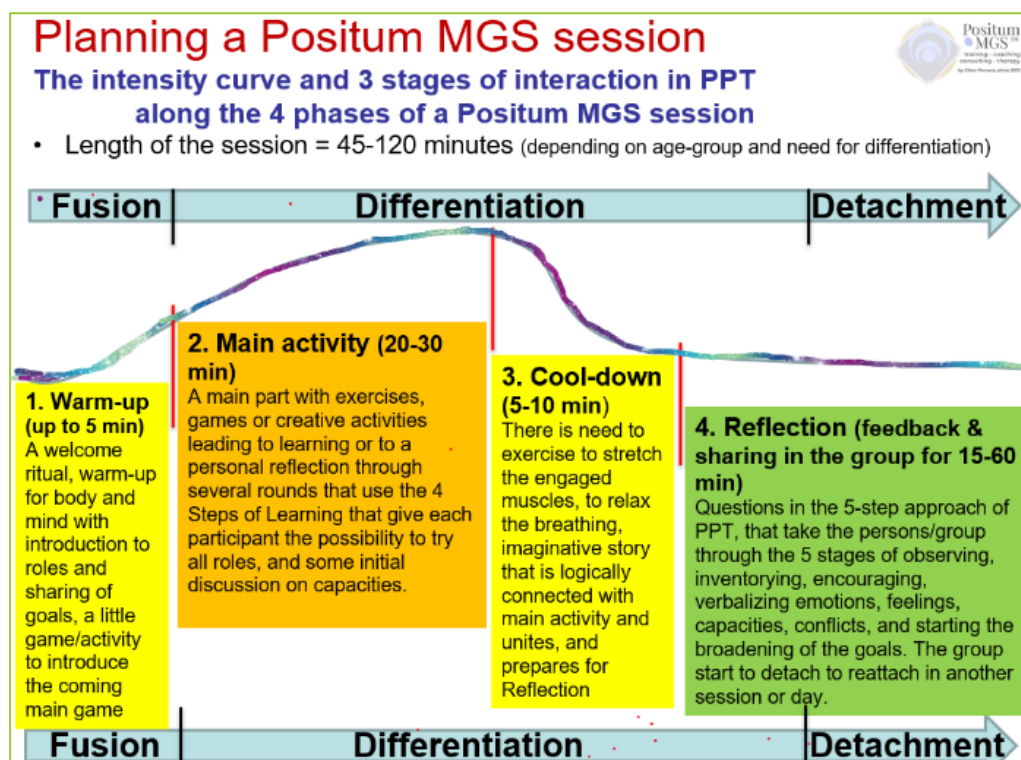


Fig. 3: Stages and steps in a Positum MGS session

Fourth, the deep self-experience process of a Positum MGS session is guided by six principles that every group facilitator needs to keep in sight and respect when facilitating a session. They are summarized in Figure 4.

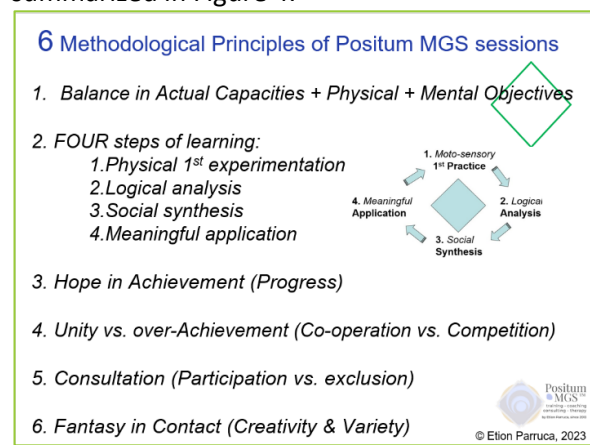


Fig. 4: Principles of Positum MGS

These principles are an integration of the three guiding principles of PPT, i.e., (1) balance, (2) consultation and (3) hope (Peseschkian, 1986, 1987, 2013) as well as the six methodological principles of the MGS Methodology, namely, (1) objectives, (2) three steps of learning, (3) progress, (4) co-operation, (5) participation and (6) creativity and variety (Meuwly, 2011). The author has readapted and recombined them into six meta principles that are needed to guide a helpful process of

triggering difficult and repressed emotions and memories while there is also laughter and joy in a safe and trusting group space. As previously argued by the author (Parruca, 2013, 2022), both PPT and MGS specialists can find in the combined approach a fresh and useful application where both methods can benefit from one another.

The example of a traditional game that is transformed into a psycho-social transcultural one through the Positum MGS will practically illustrate the above theoretical considerations. In accordance with the principle of 'Consultation', a set of key questions need to be kept in mind and practiced when guiding a reflection after a game. These questions help the group participants to go through the five stages of consultation in PPT. The five stages are mostly undergone through the feedback with targeted questions, as discussed by the author (2013, 2022):

- How do you feel after this game and why so?*
(This question is answered by all group members possibly, unless they don't want to. It serves as Distancing/Observation stage in PPT)
- What was difficult about the game/role and why?* (They serve as Inventory stage in PPT)

3. *What did you like about the game/role? Why so?* (They serve as Situational Encouragement stage in PPT)
4. *What were the capacities set as objectives and when did you notice them being met? When not? Why?* (They serve as Verbalization stage in PPT)
5. *What can we do differently when we play the same game in a future session?* (It serves for Broadening of the Goals stage in PPT).

Being played in a Positum MGS approach, the games have similar functions as in stories (Peseschkian, 2006b) in a group. Application of a few such games demonstrates this fact, when group participants are invited to reflect on the feelings emerging from the game, how it relates to their reality, and how the learning from the game can be utilized to deal more resiliently in the future (Parruca, 2013, 2022). Therefore, the author has suggested, alternatively, that when the group has been stabilized through 3-8 sessions, the facilitator can introduce the following questions of a therapeutic nature, between questions 4 and 5. They contain the so-called “protection factor” as discussed by Meuwly (2012) and Parruca (2013, 2022), in order to evaluate the risk factors and resources for resilience in the life of the child. They serve to further enhance verbalization and differentiation, and to ultimately lead to the broadening of the goals and detachment:

- What does the game remind you of from the past or in real life?
- What concept (principle, moto) is leading your behaviour and what can be changed in it?
- How do you want to use the learning from today’s game in the future?

Each of these key questions can be supplemented by related mini-questions, if necessary, to help the child or youth (12-17 years old), or adult to conclude one stage and be ready for the next one. When training professional adults to use the approach, the questions are a little different and, in more depth, developed to correspond their maturity and ability for self-discovery.

2.2. *Practical illustration of transforming traditional games into Positum MGS ones*

For the purpose of the article, the example of “*The witches*” game is brought for illustration. Although it is a game that has taken a

transcultural character when developed by Heiniger & Meuwly (2007, 2012), it is based on the original traditional “freeze-unfreeze” game that is played with two main social roles: the witches and the villagers, with the latter ones being frozen by the touch of the witches, which are self-appointed before the start of the game. The witches chase in silence, by walking instead of running. The freezing leads to disqualification and end of the game when all villagers are frozen. In contrast, the psycho-social approach in Positum MGS introduces the principles of ‘Hope in Achievement’ and ‘Unity vs. Overachievement’, while there is physical contact characterised by the actual capacities of responsibility, affection and love. The game concept links with child real situations of danger and rescue, unsafety and safety, bringing the capacity of contact (both physical and emotional) at the forefront and deals with the question of touching, personal borders, the people who are threatening or those who are protective, or even the feeling of hopelessness, helplessness, guilt, and shame. The Positum MGS approach introduces also the social role of the ‘fairy godmother or godfather’ who helps the group work with the capacities of hope and safety, free from fear, anxiety and helplessness. The details are explained in the following.

Actual Primary and Secondary Capacities:

- The capacities of safety, physical and emotional contact, affection, trust, hope, responsibility for others, obedience and honesty in respecting the rules, as well as unity and empathy when unfreezing the fellow villagers come to the front as psycho-social objectives to be observed and reached.

Other Capacities:

- On a mental level, the capacity of observation and concentration are developed in spotting the witches; strategic thinking is required amongst the witches to work together to bewitch all the villagers, as well as amongst villagers to develop a plan to protect and free the others.
- On a physical level, everything is walked at a fast pace, and avoiding the witches requires an ability to react quickly, flexibility and agility.

Environment, Vision of Goals, and Social Roles

The game requires a relatively large space, ideally outdoors, marked out and recognised by the participants. The game begins with the players (minimum eight) standing in a circle, the witches and the villagers. The witches' goal is to bewitch all the villagers by simply touching them. The bewitched villagers must then freeze. The villagers' goal is to keep away from the witches and to free the bewitched victims by hugging or putting their arms around them (in case of sensitivity to touch). The Positum MGS approach brings the fairy godmother or godfather in the game, who is immune to the witches' touch and whose goal is to unfreeze the villagers. This role is brought into the game after some 3-4 rounds of playing, and it creates a different dynamic and more positive feelings for the villagers due to an increased sense of hope and safety. Please note that sometimes, when working with children, adolescents or adults in the Autism Spectrum or with high sensitivity to physical contact, it is important to specify in advance what kind of touch or hug is acceptable. For instance, an air balloon could serve as an object of indirect touch by the 'witches'. The game stops when all the villagers are bewitched. Before starting, the group has their eyes closed in the circle and the facilitator designates the witches (one for every 4-5 or so players) by touching them discretely on the back. Everyone opens their eyes and the game can start at a fast-walking pace, but without running.

Rules:

- Players are not allowed to run or speak; everyone walks in silence.
- Anyone who starts running or who goes beyond the boundary of the play area is automatically frozen.

Advice:

The facilitator must ensure the players respect the game's environment (boundaries) and the rules: no running, no speaking. Children have a tendency to accuse others of running or speaking, rather than focusing on their own fair-play during the game. The facilitator is there to remind them that they must each take responsibility for abiding by the rules. For example: the child who is touched must stop, the ones who go out of the play area or who start running must bewitch themselves immediately and stop where they are without anyone having to tell them to do so. It is not easy for children and adults not to run, but the facilitator must insist on it, for this gives the game a different

dimension compared to the usual chasing games and helps participants work with their impulse control and observe their emotions. The fact of having to walk allows more time to observe and develop group strategies (witches or villagers), by communicating in a non-verbal way. In maintaining the principle of '4 Steps of Learning', it is useful to pause the game several rounds in order to ask the group what strategies they are using, if they are playing as individuals (not being touched) or as a group (freeing their playmates). And the facilitator insists that unity, affection, respectful contact and responsibility are paramount capacities for the game to work well. Please note that physical contact might seem difficult for certain children and adults (putting the arms around someone is not always easy, especially for pre-adolescents and adolescents of opposite gender). It is therefore possible to ask the children to find another creative way of freeing the "victims". But the idea of a hug helps build links and trust for both children and adults. The freed victims can also thank the person who hugged them (by a nod of the head, thumbs up, a simple thank you, etc.).

Cool-down and Reflection (Feedback)

After playing several rounds where all participants are given the chance to try all roles, the facilitator invites the group into the circle, ideally under a shade, and asks them to close their eyes (or to look down between their feet for those who don't feel comfortable to close their eyes) and imagine that they as villagers are together with the fairy godmother resting and relaxing their body in the middle of the village square. Then, while slow breathing and stretching exercises that connect in fantasy with the main game take place, the group is invited to imagine a scenario where the evil witches, after being transformed into good witches by the magic dust of the fairy godmother, take the villagers on a journey on their brooms that ends up in a relaxing and safe place by the seaside, even with humoristic notes. After that state of relaxation, the facilitator invites the group to open their eyes and sit, opening then the floor to the typical questions that take the group through the 5-stages of consultation that were described in the previous subsection. The following Table 1 gives the results from applying the game with three groups of participants, focusing on the responses from three different persons as the game was played in three different reality situations in Albania. It relates to the experience

of a 10-year-old boy with the deadly November 2019 earthquake, the experience of extremist religious war and repatriation of a 17-year-old Albanian adolescent girl, experience of an adult trainee with the 2020-2021 COVID-19 pandemic.

Results

The “Witches” game was played with many groups and the following gleans on the reflection and feedback from three different participants of different age-group after different traumatic situations. It is noteworthy to see how the game and the questions of the facilitator help the participants connect with their emotions, feelings, the needs and expectations behind them, the capacities and concepts to be further developed, when necessary.

As it may be observed, the last few questions lead to detachment and broadening of the goals until the next group session, when the same game or a different game may be played in the beginning of the session.

Links with protection and therapeutic goals

The game requires physical contact which may allow the facilitator to observe and notice

the children or adults who are too open to such contact or those who are bothered by it. The facilitator can also ask if there is a reason for such behaviour. In cases of neurodiverse children or adults, the focus should be on how to make the contact in a comfortable way for promoting participation and inclusion. In other cases, the question of acceptable and unacceptable touching and personal borders can be dealt with for unresolved bonding and childhood trauma. This game can also provide the opportunity to encourage free associations and then talk about situations when the children and adolescents [and adults in training or self-discovery] felt powerless or ‘bewitched’, without knowing what to do. The facilitator can perhaps explore what the child can do the next time in a similar situation and whom to ask for support. Use of the ‘witch’ character means the facilitator can talk about the ‘bad people’ to avoid in real life; and the ‘villagers’ and ‘fairy godmother’ who free the ‘villagers’ can be linked to the protectors in the real world: in concrete terms, who can they turn to if they need protection and safety?

Table 1: Feedback of the “Witches” game participants

Profile of case	Luis, 10-year-old boy, Albania, 2019 earthquake survivor whose house was destroyed in a village, suffering with Acute Stress. Session took place one month after the experience in 2019.	Hana, 17-year-old girl, Albania, deported from “ISIS” post-war refugee camp in Iraq after 7 years of being away from home, suffering with PTSD. The session took place six months after repatriation in 2022.	Andy, 30-year-old man, social worker, Albania, trainee of MGS and Covid-19 survivor, suffering with Generalized Anxiety. The session took place one year after the experience, but still under pandemic situation in 2021
Questions according to PPT 5-Stage Consultation			
1. How do you feel after this game and why so? (Distancing/Observation stage)	<i>I feel tired but happy. I enjoyed hugging the others. (Smiles)</i>	<i>I felt sad that sometimes I wasn't hugged. I was waiting but nobody approached me. But it was nice to make peace with witches in the end. (Smiles)</i>	<i>I am relaxed now, but was a little afraid during the main part of the game, when being chased by the witches. Oh, definitely being a witch or flying on the broom of the witch was fun. (Smiles)</i>
2. What was difficult about the game/role and why? (Inventory stage)	<i>It was difficult to be a witch, because I couldn't catch all the villagers</i>	<i>In the role of the villager... it definitely made me feel uncomfortable whenever I was frozen and had to wait to be unfrozen.</i>	<i>The villager, definitely, because I felt stuck again after being released. My hands were cold and sweaty while waiting to be unfrozen in the first two rounds.</i>
3. What did you like about the game/role? Why so? (Situational Encouragement stage)	<i>As a villager I could give warm hugs to others and they smiled at me.</i>	<i>I am glad that I could play the role of the fairy godmother. Giving a warm hug to all and unfreezing them gave me great joy.</i>	<i>The role of the witch suited me more. [smile] It was fun to chase others rather than being chased. As three witches, we could make a strategy and co-operate in the team how to catch all the villagers.</i>
4. What were the capacities as objectives and when did		<i>Responsibility for those who were frozen. I could notice it</i>	<i>Something else that wasn't mentioned by the group was</i>

you notice them being met? When not? Why? (Verbalization stage)	We had to show affection when hugging.	in the role of the villagers and fairy godmother. Affection also, but it was not shown always, as I said before.	hope. I was telling myself to be hopeful while waiting for other villagers and the fairy godmother.
5.What does the game remind you of from the past or in real life? (Verbalization stage)	My house was destroyed by the earthquake. It was like a witch. I had to stay frozen under the table for two minutes, but my father came to rescue me by hugging me and taking me outside. He is like a fairy godfather to me. (Smiles)	For a few minutes I was frozen during the game as memories flooded my mind from the war and situation in the camp. I and my mother and sister were running all the time from something, confused and hopeless, and didn't know where the danger was coming from. I felt abandoned and alone.	Well, it was similar to my situation after getting Covid-19 and ending up in the hospital with complications. Before being infected, everybody was avoiding everyone and it was like running away from something invisible. Then, in the hospital, somehow, I had to hope in the help of the medical staff, which I now regard as the fairy godmothers and godfathers. Somehow, they were there providing relief, although walking in the middle of the pandemic. I had been vaccinated before contracting COVID, but it seemed that I was like a villager who didn't have full immunity. [smiles].
6.What concept (moto) is leading your behaviour and what can be changed in it?	No answer.	Coming back home as an adult after leaving as a child, I was hoping to find a welcoming family and community. But it was a different reality which disappointed me a lot. I understand now that real friends and family are those who care for you, not necessarily those from the same bloodline and town.	Honestly, I was guided for many years by the belief that the health system and the doctors in our country can't be trusted, because they are self-interested. But, after my own experience, I believe that there is genuine desire for service in most of the medical staff.
7.How do you want to use the learning from today's game in the future? (Broadening of the Goals stage in PPT).	When we take care of each other, it is safe and we can feel protected against anything that harms us.	After listening to the group, I can see also why people in the neighbourhood have been looking at me like a 'witch' for the last six months, like someone that needs to be avoided. I understand that, but I don't have the energy to convince everyone of the opposite. Somehow, time will change things. I leave some things in Allah's [God's] hand.	I was curious to hear what the others in the group had to say, and I am quite surprised to hear that there is a consensus about the need to behave more like villagers in our life and to be aware of who are the villagers and fairy godmother in my life. I can tell from the work experience with the children and adolescents I work that they have enough witches in their lives, but, on the other hand, they have also sufficient villagers and fairy godfathers, for which they should be helped to become aware... I have a role in that. [smiles]
8.What can we do differently when we play the same game in a future meeting? (Broadening of the Goals stage in PPT).	I would add more than one fairy godmother. I want to unfreeze as many people as possible... :)	No change in the game, but I will try to be more patient next time I find myself in the role of villager. Somehow, I have to trust and hope that if not in one round, there will be a chance to be hugged and unfrozen in another round.	I have a 14-year-old Autistic boy in my group at the day social centre. I will have to check with him first on what kind of hug or physical contact he is more comfortable. I know that he is a little hesitant when it comes to hugging. And we have to talk in the group about his need to be respected in his preference.

The positive effect of the Positum MGS approach on participants' mental health and their psychosocial wellbeing, observed as clear changed attitudes and behaviors during the game and within group dynamics, can be assessed during each session and reinforced with each successive session and reflection on the primary and secondary capacities. Some of the measurable criteria that the approach is changing and further improving in the duration of 12-50 sessions in a year, are categorized under three key components that are differentiated through a short assessment form and marked with a scale of 1 to 4, where both active and reactive states are defined and measured: (1) the improvement in the primary capacities of love/affection, unity, patience, acceptance, contact, trust, safety, empathy, openness, and the secondary capacities of honesty, politeness, justice, obedience, and responsibility, as clear indicators of increased resilience; (2) the improvement of the key conflicts within the group, as better balances between the capacities of honesty and politeness; and (3) the improvement of actual conflicts within the group, as an expression of better balance between the capacities of acceptance and openness (Parruca, 2023).

When group play or game is applied in a systematic way, respecting the methodological principles, the process of building or rebuilding the resilience through transformed traditional and transcultural games is accelerated.

Conclusions

Experience and research has demonstrated that participants in traditional games with a psycho-social approach during Positum MGS sessions, while their difficult emotions and feelings are being triggered and discussed, derive also a lot of joy and valuable reflections during and after a meeting on capacities and resources that can be newly mobilized, re-utilized, with the effects to be strengthened in a series of meetings, ultimately leading to greater psychological resilience, greater trust in the group, enthusiasm to overcome current challenges, and new ideas on how to cope with similar challenges in the future. Traditional games can be transformed into psycho-social ones by simply changing at least one of the features, while respecting the principles of Positum MGS. By being an integrative and

trauma-sensitive approach within Positive Group Therapy, Positum MGS gives both professionals and groups a space for personal growth, self-discovery, further capacity building, and strengthening of resilience in the face of loss due to pandemics, war, armed conflict, natural disasters, including earthquakes, and forced displacement that accompany them.

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Section: Modern PPT practice

EVALUATION CRITERIA FOR PSYCHOSOMATIC PRACTICE



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Received 05.05.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj199](https://doi.org/10.52982/lkj199)

Abstract

To diagnose and treat somatic disorders while considering psychosocial factors, medical and psychological practices require a comprehensive and operationalized list of criteria. The Evaluation Criteria for Psychosomatic Practice (ECP) has been developed to address this need. It builds upon the updated version of the Diagnostic Criteria for Psychosomatic Research (DCPR) by incorporating significant psychodynamic factors and restructuring its framework to better cater to the practical demands of clinical assessment, diagnosis, treatment planning, and outcome monitoring. It offers four axes for clinical evaluation that can be used together or separately, depending on the needs of diagnostic process, treatment, informing the patient, or research: psychosomatic symptoms and complaints, risk factors related to personality structure, triggers, and secondary risk factors.

By utilizing the ECP's four axes, clinicians can gain a deeper understanding of how psychosocial factors impact the clinical picture and dynamics of somatic disorders and then effectively communicate this knowledge to patients, improving compliance and collaboration in treatment. Additionally, the ECP's framework allows for a balance of psychological, physical, and social treatment interventions that can be tailored to the specific needs of the patient, ultimately leading to better treatment outcomes.

Keywords: psychosomatic health, personality structure, psychotherapy, stress, diagnostic criteria for psychosomatic practice, positive psychotherapy

Introduction

Psychosomatic medicine “strives to illuminate the connection between the mental events” social interactions, behaviours, “and bodily reactions” (Peseschkian N., 2016) within a self-regulating system of health.

It provides a conceptual framework for two primary objectives:

1. conducting scientific research to understand the impact of psychosocial factors on the development, course, treatment, and outcomes of any diseases, and
2. employing advanced psychosomatic clinical thinking and strategies to incorporate psychosocial assessment and therapy into standard medical protocols for prevention,

examination, diagnosis, treatment, rehabilitation, and health design.

Over the past few decades, psychosomatic research has yielded a wealth of knowledge and led to the emergence of new fields such as psycho-proctology, psycho-oncology, psycho-neuroendocrinology, psychoimmunology, and others.

As early as the 1960s, Dürssen A. and Jorswieck E. (1965) showed that, on average, 100 hours of analytic psychotherapy within five years of completion saves 85% of inpatient treatment days. Based on this obvious economic benefit, in 1967 in Germany, psychotherapy was included in the list of priorities of health insurance companies (Boessmann U., Remmers A., 2023). A meta-analysis showed that psychodynamic

psychotherapy can reduce the use of medical care by 77.8% (Abbass A. et al., 2009). Paying 3,200 euros for psychotherapy for one patient, the insurance company saves an average of 10,425 euros, implying the cost-benefit ratio of 3.26 (Wittmann W.W. et al., 2011).

The Diagnostic Criteria for Psychosomatic Research (DCPR), introduced in 1995 by Fava G.A. et al. (1995) to operationalize psychosocial variables derived from psychosomatic research, has been effective in assessing psychosomatic conditions, regardless of the organic or functional illness's nature (Porcelli P., Rafanelli C., 2015; Porcelli P., Guidi J., 2015; Altamura M. et al., 2015). Based on extensive experience with the use of DCPR in many patients and settings, it was revised in 2017 (Fava G.A. et al., 2017).

The purpose of this article is to present the Evaluation Criteria for Psychosomatic Practice (ECP), which builds upon the knowledge and understanding gained from the use of DCPR and incorporates the latest developments in psychodynamic ideas and theories of somatization. These theories suggest that somatic symptoms may arise as a way for the body and mind to cope with stress (Gubb K., 2013; Kirillov I., 2020), or as a response to certain triggers that activate a senso-motoric simulation (Hesslow G., 2002; 2012; Jeannerod M., 2006; O'Shea H., 2022) – reproduction of previously directly or indirectly experienced symptoms. The latest concepts of OPD-3 and Positive Psychotherapy have led to a re-evaluation of risk factors associated with personality structure. With the introduction of ECP, the causal relationship of psychosomatic symptoms with stressors, personality structure, and secondary psychosocial risks is now better understood through the more precise differentiation of related groups of symptoms and factors leading to them. These new developments allow for more accurate treatment planning, leading to improved outcomes for psychosomatic patients undergoing therapy.

The article will provide a description of the ECP criteria related to the corresponding axes, as depicted in Figure 1.

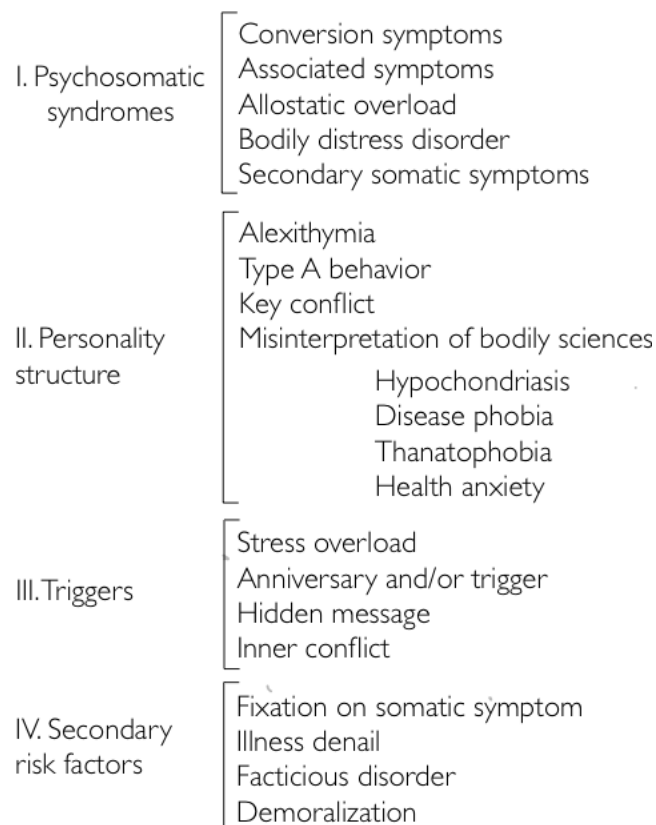


Fig. 1. ECP

Methodology

2.1. General Ideas of psychosomatics

Thinking of psychosomatics one should consider two perspectives:

1. Psychosomatic aetiology – “bodily ailments and functional disorders of the organism, the etiology and course of which are largely dependent on social and psychological circumstances” (Peseschkian N., 2016). Now research show 2 main mechanisms (Gubb K., 2013; Bouziane I. et al., 2022; Schröder L., et al., 2022) of psychosomatogenesis:

a. Stressogenic. The stress of life events, relationships and mental conflicts exceeding the coping capacities of personality structure leads to chronic inner stress that challenges somatic resilience and disturbs vegetative regulation. This can aggravate existing somatic disorders or even cause them (Alexander F., 1950). The exhaustion of somatic resilience results first in reduced impulse control and conversions (WHO, 2022), then in symptoms of tiredness (allostatic overload), and later in functional symptoms of persistent somatization, classified in ICD-11 as Bodily Distress Disorder (6C20) (WHO, 2022).

b. Associative simulation involves the top-down re-activation of symptoms. Essentially, the senso-motoric cortex retrieves the past somatic

experiences and uses them to anticipate/simulate the potential outcome of an associated triggering situation, leading to the activation of a relevant symptom (Bouziane I. et al., 2022; Schröder L., et al., 2022).

Somatopsychic reactions – the individual mental **and** social response to any bodily symptoms and disfunction defined by the individual constellation of personality structure, inner concepts, and conflicts. Those personal coping strategies can support the treatment and prompt its soon and best outcomes or, reversely, can sabotage it, resulting in a achronic course of the disorder. Somatopsychic reactions can as well develop into comorbid mental problems (demoralization (Tecuta L. et al., 2015; Sweeney D.R. et al., 1970), fixation on somatic symptoms (Biderman A. et al., 2003) or illness denial (Grassi L. et al., 2005; Grandi S. et al., 2011) or disorder (depression (Ma, Y. et al., 2021) or anxiety).

The practically useful set of criteria should:

- reflect the impact of psychosocial variables on the genesis, course, and outcome of the medical condition;
- justify the referral to psychologist or therapist;
- ground the plan of treatment and effective interventions;
- measure the treatment outcomes;
- help to design research on psychosomatics.

Meeting these goals requires a system that would differentiate psychosomatic syndromes from the risks of the personality structure decreasing capacity to process stress and affects, triggers, and secondary risks.

2.2. Psychosomatic syndromes and complaints

The goal of this set of criteria is to identify predominantly psychosomatic syndromes that cause significant distress to patients but do not reach the threshold of discernible organic changes. The primary treatment for such syndromes should focus on psychotherapeutic interventions. Although certain organic disorders, such as Alexander's (1950) "holy seven" (peptic ulcer, bronchial asthma, rheumatoid arthritis, ulcerative colitis, essential hypertension, neurodermatitis and thyrotoxicosis), anxiety disorders, and depression (Guidi J. et al., 2020), are recognized to have a psychosomatic nature, in these cases, the somatic component is given priority in

treatment to manage immediate symptoms, while psychosocial interventions are utilized to support long-term progress and remission. Therefore, these organic psychosomatic conditions are not included in this set of criteria.

We adopted the operationalization of *Conversion symptoms* (Table 1) of DCPR established by Engel (1970) and demonstrated much higher sensitivity (4,5% vs 0,4%) than the DSM-IV (American Psychiatric Association, 1994) in a sample of 1,498 patients with a range of medical conditions.

Associated symptoms (table 2) represent the specific mechanism of somatization, namely senso-motoric simulation. These symptoms can occur as part of a conversion disorder or in response to an anniversary or trigger.

Allostatic overload (table 3) described by validated (Offidani E., Ruini C., 2012; Tomba E., Offidani E., 2012; Guidi J. et al., 2016) clinical criteria (Fava G.A. et al., 2010) adopted from revised version of DCPR (Fava G.A. et al., 2017), yet restructured for better understanding.

The description of Persistent somatization (DCPR) has been adjusted to meet the criteria of *Bodily distress disorder* (Table 4) in ICD-11. It refers to patients whose chronic stress causes a disbalance in their vegetative system, which triggers bodily predispositions and result in the manifestation of multiple somatic symptoms that cannot be fully explained by a medical condition. These symptoms persist over an extended period and cause significant distress and disruption to daily functioning (Kellner R., 1994).

With a rubric of *Somatic symptoms secondary to a psychiatric disorder* (table 5) the clinician can hypothesize that some somatic symptoms (e.g., autonomic arousal (Hanel G. Et al., 2009), cardiovascular (Nemeroff C.B., Goldschmidt-Clermont P.J., 2012) and neoplastic disease (Currier M.B., Nemeroff C.B., 2014) Cushing's disease (Sonino N. et al., 1998) are the result of a psychiatric condition (particularly mood and anxiety disorders) and may remit upon the remission of the psychiatric disorder (Fava G.A. et al., 2010).

Table 1. Conversion symptoms¹ (criteria A–C are required) (Fava G.A. et al., 2017)

- A**
- one or more symptoms or deficits affecting voluntary motor or sensory function (visual, auditory other sensory disturbances, movement, gait, speech disturbances, vertigo or dizziness, non-epileptic seizures, paresis or weakness, chorea, myoclonus, tremor, dystonia, facial spasm, dissociative amnesia and trance without changes in primary perception);
 - lack of anatomical or physiological plausibility and/or absence of expected physical signs or laboratory findings and/or inconsistent clinical manifestations;
 - autonomic arousal
 - symptoms are prominent and cause distress and/or seeking medical care and/or impaired quality of life
- B** Appropriate medical evaluation uncovers no organic pathology to account for the physical complaints
- C** At least 2 of the following 4 characteristics should be present: (1) Ambivalence in reporting of symptoms (e.g. the patient appears relaxed or unconcerned as he/she describes distressing symptoms); (2) Histrionic personality features (colourful and dramatic expressions, language and appearance, demanding dependency, high suggestibility, rapid mood changes); (3) Precipitation of symptoms by psychological stress (the patient is unaware of such association); (4) History of similar physical symptoms experienced by the patient, observed in someone else, or wished on someone else.

Table 2. Associated symptoms (criteria A - D are required)

- A** Symptoms presented are closely resemble the symptoms of physical illness experienced by the patient and/or observed in someone else, or wished on someone else
- B** The symptom and/or its consequences were accompanied by significant changes in 1 or more of the following: physical and/or emotional reactions, productivity and/or rhythm of life, attitudes, outlook and/or expectations
- C** Those changes cause distress and/or seeking medical care and/or impaired quality of life
- D** Appropriate medical evaluation uncovers no organic pathology to account for physical

¹ 6B60 Dissociative neurological symptom disorder in The ICD-11.

Table 3. Allostatic overload (criteria A and B required). Adjusted from the revised version of the DCPR

- A** 1 or more of the following 3 features: (1) At least 2 of the following symptoms: difficulty falling asleep, restless sleep, early morning awakening, lack of energy, dizziness, generalized anxiety, irritability, sadness, demoralization; (2) Significant impairment in social or occupational functioning (3) Significant impairment in environmental mastery (feeling overwhelmed by the demands of everyday life)
- B** The symptoms have occurred within 6 months after onset of identifiable stressor (life events and/or chronic stress) that is judged to tax or exceed the individual coping skills when its full nature and full circumstances are evaluated.

Table 4. Bodily distress disorder² (WHO, 2022) (criteria A and B required)

- A** Multiple symptoms (fibromyalgia, chronic fatigue, esophageal motility disorders, nonulcer dyspepsia, irritable bowel syndrome, atypical chest pain, overactive bladder etc) from different groups (cardio-vascular, respiratory, urogenital, gastrointestinal, skin, pain) persistently within 3 or more months causing distress and/or preoccupation with the symptom and/or seeking medical care and/or resulting in impaired quality of life.
- B** Symptoms of autonomic arousal involving other organ systems (e. g. palpitations, tremor, flushing, sweating) and/or exaggerated side effects from medical therapy, indicating low threshold of pain sensation and/or high suggestibility

Table 5. Somatic symptoms secondary to psychiatric disorder (criteria A-C are required). Modified from the revised version of the DCPR

- A** Somatic symptoms, causing distress and/or seeking medical care and/or impaired quality of life
- B** Appropriate medical evaluation uncovers no organic pathology to account for the physical complaints
- C** A psychiatric disorder with somatic symptoms preceded the onset of somatic symptoms (e. g. panic disorder preceding cardiac symptoms)

2.3. Risk factors related to personality structure

DCPR defines the illness behaviour as the “core factor in medicine” that determines

² BC20 in ICD-11

differences in personal perception and action upon the same somatic symptom (Mechanic D., Volkart E.H., 1960). According to the Oxford Languages (2023) the definition of “Behaviour” is “ the way in which one acts” therefore the “illness behavior” should imply remedial actions and health-care-seeking behaviour (Sirri L. et al., 2013). However, DPCR very misleadingly confuses misattribution of inner states (Mechanic D., 1995) (hypochondriasis, disease phobia, thanatophobia, and health anxiety) with functional syndromes (persistent somatisation, conversion, and anniversary reaction), and reaction of illness denial.

Instead, ECPP proceeds from the assumption that the genesis and perception of disease and therefore illness behavior and possible complications of treatment may result from the lack of integration of the structural capacities of personality (Arbeitskreis OPD (Hrsg.), 2013; Kirillov I., 2021), operationalized by the constructs of alexithymia (table 6), type A behaviour (Friedman M., Rosenman R.H., 1974). (table 7) key conflict (table 8) and misinterpretation of bodily senses (table 9).

Primary Alexithymia (De Gucht V., Heiser W., 2003) seems to result from the low integration of primary structural capacity to Contact with self (Kirillov I., 2015): to perceive, differentiate and name one's own sensations, feelings, and experiences. *Secondary Alexithymia* appears when vulnerable capacity to Contact with self becomes unavailable under the pressure of experienced stress. Alexithymia correlates with higher risk and worsened outcome of such medical conditions as cardiovascular diseases, gastrointestinal disorders, cancer, and altered immune response to stress (De Vries A.M. et al., 2012; Lumley M.A. et al., 2007; Porcelli P. et al., 2003; Honkalampi K. et al., 2011).

Type A behaviour (competitiveness, high organization, ambitiousness, excessive engagement in work) tends to compensate low integration of capacities of Time and Trust and correlates with some neuroendocrine (Fava M., 1987) specificity. Those tendencies observed in 36.1% of subjects at risk of coronary heart disease and in 10.8% of patients with noncardiac diseases (Sirri L. et al., 2012).

Key conflict is the conflict of and discretion and directness (Kirillov I., 2021) (originally named by Nossrat Peseschkian (1987) as *politeness* and *uprightness/openness*). Suppression (Settineri S. et al., 2019) of

identified (unlike the case of alexithymia) impulses, emotions and behaviors tends to compensate the disbalance of capacity to Care for self and others. This pattern enhances the inner stress and even proved to significantly increase mortality at list among the patients with the cancer and cardiovascular diseases (Chapman B. P. et al., 2013).

The subjective perception of bodily sensations and health status is as valid as outcomes of clinical examination (Bech P., 1990; Rodriguez-Urrutia A. et al., 2016). *Misinterpretations of bodily senses* representing disturbed capacities of Meaning and Idealisation often lead to significant impairment of the quality of life and multiple medical referrals.

Disease phobia (table 9: B) differs from hypochondriasis (Table 9: A) in several ways. First, the fears in disease phobia are specific to a particular disease and are unlikely to shift to other diseases or organ systems (Cosci F., Fava G.A., 2016). Second, these fears tend to occur in discrete attacks rather than persist as constant worries as seen in hypochondriasis (Fava G.A., Grandi S., 1991). And third, individuals with disease phobia often avoid internal and external illness-related stimuli, while those with hypochondriasis tend to seek reassurance or engage in checking behaviours (Noyes R. et al., 2004). Health anxiety (table 9: D) concerning illness and pain is less specific than in hypochondriasis and disease phobia and response to medical reassurance.

Table 6. Alexithymia (criterion A is required)

Modified from the revised version of the DPCR.

- A** At least 3 of 6 characteristics should be present: (1) Inability to use appropriate words to describe emotions; (2) Tendency to describe details instead of feelings (e.g. circumstances surrounding an event rather than the feelings); (3) Lack of a rich fantasy life; (4) Thought content associated more with external events rather than fantasy or emotions; (5) Unawareness of common somatic reactions that accompany the experience of a variety of feelings; (6) Occasional but violent and often inappropriate outbursts of affective behavior

Table 7. Type A behavior (criterion A is required).

Modified from the revised version of the DCPR.

- A** At least 5 of 9 characteristics should be present: (1) Excessive engagement in work and other deadline related activities; (2) Steady and pervasive sense of urgency; (3) Display of motor-expressive features (rapid and explosive speech, abrupt body movements, tensing of facial muscles, hand gestures) indicating a sense of being under pressure of time; (4) Hostility and cynicism; (5) Irritability; (6) Tendency to speed up physical activities; (7) Tendency to speed up mental activities; (8) High desire for achievement and recognition; (9) High competitiveness

Table 8. Key conflict (criterion A is required)

- A** The patient tends to restrain his reactions to secure relationship, even to the detriment of his/her own interests and comfort

Table 9. Misinterpretation of bodily senses (one or more of following criteria) Criteria for syndromes have been adjusted from the revised version of the DCPR

- A Hypochondriasis (1-5):** (1) Fear or persistent idea of having, a serious disease based on misinterpretation of bodily symptoms; (2) The preoccupations persist despite adequate medical evaluation and reassurance, with opportunity for discussion and clarification; (3) Distress and/or impairment in social and occupational functioning; (4) The duration of at least 6 months; (5) 5. compulsive maladaptive actions to prevent disease.
- B Disease phobia (1-4):** (1) Persistent, unfounded fear of suffering from a specific disease (e.g. AIDS, cancer), despite adequate medical examination and reassurance; (2) Fears, in the form of attacks rather than in constant, chronic hypochondriac worries; (3) The object of fear does not change with time; (4) The duration of symptoms exceeds 6 months.
- C Thanatophobia (1-3):** (1) at least 2 attacks (within the past 6 months) of groundless fear of dying soon, despite an adequate medical assurance of the absence of any real danger, with the possibility of discussion and clarification; (2) Marked and persistent fear and avoidance of any mentions of death, immediate anxiety reaction to them; (3) Distress interferes markedly with the level of social and professional functioning.

- D Health anxiety (1 and 2):** (1) A generic worry about illness, concern about pain, and bodily preoccupations (tendency to amplify somatic sensations) of less than 6 months' duration; (2) Worries and fears readily respond to appropriate medical reassurance, even though new worries may ensue after some time.

2.4. Triggers

It is important to consider triggers of chronic stress and somatosensory simulations in the diagnostic and treatment strategies for psychosomatic conditions.

The *stress overload* (Table 10) refers to the cumulative impact of macro- and micro-traumas (Peseschkian N., 1987, Peseschkian H., Remmers A., 2020) that can deplete the psychological coping mechanisms and bodily self-regulation, making the individual more vulnerable to mental and somatic health problems. Research has shown that the number of disorders (endocrine, cardiovascular, respiratory, gastrointestinal, autoimmune, skin, and neoplastic diseases) in a population correlates with the load of life events experienced within a year before the onset of symptoms (Novack D.H. et al., 2007; Theorell T., 2012).

Anniversaries (Porcelli P. et al., 2012) or *triggering events* (Table 11) can set off a chain reaction replaying the previous experiences of general arousal, functional symptoms, associated symptoms, or conversion.

Additionally, somatization can result from repetitive internal triggers: 1) *hidden message* (Table 12) - an impulse to ask for help or to assert oneself, suppressed by a key conflict in the structure of psychodynamic patterns (Arbeitskreis OPD (Hrsg.), 2013) of dysfunctional relationships (Peseschkian N., 2016); 2) *Inner conflict* (Peseschkian H., Remmers A., 2020) (Table 13) between primary needs and the perceived threat to them (Kirillov I., 2021).

Table 10. Stress overload (criterion A and/or B is required)

- A Macrotraumas** – high concentration of significant life events and changes (real or imaginary) causing a strong emotional reaction. The amount of LCU³ (life changing units) exceeds 300 LCU for half a year or 500 LCU for a year

³ Social Readjustment Rating Scale (SRRS) in Miller M. A., Rahe R. H. (1997).

- B Microtraumas** – recurring emotional reactions to the discrepancy between the expected (“correct”) and the actual (perceived as incorrect) reality. Those reactions generate ongoing tension and irritability and effect the overall physical condition, mood, relationships and/or performance.

Table 11. Anniversary or trigger (criteria A is required). Modified from the revised version of the DCPR

- A** Emotionally charged trigger, age, or anniversary of death/terminal illness of a loved one (the patient is unaware of such association) that condition symptomatic reaction of: autonomic arousal (e.g., palpitations, tremor, flushing, sweating), or functional syndromes, or associated symptoms or conversion.

Table 12. Hidden message (criteria A and B required)

- A** Ongoing suppression in relationships of one's emotionally charged desires (impulses) to do, say, ask, provoke others to act differently.
- B** The symptom and / or its consequences allow the patient (consciously or not) to discharge the impulse, to convey a message, to provoke desired actions.

Table 13. Inner Conflict (criteria A-C are required)

- A** One complains about excessive emotional, behavioral, and mental reaction.
- B** The patient always associates his/her reaction with a specific trigger (“every time I am expected to obey, I explode with anger”), which can appear in different contexts (at work, at home, with friends, etc.)
- C** The protagonist cannot, without external help, understand and explain his needs behind the overreaction to the trigger.

2.5. Secondary risk factors

When a patient experiences somatic symptoms, their reaction to those symptoms can be influenced by their personality structure and inner conflicts. Unfortunately, some of these reactions can be maladaptive and hinder the effectiveness of treatment. For instance, *fixation on somatic symptoms* (Eccleston C. et al., 2013) (Table 14) can provoke health anxiety (Anderson, R. et al., 2011) and even stimulate the sensorimotor simulation (Edwards M.J. et al., 2012) of associated symptoms. *Illness denial* (Goldbeck R., 1997; Prigatano G. P., Sherer M., 2020; Livneh H., 2016) (Table 15) can cause treatment

avoidance and sabotage, and therefore worsen the patient's medical condition.

Patients with *factitious disorder* (table 16), a condition that affects about 1.3% of primary care patients (Fliege H. et al., 2007) and 6% of psychiatric admissions (Gregory R.J., Jindal S., 2006), may intentionally harm themselves and undergo risky procedures. This can result in significant treatment costs, sometimes amounting to hundreds of thousands of dollars (Feldman, 1994).

In medical settings, *demoralization* (Table 17) is a common occurrence that includes feelings of helplessness and hopelessness or giving up (Schmale A.H., Engel G.L., 1967). This can affect up to 30% of medically ill patients, compared to only 2-5% of healthy individuals (Tecuta L. et al., 2015). Demoralization is also shown to be linked to changes in the serotonergic and noradrenergic systems (Benedetti F., 2011).

Table 14. Fixation on somatic symptoms (criteria A is required)

- A** At least 2 out of 4 characteristics are present: (1) the patient excessively focus on physical suffering, talks about it all the time, looking for the slightest changes of the symptom; (2) desperately seeks to control the symptom; (3) helplessly afraid of new suffering to come, checking the symptom changes and new manifestations; (4) demands a clear diagnosis and effective physical treatment from the doctor.

Table 15. Illness denial (criteria A and B are required). Modified from the revised version of the DCPR

- A** Persistent denial of a physical disorder and need for treatment (e. g. lack of compliance, delayed access for medical help) as a reaction to the symptoms, signs, diagnosis, or medical treatment of a physical illness.
- B** Doctor provides the patient with an adequate appraisal of the medical situation and management (if any) to be followed, with opportunity for discussion and clarification.

Table 16. Factitious disorders (criteria A and/or B is required)

- A** Deliberate display, falsification, induction, or exacerbation of symptoms in oneself or in another (usually dependent person). Seeking treatment or benefits based on these symptoms.
- B** Other benefits associated with the relationship (care, attention, position, etc.).

Table 17. Demoralization (criteria A and B are required; criterion C is a specifier for the presence of hopelessness). Modified from the revised version of the DCPR.

- A** One perceives self as unable to cope with problems and/or feels helpless (lack of adequate support from others), while maintaining the capacity to react
- B** The state is generalized and lasts for at least 1 month
- C** The consciousness of having failed to meet expectations associated with the conviction that there are no solutions for current problems and difficulties (hopelessness)

Results

Summing-up results of ECPP

The General Evaluation table (Table 18) is a tool used to summarize data collected during the medical examination and interview. At present, based on ongoing discussion with medical doctors, and practice-based consensus of 7 practitioners who systematically applied the tool under regular supervision with over 200 patients, preliminary guidelines have been developed to interpret the results of the evaluation. It should be noted that these preliminary guidelines have not yet been subjected to statistical analysis. This is the challenge for further research.

The practitioners who participated in this preliminary testing process have undergone 10 academic hours of training to use the ECPP and incorporated it into their daily practice. Initially, after conducting a medical examination within the frame of 30 minutes, and the modified interview, the practitioners reported to spend approximately 15-20 minutes to evaluate the patient by collating the collected data against every symptom of every criterion. However, after conducting an average of 18 evaluations, they became familiar with the criteria and were able to fill out the General Evaluation table within an average of 5 minutes.

Table 18. General evaluation of ECPP

0= Not at all; 1= Some; 2= Noticeable; 3= A lot; 9= Cannot be evaluated

1. PSYCHOSOMATIC SYNDROMS					
1.1. Conversion symptoms					
1.2. Associated symptoms					
1.3. Allostatic overload symptoms					
1.4. Bodily distress disorders (6C20)					
1.5. Secondary somatic symptoms					
2. STRUCTURAL RISK FACTORS					
2.1. Alexithymia					
2.2. Type A behaviour					
2.3. Key Conflict					
2.4. Misinterpretation of body experiences					
3. TRIGGERS					
3.1. Anniversary/trigger					
3.2. Stress load (micro- & macro-)					
3.3. Hidden message					
3.4. Inner conflict					
4. SECONDARY RISK FACTORS					
4.1. Fixation on symptoms					
4.2. Illness denial					
4.3. Factitious disorder					
4.4. Demoralization					

Evaluation of criteria

- 0 – all criteria are missing
- 1 – there are some criteria, but they are not enough
- 2 – the minimum sufficient presence of criteria, and they are moderately displayed
- 3 – the criteria are more than minimally enough, and they are severely strong

Evaluation of criteria groups

- "the influence of a group of factors is not significant" if there are no rates of "2" and/or "3"
- "significant influence of a group of factors" if at least one rating of "2" is present
- "extremely significant influence of a group of factors" if there are two or more ratings of "2" or at least one rating of "3"

Overall assessment

- "Significant influence of psychological factors" – one or two groups of factors were assessed as "significant" or one group was rated as "extremely significant" – the consultation of a psychologist or cognitive-behavioral psychotherapist is needed for correction
- "Determining influence of psychological factors" – 3 or more groups of factors are assessed as "significant" or 2 or more groups of factors are assessed as "extremely significant" – it is necessary to contact a psychotherapist (preferably psychodynamic), if possible, it is necessary to organize complex psychotherapy (training of physical resilience and awareness, psychodynamic psychotherapy and correction of relationship patterns, reorganization of behavioral strategies)

Conclusions

Nimnuan, Hotopf, and Wessely (2001) demonstrated that around 50% of patients seeking outpatient care present with medically unexplained symptoms. These patients tend to utilize twice the amount of outpatient and inpatient medical care and have twice the annual medical care costs compared to those with somatic illnesses (Barsky et al., 2005). Additionally, patients with medically unexplained symptoms often spend more time in bed than those with severe major medical disorders (Croicu et al., 2014). In order to identify those syndromes and offer appropriate help to these patients, medical doctors must develop psychosomatic awareness.

The first experiences with ECPP show that it can help medical practitioners to set the groundwork for psychosomatic competences. Through just 10 academic hours of training and 18-20 cases of supervised practice, doctors can learn to identify patients with predominantly psychosomatic syndromes and evaluate the relative value and potential impact of major psychodynamic factors on any medical case.

By considering the psychosocial factors at play, medical specialists can develop an effective treatment strategy combining the medical prescriptions and recommendations with encouragement and utilization of the patient's somatic, mental, and social (Hartmann M. et al., 2010) resources. This approach may also involve referrals to health coaching (Wolever R.Q. et al. 2013; Djuric Z. et al., 2017; Sharma A.E. et al., 2016), psychological counseling (Strom J.L., Egede L.E., 2012), or psychotherapy (Wittmann W.W. et al., 2011) when necessary. Understanding these complex factors allows for a more holistic approach to patient care that addresses the interplay between biological and psychosocial factors, leading to more effective and comprehensive treatment outcomes, increased life quality of the patients and reduced utilization of medical services [157–177].

Systematic understanding of relative value and potential impact of major psychodynamic factors on any medical case will open the flow for more effective and individually tailored communication with the patient to inform him/her about the inner dynamic and roots of the existing medical condition, inducing his/her motivation to build the psychosomatic health

actively by developing self-management capacities, coping skills.

Disclaimer of Study Limitations

The ECPP, as described above, represents a preliminary adaptation of the DCPR model to meet the specific needs of clinical practice, drawing on the theoretical foundations of Positive Psychotherapy (Peseschkian N.) and OPD-3. The model has been tested and optimized in practice by the author with 43 patients, as well as by 7 supervised practitioners with over 200 patients. Additionally, the model has been presented and discussed in training seminars with mixed groups of medical doctors of different specialties.

The purpose of this publication is to invite feedback from other professionals in the field and to encourage further collaborative research on this topic. By working together to refine and validate this model, we can improve the quality of care provided to patients and promote more comprehensive and effective approaches to mental health treatment.

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Section: Modern PPT practice

ATTACHMENT, TRAUMA, AND WAYS TO INNER CONFIDENCE IN POSITIVE PSYCHODYNAMIC THERAPY



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Received 14.05.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj200](https://doi.org/10.52982/lkj200)

Abstract

Traumatic experience changes health, relation patterns and conflict reactions. Threatening events can cause desperation and can profoundly damage personality structure capacities and bonding qualities like trust. A structured process of treatment back to confidence and a balanced everyday life starting with stabilization phases, leading to integration is described.

Keywords: traumatic experience, stabilization, therapeutic alliance, despair, attachment, positive psychotherapy

A man came upon a tall tower and stepped inside to find it all dark. As he groped around, he came upon a circular staircase. Curious to know where it led to, he began to climb, and as he climbed, he sensed a growing uneasiness in his heart.

So, he looked behind him and was horrified to see that each time he climbed a step, the previous one fell off and disappeared. Before him, the stairs wound upward and he had no idea where they led; behind him yawned an enormous black emptiness

- Anthony de Mello (1998)

Introduction:

“The word ‘trauma’ means ‘injury’ in everyday language. In psychopathology and psychotherapy, the term is used both for the triggering event and the immediate reaction of the person affected and also for any traumatic stress that may remain after the incident. Conceptually, it is clearer to speak of traumatic experiences, traumatic processing, and subsequent trauma sequelae.” (Boessmann & Remmers, 2022).

The term trauma usually is used when an existential feeling of safety is damaged or destroyed. Post traumatic life quality depends greatly on former life experience in several developmental phases. The abilities such as trust, acceptance, love, patience, tenderness

are needed in a normal development of structural attachment and bonding qualities. Continuing experiences of attachment in early development can become a strong basis for coping, trust, hope and confidence in later life and in relations. In traumatic developmental conditions, the opposite experience of the client existed, as in threats, being rejected, hated or treated in a harsh and wounding way, and, therefore, resulting in a lack of an internalized safe person, place and feeling as well as in vulnerable and fragmented structural capacities of the personality.

Traumatic experience changes health, relation patterns, conflict reactions and activity. Threatening events can profoundly damage the personality structure capacities: The perception changes and focuses now on safety and threat;

the impulse regulation and actions follow the needs of physical safety; the emotional communication is limited to the trustful part that remains. The strongest damage is caused to basic trust, hope and bonding as qualities of attachment and separation needed in relations. Consecutively, the self as such, the self objects, the inner objects and representations can be changed. The imagination of formerly safe persons and situations change, and this again influences the perception, impulse reactions and emotional communication: A vicious circle of post traumatic personality pattern starts after life-threatening traumatic experience, and formerly safe relations are challenged by the change.

Methodology

2.1. The situation of mental traumatization: pathogenetic and salutogenetic bases of despair.

Three basic principles of salutogenesis and coherence described by Aaron Antonovsky (1979) are challenged in existentially significant ways in the situation of despair:

- Comprehensibility
- Manageability
- Meaningfulness.

Social support and the existence of helpful individuals, animals or objects can be added, that can become inner representations of safety to cope with an upcoming dangerous situation.

A previously experienced context of meaning and safety can become dissolved by a situation that is perceived as irreversibly threatening or guilt-ridden. In despair, the situation can no longer be understood, can no longer be classified with the previous concepts of experience. This results in a dilemma that is perceived as insoluble: any further action would intensify the potential for conflict, but refraining from action also leads to a worsening of the experienced situation. This situation of partially unconscious conflicts is characterized in psychodynamic as an inner conflict. It represents an inner drama whose resolution must always lead to conflict intensification.

"Trauma of helplessness of the ego" is what Bibring (1953) calls the state of powerlessness, paralysis, despondency, helplessness and hopelessness, torpor, lifelessness, lack of feeling, lack of relationship felt in it. All these feelings occur in despair.

In psychosomatic medicine, the *giving-up-*

given-up complex describes helplessness as *giving-up* with still passive appeal for help from outside. *Given-up* describes hopelessness as lonely, objectless despair with the feeling: 'Everything is too late' (Schmale & Engel, 1967).

The body-feeling, the holistically acting affective quality as of a bodily perception evaluating character, becomes in the despair of the traumatic situation the threatening feeling up to maximum paralyzing fear with the needs switching off. In the safe situation, on the other hand, the body-feeling is perceptible as physical calmness, enjoyment and security with balanced affectivity.

Despair is described as an innate affect, which is activated in the separation situation in humans and animals after the phase of protest before the eventual derailment of physiological regulation (Köhler, 1997) up to psychogenic death. Despair is thus not only an emotional-psychic affective phenomenon, but closely linked to the physiological regulation processes. These are influenced in their regulatory quality in the interaction with the mother or the closest emotional caregivers, so that a cortical representation emerges that eventually makes the child independent of the caregiver (Köhler, 1997) The quality of being lost and abandoned is again present in the situation of despair, as we find it e.g. before a suicide attempt.

Seen from the functional, final point of view, despair is the ability to abandon oneself to fate in the situation. In contrast to depression, actual despair in a subjectively traumatically experienced situation initially contains a very high energy potential, which is expended to the point of physiological exhaustion: "hair pulling" and hand wringing are body language expressions of autoaggressive self-blame, of energy without meaningful purpose. This enormous energy, amplified by guilt conflicts and feelings of isolation, eventually leads to a suicidal tendency as an attempt to escape guilt and the need to act, to perceive all possibilities after life as more suitable than life itself.

2.2. Despair in the therapeutic situation: Counter transference and psychodynamics

In the situation of despair, conflict and conceptual themes that can be grasped in terms of content can be described by abilities such as doubt, certainty, trust, hope, acceptance, faith, so-called "actual capacities" as contents of conflicts and concepts according to Peseschkian

(1987). They cause specific counter transference phenomena in the encounter with the guest. Conclusions can be drawn about the basic conflicts and basic themes.

Hubert Speidel (1996) gives an example of this: He had taken on an asthma patient. He describes: "In the first two sessions I hardly got any contact with the patient. I felt helpless, unhappy, wondered why the colleague had worked with him at all; in any case, I didn't know what to do with him, found him unproductive and boring, and had pessimistic expectations regarding further work. He did not come to the third session. Instead, a doctor from our intensive care unit called me: The patient had been admitted there as an emergency; he did not have status asthmaticus, but he was not breathing properly, although there was no reason for this. He, the doctor, did not know what to do. We had both witnessed a "giving up." The patient died shortly thereafter in the intensive care unit. He had, what we usually know of old people, apparently decreed his death, presumably because he had been abandoned by his central object of transmission." *Speidel* further explains that in this case the patient's appeals had not been perceived in time. The sensations triggered in psychotherapist and physician, the so-called counter transference, reflected the patient's unspoken inner state of mind: "*perplexed, unhappy, wonder why, pessimistic expectations, don't know what to do at all.*"

Psychodynamically, this may express the insufficient attachment experience that a patient unconsciously re-experiences in the current trigger situation of an object loss.

When feelings of indifference toward the patient in the presuicidal syndrome (Ringel, 1953) appear as countertransference in the practitioners, they are signs of advanced despair, the risk of suicidality is then very high. Hidden in suicidality is the thought of murdering offending, emotionally significant persons. This aggressive energy can be directed against alternative objects or against oneself, as in Sophocles, the tremendous murderous energy of Aias against the cattle instead of the murder of his comrades-in-arms who offend him in the Greek mythology.

2.3. Despair, resources and resilience

The development of the resources of the distressed person, the encouragement is in the foreground especially of the trauma-related

therapy. After the acceptance of the suffering as justified, the supportive accompaniment, entering into interaction, the broadening of the perspective and the directing to the existing, to strengths, to previous coping experiences is in the foreground through the conversation.

2.4. Treatment strategies of affective quality despair

*Christian Reimer*⁹ describes three phases of emotional processes in the substantive psychotherapeutic approach to crisis intervention:

1. grief / despair
2. protest/rage
3. distancing/reorientation.

They correspond to the formulation of three stages of human communication: Attachment, differentiation, detachment according to Peseschkian (1982). Therapeutic strategies that can be applied to the quality of despair are derived from this by Reimer (1996):

- In the first phase, *while* still experiencing full despair, the focus of the encounter is on connecting with the despairing person, accepting and encouraging the expression of grief and despair without reservation.
- This prepares the second phase of discernment, protest, anger, in which the energy of despair is rechanneled, the expression of aggressive and angry affects becomes possible.
- The third phase of emotional distancing, detachment, reorientation and integration enables reflection on the experienced traumatic state, it can be talked *about*.

The experience of despair itself can act as a driver for the development of resilience, understanding, action, faith, and a sense of meaning on the way from doubt to security. The focus is on finding meaning after the crisis of despair.

Discussion

3.1. Therapeutic practice and therapeutic relation

As therapists, we want to understand the history of continuing micro-traumatic experience, mono-traumatic or complex multi-traumatic life events, and, on the other hand, to understand the qualities of internalized objects of attachment, preventive factors, resilience and coping capacities to accompany our guests. Still,

we have to be careful: Concerning *Thomas Gruyters*⁴² that the: “anamnesis may trigger fragmented trauma memories and arousal and dissociative states. In the absence of prior information, the triggering of these states during anamnesis is in itself a criterion for the possible diagnosis of “trauma sequelae disorder.” ...”If the presence of PTSD, mono- or complex traumatization is suspected, it is recommended to conduct a “gentle” stress-resource anamnesis. The patient needs the feeling of security and stability also and especially at the beginning of a therapy and thus also during the anamnesis. It is a tightrope walk on the edge of traumatic experience, a careful sounding out, grasping and labeling of traumatic experiences without immediately going too deeply into them.” ...“There are considerable differences in the approach between (acute) monotraumatized persons and complex traumatized persons. While the former are often able to talk about the incidents quite quickly and under moderate stress, the risk of decompensation increases with increasing degree of multiple traumatization and an early point in the traumatic experience in the course of life. Patience and attentiveness are necessary to ensure that the patient remains in the “window of tolerance” as far as possible, even during the history-taking process.

One of the methods that has proven successful is timeline work: On the timeline placed on the floor in the middle, the positive experiences are recorded and placed on one side of the line and the negative, traumatic experiences on the other side, using colored index cards. This prevents the focus from being too much on the negative and desolate, and the patient from being flooded with both the traumatic experiences and an associated feeling of extreme helplessness and despair. Another method is a systematic inquiry into positive and negative events during individual stages of life (0-5, 5-10 years, etc.). The nature and extent of the traumatic material revealed in this way have a significant influence on therapy planning and further treatment steps.” (Gruyters, 2022)

Therapeutic relations represent in trauma treatment a safe relation at a safe place in a safe environment, comparable to one's safe, own room in childhood. Differently from conflict or structural therapy, we need phases of stabilization before reaching the possibility of working with traumatic history and the involved subjects. “If there are conflict pathologies or

structural deficits in addition to the trauma sequelae disorder, these should only be treated psychodynamically after a successful trauma therapy phase has been completed. In trauma therapy, compared to the treatment of other disturbance patterns, a stronger structuring of the process is necessary. The therapist is more active, designs the process overall very transparently, and strives to name and resolve possible transference phenomena as early as possible. It is important to establish a solid relationship with the patient, a very clear working alliance and a very clear orientation in the here and now. The following structure of therapy is recommended across schools: Stabilization phase, trauma confrontation, integration.” (Boessmann & Remmers, 2022) It is important that as a therapist I do *not* try to understand what I did not experience myself, instead of that to give feedback to the guest how I can describe his or her feelings.

3.2. Therapeutic approaches in the trauma treatment process

1. Stabilization starts with a first phase of body and senses: An inner safe place can be created by hypnotherapeutic affirmations like imagination of an inner safe place, an inner helping object, a therapeutic safe as a place for the traumatic events (Reddemann, 2004) until the client is ready to open it. In this phase the body and senses need an environment of safe smell, colors, positions, sounds or movements.

2. A second phase of stabilization means to create a safe place where the client lives: To find out what means safe at home, to have an order and reliability that can be controlled by the client (not by others any longer).

3. The third phase of stabilization means to change the environment outside to avoid and change possible triggers or threats, like having no contact with traumatic memories, triggers or triggering persons.

4. After stabilization it is possible to start working through the time axis and events of the trauma experience like in a movie, under the control of the client as a movie director and with the therapists as assistants. In this phase the different trauma techniques such as EMDR can be applied.

5. The integration of the post-traumatic growth in everyday life is the last phase in therapy: To confront oneself with challenging situations and persons, to reflect everyday life

with the therapist, to find out the formerly-avoided chances in life and development.

The five phases of a helpful therapeutic alliance can describe at which point in therapy we are, in which phase we are in our therapeutic relation, which attitude and methods can be applied. Tools of potential orientated psychotherapy for the specific needs of our clients can then be chosen, based on a humanistic background, finding a clear and understandable way of counseling, treatment, concerning social environment and self help.

Questions for therapists in treatment of traumatic stress

1. Concerning developmental phases, attachment, safety, conflicts and challenges, the balance of safety and frightening challenges: "Can you describe a safe situation with your parents or other important persons in a difficult/dangerous situation?"
2. The four areas of safety can be applied to find out resources for stabilization:
 - a. Body and feeling (physical wellbeing, needs, body interaction, somato-psycho compensation):
3. "What makes your body feel well, thinking of all the senses, as to smell something that calms you down, to taste something you like, to listen to something that brings you in a good rhythm, to feel something that you like to feel with your body and skin, or a situation that gives your body a good feeling?"
 - a. Achievement and activity:
4. "Which activity gives you a feeling, that you can be safe and can control the situation?"
 - a. Relations and interaction:
5. "With which person, which animal, plant or situation do you feel safe and understood?"
 - a. Imagination, hope and spirituality:
6. "Which ideas, stories, rituals, movies, prayers feel safe and are good for you?"
7. What works well in our encounter, which different kinds of resources can we find out with the experience of our guest?
8. What does trauma mean, what does attachment mean for my guest, and how do i understand that as a therapist? Which are the actual post traumatic symptoms, and what are their functions for the patient?
9. In which way can I myself, as a therapist, become stabile 'like a rock on the seaside' when my guests tell me about threatening traumatic events?
10. Which types of conflicts does my client have:
 - a. Wishes/desires vs. rules (ambivalence conflicts, possibility to understand them: Stable structure),
 - b. Existential needs vs. absence of support (the ability to fulfill needs is not developed, a conflict of deprivation exists: Vulnerable structure)
 - c. Threatening existential images and situations (There is no possibility to cope with the existential threat: A post-traumatic conflict of life or death exists, a question of existence and absence of safety: The structure of the personality is damaged and vulnerable for triggers and interaction).
11. Which are the specific defense mechanisms of my client as coping strategies, and how can they be used and understood as related to the three types of conflict?
12. Which had been former post traumatic symptoms or disorders developed after the events, such as general anxiety disorder or somatoform disorders?
13. Treatment plan: How can we start self help activity and start the stabilization of the patient? At which point is a more specific individualized trauma treatment needed? How do i experience my therapeutic position, the alliance and my transference role? How can i accept my client and myself in the relation with my guest? How can I be with the guest and being a neutral observer to accompany patients with macro- or micro-traumatic experiences, that I can not understand it in the way in which the client experienced all of it? In which of the phases of the therapeutic alliance are we now?

Conclusion

To create a strong therapeutic alliance in trauma therapy it is important to understand the role of despair, the need for stabilization phases, and to address the specific necessities of the client. Traumatic experience can change the pattern of attachment, personality structure and protection mechanisms. In treatment we address the traumatic symptoms as well as the abilities of the personality structure, including attachment and relation pattern. In this way the

structured five step process of posttraumatic treatment and a catalogue of questions for therapists, help to understand the clients situation and to moderate the therapeutic process.

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Section: Modern PPT practice

OPERATIONALIZING AND VISUALIZING PSYCHODYNAMICS IN POSITIVE PSYCHOTHERAPY (PPT)



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Received 12.03.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj201](https://doi.org/10.52982/lkj201)

Abstract

This article presents a novel conflict model for operationalizing and visualizing psychodynamics within the context of Positive Psychotherapy (PPT). The model builds upon the traditional approach of N. Peseschkian and M. Goncharov's model from 2014, further enhanced by the basic needs of love, security, and autonomy as outlined by G. v. Witzleben (2014), and the emotions delineated by P. Ekman and Traditional Chinese Medicine (TCM). The model affords an in-depth understanding of a patient's motivations and psychodynamic responses in various situations. It expands upon previous models that focused on conflicts rooted in the connection between primary and secondary capabilities. By considering the simultaneous or sequential existence of different inner conflicts, the model allows for a comprehensive view of a patient's psychodynamics. While this article only provides an excerpt of the ideas from the author's recent book, it offers general guidelines for operationalizing and visualizing psychodynamics within PPT, encouraging further exploration and understanding of individual psychodynamics.

Keywords: positive psychotherapy, psychodynamics, conflict model, traditional Chinese medicine, inner conflict

Introduction

Prof. Dr. Nossrat Peseschkian, with his observations and analysis of the psyche, has given a wide metatheory for understanding the psychodynamics of the individual's inner conflict. The objective of this article is to describe a conflict model which the author created for operationalizing and visualizing his concepts of conflict contents and dynamics within a graphic representation. N. Peseschkian's (1977a) own diagram of the actual, basic and inner conflict served as an underlying structure which then was further developed and explained through concepts of Maxim Goncharov, Gabriele von Witzleben (2014a), Paul Ekman (1970) and Traditional Chinese Medicine. In its entirety the enhanced model aims to describe systematically as many aspects of the individual conflict

contents and dynamics as possible using an operationalized process. This article is a brief synopsis of an extensive chapter on psychodynamics form from the book "Living a fulfilled life; Self-Exploration and Personal Growth with Positive Psychotherapy after Prof. Dr. Nossrat Peseschkian" (Werringloer, 2023) and has to be seen as this. The main contents found within have been described succinctly within the short following pages.

Methodology

The graphic conflict model described in the book "Living a fulfilled life; Self-Exploration and Personal Growth with Positive Psychotherapy after Prof. Dr. Nossrat Peseschkian" (Werringloer, 2023) systematically operationalizes the description of conflict contents and dynamics. It is based on Nossrat

Peseschkian's (1977a) own model of psychodynamics (Fig. 1) that describes an *Actual Conflict*, a *Basic Conflict* and an *Inner Conflict*. The *Actual Conflict* consists of the conflict situation that leads to an infringement of Primary and Secondary Capabilities by Micro- or Macro-Trauma. The *Basic Conflict* consists of the sub- or preconscious conflictive concepts about the Primary and Secondary Actual Capacities acquired during childhood that reside within the personality structure. The *Inner Conflict* is

triggered when a *Basic Conflict* is touched by an *Actual Conflict* through a series of micro-traumatic events or a major life event (Macro-Trauma). The ego that is no longer capable of handling the occurring events properly thus resorts to conflict processing through somatization and behavioral escape reactions. The individual vents his/her excess energy through a sympathetic or parasympathetic reaction.

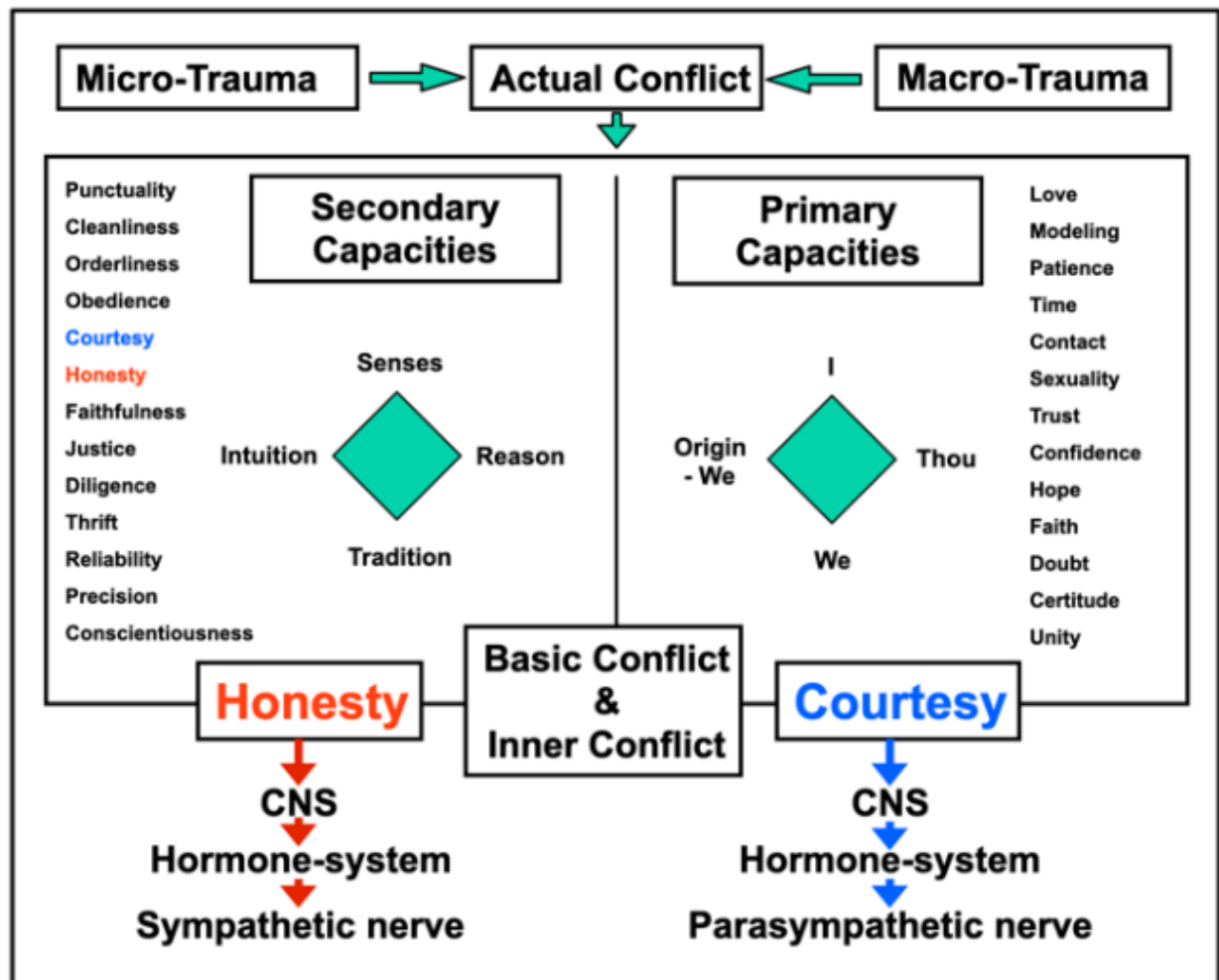


Fig. 1. N. Peseschkian's model of Psychodynamics

Nossrat Peseschkian's (1977a) own model of psychodynamics is combined with the emotional wheel from TCM (Traditional Chinese Medicine) (Fig. 2) which describes emotions identical with the universal emotions described by Paul Ekman (1970) with the exception of surprise. The TCM wheel of emotions, with its emotions *happiness* and *anger* predominated by the sympathetic nerve system and the emotions *sadness* and *fear* predominated by the parasympathetic nerve system, interlocks perfectly with N. Peseschkian's model with *honesty/candor*

(sympathetic nerve system) and *courtesy* (parasympathetic nerve system) forming a perfect association (Fig. 3). The emotion *disgust* can be seen as an emotion that is engaged by both nervous systems at the same time. P. Ekman's (1970) ideas of combined emotions is then also added through the introduction of shame and guilt... As in M. Goncharov's (2014) conflict model – for describing the locations of these conflicts within life – the *four dimensions of life* (body-health (B)/work-achievement (W)/social life (S)/Future – spirituality (F)) are

introduced into the diagram within the areas of the Actual Conflict and that of the Basic Conflict. They are also added into the area of the Inner Conflict to visualize the escape reactions (Escape into somatization, work, social life and fantasy) through arrows as shown in an example further

on. Typically-used defense reactions can also be annotated within the area of the inner conflict as a conflict reaction (for example: body-health: somatization; work: rationalization; social life: idealization/devaluation; future-spirituality: denial/splitting) as N. Peseschkian has described.

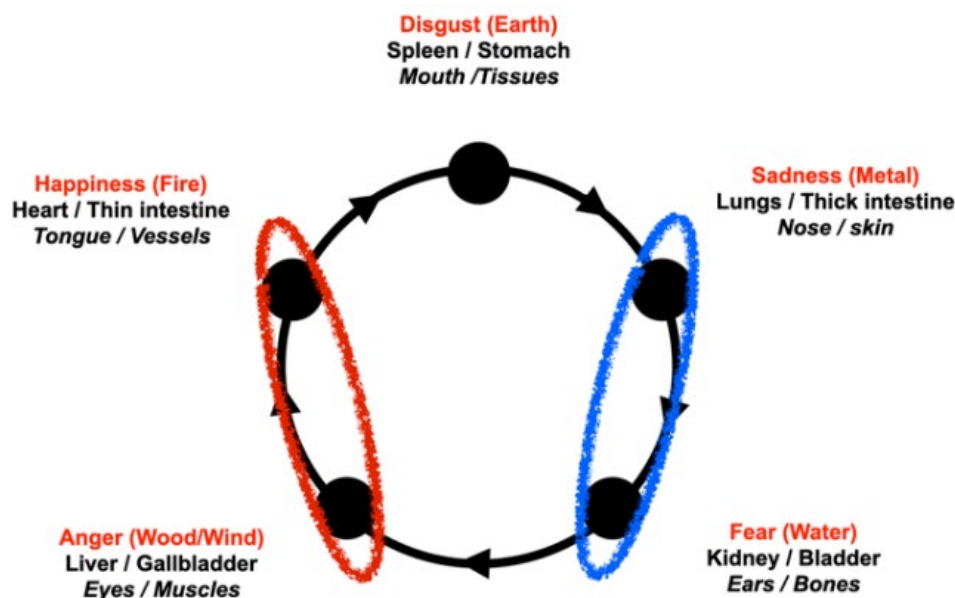


Fig. 2. TCM Wheel of emotions

The last step introduces the concept of *love*, *security* and *autonomy* as *basic essential needs* of an individual – described and used by Gabriela von Witzleben (2014b) in her work on the “triadic principle”. This is a highly enriching expansion of the concept of the basic conflict because inner conflicts are generally rooted in one or more of these three needs that are present in Nossrat Peseschkian’s work, but not all of them are explicitly mentioned as such in his conflict model (The need for love is included in N. Peseschkian’s basic capability for love and security for example is described by the capacity of trust and hope.) The importance of this differentiation becomes obvious when we look at the way children learn and see how their learning is often conditioned by the manipulation of these three basic needs. A child may have learned cleanliness because its parents had scolded it and shown it their emotional disapproval, saying they wouldn’t love it any more whenever it soiled its pants (*Cleanliness – Love*). The child might have learned how to be industrious and achieve because the parents otherwise would have punished him/her

physically (achievement - physical *security*) when he/she brought home bad grades. The child might have learned to be obedient because the parents would otherwise have locked it up in his/her room or taken away the car keys (*obedience - autonomy*). So, in addition to love, a basic conflict can be rooted in the individual’s needs for security and autonomy and can be of major help in understanding, explaining and solving the patient’s conflicts. In addition to the basic and actual capabilities, we also find these three needs in N. Peseschkian’s concept of “attachment – differentiation – detachment”. We can see how the infants’ satisfaction of its need for *love* and being mirrored is highly important in the infants’ connection to the mother/parents during the stage of *attachment* and how it is a safeguard for the infant’s survival and development. The need for *security* then evolves as predominant in the child’s stage of *differentiation* as the child progressively discovers the world around it and has to take care of him/herself. The need and longing for *autonomy* then take on its importance in the stage of *detachment* and allows the youth to

become independent. All three needs are present in all of the stages but each one has a particular role to play at a specific stage. The

three basic needs of love, security and autonomy are added individually to the diagram within the area of the basic conflict (Fig. 3).

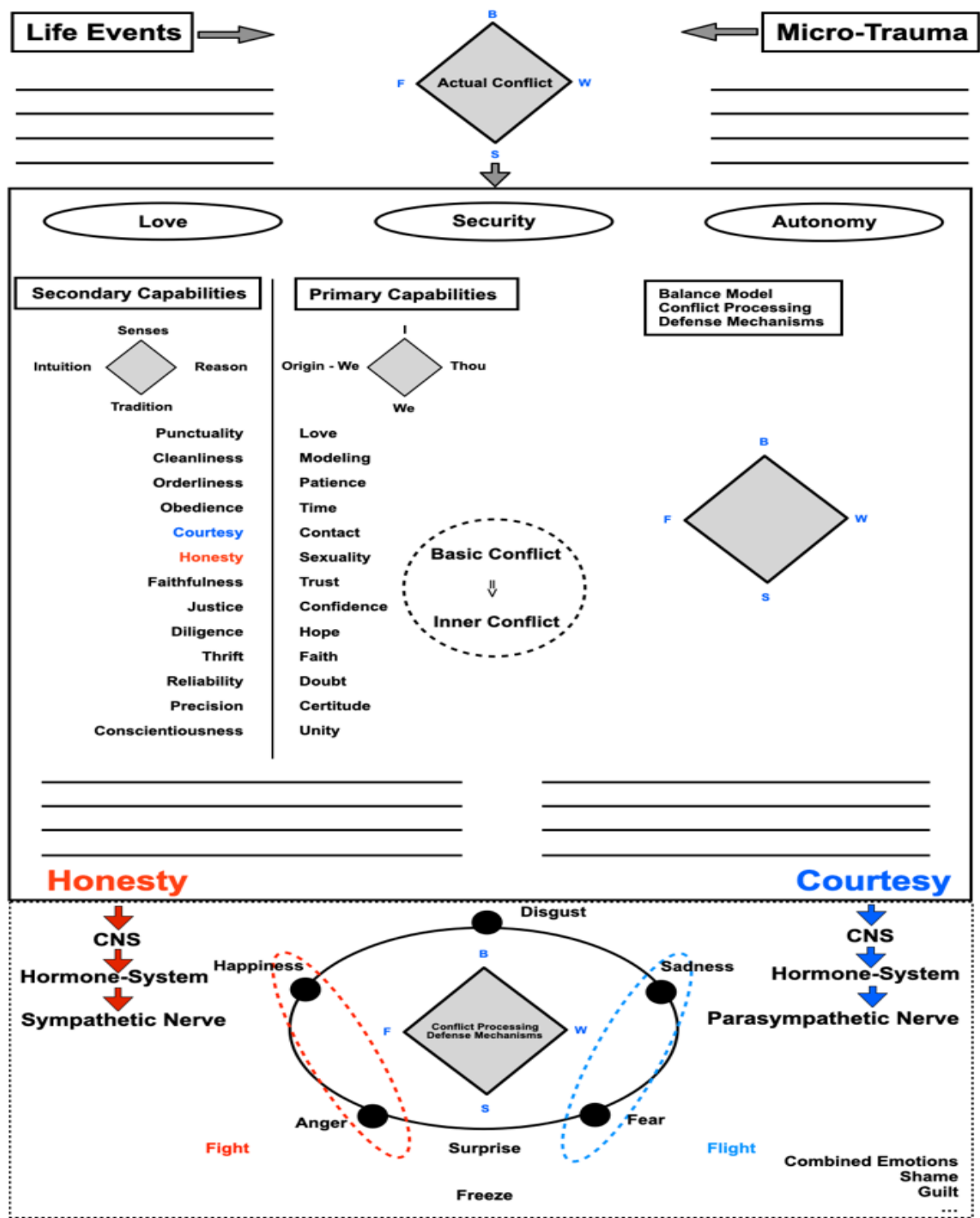


Fig. 3. Framework of the new conflict model containing the Actual, Basic and Inner Conflict

Discussion:

3.1. Conflict Dynamics

As we will now discuss successively - in positive psychotherapy, we can, per definition,

distinguish between an **Actual Conflict**, which is an *acute* or *chronic-load* situation caused by *micro-* or *macro-trauma* and the cause of the conflict with its *conflict content* (*objectives* and *behavior*) and *localization* within the four

dimensions of life. The **Basic Conflict** consists of the sub- or preconscious conflictive concepts for this situation within the personality structure acquired during childhood, with its *conflict content* (*objectives* and *behavior*) and *localization* (*Four Dimensions* and *Four Dimensions of role modeling and comprehension*). The **Inner Conflict** is the resulting subconscious seemingly *irresolvable decompensation* of the *known strategies* with internal (somatization) and external *escape reactions* within the *Four Dimensions* that do not bring a solution to the situation but at least afford a temporary relief/compensation. In the long run, the conflicts have to be solved or lead to helplessness, hopelessness, and further decompensation. So, the inner conflict results from the actual conflict with its challenges touching the basic conflict and the lack of a solution through prior, known strategies/behavior patterns and results in somatization and psychological compensation reactions with further helplessness and inner confusion. It may be a conflict on different levels of the conscious and subconscious, with the person consciously wanting something but subconsciously acting in the opposite direction, resulting in inner disharmony and failure to achieve his/her objectives. When this becomes chronic, the person becomes symptomatic.

•**Introductive example of conflict dynamics (Fig. 4):**

The repeated lack of punctuality of family members (*Actual Conflict*) at family gatherings meets one's concept of punctuality learned as a child (*Basic Conflict*) and leads to inner confusion and an outburst of anger and a headache (*Inner Conflict*).

•**The Actual Conflict (Fig. 5)**

Theory:

An *Actual Conflict* is an acute or chronic load-situation caused by *Micro- or Macro-Trauma (Life Events)* and the cause of the conflict with its *conflict content*: The *objectives* with their *localization* within the *Four Dimensions of Life* expression (*Four Dimensions: Body-Health/Work/Social Life/Future-Spirituality*) and *behavior (Actual Capacities)* to reach it.

Introductive example:

Family members repetitively come late to a social event that was planned.

Nonpunctuality (behavior – secondary actual capacity) is a *micro-traumatic* acute and chronic

event happening at a family meeting (*objective*) within the social area (*Four Dimensions*).

•**The Basic Conflict (Fig. 6)**

Theory:

As described above, the *Basic Conflict* consists of the sub- or preconscious *conflictive concepts* that reside within the personality structure. These conflictive concepts were acquired during childhood and are no longer adequate - with their *conflict content* (the *objectives (4 Dimensions of Life)* and the *behavior* to achieve them (*Actual Capacities*) and their *localization* within life and area of origin (*4 Dimensions & 4 Dimensions of Role Modeling & Comprehension*).

Introductive example actual conflict:

As children, we were taught that punctuality was a sign of respect for one another and especially family members. Those who came late were ridiculed and scolded if they did not comply.

As conflict content and conflictive concept *Punctuality (behavior – Secondary Actual Capacity)* is closely linked to the experience of *Love/acceptance (Primary Actual Capacity – that becomes a subconscious objective)* through educative conditioning (*4 Dimensions of Role Modeling & Comprehension*) in the social context and especially family-relationships (*Objective - 4 Dimensions*).

The repeated lack of punctuality of family **The Inner Conflict (Fig. 7)**

Theory:

The *Inner conflict* occurs when a *Basic Conflict* learned in childhood meets a series of *micro-traumatic* events or a major life event (*Macro-Trauma*). The ego does not have the resources and strategies to handle these events properly and resorts to somatization on the physical level and conflict-processing *escape reactions* on the external level.

Introductive example basic conflict:

Because we did not learn a calm and reflective way of reacting to repeated situations of unpunctuality at all as children, when we are overstressed by repeated or massive situations of lack of punctuality, we can no longer react in a controlled way and decompensate. This leads to verbal tirades and a headache as a flight reaction.

The repeated nonpunctuality (*Micro-Trauma*) of family members (*Actual Conflict*) meets our *Punctuality* concepts learned as children (*Basic Conflict*) and leads to the decompensation of the

ego and inner confusion with an outburst of anger and a headache (*Inner Conflict* - flight reaction within the *Four Dimensions of Life*).

In this situation, we react with *Honesty/Candor*, since this is the *Key-Conflict*

reaction strategy that we acquired as children (see *Key-Conflict* further on).

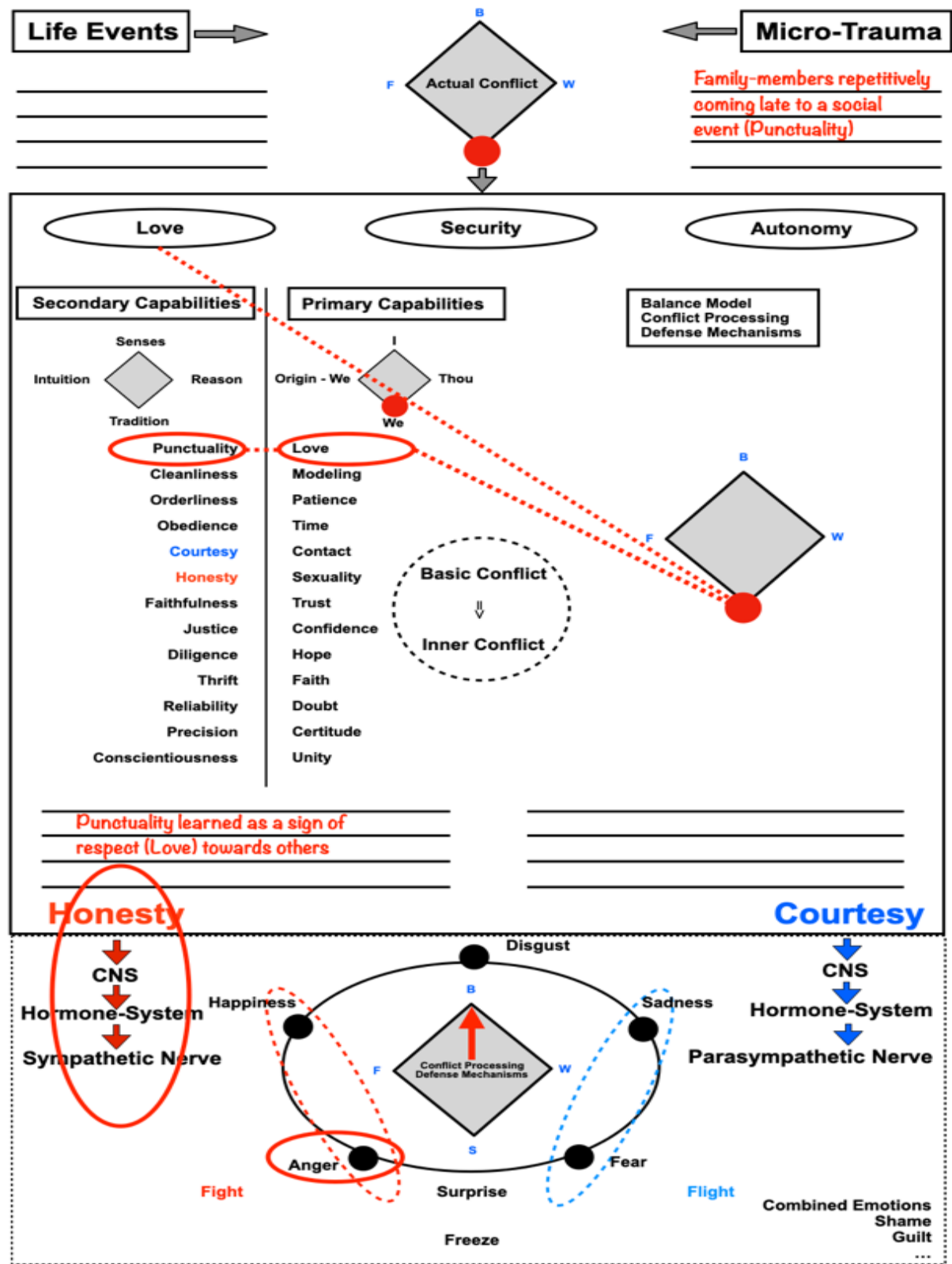


Fig. 4. Introductory example of conflict dynamics

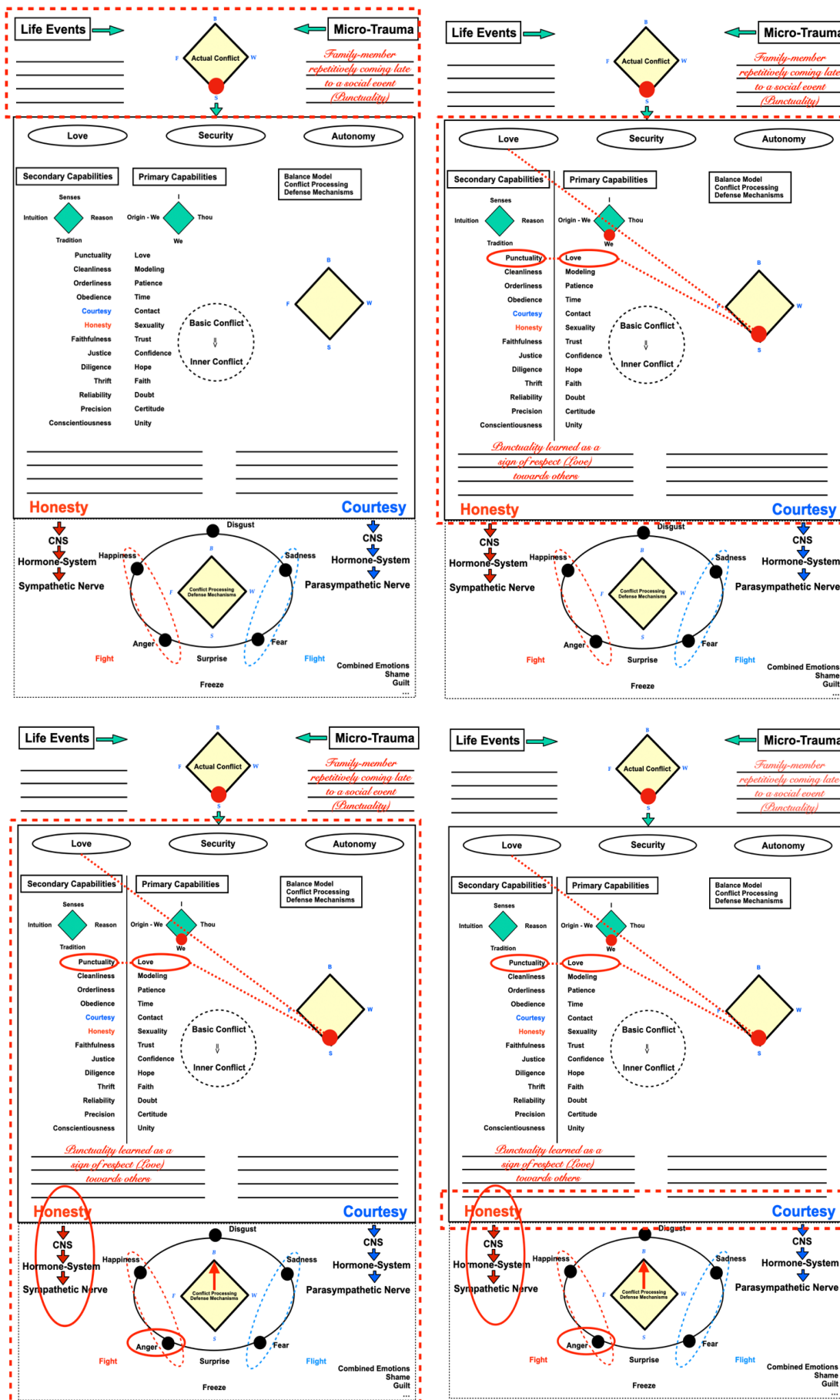


Fig. 5. The Actual Conflict; Fig. 6. The Basic Conflict;
Fig. 7. The Inner Conflict; Fig. 8. The Key Conflict

•The Key Conflict (Fig. 8)

Honesty and courtesy combine to create the *Key Conflict*. Within the individual, it is a type of switch for directing conflict energy outwards or inwards. Honesty is the capability to openly express our needs and conflict energy to the outside world, while courtesy is the ability to keep our needs to ourselves, politely not intruding into other people's lives. Courtesy allows us to prioritize the needs of others by confining conflict energy within ourselves. We need both honesty and courtesy, and when we use them in balance as strengths, we can express ourselves honestly and politely as an integral personality. If we are overly courteous, the consequence is many internal conflicts. Because we do not express our needs, we usually do not get what we want and then blame ourselves for not standing up to our needs. If we are overly honest, we inevitably create external conflicts, maybe seemingly getting what we want at first, but that short-term gain tends to cause further conflicts in the long run. Every individual has his/her propensity.

Introductory example key conflict:

We react with open anger to the unpunctuality of our family members.

As children, through genetics, for example, conditioning or maybe as compulsive reactivity, we learn to express ourselves with candor, too often explode in anger.

3.2. Explanatory example for the description of an individual's psychodynamics

During the last year, a thirty-year-old woman noticed that she and her husband were quarreling more about household tasks and wanted some time for herself. She had witnessed how husbands of friends helped out at home so their wives had more time to themselves. She thought it was not right that she did everything in the household and her husband simply rested, being pampered at home, and doing whatever he wanted to do. They communicated less; her husband became irritable, worked longer hours and no longer gave her the attention she had once enjoyed in the past. On the other hand, she became more engaged in her household and family work, felt

lonelier and less loved each day, and often suffered hypertensive crises in the evenings.

Actual conflict: There is a succession of *two actual conflicts in this situation*. The *first comes from* the continuous feeling of being treated unjustly, and the *second* is a reaction to her husband's reaction of withdrawing his attention and affection.

Basic conflict: In the first conflict situation, the Basic Conflict/Concept was the new concepts she had learned from her environment. How the household should be shared respectfully (*Justice – Love*) and that she needed some space for self-realization, just as her husband had (*Justice – Autonomy*). These concepts contrasted with the ones she had learned during childhood when her mother was always occupied with the household and the division of labor between a woman in the home and men outside the home was clearly defined. The conflict situation arose through her gradual change of perspective and values.

The origin of the *second Basic Conflict* was that her mother had never had time to play with her when she was a child. To receive some *Love* and *Time* from her mother, she had to help her with the housework. Since this made her mother happier and emotionally warmer, she experienced the feeling of *acceptance (Love)*, and she adopted household chores as a strategy to receive *Love*. Her husband's withdrawing his affection (*Love*) is the trigger to the activation of this second – though older – *Basic Conflict/Concept*.

Inner conflict: So, despite her *Courteous* personality, in the first conflict situation, the daily *Micro-Trauma* caused by unequally distributed household tasks and a need for more self-determination caused her to occasionally vent in anger with her husband. When her husband retreated and no longer gave her attention, she felt guilty, became anxious and sad, and unconsciously sought his *Love* through *Cleanliness* and *Orderliness*. This pattern was contrary to her need for *Justice*. Since she was preoccupied with cleaning, there was less possibility for the two to find time for one another or discuss their feelings, and so the situation worsened. Both felt personally rejected and escaped by working even more intensely. In the evening, the inner tension rose so high that she often experienced hypertensive crises.

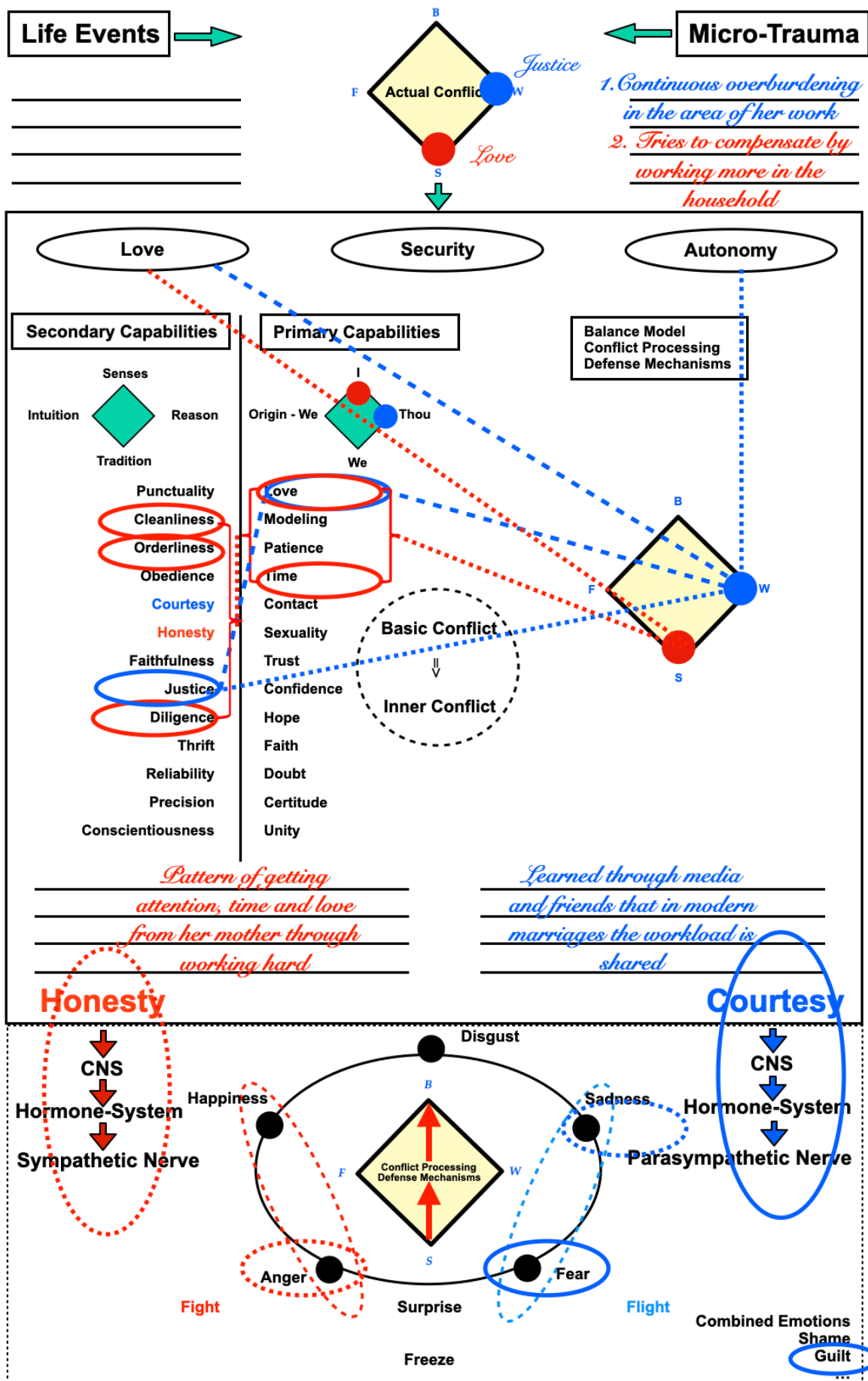


Fig. 9. Explanatory example of an individual's psychodynamics

4. The process of visualizing a conflict situation with the conflict diagram

We can visualize a conflict situation for an individual by applying our diagram in the following way:

1. *Actual conflict*

- What are the macro-traumatic or micro-traumatic events of the actual conflict? Where in what dimensions does the actual conflict affect my balance model, and what behavior or subject is touched?

2. *Basic conflict*

Actual Capabilities (Behavior):

- Do actual capabilities play a role in this event, and which ones?
- Are these my vulnerable, sensible, neuralgic actual capabilities? Are they my barking dog/my shadow self?
- *Dimension of Role-Modeling:*
- How are my individual emotional areas developed? Do I see any deficits, for example, missing self-esteem?
- Does the event touch one or more of the four emotional areas, and which ones? Is this the area where I have a deficit?

Four Dimensions of Life Expression (Balance Model)

- Which of the Four Dimensions is touched, and what is touched? A strategy or goal?
- Does the event touch an area that is especially important to me, and is it connected to my self-worth?
- Does it touch an area which I have neglected, that I have never occupied myself with but now must engage?
- How balanced am I now? Do I have one-sidednesses, burdens, deficits, stress, grief?
- What are my typical escape reactions? Am I using them here?
- Do I tend to use any defense mechanisms?

Learned Behavior (Actual Capacities), Strategies, and Goals:

- Do any of the items above remind me of behavior, strategies, and goals that my parents or someone who has served as a model to me used?
- *The Three Primary Needs*
- Which primary needs have been touched, and in which way? Are they especially sensitive to me? Which emotional load is triggered? Where does it lie? Why is it so

important to me?

- *Honesty – Politeness*
- Which capacity do I usually use? Which one am I expressing now?

3. *Inner conflict and its expression*

- What are my emotional reactions?
- What are my escape reactions?

Example of a patient:

A 26-year-old apprentice teacher arrives for consultation, full of fear and visibly agitated, complaining about panic attacks, cold sweats, sleeplessness, and diarrhea. He says he has been suffering from colitis for a few months now. It had all started after the beginning of his apprenticeship a year ago. He has tried his very best, but his superior criticizes him and expects more and more. Since he is investing more time at work, he has less time at home now and gets into conflicts with his girlfriend. She generally understands him well and helps him calm down, but his fears of being unable to manage the work situation, his sense of insufficiency, and fear of losing her make him well up in anger fits, and panic attacks add stress to the relationship. He says he believes that if he is not successful at his apprenticeship, he will probably never make it in life and will probably even lose his girlfriend. Most of his anger is directed at himself.

When asked about his *Four Dimensions*, good resources could be found in a healthy diet and sufficient sports. He has good friends, although he has seen them less in the past few months, yet he knows he can rely on them. He also has a profound spirituality that gives him strength in these difficult days. When relaying the past five years, he tells how he passed his teaching exam with good results. Before that, he had had several unstable relationships with women from whom he had separated, thinking they were not the right match for him. Going into his family background, we discover that his mother was very loving and had patience and time for him. She was always active, eating well, biking, and hiking, and worked as a teacher and was very fond of her job. She had good friends and was a spiritual woman as well. But she was often sad and frustrated because her husband never took time for her and the children and was too strict with them. She had fussed about this for years, but then she resigned herself to the situation because she did not want to leave her children without a father and the security of both parents because these were important values to her.

Although he never was there for them, except as a breadwinner. Two years before his maturity exam, his mother finally divorced his father and left with the children. Because of her own experience, his mother always insisted: "Find the right person that really fits you!"

In contrast to his mother, his father had never eaten well except at home; he skipped meals, had ulcers and headaches often, and never did sports. He worked "24/7" as the patient describes, and seldom went on a holiday with the family. When he went on vacation with the family, he usually took along some work to do.

26 year old male patient

Life events

(last 5 years...):

1. Colitis with strong med.
2. Bossing
3. Starting as an apprentice
4. Found „the woman of my life“
5. Finished studies
6. Several girlfriends
7. Divorce of parents

...

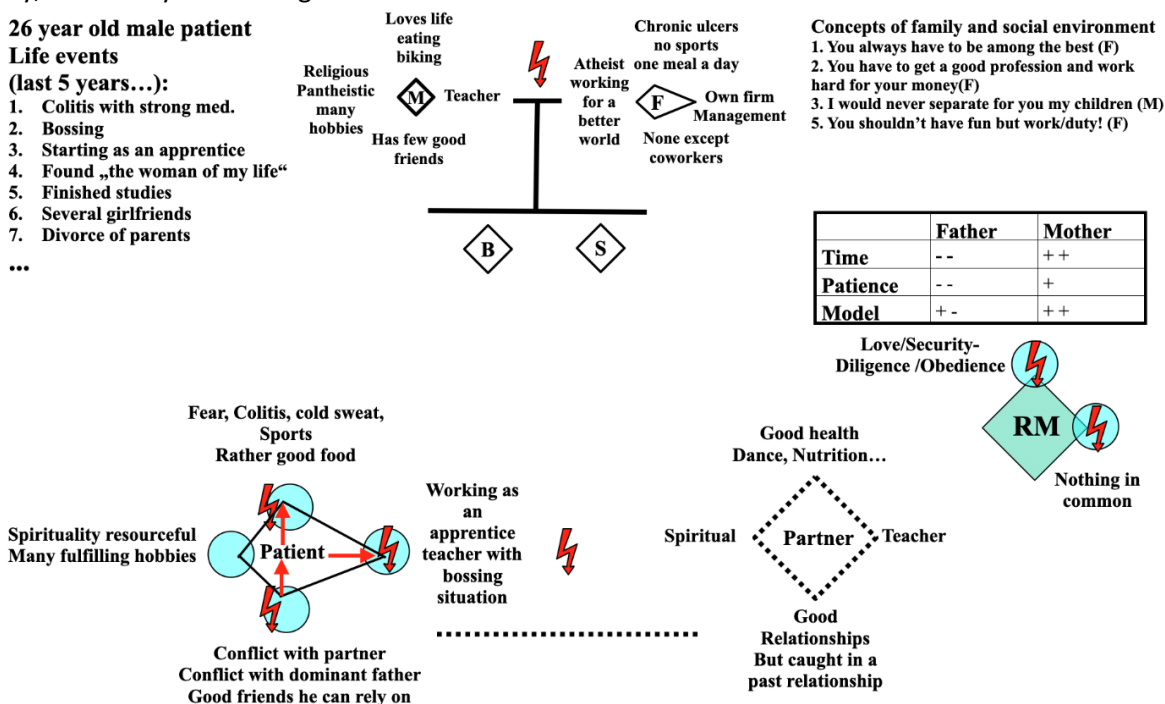


Fig. 10. Case history model of patient example

Looking at the Four Dimensions of role modeling, we find two major *Basic Conflicts* in this patient. One adopted through his father's education in the area of the "I"-relationship. That as a child, he only received positive attention when he was obedient or had accomplished something remarkable. On the other hand, when he erred, his father screamed at him so fiercely that it "scared the shit" out of him. Luckily, he had a mother from whom he received ample attention. The *second Basic Conflict* was in the area of the "Thou"-relationship. He had internalized the terrible relationship with his parents and vowed never to get into a relationship like theirs. He didn't want to find himself a "prisoner of such a marriage" in which he would quarrel with his partner about different convictions and interests day in and day out without leaving each other. Therefore, he

really wanted to be "sure of marrying the right person" and be able to live one's own interests (search for the perfect partner). This had led to changing girlfriends often. And now that he had found "the girl of his life" who had the same interests and many similar habits, he was afraid of losing her because he sometimes lost his temper, was very grumpy, and had panic attacks.

Of course, in addition to these two major *Basic Conflicts*, many more conflict contents and dynamics can be found within the case history and are of interest to analyze and describe.

Looking at this case history, we see different *Life Events* cascading: his parents' divorce, multiple girlfriends, graduation, finding "the woman of his dreams", and his apprenticeship. The unrealistic demands of his supervisor resulted in *Micro-Trauma* in the form of degradation, which brought him to

decompensation. This conflict and its results then impacted his relationship with his girlfriend, causing conflict to arise between the two.

Finally, the conflict manifested in the physical symptom of colitis.

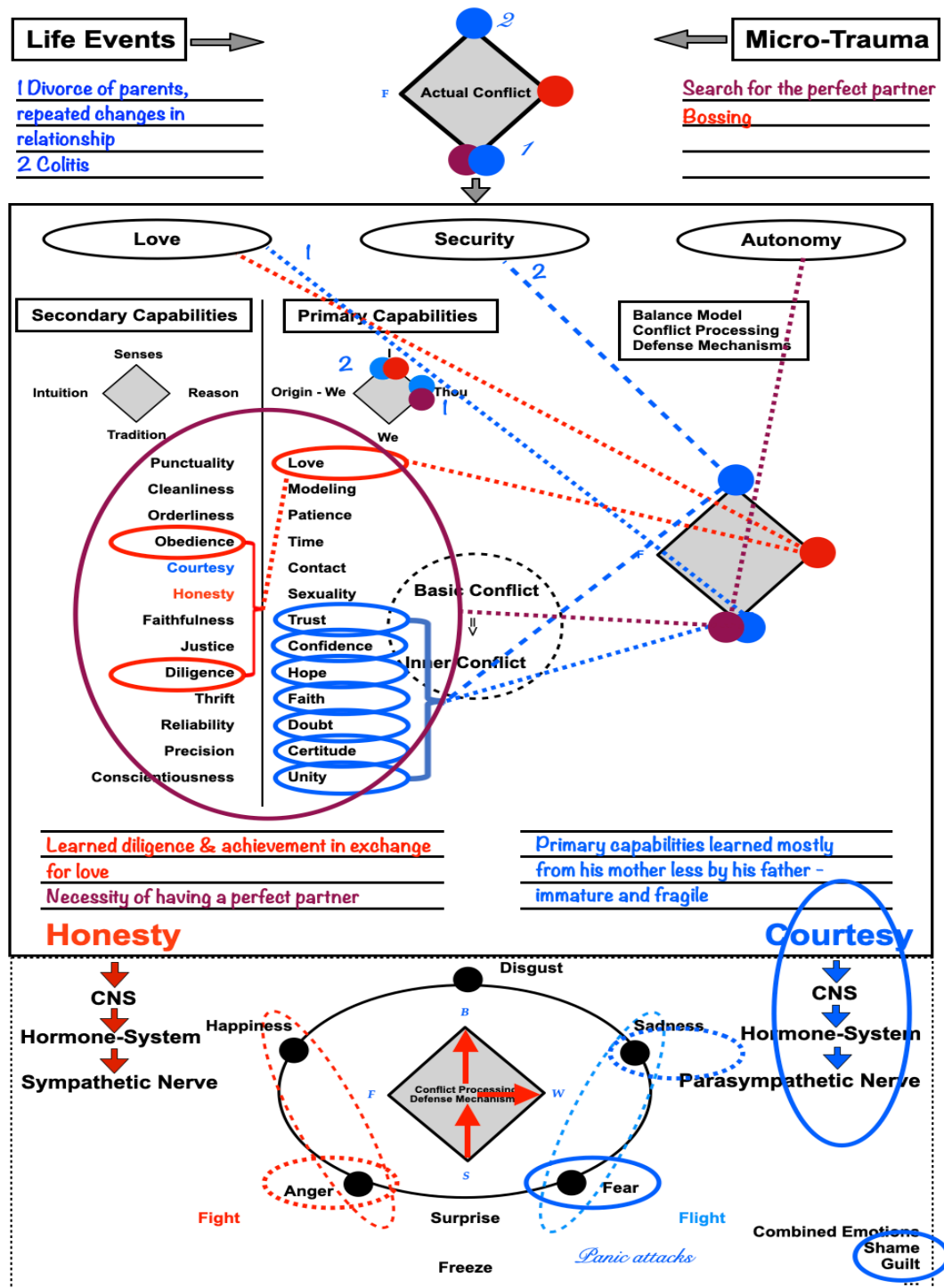


Fig. 11. Conflict model of patient example

His continuous search for the perfect partner – the one that would leave him a maximum of opportunities to realize himself – inevitably brought repeated breakups and an increasing amount of insecurity to his self-worth and ability to maintain stable relationships. The disease, and the *Macro-Traumata* of his parent's' divorce,

repeatedly changing relationships, and the insecurity in a new apprenticeship touched the areas of *Trust, Confidence, Hope, Faith, Doubt, Certitude, Unity*, and more... The disease itself is strongly connected to the sense and need for *physical Security*, the traumata within the relationships to family and partnership more to

the *security in Love*. The following *Micro-Trauma* of harassment from a superior touch on the *Basic Conflict* inflicted by his relationship with his father. His *Basic Concept/Conflict* of trying to receive attention and appraisal (*Love*) through *Obedience* and *Achievement* was triggered but was futile and led to decompensation in the form of headaches and irritable bowel movements. His further conflict-coping reaction of working harder (*escape into work and retreat from social life*) did not alleviate the conflict and meant that he saw his girlfriend and friends even less. With an *ambivalent Honesty-Courtesy* personality trait, his emotional outrage went mostly inwards. He blamed himself and felt shame and guilt. He escaped in loud fits that irritated his girlfriend and led to the next conflict. His memory of his parents' relationship and its consequences engrained in his mind, his mother's reactions, the divorce, and her sadness, consciously and subconsciously present, lead to further decompensation, making the colitis worse and eventually leading to panic attacks.

Conclusion:

With the conflict model described above, the author attempted to operationalize and visualize psychodynamics within the metatheory of Positive Psychotherapy. It is a combination of N. Peseschkian's traditional model and M. Goncharov's model from 2014 that are enhanced by the basic needs love, security and autonomy G. v. Witzleben - described in her books about triad-work - and emotions delineated by P. Ekman and TCM. The model gives an in depth look and understanding of what is moving the patient and what his psychodynamic reactions in a given situation are - based on the models of PPT of an actual, basic and inner conflict given direction by the key conflict. It goes beyond the current models that are primarily based on a basic conflict rooting in a forged connection between a secondary capability connected to a primary one. Since patients are time and again also motivated by the needs for security and/or autonomy or even all of these three basic needs at the same time, all have been taken into consideration. The model makes possible the description of different inner conflicts that exist at the same time or in sequence. Along with the sympathetic and parasympathetic reaction due to inner conflict - described by N. Peseschkian - the

visualization of N. Peseschkian escape reactions and Ekman's/TCM emotions becomes feasible. Defense reactions can also be added. On so few pages the article can only be an excerpt of the ideas which the author described in his recently published book "Living a fulfilled life; Self-Exploration and Personal Growth with Positive Psychotherapy after Prof. Dr. Nossrat Peseschkian". Nonetheless, the general guidelines to operationalization and visualization of psychodynamics within PPT are concisely described and the author hopes that the article inspires further interest and work on the understanding of the psychodynamics of the individual.

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Section: Modern PPT practice

APPLICATION OF VR-TECHNOLOGY METHODS IN PSYCHOLOGY AND PSYCHOTHERAPY



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Received 05.05.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/1kj202](https://doi.org/10.52982/1kj202)

Abstract

We shall consider the possibility of using virtual reality (VR) technologies in the treatment of phobias, psychosomatic disorders, and other psychophysical conditions. The challenge of augmenting patients' mental treatment by means of VR technologies is quite relevant in the field of psychology. A new way is quickly developing in the search for better methods of diagnosis, amelioration of anxiety and other conditions, as well as the identification of human characteristics. This new method can be characterized as deep immersion in virtual reality. This provides an opportunity to work with psychosomatics and phobias through virtual reality.

Keywords: virtual reality, psychotherapy, positive psychotherapy, emotional states, VR technologies, psychophysiological states, psychosomatics, phobias, fears

Introduction

VR technologies have become increasingly popular in recent years. Some predict a major role for them in the future of mankind, but so far, we are only at the beginning of this path. This topic is very extensive and there are many unknown aspects. First, we are interested in how this phenomenon affects the human psyche and physiology and how to derive practical benefits from this. First, in the context of psychotherapy. These technologies can become a means to help treat negative mental states (Koteneva, 2016). That is why we define the purpose of our study as the use of virtual reality technologies in the framework of psychotherapy and for the development of intellectual abilities.

The specifics of the impact of virtual reality on human physiology is due to the influence of VR on the psyche. Under the influence of VR on the senses, a person is almost completely immersed in the created virtual model and interacts with the new system at the level of audiovisual images and representations, supported by response motor reactions of the body

(Brylevskaya, 2009). VR technologies can create a stable perception of virtual reality as being true. This happens regardless of whether the brain "understands" it or not. Of course, the dissonance in the perception of realities generally has unpleasant consequences at first. Numerous studies and observations have shown that the human psyche, as well as the physical body, are extremely adaptive and able to adapt to almost any environmental conditions (Becker & North, 1998; Wallach et. al., 2006). Thus, virtual reality with deep immersion becomes only a new and different state of the surrounding world, to which psychophysical adaptation is real. Accordingly, the psyche will be able to switch between realities quite easily, adapting in the shortest period, without any negative manifestations.

"More and more people suffer from an ever-increasing number of phobias - those conditions of fear that are closely related to living beings or objects, places or time" (Peseschkian, 2016).

In medicine and psychology, psychosomatics is considered as the main influence of psychological (mainly psychogenic) factors on

the occurrence and subsequent dynamics of somatic diseases and is based on the terms "psychosomatic" (Heinroth, 1818) and "somatopsychic" (M. Yakoby, 1822) (in Malkina-Pykh 2008). This term reflects the understanding of the relationship between soul and body, in the context of an understanding broader than traditional medicine and psychoanalysis and requires consideration of the patients' transcultural and cultural-religious characteristics. Starting with Freud, the psychoanalytic concept assumes that an emotional reaction, expressed in the form of longing and constant anxiety, neuro-vegetative-endocrine changes, and a characteristic feeling of fear, is a connecting link between the psychological and somatic spheres. Thus, psychosomatic diseases include health disorders, the etiopathogenesis of which is genuine somatization experience, that is, somatization without psychological protection, when physical health is damaged while protecting mental balance (Malkina-Pykh, 2008 p. 8).

One of the objectives of our study was to investigate the possibility of a significant psychotherapeutic effect of specialized VR programs and its use as an effective tool in psychotherapy. Three blocks of research were carried out using immersion of the subjects in the environment of virtual reality and psychological diagnostic methods. In the first block, the manifestation of reactions and behavior of people in extreme virtual conditions was studied. During its implementation, we were interested in the pattern between the increase in the danger of passing and the increase in the caution and thoughtfulness of the actions of the subjects. Also, observations were made on changes in the parameters of the primary psychophysical state of the subjects, such as: blood pressure and heart rate. In the second block of experiments, the influence of non-extreme, relaxing stories on the emotional sphere was studied. Virtual aquariums, sea surf, pristine prairies produced a calming effect on the subjects. Visual stories organically complemented the corresponding acoustic effects. In the third block, a longitudinal method was used - alternate exposure to an extreme situation and a relaxing one.

This approach is seen, first, as an effective tool for psychotherapy or research in the field of psychology, psychiatry, and physiology.

The Purpose of the Study - is the possibility of implementing virtual reality (VR) technologies for psychotherapy and psychological research.

Methods: system analysis, generalization, observation, diagnostic methods, data grouping, mental state assessment, self-assessment.

Methodology

We conducted several of our own experiments in the virtual reality laboratory of our partner ARVI VR Inc. (USA) in 2017. Three blocks of research were carried out using deep immersion of the subjects in the virtual reality environment and psychological diagnostic methods. The experiments involved 2 groups of physically healthy men and women (10 people in each group) aged 23 to 30 years in equal proportion. All of them were tested with a questionnaire developed by Y. Shcherbatykh and E. Ivleva: "Questionnaire for the hierarchical structure of actual personal fears" (Shcherbatykh, 2002). The first group of 10 people corresponded to the indicators of a low level of acrophobia (1-3) and the second group (10 people) of an increased level (4-6). At the same time, the average integral indicator of fear among the subjects was in the range: for men - 77-83 points, for women - 103-107 points.

The first block of experiments was aimed at studying the manifestation of reactions and behavior of people in extreme virtual conditions. The subjects were on specially equipped sites and wearing virtual reality helmets. They had to overcome a certain section of the block bridge, suspended at a great height. The experiment consisted of several stages, with a tendency to increase the complexity of passage in the form of a change in the height of the bridge and the topography of its surface. During its implementation, a pattern was revealed between an increase in the danger of passing and an increase in the caution and thoughtfulness of the subjects' actions. A primary psychological portrait was compiled for each participant according to the Sixteen Personality Factor Questionnaire (16PF), which was then correlated with the results of their behavior in the test. The main qualities of the subjects correlated with their behavior and decisions in the context of passing the test.

The duration of the test was 5-7 minutes for each subject. The dynamics of changes in blood pressure and heart rate were recorded.

Research progress and results

Below are tables with data on blood pressure and heart rate of the subjects before, during and after each block of experiments.

Table 1. Dynamics of changes in blood pressure and pulse before the start of the experiment of block 1, immediately after and after 15 minutes (average)

Experiment conditions	Systolic pressure	Diastolic pressure	Pulse
Before the beginning	118,88	75,11	70,22
Immediately after the beginning	137,16	90,13	104,36
After 15 minutes	122,06	82,24	78,74

In the same block of the experiment, changes in the psychophysical state of the subjects were recorded, such as: increased blood pressure, increased heart rate, slight dizziness, and nausea. This state, in addition to nausea and dizziness, persisted from 5 to 15 minutes after the completion of immersion in virtual reality.

As a result of the first block of experiments, an obvious possibility of studying the psychological characteristics and character of a person, as well as their treatment through certain virtual reality programs, was revealed. In VR conditions, it is possible to diagnose a person's anxiety states, his fears and weaknesses, and more accurately select therapy methods using specialized programs of the same virtual reality.

In the second block of experiments, the influence of non-extreme, relaxing stories on the emotional sphere was studied. 10 minutes per person were allotted for immersion in virtual reality with relaxing scenes.

It was found that positive, relaxing virtual pictures with "live" landscapes and environments enhance positive emotions and have a calming and inspiring effect on a person. However, there was a clear correlation with the subject's temperament.

Table 2. Dynamics of changes in blood pressure and pulse before the start of the experiment 2 blocks, immediately after and after 15 minutes (average)

Experiment conditions	Systolic pressure	Diastolic pressure	Pulse
Before the beginning	119,76	77,34	72,37
Immediately after the beginning	122,26	80,19	88,19
After 15 minutes	120,12	80,86	76,61

In the third block, the longitudinal method was used (alternating exposure to an extreme situation and a relaxing one). This took 15 minutes per person. The alternation of an exciting and meditative situation in the virtual space showed a more rapid decrease in tension and fatigue, and an increase in the subsequent cheerful state.

Table 3. Dynamics of changes in blood pressure and pulse before the start of the experiment of block 1, immediately after and after 15 minutes (average).

Experiment conditions	Systolic pressure	Diastolic pressure	Pulse
Before the beginning	120,08	78,92	70,24
Immediately after the beginning	128,19	82,17	82,16
After 15 minutes	120,96	80,04	76,04

The research revealed the relationship between deep immersion in virtual reality and the psychophysical state of a person and its therapeutic effect.

Repetition of the experiment in 2021, on the same base in the virtual reality laboratory of our partner ARVI VR Inc. (USA), gave the same results within a margin of error of 2%.

3.1. Plans for the implementation and practical application of VR technologies in psychotherapy

Implementation methods and practical application of virtual reality technologies in psychotherapy must meet certain criteria and requirements. These are the requirements for the technical part and the software.

The technical part includes:

- a computer with a connected VR helmet.
- equipped platform for VR-therapy.
- equipment for monitoring well-being (heart rate monitors, blood pressure monitors, etc.).
- camcorder.

The software should contain a few specialized computer programs written specifically for the respective therapy. It is possible to complicate and modernize the therapy program, both programmatically and technically, depending on the tasks set. For a psychotherapy session, the patient is located on a specially-equipped platform. He is wearing a virtual reality helmet.

The psychotherapist is located as close as possible to the computer to implement and control the therapy program, as well as to monitor the patient's condition. During the session and upon its completion, video recording of the session and monitoring of the physiological state of the patient is carried out.

3.2. The prospect of using VR technologies in psychology and psychotherapy

The conducted experiments confirmed the possibility of effective application of VR technologies in clinical psychology (Becker & North, 1998; Wallach et. al., 2006) and psychotherapy in the context of behavioral therapy to remove the fears of people suffering from certain phobias. The main and most common fears are the fear of darkness, heights, closed and open spaces, spiders and snakes, and the fear of flying in an airplane. These phobias are usually accompanied by characteristic obsessive fears, increased sweating, and often provoke panic attacks.

Based on the understanding of Positive Psychotherapy (Peseschkian, 1987), the processing of fears in the space of virtual reality occurs, first, through the body and activity. In the process of being in VR, a person faces his feelings and emotions consciously and all four spheres of conflict processing are activated in one form or another. Separate characteristics of sensations can be conflicting in connection with such experiences. With the help of his/her sensations, a person establishes a connection with virtual reality, which activates his/her previous experience and experiences associated with it. The four areas of conflict processing correspond to cognition, that is, to those areas through which we enter a relationship with reality. In virtual reality, psychological processes are more controlled and directed.

In addition, the behavior, and reactions of a person in VR provide information for the psychotherapist in his work with the patient.

The approach described in this article was based on the safe and controlled ability of a

person to face his/her fears and be able to interrupt this meeting at any time. The method presented includes cognitive-behavioral psychotherapy techniques in the space of deep immersion in virtual reality. If necessary, medical support is possible, in case of risks of panic attacks, at the discretion of the psychotherapist.

Neurosis is generated not only by primary conditions (external and internal situations leading to the first appearance of the symptom), but also by secondary conditions (fixation of fear of expectation). Because phobias are caused by the desire to avoid situations that cause anxiety, it is necessary to break these circular mechanisms of neurosis. It is possible to do this without reinforcing the patient's fears. At the same time, it should be considered that a patient with a phobia is afraid of something that might have happen to him.

The cognitive-behavioral technique is carried out in two stages. The first is the need to bring the patient to the ability to relax. Fear provokes strong physical tension, up to the inability to move, which makes it impossible to work with it. Through relaxation programs, the patient learns to relax and induce this state if necessary and acquires the skills to properly respond to his fear and reduce its intensity. Methods of meditation and auto-training can be applied here. This stage will take about 30-40 days.

When the patient is prepared, the second stage of VR therapy is implemented - work with the phobia itself. Using an appropriate program of a set of exposure procedures, the psychotherapist guides the patient through the virtual spaces of his fears. This creates in a person the ability to reduce anxiety and emotional-reflex reactions to fear-inducing stimuli by consciously immersing him/herself in stressful situations and repeating them to get used to fear-inducing stimuli.

Using special VR programs, the therapist enables the patient to face his/her fears "face to face" in a safe virtual space, which the human psyche also perceives as real. The patient is confronted with stimuli that cause anxiety and fear in real life. During VR therapy, he/she gradually changes his/her reaction to the source of fears, gradually getting used to it, as a result of which anxiety gradually fades away. VR technologies allow the patient to feel that he/she is at a real height, in an airplane or in an elevator, to see creatures in open space or in the immediate vicinity that cause him/her panic

fear. So, step by step, a person burdened with phobias can be brought out of a state of anxiety and, ultimately, relieved of them.

No less serious prospects for the use of VR technologies are in the treatment of depression, stress, and various anxiety disorders. Also, the use of VR opens wide opportunities for diagnosing personal qualities and human pathologies, and in various training aspects, such as straining memory and attention (Becker & North, 1998; Wallach et. al., 2006). Here, VR programs such as quest rooms and labyrinths are more relevant.

VR can help to create an atmosphere of calm and relaxation, especially in meditation, enhancing its action and effect. It is also important to note the potential of virtual reality in training self-regulation skills and increasing the level of emotional stability.

3.3. The main problems associated with the use of VR in psychology

Virtual reality has become extremely popular in recent years as a tool for conducting various researches in the field of psychology and searching for new solutions in psychotherapy. Creating various scenarios and situations allows researchers to study the behavior and reactions of people to various stimuli.

However, the use of VR in psychology may face several serious problems: psychophysiological, confidentiality of patient data, the safety of using the technology, and the risks associated with emotional stress, which must be considered.

It must be understood that the virtual space can be very realistic and detailed, which can lead to a glut of information and emotions. This may affect the perception of reality and the psychophysiological state of participants outside of VR. In addition, it can lead to distortion and complicating the interpretation of research data and the treatment process.

In addition, intense experiences can exacerbate already existing emotional states and have a negative and even traumatic effect, which can lead to negative consequences for the participants.

Also important is the issue of ensuring the rights and interests of participants, primarily of the confidentiality of personal data and the personal life of participants.

It is also worth noting that, to date, not enough research has been conducted in the field

of virtual reality to unequivocally confirm the effectiveness of using VR to treat psychological disorders and dramatically reduce stress levels. There is a need for larger and longer studies to establish the effectiveness and safety of using VR in psychology.

Conclusions

Modern science considers the psyche as a subjective reflection of the objective world. Virtual reality is a pseudo-reality created by means of computer technology that can influence the human mind to perceive VR as something real.

The model of positive psychotherapy does not primarily try to explain the occurrence of certain conflicts but tries to understand the person in his life situation in which he becomes ill. The methods of positive psychotherapy are based on the principles of hope, balance, and counseling, which makes it possible to determine the forms and localization of conflict processing. In the process of therapy, energy is harmonized in 4 main spheres of life activity - bodily, mental, social-communicative, and spiritual. This, in turn, allows effective work with psychosomatics and phobias. This is because positive psychotherapy offers such a concept in its content process, within the framework of which various methods and special directions (metatheoretical and meta-practical aspects) can be rationally applied and complement each other (Peseschkian, 1987).

From the above data, it follows that VR technologies can effectively influence the functional state of a person, and virtual reality can affect his mental states, emotional and psychophysiological spheres of life.

Of special relevance are the development of VR technologies to help psychotherapists work with autistic people and people with post-traumatic psychological problems, as well as with people of advanced age. Although autism is a genetically determined disease that manifests itself in certain disorders in the development of the brain, VR technologies can help in this case too. As a rule, an autistic person is excessively immersed in himself and tends to completely shut himself off from the outside world, seeks to limit his contacts with the outside world as much as possible, and he/she does not perceive generally accepted norms and concepts. With a deep immersion of an autistic person in virtual reality, it

Seems possible to artificially develop insufficiently developed brain functions, stimulating it with special medical and educational computer programs. With the help of games and special exercises in the virtual space, it is possible to develop the large and fine motor skills of an autistic person, attention, memory, and also lead to the ability to communicate with other people (Mi Jin Park, 2019). At the first stage of work, the symptoms that interfere with normal life and the treatment process are eliminated.

Special VR programs can also be very effective in treating people who have experienced severe traumatic events, such as war, terrorist attack, violence, death of a loved one, or other extreme stress. The therapeutic effect of such programs is to introduce the patient into a relaxing state with the gradual acceptance of reality and a change in attitude towards the traumatic event that has occurred. For the elderly, VR programs can be used as supportive therapy for cognitive disorders.

And although the use of VR in psychological practice has great potential, however, it is necessary to solve many problems related to ethical issues for its successful implementation, the sufficiency of research and the complexity of using this technology in psychology and psychotherapy. The use of VR in this area requires special equipment and specialists trained to work with the technology and additional resources. And if these methods are positioned as tools of psychotherapy, of course, one should consider the characteristics of each patient and allow the aforementioned therapy only under the guidance of a qualified psychotherapist.

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Section: Modern PPT practice

POSITIVE PSYCHOTHERAPY AND ART



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Received 22.04.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj203](https://doi.org/10.52982/lkj203)

Abstract

Art therapy and positive psychotherapy have common points of contact, but differ significantly in their respective theoretical and practical concepts. Both are independent therapeutic methods that require extensive training or further education. Art therapy works preferably with artistic media, whereby psychodynamic processes are integrated depending on the therapeutic orientation. Conversely, Positive Psychotherapy has related approaches in a distinct form to art therapy. This applies above all to the creative process of the procedure. Both methods overlap at the point where psychological conflicts are expressed through artistic means or stories. While artistic therapies focus on this process, Positive Psychotherapy is a psychotherapeutic procedure in its own right. In this article, the approach to art therapy is presented against the background of the resource-oriented practice and theoretical approaches of Positive Psychotherapy.

Keywords: positive psychotherapy, receptive art therapy, art psychology, neuroesthetics, Nossrat Peseschkian

"Stories, fairy tales, myths, artistic productions, poetry, etc., are - besides the value they have, I art pour I art, for themselves - media and tools of a folk psychotherapy and of a "folk pedagogy" with which people helped themselves long before psychotherapy developed."

- Nossrat Peseschkian

Introduction

Positive psychotherapy is not only a new, independent method but also a framework model in which elements and techniques of other psychotherapeutic methods can be applied (cf. Peseschkian and Remmers (2013, p. 18). Thus, it is obvious to integrate applications

of receptive art therapy or iconotherapeutic approaches into the creativity-oriented, psychodynamic and transcultural framework of Positive Psychotherapy.

A literature-based and case-based study is presented here that highlights the intersections of positive psychotherapy and receptive psychotherapy. Basically, the work is based on the work in outpatient psychotherapy and the work in the framework of inpatient psychiatric treatment. Here, museum visits were regularly carried out with patients. The aim was to activate resources and cultural participation.

Methodology

In Positive Psychotherapy (PPT), literature and poetry, as well as creative writing, are used

to contribute to the patient's self-exploration. Hamid Peseschkian (2002) has described the connection between positive therapy and bibliotherapy very clearly using the example of the treatment of a patient with borderline personality disorder, who wrote over 500 pages during the entire course of therapy. The process of creative writing also supported the self-analysis function here. Early psychoanalysis (Freud) and complex psychology (C.G. Jung) repeatedly explored literary and artistic works. In the oriental stories, which are repeatedly taken up in PPT, these are concrete learning opportunities for the patient. From the cultural tradition the oriental stories were - and are still today - always a piece of knowledge mediation. They convey a pictorial way of thinking where everyday language is insufficient to achieve solutions to problems. "When the psychological pressure of suffering is so great, when entering into a conversation becomes difficult, then art/music/literary contemplation offers a possibility. It creates something unifying, enables communication, and can lead to opportunities for relief (catharsis) that are part of the therapeutic process" (Franzen, 1997, 2012). Wilhelm Salber (1999, p. 13) describes that the psychic can only be understood by relating it to art: "Art and the psychic exist only in back-and-forth movements, in the transition from one into the other, in additions and refractions". To understand the other in his creation, to really understand the meaning of creativity, presupposes a process of artistic and therapeutic reflection, which understands art also in an aesthetic dimension and psychic efficacy, and conveys itself symbolically. "Personal experiences and messages of the unconscious reveal themselves in symbols. Literature and art have the great gift of conveying this symbolic experience to us" (Franzen, 2009, p.8). On the one hand, working with art opens a bridge to the unconscious, and on the other hand, the inner psychological experience is given a possibility of expression through the purposeful engagement with creative processes.

The guidelines for art therapies (DGPNN, 2019) include 1. the recovery, Maintenance and promotion of health and health behavior, e.g., through the promotion of resources, increasing the willingness to perform by increasing self-motivation, developing one's own goals and improving the ability to self-structuring and

concentration skills, as well as improving the quality of life through stimulation and access to relaxation, enjoyment and recreational ability, as well as positive affective experience. 2. stabilization and strengthening of self-regulation, e.g., through regaining a sense of self and reality reference, development of modal and integrative perception, development of affective competences, strengthening of self-efficacy and control, and development of action skills, and 3. development of psychosocial competences, e.g. by expanding interpersonal communication and verbalization skills. communication and verbalization skills through the interlinking of nonverbal and verbal interactions, as well as increasing emotional sympathy and vibratory capacity.

There are now many randomized control trials (RCTs) on the effectiveness of art therapy with different, also clinical, groups of subjects (Ganter-Argast, 2019). In addition, the current state of research also includes systematic reviews (Miake-Lye et al., 2019) and even the development of quantitative rating instruments in Germany (Schoch, 2020). In a meta-analysis by Uttley et al. (2015), it was shown that in 10 out of 15 studies, the treatment of patients with mental illnesses with art therapy had a treatment of patients with mental illness with art therapy had a significant positive effect. Control groups, waiting list patients, or treatment as usual (TAU).

Four studies showed an improvement in mental health but no significant difference from the control group. Significant difference from the control group. Even in the WHO report of 2019

some RCT studies with art therapy were mentioned. The study situation illustrates, that there are already some quantitative studies in evidence-based research on art therapy. art therapy, but that there is still room for further development, especially in the area of especially with regard to effect factors. Existing research has identified several impact factors of art therapy that can have a positive effect on a person's psyche. Examples positive feelings, positive influence on self-esteem and social behavior, self-esteem and social behavior, promotion of self-exploration and self-expression, communication self-expression, communication, understanding and clarification models, integration, symbolic thinking, creativity (Strauß, 2019), procedural activation and Resource activation (Grawe, 2004). These factors

can be supported by a healthy and stable patient-therapist relationship (Petersen, 2002). These factors need to be further explored and developed in art therapy research. explored and developed in art therapy research.

By looking at the design created in art therapy (compare Reif, 1999, p. 70), a countertransference reaction can be triggered. "This countertransference is influenced by the existence of the image within the shared environment of the therapeutic encounter. Feelings are influenced by the image and so it can arouse a felt reaction in the viewer. The embodied image influences the countertransference by awakening a countertransference in both viewers: in the artist/client as well as in the therapist" (Schaverin, 1992, p. 121). The individual effect of the picture and the experience of the therapeutic relationship are combined in the aesthetic countertransference: "The therapist's countertransference to the art object is an aesthetic appreciation in which the eye wanders over the depicted picture. In addition, the therapist looks at the effect of the features in the picture as a whole and extends this to a consideration of how this relates to her experience of the therapeutic relationship. She looks within herself to observe her response to both image and person."

The extensive transcultural background of positive psychotherapy made it possible to understand artistic and literary creation as a form of universal language (Fromm). Communication occurs through interaction with a work of art, literature or visual art and finds its way into a psychotherapeutic setting.

Especially where a patient's ability to communicate is limited, the receptive use of art provides a visual entry point into contemplation and insight. In Nossrat Peseschkian's case, it is primarily the receptive use of oriental stories. However, these aspects can be transferred to the visual arts. Here the receptive work with visual art can help to dissolve restrictions of verbal communication. In this sense, receptive means working psychotherapeutically with the contemplation of works of art. Directive and non-directive procedures alternate. The whole context speaks of an interpersonal aspect, whereby media support the psychotherapeutic process. Viewing images trigger visual stimuli, which stimulate sensory perception. This happens in particular over the form and color

perceptions. The inner imagination and resources are activated. A psychological process is set in motion and one's own creative potential can unfold. According to Nossrat Peseschkian (1994, p. 106), every human being first experiences himself and his environment directly through the senses. The seeing, or the visual perception is a part, an important sense with which the world is experienced. A sense through which communication also takes place. Creativity is of great importance in the context of positive psychotherapy.

2.1. Art as a resource

Health is more than the absence of disease. According to Antonovsky's salutogenesis model, health depends on a sense of coherence - a feeling of confidence in the comprehensibility, manageability and meaningfulness of events, relationships and life situations (cf. Jork and Peseschkian, 2006, p. 300). The ability to use intuitions and imagination as resources and thus to design the near and distant future in an optimistic and meaningful way (cf. Franzen et al 2006, p. 111) are particularly artistic characteristics. Contemplation of art also offers an access route to buried resources. Thus, in recent psychoanalytic concepts, Christopher Bollas (2005, 29) describes that the search for symbolic equivalents of early intense affective experiences continues in adulthood through museum visits, among other things. Works of art offer such a subjective experiential space in which mental efficacies can develop and a psycho-aesthetic experience (Salber, 1999, p. 39) becomes possible. Also, for self-psychologist Ernest Wolf (1996, p. 79), an adult needs a self-supporting experience with real objects, such as art, literature, music, and religion, ideas that, by being available, can be self-objects for that particular adult. "The subjective aspect of a relationship with an unconscious object, mediated by the presence of a symbol, is crucial to its ability to serve as a self-object function" (Wolf, 1996, 79).

Panofsky explains the process of accessing the work of art as an intuitive aesthetic recreation. According to Panofsky, works of art are both manifestations of artificial "intention," and also natural objects that are sometimes difficult to isolate from their material surroundings and are always subject to the material aging process. "Thus, when we experience a work of art aesthetically, we

perform two entirely different acts, which psychologically, however, merge into one experience: we establish our aesthetic object both by recreating the work of art in accordance with the 'intention' of its creator and by freely creating a complex of aesthetic values that we give to a tree or a sunset" (Panofsky 1975, 32). Complementing this, Aby Warburg describes re-creative experience rather as a phenomenological process of "empathy" following Friedrich Theodor Vischer (Schindler 1999, p. 12) and distinguishes between "thought-image" and "art-image." Horst Bredenkamp also speaks of the "power of images" (Bredenkamp 2012, 55) and concludes that "no philosophical school has been more inspired by living images than that theory of empathy founded by Friedrich Theodor Vischer, his son Robert, and Theodor Lipps, with the aim of allowing the same empathy to operate in the turning to inanimate matter as it does toward living persons. The forms of understanding for the other or the other are in this sense consequences of the aesthetic disposition to see in the artifact not inanimate substances, but the recipient and responder of one's own sensations" (Bredenkamp 2012, p. 121).

Empathy can be defined in relation to art as a feeling of empathy or as an initially spontaneous, unprejudiced involvement when viewing a work of art. In this process, subjective psychological qualities, such as intuition, are called for. It is a matter of grasping thoughts, desires, feelings and fantasies. According to Johanna Franz (2007, p. 67), art triggers intuitive, empathic experiences in us and shapes our thinking.

Therefore, it is precisely the empathy with the work of art that is an important prerequisite for understanding the "meaning-content" and absorbing something of the "psychic energy" of the work of art. Important for the whole process are:

- To experience and understand one's own ideas, feelings, memories, perceptions, opinions, and fantasies from the past as one's own personality part in relation to the work of art.
- To learn something about one's own aesthetic point of view in order to reflect symbolic understanding also from an artistic point of view.

A relationship is formed between the work of art and the viewer, which makes it possible to relive the artistic-symbolic content:

- How do I experience these worlds of images?
- How do I perceive this sensory experience?

Only a real engagement with the work of art or the art space enables a corresponding experience. Here, the participants are first asked to relax, to arrive, and then to engage with the work of art in peace. The task is to immerse themselves in the artwork and really take time for it. This works similarly to the "Slow Art" concept (Schäfer 2017), where museum visitors are guided to take their time with an art object in order to enter into a dialogue with the art. Here, the focus is then on questions about the work, questions about the interaction with the work, and even questions about the visitor's own person and life about the experience of the work. The therapeutic process goes beyond this, however, as it is necessary to intervene in a regression-controlling and resource-oriented way into the background of the respective mental illness.

A work of art offers such a self-object experience. In this sense, the work of art becomes a supportive self-object and enters into a relationship with the self. It supports the unfolding and unburdening possibility of the self.

Neuroaesthetics is also increasingly concerned with the stabilizing influence of works of art. In addition to the neuronal foundations of the creation of art, aspects of the reception of art in particular have moved into the focus of research in recent years under the catchword of neuroaesthetics (cf. Dresler 2009, 25). In summary, it could be stated that the objective aesthetics of works of art can be distinguished from their individual subjective evaluation and that this difference is reflected in the way of looking at underlying neuronal activity (cf. Dressler 2009, 27). Here Kersten (2009, 42) confirms in the context of his neuropsychological research that the increased attention, the immediate emotional effect and the metaphorical meaning of the pictorial works are of particular importance in the perception of art. For Schurian, art is further characterized by its autopoietic effect: "As 'poiesis' literally puts it, it is the creative force that falls to and emanates from art" (Schurian, 1993, p. 7). This refers to conceptualizations such as the conscious experience of art, which can be attributed more to phenomenological psychology. Without the perceptual and emotional participation of the

viewer, art is incomplete. In the interaction with viewers and artists, not only is a two-dimensional image on a canvas transformed into a three-dimensional image of the visible world - the viewers also interpret quite individually what they see on the canvas and thus assign meanings to the image (cf. Kandel 2012, 230).

In more recent approaches, which are primarily based on the current results of brain research, Stern goes even further and acknowledges the time-based arts and artistic non-verbal therapy methods as groundbreaking for psychotherapeutic treatment because they possess specific knowledge in the mediation of forms of vitality (Stern 2011, p. 116), i.e., they focus on the dynamic properties of experience. In this sense, Stern confirms the theoretical approaches of a depth-psychologically-oriented art psychology.

It can be assumed that the processes of "experiencing art" are very distinct, which is also supported by current research in neuroaesthetics. For example, the perception of emotions in art is partly through imitation and empathy (cf. Kandel 2012, p. 519); it engages the brain systems for biological movement, the mirror neurons, and the Theory of Mind. We activate these systems automatically without having to think about them. A great work of art provides us with a deep unconscious pleasure that can nonetheless evoke conscious feelings" (Kandel 2012, 519). This is quite consistent with the James Lange theory of emotion, and is also confirmed by recent studies of the emotional brain. Semir Zeki (2010, 25) also demonstrates a significant capacity for abstraction that can be triggered by a viewing of artwork. The viewer is accompanied in (depth psychological) receptive art therapy on the background of his current conflict. The work of art offers the possibility of introspection. Imagination enables a deepening of this experience. Only then does a symbolic understanding, a self-object experience through art become possible, for no work of art can be adequately experienced in the sense of Clemenz (2011, p. 14) without sensation, without affect. Affects necessarily enter into the perception of form, just as, conversely, form necessarily influences and alters our affects under certain circumstances. Moreover, affects constitute part of the form itself: They are fused into the artistic form and thus transformed. Affects thus become part of the "aesthetic idea" (Kant) of the artwork. In particular, the transcendent quality of

aesthetic experience is given prominent importance in Leikert (2012, p. 127). This moment of transcendence as a cathartically altered experience is central to the considerations and is an important basis (cf. Franzen 1992,1997) for the effectiveness of receptive art therapy procedures (Franzen 1997). For Klaus Matthies (1988, p. 83) it is obvious to relate "the worlds of feeling that all the arts contain (from which the arts proceed, to which they refer) with the worlds of feeling of everyday life, as they are especially significant in therapeutic view and intention." "Moreover, he determines a double meaning of catharsis, since it is involved in the fact that "aesthetic enjoyment (aesthetic experience) has a substantial spiritual part. (...) In this sense, catharsis is an important "purging" process: process of reappraisal, purification, renewal" (Matthies, 1988, p. 90).

In a work of art, in fact, all emotional experiences are inherent - and those experiences which seem to find their way to the viewer are perhaps the most distant from him (Hecht 2014, 7). "Works of art, because of their complexity, are able to provide a rich palette of associations and reactions for patients" (Sarbia, 2015, p. 193). The forms of interaction, those mutually constituting patterns of relations between the symbolic object or the symbolic process-the work of art-the producing subject-the artist's personality-and the receiving subject-the viewing person-that can be observed in front of the painting are analogous to the therapeutic as a cognitive process in the scene in front of the work of art (Engelhardt, 2021, p. 15). Indeed, it is so. When looking at his art space, it is possible to participate in it through an aesthetic experience.

On the one hand, imaginings have the surplus of meaning in common with works of art due to their symbolic quality; on the other hand, they represent a special "product" with a beginning, an end and certain stylistic features - such as striking breaks or a clear narration. The process of imagining, with its moments of emotional density, the primary process, the kinesthetic-sensual experience and the corresponding altered sense of time of the patient is related to the "flow" processes known from creativity research (Bahrke u. Nohr 2013, p. 16). At the same time, in the context of therapy, the image offers the possibility of opening up the patient's experiential spaces.

2.2. Impact factors & creativity

The integration of aesthetic possibilities of experience into the therapeutic process simultaneously enables a mirror function. In this mirror function, identification occurs. Associations are reinforced. In the scenic/symbolic contemplation of the work of art and the associated associations, of contradictory parts of movement, the unconscious meaning is experienced as it were. It is important to understand the distinction between manifest and latent meaning, i.e. the external and unconscious sides, of the work of art. Pictorial representations make their contents appear closer to the ego and thus facilitate identification with them. Detached from the immediate world of experience, works of art help to create a more distanced relationship to one's own conflicts. Sonja Pöppel (2016, pp. 240-246) has summarized the factors of effect of receptive art therapy accordingly in her dissertation:

- relaxation, relief, conflict management
- Mobilization/Activation/Motivation
- Triggering healing forces in the viewer
- Promoting communication skills/building rapport
- Promotion of the perceptive ability
- Promotion/change of self-perception and perception of others
- Improvement of the ability to concentrate/endurance
- Stabilization/identity formation
- Promotion of design activities and creativity
- Promotion of self-esteem
- Promotion of cultural participation/socialization

In addition, art forms that can simultaneously convey movements or inner images have an intense psychological effect. Accordingly, they can be used to deepen the imaginative experience and stimulate creative processes. The visual engagement with the artwork also leads to a relief of unconscious feelings, which intensifies the activation of resources at all conscious and unconscious levels, and allows a self-object experience. The art experience takes place in a relational space. Only here does the aesthetic-symbolic experience take place with the following efficacy factors:

- Mirror function.
- Model function.

- Containing.
- Depot effect.
- Verbalization of experience content.
- Symbolic experience.
- Promotion of Creativity.

Since aesthetic conditions are neuronally appropriated and neuronally represented (Menzen, 2017, p. 136), we also need neuropsychological foundations for understanding the effective factors of receptive art therapy procedures. For example, Merlin Donalds (2008, p. 11) points out that all the symbol tools which our brains work with are imported from culture. Thus, symbol formation requires intensive acculturation; that is, for this to occur, individuals must grow into the culture of the society that surrounds them (cf. Donald 2008, p. 161). For Donald (2008, p. 278), symbols emerge from the tension between the two sides of a cognitive symbol system, namely between the form of the symbol itself and the levels of meaning to which it is attached and on which it in turn acts. This also refers to collective experience and the meaning that artists, in particular, convey in their artworks so that the viewers' inner images widen and change, become looser and more open (cf. Hüther. 2005, p. 17). C. G. Jung understands that the archetypal recourse is also the secret of the effect of art: "The creative process, as far as we are able to follow it at all, consists in an unconscious revival of the archetype and in a development and shaping of the same up to the completed work" (Jung G.W. 15 vol., 1995, p. 95).

Many artists have, therefore, not only drawn attention to the socio-psychological scene of their time in their works of art, but they are unconsciously able to draw on archetypal symbols through their deep sensitivity. The art historian Franz Meyer (1989, 126) assumes that the will of the artists to use the work of art as a symbolic operator and the recourse to old symbolic images are attempts to activate the power of mythical, holistic thinking and to make it fruitful for our time. But above all, the personal relational experience is processed in the work of art as if in a container. This connection can also be explained in terms of the Containing concept by Wilfred R. Bion (2016) and transferred to art. In this very broad understanding, works of art can also be reflected as containers: "A painter's landscape painting contains a wide variety of sensory and emotional impressions to which the artist was exposed while viewing the landscape.

The painting is the materialized result of the containing process" (Crepaldi, 2022, p. 13). It is created through a subjective process. Which is also triggered in the viewer, from which something new and unique then emerges and becomes a supporting, subjective reality. Ultimately, the researcher is also enmeshed with his or her prior cultural experiences, for interpretive research is an encounter and relational event, a profoundly sociocultural practice, Straub (2022, p. 134). Without my own engagement with the artistic object, I cannot participate in the experience. The result is creative ambiguity.

From the perspective of Gestalt psychology, Rudolf Arnheim explains that the organization of visual forms in the work of art always refers to

basic experiences of human existence. For Arnheim (1991, 106), true aesthetic experience is not limited to the passive reception of a work of art, but occurs in an active interplay between the artist's work and the viewer's reaction. Viewing a work of art or experiencing an art space support the verbalization of experiential content. A creative dynamic is encouraged. Working with creativity and symbols is empathic explaining rather than interpreting. The explanation should be accepted and understood by the client, it cannot be interpreted in the opposite direction of his current self-experience. At the same time, the symbol can say something not only about the current state and process of the self, but also describe past and present object (person) relations.

Practical example

In this sense, the artistic symbol serves as a representative self-object of one's own self-experience (Kohut, 1977). Franz Marc expressed in his animal paintings the relationship to nature. The beauty of a shattering world (Meyer-Büser, 2009), was captured on an intense, felt level by Franz Marc before World War 1 literally tore these experiences of nature apart with its cruelty. In a kind of "close-up," Franz Marc captured the pristine spiritual dimension of nature in his paintings. The freedom of art, the freedom of thought, the freedom of nature. In the symbol of the cat, these freedoms appear alive: The love for oneself, felt mindfulness, freedom. The work of an artist such as Franz Marc emerged in this language of color and form from an introspection. This psychic energy is conveyed to the viewer. Franz Marc's "white cat" (illustration) offers a projection surface for an introspection and for imaginations that ultimately stand for "self-respect". His magnificent paintings, which have an almost magical effect, and which express his own loneliness and how he deals with it, are particularly suitable for reflecting feelings. Depending on the degree of sensitivity of the viewer, a need for harmony seems to be in the foreground here, which becomes effective in the entire composition of the painting.

One Borderline patient reported anxiety, fatigue, and depression at the beginning of therapy. "I often feel a sense of deep sadness inside me". She often felt completely overwhelmed. After a hospital stay, she "started cutting again." "I cut my arm with a razor blade two to three times a week because I can't stand the pressure." The patient reports difficulties with her job and she has experienced "a lot of violence." Often, she would sit at home and not know what to do. The patient appeared physically and emotionally tense. Her mood was clearly depressed. There was difficulty in differentiating affects. A weakness of the ego could be assumed. There was a general structural weakness and narcissistic vulnerability. The disorder was associated with marked limitations in social functioning. Preferential defense: splitting, denial, affect isolation and impulse breakthrough alternate; dissociations by self-injuries; identification with the aggressor. In addition to a conflict- and structure-related etiology, the patient also had a currently effective trauma-related problem, which was made clear by the acutely pressing memories. Structurally, developmental deficits according to OPD were mainly in self-control (outbursts of rage, self-injury) and self-awareness. The old mode of regulation and defense of one's own affects seemed to fall away after the overload. Genetically, the present conflicts could be linked to a markedly unfavorable family development. The assumption was that the patient had not experienced any sufficient stable affective regulation of states of tension and positive mirroring in her early contact with her biological mother. Early violent assaults and the associated traumatic experience in relationships could be assumed. In the current conflict situation with the lack of demarcation from former partners and the family overload, her own strong aggressions, resulting from a felt injustice, which she had also felt in her early family experiences, were not allowed to be experienced appropriately and so she turned against her own self. Thus, only within the framework of her structural deficits, she has the possibility to direct the pressing deep feelings of guilt as well as unrestrained rage

punishingly against her own self or her body or to dissipate them by means of impulse breakthrough in an affectively immature way, so that it came to the described complex decompensation. It was important to establish a stable therapeutic relationship in an atmosphere of trust, security and appreciation. This first led to a relief, on the basis of which a slow approach to the trauma suffered and finally a trauma treatment could follow. Very dosed reanimations of the traumatic event with the help of special trauma-therapeutic techniques, which had the goal of her being able to endure the memories, helped her to increasingly strengthen her ego and to improve her control. In addition, a basic resource-oriented approach seemed to be indicated for the patient. As protection of the self, the narcissistic withdrawal tendencies and the strong defense against unconsciously affectively occupied material still needed to be respected in the long term. In addition to the basics of catathym-imaginative psychotrauma therapy (Steiner and Krippner 2006), I worked with the resource-oriented approach of positive psychotherapy and repeatedly offered art images in the course of therapy in order to achieve a stabilization of self-esteem in the patient through a symbolic experience. We were able to anchor her personal interest and preference for cats in the therapeutic work on Franz Marc "The White Cat" (Franzen, 2009). She stated that she had been searching for an "inner safe place" for a long time. She found it in the painting by Franz Marc. She could finally imagine what such a place must be like for her. "Yes, this white cat, it lies next to me, it purrs, I can stroke it, it calms me, I feel its warmth, feel protected by it, as it were, and completely safe." This then helped her to balance herself in everyday life so that she no longer hurt herself. The picture thus fulfilled a mirror and model function.



Fig. 1. Franz Marc 'The white cat' (cat on yellow cushion) 1912) Marc, Macke and Delaunay. Exhibition at the Sprengel Museum Hannover 2009 (reprint rights available)

Discussion

The function of the use of stories, which can also be related to the work with works of art,

found in Positive Psychotherapy (Peseschkian, 2002), can be determined as follows:

In the mirror function, identification occurs. Associations are reinforced. In the scenic/symbolic observation of the work of art

and the associated associations, of contradictory parts of movement, the unconscious meaning is experienced as it were. Exercises in the functioning of art and the content of the unconscious meaning offer receptive art-therapeutic procedures, since the introduction to psychological connections can of course also take place through a picture or a poem. It is important to understand the distinction between manifest and latent meaning, i.e. the external and unconscious sides, of the work of art. Pictorial representations let their contents appear closer to the self and thus facilitate the identification with them. Detached from the immeasurable world of experience, stories and images help to create a more distanced relationship to one's own conflicts.

3.1 Model function

As in the work with stories in Positive Psychotherapy, works of art offer a model function by making a symbolic experience possible. I know from many personal conversations with clients that the use of artistic media has a supportive effect and leads to an improvement in communication, that they enjoy working with it and find it enriching not only in the situation of the therapy interaction, but above all they take this inspiration with them into everyday life and look for forms of creative engagement themselves. There is an unfolding of the ability to communicate more freely with each other in the group, and that is significant. This then also leads to a structuring of everyday experience. I have noticed, for example, that especially with psychiatric clients, the sometimes-indiscriminate consumption of media was reduced and an engagement with cultural offerings took place. After several sessions, I encourage the participants to bring their own pictures, music, literature or films that describe their current situation and awaken memories. Initially, the picture then stands as an example of a possible change; it represents the motivation to develop new positive life plans.

Conclusion

Creative methods can be used to build, activate or revive inner resources (Kruse, 1997, p. 47). The effective factors of creativity lie, among other things, in the change of emotions, that is, the therapeutic access to the emotional world of an individual in order to help him/her to get to know his/her feelings better, to make

blocked areas of feeling accessible again and to express him/herself emotionally (Kruse, 1997, p. 32). Art is an essential component of a personality and identity development in this process of shaping our relationship and the associated development of perception (cf. Sel, 2010, p. 69, Richter-Reichenbach 2011, p. 42). Thus, the artistic subject has molded, represented, inscribed his relational experience in his work of art, which the viewing subject can feel, relive, and read (cf. Engelhardt 2021, p. 14). It comes to a relational event, whereby designed and art are from the outset not the outflow of a subject simply standing for itself, "but testimony to an interaction, a communication: an interrelationship of this subject in its confrontation with someone standing beyond the I" (Schneider, 2017, 285).

The primary goal here is to broaden the patient's perspectives, which predominantly relate to the implementation and goal of a traditional psychotherapeutic concept. The view and the cognition of the patient as well as of the therapist shall thus be directed beyond the defined horizon of the actual area of mental suffering to additional, though external, but nevertheless crucial aspects" (Schurian, 2009).

Art can comfort and accompany, can take on an important function in life crises, encouraging, representing experiences and feelings. The work with visual art in psychotherapy contributes to stabilizing the meaning and value systems of the patients, promotes the ability to communicate and is a contribution to the structuring of everyday life. In this sense, Positive Psychotherapy has revived the cultural tradition of literary or artistic lore and endowed it with a garb from depth psychology.

The processes within Positive Psychotherapy are more complex from a psychodynamic point of view, as they are usually integrated into a guideline psychotherapy and oriented towards a psychoanalytically based procedure (depth psychology, psychoanalysis). Both Positive Psychotherapy and Art Therapy work with symbols and the symbolic level is of outstanding importance. Only the spiritual energetic content enables the symbol to function as a spiritual carrier of meaning and to be used in the conscious appropriation of reality (Hampe 1999, p.62). For the art therapist Ruth Hampe, the activation of inner images is essential for the aesthetic process (Hampe, 2009, p. 180). Through the activation of inner images, access to

self-experience can be stimulated and processed within the framework of a symbol drama. The aesthetic transformation as an inner-psychic processing process in the representation of inner images thus becomes a resource and resilience factor (cf. Hampe 2009,181). This resource-oriented approach is found as a highlighted focus in art therapy. The clearest distinction between art therapy and positive psychotherapy lies in the active process of shaping. From the beginning, the shaping of the relationship leads through an art object. This is where art therapy differs from Positive Psychotherapy. While art therapy is on its way to learn from the depth dimension, the understanding of symbols and relationship design of Positive Psychotherapy for its own therapeutic work, a stronger integration of art therapy into the theory and practice of Positive Psychotherapy could be beneficial. This refers to overlaps and additions that maintain the autonomy of both art therapy and positive psychotherapy. Nevertheless, both methods can benefit from each other.

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Section: Psychotherapeutic work during wartime

EXISTENTIAL ASPECTS OF POSITIVE PSYCHOTHERAPY: ANSWERS TO THE CHALLENGES OF WARTIME



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Received 02.04.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj204](https://doi.org/10.52982/lkj204)

Abstract

The article presents the author's perspective on various levels of psychological assistance that can be provided in crisis situations. The focus is primarily on the highest level of assistance, which is existential therapy. Within the context of existential therapy, the author emphasizes the importance of addressing existential aspects of positive psychotherapy.

Furthermore, the article proposes a new concept of "actual capacities" as a type of existential activity. These actual capacities are selected based on four existential conflicts identified by I. Yalom, and they help individuals to confront these conflicts without resorting to neurotic defenses. In this way, actual capacities serve as existential activities, contributing to healthier responses to the challenges of existence. By developing actual capacities as existential activities, individuals may be better equipped to cope with the givens of existence.

Keywords: positive psychotherapy, existential therapy, actual capacities, crisis situations, existential activities

Introduction

The war in Ukraine, which began on 24th of February 2022 with a large-scale invasion by the Russian Federation, has affected, to varying degrees, not only every citizen of Ukraine but also the international democratic community. The war as a macro-event and stressor is probably the first in the ranking of traumatic events. Thus, psychological assistance to the general population is becoming very important.

Having stabilized myself emotionally through volunteer work (processing through activities), I began to conduct self-help groups consisting of my colleagues and individual therapy clients. Initially, it was an emotional response to macro- and micro-events related to the war, mutual support and emotional stabilization in the group (processing through contacts). Over time, there was a need to rethink the events, to find personal meanings and one's role in the

situation. Existential questions of life and death, freedom and responsibility, justice, humanity, etc. began to surface. This confirmed my vision of the levels of psychological assistance in crisis situations. First – crisis interventions for emotional stabilization, then – crisis counseling, which requires responding to and rethinking traumatic events, finding their positive functions, and using them for personal growth. And this is a bridge to the third level of psychological assistance – the spiritual level of perception of traumatic events, taking a personal position on them, facing existential data and conflicts (existential psychotherapy).

Methodology

As a positive psychotherapist, I see the great potential of positive and transcultural psychotherapy in existential topics. In this work, I consider the main task to be the integration of the concepts of existential psychotherapy with

the concepts of positive psychotherapy of N. Peseschkian and the latest concepts of his followers in this topic.

The hypothesis of the study is that existential conflicts arising from human confrontation with such existential givens as death, isolation, freedom, and meaninglessness (Yalom, 2008) are universal, permanent, human basic conflicts that are not realized in everyday life due to neurotic defenses. Crisis states can violate these defenses and bring existential conflicts from the subconscious to the surface ("Sleeping Dogs Wake Up"). Now a person has a choice – to strengthen defenses or to face these situations directly. Such a meeting requires a special kind of inner activity – existential activity.

The concept of existential activities was proposed by Y. Kravchenko in his article "My Existential Health: The First Three Letters," which was not published but is cited by S. Fursova-Vine in a historical review of the development of the existential component of positive psychotherapy (Fursova-Vine, 2017). He defines existential activities as healthy ways of reacting to the given of being (existential given) (Kravchenko, 2016). And these are not so much actions and deeds as the ability to live the encounter with existential given in the most adequate way.

In positive psychotherapy, the concept of predetermined fate (what we cannot change) corresponds to existential data (Peseschkian, 2016). When faced with predetermined fate, a person develops certain actual capacities that allow him or her to rise above the situation, realize the existential conflict and withstand its tension while maintaining his or her integrity. Such actual capacities are existential activities, i.e., they are capacities that allow one to withstand the tension of existential conflicts without using neurotic defenses.

Discussion

Let us consider four well-known existential conflicts and try to find relevant capacities that can act as existential activities adequate to these conflicts.

The first conflict in the model pertains to the Life-Death conflict, which refers to an individual's confrontation with the finitude of their existence. This conflict is situated in the realm of the "I" according to the model. The article examines the actual capacities that can

help individuals mitigate this confrontation and make the conflict more bearable. I. Yalom's existential concept underscores the interconnection of life and death, which exist simultaneously and not sequentially. Death has a profound impact on our experience and behavior, continuously penetrating the boundaries of life. (Yalom, 2008).

Life and Death are connected by time. Synonyms and associations of time – instant, moment, eternity, timeliness, transience, simultaneity, duration – are closely related to the concepts of Life and Death. Time unites life and death and allows us to see this conflict in perspective. People who have experienced near-death experiences have a sense of the transience of life and the value of the moment. One of N. Peseschkian's favorite sayings: "We cannot add days to our lives, but we can add life to each of the days."

It is logical to assume that the actual capacity of **time** appears in this conflict as an existential activity.

The next actual capacity that can perform the function of existential activity in the Life-Death conflict is patience, **patience** as the capacity to withstand and accept life and to wait patiently for one's death. "To be able to withstand life", "to be able to be" is the first fundamental existential motivation according to A. Lengle (Lengle, 2001).

One can see the relationship between the formation of self-concept and the attitude to life and death. The actual capacity that forms unconditional self-acceptance (self-worth) are time, patience, and a model. Unconditional acceptance of life and death is also related to **patience** and **time**. A person who has received a sufficient amount of love in the form of quality time and a patient attitude is able to cope more easily with the conflict between Life and Death. According to I. Yalom, the anxiety of death is inversely proportional to the satisfaction with life (Yalom I., 2008). And this provides an important support for psychotherapeutic practice. Helping a client to cope with death anxiety means teaching him or her to enjoy life more.

The next existential conflict we will consider is the Isolation – Intimacy conflict. Existential isolation is the flip side of our uniqueness. The confrontation with death will inevitably lead an individual to experience isolation and loneliness ("We come into this world alone and leave it

alone"). There is no lonelier human experience than the experience of dying. To the extent that a person is responsible for his or her own life, he or she is alone. Responsibility implies authorship, and to realize one's authorship means to give up the belief that there is someone else who creates and protects you." (Yalom, 2008).

Obviously, from the point of view of positive psychotherapy, this existential conflict belongs to the sphere of "You". Like any existential conflict, it is fundamentally insoluble, but it can be mitigated by certain actual capacities, which will be existential activities in relation to it. What actual capacities can fulfill this function?

Erich Fromm believed that isolation is the primary source of anxiety and emphasized the feeling of helplessness that accompanies the fundamental disconnection of the human being (Fromm, 2019).

The fear of existential isolation is the driving force behind interpersonal relationships. The problem of relationships is the problem of fusion-isolation. A person must separate himself from another to experience isolation: a person must be alone to experience loneliness. However, it is precisely the encounter with loneliness that makes it possible for a person to become deeply and consciously involved in another. Martin Buber believed that the desire for relationships is "innate," given from the beginning. A child has an impulse to contact with another being, initially tactile, and then "optimal" (Yalom, 2019).

The positive vision of the human being in positive psychotherapy similarly testifies to the innate capacity for love.

Thus, the existential activities that are the connecting link in the Isolation - Intimacy conflict may be the actual capacities of **contact** and **love**. Love does not cancel our separation, which can be accepted without fear but cannot be eliminated. Love is the best way to deal with the pain of separation. But not all forms of love can mitigate this conflict. Buber, Maslow, and Fromm came up with similar formulations of "self-sufficient love". Fromm distinguished symbiotic fusion from "mature" love (Fromm E., 2018).

And these ideas are very important for a psychotherapist. In order to help a client cope with the fear of loneliness, not at the expense of symbiotic relationships, it is important to develop his or her ability to love from the childish need (to receive love) to adult "mature" love,

capable of giving. And yet, one of the fundamental facts that the client has to discover in therapy is that although contact, love, and encounter with the other can mitigate existential isolation, it cannot cancel it.

To separate oneself from others is also to feel one's autonomy, independence, and ability to choose. And here we encounter the next existential given – Freedom and its concomitant Responsibility. Freedom and Responsibility imply the authorship of one's life and destiny, depriving us of support in the outside world and expectations of transferring responsibility for our lives to others. The realization of the fact of our own construction of ourselves and the world and our own responsibility is seriously frightening. Many existential philosophers have described it as an anxiety of lack of ground, as a "pre-anxiety" - the most fundamental of all, penetrating even deeper than the anxiety of death. We avoid situations that could lead us to realize the fundamental lack of ground. We look for structure, authority, grandiose projects, magic-something bigger than ourselves. E. Fromm in "Escape from Freedom" says that even a tyrant is better than the complete absence of a leader (Fromm, 2005).

The poles of this existential conflict are Freedom and Responsibility on the one hand, and Belonging as an opportunity to be part of something bigger, which allows you to share responsibility, to feel the structure, i.e. the soil, on the other hand. This conflict can be attributed to the sphere of "We", considering "We", according to N. Peseschkian's "circles" from the family to humanity or even to the Universe. This conflict can be mitigated by the actual capacity to **trust**, as the capacity to rely on oneself and the world, to trust others and share responsibility with them, as well as the capacity to **unity (integrity)** of the individual and **unity** with others and the world. In fact, this is the realization of N. Peseschkian's transcultural principle of "unity in diversity." It is important to distinguish such unity from dependence, which can be realized in various defense mechanisms related to the anxiety of freedom and responsibility. Most of these defenses are manifested either in underdeveloped trust and the need for control, or in naive gullibility and dependence on authority. And the goal of therapy will be to harmonize this actual capacity. And only then will it fulfill the function of existential activity. The next existential conflict

we will focus on is the conflict of Meaninglessness - Meaning. Viktor Frankl argued that twenty percent of neuroses are of "noogenic" origin, i.e., they arise from the lack of meaning in life (Frankl, 2006).

The questions of the meaning of life, values, ideals, attitude to something bigger than the person himself, beyond his life, belong to the sphere of "Primal-We". The problem of meaning consists of two irreconcilably opposite truths: a person needs meaning, the absence of meaning, goals, values and ideals in life causes significant suffering; however, the existential concept of freedom states that the only truly absolute fact is the absence of absolutes, there is no "meaning", no great plan of the universe, no guiding life orientations, except those created by the individual. The problem is to find one's individual meaning in a world that has no common meaning.

Much has been written about the realization of individual meaning by V. Frankl. He believed that the path to meaning lies through the realization of values and identified three groups of values - the values of creation, the values of experience, and the values of relation (attitude). C. Rogers (1961) and A. Maslow (1962) saw the source of personal meaning in self-actualization. The idea of self-actualization is also present in positive psychotherapy. At the same time, it also contains the idea of self-improvement as an extension of identity. In the course of an individual life cycle, there is a gradual evolution

of meanings. This confirms Erik Erikson's theory of the life cycle and tasks at different life stages. And here we can refer to V. Karikash's concept of the "Five Peaks of Destiny" and five existential identities (Karikash, 2009), which develops the existential aspects of positive psychotherapy and is in line with these ideas.

H. Peseschkian emphasized two main ways of gaining meaning: gaining general meaning (religion) and searching for individual meaning (science, psychotherapy). However, even the search for individual meaning is not comprehended rationally, but through faith and the pursuit of ideals.

Thus, in this existential conflict, such actual capacities as **faith** and **ideal** come to the fore as existential activities.

Faith as an existential activity is the capacity to enter into a relationship with the unknown and unknowable, the capacity to be open to life and the world and thus to be "touched by life," i.e. to live existentially.

Conclusions

In summary, the Table 1 depicts the four existential conflicts proposed by I. Yalom, along with their correlation with the domains of relationships (i.e., role models) in the PPT framework. Moreover, the relevant capacities that function as existential activities with respect to these conflicts are identified.

Table 1. Existential conflicts and actual capacities (AC) as existential activities

Relationship's sphere	Existential conflict	AC as existential activities	Motivating mottos
I	Life-Death	Time Patience	"We can't add days to our lives, but we can add life to every day."
You	Isolation-Intimacy	Contact Love/ acceptance	"It's a pleasure to be with you, but it's a pleasure to be without you"
We	Freedom and Responsibility - Belonging and sharing of responsibility	Trust Unity	"Unity in Diversity"
Primary-We	Meaninglessness Meaning	Faith Ideal	"According to your faith it will be given to you"

The author's conclusions regarding actual capacities as existential activities are drawn from

their personal psychotherapeutic experience and review of relevant literature. Although the

author acknowledges the potential limitations of their conclusions in terms of reliability and objectivity, they suggest that their findings could serve as a basis for further exploration in the area of actual capacities as existential activities.

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Section: Psychotherapeutic work during wartime

ФЕНОМЕНОЛОГІЧНІ АСПЕКТИ ПСИХОТЕРАПЕВТИЧНОЇ РОБОТИ ІЗ АКТУАЛЬНОЮ ЗДІБНІСТЮ «НАДІЯ» У ЧАСІ ВІЙНИ

Phenomenological Aspects of Psychotherapeutic Work with the Actual Ability of "Hope" in Wartime



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Received 28.04.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/ikj205](https://doi.org/10.52982/ikj205)

Анотація

В час динамічного та непередбачуваного характеру війни, психотерапевтичний процес зазнає великих викликів та потребує особливо пильної уваги до первинної актуальної здібності надія. У статті представлено опис, спостереження та перспективи психотерапевтичної роботи із дослідження та активації надії, робота із клієнтом у цій темі за п'ятикроковою моделлю Пезешкіана. Також акцентовано важливість самоспостереження психотерапевта та його потенційна роль як зразка для наслідування.

Ключові слова: макроподія, війна, п'ятикрокова модель Пезешкіана, надія, позитивна психотерапія

Abstract

In the time of dynamic and unpredictable nature of war, the psychotherapeutic process faces great challenges and requires particularly close attention to the primary actual capacity of hope. The article presents a description, observations, and perspectives of psychotherapeutic work on exploring and activating hope, working with a client on this topic using a five-step model. The importance of psychotherapist's self-observation and his potential role as a role model is also emphasized.

Keywords: macro-event, war, Peseschkian's five-step model, hope, positive psychotherapy

*Так! Я буду крізь сльози сміятись,
Серед лиха співати пісні,
Без надії таки сподіватись,
Буду жити! Геть думи сумні!
- Леся Українка (1890р.)*

Вступ

Проживаючи останній рік у часі війни та спостерігаючи безпрецедентний процес інформаційної включеності усієї громадськості у її контекст, незалежно від

місця проживання у світі, маємо виклики і як люди, і як психотерапевти втримувати свій емоційний стан та бути доброю опорою для себе, наших рідних та клієнтів. Доволі непросто реалізувати це завдання безпосередньо перебуваючи у процесі екзистенції великої макроподії, що триває і немає передбачуваного завершення ні у часі, ні в остаточному результаті. Ми можемо активізувати у собі та спонукати до активізації в інших зокрема таких актуальних здібностей

як терпіння, єдність, впевненість у здібностях, досягненнях, віри, надії та ін..

В даній роботі зосереджено увагу та пропонується широко розглянути феномен первинної актуальної здібності (далі у тексті АЗ) надія у психотерапевтичній взаємодії. Оскільки надія є однією із базових принципів на який у своїй роботі опираються ППТ терапевти, важливо тримати у фокусі власний стан цієї АЗ та рефлексувати про загальні настрої у суспільстві, відслідковуючи можливості впливу свого стану на стан клієнта під час консультування та психотерапії. Під час війни важливо досліджувати концепції клієнта щодо надії, незалежно від запиту, аби продуктивно сприяти втримуванню балансу між реальністю та бажаним майбутнім, без западання у наївний оптимізм, що може бути потенційно шкідливим та, навіть, ризиковим для життя. З іншого боку, зберігаючи ідею позитуму, мусимо брати до уваги й потенційну травматизацію від втримування непередбачуваності майбутнього із щоденними об'єктивними ризиками та втратами, що загрожує емоційним виснаженням та ураженням усіх сфер життя.

Обговорення

Міркування щодо феномену надії беруть свій початок із філософських трактатів та релігійних концептів багатьох вірувань. Ось як, маючи цілісний погляд на реальність, говорить про це Сенека у «Моральних листах до Луцилія»: «Скільки-то трапляється такого, на що ми ніколи й не сподівалися! Скільки сподіваного так і не збулося! ...сама лиха доля не може похвалитися постійністю. Біда, кажу, може прийти, а може й не прийти; а поки її нема, розраховуй на краще. ...надією вгамуй страх...» (Сенека, 1999). Християнство виокремлює надію, як чесноту та застерігає від двох гріхів проти надії: її надміру та безнадії. Надалі надія, як емоційний стан та реакція, продовжила бути предметом дослідження й для багатьох психологів. Важливо зазначити, що опираючись на власний життєвий досвід збереження надії та сенсу життя у нелюдських умовах концтабору В. Франкл теоретично опрацював ці ідеї та втілював їх у психотерапевтичному напрямку – логотерапії. Він зазначає: «Людина не може існувати без опори в майбутньому. У нормальних умовах усе сьогодення

ґрунтується довкола майбутнього, притягується до нього, як металева стружка – до полюсів магніту» (Франкл, 2016). Відтак, надія стає тим, що обіцяє людині настання майбутнього, а сенс та мета додають сил витримати теперішнє. Також серед психологів-дослідників варта виділити роботи К. Р. Снайдера (Snyder, 2000), в яких уже окрім концепту долі та фатуму включено й власні здібності людини. Він так визначає надію: «Це віра в те, що у вас є як бажання, так і засоби досягати своїх цілей, якими б вони не були» (цит. у Гоулман, 2020).

У класичній Позитивній психотерапії Н. Пезешкіан неодноразово наголошує на важливості збереження ідеї, згідно якої людині притаманні різноманітні здібності, можливості та шанси, які вона сама або з допомогою своїх рідних та/чи психотерапевта може розвинути, розкрити чи активізувати. І у фразу, «Я не можу цього зробити!», яка часто є ригідним переконанням, він пропонує додати всього лишень одне слово, що додає перспективи: «Я *поки* не можу цього зробити!» (Корнбихлер, 2015)

У великому академічному тлумачному словнику української мови слово «надія» визначається як впевненість у можливості здійснення чогось бажаного, потрібного, приємного; сподівання (Бусол, 2005) і походить від слов'янського слова «над» - вживається при позначенні предметів, осіб вище яких відбувається дія. Отож, це те, що передує дії.

Феномен даної первинної актуальної здібності, її природа, умови формування та способи розвитку продовжує цікавити вчених, дослідників та філософів. Із сучасних зарубіжних авторів можна зазначити роботи вже вищезгаданого К. Снайдера (Snyder, 2000), а також Е. Скіолі та Г. Біллер (Scioli, Biller, 2010); українських – Т. Титаренко (Титаренко, 2005).

Методологія

Основна мета роботи – спроба осмислити феномен надії як важливі, а іноді й основної опори у психотерапевтичній роботі в час повномасштабної війни. Станом на сьогодні в Україні і терапевт, і клієнт є ураженими щоденним екзистенційним викликом близькості смерті як великої фігури із сфери сенсів; невідворотністю втрат різної глибини у

будь-якій чи в усіх чотирьох сферах за балансною моделлю та активацією великої кількості актуальних, внутрішніх та базового конфліктів. Вперше ми проживаємо унікальний досвід війни, який радикально відрізняється від досвіду локальних конфліктів та навіть досвіду Другої Світової війни і маємо справу, з одного боку, із новим способом ведення бойових дій агресором (терористичні ракетні атаки на цивільне населення по усій території України, екоцид, інформаційно-психологічні операції та ін.), з іншого – із гарним розвитком, доступністю та масовістю психотерапевтичної допомоги, яка надається в умовах реального часу. Отож, опираючись на роботи із дослідження феномену надії та масив напрацювань зарубіжних та вітчизняних авторів до початку повномасштабного вторгнення, основним методом дослідження у даній роботі виведено спостереження за терапевтичним процесом, а також самодослідження та саморефлексія терапевтом у даній тематиці.

Основна частина

Надія – це внутрішнє відчуття бажаного майбутнього з опорою на власні АЗ та позитивний попередній досвід взаємодії зі світом та важливими людьми. Коли ми працюємо у психотерапевтичному процесі із клієнтами, що мають складні екзистенційні питання, то опираємось на надію, що наші компетентності як психотерапевтів, отримані в процесі навчання та клінічного досвіду, стануть у нагоді конкретно цій особі, а дослідження та розвиток її АЗ допоможуть їх вирішити. Так це чи ні – відповідь у майбутньому, але потенціал для цього у минулому та теперішньому. В процесі розвитку та виховання дитина отримує підтвердження своїм надіям. Будемо стояти на тому, що кожен із нас має бодай мінімальний рівень розвитку цієї АЗ через отримання позитивного підкріплення від самого життя – темрява та тиск пологового процесу, який неможливо опрацювати у той момент когнітивно, лиш емоційно відчуті, завершується світлом та лагідними обіймами рук, що приймають нас у великому світі. Якщо людині щастить, то вона отримує й подальший досвід допомоги у складних ситуаціях, який Дж. Боулбі визначає як необхідну умову для формування *надійної*

прив'язаності (Бріш, 2012). Якщо ж особа у процесі зростання та виховання (базовий конфлікт) отримувала велику кількість розчарувань та фрустрації і «її ніколи не навчали, що з будь-якої складної ситуації можна знайти вихід, то така людина буде схильна до безнадії» (Peseschkian, 2016).

АЗ надія представлена у ДАО (Диференціально аналітичний опитувальник) двома крайніми точками: у надлишковому розвитку цієї здібності – як надмірна обнадійливість/наївний оптимізм, який характеризується нереалістичним поглядом на власні можливості, інших людей чи очікувань до світу; у дефіциті – як безнадія, що може виражатися симптоматично, як втрата сенсу та мети життя, розчаруванням у собі та інших людях. Опираючись на збір інформації під час первинного інтерв'ю, а також досліджуючи макроподії та базові концепції за моделлю наслідування, можемо мати повноту картини та вийти на сталі концепції клієнта, що трансюють його переконання про надію. Таким чином, на перших двох стадіях п'ятикрокової моделі у Позитивній психотерапії (Peseschkian, 2026), дистанціюванні та інвентаризації, ми знайомимось із минулим та теперішнім нашого клієнта, а також із власними контрпереносними переживаннями у відповідь на його історію. Метафорично можемо означити цей процес як «пошук надії».

На стадіях ситуативного підбадьорення та вербалізації психотерапевт займає більш активну позицію та інтервенціями може підсвічувати клієнту те, що поки останній сам не помічає: сильні потентні АЗ або ж, реінтерпретуючи попередній досвід, включає у нього «сліпі» зони, де було місце для підкріпленої надії, але обмежуючі концепції не дали змоги їх зауважити. Також тут важливо зазначити, що сам терапевтичний стосунок в цілому, а не лише цей окремий етап, є тим добрим полем для отримання нового досвіду надії. Рамки та психотерапевтичний контракт, у межах якого спеціаліст залишається передбачуваним та раз по раз виправдовує очікування на зустріч, а також психотерапевтичний контакт, що базується на принципі не осудливого прийняття та вірі психотерапевта у безумовну цінність та можливості клієнта – це необхідні умови для розвитку цієї АЗ. Надійність

терапевта також визначається і його здатністю дотримуватися етичних принципів роботи. Зокрема, найважливішими в даному контексті будуть конфіденційність та відсутність зловживань стосовно клієнта. Метафорично дамо назву цьому процесу як «відновлення/відродження надії».

Стадія розширення цілей покликана не лише для розуміння як по-іншому можна обходитися із актуальним конфліктом, але й дозволяє зафіксувати нові, раніше недоступні або ж невідомі емоційні стани та переживання. Відновлена надія дозволяє розширити поле зору і на вирішення проблеми, а також і на ті АЗ з допомогою яких це можна зробити. Новий погляд на себе, на інших, на світ – більш чесний та реалістичний, з одного боку, і більш варіативний, з іншого, дозволяє клієнту допустити існування різних сценаріїв майбутнього. Вихід за межі звичних поглядів та поведінкових реагувань додає гнучкості та залучає уяву у проєктування власних дій. Слова вцілілої у таборі смерті психологині Едіт Егер здатні проілюструвати цей процес трансформації концепції на практиці: «Мамині слова «добре, що в тебе є мізки, бо з вродою тобі не пощастило» лише розпалювали мій страх, що я неповноцінна, нікчемна. В Аушвіці мамин голос у моїй голові набув іншої виразності. *У мене є мізки. Я розумна. Я з усім впораюся.* Слова, що лунали в моїй голові, сприяли здатності зберігати надію» (Егер, 2022). Знаючи та підкріплюючи нові когнітивні та емоційні конструкти, а також порівнюючи як було і як є зараз, можемо спонукати клієнта самостійно керувати власним станом попри складні обставини у його житті. Метафорична назва для даного етапу «втримування та збереження надії».

Висновки

Повертаючись до контексту у якому українські психотерапевти перебувають станом на лютий 2023 року, а також розуміючи професійні виклики після завершення війни (коли б це не відбулось) усвідомлюємо, що матимемо справу із пулом клієнтів, що унаслідок макроподій останніх років мають/матимуть ураження АЗ надія. Вбачаю тут особливу і унікальну задачу для українських психотерапевтів, залишаючись у професійній ролі, зберігати надію бути

якісними спеціалістами не випадаючи із реальності і чітко усвідомлюючи власні реагування на виклики війни. На симпозіумі з етики від спільного проєкту УСП та ЄАП, що відбувся у роковини початку війни 24.02.2023р. і мав назву «Етичні виклики для психотерапевтів у нашому мінливому світі», пролунала теза одного із колег про те, що «ми усі зараз психологи у «концтаборі» і саме це, вважаю, повинно братися нами до уваги перед тим, як зустріти клієнта у своєму кабінеті (налаштування та моніторинг свого стану), під час роботи із ним (відслідковування контрпереносу), та після того як він піде (рефлексуючи над процес-аналізом). Піклування про себе та самодопомога покликана на втримування та збереження власної надії, що може стати й добрим зразком для наслідування іншими людьми.

Завершити свої роздуми хочу цитатою мовою оригіналу із роботи Д-р. Степана Балея «З психології творчості Шевченка» як прикладом того, що паростки ідей великих фігур із колективного Пра-Ми формують ставлення та закладають ґрунт для концепцій, що можуть перебувати у несвідомому полі усього народу і впливати на реальність, а також як добрий приклад саморегуляції та відновлення емоційного стану перебуваючи в обставинах обмеженої волі: «Є в дневнику Шевченка інтересне місце, де він веде полеміку з Гете на тему значіння надії для чоловіка. Поетові розходить ся о слідуєчу річ. Сам він сидить у кріпості, а мріється йому стріча з людьми «милими його серцю», мріється побут в академії штук і в петербурзькій опері. Щось наче надія на те все знімається в його душі. Та тут же зараз підноситься внутрішній голос і стає дорікати йому, що він забавляється вигадками не основаними на нічім і тиснуть ся йому в душу Гетові слова «що надією живуть нікчемні душі»... Річ інтересна: надіятися «на сліпо», се в почуванні Шевченка, не як дехто думав би, нерозумно, лиш – нікчемно. І щоби оправдати себе перед собою за проґрішеніє хвилиною надійної злуди, поет уважає доконечним переводити аж таку довгу аргументацію вговорюючи в себе, що і матеріялісти надіються, а з другого, що він став би атеїстом, не маючи надії.» (Балей, 1916)

Бо навіть у час, коли світло надії тьмяніє чи гасне, у наших серцях залишається місце для віри.

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Section: Special articles

MICROAGGRESSIONS AS A SYMPTOM: UNDERSTANDING AND ADDRESSING SUBTLE HOSTILITY IN POSITIVE PSYCHOTHERAPY



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Received 09.05.2023
Accepted for publication 15.06.2023
Published 01.07.2023
DOI: [10.52982/lkj206](https://doi.org/10.52982/lkj206)

Abstract

This article examines the history, complexity, and psychotherapeutic approaches to microaggressions, everyday verbal, nonverbal, or environmental slights that convey hostile messages to marginalised individuals. The concept traces back to the works of Derald Wing Sue, with microaggressions often related to discrimination, stereotypes, and prejudices, causing psychological harm. The Positive Psychotherapy (PPT) approach uniquely addresses microaggressions by transforming negative experiences into opportunities for personal development. The article further delves into the interconnectedness of aggression and microaggressions in contemporary society, highlighting the influence of power dynamics, capitalism, and critical social theories. Methodological recommendations and mindfulness-based interventions are also discussed, emphasising self-awareness, non-judgmental acceptance, emotional regulation, empathy, and cognitive flexibility. Addressing microaggressions necessitates a collaborative effort to promote understanding, empathy, and respect for diversity and difference in all aspects of life.

Keywords: microaggressions, positive psychotherapy, aggression, social justice, cultural competence

Introduction

Microaggressions, subtle and unintentional slights, are a significant concern in psychotherapy, impacting marginalized groups significantly. These slights, often borne from discrimination or prejudice, have deep psychological and social roots, but also serve as an adaptive mechanism in a society discouraging overt aggression. While integrating perspectives from various psychotherapeutic schools, this paper focuses on elucidating the intricate nature of microaggressions and proposes specific strategies from Positive Psychotherapy to manage and mitigate their impact.

Methodology

Our methodology, grounded in comprehensive literature review, drew from seminal theories of aggression and power

dynamics (Freud (in Read, 1934); Lorenz, 1966.; Foucault, 1990; Fisher, 2009; Lindsay & Pluckrose, 2020). Positive Psychotherapy (Peseschkian, 1987) and its transformative approach were central to our discussion, alongside mindfulness-based interventions renowned for enhancing self-awareness and emotional regulation. We also considered multicultural psychotherapy approaches (Pedersen, 2000) and the importance of therapists' self-reflection (Norcross & Guy, 2007) to avoid unconscious biases and potential microaggressions. The influence of microaggressions on mental health, as outlined by Sue (2010, 2016, 2022), Constantine (2007), Nadal et al. (2010, 2014) and Kaplan (2014), provided key insights. This methodology aimed to interweave these diverse perspectives to offer a nuanced understanding of microaggressions in psychotherapy.

Discussion

In recent decades, microaggressions in psychotherapy has become a pressing issue. Theoretical studies of microaggressions in psychotherapy can be traced back to the works of Derald Wing Sue and his colleagues (Sue et al., 2007), who developed a classification system for different types of microaggressions:

"Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership."

In the context of psychotherapeutic approaches, microaggressions can be defined as implicit, indirect, or unintentional expressions of aggression, which often manifest in everyday interpersonal interactions (Sue et al., 2007). Microaggressions may be related to discrimination, stereotypes, or prejudices, and can cause significant psychological harm to marginalised groups (Nadal et al., 2014).

Microaggressions can also be considered as symptoms of deeper psychological and social processes, as well as a means of adaptation to a situation where aggression is increasingly prohibited in modern society (Kaplan, 2014). In conditions of suppressing open aggression, microaggressions can serve as an indirect means of expressing negative feelings and, more importantly, indicating existing needs of the individual.

Various psychotherapeutic schools have their approaches to working with aggression. For example, Freudian psychoanalysis and Konrad Lorenz's theory consider aggression as a fundamental instinct that can be sublimated or processed by the psyche. Nossrat Peseschkian's positive psychotherapy emphasizes the importance of transforming negative emotions, such as aggression, into positive qualities and resources for personal development. Peseschkian argues that it can be transformed into a positive force for self-development and personal growth. In this way, PPT (positive psychotherapy) approach provides a unique perspective on working with aggression and microaggression in the therapeutic context.

3.1. Why microaggressions is not about small things, but about complex things

The works of Freud (2018) and Lorenz (1966) provide a foundational understanding of aggression as an instinctual and powerful force in human nature. Freud proposed the concept of two opposing instincts: the life instinct (Eros) and the death instinct (Thanatos). According to Freud (in Read, 1934), aggression is an integral part of human nature, and it can be directed outward (towards other people) or inward (towards oneself) in the form of guilt, masochism, or depression. Lorenz similarly viewed aggression as an innate and instinctual force in animals and humans, which can be channeled into productive or destructive behaviors.

Aggression and microaggressions are interconnected, and understanding their relationship are crucial in addressing both. The modern world order has created conditions that suppress open aggression, leading to the rise of subtle and implicit forms of aggression such as microaggressions. Cancel culture and the increasing demand for conformity have created a climate of resentment and hostility, further fueling the prevalence of microaggressions.

The works of Foucault, Fisher, and Lindsay provide insight into the underlying processes that contribute to the prevalence of microaggressions in contemporary society. Foucault's analysis of power and biopolitics highlights how power dynamics shape social interactions and contribute to the creation and maintenance of inequality. This framework can be used to understand how subtle forms of aggression, such as microaggressions, emerge because of uneven power structures and the desire to maintain control over others.

Mark Fisher's "Capitalist Realism" argues that capitalism has become the dominant cultural, economic, and political system, leading to a sense of inevitability and resignation among individuals. In this context, microaggressions can be seen as a symptom of the alienation and dissatisfaction that result from living within a capitalist society that perpetuates inequality and fosters competition.

James Lindsay's "Cynical Theories" critiques the highly politicized ideas that have emerged from critical social theories, arguing that they contribute to division and conflict within society. These theories often emphasize systemic oppression and inequality, which can lead to an

increased focus on microaggressions as a manifestation of these issues. In this way, microaggressions can be understood as both a product of and a mechanism for perpetuating the social divisions highlighted by these theories.

3.2. Positive Psychotherapy and Microaggressions

Positive Psychotherapy (PPT) focuses on exploring the positive aspects of a person's personality and experience, emphasizing their potential for self-healing and growth. In the context of working with microaggressions, PPT provides a unique perspective that can help individuals transform negative experiences into opportunities for personal development.

As Nossrat Peseschkian once said: "Aggression is the instinct that drives us towards success and development, but it can also be the root of all destruction." (Peseschkian, 1987).

PPT views aggression as a force that can be sublimated and transformed into a positive resource for personal development. This approach emphasizes the importance of developing skills to control and direct aggressive impulses in a positive direction. According to PPT, this can be achieved through several methods, including developing assertiveness, learning to communicate effectively, and practicing empathy and understanding.

In PPT, the therapist aims to help the client to identify and work with their strengths and potential for growth rather than just focusing on their problems and deficits. This approach enables individuals to develop a positive self-image and focus on their potential for change and development, leading to greater resilience and adaptability to life's challenges.

Working with microaggressions in PPT involves specific techniques such as appreciative inquiry to reframe the microaggression experience, focusing on inherent strengths to develop resilience, and fostering positive interpersonal relationships to dilute the negative effects of microaggressions. These steps help individuals to develop a positive outlook on the experience, identify opportunities for personal growth and development, and enhance their psychological fortitude.

For example, if a person experiences a microaggression related to their race or ethnicity, the PPT approach would involve exploring how this experience can help them better understand their cultural identity and

what positive resources and strengths can be derived from it.

The PPT approach to microaggressions also emphasizes the importance of developing positive communication skills, including assertiveness, empathy, and active listening. These skills can help individuals effectively express their needs and boundaries while also understanding and respecting the perspectives of others.

3.3. Strategic Guidelines for Addressing Microaggressions

Numerous methodologies can be employed in psychotherapy to address microaggressions:

Detecting and acknowledging microaggressions: A crucial phase in therapy revolving around microaggressions is the recognition and pinpointing of these understated, unintentional acts of discrimination (Sue et al., 2009). This paves the way for an open dialogue and efforts towards eradication.

Establishing constructive coping mechanisms for microaggressions: Therapeutic sessions can facilitate the development of advantageous strategies to handle microaggressions, encompassing self-defence skills, assertiveness, and resilience (Nadal et al., 2010). These skills equip clients to manage the adverse implications of microaggressions in their routine life.

Cultivating cultural competency among therapists: This involves therapists gaining cognizance of their inherent biases, stereotypes, and potential microaggressions towards clients (Constantine, 2007).

Formulating and applying techniques for discussing and processing microaggressions during therapy: For instance, the SLUI method (Speak Up, Listen Up, Understand, and Join) provides a structured format for microaggressions discourse (Sue, 2016).

3.4. Positive Psychotherapy: A Practical Approach to Addressing Microaggressions

Understanding the principles of PPT and applying them to instances of microaggressions can bring about personal development and transformative growth. Let's consider a practical example to illustrate this.

Imagine a client who regularly experiences microaggressions related to their ethnicity at their workplace, which has resulted in feelings of

alienation and stress. In a PPT context, the therapist may first acknowledge these experiences, validating the client's feelings. Subsequently, they would guide the client to explore the positive aspects of their ethnic identity and the strengths it brings, such as resilience, a rich cultural heritage, and a unique perspective on life.

The therapist might encourage the client to develop assertiveness and communication skills to navigate these microaggressions more effectively. For instance, they could role-play scenarios with the client, allowing them to practice articulating their feelings and setting boundaries. This process aids in transforming negative emotions into positive qualities and personal development resources.

Incorporating mindfulness interventions is another key strategy that aligns with PPT. Mindfulness helps the client to stay present, cultivate acceptance, and regulate their emotional responses. For example, the client may be guided to practice mindfulness exercises that cultivate awareness of their feelings when they encounter microaggressions, without judging or denying these emotions. This self-awareness can promote accountability and inspire change in how the client responds to future occurrences of microaggressions.

3.5. Mitigating Microaggressions via Mindfulness-Based Interventions

Therapeutic strategies like Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT), known for their efficacy in dealing with psychological issues, have grown increasingly popular. These approaches foster the cultivation of present-moment cognizance and non-judgmental acceptance of personal thoughts, emotions, and experiences.

In Positive Psychotherapy, implementing mindfulness-based interventions is a key strategy in addressing microaggressions. This approach offers several benefits:

- Augmented self-awareness: Encouraging present-moment awareness can heighten individuals' perception of their thoughts, emotions, and actions, including potential microaggressive behaviors. This self-awareness forms the basis for recognizing and addressing microaggressions.
- Non-judgmental acceptance: Practicing mindfulness encourages the development of a compassionate, non-judgmental attitude towards oneself and others. This allows individuals to identify and accept their microaggressive behaviors without harsh self-criticism or denial, fostering a sense of accountability and behavior modification.
- Emotional regulation: Mindfulness aids in the development of effective emotional regulation skills, particularly useful in managing emotions that underpin microaggressive behaviors, such as anger or frustration.
- Empathy and compassion: Mindfulness practices can boost empathy and compassion, enhancing understanding of the impact of microaggressive behaviors on others and motivating behavioral change.
- Cognitive flexibility: Mindfulness facilitates cognitive flexibility, empowering individuals to challenge and reshape negative thought patterns that may contribute to microaggressive behaviors.

Incorporating these strategic recommendations, psychotherapists can more effectively aid clients grappling with microaggressions, promoting a more inclusive, empathetic therapeutic atmosphere. Additional strategies comprise:

- Integration of multicultural approaches in psychotherapy, considering various cultural, ethnic, racial, and social facets of the client's personality to enhance therapeutic interactions (Pedersen, 2000).
- Reflection and self-reflection, as crucial elements of professional development for therapists (Norcross & Guy, 2007). Therapists' awareness of their biases, stereotypes, and potential microaggressions is key to effective work with diverse clients. Regular reflection helps identify and eliminate unintentional microaggressions and improves the quality of psychotherapeutic work.
- Creating a safe space for discussing microaggressions during therapy. Therapists can employ diverse techniques to foster an environment of trust and openness, allowing clients to express their

experiences with microaggressions (Sue, 2016).

- Application of an intersectional approach in therapy, accounting for clients' multiple, intersecting social identities and experiences.

Conclusion

In conclusion, microaggressions are an essential issue in contemporary society that requires greater attention and understanding. The complexity of this phenomenon is related to the deep-seated psychological and social processes that contribute to its manifestation.

By recognizing and working with microaggressions in psychotherapy, individuals can develop greater resilience, adaptive coping strategies, and positive communication skills. The PPT approach, through its unique focus on amplifying positive attributes and applying mindfulness techniques, provides an effective strategy for working with microaggressions. This approach underscores the importance of identifying an individual's strengths and leveraging these for growth amidst the challenges posed by microaggressions.

At the same time, it is essential to recognize that the issue of microaggressions is related to broader contemporary social and cultural issues, such as various types of inequality, political and social polarization, refugees and forced displacement, resentment, spreading the culture of cancellation, that could fuel further dividing society. Therefore, addressing these root causes of microaggressions requires greater attention to social justice and cultural competence in all areas of life.

Ultimately, working with microaggressions requires a collaborative effort from individuals, communities, and society to foster greater understanding, empathy, and respect for diversity and difference.

As Helen Pluckrose and James Lindsay (2020) noted in their book "Cynical Theories," "We need to be able to confront social injustice without creating new injustices." It is our responsibility as mental health professionals to address microaggressions in a way that is ethical, effective, and compassionate.

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<https://doi.org/10.1002/capr.12481>

Section: Special articles

AN OVERVIEW OF THE MENTAL HEALTH SERVICES IN ENGLAND AND THE ROLE OF THE PSYCHOTHERAPIST IN THIS CONTEXT



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Received 10.05.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj207](https://doi.org/10.52982/lkj207)

Abstract

The article discusses the increasing prevalence of antidepressant use in the UK and concerns surrounding the reliance on psychotropic medication. The impact of the COVID-19 pandemic on mental health is also mentioned, along with the increasing rates of probable mental disorders in children and young people.

The author highlights the role of psychotherapists in discussing medication-related topics with clients and advocating for collaboration with Family Doctors (GPs) and psychiatrists. It suggests that a combination of pharmacotherapy and psychotherapy may be more effective than medication alone, but long waiting times for therapy services pose a challenge. Staff shortages in mental health services are identified as barriers to adequate care and patient involvement in decision-making processes.

The Balance Model is proposed as a framework for planning interventions, focusing on the four areas of life (physical, mental, emotional and spiritual) to support clients in managing the side effects of starting or stopping medication. Overall, the article calls for a comprehensive approach to mental health treatment that considers both medication and psychotherapy, addresses the challenges associated with medication use, and advocates for improved training and collaboration among healthcare professionals.

Keywords: mental health, antidepressants, benzodiazepines, repeat prescription, side effects, withdrawal, positive psychotherapy, Balance model

Introduction

In my practice, I often hear patients say, "I have been taking antidepressants for the past six years, I don't feel any better, but I'm worried that my condition may worsen if I stop taking them." In response, I typically suggest that they consult with their General Practitioner/ Family Doctor (GP). It has become increasingly common for patients to be on antidepressants, and I have noticed that unmedicated patients are rare in my practice. To gain a better understanding of this phenomenon, I looked for more information on the topic.

According to my findings, in England, prescribing the 10 most popular antidepressants

(Citalopram, Amitriptyline, Sertraline, Mirtazapine, Fluoxetine, Venlafaxine, Duloxetine, Paroxetine, Trazodone, and Escitalopram) has increased by 25% from 58 million in 2015 to 72 million in 2019. These 10 antidepressants make up 96% of all antidepressant prescriptions. Citalopram, an SSRI, was the most frequently prescribed antidepressant, and between 2015-2019, it was among the *top 20 most commonly prescribed medications in England across all prescription items*. (Lalji et. al., 2021)

Since 1998, there has been a significant increase of over 3 million prescriptions for antipsychotics. Additionally, in the UK, there are currently 296,929 individuals who are long-term users of benzodiazepines. Interestingly, data

indicates that as many as 119,165 of these individuals may be willing to accept prescribed drug dependency withdrawal services, however, this service is not offered. According to the current British National Formulary (BNF) guidelines, benzodiazepines and Z-drugs, including Zolpidem, Zopiclone, and Zaleplon, should only be prescribed for up to 4 weeks. However, anecdotal evidence suggests that many patients are being prescribed these drugs for much longer periods. This presents a serious public health concern, as there is evidence that prolonged use of these drugs can lead to adverse physiological and neurological effects, as well as complications associated with protracted withdrawal (Davies et. al., 2017),

The Royal College of Psychiatrists suggests that the increase in the number of people being given psychotropic medicines is due to more individuals with mental illness seeking medical advice. However, others believe that the rise in prescriptions is a result of overstretched mental health services and doctors feeling that they have no other options for patients. A study by the Mental Health Foundation found that 78% of GPs had prescribed an antidepressant when they believed that an alternative approach might be more appropriate. It is estimated that one-third of individuals taking antidepressants long-term in the UK have no clinical reason to continue treatment and could potentially try stopping (Cruickshank et al., 2008).

Data collected by the Office for National Statistics (ONS) revealed a rise in the prevalence of moderate or severe mental disorder following the onset of the pandemic. Between July 2019 and March 2020, the prevalence was recorded at 10%. However, by June 2020, it had increased to 19%, and further rose to 21% from January to March 2021, indicating a significant impact of the pandemic on mental health.

In a 2022 survey focusing on children and young people's mental health, it was found that 18.0% of children aged 7-16 were deemed to have a probable mental disorder in 2022, a significant increase from the 12.1% reported in 2017. Among individuals aged 17-19, the percentage with a probable mental disorder rose from 10.1% in 2017 to 25.7% in 2022 (Baker & Wade, 2023).

It is not uncommon for clients to ask whether they should consider taking antidepressants, but providing a straightforward answer can be challenging. There is a range of perspectives

regarding the efficacy of antidepressants in alleviating depression symptoms. Some mental health professionals harbor doubts about their effectiveness, while others deem them indispensable. However, similar to other treatments, these medications may be beneficial in certain scenarios but not others. They exhibit effectiveness in cases of moderate, severe, and chronic depression, but are likely less effective in mild instances. Additionally, they can give rise to side effects. Engaging in a thorough discussion with your doctor regarding the advantages and disadvantages of antidepressants is crucial. Typically, antidepressants are prescribed for daily use. Initially, the objective during the first weeks and months is to alleviate symptoms and, if feasible, achieve remission from depression. Once this goal is attained, the treatment is sustained for a minimum of four to six months. This continuation therapy is essential to prevent the recurrence of symptoms. In certain cases, the medication may be taken for an extended period to prevent relapses. The duration of treatment is also contingent upon the progression of symptoms over time and the likelihood of depression resurfacing. (Overview – Antidepressants – NHS, 2023)

Mental Health services in the UK are split into two main categories: primary services such as GP practices or talking therapies services such as IAPT (Improving Access to Psychological Therapies – CBT based 6-12 sessions talking therapy service) and secondary services such as inpatient/ outpatient services, specialized services (eating disorders, personality disorders, etc.), or Community Mental Health Teams.

A report by the CQC (Care Quality Commission) raises concerns about staff shortages and the impact this has on patient care. The mental health sector continues to grapple with challenges surrounding workforce retention and staffing shortages, which have been further exacerbated by the COVID-19 pandemic and the departure of staff due to retirement or seeking alternative employment.

Insufficient staffing levels can have a detrimental impact on both patient and staff safety. Moreover, chronic staffing shortages have impeded the ability of staff to respond effectively to incidents, often resulting in untrained personnel being assigned responsibilities beyond their capacity to safely carry them out. These factors contribute to the

development of closed cultures, further escalating risks.

Patients have also experienced difficulties accessing therapeutic care due to staffing shortages, resulting in reduced patient involvement in decision-making processes (Monitoring the Mental Health Act in 2021 to 2022; Staff shortages and the impact on patients, 2022).

“Not having the right levels and skill mix of staff can affect the services’ ability to provide safe and effective care and treatment that is in line with the guiding principles of the Mental Health Act Code of Practice.” This means that patients who should be assessed and reviewed by a psychiatrist are often only seeing their GP (Monitoring the Mental Health Act in 2021 to 2022; Staff shortages and the impact on patients, 2022).

Despite over 40% of all GP appointments involving mental health issues, and with demand rising, there is currently no mandatory practice-based mental health training for GPs in the UK. Less than half of GPs who completed their training in 2017 opted to take a psychiatry placement, exacerbating the issue. According to MIND’s 2017 Big Mental Health Survey, this lack of training can leave patients in the dark about the potential side effects of psychotropic medication. Around one-third of patients prescribed medication for their mental health would have liked more information from their GPs about the possible side effects. (Mind, 2018). This is supported by similar findings in the research done in 2022 by Mind on the lived experience of mental health (Gunstone et. al., 2022). Additionally, GPs face multiple pressures from stress, overwork, and the demands of Clinical Commissioning Groups (CCGs) and patients. Limited prescribing pathways may also contribute to the over-reliance on medication as opposed to talking therapies, especially in mild depression. Encouraging a cultural shift towards a preference for talking therapies over medication will require addressing the lack of mandatory mental health training for GPs.

Numerous studies indicate that a combination of pharmacotherapy and psychotherapy yields greater effectiveness compared to treatment solely relying on antidepressant medication. However, in primary care settings, the prevailing practice often involves offering either pharmacotherapy or CBT, with limited instances of both being provided concurrently. A possible reason for this

could be the long waiting times. According to a recent assessment of Mental Health Services, the average waiting time for primary care talking therapy services, known as IAPT, is approximately 21 days from referral to assessment, however, certain regions in England have reported waiting times as long as 299 days. Furthermore, the average waiting time between the first and second treatments is around 50 days, but in certain areas, it can extend to 291 days. (Baker & Wade, 2023).

1.1. The potential risks of relying on repeat prescriptions

The increasing number of individuals who take antidepressants but don't find them helpful is raising concerns about our society's reliance on prescription drugs. Dr James Davies, a psychotherapist and reader in Social Anthropology and Mental Health at the University of Roehampton UK, warns that we may be in the midst of a psychiatric drug epidemic, with prescribed drug dependency being a particular concern. Currently, over 15% of the adult population in the UK is on psychiatric medication, and this number continues to rise. Studies in the UK indicate that about half of the individuals on antidepressants have been taking them for two years or more, which is consistent with similar findings in the USA. However, as patients take antidepressants for a longer period, the frequency of mental health reviews tends to decrease, reducing the chances of re-evaluating the appropriateness of the treatment and potentially leading to unnecessary continuation. As a result, patients may receive repeat prescriptions, be reviewed infrequently, and assume that they are expected to continue treatment indefinitely (Davies ed., 2017).

The situation is similar with benzodiazepines, which are frequently prescribed for anxiety-related conditions, resulting in patients taking drugs that were only meant for short-term use. It is like being given antibiotics for a chest infection and taking them for two decades simply because nobody reviewed the case. For instance, one of my clients was prescribed Lorazepam after failing an exam as a teenager, and 34 years later, when she came to me for help, she was still taking it.

Research also indicates that the use of antidepressants can increase the likelihood of depression developing into bipolar disorder, impair patients and lead to government

disability claims. Science writer, Robert Whitaker, highlights that disability claims due to depression and anxiety increased from 721,000 to 1,081,000 in the UK between 1998 and 2010. This corresponds with the increased use of antidepressants, which could worsen long-term outcomes (Davies ed., 2017).

Discussion

3.1. Side Effects & Withdrawal

The difficulty of discontinuing benzodiazepine treatment is widely recognized, and even street users are aware that quitting "cold turkey" can be more painful and difficult than quitting heroin. Many of my patients and some of my family members who have been prescribed Xanax (Alprazolam) have expressed the need for reassurance that their symptoms during withdrawal are not a sign of mental illness and that the process of withdrawal takes time and support. It is important for them to know that they are not alone in this journey.

What is less known is that with any SSRI, 50% of the patients will experience some form of side effects and withdrawal. If there is a plan to put someone on antidepressants, there also needs to be a plan of taking the person off the medication.

One of my clients who had been on antidepressants for two years after being diagnosed with Postpartum OCD (by the GP), decided to discontinue the medication. I recommended that she see her doctor to come up with a plan to gradually stop taking Fluoxetine (Prozac). The GP's proposed plan, involved taking half a tablet per day for the first week, followed by half a tablet every other day for the second week. However, my client immediately experienced a range of withdrawal symptoms, including insomnia, digestive issues, headaches, nausea, dizziness, and passive suicidal ideation. Despite these symptoms, the GP failed to recognize the withdrawal and instead increased the dosage of Fluoxetine. After several discussions between myself, the patient, the GP, and the charity Bridge Project, (<https://thebridgeproject.org.uk>), it was decided that the patient should be put on a liquid form of the medication so that she could gradually reduce the dosage and avoid more severe withdrawal symptoms.

It is important to underline that withdrawal can last months, not just weeks, and our clients

need support to understand and rebalance their nervous systems. (Nice Guideline NG222, 2022).

3.2. The way forward for psychotherapists?

As psychotherapists, we often have conversations with our clients about medication, including its potential side effects and withdrawal symptoms. However, I have noticed gaps in understanding and knowledge in myself and among some professionals during supervision sessions. Some therapists may feel that it is not their place to discuss medication-related topics because they are not medical doctors. But if we do not talk about it, who will?

Due to the current state of affairs in Mental Health services in England, we often find ourselves therapeutically holding patients who need specialized medical interventions.

We have a place in the patient's journey, whether it involves initiating psychotropic medication or supporting them towards a medication-free approach. However, it is imperative that any decision to start or stop medication is made under the supervision of a doctor. Our collaboration with the patient's general practitioner (GP) and preferably, when available, a psychiatrist is vital for successfully implementing this process.

In my experience, when they come to see a therapist, clients do not seek medical expertise on withdrawal or side effects but value psychological support, curiosity, and a safe space to explore their experiences. Therapy can provide a support system that patients do not typically receive from doctors. Together with our clients, we can create a plan that is not fixed and rigid, but that considers what actions can be taken when things are challenging.

As Positive Psychotherapists, we can use the Balance Model as a framework to plan this intervention. The Balance Model takes into consideration the four areas of life: Body, Achievement, Relationships and Future/Fantasy. Together with the client we structure and plan their journey of managing the side effects of starting/stopping medication and rebalancing the client's nervous system. The unique feature of the Balance Model is that it covers the four most critical dimensions of well-being: physical, mental, emotional and spiritual. For example, the intervention might include: recognizing body changes, improving diet, increasing exercise, learning or practicing a new skill, celebrating small achievements, maintaining social contacts,

engaging in a conversation with a trusted individual can provide a sense of relief, journaling, encourage creativity in expressing sensations, emotions and thoughts, practicing mindfulness, yoga, guided meditation or trying reflexology. These small changes and steps can make a significant difference in someone's life because struggling with withdrawal or side effects can be easily misconstrued and lead to feelings of isolation for our clients.

Conclusions

As therapists, does our ethical responsibility change, when we learn about the potential harm that long-term use of psychotropic medication can have on our clients?

Many therapists have likely encountered clients who are taking or stopping psychotropic medications, and specialized training is not always necessary or available for them to assist clients with problems related to medication side effects or withdrawal during therapy.

In my opinion, it is important to educate ourselves to consider this issue and take informed steps within the framework and scope of therapy.

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Resources and information:

- The UK Council for Psychotherapy together with APPG for Prescribed Drug Dependence, British Psychological Society, National Counselling Society, British Association for Counselling and Psychotherapy have put together a **Guidance for Psychological Therapists**. URL: <https://prescribeddrug.info>.
- **The Harm Reduction Guide to Coming off Psychiatric Drugs** by Will Hall is a free eBook available in 18 languages. URL: <https://willhall.net/comingoffmeds/>
- Collection of **knowledge and experience** at URL: <https://www.survivingantidepressants.org>
- **Let's Talk Withdrawal** – a podcast where experts and people with first-hand experience talk about antidepressants and withdrawal. URL: <https://www.letstalkwithdrawal.com/podcast/>
- **The Pill That Steals Lives**, Katinka Blackford, John Blake Publishing, 2016 – K. Blackford, a documentary filmmaker, first-hand experience on being prescribed Escitalopram.

Section: Special articles

ТРАНСКУЛЬТУРАЛЬНЫЙ АСПЕКТ ПОСТРОЕНИЯ ПРОФЕССИОНАЛЬНЫХ ОТНОШЕНИЙ ПСИХОЛОГА И КЛИЕНТА С ВИДИМЫМ ОТЛИЧИЕМ

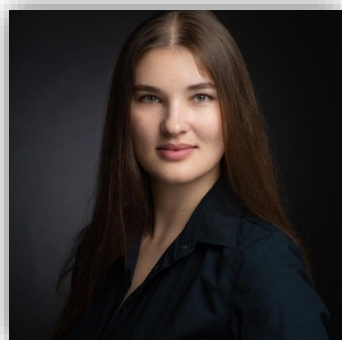
The transcultural aspect of building professional relationships between a psychologist and a client with a visible difference



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Received 10.05.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/1kj208](https://doi.org/10.52982/1kj208)

Аннотация

В статье обосновывается правомерность использования идеи транскультуральности для понимания природы психологического барьера, с которым сталкиваются психологи при построении профессиональных отношений с клиентами, имеющими видимые отличия во внешности. Авторы аргументируют использование понятия «видимое отличие» для корректного обозначения людей с особенностями внешности, природа которых напрямую связана с нездоровьем. Клиент с видимым отличием рассмотрен как принадлежащий к особой культуре – «культуре инвалидности», так как его образ жизни вызван или поддерживается физической или психической инвалидностью. Результаты исследования, проведенного с участием практических психологов профессионального сообщества г. Хабаровска (Россия), позволяют подтвердить предположение о наличии специфического барьера, ощущаемого и психологом, и клиентом как противопоставление «Я –

Другой». Природа упомянутого барьера связана с культурными особенностями современного социума, так как в обществе сильны установки «культуры полезности» – концепции, при которой ценность человека определяется его способностями к исполнению полезных функций. Транскультуральный подход при построении профессиональных отношений является наиболее адекватным методом, использующим различия как ресурс оказания помощи клиентам.

Ключевые слова: транскультуральность, физическая инвалидность, видимое отличие внешности, профессиональные отношения, практическая психология, позитивная психотерапия

Abstract

The article justifies the legitimacy of using the idea of transculturality to understand the nature of the psychological barrier that psychologists encounter when establishing professional relationships with clients who have visible differences in appearance. The authors argue for the use of the concept of "visible difference" to accurately denote individuals with distinctive physical features whose nature is directly related to a health condition. A client with a visible difference is considered to belong to a particular culture - the "disability culture" - as their lifestyle is caused or influenced by physical or mental disability. The results of the study, conducted with the participation of practicing psychologists from the professional community in Khabarovsk, Russia, confirm the assumption of the existence of a specific barrier felt by both the psychologist and the client as an opposition of "Self - Other." The nature of this mentioned barrier is associated with the cultural characteristics of contemporary society, as there are strong inclinations towards the "culture of usefulness" - a concept in which a person's value is determined by their ability to perform useful functions. The transcultural approach in establishing professional relationships is the most appropriate method that utilizes differences as a resource for assisting clients.

Keywords: transculturality, physical disability, visible difference in appearance, professional relationships, practical psychology, positive psychotherapy

Введение

Транскультуральность сегодня – это феномен, отчетливо проявляющийся в обстоятельствах, при которых имеет место более чем одна культура. Однако контекст публикаций по-прежнему довлеет к обсуждению общественно-политических процессов и этноконфессиональных вопросов, к дискуссии преимущественно сквозь призму дилеммы «Восток–Запад». Между тем в аспекте транскультуральности уместно говорить и тогда, когда речь заходит о межклассовых различиях (пересечение культурных ценностей, транслируемых представителями различных классов и сословий), возрастных различиях (проблемы «отцов и детей») и др. На наш взгляд, в контексте транскультуральности могут быть рассмотрены особенности построения контакта между людьми здоровыми и людьми, образ жизни которых вызван или поддерживается физической или психической инвалидностью.

Довольно пространным и даже туманным понятием «видимое отличие» мы обозначили феномен, который в области специальной

(коррекционной) психологии со времен Л.С. Выготского (1924) называется «дефектом»; то, за чем законодательно (Федеральный закон № 120 от 30.06.2007) закреплено определение «ограниченные возможности здоровья»; то, что в практике социальной защиты населения именуется инвалидностью (Постановление правительства РФ от 5.04.2022 г. № 588). К настоящему времени в теории и практике психологии нет общепринятого корректного термина для обозначения этого явления. Наиболее удобным и при этом корректным, а главное – нашим, психологическим, не заимствованным ни из клинической практики, ни из проблемного поля дефектологии, мы посчитали термин «видимое отличие», предложенное Н. Шнаккенберг (2018).

Инициированное нами исследование было проведено с участием людей, имеющих заметные отличия внешности, природа которых напрямую связана с нездоровьем. Отличия, воспринимаемые повсеместно как отталкивающие: грубые деформации лица и тела, тяжелые нарушения функций сенсорных систем и органов движения, выраженные

изменения кожных покровов, ярко проявляющийся специфический неприятный запах, не связанный с погрешностями гигиены и т.п. Таких людей на бытовом уровне называют некрасивыми, страшными, уродливыми и пр.

Клиента с видимыми отличиями можно отнести к категории уникальных хотя бы потому, что построение профессиональных отношений с ним рождает много чувств и переживаний, с которыми практикующему психологу приходится сначала совладать, а потом, входе специально организованной работы их идентифицировать и интегрировать. Опыт длительного консультирования подобных клиентов не найден нами в специальной литературе, не был представлен в рассматриваемых в профессиональном сообществе кейсах. Таким образом, налицо противоречие между потребностью профессионального сообщества практических психологов в ясном понимании сути трудностей, сопровождающих процесс консультирования и терапии клиента с видимыми отличиями, и недостаточностью научных исследований названного явления.

Планируя исследование, мы преследовали цель: теоретически обосновать и практически подтвердить наличие специфических культуральных барьеров в процессе построения профессиональных отношений практического психолога и клиента с видимыми отличиями; доказать возможность и эффективность использования транскультурального подхода в психологическом консультировании и психотерапии такого клиента.

Методология

Научные публикации, ставшие основой для проведенной нами работы:

- труды, посвященные взаимодействию души и тела: В. Мухина (2003), А.В. Смирнов (1998), А.Ш. Тхостов (2002) и др.;
- исследования, раскрывающие особенности формирования и развития идентичности людей с видимыми отличиями: М.М. Орлова (2012), С.В. Чебарыкова (2017), Н. Шнаккенберг (2018) и др.;
- изыскания, раскрывающие проблемы Другого в философии различий: Е.А.

Елесеов (2013), Т.Н. Кочеткова (2016), Е.Р. Ярская-Смирнова (1997) и др.;

- работы, посвященные характеристикам взаимоотношений людей через призму психологической дистанции – отношения к Другому как к «Своему», «Иному» и «Чужому»: Л.И. Гришаева (2003), Л.С. Перепелкин (2015), А.П. Садохин (2007), В.В. Феррони (2012) и др.;
- положения принципа транскультуральности как базового подхода в организации профессионального общения в позитивной психотерапии: Н. Пезешкиан (2019), Х. Пезешкиан (1999) и др.

Обзор научных и научно-методических изданий, раскрывающих теорию исследуемого вопроса, уже опубликован нами (С.В. Чебарыкова, И.В. Куклина, 2022). Выводы, которые мы сделали на их основе:

1. Клиент с видимым отличием может быть рассмотрен как принадлежащий к особой группе, особой культуре – культуре инвалидности. Формирование его личности происходило под влиянием патогенных факторов, оставивших неизгладимый след на внешности и тем самым исказивших процесс и результат его идентификации.
2. Наличие видимого отличия ставит его носителя по одну сторону культурального барьера в то время, как люди с внешностью, не выходящей за границы так называемой нормальности (обычности), находятся по другую сторону. Этот барьер ощущается обеими сторонами в виде противопоставления «Я – Другой».
3. Восприятие Другого может складываться по разным моделям: «Свой», то есть похожий на меня, родственник, близкий; «Иной», не похожий на меня во многих проявлениях, но готовый к диалогу и рассматриваемый как потенциальный ресурс для развития; «Чужой», то есть чуждый, непонятный и враждебный.
4. Концепции восприятия Другого как «Своего», «Иного» или «Чужого» у людей с видимыми отличиями являются результатом опыта выстраивания внутригруппового и межгруппового взаимодействия. В том случае, если коммуникации носили деструктивный характер, восприятие окружающих будет

отличаться неполнотой, а сами люди будут представляться источником опасности.

5. Изменение патологических паттернов в отношениях с окружающими может быть достигнуто только в процессе получения позитивного опыта – через выстраивание эффективного взаимодействия, примером которого могут выступать профессиональные отношения с психологом.
6. Позитивная транскультуральная психотерапия является методом, созданным изначально на стыке культур Востока и Запада. Сегодня это активно развивающийся метод, использующий различия культур как ресурс оказания помощи клиентам.

Организация исследования и методы

Исследование проведено в период с сентября 2020 г. по декабрь 2022 г. на базах: «Центр психологического здоровья» и «Региональный ресурсный центр по организации комплексного сопровождения лиц с расстройством аутистического спектра и тяжелыми множественными нарушениями развития» г. Хабаровска.

Этапы исследования:

Подготовительный этап, в ходе которого нами был проведен анализ теоретических источников по интересующей нас проблеме. Были изучены труды отечественных и зарубежных исследователей, определенных в качестве методологической основы.

Этап пилотажного исследования, призванный объективировать имеющееся у нас интуитивное суждение о том, что практические психологи испытывают трудности в работе с людьми, имеющими видимые отличия.

Аналитический этап, в ходе которого нам удалось проанализировать природу выше указанных трудностей, связать их с возникновением психологического барьера особого типа – культурального барьера.

Этап углубленного исследования, в ходе которого была осуществлена практическая работа (длительная немедицинская психотерапия) с участием клиентов, имеющих видимые отличия. Работа сопровождалась проведением систематической супервизии, в фокусе внимания при описании кейсов находился спектр переживаний психолога и

клиента в части особенностей их профессиональных отношений.

Завершающий этап исследования, представляющий собой подведение итогов и формулировку основных выводов, касающихся значимости использования транскультурального подхода в организации профессионального общения практического психолога.

Участники исследования:

- на этапе пилотажного исследования: психологи, практикующие в различных методах психотерапии); будущие специалисты-психологи из числа студентов и слушателей курсов и спецсеминаров по ППТ;
- на этапе углубленного исследования: клиенты с видимыми отличиями, проходящие длительную немедикаментозную психотерапию; практические психологи, работающие в методе позитивной транскультуральной психотерапии.

Для реализации сформулированной цели и проверки гипотезы нами был подобран специальный комплекс исследовательских методов. Этот комплекс включает в себя:

- анкетирование (собственная разработка);
- фокус-группа;
- беседа (структурированное интервью Н. Пезешкиана, адаптированное Х. Дайденабахом);
- метод кейсов;
- «Операционализация конфликтов» (в редакции М. Гончарова (2019).

Результаты

С целью объективизации сложившегося интуитивного суждения о том, что у практических психологов имеют место специфические трудности в установлении и поддержании контакта с клиентом, имеющим видимые отличия, нами было проведено пилотажное (пробное) исследование. Для этого нами последовательно были использованы метод анкетирования (авторская анкета) и фокус-группа.

Анкета была разработана нами самостоятельно. Инструмент прошел процедуру рецензирования и получил экспертное мнение специалиста отдела развития инновационной и научно-

исследовательской деятельности КГАОУ ДПО «Хабаровский краевой институт развития образования» о соответствии требованиям к средствам получения первичной социально-психологической информации. Респондентам был предложен ряд вопросов и утверждений, позволяющий прояснить: является ли видимое отличие человека (клиента) барьером для выстраивания профессионального общения. Сформулированные вопросы и их назначение представлены нами в приложении.

К участию были приглашены психологи, практикующие в различных методах психотерапии (откликнулись 22 чел) и будущие психологи: из числа студентов профильного вуза (9 чел) и слушателей курсов и спецсеминаров по ППТ (13 чел). Большая часть опрошиваемых имеют опыт работы в сфере практической психологии, из них 45,5 % свыше 3-х лет. Однако значительная часть (88,6 %) опрошенных не только не имеют опыта профессионального общения с клиентами, имеющими видимые отличия, но и в большинстве своем крайне мало взаимодействует с ними в реальной социальной практике. Вместе с тем, при ответе на вопрос 1.4 *Раздела 1. Приложения* (об опыте работы с клиентами, для которых проблему составляют отношения с человеком с видимым отличием) 22,8 % респондентов смогли сослаться на подобный опыт. Это косвенным образом подтверждает актуальность исследуемой нами проблемы.

Так как подавляющее большинство участников исследования не имеют собственного опыта, к анализу были привлечены ответы, характеризующие гипотетические представления и ожидания. Интерес представляют данные по частоте контактов психологов и людей с видимыми отличиями в зависимости от нозологии. Из ответов следует, что вероятность профессиональной встречи с неслышащим/ незрячим/ безречевым клиентом приближается к нулю. Невысока вероятность работы с людьми, имеющими выраженные двигательные и интеллектуальные нарушения: ее допускают лишь 9 % ответивших. 81,8 % опрошенных признают гипотетически возможными контакты с теми, чьи ограничения носят характер косметических дефектов (дисплазии лица и тела, изменение кожных покровов), но при

этом они не готовы взаимодействовать с клиентами, источающими неприятный запах. Анализ данных, касающихся возможных ограничений по возрасту клиентов с видимыми отличиями выявил, что наибольшие трудности ожидаются от работы с детьми: готовность вести психологическую работу с ними демонстрируют лишь 11 % опрошенных.

Все 100 % респондентов утвердительно ответили на вопросы, касающиеся наличия барьеров общения. Отмечается, что трудности носят не только объективный характер (физический барьер как препятствие к установлению контакта), но и социальный (неготовность/неспособность преодолеть социальные различия) и психологический (невозможность справиться с эмоциональным фоном, сопровождающим процесс коммуникации).

Важным результатом анкетирования считаем то, что 3 респондента (6,8 % от выборки) признали себя человеком с видимым отличием. Они приглашены к проведению дальнейшей исследовательской работы и ее результаты только еще предстоит обобщить.

Сложности, с которыми столкнулись практикующие специалисты (в том числе начинающие) и будущие психологи при ответе на вопросы анкеты, подвигли нас на проведение фокус-группы. К участию были приглашены члены постоянно действующей интервизорской группы (7 человек) психологов г. Хабаровска. Ключевые вопросы, вокруг которых была организована дискуссия: Имеете ли Вы опыт работы с клиентами, имеющими видимые отличия? Ощущали ли Вы наличие психологического барьера при работе с клиентами, имеющими видимые отличия? Отмечали ли клиенты, имеющие видимые отличия, присутствие такого барьера? Можно ли утверждать, что обсуждаемый барьер общения связан с установками, распространенными в социуме, и носит характер культурно обусловленного?

Подробное описание организации и результатов проведенного мероприятия представлено нами в виде научной публикации (С.В. Чебарыкова, И.В. Куклина, А.В. Гарднер, 2023). Отметим здесь лишь основной вывод: в ходе серьезного и вдумчивого обсуждения коллеги пришли к пониманию, что построение

профессионального общения практического психолога и клиента с видимыми отличиями сопровождается ощущением наличия особого барьера, имеющего культуральную обусловленность.

Содержанием этапа углубленного исследования стала собственно практическая профессиональная деятельность: под патронатом опытного психотерапевта-супервизора осуществлена продолжительная немедицинская психотерапия с участием клиентов с видимыми отличиями. Ниже представлены некоторые из запросов клиентов-участников углубленного этапа исследования:

Кейс 1. Ж, 30 лет (врожденная патология). Видимое отличие: альбинизм, нистагм глаз, логоневроз (заикание). АК: Осложнившиеся отношения с партнером. «Я нуждаюсь в принятии, любви и заботе. Я – инвалид, но прикладываю много сил, чтобы быть автономной, вести образ жизни обычного человека. Я заслуживаю здорового партнера, и разговоры близких о возможности брака с инвалидом меня обижают». Характеристика барьера со стороны психотерапевта: трудности удержания зрительного контакта, непривычно слушать речь с запинками.

Кейс 2. М, 23 года (рано приобретенная патология). Видимое отличие: тяжелый хронический псориаз, маленький размер полового члена (возможно, причина псориаза на почве дистресса). АК: одиночество, потеря надежды на полноценные отношения. «Я не привлекателен, меня нельзя любить (хотеть). Нормальные женщины любят здоровых, внешне привлекательных. Меня тоже интересуют только привлекательные женщины. А те, кому я нравлюсь, не нравятся мне (они сами не привлекательны, не сексуальны)». Характеристика барьера со стороны психотерапевта: страх заразиться, желание после сессии мыть руки, обеззараживать пространство.

Кейс 3. М, 27 лет (поздно приобретенная патология). Видимое отличие: дефект конечностей (потеря кистей рук) вследствие недавней травмы. АК: потеря смысла жизни, утрата цели. «Я потерял свою ценность, возможность быть самостоятельным, независимым вместе с утратой здоровья. Я стал никому не нужен. Я нуждаюсь в любви и поддержке, а не в жалости. Но я жалок и то, как ко мне относятся окружающие –

закономерно». Характеристика барьера со стороны психотерапевта: страх потерять здоровье в результате несчастного случая (за себя и близких).

Кейс 4. Ж, 22 года. Девушка обычной внешности, но в прошлом у нее несколько пластических операций (коррекция носа и ушных раковин, установление филеров-нитей и т.п.). АК: осложнившиеся отношения с партнером. «Любят только красивых. Я была несовершеннолетняя, и поэтому меня нельзя было любить просто так. Я приложила много усилий для того, чтобы стать красивой и теперь должна прикладывать много сил, чтобы продолжать быть красивой». Характеристика барьера со стороны психотерапевта: раздражение, так как в ее словах звучит: «вы и сама не очень-то красивая, и я не знаю, как вы живете с этим».

Кейс 5. Ж, 39 лет, мама ребенка-инвалида (включает ребенка, имеющего видимые отличия, в свои границы). Видимое отличие у ребенка: синдром Лоу. АК: сложности в отношениях с родственниками. «Я и мой ребенок (мы с ней) – одно целое и мы «не в порядке». Я родила нездорового ребенка – я виновата перед мужем и родными. Я люблю того, кто не ценен для других, кого любить нельзя». Характеристика барьера со стороны психотерапевта: страх родить нездорового ребенка в будущем.

Построение длительных терапевтических отношений с клиентами, имеющими видимые отличия, сопровождалось возникновением целого спектра собственных переживаний. В каждом конкретном случае контрперенос имел качественное своеобразие, объясняющееся как особенностями личности клиента, так и характером имеющегося физического отличия. Вместе с тем имело место и сходство: общение рождало смешанные чувства, одновременно присутствующие: сочувствие; радость от отсутствия у себя подобных проблем; вина за испытываемую радость; страх за то, что нынешнее благополучие может быть утрачено. Ход проведения работы и содержание собственных переживаний, рождающихся в общении с клиентами, имеющими видимые отличия, были регулярно обсуждаемы. Они стали залогом качества проводимой работы и необходимым условием сохранения

эмоционального благополучия практического психолога.

Формат данной статьи не позволяет во всей полноте изложить нюансы проведенной работы: особенности установления контакта с клиентом, развитие отношений, переживания контрпереноса, содержание супервизионных сессий и интервизионных встреч. Но мы знаем, что в нашем журнале предусмотрена возможность представления кейсов. И если публикация вызовет живой интерес со стороны профессионального сообщества, то на страницах одного из следующих выпусков такой кейс имеет все шансы появиться.

Обсуждение

1. В профессиональном сообществе практикующих психологов подтверждено наличие проблемы выстраивания профессиональных отношений с клиентами, имеющими видимые отличия. Специалисты признают недостаточность опыта работы с названной категорией клиентов в силу факторов объективных (малое количество обращений) и субъективных (наличие психологического барьера, ощущаемого как клиентом, так и практическим психологом).
2. Природа упомянутого барьера признана связанной с культурными особенностями современного социума. Ситуация такова, что с одной стороны, в обществе все еще представлена модель «культуры полезности», проявляющаяся в восприятии лиц с ОВЗ и инвалидностью как малоценных, а с другой – не получило достаточного распространения знание этики общения с лицами, имеющими ограничения жизнедеятельности.
3. Профессиональное сообщество проявляет высокую заинтересованность в результатах нашего исследования. Отмечается, что опыт построения отношений с клиентом, имеющим видимые отличия, может расширить представления о природе человека и обогатить не только профессиональный, но и жизненный опыт. Осуществленный нами развернутый анализ полученного опыта может стать основанием для рефлексии своего профессионального багажа и расширения горизонта его возможностей.
4. Осуществление психотерапевтической работы с клиентами, имеющими видимые отличия, выявил присутствие общих проявлений. Так, всех клиентов отличает наличие актуального конфликта, локализирующегося в сфере контактов со значимыми людьми, переработка которого происходит в сфере смыслов. Общим для всех является и характер базового конфликта: это дезадаптивная концепция, имеющая культуральную основу и связанная с присвоением одной из моделей отношения социума к инвалидности /нездоровью: ценен только здоровый, привлекательный, успешный, молодой, жизнерадостный, состоятельный. «Лучше быть здоровым и богатым, чем бедным и больным». Упомянутая установка локализуется в «Мы-концепции» (сложившееся отношение к окружающему, социуму), формируется бессознательно под влияние СМИ и отношения со стороны старших как наследие культуры полезности.
5. Паттерны поведения, осложняющие взаимоотношения людей с видимыми отличиями в реальной жизни, проявлялись и во взаимодействии с психологом. Построение профессиональных отношений и их последовательная рефлексия стали лабораторией для формирования и развития навыков эффективного общения с окружающими.
6. Использование транскультурального подхода при построении профессиональных отношений с клиентом, имеющим видимые отличия, основывается на умении психолога самому видеть и показывать другим не только то, что отличает между собой людей, составляющих разные социальные группы, но и то, что у них есть общего. Таким образом, человек, воспитанный в так называемой «культуре инвалидности» и привыкший видеть в первую очередь свою непохожесть, инаковость, отличность от окружающих, получил новый опыт межличностного взаимодействия.

Заключение

В завершении отметим, что наше исследование особенностей построения профессиональных отношений практического психолога и клиента с видимыми отличиями не претендует на законченность и полноту. Мы сконцентрировали свое внимание на людях, чьи видимые отличия обусловлены нездоровьем. За его границами остаются случаи, когда отличия являются результатом намеренных действий человека, стремящегося всеми доступными способами подчеркнуть свою индивидуальность. Мы имеем ввиду людей с вызывающими татуировками, людей, использующих большое количество филеров и т.п. Кроме того, в настоящее время интерес приобретает вопрос использования транскультурального подхода в работе с людьми с гендерной дисфорией (трансгендерами).

Постскриптум. В то время, когда статья готовилась к публикации, стали появляться сообщения о физически здоровых людях, которые идентифицируют себя инвалидами и добровольно наносят себе увечья. Трансинавалидность претендует на новый тренд. Похоже, что заявленная нами тема получает новую грань осмысления.

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Приложение

Анкета, разработанная с целью выявления трудностей практических психологов в установлении и поддержании контакта с клиентом, имеющим видимые отличия

Раздел 1. Общие сведения

- 1.1 Как долго Вы находитесь в пространстве практической психологии? (позволяет оценить шанс встречи с клиентом, имеющим видимые отличия)
- 1.2 Имеете ли Вы опыт взаимодействия с людьми, имеющими видимые отличия в обычной жизни? Если да, то насколько

тесно это общение? *(позволяет оценить представления о круге проблем, с которыми сталкивается имеющий видимые отличия человек)*

- 1.3 Имеете ли Вы опыт работы с клиентами, имеющими видимые отличия? Насколько долгим был процесс консультирования (терапии)? *(позволяет оценить глубину профессионального погружения в проблемы, с которыми сталкивается имеющий видимые отличия человек)*
- 1.4 Имеется ли у Вас опыт работы с клиентом, для которого взаимоотношения с человеком, имеющим видимое отличие, является актуальной проблемой? Например, если клиент находится с ним в родственных (супруги, родители, сиблинги), дружеских или деловых отношениях и свои проблемы рассматривает с учётом имеющегося между ними отличия? *(позволяет выявить косвенный интерес к исследуемому явлению)*
- 1.5 Находится ли человек с видимыми отличиями в числе Ваших клиентов в настоящий момент? *(позволяет определить: проблема взаимоотношений с клиентом, имеющим видимые отличия, имеет гипотетическое значение для практического психолога или является насущной потребностью)*

Раздел 2. Рефлексия собственного опыта выстраивания профессиональных взаимоотношений практического психолога с людьми, имеющими видимые отличия (при наличии)

- 2.1 Каков возраст клиентов, имеющих видимые отличия, с которыми Вам приходилось работать? *(позволяет выявить личный опыт построения профессиональных взаимоотношений с исследуемой группой клиентов)*
- 2.2 С какими вариантами видимых отличий, осложняющих общение, вы сталкивались? С какими вариантами Вы не готовы взаимодействовать? *(позволяет выявить личный опыт построения профессиональных взаимоотношений с исследуемой группой клиентов, наличие ограничений)*
- 2.3 Ощущали ли Вы наличие психологического барьера (не такой, как я; отличающийся от меня в чём-то важном; принадлежащий к особой

социальной общности, в которую я не вхожу), при работе с клиентами, имеющими видимые отличия? *(позволяет выявить личный опыт построения профессиональных взаимоотношений с исследуемой группой клиентов)*

- 2.4 Отмечали ли клиенты, имеющие видимые отличия, присутствие такого барьера? Если да, то коротко охарактеризуйте их. *(позволяет выявить личный опыт построения профессиональных взаимоотношений с исследуемой группой клиентов)*
- 2.5 Заявляли ли клиенты, имеющие видимые отличия, о каких-либо правилах для Вас, связанных с их особым статусом? Если да, то какие? Каким образом Вы реагировали на это? *(позволяет выявить особенности построения контакта со стороны клиента, имеющего видимые отличия и границы, в которых уместно проявление гибкости со стороны практического психолога)*
- 2.6 Охарактеризуйте реальные трудности, сопутствующие Вашей работе с клиентами, имеющими видимые отличия: трудности, связанные с особенностями личности клиентов; трудности, связанные с особенностями личности психолога, с его характерным стилем профессиональной деятельности. *(позволяет выявить круг реальных проблем (в том числе в части переноса и контрпереноса), с которыми сталкивается практический психолог)*
- 2.7 Достаточно ли было Вам знаний теории общей психологии и психотерапии для эффективной работы с этими клиентами? Если нет, то какую информацию и где Вы искали и успешны ли были Ваши поиски? Какие источники показались Вам наиболее полезными? *(позволяет выявить нацеленность на получение дополнительной информации о клиентах, имеющих видимые отличия, а также характер использованных источников (научные, научно-методические, научно-популярные))*
- 2.8 Есть ли какое-либо удобное определение этой категории клиентов, которым Вы пользуетесь при общении с коллегами? Имеются ввиду так называемые «термины для служебного пользования», не имеющие хода в социальной практике. *(вопрос важен для составления*

тезауруса; ответы могут дать представление об эмоциональном аспекте отношения к данной категории клиентов)

Раздел 3. Гипотетические представления и ожидания будущего практического психолога от общения с людьми, имеющими видимые отличия (при отсутствии собственного опыта)

- 3.1 Согласны ли Вы с утверждением, что опыт построения отношений с клиентом, имеющим видимые отличия, может расширить Ваши представления о природе человека и обогатить ваш не только профессиональный, но и жизненный опыт? *(позволяет выявить представления о возможности построения контакта с клиентом, имеющим видимые отличия, в социальной действительности и практической деятельности)*
- 3.2 Готовы ли Вы включаться в консультативный (терапевтический процесс) с клиентом, имеющим видимые отличия? Если да, то с какими вариантами видимых отличий вы готовы и с какими не готовы взаимодействовать? С чем связаны эти предпочтения/ограничения? *(позволяет выявить представления о возможных особенностях построения контакта с клиентом, имеющим видимые отличия, гипотетические ограничения)*
- 3.3 Каков возраст клиентов, имеющих видимые отличия, с которыми Вы могли бы работать? С чем связаны эти предпочтения/ограничения? *(позволяет выявить представления о возможных особенностях построения контакта с*

клиентом, имеющим видимые отличия, гипотетические ограничения)

- 3.4 Охарактеризуйте предполагаемые трудности, сопутствующие работе с клиентами, имеющими видимые отличия: трудности, связанные с особенностями личности клиентов; трудности, связанные с особенностями личности психолога, с его характерным стилем профессиональной деятельности *(позволяет выявить круг гипотетических проблем (в том числе в части переноса и контрпереноса), с которыми, по мнению респондента, может столкнуться практический психолог)*
- 3.5 Если в работе с клиентом, имеющим видимые отличия, потребуется проявить гибкость и сдвинуть границы профессиональных отношений, будете ли Вы готовы сделать это? В какой степени? *(позволяет выявить представления о возможных особенностях построения контакта с клиентом, имеющим видимые отличия и о границах, в которых уместно проявление гибкости со стороны практического психолога)*

Раздел 4. И в заключение....

- 4.1 Имеете ли Вы какую-нибудь заметную особенность внешности или поведения? Могли бы Вы охарактеризовать себя человеком, имеющим видимые отличия? Если да, то придаёте ли Вы этому факту какое-то особенное значение? *(позволяет выявить принадлежность практического психолога к изучаемой группе)*

Section: Special articles

ПЕРВИЧНЫЕ АКТУАЛЬНЫЕ СПОСОБНОСТИ ЛИЧНОСТИ, ПРОИЛЛЮСТРИРОВАННЫЕ В БИБЛИИ

The Primary Actual Capacities of the Individual Illustrated in the Bible



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Received 10.05.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj209](https://doi.org/10.52982/lkj209)

Аннотация

В данной статье перечисляются предложенные Н. Пезешкианом первичные актуальные способности человека, которые проявляются в поведении, в действиях и в отношениях между библейскими персонажами. Последние попадают в ситуации, в которых им приходится тренировать, развивать и выказывать свои первичные способности, несмотря на явные противоборствующие факторы. В жизни сегодняшнего человека также происходят ситуации, в которых он сталкивается со сложными жизненными проблемами, неразрешенными вопросами и трудным выбором. В таких конфликтных ситуациях механизм действия первичных способностей помогает человеку находить решение данных проблем, не уходя далеко, а пользуясь своими же актуальными способностями. Но поскольку эти способности иногда могут находиться в дефицитном положении, перед психотерапевтом встает задача активизировать или развивать их с помощью разных инструментов. В перечень этих инструментов входят также притчи и истории, которые помогают клиенту лучше представить свою ситуацию. В статье предложены библейские истории как инструменты развития первичных способностей.

Ключевые слова: первичные актуальные способности, Библия, позитивная психотерапия

Abstract

This article lists N. Peseschkian's proposed primary actual capacities of a human, which manifest themselves in the behavior, actions and relationships among the biblical characters. The latter find themselves in situations in which they have to train, develop and exhibit their primary capacities in spite of clear opposing factors. In the life of today's man there are also situations in which he is confronted with difficult life problems, unresolved issues and difficult choices. In these situations of conflict, the mechanism of primary capacities helps the individual to find solutions to these problems, not by going too far, but by using his or her own actual abilities. But since these skills can sometimes be in a deficit position, the psychotherapist is faced with the task of activating or developing them with the help of different tools. The list of these tools also includes parables and stories that help the client to visualize his situation better. The article suggests biblical stories as tools for the development of primary abilities.

Keywords: primary actual capacities, the Bible, positive psychotherapy

Введение

Психотерапевт, работающий в методе Позитивной психотерапии, на определенном этапе своей работы ищет, в какой именно первичной актуальной способности у клиента наблюдаются дефицитарные возможности. По Пезешкиану (1987), первичными актуальными способностями являются терпение, контакт, вера, уверенность, сомнение, пример, любовь, сексуальность, единство, надежда, время, доверие. Все эти способности вытекают из базовой способности человека любить, когда ребенок следует примеру взрослых. Итак, найдя ту первичную актуальную способность, которая не справляется с конфликтным напряжением в базовом конфликте или недостаточно развита, специалист начинает “возвращать” ее. Предлагаются разные способы формирования и/или развития данной способности. В данной статье рассматриваются случаи, в которых проявления первичных актуальных способностей происходят в Библии. Они могут послужить примером, своего рода инструментами, для работы с клиентом на стадии вербализации. Библия обладает огромным потенциалом первичных способностей.

Методология

Предложенные Н. Пезешкианом (1987) первичные актуальные способности проиллюстрированы большим количеством эпизодов из библейских историй.

Способность терпения в Библии можно увидеть в истории Иакова – сына Исаака. Бежавший от своего брата, он поселился в городе Харран. Выдержав у своего хозяина, пастуха Лавана, долгие годы тяжелой работы, унижительный обман с подменой невесты, Иаков наконец добивается и любимой Рахели, и семьи, и достатка. Двадцать лет терпения и усердия приносят свои плоды (Бытие 31:38). Способность терпения хорошо проиллюстрирована также в истории Иова. Его, лишенного всего: детей, слуг и богатства, – поразила проказа, ему пришлось покинуть свой родной город. И даже будучи осужденным друзьями и женой, Иов проявил удивительное долготерпение в ожидании ответа от Бога. Вскоре Господь исцелил его от

болезни, у него родилось столько же детей, сколько он потерял, и он вдвое разбогател (Иов 38-42). История Иова буквально пропитана терпением. В Библии указаны еще и другие случаи, где люди проявляют способность к **терпению**, т.е. принятию себя, окружающих людей и обстоятельств, даже если они не устраивают его, и отодвигают момент достижения желаемого, давая возможность развития чему-то другому. (Пезешкиан Н., 2006)

Первичная способность **единство** метко описана Пезешкианом следующим образом: “Единство - способность интегрировать аспекты актуальных способностей, базовых способностей, системы ценностей и опыта. Это психологическое единство должно поддерживать единство личности, что означает способность интегрировать как единое целое функции, характеристики и потребности тела, окружающей среды и времени. Преобладающим над ними является «всеобщее единство», которое означает способность устанавливать отношения с другими людьми, группами, формами жизни, вещами и силами, а также понимать существующие взаимосвязи”. (Пезешкиан Н., 2006). В некотором смысле это внутриличностная и межличностная синхронизация. Внутриличностная, потому что человек начинает синхронизировать разные компоненты и проявления своей личности между собой, даже противоречивые и взаимоисключающие. Человеку лучше удастся быть в единстве с другими, если данная способность хорошо развита по отношению к самому себе. В Библии проявление способности единства можно наблюдать в истории Иерихона. Стены Иерихона были настолько крепки, что никому не удавалось взять его, но “Народ воскликнул, и затрубили трубами. Как скоро услышал народ голос трубы, воскликнул народ громким голосом, и обрушилась стена [города] до своего основания, и народ пошёл в город, каждый с своей стороны, и взяли город.” (Книга Иисуса Навина 6:19). Израильтяне семь дней подряд вместе обходили город трубя и крича, и только на седьмой день стены города рухнули. Все представления о том, как была развита способность единства у среднестатистического израильянина, который участвовал в взятии Иерихона,

говорят об идентификации и согласованности его переживаний, мыслей и целей с остальными. Также, нельзя не заметить, насколько едина была семья Ноя, когда Господь повелел ему построить ковчег. На протяжении всего строительства семья Ноя подвергалась злым насмешкам со стороны соседей и полному непониманию, но поддержка семьи, и особенно его сыновей, помогла ему завершить дело. Идея единства была настолько развита в этих людях, что, отождествляя свои переживания и цели друг с другом, они смогли сконцентрировать свои усилия и за тридцать лет построить ковчег (Быт. 6: 8-22).

Уверенность как одна из первичных актуальных способностей помогает человеку, опираться на свои убеждения и представления о личностных ресурсах, действовать, полагаясь на свои потенциальные возможности, несмотря на препятствия. В книге Даниила идет повествование о трех мужчинах - Седрахе, Мисахе и Авденаго, которые были назначены правителями в Вавилонской области. Они верили в Бога и придерживались его законов. Но царь Навуходоносор велел всем жителям страны поклоняться статуе золотого истукана, а не подчинившихся этому приказу, бросить в печь. То есть вера Седраха, Мисаха и Авденаго была настолько всеобъемлющей, что преодолела даже страх потери всех благ и страх смерти. Их уверенность была не только в том, что Господь их спасет от страданий, но и в том, что даже если они погибнут, то унаследуют вечную жизнь с Богом. В конце истории мы видим, что огонь не навредил им, даже их одежда не сгорела. Уверенность в том, во что они верили, была вознаграждена. (Даниил 3:8-33) Следующий пример проявления уверенности не заставляет далеко ходить. Речь идет о Данииле, который из-за происков завидовавших ему мудрецов был брошен по приказу царя в ров со львами (Даниил 6:16). Будучи уверенным в вере отцов своих, Даниил в ситуации жесткого выбора продолжал молиться своему Богу.

Способность **времени** разворачивается в нас, давая нам возможность чувствовать себя в разных промежутках времени. Как объясняется И. Кирилловым (2022), – это способность интегрировать прошлое, настоящее и будущее, осознавать последовательность событий, которые могут

привести к удовлетворению потребностей. Когда рассматриваем способность времени в таком ракурсе, мы вспоминаем один из эпизодов, связанных с Давидом, еще когда он был пастухом. Испугавшись пророчества Самуила о царствовании Давида, царь Саул преследовал Давида на протяжении пятнадцати лет. Однажды Давид застал Саула в пещере, где царь остановился по нужде. Саул не видел Давида, и тот мог с легкостью убить его, чтобы ускорить свое восшествие на трон, но он решил не поступать так. В тот самый момент Давид продемонстрировал свою способность времени: увидев Саула, он вспомнил про пророчество Самуила, про то, как к нему относился Саул (прошлое), он прекрасно осознавал “благоприятную” возможность, которая предстала перед ним на тот момент (настоящее), и он надеялся на будущее, где Саул покидает трон, и он становится царем (будущее) (1 Царств 24:3-8). Способность времени также означает, что человек уделяет время тем людям и явлениям, которые ему интересны, и не отказывается от внимания по отношению к себе. С данной формулировкой времени есть параллели в истории Марфы и Марии: “Женщина, именем Марфа, приняла Его в дом свой; у неё была сестра, именем Мария, которая села у ног Иисуса и слушала слово Его. Марфа же заботилась о большом угощении и, подойдя, сказала: Господи! или Тебе нужды нет, что сестра моя одну меня оставила служить? скажи ей, чтобы помогла мне. Иисус же сказал ей в ответ: Марфа! Марфа! ты заботишься и суетишься о многом, а одно только нужно; Мария же избрала благую часть, которая не отнимется у неё” (Лука 10:38-42). Несмотря на то, что слово “забота” здесь больше связывается с Марфой, способность времени проявляется больше в поведении Марии. Потому что ей хотелось уделить свое время словам Учителя и нахождению с Ним, а не бытовым заботам.

Способность **сомнения** часто проявляется в библейских историях. При помощи данной способности мы анализируем правдивость тех или иных явлений, задействуя свое критическое мышление. В книге Судей эту способность выказывает Гедеон и тогда, когда просит Господа открыть ему знамения для сражения против врагов Израиля, и тогда, когда перед сражением у него остаются всего триста человек. Ожидание ответов от Бога

иллюстрируют не что иное, как способность сомневаться, ведь шаги, которые должен был предпринять Гедеон, были судьбоносными не только для него, но и для всего народа (Книга Судей 7:2-9). Царица Есфирь тоже засомневалась, когда ей предложили попросить царя о милости к своему народу. По сути, она должна была нарушить строгий придворный этикет, явившись к царю без приглашения. Есфирь, конечно, знала, что это грозит ей смертью. Сомнения в ее ситуации были проявлением высокой осознанности и критического мышления. Движимая уже другими первичными способностями, Есфирь выполнила свою миссию (Есфирь 4: 11-16).

Сексуальность/ Нежность – это способность получать наслаждение от своего тела, а также доставлять это наслаждение другому. В Библии эти чувства проявились главным образом в книге Песнь Песней. Это ярчайшее поэтическое выражение сексуальности, пронизанное глубокой нежностью. “Как прекрасна ты, милая моя, как прекрасна! Глаза твои за вуалью, словно голуби. Твои волосы, как стадо черных коз, что сходит с горы Галаад. Зубы твои белы, как стадо выстриженных овец, выходящих из купальни. У каждого есть свой близнец, никто из них не одинок. Губы твои, словно алая лента, уста твои прекрасны. Щеки твои за вуалью — румяны, как половинки граната. Шея твоя, как башня Давида, изящно сложенная, украшенная тысячей щитов, все они — щиты воинов. Груды твои, как два олененка, как двойня газели, пасущиеся среди лилий”. (Песнь Песней 4:1-5). Вспомним и знаменитую встречу Иакова с юной Рахелью, и вспыхнувшее между ними чувство, которое они пронесли с собой всю жизнь. “Лия была слаба глазами, а Рахиль была красива станом и красива лицом. Иаков полюбил Рахиль и сказал: я буду служить тебе семь лет за Рахиль, младшую дочь твою” (Бытие 29: 17,18).

Говоря о способности **контакта**, имеются в виду возможности человека взаимодействовать с другими людьми и явлениями, и в то же время иметь доступ и к самому себе. Другими словами, контакт – это уделение внимания себе и другим. В случае с Иосифом мы видим, насколько хорошо ему удается устанавливать контакт с самим собой, открывая и принимая в себе такие новые и сверхъестественные качества, как толкование

сновидений. Хорошо развитые способности контакта также видны, когда Иосиф становится доверенным слугой Потифара. И даже после того, когда из-за жены Потифара Иосифа бросают в темницу, ему удается установить контакт с другими заключенными, помогая им. В дальнейшем, используя свой дар толкования снов, Иосиф так сблизается с фараоном, что тот заявляет: “Без тебя никто не двинет ни руки своей, ни ноги своей, во всей земле Египетской” (Быт. 41:44). Таким образом, он становится визирем Египта. Способность контакта Иосифа видна даже тогда, когда его семья, гонимая голодом, прибыла в Египет. Имея высокие полномочия, он мог бы отомстить братьям, но решает простить их, сохранив и продлив с ними отношения. Примером хорошо развитой способности контакта являются также апостолы, которым удавалось, несмотря на разные гонения, все-таки уделять внимание каждому человеку, обмениваясь с ним информацией (книга Деяния Апостолов).

Доверие является очень важной способностью человека, которой он учится с детства, наблюдая за взрослыми. С помощью этой способности человек, не ожидая опасности от других людей, начинает строить или поддерживать с ними отношения. Проявлением способности доверия является тот эпизод, когда Иисус, будучи на кресте, доверил свою мать апостолу Иоанну. “Иисус, увидев Матерь и ученика тут стоящего, которого любил, говорит Матери Своей: Жéно! се, сын Твой. Потом говорит ученику: се, Матерь твоя! И с этого времени ученик сей взял Ее к себе” (Иоан 19:26,27). Он был уверен, что Иоанн сможет позаботиться о Марии после Его ухода. Хорошим примером доверия можно считать историю, в которой Авраам, посылает слугу за своей невесткой в далекий край. Это было довольно ответственным и непростым решением, поскольку речь шла о его любимом сыне и наследнике Исааке, и к тому же, на тот момент Сарры уже не было рядом с Авраамом (Бытие 24:4).

Способность **Примера/Идеала** помогает человеку пробовать на себе поведение, свойство, стиль мышления другого человека. Моисей всегда был примером для Иисуса Навина, который на протяжении всего странствования в пустыне был главным помощником Моисея и после его смерти

выполнял те же функции, что и Моисей (Числа 27:18-23). Таким же образцом подражания являлся Илия для Елисея, своего постоянного последователя. То, как он подражал учителю привлекало внимание у людей. Индикатором способности примера в обоих случаях было то, что ученики всегда продолжали дело наставника (4-я Царств 2:1-6).

Способность **веры** проявляется, когда человек выстраивает отношения с трансцендентным, непознаваемым, ожидая какого-то ответа или взаимодействия. Способность веры хорошо проиллюстрирована в истории женщины, которая двенадцать лет страдала кровотечением и никак не могла излечиться. По закону Моисея, женщины с такой болезнью считались нечистыми и не должны были появляться на людях. Она исцелилась, уверовав в то, что ей поможет одно только прикосновение к одежде Иисуса. Она проявила веру в неизвестное (Лука 43-48). Еще один пример веры, который удивил даже Иисуса Христа, – это история про сотника, хозяина больного слуги. Получив обещание от Иисуса, что Он придет и исцелит его, сотник сказал: “Господи! я не достоин, чтобы Ты вошёл под кров мой, но скажи только слово, и выздоровеет слуга мой” (Матфея 8:8). Сотник верил не только в то, что его слуга может излечиться, но и в то, что чудо исцеления может произойти на расстоянии. На что Иисус произнес: “Истинно говорю вам, и в Израиле не нашёл Я такой веры” (Матфея 8:10).

Надежда – это способность оптимистично настраиваться на будущее, несмотря на отрицательные факторы; это ожидание положительного сценария событий. Способность надежды наглядно видна в истории Анны, которая была бесплодна, а муж взял себе другую жену. Анна долго молилась и надеялась, что Господь свершит чудо. Ответом на ее надежды был ответ первосвященника Илии: *“Иди с миром, и Бог Израилев исполнит прошение твое”* (Первая книга Царств 1:17). Вскоре у Анны родился сын - Самуил. Похожую историю можно проследить у Авраама, который, покинув свой дом, покорно следовал туда, куда ему укажет Бог. Все эти долгие годы он ожидал чуда – рождения наследника. Так ему обещал Господь. В этом Авраам проявил способность надежды, сохранившейся в нем до

преклонных лет, - до рождения долгожданного Исаака (Бытие 21).

Как описывает Н. Пезешкиан, **любовь** является как базовой способностью, так и одной из первичных. Она дает возможность человеку строить эмоциональные отношения с другими, принимать себя, других людей и окружающий мир (у Кириллова, 2022). Понятно, что примеров проявления любви в Библии множество. Одна из таких историй - повествование о Руфь, которая, выйдя замуж за одного из сыновей Ноемини, вскоре осталась вдовой. Она могла оставить свекровь и уйти, но у них были настолько теплые и близкие эмоциональные связи, что Руфь осталась со свекровью, проявив к ней свою любовь и заботу (Руфь 1:16-18). Еще один пример любви продемонстрирован в истории Ионафана и Давида. Будучи сыном царя Саула, Ионафан считал Давида примером для подражания и был так предан ему, что спас его от преследования со стороны Саула, желающего гибели Давида. Даже гнев отца, оскорбления и брошенное в него копье не заставили его выдать друга. “И снова Ионафан клялся Давиду своею любовью к нему, ибо любил его, как свою душу” (Первая книга Царств 20:17).

Обсуждение

Выявление первичных актуальных способностей у библейских персонажей помогает не только в их дальнейшем использовании в работе психотерапевта, но и в глубоком осознании и понимании каждой актуальной способности. Стоит отметить, что в любой из вышеупомянутых историй, читатель, возможно, заметит больше одной способности. Например, в истории, в которой рассказывается про способность доверия, можно разглядеть также надежду и уверенность, но, поскольку доминирующей способностью в данном эпизоде является именно доверие, история акцентируется именно с этой позиции.

Заключение

В пятиступенчатой модели (по Пезешкиану, 1987), на стадии вербализации, специалист, работающий по методу позитивной психотерапии, может использовать разные притчи и истории, которые соответствуют ситуации клиента.

Предполагается, что истории, выбранные из Библии, тоже могут послужить инструментом. Разумеется, необходимо отметить, что применение данных эпизодов в работе с клиентом имеет сугубо индивидуальный характер. То есть специалист действует по своему усмотрению: конкретно какую историю и с каким клиентом выбрать для отработки определенной способности. В данной статье выбрано по две истории про каждую первичную актуальную способность. Безусловно, в книге, из которой были взяты эти примеры, есть множество других эпизодов, достойных упоминания, но из-за ограниченности в объеме, использовались только некоторые из них.

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Section: Psychotherapeutic cases

PATIENTS ENCOUNTER WITH DIAGNOSES AND ILLNESS IN TRANSCULTURAL PERSPECTIVE



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Received 15.04.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj210](https://doi.org/10.52982/lkj210)

Abstract

The world of today is full of diversity. With migration problems, religious groups and many conflicts in this world it is important to bring into our focus the different world-views of understanding illness and treatment in different cultural and religious settings. In my article three cases are presented to explain exactly how different Traditions treat patients with diverse sicknesses and their approach to establish the diagnosis of organic and psychic problems. The object of this expose is to explain the way and manner of encounter when one visits a country with some sort of illness. These cases are experiences of my clients in interaction with Therapists in their cultural settings. Importantly, as a Positive Psychotherapist, this information helps to accommodate all aspects of interaction needed to give a safe background for clients. My method is more or less analytic and descriptive. Many illustrations in this work portrays my many years of experience working with people of different cultures and clients. Moreover, it is very important for our understanding of our clients always to see beyond our horizon.

Keywords: psychosomatic health, personality structure, psychotherapy, stress, diagnostic criteria for psychosomatic practice, positive psychotherapy

"If two people each have an apple and then exchange them, they will still have only one apple. But if the same two people have an idea and exchange them, they will have two or many ideas"

- George Bernard Shaw

Introduction

Transcultural psychotherapy has its roots in the professional world's preoccupation with various human issues. What do they all have in common and what makes them different? The transcultural approach plays a central role in Peseschkian's positive psychotherapy. The question here is how the same problems or conflicts are perceived and dealt with in other cultures, how other people in their own culture and family deal with them. Comparing how other peoples or cultures evaluate similar patterns of

behavior broadens our horizons. You no longer have to interpret behavior based solely on the given standards of value, but rather compare them with other concepts. By relativizing one's own values, prejudices are questioned, fixations are broken and communication blocks are removed. (Peseschkian, 1998).

Based on consultation procedures in different countries and cultures, I would like to point out the different settings of Patient-Consultant interaction, understanding of Illness, and the treatment possibilities in different cultures. (I chose Dornbirn, Austria, Hong Kong, China, and Okigwe, Nigeria)

In these conversations in different cultures, the actual management of Illness and its processes will depict the different systems in different cultures. My aim is to broaden the patients' and consultants' understanding of approaches to illness and its treatment. I will also

discuss the different notions of illnesses according to the model conceptions in different cultures, philosophies and ideologies. My focus is more or less to give a broad understanding of the views of illnesses in different cultures in order to avoid partial diagnoses. It is not my intention to evaluate the efficacy of the different approaches, but it is my conviction that the Therapist with the help of the patient can develop those subtle and complex skills necessary for successful therapeutic work in various cultures. It is important to stress that Positive Psychotherapy encourages such diverse skills. When a Patient visits a therapist or consultant, it is paramount to use intuition which is closely related to empathy. Both empathy and intuition are means of obtaining quick and deep understanding that will help to overcome cultural divergences.

Cases

2.1. Dornbirn

The patient from Türkiye told how his consultation hours in a doctor's office in Dornbirn had gone. He had gone to the doctor with a bad headache and didn't know why. "Maybe I have a lot of worries with my wife and children," he said. When he called the doctor's medical office, the doctor's assistant gave him an appointment for Tuesday at 10:00 am. At the same time, she asked him if he had any insurance permit at all and that he should please bring it to the consultation. His headache got worse after that phone call. On Tuesday he arrived at the practice at 9.30 a.m. and handed his medical certificate and medical insurance card to the doctor's assistant. There were other patients in the practice ahead of him, so the assistant asked him to sit down until he was called. He sat in the corner, did not know anyone and felt insecure and lonely. He could not bother with the newspapers lying around or talk to anyone to pass the time because he could not speak good German. At 10:15 a.m. his name was called, which was also not pronounced correctly. When he came into the doctor's room, the doctor shook his hand and asked him to sit down. He asked his patient: "What can I do for you?" He replied: "I have a headache." The doctor further asked: "Since when?" "For a month." Then the doctor asked whether the headache was new or was it some thing that was permanent in his life history including his childhood. "No, it's new,"

the patient replied. Then the doctor got up, measured the patient's blood pressure, listened to his heartbeat, and prescribed a painkiller for him (paracetamol). He told him to come back in two weeks. Although, he saw an inscription in his medical Office, "Doctor for general medicine and psychotherapy", there was no conversation. The whole treatment took only 10 minutes. He then gave him 10 days of sick leave.

2.1.1. Transcultural comment:

Surprisingly, the first conversation with some psychotherapists is fundamentally similar to the question: "What can I do for you?" Psychotherapists nevertheless try to understand, focus, interpret and diagnose the patient's problem. Psychotherapists endeavour to go beyond and ask: What is my mission, what do you want, what can I do for you? The client is asked to articulate his or her problems him/herself. In the diagnostic conversation we try to grasp how a person experiences him/herself and his/her world and how he/she processes his/her conflicts. (Schelling, 1985)

In a long tradition of medical and psychological understanding of diagnosis, an objectifying diagnosis, the process of coming closer to the essence of illness, is highly valued, Psychotherapists use the communication space to recede into the background in its dialogical, atmospheric and cognitive meaning.

The modes of treatment in some psychotherapeutic schools are characterized by introspection. The patients talk about their illnesses, how they deal with their illnesses, how these illnesses are represented in the fabric of the patients' actions, fantasies and symptoms. The clients interpret themselves in language, speaking, they present their understandings of themselves and the interpretation of their worlds, through speaking, they try to bring their history into their understandings. This type of problem analysis is a typically Western peculiarity that is deeply rooted in Western culture. Yes, the introspective element of Western civilization is ancient and can be traced back to classical Greek thought, where self and identity are increasingly defined through actively viewing, examining and weighing the events and adventures of one's life. The process of introspection was closely related to the idea of the actual "I", as found its typical expression in the Socratic "Know thyself". (Kakar, 1984).

2.2 Hong Kong

"A friend told me about a consultation he had had in Hong Kong with a Chinese medical doctor after many years of kidney problems. On the recommendation of a travel acquaintance, he had gone to see a Chinese doctor between two flights. As a person with many social commitments and social assignments, he was, of course, used to ignoring his desperation and his illness as much as possible. "Grin and bear it," they had said to him in a famous American clinic when he visited. The Chinese received him, they talked about this and that, but the illness did not seem to interest the doctor particularly. He inquired about his visitor's work, his preferences, got him to tell a love story, which my friend could not cope with, and wanted to know this and that about his youth, his parents, his family. The conversation was by no means profound, it stayed within the bounds of polite convention. The Chinese Doctor went to the window and talked about the movements of ships in Kowloon Bay, about shopping in Hong Kong. The doctor explained his setup, explained an acupuncture model and sent for tea. When my friend, who had been made relaxed by the peculiar-tasting tea, cautiously asked when they would get down to business and what the doctor would prescribe for him, the Chinese doctor said with a smile that they had been talking about the matter for a long time, and pointed to the tea they had drunk together and said: That is the medicine that I have to offer you because of my diagnosis. "Diagnosis?" my friend asked. "Well yes," said the Chinese doctor, "you have told me most of what I needed to know." He said that he had had the honour of listening to his guest speak and watching him walk, observing his sitting, his movements, his eyes and fingernails. Then, with a polite apology, he pressed his finger on two spots on my friend's back, saying: "Here and there it hurts, doesn't it?" He explained that there were a couple of mistakes in his guest's posture, which the doctor naturally could not correct in fifteen minutes, since that was not where the problem lay. He explained that instead, the pain is an expression of a disorder, of a painful relationship to certain things that my friend had encountered and to which he reacts with excitement. This tension is now ingrained in him, and in order to resolve it, he would need help from someone in his homeland who understands something about body and soul, but also knows the patient's way of life. Pain is

valuable and for the time being indispensable because it indicates the point from which one must work oneself back to its origin, which is to be sought in a presumably well-founded dissatisfaction. If, starting from the back pain, he manages to walk the path to his satisfaction, probably a long way, the pain will no longer be necessary. The kidneys, as a sensitive organ, naturally react to the indicated shift in focus. But the kidneys are secondary, and the tea here, of which he gives him a bag, will also do him good." (Schelling, 1985)

2.2.1 Transcultural Commentary

In this type of therapy, the patient is greeted politely. All of his movements, signals, thoughts and speech expressions are carefully observed and when necessary physical touch is also used. In this type of therapy, health means a harmonious interaction of the body's organs and a balanced flow of energy. (Cheng, 1993)

A pathology actually arises from a flow of "zang" (five); "Fu" (six) and "Qi" (energy flow), i.e. a disturbance of the Yin-Yang or the Wu-Xing principle. The treatment aims at harmony between the principles by strengthening the deficient principle and weakening the overactive one. Treatment methods include herbal medicine, acupuncture and psychological influence. (Cheng, 1993).

In this tradition, a theoretically well-founded psychotherapy does not exist. The treatment takes place through self-monitoring and clarification in therapy sessions. Deep psychological assumptions and an unconscious are alien to Traditional Chinese Medicine (TCM), psychotherapy takes place in one or two sessions and assumes the workings of self-healing powers. If demons or spirits have been diagnosed as the cause of illness, this is also taken into account in the healing process and spirit expulsions are carried out. (Cheng, 1993)

2.3. Okigwe (Nigeria)

Prehistory:

A woman, 30 years old, had multiple miscarriages. For many years she was treated by a doctor who had studied in Germany, but nothing helped. She is a Christian and believes in the power that God will help her if she allows herself to be helped. So, she decided to visit a "Dibia" (medicine man, healer). There are no appointments to visit medicine men and women; anyone with problems can come and be helped

immediately. This woman came to the medicine man early in the morning after a long journey and he already knew that a woman would come to see him. He had found it out through his dreams. The greeting rituals are quite long, there is no hurry with the medicine men. Here the difficulties of the long journey are asked about, the family situation is recorded, the mental and physical complaints are recorded, mistakes in the relationship are determined, whether certain taboos are observed or not, e.g. whether the woman had sexual contact with someone during her menstruation, the woman's attitude etc. After this first exploration, they both go into the jungle (bush). Each "Dibia" always has a tree where he performs his ritual actions. The woman is given a place next to the tree and the oracle is asked what she has, what disease or demon is preventing the pregnancy. What evil spirit or human will not allow pregnancy? In general, no blame is sought, but blockages, obstacles or cracks in the living conditions. The medicine man remains alone, puts himself in a trance and tries to perceive the woman's situation. During this time of waiting, the woman can enjoy the silence of the jungle, perceive the various insects and reptiles, etc. After this consultation with the gods, the medicine man says a prayer, looking for the necessary medicines for the woman from a mixture of different plants and herbs of the forest. This mixture is then taken by the woman and painted and smeared on the various parts of her body. Treatment is always free, but the woman can donate to the medicine man after the birth of her child. (Mbabuike, 1988).

2.3.1. Transcultural Commentary

The understanding of therapy and the way medicine men deal with clients are determined by a number of factors. The profession of medicine man can only be inherited, not learned. Healing is intuition only or determined by the gods. Without ritual actions there is no healing. Conversations take place between the patient and the gods, and the medicine man acts as mediator. Therapy is free because healing is a gift.

Cures are fetched from nature and concocted by the medicine man; these are revealed through a trance state. The holistic view of the disease is required: body, soul, spirit. (God and environment) Amulets, stones, statues and other items are used when required.

All above illustrated cases with different therapeutic settings to alleviate organic and psychic abnormalities are included in the balance system of positive transcultural therapy. In the therapeutic relationship of PPT the Therapist or consultant has the opportunity in the areas of Observation and distancing, making inventory, situation encouragement and broadening goals to have deep insight into the Patients Biography, Value and Belief- systems, capabilities, support qualities, bodily and other instruments in the patient's life style.

Discussion

3.1. Analysis of Illness in the transcultural setting

The concept of illness in psychotherapeutic schools is multifaceted and complex. It is an expression of different perspectives and images of people. Looking over the fence is still by no means common among psychotherapeutic schools: (Pritz, 1992). That is unfortunate. Because the heterogeneity of the views that can be determined, which is also evident with regard to illness, opens the view to how diversely the phenomenon of illness can and must be seen if one wants to do justice to the people who are ill and who suffer from illnesses, and if one wants to find adequate ways of healing.

Transcultural psychotherapy deals with such different conceptions of diseases and tries to convey an integrative view of the disease. This applies to people as members of a group and as individuals.

Peseschkian summarizes the historical considerations of the disease and its development in different geographical and social treatment methods in the following models: deification model, demon model, sinner model, stigma model, genetic model, will model, medical model and environmental model. (Peseschkian, 1987)

3.2. The Deification Model

Illness is understood here as a divine medium. Here it is interpreted as a divine influence. The patient is seen as a divine instrument or mouthpiece. He is sometimes perceived as a priest with certain powers. At this time the deification model is noticeable in forms of family neuroses, the patient acts as a symptom carrier for the entire family problem, for example, in addiction.

3.3. *The demon Model*

In this model, illness is caused by evil spirits, demons and devils. Here the world is divided into two groups: the world of good spirits, bringing blessings, and the world of evil spirits, bringing calamity. Here, as in Chinese medicine, balance is sought (Yin-Yang). Prayers, alms, etc. are used to cast out the bad spirit. Today some conflicts in partnership, in raising children, racism, wars between nations seem to be determined by this split worldview.

3.4. *The sinner Model*

Illness comes from a disregard for divine norms. If a person does not follow the divine order, he/she will be punished with sickness. This world view of reward and punishment is present in many religions and human relationships. Today the problem of splitting is very relevant, for example on the relationship level. The development of rejection tendencies, aggression, hate, jealousy are fueled. The patient is to blame for his illness.

3.5. *The stigma Model*

Illness is understood here as God's will to be endured and tolerated. Any kind of illness is compared to the suffering of Jesus Christ. Compassion is shown towards those who suffer. There are many Christian groups today who believe that illness is seen as a temptation from God. If a person overcomes this temptation, that person will be accepted by God.

3.6. *The genetic Model*

Diseases can be hereditary. One looks for hereditary characteristics, genetic connections, family analogies, correlations of origin and tribal characteristics. The disease is understood as a transmissible pattern of behavior. As Peseschkian put it, this type of assessment leads to the following: On the one hand, the role that a person can play in a group is determined by the person's alleged genetic behavior. On the other hand, changes in behavior are hardly possible, since they would always have to break through the inherited behavior. Constellation therapy forms, kinesthetically oriented and medical therapies are open to this type of diagnosis.

"When the source of life is purified, the life energies can become healthy."

3.7. *The will Model*

This model is incumbent upon the philosophical movements of existentialism, the Enlightenment, and psychoanalysis. These state that man is a unique, one-off and unmistakable individual. Only he can heal himself. Many psychotherapeutic schools base their healing processes on the will of the patient. Only he /she can conquer his /her illness. Illness is understood here as suppression of the ego, as rejection of the self or as an overpowering external influence. Therefore, the I or the Self must be strengthened. Illness occurs when the superego and id do not give the ego agency. However, such a world view of the development of the disease could overwhelm depressive patients.

3.8. *The medical Model*

Illness is judged on the basis of the formation of symptoms and on the basis of demonstrable, objectifiable causes. The diagnostic procedures are emphasized, only what is clearly discernible in the diagnosis is cured. The science-oriented methods tend to make such assessments of illness. Here, however, Peseschkian criticizes a versatile and holistic view of the development of the disease. Conditions of illness include, but are not limited to, psychosocial factors, eating habits or attitudes towards alcohol, physical activity and nicotine, professional anger, family strife, constant stress, feelings of failure, hopelessness, and feelings of meaninglessness.

"One tries to help someone who has already fallen into the well." Fortunately, different accents are set today in the disease assessment of some specialists.

3.9. *The environmental Model*

Every disease is viewed as a product of the environment. The scapegoat is society, the environment, nature, etc. Here society demands (and promotes the emergence of diseases, e.g., the state demands the sale of cigarettes and alcohol, the emphasis on constant performance, environment-like diseases due to the Environmental pollution (noise, pollution, etc.). Parents who accept this pressure and are, therefore, no longer able to fulfill their parenting responsibilities are seen as the culprits when their children fail.

3.10. *The growth Model*

People's thinking in growth and global categories have had a devastating effect on health and disease. The mega-phenomena allow

people to paint a picture of the world, which is global and powerful on the one hand but which no longer perceives the individual human being on the other hand. Mega stores, mega apartment blocks, etc. are being built all over the cities. The increase in crowds and population concentration in the cities is also alarming. The digital Globalization of information is causing emotional dementia. Thus, there is an increase in the number of unemployed, an increase in poverty and an increase in the problems of the elderly, etc. Of course, this development has important psychological, sociological and financial consequences. In addition to the growing gap between rich and poor, family and environmental problems are enormous. Divorce rates have risen in many industrialized countries, childhood mortality has almost doubled in developing countries, the mass killing of animals and birds for any disease (BSE) is shocking. This tendency leads to new diseases such as burnout syndrome, ADHD (attention deficit and hyper syndrome), Corona, loss of meaning, fear of loss and other diseases such as cultural neurosis, cultural psychosis, xenophobia, criminal exploitation of the weaker in society, etc. (Drewermann, 1991).

Conclusions

In conclusion, the article underscores the significance of the transcultural approach in psychotherapy, particularly as it is manifested in Peseschkian's positive psychotherapy. This approach promotes the understanding and comparison of how different cultures perceive and handle similar problems or conflicts. This transcultural perspective enables the relativization of one's own values, challenges prejudices, and mitigates communication impediments.

Through the exploration of patient-consultant interactions in different settings, such as Dornbirn, Austria, Hong Kong, China, and Okigwe, Nigeria, the author illustrates the diverse understandings and management of illness across cultures. The aim is to enrich the understanding of both patient and consultant when it comes to illness and its treatment, thus advocating for a more holistic and culturally sensitive approach to diagnoses. The author emphasizes the importance of recognizing different cultural conceptions, philosophies, and ideologies in the comprehension of illnesses,

highlighting the necessity for a broad perspective to avoid partial or biased diagnoses.

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Section: Republished article: Practical Case in PPT method

ONCE UPON A TIME THERE WAS A GRAY CHAMELEON

A documented treatment of a patient with Borderline Personality Disorder with Positive Psychotherapy from the perspective of the patient and the therapist*



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Received 16.04.2023

Accepted for publication 15.06.2023

Published 01.07.2023

DOI: [10.52982/lkj211](https://doi.org/10.52982/lkj211)

* English translation and modification of the original German publication: „Bibliotherapie und schriftliche Selbstreflexion durch den Patienten. Beispiele für die Intensivierung eines psychotherapeutischen Prozesses am Beispiel der Behandlung einer Patientin mit Borderline-Persönlichkeitsstörung“. Psychodynamische Psychotherapie 2002; 1:52-68.

Abstract

Even though the borderline personality disorder (BPD) belongs to the most common personality disorders, its treatment is still a great therapeutic challenge. The different approaches have one thing in common – the request for a flexible setting depending on to meet the patient's needs. After a brief introduction, we report about a 27-year-old female patient who was treated successfully in a 33-hour-session individual therapy. The applied method was positive psychotherapy, a humanistic psychodynamic method. Additional techniques are explained. The patient wrote more than 500 pages as homework during the treatment period of 10 months. This material gives an insight into the therapeutic process and its transference phenomena from the perspective of the patient. The therapist's comments conclude this and give an insight into the countertransference. The applied therapeutic techniques, especially the writing, homework, tales and bibliotherapy are discussed. Finally, in conclusion, a more innovative approach for the treatment of borderline disorders is called for.

Keywords: borderline personality disorder, positive psychotherapy, psychodynamic psychotherapy, homework, bibliotherapy

Introduction

Borderline personality disorder (BPD) is one of the most common personality disorders. The prevalence of BPD is estimated at about 2% in the general population, about 10% in outpatients and about 20% in inpatient psychiatric patients (Eckert et al., 2000; Widinger and Weissman, 1991). In clinical populations with personality disorders, it ranges from 30-60% (DSM-IV). After analyzing the existing epidemiological data, Stone (2000) predicts that

BPD is about to develop into a mass phenomenon. The diagnosis of borderline personality disorder, which used to be a diagnosis of embarrassment, has been made considerably easier by the inclusion of this disorder in the DSM-IV (1996) and ICD-10 (1995) classification systems, although special interview forms are also required (Gunderson, 1985; Kernberg, 1991) and cannot replace the perception of the therapist.

The existing therapy concepts are based on the different views on the etiology of the

borderline disorder. Nevertheless, certain general treatment principles (Dulz et al., 2000; Rohde-Dachser, 1979, 1995) have developed over the course of development, the importance of which is generally recognized by many psychodynamic-oriented psychotherapists. A variable setting that must be adapted to the respective needs, abilities and limitations of the patient is regarded as the overriding principle of any borderline therapy. Furthermore, personal sympathy, technical neutrality, a holding function, and clear setting of boundaries were required (Dulz and Schneider, 1995). The therapy is generally considered to be difficult, so that dropout rates between 17% and 67% have been reported (Dammann et al., 2000), with dropout rates appearing to be lower in the inpatient setting than in the outpatient setting.

Despite investigations into the positive connection between the assignment of homework and the success of therapy (Kazantzis et al., 2000), psychodynamic therapists in particular use these techniques less frequently than their CBT colleagues (Borgart and Kemmler, 1991). A transcultural study (H. Peseschkian, 2002) between German and Russian psychotherapists showed that up to 70% of German patients regularly wrote down topics and insights between sessions. Despite calls for a variable setting, little is known about the use of bibliotherapy, homework, and note-taking in the treatment of borderline personality disorder. Even in the case of in-patient treatment of borderline patients lasting several months, accompanying therapies are most likely to be used in the form of body-centered and creative procedures in addition to individual and group sessions (Dulz and Schneider, 1995).

We report below on a 27-year-old female patient with a borderline personality disorder who was successfully treated during 33-session outpatient individual therapy. The humanistic psychodynamic therapy was based on treatment techniques from positive psychotherapy (after N. Peseschkian), psychodynamic and cognitive-behavioral therapy. Through the targeted use of certain techniques, especially homework, writing down and bibliotherapy, resistance could be reduced, and the duration of therapy shortened. During the therapy, the patient wrote down more than 500 pages, most of which reflect her insights and therapy experiences. This 'inside view of a psychotherapy' makes this case interesting, at the same time it has possible

consequences for the treatment of patients with borderline disorders.

Case

2.1. General preliminary remarks and case history

The then 29-year-old patient Viktoria came to the author's working place by the advice of a friend. The patient had been living with her boyfriend Markus for a year. He had been transferred to the city for two years for professional reasons. In the first session, the patient reported that her symptoms had been increasing for a year - a few months after moving to this city. She would cry a lot, was aggressive towards herself, she felt depressed, had a lot of inner restlessness, was often tired and exhausted. She would often hit her head against the wall out of anger; she reported about bulimic tendencies, and fear and anxiety. Increasing problems with her fiancé, who would not understand her; she perceived him as being cold and he would hardly speak about emotional issues. In recent weeks, often after arguments with her fiancé, she had injured her left forearm with a knife, which had led to a significant release of tension. She also threw plates through the whole apartment and sometimes destroyed even furniture in emotional outbreaks. In addition, she had suffered from recurrent migraine-like headaches since childhood.

2.2. Biographical case history

The 29-year-old patient had an older brother (+ 1 year) and she initially grew up with her parents. Her parents divorced when the patient was 13 years old. She grew up with her mother and stepfather. The divorce was never explained to her. The mother always spoke very negatively about the father: He would never take time for her; he would constantly cheat on her mother and then left the family. She never had a good relationship with her father. She reported about sexual abuse by an older family member when she was 6 years old. Since that age, she would scratch her fingers regularly.

After the parental separation, the father moved out. Her brother stayed with her father and she with her mother. The mother started to work full-time. She had to change the school. Six months later the first signs of bulimia appeared; difficulties at school and behavioral problems started. Since that time (age 13) she would

constantly flirt with men, fall in love often and be in relationships with men constantly.

"I can't be alone. I feel better when I'm in love. I often had two boyfriends at the same time." The partnerships never longer than one year. After that, she quickly entered into a new relationship. She was never without a partner for more than two months. In the last 6 years she had been only in long-distance relationships. She never rejected men physically, but never enjoyed the sex with them; she couldn't indulge. She fled into fantasy and indulged in sexual thoughts there. At the age of 14 I had my first sexual contact with a boy who was a few years older than me ("he undressed me and "stroked" me so that I only noticed this loveless experience years later that I had lost my virginity"). One month later the onset of bulimia. For years ago, she met her Fiancé Markus, and they had a long- distance relationship until they moved to the recent city. Before that, there was a lengthy phase of separation, during which the patient had short, intense relationships with various other men. The move to this city meant to live together for the first time. The patient was an office manager, her fiancé a consultant.

Diagnostically, the patient met the ICD-10 criteria for emotionally unstable personality disorder of the borderline type (F 60.31) and the criteria for borderline personality disorder (301.83) of the DSM-IV. The focus was on mood swings, crying, anxiety (especially when she felt being abandoned), aggression, outbursts of anger, inner restlessness, self-mutilation with knives on the forearms, recurrent suicidal thoughts, a feeling of inner emptiness, devaluation of friends and an ambivalent relationship with men.

Psychotic symptoms were not present at any time. The physical examination was without pathology, except for old and recent injury scars on the forearms.

The therapeutic setting consisted of weekly individual sessions, each lasting 50 minutes. Twice the patient's fiancé was invited. Drug treatment was given briefly for ten days with lorazepam (1 mg daily) for acute suicidal decompensation and later for insomnia with amitriptyline (10 mg at night). The health insurance of the patient's employer covered 80% of the costs of the outpatient treatment. The rest was paid by the patient herself.

2.3. The Therapeutic Process

During the treatment, the patient received regular "homework". This consisted of writing down events between sessions (referred to as the "weekly report" by the patient) and of insights gained from studying the therapeutic literature given by the therapist. In total, the patient wrote down 501 pages during the 34 sessions, already 58 pages after the first interview. These documents were used for the patient's subsequent observations about the course of therapy and give a unique insight into the therapeutic relationship and its transference phenomena from the perspective of the patient. Extracts are anonymized below and published with the patient's consent.

2.3.1. The psychotherapy from the patient's point of view

The following statements were compiled by the patient towards the end of the therapy in a report and discussed in the last two sessions. They reflect the exact wording of the written documents of the patient. The report was only minimally modified, mainly to protect anonymity.

2.3.1.1. Background

I am a big fan of psychology and psychotherapy. The subject has fascinated me for as long as I can remember. When we read Kafka in school, I was absolutely fascinated with interpreting his texts. My teacher liked what I said. I found it extremely interesting to repeatedly discover the problems with his father in Kafka between the lines or to openly present them.

I suffered from bulimia until 1988, specially from May 1984 to 1987 it was very severe. After that, there were cases of binge eating with or without vomiting afterwards. As a teenager my mother, my brother, my mother's second husband and I had a group discussion with a child psychologist. After that I had another session alone, actually with my boyfriend joining, because he had brought me to the session and the psychologist suggested him to come in. The conversation was awful. I had the impression to deal with two witches. They were two. One asked questions, the other wrote down. Sometimes they would comment on each other, once one would say, "Do you think Victoria can afford to stop [vomiting]?" They provoked me. My friend said afterwards that he too found that comment

strange, but thought it was part of therapy to trigger some sort of defiant reaction in me to stop vomiting. I'm glad he told me that because I felt confirmed that I just couldn't stop doing it. I didn't go there anymore. My mother did not support me going there. Money was one of the reasons, perhaps one of the most important. Today I think that maybe my mother was afraid of what I might have learned in therapy. What the two witches had conveyed to me was that I wasn't responsible for disputes between my mother and her second husband and that I should stay out of it. That helped me in the future. I believe that with my mother's support I would have gone further to the witches. Maybe I would have learned a lot earlier. Well, that was more than 10 years ago. I am glad that in the city I had the chance to undergo psychotherapy with Dr. Peseschkian (Dr. P.) to carry out...

The first session with Dr. P. I had on November 6, 1996. Exactly one year earlier I would have liked to contact him, but I didn't know about this possibility. November is a terrible time for me in the city. In November 1995 I had seriously considered killing myself for the first time. In my imagination I had this thought before. But the thought has never been so clear. It reassured me at the time that I had the choice to end it all here. I calmed down. I was counting the days until Christmas vacation. Markus was on so many business trips during this time. At that time, he persuaded a friend of ours to stay with me for a few days. I never spoke to anyone about it, but I feel like I really would have killed myself at the time if I'd stayed alone. I started destroying more and more, I almost ruined all our dishes, I once smashed our kitchen door when we were once again out of water and expecting guests. Then the summer got better, I think the city is great in the summer: We undertake more, I'm less afraid, I'm generally much more relaxed. Then autumn came again, I became more and more depressed and aggressive. I cut and tore clothes, ruined everything, kicked the laundry box. Very bad was a Sunday when I kicked this box again, I scratched my face and neck with my nails, banged my head against the wall, against the box, against the bed, my whole forehead was blue. I used to calm down when I was in pain like this, but not this time; I then cut my left forearm with scissors.

Unfortunately, the scars are still easily visible. I don't know how other people perceive that. I see them every day in the summer now and I

really regret it. I hope these scars don't stay forever. Likewise, I have scars on my belly. Sometime in late 1995 or early 1996, when Markus once again rejected me when I wanted tenderness from him, I couldn't handle it and was so hurt. I blamed my belly scars, even though I wasn't much, if anything, fatter than I am today (I feel fine today, I always want to lose 1-2 kg chronically, but I feel fine in principle). At that time, I took the scissors again and cut my stomach into lengthwise strips. These scars are still easily visible today - again for me every day, for others maybe not noticeable at all.

2.3.1.2. Course of therapy

In our first session, Dr. P. asked general questions. It was difficult for me to explain what the problem was because I didn't know myself. I just felt incredibly bad, I had aggression, depression and suicidal thoughts. I felt sick and powerless. I couldn't speak properly either, I couldn't find the words to describe situations, problems, circumstances, pain, etc. The relationship with Markus was an absolute mess, full of misunderstandings, arguments and unrest. We only addressed the problem of finger scratching on my own initiative throughout the therapy. I didn't even know that it was also a psychosomatic problem, I've been scratching for so long. (Actually, six months after the beginning of the therapy, I actually stopped cutting myself anymore, probably because the pressure had been relieved by the clarification of many problems and I was also in the process of learning better and better how to discuss, structure and solve new problems). Dr P. asked a lot in the first session. Then he suggested that I should write down everything that had been important during the last 4 years. I wrote almost 60 pages about the past 5 years or so. My body fully responded. I felt so sick that I even didn't go to work for the first time. I had a slight fever, felt so weak and sick. We talked a bit about this report. It was hard for me, especially the rape-like experience stories.

Soon Dr. P. gave me the book of Oriental Stories [The Merchant and the Parrot by Nossrat Peseschkian] which absolutely fascinated me. I read it in a few days and analyzed it in detail. I was or was still ill and didn't go to work. I just couldn't go to the office anymore. This book was absolutely fascinating to read. I learned so much about myself, among other things, that it became clear that the problem of saying

goodbye, of letting go, would become one of the most important themes in therapy. I didn't realize that at the time. Dr P. had suggested that I should no longer criticize Markus, but rather write down anger and conflicts. I wrote at least 10-15 pages from session to session. In retrospect, that was very helpful. The mood between Markus and I improved over time and we both learned to speak constructively to each other instead of scolding or yelling accusingly. A note in my calendar at the end of November describes a decisive improvement in our relationship. Typically, my state of mind, my well-being fluctuated a lot. There were days when I felt good and happy to be in the city and satisfied with my situation, then there were days when I just wanted to die. These fluctuations in themselves were also very energy sucking.

In a next session, Dr. P. showed me in a kind of atomic form what and who is important in my current life [social atom]. I was totally stressed out when he asked me to do it. I suddenly didn't know even how to draw an atom anymore. I drew it in circles, unlike Dr. P. had suggested and I was totally embarrassed. He did not criticize, fortunately, and of course not. It wasn't really about the shape of the atom, but about the statement. It became clear what an idealized place my mother held in my life. Back then in **November-December** [1996] I wasn't at all sure who had a more important place in my life or rather who I was closer to. There was a certain rivalry between mother and boyfriend. I drew such an atom again in June 1997, it looked different. My father's status had improved, my mother had a new status that reflected less connectedness. It's also interesting to note that I'm a little less superstitious these days, and believe more in myself.

I believe in God and pray, but I know that I have to initiate and take charge of things. In my opinion, for a while I was even in danger of being lured by a sect, today they wouldn't have a chance with me. Dr P. suggested using the Christmas vacation to observe the family, my father and my role in the family. From **January** 1997 we discussed the topic of family, mother and father more intensively. It was so exhausting for me. Dr P. already knew my limits very well at this point. He knew how to talk to me to achieve a certain effect. As much as I liked him in November, he became uncomfortable for me at that time. We also talked about showing real feelings.

I always held back tears and smiled instead of crying. Dr P. strongly criticized this in a session in which we talked intensively about my father. We were in a different room during this session, it may be coincidence, or it was intentional, because I associate uncomfortable feelings with this session. I was totally exhausted after the session and couldn't stop crying. That was the first and only time that I had called Dr. P. privately. I spoke to his wife. Dr P. then called me back. I was very happy because I didn't know how to behave anymore. Dr P. recommended that I write it down, which I did. I was glad of this advice because I didn't want to write anymore, I felt terrible and even cried so much in the office that I couldn't work that day. My body reacted I often had headaches and also stomach pains.

From the end of **February**, I felt much better, the relationship with Markus brought joy and energy again. This high wasn't permanent, but it was a start. I hadn't taken any medication yet. From the middle of March, I had so many headaches, I could hardly sleep and I was very exhausted. In the office I was hardly productive in the afternoon. Dr P. prescribed me Saroten [amitriptyline 10 mg at night]. I slept better from now on and recovered.

March was an important month. I prepared the conversation with my father, whom I had not seen for years. It was so hard. I cried at home, and during the sessions. Then I had prepared the conversation and played it through several times myself. I didn't take up the offer to talk to Dr. P. to roleplay through the conversation. I would have been embarrassed, I felt well enough prepared. Today I know that this conversation was and will be one of the most important in my life. The relationship improved, we cleared up so many misunderstandings. I realized that my father loved me and had suffered greatly because I had turned away from him. I also saw that he was very sorry about the divorce. I also suddenly realized that I had not critically reflected on comments and recommendations of other people - especially from my mother - and that in the future I will do so, so that such serious mistakes due to one-sided influence do not happen to me again. After talking to my father, I suddenly had the feeling that I do have a father. This contributed significantly to my personality development and to my attitude and general way of life.

April was marked by beautiful moments, but also many crises with Markus. It was about

misunderstandings, disputes and the inability to have a good partnership. I was already a little calmer, but then I suddenly had emotional outbursts that were accompanied by vandalism. One evening I freaked out, probably again because of fear of loss and desire to cling. I destroyed a picture, a book, and a vase of Markus. I could hardly stop. When I had calmed down, the bad conscience came back and I was very embarrassed in front of Markus. I then started another admirable book by Dr. Nossrat Peseschkian, "33 and 1 form of partnership". I would recommend this book to any couple. I learned so much from reading this and I keep thinking about it. I analyzed the book in detail during our vacation and was "blown away" by what I recognized and suddenly saw. As the weeks went by, communication with Markus improved, I broke away from my mother more, built a bit of a relationship with my father and generally had more energy for my life. I was also able to work better again and felt much more comfortable in the office thanks to my more mature, perhaps more objective approach. I spent a few days in June back home for job interviews. What was interesting was that my mother wasn't home at that time. In the past, I would never have gone home to see other family members on the weekends without seeing my mom. I see this as a great success that I opened myself up for future contacts within and, of course, outside of the family. At some point I had reached the point where I was already doing very well. I was kind of willing to bring the therapy to an end, then sometimes I wasn't.

Then came **the** topic. I had forgotten the topic of farewell, although at the beginning of the therapy the story about the glass sarcophagus [see *The Merchant and the Parrot*] already showed how much that touched me. It got exhausting and I cried a lot and lost a lot of energy. Dr P. suggested that I should make a plan about the activities I would have to do before leaving the city and then in my new place, and also to write down to what and whom I wanted to say farewell in The city. I wrote a lot and cried a lot. It was one of the most difficult subjects for me. It occurred to me that saying farewell might be so hard for me since when my father moved out - in my opinion - he didn't explain himself enough and didn't really say goodbye. I started to deal a little better with the many small farewells [regular business trips] from Markus. After a phase in which I suddenly saw the city

only overly positively and didn't want to leave at all (to avoid saying goodbye), I began to look forward to the next phase of my life.

In **June-July** the first farewells to various friends began, who themselves left the country or went on vacation and we would not see each other again before my/our departure. I experienced a "rehearsal farewell" from Dr. P. at the end of June. I was very sad. Dr P.'s idea to write a summary about the therapy helped a lot again. Another important question that once again left me totally disturbed, confused, and thought-provoking was raised by Dr. P. at the end of June. He asked if the relationship with Markus was a priority for me or not. After finally realizing that this is my priority in life (it took a lot of energy and thought and also the courage to admit that I am more interested in my relationship than my career). I thought about it a lot and then discussed the question with Markus. It brought us closer again and it's good to be able to talk about these difficult topics. The relationship with Markus improved more and more. Markus romantically asked me on a beautiful evening if I wanted to be his wife. I was touched and we talked about it in such a beautiful, close, connected, familiar, heartfelt way that it made me so happy. We deliberately renewed our engagement this time and plan to marry next year. Markus spoke very little about changes during and through therapy, his response and his openness and trust are much nicer than words he could have said during therapy.

My grandfather passed away at the end of July. I was very sad. I hadn't scratched my fingers for a while, but occasionally scratched my feet. I was afraid that the sad news would make me start again. I did not do it. I cried and thought of him. I remembered the story of the sunflowers I was reciting in church on the day of his funeral. I have learned to perceive feelings. I am very happy to be in a relationship with my father again. He also came to the funeral. For me it was important who stands and goes at which place at this event. My grandmother walked behind the coffin with my mother. Markus and I behind them. Mom's second husband and my father walked a little to the right, one a little in front of me, one a little behind me. I suddenly had slight aggression towards my mother's second husband. I don't want to "get into it" but I'm glad I stopped glorifying him in order to give my mother a support that she made back then the

right decision. I am closer to my father because he is my father. I respect Josef as my mother's second husband and am glad that the two have a reasonably good relationship. I'm not trying to idealize him as the super guy anymore. My mother must be happy with him, I'm glad that we get along really well. I'm so relieved and glad I learned to deal with reality. I can deal with both happy and sad situations and share joy and sorrow. I have also learned to differentiate in terms of who I can share and show my feelings with at the appropriate time. I can also distinguish between specific characteristics that I might find disturbing about a person and the personality itself, which may also have many good sides.

Luckily, I'm ready to have constructive discussions with Markus about anything, especially in the office - I'm happy to discuss it with Markus beforehand. I have the feeling that I can also discuss important topics with other people, I prepare myself and try to organize my thoughts. When a problem comes up, I can now keep my head clear, I often write my thoughts down to organize them and then think it over again and look for alternatives and possible solutions.

2.3.1.3. My Relationship with My Therapist

I'm not sure how I felt when I met Dr. P. the first time. He certainly seemed trustworthy, he's such a good listener. The first sessions in particular were extremely strenuous for me. I was totally exhausted afterwards, got migraine attacks after the first 3-4 sessions. Dr P. has the gift of incredibly motivating me about something to think. Of course, I think about it and I write it because I know it will help me. However, even with unpleasant topics such as "farewell" where I almost refused to write anything about it, I did it anyway - perhaps also because I was afraid that we would otherwise discuss it in the session without my preparation. I admire Dr. P. for analyzing extremely quickly and finding out sensitively what the problem is, what needs to be addressed. Even though he knows so quickly, he still waits for the right time to discuss the topic with me or to raise the relevant questions...Dr. P. always spoke to me in the way, with the tone, that is and was most conducive to improving my condition and always found the right questions and stories to keep me thinking and analyzing and learning.

He found out pretty quickly that I would accept a concept or do something because "the others are doing it anyway". I have to laugh because I only realized this through him. For example: I wasn't sure if I could go to the sessions during working hours. I got the impression that for Dr. P. it would be more pleasant during the day, for me too in principle. But I still had the fear, caused by my ex-boss, that I wasn't even allowed to leave the office during the day to go buy an apple. I couldn't imagine leaving during working hours. Once I had to, because the urge to talk with Dr. P. was greater than skipping the session. On the day in question, I had no time in the evening; it wasn't Dr. P. who refused. Well, anyway, I left during working hours and no one had a problem with that. Dr P. then casually mentioned that the others also came during working hours and that many people were doing therapy anyway. I was reassured and then, and from January 1997 I always came in the afternoons, with Markus once in the evening and once in the morning.

At the beginning of the therapy, Dr. P. tried to build up a trusting relationship. I trusted him, felt understood and really dared to tell my secrets and even to discuss very uncomfortable topics. The trust grew and so did the bond. I soon discussed everything with him, starting with my job, parental home, sex, the desire to have children, arguing with Markus, etc. The bond almost risked becoming too great, because at some point in November or December I suddenly had the feeling that there was a danger that I fall madly in love with him. I then had a bad conscience towards Markus and towards Dr. P. He listened so well and didn't criticize me, he encouraged me and gave me backing for new behavior. I didn't want to fall in love with him, I knew he was happily married. I never spoke to him or anyone about it, I didn't worry too much, thinking that surely many patients feel this way and that he is used to it. The "being-in-love-phase" didn't last long (only 7 days) because Markus soon came along to one of the sessions, which helped me to get down to earth, plus I didn't want to fall in love with Dr. P., but to love again Markus - and Dr. P. after all was my doctor. So, I saw Dr. P. as the ideal brother, ideal friend, maybe even ideal father. It was clear to me that this had to be part of the therapy, could be a motivating sympathy, which for various reasons, unfortunately or because of my previous history, turns into infatuation. I knew that I didn't really

know Dr. P; he behaved in a way adjusted to my situation... For a long time, he never smiled with me during the sessions because I had and sometimes still have the problem of smiling even though I want to cry. There was nothing to smile about in the sessions for a long time, so why should he have.

When we dealt with the topic "Father" in more detail around February, it got difficult. It was so exhausting and awful for me, I was getting annoyed with Dr. P. He got me right out my reserve. I remember the one session where he openly and directly criticized me for smiling. He said something that it's surprising that I smile even though I tell very sad and serious stories about my father. I could have cried like that, but I held myself back, so that my whole body was shaking and I began to freeze during this session. We were in a different room that day, it may be coincidence or it may have been planned. I often remembered this session, so maybe it was a good thing that it was held in another room.

I think in April I had a phase where I thought my problems were so ridiculous and that Dr. P. would have to nag about me as I'm making little progress, we're still discussing the same old stories and next to nothing is changing. I lost my motivation a bit, but I didn't want to stop therapy. Dr. P. initiated a conversation - fortunately - because we talked openly about it and he asked whether I might be dissatisfied with myself and therefore assume that he is annoying. It probably was. I was glad we went ahead and that we had cleaned up the issue.

I think in May I got pretty angry again after a session with Dr. P. probably because I recognized myself too well or because he provoked me to think about too uncomfortable questions. In addition, I developed a closer connection to Markus during this time, in a way I was no longer just dependent on Dr. P. to discuss difficult subjects. I said to myself one evening that if Dr. P. was such to me, I wouldn't go to the sessions anymore. I soon dismissed the thought, firstly because I knew that I couldn't just stop now, it would be a shame not to finish the therapy— as far as it's possible; another reason was that I knew Dr. P. had to behave like this so that I could finally take a step in my development and clarify important questions regarding my future and relationship with Markus. And thirdly, he would certainly have asked me why I didn't want to come anymore, before I discussed this with him, I would rather clarify it with myself and then

know anyway that it would be better for me to continue the therapy to the end.

Dr P. became more and more the advisor and role model over the course of May and June. He always listened so well and asked questions so well, sometimes deliberately provocative - but always with a meaningful and important purpose. I also learned new questioning techniques from him, which helped me to save energy in my life, since I no longer provoked serious arguments with others as often. As the therapy progressed, Dr. P. increasingly became an advisor, an observer who intervened in an advisory capacity. He asked me questions that were supposed to make me think, he asked sometimes provocative questions or questions that totally questioned my previous concepts. It was always very upsetting and uncomfortable for me. I had reached a stage by June 1997 where I already felt much calmer inside. After the sessions with Dr. P. I felt agitated and was torn out of my apparent calm. It was interesting that I then thought a lot and discussed the relevant questions with Markus. I then felt much better, Markus much closer, and this gave me a lot more clarity, because by rethinking and questioning my thoughts, concepts, plans, attitudes, and decisions, maybe even changing them completely, I felt then safer, calmer and more prepared for the future.

At the end of June, we had a rehearsal farewell. I was very sad and thought at first, how could I go on without talking to Dr. P. As always, Dr. P. had the idea. He suggested that I should write a summary of the therapy and write down any remaining questions etc. That helped me a lot and I'm already prepared for our next rehearsal farewell for a probably a little longer time.

I'm looking forward to my new phase of life. At the same time, I'm also a bit sad that Markus and I will be living apart for a while. Then I think it gives us a chance to see some issues from a distance and then be even closer again with new experiences and ideas. I really hope he finds an interesting job in... If not, it's clear that I will change because our most important goal is to be together. But I really hope it works. I'm also worried because my mother will try to get fully involved, but I see it as a challenge to find the right balance together. I will have "clarifying and important" conversations about divorce and related issues with the whole family. I have to be very careful with my mother because she has a

great need for connection but tends to get too attached to me. I'm curious to see how everything develops and will make notes from time to time to record further developments and to observe and perceive them from a distance. I look forward to writing or emailing Dr. P. no later than early March. Maybe I'll email him beforehand. I'm so glad that I have more control over my life now and approach everything a little calmer. If something annoys me, I very often recognize what could actually be behind it and then it won't be so bad.

2.3.1.4. My development from my point of view

I have the impression that I have experienced a remarkable and pleasant maturation process as a result of the therapy. I came to the city in August 1995 in the baby stage of immaturity and clinging, especially to my mother. The reasons that led to this are undecided, I just take it as a fact that the uneasiness caused by this immaturity of my personality and the troubled relationship with my father was inevitable. Through the therapy I developed further and was able to detach myself from my mother. I recognized and reconsidered my actual abilities [socialization norms in positive psychotherapy] and work on reviving neglected abilities. My relationship skills, partnership skills and, in this context, my ability to separate were developed. I learned how to communicate. I learned to recognize my feelings, own them and then act on them. My thoughts became more organized and clearer, which in turn enabled me to communicate better and also to listen much better. I listen now and do not immediately relate to myself, but first of all I perceive, then I try to analyze and interpret. I learned new ways to deal with acute conflict and great discomfort. I learned to cry and openly express my feelings - at the right time and at the same time I was able to keep a "poker face" when it made sense to me, for example in the office. It all took a lot of pressure off me, which allowed me to stop scratching my fingers for years. I've learned to sort of take control of my life. I set priorities and goals in my life and discuss everything important with Markus since our relationship has top priority. I feel very well again, strengthened and strong and ready for the challenges of life.

Another part of my opinion as to why I benefited greatly from therapy was that I had the opportunity to read the excellent, excellent books by Dr. Nossrat Peseschkian. This gave me a better

insight into the therapy. Reading enabled me to gain deeper and more detailed access to my problems, which was helpful for processing and improvement. Another not insignificant point is that I tend to behave like I suppose it is expected of me. I read the book on family therapy and saw myself in the 'Five Stages of Therapy' [cf. Peseschkian, N., 1980]. I thought about it and wondered what a next step should/could be according to theory. I tried alternative behaviors and responses, and encouraged by many conversations with Dr. P. I've reached the level of responsiveness I can accept for myself and feel responsible for the consequences of.

2.3.1.5. Topics that were dealt with in therapy.

My current situation; communication with partner; partnership, meaning and goal; Sex; current skills; Father; Mother; divorce of my parents; Taking leave; fear of loss, desire to cling; children (why, when); set boundaries (I can say no); smile, perceive and show real feelings; Job; Future with Markus.

2.3.1.6. Topics not covered

Bulimia during puberty; rape-like experiences in my past.

2.3.2. Therapy from the therapist's point of view

Below are my subjective experiences of the therapy and my therapeutic actions. The observations are based on my written notes during the sessions.

2.3.2.1. Phase of attachment: the first sessions

The first session dealt with the patient's symptoms, general sociodemographic data and stressful life events of the last few years. I orientated myself at the semi-structured psychodynamic first interview of positive psychotherapy (Peseschkian, N., Deidenbach, H., 1988). Throughout the rest of the therapy, the therapeutic approach was semi-structuring, i.e. facts and data are asked for and collected in a targeted manner, while at the same time the communicative aspect between therapist and patient is taken into account. This attitude has also been termed 'participating observation' (Reimer, 1996). Diagnostically, it was not difficult to classify the patient as a client with borderline personality disorder, since she showed all the typical symptoms.

As her first homework assignment, she was asked to write down a few things about the individual stressful events in her life. In order to reduce the tension, I felt out about her relationship, I recommended that from now on she should no longer criticize her partner, but instead write down problem situations and bring them with her.

To my great astonishment, she brought 58 handwritten pages about her life events to the second session (3-5 pages are usual). I asked her to share the most important insights that this exercise had brought her. Other stressful life events were then discussed. At the same time,

it became clear that she was dealing with topics such as justice, anger, aggression, orderliness and politeness. At the end of the second session, I gave her a book (The Merchant and the Parrot) and recommended that she read the individual stories and transfer them to herself as far as possible.

For the third session, the patient brought dozens of pages with her thoughts on individual stories in the book she was given. She had rewritten the stories in her own words and partially referred to herself. We continue the first interview with a focus on the basic conflict. This was made more difficult by the patient's unconscious resistance, so that she initially had no memories of events before the age of 12. It was about her relationships with parents and her relationships with men. Then she asked me for another book, I – somewhat reluctantly – gave her another (Positive Family Therapy by Nossrat Peseschkian).

During the entire therapy, the patient wrote about 10-15 pages between sessions at home (501 pages in total) and brought them to the therapy session. I always took note of them in a friendly manner, but I did not always respond to it. It quickly became apparent that this was not necessary. The writing had a kind of diary or self-analysis function. There would have been a risk that the therapy sessions would have like a reaction of the patient's notes and that the patient would thus have determined the course and topics of the therapy. According to Borgart and Kemmler (1989), homework in psychotherapy is: "...tasks that the client carries out outside of the therapy room between therapy sessions in order to practice and deepen what has been learned in therapy, to transfer it to his specific area of life or to use observation material for the next therapy session." At least

since the work of Shelton and Ackermann in 1978, a number of homework tasks in psychotherapy have been known. Despite the overall positive experience, homework is rarely used as a technique, especially by psychodynamic therapists (Fehm and Fehm-Wolfsdorf, 2001).

2.3.2.2. Phase of differentiation: initial phase of therapy

In the next approx. 6 sessions, the patient's symptoms initially improved. At the same time, there was a clear reduction in partnership conflicts because she first learned to listen more, to let her partner speak and to write down conflicts. We discussed the contents of the partner conflicts in relation to the socialization norms of orderliness, achievement, cleanliness, justice and contact. Furthermore, her previous relationship patterns were discussed and slowly worked through.

In this first phase, the aim was to build a relationship of trust with the patient and at the same time to achieve initial relief. Writing down her experiences between sessions and parallel processing of the psychotherapeutic literature in the form of a bibliography were irreplaceable aids. At times I almost had the feeling that two therapies were running in parallel - one with me during the sessions and one with the books at home. At the same time, the patient offered many topics and thoughts that "invited" me to go deeper, which I deliberately avoided, however, in order to avoid reactivation of her old problems of abuse and dependency at the wrong time.

As early as the 6th session, the patient's fiancé was included in a session in order to establish initial contact, to objectify my perceptions and at the same time not to let the contact between the patient and him break off. Since the patient tended towards idealization and devaluation due to her structure and there was a risk of idealizing the therapist, this turned out to be an important step at the right time in retrospect.

2.3.2.3. The therapeutic process in the main phase

From the 10th session we concentrated on the relationship with the parents, the gender images and role models. Here the idealization of the mother ("she was like God to me") and the devaluation of the father ("he was a pig, like the devil") became very clear. Gradually she

managed to overcome her resistance so that she could open herself to a new image of her father and her mother (de-demonization and de-idealization according to Eckert et al., 2001). It was also very helpful to use monodrama in one session to work through the problem she had with a male colleague.

In the 14th session, I discussed the possibility of a real conversation with her father for the first time. The patient initially reacted with a strong resistance, which expressed itself in fear ("He (the father) could collapse during such a conversation and so could my mother"). She was systematically prepared for this conversation in the following sessions, and the questions to be discussed were discussed, so that after the 16th session she flew home to have such a conversation with her father for the first time (there had been no contact for more than 12 years). Contrary to her expectations, the conversation went very well, and she was able to clarify many questions for herself. It was certainly the turning point in this therapy for the patient ("I was used to have to hate my father in order to love my mother. But now I don't have to hate him anymore. I can finally have a relationship with my father."). Although the subject of fathers came up again and again, it had developed a kind of momentum of its own, so that we could concentrate on other conflicts. During further therapy, she proudly reported about contacts with her father, the improvement in her relationship with men, and a reduction in her hatred of men. The absence of the migraine during further encounters with the father, for the first time in his life, was characteristic.

From the 18th session, the subject of sexuality became the second major problem area that we worked on together. It was about her sexual fantasies, her relationship with men, the question of closeness and distance and her fear of loss, especially when her boyfriend was on business trips (he had to go on trips up to 3 times a week). During this phase, the patient decompensated suicidal, so that short-term drug treatment with lorazepam (1 mg daily) for 10 days became necessary. The treatment frequency was briefly increased to 2 sessions per week. The partner was included once in the 20th session and in the 22nd session a 20-minute conversation between me and the fiancé also took place for the first time without the patient (but with her consent). Practicing

communication techniques with both of them was very important, drawing boundaries and practicing concrete intervention techniques when she was plagued by fear of loss. During this time, she was also encouraged to develop other areas of life that had previously been neglected. This was above all the area of 'social contacts' [in the balance model], which was also very good for her so that she was no longer just fixed on her partner.

2.3.2.4. Detachment phase: The end of therapy

Already in the first session, the patient had stated that she would leave the city in approx. 8-9 months, which also limited the time for therapy. Therefore, from the beginning, the goal of this therapy was the reduction of symptoms and the focus on the actual neurotic conflict. In the 25th session, about three months before the departure date, she discussed her impending departure from the city and the planned move. This was associated with an initially professional separation from her fiancé and brought up the fact of the end of therapy. In the remaining 5-7 sessions, saying farewell became the third major problem area of therapy. Initially, the patient reacted to the topic with insomnia, so that an evening dose of amitriptyline (10 mg) became necessary. The never clarified farewell from the father after the separation of the parents was reactivated. It was very helpful for the patient to write down her thoughts and feelings, to make plans for the future and to review the therapy. This helped her, for the first time in her life, to admit her feelings and to learn that separation and farewell are a real part of life. Through numerous encouragement interventions, she was strengthened that she was able to take on the challenges of the future.

Due to a vacation, a trial farewell lasting 6 weeks could take place, which the patient was able to book as a great success. In the last two sessions (32nd and 33rd), the previous therapy was discussed, the patient's and the therapist's expectations of the treatment, the completed and still open points addressed openly. Despite moving to another country, I tried not to present the farewell as final. It was agreed that she should contact me in about 6 months (by e-mail) and that she could contact me at any time in a crisis situation and that I would not feel burdened by it. Ending therapy can be one of the most difficult exercises that patient and therapist have to face (Reimer, 1996). In this treatment case we followed the

recommendations for the termination phase of Reimer (1996) and Kernberg (1993).

2.3.2.5. Countertransference

Countertransference includes all of the therapist's emotional responses to the patient. Although recognizing and managing countertransference is essential to the delivery of any therapy, awareness of countertransference is of paramount importance when working with borderline patients (Kernberg, 1993). Because borderline patients use defenses well suited to evoking strong emotional states in the therapist, countertransference reactions develop rapidly, with great immediacy and intensity.

In the first sessions, I first had to deal with my own "prejudice" towards borderline patients in the sense of "difficult, unproductive patients", which was not difficult for me, since the patient initially appeared to be in need of help, weak and helpless. I felt like an older brother who should accompany, comfort, soothe and encourage her without being intrusive. She responded to the type of attention with a positive transference, which was probably also reflected in the "good" completion of the homework. Of course, resistance and negative transference reactions also interfered from time to time. She always showed greater resistance when I demanded something from her and confronted her with her own behavior (the patient describes such an incident with the session in another treatment room in relation to the topic of inadequate smiling).

The conversation with the fiancé of the patient took place at a time when she was suicidal and decompensated and acting "typically borderline". I was furious and annoyed that after the "great success" (clarifying discussion with her father) she was now falling back into her old behavior pattern. At the same time, a close therapeutic relationship had developed, also by the patient's very active cooperation (which patient writes down 500 pages?).

When her fiancé asked me how I assess the prognosis and whether she would ever get better, I said to him that the prognosis of such disorders is difficult to be assessed and it should probably be counted among the more difficult cases. In my subsequent self-reflection, I realized that my anger on the one hand, but also my desire to continue working with the patient for

as long as possible ("The fiancé actually disturbed our relationship. Who needs him anyway?") had led me to this statement.

2.3.2.6. The patient four years after the end of therapy

The patient has married her fiancé and is the mother of two children. Her condition is stable, there have been no suicidal lapses or a renewed outbreak of the symptoms. About once a year, she sends an email or card to the therapist, giving a brief account of her condition and life.

2.4. Consequences for practice

As the supreme principle of every borderline therapy a variable setting is considered that reflects the respective needs, abilities and limitations of the patient must be adjusted (Dulz and Schneider 1995). In addition to the recognized general principles of outpatient and inpatient borderline therapy (Eckert et al. 2000), in certain borderline patients on the

Basis psychodynamic approaches further techniques are applied or attempted. It

has already been requested (Fehm and Fehm-Wolfsdorf 2001) that it is urgently necessary

to systematically teach at postgraduate training institutes dealing with homework in the therapy. Also, the creative development of appropriate homework and how to convey it to the patient should be taught and learned. I'm thinking about this in particular about the use of stories and fairy tales, the writing down at home, the therapeutic use of appropriate literature (bibliotherapy) and the encouragement to do specific homework. My hypothesis is that these techniques and approaches by limiting transference reactions and by reducing the defense could contribute to the effectiveness of borderline therapy. Future research on these issues will be necessary.

2.5. Closing poem by the patient (as a farewell gift for the therapist)

The bright colors

Once upon a time a gray chameleon came to Dr. P. and asked for his help. Dr P. asked: "How did it happen that you became a gray chameleon?" The chameleon explained that it always does what is asked of it or how it thinks it is being asked to do, which is why it is under a lot of pressure and has also lost its personality and style. At the beginning of the therapy, the

chameleon was gray - it was sad, powerless, depressed and very desperate.

It was very unhappy because it was about to destroy its home, its body and its soul, and in addition the soul of the fox with whom it lived in the foreign country, as well as the precious relationship with him. Dr P. asked many questions and listened carefully.

Appropriate comments at the right time helped the chameleon to realize that many other colors than the sad gray shimmered within him. The role of the little mouse appealed to the chameleon as an alternative. But even this role did not combine all abilities and could not evoke all colors that would be helpful on the way to a stable partnership with the fox and on the way to a fulfilled, happy private, family and professional life.

It was a difficult time and task for the chameleon, its surroundings and the wonderful doctor. Dr P. also changed his colors by silent agreement during the course of the therapy. To help the tired gray chameleon, Dr. P. blush a little. He attacked the chameleon a bit to lure it out of its reserve. So, it learned to joke and be super sad and turn green angry. Dr P. always supported the learning chameleon with further stories, questions and admirable, patient listening. The chameleon began to recognize its concepts and tried to stop copying unchecked humans as role models. It recognized that it can be unique, can choose its own concrete mix of colors and can and should learn through observation. It abandoned the goal of having to copy its mother and lived more quietly from that point on. It became more authentic and the time came when it was no longer a chameleon in the original sense.

It is difficult to say which animal it became. In any case, it had become a truer and more stable personality. It could deal with reality and was immediately able to be yellow active, blue calmly waiting - while listening and white concentrating. It could react green angrily with the ability to communicate constructively. It could be sensitive to pink and was now able to combine all possible colors in different intensities into a mixed tone that was suitable for the situation. Dr P. had given back all the bright and calm colors to the originally gray chameleon through his colorful therapy. The chameleon beamed with happiness and gratitude. It wanted Dr. P. and his family all the

colors and joys of this world and enveloped everyone with positive thoughts....

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WAPP NEWS

World Association for Positive and Transcultural Psychotherapy, July 2023

Dear WAPP members,

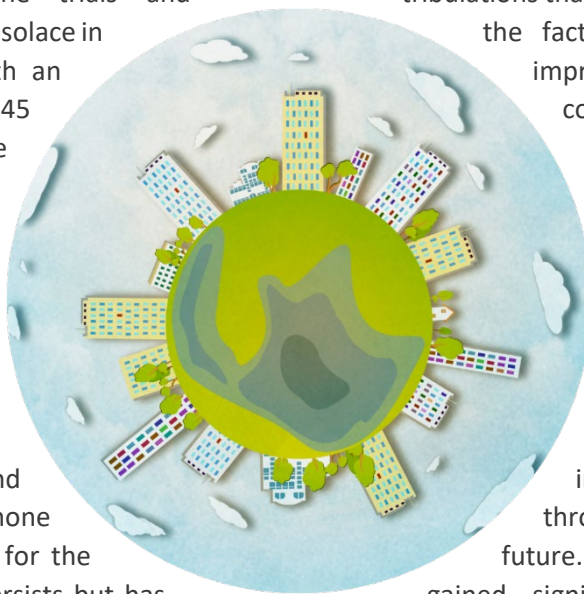
Dear friends and supporters of Positive Psychotherapy worldwide,

As we reflect upon the trials and six months of 2023, we find solace in steadfast and united. With an over 2200 individuals from 45 we have confronted the unrest, political human rights, and inequality. Amongst ongoing Russian war especially impacted members.

Yet, it is precisely during collective solidarity and community have shone preserve a sense of hope for the Psychotherapy not only persists but has invaluable and timely approach to addressing mental health and navigating life's complexities.

tribulations that have characterized the first the fact that we have remained impressive membership base of countries across 5 continents, tumultuous waves of social turbulence, eroding escalating economic these challenges, the against Ukraine has many of our cherished

these testing times that our indomitable spirit as a through, enabling us to future. The demand for Positive gained significant recognition as an



We owe our success to your exceptional work and unwavering commitment. Here are just a few of our accomplishments together:

EXPANSION AND REACH:

Through your efforts, we have extended our reach and impact, making Positive Psychotherapy accessible to individuals across the globe. PPT trainings are offered in more than 20 countries worldwide.

RESEARCH AND INNOVATION:

Our collective dedication to research has contributed to the advancement of the Journal "The Global Psychotherapist", uncovering new insights and innovative practices. A multi-center research is on its way.

TRAINING AND EDUCATION:

By developing comprehensive standards and offering training opportunities, we have equipped countless Positive Psychotherapy practitioners with the skills and knowledge needed to make a difference in the lives of others.

COMMUNITY SUPPORT:

Our "positum" community has provided essential support and resources to one another, fostering an environment of collaboration and growth.

1st WAPP Strategic Meeting,

15-17 February 2023, Istanbul (Türkiye)



During the past challenging three years most of our trainings and meetings were conducted online. However, as psychotherapists and consultants we know how important the direct personal meeting is. Therefore, The WAPP Board of Directors decided to organize a working meeting with the members of the Board, of the three committees, the assistants of the head office, as well as some of the main trainers, organizers, and potential multipliers of WAPP.

The focal points of the meeting were a) organizational – WAPP as a non-governmental organization, its members and its aims, priorities, and functions in societies around the world, and b) method-based – PPT and how we should move forward and develop the method and trainings. Probably the most striking aspect of our meeting was the involvement of more and more individual members in strategies and decision-making of WAPP.

You can imagine people from countries at war with each other, focusing on our common goal: making a mark and changing the world by working on mental health, shaping healthy generations through our work with children and youth – and thus perceive the ambience of our sessions. It was a powerful experience to see people put aside the national problems and focus on our common goal.



In the period from February until July 2023, the WAPP Board, the committees and working groups have managed to organize 53 (!) online working meetings and 8 events: webinars, workshops, memorial evenings, Annual General Assembly of WAPP members. A new tradition was established: every year on June 18, the birthday of Dr. Nossrat Peseschkian, the founder of PPT, we will celebrate a *#PositivePsychotherapyDay*, in order

to draw the attention of the general public to this method. And we are planning more!

07 October 2023 - Jubilee International Conference “30 years of Positive and Transcultural Psychotherapy – Fruits of Time” – IN-PERSON in Varna, Bulgaria. [Details](#)

13-15 October 2023 – First International Caucasian Conference on PPT “Positive and Transcultural Psychotherapy as a Bridge between Cultures”. IN-PERSON in Tbilisi, Georgia. [Details](#)

13-14 November 2023 - National Positive Psychotherapy Conference “THINK ABOUT YOUTH” - Child and adolescent psychotherapy”. IN-PERSON in Oradea, Romania. [Details](#)

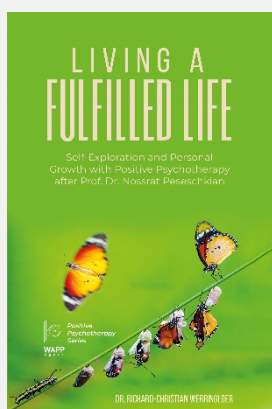
17-18 November 2023 - International Trainers Seminar – ITS (for trainers and candidate-trainers only) – ONLINE (*details upcoming*)

19 November 2023 - 2nd Online World Conference on Positive Psychotherapy (open for everyone) – ONLINE (*details upcoming*)

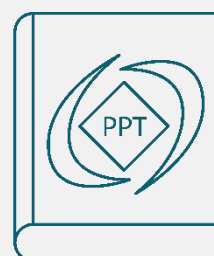
19-20 March 2024 - 2nd WAPP Strategic Meeting (by invitation only) - IN-PERSON in Istanbul (Türkiye) (*details upcoming*)

21-23 March 2024 - International Conference on Positive Psychotherapy (open for everyone) - IN-PERSON in Istanbul (Türkiye) (*details upcoming*)

15-17 November 2024 - Super Conference – ONLINE (*details upcoming*)



A new book of Dr. Richard-Christian Werrigloer has been published and available to purchase in paperback or Kindle versions on [Amazon](#) and as e-book on WAPP's [website](#) as well as other books of WAPP Press.



WAPP
P R E S S

One main goal of the Istanbul gathering was to include more members actively in working groups, special interest groups, or committees. There are so many possible tasks in front of us, but we can only achieve them, if more members get actively involved. After the Strategic meeting WAPP's organizational structure was updated (see Fig. 1).

The three main committees will continue their work, with members appointed by the Board directly. These three committees cover the large areas of governance, training, and publication.

Each committee can form several working groups. The members of these working groups will not be appointed by the Board, but every interested WAPP member can write to the Head Office and your request will be forwarded to the responsible main committee. These working groups meet regularly online (1-2x per month), and report to the responsible committee. If there is a special area in which you are interested or have something to contribute, you are more than welcome to volunteer as a member. Please write to the Head Office at wapp@positum.org

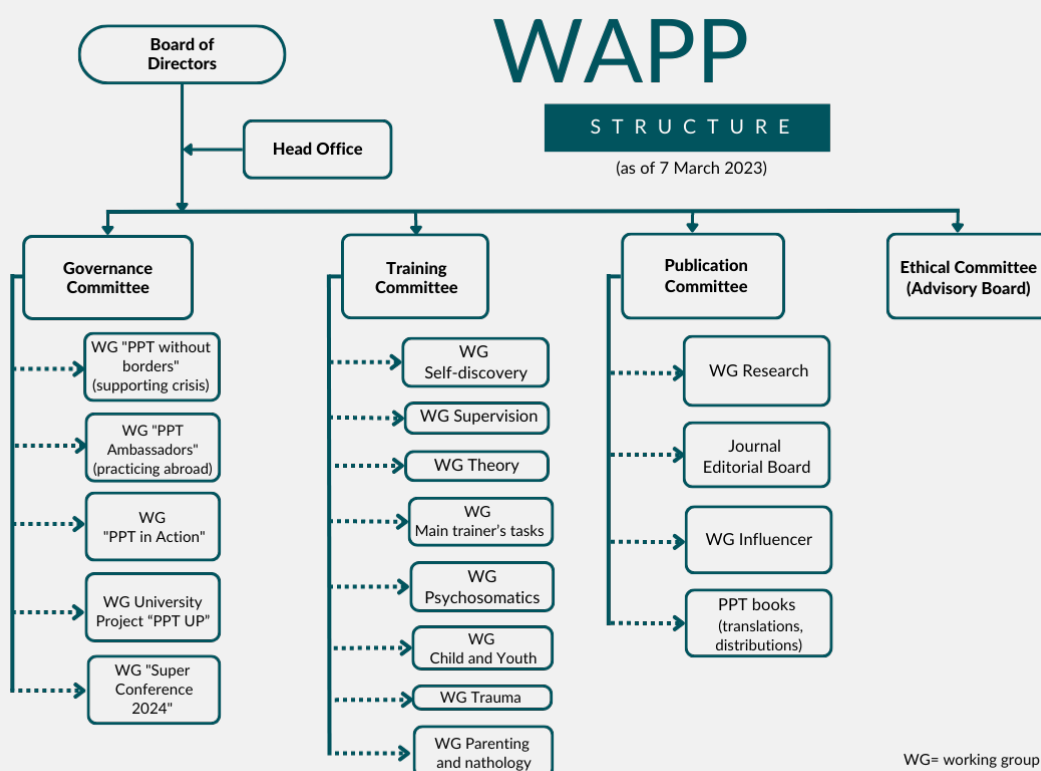


Fig. 1. Updated WAPP Structure (as of March 2023)

As we reflect on these achievements, let us continue to build upon our progress and strive for even greater impact. Together, we can face the challenges ahead and continue to make Positive Psychotherapy a beacon of hope and healing in a troubled world.

Thank you for your unwavering dedication and unwavering commitment. Your contributions are invaluable and deeply appreciated.

With deep gratitude and best wishes

The WAPP Board of Directors and Head Office



WORLD ASSOCIATION
FOR POSITIVE AND TRANSCULTURAL
PSYCHOTHERAPY

Information and Guidelines for Authors

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

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The Global Psychotherapist (JGP) is an interdisciplinary digital journal devoted to Positive Psychotherapy (PPT after Peseschkian, since 1977)TM. 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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Here are three basic examples:

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

For books:

- [2]. **PESESCHKIAN, N.** (2016). *Positive Psychosomatics: Clinical Manual of Positive Psychotherapy*. Bloomington, USA: AuthorHouse.

For non-English resources:

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

For chapters within multi-authored books:

- [4]. **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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