THE GLOBAL PSYCHOTHERAPIST

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

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Contents

Welcome Letter by the Editorial Board

Dear Readers,

It is with great pleasure that we welcome you to the latest edition of "The Global Psychotherapist" Journal. As the editorial team, we are excited to present a diverse array of articles covering various aspects of Positive Psychotherapy (PPT) in our upcoming publication.

As we navigate crises, wars, and the myriad challenges of the modern world, the need for robust mental health support becomes increasingly evident. Each study, case, and training protocol presented herein contributes to the ongoing discourse on the critical role of psychotherapy in fostering resilience, understanding emotions, and promoting overall well-being. These contributions serve as beacons of hope, emphasizing the positive impact that psychotherapeutic practices can have on individuals and communities grappling with adversity.

The following edition of "The Global Psychotherapist" Journal encapsulates a diverse spectrum of studies and cases within Positive Psychotherapy (PPT), showcasing its relevance in addressing the complex psychological dimensions of our time. From healthcare professionals facing the rigors of their profession to multicultural students navigating new environments, and individuals coping with chronic ailments, these articles shed light on the transformative power of psychotherapeutic interventions.

Section: Preliminary Studies in PPT:

In the groundbreaking study, Tuğba Sari, Dilek Patir and Melikegül Bedir explores the impact of a Test Anxiety Group Psychoeducation Program, rooted in the Balance Model of Positive Psychotherapy, on the test anxiety of 14 high school students in Ankara, Turkey. The findings underscore the efficacy of targeted interventions in alleviating test anxiety among high school students.

Elmedina Cesko's research sheds light on the benefits of Positive and Transcultural Psychotherapy in multicultural student groups. The study, conducted in Turkey, aims to evaluate the effectiveness of psychotherapeutic methods in helping students navigate the challenges of adapting to a new environment.

Elena Drajeva and Slilyana Stamova present a pioneering study focusing on psychological support for women diagnosed with endometriosis. The research investigates the differences in coping mechanisms among patients who receive psychological support and those who do not, providing valuable insights into the role of Positive Psychotherapy in chronic illness.

Seda Öner, Aysel Karaca, Nuriye Yildirim Şişman explore the development and evaluation of a positive psychotherapy-based resilience program for nurses. Employing a randomized controlled design with a sample size of 72, the study measures nurses' resilience levels through pre-test, post-test, and a 3rd-month follow-up. Findings highlight the effectiveness of the program in enhancing nurses' resilience and well-being.

Ioana Ntarla and Gabriella Hum explore the correlation between psychotherapists' resilience and the primary capacities of Nossrat Peseschkian’s Positive Psychotherapy theory. The study spans across various countries, suggesting that developing primary capacities enhances therapists' resilience in the face of professional challenges.

Section: Modern Practice in PPT:

Birgit Werner's article introduces a resource-oriented approach to trauma therapy using Positive Psychotherapy. The author emphasizes the activation of existing abilities, contributing to the stabilization and integration of traumatic experiences in patients.

Ivan Kirillov's article delves into the intricate world of emotions in psychotherapy. Grounded in theoretical frameworks, it seeks to develop a comprehensive definition of emotions applicable in both theoretical and practical aspects of psychotherapy.

Arno Remmers explores ethical questions in family therapy, emphasizing the need for a differential family therapy based on evidence and outcome-based studies. The article discusses principles, methods, and ethical dilemmas in the context of psychodynamic therapy.

Veronika Ivanova's report highlights the benefits of Positive Psychotherapy in medical education. Drawing on more than a decade of experience, the author showcases how Positive Psychotherapy aids medical students in developing therapeutic listening skills and understanding psychosomatic relationships.

Igor Olenichenko discusses the integration of projective methods in Positive and Transcultural Psychotherapy to explore hidden aspects of clients' personalities and conflicts. The article emphasizes the synergy achieved by combining projective methods with the five-step strategy, balance model, and other PPT techniques.

Irina Serova's article explores the application of Positive and Transcultural Psychotherapy in organizational settings. With over two decades of international management and psychotherapy practice, the author discusses the importance of promoting mental health within professional environments.

Section: PPT Cases:

Serhii Sheremeta's article delves into the understanding of the function of eating disorder symptoms in adolescents. Based on Positive Psychotherapy principles, the article emphasizes the importance of understanding and addressing the role of symptoms in psychotherapeutic processes.

Sultan Uncu's study examines the functionality of the balance model, an inventory in Positive Psychotherapy, in treating panic disorder. Through a case study approach, the article highlights how the balance model contributes to insight, symptom recognition, and positive development in individuals with panic disorder.

Ekaterina Kuzmina's article explores the use of Positive Psychotherapy tools in accompanying clients through bereavement. The study focuses on the impact of grief crises on actual abilities, the balance model, and therapeutic tactics, providing insights into the dynamics of therapy.

Section: PPT Training:

Etion Parruca continues to introduce us the Positum MGS coaching protocol within the framework of Positive Group Psychotherapy training. The article highlights the importance of using psychosocial transcultural games as resilience-building tools in groups affected by war, disasters, and refugee crises.

Section: Special Articles:

Alfred Nela's comprehensive article provides an overview of the psychological impact of armed conflicts on children. Based on a systematic review of literature, the study emphasizes the importance of identifying, diagnosing, and providing psychosocial support for children affected by war trauma.

Erick Messias explores the use of poetry, particularly the works of Fernando Pessoa, as a tool in psychotherapy. The article argues for the therapeutic value of Pessoa's poetry in supporting individuals through the process of healing.

Olga Lytvynenko's review of "The Matrix and Meaning of Character: An Archetypal and Developmental Approach" by Nancy J. Dougherty and Jacqueline J. West highlights its unique perspective on character typology. The authors ingeniously use fairy tales and archetypal imagery to delve into nine-character structures linked to early development and archetypal themes. The review underscores the book's alignment with positive psychotherapy principles, emphasizing the exploration of abilities, resources, and potentials within each individual.

As we draw the curtain on this enriching edition of "The Global Psychotherapist" Journal, we are saddened to share an OBITUARY in loving memory of Dr. Gunther Hübner (*14.03.1957 † 16.10.2023). Dr. Hübner's profound contributions to Positive and Transcultural Psychotherapy, as recognized by the German Association for Positive and Transcultural Psychotherapy (DGPP) and the Peseschkian Foundation, leave an indelible mark on our community.

In the spirit of continuity and shared knowledge, the WAPP news sections feature the latest updates from the Positive and Transcultural Psychotherapy community. These updates serve as a testament to the vibrancy of our field and the collective commitment to advancing positive mental health practices worldwide.

We hope that these articles contribute to the evolving landscape of Positive Psychotherapy and inspire practitioners, researchers, and educators in the field. We extend our deepest gratitude to all contributors, readers, and our esteemed community for your unwavering support. Together, we continue to foster a global dialogue that promotes well-being and resilience through Positive and Transcultural Psychotherapy. Thank you for your continued support, and we look forward to your insightful feedback.

Sincerely,

The Editorial Board

The Global Psychotherapist,
Journal of Positive and Transcultural Psychotherapy

Section: Preliminary studies in PPT

INVESTIGATING THE EFFECT OF A GROUP PSYCHOEDUCATION PROGRAM ON TEST ANXIETY: IMPLEMENTATION OF THE BALANCE MODEL WITHIN THE CONTEXT OF POSITIVE PSYCHOTHERAPY

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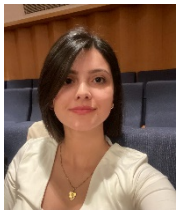

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Abstract

The aim of this study is to investigate the effect of a Test Anxiety Group Psychoeducation Program based on the Balance Model within the context of Positive Psychotherapy on the test anxiety scores of high school students experiencing test anxiety. The experimental group consisted of 14 students, 8 females and 6 males, attending the 11th grade in a state high school in Ankara/Türkiye, who were identified by the school guidance service as experiencing test anxiety. The students in the psychoeducation group were assigned using the purposive sampling method, a non-random sampling technique and a subset of purposeful sampling. The Test Anxiety Group Psychoeducation Program was based on the Balance Model within the context of Positive Psychotherapy and consisted of 6 sessions lasting 90 minutes each, utilizing methods mainly from positive psychotherapy, drama techniques, and stories. A Test Anxiety Inventory comprising 20 items was administered to the participants. The subscale scores of Emotionality and Worry, as well as Overall Anxiety Score were utilized. A single-group, pre-test post-test experimental design was used in the research. The outcomes showed that after participating in the Test Anxiety Group Psychoeducation Program, the experimental group's test anxiety scores significantly decreased.

Keywords: positive psychotherapy, balance model, test anxiety

Introduction

Anxiety is an emotional response to environmental and psychological events that is defined by worries about the future (Öner, 1990; Erylmaz, 2010; Köknel, 1989). It is a state that is connected to many negative emotions. According to Spielberger (1972), anxiety is an unpleasant emotional state marked by tension and worry. There are several factors that might contribute to anxiety, including exposure to stressful life events, having anxious family members, having had trouble with childhood relationships with parents, teachers, or friends, as well as having medical or mental conditions (Erözkan, 2004; Erylmaz, 2012).

One of the key components influencing how a nation's society is shaped is its educational system. Primary, intermediate, and postsecondary education are the three main phases of Turkey's complicated educational system. The Higher Education Institutions Exam (YKS), an entrance exam for universities, is given at the Conclusions of high school. The choice of university that students attend is thought to be strongly influenced by YKS. These tests, which are essential for the Turkish educational system's move to higher education institutions, cause a significant amount of exam anxiety among students. Students encounter exams and deal with test-related anxiety starting at a very young age. Exam anxiety is now recognized as a distinct form of anxiety (Erözkan, 2004). According to Sarason et al. (1958), Spielberger (1972), Vogelaar et al. (2016), exam anxiety is a state of emotion characterized by cognitive, emotional, and behavioral symptoms that block a person from displaying his/her true performance in a formal exam or evaluation and increase the person's tension. Exam anxiety includes two components, worry and emotionality, according to Liebert and Morris (1970). The worry dimension is the cognitive component of exam anxiety and includes performance-related cognitive expressions of anxiety. The emotionality dimension, on the other hand, is concerned with the physiological and emotional reactions to exam anxiety, including sweating, blushing, shaking, and nausea. Exam anxiety can be useful for students up to a point because it may inspire them to do better. Beyond a certain point, adolescents might lose the ability to handle this feeling, which could have detrimental effects (Khan, 2008). Those with high anxiety interpret this arousal as a cue to work harder during the exam, even though others with average levels of anxiety have identical physiological arousal before and after the exam. As a result of their concerns, those with high levels of anxiety, on the other hand, frequently perceive this arousal negatively (Sahin et al., 2006). High levels of exam anxiety can cause students to exhibit symptoms including poor concentration, memory loss, and stomach pain as well as physical symptoms like headaches and lack of attention. Exam anxiety can have a substantial negative impact on students' performance, and as a result, on their preferences for universities and potential future careers.

Psychoeducational group interventions are an effective method to help students cope with exam anxiety and reduce their anxiety levels. These group sessions provide support and guidance to students in developing anxiety-coping skills. In Turkey, various psychoeducational programs have been implemented and studied to address exam anxiety. These programs may be based on different therapeutic approaches, with Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) being the most commonly used therapeutic modalities (Bozanoğlu, 2005; Çiydem & Şavklı, 2022; Gençdoğan et al., Koruklu et al., 2006; Yıldırım & Bahayi, 2023). CBT is a widely utilized approach that focuses on identifying and modifying negative thought patterns and behaviors associated with anxiety. EMDR, on the other hand, utilizes eye movements and desensitization techniques to address distressing memories or experiences linked to anxiety. Through these psychoeducational interventions, students are equipped with practical strategies to manage exam-related stress and enhance their ability to cope with anxiety. These efforts aim to improve students' overall well-being and academic performance by fostering healthier responses to exam-related challenges.

Positive psychotherapy has been the subject of only a small number of studies, which emphasizes the need for additional research to determine its potential advantages and uses. Positive psychotherapy may help people who are anxious about exams since it places a strong emphasis on fostering a balanced model, strengths, and coping skills. It is a transcultural, humanistic, psychodynamic, and conflict-

resolution method (Peseschkian, 1986; cited in Sarı, 2015). Positive psychotherapy concentrates on fostering positive views of people, understanding the influence of early life events on personality development, and assisting people in acquiring the skills required to meet their needs. Because of this, it is believed that positive psychotherapy can be useful in easing severe exam anxiety. A group psychoeducation based on the balance model of positive psychotherapy has been created in this situation. According to the basic principles of positive psychotherapy's balance model, life energy is distributed in four areas. Individuals cope with the conflicts they encounter in life and strive to achieve balance among these four dimensions: physical (through senses), achievement (through intellect), relationship (through traditions), and fantasy (through intuition) (Peseschkian, 2002). Positive psychotherapy argues that individuals can be fully healthy and productive only when they achieve balance in these four fundamental dimensions. Additionally, these four areas also represent individuals' basic needs in their daily lives. Individuals have daily physical, mental, relational, and spiritual needs. In order to fulfill these needs, individuals need to develop various life skills in each dimension. However, the balance in each individual's life may be disrupted from time to time, and individuals may find themselves not adequately meeting their daily needs, either consciously or unconsciously (Sarı, 2015). Exams can present a situation that disrupts this balance, so it is believed that group psychoeducation based on the balance model may be effective in addressing exam anxiety. The aim is for students to recognize and develop the skills to meet their needs in each dimension, thus restoring the balance.

Based on the literature review, it has been determined that there are several group studies based on positive psychotherapy (Eryılmaz, 2010; Eryılmaz, 2012; Sarı, 2018; Sarı & Yıldırım, 2022). However, studies focusing on reducing exam anxiety based on positive psychotherapy are quite limited (Sarı & Taşlıçukur, 2018). This experimental research has been conducted to address this gap in the existing literature and demonstrate the effectiveness of interventions using positive psychotherapy in reducing exam anxiety and provide guidance for future studies. Thus, the aim of this experimental study is to examine the effectiveness of a group psychoeducation program based on the Balance Model in the context of Positive Psychotherapy on high school students' exam anxiety scores. The hypothesis of this experimental study is that when the pre-test and post-test scores of the experimental group are examined, there will be a significant decrease in exam anxiety scores.

Methodology

2.1. Model of Research

In this study, a single-group pre-test, post-test quasi-experimental design was used to examine the impact of a group psychological counseling program based on the balance model within the context of positive psychotherapy on secondary school students who are currently experiencing exam anxiety.

2.2. Participants

The study's experimental group consisted of a total of 14 senior students, comprising 8 females and 6 males, who are enrolled in a large public high school in Ankara. Students who felt extremely stressed out about the Higher Education Entrance Exam (YKS) applied to the program after the school counselor announced that a group study on managing test anxiety would begin. These individuals scored highly on tests of test anxiety, according to preliminary evaluations conducted using a standardized scale. All of these students were consequently added to the group study. In this study, the participants in the experimental group were assigned using non-random purposive sampling, which is a subset of the purposeful sampling method, to select individuals who meet specific criteria for the study.

2.3. Data Collection Tools

The Exam Anxiety Inventory: The adaptation of the inventory developed by Spielberger into Turkish was carried out by Öner (1990). The Exam Anxiety Inventory (EAI) is a four-point Likert-type questionnaire consisting of 20 items. Through exploratory and confirmatory factor analysis, the EAI was found to have two sub-dimensions: Worry (EAI-W) and Emotionality (EAI-E). The Total Exam Anxiety Score (EAI-T) is obtained by summing the scores of the two subscales, representing the two main dimensions of exam anxiety. As all three scores (Worry, Emotionality, and Total Exam Anxiety) increase, the level of anxiety, worry, and emotionality also increases (Öner, 1990). In this

study, the Worry score, Emotionality score, and Total Exam Anxiety score obtained from the study group were all evaluated.

2.4. Experimental Procedure

The exam anxiety group psychoeducation program based on the balance model within the context of positive psychotherapy consists of 6 sessions, each lasting an average of 90 minutes. Due to the extended duration of each session, the program was conducted outside of school hours. Prior to the commencement of the study, permission forms from the families of the students in the experimental group were obtained.

For the study, the library hall of Çankaya Anatolian High School was selected for this program because it is equipped with the necessary technical facilities. Necessary preparations, such as setting up the session arrangement, were made for the study. A whiteboard, pens, computers, a projector, colored pens, paper, cardboard, strings, and other supplies were all set up and ready to use.

The psychoeducation program was developed using the balance model and three positive psychotherapy principles (hope, balance, and consultation). It was built on the theoretical foundations of positive psychotherapy.

Each session started with a warm-up activity. Each session also included the use of a proverb or story. Participants in these sessions engaged in exercises and activities intended to foster optimistic feelings, boosting resilience, creating coping mechanisms, and strengthening psychological functioning. While theatre techniques and storytelling offered chances for self-expression and the investigation of personal histories, the incorporation of cognitive-behavioral approaches allowed for the discovery and adjustment of negative ideas and beliefs. The specifics of what was accomplished in each session are listed below. The program is summarized in Table 1. Each session started with a warm-up activity. Each session also included the use of a proverb or story. Participants in these sessions engaged in exercises and activities intended at fostering optimistic feelings, boosting resilience, creating coping mechanisms, and strengthening psychological functioning. While theatre techniques and storytelling offered chances for self-expression and the investigation of personal histories, the incorporation of cognitive-behavioral approaches allowed for the discovery and adjustment of negative ideas and beliefs. The specifics of what was accomplished in each session are listed below, as summarized in Table 1.

In the first session, the group facilitator informed members about the program and provided positive psychotherapy within the framework of the balance model. Warm-up exercises were carried out to enable participants to get to know one another and feel at ease with the group process. Group rules were formed, written on cardboard, and posted in an accessible spot after taking into consideration the recommendations from the participants. On colorful post-it notes, participants were asked to list what they expected from the program. There were definitions given for anxiety and exam anxiety. The group leader discussed the causes of exam anxiety and its effects on people. The participants were asked to discuss any effects they have noticed in themselves. On tiny pieces of paper, they responded, and those papers were pinned on a bulletin board.

In the second session, the "Two Frogs" story was read, and the story was discussed with the participants. Then, the balance model in Positive Psychotherapy was explained, and each dimension was thoroughly discussed. Based on this information, the group members were asked to draw their own balance models and were instructed to keep them until the end of the group sessions.

In the third session, the participants were reminded of the balance model, and they shared their experiences regarding what happens in their bodies when they experience anxiety. The responses were written in the "body" section of the balance model chart on the whiteboard. After noting down the responses, the group members were asked about their views on coping strategies for dealing with such challenging situations. Then, techniques for controlling the body (such as proper breathing and achieving relaxation) were explained. The "Safe Place" exercise was conducted during the session.

In the fourth session, the "Treasure of Knowledge" story was read, and the story was discussed with the participants. They were reminded of the balance model, and questions were asked about how their performance area is affected when they experience anxiety. The

responses were written in the "success/performance" section of the balance model chart on the whiteboard. The group discussed the effects of anxiety on the performance area. Participants were then asked to set goals related to their performance areas for the next 1 week, 1 month, 3 months, 6 months, 1 year, and 5 years and to make plans on how to achieve those goals. They were instructed to hang the papers with their plans in a place where they can see them regularly in their rooms.

In the fifth session, the participants were reminded of the balance model, and they were asked questions about how their "relationship" area is affected when they experience anxiety. The responses were written in the "relationship" section of the balance model chart on the whiteboard. The group discussed the effects of anxiety on the relationship area. Brainstorming was done on how to cope with the negative effects. Communication and communication barriers were explained. The "Love Bombardment" exercise was conducted, and participants shared their experiences during the activity.

In the sixth and final session the participants were asked to consider how anxiety impacts the "future/spirituality" aspect of the balance model. The answers were noted in the balance model chart's "future/spirituality" section on the whiteboard. The group talked about coping mechanisms for anxiety's detrimental effects on spirituality and the future. Participants were given a metaphorical lens through which to view and examine many facets of their own lives, such as their dreams, goals, and spiritual beliefs, after the story "Dreams" was read. After that, participants were instructed to look over the balance model they had created at the start and maintained throughout the course of the program. Participants were invited to record any shifts in their viewpoints or experiences in relation to the four areas of the balance model in writing. In addition, the fourth session's goal-setting and planning exercise for the performance area was expanded to cover all four areas of the balance model, enabling participants to plan and set objectives for every facet of their lives in order to attain a sense of overall balance and wellbeing. In the first session, they wrote expectations on post-it notes, which they then evaluated. The program was finished, and the last test was given.

Table 1.

Exam Anxiety Group Psychoeducation Program Based on Positive Psychotherapy

Session	Aim	Technique
1-Introduction	Introduction involves introducing the participants to the process, establishing group rules, and providing information about exam anxiety.	Warm-up exercise
2-Introduction of the Balance Mode	Introducing the balance model according to Positive Psychotherapy and having the participants draw their balance models. Visualizing and conceptualizing their own balance in different life areas, fostering self-awareness and understanding of how different aspects of their lives interact and influence each other.	Warm-up exercise *Two Frogs Story** Balance model Relaxation exercise
3-Physical Dimension	Exploring physical responses to anxiety, introducing coping strategies, and incorporating relaxation exercises to support the participants in managing their test anxiety effectively.	Warm-up exercise Proper breathing exercise Relaxation exercise Safe place visualization exercise
4-Achievement Dimension	Recognizing the effects of exam anxiety on the achievement area and developing the skills in this area by identifying and improving their abilities such as goal-setting, and planning, empowering the participants to work towards their desired achievements and personal growth while managing their test anxiety.	Warm-up exercise *Treasure of Knowledge Story** Developing realistic thoughts exercise Goal-setting exercise
5-Relationship Dimension	Exploring the effects of anxiety on relationships, identifying coping strategies, and facilitating effective communication and interpersonal support among the participants.	Warm-up exercise Sharing information about communication

		and communication barriers Love Bombardment exercise
6- Future/ Spiritual Dimension	Developing the ability to recognize and cope with reactions in the area of future/spirituality when experiencing anxiety. Self-reflection, goal-setting, and evaluation of personal growth and development across all aspects of the balance model.	Warm-up exercise *Dreams and Aspirations Story** Future balance model

**The stories can be accessed from Prof. Dr. Peseschkian's book "Positive Psychotherapy in Everyday Life" (2016).*

2.5. Data Analysis

In the study, non-parametric tests were used for data analysis due to the number of participants. The Wilcoxon Signed-Rank Test was used to compare the pre-test and post-test scores of the experimental group. A significance level of 0.05 was accepted to interpret the results of the statistical analysis.

Results

The descriptive statistical findings of pretest and posttest scale applications on the experimental group students are presented in Table 2.

Table 2.
Descriptive Statistical Findings of Pretest and Posttest Scale Applications on Students in the Experimental Group

Inventories	Experimental Group	N	Mean		Mİn.	Max.
Emotionality	Pre-test	14	36,78	6,13	23	45
	Post-test	14	24,64	4,20	16	31
Worry	Pre-test	14	22,28	4,10	16	30
	Post-test	14	15,64	4,22	10	23
Overall	Pre-test	14	59,28	9,71	39	75
	Post-test	14	40,28	7,90	28	53

The mean pretest scores of the students in the psychoeducation group for the Emotionality subscale were 36.78, while the posttest scores were 24.64. For the Worry subscale, the mean pretest scores were 22.28, and the posttest scores were 15.64. Regarding the total Test Anxiety scale, the average pretest scores were 59.28, and the posttest scores were 40.28.

The comparison of the exam anxiety pretest and posttest scores for the participants who took part in the positive psychotherapy-based exam anxiety coping study was conducted using the Wilcoxon Signed-Rank Test for the experimental group's pretest and posttest scores, and the results are presented in Table 3.

Table 3.
Results of the Wilcoxon Signed-Rank Test applied to the pretest and posttest scores of the experimental group

Test Anxiety	Pre-Post Test	N	Mean Rank	Sum of Ranks	z	p
Total Score (EAI-T)	Negative Rank	12	8,50	102	-3,111	,002*
	Positive Rank	2	1,50	3		
	Equal	0				
Worry (EAI-W)	Negative Rank	12	8,50	102	-3,111	,002*
	Positive Rank	2	1,50	3		
	Equal	0				
Emotional (EAI-E)	Negative Rank	12	8,50	102	-3,111	,002*
	Positive Rank	2	1,50	3		
	Equal	0				

**p<0,05*

Upon analyzing Table 3, it is evident that there are significant differences in the worry and emotionality subscales, as well as the total score of exam anxiety, between the pre-test and post-test measurements of the participants in the experimental group who took part in the positive psychotherapy-based exam anxiety coping study (Total Score z=-3.112, p<0.01). A closer examination of these differences reveals that both worry and emotionality subscale scores showed a significant decrease in the post-test. This finding supports the effectiveness of the positive psychotherapy-based exam anxiety coping program, which spanned six sessions, and confirms the acceptance of the hypothesis.

Discussion

In this study examining the effectiveness of a positive psychotherapy-based exam anxiety coping group psychoeducation program on high school students' exam anxiety scores, significant differences were found in the pre-test and post-test total exam anxiety scores, as well as in the emotionality and worry subscale scores of the participants in the experimental group who participated in the positive psychotherapy-based exam anxiety coping program. A decrease in exam anxiety was observed in the post-test. These findings demonstrate that the positive psychotherapy-based exam anxiety coping group psychoeducation program is effective in reducing both the emotional and cognitive aspects of exam anxiety in high school students.

When the literature is examined, it is observed that there is a limited number of studies conducted in the context of positive psychotherapy aiming to reduce test anxiety. In the only study identified so far, Sarı and Taşlıçukur (2018) examined the effectiveness of the Positive Psychotherapy-based test anxiety group counseling program on middle school students. The findings indicate that the test anxiety program was significantly effective on the test anxiety of the participating students, and the implemented program can be considered as a viable intervention for reducing test anxiety in adolescents.

Even though there aren't many studies that address test anxiety in the context of positive psychotherapy, it's evident that different psychoeducation group interventions have been conducted within the positive psychotherapy framework on various topics. Eryılmaz (2010), for instance, claimed that she could implement her "Program for Expanding Goals for Adolescents in the Context of Positive Psychotherapy and Developmental Counseling" in schools. Eryılmaz (2012) conducted an examination of the efficacy of the "Expanding Goals for Adolescents Group Guidance Program" within the framework of positive psychotherapy. The results indicated that there was a significant difference between the experimental and control groups with respect to the acquisition of lifelong goals and increased life satisfaction. Furthermore, Sarı and Yıldırım (2022) examined the impact of gratitude diary writing, utilizing the balance model, on the level of subjective well-being and gratitude among secondary school students. Their findings indicated that writing a gratitude diary elevated the levels of both these constructs among teenagers. The positive outcomes of these experimental investigations that emphasize positive emotions and positive psychotherapy confirm the conclusions of our investigation.

The findings of our study align with the holistic approach of positive psychotherapy, which takes into account the body, relationships, thoughts, hope, and spirituality (Eryılmaz, 2017). It is believed that this all-encompassing strategy was crucial in producing successful outcomes for the current investigation. It is known that test anxiety has important cognitive, relational, physical, and origins and effects. By using the comprehensive balance model of positive psychotherapy, the program utilized in this study effectively addressed the various aspects of test anxiety and gave participants skills and knowledge to cope with anxiety in different ways.

For instance, the balance model's body-oriented exercises, like correct breathing and relaxation methods, can help reduce test anxiety. By influencing stress hormone levels and encouraging the release of endorphins, which are chemicals associated with happiness and wellbeing, these exercises can lessen test anxiety (Erözkan, 2004). With the aid of these exercises, test anxiety can be decreased by instilling feelings of comfort and tranquility. Participants also acknowledged the importance of exercise and self-care. Regular exercisers frequently express feeling more confident and physically better (Polat et al., 2020). Anxiety related to exams may diminish due to heightened self-assurance and self-efficacy, as individuals may perceive themselves as more capable and

equipped to manage demanding circumstances like examinations. People who suffer from test anxiety may hold unfavorable beliefs about failing in the context of exams in the achievement domain. Test anxiety can be effectively decreased by adopting positive thoughts and beliefs (Öner, 1990). Additionally, test-anxious people may frequently feel helpless or inadequate. Individuals are encouraged to highlight and concentrate on their unique strengths through positive psychotherapy and the balance model (Eryılmaz, 2020; Peseschkian, 2015). This method can help people feel more confident in themselves, which will make it easier for them to deal with test anxiety (Sarı, 2015).

When one considers the relationship domain, one can see how communication and relationship skills enable people to interact more effectively with their social surroundings. Being able to communicate effectively can help one feel more understood and supported by others, which is beneficial during exam season when people are more stressed and anxious. One of the most important things in managing test anxiety is having a strong social support system. Good relationships with teachers, family, and close friends may result in increased understanding and support for exam-taking individuals (Yıldırım & Bahayi, 2023). This may lessen test-related anxiety. Regarding the final domain of the balance model, which is future/spirituality, spirituality can enhance people's perception of their life's meaning and purpose (Karslı, 2019). This sense of direction and meaning can serve as a driving force behind study sessions and provide comfort to individuals experiencing exam anxiety. People can find a sense of purpose and the willpower to overcome exam-related obstacles when they connect their studies to a greater purpose.

Furthermore, by discussing their fears in the framework of the balance model, students who were feeling severe test anxiety were given the chance to view themselves holistically. Students developed a better awareness of the many aspects of their lives that had been influenced by test anxiety by talking about their feelings and difficulties within the balance model. This holistic perspective likely enabled them to recognize the interconnectedness of different aspects of their lives and how these dimensions influence each other, including how test anxiety can spill over into other areas. Through the stories shared, they also had the chance to gain a new perspective, perhaps realizing that they are not alone in their struggles and that others have overcome similar challenges. Furthermore, they created specific roadmaps for each dimension of the balance model. Many of them reported implementing concrete steps they developed into their daily lives. It is believed that this holistic daily life organization helped students in balancing their intense anxiety.

Suggestions

In this study, the Positive Psychotherapy-based Balance Model Group Psychoeducation Program for test anxiety was conducted with 14 11th-grade students identified as having high test anxiety. The program was found to be effective in reducing students' test anxiety scores. However, the study has some limitations in terms of its sample. Future studies can strengthen the experimental design by including a control group. Additionally, the Positive Psychotherapy-based Balance Model Group Psychoeducation Program can be applied to various samples, including different school types (e.g., elementary, middle, high schools), different age groups (e.g., children, adolescents, adults), and groups with varying sample sizes (e.g., small or large groups).

Despite its limitations, the study contributes valuable insights to the field of positive psychotherapy and offers practical applications for supporting students' well-being during times of anxiety and stress. School psychologists and counselors can organize similar positive psychotherapy-based interventions and provide support to students in coping with anxiety during challenging times.

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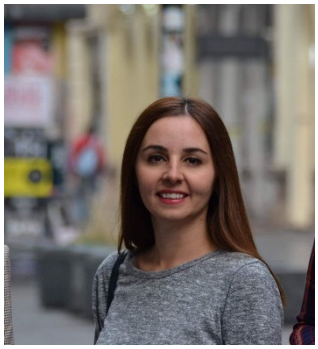
Section: Preliminary studies in PPT

ASSESSMENT OF BASIC BENEFITS OF POSITIVE AND TRANSCULTURAL PSYCHOTHERAPY IN WORKING WITH A GROUP OF MULTICULTURAL STUDENTS



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Abstract

This research was done with a group of multicultural students who were pursuing their studies in Turkey. The aim of the research is to evaluate the benefits of Positive and Transcultural Psychotherapy in working with groups of multicultural students. The research data are based on the therapeutic process, which was used in ten psychotherapeutic sessions by applying Positive and Transcultural Psychotherapy, with the methods and techniques, such as: the concept of positum, the principle of hope, the balance model, stories and the psychotherapeutic process, all made within the five phases of therapy.
The participants in the group therapy were six females from different national backgrounds. All participants expressed complaints about the adaptation process in the new environment. The research results are based on oral data from participants' feedback at the end of each session and at the end of the therapeutic process.

Keywords: student group, multicultural, adaptation, positive psychotherapy, therapeutic process

Introduction

Positive psychotherapy is a short-term psychotherapeutic method with a psychodynamic, humanistic and intercultural approach which is based on three main principles: the principle of hope, moderation and counseling which respectively symbolize the global identity, the social identity and the identity of everyday life (Peseschkian, 2016).

Adapting to a new living place, to a new culture, to another country is a challenge for every person who immigrates or takes a path to live in another country, that is different from the previous one.

Knowledge of cultural factors and coping skills are often necessary throughout the psychotherapeutic process to achieve successful treatment outcomes. Culturally appropriate behavior as well as psychotherapeutic appropriateness can be challenging because cultural issues are often misinterpreted or even overlooked (Tseng, 2001).

Since Positive Psychotherapy is essentially a psychodynamic approach and is based on the humanistic concept and offers a transcultural - multicultural point of view (Peseschkian, 1986), then even in working with group members from different countries / cultures, treatment with this psychotherapy approach seems to work toward a successful life. At the same time, Positive Psychotherapy aims to deal with conflicts based on personal resources/skills, strengthening and not neglecting the cultural aspect of the person.

Methodology

2.1. The Research Problem

The various study abroad programs carry with them benefits and advantages, on the other

hand, they can also be challenging for young students. During this, problems such as:

1. International students face numerous challenges during the phase of adaptation to the new environment.

a) The main challenges of the students are related to the clash of concepts, namely different cultures.

b) Difficulties in socialization are worrying as they affect the psycho-emotional and academic state of the student.

2.2. Research Hypothesis

The main research hypothesis is:

Positive and Transcultural Psychotherapeutic sessions bring about smoother adaptation for international students who experience difficulties during the phase of adaptation than are experienced by students who do not attend sessions of positive and transcultural psychotherapy.

2.3. Limitations of the Research

Participants from different countries cannot represent the entire country of their origin, therefore this does not mean that their opinions are the same as those of other citizens from the country. Thus, with only one or two representatives, the unique opinion of the community cannot be generalized.

The research also has a limit in terms of gender. Because all the subjects were female, the results of this research can be addressed to the female gender.

2.4. Research Design

The research is qualitative and aims to deal with the difficulties related to the adaptation phase of international students. The sample included international students who were part of the study program in Turkey and who sought help to overcome adaptation challenges.

Since the research is qualitative, the total of ten group sessions were evaluated by using the methods and instruments from Positive and Transcultural Psychotherapy. Although the personal experiences were analyzed, the evaluations of the results were made based on the feedback of each participant in the group.

Discussion

According to Şen (2008), theories of multicultural relationships provide explanations of how multicultural differences affect the understanding of one's own culture and the other's culture, and then these differences affect the process of relationship reporting. For students from different cultural backgrounds, it is important to understand how these differences affect the relationship process during the study period.

The psychotherapeutic process began by discussing the group members' concerns with the therapist and the group participants, working on situational normalizing first, then by practicing the Positum concept, developing attachment, building the principle of hope and working and functioning in group form.

The process moved on to the application of the balance model because using the balance model, as a tool of Positive and Transcultural Psychotherapy, in working with students of different cultures seems to be effective in enabling the achievement of relevant results. According to Peseschkian (2000), the balance model provides similar results to a holistic view of emotions, cognition, relationship dynamics, meaning and intuition that are addressed according to the client's condition, for a person can only be fully healthy and productive when the person balances these four basic aspects of life. People often find themselves in a transcultural relationship. The effectiveness of this relationship depends on the interaction with both cultures and how much the persons understand and accept each other's culture. The more common points there are between the two cultures, the more the person adapts and the easier it is to understand the other culture (Şen, 2008). So, during the situational encouragement stage, we worked toward creating interaction with this new culture which makes the adaptation process easier as well as creating new perspectives for them.

During adaptation in a foreign environment, students face the problems of communication difficulties, conflicts in social and moral values, creating social and professional relationships, the feeling of being a foreigner, as well as adaptation to the new education system (Güçlü, 1996). On the other hand, Positive and Transcultural Psychotherapy with a transcultural, dynamic and comprehensive

approach sees man as a good being by nature and with many abilities and potentials (Peseschkian, 1985), therefore the use of methods and instruments of Positive and Transcultural Psychotherapy have become the main sources and reasons for successful therapeutic achievement. At the end of the sessions, there were changes in the participants, especially in terms of culture, initiative and social relationships.

During the psychotherapeutic process in ten sessions with the group of multicultural students, visible results were achieved in improving the psycho-emotional state of the participants. At the beginning of therapy, the participants reported difficulties in adaptation to the new environment, followed by language and academic difficulties, lack of and difficulties in socialization, difficulties in accepting the new culture and changes in eating and sleeping habits. These situations were reflected in the reduction of the quality of their lives. However, during the psychotherapeutic process, with the use of Positive and Transcultural Psychotherapy techniques, the participants in the group reported significant changes in the improvement of their psycho-emotional state and in the ease of adapting to the new environment. At the end of the sessions, there were changes in the participants, especially in terms of cultural meaning, they were taking more self-initiative and they were able to create new social relationships.

Table 1.
Demographic data of the group subjects

Participant	Age	Gender	State of origin	Studying period	Study level
1	20	Female	Zimbabwe	16 months	Bachelor
2	25	Female	Somalia	16 months	Master
3	18	Female	Svaziland	6 months	Bachelor
4	18	Female	Svaziland	6 months	Bachelor
5	19	Female	Kazakhstan	6 months	Bachelor
6	24	Female	Kazakhstan	6 months	Master

Conclusions

In ten sessions with the group of multicultural students, visible results in improving the psycho-emotional state of the participants were achieved. At the beginning of the psychotherapeutic process, the participants reported difficulties in adapting to the new environment, followed by language and academic difficulties, lack of and difficulties in socialization, difficulties in accepting the new culture and changes in eating and sleeping habits. These situations were reflected in the reduction of the quality of their lives. However, during the psychotherapeutic process, with the use of Positive and Transcultural Psychotherapy techniques, the participants in the group reported significant changes in the improvement of their psycho-emotional state and in the ease of adapting to the new environment.

We held a meeting of the group after 4 months following the end of the psychotherapeutic process, and even after those participants reported that their psycho-emotional condition continues to be good and their quality of life had improved.

Lastly, holistic approach, the importance of personal concepts, working towards re-building the life balance, encouragement on working and overcoming conflicts, as well as the verbalization of concrete steps not only lead to the return of a good state of psycho-emotional stability, but at the same time, with the broadening of the goals, the participants engage in self-help and become independent from the therapist. By adding the transcultural approach and working with multicultural student groups, Positive and Transcultural Psychotherapy remains a favorable alternative that brings successful therapeutic results.

4.1. Recommendations

Initially, it would be well to recommend the use of a measuring questionnaire for measuring the psycho-emotional state of the participants. This can be done at the beginning of the therapy

and at the end, it will be important to compare the results and have numerical data. Otherwise, in this research, the results are based only on the oral data of the participants, on their feedback.

Another recommendation could be to include participants from both genders in the group, and then to analyze these results.

While in the theoretical aspect, it is recommended that other instruments from Positive and Transcultural Psychotherapy be included in the next researches, such as: the Differential Analysis Inventory (DAI) and/or the Wiesbaden Inventory for Positive and Family Psychotherapy (WIPPF) questionnaires, as they may affect the quality of future findings.

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Section: Preliminary studies in PPT

STUDY ON THE WAYS OF ACCEPTING AND COPING WITH THE ENDOMETRIOSIS DIAGNOSIS

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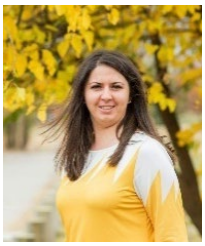

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Abstract

The present article discusses the topic of chronic ailments and the need for psychological support related to them. We are presenting information on the first-ever study held in Bulgaria of women suffering from Endometriosis, accepting the diagnosis and ways of coping with the macro-traumatic event of receiving the diagnosis. The study illustrates our effort to establish whether there is a difference in the ways women cope with such a hard diagnosis as Endometriosis among patients utilizing psychological support and patients who refrain from it. We also describe the results from the preliminary study aiming to establish to what extent psychological work affects the ways of coping with the Endometriosis diagnosis. .

Keywords: positive psychotherapy, endometriosis, woman, support, diagnosis

Introduction

"People are unique and what we need to do is to take care of the person, not their illness" Hippocrates

Nowadays a plethora of people live with a chronic ailment. One such condition has touched us as well. Endometriosis is considered a socially significant illness worldwide, as it affects 1 in 10 women while information on the topic is utterly insufficient. Due to the illness' symptoms, related to unexpected and inexplicable pains during menstruation (and not only), weariness despite having rested well, intestinal swelling and discomfort, sudden feelings of alarm, depression, etc., women suffering from Endometriosis experience difficulties in maintaining relationships with their families, intimate partners, friends and even professionally. "As per the stressors scale proving there are events with higher stressogenic intensity and events experienced as weakly bothersome, the disease is placed at one of the top positions in the scale of stressful events as per the Holmes and Rahe study 1967; Rahe, 1969, carried out in several countries such as the USA, Sweden, the Netherlands, and Japan, with results mirroring each other in various countries and cultures".

This stressful event affected our lives as well and turned them upside down from the very beginning, as we were not spared the feelings of helplessness, fear and not finding a point to life. However, our professional knowledge and

experience in a psychotherapeutic aspect saved us from the spiraling plummeting that, sadly, a lot of women experiences. Knowing from personal experience how difficult to diagnose that condition is and how it can rob patients of their lives, we created a support group on social media that currently exceeds 4800 members. Managing the group, we succeeded at creating a space where women suffering from Endometriosis can talk about any and all problems rooted in their condition – their physical, psychological, emotional, and social functioning.

That is why we aimed at working to increase awareness of this condition and the consequences it brings on a psychological level. We have been working with doctors who realize the need for a multidisciplinary approach to treatment and participate in the present study by directing patients to us and supporting and interpreting the patients' symptoms.

1.1. Grounds of the study

Endometriosis was first described by Daniel Shroen in 1690 r. in his paper "Disputatio Inauguralis Medica de Ulceribus Ulceri". The condition's symptoms were presented by Arthur Duff in 1769, and the first publications with regard to the pathogenesis of the condition appeared in the second half of the 19th century. The condition was described by Karl von Rokitansky in 1860 and he defined it as the existence of an active endometrium outside the uterus cavity.

Endometriosis is a condition where parts of the uterus lining cells expand outside the uterus, causing inflammation that leads to numerous intergrowths in the female body. As a result of regular female menstruation, these lesions swell and bleed internally at the intergrowth locations. Such lesions (hot spots) can be identified as located not only in the pelvic area but also in the gastrointestinal tract, the bladder, the lungs, and even the patient's brain. Endometriosis is a common condition but due to the wide array of symptoms, diagnosing it could potentially happen 8-12 years after its first occurrence. About 2-10% of women experience this condition while in their reproductive stage, 35-50% of them also suffer from fertility issues and pain.

Endometriosis is not a cancer but behaves like one. It is a chronic, hormonally dependent condition found in women of reproductive age, and it is not dependent on race or social status in any way.

People refer to Endometriosis as the "quiet" and "multifaced" condition and very often it has strongly expressed general symptoms, but it is not a rare occurrence that a patient does not exhibit clear symptoms at all. Some of the most frequent symptoms of Endometriosis are:

- Acute pain which is not affected by taking standard painkiller medication
- Pain that lasts for the duration of the whole menstrual cycle
- Pain that starts before the menstrual cycle begins and lasts after it ends
- A very long or very heavy menstrual cycle, sometimes both, lasting longer than 10 days
- Pain during urination or defecation, manifested strongly during the menstrual cycle
- Major swelling in the abdominal area and intestinal pain for the whole duration of the menstrual cycle and not only.
- Weariness which is not affected by hours of sleep
- Higher temperature during a menstrual cycle or stable sub febrility regardless of what day of the month it is
- Miscellaneous

Although pain can be managed by pharmaceutical inhibition of ovulation and menstruation, it is very often that lesions cannot be removed. A surgery most frequently leads to pain subsiding but its effect is usually temporary.

The arguments and dilemmas with regard to this mysterious ailment, its diagnosis and appearance, clinical description, and treatment continue worldwide. Eskenazi's research and his theory that Endometriosis can be found in 10% of the general female population stimulated a number of authors to aim at making the epidemiology of the condition clearer. However, using various data sources and relating them to a number of definitions has led to the fact that despite the large number of publications made on the matter, the argument on how impactful Endometriosis is remains unresolved to date.

Endometriosis is a common chronic gynecological pathology with a huge negative impact on female health. Besides heavy physical symptoms, Endometriosis is linked to a few

accompanying psychiatric conditions, including depression and anxiety.

The Endometriosis stage is not directly related to the severity of the symptoms and repeat symptoms are common. It is believed that the symptoms are related to psychological distress the same way they are in cases of depression and anxiety conditions.

As a result of our practice in psychotherapeutic groups for women suffering from Endometriosis, it is our observation that accepting the diagnosis and living with Endometriosis is largely dependent on whether doctors and family members (significant others) can identify and validate a woman's pain and suffering.

Providing psychotherapeutic help to a patient suffering from Endometriosis is crucial for developing strategies aiming at decreasing the psychological stress and as a result, improving the patient's quality of life. It is a good and promising beginning for women suffering from Endometriosis to accept the diagnosis and improve their own everyday functioning. It has been our observation that women who have sought psychotherapeutic intervention find it easier to accept the condition and identify ways of coping with it in comparison to women who have not.

Methodology

Our study aims to establish whether there are significant differences to be found in the ways women cope with being diagnosed with Endometriosis when they utilize psychotherapeutic help and when they do not. It is our hypothesis that women who receive psychotherapeutic help will exhibit a prevalence of positive ways of coping with the diagnosis whereas women who do not will largely present the negative ones.

The study was carried out in collaboration between gynecological doctors and positive psychotherapists between January 2019 and October 2022. The gynecologists were tasked with finding 44 women suffering from Endometriosis who would like to participate in our research and be supported by psychotherapeutic help in the first six months after being diagnosed, as well as 44 women who would like to participate but are not interested in receiving psychotherapeutic support.

The positive psychotherapists' team provided 44 women with psychotherapeutic help once a week during the first six months after being diagnosed.

Positive and transcultural psychotherapy allows us to build a fuller picture of the patient's ailment, respectively a better doctor-patient connection, "besides, it encompasses any and all ailments of the body and the psyche and can serve as both help in finding our way, as well as a diagnostic tool and a therapeutic approach to all narrower medical fields".

The Positive psychotherapy model "engages with the ailment as well when a primary body reaction to a conflict experience is present, on the grounds of which an organ-pathology finding occurs later on", and that makes it particularly appropriate to use when working with women diagnosed with endometriosis.

2.1. Subjects of the study

88 women of Bulgarian ethnic origin diagnosed with Endometriosis participated in our study. The diagnosed women are of an average age of 31.99 years old (minimal age - 19 and maximum age - 42). Demographic data shows that 47% of them are of higher education, 53% of them have high-school level education, 54% of them are married, 19% of them are divorced and 27% of them are single.

With regard to religious affiliation – 100% of them are Orthodox Christians.

With regard to the condition and the medical data related to it, 100% have gone through laparoscopic surgery for endometriotic cyst removal. All patients have had lesions removed and endometriotic hot spots burnt, and they also went through a histological test proving the presence of Endometriosis.

The research was held in the territory of the cities of Sofia and Varna in Bulgaria.

2.2. Research Instrument

For the purpose of the present study, the subjects participating in it filled in the Brief COPE (Carver, 1997) Questionnaire for measuring the positive and negative ways of coping with situations six months after being diagnosed. The questionnaire consists of 28 questions, divided into 14 scales, each of which includes two questions – positive and negative ways of handling a situation, whereby each of the groups holds 7 scales.

The positive scales are:

Active coping (questions 2 and 7)
Utilizing emotional support (questions 5 and 15)
Positive reformulating (questions 12 and 17)
Planning (questions 14 and 25)
Humor (questions 18 and 28)
Acceptance (questions 20 and 24)
Being religious (questions 22 and 27)

The negative scales are:

Distraction (questions 1 and 19)
Denial (questions 3 and 8)
Substance use (questions 4 and 11)
Instrumental support use (questions 10 and 23)
Behavioral denial (questions 6 and 16)
Expression (questions 9 and 21)
Blaming yourself (questions 13 and 26)

1. I find something to keep me busy or get involved in doing things that keep my attention away from the condition.
2. I direct my efforts to do something to improve my situation.
3. I tell myself "That it cannot be real!"
4. I take alcohol or sedatives to feel better.
5. I receive emotional support.
6. I give up when I try to cope with it.
7. I take certain measures to improve my situation.
8. I refuse to believe this is happening.
9. I say things to chase my negative feelings away.
10. I receive help from people giving me advice.
11. I use alcohol or sedatives to help myself get over it.
12. I am trying to accept it from a different perspective so that it seems a little more positive to me.
13. I blame myself.
14. I am trying to come up with a strategy for what to do.
15. I feel accepted and understood by someone.
16. I have given up on making efforts to cope.
17. I am trying to look at what is happening to me from a positive perspective.
18. I am joking with what has been happening to me.
19. I come up with things to do, for example going to the cinema, watching TV, dreaming, sleeping, or shopping, so that I think about it less.
20. I accept reality and the fact this is happening to me.
21. I express my negative feelings.
22. I try to find solace in my religious beliefs and/or my spiritual convictions.
23. I try to accept the advice and help offered to me by people on what to do.
24. I am learning to live with it.
25. I consider my next steps very carefully.
26. I blame myself for what has been happening to me.
27. I pray and/or meditate.
28. I look at the situation from a fun perspective.

According to the scale's author, it is possible to use separate parts of it independently and selectively, accounting for time constraints in its filling-in or as per the goal of the specific research and need of the testing sample.

The subjects studied filled in the questionnaire anonymously and answered using a 4-level scale in the Likert format from 1 – "I never do that" to 4 – "I do that very often", with no option for neutral opinion.

The result from each of the 14 scales for handling situations represents an average from both answers given and varies between 1 (minimum) and 4 (maximum). The higher values in the 7 positive scales correspond with a higher level of coping with the situation and the highest values in the 7 negative scales correspond with a lower level of coping with the condition.

The Brief COPE questionnaire's reliability is Cronbach's alpha 0,706 on the whole method. As a result:

- with positive ways of coping with the condition (α=0,779);
- with negative ways of coping with the condition (α=0,777)

2.3. Statistical methods

- Cronbach's Alpha – for measuring the reliability of the internal scales agreement;
- Mann Whitney's U Criterion – for measuring the reliability of the differences in the results received in groups
- Kruskal-Wallis Test (H-criterion) – for comparing and evaluating the statistical importance when more than two findings of a given criterion exist;
- The results were processed with SPSS v. 20.0 for Windows.

Results

Tracing the trajectories of the attitude development in the subjects studied – 88 women diagnosed with endometriosis, 44 in an experimental group and 44 in a control group – has revealed the statistical significance of the results in 5 of the positive ways of coping scales (table 1) and 4 of the negative ways of coping scales (table 2).

Table 1.
Positive coping scales data distribution

	v2	v7	v15	v5	v12	v17	v20	v24	v27
Mann-Whitney U	634,5	735,5	500,5	500,5	547,5	547,5	419,5	419,5	638,5
Wilcoxon W	1624,5	1725,5	1490,5	1490,5	1537,5	1537,5	1409,5	1409,5	1628,5
Z	2,97	2,063	4,112	4,112	3,694	3,694	4,794	4,794	2,904
Asymp. Sig. (2-tailed)	,003	,012	,000	,000	,001	,001	,000	,000	,004

Table 2.
Negative coping scales data distribution

	v4	v11	v1	v19	v3	v8	v6	v16
Mann-Whitney U	620,0	620,0	663,0	663,0	681,0	681,0	686,0	686,0
Wilcoxon W	1610,0	1610,0	1653,0	1653,0	1671,0	1671,0	1676,0	1676,0
Z	3,013	3,013	2,520	2,520	2,480	3,013	3,013	4,796
Asymp. Sig. (2-tailed)	,003	,003	,012	,012	,013	,003	,003	,000

In the **Active coping scale,** juxta positioning the answers to **question 2** *"I direct my efforts to do something to improve my situation."* - shows that 84% of the women in the experimental group and 34% of the women in the control group (u=2,97; a=0,003) are inclined to be active not just mentally, but physically as well. There is nothing that stands out in the answers of the women in the control group with regard to a specific activity as per **question 7** *"I take certain measures to improve my situation"*. Only 20,4% of them have their intentions turned into actions, unlike the experimental group where 93,2% of the women switch from intentions to active behavior in reality (u=2,06; a=0,012).

A specificity in the **Utilizing emotional support scale** that we were able to identify is how important the feeling of being accepted and the diagnosis being tolerated is on behalf of the others. 79,5% of the women in the experimental group and almost half of the women in the control one (40,9%) have the feeling they are receiving **emotional** support – **question 5**, *"I receive emotional support"* (u=4,11; a=0,000). There is a significant difference in the results for **question 15** *"I feel accepted and understood by someone"* (u=4,11; a=0,000). 81,8% of the women in the experimental group have a real sense of their own self-worth despite the diagnosis and that is a fact for only 18.2% of the women in the control one.

Judging from the **Positive reformulating scale – question 12:** *"I am trying to accept it from a different perspective so that it seems a little more positive to me"* (u=3,69; a=0,001) and **question 17:** *"I am trying to look at what is happening to me from a positive perspective"* (u=3,69; a=0,001), it is obvious that the women from the experimental group (81.8%) distribute their attitude towards the diagnosis equally in the scope of "I want it to be true and I am managing to achieve it". Almost half of the women in the control group, with a minor difference with regard to the positive aspects of their condition, i.e., question 12 - 43,2% and question 17 – 40,9%, are inclined to not see, feel, or look for a positive reformulating of their diagnosis.

The studied groups' profile in the **Acceptance scale** shows statistically significant differences with regard to the diagnosis. When answering **question 20** *"I accept reality and the fact that this is happening to me"* (u=4,79; a=0,000),

90,9% of the women in the experimental group and only 40,9% of the women in the control one demonstrates understanding and realization that the condition is a fact. Data is distributed in a similar way when answering **question 24** *"I am learning to live with it"* (u=4,79; a=0,000). 88,6% of the women in the experimental group not only accept reality and the fact that they are sick with Endometriosis but direct their efforts at creating conscious strategies to utilize the knowledge of what it is to live with that condition. Only 38,6% of the women in the control group demonstrated the same attitude.

Data obtained in the **Being religious scale** have shown statistical significance only in the answers to **question 27** *"I pray or meditate"* (u=2,90; a=0,004), where 79,5% of the experimental group and 61,4% of the control group utilize faith in salvation that comes from outside (God) and the power of their internal resources. We do not observe statistical significance in the answers to **question 22** *„I try to find solace in my religious beliefs and/or my spiritual convictions"*, which leads us to presume that women from both groups rely more on a miracle than the support of religious or spiritual beliefs.

Age, education, and marital status do not prove to be significant or defining when choosing positive strategies for coping with the condition.

Tracing the trajectories of developing attitudes for negative ways of coping with the condition has shown that the most significant and dominating among the women from the control group (68,2%) is the strategy listed in the **Substance use scale** – **question 4** *"I take alcohol or sedatives to feel better."* (u=3,01; a=0,003). Almost half are the women in the experimental group (34,1%) turn to alcohol in order to feel better. The answers to the systematic substance use in **question 11** *"I use alcohol or sedatives to help myself get over it"* (u=3,01; a=0,003) paint a similar picture, 88,6% of the subjects studied from the control group depend on alcohol and other substances for salvation and avoiding the reality of their condition. Only 27,3% of the members of the experimental group utilize that strategy.

In the **Distraction scale** the results of **question 1** *"I find something to keep me busy or get involved in doing things that keep my attention away from the condition"* (u=2,52; a=0,012) show that in the case of 79.5% of the control group subjects keeping their minds off both thinking about the diagnosis and the conscious strategies for accepting it proves to be a good support strategy. This self-help method is not rejected by the experimental group either, a little over half of the women there (59,1%) are also heavily dependent on it. The situation is identical to the data obtained when answering **question 19** *„I come up with things to do, for example going to the cinema, watching TV, dreaming, sleeping or shopping, so that I think about it less."* (u=2,52; a=0,012), where 88,6% of the control group and 59,1% of the experimental one use their activities and imagination to keep the thought of the condition away. It is obvious that more women in the control group use the distraction strategy, while the women from the experimental group are more moderate and consistent in using distraction as a way not to think about their condition.

There is a statistical significance found in data collected under the **Denial scale**, namely in **question 3** "*I tell myself "That it cannot be real!""* (u=2,48; a=0,013). 86,4% of the subjects in the control group and 40,9% from the ones in the experimental group remain in the denial phase in the context of surviving the crisis of "being diagnosed with an untreatable condition" radically different in the results obtained from answers to **question 8** *"I am refusing to believe this is happening to me"* (u=3,01; a=0,003). 88,6% of the control group demonstrate a "denial reflex" with regard to reality and only 18.2% of the experimental group seek solace in denying in the psychological protection sense.

The last scale that features statistical data significance is the **Behavioral refusal scale**. In **question 6** *"I give up when I try to cope with it"* (u=3,013; a=0,003) 86,4% of the women in the control group lose faith in themselves, their actions, activities, and finding a point to making an effort, whereas that is the case in only 34.1% from the experimental group. Answers to **question 16** *"I have given up on making efforts to cope"* (u=4,794; a=0,000) paint a completely different picture. 90,9% of the subjects in the control group are refusing or have refused on a number of occasions to make an effort to cope, whereas that is the case with only 15.9% of the experimental group.

Age and education level do not show any statistical significance in the negative scales, but there is one to be found under the family status factor in the Denial, Substance Use, and Behavioral Refusal scales (table 3).

Table 3.
Denial, Substance Use, Behavioral Refusal scales data distribution

	v3	v6	v8	v4	v11	v16
Chi-Square	14,901	14,502	14,901	6,148	6,148	14,502
Df	2	2	2	2	2	2
Asymp. Sig.	,001	,001	,001	,026	,026	,001

a. Kruskal Wallis Test
b. Grouping Variable: family status

Answers to the questions in the **Denial Scale** (q..3 and q. 8 - c2 = 14,90; p < 0,001) demonstrate that 30,7% of the married, 13,6% of the divorced, and 5,7% of the singles out of the total of subjects studied (N 88) are refusing to believe and accept their diagnosis. Data leads us to believe that a partner's expectation of parenthood directs married women into refusal as a utilized coping strategy.

Again, 40,9% of the married women constitute the largest percentage of subjects studied in both groups (N 88) inclined to turn to alcohol and use of other substances (**Substance use scale**, q.4 and q.11 - c2 = 6,14; p < 0,026) in order to turn their attention away from the disease. That coping mechanism is utilized by only 12,5% of the divorced and 5,7% of the single women studied.

Married women's share of the results under the Behavioral refusal scale (q. 6 and q.16- c2 = 14,50; p < 0,001) is the largest again – 40,9% compared to 11,4% of the divorced and 13,6% of the singles. The almost identical distribution of results in the divorced and single groups leads us to presume the difference between them and the married women group lies in the attitude they receive from their circle of significant others (husband, partner, mother, etc.) towards women as a whole and the condition in particular.

Analyzing the Brief COPE questionnaire's results allows us to point out that women from the experimental group are inclined to be active not only in their thoughts and ideas **(Future/Sense area)** but also in their actions and activities **(Activities area)**, whereas women from the control group remain "trapped" in their fears and worries. It is obvious from the results that the women from the experimental group have learned to use and rely on emotional support, to find and trust it and not to doubt the patience and attention of their significant others **(Contacts area)**.

To recapitulate, data supports our hypothesis that women utilizing psychotherapeutic help will demonstrate a prevalence of positive ways of coping with the diagnosis whereas women without psychotherapeutic help will demonstrate a prevalence of the negative ones.

Discussion

Data from the study reveals the true picture of women suffering from Endometriosis as we manage to touch their lives unmasked.

The results in the **Active coping scale** demonstrate that women from the control group are refusing to make changes in their current state on the grounds of efforts from an active standpoint and taking actual measures to follow consistently afterward. We could speculate that these women lack the self-confidence that they can cope with activities in real life. They are also unsure and afraid of what results such activities may yield.

That is what leads us to deduce from data in the **Positive reformulating** and **Acceptance scales** that the women in the control group demonstrate how difficult it is for women to accept their condition as a problem that could be sending a different message. Such additional responsibilities that lead to unveiling deeply hidden circumstances that have resulted in the condition in question keep them passive in bearing their pain. "There is nothing to be done, you just have to live with it", "That was my destiny", etc. is the attitude that keeps them away from discovering what function the disease has in their lives.

The results in the **Denial**, **Behavioral denial**, **Distraction**, and **Substance use scales** as self-help strategies show us the difficulties the women from the control group experience when being in contact with others and themselves, which is visible from their unwillingness to work with a psychotherapist. Working with the psyche is something that threatens the status quo and

could provoke making sense of emotions, feelings, and connections, which is worrisome.

Symbolically, Endometriosis could be viewed as a woman's attempt to merge with a person who is a significant other for her. The impossibility of doing so leads her to satisfy that need of hers in a different way – by merging with herself and adopting counter-dependent behavior.

Working with that matter allows us to speculate that Endometriosis reveals itself in an auto-aggressive sense as well – "I am bonding with myself, I am swallowing myself. I cannot give up, I cannot trust, and I control everything at all times. Only I can love truly and candidly, and feel sorry for myself, which is why I am often alone with my pain."

From the standpoint of a language picture, we find the following to be appropriate: the uterus is a house, fireplace, field.

Our psychotherapeutic experience with women suffering from Endometriosis and the results from the current study leads us to deduce that at a psychodynamic level all home related fears (security, safety); the fireplace (love, acceptance, warmth, attention, patience) and the field (trustworthiness, punctuality, clarity in all contacts) could be reflected in the uterus.

Our practice with the experimental group shows that we can identify a number of fears at a psychodynamic level: inability to give birth, giving birth to a sick child, having miscarriages, getting pregnant at the wrong time, getting pregnant from the "wrong" man, shame for not wanting to be a mother, fear of being a bad mother, fear of resembling her own mother, fear of losing a husband due to pregnancy, fear of losing male attention, fear of betrayal and many others. If a woman suppresses such feelings within herself or they become too big to handle, the uterus takes the load on its shoulders.

Results from the experimental group show us that women suffering from Endometriosis and using psychotherapeutic help have improved their emotional closeness to a person (**Contacts area**) and are ready to cooperate in establishing strategies on how to act (**from the Future/sense area to the Activity area)** in order to change the life model that they had lived up to that point. Their ability to dare to comprehend the problem at a deeper level grows, and they are less likely to resort to coping strategies described in the **Distraction scale**.

When exploring their experience after six months of psychotherapeutic support, the women from the experimental group utilize strategies from the **Substance use** scale less and less.

The data described leads to deduce confidently that psychotherapeutic support of women suffering from Endometriosis allows for positive coping strategies to prevail over negative ones.

Positive and transcultural psychotherapy provides the patient with an environment where their disregarded and suppressed abilities flourish and later on become instrumental in the formation of new abilities for coping with hard life circumstances. Respectively, the data described shows that psychotherapeutic help provided to women suffering from Endometriosis via positive psychotherapeutic methods allows for the positive coping mechanisms to prevail unlike when women do not receive any therapy.

Conclusion

Endometriosis is a huge challenge that changes one's way of life on a physical, psychological, emotional, and social level. Besides experiencing pain, women suffering from that condition have a number of psychological tasks ahead of them to solve that are rooted in the nature of the said condition – fear of living with a chronic condition, uncertainty related to its treatment, the potential decrease or even loss of reproductive ability, etc.

The results obtained in the present study demonstrate a number of differences between the control and the experimental group in using positive or negative coping strategies for handling the Endometriosis diagnosis. Women from the experimental group demonstrate a prevalence of positive ways of coping as they have taken advantage of psychotherapeutic support, whereas it is exactly the opposite with the women from the control group. This preliminary study leads to a number of additional questions and new study tasks. Studying the matter in depth will unveil new opportunities for a better understanding of how to provide for the psychotherapeutic needs of patients suffering from Endometriosis.

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Section: Preliminary studies in PPT

THE EFFECT OF POSITIVE PSYCHOTHERAPY-BASED RESILIENCE PROGRAM ON RESILIENCE IN NURSES: A STUDY PROTOCOL

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Abstract

Resilience has been recognized as an important concept, especially for nurses who face many risk factors in their professional lives, provide professional care to patients with difficulties and needs in all circumstances, and have to comfort the patients. Prevention efforts and support and skill development interventions to improve the well-being and coping skills of nurses lead to sustainable changes for nurses. For this reason, this study aims to develop a resilience program for nurses, examine the effect of the program on nurses' resilience, and report the related process. In the study, a randomized controlled experimental design was created to determine the resilience levels of nurses. The study sample consisted of nurses who met the inclusion criteria of the study. The G*power 3.1 program was used to determine the number of nurses in the experimental and control groups and the minimum sample size was calculated as 58. However, the sample size was defined as 72 (36 in the experimental, 36 in the control group) considering the possibility of dropouts (the number of those who did not continue the study) during the research period. In the study, measurements were made three times (pre-test, repeated post-test, and 3rd-month follow-up test). Within the scope of the study, a "Personal Information Form" and the "Resilience Scale for Adults" was applied to the nurses. After data collection and analysis, the findings were explained. The effectiveness of the positive psychotherapy-based resilience program on the resilience of nurses was evaluated.

Keywords: resilience, nurse, positive psychotherapy

Introduction

Resilience is one's capacity to show emotional, mental, and behavioral flexibility in coping with difficulties, stress, trauma or challenging situations of life, to cope with negative circumstances, and to overcome them with strength. At the same time, as a personality trait, resilience refers to the ability to quickly recover, overcoming difficulties, resistance, flexibility, and solidity (Gürgan, 2010; Basım, 2011). It has been reported that people with high resilience are more successful in adapting to change and struggling against obstacles and experience less emotional exhaustion (McAllister & Lowe, 2011). Potential risky conditions that individuals face in their professional lives and their protective factors also affect their resilience. In health services, every step taken and every initiative taken directly affects human life or the quality of life. Health workers may encounter psychologically challenging events at very high rates and may be exposed to the psychological effects of physical fatigue brought about by intense working (Karacaoğlu & Köktaş, 2016). It has been stated that psychological resilience is an important concept, especially for nurses who face many risk factors in their professional lives, have to provide professional care services to patients with difficulties and needs under all circumstances, and have to comfort the patients (McAllister & Lowe, 2011; McCann, 2013).

Interventions to psychologically empower an individual aim to reduce the impact of stressors and change the individual's response to the stressor. This includes cognitive reconstruction of the individual, revision of expectations, and adoption of new goals. Individuals react differently to different stressors while coping. Active coping methods are used if the stressor is controllable or avoidable whereas passive coping methods such as avoidance or inactivity may be used if the stressor is unavoidable and uncontrollable (Linley & Joseph, 2006). In individual empowerment, the positive psychotherapy approach integrates symptoms with strengths, resources with risks, weaknesses with values, and hopes with regrets and is a psychotherapy approach based on the principles of positive psychology, that endeavors to understand the natural complexities of human experience in a balanced manner (Xin & Ren, 2021).

Throughout history, the development of psychotherapy has shown that relying only on certain principles and focusing on a set of psychodynamics only to understand disorders is not a practical solution. It has also been considered important to deal with the inherent abilities and virtues of human beings. With the introduction of these efforts, positive psychotherapy was theorized by Nossrat Peseschkian (1970). Positive psychotherapy is a holistic and source-oriented therapy based on analytical therapies such as psychodynamic and humanistic therapies, but it adopts a cross-cultural approach targeting positive aspects of conflict resolution skills. The main goal of positive psychotherapy is to elicit the positive, reinterpret symptoms/discomforts in a positive manner, and help clients achieve balance in their lives (Peseschkian, 2002, 2019).

Peseschkian identified three basic principles in positive psychotherapy: hope, consultation, and balance. According to positive psychotherapy, each individual lives his/her life in four dimensions: body, achievement, relationship, and future/spirituality. These four dimensions comprise the building blocks of the third fundamental principle of positive psychotherapy, balance. According to positive psychotherapy, the clues of how individuals perceive themselves and their environment and how they deal with reality are found in the degree to which they invest in each of these four dimensions. In positive psychotherapy, it has been emphasized that individuals improve their mental health by distributing their energies and efforts in a balanced manner to four basic domains of need as predicted by the balance model (Peseschkian, 2016). Within the scope of the research, the 8-week resilience program prepared based on the basic principles of positive psychotherapy was planned to be applied to nurses.

This study aims to determine the effect of the Positive Psychotherapy-Based Resilience Program on the resilience of nurses.

1.1. Research hypotheses

Ho: There is no difference between the mean resilience scores of the nurses after the Resilience Program applied.

a. There is a difference between the groups in terms of mean resilience scores.

b. There is a difference in the mean resilience scores according to time.

c. There is a time-group interaction in terms of mean resilience scores.

Methodology

2.1. Study Design

The study had a randomized controlled experimental design. The study complied with the CONSORT (Consolidated Standards for the Reporting of Studies) used for reporting randomized controlled trials. The study was registered with the Clinical Trials Number, a protocol record was created, and an ID number was obtained (ID: NCT06080230).

The research sample consisted of nurses who work in a university hospital in a province in the northwestern part of Turkey and met the inclusion criteria. The G*power 3.1 program was used to determine the number of nurses in the experimental and control groups. The study protocol consisted of 3 phases: randomized controlled pre-test, repeated post-test, and 3rd-month follow-up test. In this context, a two-way analysis of variance (TWO-WAY-ANOVA) was used. This method is used in the comparison of at least two different measurements of two or more groups both between groups and between measurements. This method is a parametric method and the data must be normally distributed. Under conditions with an effect level of 0.40 (large effect), an error level (a) of 0.05, and a power of the test (1-B) of 0.95, the minimum sample size required for a statistically significant difference between both groups and measurements was calculated as 58. Each group should comprise at least 29 participants. The number of dropouts (the number of those who did not continue the study) was taken as 14 and the sample size was determined as 36 for each group (Friborg et al. 2003). The sample was assigned to the experimental and control groups using the “simple randomization method”. The assignment process was performed by an independent researcher using the website https://www.random.org/web. An independent researcher created 2 groups of 36 people from the participant list created from the nurses who were eligible for participation in the study through the https://www.random.org/web website. Which of these groups would be the experimental group and which would be the control group was decided by drawing lots. Thus, the researcher will be unaware of which participants were initially assigned to the experimental or control group. The CONSORT flow diagram in the study is shown in Figure 1.

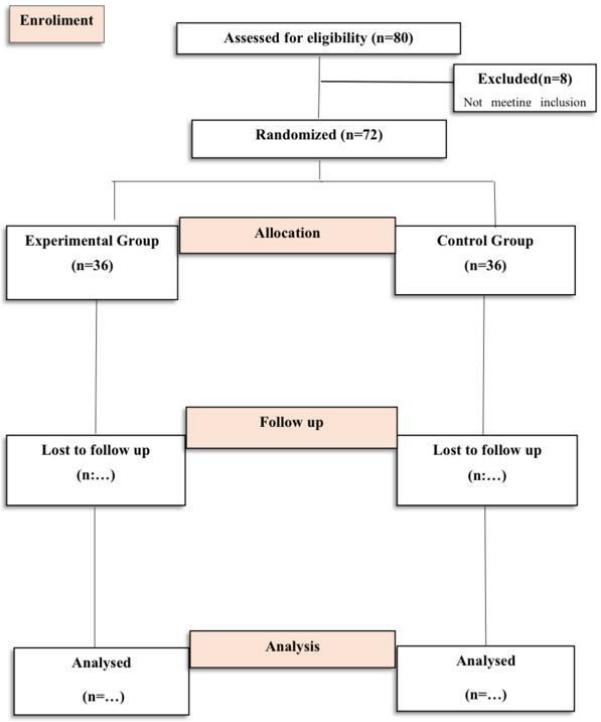

Fig. 1. The CONSORT flow diagram

The dependent variable of the research is the resilience levels of nurses and the independent variable is the resilience program applied in the research.

2.2. Inclusion Criteria

- Working as a nurse at Düzce University Health Practice and Research Center
- Volunteering to participate in the study

2.3. Exclusion Criteria

- Wanting to withdraw from the study voluntarily and having to leave the hospital for various reasons
- Developing an acute mental illness or symptom during the study was excluded from the study.

2.4. Establishment of the program

The program was prepared by the researchers based on the literature on positive psychotherapy. Expert opinions were obtained from a total of 9 positive psychotherapists for the detailed content of the program which was planned to be eight sessions (session purpose, goals, activities, stories, and practices used in the content) and the “participant guidebook” was prepared specifically for the participants. The

experts were expected to evaluate the program in terms of content, clarity, and duration. After expert evaluations, necessary revisions were made and the program was finalized.

2.5. Program Content

The program content was based on the theories and practices of positive psychotherapy. Stories and metaphors were used in the program based on three basic principles. The use of stories is very important in positive psychotherapy. Peseschkian argued that stories are an important aid in the psychotherapy process. Story use has many functions, including applicability to the problems of daily life and the client's ability to identify with the story (Peseschkian, 2019).

The program was prepared based on the principle of balance and hope and aimed to develop some skills for participants to find balance and set new goals. According to the principle of balance, individuals should utilize the dimensions of body, achievement, relationship, and future/spirituality in a balanced way in order to solve their problems. Because, according to the positive psychotherapy approach, individuals will be able to be fully healthy and productive when they are able to balance the importance, they attach to these four basic dimensions of life and the time and energy they allocate to them (Peseschkian, 2019; Alpay & Kara, 2018).

The entire program follows five consultation steps (observation-distancing, inventory, situational encouragement, verbalization, and goal expansion) and each session is designed to meet one consultation step. In positive psychotherapy, the principle of consultation means that the psychotherapy process is carried out in five stages. In the first stage, observation/distancing, the client's problem is briefly defined. In the second stage, inventory, the causes of the individual's problem are searched for. In the third stage, situational encouragement, the client's strengths are emphasized, and a positive interpretation of the symptom is made. The fourth stage, verbalization, is the action stage. In the fifth stage, goal expansion, the client is prepared for the future (Peseschkian, 2016; Eryılmaz, 2020).

The session contents were also structured to follow the five steps of the consultation stages as in the entire program. The content of each session followed the five steps. Each session, based on the principle of hope and balance, is aimed at making the participants gain the ability to establish balance and re-establish goals related to the subject of that week. Exercises appropriate to the content were included. It was planned to give homework at the end of each session and to start the next session with homework. Each session will be closed with a one-minute silence exercise.

The objectives and themes of all sessions of the program are presented in Table 1.

Table 1.
Program themes and objectives

Session	Theme of Session	Objective
FIRST SESSION (Observation - Distancing)	Introduction	Participants learn the purpose and rules of the group and recognize the existing resources they have in their daily lives.
SECOND SESSION (Inventory)	Life Balance	Participants can understand the function of the balance model, recognize their needs, and take action to achieve balance in their lives.
THIRD SESSION (Inventory)	Real Capacities	Participants recognize the capacities in positive psychotherapy and the importance of finding a balance between their capacities.
FOURTH SESSION (Situational Encouragement)	Self Esteem (Self Acceptance, Self Belief, Trust Yourself)	Participants realize their current capacities and increase their level of self-belief, trust themselves in changing what they want to change, and accept what they cannot change.
FIFTH SESSION (Verbalization)	Contact (contact with the body - emotions)	Participants learn to get in touch with their bodies and emotions and their capacity to stay with emotions increases.
SIXTH SESSION (Verbalization)	Relationship (Contact with the other)	Participants recognize their ways of establishing relationships and replace dysfunctional ways with new ones.
SEVENTH SESSION (Verbalization)	Self-help	Participants learn a new map that they can use in response to challenging life events by integrating the knowledge learned in this psychoeducation.
EIGHTH SESSION (Goal Expansion)	Goodbye	Participants realize the contribution of the program and make plans on how to follow the program in the future.

The implementation part of the second session is presented below as an example of the program content:

SECOND SESSION (Inventory); *Life Balance*

Session Objective: Participants can understand the function of the balance model, recognize their needs, and take action to achieve balance in their lives.

Implementation:

- The previous session is evaluated. The unclear parts and the homework are reviewed. (10 minutes)
- The balance model is introduced (A Power point slide show has been prepared). (20 minutes) ***Observation-Distancing***
  - Components of the body dimension: nutrition, sleep, exercise, smoking, health problems, etc.
  - Components of the achievement dimension: meaning attributed to achievement, satisfaction with the profession, performance expectation, etc.
  - Components of the relationship dimension: styles of establishing a relationship, expectations, etc.
  - Components of the spirituality dimension: finding meaning in life, goals for the future, etc.
- Group members draw their own balance models (20 minutes) ***Inventory***
  - *Exercise:* Worksheets with balance model graphs are distributed to the group members. Each group member is asked to show how he/she allocates his/her daily life energy by drawing on the graph. The sum of the energy distribution should be 100%. Each participant is supported and guided to draw his/her own model.
- Group members recognize how they use their resources in daily life to achieve balance in the four dimensions. (15 minutes) ***Situational Encouragement***
  - *Story:* The Traveler's Story
  - Through this story, group members are encouraged to think about the burdens they are aware of or not aware of in daily life.
- All group members explore how their balance is disrupted against challenging life events. In the balance model, they suggest how they can meet their needs in order to regain balance. (15 minutes) ***Verbalization***
  - The scale metaphor is used to emphasize the importance of establishing a balance between dimensions.
  - *Exercise:* Group members are asked to write down what they can do about the dimension or dimensions with excess or insufficient energy on the balance model they drew at the beginning of the session. They are assisted by the following two questions.
    - What do I need? What do I want?
- Each group member expresses what would be different in his/her life if he/she could maintain the balance in the future. (10 minutes) ***Goal Expansion***
  - *Homework:* How will you work on this dimension or dimensions every day to address the needs you have recognized on the balance model? Please plan applicable actions that you can take at regular intervals and write them down in your participant handbook.
  - *Closure:* Participants are encouraged to check their moods. Group members are asked to be silent for one minute. Participants are guided to their bodies and sensations by instructions given.

2.6. Participant Guidebook

The participant guidebook prepared by the researcher starts with the purpose of the program and a brief introduction to positive psychotherapy. Each session is addressed separately in the guidebook and content appropriate to the session theme is shared at the beginning of the session. The materials to be used in practice are shared in the guidebook in their sessions so that the participants can reuse them. The stories told in each session are included in the guidebook so that the participant can re-read them. Suggested homework and easy-to-apply examples that can help in homework are included at the end of each session. Expert opinions were taken from ten positive psychotherapists for the suitability of the participant guidebook.

2.7. Implementation Phase

A pre-interview was conducted with all nurses who agreed to participate in the program. The volunteering nurses were informed about the purpose and process of the program. Information regarding eligibility to participate in the program (not being in the acute phase of any physical or mental illness) was collected. An informed consent form was signed by the nurses included in the study.

This research is part of a doctoral dissertation. Two of the researchers have a master's degree in positive psychotherapy. Likewise, the other researcher completed positive psychotherapy basic training. All groups and sessions were conducted by the same researcher (who has a master's degree in positive psychotherapy).

2.8. Program Implementation Setting

The program sessions were held in a meeting room of the hospital where the research was conducted. The meeting room was arranged with a U-shaped seating plan so that all participants could see each other. There was a barcovision device and a computer to be used in some sessions. Other materials to be used in the study were provided by the researcher (wood, envelopes for letters, note papers, etc.).

2.9. Preliminary Application

- The preliminary application of the program was carried out with nurses who work day shifts in the hospital.
- After each session, supervision support was received from an experienced psychotherapist who has a master's degree in positive psychotherapy.
- The program consisting of 90-minute sessions for 8 weeks was applied to the preliminary application group.
- The preliminary application group started with 12 participants and ended with 12 participants.
- No changes were made to the content of the program after the preliminary application. The data of the preliminary application group were found suitable for inclusion in the study data.

2.10. Implementation of Positive Psychotherapy-Based Resilience Program

- Prior to the program, the resilience scale for adults was administered to the participants in the experimental group.
- The participants in the experimental group were divided into 3 groups of 12 participants. The number of nurses in the groups is consistent with the literature (Sawyer, 2021; Janzarik et al., 2022).
- Within the scope of the research, an 8-week "Positive Psychotherapy-Based Resilience Program" was implemented for the nurses in the experimental group. The program consisted of 8 weeks of 90-minute sessions. The number and duration of the sessions are in line with the literature (Sawyer, 2021; Janzarik et al., 2022).
- Sessions were held at the same time on the same day of the week. In determining the time and date of the session, attention was paid to the work hours of the nurses.
- The nurses in the groups were nurses working during day and night shifts and in different units of the hospital.
- The participant guidebook prepared by the researcher was given to the participants in the experimental group in the first session.
- As in the preliminary application, supervision support was received when necessary, from an experienced psychotherapist who has a master's degree in positive psychotherapy.

Post-Test (Second Measurement) Application

At the end of the program, the resilience scale for adults was implemented simultaneously to the intervention and control groups.

Follow-up Test (Third Measurement) Application

Twelve weeks after the end of the program, the resilience scale for adults was implemented simultaneously to the intervention and control groups.

Control Group

Necessary information about the research was given to the nurses in the control group. No application was made. Pre-test, post-test, and follow-up tests were implemented.

2.11. Data Collection

All nurses working in the institution were informed about the details of the study. A "Personal Information Form" and the "Resilience

Scale for Adults" were implemented for the nurses who agreed to participate in the study and whose written informed consent was taken. The "Resilience Scale for Adults", which was administered at the beginning of the study, was administered immediately after the last session of the intervention. The 3-month follow-up test was applied 12 weeks after the last session. The measurements of the control group was made on the same day as the intervention groups.

Data collection tools

1. Personal Information Form:

This form regarding the introductory information of the participants was prepared by the researcher.

2. Resilience Scale for Adults:

The Resilience Scale for Adults was developed by Friborg et al. (2003) and consists of the dimensions of "personal strength", "structural style", "social competence", "family cohesion", and "social resources". A later study (Friborg et al., 2005) showed that the scale better explains the resilience model with its six-dimensional structure. In the study conducted by Friborg et al. (2005), the "personal strength" dimension was divided into two, "perception of self" and "perception of future", and a six-dimensional structure was created. In the scale, "structural style" (3, 9, 15, 21) and "perception of future" (2, 8, 14, 20) dimensions are measured with 4 items each; "family cohesion" (5, 11, 17, 23, 26, 32), "perception of self" (1, 7, 13, 19, 28, 31) and "social competence" (4, 10, 16, 22, 25, 29) dimensions are measured with 6 items each; the "social resources" (6, 12, 18, 24, 27, 30, 33) dimension is measured with 7 items. The Turkish validity and reliability study was conducted by Basım (2011).

2.12. Data Evaluation

The SPSS package program was used for data analysis. Whether the data are normally distributed was evaluated. Number, percentage, standard deviation, mean, chi-square, independent and dependent samples t-test, statistical test value and degrees of freedom (t, F, r, etc.), effect size (ES), confidence interval (CI), and statistical power were provided in the analysis of the data. A similarity analysis was made for the experimental and control groups. In case of missing data in the research, Intention to Treat and ITT analyses will be used to overcome the missing data. The Cronbach alpha internal consistency coefficients will be calculated to examine the consistency of the scales.

Results

The effectiveness of the positive psychotherapy-based resilience program on nurses' resilience and the development of balanced life skills was evaluated.

- The program, which was prepared based on positive psychotherapy, was predicted to increase the resilience of nurses and ensure nurses gain balanced life skills.
- This randomized controlled trial provided evidence-level guidance.
- The research is expected to contribute to the literature on nursing and positive psychotherapy.

Conclusions

Nurses who face many known risk factors and stressors need to be supported with some interventions. It is important, but not sufficient, to treat the current effects of high stress. Prevention, support, and skills development interventions to improve nurses' well-being and coping skills can lead to sustainable changes for nurses (Sawyer, 2021). Various training and intervention programs have been implemented to increase the resilience of nurses. Studies have shown that resilience programs not only increase nurses' resilience but also reduce stress, anxiety, depression, and burnout and increase mindfulness and self-efficacy. The training programs implemented include different techniques such as face-to-face workshops, web-based learning, audience notes, electronic discussions, and mind-body exercises (Xin & Ren, 2021).

The effectiveness of developing and strengthening resilience in coping with the stressful nursing environment has been evidenced. Good relationships with family, friends, and colleagues enable nurses to focus on their beliefs and values and give them the strength to cope with negative conditions in the work environment. This is related to the "relationship" and "spirituality" dimensions of the balance model in positive psychotherapy. The relationship dimension is associated with sharing with others and engaging in activities that allow individuals to have a good time, while the spirituality dimension is associated with

engaging in activities that allow individuals to feel good about themselves spiritually. In this context, the balance between work life and social life is very important in developing resilience (Peseschkian, 2002; Sawyer, 2021). Approaches to the profession of nurses with high resilience affect the care services they provide positively (Quinal et al., 2019). This is associated with the "achievement" dimension of the balance model. The achievement dimension concerns individuals' orientation towards activities related to their academic and professional development. Another dimension in the balance principle of positive psychotherapy is the "body" dimension which is associated with engaging in activities that make individuals feel good about their body/health. Nurses often neglect their own emotional and physical needs while providing care to others. Self-care practices are considered an important strategy for nurses to protect their health. It has been reported that adequate rest, self-care, and social support are of great importance among the coping resources of nurses and that these resources are positively linked to the quality of life (Peseschkian, 2002; Sawyer, 2021; Quinal et al., 2019; Wu et al., 2011; Günüşen, 2017).

With this program prepared based on the principles of positive psychotherapy, it is envisioned that nurses will gain skills to be in balance in life and that their resilience will increase. Thus, the quality of patient care can be positively influenced by higher quality of life in their personal lives.

1 Declarations

1.1 Study Limitations

The results cannot be generalized to all nurses since the study will be conducted with nurses working at Düzce University.

1.2 Funding source

The study has no financial support.

1.3 Competing Interests

The authors declare that there is no conflict of interest.

2 Human and Animal-Related Study

This research will be carried out in accordance with the principles of the Declaration of Helsinki (2008). Ethical approval (03/06/2023 -Decision no: 2023/31) was granted by the Ethics Committee of a university and written permission was obtained from the hospital where the research will be conducted. Nurses who agree to participate in the study will provide verbal and written consent after the purpose of the study is explained. Participants will be told that they are free to participate in the study and that they can withdraw from the study at any stage. The participants will be informed that the results of the research will be published for scientific purposes without any identification

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Section: Preliminary studies in PPT

RESILIENCE OF PSYCHOTHERAPISTS THROUGH THE LENS OF THE PRIMARY CAPACITIES OF NOSSRAT PESESCHKIAN'S POSITIVE PSYCHOTHERAPY

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Abstract

This study explores the correlation between the resilience of therapists and the primary capacities of Nossrat Peseschkian's Positive Psychotherapy theory. The aim of the study is to examine whether the developmental state of these capacities, related to the emotional aspects of an individual, can work towards increasing the resilience of therapists. A cross-sectional study was conducted to collect and analyze numerical data using questionnaires, to examine the relationship between primary capacities as an independent variable and resilience as a dependent variable. The study included 93 participants, psychotherapists from Greece, Romania, UK, Spain, Poland, Ukraine, Germany and Austria, all of them over 24 years of age with more than 1 year of experience as psychotherapists. A statistically significant correlation was found between the therapists' primary capacities and resilience. Therapists with a higher level of primary capacities were more likely to be resilient in the face of adversity. This suggests that developing primary capacities can help therapists cope with the challenges of their work and maintain their well-being.

Keywords: primary capacities, resilience, well-being, positive psychotherapy

Introduction

Resilience has long been the subject of research and yet always topical with the focus being either on internal factors or external ones in relation to the individual, such as family environment, social and cultural context etc. (Fleming et al.,2008).

As a property, resilience gives the individual the ability to adapt positively to adversity and challenge in life through protective and successful coping strategies.

A number of internal and external factors can determine the degree of an individual's resilience dynamic, the latter being a skill that can be cultivated and developed (APA Dictionary of Psychology). Currently, researchers are still focusing on the individual dimensions of resilience, supporting through their work and findings that resilience is an internal ability and skill, the latter being studied in a wide range of

research during the last half-century (Wagnild and Young,1993; Oshio et al., 2003; Sinclair and Wallston, 2004). This is the direction of this study as well.

Therapists are by definition in circumstances that test their mental strengths, as they are constantly confronted with conditions and situations that must be handled with empathy and acceptance combined with a preventive and self-protective attitude to maintain mental equilibrium (Cooper et al,.2013). Their resilience in these circumstances is a necessary condition to maintain their functionality and good mental health which can be challenged under various adversities, among which was the COVID-19 pandemic (Aafjes-van Doorn et al., 2022).

From the perspective of positive psychotherapy, man inherently possesses two fundamental interconnected capacities, the capacity to love and the capacity to know and understand things (Peseschkian, 1996). One's capacity to love enables a set of primary capacities to be activated and developed, such as of patience, sexuality and tenderness, love and acceptance, time, contact, hope, trust, and faith. From the fundamental ability of knowing flow some secondary capabilities such as one's ability to maintain order, the ability to be punctual, to be honest, kind, obedient, faithful, frugal, and just.

Both sets of capabilities of the individual - primary and secondary - form a matrix of abilities in which the primary capacities seem to regulate mainly the emotional aspects of the individual, while the secondary ones mainly determine the behavior and action of the individual (Peseschkian & Walker, 1987). Therefore, in the context of therapy, both primary and secondary competencies of the therapist can either work towards increasing resilience in the work context or undermine it, depending on their content, development and direction.

The therapist's resilience is an important factor for his/her health and well-being as well as the therapeutic process and outcomes. The Primary Capacities in Positive Psychotherapy constitute core features and their development defines to a wide extent the functionality and well-being of a person.

There are several researches which explore the relations between resilience and different factors as secondary trauma, COVID19 as a special stressor.

Lazos, Kredentser (2021) in their research underline that in Ukrainian therapists is a statistically significant inverse relationship between psychotherapist resilience and secondary trauma as a result of therapists' contact with trauma victims.

Tavel&all (2022) found out in their research regarding COVID19 as stressor, that higher dispositional resilience significantly reduced the level of perceived stress among psychotherapists.

A Greek group of researchers Lakioti, A., Stalikas, A., & Pezirkianidis, C. (2020) found out that positive emotions, and satisfaction with relationships (factors described by Positive Psychology – Seligman theory) might play an important role in the development of strategies for improving therapists' mental health and functioning.

There is also underlined a statistically significant positive relationship between psychotherapist resilience and indicators of their professional experience (as receiving personal therapy, ongoing supervisory support as well as trauma coping training) (Lazos, Kredentser, 2021).

There are no researches focused on capacities described by Peseschkian and their relations with resilience of therapists. This paper explores how the developmental state of the primary capacities is connected with a therapist's resilience, whether it be increasing or hindering it. The reason why the primary rather than the secondary capacities has been chosen to be explored in relation to resilience is not only that they are the capacities on the basis of which the secondary group is developed, but also that they are the ones closer to the emotional content of the self and the basis on which the secondary one's manifest (Jork & Peseschkian, 2006).

Methodology

2.1. Research Aim

The purpose of this research is to explore the relationship between a therapist's resilience and primary capacities. The research questions included in the research were the following:

1) Is there a relationship between the therapist's demographic characteristics and the therapist's resilience?

2) Do therapists whose primary capacities are more developed, appear to be more resilient than others?

2.2. Design

A quantitative method was used for the study, collecting, and analyzing numerical data through questionnaires to investigate the relationships between variables, and to draw conclusions about the population under study. The study was a cross-sectional study in which data were collected at only one point in time.

2.3 Research tools

In the present study, the survey was conducted using an online questionnaire consisting of 56 questions which took about 20 minutes to complete. The questionnaire was developed and consisted of demographic information about the therapists, such as gender, age, marital status, country of residence, academic level, years of work, work context, and appropriate measurement tools for the purpose of the study.

We used the Connor - Davidson Resilience Scale (CD-RISC) to measure the psychological resilience of the sample of mental health professionals. The CD-RISC questionnaire contains twenty-five (25) self-report items (based on participants' beliefs and perceptions) that are rated on a five-point Likert scale (0 = "Never", 1 = "Rarely", 2 = "Sometimes", 3 = "Often", 4 = "Always"). The twenty-five items of the scale are grouped together and correspond to five different factors that include specific characteristics related to the therapist's qualifications. These factors are related to the following qualities:

- Personal competence,
- High standards and perseverance,
- Confidence in intuition,
- Tolerance of difficulties and stressful events,
- Positive acceptance of change and secure relationships,
- Control
- Spiritual influences.

Higher scores indicate higher levels of resilience, and scores can range from 0 to 100. A score can be derived for each factor, but also an overall score for the scale. The scale in the English version, which was applied to a general population, shows good internal consistency with a Cronbach's a index of 0.89 (Connor & Davidson,2003).

The WIPPF questionnaire - Wiesbaden Inventory for Positive Psychotherapy and Family Therapy International Version 2.04 was developed by Peseschkian and Deidenbach (1988) and adapted by A. Remmers in 1995 for international use. WIPPF assesses the Actual Capacities - both the Primary and Secondary - which can potentially constitute areas of conflict (Tritt, K. et al., 1999). More specifically the questionnaire consists of 88 questions covering all actual capacities, both primary and secondary of which 24 refer to the primary capacities, which was the focus of this paper, hence the exclusion of questions relevant to the secondary capacities. The 24 items are rated on a four-point Likert scale (1 = "Fully disagree", 2 = "Partially disagree", 3 = "Partially agree", 4 = "Fully agree"). For this reason, the questions related to the therapist's secondary capacities were excluded from this study.

2.4. Data collection process

The survey instrument was used to collect data from therapists in different countries. The study period was from April to June 2023 and the collection was administered through chain-referral sampling. 93 questionnaires were collected. Participants were over 24 years of age. The sample group participated in the study by completing an electronic questionnaire sent via email. Potential participants received an invitation email with details about the study and a link to the survey.

2.5. Analytical Procedure

The therapists' resilience was considered as the dependent variable and the therapist's primary capacities as the independent variable. Categorical variables were expressed as absolute and relative frequencies (N, %). Quantitative variables were presented as mean (SD) values. All continuous variables were tested for normality using the Kolmogorov-Smirnov and Shapiro-Wilk tests. The Student's t-test for independent samples was used to assess the relationship between a categorical and a qualitative variable when the sample met the normality assumption.

The non-parametric Mann–Whitney U test was also applied to analyse differences between groups. Moreover, the one-way ANOVA and the corresponding non-parametric Kruskal Wallis test were used to examine statistically significant differences between a quantitative and a qualitative variable with more than two

categories. The non-parametric Spearman's correlation coefficient (r) was used to assess the linear correlation between two quantitative variables. All statistical analyses were performed using IBM SPSS Statistics v25.0. The aforementioned statistical tests were performed at a significance level of 0.05.

2.6. Ethical Issues

Given the nature of this project, certain ethical considerations were taken into account. All study participants were informed of the purpose of this study and had the opportunity to decline participation or withdraw consent at any time. Information obtained from participants was kept confidential and individuals were not identifiable as the data collected were stored anonymously in an electronic database.

Results

3.1. Demographics

The basic demographic characteristics of the sample are shown in Table 1. Most of the participants were female (n=78, 83.9%). Regarding age, the majority of the sample was 36-45 years old (n=44, 47.3%), 30.1% (n=28) were 46-56 years old, followed by participants aged 24-35 years (n=16, 17.2%) and 57-67 years (n=5, 5.4%). Concerning family situation, most participants were married (n=54, 58.1%), followed by unmarried (n=26, 28%). 31.2% (n=29) of participants had 1-5 years of work experience, followed by those with 11-15 years (n=24, 25,8%) and up to 16 years (n=23, 24,7%). Most of the participants worked in the private sector (n=78, 83,9%), 14% (n=13) worked in the public sector and 2 participants were volunteers (n=2, 2,2%). Of the 93 respondents, 86% (n=80) had completed post-graduate studies, 5 participants (5,4%) had completed basic degree education, and 8 participants (8,6%) had a PhD.

3.2. Reliability

The reliability of the scales used in the current study was assessed by calculating Cronbach's alpha (α). The subscales of the questionnaire CD-RISC showed good reliability, as the Cronbach's alpha coefficient was greater than 0.60. For the subscale "Positive acceptance of change and secure relationships", the reliability was below the acceptable threshold. The CD-RISC -25, takes values from 0 to 100, with higher values reflecting greater resilience. The mean (SD) of the overall resilience scale was 70.22, indicating a high level of resilience (Table 1).

Table 1.
Descriptive statistics and reliability analysis for CD-RISC questionnaire

	Mean	*SD*	*Min-Max*	*Cronbach's alpha*
Personal competence	23.46	4.14	14-32	0.807
Confidence in intuition	18.25	3.34	10-27	0.639
Positive acceptance of change and secure relationships	15.29	2.49	9-20	0.538
Control	8.73	1.96	1-12	0.632
Spiritualinfluences	4.48	2.07	0-8	0.613
Resilience	70.22	10.94	37-91	0.878

In addition, the Cronbach's alpha for the WIPPF questionnaire was lower than 0.6. The primary capacities take values from 3 to 12, with higher scores reflecting greater agreement with each capacity. Higher scores were for the capacities hope (Mean = 10.22), trust (Mean = 10.02) and love/acceptance (Mean = 10.02) (Table 2).

Table 2.
Descriptive statistics and reliability analysis for WIPPF questionnaire

	Mean	*SD*	*Min-Max*	*Cronbach'salpha*	
Patience	9.02	1.59	6-12	0.576	
Hope	10.22	1.42	6-12	0.561	
Sexuality/Tenderness	9.84	1.46	6-12	0.415	
Trust	10.02	1.14	7-12	0.188	
Time	9.26	1.57	6-12	0.441	
Faith/meaning of life	9.39	1.96	4-12	0.599	
Contact	9.49	1.33	5-12	0.263	
Love/acceptance	10.02	1.33	7-12	1.379	1.380

3.3. Relationship between Resilience and Primary Capacities

The spearman correlation coefficient was performed to evaluate possible relationship between resilience and primary capacities of therapists. According to the results, a positive, significant correlation was found between "Personal competence" and patience ($r = 0.462$, $p < 0.01$), hope ($r = 0.505$, $p < 0.01$), time ($r = 0.404$, $p < 0.01$), faith/meaning of life ($r = 0.268$, $p < 0.01$), contact ($r = 0.341$, $p < 0.01$) and love/acceptance ($r = 0.356$, $p < 0.01$).

Furthermore, the "Confidence in intuition" subscale was positively correlated with patience ($r = 0.359$, $p < 0.01$), hope ($r = 0.479$, $p < 0.01$), trust ($r = 0.305$, $p < 0.01$), time ($r = 0.330$, $p < 0.01$), faith/meaning of life ($r = 0.229$, $p < 0.01$), contact ($r = 0.230$, $p < 0.01$) and love/acceptance ($r = 0.308$, $p < 0.01$). A positive significant correlation was observed between "Positive, acceptance of change and secure relationships" and patience ($r = 0.372$, $p < 0.01$), hope ($r = 0.296$, $p < 0.01$), time ($r = 0.316$, $p < 0.01$), faith/meaning of life ($r = 0.222$, $p < 0.01$) and love/acceptance ($r = 0.326$, $p < 0.01$).Positive, significant correlation was also found between "Control" and patience ($r = 0.384$, $p < 0.01$), hope ($r = 0.495$, $p < 0.01$), time ($r = 0.326$, $p < 0.01$), faith/meaning of life ($r = 0.300$, $p < 0.01$), contact ($r = 0.291$, $p < 0.01$) and love/acceptance ($r = 0.263$, $p < 0.01$). Moreover, the "Spiritual influences" subscale was positively correlated with patience ($r = 0.225$, $p < 0.01$), hope ($r = 0.331$, $p < 0.01$), time ($r = 0.443$, $p < 0.01$), faith/meaning of life ($r = 0.566$, $p < 0.01$) and love/acceptance ($r = 0.292$, $p < 0.01$). Finally, resilience was positively correlated with patience ($r = 0.471$, $p < 0.01$), hope ($r = 0.545$, $p < 0.01$), time ($r = 0.473$, $p < 0.01$), faith/meaning of life ($r = 0.367$, $p < 0.01$), contact ($r = 0.306$, $p < 0.01$) and love/acceptance ($r = 0.406$, $p < 0.01$).

Table 3.
Spearman correlation coefficient between resilience and primary capacities

	Personal competence	*Confidence in intuition*	*Positive acceptance of change and secure relationships*	*Control*	*Spiritual influences*	*Resilience*
Patience	0.462**	0.359**	0.372**	0.384**	0.225*	0.471**
Hope	0.505**	0.479**	0.296**	0.495**	0.331**	0.545**
Sexuality/Tenderness	0.062	0.071	-0.063	0.075	-0.029	0.055
Trust	0.096	0.305**	0.080	0.103	0.106	0.177
Time	0.404**	0.330**	0.316**	0.326**	0.443**	0.473**
Faith/meaning of life	0.268**	0.229*	0.222*	0.300**	0.566**	0.367**
Contact	0.341**	0.230*	0.112	0.291**	0.132	0.306**
Love/acceptance	0.356**	0.308**	0.326**	0.263*	0.292**	0.406**

*Note. **p<0.01, *p<0.05*

3.4. Therapists' Resilience and Demographics

Appropriate statistical tests for the questionnaire CD-RISC were conducted to compare the resilience between males and females. No statistically significant difference was found in the total resilience scale (Statistic = -0.031, p = 0.975) and the subscales "Personal competence" (Statistic = -0.042, p = 0.967), "Confidence in intuition" (Statistic = 0.954, p = 0.343), "Positive acceptance of change and secure relationships" (Statistic = -0.247, p = 0.805), "Control" (Statistic = -0.048, p = 0.962) and "Spiritual influences" (Statistic = -0.369, p = 0.712) (table 1, appendix A).

Moreover, one-way ANOVAs and Kruskal-Wallis tests were performed to investigate whether there was a relationship between age and resilience. No statistically significant difference was found in the overall resilience scale (Statistic = 2.329, p = 0.103) and the subscales "Personal competence" (Statistic = 1.911, p = 0.385), "Confidence in intuition" (Statistic = 4.941, p = 0.085), "Positive acceptance of change and secure relationships" (Statistic = 2.528, p = 0.085), "Control" (Statistic = 0.316, p = 0.854) and "Spiritual influences" (Statistic = 5.802, p = 0.055). Although there was a trend in our sample, older psychotherapists showed higher resilience but it was not significantly higher (table 2, appendix A).

Table 3 in appendix A shows the results of one-way ANOVAs and Kruskal-Wallis tests to compare resilience according to family situation. No statistically significant difference was found in total resilience scale (Statistic =1.417, p = 0.243) and the subscales "Personal competence" (Statistic = 0.852, p = 0.837), "Confidence in intuition" (Statistic = 1.69, p = 0.639), "Positive acceptance of change and secure relationships" (Statistic = 1.539, p = 0.21), "Control" (Statistic = 4.622, p = 0.202) and "Spiritual influences" (Statistic = 4.35, p = 0.226). Married psychotherapists appeared to have the highest resilience, but this relationship was not significant.

Appropriate statistical tests for the questionnaire CD-RISC were conducted to compare resilience according to years of experience. A statistically significant difference was found in subscale "Positive acceptance of change and secure relationships" according to years of experience (Statistic = 2.962, p = 0.036). Bonferroni post-hoc comparisons revealed that participants with more than 16 years of experience had more positive acceptance of change and secure relationships than participants with 0-5 years of experience (p =

0.036). No statistically significant difference was found in the total resilience scale (Statistic = 0.933, p = 0.428) and the subscales "Personal competence" (Statistic = 0.420, p = 0.739), "Confidence in intuition" (Statistic = 1.211, p = 0.311), "Control" (Statistic = 1.336, p = 0.721) and "Spiritual influences" (Statistic = 1.207, p = 0.312) (Table 4).

Table 4.
Comparisons of the CD-RISC scale according to years of experience

	Years of experience					
	0-5	*6-10*	*11-15*	*16 and over*		
	Mean (SD)	*Mean (SD)*	*Mean (SD)*	*Mean (SD)*	*Statistic*	*p*
Personal competence	23.1(4.2)	23.76(4.15)	23(4.44)	24.17(3.89)	0.420	0.739
Confidence in intuition	17.31(3.82)	19(2)	18.67(2.99)	18.43(3.73)	1.211	0.311
Positive acceptance of change and secure relationships	14.28(2.68)	15.76(2.75)	15.33(1.97)	16.17(2.19)	2.962	0.036
Control	8.45(2.41)	8.76(1.79)	8.63(1.56)	9.17(1.85)	1.336	0.721
Spiritual influences	4.62(2.34)	3.65(2.32)	4.58(1.91)	4.83(1.59)	1.207	0.312
Resilience	67.76(12.36)	70.94(10.23)	70.21(10.29)	72.78(10.2)	0.933	0.428

In addition, one-way ANOVAs and Kruskal-Wallis tests were also performed to investigate whether there was a relationship between work context and resilience. No statistically significant difference was found in the total resilience scale (Statistic = -0.925, p = 0.357) and the subscales "Personal competence" (Statistic = -1.400, p = 0.162), "Confidence in intuition" (Statistic =-0.860, p = 0.390), "Positive acceptance of change and secure relationships" (Statistic =-1.594, p = 0.111), "Control" (Statistic =-0.970, p = 0.332) and "Spiritual influences" (Statistic =-0.590, p = 0.555). Psychotherapists working in the private sector had higher resilience, but it was not significantly higher (Table 4).

Table 5 shows the results of one-way ANOVAs and Kruskal-Wallis tests comparing resilience according to educational level. No statistically significant difference was found in total resilience scale (Statistic =1.106, p = 0.335) and the subscales "Personal competence" (Statistic =1.804, p = 0.406), "Confidence in intuition" (Statistic =0.991, p = 0.609), "Positive acceptance of change and secure relationships" (Statistic =1, p = 0.607), "Control" (Statistic =1.411, p = 0.494) and "Spiritual influences" (Statistic =3.882, p = 0.144). Psychotherapists with higher levels of education had higher resilience, but not significantly higher (table 5).

Table 5.
Comparisons of CD-RISC scale according to level of education

	Level of education				
	Basic degree Mean (SD)	*Postgraduate level Mean (SD)*	*Doctoral degree Mean (SD)*	*Statistic*	*p*
Personal competence	21.2(6.14)	23.5(4.03)	24.5(3.93)	1.804	0.406
Confidence in intuition	17.6(2.7)	18.18(3.41)	19.38(2.97)	0.991	0.609
Positive acceptance of change and secure relationships	14.6(2.51)	15.29(2.52)	15.75(2.38)	1.000	0.607
Control	8.2(2.17)	8.71(1.99)	9.25(1.49)	1.411	0.494
Spiritual influences	3.8(1.64)	4.41(2.02)	5.63(2.62)	3.882	0.144
Resilience	65.4(14.5)	70.09(10.7)	74.5(11.08)	1.106	0.335

Conclusions

The aim of this study was to examine the relationship between therapists' primary capacities and resilience. The importance of examining such a relationship lies in the intrinsic nature of the profession of the therapists belonging to the group of helping and healing professions, frequently experiencing several hazards undermining their resilience. According to literature, providing services to patients and engaging in intense interaction with them, can lead to burnout syndrome, vicarious trauma or secondary traumatic stress, compassion fatigue and ethical vulnerability (Faber and Norcross,2005; Figley,2002; Hernandez et al.,2010; Larson,1993; Rothschild, 2006; Tjeltveit & Gottlieb,2010). In total 93 therapists participated in the research, and they answered a structured questionnaire. Most of them were female (n=78, 83.9%) and worked in the private sector (n=78, 83.9%).

The research results revealed that there is a positive correlation between the variable "resilience" and the variables: "patience", "hope", "time", "faith/meaning of life", "contact" and "love/acceptance". Besides, the research revealed a correlation between the "confidence in intuition" subscale and trust.

From our attempt to correlate the primary research results with the literature review, it is worth saying that the ability to manage time effectively and in a more balanced way helps therapists to allocate their time and energy in a more self-protective manner. This allows them to promote their self-care and professional and personal well-being (Peseschkian,1987; Peseschkian, 2016a; Sinici et al.,2014). In other words, resilience is correlated with time, as a balanced investment and allocation of time offers therapists several benefits (Cope, 2009; Peseschkian, 1987; Peseschkian, 2016a) that contribute to fostering a better-balanced life overall (Ziede & Norcros,2020).

In addition, the correlation of the therapists' resilience with patience can be explained by considering previous research results, presenting that patience is an indispensable capacity linked with the therapist's empathetic skills, namely, unconditionally accepting and respecting the uniqueness of the client (Freire,2013; Rogers,1980) and patiently following their pace towards healing (Cope, 2009; Peseschkian, 1987; Peseschkian,2016a). Besides, it has been found to help therapists, especially those with traumatized clients, develop vicarious resilience (Gold,2017; Hernandez et al.,2007). It is also linked with the therapists' patience regarding therapy results and their capacity to value delayed gratification by experiencing feelings of reward. Conversely, other findings maintain that therapists can be subjected to vicarious traumatization, experiencing physical and mental health issues thus interfering with the outcomes of the therapeutic process (Rothchild,2007).

The correlation of the therapists' resilience with faith/meaning of life, found in this study, can also be supported by research findings maintaining that fostering a sense of meaning, related to both their choice of the specific

profession and their personal lives, can be a deterrent of burnout increasing compassion satisfaction (De Lange & Chigeza, 2015; Harishankar, 2014). This capacity motivates individuals realize their dynamic and potential, cultivating personal and professional growth and life purpose (Cope, 2009; Michalchunk & Martin, 2019; Peseschkian, 1987; Peseschkian, 2016c) and therefore, their vicarious resilience as well (Gold,2017; Hernandez et al.,2017).

Previous research findings (Bennet-Levy et al., 2015, Rabu et al.,2016) argue that therapists' devotion to personal growth and development allows them to experience positive emotions such as enthusiasm which can both stem from and cultivate the capacity of hope, which also correlated with high resilience levels in this study. Research has shown that if the capacity of hope is well developed the therapists will be optimistic about both their self-efficacy toward fulfilling life goals and plans and about therapy results as well (Bailey et al., 2007).

Faith and hope are also linked with spirituality, which has been found to constitute a protective factor against burnout, emotional fatigue and detachment as therapists who cultivate a spiritual aspect of themselves have been found to be less prone to the aforementioned hazards (Hardiman & Simmonds, 2013). However, it has also been found that spirituality of therapists can be adversely affected when exposed to the traumatic experiences of their clients (Edelkott et al., 2016).

Furthermore, the correlation of the therapists' resilience with contact can be explained considering that if the capacity of contact is well developed it will lead individuals to seek social interaction. According to previous research findings (Cope, 2009; Peseschkian, 1987; Peseschkian, 2016c) social interaction, which encompasses another capacity, that of trust, is beneficial for coregulation and thus individuals who interact frequently with others tend to be more extrovert. As it has been noted (Skovholt & Trotter, 2016; Yalom & Leszcz, 2005) therapists, who are open to communication with their peers can benefit by, among other things, healing their traumas. Additionally, therapists can benefit from social interaction and contact as they manage to experience a good quality of life, which in turn elevates their well-being (Skovholt & Trotter, 2016).

Last but not least, the correlation of the therapists' resilience with love/acceptance lies in the way therapists perceive themselves, how they trust themselves and their professional skills and at the same time how they respect and accept themselves, recognizing their limitations and boundaries with kindness and understanding, becoming thus more compassionate toward both themselves and their clients (Harishankar, 2014; Valente & Marotta, 2005; Ziede & Norcross,2020). It is also connected with another crucial factor impacting resilience of therapists which is self-care, namely the monitoring, fostering and maintaining personal wellness, both physical and mental (Coster & Achwebel, 1997; Lakioti et al., 2020).

According to relevant research, this can be done through self-care practices such as personal therapy, supervision, promoting professional and financial security and satisfaction as well as through meeting physiological needs, that is sleeping, taking breaks, exercising or maintaining healthy relationships (Ziede & Norcross, 2020; Skovholt & Trotter, 2016)nurturing thus a healthier, more energetic self as a prerequisite for a more effective , ethically informed and responsible practice(Norcross &VandenBos,2018; Pope & Vasquez,2016).

It also means that therapists have the capacity to connect emotionally with others (Cope,2009; Peseschkian, 2016a) toward a balanced life and consequently to becoming more resilient, compared to therapists who have not developed the capacity to experience love/acceptance. Additionally, according to relevant literature (Lakioti et al., 2020; Lee et al., 2010) the acceptance of the self and others helps therapists to experience self-efficacy and satisfaction from their work.

Finally, the research revealed a correlation between the "confidence in intuition" subscale and trust. This seems reasonable as trust enables individuals to rely on their social regulation system and develop a sense of safety (Porges, 2022).

Apart from the correlation between therapists' resilience and their primary capacities, this research attempted to find connections between therapists' resilience and demographics such as age, gender, family situation, years of experience and work content. The only correlation, the research results

revealed, was the correlation between the variable "resilience" and the variable "years of experience". Specifically, the research results revealed that therapists with more than 16 years of experience had more positive acceptance of change and secure relationships compared to therapists with 0-5 years of experience.

There is clearly still much to learn about the role of resilience in psychotherapy. Perhaps one of the most important implications of the study of resilience is that it may lead to new coping strategies, which can help therapists to develop resilience through the cultivation of their primary capacities.

Such strategies could be beneficial to therapists by protecting against various issues such as burnout, vicarious trauma, compassion fatigue, ethical vulnerability, and by helping them to inform and improve their practices towards better therapeutic outcomes.

Understanding how resilience is developed is integral to better understanding how therapists could develop resilience. Therapists need to develop primary capacities such as patience faith/meaning of life contact and love acceptance. Future researchers could conduct phenomenological, qualitative studies to help the scientific community understand how therapists experience resilience in relation to their primary capacities.

4.1. Study Limitations

There is a need for quantitative studies in large representative samples. Such studies could provide useful information about the extent and the frequency of the under-investigation phenomenon. For instance, future quantitative researchers could examine how the overdevelopment of some, or all the primary capacities can correlate positively or negatively with resilience. A research question, that could lead future research on the above-mentioned research problem, could be "Is managing time successfully but in a more rigid way still a favorable predictor of resilience in therapists?" To a similar direction other research questions could be: "How secondary capacities are correlated with resilience of therapists?", "How are the secondary capacities conducive or unconducive towards promoting resilience of therapists?" and "How can they interfere with the primary capacities and resilience of therapists?".

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Section: Modern PPT practice

RESOURCE-ORIENTED WORK WITH TRAUMATIZED PATIENTS

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Abstract

Already since the period following World War 1 until the Vietnam War, criteria of traumatization aftermath of the Vietnam war, the criteria for traumatization have been identified and psychotherapeutic aids have been tested and validated. With its possibility of resource activation, Positive Psychotherapy has made another approach available for analyzing the trauma-triggering triggers, for the identification of competencies that are already being used and for the activation of existing, unused abilities, which leads the patient into a stabilizing process and integration of his/her experiences and thus, together with the cross-school psychotherapeutic interventions, promotes the process of individual recovery.

Keywords: trauma, positive psychotherapy, balance model

Introduction

Whenever people experience powerlessness and helplessness and the feeling arises that they cannot avoid or end a subjectively perceived threat, this experience is "frozen". Life events that resemble this traumatizing situation are avoided, and if this is not possible, the well-known, diverse flashbacks with corresponding symptoms occur, which we psychotherapists encounter again and again in our work with our patients.

Within the framework of Positive Psychotherapy by Prof. Dr. med. Nossrat Peseschkian, we have a model available to us in psychotherapy and counseling with the help of which we can (Peseschkian, 2016):

a) perform a differential analysis of the trauma content
b) perform an equally differentiated analysis of the resources used by the patient to cope with and process the traumatic event, and finally
c) Identify skills/resources that the patient also has available in his or her individuality but does not use under the stressful condition.

At this point, it should be noted that the current state of scientific knowledge on trauma research is not repeated in this article, but is assumed to be known or readable, so that we focus on the use and application of the Positive Psychotherapy model in the context of trauma work and therapy.

Methodology:

This is the balance model, or the model of the four areas of life. Peseschkian starts from the thesis that every person lives and experiences his life in and through four (life) areas. Each of these areas contains abilities, competencies, resources, which develop age-appropriately and end up depending on personality and life circumstances.

Furthermore, each of the areas of life includes challenges and tasks that have to be

mastered in the respective age phases, as well as lifelong challenges for people in concrete situations. Through these challenges, resources of the areas of life are trained and are available as familial strategies. The four areas of life are named:

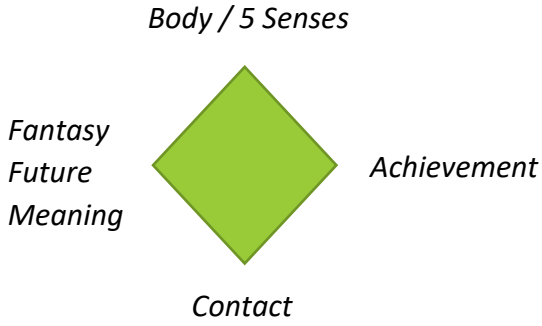


Fig.1. The 4 areas of life according to Prof. Dr. N. Peseschkian

They are operationalized as follows:

Body:
Waking/ sleeping rhythm
Nutrition
Hygiene
Aesthetics
Movement

Senses:
Sight
Sound
Smell
Taste
Touch

Fantasy:
Wishes, dreams. Creativity
Future: Planning one's own lifetime
Giving meaning:
Where do I come from? Where am I going? What is my mission in life

Achievement:
Livelihood support within the framework of the individual developmental stage: Infant/ child/ adult/

Contact:
any form of interaction: with others and with oneself

Fig.2. The 4 areas of life according to Prof. Dr. N. Peseschkian and Birgit Werner

It becomes apparent that the more diverse the challenges of personal life are and have been in the past, the more conscious and developed are the resources and abilities of the four areas of life. (From the point of view of developmental psychology, it can be concluded that it is helpful and self-esteem-boosting for a child if caregivers allow and encourage independence in a child's actions in a manner appropriate to his or her age). Strategically, every person in crisis situations primarily falls back on strategies/resources that are subjectively most familiar and most practiced and tries to solve the crisis with them, regardless of whether these resources are adequate or not. As a rule, partial feelings of success are achieved in this way.

Beginning of the crisis

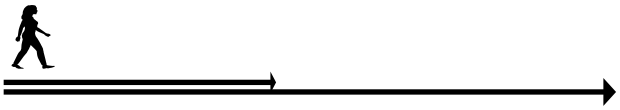
Crisis solution

Fig.3. Crisis Management Process I Birgit Werner

If these are not satisfactory, a situation arises that involves different, less frequently used resources using the trial and error principles. If this process does not lead to the desired success, helpers are involved to end the situation of powerlessness and helplessness. This principle applies to trauma as well as to any kind of conflict or life crisis.

The use of less familiar/ new resources is necessary to achieve the goal.

Beginning of the crisis



Crisis solution

achieved intermediate result

Fig.4. Crisis Management Process II Birgit Werner

Discussion

For the therapist, the first step in the method is to identify the trauma(s) in the setting. the trauma(s) is based on the patient's description and the perceptible symptoms in the setting. Balance model on the basis of the patient's description.

Here are a few examples:

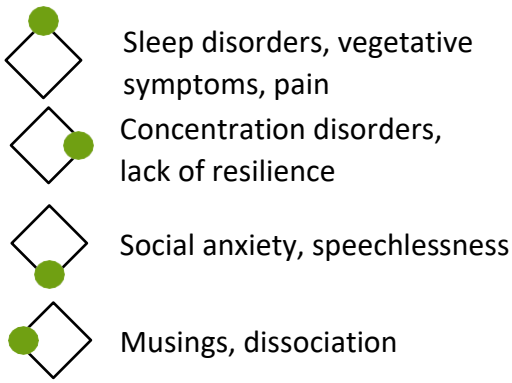


Fig.5. Question: In which areas has trauma escalation taken place?

Depending on the structural level of the patient, this analysis can be discussed with the patient in a more or less differentiated way.

In the second working script, we use the model of the four domains of life to differentiate the symptoms of the patient. Here are a few examples:

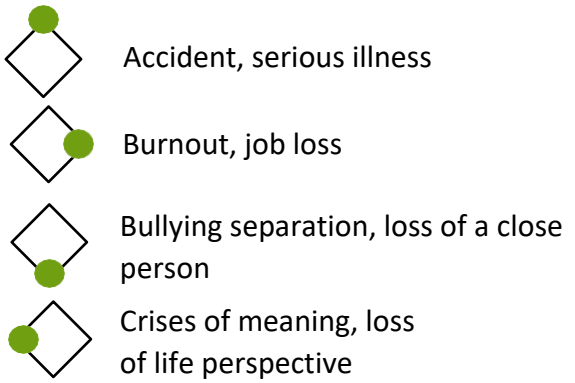


Fig.6. Question: What symptoms have arisen as a result of the traumatization?

The third step takes place, also more or less differentiated, depending on the structural level of the patient. Here the question of analysis is: *What resources has the patient used so far to regain control over his/her own life after the traumas and to process the symptoms that have arisen?*

Here, the resources familiar to and trained by the patient become apparent. In the comparison of the areas of life in worksheets 2 and 3, a clear picture emerges of which areas of life are particularly heavily burdened and which areas of life are used to a particularly high degree to compensate for and process the trauma. This insight can give the therapist a suggestion as to which of the four areas of life can be used more extensively.

In the fourth step, we consider together with the patient which resources and abilities are generally available to people. The therapist can give some suggestions at this point and should enable the patient to develop those resources which he/she has become acquainted with and possibly observed in other people.

It is generally our goal to guide the patient toward self-help, which is especially important after a trauma, in order to help the patient to get out of the passive back into an active life situation.

Together in the Session we discuss which of these concrete resources can be tried out for the life situation of the patient in addition to the familiar strategies in order to achieve symptom reduction and an awareness of more extensive self-control, so that the psychological and physical ability to cope is improved. Here, too, a few examples are given:

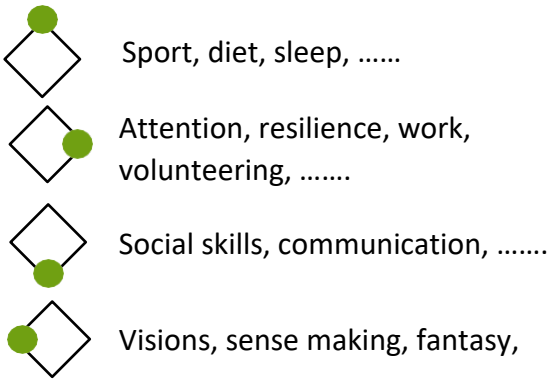


Fig.7. Question: What resources and abilities are available to people in principle?

In the further course of therapy, it is now useful to repeatedly pay attention to the patient's ability to act and to reflect on this with him. With regard to the resources used, a fine-tuning can continue to take place in the therapeutic dialogue.

Conclusions

In order to process a trauma, people fall back on their individually familiar coping strategies immediately after the event has occurred. The individually experienced symptoms represent completely normal, natural reactions to the extraordinary, unfamiliar event of trauma, which is not mastered with the familiar strategies. With the Balance Model of Positive Psychotherapy, three significant factors of psychotherapeutic work can be differentiated according to the four areas of

life: 1. the analysis of the traumatizing factors, 2. the analysis of the coping strategies already used, in the sense of an actual-value assessment, 3. the recognition of the coping possibilities available and not yet used, in the sense of the target-value analysis.

In addition to the various techniques and strategies of trauma therapy, the application of the model of the 4 areas of life in the variations mentioned here and those that each psychotherapist can further develop, give an additional possibility for the patient to activate and stabilize his/her own self-help and thereby contribute to his/her own recovery and a more stable self-worth.

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Section: Modern PPT practice

EMOTIONS IN POSITUM

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Abstract

The article aims to develop a definition of emotions that would be both theoretically and practically applicable in psychotherapy (prescriptive), while also aligning with the everyday (descriptive) understanding of the term. The arguments are grounded on sound review of relevant theories that help to grasp the somatic and psychological mechanisms that enable the experience and utilization of emotions. Emotions are differentiated from feelings and stress. The intratheoretical consistency of the newly formulated understanding of emotions with the model of conflictogenesis of positive psychotherapy has been demonstrated.

Keywords: emotions, stress, positive psychotherapy, psychosomatic

Introduction

The term "emotion," derived[1] from the French word "*émouvoir*" meaning "to excite," encompasses a wide spectrum of feelings, passions, and attachments. While this descriptive definition captures the essence of emotions, it only vaguely outlines their diverse categories (Scarantino, 2012) such as anger, fear, joy, sadness, and disgust.

Both Buddhist teachings (De Silva, 2011) and pre-Christian Western philosophy recognized passions and affections as manifestations of human needs and capabilities. Building on this foundation, the Stoics viewed moderate passions as tools for prudent judgment (Didymus, 1999), whereas Aristotle (2014) regarded pathos as fundamental for virtue (ethics). Across these perspectives, it was acknowledged that excessive emotions hinder the ability to distinguish between the concepts of "good" and "bad." In Christian philosophy (Roberts, 2007), emotions were seen as reflections of the divine "imago-dei," encouraging their application for rejoicing in God and exercising wise self-management (Roberts, 2021).

Emotions' impact on health has long been recognized by Chinese, Middle Eastern, and European medical traditions.

Emotions play a pivotal role in shaping human experience, decisions, and behavior. Yet, despite fervent exploration by poets, philosophers, and scientists, a universally accepted definition of emotions remains elusive.

Most definitions broadly describe the category (“a strong feeling, such as love, fear, or anger” (Oxford Advanced American Dictionary, 2023), “or strong feeling in general” (Cambridge Dictionary, 2023) “arising from one’s circumstances, mood, or relationships with others” (Lexico Dictionaries, 2021), the obvious nature (“a mental process of medium duration”

[1] Hypothetically since 1579 (Taylor G.J., Bagdy R.M., Parker J.D., 1997)

(Wikipedia, Russ., 2023) and the function ("reflecting a subjective evaluative attitude to existing or possible situations and the objective world" (Wikipedia, Russ., 2023)) of emotions.

The American Psychological Association Dictionary makes it more specific and practical, stating that an emotion is "a complex reaction pattern, involving experiential, behavioral, and physiological elements, by which an individual attempts to deal with a personally significant matter or event. The specific quality of the emotion (e.g., fear, shame) is determined by the specific significance of the event. For example, if the significance involves threat, fear is likely to be generated; if the significance involves disapproval from another, shame is likely to be generated. Emotion typically involves feeling but differs from feeling in having an overt or implicit engagement with the world." (American Psychological Association)

Unfortunately, even this definition does not fully account for such modern and practically relevant insights into the neurophysiology (Malezieux, Klein, Gogolla, 2023) and mental functions of emotions as peptide theory (Pert, 1974, 1999; Okdeh, et al, 2023) and differentiation from autonomic arousal (stress) (Schachter & Singer, 1962; Kirillov, 2019), the universality of emotional reactions (Ekman, 2016) and social construction of how they perceived and processed (Barrett, 2017). This lack of agreement as to what emotions are (Ortony, 2022) leaves a huge gap in understanding, study, and usage of one of the most important psychosomatic phenomena.

This article aims:

- to consolidate developing and often disagreed (Scarantino, Griffiths, 2011) theories of emotions to formulate a contemporary, somatopsychic, scientific and useful for psychotherapeutic practice (prescriptive) and accessible for everyday use (descriptive) definition of emotions;
- to differentiate emotions from feelings and stress;
- to use the clarified understanding of emotions to deeper the understanding of conflictogenesis in positive psychotherapy;
- to open new perspectives for practical experimentation with emotion-informed interventions in psychotherapy.

Methodology

The scientific exploration of emotions and attempts to establish a prescriptive definitive understanding began in the early 19th century[2].

Charles Darwin's exploration of nonverbal emotional expressions highlighted their universality across cultures and even among animals. In 1872, he proposed (Darwin, 1872) that evolutionary-developed emotions no longer held the same survival or communication significance for modern humans.

William James (1884) and Carl Lange (1885) independently theorized that the perception of a stimulus directly triggers an autonomic nervous system response, which the brain then interprets as an emotional experience (Carlson, 2012). This viewpoint (Fig. 1) suggests that emotions emerge from bodily reactions, such as "we feel sad because we cry, angry because we strike, afraid because we tremble." (James, 1884). This perspective is supported by observation that changes of body posture, facial expressions, breathing patterns, and more can evoke distinct emotional states (Laird, J., 2007). In line with this idea Freud (1915/1957) thought that it is "of the essence of an emotion that we should be aware of it", yet it is frequently remains suppressed and unconscious.

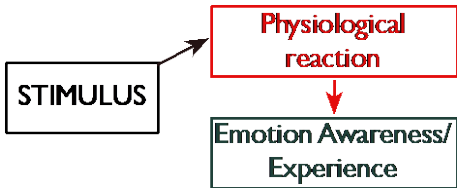

Fig. 1. Emotions in James-Lange theory

Jesse Prinz (2004) and James Laird (2007) further proposed that the body responds directly (without consciousness) to stimuli with specific emotions, much like our vision or touch inform us about our interaction with the environment.

Subsequent discoveries in neuroscience (Pace-Schott, et al., 2019) led to the development of the James-Lange theory by Joseph E. LeDoux (1996), Robert Zajonc et al. (1997), John T. Cacioppo (1998), and Antonio Damasio (2008). Modern neuroscientists

[2] According to Taylor G.J. and Bagby R.M. (2021), the term "emotion" is attributed to Thomas Browne in the early 1800s, and it is suggested that the contemporary understanding of emotion did not fully crystallize in the English language until the 1830s.

(Dalgleish, 2004) widely recognize this theory's value, acknowledging that somatovisceral and central nervous system responses associated with emotions prompt adaptive behavioral reactions.

Walter Bradford Cannon (1929) building upon Philip Bard's (1928) research, challenged the notion that the fight-or-flight response (stress) alone can fully explain the rapidity, intensity (Carlson, 2012), diversity, and duration (Cannon, 1927, 1929) of emotional experiences. Based on the observation that sensory and sensory-motor input initially passes through intermediary brain structures, particularly the thalamus, before undergoing further processing, he suggested that sensory stimuli triggers both (Fig. 2) physiological reactions and their conscious processing (awareness/experience) simultaneously (Cannon, 1929).

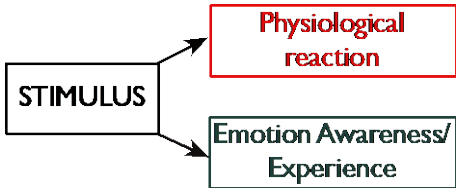

Fig. 2. Emotions in Cannon's theory

In experiment, subjects injected with adrenaline experienced physical arousal but didn't perceive it as an emotional experience due to the lack of an actual emotional stimulus (Marañon, 1924). In other experiments (Stanley, & Singer, 1962), emotions were prompted by reactions of other people indicating the interplay between intensity of adrenalin induced arousal and contextual emotional assessment.

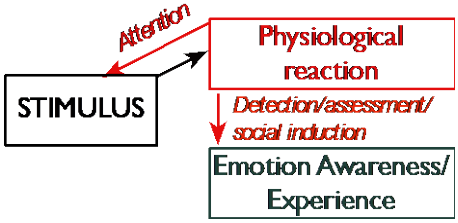

Fig. 3. Emotions in Two-Factor theory

The **two-factor theory** (Fig. 3) of Schachter, S., Singer, J. (1962) posits that arousal influences cognitive evaluation and then shapes the emotional experience of 1) general physiological arousal and 2) the experience of emotion itself.

Most studies have failed to replicate the original findings (Rogers, Deckner, 1975), presumably due to the later discovered dose dependency (Cotton, 1981) of epinephrine injection and arousal. The only successful replication has been that of Erdmann and Janke (1978), which employed a different drug (ephedrine) and different procedures.

Nevertheless, this theory has made an important contribution to the understanding of emotion by separating the activation of the sympathetic nervous system Dror, O. E. (2017) from subsequent cognitive (miss)interpretation.

For C.G. Jung (1938/2011) Emotion is "an involuntary reaction", "the chief source of consciousness". He emphasizes that emotion is the result not only of a physiological response to a stimulus, but also of the activation of a particular complex. Therefore, it brings the archetypes, "a piece of life, an image" (Jung, 1968) "from darkness to light or from inertia to movement" (Jung, 1938/2011)

Paul Ekman views (Fig. 4) emotions as universal evolutionary processes (Ekman, 2023). His findings are consistent with a 2014 survey (Ekman, 2016) of 248 scientists who frequently publish emotion research. Most of them agreed on the universality (88%) of anger (91%), fear (90%), disgust (86%), sadness (80%), and joy (76%). They also associated each emotion with recognizable facial expressions and vocal tone changes (80%) and specific universal triggers (66%). 49% of the scientists regarded emotions as discrete and distinct processes, while 11% saw them as socially and psychologically constructed phenomena, and 30% used both approaches.

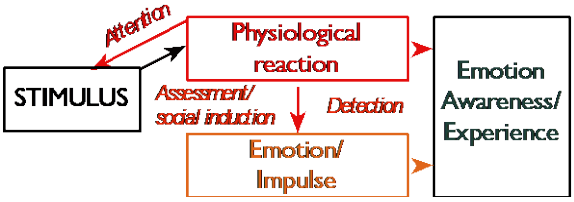

Fig. 4. Emotions in Ekman's theory

The main criticism of Paul Ekman challenges the universality (Barret, et al. 2007; Barret, 2017) and "basicness" criteria of "basic emotions" (Ortony, 2022) based on the fact that different theorists proposed substantially different lists of basic emotions.

Candace Pert hypothesized that emotions are shifts in feelings brought about by peptides ("molecules of emotion") circulating in the body (Freedman, 2007). We perceive these sensations as distinct emotions and impulses: fear motivates escape, anger incites a fight response, disgust triggers avoidance, and joy propels optimal action or recovery.

She built her argument on following three discoveries (Pert, Snyder, 1973; Pert, Pasternak, Snyder, 1973; Pert, 1974):

1. Peptides[3] of our body, similar to mood-altering drugs, trigger highly specific cell receptors[4], activating the cell's chemical and electrical activity, prompting DNA to produce proteins needed to biologically engage tissues and organs in survival and adjustment.

2. Modification of specific peptides activity leads to predictable change of mood.

3. A high concentration of opiate receptors has been found on brain cells in areas responsible for object recognition, action coordination, and cognition (supporting the idea of pleasure to be a key decision factor).

Pert's theory proposes a hypothesis that one can develop a physiological dependence on emotions, similar to opioid-like substance addiction. Prolonged experience of an emotion could lead to an increase in receptors for the corresponding peptide in new cell generations, establishing a new homeostasis. If proven trough, this could explain why a depressed person might experience physical discomfort when attempting to smile; cells could be signalling an "alarm" due to the drop in the accustomed concentration of hypothetical "sadness peptides."

The peptide theory of emotions is criticized for the following:

1) reductionism, ignoring the social contexts (Barret, et al., 2007; Barret, 2017), individual experiences and cognitive processes.

2) lack of research linking specific peptides with particular emotions.

Yet Pert's discovery stimulated further research and hypothesis. So, Buck, R. (2010) suggested that discrete feelings arise from combinations or "cocktails" of neurochemicals. Further studies demonstrated the involvement of multiple neuropeptides in anxiety and depression (Liang, et al., 2021; Okdeh, et al, 2023)

Lisa Feldman Barrett, in her work "How Emotions Are Made" (2017, 2019), challenges the idea of universal emotions. She highlights the role of personal and cultural experiences in shaping individual perceptions of emotions. However, her view doesn't oppose the "classic theory"; it just stresses that each person perceives a "specific array of bodily changes" differently based on cultural and personal experience of awareness – the "construction of emotions" (Fig. 5) Hence, when observing others' emotions, we essentially interpret their experiences, relying on our subjective perceptions and interpretations.

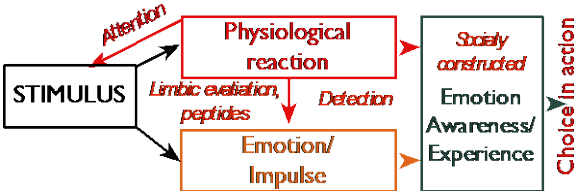

Fig. 5. Emotions, summarized

In this context, the idea of the social construction of emotions highlights that although the initial emotional impulse arises automatically in response to a trigger, the perception and interpretation of that impulse, as well as the subsequent action or inaction, is the subjective result of the interaction of body, environment, and social-psychic factors (Barrett, 2017). This view provides a key to understanding the mental states and motives of individuals and groups.

Various authors have criticized the constructive theory of emotion (Pober, 2018) for its lack of specificity and internal consistency, as well as its overemphasis on constructs and failure to understand the complex interplay between brain, body, and environment.

The **Component Process Model identifies the following key stages in experiencing** emotions (Scherer, K.R., 2005):

1. cognitive (limbic, preconscious) **evaluation**[5],
2. **bodily symptoms**,
3. **impulse**[6] (the actual emotion),
4. **expression**,

[3] Peptides are synthesized in the nucleus of a nerve cell by direct division of DNA from 2-50 amino acid residues (molecules consisting of more than 50 amino acids referred to as proteins). Sometimes, peptides called neurohormones because short peptides are working as neurotransmitters and long peptides work as hormones.

[4] Highly selective neuropeptide receptors are complex structures that unmistakably recognize their corresponding peptides.

[5] This point tends to generate the most debates. Most likely, at this moment, a preconscious evaluation of the current event takes place based on the so-called "emotional database" (Fivush, R. at al. 2009; Richardson, M.P., Strange, B.A., Dolan, R.J., 2004; Kirillov, I., 2019), which combines innate reflexes (universal emotion triggers) and those acquired through previous individual experiences (*Basic Conflict*). It is the meter of general agreement that the amygdala plays the key role in this process (Šimić G., et al., 2021).

[6] Hypothetically, such readiness for specific actions is facilitated by physiological processes that are specific to each emotion. (Ekman, P., 2016; Pert, C. B., 1999).

5. **feeling** (subjective experience: "I'm scared"), and

6. **choice embodied in action** (Lazarus, R., 1991).

Cognitive theories emphasize the role of cognitive evaluation of context and intention formation (coping strategies) in triggering emotions. Emotions are the simplest form of information processing – an automatic and sometimes unconscious judgment (Solomon, 1993) that guides further behaviour (Chaiken, Liberman, Eagly, 1989). "Series of emotional states over time and organized around an underlying theme" that affects relationships and behaviour is an affective event (Weiss, Cropanzano, 1996; Weiss, Beal, 2005). Griffiths, P.A. and Scarantino, (2005) argue that these expressions are strategic steps to build relationships and reach agreements in adapting to complex social systems (Kotrschal, 2013).

Neurobiology of emotions. Reptiles' reflexive postures and movements in response to stimuli were evolutionarily enhanced in nocturnal mammals by developing neural pathways processing odors, that are gradually developed into the limbic brain. Presumably, these newly formed reflexes, over time, developed into patterns of emotions. Therefore, fear and anxiety[7], which guide adaptive defensive behavior in case of perceived threat (Blanchard, C.D. et al. 2001), are associated with the activation of the limbic system (Broca, 1878; Papez, 1937; MacLean, 1952): amygdala (Steimer, 2002), hippocampus, thalamus cingulate cortex, etc.

Impulses from limbic structures enter the frontal lobe via the ventromedial prefrontal cortex (vmPFC), which is involved in predicting emotional outcomes (the internal feeling "How will I feel if ...?") and thus in decision making. (Damasio A., 1999).

Activation of the dorsolateral prefrontal cortex (dlPFC) suppresses limbic system impulses when immediate needs must be denied in order to meet them better and/or less costly later. Monkeys with disrupted dlPFC connections always seek immediate reward.

Today, it is considered that the activity of the right prefrontal cortex is associated with the suppression of emotions and passivity, while the functioning of the left prefrontal cortex is linked to social activity (Schmidt, 1999) and the response to stimuli that appear[8] attractive (Kringelbach, et al., 2003) or provoke anger (Harmon-Jones, et al., 2004).

Results

3.1. Definition of emotions

Considering all the above-mentioned theories and discoveries, we can suggest the following detailed (Tab. 1) and short (Tab. 2) definition of emotions.

Table 1.
Detailed definition of emotions

Emotions are *innate universal (Wierzbicka, 1999) scripts of somatic responses experienced subjectively according to the individual psychodynamic background and aimed: to focus attention on trigger; to channel the stress energy into survival, adaptive, and procreational actions; to reinforce[9] optimal[10] solutions of recurring problems (Ekman, 1992); to communicate (Izard, 2011) the subjective value of events, ideas, and actions (Fielding, L., 2015); to partially or fully consciously verbalize, categorize (Lerner, et al 2015) and evaluate the actual inner state and/or anticipated level of satisfaction ("will I like it or not") with the results of predicted events or actions; to make a choice/decision and to act towards it.*

Table 2.
Shorten definition of emotions

Emotions are *innate universal scripts of somatic responses experienced subjectively according to the individual psychodynamic background and aimed to optimize survival, adaptation, and procreation.*

[7] LeDoux J. (2018) believes that the amygdala controls innate emotions (fear and anxiety) and "then we elaborate it through cognitive and conscious processes." in social and cognitive environments.

[8] When the left prefrontal cortex is selectively activated, subjects tend to positively evaluate moderately attractive (Drake, R.A., 1987) and even negative (Merckelbach, H., van Oppen, P., 1989) visual stimuli.

[9] Emotional events attract more attention, are better remembered, and are easier to spontaneously replay and purposefully recall (D'Argembeau, A., Comblain C., Van der Linden, M., 2003).

[10] Evolutionary-motivational function (Pinker, S., 1997, Schacter, D.L. et al. 2011): Emotions have evolved as physiological mechanisms to motivate adaptive behaviour (Gaulin, S.J.C., McBurney D.H., 2003).

That said, different cultures may interpret certain emotions differently (Russell, 1991) based on their collective experience.

Since emotions are functional and adaptive by nature, their division into "positive and negative" rather reflects the social acceptability of certain affects or their subjective psychophysiological pleasantness or unpleasantness. Moreover, the latter is often associated with the sensual and physical experience, not of the emotion itself, but of growing tension of stress or of anxiety resulting from suppression of arising impulses.

3.2. Differentiation of emotions from feelings and stress

To avoid common misunderstandings and misconceptions it is important to differentiate emotions from feelings and stress.

Feelings - a concept that, depending on the context, can describe two different phenomena:

1) *feelings as persistent emotional attitudes* based on the experience of interaction with the object:

- "a self-contained phenomenal [subjective] experience" (VandenBos, G., 2006),
- "evaluative and independent of the sensations, thoughts or images evoking them"(Jung C.G., 1934/2022; VandenBos, G., 2006);
- conscious subjective interpretation of emotions, as a subjectively estimating attitude to real or abstract objects (Leontyev, A.N., 1971), for example, *"I feel that (I don't) know this", "I feel that this is (not) fair".*
- "purely mental [phenomena], whereas emotions are designed to engage with the world" (VandenBos, 2006).

2) *feelings as "any experienced sensation"* (VandenBos, 2006) - the process of reflection in CNS of specific characteristics and states of external and internal environment such as tactile sense, temperature, pain etc. (impulse from receptors engaged by specific stimuli (Bradford, 2017), is transmitted to CNS, recognized and registered there in the form of specific experiences such as basic senses (sight, audition, gustation, olfaction, somatosensation, equilibrioception, proprioception, and termoception), and "primary" "homeostatic" senses[11] (pain, hunger, thirst, tiredness, anxiety, excitement). Most modern scientists, following Plato, Aristotle, Spinoza, Descartes, etc., agree that emotions are one of the feelings qualitatively different from other feelings.

Stress is the nonspecific arousal, charging the emotion with energy according to the degree of (dis)satisfaction. Meanwhile, the emotion is the situation/perception-oriented reaction generating the specific impulse to act.

Notably, Walter Cannon (1929), Hans Selye (1955), Stanley Schachter, Jerome Singer (1962) and Dror, O. E. (2017) also emphasized that visceral arousal (stress) is nonspecific and appears to be the same for all emotions. Based on this, both theoretically and practically, it is reasonable to distinguish stress (general arousal) from emotions (distinct, physiological, and expressive).

3. Emotions in conflictogenesis explained with models of Positive psychotherapy.

In view of the above-given definition of emotions, we can better describe and understand the conflictogenesis in terms of Positive Psychotherapy (Peseschkian, N., 1987). At the same time, considering emotions in the context of conflict psychodynamics, we verify the theoretical consistency (Scherer K.R. 2022) of the proposed definition and generate new ideas about the internal dynamics of emotions and, consequently, the possibilities of their regulation. The following explanation and visualisation (Fig. 6) are just hypothetical speculations to provoke further discussions and research.

Whenever happening on a background of *precondition*[12] (Fig. 6 A) an *event*[13] (Fig. 6 B)

[11] The so-called "primary" "homeostatic" (Craig, A.D., 2003) emotions/states/signals are "subjective elements of instincts - genetically programmed behaviours that maintain homeostasis." *(Denton, D.A., 2009)*.

[12] **The precondition** of the body *(stress, emotions, hunger, fatigue, etc.)*, psyche *(needs, archetypes and images (Jung, C.G. 2020) concepts, expectations from Basic Conflict (Peseschkian H., Remmers A., 2020))*; relationships *(image of self/others, position in hierarchy, expectation of treatment and help, habitual algorithms of exchange)* and behavior *(habitual patterns of action and their outcomes)* can affect one's perception of the situation and emotional response.

[13] **An event** is usually a consciously noticed change, person, place, situation, feeling, thought, image or memory occurring here and now, triggering the **Actual Conflict (AC)** of what is accustomed and habitually expected with changing reality.

resembles *conflict potential*[14] in our "*emotional database*"[15] (Fig. 6 C), universal (innate) and learned in a basic (Peseschkian H., Remmers A., 2020) *conflict*[16] (Fig. 6 D), *the selective filter of perception*[17] (Fig. 6 E), prompts one to experience it (correctly or wrongly) as a *trigger*[18] – a threat to the activated primary need or as a possibility to meet it. Activated by a trigger, *conflict potential* (Fig. 6 F), stored in an "*emotional database*" turns into an *Actual Unconscious* (Boessmann, U., Remmers, A. 2021) *Inner Conflict*[19] (Fig. 6 G), unfolding an *emotional impulse* (Fig. 6 H) to act for protection and satisfaction of need, which is predicted to be threatened or met by the concept formed in BC. This impulse can be adaptive or maladaptive and even destructive.

For example:

- a childhood experience of being electrocuted may result in a caution at the sight of an exposed wire;
- an excessive emotional punishment for childhood mistakes may result in an inadequately paralyzing fear of making a mistake.

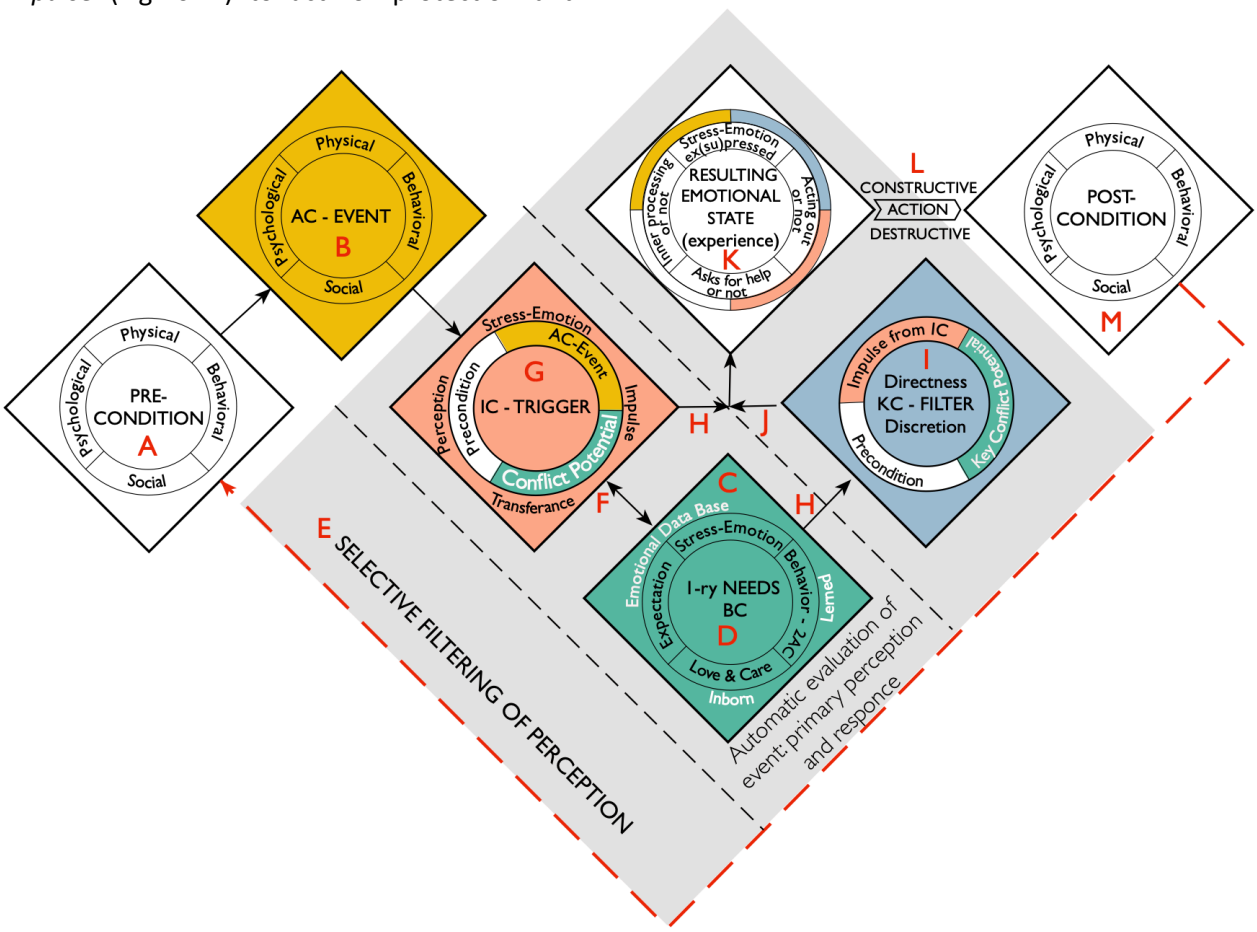

Fig. 6. Emotions in conflictogenesis explained with models of Positive psychotherapy.

[14] **A Conflict Potential (CP)** is formed by an experience of the child's attempts to meet his/her primary needs in a BC. It consists of associated stress, emotion, behavior, and satisfactory or unsatisfactory results, summarized as a concept/expectation. CP is stored in an EDB and unfolds when activated by a trigger.

[15] ***An "emotional database" (EDB)*** consists of innate (universal) and acquired memories (emotionally charged concepts linking certain norms and patterns of behaviour (secondary capabilities) to the satisfaction of primary needs and to expected patterns of relationships and corresponding behaviours aimed to meet and protect these needs).

[16] The **Basic Conflict (BC)** *of the child's needs with the needs and abilities of primary caregivers begins in early childhood. Later, it develops (there and then - in the past) in emotionally meaningful relationships based on transference.*

[17] ***The selective filter of perception*** is conditioned by the EDB formed in the BC. It categorises an actual event as an important (***trigger***) or unimportant.

[18] **A trigger** is a perception of an event as either a threat or an opportunity to meet a particular need, based on automatic evaluation of the event against universal (innate) and acquired in BC algorithms of the EDB.

[19] **Inner conflict (IC)** usually unconsciously happens here and now as a clash of an actualized need with an event (AC) perceived (because of the conflict potential formed in the BC) as a threat or opportunity to meet this need.

Key Conflict (KC) (Fig. 6 I): if EDB categorizes this primary emotion-specific impulse (Fig. 6 H) as a chance to meet a need, it allows it to act it out (directness/openness/honesty (Kirillov, 2020; Goncharov, 2020)). If EDB assesses such a drive as a threat, it suppresses such an emotional action and expression (discretion/courtesy/politeness (Kirillov, 2020; Goncharov, 2020)) .

The result of the emotional impulse of IC filtered by a KC (Fig. 6 J), both of which are conditioned by EDB and conflict potential formed in BC, triggered by the event of AC against the background of the precondition, is experienced as a resulting emotional state (Fig. 6 K), characterized by:

1) ***bodily changes***:

- autonomic arousal of stress (tension, change in breathing, increased heartbeat, etc.) proportional to the level of perceived threat/opportunity;
- emotion(s) associated with a similar event in EDB;
- the associated impulse of a reflexive (innate or acquired) action generated in the motor cortex.

2) ***mental subjective*** (in the context of available concepts, identities, archetypes, images and narratives) **experience**:

- of the emotion ("How am I feeling sadness or anger?");
- active processing/ ignoring/ suppressing/ replaying of the emotion(s) impulse(s), IC, KC and related needs.

3) ***social experience***

- seeking/refusing help (explicitly or implicitly, consciously or not);
- expected communication algorithm (help, refusal or punishment);

4) ***behavior***

- action automatically initiated by an emotion-specific inner impulse (yelling, hitting, crying) can be acted out externally (yelling, fighting, crying) or internally (suppression (discretion) or reconsidering).
- action and inaction (Fig. 6 L) can be constructive (lead to a desired outcome, improve the situation and relationships) or destructive (fails to produce the desired outcome, making the situation worse and cooperation with others difficult).

The resulting emotional state becomes a postcondition (Fig. 6 M) for the experienced emotional episode and a precondition for the following events and participates in the selective filtering of information, changing the perception and interpretation of reality according to the prevailing emotion. For example, anger increases irritability to any stimuli.

Conclusions

Described analyses of developing theories of emotions and modern research allowed to formulate a detailed, theoretically accurate and applicable in the practice of psychotherapy (prescriptive) definition of emotions, as well as a simplified, short version of it, convenient for daily use (descriptive).

The expanded definition of emotions enables the clear separation of emotions from feelings and stress, which makes it possible to diagnose various levels of emotional dysregulations and dysfunctions differentially and to plan effective interventions to develop the relevant structural capabilities of personality. The latter is significant for the treatment of patients with borderline, post-traumatic and mood disorders, as well as for the correction of alexithymia and the development of emotional maturity skills in healthy people.

Intra-theoretical consistency verification of the proposed definition of emotions with the model of conflictogenesis in positive psychotherapy revealed:

- the absence of logical and theoretical contradictions;
- complementarity of the tested constructs, which allowed to describe and visualize the emotional dynamics of conflictogenesis in more detail, taking into account the proposed definition of emotions.

This description and visualization suggest the most effective "targets" of interventions for the treatment and prevention of mental disorders, as well as for the promotion of psychosomatic health:

1) Optimization of preconditions of emotional reactions and inner conflicts (strengthening the autonomic nervous system for the optimization of physical stress resilience; development of interpersonal skills; differentiation, verbalization and visualization of bodily sensations, intrapsychic processes,

thoughts and images (Jung, C.G. 2020); practice and adaptive correction of behavioral algorithms).

2) Psychodynamic (using transferential therapeutic relationships (Boessmann & Remmers, 2021)) "installation" of flexible-adaptive potentials of reactions into the "emotional database" (optimization of key conflict solutions; formation of dynamic expectations and strategies to meet primary needs in changing conditions).

3) Development of primary capacities (Kirillov, 2015). to regulate emotions, impulses caused by them and their consequences.

The results obtained in this article provide a good foundation for further reflection, discussion and research.

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Section: Modern PPT practice

FAMILY THERAPY AS A DYNAMIC BALANCE OF ACTION AND INACTION. TO ACT OR NOT TO ACT - DILEMMAS IN FAMILY THERAPY

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Abstract

Four principles of ethical questioning in family therapy dilemmas are the basis for ethical questions in family therapy as a guideline for to act, how to act, or not to act. An example of an ethical dilemma from the practice of family therapy is described.
A "package insert" for family and couples therapy as information about family therapy is comparable to information on the effects of medication: Why not apply the same standard when it comes to effective procedures?
Methods of family therapy and individual therapy have been developed side by side and one after the other, for which a clear differential indication and systematization of application still needs to be developed. An experience- and outcome-based family therapy (EBF) could be the goal. The therapeutic position and a guideline for families in therapy are discussed. The application of a five-step process model to find out and to solve the ethical questions is developed and presented.
We dare to present the thesis that a differential family therapy based on effect and side effect studies with informed consent of the patients or family members can be the basis for a critical classification of the methods to a general "Evidence Based Family Therapy" (experience-based family therapy).

Keywords: attachment, trauma, positive psychotherapy, psychodynamic therapy, ethical dilemmas, family therapy

Introduction

If family therapy were a surgical operation, the matter would be clear: A patient comes with complaints, an organ is diagnosed as diseased, which can also be proven. The team sits down to discuss the possible risks, the objectives and the expected course of the procedure. The team then discusses the surgical approach, what is to be removed, what is to be left in place, the anesthesia and how much the patient and also the surgeons can be expected to pay. The question of the price is - in this country - usually settled in advance by the insurance company. Standardized operations according to guidelines take place in acute hospitals. The ethics of surgeons are based on obvious and provable criteria.

An example will be presented here to visualize the dilemma therapists find themselves in: Family M., consisting of father, mother and their child comes to a family therapist. Other potentially powerful but optional family members are not brought (the mother's mother, who comes for the weekend; the mother's best friend; the father's deceased but still respected father). The 17-year-old daughter, L., is identified as the patient. She has anorexia, weighs 42 kilos with a height of 174 cm and continues to lose weight. Since the age of 13, she has been in

alternating treatments in university clinics, with psychologists and counseling centers The mother P. had the idea to now see this therapist. She herself is depressive, overstrained and in need of harmony, at the same time overweight and motherly caring. The father G. comes along. He drinks and decompensates at work. He will probably lose his job soon but does not yet see a problem.

The participants in a first meeting might come with the following, not verbally expressed expectations:

Daughter (index patient with anorexia): *Hopefully everything will end soon. They are always dragging me somewhere else. They should just leave me alone. I hope they'll leave me alone if I do everything right. They can't reach me anyway, they have no idea. I would much rather be somewhere else. (One of their ulterior motives: He looks all right. But that was also the case with the others before. And he won't understand me either. If only he could teach my parents that I'm finally allowed to live the way I want!)*

Mother of the patient: *I have almost no strength left, he (the therapist) should be in charge now. He should cure my daughter so that she eats, learns, never contradicts and marries well. He is supposed to teach my husband not to fly off the handle all the time. He is to give me comfort, praise and relief. (Afterthought: Oh, I'm so tired of this, I'm just living for the family, I finally need a cure myself!)*

Father of the patient: *I have to be careful. That I come is already too much. Let's see what he can do. Just don't reveal too much. It's not all that important/will be fine on its own. A beer would be good (ulterior motive: These psychos are all the same. This one doesn't have a clue either, the way he talks to us, he won't be able to talk my daughter and my wife into their conscience. Another ulterior motive, very deep: If only he knew how I feel!)*

Therapist: *A family is coming. They will certainly bring their daughter as a patient. Again, a piece of work until the others realize that they are also part of the system. What should I take on myself? Merely remove the life threat? Promote the daughter's autonomy? Or make the mother more detached as well? Or also want to make the father do something? Stabilize the family? Encourage the wife to separate? Who are the other important people who didn't come? Can the family even pay? (One of his ulterior motives: maybe I'll send them to the clinic after all).*

The first sentence from the mother was*: "Our daughter is very sick, maybe you can help her?"* The first session can begin.

The therapist is now faced with the question of priorities in the procedure from the very beginning. Which task and objectives can he accept, which one can he rejects, which one does he see implicitly for himself, which one is formulated? In the decision he wants to put the welfare of the individual person in the foreground - but for which one of all the persons in the family system? Is there something good for the family as a whole? He is faced with the decision to act or to refrain from acting, which he has learned in family therapy and psychotherapy training. He obviously needs clear criteria for an ethically sound decision.

His approach represents a result of simultaneously acting interests, implicit and explicitly expressed expectations, goals and appreciations.

Four principles of ethics

The four principles described by Beauchamp and Childress can be used here as a guide for ethical issues in family therapy to question the dilemmas of deliberate action and interaction in family therapy below:

1. **self-determination/autonomy of the patients**
2. **the treatment should not harm the patient**
3. **the treatment should be useful for the patient**
4. **equity in the treatment system**

(Modified after Beauchamp and Childress 1989).

1. The Patient's Right of Self-determination

"I can take care of myself, I know what is good for me" (patient).

The patient's right of self-determination to act or refrain from acting therapeutically in a treatment contract with informed consent is the first ethical guideline to look at.

In the case example the daughter will probably develop with therapeutic support in a different autonomy development than the

mother is currently comfortable with, and there may be heated arguments. As a therapist, do I inform her about this? Will the parents still support the daughter financially in treatment? Do the father and mother agree to bring in their own problems, which seem to find their outward expression in the daughter's symptomatology? Can the marital problems be addressed in the presence of the daughter? Who agrees to what, and are all involved aware of the possible consequences?

Especially with minors involved, as in the example above, ethical issues of informed consent of the adolescents versus consent of the parents regularly arise, e.g., in connection with the assumption of costs in aid proceedings on behalf of the parents. Self-determination in individual psychotherapy is easier to achieve than in system-oriented family therapy, in which several autonomous persons and at the same time an inherently specific family organism appears. Individual goal of one person and the possible goals for the family system challenge therapists:

Salus privata, the individual health is focused on for the individual family member. Therapeutic aids serve their assertion against interests of other family members, among other things, and one person might seek an alliance against the others. The priority for individuality and autonomy is typical for individual therapy settings, as individuation is seen in individualistic cultural environments as a sign of maturity, like the development of individual skills in competition with other individuals

In the example above, the anorectic patient wants to be accepted as she is by her parents, and involves the therapist into her understanding of her behavior, and wants to give the responsibility with all the consequences to the therapist. Anorexia in the index patient can be seen as an expression of the attachment-detachment conflict in individuation, as a case typical for central Europe.

Salus familiae, the health and functioning of the family means to see goals for the social community, for the narrow or wider family. This perspective carries the expectation that the therapeutic aids will serve their assertion against the outside world, and to unite them in their identity and function. Priority is given for family association, group, community, as in a collective cultural environment. In this case group coherence is seen as a sign of maturity, development of the unit's skills in competition with other groups and families.

Further possible restrictions of the patient's self-determination arise in the context of therapeutic interventions through the person of the therapist in the therapeutic relationship, valid especially in family therapy. *Leonore Kottje-Birnbacher* and *Dieter Birnbacher in* their article "Ethical Aspects of Psychotherapy and the Consequences for Therapist Training" present as possible negative consequences of therapy an instrumentalization of the patient for self-serving purposes, therapy as an end in itself, too strong identification of the therapist with the patient, or a systematic pathologizing. Resulting damages concern the next basic rule of ethics mentioned above.

2. The Treatment Should Not Harm the Patient

"What one particularly likes to do is rarely particularly good" (W. Busch)

Case study: Anorexia of an index patient: In the 4th family therapy meeting, the "paradoxically" intended advice is applied to consider whether the therapy should be continued. As an argument, the possible impact of therapy on the role of the individual members is suggested: the overprotective and depressed mother would lose tasks in the family, the threatening anorectic daughter could lose the care, the father, devalued in his job, would possibly lose the accustomed family cohesion. The intention was to stimulate a discussion within the family about the therapeutic path and to form an alliance, if necessary even against the therapist. The ***autonomy of the family system,*** not that of the individual family members, was in the foreground.

The ethical dilemma between the good of the individual and the good of the family as an organism is a constant theme in family therapy and the nature of interventions. Benefits and harms in acting or not acting were also for *Mara Selvini-Palazzoli* reason for a constant development and review of the interventions.

The intervention should not do any harm: There is little data on this from couple and family therapy. Some authors discuss rules of negative indication. Above all, the therapists' experience and ability to set boundaries is given as a variable

to define negative indication. The therapists' own image of man and their own family ideal as well as their family reality and couple relationship consciously or unconsciously enter into the therapy as a factor and can have a positive or negative effect on the affected person via countertransference. For this reason, self-awareness is sometimes given a lot of space in the training courses, in order to consciously reflect on the personal influence in the therapy.

Some situations seem tempting to ask conflict-discovering questions. Refraining from doing so may occasionally be far more effective and less dangerous to the continuance of a community expressly mandated to be fostered. The alternate action can encourage resources to promote mutual acceptance in a partnership. Subsequently, active action to promote the ability to deal with conflict is useful. Refraining from giving advice in therapy promotes autonomy of intra-family counseling.

Contraindications to procedures or techniques of family therapy are so far hardly named in therapeutic guidelines, in the literature - much less frequently than indications - defined for family problems and therapist factors, also relate to family typology. Official AWMF guidelines do not yet exist in Germany for family therapy, although guidelines for child and adolescent psychotherapy and psychiatry already contain the concept of family therapy in the cases of schizophrenia, affective or eating disorders in the context of therapy.

What in detail can be seen as possible *harm* to a family and its individual members as well as caregivers should be defined in the interview. Typical possibilities of harm known from previous research and experience should be shared by the therapist. This represents an initial characteristic of "evidence-based family therapy" or "outcome-based family therapy."

As a hypothesis, I would like to formulate from my personal experience in internal and general medicine that *omitting family therapy* or *not involving the family in* counseling and therapy can have a considerably more detrimental effect than specifically *involving the* relatives with the patients' consent and encouraging family therapy. The results of family groups of mentally ill patients are positive (Battegay), and obesity treatment is facilitated by family therapy approaches. The negative acting of relatives in the treatment can thus often be transformed into a positive family motivation to promote the individuals and the commonality (Peseschkian 2016a, 2016b).

3. Treatment Should Benefit the Patient

"There is nothing good unless you do it"

Effects of family therapy are well studied, a positive indication is well defined in the literature, as well as a possible different effectiveness of the different theoretical backgrounds. However, the differential indication for different procedures is rarely considered.

Accessibility of the family members, motivation, special problem areas, disturbance patterns are considered as indication criteria. Accepting outside orders for therapy is a relative contraindication: the skilled patient, the selected family member, the black sheep sent into the family therapy desert ("the black sheep in the family are often the nicest").

Family therapy achieves high effects on child behavior disorders, family problems, communication and problem-solving disorders, phobias, schizophrenic symptoms, psychiatric symptoms *(Shadish, Ragsdale, 1996)*. Couples therapy, according to the same research, significantly affects dissatisfaction in the partner relationship, specific problem-solving difficulties. The probability that a client treated with couples or family therapy will do better than a control group member is about 67% *(Shadish, Ragsdale, 1996)*.

What in detail can be seen as a *benefit* for a family and its individual members as well as reference persons is to be defined in the conversation. Typical effects known from previous research and experience should be shared by the therapist. This constitutes a characteristic of "evidence-based family therapy" or "research-based family therapy." Quality is defined in quality management as "the totality of the characteristics of an entity with respect to its ability to meet established and anticipated requirements". In treatment it is also the definition of the desired target criteria and their benchmarks. The yardsticks also yield a measure of disadvantage or harm.

Table 1.
Three interaction stages in family therapy

3 stages of interaction that are emphasized differently in various family therapy practices:		
Attachment	**Differentiation**	**Detachment**
Empathy, unconditional acceptance, emotional feedback	Communication change, clarification, reinterpretation	Dissociation, dissociability, historical interpretation
Proximity ability - Bonding -	*Ability to distinguish* - Differentiation -	*Ability to distance* - Autonomy -
Emphasis on commonality, Loyalty and harmony	Conflict ability and Assumption of differences	Emphasis on autonomy and boundary setting
above all humanistic orientation	especially: behavioral therapy, systemic oriented therapies	mainly short-term therapy, psychodynamic and analytical methods

4. Justice in the Treatment System

Justice in the treatment system is to be applied within the family therapy first of all to the circle of the participants and the question of the inclusion of relationship partners in the therapy. The decision about the inclusion of relatives in a therapy always deals with the question of the rights of the individual to achieve a treatment success of an individual kind or to achieve the change or improvement of a relationship system for himself, if necessary, also at the expense of the relationship partners or in coordination with them. Typical for this is the situation of today's individual therapy especially of analytic character, not to include parents or relatives at all. To the detriment of a positive, understanding relationship, they are not actively enabled to participate in the therapeutic clarification and change of relationship. As a rule, an analyst will not include partners or parents in individual therapy, but will recommend separate therapists for other family members if necessary. In behavioral therapy, too, the involvement of relatives is useful, appropriate to problem solving, effective in extending symptom success by stabilizing relationships.

Justice in the therapeutic system also means making the selection of people who seek family and couples therapy dependent on criteria that do not affect their dignity. Thus, poverty cannot be an ethically justifiable criterion for non-acceptance of clients, but a lack of fees for the therapists can be an individually justifiable criterion for non-acceptance (salus publica - salus privata). Here a new ethical question arises, especially for the field of preventive and curative family therapy, which arises in the overall social context as well as in the individual therapeutic encounter. Action by individual therapists even in the face of low remuneration or refraining from action due to economic constraints are everyday dilemmas that also resurface in the context of the health care system as the issue of budgeting and rationing. In the private sector setting of today's family therapy, which also involves illness, this ethical issue arises daily in the low availability of family therapists for suffering families alone.

Yet missing: A "Package Insert" of Family and Couple therapy

"For effects and side effects, ask your family therapist": Information about family therapy is analogous to information about medications. Since both are proven effective procedures, the same standards can be applied. A "package insert" can provide guidance for action and inaction between client and therapist.

- *Indication:* Which procedure will be useful and how?
- *Contraindication:* What speaks against the procedure?
- *Main effects:* What is the likely effect of the procedure?
- *Side effects:* What are the possible adverse effects?
- *Interaction:* Which simultaneous action is useful or detrimental?

Suggested Model of a Systematized, Outcome-based Family Therapy

The thesis is ventured that a differential family therapy based on effect and side effect studies with informed consent of the patients or family members can be the basis for a critical classification of actions and omissions in a general "Evidence-Based Family Therapy".

A cross-method view of family therapy indications yields advantages of various procedures. As *Grawe* notes, "the interpersonal perspective is ... far too important for psychotherapy to be left to *one* school of therapy " He urges research into family and couples therapy, which obviously works but is not substantiated on the basis of the evidence requirements that apply to medicine. Despite relatively lower effect representation the humanistic family therapy is effective in its approach, the eclectic family therapy, the behavior therapeutic, the psychodynamic and the systemic can prove in studies in the approach a positive effect on the therapy goals. The difference in effectiveness seems to be partly related to the theoretical approach, different target approaches, implicit outcome desires, and different operationalizability, not solely to actual differences in effectiveness. For the individual family, a selection from the available methods must be made that is indicated by the family's mission and the therapist.

The need for a clear indication, as described by *Bommert (*1990) and listed by *Shadish (*1997), becomes particularly clear in the case of disorders that were treated by family therapy without any demonstrable success. According to this, so far, no effect of family therapy can be secured in the studies examined by him in delinquency, on school performance, substance abuse, dealing with physical illnesses. According to *Shadish's* meta-analysis, couples therapy showed, for example, no significantly demonstrable effect on affective psychoses, physical illnesses and their coping, divorce problems, sexual disorders.

The systematization of a method-spreading family therapy was brought by *Peseschkian* 1980 and 1991 already in a quite comprehensive form. In a five-step procedure the advantages of the different methods are combined and applied in a sequential order for therapy, self-help and family therapy. The research situation on differential indications and side effects or interactions has not yet been explicitly considered. Implicitly, some of the dilemmas mentioned are taken into account by the step-by-step procedure and the inclusion of the individual and the involved reference persons:

Five stages of Positive Family Therapy according to *Peseschkian (2016):*

1. Observation, distancing: Empathy and emotional feedback as in humanistic methods is supplemented by early change of location and positive reinterpretations of problems At the same time, stimulation of early self-help by those involved counteracts dependence on therapists; the actions of family members are given priority at an early stage.
2. Inventory: *Grawes* clarification dimensions used systematically by inventorying the bonding and conflict abilities of the family members, their strong and their developmental areas, similar to behavioral therapy. Conflict level and relational ability are considered in parallel with the understanding level in the clarification phase: Primarily, the solution orientation is omitted.
3. Situational Encouragement: Family resources are verbalized and systematically used, increasingly independent of the therapist.
4. Verbalization: Conflicts are narrowed down and deliberated in the couple and family group. Autonomous individuation and group cohesion are promoted at the same time, conflict ability and solution strategies are developed. The family is the acting part, the therapist is still the moderator but refrains from active intervention.
5. Goal expansion: The goal development according to the original intentions gives the family and the individuals involved new motivation and perspectives. This phase is only prepared by the therapeutic side; the actors are family members.

The Five Steps apply to the initial interview with the family, the course of therapy, and self-help guidance for those involved.

The step to a Dynamic Family Therapy, whose differential indication of interventions is based on the evidence of previous studies and regular exchange of experience about unexplored areas, is not far from this systematics of *Peseschkian.* By Dynamic Family Therapy is meant here the consideration of sociodynamics and individual psychodynamics as well as the ability- and conflict-content-related use of procedures, which enables a dynamic and autonomous development of family systems.

An evidence-based or experience-based family therapy (EBF):

Self-determination in an informed consent treatment contract based on the following steps:

Data-based information on
already verified or still innovative action and possible, reasonably required or intended omission
and the possible consequences for all involved

Outcome-Based Family Therapy takes into account the autonomy of the family, partners, and individuals in the family and asks about goals of the individuals, the group, and outsiders. The possible negative consequences of an intervention are verbalized based on prior experience and research findings. This is contrasted with the goals and requirements that are achievable for the individuals, couples, and families. The quality of a treatment is defined by the participants in relation to their own requirements on the family and treatment side. Within the development of the therapy, the selection of treatment interventions is again based on the goals defined here. In the individual psychotherapy and in the couple and family therapy setting, the secondary consequences for the interpersonal relationships are to be mentioned. The concept of the "ecological frame", the harmlessness for the extended environment, accompanies family and couple therapy as an ethical issue.

The goal is differential family therapy based on efficacy and side effect studies with informed consent of the patients or family members. Through this, action and inaction are jointly deliberated by the therapists involved and family members present, similar to what happens before surgery. In contrast to the surgical procedure, in family and psychotherapy a continuity of informed consent and an explanation of possible consequences of the therapy is continuously possible.

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Section: Modern PPT practice

POSITIVE PSYCHOTHERAPY TO SUPPORT MEDICAL STUDENT EDUCATION

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Abstract

The purpose of this report is to report on the benefits of using the method of Nossrat Peseschkian, modified by Professor Ivanka Boncheva and applied by her students in a medical environment and especially in the training of medical students. More than ten years of experience working with medical students and applying the postulates of positive psychotherapy help to acquire skills and understand the difference between simply asking questions and getting answers and the skill of " therapeutic listening". Understanding transference and countertransference relationships. The concept of the psychosomatic arc is also used to explain the complex relationships between illness and emotion.

Keywords: positive psychotherapy, medical communication, psychosomatics

Introduction

Training students in medical psychology is challenging, especially in the modern medical environment, which increasingly adheres to a symptom-oriented model and shows little interest in the role of contact or causal analysis.

Michael Balint (1975) writes about his "medical man," which sounds archaic in today's increasingly mechanized and rigorously differentiated world of medicine. However, short medical-psychological courses, exercises and seminar lessons are the space in which the door is opened for future physicians to understand the role of personality in the process of connecting, communicating and establishing a therapeutic, that is, healing contact with the patient. Balint's contributions and approach have left a lasting impression on medicine because they have changed the way the physician sees himself and his work. Despite the awareness of the key role of personality and its abilities to empathically connect in the communicative process, there are too few scientific publications that examine the problems young physicians face in understanding and communicating with their patients. In one study, Boncheva concluded that the psychological barriers in the physician's behavior and communication with the patient are directly related to the attitude acquired since medical training. The emphasis is placed on better "contact" with the disease and not with the sick person, which is confirmed by the results of the study. The orientation towards "uncovering the morbid" and the patient's experience remain inaccessible to the physician despite the conscientious and respectful attitude (Boncheva, 2013). The role of communication in medical psychology is examined by Kozhuharov and Ivanova (2013), highlighting the fact that the medical profession is a "communicative" profession. As a profession with such a strong social element, it cannot be practiced without theoretical knowledge and practical communication skills. The relationships between

medical personnel and patients raise important issues in medical practice and medical deontology (Balkanska, 2010). The reason for this lies in the complex nature of human behavior and the need to analyze it in its psychological, interpersonal, and social essence. Technological means cannot take over the role of medical professionals who, through their daily communication, observation, and interaction, try to understand human behavior and experiences in health and illness. Therefore, medical care should include not only technical competence, but also the implementation of effective professional communication based on personal care for the person, expressed in terms of attention, sympathy, emotional warmth, respect and support. The success of the interview depends on the physician's ability to observe and understand what is happening between him and the patient during the interview, or in other words, to use the physician-patient relationship for an effective examination. A good doctor-patient relationship is critical to good practice.

Methodology

Methods of positive psychotherapy were used - the understanding of the stages of therapy and stages of contact, the method of the “three stages of interaction” (Peseschkian, 2020) and Conducting group interviews of students in the roles of patient and doctor. „Psychosomatic arc”. (Peseschkian H., Remmers, 2020)**.** The sample studied consists of second- and third-year students taking a compulsory course in "Medical Psychology" (N=108). Thanks to Professor Boncheva's project, we were able to obtain approval for the programme, which also includes the methods of positive psychotherapy (from the university's ethics committee). We tried to make the workshop craft unstructured, without rigid structure, adaptable to different groups of students, in the end it turned out, as in a psychotherapeutic context, with freedom of creativity and willingness to improvise, within the framework of positive psychotherapy. In summary, the training courses had the following structure.

2.1. Special features of professional communication "patient - doctor"

The patient in the role of communicator; the doctor – in the role of communicator

Dialogic conversation - an opportunity to participate in the therapeutic process. Specificity of the conditions for the application of a simple or complex dialogue.

The initial psychotherapeutic interview

The nature and characteristics of the classic clinical interview.

Preconditions and dynamics:

- Prerequisites: the three stages of interaction; the art of listening; empathy; the art of making oneself understood by the partner; trifocal approach (bio-psycho-social treatment of the illness).
- Dynamics: a five-stage model in the development of non-directive contact with the patient; from the image of the symptom to the experience of the illness (inner image of the illness); from the patient's personal resources to medical care; negotiation and support in coping.

Aim and tasks of the non-directive psychosomatic approach

- To understand the sufferer as a whole person rather than the illness.
- Establishing a therapeutic relationship (patient + doctor) to combat the illness.
- The therapeutic contact should be intensive and effective in a short period of time.

General conditions for the doctor's contact with the patient:

- Atmosphere of the conversation - temporal and spatial framework conditions

- non-verbal part of the conversation - posture, facial expressions, gestures, tone of voice, the psychological significance of pauses

Course of the primary therapeutic conversation with the patient

- Initial phase - freedom in presenting the patient (open questions); active listening (reflection); emotional support through empathy, empathetic understanding.
- Adaptation phase - thematization (extraction of the essentials); concretization (confrontation); multifaceted consideration (catalogue questions); analysis (summary).
- Closing phase – conclusion, discussion of perspectives, planning a new contact.

The diagnosis as feedback. Its psychological significance for the doctor and the patient.

Answering the patient's questions - the difficult questions.

Discussion

In medical-psychological training, emphasis is placed on the ability to create therapeutic communication. As Shipkovenski (2016) states, «A communication between a physician and a patient can be either therapeutic or iatrogenic»." That is, either salutary or harmful to the patient. Aspiring physicians who are taught to follow the instructions of standardized conversation are surprised to learn that there is another way to talk to and listen to the patient, to be empathetic, and to make oneself understood.

Under the training and supervision of Professor Boncheva (2013), we university assistants and specialists trained in positive psychotherapy prepared to present Peseschkian's ideas to people oriented to the natural sciences, which was a challenge. It was important for students to develop an understanding of the different levels of communication - that of content and that of attitude. We tentatively introduced the concepts of the unconscious, the hardest part was presenting and defending the point of view about the role of emotions in doctor-patient communication. Medical students, unfortunately, often hear from their teaching physicians that they should not show or care about feelings, that they should "cut corners," etc. An important point that Professor Boncheva brought to the training was that increasing sensitivity to what is common, the same, and significant to both parties in communication reduces the need to look for the difference. The most important of the rules for successful communication is successful listening, or as it is called in the psychotherapeutic lexicon, "therapeutic listening." It was also interesting to see the way in which the understanding of the three phases of interaction is presented (Peseschkian 2020), relating them to the periods in human life and the development of relationships between people, not only in a professional environment, which definitely helped the students to get the slightest interest, if not a full understanding of the value of contact, regardless of its factual content. In the seminar courses on nonverbal communication, the views developed by Remmers (Remmers 2023) on the role of emotional and physical synchronisation with the patient during a session, the transference and countertransference relationships, and the psychosomatic arc (Remmers, 2022) were useful.

Special attention is given to the interaction phases, especially the first one, which is the most difficult to understand by rational explanations. After a brief introduction and a description of each phase, students conduct sample conversations in the role of the doctor and the patient. It is noticeable that there is strong resistance to sitting in the "doctor's" chair, and the image of the "sick person" is overplayed and humor is included as a defensive reaction. The most difficult to deal with is the first phase of interaction. In 108 interviews conducted, in 98 cases it is omitted altogether, in the rest it is offered in an incomplete version, and in most cases sympathy is expressed instead of empathy. Students do much better with the "differentiation" phase, it is closer to what they are familiar with, but again, in 108 interviews, 75 are searching and focus only on somatic symptoms, contact anxiety, whether it is a personal problem or a psychological problem. There is also a lack of ability to analyze a somatic symptom and relate it to a psychological problem. The last phase of "detachment" is almost as difficult as the first phase of connection. Despite the previous discussion about the importance of feedback, 68 interviewers forget to give it and end the interview abruptly, the rest seek the support of the moderator and then manage to finish their interviews.

In the complex relationship between emotions and the occurrence of so-called psychosomatic diseases, the scheme with the psychosomatic arc plays an excellent role, optimizing an otherwise too complex and abstract process of psychosomatization and making it logical and easy to follow. Peseschkian's (2020) explanation of the entanglement of the whole organism with the neurophysiological, hormonal and nervous systems and the connection with emotional processes is vividly presented in the «psychosomatic arc» and students spontaneously share that for the first time they are able to see in a systematic and scientific way suggestions about things they previously only suspected. By learning about the systems that are in constant feedback with each other, students reflect on and share personal

experiences or observe in their vicinity symptoms noted by medicine, virtually with unexplained etiology.

If more medical psychology hours were included in the national medical curriculum, perhaps other methods of positive psychotherapy could be incorporated, such as self-awareness through „WIPPF", introduction to transcultural coping skills through the offering of patient images and stories. So far, despite the difficulties we encounter, we can state that the feedback from the students is positive (Students complete an anonymous survey in which they evaluate the training and provide recommendations for increasing their communication hours).

Many of them are looking for additional literature and express their interest in psychology and positive psychotherapy methods.

Conclusion

In conclusion, we can confirm the usefulness, applicability and comprehensibility of the methods of positive psychotherapy in the medical-psychological training of future physicians. Although the courses in "medical psychology" are too few to fully teach therapeutic skills, they have their function: to arouse interest in the process of communication, precisely in its value as a process and not only as a means to achieve medical goals.

In an easily understandable way, we try to teach the most difficult thing, which is the ability to listen to the patient and to make oneself understood to him.

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Section: Modern PPT practice

THE USE OF PROJECTIVE METHODS IN POSITIVE PSYCHOTHERAPY WHILE WORKING WITH CLIENTS WITH PSYCHOSOMATIC DISORDERS

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Abstract

This article discusses the use of projective methods (introduced by Lawrence K. Frank) while working with clients with psychosomatic disorders. In particular the use of the Positive and Transcultural Psychotherapy method (PPT) is presented. PPT provides tools to explore hidden aspects of the client's personality and conflicts, aiming to ensure a balanced therapeutic process. We will demonstrate great synergy achieved by combining projective methods with the five-step strategy, PPT and balance model.

Keywords: positive psychotherapy, psychosomatics, projective methods, balance model, metaphorical maps

Introduction

Positive and transcultural psychotherapy (PPT) is an approach aimed at achieving psychological well-being by integrating cultural factors and encouraging positive emotions. It recognizes the influence of culture on people's perceptions, values, and experiences and aims to promote therapeutic growth in diverse cultural settings. Ergo, it can be defined as a form of humanistic psychodynamic psychotherapy that is grounded in a positive perspective of human nature. "Humanistic psychodynamic psychotherapy" is an integrative therapeutic approach that combines elements of humanistic and psychodynamic theories.

Humanistic Psychology: This perspective emphasizes individual growth, self-actualization, and the inherent goodness in people. It focuses on the present moment and the person's subjective experience.

- Psychodynamic Theory: This theory, often associated with Sigmund Freud, explores the influence of unconscious thoughts and past experiences on present behavior. It delves into the role of the unconscious mind, defense mechanisms, and early childhood experiences.

The integration of these approaches in humanistic psychodynamic psychotherapy seeks to address both the immediate concerns of the individual (humanistic) and the underlying, often unconscious, factors influencing behavior (psychodynamic). The goal is to foster self-awareness, personal development, and a positive understanding of human nature. PPT is an integrative method that includes humanistic, systemic, and psychodynamic elements. It is also a transcultural approach that considers the cultural diversity and resources of clients.

Positive psychotherapy strives to help a person reveal his hidden potentials, develop his strengths and resources, and cope with difficulties and problems in life.

One of the powerful tools used in the PPT system is the use of projective techniques.

Projective psychotherapies are methods that are used to reveal hidden aspects of personality, based on the assumption that a person projects his internal conflicts, motives, feelings and attitudes onto vague or ambiguous external stimuli, revealing aspects of his personality that

may be hidden or suppressed. Projective techniques are psychotherapy methods that use ambiguous stimuli, such as pictures, words, stories, or drawings, to reveal the client's unconscious thoughts, feelings, and conflicts. Based on their results, the therapist interprets these reactions and helps the client understand and resolve them. Examples of projective techniques are the Thematic apperception test, Rosenzweig Picture Frustration Study (P-F test), Szondi test, House-Tree-Person (HTP) technique and others.

Projective psychotherapy techniques for various disorders can be used as part of positive psychotherapy to:

- Diagnose the causes and factors of anxiety, identify the type of anxiety disorder and its severity.
- Help the person become aware of unrealistic or irrational thoughts, beliefs and expectations that cause or maintain anxiety.
- Promote the development of positive thinking, self-esteem, and self-acceptance in an individual.

Projective methods are often used in combination with other psychotherapy techniques. They can be helpful for clients who are experiencing difficulties express their thoughts verbally, have high levels of resistance or defensiveness, or suffer from complex or chronic anxiety disorders.

One of the projective methods is metaphorical cards. They provide a creative and versatile means of expression, allowing therapists to engage clients in a deeper exploration of their thoughts, emotions, and cultural identities. In this article we will look at the meaning and benefits of metaphorical cards within the framework of positive transcultural psychotherapy when working with clients with psychosomatics.

Psychosomatic disorders represent a serious problem for the health and well-being of people, as they include physical symptoms caused by psychological factors. In such cases, psychotherapy can play an important role in alleviating symptoms and improving the quality of life of patients. One of the effective approaches in psychotherapy are projective techniques that allow one to explore unconscious processes and emotional conflicts.

There are several theories of psychosomatic disorders.

The main theory connects psychosomatics with heredity, which does not at all exclude other versions. The influence of the genes of ancestors, when stress affects a person, leads to malfunctions in the body in weakened organs and functions. When the human body is at rest, it is controlled by the parasympathetic nervous system. When there is any load on the body, the sympathetic nervous system is activated. During stress, an increased amount of cortisol and adrenaline hormones are released into the blood. The emotional tension that appears at the same time, if it does not find a way out, may have a negative effect on a patient’s nervous system. It manifests itself in many aspects: from changes in blood pressure and heart rate, to the level of metabolism and sexual functions. Also, it can lead to changes in body tissues, and even irreversible damage to organs. The autonomic nervous system responds to various emotional experiences in specific patterns. The choice of the affected organ is determined to a certain extent genetically (Golbidi, et al., 2015).

Crucial information for therapy includes details about hereditary chronic illnesses. Many of them may not manifest themselves throughout life, but under the influence of any events that cause stress and distress, they may manifest themselves in an unexpected way in the form of psychosomatic disorders. In addition, psychosomatics can aggravate existing diseases, such as stomach ulcers, hypertension, psoriasis, eczema, and heart disease (Jindal, & Jennings, 2010).

In addition, psychosomatic disorders often develop against the background of post-traumatic stress, for example, in people who have survived war or repression. Thus, after the end of the Second World War, British doctors drew attention to a serious outbreak of stomach ulcers among soldiers and officers. Further research showed that this epidemic was not connected with the diet of servicemen or smoking - its main cause was emotional upheavals associated with hostilities (Jackson, 2015).

People with the personality characteristic of alexithymia, that is, with difficulties in defining and describing their feelings, emotions and bodily sensations, are at risk of psychosomatics. Alexithymia can make a person with stress and suppressed emotions, capable of causing psychosomatic phenomena, consider himself completely healthy. Therefore, there are great

difficulties with such people in psychotherapeutic work.

Case

Client Inna S., 32 years old, a refugee from the war zone (Kherson, Ukraine). She complained about the instability of her emotional state, poor sleep, chronic headaches that often appear after serious emotional stress. During the survey, other external symptoms were revealed: atopic dermatitis, excess weight.

Before that, she had consulted specialists: a neurologist, a dermatologist, and an endocrinologist. All clinical studies did not reveal obvious pathologies or confirmed diseases corresponding to the symptoms. The attending physician recommended consultation with a psychologist and work with him, due to the presence of clear signs of a psychosomatic disorder.

According to her, the clear symptoms listed above appeared after leaving Ukraine at the very beginning of hostilities. She left alone; she has no close relatives. She lives only on help from the state, cannot find a job, rarely leaves her apartment. Even though she left for a favorable and safe country (Ireland), the physical symptoms manifested themselves more intensively. Externally, in her opinion, she had no serious grounds for concern.

At the observation stage, in the client's spontaneous stories, it was possible to identify the actual and basic conflicts, the engaged actual abilities, and how she relates to herself. Although the main complaints centered around physical discomfort and poor health, other collected information in addition to physical signs, indicated an internal conflict. "The linguistic material often contained concepts voiced by such phrases as: “I have to cope on my own”, “I’m ashamed to ask for help”, “I don’t admit that I’m not capable of (anything)”, “I go out of my way to achieve."

I decided to use projective techniques to explore the emotional and psychological factors associated with headaches and other symptoms.

She was asked to complete the Rosenzweig Frustration Test [9], skin disease and obesity questionnaires (Peseschkian, 2006: p. 254, p.13)], and rate her satisfaction with each area using the Balance Model.

The client's conflict processing took place in the body/senses sphere. This manifested itself not only in headaches, but also in skin problems. Abilities in the field of activity were practically blocked by self-doubt and self-pity. In the area of contacts, the client was influenced by ambivalent attitudes regarding communication. She had a need for communication and close relationships, but at the same time she was afraid to get close to people. In the realm of fantasy, she was dominated by negative attitudes and ideas. The client felt lonely and abandoned, worried that she would not be able to start a full-fledged family, that she would not marry for love, that she would never have her own home.

In the process of working with psychosomatic disorders, projective methods were mainly used: metaphorical cards, art therapy, fairy tale therapy.

One of these techniques was to invite Inna to draw her headache. Another was the technique of writing her own fairy tale. I asked the client to write a fairy tale that reflected her problem. We then analyzed the story together using symbols, metaphors, and cultural references. “Stories serve the function of expanding concepts and... opening doors for fantasy,” as Nossrat Peseschkian often emphasized (Peseschkian, 2016a).

Based on the fact that the main psychological cause of psychosomatic disorders is the suppression of emotions, it was necessary to identify these emotional blocks.

When describing images using the Rosenzweig test, it was noted that relatively neutral descriptions were accompanied by noticeable emotions and feelings. The overall reaction seemed externally accusatory. She attributed her troubles to external factors perceived as threats and obstacles to meeting her needs. A consistent tendency toward frustration was identified. Disruptive emotional states manifested as frequent and prolonged periods of unfavorable physical and mental well-being, which almost constantly colored various aspects of her life.

The questionnaire (Peseschkian, 2006: p.254, p.139) confirmed the information received at the observation stage about Inna’s deficiency of some of the most important abilities, such as trust, social connections and a sense of justice. Hyperbolic frugality stimulated self-restraint, both material and spiritual.

During the process of drawing a headache, working with metaphorical cards, and writing a fairy tale, Inna was able to express her emotions,

fantasies and conflicts through the images and metaphors of the cards and her own fairy tale. She described her sensations and feelings associated with physical problems. This made it possible to process the request at the verbalization stage and help the client realize that headaches, excess weight, and skin problems are a physical expression of her emotional problems and negative attitudes. In addition, it helped her open paths to new meanings and perspectives.

We went back to the "balance model" and I asked her to sketch out ways she could improve her balance. This method helped Inna to understand her needs, values, potential, and to achieve harmony and integration. Examining the client's complaints through the lens of psychosomatics helped clarify which current needs were unmet. These needs were identified as Trust and Justice.

My task was to teach the client effective ways to relieve anxiety, relaxation, and self-control, manage her emotional reactions, express feelings, discuss psychological difficulties with other people, make decisions, build personal boundaries, step over feelings of shame and guilt, and manage her childhood's automatic reactions and replace them with more mature ones.

Discussion

One way or another, disasters and crises are part of life, regardless of the cultural, natural, and social environment. Many people are exposed to the consequences of both social crises and persecution, armed conflicts and various types of disasters, and individual crises and losses. And even those "who survive such disasters are often left feeling helpless or depressed, wracked with guilt or anger, caught in a maelstrom of trauma" (Ayalon, 2007). And they need a huge resource to get out of this whirlpool of despair and helplessness. One of the effective tools in positive psychotherapy is projective methods that consider the cultural, social and ideological characteristics of patients.

From this point of view of cultural sensitivity and inclusiveness, the number 1 issue in today's psychotherapy and psychiatry is the concept of the human being, the system of his/her vision, since all other tasks and problems stem from this issue. In turn, this cardinal question relates to the image of the psychotherapist him/herself, as well as the corresponding features of the method he/she uses, representing a certain psychotherapeutic school or direction (Peseschkian, 2022).

Positive psychotherapy is primarily aimed not at eliminating certain violations (conflicts, disorders, problems), but first, at identifying and mobilizing the client's abilities and resources, revealing his potential for self-help. The positive approach is based on a positive vision of the person, a positive interpretation of the problem, a transcultural approach and the use of metaphors, legends, and parables in therapy.

Projective techniques are a valuable diagnostic and therapeutic tool in positive transcultural psychotherapy, providing clients with the opportunity to explore their emotions, cultural identity, and personal experiences. Additionally, they allow clients to express their thoughts, feelings, and perceptions through direct projection onto materials such as drawings, word associations, games, and shapes. By incorporating culturally sensitive imagery and promoting intercultural dialogue, these techniques promote deeper understanding between therapist and client and allow the patient to express and acknowledge emotions and internal conflicts, which contributes to psychological and physical recovery. In addition, the use of these techniques helps to increase resilience and positive emotions, empowering clients in their therapeutic journey. By integrating projective techniques into the practice of Positive and Transcultural Psychotherapy, therapists can increase the effectiveness and cultural responsiveness of their interventions, ultimately promoting the holistic well-being of people from diverse cultural backgrounds.

An example of a projective technique of psychotherapy for anxiety and somatoform disorders in the method of positive psychotherapy can be the "Tale of Oneself" technique, in which a person talks about him/herself in the form of a fairy tale. This allows him/her to express his/her emotions, experiences, desires, and fears in a safe and distanced manner. A psychotherapist analyzes the content of a fairy tale, identifies key symbols and motifs, and helps the person find positive solutions to his/her problems.

Researchers of psychosomatic disorders argue that at their core there is a blockage of emotional energy, which for various reasons cannot be realized through consciousness, and,

remaining in the unconscious part of the psyche, affects the functioning of the body. That is, almost all acquired diseases are an internal conflict manifested at the biological level or a kind of “failure in the mechanics of the body.” (Peseschkian, 2016b; Kirillov, 2020; Jindal & Jennings, 2010).

Therefore, the methods used in PPT, which stimulate a person to participate actively and creatively in life, to have meaning and purpose, and develop his/her interests and hobbies, are highly effective in the treatment of psychosomatic disorders.

Conclusions

Using the example of the case described in this article, we see how projective methods can be effectively used to help patients with psychosomatic disorders. These techniques allowed the exploration of emotional factors associated with physical symptoms. They helped our client to recognize and express her emotions, conflicts, and coping strategies, which contributed to her psycho-physiological recovery.

Psychosomatics cannot be cured by acting solely on the body. It is treated through a combination of psychotherapy to relieve stress and anxiety and treatment of physical symptoms.

Giving the term “positum” a broader meaning, Nossrat Peseschkian emphasized that the positive aspect of the disease is just as important for understanding and clinical treatment of the disease as the negative aspect. Therapy aims to mobilize existing abilities and potential for self-help and focuses on positive aspects of personalities of people involved, rather than simply viewing them as a collection of symptoms to be treated. Peseschkian believed that symptoms and disorders are reactions to conflict, and therapy is called "positive" because it takes the integrity of the individuals involved as a given (Kirillov, 2020). In PPT, disorders are viewed through a “positum” lens. Depression, for example, is seen as “the ability to respond to conflict with deep emotions”; fear of loneliness is seen as “the desire to be with other people”; alcoholism is reconceptualized as “the ability to provide oneself with warmth (and love) not received from others”; psychosis is seen as “the ability to live in two worlds at the same time”; and heart disorders are seen as “the ability to hold something very close to the heart” (Peseschkian, 2006).

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Section: Modern PPT practice

PERSPECTIVES OF APPLYING PRINCIPLES AND METHODS OF POSITIVE AND TRANSCULTURAL PSYCHOTHERAPY IN ORGANIZATIONS

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Abstract

The purpose of the article is to highlight the areas of business where positive psychotherapy can be applied in order to improve the business environment and to transform it into a more supportive, developing and less damaging area. The author's experience, which includes more than 20 years of international management, business training and psychotherapy practice, prompted the importance of taking care of mental health not only within psychotherapy, but also during people's everyday activities – in particular their work. The article can be useful for specialists working within organizations and for practitioners. This article can become a discussion point for formulating guides for further developing of the topic.

Keywords: occupational health, organizational psychology, professional environment, transcultural approach, positive psychotherapy

Introduction

This article is the outcome of personal reflections based on working experience as a manager, business trainer and psychologist over 20 years.

The importance of mental health is not disputed by anyone. Unfortunately, not everyone has the opportunity to attend psychotherapy, and even those who go to psychotherapy do it from time to time. But most people go to work every day. The company or organization in which a person works becomes for grown-ups the very environment with which they have to interact every day and which influences them radically. The way business had been managed for many decades led the whole society to vast layers of problems in the sphere of mental, physical and psychological health.

In June 2022 WHO published "World Mental Health Report" (World Health Organization, 2022a), which showed that work reinforces wider social problems that negatively impact mental health, including discrimination and inequality. Bullying and psychological violence are key components of workplace harassment that have a negative impact on mental health.

In September 2022 WHO and the International Labour Organization (ILO) published "WHO Guidelines on mental health at work" (World Health Organization, 2022b) and a derivative "WHO/ILO policy brief" (World Health Organization, 2022c) with recommended actions to address mental health risks such as heavy workloads, negative behavior and other factors that create stress at work. For the first time, WHO also recommended training for managers to improve their ability to prevent stressful work environments and respond to workers in distress.

In the article devoted to these publications the WHO cites the words of Guy Ryder, ILO Director-General "As people spend a large proportion of their lives in work – a safe and healthy working environment is critical. We need

to invest to build a culture of prevention around mental health at work, reshape the work environment to stop stigma and social exclusion, and ensure employees with mental health conditions feel protected and supported" (World Health Organization, 2022d).

The purpose of this article is to determine some concrete aspects of management where PPT can be applied in order to support organizational well-being.

If we take a chance to change business into a supporting and nurturing environment, we can serve to ensure the mental health of a large part of the population. As we know from Nossrat Peseschkian: "If You Want Something You Never Had, Then Do Something You Never Did". PPT has all the necessary instruments to make this process happen. In this article we will review some of them.

Methodology

Contemporary literature about psychological well-being addresses the issue of work in various aspects. The term "therapy" in relation to business is not widely used in professional literature. One of the researchers who uses it in his works is Dr. Ichak Adizes. He ruminates in his publications about a healthy organization and names the process of transforming the organization as a "systemic systematic process of organizational therapy". "A healthy organization is integrated externally and internally. It does not waste the fixed energy available. It is symbergetic, for which a culture of mutual trust and respect is needed and for that, common vision and values, correctly designed diversified organizational structure, a systemic disciplined decision-making process, and leaders that command and grant respect and trust are a must" (Adizes, 2016).

He also formulates the principles of organizational therapy:

Why: The aim is to bring the company to Prime, which means that the organization is flexible and in control. It copes proactively and efficiently with its changing environment.

How: The vehicle is participative change.

What: What you work on depends on the organization's stage on the lifecycle.

Who: The organizational therapist needs to form a team of people who together exercise authority, power, and influence on the subject worked on. Working as a team, those people have the authority to say both yes and no to the potential changes which the team will be making (Adizes, 1996).

Edgar Schein, a founder of organizational psychology, in his interview to "The Academy of Management Executive" (Schein, 2000) says "The paradox, or the thing I have the hardest time getting across in my process consultation workshops, is that we have the model pretty well worked through for dealing with an individual, but we have very few models for how to do stress reduction or therapy with groups and larger systems. We can sit down with individual executives and counsel them.

We sort of know how to do that. However, in dealing therapeutically with a larger system, an organization, because we use individual or small group models, we are surprised when we can only improve the functioning of the individual or the small team" (Schein, 2000).

It is really a very important aspect which we need to bear in mind when going into organizational therapy, that it must be effective at all levels: the individual, the small group, and the larger system. The PPT view is unique in its' openness to various tools, which can be easily integrated into the frame concept and applied to different types of interaction.

In one way or another, many business consultants refer to definitions which are not directly called psychotherapeutic but have a lot in common. Stephen R. Covey, known as one of the worldwide leading business consultants, in his book "The 7 Habits of Highly Effective People", first published in 1989, described the 7 habits of effectiveness which can be applied both for individuals and organizations. Covey also represents in his book a continuum of maturity. These are three stages of developing maturity: dependence, independence and interdependence. The author says that each of the first three habits is aimed to gaining independence, the next three habits are aimed to gaining interdependence, and the seventh habit is designed to help maintain the whole system (Covey, S., 2018). These notions definitely can be considered as related to developmental psychology.

What is remarkable is that the 4-th habit named "Think Win-Win" "…isn't about being nice, nor is it a quick-fix technique. It is a character-based code for human interaction and collaboration". It is to a great extend about trust as a basis for establishing relationships between people.

Moreover, his son, Stephen M. R. Covey, wrote a book "The SPEED of Trust: The One Thing That Changes Everything" (first published in 2006) in which he deepened the idea of the significant importance of trust. "There is no economy more profitable than the economy of trust". "Why trust? The simple, often overlooked fact is this: work gets done with and through people" (Covey, S. R. & Merrill, R., 2017). In PPT Trust is one of the primary capacities which is always in focus during the therapeutic process.

Though there are a lot of references to psychotherapeutic notions, in the business context we more often meet the term organizational well-being.

The organizational well-being approach appeared in the 70s in America and later came to Europe. Initially, these were programs aimed to attract employees to exercise - special offers for fitness clubs, but later this movement went beyond the gym and spread to other areas of life of employees and their families.

In the book "Positive Psychiatry, Psychotherapy and Psychology. Clinical Applications" Yuriy Kravchenko in chapter "Positive Psychotherapy in Organizational and Leadership Coaching", described the concepts and structure of positive psychotherapy (PPT after Peseschkian) and how they can be applied to organizations, leadership development, and executive coaching (Kravchenko, 2020).

In the same book Victoria Flynn and Erick Messias in the chapter "Professional Well-Being" write about professional burnout and chronic occupational stress and prove the value of Professional coaching (Flynn, V., Messias, E. 2020).

On the website of the WHO in the section "Occupational health" it is stated, that "Work-related stress can be caused by poor work organization (the way we design jobs and work systems, and the way we manage them), by poor work design (for example, lack of control over work processes), poor management, unsatisfactory working conditions and lack of support from colleagues and supervisors" (World Health Organization, 2020).

Today, companies are increasingly striving to create a holistic approach, rather than separate elements, aimed at improving employee's well-being. If we type into Google search "organizational psychology", it gives about 247 million results, "and organizational wellbeing 155 million. This proves great interest and current demand in developing a system which will give answers to the questions which the companies are facing today and provide tools to implement the changes.

Discussion

By the time I came to PPT, I had been working in business for about 15 years. Having psychological education, I looked at many business processes through the prism of the structure of the human psyche, and this view became especially relevant when I started conducting trainings and consultations for companies.

It was obvious that a significant part of the problems that people face in their professional activities are to some extend related to their inner world, to limitations that exist in the structure of their own psyche. But classical management consulting suggests solving these problems through methods recognized in the management science which makes it impossible.

If we look at the basis and principles of PPT in relation to the business environment, they acquire quite practical significance.

3.1. Transcultural approach

"Take any complex, potentially volatile problem—relationships in the Arab world, conflict between Serbs, Croats and Bosnians, corporate decisions, or relationships between management and executive levels in a multinational corporation—underneath any of them there are likely to be communication errors and cross-cultural misunderstandings, which prevents the problem from being resolved in a constructive way" (Schein, E.H., 1991).

National cultures are too different to be able to interact without problems. In the modern world, when it is impossible to avoid intercultural communication at all levels, anyone involved in transcultural communication should be interested in investigating cultural differences.

PPT is a culturally sensitive method. It means, that we are always questioning ourselves: what do we have in common and what is different between us?

In conducting soft skills trainings, I clearly saw that the lack of adaptation of management theories to the cultural peculiarities of the country where these theories are supposed to be applied, as well as to the characteristics of perception, interpretation and interaction with

the environment of specific people, makes these theories absolutely unworkable.

Let me give you an example: there is an instrument for setting goals SMART. SMART is an acronym that stands for Specific, Measurable, Achievable, Relevant, Time bound. The vast majority of managers in Russia have heard about this technology, they know it, but 95% do not use it in practice. I started asking why and found out that the participants do not remember the names of the elements of this technology, they have a feeling of general confusion and uncertainty whether they are using it correctly.

This is quite natural because this abbreviation is well understood by English-speaking managers -every letter and the word it stands for, has meaning to them, but there are no correlations for Russian managers, most of whom do not speak English well enough to grasp the idea. Here we definitely face the effect of the transcultural aspect of management.

When I proposed to transform this technology into a format 3+1 (1. What exactly? 2. When? 3. By what means? +1 Do I need to involve someone else?), the idea of what they need to focus on became clear for managers.

Yes, here we have lost the beauty of the form, but we have acquired a functioning instrument. In some cases, it is better to sacrifice form and gain practical benefits than not to use the instrument at all. At the same time, of course, it is important not to forget to adhere to ethical principles when telling where the idea is taken from.

3.2. PPT principles

1. **The principle of hope in PPT** implies that the therapist wants to assist his/her patients to understand and see the meaning and purpose of their disorder or conflict. Accordingly, the disorder will be reinterpreted in a “positive” way (positive interpretations) (WAPP, 2023). For example, sleep disturbance is the ability to be watchful and get by with little sleep. It is also that the change for the better can be achieved in any situation.

In relation to business, this principle can be viewed as a guideline for company management to regularly look for opportunities to improve existing procedures and working conditions and instead of criticizing problematic “symptoms”, to try to find a positive interpretation of the “problem”. Why did it appear and what purpose does it serve? What is the meaning of it?

2. **The principle of consultation** - if there is an uncertainty about the behavior of another person, it is worth going into a dialogue with him or her, and not interpreting his or her actions, guided only by one's own point of view. A huge number of conflicts occur due to the inability or unwillingness of employees to openly discuss the inevitable difficulties within the team, as well as between employees and management.

3. **The principle of balance** means to avoid extremes because any extreme becomes a source of conflict. Focusing exclusively on one side of doing business, for example, making a profit, to the detriment of comfortable working conditions or improving service for clients, can ultimately result in loss of reputation and destruction of the entire business.

The balance model presented in PPT implies that a person has four areas of life between which he/she distributes his/her vital energy (Goncharov, 2014; p. 21). In particular, a person’s life includes the following spheres:

- body/health,
- activity/achievements,
- contacts/relationships,
- meanings/future.

The sphere of the body/health includes everything related to the physical and emotional state, nutrition, rest, and physical activity of a person.

The sphere of activity/achievements includes professional implementation or what a person does most of the time (for example, for a woman raising children, taking care of them will be her field of activity).

The sphere of contacts/relationships includes relationships in the family, with friends and loved ones.

The sphere of meanings/future includes dreams, fantasies, values, and beliefs.

According to positive psychotherapy, one should strive for balance in all four areas in life - in other words, give equal attention to each of these areas.

But objectively, we often see that people in modern society devote the biggest part of their life-time to professional activities. Such an imbalance affects health, the quality of relationships with loved ones, the general mood and perception of life.

As was mentioned above, the sphere of achievements is one of four spheres of life, but if a person works in an organization, it means that he/she spends quite a lot of time inside the

system, which naturally regulates his/her life. According to the statistical report of the "Organization for economic co-operation and development", in 2022 people worked on average from 30.4 (Netherlands) to 47.5 (Colombia) hours per week (OECD.Stat, 2023). This is the period of time when a person's life is refracted through the prism of the structure in which (s)he is present. And here we can observe the following transformations. In the table below there are examples of these indicators.

Table 1.
Personal perspective at work

Personal perspective at work	
Body/ health	safety, sufficient salary, vacation, ergonomic workplace, suitable schedule, opportunity to eat healthy food
Activity/ achievements	recognition, ability to influence results, clear understanding of evaluation criteria, professional development
Contacts/ relationships	favorable climate in the team, the opportunity to openly build a dialogue with colleagues and management, timely feedback, well-established communication channels
Meaning/ future	awareness of the meaning of one's job, the ability to make plans for one's development, stability

Organization in its turn can also be considered and a system with similar spheres.

Table 2.
Organizational perspective

Organizational perspective	
Facilities, assets	maintenance of property, equipment and technological maps, organization of safety of staff and clients
Activity/achievements (business processes)	creation, development of products and services, performance assessment
Contacts/relationships	building relationships with employees, between employees, external agents
Meaning/future	mission, development plans

In each of these spheres actual conflicts can occur. "Actual conflict is the current conflictual (problematic) life situation which leads to emotional stress caused by mismatch of the expected and the observed" (Goncharov, 2014; p. 19). These conflicts can exist either separately within personal or organizational structure or be interrelated with each other.

3.3. Conflicts

In PPT, Conflict is a basic notion.

How do conflicts arise? Peseschkian describes two basic categories of causes leading to conflict: macrotrauma and microtrauma. Macrotraumas are significant life events such as job loss, bankruptcy, divorce, wedding, birth of a child, moving, loss of a loved one. [18] It is necessary to pay attention to the fact that in the series of macrotraumatic events there are both bad and good events.

The second category of events is microtrauma. Unlike macrotraumas, these events themselves do not cause significant harm, but with constant repetition, they gain cumulative effect and begin to have a traumatic impact. This could include an unclosed tube of toothpaste, disobedience of a child, or unpunctuality of a partner. We can clearly differentiate macrotrauma in time; microtrauma cannot be designated as an event; it rather looks like a regularly irritating factor or event.

In organizations both types of traumas can be observed. Here are some examples:

Table 3.
Personal perspective at work:
Micro- and Macrotraumas

Personal perspective at work	
Body/ health	Microtraumas: uncomfortable working place, noise, temperature, smell, slow internet, constantly broken printer Macrotraumas: injury in the workplace, relocation, financial crisis resulting in a reduction in wages
Activity/ achievements	Microtraumas: unclear or changing demands, management ignoring the employee's success Macrotraumas: sudden change of management (style)
Contacts/ relationships	Microtraumas: too formal communication, gossiping Macrotraumas: conflicts within the team of management
Meaning/ future	Microtraumas: misalignment between personal goals and organizational goals Macrotraumas: finding out that person's plans cannot be implemented

Table 4.
Organizational perspective:
Micro- and Macrotraumas

Organizational perspective	
Facilities, assets	Microtraumas: unreliable providers, unstable electricity supply, salary delays Macrotraumas: severe damage or destruction of assets, company relocation, pandemia
Activity/ achievements (business processes)	Microtraumas: too many long meetings Macrotraumas: strategic mistakes
Contacts/ relationships	Microtraumas: hiring employees from different cultures (transcultural aspect) Macrotraumas: corruption scandal
Meaning/ future	Microtraumas: an outdated mission that no one believes in Macrotraumas: changes in legislation, entering new markets

The lists can be continued. Any of these events can bring the company to increasing tension and actual conflicts.

In addition, we need to keep in mind that for different people and organizations, the same events can have different impacts depending on the context.

For those specialists who work within or with organizations (managers and consultants) it is highly important to be able to operationalize actual conflicts, which means to determine their localization, content and reaction to conflict (Goncharov, 2014; p. 26). Conflicts can develop in one of the spheres, while manifesting themselves in another. For example, a constantly breaking printer can make a co-worker angry and, as a result, he can speak harshly with colleagues. In fact, he has no actual conflict with his colleagues, but others may get the impression that he is in conflicting relationships with his colleagues.

Positive psychotherapy works with a model of four categories of conflicts: ***actual, key, basic*** and ***inner***.

Actual conflict refers to acute or chronic situations currently occurring. Thus, an actual conflict is a current problematic life situation that leads to emotional stress caused by a discrepancy between what is expected and what is observed. This discrepancy may be a macro- or micro-trauma, and the reaction to these conflicts can affect any of the four areas of life: body, achievements, contacts and meaning, cause different emotional, mental or psychosomatic manifestations.

Key conflict is the choice of the way of reacting to the existing conflict. The choice between the need to express one's own interests (openness/honesty) and thus remain in touch with oneself (congruence), and the need to not compromise one's self and thus remain in touch with others. (politeness/politeness).

Basic conflict is a concept, often a family one, that ceases to function due to the current conflicting life situation.

Inner conflict is an unconscious conflict of needs caused by the simultaneous existence of opposing or even mutually exclusive efforts, desires or ideals.

The business environment is one of the most conflict-filled areas of a human life. Any of the above conflicts can be found in an organization because every organization consists of people. People come to work and bring with them all

their inner processes and feelings, which influence the way they perform their tasks and how they interact with each other. In addition, there can be a conflict between family life and work life, between personal values and company values. The ability to manage this complex space is an essential skill for a modern leader. PPT provides instruments for identifying and dealing with different types of conflicts.

In western society, a number of companies have already turned towards organizing the life balance of their employees, allowing them to take their pets with them to the office, or regularly organizing family events for all employees, or providing the opportunity to exercise directly at the workplace. Such measures significantly increase the level of employee engagement, their loyalty and directly affect work results. After all, if a person enjoys what he/she does, then there is no question about his/her effectiveness.

PPT can be applied when forming a strategy for the development of business in general and employees in particular. If we take, for example, the process of forming an organization's personnel reserve, then it is based on a number of diagnostic procedures. The data obtained during these diagnostics are correlated with certain criteria that are key ones for a particular position and on this basis a decision regarding including the employee in the personnel reserve is made.

But often the assessed employee has an imbalance of required qualities: some are in deficit, while others, on the contrary, are presented in excess.

Further, an individual development plan for the employee is usually drawn up. But as practice shows, the tools that a business has are not enough to "grow" the deficient abilities.

3.4. Capacities

Capacities is a fundamental concept in positive psychotherapy, and I would like to dwell on it. There are basic and actual (primary and secondary) capacities. ***Basic capacities*** are the capacities to *love* and *know*. They are inborn and become the basis for the formation of primary and secondary actual capacities.

Actual Capacities

Content-wise, these psychologically real norms may be divided into two basic categories, which we call secondary and primary capacities.

The primary capacities develop from the capacity to love and are emotional in nature and are formed, mainly in interpersonal relationships, in which the relation to reference persons, especially the mother and father, plays an important role. The primary capacities encompass categories like *love (emotionality), modeling, patience, time, contact, sexuality, trust, confidence, hope, faith, doubt, certitude, and unity.* Primary capacities are learned by living example and represent cultural norms and rules of internal attitude towards oneself, people and the world.

The secondary capacities are an expression of the capacity to know, and rest upon the transmission of knowledge. They represent the achievement norms of the individual's social group and include *punctuality, cleanliness, orderliness, obedience, courtesy, honesty, faithfulness, justice, diligence/achievement, thrift, reliability, precision, and conscientiousness* (Peseschkian, N., 1987*)*.

In everyday descriptions and evaluations, and in partners' judgments of one another, the secondary capacities play a decisive role.

Secondary capacities are formed by learning and relate primarily to external behavior, those conditions by which one must live in order to be good, successful and accepted by others.

Actual capacities play a prominent role in our professional lives. Our modern civilization is based on typical manifestations of the actual capacities which guarantee its functional capability.

In business context both secondary and primary capacities are important for the successful operation of a company and for the creation of a healthy climate in the team. At the same time, the tools that business obtains are mostly aimed at developing secondary capacities. The problem is that there is no focus on bringing the employee's existing actual capacities, both primary and secondary, into balance and, as a result, there is no developed toolkit aimed at its implementation.

Returning to the business environment, I would like to note that the issue of people's current capacities and their compliance with the organization's requirements arises from the moment of recruitment and accompanies employees throughout the entire period of their work in the company. From the point of view of recruitment, we can say that the conflict between the requirements of the environment

(tasks, roles, positions in the company) and current employees' capacities is now emerging more and more often, since there are many positions that are at the intersection of certain knowledge and skills for which previous experience does not prepare people. Also, success in acquiring new capacities depends on many factors, including the personal experience of the person him/herself in the development of actual capacities.

In business, there is a need to evaluate an employee regularly, whether it is about taking a decision to hire, relocate the employee within the company, or dismissing him/her. In all of these, the employer needs methods that would allow the employee to be assessed as accurately and objectively as possible.

Fundamental assessment instruments, such as assessment center, include a large number of methods. But the methods themselves often focus on assessing either professional skills or psychophysiological characteristics. Assessment centers are developing scales for assessing the development of skills or qualities of employees, but again there is a "failure" in methods that would allow the organization to contribute to the development of those capacities, in particular, primary capacities that are in deficit.

3.5. Five-stage model

The five stages of positive psychotherapy represent a concept in which therapy and self-help are closely interrelated. This model is used to build a therapeutic process and consists of the following stages:

1st stage: Observation, distancing
2nd stage: Inventory
3rd stage: Situational encouragement
4th stage: Verbalization
5th stage: Expansion of goals

There are many situations in business where this model can also be successfully applied. For example, holding strategic sessions, planning sessions, meetings, providing feedback and others. What is important is that it requires very slight adaptation for business.

Here is an example of applying the Five-stage model for feedback developing talk.

Table 5.
Feedback developing talk

Feedback developing talk	
	Manager's actions
1st stage: Observation, distancing	At the beginning of the meeting, the manager asks the employee to tell in a detailed way about the completed/running task/project. At this stage, the employee offers his/her vision of what happened, describes the logic of his/her thoughts, ideas that arose during the performance of a particular task. The manager's task is to provide space for the presentation of the event. The main tool of a manager is active listening. Only after the employee completes his/her narration does the manager move on to the second stage.
2nd stage: Inventory	The manager asks clarifying questions which will allow him/her to understand the situation more accurately. While clarifying the details, it is important for the manager to identify successful solutions and the strengths that the employee used to fulfill the task.
3rd stage: Situational encouragement	At this stage, the manager gives feedback with information about the employee's strengths, what he/she did well and highlights the resources that the employee can rely on in this situation and in future work. The manager can also use positive interpretation techniques. For example, an employee complains about a lack of time, which may indicate his/her desire to do much more than he/she physically can in order to achieve better results.
4th stage: Verbalization	The verbalization stage presupposes putting forward hypotheses and discussing them. Hypotheses are put forward both by the manager and the employee.
5th stage: Expansion of goals	At the fifth stage further plans and actions are determined.

Conclusions

The concept of well-being requires a systematic and step-by-step approach. HR specialists become the ones responsible for its realization but they don't have clearly formed

track. PPT fundamentals allow the creation of an integrated, well-being approach, instead of a series of unrelated programs. Applying the principles and methods of PPT in business will bring tangible benefits both to the organizations themselves and to the specific people who work in them, thus making the whole society healthier.

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Section: PPT cases

THE MEANING AND ROLE OF THE BODY IN ADOLESCENTS WITH EATING DISORDERS: A DESCRIPTION OF THE MEANING OF THE SYMPTOM

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Abstract

The article describes the understanding of the function of the symptom of eating disorders in adolescents from the perspective of positive psychotherapy. The work of understanding the symptom is based on the work with 15-year-old adolescents in the Khmelnytsky Regional Medical Center for Mental Health. It is observed that the symptom is based on the need to control one's own emotions and experiences and such control is exercised through the body, namely, through eating behavior. It is described that when dealing with this symptom at the behavioral level, it is important to develop coping mechanisms using the balance model.Our findings on the eating disorder symptom indicate that it is important in the psychotherapeutic process to understand the symptom and how it plays a role in the life of the individual. This understanding contributes to a deeper vision of the client and his or her problem, and also influences psychotherapeutic interventions. At the same time, understanding the symptom is important for the client's internal work.

Keywords: adolescents, eating disorders, positive psychotherapy

Introduction

Adolescence is often accompanied by many changes which occur at all levels: physiological, intellectual, social, and spiritual and thus are very difficult for a person. In such a difficult period of life, adolescents are very vulnerable and many adults around them do not take into account the difficulties that the child faces. The child himself or herself simply does not have the experience to resolve the crisis. A teenager is just beginning to learn ways to solve life's difficulties and to form and rely on his/her own resources and capabilities. One of the most common problems is eating disorders. In particular, Mitchison, D. and colleagues note that from eating disorders (EDs) affecting 21.0%–36.9% of adolescents, access to the necessary specialized treatment is extremely low (Hammerle et al., 2016; Micali et al., 2015; Mitchison et al., 2019), primarily due to a lack of detection and referral (Mitchison, 2023).

In positive psychotherapy, the problem of anorexia nervosa is described by V. Ivanova, who described the impact of family dynamics on adolescents with anorexia nervosa (Ivanova, 2021); N. Shelest and L. Wojciechowska described how overeating affects the balance of life (Shelest, Voytsekhoska, 2015). Also, in the book PPT, Chekmarov M. in the section on Eating Disorder describes that this disorder belongs to psychosomatic disorders and the leading conflict

area is often in contacts. Despite the existing research, the problematic issue is underdeveloped in the field of PPT, and given the above, the purpose of this article is to describe the understanding of the function of the ED symptoms (Chekmarev, 2020).

During the experience of psychological practice with adolescents suffering from ED in 2022-2023 at the Khmelnytsky Regional Medical Center for Mental Health, we came to a certain understanding of the symptoms and how to work with them. The work was conducted with female adolescents aged 12-17. They had diagnosed anorexia nervosa and bulimia nervosa.In this case study, we plan to share our own views on the problem through about ED's of adolescents

Case

Cllient S., 15 years old. She came looking for help on her own initiative because she had lost too much weight and was referred to me by her psychiatrist. During the examination, the client was diagnosed with anorexia nervosa.

The client has been raised by her mother only, as her father died a few years ago. The child is very diligent and responsible, she studies a lot. She has a rather small social circle, good relations with her mother, but cannot share her feelings because her mother is constantly tired. During the first diagnostic interview, she said that she had been wanting to lose weight for about six months and wanted to achieve good results to be better. At that time, the client was already underweight and had no menstrual cycle. The client has good analytical skills for her age and therefore realized that this path was more harmful, but she could not cope on her own.

In our work, we began to study the symptom and became interested in what function it performs, as well as what internal conflict is going on inside this girl.

For a better understanding of the problematic issue, we propose to consider the modern classification of disorders. According to ICD-11 - feeding and Eating Disorders involve abnormal eating or feeding behaviours that are not explained by another health condition and are not developmentally appropriate or culturally sanctioned. Feeding disorders involve behavioural disturbances that are not related to body weight and shape concerns, such as eating of non-edible substances or voluntary regurgitation of foods. Eating disorders involve abnormal eating behaviour and preoccupation with food as well as prominent body weight and shape concerns.

Feeding and Eating Disorders diagnoses should not be used to classify low-level concerns related to eating or behaviours that are common or culturally sanctioned (ICD-11, 2022).

The method of positive psychotherapy considers human problems as a given, which is factual, because the meaning of positum is present. In a conflict, we can see an opportunity and a certain sense of why a person does what he or she does. This is an integral part of the psychotherapeutic process of the method - to see a healthy area that can be relied upon.

In positive psychotherapy, a conflict or crisis is analyzed according to the Balance Model (BM). The model includes four spheres of life:

- Body (physical sphere);
- Activities (material sphere;
- Contacts (social sphere);
- Fantasies/dreams (spiritual sphere);

In this case, the use of the BM served as an auxiliary diagnostic tool and at the same time helped the client to expand her vision of her own problem.

According to the method, people resolve their own crises by addressing them in the area where they arise. Or they can escape to other areas to avoid the internal tension that is felt in connection with their experiences. But then the conflict is not resolved and this can lead to negative consequences in life. The balance model presented by N. Pezeshkian is depicted in the form of a rhombus for better clarity when analyzing the problematic issue. Each symptom has a specific function for a person. The psychotherapist must see and rely on the understanding of the symptom as a guide that points to deeper problems.

As a result of cooperation and the formation of a conflict and resource map, it was noticed that regardless of stressors and crises in life, adolescents try to compensate by bringing out their own okayness through the body. Often, adolescent girls come to the ED because they are unable to cope with their experiences using other strategies.

In this experience, adolescents try to control their emotions first and foremost, they try to control themselves, but this is not always possible due to their lack of experience. During our work, we often observe situations in which

the mothers of such children cannot control their own emotions and are unable to containerize the emotions of their children. In this case, such a mother-child relationship creates additional pressure on the adolescent, as the emotions of the parents are added to their own situations in life.

That is why we need to ask clients about resources and what helps them solve problems in their lives. In this work, we first focused on maintaining and expanding support methods and also on the desire to be better not only through the body. The distancing stage in dealing with such symptoms acted to help increase motivation for change and support for one's own strength. After 20 sessions with this girl, we were able to restore her weight to normal and help her expand her vision of life, while working with her continues. We were able to stabilize the client and only now we were able to move on to working through the deep feelings that this girl was experiencing.

Discussion

In the course of the work, a hypothesis was put forward that ED can serve as a way of responding to internal experiences. The body is one, and often the only, object in adolescents' lives that they can influence. It is through changing the shape and weight of the body that they can achieve:

First, it gives a sense of control in their own lives, which helps to fight anxiety, which is a very common phenomenon in people's lives. In the language of PPT, they can decompensate their own experiences through a certain area;

Secondly, by influencing life through the body, they will receive approval from others and themselves that they have changed for the better. In the language of PPT, they satisfy their own emotional needs for self-worth and acceptance.

Symptom functions exist to help a person cope with experiences, but this is not a way to solve the problem, and that is why over time the symptom begins to harm and leads to mental disorders. In his work What does our body tell us in therapy? A. Remers describes the importance of emotions and their impact on the body and mental health. And with this in mind, how this relationship manifests itself in the psychotherapeutic process [5].The above understanding of the symptom leads to the Conclusionsthat when working with adolescents at the behavioral level, it is advisable to use options for expanding ways to cope with stress. That is, mastering more coping strategies using the balance model. Such work has the following features:

- It helps to reduce the intensity of experiences;
- Develops self-help and self-regulation skills in adolescents;
- Gives the opportunity to gain strength to move forward in the therapeutic process.
- At the same time, such work helps to master the skills of reflection and perception of emotions as informants that help to understand what the person is hurt about and needs.

An article by K. Ovcharek is useful when working with this symptom. The author describes exercises for regulating one's own emotions through the body, relying on body-oriented psychotherapy (Ovcharek, 2017).

Each area of the balance model should be used in the work on expanding ways to overcome stress and regulate emotions. Each possibility of working with emotions should be analyzed, talked through and practiced separately in sessions, for example:

- Working with the body: breathing, relaxation, physical activity, taking care of basic needs;
- Working with the field of activity: skills and abilities, disciplines that are used in education;
- Working with contacts: people who can help to cope with emotions through communication, games, joint activities;
- Working with the sphere of dreams and fantasies: hobbies, video content (movies, anime, TV series), where the adolescents can release emotions and make dreams to strive for. At the same time, the characters can be examples of how to solve problems.

Conclusion

Our findings on the eating disorder symptoms indicate that it is important in the psychotherapeutic process to understand the symptoms and how they play a role in the life of the individual. This understanding contributes to a deeper vision of the client and his or her problem and also influences psychotherapeutic interventions. At the same time, understanding

the symptom is important for the client's internal work.

We see prospects for further research in the in-depth study of eating disorders and the use of positive psychotherapy with people suffering from these disorders.

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Section: PPT cases

THE FUNCTIONALITY OF THE BALANCE MODEL, ONE OF THE POSITIVE PSYCHOTHERAPY INVENTORIES, ON PANIC DISORDER IN THE CONTEXT OF A CASE

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Abstract

The aim of this study is to examine the functionality of the balance model, one of the inventories in positive psychotherapy, in treating panic disorder, and the positive developments it adds to the individual's life, in the context of a case study. In the study, conducted with a 27-year-old female patient diagnosed with panic disorder, it was observed that the balance model provided the individual with insight, and helped her learn to establish a connection between problems and symptoms by recognizing the underlying problems and avoiding individuals who caused her difficulties. Over time, it created balance in her daily life and contributed positively to her development.

Keywords: positive psychotherapy, the balance model, panic attack, panic disorder

Introduction

Positive psychotherapy, which has a humanistic philosophy, is a dynamic approach. While it works to solve individual's conflict, it also aims at focusing on an individual's strengths. Eventually it intends to teach people to be their own therapist.

The balance model, a key concept in Positive psychotherapy, describes a healthy individual. It focuses on the balance of four areas of life: body, responsibilities, relationships and fantasy.

Panic Disorder characterized by unexpected panic attacks that occur repeatedly.

Panic Disorder, which is seen frequently, causes distortions of functionality in an individual's social and vocational life. With pharmacological treatment, it is aimed to adjust physio pathological processes that cause the illness, to eliminate the biological activities underlying the disease, to solve the corrupted functionality in panic disorder and the treatment is continued with psychosocial support.

This study investigates the functionality of the balance model of positive psychotherapy when used with panic disorder and the ensuing positive developments that improve the individual's life. A. L., a 27-year-old female patient had been diagnosed with panic disorder which caused distortions in the flow of her daily life.

This woman started therapy using the tools of positive psychotherapy. It is understood that the balance model gives the individual insight to recognize the underlying problems and preferred escape mechanisms and helps him/her to learn how to establish the connection between problems and symptoms, also, how to create a balance over time in daily life.

Methodology

2.1. Positive Psychotherapy

Positive Psychotherapy is a method of treatment which was developed in Germany by

neurology and psychiatry expert Nossrat Peseschkian and his colleagues beginning in 1968. Positive Psychotherapy, which has a humanistic philosophy and roots in the psychodynamic approach, also cares about one's cultural habitat. Positive psychotherapy views a person as a whole and also emphasizes the person's culture; it focuses on the individual's strengths in the resolution of conflicts. It was designed ultimately to teach the person to become his/her own therapist (Peseschkian: 2002, and Peseschkian 2016, 2020).

Positive Psychotherapy is a mirror of an idea among cultural differences. The word 'Positive' has its origin in the Latin word "Positum", with meanings of "reality, something is factual and determined." This " factual and determination" refers much more to the capability of finding new, and maybe better solutions to problems, which every single person is capable of, than to the lack of development in an area which has not been acquired because of sickness or other problems (Peseschkian: 2002, 2016, 2020).

Positive Psychotherapy describes the person as healthy if he/she can deal with his emotional and physical problems acceptably. Positive Psychotherapy intends to make one's strengths more effective and reminds one even from the beginning of therapy that he/she has strong sides as well. In Positive Psychotherapy, a patient cannot be identified only by his/her symptoms. It defends the idea that the patient also has talents and capabilities. Positive Psychotherapy says that symptoms only trick us into not seeing our current problem clearly. No matter what these symptoms are, they are just elements for us to cope with. But despite making us escape from problems, these symptoms can also be useful for us. Thus, we should seek to find the reasons behind the symptoms and what the symptoms are trying to achieve, instead of directly eliminating them (Peseschkian: 2002, 2016, 2020).

Positive psychotherapy is based on three principles: Hope, Balance and Counselling. The principle of hope expresses the desire to help a person understand the meaning and purpose of their conflict. The principle of hope gives the individual the belief that they can solve his problems with their own abilities. People have primary and secondary abilities. There are certain abilities. These real abilities constitute the individual's capacities to love and know. The capacity to love constitutes the individual's primary abilities, and the capacity to know constitutes the secondary capabilities. Primary abilities are emotional abilities and include love, patience, time, contact, trust, hope, belief, doubt, certainty, while secondary skills are considered as unity, they are also behavioral skills and are considered as order, punctuality, cleanliness, courtesy, justice, straightforwardness, frugality, obedience/harmony, ambition/success, reliability. Consultancy means that individuals are in contact with the individuals around them in the process of solving problems, Positive psychotherapy attaches great importance to real abilities and according to positive psychotherapy; to assess the patient's capacity with areas of conflict; to help the patient; created an inventory from a list of real talents. This inventory is used as the Differentiation Analysis Inventory. (Peseschkian; 2002, 2016, 2020)

Finally, the principle of balance is; defining the healthy individual in positive psychotherapy; It focuses on balance in four areas: body area, work-success-responsibility area, social contact area and spiritual, fantasy area. (Peseschkian; 2002, 2016, 2020)

Positive Psychotherapy has a five-phased therapy framework. These five stages include; various tools and inventories are placed in an orderly manner.

1) Observation and Setting Distance, involves gathering information about the patient's life story and the formation of symptoms.
2) For example, stories can be used, and positive comments can be made.
3) Inventory; by using inventories in this process, one wonders how they learned to cope with the micro traumas they experienced in the last 5 years (what happened to you and your family?).
4) Situational Encouragement, the focus is on strengthening individual qualities corresponding to those considered negative. The therapist explores which aspects the individual has resolved and what they have learned from their problems.
5) Verbalization, unspoken issues can be addressed, and the therapist helps the individual identify what they want to resolve.
6) In the Expansion of Goals phase; now the

patient can learn not to carry their conflicts to different areas, and can learn new goals that they had not thought of before. The patient is expected to learn how to help themselves.

Positive psychotherapy; With these five stages, works in different areas such as marital conflicts, psychosomatic conditions, individual problems and psychopathology (Peseschkian: 2002, 2016, 2020).

Balance Model, Real Abilities, Life Events, Micro traumas, Positive Interpretation, Stories, Sayings, Transcultural Issues, Model Dimensions, 5-Step Process and Three Steps of Interaction are the basic techniques of Positive Psychotherapy. As additional techniques there are; Family slogans, Situational Control, Psychovampire, Psychoserum, Genogram, Will, Letter to the Organ, Questions to the Symptom (Peseschkian: 2002, 2016, 2020)

Positive Psychotherapy maintains that dwelling exclusively on one's problem or illness causes regression while examining one's talents and capabilities promotes progression. The end result of this therapy is to teach the patient self-help. With this therapy, the patient learns how to be a therapist for him/herself and to help those close to him/her (Peseschkian: 2002, 2016, 2020).

Balance Model

Positive psychotherapy focuses on solute genesis which means how health is created, and explains this situation on the balance model. According to the balance model, four areas are very important in our lives: body, success, social contact and spirituality. It aims to review each of these one by one in the patient's life. It gives us important information about the patient's life. At the same time, the questions we ask about each area cause the patient to wonder and realize. Concretely, the individual realizes how he/she spends his/her life and how he/she spends his /her energy.

Body Area; the first of these domains is the body area. The relationship between the individual and his/her body is also very important for his/her spiritual life. How many hours do you sleep a day, do you do sports, do you take your medication regularly? With questions such as sleep patterns, eating habits, physical health, sports, personal care, and sexual life, information is obtained from the client.

Work / Achievement Area; another area is the success area. How long does the client's work life take or, in order to understand the work tempo of the individual, it can be asked how an ordinary day passes. How long do you work? Are you efficient at work? Does you consider yourself successful? What are your responsibilities outside of work?

Contact/ Relationship Area; another area in the balance model is the contact area. Our social relationships are at the forefront here. The contact area has two sides. One is our family and the other is our relationships. (If married, couple relationships are emphasized, if single, family and close relationships are emphasized). Do you live alone? How many siblings do you have? What is the age range between you and your siblings? How often do you see your mother and father? How often do you see your family members? How much time do you spend with friends? Do you have long-term friendships? Do you have a romantic/close relationship? Do you spend time with him/her? Detailed information about the individual's relationships can be obtained with those questions.

Future/ Meaning Area: another area is fantasy area, spiritual area; it is all about our inner world. Do you like to make plans and do you like to dream? Are these aims realistic aims? What is going through your mind when you are alone? Do you get anxious thoughts too? Do you like to spend time on your own? What do you think about social media? What is important for you in the life? For example, when you are 70 years old, what must have happened in your life to be able to say that you had lived the most beautiful life? With the Individual's answers to the questions, we can learn about their expectations for the future.

Balance model; all our time, if we have 100 units of energy in our lives, it mentions about being able to distribute 100 units as 25 units in these 4 areas. In the balance section, the individual gains awareness of his/her own life and aims are determined on the areas that need support and development and the studies are continued. The determined aims are followed up in subsequent sessions contribute the healthy development of the individual through awareness and action (Peseschkian: 2002, 2016, 2020).

1.1. Panic Disorder

Panic disorder is a kind of illness that happens frequently and which can make it hard for a

person to do well in their social and work life (Tükel, 2000). Generally, Panic Disorder is described as a mental problem where a person has sudden and repeated moments of intense fear, known as panic attacks. The main thing in this disorder is the Panic Attack, so first, we look at the signs of a panic attack. Even though a panic attack itself is not a mental disorder, it is something you can see in many mental problems grouped under anxiety disorders, with Panic Disorder being the main one. According to DSM-V-TR, a Panic Attack is when you feel really scared and uncomfortable, and you have at least four of thirteen signs, both in your thoughts and in your body. These thirteen signs include a fast heartbeat, sweating, shaking, feeling like you cannot breathe, chest pain or discomfort, feeling sick or having a stomachache, feeling dizzy, not being able to feel parts of your body, self-alienation, being afraid of losing control, and being afraid of dying. Even though these attacks are short, they can be at their worst for about 10 minutes (APA 2013).

Epidemiology of the Panic Disorder

It is seen that Panic Disorder, which is a common disease, has increased especially on the life style and the prevalence rates compiled within last ten years. If we assume that it includes not only Panic disorder, but also Panic Attacks, Certain-Limit Panic Attacks and Agoraphobia, which isn't even associated with Panic Attack, the results increase observably. As an addition, at least 1/3 people having Panic Disorder suffer from Agoraphobia. (Tükel, 2000)

Epidemiologic searches also show us that with %1,5-%3 chance on Panic Attack and with %2-%4 chance on Panic Disorder, they keep occurring occasionally throughout life. (Kaplan & Sadock 2004) Also, it tends to occur generally men than women. All the same time, it can be seen some problems associated with anxiety in the childhood stories of people suffering from Panic Disorder (Köroğlu & Güleç 2007, Tükel 2000).

Panic Disorder's possibility of occurrence is less likely to be seen on the married people than single people while it is more likely to be seen on the people living in city than in rural (Tükel, 2000).

Determinants of the Panic Disorder

General Opinion and Behavior

Until Panic Attack occurs, any distortion can't be seen in the patient's appearance; yet during the Panic Attack, patient can easily be seen immensely anxious and fussy.

Speaking and Relationship Building

Until Panic Attack occurs, any distortion can't be seen in the patient's speaking and relationship process; but while the Panic Attack happening, distortions and flickers can start in patient's voice and speaking because of immense fear. The more clinic symptoms rise, the more harder communicating for patient it gets, patient may even choose to avoid communicating (Öztürk O. Uluşahn A. 2011).

Affect

During Panic Attack, not only premature fear seizures take effect emotions; but also, it can be seen anxiety and arousals. After the Panic Attack, patient fears of having a panic attack once more and this fear comes with dread of death, losing control and going crazy, which all are determinants of Panic Attack. Even slightly, these fears can be seen after the Panic Attack. Fearing of Panic Attack to repeat, anticipatory anxiety may happen on the patient.

Cognitive Abilities

Patients have not any distortions on the cognitive abilities except Panic Attack; yet during the Panic Attack, situations feeling like not recognizing people around or feeling like having a perception disorder can be observed. Also, alienation to oneself or unreadiness may be seen (Öztürk O. Uluşahin A. 2011).

Thought Process and its Content

On the patient, it cannot be observed any distortions about thought process and its content but Panic Attack; yet an intense anticipatory anxiety may be seen.

Physical and Physiological Symptoms

Other eleven symptoms occurring during Panic Attack, apart from dread of death and dread of going crazy, are physiological and associated with autonomous nervous system. A lot of physiological symptoms such as Palpitation, Sweating, Trembling, Ache or Tightness feeling on the chest, having urine often, increase in the blood pressure may be observed.

Departure and Ending in the Panic Disorder

In Panic Disorder, which is a chronic disorder, there are individual differences. In one- or two-year observations, Panic Disorder generally shows positive progress while showing generally negative results in long period observations (Tükel, 2000).

Some indicators of negative progresses in Panic Disorder recovery are Low Socioeconomic Level, Finding Recovery Methods Late, Intensify of the Phobic Avoidance, Found of Comorbidities, Being Female and Continually Negative Family Behavior (Öztürk, Uluşahin, 2011).

Development and Departure

Like occurring in the childhood period, it is also not common for Panic Disorder to occur after the age forty-five. In the US, starting of Panic Disorder range is around twenty and twenty-four. If it isn't cured, disorder keeps occurring continuously with exacerbations and appeasements. On some individuals, Panic Disorder occurs periodic after long years of appeasements while it comes back with severe symptoms on other individuals. At the same time, it can be seen long appeasements without any relapses on a very little group of people. Panic Disorder may get worse with other anxiety disorders or comorbidities (APA, 2013).

Factors Determining the Occurrence Possibility and Ending of the Disease

In contrast to the fact that insufficient of our knowledge about whether there are any factors that may cause the start of the Panic Disorder, we can make a prediction about what happens before their occurrence. Tendency to believe the negative emotions coming from the birth; tendency to believe that anxiety symptoms are malicious, dread seizures seen in the childhood period are believed to play an important role at the start of the Panic Disorder. As not being certain, these foresights, severe anxiety of leaving, which happened in the childhood, may be shown as an important role of the development of the Panic Disorder (APA, 2013).

When we tackle the effective environmental factors of ending and possibility of occurrence of the Panic Disorder; we generally see physical and sexual exploitation. Smoking is also detrimental for Panic Disorder and its start. At the same time, on individuals, a difficult situation to handle is frequently seen before the start of the Panic Attack and Panic Disorder.

Pharmacological Treatment on the Panic Disorder

With the Pharmacological Treatment, it is aimed to cure physiological periods causing to occurrence, to clear the biological tendency hidden beneath the disease and to resolve the distorted functionality (Alkın, 2002).

Generally, within a few weeks after the start of the treatment, it is advised to start using a medicine by doctor approve; yet, because Panic Disorder is a long period disease, it is important to choose a drug which effects after a few week or a month, also it should be easily tolerable. With these, it is also important to tackle comorbidities (Köroğlu & Güleç 2007).

Psychosocial Treatments on the Panic Disorder

Psychodynamic Psychotherapies

With the Psychodynamic Therapies of the Panic Disorder (PDT), it is aimed to explain anxiety's and distortions', which are associated with Panic Disorder, unconscious reasons. This process includes establishing transfer relation and expressing, accepting one self's repressed anger. According to the PDT, if individual knows and expresses one self's emotions, this makes anxiety, comes up as Panic Disorder, disappear (Köroğlu & Güle. 2007).

Also, according to the PDT, there are relational reasons in the fundamental of the psychopathology and because of this PDT has an undeniable effect in the recovery of the anxiety disorders (Kaya 2020).

First psychodynamic rating of the individual having got PB starts with the comprehensive psychiatric rating. Therapist asks questions about not only where and when the problems happened but also the story of the first Panic Attack. Eventual goal of the PDT is to decrease and cut off the individual's anxiety. Therapist's goal, in the PDT, is to comprehend individual's unconscious conflicts, and to cooperate to alter the conflicts after this. PDT technique also aims to rate and decrease the anxiety level in other issues such as anger associated with the Panic Attacks and sexuality too (Kaya 2020).

1.2. Cognitive Behaviorist Therapies

CBT technique is known for its utility in the treatments of all anxiety disorders including common anxiety. With the PDT technique; we aim to alter individual's false beliefs and stereotypes about the expected possible harm and its results, in sight of the clear cognitive and behaviorist ways. In the first step of the treatment of the Panic Disorder used CBT, it is aimed to remove the arousal symptom with the breath and relaxation exercises. After that, treatment continues with making the individuals realize their suffering from Panic Disorder,

noticed about distortions which may lead to change one self's unfunctional stereotypes (Bingöl 2020, Kaya 2020).

In CBT, it is told to the individuals about the Panic Attacks' nature and loop with psycho-education. Also, to change this loop, exposure technique is used frequently (Köroğlu 2015). According to the Durna; the exposure techniques used in the treatments resemble exposure of the individual to physical sensations, which has both role in the start and development period of the disease (Durna, 2016).

1.3. Positive Psychotherapy and Panic Disorder Treatment

Positive psychotherapy is about understanding why a symptom happens in panic disorder. It is about accepting the symptom and trying to understand it. We use specific questions to figure out when the first panic attack happened, when they usually happen, if there are times when they do not happen, and if there are times when they happen more or less. We also ask what would happen if they did not happen at all. In positive psychotherapy, we focus on a person's potential and how they deal with things. We use the information to find out what might be causing the problem from a psychological point of view. While looking at a personal background, we also try to bring out things they are good at but might not know about. We show that they are good at dealing with things and we respect that. During panic disorder, we help people find ways to deal with problems and learn new skills. We might also teach them about panic attacks. We use surveys to help them understand what is going on, and we work with them to find solutions to the problems. The balance model, especially, helps people see problems and things they avoid in their lives, and with the help we give, they can start doing things differently.

Functionality of balance model and positive psychotherapy in panic disorder

Panic disorder symptoms can cause the individual avoidance in the areas of physical, success, relationships and spirituality. Panic disorder; It may cause the individual avoidance and disruption in all four areas; It seems to be an inventory in which the individual with panic disorder can see the avoidances concretely and experience the changes concretely. While the balance model considers the body area of the individual, it also focuses on diet patterns and sleeping patterns. For example; Excessive caffeine consumption – more than 250 mg / more than 3 glasses per day – triggers the rise of anxiety. This information is given to the patient during the psychoeducation period; we can also obtain information about the patient's coffee consumption during the balance model process. In this case, the patient himself will associate coffee consumption in his daily life. In this case, from the perspective of the determinants of panic disorder; the individual excessively goes through the area of fantasy to avoid from daily actions and relationships, as well as the avoidances in the field of success, the patient should take actions as much as he can, the balance model can also provide positive developments during the process

Case

Patient/client description

A. L., 27-year-old female, graduated from university. She is a sales manager in a shop. She lives with her father, mother and brother. She is engaged and she is planning to get married soon.

Sometime after she came home after work, she complained of numbness in her body, dizziness and severe chest pain, and presented to the emergency department of the hospital fearing that she was having a heart attack and would die. When she was first evaluated at the hospital, she was observed to be agitated, very anxious, shaking and crying. In the emergency department, she was evaluated for acute myocardial infarction and no findings were found. Although A. L. was informed that the laboratory and follow-up results were normal, the psychiatry unit was requested for a consultation due to the suspicion that there might be a psychiatric condition since the patient did not feel well, requested different tests because she continued to worry and cry.

During the psychiatry interviews, she stated that for the last 2 months, she had been experiencing abdominal pain or sometimes dizziness accompanied by sweating, feeling as if she could hear the sound of the heart beats from the outside, fever, fainting and chest pain, which she could not fully express, which she interpreted as internal distress. She stated that she experienced such conditions suddenly and for no reason; she felt relieved within 15-20 minutes; but this time she was also afraid that she would die.

In the psychiatric evaluation, the patient was started to be followed up with positive psychotherapy support in addition to pharmacological treatment in order to reduce the existing symptoms.

Case History

A. L. expressed that she has a brother, her father was a construction worker and her mother was a kitchen worker at the restaurant then. She grew up in a family which had always arguments, fights and financial problems. And also, she indicated that tense family atmosphere that she was in increased in pandemic conditions more. Not to receive their salary or receive it less as 3 people in the family, the uncertainty of the process makes her think the problems more especially at night and her insomnia and waking up frequently during the night were indicated. It was observed that she was worried intensely and fussy in the examination of mental state. She indicated that she lived a scary about death or living the same situation like she had lived. Case was evaluated as cooperative and compatible at the meetings. A. L indicated that there was no problem until that time, especially until the pandemic period her sleep period was regular and enough. She expressed about her excretory system that she had had a chronic constipation since she had been in primary school. She indicated that she had excessive consumption of coffee and cigarette. Case; she expressed that she did not want to go outside anymore, had difficulty eating, had a nausea constantly. It was not observed any problems on her personal care. It was observed a mood which was slow and tired in her body movements. It was seen no problem in her general appearance. It was not observed any disorder in her speaking and building a relationship, but it was observed that she had tremor in her voice. The patient stated that she had intense sweating, tremors, feeling of pain in the chest, rapid heartbeat, fainting, nausea, and that there was no alcohol or drug addiction.

Description of Work

This study's goal is to detect whether balance model, a sub-branch of Positive Psychotherapy, can be effective on treatment of panic disorder or not, on a real example. Due to this, patient's panic disorder symptoms and clinical appearance are examined meticulously.

Panic Disorder is a characterized disorder because of Panic Attacks which occur continually and unexpectedly. It can be relative but generally Panic Attacks reach their peak point within 10 minutes and they also create dread and personal issues. Being iterator and more than one and unexpectable Panic Attacks; means they can occur without any specific reasons. Unable to breathe, palpitation, ache feeling on chest, faint, being unable to stand, dizziness and similar symptoms can be counted as complaints of Panic Disorder (APA 2013, Çölkesen,2004). In accordance with this given information, it is discovered that patient sought for medical help because of numb feeling on body, dizziness, serious chest ache and so feeling like she is getting a heart attack thus she will die. Also, it is detected that she has exposed sweating, trembling, feeling like she can hear her own heartbeat with bare ear, fever, feeling like she will faint, nausea, ache on chest, dread of death and anticipatory anxiety problems which all come with sudden stomach ache or dizziness, for the last 2 months.

Panic Disorder, appears frequently, is seen as prevalence increases in last ten years' life and year statics. Panic Disorder occurs on 15-24 age range people. Panic Disorder decrease by person's age, actually it is encountered over 65 years old people. It is quite rare to experience Panic Attack at young ages, and also it is not very common for it to occur over 45 years old people. In PD, a chronic disorder, it is normal to have personal differences.

In sight of epidemiological information, patient is a female and 27 years old. When we decided to learn whether it is genetic or not, we detected that patient's aunt has also PD. And her father is an alcoholic. It is possible that intensive fears, separation anxiety because of her parents' conflict and physical exploitation were happened in her childhood to be effective about PD's evolution. It is also evaluated within PD that symptoms started to occur in the pandemic when it was difficult to deal with problems both in economical and spiritual way.

Actual Outcome

There is no drug addiction or any laboratory findings that could explain these symptoms, and there are not any physical health problems. She scored 21 on the anxiety rating scale of Hamilton. This score showed that the case also had moderate level of anxiety. The case meets the diagnostic criteria of Panic Disorder according to DSM-V criteria in terms of symptom amount,

duration and differential diagnosis. There was no abnormality in the laboratory findings of the case. The treatment process was continued with pharmacological treatment and psychotherapy

The patient concluded the therapy sessions in the 40th session because she moved to another city. During the sessions; Significant changes were observed in the patient's life. With usage of the balance model, the patient took actions to reduce his avoidance in line with his own wishes and needs. In line with the four areas of life being affected by each other, improvements in one area are reflected in other areas over time, and the patient shapes his life through the balance model with his own awareness.

Discussion

The aim of this study is to examine Panic Disorder through a case. In this context, a general view to the epidemiology, causes, diagnosis, and treatment of Panic Disorder is provided in the case. The case fulfills the criteria for diagnosing Panic Disorder as per the DSM-V criteria, considering the number of symptoms, duration, and differential diagnosis. In the case presented, after getting home from work, the person felt numbness in her body, dizziness, and complained of severe chest pain, which led her to think she might be having a heart attack and might die. So, she decided to go to the hospital's emergency room. Even though her lab tests and results were normal, the patient still didn't feel well. She asked for more tests and continued to feel anxious and cry. She met at least four of the 13 symptoms of a panic attack according to the DSM-V criteria. During the psychiatric interview, it came out that these attacks had been going on for the past two months, but she was initially seen as mere discomfort. The sudden onset of these attacks, her calming down in 15-20 minutes, and the ability to distract herself all pointed to a Panic Disorder diagnosis in this case.

Experiencing fits of fear during childhood can suggest future Panic attacks and Panic Disorder, although it is not certain. Also, a history of severe separation anxiety in childhood might indicate the development of Panic Disorder (APA, 2013). When considering environmental factors that could play a role in the beginning and progression of Panic Disorder, a history of childhood sexual and physical abuse is often seen, as well as smoking. Additionally, individual often experiences a major life event she struggles to cope with in the months before the onset of Panic Disorder or Panic attacks (APA, 2013). With this information in mind, it appears that the intense childhood fears the patient went through, the physical abuse due to her father's alcoholism and violence towards her and her mother and the mother's frequent departures, along with the early responsibilities the patient had to take on, looking after siblings and doing household tasks, as well as the physical abuse she experienced during childhood, combined with the onset of symptoms during the pandemic, a challenging period, all suggest the diagnosis of Panic Disorder when considering the beginning and progression of the illness. Panic Disorder is a chronic and frequently seen illness that can disrupt a person's social and work life (Tükel, 2000). With this information, during the psychiatric interview, the patient's hesitation to go to work, reluctance to leave home, and not wanting to be alone, along with problems in their social and work life, all point to the possibility that Panic Disorder may be behind these disruptions.

Positive Psychotherapy

A patient's process;

In these therapies which have been made with a panic disorder patient with Positive Psychotherapy method, five step treatments has been used and the patient has been watched carefully.

1) Observation and conversation

Patient's life has been listened and positive comments have been pronounced. A mini psycho-education has been taught about his current and special situation.

2) Treatment

At the inventory stage, the "story of voyager" has been shared with patient. Micro traumas were talked with the client. Her ability to cope with those micro traumas was evaluated. It was focused on the experiences of the last five years. Changement analysis inventory had been implemented and balance model method was used.

The patient who has been exposed with balance model expressed that she had had difficulty at eating, always had nausea and wanted to stay at her home. She clearly said that she drank too much coffee, smokes too much, avoided to take a shower because of death dread and did not want to see anyone anymore. She underlined that she went his work for just necessity, always thought about her current and

obscure situation, focused on her future.

These results were given to us when we had asked her about how she feels while being exposed by the Balance Method.

Body: she did not to want to take a shower, avoided from doing activities like sports or jogging, she consumed too much coffee or tea, she had smoking addiction and she was reluctant to eat.

Work/Achievement: she stated that she has no responsibility at home; going to work was an obligation and also having difficulties in that period because of the obligation.

Contact/Relationship: due to the pandemic lockdown, she diminished meeting with people and she stated that she did not want to see anyone including her boyfriend.

Future/Meaning: Constantly anxious opinions about the future enable her to read book so she tried to the relaxation techniques like yoga and meditation but not to be able to complete them.

She wanted to have some homework like jogging, reducing the consumption of coffee and reducing the smoking or a kind of sport.

3) Situational Encourage

When we reach to the situational encouragement stage, during the sessions, she tried to make a sense of the situation she was in. During those sessions she was asking too many questions and she avoided expressing her feelings.

After the psychoeducation about Panic Attack, a reliable relationship was established.

In this stage while considering the balance model again, the change occurred as in the table.

Body: during the sessions, sleeping and eating patterns were settled down. She has begun to do personal care. She has started doing yoga. She has also tried to understand what her body tells her when she is ill.

Work/achievement: She has started to go to work more eagerly and taken responsibilities of her own and her daily routine household chores.

Contact/ Relationship: She has gained awareness on the subject of relationship needs and necessities. She has started to attain recreational Activision with her friends. She has started to contact, and tried to manage a strong relationship and created a clear communication with her boyfriend.

Future/Meaning: She has limited the mobile phone usage duration. She has diminished the negative thoughts. She has gained a more positive point of view for the future. She has mentioned that with the help of positive changes and awareness, she has had the reliance on the process.

4) Verbalization.

Patient has expressed a thought of hers about making new changings in order to create a balance in her life radically. Furthermore, it has been evaluated what kind of subjects that would be dealt with.

The client's constant financial problems and a problematic relationship between her father and mother, her responsibilities of her brother since her childhood have leaded her to feel incomplete, insufficient and loneliness.

During the pandemic lockdown, with the occurrence of more financial problems and the expenses of marriage, the client's financial problems became harsh. In the sessions, while gaining the awareness she expressed herself more comfortable and comparing the old experiences with nowadays and making sense of those experiences and realizing the source of the anxiety make the client feel independent.

5)Expanding Goals

When the patient had reached to this step perfectly, she was asked to rate her feelings one more time. All her feeling-rate numbers were stabilized at 25. The client informed that she was going to go on the therapies with a therapist who would work on positive psychotherapy in her new city. Moreover, she emphasized that she would deal with the relationship in marriage. In the context of positive psychotherapy, although the function of the symptom is focused on, the client may face some new problems when she comes across with new but harsh situations in her life so the study should go on with the new situations.

Conclusions

In conclusion, this case is based on the symptoms of panic disorder, the clinical picture of panic disorder has been studied in details. At the same time, the treatment of panic disorder has progressed together with pharmacology and positive psychotherapy. The effects of the balance model, one of the inventories of positive psychotherapy, on the individual's life were monitored. In this study, in addition to positive psychotherapy practices, the balance model, one of the inventories of positive psychotherapy found to be effective in providing insight to the individual, recognizing the underlying problems and avoidance of individuals, and learning to

establish a connection between problems and symptoms. In addition to the positive psychotherapy practices with the help of balance model, it has been observed that the client's spiritual energy, previous experiences and the dynamic conflicts create an awareness on the effects of the client's illness. In the client's daily life, the balance model gradually has affected to create a balance and created a positive effect on the course of the disease.

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Section: PPT cases

СОПРОВОЖДЕНИЕ КЛИЕНТА В ПРОЖИВАНИИ УТРАТЫ С ОПОРОЙ НА ПРИНЦИПЫ И ЦЕННОСТИ ПОЗИТИВНОЙ ПСИХОТЕРАПИИ. СЛУЧАЙ ИЗ ПРАКТИКИ

ACCOMPANYING THE CLIENT IN BEREAVEMENT BASED ON THE PRINCIPLES AND VALUES OF POSITIVE PSYCHOTHERAPY. CASE STUDY

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Аннотация

В статье рассматривается использование инструментов позитивной психотерапии в сопровождении клиента в проживании утраты, изучается влияние кризиса горя на Актуальные способности, изменение модели баланса и определение терапевтической тактики для ведения клиента, отслеживается динамика терапии.

Ключевые слова: утрата, кризис горя, позитивная психотерапия, актуальные способности, модель баланса

Abstract

This article examines the use of positive psychotherapy tools in accompanying a client in bereavement, exploring the impact of the grief crisis on Actual Abilities, changing the balance model and determining therapeutic tactics for managing the client, and tracking the dynamics of therapy.

Keywords: bereavement, grief crisis, positive psychotherapy, actual capacities, balance model

Вступление

Кейс

Клиентка А. (23 года) обратилась за психологической помощью после внезапной смерти мужа от острой сердечной недостаточности около 3 недель назад. В момент обращения «А» испытывала фоновую тревогу с приступами страха и печали, приступы гнева, снижение концентрации, которая вызывала проблемы в деятельности: повседневной и профессиональной. По словам клиентки, она осознала факт смерти мужа, находясь на похоронах, однако постоянно чувствует его присутствие, часто видит его во снах, ощущает его прикосновения, обращается к нему мысленно в минуты острой печали и как будто бы

получает его поддержку – ей становится легче. От работы с психотерапевтом А. ожидала облегчения своего состояния, которое выражалось бы в снижении уровня тревожности, восстановлении работоспособности, улучшении общего эмоционального фона.

Учитывая жизненные обстоятельства (утрату), которые привели к возникновению симптомов у клиентки, можно сделать вывод, что она находится в процессе горевания.

Методология:

В. Волкан и Э. Зинтл в своей книге «Жизнь после утраты. Психология горевания» выделяют две стадии горевания: кризис горя и работа горя (Волкан & Зинтл, 2007). Кризис горя начинается с момента утраты и продолжается до принятия факта утраты. За время проживания этой стадии человек проходит через этапы отрицания, расщепления, тревоги, гнева. Когда же, в итоге, он приходит к осознанию и принятию неотвратимости потери, кризис горя завершается и начинается работа горя – период осмысления отношений с умершим и смягчения тяжести перенесённой утраты.

Симптомы, описанные клиенткой, указывают на ее нахождение на стадии «Кризис горя». Прямого (вербального) отрицания факта смерти своего мужа клиентка не проявляла. Однако отмечала симптомы расщепления. Волкан определяет его как особый вид отрицания, при котором объект утраты (в данном случае умерший муж) как будто бы незримо присутствует рядом, и, ощущая это присутствие, горюющий испытывает облегчение. Среди симптомов расщепления: «присутствие» мужа за спиной во время приёма душа, ощущение его дыхания рядом на кровати, в лифте, а также в эпизодах со «знаками» в виде облака, закрывшего солнце в момент, когда А. мысленно обращалась к нему с каким-то вопросом. Или собаки определенной породы, которая сорвалась с поводка в парке и подбежала к А., когда та также воспроизводила в памяти беседу с мужем в этом же парке на важную для нее тему. По ее словам, любое такое «посещение» приносило ей облегчение и временное успокоение.

Уговоры – еще один этап, характерный для кризиса горя. По своему содержанию похож на «торг», описанный в классификации Э. Кюблер-Росс (Кюблер-Росс, 2021). Клиентка мысленно возвращается в день смерти мужа и задает себе вопрос: «А могла ли я что-то сделать, чтобы это предотвратить?». Так, клиентка фантазирует о том, что могла бы прийти домой раньше или позвать мужа в этот вечер куда-то сходить вместе, чтобы оказаться рядом и спасти его. В эти минуты она испытывает приступы невротической вины, наделяя себя ответственностью за произошедшее.

Гнев стал также значительной частью эмоциональной жизни клиентки. Часто, думая о муже и ведя с ним воображаемый диалог, А., неожиданно для себя самой, вдруг начинает злиться на него, обвинять в том, что он не уделял должное внимание своему самочувствию, умер, и, по сути, «бросил» ее. Также у нее случаются вспышки сильного гнева по отношению к близким. Так, подруга, которая переехала к ней, чтобы поддержать в тяжёлый период, вызывает у нее приступы крайнего раздражения: не какими-то своими действиями или словами, а просто тем, что она находится рядом. Злость и раздражение вызывают любые попытки родственников или друзей успокоить фразами типа «Всё будет хорошо», рассказы знакомых женщин о своих партнёрских отношениях. Приступы гнева сменяются печалью и ощущением безысходности и иногда чувством вины.

Тревога сопровождает клиентку, в основном, на работе. В течение дня она вспоминает близких родственников, друзей, свою кошку, и тревога перерастает в страх, что они все тоже могут умереть, а ее в этот момент не будет рядом, чтобы их спасти.

Отдельное внимание В. Волкан уделяет сновидениям во время кризиса горя (Волкан & Зинтл, 2019). Сюжетные линии этих сновидений отражают конфликт, связанный с принятием смерти. В случае с клиенткой это, преимущественно, отрицание. А. видит сны, изображающие счастливые картинки их с мужем совместной жизни. После пробуждения клиентка испытывает расщепление – ощущает присутствие мужа, его поддержку, заботу о её душевном спокойствии.

2.1. Влияние кризиса горя на актуальные способности

Во время кризиса горя фрустрируются **первичные способности** (Peseschkian, 1987).

Контакт. Сама утрата человека и есть завершение контакта с ним.

Доверие. Горюющий рассчитывал на продолжение отношений и теперь чувствует себя покинутым и обманутым.

Любовь. Утрачен человек, который давал любовь и который мог принять любовь.

Вера. Если Бог есть, как он может допустить такое?!

Уверенность. Достаточно ли я хороший, если со мной случилось такое? Достаточно ли я сильный, чтобы справиться сейчас со своей жизнью?

Сексуальность. снижение либидо, притуплённое ощущение удовольствия или его отсутствие от того, что раньше его доставляло.

Надежда. Боль от утраты никогда не утихнет. Я больше никогда не смогу быть счастливым.

Степень выраженности отдельных **вторичных способностей** в этот период также может отличаться от привычной.

К примеру, у клиентки, по ее словам, возникли трудности с заботой о чистоте *(*она стала реже делать уборку), снизились точность (стала значительно медленнее выполнять привычный объём работы) и пунктуальность (стала чаще опаздывать). Также, в силу участившихся приступов агрессии, клиентка стала чаще проявлять открытость.

2.2. Влияние кризиса горя на модель баланса

Модель баланса (Пезешкиан, 2002; Кириллов, 2019) в период кризиса горя также претерпевает изменения.

В сфере **тела**. Клиентка отмечает участившиеся головные боли, боли в мышцах, нарушения сна, реакции со стороны сердечно-сосудистой системы (тахикардия, ощущения «замирания» сердца), отсутствие аппетита, которое чередуется с его резким повышением, набор веса, нарушения сна (долгое засыпание, прерывистый сон или слишком длительный сон, невозможность проснуться). Сильные эмоциональные реакции (печаль, агрессия), которые проявляются в теле через плач или крик. Эпизоды апатии.

В сфере **деятельности**. Снижение работоспособности, уменьшение объёма работы и количества рабочего времени, отсутствие интереса к профессиональной деятельности, пренебрежение бытовой деятельностью

В сфере **контактов**. Одиночество, отсутствие желания общаться с близкими, стремление к уединению.

В сфере **смыслов**. Крушение планов на будущее, непонимание, как строить жизнь дальше, склонность к мистификации, желание курить и пить алкоголь.

2.3. Применение принципов и инструментов позитивной психотерапии (ППТ)

Главная задача терапии на данном этапе – сопровождать клиентку в «нормальном» проживании кризиса горя, что необходимо для осуществления перехода на стадию «работы горя». Отметим, что понятие «нормы» или «нормальности» в данном контексте не предполагает каких-то рамок или чёткой структуры, последовательности возникновения эмоций или состояний, а также строгих временных рамок скорби, что противоречило бы ценностям гуманистического подхода в психотерапии. Используя термин «нормальный», Волкан подразумевает неосложнённое горевание, при котором у человека открыт доступ к эмоциям, позволяющим ему проживать стадии гнева, отрицания, расщепления, тревоги. И на момент обращения состояние клиентки соответствовало данному статусу.

В первичном терапевтическом плане – поддержка клиента в остром состоянии с постепенной его стабилизацией, поиск и обеспечение в терапевтическом пространстве ресурсов для проживания периода кризиса горя, отслеживание динамики состояния модели баланса и вторичных актуальных способностей (АС). При этом в терапии следует придерживаться принципов позитивной психотерапии (ППТ): консультации, баланса и надежды (Кириллов, 2019)

Поскольку у клиентки фрустрированы большинство первичных АС, особенно важно устроить терапевтическое пространство таким образом, чтобы не спровоцировать усугубления их фрустрации.

2.4. Работа с первичными актуальными способностями (АС)

Контакт. Установление стабильного сеттинга как гарантия терапевтического контакта с обеспечением клиентке приоритета в выборе времени (в рамках рабочего дня терапевта). Предоставление возможности на запрос внеплановой сессии (в случае резкого и стабильного ухудшения состояния).

Клиентка была мотивирована к работе с психологом и смогла выдерживать сеттинг, не отменяя и не перенося сессии. На 6-й встрече она сообщила, что ждет каждого нового сеанса психотерапии, а в течение недели записывает инсайты и вопросы, которые хотела бы задать психотерапевту.

Принятие. Безоценочное взаимодействие, недопущение критики, контроля и прямых указаний. В терапевтическом пространстве клиентке позволяются любые эмоциональные реакции. Большое внимание уделяется обсуждению ее эмоциональных реакций в отношении других людей и легализация этих эмоций. Так, клиентка разрешает себе злиться и проявлять открытость для того, чтобы защитить границы: сообщает подруге, что дальше хочет жить одна и благодарит ее за помощь. Просит родственников не задавать ей вопросов, которые ей неприятны, не ходит на семейные встречи, если не чувствует сил и желания. Не поддерживает разговоры на темы, которые в настоящий момент являются для нее болезненными. А. позволяет себе печалиться, плакать, не пытаясь бороться с чувствами или игнорировать их. В дни, когда печаль становится слишком интенсивной, снижает количество рабочих часов для того, чтобы уделить время и место проживанию этой эмоции. В контактах определяет несколько человек, способных обеспечить атмосферу принятия, и придерживается взаимодействия с ними. Может попросить о помощи, если это необходимо. Клиентка принимает свою уязвимость и большую часть своих проявлений.

Доверие. Наблюдается рост по мере развития терапевтических отношений. Так, через 2 месяца клиентка озвучивает во время сессии истинную причину смерти мужа (однократное случайное употребление ПАВ в избыточной дозировке). Через три месяца сообщает, что начала знакомиться с мужчинами в социальных сетях. Оба эти факта она тщательно скрывает от окружающих, так как испытывает стыд, связанный со страхом осуждения. Смерть мужа могут стигматизировать, а ее подвергнуть критике, так как клиентка уверена в том, что окружающие ожидают от нее скорби и стремления к уединению, а не поведения, направленного на расширение круга общения. Доверие в терапевтических отношениях позволяет работать с темой стыда. В результате клиентка определяет, что смерть мужа – это несчастный случай, который мог произойти с любым человеком, а ее стремление к контакту – это один из способов утолить эмоциональный голод, возникший после понесенной утраты. После этого А. продвигается в сторону принятия утраты: разбирает вещи мужа в съемной квартире, откуда она съехала сразу после трагедии, отдает другу мобильный телефон мужа, отказавшись от идеи изучить его содержимое. Женщина идёт на баскетбольный матч с участием команды, в которой играл муж, и после матча дарит его форменную майку одному из игроков – на память. На протяжении всего этого времени А. продолжает испытывать приступы печали, но не такие продолжительные, как раньше.

Сексуальность. Значительное внимание уделяется исследованию отношений клиентки с телом, разделяя связь телесных удовольствий, получаемых в отношениях с мужем, и тех, что были доступны ей самой. В процессе терапии к клиентке постепенно возвращается способность получать удовольствие: от еды (А. проявляет избирательность в еде, стараясь употреблять то, что считала вкусным раньше и отмечает, что уровень наслаждения вкусом повысился); от тактильных ощущений (массаж, ванна, уходовые процедуры); от секса (через 4 месяца у клиентки появился постоянный половой партнёр).

Надежда. В работе с темой надежды роль терапевта часто сводится к интерпретациям проявлений клиентки, указывающих на рост данной АС: «Похоже, это про надежду», «Мне видится здесь надежда» и т.п., оставляя право клиентке «примерить» это на себя и принять или опровергнуть. В процессе терапии клиентка учится видеть и отмечать у себя похожие ощущения. В целом, расширение сферы контактов, осознанное стремление к удовлетворению своих потребностей повышают уровень надежды клиентки на то,

что ее жизнь может наполниться ресурсами и стать гармоничной.

Уверенность. Рост уверенности – постепенный процесс от возвращения ощущения «нормальности» до ощущения «я достаточно хорошая». На ранней стадии кризиса горя терапевт «легализует» состояние клиентки: «мне больно, я испытываю трудности там, где раньше не испытывала – и это нормально». На более поздних стадиях – акцентирует внимание на достижениях клиентки и умении их присваивать: «Я смогла пройти онлайн-курс, который долго откладывала», «я нарастила объем клиентов и справляюсь с работой», «я вступила в отношения с мужчиной, в которых стараюсь оставаться собой, и он принимает меня в моём горе», «я могу открыто говорить с друзьями и расставлять свои границы», «я уделяю внимание потребностям тела» и т.п.

Вера. Тему судьбы, Бога, высших сил клиентка рассматривает в контексте ответственности за события, происходящие в жизни людей. Главная роль терапевта – контейнировать и перефразировать умозаключения клиентки, не вступая в дискуссию и не обесценивая значимость ее взглядов для формирования ее внутренней устойчивости. По мере проживания кризиса горя клиентка чаще рассматривает тему ответственности, ее разделения между Богом и человеком. Также контакт с умершим мужем частично возвращается клиентке в ее сознании как контакт с духом, который обладает силой и способностью оберегать ее и защищать. Таким образом, клиентка переводит отношения с мужем из сферы контактов в сферу смыслов (отношений с трансцендентным).

Обсуждение

Изменение модели баланса через 8 месяцев терапии:

В сфере тела. У клиентки прошла большая часть соматических симптомов, восстановились сон и аппетит, прошла склонность к перееданию, нормализовалась масса тела. Клиентка восстановила физическую активность путём занятий с тренером в тренажерном зале, в который также ходит её мать (таким образом, попутно происходит наполнение сферы контактов). Приступы тревоги стали реже. Клиентка ориентирована на распознавание и проживание эмоций.

В сфере деятельности. А. восстановила профессиональную деятельность в полном объёме, включая плановое повышение квалификации. Вернулась к привычному ведению быта, организовала ремонт на рабочем месте.

В сфере контактов. Сфера стала более наполненной. У клиентки появился партнер, отношения с которым дают ей ресурс в виде принятия, сексуальности, надежды. В отношениях с близкими клиентка стала проявлять больше открытости, что способствует более качественному удовлетворению эмоциональных потребностей и более глубокому контакту.

В сфере смыслов. Клиентка строит планы по развитию профессиональной деятельности, рассматривает возможность повторного замужества в перспективе, а также возможность материнства.

Заключение

Через 8 месяцев терапии (30 сессий), проводимой с опорой на принципы ППТ, у клиентки наблюдаются симптомы перехода на стадию работы горя.

Волкан описывает данные симптомы следующим образом: «После того, как мы принимаем смерть своих близких, нам хочется продвижения, исчезновения боли и погружения в жизнь. Эмоциональное присутствие ушедшего человека все еще дает о себе знать, вынуждая нас выстраивать новые и более подходящие взаимоотношения… Существуют два главных составляющих для успешной работы горя: пересмотр отношений, то есть оценка их значения для нас, и затем превращение их в память без будущего». (Волкан & Зинтл, 2007).

Клиентка больше не испытывает симптомов кризиса горя: расщепления, гнева и тревоги, которые можно связать с фигурой умершего мужа. Женщина принимает изменения в своей жизни: строит новые отношения, при этом она ориентируется на свои потребности и ценности, которые удовлетворялись раньше, вспоминает и анализирует прошлый опыт, однако проекций прежних отношений с умершим мужем на новые с нынешним партнёром не возникает. Фокус в терапии постепенно

смещается с проживания эмоций по поводу утраты на анализ текущих отношений и актуальных конфликтов в разных сферах, а также построении планов на будущее.

В процессе терапии наблюдается рост (восстановление) первичных способностей и возвращение к прежним показателям выраженности вторичных. Также можно определить разрешение актуальных конфликтов, в том числе одного из наиболее длительных.

Это конфликт в сфере контактов с переработкой в сфере тела (клиентка испытывала сильнейший стресс, много эмоций и соматические симптомы в связи с утратой контакта с мужем). В содержании данного конфликта – надёжность. Клиентка ожидала надёжности от мужа (он будет беречь свою жизнь и здоровье, чтобы оставаться живым), а он совершил безответственный поступок (употребление наркотика), который привёл к его смерти. Это привело к фрустрации ряда первичных АС, в частности, доверия. Таким образом, Базовый конфликт локализуется в сфере «ТЫ» и может быть определен как: «Я могу доверять любимому человеку, только если он надёжный». Внутренний конфликт связан с тем, что данная концепция стала дисфункциональной: ненадёжность со стороны мужа привела к фрустрации потребности в доверии и вызвала импульс к обвинению его в случившемся. Разрешением конфликта можно считать изменение отношения клиентки к поступку мужа (если изначально для нее это было проявлением ненадёжности, то теперь стало несчастным случаем) и расширение Базовой концепции: «Даже с надёжным человеком может произойти несчастный случай».

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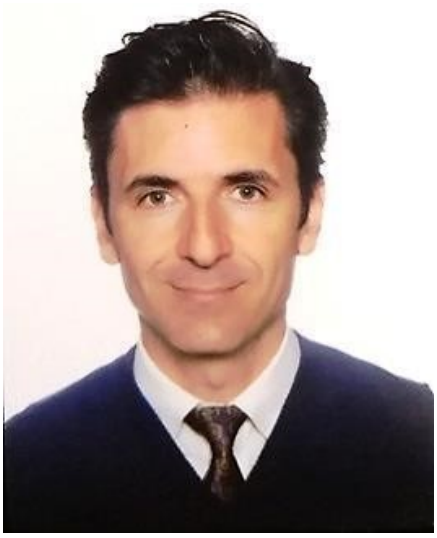
Section: PPT training

POSITUM MGS COACHING PROTOCOL IN THE FRAMEWORK OF POSITIVE GROUP PSYCHOTHERAPY TRAINING FOR SPECIALISTS WORKING WITH GROUPS OF CHILDREN AND ADULTS AFFECTED BY WAR, DISASTERS AND REFUGEE CRISES: A CASE STUDY



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Abstract

War brings destruction in the broader sense, forcing millions to flee their homes, and resulting in an increased burden of depression, anxiety, PTSD and other mental and behavioral disorders. This burden grows even more in the framework of pandemics and natural disasters, as social and protection services experience crisis of resources. Providing one-to-one mental health care is no longer feasible for masses of refugee and internally displaced children and adults who need support, and, as a result, the need to have increasing numbers of mental health specialists who intervene in groups becomes more and more emergent. The paper reviews the Positum MGS approach to work with groups of children and adults in refugee settings, and not only, suggests the 'Positum MGS coaching protocol' within the framework of group Positive Psychotherapy (PPT after Peseschkian, since 1977)™. Empirically supported and demonstrated by a case in the paper, the protocol being applied by a Positum MGS trainer or team of trainers, during an in-person training of 4-5 days, helps trainees greatly in learning to use psychosocial transcultural games and related techniques as resilience-building tools with groups of children, adolescents or adults. Either in the position of PPT trainers, psychotherapists, consultants or students, the participants in a Positum MGS core training and coaching or PPT training at basic or master levels with a focus of working with groups, can be supported through the suggested coaching protocol and questions in line with the 5-stage consultation of PPT.

Keywords: training, coaching protocol, Positum MGS, 5-stage consultation, positive psychotherapy

> *"Take ye counsel together in all matters, inasmuch as consultation is the lamp of guidance which leadeth the way, and is the bestower of understanding."*
>
> - Bahá'u'lláh (1817-1892)

Introduction

As governments, public health agencies, mental health organizations, the wider academic and scientific community and other societal actors are learning to properly consult and fully cooperate on the needs of humanity and

vulnerable populations, including refugees and internally displaced people – with the most recent estimate of some 108.4 million people being forcibly displaced worldwide, according to UNHCR report (2023) – humanity is currently facing an increasing burden of the prevalence of mental health disorders, while wars, pandemics, natural disasters and resulting phenomena, such as forced displacement and refugee crises affect both developed and developing countries. The report points out that such a high number of refugees and internally displaced people was at the end of 2022 "as a result of persecution, conflict, violence, human rights violations or events seriously disturbing public order". A systematic review and meta-analysis of Henkelmann et al. (2020) indicates "a challenging and persisting disease burden in refugees due to anxiety, mood disorders and PTSD". More specifically, it states:

> Prevalence rates were 13 and 42% (95% CI 8–52%) for diagnosed and self-reported anxiety, 30 and 40% (95% CI 23–48%) for diagnosed and self-reported depression, and 29 and 37% (95% CI 22–45%) for diagnosed and self-reported PTSD. These estimates are substantially higher relative to those reported in non-refugee populations over the globe and to populations living in conflict or war settings, both for child/adolescent and adult refugees. Estimates were similar over different home and resettlement areas and independent of length of residence. (Henkelman et al, 2020)

Henkelmann et al. (2020) further point out "the relevance of developing public health policies in host countries" and recommend that "scalable interventions, tailored for refugees, should become more readily available". If the above-cited numbers on prevalence rates of depression, anxiety and PTSD do not seem alarming, what else could be for the mental health community and that of Positive and Transcultural Psychotherapy?! What professional interventions can be offered to address the needs?

In this context, one among several possibilities for such scalable and tailored interventions to build capacities for mental health, psychosocial and pedagogical specialists in host countries and localities who want to work with groups of children or adults affected by war, pandemics and natural disasters, can be supported by the Positum MGS™ approach developed by Parruca (2013, 2022, 2023b). Since the start of the war against Ukraine in February 2022, as well as predating and recently new armed conflicts and wars in other regions, the Positum MGS approach within the framework of Positive and Transcultural Psychotherapy [PPT after Peseschkian, since 1977]™ has trained, with the care of the WAPP Support Project, more than 70 specialists with a PPT background and training, who are actively engaged in providing support to groups of children and adults. In the framework of capacity building, a specific 'Positum MGS coaching protocol' is applied during the training and, ideally, after the training for up to eight sessions.

Coaching is a broad concept in the process of training and capacity building. However, it takes a specific meaning and adopts a unique procedure in the context of Positum MGS training and further capacity building when using psychosocial games and feedback techniques originating in the MGSC Methodology (Jázs, 2023; Meuwly, 2011). Therefore, in its strict sense, the Positum MGS coaching protocol comes to the assistance of specialists who are trained to use psychosocial transcultural games as instruments that have functions, similar to stories in PPT for and with individuals and groups (Peseschkian, 1986, 1987, 2006). Greatly based on the coaching procedure suggested in the framework of the MGSC Methodology training (Meuwly, 2011), it is expanded by Parruca (2013) with PPT elements to further develop the role of a Positum MGS trainer, in order to support the trainee into a deeper self-discovery when undertaking a joint reflection and positum feedback that are embedded within the framework of PPT's 5-stage consultation (Peseschkian, 1987, 2013), while these five stages are also applicable in group psychotherapy (Remmers, 1999). The aim of the Positum MGS coaching protocol is to equip the trainee with the required confidence to facilitate group sessions for children or adults, which support their psychological resilience, and to become aware of defense mechanisms, such as generalization (Peseschkian, 1987, 2013), as well as denial, projection, justification, rationalization, irony, and resistance (Meuwly, 2011) that may be barriers to efficacy on the part of a group facilitator – either a trainer, psychotherapist or consultant receiving coaching.

Methodology

At this point, it may be helpful to clarify certain definitions connected with facilitation, training and coaching in the context of the Positum MGS approach, as guided by Positum MGS methodological principles and its Coaching Protocol, that ultimately serve the purpose of providing qualitative group psychotherapy:

- *"Group psychotherapy"* in the framework of Positive Group Psychotherapy and Positum MGS, is group therapeutic work undertaken with beneficiaries – children and adults in need of mental health and psychosocial support – by keeping in mind PPT and Positum MGS principles, focused on the identification of experienced emotions and feelings during and after a group psychosocial transcultural game; of needs and expectations associated with them in the sense of actual capacities; of conscious and unconscious concepts connected with those actual capacities; of misunderstanding at the basis of those concepts; of conflicts and their reaction in the domain of body, achievement, relations and phantasy; of mindfulness and exploration of the actual, basic, key, and inner conflicts at intrapersonal, interpersonal, group and systemic levels; as well as gaining a broader perspective on future action and acting on those decisions arrived at individual or group level (Dobiała, 2020; Parruca, 2013, 2022, 2023b; Peseschkian, 1986, 1987).
- *"Session facilitation"* by a trainee consists of leading a group of peers during the last two days of a core Positum MGS training of 4-5 days, and/or after the training a group of ideally 6-12 beneficiary children or adults who receive mental health and psychosocial support in a public or private institution, into a session of 45-120 minutes where psychosocial transcultural games are applied for up to 45 minutes with a gradual progression of intensity, followed by a relaxation phase, and concluded with a reflective feedback of up to 75 minutes, taking the group through the PPT's 5-stage consultation and therapy (Parruca, 2013, 2022, 2023a, 2023b).
- *"Group training and coaching"* facilitated by one to three Positum MGS trainers consists of a 4-5-day core or advanced training in a block of days or carried out during two weekends, where ideally 10-12 students and practitioners of PPT learn interactively and under coaching in teams how to use psychosocial transcultural games and related techniques for use in group therapy in the PPT framework, containing elements of training in both theoretical concepts and practical skills when participating in group psychosocial transcultural games as instruments of educational self-experience and self-discovery. Group training and coaching enhance competencies at four levels: psychological, social, methodological and technical (Parruca, 2013, 2022, 2023a, 2023b).
- *"Individual coaching"* facilitated by a Positum MGS trainer, facilitator or peer trainee, consists of observing and assessing the performance (Parruca, 2023c) of the trainee while s/he facilitates a session for a group of peers or beneficiaries, followed by mutual constructive feedback with the trainee under coaching for training and educational self-discovery, and of further enhancing the competences at four levels (Parruca, 2013, 2022, 2023b);

As it will be demonstrated in the relevant paragraphs about the Coaching Protocol, it is noteworthy to consider that its value and use emerge during the last two days of the training and continue for the following 5-to 6 months after the training, as the trainee starts to use the Positum MGS approach with beneficiary children or adults. Thus, the Protocol is strictly connected with the time when the trainee starts to apply what has been learned during the training.

One key instrument to measure the learning and performance of a trainee in the framework of 5-6 months after receiving a core training, is an assessment form that contains 44 performance indicators under 14 competencies at psychological, social, methodological and technical levels (Parruca, 2023c). It measures progress and affects on a scale of 1 (not at all) to 4 (always), ranging from a total of 44 to 176 points. This instrument was based on a follow-up tool developed by a team of psychosocial specialists and used during the Terre des hommes Foundation's MOVE Project

with some 50 trainees in Albania, Moldova and Romania between 2008 and 2010. (Lasku & Lopari, 2012; Meuwly, 2011). The follow-up tool served as the basis for the empirical collection of data on the effect that the application of the MGSC Methodology had on children and the professionals working with them. Referring to the positive changes and improved skills seen in some 50 professionals in Albania, Moldova and Romania that received basic training and 6-8 coaching sessions originally, compared to the control group that was not trained and coached in the methodology, Meuwly (2011) highlighted the following positive effects:

> […] Increased self-confidence, as they felt more competent to perform their work; […] More empathy, as they changed their way of looking at child ren as responsible actors whose self-respect is to be nourished; […] A new way of communicating, more fluent, sympathetic and effective with their colleagues, families and children; […] Better handling of conflicts, based on mediation of the needs and interests of all parties; […] Integration of the principles of participative, interactive pedagogy with the use of feedback that changes their way of facilitating and brings them closer to the children; […] Less competition and more cooperation, creating an atmosphere of confidence, respect and integration between the children. (p. 3)

Moreover, specifically in Albania, based on the findings of the research in the field, related to the multi-dimensional impact of the MGSC Methodology among some 250 professionals who were trained and then coached for 2-8 sessions, while implementing the methodology with some 2,500 children, Lasku & Lopari (2012) indicated:

> On a *personal level* among professionals, it was observed that as a result of experiential learning by participating in practical activities, they developed more self-confidence, more empathy, and improved skills to lead a group of children. Also, this improvement was noticed by the increased self-awareness of their needs and resources as individuals, turning them into resources for the children they work with. On a *social level*, better communication skills with colleagues and families and better stress management in work environments. At the *methodological level*, that is, in the practice of working with children, the methodology positively encouraged a participatory pedagogy where the child is at the center of the process, is actively listened to, empathized and the opinion and point of view expressed takes importance. (p. 4)

Stressing the importance of coaching as an integral part of the training, based on the vast training and coaching experience of some 250 psychosocial and pedagogical specialists applying the methodology with some 5,000 children in the three countries, Meuwly (2011) states:

> Coaching or individual follow-up is part of the process of training and the integration of new skills, and it should be taken into account when planning training and its follow-on activities. The effectiveness of the process of strengthening skills largely depends on the time devoted to it and the resources available in the coaching stage. (p. 4)

The following deals with the coaching process of a new trainee who facilitates a session with peers during the training, or who will start practicing with a group of children or adults s/he works with. The Positum MGS trainer/coach, in addition to a core training package of four-five days that include psychosocial modules and game methodology ones within the PPT framework, is responsible to provide at least two up to ideally eight individual coaching sessions to the trainee. If not possible, it may be substituted by in-person or on-line supervision. With the development of the on-line video communication technologies, the trainer may observe the performance of a trainee in distance, to be afterwards engaged in mutual feedback. This process has its crucial role, because, as mentioned, it helps the trainee-facilitator greatly to conduct a Positum MGS session with the group – each following session being improved and appropriate psychosocially, technically and methodologically, after the feedback received

from the trainer/coach during the previous coaching session(s).

Based on the above, the Positum MGS coaching protocol requires firstly, a trainer or team of trainers to closely observe a trainee who is demonstrating what has been learned and, secondly, engage in mutual constructive feedback on what was observed. Either after demonstrating the facilitation of a psychosocial transcultural game session for a group of peer trainees during a Positum MGS training, or after facilitating a first Positum MGS session for a group of children, adolescents or adults, the coaching protocol is moderated in a way that considers the 5-stage consultation process. Therefore, the coaching role of the trainer consists of two main tasks: (a) observing in background the trainee-facilitator during the facilitation of a group session, and (b) facilitating mutual constructive feedback that considers the 5-stage consultation procedure. More specifically, these two main tasks have their mini-tasks and objectives described in details in the following.

(a) ***Observing in background*** the trainee during the Positum MGS session with the group of children or adults while s/he facilitates the game and feedback session for about 45-120 minutes, depending on the age-group of participants and their differentiation need in the group. The trainer keeps notes on the elements of the session, making a written assessment of the trainee's performance and progress indicators, including planning and facilitation of the session, respect for methodological principles, and the attitude and skills (actual capacities) of the trainee, both well-developed and to be developed (Parruca, 2023c). With the trainer observing in the background, the trainee learns to getting used to and becoming more comfortable with the idea of being assisted psychosocially, technically and methodologically, and therefore, is attached to the trainer/coach, while facilitating a session with the group that has to go through the attachment, differentiation and detachment phases of interaction (Peseschkian, 1986, 1987);

(b) ***Mutual constructive feedback*** after the game and feedback session with the trainee for about 30 minutes on feelings, thoughts, what was difficult and went well, and needs for improvement for the next session, by respecting the coaching principles and guidelines of protocol. This second part is led by the trainer(s) by posing a set of questions to the trainee-facilitators, which help them reflect on the experience, bring to conscience their actual, key, basic and inner conflicts, and verbalizing them, as well as a few actions to be undertaken next time with the group, in terms of improving the quality of the session. This process consists of the differentiation and de-attachment phases of the trainer-trainee coaching relationship. The protocol of questions posed by the trainers to the trainees and discussions on them are provided in the following coaching case, featuring a social worker, male, 32 years-old, married, Albanian, working with Albanian children and adolescents who had returned from the ISIS war-zone of Iraq and Syria:

1. "How do you feel after the facilitation of this session and why?" This question is aimed at helping the trainee get in touch with the emotion(s) or feeling(s) of the moment, depending on how s/he perceived his/her own performance and that of the group, as well as the general sense about the session. In connection to PPT, this question helps strengthen the attachment between the trainer and the trainee, and is the continuation of the observation task and of the Observation/Distancing stage on the part of both trainee and trainer, which started with observing the session that the trainee facilitated with the group. Here, the trainer has to listen empathically and note down key elements of what the trainee says. To demonstrate, in one case of coaching during training, the trainee said:

"I actually have mixed feelings. On one hand, I am glad that the group reacted very positively to this new game, but I felt a little sad and embarrassed in the end, as there was some tension between me and Sarah, after I interrupted her and asked her to be briefer. I noticed she felt a little upset by my remark, and hope she didn't take me wrong."

The trainer notes down key words from the answers and feelings of the trainee, after mirroring what was said by him/her. This process strengthens their attachment and lowers potential defense mechanisms on the

part of the trainee. Then, the trainer poses the next question:

2. "What was difficult during your facilitation role and why?" This intends to help the trainee make a deeper analysis of his own performance, in terms of which capacities (in the form of skills, attitudes, or actual capacities) were not very helpful to the group, as well as the group reactions to the facilitation style. Related to 5-stage consultation in PPT, this question leads to the stage of Inventory. The trainer notes down what the trainee says, in order to compare with his/her own notes from the observation of the session in the group. Again, the trainer here listens attentively, without interrupting or asking disruptive questions. The trainee says:

"In addition to what I said about Sarah, I felt I was not clear about the rules of the game in the main part. It seemed it created some confusion for the group, which was reflected in their feedback as well."

The open nature of the question helps the trainee feel that he can trust the trainer and be more open and, as a result, the defense mechanisms are further reduced, when the next question is made:

3. What did you like about your facilitation role and style? This question helps the trainee to become more aware of what he did well, what specific actual capacities and skills helped the group interact, learn and share. It helps the trainee move to the 2nd PPT's consultation stage of Situational Encouragement, as he shares the inner resources that he/she has access to at that point:

"*Well, I was prepared for the session, clear about the objectives to be met during the game, listened to their suggestions during the mini-feedbacks … I increased the level of participation and cooperation according to their suggestions when the game was retried with a few progress steps, and showed empathy to their feelings during the closing feedback.*

As it may be noticed, the trainee has a good awareness of the implemented plan and methodological principles (Meuwly, 2011; Parruca, 2013, 2023b), while pointing out the intrapersonal and interpersonal dynamics (Dobiała, 2020), as well as social competences, such as empathy (Remmers, 2010). This stage prepares the trainee for the next critical question:

4. "What were the objectives of the session and to what degree were they met? This question helps the trainee focus on the objectives he wanted to achieve (in terms of primary and/or secondary capacities to rehabilitate or develop) by the end of the session with the group. The trainee brings his own perception on what degree the objectives were met in a scale of 1 to 4 when observing and evaluating the performance of individuals within the group (Parruca, 2023a) and why he sees it that way. The trainer keeps notes while listening actively. In terms of PPT, this question is completing the uncovered elements of the 2nd stage of Inventory, however, it helps the trainee move to the stage of Verbalization as he moves deeper to the content of the conflict area. In the case, the trainee answered:

"Based on the difficulties the group members have outside the institution, I planned to work with the actual capacities of trust, honesty, respect and contact. The first three were quite visible during the game, and the group could elaborate on them during the closing feedback, but you could see yourself how the group struggled to establish physical contact during the main and relaxation parts. I didn't understand why, and they did not even want to talk about it during the feedback, when I asked them why they did not want to shake hands in the moment of the relaxation part."

This answer of the trainee sets the stage for constructive feedback on the part of the trainer, as both can move to a deeper Verbalization stage. At this point, the trainer asks:

5. After reflecting again on what you shared and perhaps questions you might have about your performance, are you ready to receive my feedback? In case of a closed body language, the trainer may decide to not give feedback. The closeness would trigger defense mechanisms in the trainee, resulting in poor absorption of the feedback given by the trainer. And therefore, it is recommended to give no

feedback at all (Meuwly, 2011; Parruca, 2023b). Otherwise, at this stage, the trainer confirms the positive qualities, attitudes and skills (actual capacities) perceived during the trainee's performance as group facilitator, and consequently, highlights additional positive elements of which the trainee was not aware of himself. This moment can supplement the PPT's 3rd stage of Situational Encouragement as the trainee is reminded of his key primary and secondary capacities, while being verbalized by the trainer. In this case, the trainer said:

"*I am glad to see that the training you received has been well-understood by you, and this was demonstrated by your diligent preparation for the session, the attachment you could establish immediately with the group through your genuine politeness, warm tone of voice and cheerfulness. In addition to that, you were clear about the actual capacities as objectives to be met during the game; you encouraged such methodological principles as unity vs. over-achievement and hope in achievement, in the form of active participation and cooperation by the group; listened to their suggestions during the mini-feedbacks and increased the level of progress, when the game was retried with a few progress steps; showed empathy to their feelings and helped them go through all the key questions during the closing reflection. I am really pleased that you took the necessary time for all the parts of the session."*

At this point, the trainee feels calmer, encouraged, with lowered defenses. This encouraging feedback is very necessary, because it builds further trust between trainer and trainee, as well as greater confidence and a sense of achievement in the trainee. He is ready to go to the next stage:

6. The following discussion allows the trainer to provide feedback on what needs to be improved, by referring to specific and concrete moments and elements of the group session facilitated by the trainee. The trainer says tactfully, for instance, by referring to the trainee's actual capacities of patience, time and courtesy:

"I noticed on both mini-feedbacks that you were not allowing Sarah to finish her suggestions, and also, during the closing feedback, you cut her off when she was speaking about the detailed way she cooperated with Mario. On the other hand, you did not cut off the other children. I am wondering why?"

By taking the time to reflect in order to operationalize the conflict models in PPT (Goncharov, 2020) the trainer and trainee come closer to the truth about unconscious and conscious behavior. While the above statements point at a visible actual conflict with its domain in the relationship area, involving as content the actual capacities of 'patience vs. honesty', as well as the key conflict of 'honesty vs. politeness', the basic conflict with a similar content becomes visible, as the trainee replies:

"I don't know why, but Sarah always reminds me of my elder sister, Joana, who would talk endlessly sometimes, and this would drive our mother crazy, as she didn't have the time and nerves to listen to her. She would say angrily: 'Stop it now Joanna, I get it!'… I kind of liked the way our mum would make her stop. Maybe, Sara... No, no, it can't be.... Surely, I was under the pressure of time, and cut her off."

At this point, the trainer intervenes to avoid any further raising of defense mechanisms, such as justification among other mechanisms (Meuwly, 2011). The trainer states:

"Well, you have to check this. I'd encourage you to be more aware of your levels of patience towards different children in the group and allow them to go to the end of their speech, as long as they don't take unnecessary time from the others. In this way they will feel more respected and listened to."

As described above, the trainee is helped to check whether a certain attitude or behavior is a pattern or prone to a basic or inner conflict, and a very brief discussion takes place on that. As the trainee is assisted to go through the 4th stage of Verbalization, where his previous statements on negative or not-so-

helpful attitudes, coupled with the observations of the trainer, find full and clear expression in basic concepts and misunderstandings built until that moment, while the trainee honestly verbalizes them. In helping the trainee to solve the key conflict with the trainer in an atmosphere of mutual trust, the trainer helps to mirror and clear out those misunderstandings, at least at the reflection level. As the stage of Verbalization is quite traversed, what follows next is the question:

7. "Reflecting on the feedback you received by the group and what we have discussed so far, what are two or three things that you would do differently during the next session with the group?" This question helps the trainee reflect on 2-3 actual capacities or attitudes that were identified either by himself or the trainer previously, that need to be further developed. The question puts the trainee in the future thinking mode, so that the next session with the group would be ideal, if those changes were adopted. In terms of PPT, this is the 5th consultation stage of the Broadening of the Goals. The trainee leaves the coaching session with a clear view of his inner resources and new objectives in terms of improvement for the next session with the group. In the case, referring again to the previous statements, the trainee answers:

> *"Certainly, I have to be careful with Sarah and other children in terms of interrupting them unnecessarily. I should be patient and give her and the others the necessary time to fully express their thoughts."*

This last question and answer serve to the detachment step for the live interaction between the trainer/coach and the trainee until the next coaching session in a week or so. Then, it becomes imperative for the coach to check during the next coaching session that the statements and decisions made by the coach during the stages of the Verbalization and Broadening of the Goals are implemented without falling into the old pattern. In the above case, during the following coaching session, the coach observed that the trainee showed patience to the child during the reflection part, and experienced the facilitation role with more certitude. These two indicators of result in terms of actual capacities developed by the trainee are noteworthy in the capacity building process that the Positum MGS coaching protocol promotes.

To summarize the process described above, *Table 1* may be of help:

Table 1.
Coaching Protocol during Positum MGS training or post-training group session

Questions sequence and guideline according to Positum MGS coaching protocol after observing in background a group session facilitated by the trainee	**PPT interaction step & stage of consultation**
1. "How do you feel after the facilitation of this session and why?"	*Attachment* 1.Distancing/Observation
2. "What was difficult during your facilitation role and why?"	*Differentiation* 2.Inventory)
3. "What did you like about your facilitation role and style?"	*Differentiation* 3.Situational Encouragement
4. *"What were the objectives of the session and to what degree were they met?"*	*Differentiation* 4. Verbalization
5. "After reflecting again on what you shared and perhaps questions you might have about your performance, are you ready to receive my feedback?"	*Differentiation* 3.Situational Encouragement 4. Verbalization
6. A discussion allows the trainer to provide feedback on what needs to be improved, by referring to specific and concrete moments and elements of the session facilitated by the trainee with the group. Concrete suggestions are given.	*Differentiation* 4. Verbalization
7. "Reflecting on the feedback you received by the group and what we have discussed so far, what are two or three things that you would do differently during the next session with the group?"	*Detachment* 5. Broadening of the Goals

Discussion

The particularity of this Protocol consists firstly, of the efficient use of the MGSC coaching protocol within the 5-stage consultation of PPT in just one 45-minute session, thus giving trainers a focused framework to help trainees build capacities. And secondly, the Protocol provides questions that switch the Inventory and Situational Encouragement stages, whereas the

original MGSC Coaching Protocol poses questions that do not follow this order. Therefore, PPT practitioners can be more easily oriented through the process by adhering to a PPT logical framework. Furthermore, as the Positum MGS approach of training and its coaching protocol for PPT professionals working with groups of children and adults affected by war, disasters and refugee crises helps to further build the capacities of the professionals, their intervention with children demonstrates to take additional value. Due to its stabilizing, resource-oriented and resilience-building effects, the Positum MGS approach for training and its coaching protocol demonstrate, similar to the MGSC Methodology, universal applicability for children and adults who experienced neglect, abuse (physical, emotional, sexual), exploitation, and discrimination, loss, and grief, including children and adults in the neurodiverse spectrum (Parruca, 2022, 2023b). Applying the methodology with children and adults in destabilized states during the experience of psychotic episodes and related disorders is not recommended unless the person is stabilized and the group is well-attached; it should be applied with caution. However, PPT practitioners may find Positum MGS approach to group therapy as universally applicable to all mental and behavioral disorders, because it is an integrative approach within PPT's meta-theory and meta-practice, which "offers a conceptual framework for working with all illnesses and disturbances" (Peseschkian, 2013, p, 69).

Another essential aspect for the effective application of the coaching protocol takes in consideration that the Positum MGS coach or team of coaches – PPT trainers, supervisors and psychotherapists who are familiarized with the procedure – are not only aware of the transference of the trainee, but are also encouraged to dwell on their own counter-transference, so that they may make best use of it for both group self-discovery and coaching purposes under training. Taking a "holistic approach", according to Goncharov (2012), is a necessity to understand and analyze the counter-transference:

> This […] approach is based on a broader definition of counter-transference, and calls for a more active technical use of counter-transference in therapy. Many representations of this approach are discussed with the patient and influence their counter-transference, seeing it as an important part of the psychotherapeutic process. The desire to analyze all reactions towards the patient, sooner or later leads to a more-or-less complete painting of any 'white spots' or unconscious moments. It is useful or even necessary to understand, and be able to analyze, the counter-transference, in order to effectively use it in psychotherapy. If the therapist does not do that, he/she can never get that valuable experience and therefore possibly limit their therapeutic options.

The experienced counter-transference and the trainer's awareness about it, is thus, essential in the coaching process, as the real emotional states of the trainees can be reflected in the feedback given by the trainer in the coaching process. For example, although the trainee speaks of "feeling sad" after the session with the group, yet he comes across as anxious through his body language and non-verbal communication. The coach has a responsibility to check that emotion or feeling and the needs behind that during the Observation/Distancing and Inventory stages, in order to clear any needs for trust, certitude and safety on the part of the coach.

Conclusions

Either in the position of PPT trainers, psychotherapists, consultants or students, the participants in a Positum MGS core training and coaching or PPT training at basic or master levels with a focus of working with groups, can be supported through the recommended coaching protocol in line with the 5-stage consultation of PPT, to encourage aspects of adequate self-awareness that address the actual, key, basic and inner conflicts experienced by a trainee during the group session facilitation. The recommended coaching protocol through observation and constructive feedback, as a decade-long tested procedure in the field of mental health and psychosocial support, helps a professionals under training to objectively assess his own performance and efficacy with a group of beneficiaries, lower unnecessary defense mechanisms towards the group and trainer, and increase openness for positive changes, aiming at further building competences at technical, methodological, social and psychological domains. The close consultation process

between a trainer and trainee leads to a better understanding of the Positum MGS approach within PPT and a more effective and efficient application of the approach with groups of beneficiaries. As such, the suggested coaching procedure helps to increase the efficacy of the professionals' therapeutic work with groups of refugee children and adults affected by armed conflicts, war, pandemics, natural disasters, and a plethora of related or other micro- and macro-traumas, as well mental and behavioral disorders.

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Section: Special articles

PSYCHOLOGICAL EFFECTS OF ARMED CONFLICTS ON CHILDREN

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Abstract

Armed conflicts have caused extreme social crises worldwide, where children represent the most vulnerable group, often experiencing severe trauma and violence in war zones. Globally, one in four children lives in a country affected by armed conflicts, natural disasters, or epidemics. This study aims to provide an overview of research on the psychological impact of armed conflicts on children, including the types of mental disorders that result after war trauma and interventions to minimize psychological damage after exposure to war and conflict. The research was based on a systematic review of the literature, using the Elsevier, Google Scholar, and PubMed databases. Key terms used in the research include: war and mental health or armed conflict, children or refugees and trauma or exposure to war trauma; and post-traumatic stress disorder. Children's continued exposure to war trauma is associated with mental health problems including post-traumatic stress disorder (PTSD), depression, suicidal thoughts or behaviors, dissociative disorders, depersonalization, derealization, numbing, catatonia, and behavior disorders, especially aggression and violent criminal behavior. Based on the studies used, the results show that the crises caused in children by wars has significant effects on mental health, such as anxiety, depression, post-traumatic stress, sleep disorders, and suicidal thoughts. The cited studies recommend increasing human resources for the identification, diagnosis, rehabilitation, and psychosocial support of children who are evacuated from war zones to other countries.

Keywords: armed conflict, children, mental health, exposure to war trauma, positive psychotherapy

Introduction

Over one billion children worldwide live in countries or territories destroyed by armed conflicts, war, or terrorism, and 90% of the world's children and adolescents live in low- and middle-income countries.

Armed conflicts have a significant impact on mental health in affected populations, particularly among vulnerable groups such as children. Exposure to traumatic events is a major factor in the mental health consequences of war for children. However, for children in particular, the deleterious effects of war trauma are not limited to specific mental health diagnoses but include a broad and diverse set of developmental outcomes that have significant consequences for family relationships, peers, performance in school, and general satisfaction in life.

Wars fought in the last quarter of the century almost exclusively affect countries with low resources and are usually associated with a variety of risk factors at different ecological levels, e.g., extreme poverty, lack of resources for health insurance, the breakdown of the

school system, as well as an increase in the level of violence in the family and in the community. Children are particularly sensitive to the stressors experienced by armed conflicts, and as a result, their effects are present in several aspects of life, such as mental health, physical health, academic achievements, and social relations.

Methodology

2.1. Purpose and objectives of the research

The study examined the impact of armed conflict on children's mental health. The systematic literature review aims to identify and analyze the psychological effects of war on children.

2.2. Literature search terms and research process

Based on the object of the study, Google Scholar, Elsevier, and PubMed databases were used. The specific search terms were: armed conflict and mental health or war and children or exposure to combat events and post-traumatic stress disorder.

Results

Based on the selective criteria, 14 items were considered appropriate for use (Fig. 1). For scientific articles, the study was designed and followed the guidelines of the report for systematic review in the PRISMA process (PRISMA, 2021).

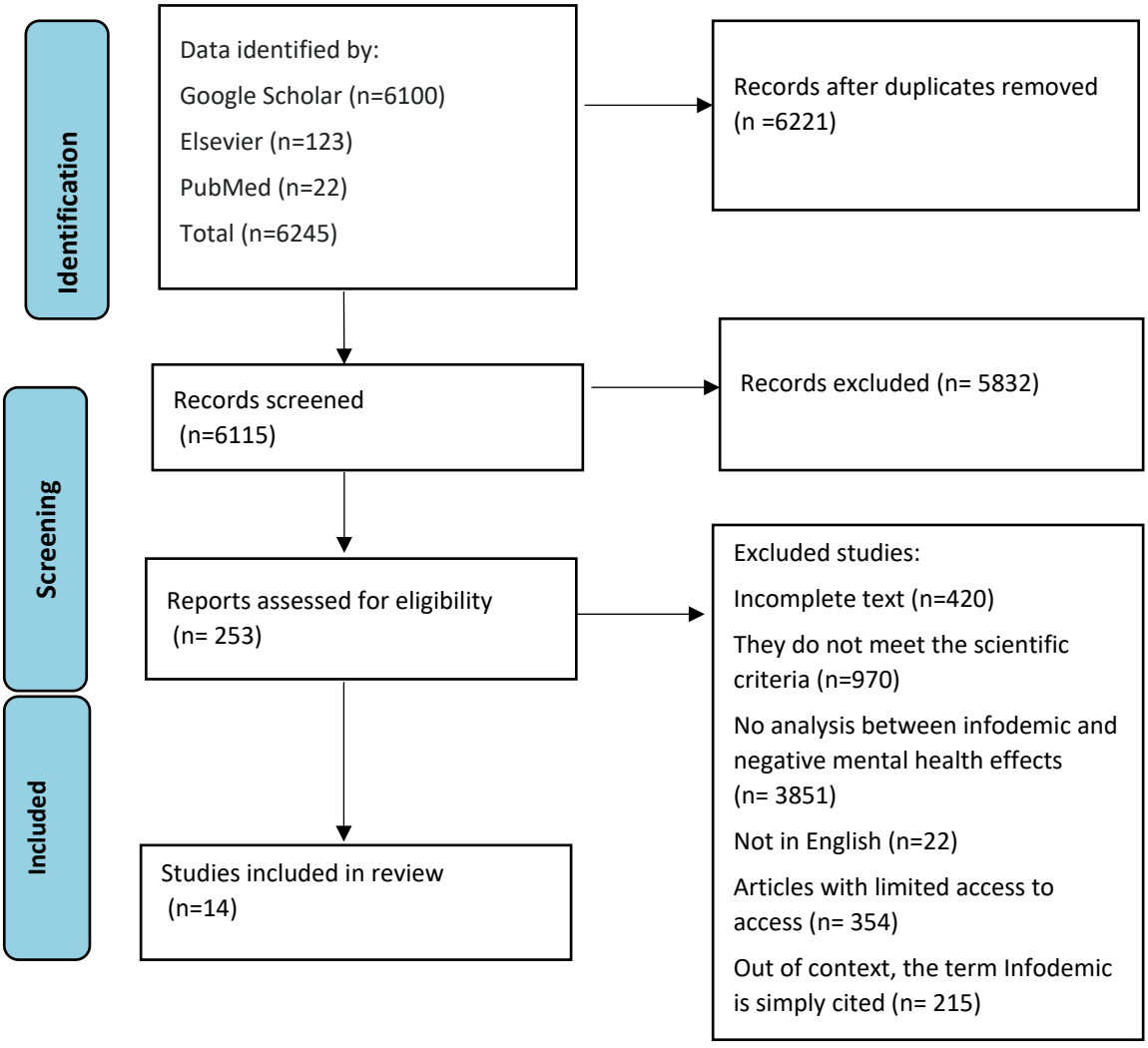

Fig 1. Flow chart of the research strategy

3.1. Psychological effects of armed conflicts on children

Children growing up in war zones are at significant risk of developing mental health problems related to their trauma, e.g.,

irritability, outbursts of anger, and internal and external symptoms. Or psychological disturbances that prevent them from functioning in daily life. Smith (2001) asserts that the most important variables that determine the effects of war on children's mental health are: deprivation of basic resources such as: shelter, water, food, school, and health care; broken family relationships due to loss, separation, or evacuation; stigma and discrimination significantly affecting identity; a pessimistic outlook; a constant sense of loss and grief; an inability to see the future with optimism; and the normalization of violence. In this regard, studies conducted in war zones show that exposure to traumatic events leads to the development of post-traumatic stress disorder (PTSD) in childhood and adulthood (Elbert et al., 2009). Traumatic exposure can be direct or indirect. Direct exposure occurs when a child has personal experience with a traumatic incident, such as living in a conflict zone or experiencing the death of a parent. Conversely, indirect exposure occurs through television, the Internet, or hearing others talk about a traumatic event. Indirect exposure through the media can also cause significant distress. After the 9/11 attacks and the Oklahoma City bombing, children who watched more television coverage of traumatic events experienced more post-traumatic stress symptoms (Fremont, 2004). Wars and armed conflicts are often associated with behavioral changes in children; for example, children may experience trauma, stress, anxiety, or depression due to the closing of a school, the destruction of infrastructure in their homes, or the loss of family members or friends (Liu, 2017). Chronic exposure to trauma is associated with mental health problems including post-traumatic stress disorder (PTSD), emotional disturbances, depression, and suicidal ideas. Toxic stress in children can inhibit the development of the brain and other organs and increase psychopathological damage, as well as cognitive and emotional impairment. The effects are likely to continue into adulthood, even after the war is over. Various studies have been conducted to determine the incidence of PTSD caused by exposure to traumatic war events. A study conducted with Kuwaiti children who had experienced the war found that 70% of them showed moderate to severe PTSD symptoms (Nader et al., 1993). A later study, involving a sample of Iranian children who had witnessed a public hanging near their school in Isfahan found that 75% reported a tendency for moderate to severe PTSD symptoms (Attari et al., 2006). According to a study conducted in Palestine, 41% of children in the Gaza Strip tended to show moderate to severe symptoms of PTSD (Thabet & Vostanis, 2000). The findings of another study showed that the incidence of post-traumatic stress in 121 Palestinian children exposed to bombing was twice as high as the results found in the previous study, 87% showed moderate to severe PTSD (Qouta et al., 2003). A recent study of Tamil families in post-war Sri Lanka found that children's exposure to mass trauma was one of the key predictors of children's self-reported victimization in their families. Findings reflected that about 47% of children exhibited moderate PTSD, 30.4% exhibited severe PTSD (Fasfous at al., 2013). In a study involving 96 Syrian children aged 10–14, conducted in a host camp in Munich, Germany, 45% of families reported that civil war was the main reason for leaving, 25% were also at personal risk 21% reported that they had lost their homes (Soykoek, 2017). So far, two studies have been conducted regarding the psychological effects of the war in Ukraine. The first was a cross-sectional study that measured post-traumatic stress disorder (PTSD) and found that 28.0% of 1,505 adolescents aged 10-15 years showed symptoms of PTSD (Kar, 2009). However, the study was conducted in a city not at war, and adolescents' experiences of war were not measured. The second study was a longitudinal study that measured the risk of PTSD and depression in adolescents. The authors found that 33.9% of 160 adolescents aged 15 to 17 who had PTSD developed depression, compared with 8.5% without PTSD. Children may experience acute PTSD, with hyperarousal, reexperiencing, and disrupted sleep, or chronic PTSD, characterized by dissociation, limited affect, and sadness. Exposure to trauma increases both internal and external reactions in children. Internal reactions, such as depression, suicidal thoughts, worry, and anxiety, were prevalent among Liberian youths exposed to armed conflict and in a study of 300 Syrian refugee children in Turkey (Chrisman & Dougherty, 2014). These Syrian refugee children, who were exposed to war, usually showed excessive anxiety and fear, manifested by behavior, dependence on parents, and fear of being alone or sleeping in the dark. The children were not only exposed to the war in their

country, but also to many traumatic events during the journey. A study conducted after Hurricane Katrina examined posttraumatic stress disorder (PTSD) and associated disorders in 70 preschool children (ages 3–6 years) and their caregivers. The rate of PTSD in children was 50.0% using age-adjusted criteria. The rate of PTSD was 62.5% for those who stayed in the city and 43.5% for those who evacuated (Scheeringa & Zeanah, 2008). A longitudinal study was conducted in the Gaza Strip with 234 children aged 7 to 12 years who had experienced war conflicts one year after the initial assessment, i.e., during the peace process. The rate of children reporting moderate-to severe PTSD reactions was reduced from 40.6% to 10%. PTSD reactions tend to decrease in the absence of further stressors, although a significant proportion of children still present a range of emotional and behavioral problems (Thabet, 2020). According to a meta-analysis that assessed the overall prevalence of PTSD in refugee children, the results showed that 22.71% reported symptoms of PTSD and 13.81% presented high levels of depression (Blackmore et al., 2020b). Another study included 24,786 refugee children displaced in European countries; the data presented reported rates of PTSD ranging from 19.0% to 52.7% (Khamis et al., 2019). Findings indicated that unaccompanied minors had higher PTSD symptoms than other youths accompanied by parents or guardians (Michelson & Sclare 2009). A cross-sectional study involving 2,766 students aged 11 to 17 living in the war-affected Donetsk region and Kirovograd in central Ukraine was conducted from September 2016 to January 2017. The reported data showed that the trauma of war and daily stress in adolescents was about 60%; in adolescents who had witnessed armed attacks, it was 14%; and in those who had been victims of violence and had been forced to leave their homes, it was 28% (Osokina et al., 2023).

According to another study that aimed to assess post-traumatic stress disorders among children and adolescents in conflict-affected areas in the Amhara region of Ethiopia, of 846 children, 69.8% had experienced trauma, 36.45% had developed posttraumatic stress disorders (Biset, 2023). Research was conducted in Bosnia-Herzegovina with 186 children, of whom 48.4% were refugees. The results showed that post-traumatic stress disorder (PTSD) was present in 51.6% of the children. The prevalence of PTSD was higher among children who lost a parent but lived with the surviving parent than among children in orphanages. Depression was present in 22.6% of children, with no difference between groups. Children with the lowest rate of psychological disorders were those who lived with both parents (Hasanović et al., 2006). Self-reported survey data were collected from a sample of 2,004 parents of children aged under 18 years from the general population of Ukraine, approximately 6 months after the invasion by Russia. All participants had been exposed to at least one war-related stressor, and the mean number of exposures was 9.07. Additionally, 25.9% met diagnostic criteria for PTSD. Participants who had the highest exposure to war-related stressors were significantly more likely to meet criteria for PTSD compared to participants who were less exposed (Karatzias et al., 2022). In a study conducted in Palestine with 1029 students aged 11-17 years, the reported results showed that about 88.4% of the majority of children and adolescents had experienced personal trauma, and about 83.7% witnessed the trauma of others. The data also showed that the prevalence of PTSD was 53.5%. Children who had experienced personal trauma, the trauma of others, and property damage were significantly more likely to be diagnosed with PTSD than those who had not. The most severe trauma was personal trauma, followed by witnessing the trauma and then observing the destruction of residences or properties (El-Khodary et al., 2020).

Regarding the traumatic effects, an exhaustive explanation is given by Peseschkian's positive psychotherapy, which emphasizes that some traumas accumulate in the form of small, repeated psychic injuries that cause what is called "microtrauma". In an actual conflict, when coping mechanisms are overwhelmed, an old unconscious basic conflict may arise, pitting primary emotional needs such as trust, hope, or tenderness against secondary capacities or social norms such as order, punctuality, justice, or openness. When the previous compromise that worked to resolve the underlying conflict is no longer effective, an internal conflict arises, leading to symptoms that are seen as attempts at resolution. These conflict reactions can be represented using the Balance Model, although they may not bring solutions, they still have an impact (Peseschkian, 1987).

Conclusions

The findings of the cited studies show that exposure to armed conflicts or experiencing combat events causes severe trauma and increases the risk of mental disorders. Previous research has found that the trauma of non-violent war can affect mental well-being in the same way as direct trauma. Forced evacuation exposes children to additional stressors, including separation or loss of family members, close peers, the community, etc. Exposure to war trauma increases both internal and external reactions in children. Internal reactions, such as depression, suicidal thoughts, worry, and anxiety, were prevalent among young Liberians and Syrian refugees exposed to armed conflicts. These children who were exposed to war showed excessive anxiety and fear, manifested by dependent behaviors, attachment to parents, and fear of being alone or sleeping in the dark. Traumatic events and daily stress were strongly associated with psychological distress in adolescents living in a war-torn region of Ukraine. These findings can help understand, measure, and address the long-term impact that the current escalating war in Ukraine will have on the mental health and social functioning of children and adolescents. Based on the results of the studies, it is recommended to undertake mass controls of children and adolescents for the identification and diagnosis of mental health disorders and to increase human resources for treatment, rehabilitation, and psychosocial support. Interventions should take into account children's background, including gender, age, where they live, and their socio-economic status (e.g., family income, parental education level, family size), to alleviate psychological symptoms and increase their resilience. Parenting practices appear to play a crucial role in children's psychological well-being in a war context, both as a risk and a protective factor. Consequently, adequate health care programs for war-traumatized communities require individual and family-level approaches. The latter would assess and treat possible problems between the parents as well as in the parent-child relationship. This can stop a potentially vicious cycle of war trauma, psychopathology, and dysfunctional family dynamics, including the abuse of women and children.

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Section: Special articles

POETRY AND PSYCHOTHERAPY: THE CASE FOR FERNANDO PESSOA AS A THERAPIST. POETRY AS A TOOL IN PSYCHOTHERAPY

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Abstract

Nossrat Peseschkian incorporated the use of stories as a key element of Positive Psychotherapy (Peseschkian 2016). Poetry has also been proposed as a powerful tool in psychotherapy and defined as "the use of language, symbol and story in therapeutic, educational and community-building capacities." (Mazza 2016). Among great poets Fernando Pessoa is relatively unknown due to his writing in Portuguese and to the complexity of his multiple styles, personas and perspectives. Yet, this very complexity makes his poetry, alongside his unique prose, powerful tools to be used in psychotherapy. Finally, his poems are easily accessible in both Portuguese and English today. This article starts with a brief biographical introduction to Pessoa, followed by examples of his work under different voices that can be used by mental health professionals in supporting persons in the process of healing through psychotherapy.

Keywords: poetry, psychotherapy, narrative approach, positive psychotherapy

Introducing Fernando Pessoa - 1888-1935

Born in Lisbon, Portugal, Fernando Pessoa lost his father to tuberculosis at the age of five. Soon thereafter his mother remarried and the family moved to South Africa where Fernando received his education in English. At the age of seventeen he returned to Portugal to attend college never to leave Lisbon again. Despite being a talented student Pessoa did not complete his college education in order to dedicate his life to writing poetry independently and supported himself financially by writing and translating commercial letters - he never married and had no children. Pessoa was part of the generation that introduced modernism in Portugal with the literary magazine Orpheu. In 1914 Pessoa started to write poetry as three different poets, literary personas he named his "heteronyms" to emphasize them being more than pseudonyms. Those three poets are: Alberto Caeiro, Alvaro de Campos, and Ricardo Reis - each writing in their own style, with their own perspectives, and even opinions of each other. Despite his enormous talent and recognized mastery in poetry and prose, Pessoa only published a few chapbooks with some of English poems and one book of poetry in Portuguese. Upon his death, at the early age of 47, he left a trunk full of writings, both poetry and prose, that would be rediscovered in the 1950's and since then considered a national treasure in Portugal and beyond. For a comprehensive account of Pessoa's life and works see (Zenith 2021).

Fernando Pessoa's own poetry

When writing poetry as himself, sometimes referred to as "ortonym" in opposition to his "heteronyms", Pessoa had specific themes which can be used to give those in therapy a new perspective. One such theme was the opposition

between thinking and feeling exemplified in a poem titled “This” starting with:

They say I fake or lie
All I write. No.
I just feel
With my imagination.
Not with the heart.

This perspective of imagining feelings, or thinking feelings, can help persons overwhelmed by emotions and strong feelings gain some understanding and control over such emotions and feelings - an approach sometimes framed as “cognitive control of emotions” (Kohn et al. 2021). This approach can give a person a much needed distance to attain a sense of calm over these strong emotions. Another example of thinking instead of feeling - or of thinking over feeling - can be found in the poem starting:

I feel so much
That I'm often persuaded
That I'm sentimental,
But I recognize when I measure myself
That it's all thought,
That I didn't really feel.

Case example: Autism Spectrum Disorder and “imagining feelings”

The patient was an adult who had struggled his whole life with understanding feelings - both his own and others’. As described in the DSM-5 criteria for Autism Spectrum Disorder, he presented “deficits in social-emotional reciprocity, ranging from abnormal social approach and failure of normal back and forth conversation; to reduced sharing of interests, emotions, or affect.”(American Psychiatric Association 2021). The therapist shared Pessoa’s line “I just feel with my imagination” which helped the patient work on imagining emotions that would be appropriate in specific social encounters and interactions.

Longing for lost childhood is another there in Pessoa’s poems when writing as himself. This recurrent theme in Pessoa writing as himself sometimes point to a childhood that actually never was. This idea is embedded in the perception that time has passed and that the vision of the world through infant eyes is lost forever, only to remain as an idea or memory. One such poem starts:

The child I once was cries on the road.
Where I left him when I came to be who I am;
But today, seeing that what I am is nothing,
I want to go and find who I was where he stayed.

These longings - and sharing such perspectives - can be helpful to patients dealing with trauma and loss - what today we conceptualized as “adverse childhood events” and have been linked to a number of negative health outcomes (Harris 2018). The poem express a well-known longing for things past including an idealization of this lost past, with another example being the poem “Christmas” in which the poem imagine the snow over the little house - something that never happened:

And how white with grace
The landscape I don't know,
Seen from behind the window
Of the home I'll never have!

Pessoa writing as Alberto Caeiro

Of the three main “heteronyms” Alberto Caeiro is recognized by the others, and by Pessoa himself, as their “master.” Caeiro’s main work is a collection of poems titled “The Herd Keeper” - sometimes translated as “the keeper of the sheep.” In this series of poems Alberto Caeiro exposes and explains his philosophical position of being an “sensacionismo” as Pessoa called the approach. Sensacionismo emphasizes the importance of sensory perception and the immediate experience of the world over abstract intellectualism. As such, Caeiro proposes a basic description of nature based on sensations alone, without the elaboration of metaphors or metaphysics. This approach can be understood as a variation of intellectualization, a defense mechanism that can best be referred either to a variant of the more basic defense of isolation of affect, or to the psychological translation of emotional issues into intellectual terms (Arnold 2014).

In these opening lines of poem 9, Caeiro introduces the central metaphor of the poem: the poet as the herd keeper, with the herd being his own thoughts. This metaphor underscores the idea that Caeiro's thoughts, like a herd, are simple and natural. He doesn't engage in complex philosophical ponderings but instead embraces the immediacy of sensory experience.

I'm a herd keeper.
The herd is my thoughts
And my thoughts are all sensations.

I think with my eyes and with my ears
And with hands and feet
And with the nose and mouth.

Caeiro continues to emphasize the primacy of the senses in his thinking process across his poetic works. He doesn't rely on abstract reasoning or intellectual analysis; instead, he engages with the world directly through his senses. This direct sensory experience is a fundamental aspect of his "sensacionismo" philosophy.

To think of a flower is to see and smell it
And to eat a fruit is to know its meaning.

Caeiro suggests that true understanding comes from a direct engagement with the object or idea in question. Above he uses the example of thinking about a flower by seeing and smelling it. This tactile and sensory approach to thought underscores his rejection of abstract, detached reasoning. To truly understand something, he believes in immersing oneself in the sensory experience of it.

Caeiro paradoxically suggests that while his approach doesn't necessarily yield a structured intellectual understanding of a subject, it allows him to grasp it on a more profound, intuitive level. This aligns with his belief in the importance of immediate sensory experience over abstract analysis.

In "The Herd Keeper," Fernando Pessoa, writing as Alberto Caeiro, presents a poetic philosophy that celebrates simplicity, direct experience, and the beauty of the natural world. Through his sensory engagement with the world, he invites readers to embrace a more immediate and authentic way of perceiving and understanding life.

These poems can assist in therapy as reminders for patients - and therapists - about the importance of moments, directly experiencing the world without too much intellectualization or overthinking.

Pessoa writing as Alvaro de Campos

Of the three full-fledged heteronyms, Alvaro de Campos is the favorite of many readers, being a modern, audacious, and direct poet, who despite considering Caeiro his master lives away from the idyllic fields as a naval engineer fully immersed in the city and its modern life and machinery. One of the famous poems as Alvaro de Campos describes the experience, so common among those with depression and anxiety, that everyone else seems perfect and "a winner" while the poet-narrator describes himself as " so often lowly, so often piggish, so often vile." This poem is titled "poem in a straight line" and midway through it asks:

Come on, I'm tired of demigods!
Where are there people in the world?
So am I the only one who is vile and wrong on this earth?

Alvaro de Campos also talks about being "weary", a feeling so prevalent among those with depression and anxiety. Suicide is another topic brought on by Alvaro de Campos when he asks at the start of a poem: *If you want to kill yourself, why don't you want to kill yourself?* The poem continues with a description of the futility of life and how others will forget those who died. There are some lines however in which the poem talks about the feeling of being important and elaborates that:

You're important to you, because you're what you feel.
You are everything to you, because you are the universe,
And the universe itself and the others
Satellites of your objective subjectivity.
You are important to you because only you are important to you.

Calling attention to the subjective importance each of us have for our own selves can remind our patients - and ourselves - of the need to center ourselves in our unique point-of-view to the world. It also reminds us not to depend on others, on their approval or their affection, to be well.

In that which is among Brazilian readers possibly the best known of poems by Pessoa as Alvaro de Campos, *The Tobacco Store*, the poem starts with a powerful contrast between what he is - we are - and what he contains - we contain - in terms of aspirations:

I am nothing.
I will never be but nothing.
I can't wish but to be nothing.
Aside from this, I have in me every dream in the world.

The poem goes on for many pages contrasting the subjective world of the poet with the concrete, outside world exemplified by the tobacco store. At some point the poet, who writes verses, and the tobacco store owner are contrasted as follows:

He will die and I will die.
He will leave the sign, I will leave verses.
At a certain point, the sign will die too, the verses too.
After a certain point, the street where the sign was located will die,
And the language in which the verses were written.
The rotating planet on which all this took place will then die.
In other satellites of other systems, anything like people
will continue to make things like verses and live under things like signs,

Which can be read as a short ode to the eternity of poetry - and the effort of the concrete world - thought the poem rapidly returns to his vision of futility:

Always one thing facing another,
Always one thing as useless as the other,
Always the impossible as stupid as the real

These are some examples of how the poems written by Pessoa as Alvaro de Campos can assist in giving patients - and therapists - opportunities to ponder on some of the deep existential matters brought on by depression and anxiety.

Case example: not relying on others for your own happiness

Patient was a woman in her mid-40's. She was single and although her core depressive symptoms decreased with treatment she continued to complain about not having a partner or a family. At times her loneliness was the main motive of the psychotherapy sessions - in those sessions she would proclaim: "if only I had a partner for life, things would be perfect!" After supporting the patient and developing a strong therapeutic alliance the therapist mentioned Pessoa's lines:

You're important to you, because you're what you feel.
You are everything to you, because you are the universe,
And the universe itself and the others
Satellites of your objective subjectivity.

Upon hearing this the patient repeated the sentence "you are the universe" and modified it to "I am the universe!" She appreciated the perspective of being, as she described, "self contained" and her beliefs that she would only be happy if she had others around her decreased - without never completing subsiding.

Pessoa writing as Ricardo Reis

The third full-fledged heteronym is a physician who writes classic odes: Ricardo Reis. The American literary critic Howard Bloom, in his *Western Cannon*, while calling Campos and Caeiro "great poets", calls Reis "an interesting minor poet." (Bloom 2014). Given his background on classical education and form, it is not surprising that Ricardo Rei's poetry from a philosophical perspective lean towards two schools from classic antiquity: Epicureanism and Stoicism. From Epicureanism Reis brings in the perspective of the importance of joy repeated in poems like:

Every day without enjoyment wasn't yours
You only lasted in it. How long you live
Without enjoying it, you're not living.

From Stoicism Reis brings the idea of living "placidly" which can be interpreted as the "ataraxia" idea of the Stoics:

To the night that comes in doesn't belong, Lydia,
The same ardor that the day asked of us.
Let us placidly love
Our uncertain life.

From the Stoics you can also identify the resignation facing the world and facing death, as in:

Nothing is left of nothing. We are nothing.
A little in the sun and the air so we lag behind
The unbreathable darkness that weighs us down
The damp earth imposed on us,
Postponed corpses that procreate.

In one poem he merges the two philosophical perspectives and calls himself a "stoic without hardness."

Deny me anything, Luck, but to see her,
That I, 'stoic without hardness,
In the engraved sentence of Fate
want to enjoy letters.

This Stoic stance written so many decades ago fits well with the current interest in this philosophical school as a precursor to

psychotherapeutic interventions (Robertson 2018). Another philosophical perspective not frequently mentioned when discussing Ricardo Reis' odes is Buddhism. One of the "four noble truths" of Buddhism is:

Suffering is caused by craving.

In Ricardo Reis we find time and again the notion that it is key to life is "not to want", as in:

But to those who expect nothing
Everything that comes is grateful.

And again in:

Want little: you will have everything.
Want nothing: you will be free.

Furthermore, in several Odes we see Pessoa, writing as Ricardo Reis, develop the Buddhist theme of impermanence as in the verses above stating that "Nothing is left of nothing. We are nothing." As with Stoicism and its relationship to psychotherapy, Buddhism too has been recognized as dialoguing with psychotherapy (Mathers, Miller, and Ando 2013).

Examining Reis' poetry from these different philosophical perspectives can enrich the reader, and the therapist, in two ways: first, it gives the reader a complex philosophical background on which to refer back on the ideas posed by each poem; second, it makes one realize how contemporaneous Pessoa/Reis can be today when we are ready to embrace a multicultural, multilingual and multi-tradition existence. In that sense reading Pessoa/Reis is as much enriching today as it was one hundred years ago when these verses were penned - or thousands of years ago when those philosophies of Buddhism and Stoicism were first proposed.

For therapists, and their patients, the Stoicism, Epicureanism, and Buddhism reflected in these poems can serve to minimize anxiety and the many dreads brought on by mental illness and trauma.

Case example: Taking Reis' Stoic perspective into action

The patient was a middle-aged woman questioning her achievements in life - both professional and material. After establishing a strong therapeutic relationship, the therapist mentioned Reis' lines:

Want little: you will have everything.
Want nothing: you will be free.

The patient paused and elaborated on how liberating it would be not to want too much and that led to a discussion about how much she already had achieved. In this instance the poem served as inviting the patient to question her own norms and expectations, as proposed by Remmers when using traditional stories (Remmers 2022).

Conclusions and Summary

The poetry of Fernando Pessoa, in each of his many voices, can assist therapists and their patients in the process of healing by addressing universal themes such as: the nature and place of feelings; the many facets of the self; how to deal with suffering in the world; how to consider our existential position in the face of death. Pessoa's deeply honest while still aesthetically elegant view of life as this collection of impression, sensations, and fleeting emotions can certainly help patients appreciate their own struggles with these same emotions and feelings. Finally, Pessoa's brutally honest assessment of himself and others is also a call to re-evaluate the weight we give to others' opinions and the proper place of these opinions in our mind, our attitudes and our behaviors towards the self and others.

The life of Pessoa itself can also serve as solace to patients living alone in pursuit of their dreams and aspirations. To see one immerse one's life in the language, to the point of proclaiming "my motherland is the Portuguese language" like Pessoa once wrote, as a means to produce art can also inspire others to immerse themselves in their own medium for creation and creativity.

The ideas, and the expression of such ideas as poetry by Fernando Pessoa and his heteronyms, correlate well with the balance model in Positive Psychotherapy (Messias, Peseschkian, and Cagande 2020). One can see Caeiro, the poem of essence, as the "body" or physical area of life. Campos, the poem of modernity, can be read as the poet of achievement and work. Reis, the philosopher poem, can be read as the "spiritual" area attached to meaning. Finally, Pessoa writing as himself, can be associated with the are of relationships and contacts given his longing for lost childhood and connection with others.

Reading Pessoa's poems - and his prose which is not addressed in this paper - can not only make us better therapists but also more complete and compassionate human beings to ourselves and

towards others.

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BOOK REVIEW

by Olga Lytvynenko

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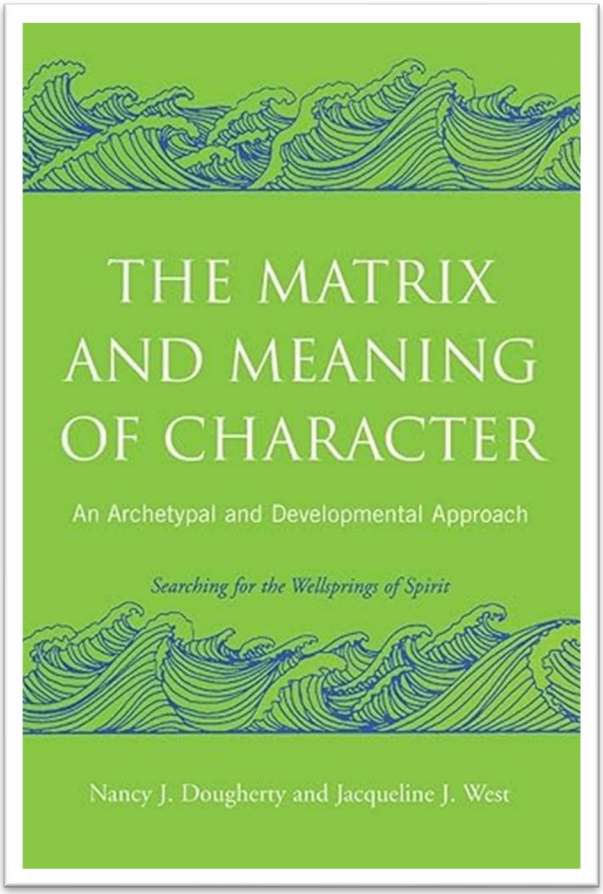
Email: dr.olgalytvynenko@gmail.com



Nancy J. Dougherty, Jacqueline J. West

"THE MATRIX AND MEANING OF CHARACTER: AN ARCHETYPAL AND DEVELOPMENTAL APPROACH"

Publisher: Routledge; 1st edition (2007)
Language: English
Paperback: 312 pages
ISBN-10: 0415403006
ISBN-13: 978-0415403009

"Where there's a wound, there's potential."
N. J. Dougherty, J. J. West

As we begin our practice, each of us in the helping professions, psychhologists and colleagues, is confronted with an inner need to understand how human beings work, what human character is, what the logic of intrapsychic affect is, and how all this manifests itself in behavior. We dream of a fulcrum that will help us to hold on among the manifestations of a wide variety of phenomena: properties, qualities and abilities, a large number of emotions and illogical human behaviors.

In the world of scientific psychology, medicine and psychotherapy, there are different classifications of characters and disorders. The book "The Matrix and Meaning of Character an Archetypal and Developmental Approach Searching for the Wellspring of Spirit" provides a very interesting way to look at people's character types using fairy tale and archetypal imagery. Like many Jungian books, "The Matrix..." fascinates us with its images and poeticizes the human character, but at the same time all this figurative and poetic language is based on a clear structure of the proposed typologization of individuals.

So, the authors offer an original perspective on character typology. They believe that the diagnoses of medical classifications can sound offensive to the patient and offer a lively diagnostic language that can make clinical work not only effective but also fun, allowing you to penetrate the psychic depths and find the right direction. The book describes nine-character structures tied to stages of early development and archetypal themes. As each person's psyche develops, it passes through three different stages, which have been given the

following names: primitive, or early, narcissistic, and preneurotic. The individual also internalizes one of three specific relationship patterns: avoidant, seeking, or antagonistic. The pattern of attitudes that actually defines a person's life arises from a set of factors that includes archetypal forces, biological predisposition, developmental conditions, and the element of chance or what is called the mystery of life. The three structures of character that form around the pattern of relationships are described in thematically related yet quite different images, fairy tales, and life stories. Thus, three developmental stages overlap with three different relationship patterns, giving rise to the character structures described: schizoid, counterdependent narcissistic, obsessive-compulsive, borderline, dependent narcissistic, hysterical, psychopathic, alpha-narcissistic, passive-aggressive.

The analysis of all these nine-character structures through fairy tales and myths is very impressive, in my opinion, and at the same time effective for clinical work with patients. Readers can try to recognize themselves in the images described and, by engaging in their emotional experience, reflect on what is closer to them, what abilities, resources and potential the fairy tale and the character of the hero carry. The Girl with Matches, Cassandra, Aphrodite, Brother Fox, Peter Pan, and other fairy tale and mythological characters infuse life, creativity, and energy into places in the patient's life that may seem unusually vulnerable. As the book poetically notes, "Demons that seem exceptionally pathological and haunting can become powerful guides to help us connect to the spiritual world."

So, the authors conclude that at the core of character structure is a paradox: "The core of any character contains a paradox: on the one hand, it is a protective structure, on the other, it is adaptive and has the potential for development, filled with an inspiring archetypal presence. Thus, our traumas, our personality and our abilities are directly related to each other. Within the character structure itself lies the seed of transformation and individuation." The character structure is an individual portrait that represents archetypal themes and personal traumas, as well as what has been dealt with and what has had to be defended against at a particular stage of development.

The authors also argue that transformation does not happen in spite of, but because of character structures; it is through one's wounds that one is able to heal at the deepest level, awaken creative energies, and start the process of individuation. At the end of the book, Dougherty and West express the hope that by understanding the peculiarities of different character structures through this book, each of us will be able to understand ourselves better and more deeply.

The book is very close to the spirit of positive psychotherapy, as it is based on an exploration of the abilities, resources, and potentials that are present in every personality, every character, and every trauma, and is thus highly recommended by me for study and use.

OBITUARY

In loving memory of Dr. Gunther Hübner

(*14.03.1957 † 16.10.2023)

by the German Association for Positive and Transcultural Psychotherapy (DGPP) and the Peseschkian Foundation

A LIFE FULL OF WISDOM, WARMTH AND COMMITMENT

It is with heavy hearts that we bid farewell to our esteemed colleague and friend Dr. Gunther Hübner. He was not only an outstanding psychotherapist and family therapist, but also a mentor, advisor and a true friend to us all. His sudden death leaves a painful void in our hearts and in the world of psychotherapy.

Born in Africa, where his father worked as a doctor, he returned to Germany as a child with his family and pursued his education. His schooling, professional training and studies endowed him with an extensive foundation of knowledge and experience.

Early on he met Prof. Dr. Nossrat Peseschkian, the founder of Positive Psychotherapy, and became one of his first collaborators. Dr. Gunther Hübner was a co-founder of the German Society for Positive Psychotherapy (DGPP) in 1978, later its president, and served on its board until his passing. In 1996, he was a founding member of the World Association for Positive Psychotherapy (WAPP) and was a member of its board for several years. His involvement also extended to the Peseschkian Foundation and its Board of Trustees. Dr. Gunther Hübner lived Positive Psychotherapy and led us in countless training cycles, courses, seminars and lectures in Germany and abroad in which he was an enthusiastic proponent of Positive Psychotherapy until his death. In addition, he ran a private practice for individual, couple and family therapy and was able to help hundreds of patients and clients.

Dr. Gunther Hübner was a man of remarkable wisdom and deep knowledge. His commitment to people's mental health and well-being knew no bounds. His ability to listen empathically and give insightful advice was a source of inspiration to us all. He knew how to help people not only overcome their inner conflicts, but also to find hope and joy in life again. What particularly distinguished Dr. Gunther Hübner was his incomparable humor and caring. Even in the most difficult moments, he was able to put a smile on the faces of his patients and friends. His friendly nature, humility and generosity touched and inspired many of us. Dr. Gunther Huebner was also a talented athlete and a passionate spirit. He

knew the importance of physical health, responsibility and purpose. His energy and enthusiasm for life were contagious and encouraged us to be mindful, to bring out the best in ourselves and to contribute.

In addition to his outstanding therapeutic work, Dr. Gunther Hübner was deeply rooted in the Bahai faith. His belief in the unity of humanity and the importance of compassion, love and tolerance was an important source of his wisdom. He exemplified these values in his daily life and thus inspired us all.

Undoubtedly, Dr. Gunther Hübner was a citizen of the world who had the ability to connect with people from all parts of the world and to speak on a wide range of topics. Thus, Dr. Gunther Huebner was not only a teacher, counselor and companion to countless training candidates and experienced psychotherapists, but he also opened the hearts and changed the lives of many people. His legacy will live on in the hearts and minds of those who were fortunate enough to know him.

Dr. Gunther Hübner's funeral took place on Thursday, October 26, 2023 at the cemetery in Hofheim-Langenhain with some 200 persons. The World Association for Positive and Transcultural Psychotherapy has named a star after Gunther and presented the official certificate to the family.

There was also an opportunity to say goodbye to him at a memorial service on November 5, 2023 at the Bahá'í Center in Langenhain.

In gratitude for his friendship, his wisdom and his love for humanity, we will always carry Dr. Gunther Hübner in our hearts. May his soul rest in peace.

Our thoughts also go out to his family. May they find sufficient strength, peace, courage and confidence at this difficult time.

Board of Directors, Advisory Board and DGPP Office

WAPP NEWS

World Association for Positive and Transcultural Psychotherapy, January 2024

Dear WAPP Members,
Dear friends and advocates of Positive Psychotherapy worldwide,

As we contemplate the challenges and triumphs that defined 2023, we draw comfort from our collective resilience and unity. This success is a testament to your outstanding efforts and unwavering dedication. In the paper, we highlight a few milestones achieved as a collective.

In a remarkable stride, the World Association for Positive Psychotherapy has hit a milestone, boasting a whopping 2200 members from 52 countries spanning 6 continents in the year 2023. Positive Psychotherapy is spreading far and wide, transcending borders and cultural boundaries.

Three committees, eighteen working groups, and sixty dedicated volunteers are tirelessly contributing to the development of the Association and the advancement of the method. We extend our heartfelt gratitude for their unwavering commitment.

A pivotal accomplishment from the past year includes the overwhelming approval of updates to WAPP's bylaws at the Extraordinary General Member Assembly on December 6, 2023. This collective decision marks a significant step forward in refining our organizational structure to better serve our community.

Your support and active participation have been instrumental in making this change happen. Together, we're shaping the future of WAPP, and we're grateful for each member's valuable contribution.

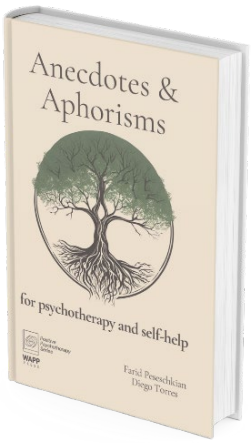
With deep gratitude and best wishes
The WAPP Board of Directors and Head Office

WAPP PRESS

Damian, Ovidiu & Hum, Gabriela (2023). Facing The Mirror: Positive Psychotherapists Revisiting Their Past. Wiesbaden: WAPP Press, 2023. — ISBN 978-3-910225-24-4

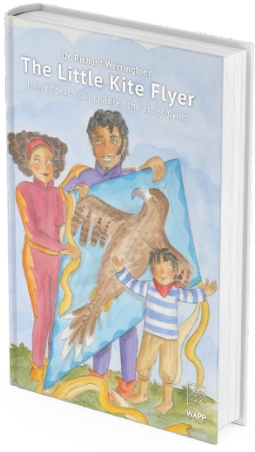
E-book

Paper book



Peseschkian, Farid & Torres, Diego (2024). Anecdotes & Aphorisms: for psychotherapy and self-help. Wiesbaden: WAPP Press, 2024. — ISBN 978-3-910225-21-3

Will be available soon



Werningloer, Richard-Christian (2023). The Little Kite Flyer: How to teach our children the art of "flying". 2nd Ed. Wiesbaden: WAPP Press, 2023. — ISBN 978-3-910225-17-6

E-book

Paper book

PPT

WAPP
PRESS

For the last 6 months "WAPP Press" has prepared and published 2 new books, 2 revised and updated second editions, 4 first-ever translated in Persian books of Nossrat Peseschkian.

All authors interested in collaborating with us are welcome to visit:

WAPP Press

WAPP ONLINE

In a stride towards making Positive Psychotherapy more accessible, WAPP has recently unveiled an exciting initiative – a comprehensive video course "Introduction into Positive Psychotherapy" - series comprises 18 bite-sized lessons, each running between 3 to 5 minutes, designed to elucidate the fundamental concepts of Positive Psychotherapy.

These succinct video lessons are crafted to offer viewers valuable insights, practical techniques, and a profound understanding of the Positive Psychotherapy method. Whether you're a seasoned practitioner or someone curious about this transformative approach, these videos serve as a concise yet enriching resource.

We extend a warm invitation to our community and beyond to not only explore these lessons personally but also to share them generously. The videos are now live on WAPP's YouTube channel Positive Psychotherapy

TRANSCULTURAL NEWS

Chinese Delegation Lights Up Wiesbaden

In August 2023 Wiesbaden played host to a dynamic Chinese delegation comprising 15 individuals representing five centers scattered across various cities. Over several intense days, they immersed themselves in PPT training.

But the visit wasn't just about seminars; the delegation also delved into insightful organizational consultations with the Head Office, tackling crucial matters of cooperation.

We express our heartfelt gratitude to our Chinese friends for embarking on this journey. Their warm visit left us inspired!

Training Triumphs Despite Global Challenges

Amidst the ongoing war in Ukraine, Ukrainian trainers and organizers shines a resilience through as persist in conducting regular modules on PPT.

The first-ever International Basic Course has been kickstarted at the London PPT center, uniting participants from Samoa, Thailand, the UK, Portugal, and the USA, spanning four vastly different time zones.

India has welcomed its inaugural Basic Course on PPT, marking a significant step in the expansion of Positive Psychotherapy in the East. Meanwhile, training has resumed in Kazakhstan, contributing to the development of Positive Psychotherapy in diverse regions.

Celebrations are in order as two Basic Course groups have successfully earned certification in Ethiopia, a testament to the global impact of WAPP.

But that's just the tip of the iceberg – numerous other courses have been conducted worldwide, spreading the positivity and wisdom of PPT to eager minds across the globe.

WAPP continues to be a beacon of hope, breaking barriers, and fostering a global community committed to the transformative power of Positive Psychotherapy.

EXCITING EVENTS IN THE SECOND HALF OF THE YEAR 2023

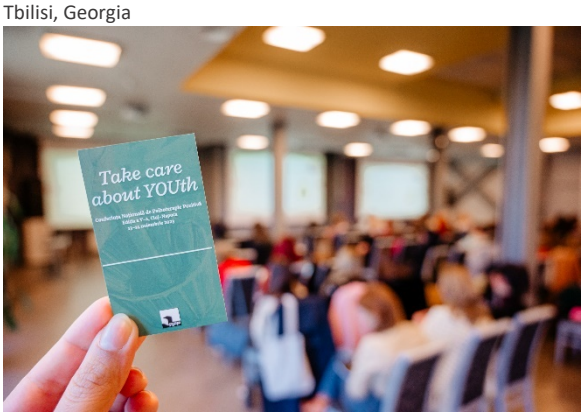
Ukrainian- Summer School 7th Edition in Shabla, Bulgaria, July 2023

Romanian Summer School – 16th Edition, July 2023

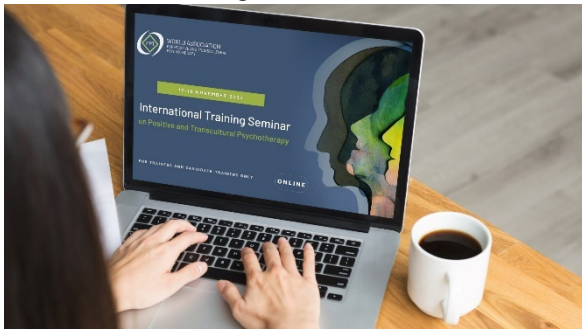
The International Conference on PPT, August 2023 in Shenzhen, China

First International Caucasian Conference on PPT, October 2023 in Tbilisi, Georgia

Jubilee Conference “30 years of PPT in Bulgaria – Fruits of Time”, October 2023 in Varna, Bulgaria



5th National Romanian PPT Conference, November 2023 in Cluj Napoca, Romania



The 24th International Training Seminar on Positive Psychotherapy, November. 2023, online

Second Online World Conference on Positive and Transcultural Psychotherapy, November 2023

FUTURE EVENT

Information and Guidelines for Authors

Full and up-to-date "Information and Guidelines for Authors" are on the JGP website:
positum.org/ppt-journal/

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

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

Review Process: All manuscript submissions - except for short book reviews - will be anonymized and sent to at least 2 independent referees for 'double-blind' peer-reviews. Their reviews (also anonymized) will then be submitted back to the author. "The Global Psychotherapist" Journal uses software "Unicheck" to detect instances of overlapping and similar text in submitted manuscripts and accepts in case of a satisfactory result (determined for each of the articles on an individual basis by the ratio of the original text fragments, borrowed fragments and the presence of formalized links – 85 %).

Submissions can only be sent by an email attachment in DOC, DOCX, RTF format to *journal@positum.org*
For article's formatting, including information about the authors, the Editorials ask authors to use special templates.

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

References: The author must list references alphabetically at the end of the article, or on a separate sheet(s), using a basic Harvard-APA Style. The list of references should refer only to those references that appear in the text e.g. (Fairbairn, 1941) or (Grostein, 1981; Ryle & Cowmeadow, 1992) or (Kohn et al., 2021) or (Peseschkian & Remmers, 2020): literature reviews and wider bibliographies are not accepted. Details of the common Harvard-APA style can be sent to you on request or are available on various websites.

References from previously published articles of this Journal are encouraged.

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

Here are three basic examples:

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

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

[2]. **SHADISH, W. R., & RAGSDALE, K.** (1996). Random versus nonrandom assignment in controlled experiments: Do you get the same answer? *Journal of Consulting and Clinical Psychology*, 64(6), 1290–1305. https://doi.org/10.1037/0022-006x.64.6.1290

For books:

[3]. **PESESCHKIAN, N.** (2016). *Positive Psychosomatics: Clinical Manual of Positive Psychotherapy.* Bloomington, USA: AuthorHouse. 601 p.

For non-English resources:

[4]. **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:

[5]. **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.

For Web resources:

[6]. **FIELDING, L.** (2015). *Listening to Your Authentic Self: The Purpose of Emotions.* HuffPost. URL: https://www.huffpost.com/entry/finding-your-authentic-pu_b_8342280 Accessed: 5.11.2023

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