

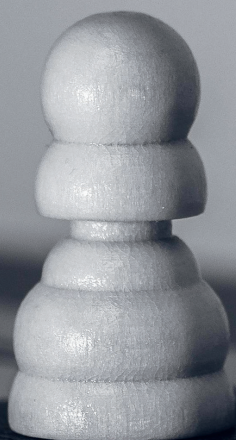
THE GLOBAL PSYCHOTHERAPIST

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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 applications 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, various aspects of psychotherapeutic training and education, applications of PPT in counseling, education, and management, letters to the editor, book reviews, and more. The Journal welcomes manuscripts from different cultures and countries.

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Welcome Letter by the Editorial Board



by Olga Lytvynenko

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Dear Readers,

Here we are in 2026, and the world still feels like it's holding its breath: wars continue, economies are unsteady, people everywhere are carrying more weight than before. Yet in the middle of all this, Positive and Transcultural Psychotherapy (PPT after Peseschkian, since 1977)™ keeps offering something quietly powerful: a way to find balance and cultural understanding, and to see strengths even in pain. It reminds us that hope and connection are not luxuries, they are resources we can actually use, right now.

Starting with this volume, we introduce a new structure to enhance accessibility and inclusivity: the journal will now be divided into two parts. The first part features peer-reviewed indexed articles that adhere to rigorous scientometric standards. The second part comprises peer-reviewed professional articles, offering space for innovative case studies, practical applications, and reflective insights that may not fit traditional academic frameworks but provide immense value to practitioners. This change lets us keep high academic quality where it's needed while at the same time opening the door wider for colleagues who have rich clinical experience, creative ideas and important observations to share.

In this January 2026 issue, you will find a rich mix of contributions.

From studies on hope, well-being and life balance, Positive Psychotherapy (PPT) in Chinese psychosomatic medicine, support for Ukrainian veterans and women in hardship, to explorations of marital satisfaction, intergenerational capacities, diabetes psychoeducation and existential adaptation in wartime. Theoretical articles look at meaning as a primary capacity, PPT's integrative power and elderly well-being. Practical pieces introduce new models for intrapersonal growth, inpatient psychiatry, eating disorders, body work, prison therapy cases, transcultural transference, ethics in wartime, joy-dignity-coherence, AI's role in isolation, and publication barriers. The second part brings professional insights on mental status, pain, time pressure, suicide prevention, school groups, social media's impact on teens, emotional mapping tools, and a deep interview with Arno Remmers on PPT's development in Bulgaria.

Looking forward, we are actively working toward broader indexing and, eventually, an impact factor. You can expect an updated editorial policy and author guidelines in the coming issues. These steps are necessary so that everyone who publishes with us receives proper visibility and recognition in the international academic world.

We extend our deepest gratitude to our authors, reviewers, and readers for sustaining this vital dialogue. Special thanks to our technical secretaries and editorial team members who do so much behind the scenes to make every issue possible.

Together, let us continue building a more hopeful, balanced world through shared knowledge and compassionate practice.

*With sincere appreciation,
on behalf of*

The Editorial Board

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

AI's Role in Psychotherapy Publishing

On the thoughtful integration of artificial intelligence in scientific writing for psychotherapy and mental health studies.

- *by the Editors*

Writing scientific articles in psychotherapy and mental health research requires deep engagement with complex topics such as therapeutic processes, emotional dynamics, and ethical considerations. It serves not only as a means of communicating findings but also as a process that sharpens critical thinking, fosters original insights, and ensures the integrity of evidence that influences clinical practice and patient outcomes.

As editors of our journal, dedicated to advancing psychotherapy and mental health research, we recognize the rapid progress of technology. Artificial intelligence (AI), including large language models (LLMs), can provide valuable support. It may assist in outlining structures, refining grammar, improving readability, or translating content, thereby allowing authors to focus on substantive ideas. When used judiciously as a supportive tool, AI can reduce routine cognitive load and facilitate exploration of nuanced psychological concepts.



Figure 1 is generated by AI

However, in fields like ours, where interpretations of human experiences demand empathy, contextual understanding, and ethical nuance, overreliance on AI carries significant risks. Recent years have seen a surge in submissions involving AI, complicating verification of authenticity, detection of inconsistencies, and maintenance of scholarly standards. Manuscripts increasingly feature AI-generated literature reviews, analyses, or sections without adequate human oversight, which can introduce inaccuracies. **LLMs frequently produce "hallucinated" facts or fabricated citations, particularly in specialized domains requiring verified psychological evidence** (Ji et al., 2023; Walters & Wilder, 2023).

| Independent human authorship remains essential

It promotes thorough engagement with primary sources, critical reflection, and authentic synthesis – core to advancing psychotherapy knowledge. Research demonstrates clear cognitive benefits from manual processes: handwriting, compared to typing, leads to more elaborate brain connectivity patterns, particularly in theta/alpha frequencies across parietal and central regions, which support memory formation and encoding new information (van der Weel & van der Meer, 2024). This widespread neural engagement is beneficial for learning and deeper processing, implications that extend to scientific writing where independent authoring fosters intellectual rigor irreplaceable by AI.

Risks of excessive dependence:

- **Loss of critical thinking:** delegating mental tasks externally reduces reflective and analytical engagement
- **AI "hallucinations":** fabricated facts and references, especially in specialized fields of psychological evidence

Overreliance on AI can erode these benefits. Studies show that using LLMs for essay writing accumulates "cognitive debt," with reduced neural connectivity in memory and creativity networks, poorer recall, and lower ownership of produced work over time (Kosmyna et al., 2025). Frequent AI tool use correlates with weaker critical thinking abilities, mediated by cognitive offloading—delegating mental tasks externally, which diminishes reflective and analytical engagement (Gerlich, 2025; Zhai & Wibowo, 2024). In educational contexts, excessive dependence impairs decision-making, analytical reasoning, and independent skills, potentially leading to superficial analyses and reduced creativity (Zhai & Wibowo, 2024). AI in research also risks enabling "doing more, but learning less," where efficiency gains narrow inquiry and limit deeper understanding (Messori & Crockett, 2024).

| "Writing is thinking. Human understanding and responsibility remain indispensable in psychotherapeutic research."

Even advanced AI remains imperfect, prone to biases, fabrications, and misinterpretations in mental health contexts. Our journal prioritizes verified, trustworthy knowledge amid post-truth vulnerabilities. We commit to human-checked information: authors who conscientiously read sources, reflect, critique, and synthesize responsibly. Routine checks using AI detection tools and manual reference verification often reveal fabricated sources or hallucinations, imposing substantial burdens on our technical team, editors, and reviewers.

To protect quality, from our next issue onward, we will require transparent disclosure of any AI use. **At initial screening, manuscripts containing AI-fabricated elements, such as claims, interpretations, analyses, or references, will be rejected prior to content evaluation or peer review.** Issues identified later, even during final preparation after apparent acceptance, will result in withdrawal. This approach aligns with broader calls for accountability in scientific publishing, including the recognition that "writing is thinking" and the need to value human-generated work amid LLMs (Editorial, 2025).

Authors are encouraged to use AI responsibly: as a tool for support, with independent verification of all outputs, full accountability for accuracy and originality, and priority given to human insight. This balanced integration helps safeguard the integrity of psychotherapy and mental health scholarship.

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PART I. PEER-REVIEWED INDEXED ARTICLES

Section: Research and innovations in Positive Psychotherapy (PPT)

The Predictive Roles of Hope and Subjective Well-Being in Life Balance: Evidence from a Positive Psychotherapy Framework

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Abstract

The present study examined the predictive roles of hope and subjective well-being in individuals' levels of life balance, drawing on the theoretical framework of Positive Psychotherapy (PPT). The sample comprised 319 adults residing in 57 provinces across Türkiye. Data were collected using the Subjective Well-Being Scale (Akin & Satıcı, 2013), the Dispositional Hope Scale (Tarhan & Bacanlı, 2015), and the Harmony in Life Scale (Satıcı & Tekin, 2017). Statistical analyses were conducted using SPSS 26, employing Pearson's product-moment correlation, multiple linear regression, and independent samples t-test. The findings indicated that hope and subjective well-being were positively and moderately correlated, while both variables significantly predicted life balance. Gender differences were not statistically significant. Interpreted through the lens of Positive Psychotherapy, the results highlight that individuals with higher levels of hope and subjective well-being achieve greater equilibrium across the four core life spheres: body/health, achievement/work, relationships, and future/meaning. These findings support PPT's assumption that well-being depends on the balanced and conscious use of one's primary capacities, particularly hope. The study suggests that interventions aimed at fostering hope and subjective well-being can enhance overall life balance and promote adaptive functioning within both clinical and everyday contexts.

Keywords: hope, subjective well-being, life balance, Positive Psychotherapy, balance model

Introduction

Subjective well-being (SWB) refers to individuals' cognitive and affective evaluations of their lives and encompasses both positive emotions and the relative absence of negative affect. As a central indicator of hedonic well-being, it is often discussed in terms of concepts such as happiness and life satisfaction. Although

its philosophical roots can be traced to thinkers such as Aristotle and Epicurus, systematic empirical investigations emerged in the twentieth century.

Diener's (1984) conceptualization of SWB as "the degree to which individuals judge the overall quality of their lives positively" has shaped contemporary research, and extensive

empirical evidence indicates that higher levels of SWB are associated with better physical health, stronger social relationships, and greater life satisfaction. Within the broader field of well-being science, both Positive Psychology and Positive Psychotherapy (PPT) emphasize human strengths, developmental potential, and flourishing; however, they differ in their theoretical orientations and applications. Positive Psychology, introduced by Seligman and Csikszentmihalyi (2000), is a research-driven movement concerned with understanding happiness, meaning, character strengths, and the conditions that promote optimal functioning. In contrast, PPT translates these principles into a structured therapeutic model that seeks to foster balance, inner capacities, and adaptive coping in clinical practice. Thus, while the two perspectives are complementary, PPT operationalizes well-being principles in ways that directly inform intervention design and therapeutic implementation (Diener, 1984; Diener et al., 2006; Seligman & Csikszentmihalyi, 2000; Seligman, 2011).

In contrast, Positive Psychotherapy (PPT), developed by Nossrat Peseschkian (1987), is a distinctive therapeutic approach grounded in psychodynamic and intercultural principles. PPT views psychological symptoms not merely as pathological signs to be eliminated but as opportunities for understanding inner conflicts and fostering the development of individual potentials. The theory conceptualizes well-being through the Balance Model, which describes harmony among four fundamental life spheres: body/health, achievement/work, relationships, and future/meaning. Additionally, the Capacity Model distinguishes between “primary capacities” (e.g., hope, love, patience) and “secondary capacities” (e.g., order, punctuality, honesty) as key resources for maintaining this balance (Peseschkian & Remmers, 2025). Whereas Positive Psychology primarily aims to enhance well-being at a general, population level, Positive Psychotherapy operationalizes these concepts within a therapeutic, intercultural, and meaning-centered framework (Kyrychenko, 2021). From the perspective of Positive Psychotherapy (PPT), subjective well-being is not limited to the perception of “happiness” or “satisfaction”; rather, it is understood as a dynamic state defined by the individual’s ability to maintain balance across four fundamental life spheres: body/health,

achievement/work, relationships, and future/meaning (Peseschkian, 1987; Peseschkian & Tritt, 1998). Within the Balance Model, long-term one-sidedness or overinvestment in any single sphere may lead to psychological maladjustment. In contrast, the therapeutic goal is to help individuals recognize their inner capacities and distribute their energy more evenly across these areas. The framework of primary and secondary capacities, together with the capacities to love and to know, provides the conceptual foundation for achieving such a balance. This model integrates psychodynamic and intercultural principles, emphasizing meaning and values as central components of mental health (Peseschkian, 1987; Peseschkian & Remmers, 2025).

Accordingly, in this study, subjective well-being is first conceptualized within the positive psychology literature (e.g., Diener, 1984; Diener et al., 2006) and then reinterpreted through the lens of Positive Psychotherapy’s Balance Model and capacity approach. Positive Psychology highlights human strengths and potential as a broad psychological framework, whereas Positive Psychotherapy, developed by Nossrat Peseschkian, is a distinctive therapeutic method grounded in psychodynamic and intercultural foundations. In this research, both hope and subjective well-being are examined within the context of PPT’s Balance Model, fundamental capacities, and value-oriented approach.

Empirical research has shown that a variety of factors contribute to an individual’s subjective well-being, including genetic influences (Lykken & Tellegen, 1996), personality traits (Costa & McCrae, 1992), and life events (Lucas, 2007). Moreover, numerous studies have demonstrated that interventions such as mindfulness-based practices (Brown & Ryan, 2003) and positive psychology interventions (Seligman & Csikszentmihalyi, 2000) can lead to measurable improvements in subjective well-being. One important dimension of subjective well-being is life balance, which refers to the degree of harmony and integration across various life spheres such as work, relationships, and personal development. Individuals who experience greater balance in their lives tend to report higher levels of well-being (Diener, 2009).

From the perspective of Positive Psychotherapy (PPT), this concept of “balance” corresponds directly to the Balance Model. According to PPT, individuals achieve higher

levels of well-being when they can maintain equilibrium across four core life spheres: body/health, achievement/work, relationships, and future/meaning (Peseschkian, 1987; Peseschkian & Remmers, 2025). Prolonged one-sidedness or overinvestment in any single area may lead to psychological disturbances rooted in imbalance. PPT further emphasizes the role of primary capacities such as hope, patience, and love as conscious and balanced inner resources that sustain subjective well-being (Peseschkian & Tritt, 1998).

Life balance can be fostered through various mechanisms, including setting and pursuing personal goals, maintaining positive interpersonal relationships, and engaging in activities that align with one's values and interests (Steger et al., 2009). In addition, mindfulness practices have been shown to enhance work-life balance by helping individuals become more aware of their thoughts and emotions and respond to them in a nonjudgmental, balanced manner (Biegel et al., 2009).

Empirical studies have demonstrated that various factors, including genetics (Lykken & Tellegen, 1996), personality traits (Costa & McCrae, 1992), and life events (Lucas, 2007), contribute to an individual's subjective well-being. Moreover, a growing body of evidence indicates that mindfulness-based practices (Brown & Ryan, 2003) and positive psychology interventions (Seligman & Csikszentmihalyi, 2000) can effectively enhance subjective well-being. However, within the framework of Positive Psychotherapy (PPT), the concept of hope is approached more broadly and more balanced. According to PPT, hope is not merely a forward-looking expectation or motivational drive; rather, it is defined as a primary capacity that should be exercised responsibly and in moderation within the Balance Model (Peseschkian & Remmers, 2025).

In the PPT approach, overusing the capacity for hope can lead to unrealistic expectations, disappointment, and emotional imbalance, whereas underusing it can result in hopelessness, passivity, and withdrawal from personal goals. For instance, a PPT-based hope placement intervention was found to

significantly increase participants' levels of hope and their perceived sense of purpose in life (Gülirmak Güler et al., 2024). This finding underscores the importance of guiding the use of hope in a therapeutically balanced way. Accordingly, in this study, hope is first examined within the framework of positive psychology literature and then reinterpreted through the lens of PPT's Balance Model, capacity approach, and its hope-related therapeutic strategies.

In conclusion, hope is positively associated with subjective well-being and life balance. Hope plays a crucial role not only in coping with stress and adversity but also in developing a sense of meaning and purpose in life. Furthermore, hope motivates individuals to pursue goals and aspirations across different areas of life.

The present study aimed to examine the predictive roles of individuals' levels of hope and subjective well-being in their life balance. To achieve this aim, the following research questions were addressed:

- Is there a significant relationship between individuals' levels of hope, subjective well-being, and life balance?
- Do individuals' levels of hope and subjective well-being significantly predict their levels of life balance?
- Do individuals' levels of life balance differ significantly by gender?

Methodology

2.1. Sample

The sample for this study comprised 319 individuals aged 18-53 ($M = 29.89$, $SD = 7.48$), including 250 women (70.6%) and 104 men (29.4%). Participants were recruited through online surveys distributed via web-based platforms and participated voluntarily. They completed scales assessing hope, subjective well-being, and life harmony, as well as demographic questions on gender, age, and family structure. The research project was approved by the Social Sciences Research Ethics Committee of Yıldız Technical University (Approval No.: 20230602161). The characteristics of the study group are presented in Table 1.

Table 1. Characteristics of the study group

Variable	Frequency	%
Gender		
Female	227	71.2
Male	92	28.8
Education Level		
Primary School	15	4.7
High School	25	7.8
Bachelors Degree	174	54.5
Graduate Degree	105	32.9
Number of Siblings		
0-3 Siblings	224	70.2
4-7 Siblings	86	27.0
8 and higher	9	.9
Perceived Socio-Economic Status (SES)		
Low	48	15.1
Mid	201	63.0
High	70	22.0

Table 2 presents the results of the regression analysis conducted using the stepwise method. Parameters other than the predictors included in the model were excluded.

When Table 2 is examined, it is observed that the model investigating the extent to which students' scores on the Adolescent Decision-Making Styles Scale (ADMSS) and their parents' scores on the Wiesbaden Positive Psychotherapy and Family Therapy Inventory (WIPPF) predict students' scores on the Test Anxiety Inventory (TAI) is statistically significant, with an explained variance of 33.4% ($p < .05$). Students' scores on the "Panic" subscale of the ADMSS positively predict their TAI scores ($\beta = 0.46$; $p < .05$), indicating that higher panic scores are associated with higher test anxiety scores. In contrast, students' scores on the "Cautious-Selective" subscale of the ADMSS negatively predict their TAI scores ($\beta = -0.26$; $p < .05$), suggesting that greater cautious-selective decision-making is associated with lower test anxiety. Additionally, parents' scores on the "Punctuality" subscale of the WIPPF are positively associated with students' TAI scores ($\beta = 0.20$; $p < .05$).

2.2. Measures

Several instruments were employed in the present study, as detailed below:

2.2.1. Personal Information Form

A researcher-developed personal information form was used to collect demographic data, including participants' gender, educational level, birth order, and perceived socioeconomic status (SES).

2.2.2. Dispositional Hope Scale (DHS)

Participants' hope levels were assessed using the Dispositional Hope Scale (DHS; Snyder et al., 1991). The scale consists of 18 items (e.g., "I meet the goals that I set for myself") rated on an 8-point Likert scale ranging from 1 (definitely false) to 8 (definitely true). In the present study, the Turkish version adapted by Tarhan and Bacanlı (2015) was used. The Turkish adaptation comprises two subdimensions: Alternative Pathways Thinking and Agency Thinking. Scores range from 8 to 64, with higher scores reflecting higher levels of hope. The scale has demonstrated good internal consistency reliability ($\alpha = .84$; $KMO = .86$), and fit indices of the confirmatory factor analysis were at acceptable levels ($GFI = .96$, $AGFI = .92$, $RMR = .08$, $NNFI = .94$, $RFI = .90$, $CFI = .96$, $RMSEA = .077$).

2.2.3 Subjective Happiness Scale (SHS)

Participants' subjective happiness was measured using the Subjective Happiness Scale (SHS; Lyubomirsky & Lepper, 1999). This scale contains four items (e.g., "In general, I consider myself a happy person") rated on a 7-point Likert scale ranging from 1 (very unhappy) to 7 (very happy). Total scores range from 4 to 28, with higher scores indicating greater subjective happiness. The Turkish adaptation of the SHS was conducted by Akin and Satıcı (2011). Results of the confirmatory factor analysis indicated good fit indices for the Turkish version (RMSEA = 0.00, NFI = 0.99, CFI = 1.00, IFI = 1.00, RFI = 0.98, GFI = 1.00, AGFI = 0.99, SRMR = 0.015).

2.2.4. Harmony in Life Scale (HLS)

Participants' level of life harmony was assessed using the Harmony in Life Scale (HLS; Kjell et al., 2016). The HLS is a unidimensional scale consisting of five items (e.g., "I am in harmony") rated on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). Total scores range from 5 to 35, with higher scores indicating a greater level of harmony in life. The Turkish adaptation of the HLS was carried out by Satıcı and Tekin (2017). Confirmatory factor analysis supported the unidimensional structure of the scale and indicated an acceptable fit. The scale also demonstrated adequate internal consistency ($\alpha = .78$) and test-retest reliability ($\alpha = .89$).

2.3. Procedure

The data were collected online following ethics committee approval. Instructions for completing the instruments were provided on the first page of the online survey. The collected data were reviewed and prepared for analysis by the authors.

2.4. Data Analysis

Data analyses were conducted using SPSS 26. Prior to the analyses, the assumptions of each test were checked. Pearson's product-moment

correlation coefficient, multiple linear regression analysis, and an independent-samples t-test were used to examine relationships and differences among the study variables.

Results

In this study, the relationships among the variables were first examined. Pearson's product-moment correlation coefficient was used to examine the relationships among individuals' levels of hope, subjective well-being, and life harmony. The results indicated significant positive correlations: between hope and subjective well-being ($r = .41$, $p < .01$), between subjective well-being and harmony in life ($r = .42$, $p < .01$), and between hope and harmony in life ($r = .72$, $p < .01$). While the correlations between hope and subjective well-being and between subjective well-being and harmony in life were moderate in strength, the correlation between hope and harmony in life was strong. The intercorrelations among the variables are presented in Table 2.

Table 2.
Correlations Among Variables

	Correlation		
Hope	1	2	3
Subjective well-being	-		
Harmony in life	.41**	-	
M	.72**	.42**	-
SD	47.42	17.07	25.99
	5.86	3.78	10.21

Note. ** $p < .001$.

An independent-samples t-test was conducted to examine whether life harmony levels differed by gender. The results indicated no significant gender differences in life harmony ($t = .91$, $p > .05$). The analysis results are presented in Table 3.

Table 3. Gender Differences in Harmony in Life

	Gender	N	M.	Sd.	t	p
Harmony in Life	Female	227	26.16	6.00	.12	.71
	Male	92	26.08	5.70		

$p > .05$

To determine whether hope and subjective

well-being predicted life harmony, the

assumptions of multiple linear regression were tested. Examination of histograms and normal distribution curves indicated that the data were normally distributed. Multicollinearity, which occurs when two or more predictor variables are highly correlated and may threaten the regression model, was also assessed. The variance inflation factor (VIF = 1.20) indicates that multicollinearity is not a concern and remains within acceptable limits.

Results of the multiple regression analysis revealed that hope and subjective well-being were strongly associated with harmony in life ($R = .73$), accounting for 53% of the variance ($F(2, 319) = 202.01, p < .05$). Both hope ($\beta = .22, p < .01$) and subjective well-being ($\beta = .38, p < .01$) made significant contributions to the model. Predictors of harmony in life are presented in Table 4.

Table 4. Multiple Regression Analysis Predicting Harmony in Life

Variables	B	β	t	p	R	R^2	ΔR^2	F
Model	4.20		3.55	.00	.73	.53	.53	202.00
Hope	.38	.66	16.56	.00				
Subjective Well-Being	.22	.14	3.62	.00				

$p < .01^*$

Discussion

The findings of this study revealed that subjective well-being and hope are strong predictors of life balance. As individuals' subjective well-being increases, their life satisfaction, social relationship quality, and psychological health indicators also tend to improve (Sorbi et al., 2019). Similarly, hope is a fundamental factor supporting individuals' capacity to cope with challenges, pursue their goals, and maintain psychological resilience. These findings are consistent with the theoretical framework of Positive Psychotherapy (PPT). According to PPT, an individual's ability to maintain balance in life depends on the conscious, moderate use of their basic capacities (Peseschkian & Remmers, 2025). Within this perspective, subjective well-being is not limited to happiness or satisfaction. However, it is instead associated with the harmonious integration of the bodily, relational, achievement, and meaning/future spheres of life.

In culturally interdependent contexts such as Türkiye, hope, subjective well-being, and work-life balance are strongly linked to social connectedness, family relationships, and community support. Recent studies with Turkish samples show that hope contributes to subjective well-being not only as an individual cognitive–emotional resource but also as a relational capacity supported by meaning in life, sense of coherence, and shared values (Satici et

al., 2023; Yalçın & Malkoç, 2015; Yalnızca-Yıldırım & Cenkseven-Önder, 2023). Moreover, large-scale work on happiness and life satisfaction in Türkiye indicates that family bonds, religiosity, and other contextual characteristics are among the central determinants of everyday well-being (Sönmez & Altunsu Sönmez, 2018). Taken together, these findings suggest that the predictive roles of hope and subjective well-being for life balance observed in the present study should be interpreted within a cultural frame in which close relationships, collective goals, and social obligations are central to how individuals experience and regulate their psychological resources.

From the standpoint of PPT, hope represents an individual's capacity to formulate, sustain, and pursue meaningful life goals. However, PPT also emphasizes that hope, while a valuable inner resource, can become maladaptive if misused. Excessive hope may lead to unrealistic expectations, disappointment, and long-term imbalance, whereas diminished or insufficient hope may result in hopelessness, passivity, loss of motivation, and depressive symptoms (Hoppen & Morina, 2021; Güllümac Güler et al., 2024). Therefore, the balanced regulation of hope is essential for enhancing both personal well-being and social harmony. The present findings support this theoretical assumption: higher levels of hope and subjective well-being are associated with stronger experiences of life balance.

Conclusion

The results also align with findings from studies across different age groups and cultural contexts. For instance, PPT-based group therapy interventions have been shown to significantly increase hope levels among both adolescents and adults, consequently enhancing perceived life satisfaction and balance (Mahmoudi & Khoshakhlagh, 2018; Engelhardt et al., 2024). Recent intervention studies have further demonstrated that PPT effectively reduces depressive and anxiety symptoms while simultaneously increasing positive outcomes such as happiness, subjective well-being, and life satisfaction (Rashid & Seligman, 2018; Taghvaenia & Alamdari, 2019). Accordingly, the findings of this research have both individual-level and practical implications for clinical and educational contexts.

These findings offer several implications for PPT-informed clinical practice. Since hope emerged as a strong contributor to life balance, practitioners can incorporate structured hope-oriented tasks such as clarifying personal aims, generating alternative pathways for action, and strengthening agency through reflective dialogue. Within PPT, hope is conceptualized as a primary capacity, alongside patience and love, and therapeutic work aims to cultivate these capacities through concise, intentional exercises. The Balance Model also provides a practical framework for designing micro interventions that help clients redistribute emotional and cognitive energy across the spheres of body and health, achievement and work, relationships, and meaning and future. These exercises may

help clients restore harmony and identify areas of imbalance in daily functioning. In addition, the fifth phase of PPT, known as broadening goals, offers an opportunity to work directly with the capacity for hope by encouraging clients to formulate realistic, meaningful, and value-aligned goals. This process helps individuals recognize overused or underused capacities and achieve a more stable inner equilibrium. Taken together, these strategies demonstrate how PPT principles can be applied in clinical practice to strengthen life balance through capacity development and the cultivation of grounded, purpose-oriented goals.

In light of these results, it is recommended that PPT-based interventions be implemented more widely to foster hope and subjective well-being. Particularly in professional, educational, and family settings, individuals should be encouraged to invest their energy more evenly across the Balance Model's spheres while cultivating hope through realistic goals and value-oriented pursuits. Moreover, psychoeducational programs should be developed to raise awareness of the risks of both excessive and insufficient use of hope, thereby helping individuals use this capacity more consciously and adaptively. Future research should replicate these findings across diverse cultural contexts using longitudinal designs and further explore individuals' subjective experiences through qualitative methods. In doing so, the interconnections among subjective well-being, hope, and life balance can be strengthened not only at the theoretical level but also through practical interventions applicable to everyday life.

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*Section: Research and innovations in Positive Psychotherapy (PPT)***The Application and Reflections of Positive Psychotherapy in Traditional Chinese Medicine Psychosomatic Clinics****Huang Lifang**

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Abstract

In this study, the clinical value of Positive Psychotherapy in the traditional Chinese medicine (TCM) psycho-cardiovascular clinic was explored through questionnaires and experiments.

In Experiment One, the predominant somatic complaint among patients in the psycho-cardiovascular department was digestive. The outcome of Experiment Two showed that Positive Psychotherapy, along with Traditional Chinese Medicine treatment, was efficient in reducing the anxiety and depression levels of the patients.

The essential pathogenic principle of somatic form disorder, as described by TCM, is centered on the issues of liver dysfunction in governing the body's Qi, as well as Yin and Yang imbalance within the internal organs. At the same time, TCM theory emphasizes the psychological elements of patients. This is consistent with the multi-pathogenic principle in modern medicine, which posits that pathogenic processes involve elements of biochemistry, psychology, and social factors. Positive Psychotherapy, through the process of rebirth and rebuilding the cognition and internal potential of the patients, fits the theory of "regulate liver depression and regulate qi flow" and "unify form and spirit" in TCM. Psycho-cardiovascular TCM outpatient clinics may, as an innovative approach, integrate Positive Psychotherapy into the overall treatment and provide new references and insights for the establishment of a Chinese-style psycho-cardiovascular medical system.

Keywords: somatization symptoms, Positive Psychotherapy, Yin-Yang and Five Elements theory, traditional Chinese Medicine

Introduction

Somatization Disorder is a general term for a category of mental disorders characterized by complex and variable physical symptoms. Its primary clinical manifestations involve multiple organ systems. Common symptoms observed in TCM psychosomatic outpatient clinics include discomfort and sensory abnormalities (such as burning sensations or numbness). (Gao & Zhang, 2013)

Patients repeatedly seek care at general hospitals and specialty clinics due to persistent symptoms and ongoing anxiety. Despite undergoing various examinations, their concerns remain unresolved. Some patients exhibit significant comorbid anxiety and depression, severely impacting their work and daily life.

The 2025 Expert Consensus Guidelines on Diagnosis and Treatment of Somatic Symptoms in General Hospitals indicate that somatic symptoms have a high prevalence, accounting for 20%–50% of outpatient visits at primary care facilities. However, the diagnosis rate in general outpatient departments of Chinese general hospitals is only 33.8%. The pathogenesis of somatoform disorders remains unclear and is influenced by biological, psychological, and social factors. It correlates with individual personality susceptibility (e.g., neuroticism), early trauma, and stressful life events (Branch & Group, 2025). For such patients, establishing a strong doctor-patient alliance is crucial. A comprehensive assessment of somatization symptoms from a bio-psycho-social perspective is essential. While screening for organic diseases, it is particularly important to consider potential comorbid anxiety or depression and analyze the influence of psychological factors on the disease or symptoms.

In Traditional Chinese Medicine (TCM), somatoform disorder does not have any distinct diagnostic name and is classified under syndromes named "depression syndrome," "insomnia," and "palpitations." However, TCM, together with the Western medicinal system, always attributes the development of this disease to psychological instability or psychological disturbances. The body systems most commonly involved in psychosomatic-related clinics in Traditional Chinese Medicine are the spleen-stomach system, followed by the Qi-blood-body fluids system, then the heart system, then emotional disorders (emotional

symptoms), and finally the head-body-limb system (Li et al., 2019). In accordance with the treatment principle, Traditional Chinese Medicine consistently regards the dysfunctional liver and viscera as the root pathologic principle and mechanism. The liver is wood, and wood loves free-flow activity and hates stagnation. As mentioned, it regulates Qi activity, modulates mechanisms, and is associated with "joy and pleasure" and "anger" (Zhou et al., 2008). Psychological instability adversely affects the body, impairs liver function in regulating free-flow activities, and, consequently, generates stagnated "liver Qi." Prolonged stagnated "liver Qi" will develop into "liver Qi stagnated and transformed into fire by long-lasting stagnation of Qi," "liver Qi stagnated and accompanied by spleen deficiency by excessive wood overcoming and conquering the earth and spleen functions," and then stagnated Qi consumes body "blood and body fluids, and then affected other organs, and then affected five internal systems' balance of Qi and blood." Hence, the differential diagnostic aim should primarily focus on the "liver," with malfunction in "dispersal" as the guiding principle, with other signs and symptoms, such as stagnated fire and spleen deficiency, being less crucial. Traditional Chinese Medicine, following the principle of "unity of heaven and humanity," consistently de-emphasizes the separation of body and mind and therefore considers all the global concepts encompassed by "unity of heaven and humanity and body and mind." The body and mind are inseparable and mutually cause. Even though patients often refer to complaints in the body, they always reflect psychological disturbance or conflict in the mind. The body and mind mutually cause and are inseparable. Hence, Traditional Chinese Medicine always designs treatment plans that aim to relieve and eliminate psychological disturbances and disorders by alleviating bodily symptoms, regulating and relieving liver activity, and reducing depression. "Resolution of depression" is achieved through emotional counseling based on trust between physician and client, as follows in Ling Shu: "Give them advice on their defects, speak to them of their merits." Positive Psychotherapy, with all its attributes, is used as an adjunctive method of healing together with various herbs and pharmaceutical preparations. Hence, by relying on trust between physician and client, as well as on herbs, acupuncture, and other techniques,

both the mind and body are cured simultaneously, and as such, “Yin and Yang are perfectly balanced.”

Positive Psychotherapy is an integrative model of therapy developed by Professor Nossrat Peseschkian through his cross-cultural studies. In different models of therapy, the conventional approach to psychotherapy considers the client as the bearer of the symptoms and disorders, and the treatment aims at curing the psychological damage. But Positive Psychotherapy implies that the symptom or disorder is actually the positive capabilities of the client, which have been interrupted, neglected, and inadequately developed within the client throughout his or her growth period. Therapists need to understand the 'two legs' of the client's development process. The aim is not only to cure symptoms but also to explore the client's positive capabilities, and therapists should look for potential within the client's conflicts and hopes for progress amid adversity. (Cui, 2009; Hao & Yue, 2000; He, 2007; LIXiao-guang. & XUYa-xia., 2007).

From the standpoint of the treatment process, the five-stage integrated treatment of Positive Psychotherapy comprises observation/distancing, inventory, situational encouragement, verbalisation, and goal expansion. It draws on both Eastern and Western mythologies and narratives and employs them through stories and dialogue to assist the individual in transforming their cognition. This is consistent with Traditional Chinese Medicine's principle of whole-observation and treatment according to the patient's overall health. Traditional Chinese Medicine views humans as an integrated whole comprising mind and body, and both are mutually necessary for survival. The integration of Positive Psychotherapy with Traditional Chinese Medicine involves using herbs within Positive Psychotherapy techniques to balance the body and mind through “a mutually supportive body and mind” (Yu et al., 2021).

Methodology

All the studies have received ethical approval.

2.1. Experiment 1

In this study, 2,000 patients visiting the outpatient department of psychosomatic

medicine at a hospital were selected as research participants to understand the reasons for their hospital visits. The random sampling process enabled the selection of outpatient visitors for surveying, resulting in the collection of 2,000 questionnaires. The questionnaires were conducted through the use of a 'patient background information' and 'Somatization Symptom Self-Rating Scale' devised by the researchers.

The Patient Demographic Questionnaire included general details such as gender, age, and education level.

The Self-Rating Scale for Somatization Symptoms (SSS) demonstrated high test-retest reliability ($r = 0.96$). The correlation coefficients for the total score and the factors range from 0.76 to 0.88 and from 0.56 to 0.70, respectively. The SSS has been validated as reliable and valid (Ji, Jian, et al., 2020). The SSS comprises 20 items, identified as follows: 10 items for somatization symptoms, 4 items for depressive symptoms, 4 items for anxiety symptoms, and 2 items for anxiety-depression symptoms. Each item is rated on a 4-point scale: no symptom (1 point), mild (2 points), moderate (3 points), and severe (4 points). The total score ranges from 20 to 80 points. SSD assessment for psychosomatic patients follows ICD-11 criteria, with total scores distinguishing severity levels: Normal: 20–29 points, Mild: 30–39 points, Moderate: 40–59 points, Severe: ≥ 60 points

The Criteria for the Patient Questionnaire are as follows:

1. All patients must fulfill the diagnostic criteria for anxiety/depression in Western Medicine ICD-11 and the criteria for “depression syndrome” in Chinese Medicine, with the pattern identification of liver Qi stagnation and spleen deficiency.
2. Aged 18-65 years.
3. Primary onset of the disease.
4. Alert consciousness without severe impairment of cognition.

Exclusion Criteria:

1. Affective psychoses, mental conditions due to and related to general diseases, organic mental conditions, paranoid conditions, stress-related conditions, schizoaffective conditions, schizophrenia, and a history of either alcohol or substance abuse.

- History of chronic general diseases, including high blood pressure, kidney disease, Diabetes, or chronic heart disease.

2.2. Experiment Two

2.2.1. Sample

A total of 80 patients visiting the psychosomatic outpatient department of a hospital in 2024 were randomly assigned to an observation group and a control group, with 40 patients in each group. Inclusion criteria:

- Patients met both Western medical ICD-11 diagnostic criteria for anxiety/depression and Traditional Chinese Medicine (TCM) diagnostic criteria for "depression syndrome," with a pattern differentiation of liver Qi stagnation and spleen deficiency.
- Patients aged between 18 and 65 years.
- Primary onset of symptoms.
- No prior medication use or participation in psychotherapy/counseling at enrolment.
- Informed consent obtained.
- Clear consciousness with no severe cognitive impairment.

Exclusion Criteria:

- Patients with affective disorders, mental disorders caused by physical illnesses, organic brain disorders, paranoid psychosis, stress-related mental disorders, schizoaffective disorder, schizophrenia, or a history of alcohol/drug abuse.
- Patients with a history of severe physical illnesses such as hypertension, kidney disease, diabetes, or heart disease.
- Patients refusing mental health education/psychotherapy.

2.2.2. Research Methods

Intervention Measures

The observation group received standard treatment and psychotherapy support. In addition, the intervention group received health education for 20-30 minutes during an outpatient visit. The health education session was conducted by a psychiatrist, together with either a Positive Psychotherapy counselor or a clinician with psychological and medical backgrounds who had completed at least 24 hours of Positive Psychotherapy training, or a

clinical graduate student. The follow-up visit was conducted one month later. Written informed consent was required from all participants to participate in the research.

Intervention Method

Chiefly involving one-on-one individual advice between counselor and client. Intervention Content:

- In the first consulting visit, the physician gives the client an early diagnosis and plan of treatment.
- For clients experiencing light to moderately severe psychosomatic illnesses, four alternatives are proposed: psychotherapy, psychological education, combined medicinal and psychological education, and combined medicinal and psychotherapy. In psychotherapy / psychological education, mainly centered on the five-step Positive Psychotherapy, the aim is to help the client understand their problem from a psychological point of view and reduce anxiety and depression.
- Clients are advised on healthy lifestyle practices, mainly quitting smoking, stopping drinking, practicing moderate exercising, and refraining from overtaxing their brains, while recognizing the value of giving high priority to their psychological health. The entire intervention takes one month, including both outpatient treatment and follow-up studies.

2.2.3. Evaluation Criteria

GAD-7 Generalized Anxiety Disorder Scale

The GAD-7 consists of 7 items, each with 4 response options: Not at all, Several days, More than half the days, Almost every day. Scores are assigned the values 0, 1, 2, and 3. The total score is out of 21 points. A total score ≥ 5 is considered positive, indicating possible anxiety. Scores of 5–9 may indicate mild anxiety, 10–14 may indicate moderate anxiety, and 15–21 may indicate severe anxiety.

PHQ-9 Patient Health Questionnaire

The PHQ-9 consists of 9 items, each with 4 response options: Not at all, Several days, More than half the days, Almost every day. Scores are assigned the values 0, 1, 2, and 3. The maximum total score is 27. A total score ≥ 5 is considered positive, indicating possible depressive symptoms. Scores of 5–9 may indicate mild

depression, 10–14 may indicate moderate depression, and 15–27 may indicate severe depression.

2.2.4. Statistical Analysis

Data entry was performed using Excel 2003, and statistical analysis was conducted using SPSS 24.

Results

3.1. Somatization Patterns Among Outpatients in the Psychosomatic Medicine Department

The types of somatization disorder among patients who visited the outpatient clinic for psychosomatic medicine are shown in Figure 1.

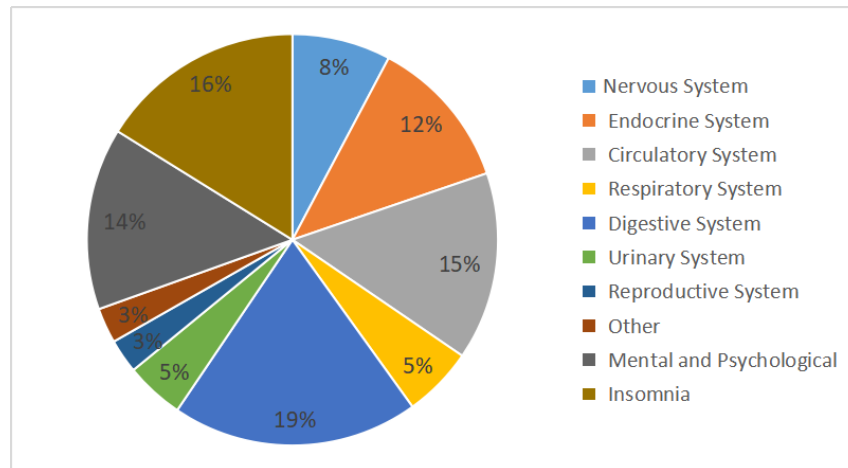


Figure 1. Proportion of Somatization Disorder Types Among Outpatients in the Psychosomatic Medicine Department

2,000 patients that visited the outpatient clinic for psychosomatic medicine were surveyed, including: Endocrine system - 260 patients, which accounts for 12% out of total; Circulatory system - 320 patients, which accounts for 15% out of total; Respiratory system - 120 patients, which accounts for 5% out of total; Digestive system - 420 patients, which accounts for 19% out of total; Urinary system - 100 patients, which accounts for 5% out of total; Reproductive system - 58 patients, which accounts for 3% out of total; Psychiatric/Psychological - 310 patients, which accounts for 14% out of total; Insomnia - 350 patients, which accounts for 16% out of total; Other Types - 60 patients, which accounts for 3% out of total.

3.2. Comparison of Anxiety and Depression Scores Between Two Groups of Psychosomatic Outpatients

Following two weeks of interventions, PHQ-9 scores declined in the intervention group relative to baseline, $p < .05$, indicating a significant within-group difference (see Table 1). Following four weeks of interventions, PHQ-9 scores declined in the intervention group compared with scores obtained prior to the interventions ($p < .05$), indicating a significant within-group difference.

Table 1. Comparison of Depression and Anxiety Scale Scores Between Groups

Group	Item	Pre-intervention	After 2 weeks of intervention	After 4 weeks of intervention
PHQ-9	Intervention Group	10.20 ± 2.67	8.20 ± 2.37*	6.60 ± 2.39*
	Control Group	10.65 ± 2.67	9.78 ± 3.10	7.53 ± 2.89
GAD-7	Intervention group	8.85 ± 3.06	7.28 ± 2.77*	5.88 ± 2.52*
	Control Group	9.03 ± 3.44	8.25 ± 3.30*	6.18 ± 2.75*

Note: * $p < .05$.

After two weeks of treatment, there was a significant difference in PHQ-9 scores between the intervention and control groups ($p < .05$). After four weeks of treatment, there was a significant difference in PHQ-9 scores between the intervention and control groups ($p < .05$).

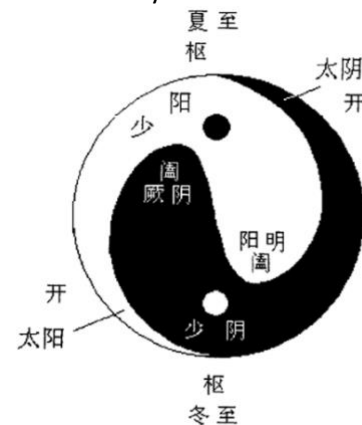
GAD-7 scores after two weeks of treatment were lower in the intervention group than before the intervention ($p < .05$). This indicates there is a significant difference within this group. GAD-7 scores after four weeks were lower in the intervention group than before the intervention ($p < .05$).

At two weeks, the intergroup comparison of GAD-7 scores between the two groups showed $p > .05$. This indicated that there were no significant differences between the two groups. At four weeks, the intergroup comparison of GAD-7 scores between the two groups showed $p > .05$.

Discussion

The core pathogenesis of somatoform disorders involves impaired regulation of liver Qi and disharmony between Yin and Yang within the internal organs. The liver, belonging to the wood element, governs the free flow of Qi. It thrives on smoothness and abhors stagnation. Emotional disharmony leads to Qi stagnation, which over time transforms into fire and invades the spleen, resulting in patterns such as liver Qi stagnation with fire transformation and liver Qi stagnation with spleen deficiency. The patient's recurrent somatic symptoms represent an external manifestation of psychological conflict, embodying the pathological characteristic of "unity of form and spirit." As stated in the Classic of Categories: Yin and Yang: "The Dao is the principle of Yin and Yang. Yin and Yang are one, divided into two." *The Suwen*: Great Treatise on the Origin of Heaven also states: "The five movements and Yin-Yang are the principles of heaven and earth. Yin-Yang and the Five Elements form the foundation of all transformations. When Yin-Yang imbalance occurs, the interaction between the patient's "Yin" and "Yang" becomes disrupted. The internal emotional suppression associated with "Yin" and the external symptom manifestations associated with "Yang" mutually influence each other, creating a vicious cycle. This results in an imbalanced state characterized by either "Excess Yang and Deficient Yin" or "Excess Yin and

Stagnant Yang." Positive Psychotherapy employs a five-stage intervention to guide patients in understanding their illness from a psychological perspective. Its essence lies in helping patients reconstruct their cognitive frameworks, rebalancing overdeveloped external physical symptoms with delayed emotional regulation, thereby harmonizing psychological imbalances of Yin and Yang. This intervention shares the same underlying principle as the traditional Chinese medicine concept of "soothing the liver and resolving depression, regulating Qi flow", both aiming to restore the steady state of "Yin and Yang in equilibrium." Clinical data show significant reductions in patients' GAD-7 and PHQ-9 scores post-treatment, confirming the pivotal role of Yin-Yang harmonization in the integrated mind-body treatment.



1. 太阴: in Chinese we call it "tai yin"
2. 太阳: "Tai Yang"
3. 少阴: "Shao Yin"
4. 少阳: "Shao Yang"
5. 夏至: June solstice
6. 冬至: The Winter Solstice
7. 阳明: "Yang Ming"
8. 厥阴: "Yin Jue"

Figure 2. Three Yin and Three Yang Tai Chi Chronophase Diagram

The synergy between Positive Psychotherapy and TCM fundamentally embodies the practical application of the "mutual rooting of Yin and Yang" theory in psychosomatic medicine. This study further integrates the Five Elements theory into the treatment approach, emphasizing imbalances in the internal organs and shifts in pathogenic mechanisms, reflecting a systemic "unity of heaven and humanity" perspective. The Five Elements connect human organs with natural and social environments, emphasizing "symbiotic relationships" and dynamic

equilibrium. It addresses individual stressors – such as liver *Qi* stagnation (Wood element) – while coordinating social adaptation – such as spleen-stomach function (Earth element) – and is supplemented by the "verbal verbalisation" phase, which uses mythological allegories. This approach aligns with TCM's principle of "adapting treatment to time, place, and individual." Unlike traditional pharmacotherapy, which prioritizes restoring organ function, Positive Psychotherapy emphasizes activating the patient's inner potential to promote "mutual support between body and mind." This synergistic approach makes the harmonization of Yin and Yang more sustainable.

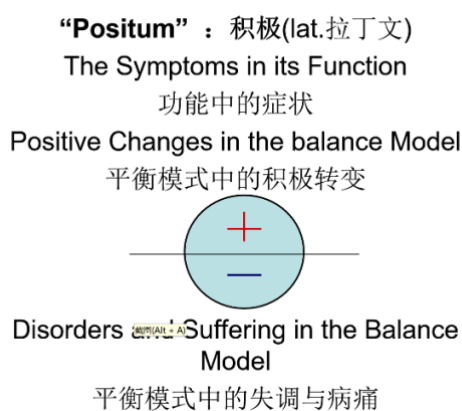


Figure 3. Balance Model in Positive Psychotherapy

It primarily introduces the practical application of Positive Psychotherapy in TCM psychosomatic clinics, with some limitations. It has a small sample size, for which further validation may be necessary. Also, there are individual differences in medication among

patients in psychosomatic clinics. The aforementioned study did not have fixed medication regimens, opting for the concept of 'medication plus psychological therapy.' It aimed to validate the active role of psychological therapy in alleviating negative emotions among patients. It has numerous practical applications because it identifies the feasibility of integrating psychological therapy into routine treatment in TCM psychosomatic clinics, with profound implications for developing a new concept for China's psychosomatic medical system with Chinese cultural features. Future studies must explore closer collaborations between different areas, with further applications for Yin-Yang theory in dynamic psychological studies, aiming for an in-depth integration with traditional views on modern science.

Conclusion

In conclusion, there is initial affirming evidence for the therapeutic role of Positive Psychotherapy in TCM's psychosomatic outpatient clinic, with its mechanism for efficacy being in full alignment with Yin-Yang philosophy on mind-body harmony, in addition to Five Elements theory. Through integrated treatment, it fulfills its ultimate objective: "regulating the mind to coordinate with the body, while regulating the body to nurture the mind," thereby providing more individualized therapeutic interventions for each type of psychosomatic illness. Future studies could further explore its mechanisms and develop innovative paradigms to promote the advancement of integrated Western-Chinese Medicine in the field of psychosomatic illness.

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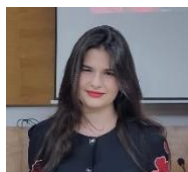
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Abstract

The theory of Positive Psychotherapy (PPT) integrates fundamental psychological principles, positioning it as a robust and comprehensive modality alongside other established approaches. Positive Psychotherapy is a scientifically validated psychotherapeutic modality that extends the therapeutic focus beyond the deficit model (psychological problems) to include the systematic conceptualisation of human resources and strengths (actual capabilities). As part of this empirical tradition, researching the relationship between dysfunction and capabilities is key to refining interventions in the psychotherapeutic process. This paper presents a pilot, exploratory study (n = 59) as part of a University project that examines the links between early dysfunctional schemas (YSQ-R) and current capabilities (WIPPF). Data from statistical analyses suggest significant correlations with inner conflict content (e.g., low manifestation of “Hope” is associated with schemas such as “Dependence/Incompetence” [DI]) and with compensatory, externally manifested abilities (e.g., high manifestation of “Politeness/Courtesy” and “Sexuality”). These results may provide important evidence supporting the need for an integrative approach to the explanatory model and the subsequent psychotherapeutic process. A combination of the theoretical framework of Schema Therapy and evidence-based PPT accurately differentiates authentic and compensatory capabilities, which are part of an individual's conflict dynamics. This process may increase the precision and effectiveness of psychotherapy. These results are also associated with a higher level of mentalisation in the psychotherapist's repertoire.

Keywords: Positive Psychotherapy, schema therapy, resource, deficit, integrative approach

Introduction

In recent decades, psychotherapy has undergone a significant transformation, moving from a model dominated almost entirely by the study of pathology (Held, 2004) to a more biopsychosocial salutogenic approach (a holistic view of the client). At the heart of this change is Positive Psychotherapy (PPT), which, through its tools, reveals the resource hidden behind the deficit/symptom. It is important to note that this process encompasses three related psychological trends: humanistic, transcultural, and psychodynamic, which are embedded in the theoretical framework of Positive Psychotherapy (Peseschkian, 2016) and the broader academic movement of Positive Psychology associated with Martin Seligman (Seligman, 2011).

These two approaches have different origins, but both schools share a fundamental therapeutic focus: a shift toward what is “positive” in people, rather than what is “not positive”. This approach is not only philosophical or descriptive, but it is also deeply rooted in empirical evidence across different modalities. Numerous meta-analyses confirm the effectiveness of positive psychological interventions (PPIs) in increasing resilience, well-being, and life satisfaction, and in reducing anxiety and depressive symptoms (Sin & Lyubomirsky, 2009; Carr et al., 2021). The positive approach is not chaotic or aimless; it always occurs within a specific context, identifies

the function of dysfunction, and has psychotherapeutic meaning.

The strength of PPT lies in its understanding of the individual as a whole, focusing on resources and cultural influences, enabling the individual to draw on ready-made experience. Psychotherapeutic practice to be “evidence-based” must continually evolve in response to new empirical data (Rashid, 2015). This article contributes to this tradition by presenting data from a pilot study that helps to deepen our understanding of the interaction between deficits and resources. It explores the search for the “plus” behind the “minus”: the individual's ability to create their own life, take responsibility for adaptive decisions, and effect the changes they need.

1.1. The empirical basis

A central mechanism in most contemporary therapies and the main focus in PPT is the discovery, activation, modelling, and development of resources (Flückiger & Grosse Holtforth, 2008). This principle, validated by extensive research (Grawe, 2004), posits that therapeutic change is facilitated by identifying and strengthening the client's existing strengths, abilities, and resources. Developing those that are “in the shadows” and/or building new, adaptive, and relevant ones. Peseschkian (1987, 1996) proposes an integrative model in which each psychological condition can be viewed simultaneously as an area of vulnerability and as

a source of resources (“Where there is a problem, there is also a solution”) (Peseschkian, 1987; Peseschkian, 2016a). This methodological rethinking fits into the broader paradigm of humanistic and existential psychotherapy (Rogers, 1951, 1961; Frankl, 1963, 1978), which emphasises personal growth, meaning, and freedom of choice. This connection between Positive Psychotherapy, as a humanistic method, and the theoretical frameworks of humanistic and existential psychotherapy provides evidence of its scientific value. It is an important aspect that demonstrates that PPT has its own theory, consistent with its predecessors.

Positive Psychotherapy provides structured tools for this process, such as the Five Stages of Psychotherapy as a Model for the Therapeutic Process, the transcultural approach, and the Balance Model described by Peseschkian (1987).

A central question in evidence-based psychotherapeutic practice is: *What resources do we activate?* Empirical data provide evidence for distinguishing **authentic resources** (“positive” psychological experiences stabilised over the lifetime) from more superficial, compensatory strategies (compromised psychological experiences, also stabilised over time) that mimic resources. Statistical analysis of psychological profiles in this pilot study becomes valuable, providing a starting point for an in-depth psychotherapeutic process. Building on the theoretical distinction between authentic and compensatory capabilities in Positive Psychotherapy and the schema-based model of persistent maladaptive patterns, the present pilot study explores preliminary associations between YSQ-R schemas and WIPPF capability profiles.

1.2. Pilot study

To further explore the relationship between overt capabilities and hidden dysfunctions, or between overt dysfunctions and capabilities in the “shadow,” a two-year study is currently being conducted at the Medical University of Plovdiv with the following focus: standardisation of the revised version of the Dysfunctional Schemas Questionnaire (YSQ-R). Forward and reverse translation procedures were conducted, and the reverse translation items were approved by the instrument’s creator, Dr. Christopher Lee, Australia. Permission has been granted to use the questionnaire for non-commercial scientific purposes. Standardisation and reliability of the

Wiesbaden Questionnaire on Positive and Family Psychotherapy for the Bulgarian population (WIPPF), permission granted by the Academy in Wiesbaden for the specified project, correlation analysis between the data from the two questionnaires, and searching for proofs of evidence-based psychotherapeutic guidelines as a summary and conclusion from the pilot study (using a translation approved for Bulgaria).

Methodology

2.1. Aim and design

The present pilot study aims to explore preliminary associations between early maladaptive schemas (YSQ-R) and current capabilities (WIPPF) within an integrative PPT–Schema Therapy framework. The study uses an exploratory pilot design with two measurement points (T1 and T2).

The pilot study included 59 healthy participants (61% men, 39% women) with a mean age of 29.4 ($\pm$ 8.9) years, who were grouped by demographic characteristics as described in Table 1. *In the expanded study, this demographic difference will be balanced.*

Table 1. Sociodemographic Characteristics of the Sample (n = 59)

Characteristics	Number
Age (years)	29.4 $\pm$ 8.9
Gender	
Male	36
Female	23 (39%)
Education	
No education	–
Primary	–
Basic	–
Secondary	25 (42.4%)
Higher	34 (57.6%)
Sexual Orientation	
Heterosexual	50 (84.8%)
Bisexual	–
Homosexual	9 (15.3%)
Marital Status	
In a relationship	17 (28.8%)
Single	31 (52.5%)
Married	7 (11.9%)
Unmarried	–
Engaged	2 (3.4%)
Widowed	–
Divorced	2 (3.4%)

2.2. Sampling procedure, measures, and analysis plan

A convenience sample was recruited within a university research project. The YSQ-R and WIPPF were selected due to their theoretical relevance to Schema Therapy and Positive Psychotherapy and their established use in research. Planned analyses included descriptive statistics, internal consistency (Cronbach's alpha), and exploratory association analyses (correlations), interpreted cautiously given the pilot nature of the study.

Results

This section presents the empirical findings. Interpretative and clinical implications are addressed in the Discussion.

3.1. Reliability for the YSQ-R subscales

The reliability analysis shows that the internal consistency (Cronbach's alpha) for the YSQ-R subscales is good to excellent, which is confirmed by both measurements (test and retest). The highest reliability was found for the scales "Defectiveness/Shame" and "Failure". The lowest consistency values were reported for "Privilege/Grandiosity" and "Punishment" (directed at others). Table 2 shows the α values for each "wave" (stage) of measurement.

Table 2. Reliability assessment of YSQ-R (Cronbach's alpha)

Schema	α Time 1	α Time 2
<i>emotional_deprivation (ED)</i>	0.811	0.793
<i>abandonment_instability (AI)</i>	0.778	0.782
<i>mistrust_abuse (MA)</i>	0.832	0.807
<i>social_isolation (SI)</i>	0.877	0.860
<i>defectiveness_shame (DS)</i>	0.932	0.934
<i>Failure (F)</i>	0.92	0.928
<i>dependence_incompetence (DI)</i>	0.908	0.896
<i>vulnerability_harm (VH)</i>	0.808	0.817
<i>enmeshment_undeveloped_self (EUS)</i>	0.76	0.742
<i>Subjugation (S)</i>	0.841	0.849
<i>self_sacrifice (SS)</i>	0.825	0.849
<i>emotional_inhibition (EI)</i>	0.838	0.837
<i>unrelenting standards (US)</i>	0.808	0.782
<i>entitlement_grandiosity (EG)</i>	0.624	0.585
<i>insufficient self-control (ISC)</i>	0.856	0.846
<i>negativity_pessimism (NP)</i>	0.842	0.850
<i>punitiveness_self (PS)</i>	0.783	0.798
<i>punitiveness_other (PO)</i>	0.656	0.671

Descriptive statistics indicate stable means between the first (T1) and second (T2) measurements. The highest mean values are observed on the scales "Self-sacrifice" and "Unrelenting standards", and the lowest on

"Enmeshment/Underdeveloped Self" and "Dependence/Incompetence". The results are summarised in Table 3, presenting mean values (M), standard deviations (SD), and observed ranges.

Table 3. Mean values (M), standard deviations (SD), and observed ranges of values

Schema	T1 Mean	T1 SD	T1 Min	T1 Max	T2 Mean	T2 SD	T2 Min	T2 Max
<i>emotional deprivation</i>	2.60	1.13	1.0	5.40	2.66	1.10	1.00	5.40
<i>abandonment_instability</i>	2.44	0.91	1.14	4.86	2.50	0.92	1.14	4.86
<i>mistrust_abuse</i>	2.31	1.02	1.0	5.5	2.34	1.00	1.00	5.33
<i>social_isolation</i>	2.60	1.25	1.00	6.0	2.70	1.19	1.00	6.00
<i>defectiveness_shame</i>	1.91	1.19	1.0	6.0	1.93	1.21	1.00	6.00
<i>failure</i>	2.32	1.29	1.00	6.00	2.36	1.31	1.00	6.00
<i>dependence_incompetence</i>	2.17	0.97	1.0	5.75	2.20	0.93	1.00	5.62
<i>vulnerability_harm</i>	2.39	1.02	1.0	4.83	2.35	1.03	1.00	4.83
<i>enmeshment_undeveloped_self</i>	2.12	0.81	1.00	4.86	2.13	0.80	1.00	4.86
<i>subjugation</i>	2.64	1.12	1.0	5.60	2.63	1.16	1.00	5.60
<i>self_sacrifice</i>	3.7	1.08	1.50	5.83	3.72	1.13	1.33	5.83
<i>emotional_inhibition</i>	2.53	0.96	1.11	4.89	2.54	0.96	1.11	4.89
<i>unrelenting_standards</i>	3.67	1.04	1.29	5.57	3.67	1.01	1.29	5.57
<i>entitlement_grandiosity</i>	3.25	0.88	1.5	5.0	3.33	0.86	1.50	4.8
<i>insufficient self-control</i>	2.74	1.05	1.14	5.86	2.77	1.05	1.14	5.86
<i>negativity_pessimism</i>	2.92	1.17	1.33	5.83	2.93	1.20	1.33	5.83
<i>punitiveness_self</i>	2.72	1.04	1.0	5.40	2.71	1.05	1.00	5.40
<i>punitiveness_other</i>	2.69	0.92	1.25	5.50	2.78	0.91	1.25	5.5

The intercorrelations at the first measurement (T1) were consistent with theoretical expectations. The strongest correlations were found between “Failure” and “Dependence/Incompetence” ($r = .717$), “Mistrust/Abuse” and “Social isolation” ($r = .675$), “Defectiveness/Shame” and “Social isolation” ($r = .637$), “Defectiveness/Shame” and “Abandonment/Instability” ($r = .605$), and “Dependence/Incompetence” and “Vulnerability to Harm” ($r = .535$).

Which schemas go hand in hand? If one schema is strong, is the other also strong?

People who feel like a “failure” also feel “dependent/incompetent” (this is the strongest connection). People who have “mistrust” towards others also feel “socially isolated”. People who feel “shame” about themselves also “socially isolate” themselves and fear “abandonment”.

The patterns are linked in logical “clusters” of problems, just as Jeffrey Young's theory explains (Young, 2003).

Longitudinal mixed-effects models (adjusted for age and gender and with random intercepts for participants) showed no significant change in mean levels between the first (T1) and second (T2) measurements for “**Emotional deprivation**” ($\beta_{\text{time}} = -0.019$, $p = .240$), “**Abandonment/Insecurity**” ($\beta_{\text{time}} = +0.009$, $p = .405$) or “**Distrust/Abuse**” ($\beta_{\text{time}} = -0.008$, $p = .739$).

The complex statistical model (longitudinal) shows whether the respondents' schemas weakened or strengthened between the first and second measurements. (This is important to see whether the schemas are *stable*, as claimed in the theory.) The analysis shows that the schemas **did NOT change significantly**. The results for schemas such as “Emotional Deprivation,” “Abandonment/Insecurity,” and “Mistrust/Abuse” were nearly identical across both measures. This is consistent with the schemas being relatively stable and persistent over time (Figure 1. They form a stabilised psychological experience over time – a Basic conflict in Positive Psychotherapy.

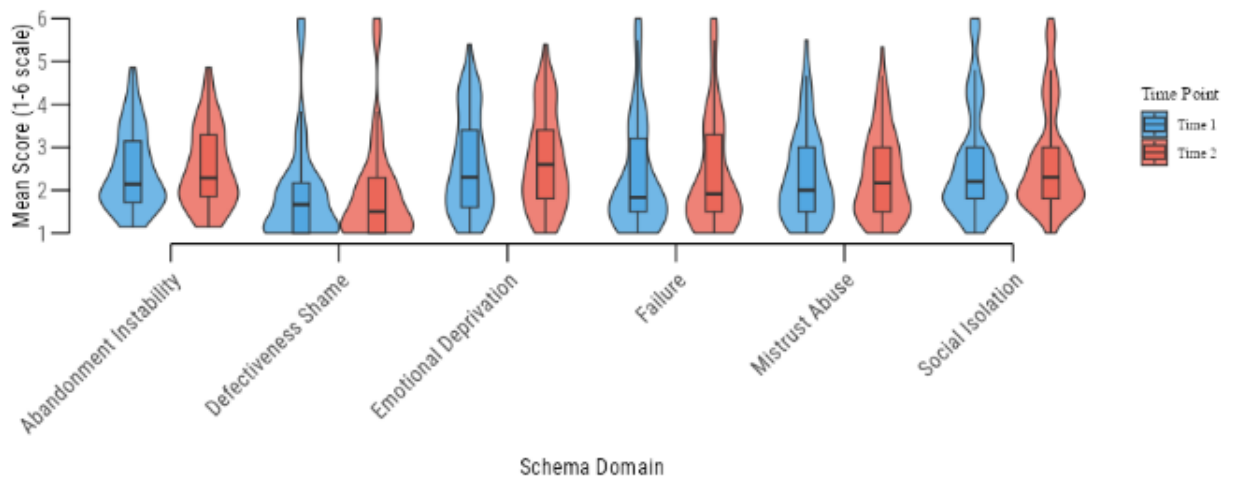


Figure 1. Stability of dysfunctional schemas over time

Clinical activation (defined as a mean ≥ 4) was low to moderate and remained stable overall. Tables 4a and 4b show the proportions (percentages) above the threshold value, as well as the percentages of high confirmation at the item level (defined as ≥ 5 on items from the same scale).

After analysis, how many participants had scores above a threshold (average 4), considered

a “clinically activated” or problematic pattern? Only a **small to moderate number** of people in this (probably healthy) sample had such strong patterns. Most participants did not exhibit strongly expressed patterns, and among those who did, the number remained stable at the second measurement. Tables 4a and 4b show the percentage of people who are “above the line.”

Tables 4a and 4b. Threshold value shares

4a

Measure	T1 n clinical	T2 n clinical	T1 % clinical	T2 % clinical
<i>emotional deprivation (mean ≥ 4)</i>	18	15	20.5	18
<i>abandonment_instability (mean ≥ 4)</i>	8	7	9.09	8.5
<i>mistrust_abuse (mean ≥ 4)</i>	9	8	10	9.7

4b

Measure (item-level)	T1 % items ≥ 5	T2 % items ≥ 5
<i>emotional_deprivation_percent_high</i>	38.6	45
<i>emotional_inhibition_percent_high</i>	53	57
<i>mistrust_abuse_percent_high</i>	27	31.7
<i>abandonment_instability_percent_high</i>	46.6	48

The analysis of measurement invariance over time (Measurement Invariance) for the latent factor defined by “Emotional Deprivation”, “Abandonment/Instability”, and “Mistrust/Abuse” **confirmed the models under progressively more stringent restrictions**. The chi-square difference test (χ^2) did not show a significant deterioration in model fit when moving from **configurational** to **strict invariance**. The fit indices (CFI = 1.000, RMSEA = 0.000,

SRMR ≤ 0.014 for all models) **further confirmed the invariance**. Tables 5a and 5b present the comparisons and fit indices.

When we are testing a hidden (latent) factor – “Core of Distrust” – which combines the three patterns: “Emotional Deprivation”, “Abandonment”, and “Mistrust”. This “factor” remains the same when measured at Moment 1 and Moment 2 – “measurement invariance”. The result for this criterion is highly valid, and “strict

invariance” has been achieved – this is the highest level of stability verification. This means that:

1. These three schemes are often grouped in the same way at both moments (configurational).
2. The score of “5” in the first measurement means *the same* as “5” in the second measurement (scalar).
3. Even though there is a statistical error in the measurement, it is the same (strict).

4. These results suggest that the questionnaire shows acceptable reliability over time in this pilot sample. This proof justifies comparing the results from Moment 1 with those from Moment 2, since we are measuring the same dysfunctional schema. (The indices CFI=1.000 and RMSEA=0.000 indicate excellent model fit in this sample).

Tables 5a and 5b. Comparison of compliance indices

5a

Model	Df	AIC	BIC	Chisq	Chisq diff	RMSEA	Df diff	p
Configural	0	1400.8	1457.3	0.000		0		
Metric	2	1396.9	1447.1	0.0880	0.0880	0.00	2	0.9570
Scalar	4	1393.0	1436.9	0.1700	0.0821	0.0	2	0.9598
Strict	7	1387.1	1421.6	0.2665	0.0965	0.00	3	0.9923

5b

Model	CFI	RMSEA	SRMR
Configural	1.000	0.00	0.00
Metric	1.00	0.	0.0086834
Scalar	1.0	0.	0.0101979
Strict	1.0	0	0.0141846

3.2. Reliability for the WIPPF subscales

Cronbach's alpha for the WIPPF is 0.856 at T1 and 0.858 at T2 across **19 of the 27 subscales**. Because we are assessing the informativeness of trends in the sample within a pilot study, we included only the subscales corresponding to the Primary and Secondary capabilities in the original questionnaire. These data demonstrate consistent results and excellent reliability.

3.3. Statistical results related to the psychotherapeutic process

Correlation analysis reveals a preliminary, exploratory psychological pattern:

1. **Core of “demoralisation”** (*a descriptive term for the loss of certain abilities*): a strong and consistent negative correlation was found between the three dysfunctional schemas – “Abandonment/Instability” (AB), “Failure” (FA), and “Dependence/Incompetence” (DI) – and the actual capability “**Hope**” (H).
2. **Strength relationship**: This is a particularly strong relationship in the

“Dependence/Incompetence” (DI) schema, where the feeling of incompetence is almost directly related to the loss of hope and the feeling of hopelessness ($r = -0.531, p = 0.000$).

3. **Emotional state**: is associated with lower levels of actual capabilities “**Honesty/Directness**” (HD) and “**Love & Capacity for Relationships**” (L), relating to a state of shame or emotional withdrawal.
4. **Compensatory model**: the most significant result is the correlation between this internal deficit and external behaviour. The data show a clear “people-pleasing” model:
 - The “Failure” (FA) and “Dependency” (DI) schemas correlate positively with increased “**Politeness/Courtesy**” (P).
 - The “Abandonment” (AB) pattern correlates positively with increased “**Sexuality**” (S), Figure 2.

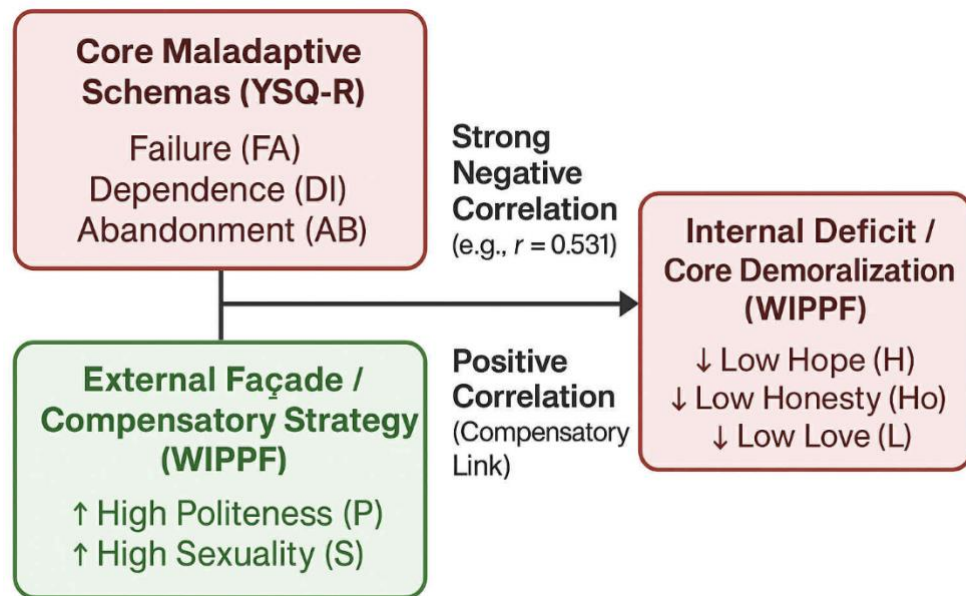


Figure 2. Relationship between demoralisation, shadow abilities, and abilities related to compensatory behaviour

3.4. Summary of data

The statistical data outline a coherent and clinically meaningful psychological profile- an individual who experiences deep internal demoralisation (low manifestation of “Hope”)

has developed a compensatory façade of hyper-adaptability (high manifestation of “Politeness / Courtesy” and “Sexuality” to manage their internal distress and maintain their relationships, Table 6.

Table 6. Correlations Between (YSQ-R) and WIPPF Actual Capabilities (Pearson r).

Early Maladaptive Schema (YSQ-R)	Correlated Capabilities (WIPPF)	r
AB – Abandonment	Sexuality (S)	0.257
	Obedience (O)	-0.266
	Patience (P)	-0.329
	Hope (H)	-0.376
FA – Failure	Politeness/Courtesy(P)	0.382
	Trust (T)	0.325
	Honesty/Directness(Ho)	-0.300
	Hope (H)	-0.342
	Love&Capacity for Relationships (L)	-0.399
DI – Dependence/Incompetence	Politeness/Courtesy (P)	0.269
	Honesty/Directness(Ho)	-0.366
	Hope (H)	-0.531
	Love&Capacity for Relationships (L)	-0.267

Discussion

The results of the present study show significant implications for clinical practice within Positive Psychotherapy. For instance, the strong negative correlation ($r = -0.531$, $p = .000$)

between the “Dependence / Incompetence” (DI) schema and the capability “Hope” (H) provides an empirical basis for a deeper understanding and case conceptualization of the therapeutic process. When high levels of “Politeness / Courtesy” (P) or “Sexuality” (S) are observed

during psychotherapeutic assessment, our findings encourage the therapist to formulate a key clinical hypothesis: *Is this capability has authentic, mature resource, or does it serves as a compensatory strategy designed to manage internal distress associated with schemas such as "Failure" (FA) or "Abandonment" (AB)?*

This distinction directly impacts the management of the therapeutic alliance. Clients with this profile – high compensatory adaptability and low internal hope – often present as “easy” or “good.” They may be agreeable and compliant, avoiding confrontation, thereby reproducing their “people-pleasing” strategy within the therapeutic session and demonstrating socially desirable behaviour. In this context, the positive psychotherapist's task is to use the therapeutic alliance as a space for corrective emotional experience. This involves first validating compensation (“*I see how hard you are trying...*”) and then non-confrontationally exploring the hidden function. This process allows the therapist to subsequently model and/or activate “Honesty/Directness” (Ho) – the data show that it is suppressed in this profile.

Therefore, the study's data suggest a clear refinement of the therapeutic process. The therapist assists the client rather than focusing on the high manifestations of “Politeness/Courtesy” – “focus away from” (the data show that it is already compensatorily high), and towards the Positive Psychotherapy interventions, building the suppressed but fundamental capabilities. For example, with identified “Failure” (FA) and “Dependency” (DI) schemas, interventions can be purposefully focused on cultivating authentic “**Hope**” (H) and a sense of competence. With an “Abandonment” (AB) schema, the focus shifts to building authentic “**Honesty/Directness**” (O) and “**Love & Capacity for Relationships**” (L) in the context of secure attachment.

These empirical findings are not a criticism of Positive Psychotherapy; on the contrary, they provide valuable data that help to **refine and deepen** it. The results illustrate an important clinical phenomenon: not all “positive” manifestations are authentic resources. The “Politeness/Courtesy” demonstrated by the study participants does not seem to stem from inner well-being, but rather serves as compensation for a deep fear of failure and dependence.

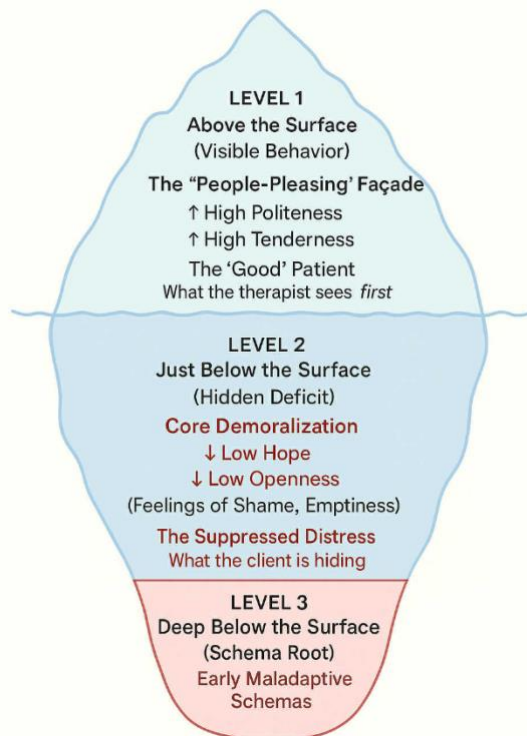
This finding has direct therapeutic applications. If a therapist applying PPT focuses solely on encouraging this “Politeness/Courtesy” (as a visible resource), they may inadvertently reinforce a maladaptive compensatory strategy, leaving the core of demoralisation (low manifestation of “Hope”) untouched, underdeveloped, and in the “shadow”.

This reveals the potential for **synergy** between Positive Psychotherapy (the resource) and Schema Therapy (the dysfunctional content) (Young et al., 2003). This integration of resources as a starting point for processing deficits has long been proposed by authors such as Louis et al. (2018). This allows us to use the best of both worlds:

1. **Insight from Schema Therapy:** YSQ-R data allow us to identify and hypothesize about the origin of internal deficits (FA, DI schemas) and recognize “Politeness” as compensation. This protects us from misidentifying it as an authentic resource.
2. **Interventions from Positive Psychotherapy:** once the schema has been identified, the powerful tools of PPT (Peseschkian, 2016) can be targeted much more precisely. The therapist can work not to reinforce the compensatory “Politeness,” but to purposefully build the authentic resources that are missing in the data: “**Hope**,” “**Honesty/Directness**,” and “**Love & Capacity for Relationships**.”

This approach avoids the pitfalls of “superficial positivity” (Lomas & Ivztan, 2016) by relying on a comprehensive, data-based conceptualisation of the client (Bach & Bernstein, 2019). Research on “positive schemas” also supports this integrative direction (van Vreeswijk & Broersen, 2012; see Figure 4).

Psychodynamic Iceberg Model Structure of the “People-Pleasing”



4. Integrative psychodynamic model

Conclusion

Positive Psychotherapy is an evidence-based field; its effectiveness has been demonstrated in numerous studies (Carr et al., 2021; Sin & Lyubomirsky, 2009). Like any other mature scientific discipline, the effectiveness of Positive Psychotherapy depends on its capacity to evolve and refine itself in response to new empirical data.

The pilot study presented here contributes to this ongoing refinement process. Providing preliminary statistical evidence for the distinction between compensatory and compromising “facades” (e.g., high manifestation of “Politeness/Courtesy”) and internal deficits (e.g., low manifestation of “Hope”) suggests the potential benefits of a deeper, integrative approach. By synergistically combining schema concepts with the resource-activation techniques of Positive Psychotherapy, this study points toward a more nuanced and clinically sensitive model of practice.

Limitations

The results of this pilot study should be interpreted in light of several limitations. First, the study utilizes a correlational design. Although the data show a strong statistical relationship (e.g., $r = -0.531$ for DI and “Hope”), they cannot establish causality. We cannot claim that the “Dependence” schema is associated with low levels of “Hope” (or vice versa); we can only say that the two are *strongly associated in this sample*.

Second, the sample ($n=59$), while adequate for a pilot study, is small and was recruited voluntarily. Future research with larger and more diverse populations, including clinical responders, is necessary to further examine the validity and generalizability of the findings. Third, both the YSQ-R and the WIPPF are self-report assessment tools and are subject to potential biases, most notably social desirability. This factor is particularly relevant given the high compensatory scores observed for “Politeness/Courtesy.”

These limitations outline clear directions for future research. Of particular interest would be a **longitudinal intervention study** to track how the relationship between schemas and compensations changes over the course of Positive Psychotherapy. Furthermore, the empirical basis of the integrative model would be significantly supported by a **randomized controlled trial (RCT)** comparing the effectiveness of standard PPT with an integrative model (Schema-PP) based on the conceptualization presented here, particularly in clients with an identified demoralization profile. Finally, **qualitative studies** (e.g., semi-structured interviews, detailed initial psychotherapeutic interviews) could complement these quantitative data by exploring in depth the subjective experiences of clients who present a façade of hyper-adaptability.

Declarations

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- All authors affirm our commitment to the objectivity of this work and declare that we have no conflict of interest.
- We are committed to the protection of our participants. This study was carefully reviewed and approved by the Scientific Ethics Committee (SEC) at the Medical University – Plovdiv, Bulgaria (Protocol No. 7/25.06.2025).
- This article is a result of teamwork. Each listed author was actively involved in the project, contributing to the study design, pilot data collection, and analysis of results. Furthermore, every author participated in the writing of this manuscript and has approved the final version you are reading.

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Section: Preliminary studies in Positive Psychotherapy (PPT)

Honesty and Courtesy in Communication: A Phenomenological Study with Turkish Young Adults

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Abstract

The study investigates how young adults perceive and experience honesty/directness and politeness/courtesy in their relationships. The research employed a phenomenological analysis. Qualitative data were obtained by administering semi-structured, open-ended questions to 32 participants via Google Forms. Phenomenological thematic analysis resulted in 13 themes and 35 codes. The findings reveal that participants defined honesty as clarity and sincerity, and courtesy as a value based on empathy and respect. They do not view courtesy and directness as opposing capabilities; rather, they hold that a balanced use of both is important for healthy communication. However, situations where the use of both capabilities in relationships becomes difficult were also identified. This is a pioneering study on how directness and courtesy are experienced in Türkiye in a cultural sense. There is a gap in the literature regarding the evaluation of these two capabilities in a relational context. It will form the basis for future scale studies in this field.

Keywords: directness, honesty, courtesy, key conflict, phenomenological study, Positive Psychotherapy

Introduction

The incompatibility between internal and external values/concepts, or internal inconsistency, can be defined as conflict (Peseschkian & Remmers, 2025). Although these conflicts, which are likely to occur in young adulthood, may be challenging and negative for the individual. They can be viewed as an opportunity when addressed within the context of Positive Psychotherapy (Karakurt & Sarı, 2025;

Sarı et al., 2025). Individuals can discover their abilities for courtesy and directness through these conflicts. In this context, positive traits such as directness/honesty and courtesy can be considered important psychological resources. That shapes how individuals cope with the challenges of this period. A balanced level of courtesy and directness/honesty, and their balanced use together, play a critical role in the healthy management of conflicts and the maintenance of social relationships. For

example, if an individual responds to a conflict with a high level of courtesy, it is unlikely that the other party will violate their boundaries. In another example, if a person responds to a conflict with a high level of directness/honesty, an escalation of the conflict is inevitable (Sarı T., 2015; Positive Psychology, 2024)

Honesty and courtesy together form the key conflict (Werringloer, 2023). Positive Psychotherapy views the relationship between these two abilities as a key conflict. Individuals can explain their response to the conflict either honestly or through courtesy. According to Goncharov (2025), honesty/directness is defined as the free expression of one's inner feelings, needs, emotions, and thoughts, regardless of others' reactions. In contrast, courtesy is defined as the ability to avoid conflict and maintain harmony at the expense of suppressing one's own needs (p. 337). When evaluated in terms of early-life experiences, parents struggled to regulate their infants' emotional impulses. Furthermore, if they expect courtesy and obedience, the child may prefer to suppress their internal tension rather than manage their internal conflict, such as avoiding conflict to maintain the relationship and prioritizing the needs of others. Honesty, by contrast, is the capacity to express the resulting internal conflict outwardly and to pursue one's own needs (Krillov, 2025).

According to Eryılmaz (2020) and Goncharov (2025), the key conflict is an internal, conscious struggle between the need to express one's own interests (honesty/directness) and maintain one's integrity and the need to keep one's attitude toward oneself and others (politeness/courtesy). Both concepts are important for the individual to experience their relationship with themselves and their environment in a healthy way. If the relational perspective is grounded in a biological background, according to Peseschkian (2016), the key conflict is one of the most sensitive points in symptom production; courtesy is associated with fear in the central nervous system, while honesty is associated with aggression. Thus, depending on the level of use, politeness elicits a conflict-avoidance response, whereas honesty may elicit confrontation. In another study, individuals who handle conflicts through effective communication skills report more productive and positive outcomes (Canary & Cupach, 1995). For this reason, it is essential to

thoroughly research and understand the concepts of courtesy and directness, and to apply them to the field of mental health.

A review of national and international literature reveals that scales have been developed to measure individuals' kind, helpful, and tolerant behaviors toward others (Rushton, 1981; Goldberg, 1992; Carlo, 2002; Okur, 2024), and scales to measure honesty/directness (Rathus, 1973; Bilgiç, 2011; Atak, 2013) are available, but the two concepts have not been researched in the context of communication. Courtesy is evaluated in terms of behaviors exhibited, whereas directness/honesty is evaluated in terms of directness toward values or experience. The role of these concepts in communication has been evaluated through the key conflict in Positive Psychotherapy. The concept has been studied at the theoretical and practical levels. However, no qualitative research has been found on how these concepts are perceived and used within the culture in which they exist.

In this context, when Türkiye is considered, the findings cannot be separated from culture, as the country's culture is defined as interdependence and closeness to other cultures (Kağıtçıbaşı, 1996). According to Hofstede's (2023) study, in Türkiye, rather than individualism, emphasis is placed on "us," the environment, family, and friends; a tendency toward harmony and cooperation is at the forefront; and acting according to social norms rather than individual desires is important. Given the dominant culture in Türkiye, studies indicate that indirectness and courtesy are used more frequently in communication, thereby contributing to social harmony and the preservation of intra-group relationships (Marti, 2006; Park, 2012). According to cross-cultural studies, Türkiye adopts a mediator role in communication and conflict (Kozan, 1989), avoiding and postponing conflict (Cingöz, 2007), and prioritizing the preservation of communication and relationships over conflict resolution in situations of disagreement.

A review of the literature reveals that the meaning of honesty and courtesy, two key capabilities in Positive Psychotherapy, in terms of communication and their cultural equivalents, has not been studied. This points to a significant research gap in the literature. The study aims to examine how Turkish young adults experience and perceive honesty/directness and courtesy in

communication. The findings are expected to contribute to the literature, both theoretically and practically. The research essentially seeks to answer four questions:

1. How do young adults perceive and experience courtesy in communicative terms?
2. How do young adults perceive and experience honesty/directness in communicative terms?
3. What are young adults' perceptions and experiences regarding the balanced use of honesty/directness and courtesy?
4. How do young adults perceive themselves in terms of using honesty/directness and courtesy?

Methodology

2.1. Research design

The study employed a phenomenological research approach, a qualitative method. The phenomenological research approach focuses on the significance of individual participants' experiences (Creswell, 2016). In this method, participants were asked open-ended questions across four frames about their perceptions and experiences regarding honesty and courtesy, and the balanced use of both.

2.2. Sample

32 young adults aged 18-30 (mean age = 23) participated in the study (25 female and 7 male). Their educational backgrounds included 20 university students, 9 university graduates currently working, and 3 with master's and doctoral degrees. Participants were selected for the study using convenience sampling.

2.3. Data collection tools

In the phenomenological approach section of the study, the researcher designed a questionnaire. This contains open-ended questions that elicit participants' experiences regarding courtesy and directness, and the balanced use of these capabilities. It was administered via Google Forms. Ethics committee approval for the study was obtained on October 2, 2025, with decision number 509. Before the interviews, participants provided consent, and information about the study was provided. The interviews were mostly conducted face-to-face.

Participants were asked questions in four categories to collect data. Questions related to honesty capability, courtesy capability, the balance between honesty and courtesy, and participants' experiences of these abilities in their daily lives, in terms of their own reactions, were asked. Following thematic analysis of the qualitative data and a literature review, items for the Honesty and Courtesy scale were developed.

2.4. Analysis

In this study, qualitative data collected through semi-structured open-ended questions were analyzed. Using the phenomenological method, data analysis for each question was conducted in three stages.

In the first stage, meaningful statements and sentences regarding participants' views on the concepts of honesty and courtesy were identified. In the second stage, the meanings derived from these statements were synthesized into themes. In the third stage, these themes were interpreted to provide comprehensive definitions of participants' experiences of honesty and courtesy (Creswell, 2016).

During qualitative data analysis, the researcher paid attention to validity and reliability criteria. In accordance with the principle of descriptive validity (Maxwell, 1992), the researcher conveyed the participants' views as they were, without adding any interpretation.

During the analysis phase of the study, a researcher conducted the process. To prevent data compromise due to potential research bias, the coding process was repeated iteratively, and the resulting data were compared with the primary dataset. The emerging themes were compared with the current Positive Psychotherapy literature throughout the process. When no new themes emerged in the iterative coding process, data saturation was considered to have been reached.

2.5. Ethical consideration

Ethics committee approval was obtained on October 2, 2025, and data collection was conducted on October 3-10, 2025.

Results

The data (open-ended responses from 32 participants) were read and pre-coded. Similar codes were grouped to identify main themes and sub-themes. A single coder conducted the

analysis. Based on qualitative data from participants, 13 themes and 35 codes were identified to examine individuals' views on the concepts of courtesy and directness.

The first research question of the study: How do young adults perceive and experience courtesy in communicative terms? To measure this question, participants were asked during the interview, "What does courtesy mean to you?" and "How do you show courtesy in your communication with people? Can you give an example?" and "Can you give examples of situations where courtesy is difficult in communication?" All responses to the questions (n=32) were evaluated, and content analysis resulted in 3 themes and 12 codes. (Table 1).

The first theme, **Definition of Courtesy**, indicates that participants generally associated

courtesy with respect, empathy, refraining from harming others, and tolerance. They relate to social norms, which means that the concept is also perceived as a social value. The second theme, **Behaviors that Demonstrate Courtesy**, captures how participants demonstrated courtesy in their daily communication – through behaviors such as polite speech, careful listening, and sensitivity to others' feelings and needs. Finally, the third theme, **Situations Where Courtesy Becomes Difficult**, reflects moments in which maintaining courteous behavior proved challenging. Participants noted that courtesy often becomes difficult in situations involving emotional strain, perceived injustice, or fear of being misunderstood or exploited.

Table 1. Thematic Analysis Related to Politeness/Courtesy Capability

Theme	Codes	Samples Quotes
T.1: Definition of Courtesy: Respect and Courtesy	Courtesy and Good Manners: Acting in accordance with social norms, being polite and respectful.	"Being polite and respectful means living in accordance with social norms."
	Empathy and Tolerance: Not hurting the other party and behaving thoughtfully and understandingly.	"Politeness is subtle, thoughtful, and empathetic, showing that you care about the other person and respect them."
	Virtue/Goodness Level: A fundamental level of behavior or goodness that every person should possess.	"The minimum level of goodness that a person should possess."
T.2: Behaviors That Demonstrate Courtesy	Verbal Expression Style: Use polite expressions such as requests, thanks, and greetings.	"By adjusting my tone of voice and avoiding commands, instead making requests and expressing plenty of gratitude."
	Active Listening: Not interrupting, maintaining eye contact, and providing mutual feedback.	"It means I must treat the people in front of me with respect and be polite by carefully choosing words that won't hurt the other person or cause them to misunderstand."
	Situation Awareness: Acting by observing the other person's weaknesses and their current situation.	"I speak to the person in front of me, considering their weaknesses, thoughts, and current situation, and I act accordingly. I don't want to touch on anything hurtful."
	Courtesy/Professional Courtesy: Showing courtesy as required by one's professional or social role.	"As a healthcare worker, I try to be as courteous as possible to patients in the workplace. For example, I am respectful and polite to elderly patients and explain things to them..."
T.3: Situations Where Courtesy Becomes Difficult	Negativity from the Other Side: Encountering disrespectful, rude, persistent, or prejudiced behavior.	"If the person in front of us isn't polite, I think it's very difficult for us to be polite too."
	Emotional Intensity: Difficulty maintaining courtesy during moments of anger.	"When one or both parties get angry, politeness becomes difficult."

Perception of Abuse and Weakness: Courtesy is being perceived and exploited by the other party as a sign of weakness.	<i>'Sometimes politeness can be seen as weakness or submissiveness, and they try to push you around and dominate you.'</i>
Barrier of Openness: When courtesy sometimes makes it difficult to speak honestly and openly.	<i>"It prevents you from reflecting something as it is, making it difficult to convey your feelings directly."</i>
Boundary Violation and Burnout: When courtesy requires compromising personal boundaries or goes unrequited.	<i>"Politeness can become a situation where it becomes difficult to constantly compromise yourself."</i>

The second research question of the study is: How do young adults perceive and experience honesty in communication? To measure this, participants were asked, "What does honesty mean to you?" "How do you show that you are open in your communication with others?" and "In what situations do you think honesty is difficult or problematic?" When the responses to these questions were examined, 3 themes and 13 codes were identified (Table 2).

In the 4th theme, **Definition of Directness: Clarity and Honesty**, participants viewed directness as a form of expression, defined as conveying feelings and thoughts without filtering. In theme 5, **Ways of Putting Directness into Action**, participants' openness is put into practice in daily life. The 6th theme is **Limits and Difficulties of Directness**. These are contexts where participants' use of directness is limited or difficult. Areas in which they hesitate to be honest.

Table 2. Thematic Analysis Related to the Honesty/Directness Capability

Theme	Code	Sample Quotes
T.4: Definition of Being Open: Clarity and Honesty	Clarity and Transparency: Be straightforward, simple, and concise.	'Clarity, transparency, communicability'
	Emotional Expression: Conveying feelings and thoughts as they are, in their purest form.	<i>"Directness means reflecting what comes from within us to the other side as it is, which expresses honesty."</i>
	Place and Time: Clarity is a form of communication and must be done consciously.	<i>"Being able to express words in accordance with feelings at the right time and place."</i>
	Integration with Courtesy: Clarity alone is not sufficient; it must be presented with courtesy.	<i>"Directness for me means being able to express feelings and thoughts to the other person with complete clarity, but gently."</i>
T.5: Forms of Translating Directness into Action	Direct Communication: Expressing thoughts, desires, and feelings directly.	<i>"By saying what's on my mind."</i>
	Eye Contact and Focus: Demonstrating interest in the conversation.	<i>"By maintaining eye contact during communication and not paying attention to anything else."</i>
	Standing Behind Your Ideas: Taking responsibility for what you say, being determined.	<i>"By standing behind what I said."</i>

T.6: The Limits and Challenges of Directness

Explanation Mechanism: Expressing oneself fully by sharing reasons and thought processes.	<i>"When discussing a topic, I ensure they fully understand my thought process by explaining why I said what I said."</i>
Vulnerability and Potential for Harm: Moments when directness could hurt the other person.	<i>"Sometimes what comes to mind can hurt the other person."</i>
Social/Personal Risks: Fear of judgment and lack of confidence.	<i>"If we show too much openness, people may judge this situation because it undermines seriousness."</i>
Emotional Barriers: The uncontrolled expression of intense emotions, such as anger.	<i>"In moments of anger, we feel different emotions and may say things we don't actually want to say, so it's dangerous in such moments."</i>
Context and Relationship Level: The necessity of transparency varies with the degree of intimacy.	<i>"I think the level of openness should vary depending on the level of intimacy with the other party. If we're not very close, it's best not to be too open..."</i>
Communication Failure: The feeling that mutual understanding cannot be achieved.	<i>"The thing that makes it hardest for me to be open is the feeling that no matter how open I am, the other person won't understand me anyway."</i>

The third question of the study is: What are young adults' perceptions and experiences regarding the appropriate balance between directness and courtesy? To measure this question, we asked, "In your opinion, what is the relationship between courtesy and directness? Do they support each other, or do they sometimes conflict?" "Can you describe an example of communication where you think you were both polite and open?" "How do you think people being both polite and open makes a difference in communication?" and "What does 'balanced communication' mean to you? If such a concept exists, what behaviors does it include for you?" Content analysis conducted on the responses to these questions identified 4 themes and 13 codes (Table 3).

Theme 7 is **Tension Between Directness and Courtesy**. This theme encompasses participants'

perceptions of the relationship between directness and courtesy, and of situations in which it can lead to negative outcomes. Another theme is **Strategies Used in Balanced Communication**, which is theme 8. This theme includes examples of participants who were both polite and open, as well as the strategies they used in these situations. Theme 9, Definition and Components of Balanced Communication, includes participants' definitions and perceptions of balanced communication. Lastly, the 10th theme, Contributions of Balance to Relationships, examines the contributions of the balance between directness and courtesy to relationships and communication, as well as young adults' perspectives on these contributions.

Table 3. Thematic Analysis Related to the Balance of Directness and Courtesy Capabilities

Theme	Code	Sample Quotes
<i>T.7: The Tension Between Openness and Courtesy</i>	Conflict Focus (Fear of Vulnerability): The potential for openness to disrupt the atmosphere of courtesy or to offend the other party.	<i>"Openness and courtesy clash. Because when we are open, what we say may not please the other party, but politeness pleases everyone."</i>
	Conditional Support/Balance: Directness is only supportive when delivered courteously.	<i>"Sometimes they clash, but they support each other. Frankness without politeness damages communication."</i>
	Extremes and Indiscretion: When excessive directness crosses the line of courtesy and turns into a negative situation.	<i>"If we present openness with courtesy, a good relationship may be possible. But I think if we present openness without courtesy, a conflict situation may arise."</i>
	Role-Context Differentiation: Support/conflict situation based on the closeness of the relationship.	<i>"In my personal relationships, I am both open and kind to people I like. I am not open with people I dislike; I am only kind. In these situations, I clash."</i>
<i>T.8: Strategies Applied in Balanced Communication</i>	Emotional Management and Expression Style: Gently convey directness, without accusation.	<i>'When warning my boyfriend not to do something I dislike, I do so clearly and politely, saying something like, "I don't like this; please be more careful in such situations," rather than using an angry and confrontational tone.'</i>
	Setting Boundaries and Rejection: Being able to say no clearly without being hurtful.	<i>"When I was invited to a place I didn't want to go, and they insisted, I said that I didn't feel like going anywhere today, that I wanted to go home and rest, that I would join them another time, and that I appreciated their invitation."</i>
	Empathy and Consideration for the Other Person: Talking while caring about the other person's feelings.	<i>"Answering the question the person in front of us asks without being hurtful, for example, to someone who has dyed their hair, even if we don't like it, saying, 'You're beautiful either way, but I preferred your old look...'"</i>
	Constructive Criticism: Communicating what you don't like politely and with suggestions.	<i>"If I didn't like my friend's outfit that day, I would politely tell them, 'You'd look better if you wore this.'"</i>

<i>T.9: Definition and Components of Balanced Communication</i>	Mutual Respect and Value of Ideas: Both parties have the right to speak, and their ideas are valued.	"I believe balanced communication is a form of communication where both parties' opinions are respected."
	Personal Balance (Giving and Receiving): Not constantly being the giver or the receiver; effort should be equal.	"Balanced communication is trying to understand what the other person means while also trying to express what you want to say. It can be about using this effort in a balanced way."
	Boundaries and Moderation: Neither going to extremes nor remaining in zero communication.	"Balanced communication means neither going to extremes nor keeping communication at zero in interactions between people."
	Being Mindful: Acting with awareness of your own feelings and those of the other party.	"Being aware of both the other person's feelings and your own, and acting accordingly."
<i>T.10: The Contributions of Balance to Relationships</i>	Healthy and Sustainable Relationship: Improved communication quality and smoothness.	"It ensures healthier and more understandable communication."
	Trust and Sincerity: A secure environment in the relationship that comes with honesty.	"Sincerity and trust can increase."
	Creating a Basis for Understanding and Compromise: Preventing misunderstandings.	"Misunderstandings are prevented. Because people will care about each other's feelings, communication becomes much more respectful and beneficial for both parties."

Question 4 of the study asks how young adults perceive themselves with respect to directness and courtesy. To measure this, participants were asked the following questions: "Do people generally describe you as an open person or a compliant person? What do you think are the reasons for describing you this way?" and "When others' expectations conflict with your own thoughts, what approach do you take?" The qualitative data collected from the questions resulted in 3 themes and 12 codes. (Table 4)

Theme 11 is **Perceived Communication Identity, the Outspokenness and Accommodation Dilemma**. This is where participants position themselves regarding the balance between directness and courtesy in

communication. While some participants see themselves as more accommodating, others see themselves as closer to outspoken. Another theme is theme 12. In theme 12, **Role Change According to Relationship Context**, participants reported that the use of directness and courtesy varies across relationship dynamics. They indicated that the areas of application of their skills can vary depending on the context. Theme 13 is **Mechanisms for Coping with Conflicting Expectations**. These are the participants' coping skills when expectations and reality are mismatched. In such situations, some participants express their desires openly and without hesitation, while others compromise on their desires.

Table 4. Thematic Analysis of Participant Tendencies Regarding Directness and Courtesy Capabilities

Theme	Code	Sample Quotes
<i>T.11: Perceived Communication Identity: The Dilemma of Frankness and Conformity</i>	Compatible Definition: Avoiding conflict, trying not to disrupt the environment, and listening.	"I define myself as agreeable because I always listen to people's opinions and then find common ground."
	Outspoken Definition: Saying what comes to mind immediately, not suppressing feelings.	"I am straightforward because I value my feelings, and it is important for me to reflect that."
	Karma/Using Both: Carrying both traits in appropriate situations, demonstrating a balanced individual.	"Actually, they describe me as both."
<i>T.12: Role Change According to the Context of the Relationship</i>	Area for Improvement: Seeing frankness as a flaw.	"They describe me as agreeable, and sometimes I see it as an area where I need to improve my candor."
	Directness to Close Environment/Adaptation to Distant Environment: Only using directness in trustworthy environments.	"They describe me more as agreeable; I usually use candor with my close circle, who won't misunderstand me."
	External/Internal Perception Gap: Others perceive you as harmonious, while you perceive yourself as straightforward/open.	"People who see me from the outside describe me as agreeable, but those close to me describe me as straightforward."
<i>T.13: Mechanisms for Coping with Conflicting Expectations</i>	Personal Topic-Focused Directness: Expressing your opinion on topics that concern you.	"I am mostly agreeable. But if the topic concerns me, I don't hesitate to express my opinion."
	Seeking the Middle Ground/Balance: Combining ideas or finding a harmonious solution.	"I try to find a middle ground."
	Prioritizing Personal Values/Ideas: Not compromising on one's own values.	"If I believe my own thoughts are correct, I don't pay much attention to what others say."
	Expectation Management/Setting Boundaries: Clearly stating that you cannot meet the expectation.	"I first decide how well I can meet their expectations... if I can't, I clearly tell them I won't be able to meet their expectations."
	Personal Sacrifice/Compromise: Making concessions of one's own volition to avoid damaging the environment.	"I'm accommodating because I generally prefer not to hurt people; it has been during times when I've compromised myself."
	Emotional Regulation: Controlling emotional reactions before expressing one's opinion.	"First, I take a deep breath. If my body is reacting physically, I try to control it."

Discussion

The results illustrate that Turkish young adults view courtesy as a social value grounded in respect and empathy and express it through sensitive communication behaviors. However, they find it difficult to maintain in emotionally strained or unjust situations. They view directness as a clear and honest form of expression, but find it difficult to maintain due to relationship and contextual constraints. Ultimately, they defined honesty as clarity and sincerity, and courtesy as a value based on empathy and respect. Participants also noted that both capabilities can be difficult to use – courtesy may sometimes be perceived as weakness, and directness carries the risk of offending the other party. They emphasized that balanced communication requires the harmonious use of both capabilities. Young adults sometimes express themselves openly and sometimes seek compromise when faced with conflicting expectations. Participants emphasized that their communication roles and positions (high directness or high courtesy) varied depending on the type of relationship. In conclusion, the phenomenological analysis concluded that young adults experience a dilemma regarding these two capabilities in their daily communication within their relationships.

There may be several reasons for the study's findings. If we examine the cultural use of these two capabilities, according to the Cultural Atlas (2019), the communication style in Türkiye is indirect, courtesy is highly valued, and concerns in relationships are initially concealed but are then suddenly replaced by candor. The literature has revealed that performing kind acts positively affects well-being (Chancellor, Margolis, Jacobs Bao, & Lyubomirsky, 2018). Courtesy reduces anxiety and rumination levels (Shin & Lyubomirsky, 2016; Seligman, Rashid, & Parks, 2006). On the other hand, the use of high levels of kindness or agreeableness has been less studied, and there is a significant gap in the literature on this topic (Lowe, 2009). Various studies have indicated that individuals with high levels of courtesy/agreeableness experience stronger negative emotions when confronted with negative stimuli and exert more effort to balance these emotions (Tobin et al., 2000; Haas et al., 2007). This finding aligns with the study's third theme (situations in which courtesy is difficult) and with its findings on anger and

emotional intensity. Brown and Levinson's (1987) theory of courtesy also parallels the study's findings: while directness is seen as a 'face-threatening act,' courtesy is used to soften this threat.

A review study has revealed that while honesty has its benefits, it also has social costs. The study reported that when information shared in good faith is not expressed in a polite and respectful tone, it negatively affects social relationships (Le et al., 2022). Theme 6 (Limits and difficulties of directness) and its codes (the need to attend to social context and the emotional impact of words) are consistent with this. Another study emphasized that information shared honestly in romantic relationships, even if it is hurtful to the other party, is beneficial to the relationship in the long term. However, it was also noted that the participants in this experimental study consisted of relatively well-functioning couples and did not include conflicted couples (Le et al., 2025).

As Salija (2018) discusses, the importance of communication is not only in conveying information honestly but also in maintaining relationships with courtesy and compassion. However, the study focuses on a single culture, underscoring the need to examine communication dynamics in other cultures and to conduct in-depth research (Salija, 2018). Various sources support this finding and emphasize the importance of studying these concepts across cultures, as courtesy (indirect communication) and honesty (direct communication) vary within cultural contexts (Afriana, 2025). In individualistic cultures that prioritize independence, such as the United States and Germany, direct communication is important (Gudykunst, 1996). In contrast, in collectivist cultures that prioritize harmony, such as China and Japan, indirect communication is preferred (Ge, 2022).

Autonomy, self-disclosure, and belonging are among the needs that adults must fulfill (Véronneau, 2005). Meeting these needs contributes to individuals' psychological well-being, but individuals sometimes experience difficulties in fulfilling them (Ryan, 2000). This perspective is consistent with the findings of this study. The study reveals that young adults use honesty and courtesy but struggle to balance these abilities. While belonging is achieved through high levels of courtesy, autonomy is achieved through honesty.

Limitations

The study was conducted on a sample aged 18-30 in Türkiye and therefore cannot be generalized to different age groups and socio-cultural regions. The concepts of directness and courtesy may vary culturally. The data were collected via forms and consist solely of written statements. It was not possible to gain insight into the individuals' gestures, facial expressions, and the concepts they mentioned. In future studies, if data are collected through face-to-face interviews, background information on the statements can also be obtained.

Conclusion & Implications

This is the first study conducted in Türkiye in this context and is considered pioneering in the field. Young adulthood is a developmental period marked by intense conflicts. Individuals require tools to support their social and emotional skills. Revealing the perceptions and attitudes of Turkish young adults in this period

regarding these two capabilities can provide important insights for practitioners working with this group. In conclusion, this study is expected to fill a significant gap in this field. This study empirically indicated the theoretical basis of the balance between kindness and openness in Positive Psychotherapy.

In addition, lay the groundwork for scale development studies based on Positive Psychotherapy regarding the directness-courtesy relationship. This study provides an important foundation for both applied education and psychotherapy interventions.

The following recommendations are offered to practitioners in light of the results. Clients who need to use honesty more should be supported in gaining awareness of potential challenges and in managing them effectively. The findings indicate that courtesy is also a preferred method of communication among individuals. Therefore, practitioners should support clients' need to use courtesy while enhancing their ability to be honest. This support can help balance the client's strong courtesy skills with honesty.

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*Section: Preliminary studies in Positive Psychotherapy (PPT)***Psychological Support for Ukrainian Veterans Through the Method of Positive Psychotherapy****Olena Ihnatovych**

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Abstract

The present study examines the effectiveness of Positive Psychotherapy (PPT) in supporting psychological recovery among Ukrainian veterans. Using a mixed-methods approach, 62 veterans participated in an eight-week PPT group intervention, which followed the five-stage model: Observation and Distance, Inventory, Situational Encouragement, Verbalization, and Expansion of Goals. Quantitative measures included the Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF), the Balance Questionnaire, the Connor–Davidson Resilience Scale (CD-RISC-25), and the Satisfaction with Life Scale (SWLS). Qualitative data were collected through semi-structured interviews.

Results demonstrated significant improvements in primary actual capacities, particularly patience and trust, alongside positive shifts in participants' interpersonal tolerance (treated as an attitudinal indicator rather than a distinct PPT capacity). Participants also showed enhanced life balance across the body, achievement, contact, and fantasy domains, increased resilience and life satisfaction, and reduced intrapsychic conflict. Thematic analysis revealed experiences of meaning reconstruction, restored trust and emotional openness, and reintegration of previously neglected life domains. These findings highlight the alignment of empirical outcomes with core PPT constructs, including actual capacities and conflict transformation.

These results support the application of PPT as a culturally sensitive, strengths-based intervention for veterans, offering a replicable framework for fostering holistic well-being, resilience, and posttraumatic growth. The study contributes to the empirical validation of PPT and its adaptation for post-conflict rehabilitation contexts.

Keywords: Positive Psychotherapy, actual capacities, balance model, resilience, posttraumatic growth, Ukrainian veterans

Introduction

The psychological consequences of armed conflict extend far beyond the battlefield. Veterans returning from war often face a complex spectrum of emotional, behavioral, and existential difficulties, including posttraumatic stress disorder (PTSD), depression, anxiety, and loss of social and personal meaning. In Ukraine,

the ongoing full-scale war has led to a dramatic increase in the number of veterans who require psychological rehabilitation and reintegration into civilian life. Despite the growing network of support services, there remains a pressing need for evidence-based and culturally appropriate interventions that emphasize personal strengths, resilience, and the reconstruction of meaning rather than solely focusing on pathology or

trauma symptoms.

Positive Psychotherapy (PPT), developed by Nossrat Peseschkian in the late 1960s and 1970s, is a humanistic, transcultural approach that focuses on developing actual capacities – the positive qualities inherent in each individual that can be activated even under crisis conditions. Unlike symptom-centered modalities, PPT views conflict as an opportunity for growth and self-discovery. Through its central Balance Model, which includes the four areas of body, achievement, contact, and fantasy, PPT provides a structured framework for understanding how individuals allocate their energy and values across various spheres of life. Disruptions in this balance, often triggered by trauma, can lead to intrapsychic conflicts, while therapeutic work aims to restore harmony among these dimensions (Peseschkian, 1987).

Contemporary studies confirm that PPT has broad applicability across cultures and clinical populations. Christ et al. (2021) demonstrated its effectiveness in restoring balance and well-being in individuals with depression and stress-related conditions. Kirillov et al. (2023) found that primary capacities such as hope, love, and faith act as protective factors against stress and anxiety in crises. Eryilmaz and Şimşek (2022) explored self-control and its relation to the development of actual capacities within PPT structures, highlighting the model's relevance for emotional regulation. These studies underline that PPT's emphasis on strengths, meaning, and intercultural understanding makes it particularly suitable for populations experiencing identity disruption and moral injury, such as war veterans.

The Ukrainian context adds unique dimensions to this therapeutic challenge. Veterans often return to environments marked by social instability, economic hardship, and fragmented family systems. The need for interventions that foster meaning reconstruction, trust, and hope is therefore paramount. Previous trauma-focused approaches have primarily emphasized symptom reduction, while PPT offers a complementary, resource-oriented perspective that encourages clients to recognize their capacities, reinterpret conflicts, and rediscover purpose. The adaptability of PPT metaphors and cultural narratives also aligns well with Ukrainian traditions of resilience, community solidarity, and spiritual endurance, making it a culturally

resonant therapeutic model.

However, empirical research on the application of PPT with veterans remains limited. While the theoretical foundations and positive outcomes of PPT have been widely studied in various populations – patients with psychosomatic disorders, students, and individuals in crisis – its effectiveness in post-war rehabilitation contexts has not been sufficiently examined. This research seeks to address that gap by empirically evaluating the outcomes of an eight-week PPT-based group intervention among Ukrainian veterans.

The present study aims to empirically evaluate the effectiveness of Positive Psychotherapy (PPT) in enhancing psychological resilience and life satisfaction among Ukrainian veterans. Within the PPT framework, resilience is conceptualized as the dynamic activation of actual capacities in response to adversity. At the same time, life satisfaction reflects the restoration of balance across the four life spheres of the Balance Model. By examining changes in these indicators alongside actual capacities and intrapsychic conflict, the study seeks to demonstrate how PPT facilitates holistic recovery and posttraumatic growth in post-war contexts.

Methodology

2.1. Methodological Approach

This study employed a mixed-method design that combined quantitative and qualitative approaches to examine the psychological effects of Positive Psychotherapy (PPT) on Ukrainian veterans. The research followed a pretest–posttest quasi-experimental design without a control group, supported by a qualitative exploration of participants' subjective experiences. This design was chosen to provide both measurable evidence of psychological change and an in-depth understanding of veterans' meaning-making processes within the PPT framework. The study evaluated changes in actual capacities, life balance, and resilience following participation in an eight-week PPT group intervention.

Conceptual Status of Tolerance in the Present Study. Although tolerance is not conceptualized in Positive Psychotherapy as a primary or secondary actual capacity in the classical sense (Peseschkian, 1987), it appears in the Wiesbaden Inventory for Positive

Psychotherapy and Family Therapy (WIPPF) as an empirically derived interpersonal indicator reflecting attitudes of acceptance, flexibility, and openness in social interaction.

In the present study, tolerance is not treated as an actual capacity per se, but rather as an interpersonal attitudinal construct emerging from the activation and integration of several primary actual capacities, particularly patience, trust, and acceptance. Within the Positive Psychotherapy framework, such attitudinal indicators are understood as relational manifestations of capacity development rather than independent capacities.

Methodologically, tolerance was assessed using the corresponding WIPPF scale composed of items capturing participants' readiness to accept differences, manage interpersonal tension, and maintain respectful engagement in social relationships. The scale score was calculated according to the standard WIPPF scoring procedure as an aggregated indicator of interpersonal orientation.

Tolerance is presented in the results section alongside actual capacities for analytical clarity and comparative purposes, while its distinct conceptual status is explicitly acknowledged. Its inclusion serves to illustrate how the development of core actual capacities translates into observable relational attitudes relevant to veterans' psychosocial reintegration.

2.2. Sample

The study sample comprised 62 Ukrainian veterans (54 men and 8 women), aged 26-49 years ($M = 36.8$, $SD = 5.4$), who had returned from active military duty within the previous three years. Participants were recruited through veteran rehabilitation centers and non-governmental organizations in Kyiv and Lviv. Inclusion criteria included: completion of at least six months of military service in a combat zone; absence of acute psychosis, substance dependence, or severe cognitive impairment; and voluntary consent to participate.

Exclusion criteria included ongoing psychiatric hospitalization or unstable medical conditions. All participants provided informed consent, and the study adhered to ethical guidelines for psychological research, ensuring confidentiality and voluntary participation.

2.2. Measures

The assessment battery included standardized quantitative measures and a qualitative interview protocol consistent with the theoretical framework of Positive Psychotherapy. Actual capacities were assessed using the Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF), Ukrainian adaptation by Serdiuk and Otenko (2021). This instrument evaluates actual capacities reflecting personal resources, interpersonal attitudes, and intrapsychic dynamics within the Positive Psychotherapy model. Life balance was measured using the Balance Questionnaire based on Peseschkian's (1987) Balance Model, which assesses perceived satisfaction and allocation of personal energy across four core life spheres: body, achievement, contact, and fantasy. Psychological resilience was assessed using the Connor–Davidson Resilience Scale (CD-RISC-25; Connor & Davidson, 2003), which measures individuals' ability to cope with stress, adapt to adversity, and recover from challenging experiences. Life satisfaction was measured using the Satisfaction With Life Scale (SWLS; Diener et al., 1985), a widely used instrument assessing individuals' global cognitive evaluation of their quality of life. Qualitative data were collected through semi-structured interviews designed to explore participants' subjective experiences of psychological change, meaning reconstruction, and the integration of Positive Psychotherapy principles during the intervention.

2.3. Procedure

All therapeutic sessions were conducted in person at the Psychological Counseling and Training Center of the Ivan Ziaziun Institute of Pedagogical and Adult Education of the National Academy of Educational Sciences of Ukraine. This format ensured direct interpersonal interaction and group dynamics, which are essential components of the Positive Psychotherapy model. The intervention followed the five-stage model of Positive Psychotherapy (Peseschkian, 1987): observation and distance – facilitating self-reflection and normalization of symptoms through metaphors and stories; inventory – identifying personal strengths, capacities, and unresolved conflicts; situational encouragement – reinforcing adaptive coping behaviors and positive reinterpretation of challenges; verbalization – sharing emotional experiences

and reframing traumatic memories within a safe group context; and expansion of goals – developing long-term life goals and enhancing self-efficacy through action planning.

Each participant participated in eight 90-minute weekly sessions, led by certified Positive Psychotherapists trained by the Ukrainian Institute of Positive Psychotherapy. Group size ranged from 6 to 8 participants. Pre-assessment was conducted one week before the intervention, and post-assessment one week after completion.

Qualitative interviews were conducted individually and audio-recorded, focusing on participants' reflections on personal growth, emotional balance, and meaning transformation.

2.4. Data Analysis

Quantitative data were analyzed using IBM SPSS Statistics 27. Descriptive statistics, paired-sample t-tests, and effect sizes (Cohen's *d*) were calculated to assess pre-post differences in WIPPF, Balance Questionnaire, CD-RISC, and SWLS scores. Statistical significance was set at $p < .05$.

Qualitative data were analyzed using thematic analysis following the six-phase approach proposed by Braun and Clarke (2006), including familiarization with the data, initial coding, theme development, review, definition, and reporting. The identified themes were interpreted within the conceptual framework of Positive Psychotherapy, particularly with reference to the Balance Model and the concept of actual capacities.

2.5. Reliability and Validity

The reliability of quantitative measures was confirmed by internal consistency coefficients (Cronbach's α ranging from .78 to .91). Methodological triangulation – combining quantitative scores with qualitative insights – enhanced the validity and depth of the findings. Therapist supervision and session fidelity checklists ensured procedural consistency across groups.

Results

Quantitative Findings. Statistical analysis of pre- and post-intervention data revealed significant positive changes across several psychological indicators, confirming the effectiveness of the Positive Psychotherapy (PPT)

intervention in supporting Ukrainian veterans' psychological recovery and personal development.

Actual Capacities (WIPPF): The analysis indicated a notable increase in several primary actual capacities associated with emotional regulation, interpersonal trust, and adaptive coping following the eight-week intervention. The largest improvements were observed in the primary actual capacities of patience and trust, as well as in tolerance understood as an interpersonal relational quality (see Table 1). Although improvements in primary capacities (e.g., love, hope, faith) were less pronounced, post-intervention scores suggested a growing readiness for emotional openness and self-acceptance.

Balance Model Indicators: Using the Balance Questionnaire, participants demonstrated improved harmony across the four areas of life functioning – body, achievement, contact, and fantasy – which together constitute the holistic structure of PPT's Balance Model (Peseschkian, 1987). The most significant increases occurred in the contact and body spheres (see Table 2), suggesting improved psychosomatic awareness, communication, and interpersonal relationships. Moderate gains were also observed in achievement and fantasy, indicating a more balanced lifestyle and an increased capacity for future-oriented thinking and creativity.

Resilience and Life Satisfaction: Participants' resilience scores (CD-RISC-25) increased significantly from $M_1 = 58.2$ to $M_2 = 71.9$, and Satisfaction with Life Scale (SWLS) scores rose from $M_1 = 18.6$ to $M_2 = 22.4$ (see Table 3). These results confirm that participation in PPT not only reduced distress but also fostered posttraumatic growth through the activation of internal resources.

Reduction of Intrapsychic Conflict: WIPPF conflict indices showed a reduction of approximately 20% across participants, especially in conflicts related to control vs. submission and dependence vs. independence (see Table 3). This reflects the therapeutic process of reframing inner contradictions as opportunities for learning and meaning transformation – core to the PPT model of conflict resolution.

Collectively, the quantitative findings support both study hypotheses: (H1) PPT participation significantly enhances veterans' resilience and life satisfaction, and (H2) PPT reduces trauma-

related conflict intensity while strengthening adaptive capacities.

Qualitative Findings. Thematic analysis of post-intervention interviews yielded three overarching themes reflecting veterans' psychological transformation during the PPT process (see Table 4).

Rediscovery of Meaning and Values. Participants described a renewed sense of personal purpose and moral orientation. Many reported that the storytelling and metaphor work characteristic of PPT helped them reinterpret traumatic memories through the lens of meaning, rather than victimization. One veteran stated: «Before therapy, my memories only brought pain; now I see them as proof of my strength». This theme aligns with the concept of actualization of capacities – transforming inner conflict into self-understanding and resilience.

Restoration of Trust and Emotional Openness. Group sessions facilitated interpersonal closeness and empathy. Veterans reported that learning to share emotions within a safe environment allowed them to rebuild trust in others – a capacity often damaged by wartime experiences. Participants emphasized the therapeutic value of the Situational Encouragement and Verbalization stages, in which mutual support and positive feedback fostered a sense of belonging and acceptance.

Reestablishing Life Balance. Several veterans reflected on rediscovering balance across the four life spheres. They recognized that during military service, the «achievement» and «body» areas had dominated their lives, whereas «contact» and «fantasy» had been neglected. Through PPT's structured reflection and goal-setting, participants regained motivation to invest time in relationships, hobbies, and creative self-expression. This restoration of balance was often described as «a return to life» or «a reawakening of normality».

Integration of Quantitative and Qualitative Results. The convergence of quantitative improvements (see Tables 1–3) and qualitative insights (see Table 4) confirms the internal coherence of PPT's therapeutic logic. Statistically significant increases in patience, trust, and resilience correspond to veterans' reports of restored balance, renewed meaning, and enhanced interpersonal functioning. The five-stage PPT model proved effective in guiding participants from emotional distancing to active engagement and personal growth.

Overall, the results demonstrate that Positive Psychotherapy serves not merely as a method for symptom reduction but as a transformative framework promoting holistic recovery, identity reconstruction, and posttraumatic growth among Ukrainian veterans.

Table 1. Pre- and post-intervention scores on selected actual capacities and interpersonal indicators (WIPPF)

Capacity	Pre-test M (SD)	Post-test M (SD)	t(61)	p	Cohen's d
Patience	3.21 (0.74)	3.88 (0.69)	3.41	< .01	0.62
Trust	3.34 (0.77)	3.87 (0.71)	2.98	< .01	0.58
Tolerance	3.09 (0.80)	3.76 (0.73)	3.27	< .01	0.60
Love	3.45 (0.66)	3.73 (0.61)	1.89	.064	0.33
Hope	3.32 (0.70)	3.65 (0.65)	2.06	< .05	0.37
Faith	3.28 (0.73)	3.58 (0.70)	1.97	.053	0.35

Note. Patience, trust, love, hope, and faith are conceptualized as primary actual capacities within the theoretical framework of Positive Psychotherapy. Tolerance is presented as an interpersonal attitudinal indicator derived from WIPPF items and reflects relational manifestations of capacity activation rather than an independent actual capacity.

Table 1 presents the pre- and post-intervention scores on selected actual capacities as measured by the WIPPF. The data show significant increases in primary actual capacities such as patience and trust, as well as positive changes in tolerance, understood as an interpersonal attitude. These results indicate

enhanced adaptive coping, interpersonal openness, and emotional regulation among veterans. Although gains in other primary capacities (love, hope, faith) were smaller, the observed trends suggest a positive shift toward self-acceptance and engagement with life challenges.

Table 2. Changes in balance model spheres (balance questionnaire)

Life Sphere	Pre-test M (SD)	Post-test M (SD)	ΔM	$t(61)$	p
Body	2.91 (0.68)	3.52 (0.63)	+0.61	3.22	< .01
Achievement	3.08 (0.71)	3.53 (0.67)	+0.45	2.74	< .05
Contact	2.87 (0.75)	3.59 (0.70)	+0.72	3.66	< .01
Fantasy	2.64 (0.70)	3.01 (0.68)	+0.37	2.38	< .05

Note. Scores reflect perceived balance and satisfaction within each life sphere of the PPT Balance Model.

Table 2 illustrates changes in perceived balance across four life spheres: body, achievement, contact, and fantasy. Veterans reported the largest improvements in the contact and body spheres, reflecting improved interpersonal relationships and greater

psychosomatic awareness. Moderate gains in achievement and fantasy spheres indicate increased engagement in purposeful activities and creative or future-oriented thinking, demonstrating a holistic recovery consistent with the Balance Model of Positive Psychotherapy.

Table 3. Resilience, life satisfaction, and intrapsychic conflict indices (pre- and post-intervention)

Variable	Pre-test M (SD)	Post-test M (SD)	$t(61)$	p	Cohen's d
Resilience (CD-RISC-25)	58.2 (10.5)	71.9 (9.7)	5.63	< .001	0.90
Life Satisfaction (SWLS)	18.6 (5.2)	22.4 (4.9)	4.12	< .001	0.77
Intrapsychic Conflict Index	42.8 (9.1)	34.1 (8.6)	3.54	< .01	0.64

Note. Lower conflict scores indicate reduced internal tension and improved harmony between opposing tendencies (e.g., dependence $\leftrightarrow$ independence).

Table 3 summarizes changes in resilience (CD-RISC-25), life satisfaction (SWLS), and intrapsychic conflict indices. Veterans experienced substantial increases in resilience and life satisfaction, along with a marked reduction in internal conflicts. These results

suggest that the PPT intervention strengthened veterans' psychological resources, promoted well-being, and facilitated the resolution of internal contradictions, consistent with the theoretical framework of actual capacities and conflict transformation.

Table 4. Summary of qualitative themes from post-intervention interviews

Theme	Description	Illustrative Quote
Rediscovery of Meaning and Values	Veterans reported reconstructing personal meaning and moral purpose through reflective dialogue and metaphors.	«Before therapy, my memories only brought pain; now I see them as proof of my strength».
Restoration of Trust and Emotional Openness	Participants experienced renewed ability to share emotions and connect with others, fostering group cohesion.	«I learned again to speak honestly – not just to my comrades but to my family».
Reestablishing Life Balance	Veterans described regaining harmony among work, relationships, and creativity, aligning with the Balance Model.	«Now I can plan my life, not just survive from one day to the next».

Table 4 presents the three major qualitative themes identified from post-intervention interviews: rediscovery of meaning and values, restoration of trust and emotional openness, and reestablishment of life balance. Illustrative quotes highlight participants' subjective experiences of personal growth, interpersonal reintegration, and holistic functioning. These findings complement the quantitative results,

providing evidence that PPT promotes both measurable psychological improvements and meaningful lived experiences of recovery among Ukrainian veterans.

Discussion

The results of this empirical study provide robust evidence that Positive Psychotherapy

(PPT), when systematically applied in the rehabilitation of Ukrainian veterans, can facilitate meaningful psychological recovery and posttraumatic growth. The combination of quantitative and qualitative findings supports the central assumptions of Nossrat Peseschkian's theory – particularly the transformative potential of actual capacities and the Balance Model – in contexts of severe stress and existential crisis.

Consistent with previous PPT effectiveness studies (Christ et al., 2021; Kirillov et al., 2023), veterans demonstrated significant improvements in adaptive personal resources following the intervention. The largest gains were observed in the primary actual capacities of patience and trust, along with positive changes in tolerance, conceptualized in this study as an interpersonal attitudinal indicator reflecting relational manifestations of actual capacity development (see Table 1). These findings suggest enhanced emotional regulation, interpersonal openness, and self-regulation among participants and support the resource-oriented logic of Positive Psychotherapy in post-combat populations.

The observed improvements in patience and trust should be interpreted as changes in primary actual capacities, in accordance with the theoretical framework of Positive Psychotherapy. These capacities reflect fundamental human potentials related to emotional regulation, interpersonal connection, and meaning-making. Tolerance, while not defined as a separate actual capacity in PPT, can be understood as an interpersonal attitude emerging from acceptance and empathy, representing a relational manifestation of capacity activation rather than an independent construct.

The observed enhancement in Balance Model spheres (see Table 2) indicates a shift from survival-oriented functioning to a more harmonious lifestyle. Improvements in the contact and body spheres suggest a renewed capacity for connection, emotional expression, and physical awareness – essential elements of psychosocial reintegration.

The significant increase in resilience and life satisfaction (see Table 3) aligns with PPT's conceptualization of health as the dynamic realization of inner resources (Peseschkian, 2016). Veterans who initially exhibited withdrawal, emotional detachment, or hypervigilance reported enhanced flexibility and optimism by the end of therapy. This confirms

that PPT not only mitigates symptoms of trauma but also restores the individual's sense of coherence and hope – a process parallel to Antonovsky's (1996) concept of salutogenesis.

Furthermore, the decrease in intrapsychic conflict indices demonstrates the conflict-transformative nature of PPT. Veterans learned to reinterpret contradictions such as dependence vs. independence and control vs. submission not as pathological dilemmas but as opportunities for personal learning and self-discovery. This outcome resonates with Peseschkian's (2016) view that every symptom expresses an unfulfilled capacity, and healing emerges through the positive reinterpretation of that conflict.

Qualitative data deepened the understanding of these transformations by revealing participants' subjective experiences within the therapeutic process (see Table 4). The theme of rediscovering meaning and values underscores the role of metaphorical storytelling and cultural narratives in reconstructing veterans' personal identities. Through the guided exploration of symbolic language, participants reframed traumatic experiences into stories of resilience and contribution. This process reflects what Kuprieieva (2022) called «time perspective integration» in PPT – linking painful past experiences with future-oriented goals.

The theme of restoring trust and emotional openness illustrates the interpersonal dimension of PPT's effectiveness. In group settings, veterans re-experienced empathy and solidarity, which counteracted social isolation and moral injury. As Eryilmaz et al. (2022) noted, PPT's emphasis on self-control and emotional communication enables individuals to reconstruct secure relational patterns. For Ukrainian veterans, whose wartime experiences often involved betrayal or loss, this restoration of trust was among the most healing outcomes.

The third theme, reestablishing life balance, confirms the applicability of the Balance Model as a guiding structure for rehabilitation. Veterans' reflections on redistributing attention across the four life areas – body, achievement, contact, and fantasy – illustrate the gradual reintegration of neglected aspects of the self. This multidimensional recovery aligns with the findings of Christ et al. (2021), who demonstrated that the restoration of balance is a reliable predictor of long-term well-being in PPT-based programs.

From a theoretical standpoint, this study validates the assumption that actual capacities can be systematically trained and reinforced through structured PPT interventions. The evidence supports the five-stage model (observation, inventory, situational encouragement, verbalization, and expansion of goals) as a replicable and culturally adaptable framework. Particularly in post-conflict settings, PPT's emphasis on intercultural values and resource activation aligns with veterans' need for identity reconstruction and moral reintegration.

Moreover, the results contribute to the ongoing evolution of PPT theory by extending its empirical validation to a population exposed to complex trauma. The integration of quantitative and qualitative outcomes highlights PPT's capacity to address both intrapsychic and systemic dimensions of suffering, thereby bridging individual healing with family and social reintegration.

Practically, these findings demonstrate that PPT can serve as an evidence-based component of veteran support programs in Ukraine. Incorporating PPT principles into group therapy, psychosocial training, and peer-support systems can enhance resilience, reduce posttraumatic stress, and improve family relationships. The structured use of the Balance Model provides clinicians with a concrete tool for assessing and monitoring clients' holistic progress.

Additionally, the results provide useful material for training and supervision in PPT. Future practitioners can utilize these findings to refine intervention protocols, focusing on the enhancement of trust, tolerance, and meaning-making capacities as primary therapeutic targets in posttraumatic contexts.

Several limitations must be acknowledged. First, the sample size ($N = 62$) limits generalizability, and the absence of a randomized control group calls for further controlled studies. Second, the relatively short post-intervention period does not allow assessment of long-term maintenance effects. Future research should include follow-up measurements, comparisons with other therapeutic modalities, and exploration of gender-specific responses to PPT among veterans. Moreover, neurobiological and psychophysiological correlates of actual capacity activation could provide deeper insight into the

mechanisms of positive change.

Overall, the findings affirm that Positive Psychotherapy represents an effective, culturally sensitive, and humanistic approach to psychological assistance for Ukrainian veterans. By combining quantitative evidence with veterans' lived experiences, this study contributes to the growing empirical foundation of PPT and demonstrates its adaptability to contexts of trauma, resilience, and meaning reconstruction.

Conclusion

This study provides empirical support for the effectiveness of Positive Psychotherapy (PPT) in facilitating psychological recovery and posttraumatic growth among Ukrainian veterans. The intervention significantly enhanced veterans' primary actual capacities, such as patience and trust, and promoted positive changes in tolerance understood as an interpersonal attitude, alongside improvements in resilience, life satisfaction, and overall life balance. Qualitative findings further highlighted participants' experiences of meaning reconstruction, restored trust, and reintegration across the four life spheres of the Balance Model.

These results confirm PPT's theoretical assumptions regarding the activation of actual capacities and the transformational potential of intrapsychic conflict when approached through structured, culturally sensitive interventions. The study demonstrates that the five-stage PPT model provides a replicable framework for guiding veterans from emotional distancing to active engagement, self-understanding, and personal growth.

In practice, the findings underscore the relevance of PPT for clinical work with war-affected populations, offering concrete strategies to promote resilience, psychosocial reintegration, and holistic well-being. Future research should examine longitudinal outcomes, controlled comparisons, and the broader applications of PPT across diverse post-conflict contexts. Overall, this study contributes to both the empirical validation of PPT and the advancement of culturally responsive psychological support for veterans.

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DOI: [10.52982/lkj291](https://doi.org/10.52982/lkj291)**Abstract**

This study was designed to investigate the relationship between attachment styles and marital satisfaction among married individuals. The research sample consisted of married individuals residing in the Turkish Republic of Northern Cyprus (TRNC). A purposive sampling method was employed, and data were collected via questionnaires administered to volunteers. A total of 100 married individuals participated in the study, comprising 56 women and 44 men. The instruments employed in this research were the Experiences in Close Relationships Inventory-II (ECR-R), the Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF), and the Marital Life Scale. It was found that marital satisfaction increases as the levels of anxious and avoidant attachment decrease. A similar finding regarding the relationship between WIPPF model dimensions and marital satisfaction was that, as participants adopted another person as a model (e.g., a mother or father), marital satisfaction decreased. Actual capacities for hope, obedience, and loyalty were positively correlated with marital satisfaction.

Keywords: attachment styles, WIPPF, marital satisfaction, married individuals, Positive Psychotherapy**Introduction**

The concept of marriage, which has evolved continuously since 2000 BC, is a cultural phenomenon that significantly influences people's lives. The concept of family, which consists of the triangle of mother, father, and children, has become a core family structure, as its functionality and form have varied over the last century (Kaplan, K., 2016).

Many factors influence the continuity of marriage. Moreover, individuals' personality traits, upbringing conditions, the environment in which they were raised, and the values they adopt (Dilmaç & Bakırcioğlu, 2019), along with the level of mutual trust between partners and their reactions during interactions (Kılıçaslan, 2007), also play significant roles in maintaining marital harmony.

Many factors influence the continuity of marriage. The existence of these factors and their emergence have been extensively documented in the literature. Given that a healthy marriage is possible, marital satisfaction is also important for healthy individuals and a healthy community. One of the most basic variables to examine in marital satisfaction is attachment. Attachment Theory, first introduced by the psychoanalyst John Bowlby in 1969, emphasizes the importance of the child's sense of security and psychological development, which are shaped by the relationship with the primary caregiver (Bowlby, 1969). Secure attachment fosters emotional stability and effective communication, while insecure patterns (anxious or avoidant) tend to generate conflict and dissatisfaction (Hazan & Shaver, 1987). Attachment style plays a major

role in determining adult relationships. Based on the assumption that an individual's attachment style with their mother affects the romantic relationships in adulthood, attachment styles and their effects on marital satisfaction were investigated in this study. The current study aims to integrate these two theoretical frameworks – attachment theory and PPT – by exploring how attachment styles and actual capacity jointly influence marital satisfaction. While previous studies have independently addressed attachment and satisfaction, limited research has examined them through the lens of PPT, particularly in the context of Turkish culture. The present study integrates two major theoretical perspectives – attachment theory and Positive Psychotherapy (PPT) – to examine how attachment styles and individuals' actual capacities may shape marital satisfaction. The present study integrates these frameworks by proposing that attachment styles not only directly influence marital satisfaction but may also be associated with the activation of specific capacities, such as hope, trust, obedience, and loyalty. These capacities, central to PPT, represent behavioral and emotional resources that individuals bring into marital relationships. An insecure attachment style may hinder the development or expression of such capacities, thereby affecting marital satisfaction. This conceptual model provides the rationale for investigating attachment, PPT-based capacities, and marital satisfaction within a single analytical framework. Rather than examining these constructs separately, the study proposes a combined framework in which attachment tendencies and PPT-based strengths are considered jointly, thereby offering a more comprehensive understanding of variations in marital satisfaction. By doing so, this research aims to propose an integrative conceptual model to the existing literature.

Based on this theoretical groundwork, the study seeks to answer the following research questions:

- Do attachment styles predict marital satisfaction?
- Do actual capacities (PPT actual capacities) predict marital satisfaction?
- Do actual capacities mediate the relationship between attachment style and marital satisfaction?
- Are there differences in marital satisfaction by marriage type (love vs. arranged)?
- Do socio-demographic variables relate to marital satisfaction?

Methodology

The research employs a quantitative approach. Quantitative research methods aim to explain individuals' behaviors using numerical data and to measure them objectively through observation, experimentation, and testing (Akman, 2014).

Studies employing the quantitative research model fall into two basic patterns. Quantitative research designs are classified into scan and experimental models (Bilal, 2012).

The scan model is used as a quantitative research pattern in this study, as it is aimed to analyse more than one factor influencing the dependent variable of this research; the research pattern is accepted as a "multi-factorial design.

2.1. Sample

Convenience sampling is a non-probability sampling method that relies on data collection from members of the population who are readily available to participate in the study. For this purpose, 100 married individuals who had been married for at least 1 year and lived in the TRNC were selected. The participants' educational levels were as follows: 4% had completed primary school, 5% had completed secondary school, 30% had completed high school, 52% had completed university, and 9% had completed postgraduate studies (master's/doctoral). A similar distribution was observed in the educational attainment of the spouses: 5% had completed primary school, 3% had completed secondary school, 35% had completed high school, 49% had completed university, and 8% had completed postgraduate education. Regarding the type of marriage, 82% reported a love marriage, 17% reported an arranged marriage of convenience, and 1% reported an arranged marriage not of convenience. The study shows that the mean age of participants was 32.15 years (SD = 9.60), with an age range of 20-71 years. The average duration of marriage was 7.65 years (SD = 8.83), with a range of 1 to 40 years. The average age at marriage was 24.43 years (SD = 3.81), and the average dating

duration prior to marriage was 3.01 years ($SD = 2.21$). Participants also reported having an average of 0.98 children ($SD = 1.29$). These demographic characteristics together provide a comprehensive overall view of the sample and support the interpretability and contextualization of the study's findings.

2.2. Measures

The scales planned for use in the research are as follows.

Demographic Information Form

First, participants are given a form stating the purpose of the research, its content, the researcher's identity information, and the voluntary nature of participation; thereafter, a demographic information form is distributed. Socio-economic and educational levels, and marital relationship-related items appear in the form. Their gender, age, educational attainment, duration of marriage, and type of marriage.

Experiences in Close Relationships Scale-II (ECR-R)

It was developed by Brennan et al. by applying factor analysis to 60 scales used to measure attachment in adult romantic relationships (Brennan, Fraley, and Waller, 2000). The ECR-R is a self-report instrument designed to measure the extent of insecure attachment in romantic relationships. The adaptation of the ECR-R to Turkish was carried out by Sümer and Güngör (1999), and the expected findings regarding factor structure and related analyses were obtained (Güngör, 2000). ECR-R is evaluated as a 7-level Likert-type scale (1 = strongly disagree, seven strongly agree) (Brennan, Fraley, and Waller, 2000). As a result of his studies on the scale, Sümer (2006) identifies two dimensions: "anxiety" and "avoidance". The internal consistency coefficients for the scale are 0.86 and 0.90, respectively.

Marital Life Scale

The "Marital Life Scale," originally developed by Tezer (1996), was used to assess participants' marital satisfaction. The scale comprises 10 items scored on a 5-point Likert-type scale. Items numbered 2, 4, and 5 require reverse scoring. The potential score range for the scale is 10-50. A higher score on this scale indicates greater marital satisfaction. The original reliability analysis for the scale reported a test-retest reliability coefficient of 0.85, and internal consistency coefficients of 0.91 in the first

application group and 0.89 in the second. These findings demonstrate the high reliability of the Marital Life Scale (Tezer, 1996). Within the scope of the current research, the reliability of the scale was tested by examining the Cronbach's α coefficients, which resulted in an internal consistency value of .88.

Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF 2.0)

It is an inventory developed by Peseschkian and Deidenbach (1988). It is a scale measuring Positive Psychotherapy items and consists of 88 items, answered on a four-point Likert scale.

Data were collected online, ensuring anonymity and voluntary participation. Ethical approval was obtained. Analyses were conducted using SPSS (Version 22.0) with descriptive statistics, Pearson correlation, multiple regression, and mediation testing (Hayes, 2013). Significance level was set at $p < .05$.

2.3. Procedure

Individuals who had been married for at least 1 year and were over 18 years of age were included in the study. Divorced individuals, those living together but not married, or those who provided incomplete responses, were not included. The data were examined for missing values, and cases with more than 10% missingness were removed using listwise deletion. Both online and face-to-face methods were used to collect data. For online data collection, a survey was developed in Google Forms, and the link was distributed to participants across various community groups. Participants could complete the survey at their convenience. No personal information was requested on the survey form; therefore, responses were recorded anonymously.

All participants were given a consent form. This form included the study aim, a statement that participation was voluntary and that information would be kept confidential, and an explanation of the potential benefits and risks of the study. Individuals who agreed were directed to the survey.

2.4. Ethical Approval

This study is an ethically approved research project that was conducted as part of a 2017 graduation thesis at the Near East University Institute of Social Sciences. Throughout the research process, the institution's ethical

principles and overall research standards were adhered to.

Results

Descriptive analyses showed that participants reported moderate to high levels of marital satisfaction ($M = 39.33$, $SD = 7.13$). Table 1 presents the descriptive statistics for the Marital Life Scale (MLS).

Table 1. Descriptive Statistics for Marital Life Scale (MLS)

<i>M</i>	<i>SD</i>	<i>MIN</i>	<i>MAX</i>
39.33	7.13	12	50

Note. MLS ranges from 10 to 50. Higher scores reflect higher marital satisfaction.

Correlational findings (Table 2) indicated that anxious attachment was negatively associated with marital satisfaction ($r = -.296$, $p = .003$), and avoidant attachment showed an even stronger negative association ($r = -.576$, $p < .001$). The ECR-R total score also demonstrated a significant negative correlation with marital satisfaction ($r = -.513$, $p < .001$).

Table 2. Correlations Between Attachment Styles and Marital Satisfaction

<i>Variable</i>	<i>r</i>	<i>p</i>
<i>Anxious Attachment</i>	-.296	.003
<i>Avoidant Attachment</i>	-.576	.000
<i>ERC-R Total</i>	-.513	.000

Multiple regression analysis showed that attachment styles significantly predicted marital satisfaction, with avoidant attachment emerging as the strongest predictor. The model explained a meaningful portion of the variance in marital satisfaction.

Table 3a. Correlations Between WIPPF Primary Capacities and MLS

<i>Primary Capacity</i>	<i>r</i>	<i>p</i>
<i>Patience</i>	.045	.654
<i>Time</i>	.127	.208
<i>Contact</i>	.048	.233
<i>Trust</i>	.155	.010
<i>Hope</i>	.213	.033
<i>Sexuality</i>	.002	.994
<i>Love</i>	.094	.469
<i>Belief</i>	.096	.496

Among primary capacities, hope demonstrated a small positive association with marital satisfaction ($r = .213$, $p < .05$).

Table 3b. Correlations Between WIPPF Secondary Capacities and Attachment Styles

<i>Secondary Capacity</i>	<i>Anxious (r)</i>	<i>Avoidant (r)</i>
<i>Cleaning</i>	.254*	.297**
<i>Obedience</i>	–	-.198*
<i>Loyalty</i>	-.295**	-.201*

Several secondary capacities showed associations with attachment styles, particularly cleaning, obedience, and loyalty.

Table 3c. Correlations Between Model Dimensions and Attachment Styles

<i>Model Dimension</i>	<i>Anxious (r)</i>	<i>Avoidant (r)</i>
<i>I-other</i>	.287**	.418**

Model dimensions such as I-other demonstrated positive correlations with insecure attachment patterns, indicating that individuals with higher anxiety or avoidance in attachment may experience difficulties within interpersonal role structures.

Table 4. Regression Analysis Predicting Marital Satisfaction

<i>Predictor</i>	<i>B</i>	<i>SE(B)</i>	β	<i>t</i>	<i>p</i>
<i>Anxious Attachment</i>	-0.18	0.06	-.24	-3.02	.003
<i>Avoidant Attachment</i>	-0.31	0.05	-.46	-6.12	<.001

$R = .63$
 $R^2 = .38$
 Adjusted $R^2 = .37$
 $F(2,97) = 29.62$, $p < .001$

Table 5. Mediation Analysis of Hope Between Attachment and Marital Satisfaction

Path	Effect	SE	t	p	95% CI
<i>a</i> (Attachment → Hope)	-0.21	0.08	-2.62	.010	[-0.37, -0.05]
<i>b</i> (Hope → Marital Satisfaction)	0.19	0.09	2.11	.037	[0.01, 0.36]
<i>c</i> (Total effect)	-0.52	0.09	-5.86	<.001	[-0.70, -0.34]
<i>c'</i> (Direct effect)	-0.48	0.10	-5.02	<.001	[-0.68, -0.27]

Mediation analysis revealed that primary capacities did not mediate the relationship between attachment styles and marital satisfaction. Attachment styles maintained their direct negative effects on marital satisfaction even after including primary capacities as mediators.

Discussion

When considered alongside previous studies investigating the relationships among adult attachment styles, the primary and secondary capacities addressed in Positive Psychotherapy, and marital satisfaction, this research makes significant contributions. It is accepted that adult attachment styles strongly influence the quality of romantic relationships (Bartholomew & Horowitz, 1991; Mikulincer & Shaver, 2016). Moreover, studies conducted in Turkey also show that attachment patterns are associated with relational harmony and marital satisfaction (Güngör, 2009; Sümer & Güngör, 1999). The results of this study were evaluated in the context of this literature.

When gender is analysed, male and female participants do not differ in marital satisfaction or attachment styles. Tezer (1996) and Çelik (2006) find no significant difference in marital satisfaction between men and women. These results support our findings. The results of this study support the study's findings and suggest that gender may not be a fundamental determinant of attachment style.

The literature on Positive Psychotherapy highlights that basic capacities such as hope play an important role in an individual's life satisfaction and relational functioning (Peseschkian, 2012; Bachmann, 2018). Similarly, in this study, a significant positive relationship was found between hope and marital satisfaction. As marriage satisfaction increases, the level of hope, a primary capacity, also increases. This shows that the level of hope affects marital satisfaction. In Positive Psychotherapy, the capacity for hope means

that, even when people feel desperate, they believe there is always a way out, that they will have a good future for themselves and their families, and that they always have a life plan (Peseschkian 1996, 2002).

In Positive Psychotherapy, the capacity for hope means that, even when people feel desperate, they believe there is always a way out, that they will have a good future for themselves and their families, and that they always have a life plan (Peseschkian 1996, 2002). It has been shown that hopeful people are happier, more successful in coping with stress, and they have stronger social ties (Peterson, 2000; Snyder, 2000).

Given the research's cultural context, it can be concluded that family structures in Turkey continue to exhibit strong collectivist elements. The literature indicates that values such as commitment, solidarity, and collective action within Turkish culture influence both attachment behaviors and the maintenance of romantic relationships (Kağıtçıbaşı, 2005). Therefore, it is important to interpret the findings within the cultural context. The use of capacities may also vary across cultures; for example, capacities such as hope, patience, and perseverance may be employed in more relational contexts within Turkish culture. Comparative studies across cultures will more clearly reveal whether the relationships between capacities and attachment are universal or context-specific.

Limitations

This study has several limitations, and the results should be interpreted within this framework. First, the sample size is limited and was determined through convenience sampling, which restricts the generalizability of the findings. Second, the data were collected entirely through self-report measures, which increases the risk of bias, such as social desirability bias. Because the desire to appear positive in marriage may be greater in Turkish

culture, this could have influenced the findings. Third, the study has a cross-sectional design; therefore, causal relationships between variables could not be evaluated. In addition, some socio-demographic information was collected only in a limited manner, which makes it difficult to fully describe the sample's characteristics. Although the measurement tools used had previously been adapted into Turkish, the cultural sensitivity of these scales should also be considered, as cultural norms may influence attachment and marital behaviors.

In future studies, collecting data from both partners in a couple, employing longitudinal methods, and engaging with larger and cross-cultural samples will contribute to a more comprehensive and comparative understanding of the relationships between the variables.

Conclusion

This study examined the relationships among marital satisfaction, attachment styles, actual abilities, and model dimensions within the framework of Positive Psychotherapy (PPT). The results indicated that secure attachment and Balance Model dimensions contribute to higher

levels of marital satisfaction. In addition, individuals' awareness of their actual abilities may contribute to relational harmony. Recognizing and applying strengths such as patience, empathy, and reliability can help facilitate couples' conflict resolution processes and enhance mutual understanding.

From a therapeutic perspective, the findings suggest that bringing PPT's focus on personal resources into couple sessions may be helpful. When people become more aware of their strengths, they often manage their relationships in a calmer, more flexible, and more understanding manner.

These interventions can help individuals recognize and apply their personal capacities to strengthen emotional bonds and resilience within marriage. Additionally, exploring cultural differences in the expression of actual capacity could enrich the transcultural understanding of marital dynamics. In conclusion, this study underscores the value of combining attachment theory with Positive Psychotherapy principles. By integrating emotional security and personal strengths, practitioners can promote deeper satisfaction, empathy, and resilience in marital relationships.

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*Section: Preliminary studies in Positive Psychotherapy (PPT)***Primary and Secondary Capacities in Different Generations of the Greek Population****Aikaterini Flaka**

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Abstract

This preliminary study explores the primary and secondary capacities described by Nossrat Peseschkian in Positive Psychotherapy theory across three generations of the Greek population. The study aims to examine whether primary capacities are more characteristic of Generations X and Y. In contrast, secondary capacities are more characteristic of Generation Z. Another aim is to investigate the influence of primary and secondary capacities on gender within each generation.

The sample comprised 119 participants from Greece aged 18 to 59. According to the findings, neither age nor gender appears to be a factor shaping an individual's association with primary or secondary capacities as defined in Positive Psychotherapy. This suggests that these capacities may be universal and not influenced by age or gender – at least within the Greek population studied.

Keywords: Positive Psychotherapy, primary capacities, secondary capacities, X, Y, Z generations

Introduction

The main objective of this research is to examine the primary and secondary capacities and their distinction, as articulated by Nossrat Peseschkian in his theory of Positive Psychotherapy.

In 1977, Nossrat Peseschkian formally introduced the notion of "basic and actual capacities" (Peseschkian, 1987). As he wrote at that time, each human being is born as a letter written with invisible ink. All of us are born with

all the capacities, but it depends on where the heat is applied; only those capacities will develop and will be visible. "The actual capacities have two functions: they offer categories for making descriptions, and provide an encompassing inventory of human behaviors", as Peseschkian says in his book "Positive Psychotherapy of Everyday Life" (2016). Actual capacities are derived from two basic capabilities shared by all human beings: the capacity to know and the capacity to love (Peseschkian, N., 1987).

The Primary capacities arise on the first day of a person's life through contact with other people (Peseschkian N., 1987), from the basic capacity to Love. The Primary capacities are expressed through resources such as Time, Patience, Contact, Love/acceptance, Tenderness/Sexuality, Trust, Doubt, Hope, Faith, Model, Unity/integrity, and Confidence. (Peseschkian N., 1987)

The Secondary capacities are linked with the transmission of knowledge and thus they developed from the basic capacity to Know. They reflect the values and norms of the social group and the individual's cultural environment. Secondary capacities are expressed through resources such as Punctuality, Cleanliness, Orderliness, Obedience, Courtesy, Honesty, Accuracy, Faithfulness, Justice, Diligence, Thrift, Reliability, and Conscientiousness. (Peseschkian H. & Remmers A., 2025).

A generation may be conceptualized as a cohort of individuals of comparable age who possess a shared historical and cultural framework. Experiences occurring within the same temporal context (Ryder, 1965) serve to distinguish one generation from another (Jurkiewicz & Brown, 1998), as these collective experiences significantly shape the attitudes, values, beliefs, and expectations inherent to generational cohorts (Inglehart & Norris, 2003). Each successive generation, succeeding its predecessor, emerges with distinctive characteristics and values (Bennett & Rademacher, 1997). The observed intergenerational variation can be explained by the premise that individuals born within a two-decade span share common characteristics shaped by the historical events of that period, prevailing economic conditions, and technological advancements (Reeves & Oh, 2008).

The term "Generation X" was popularized by the 1991 novel *Generation X: Tales for an Accelerated Culture* by Douglas Coupland, which explored the lives and attitudes of young adults in the early 1990s. The present study used the period 1965 to 1980 to represent Generation X. Representatives of this generation exhibit a profound sense of accountability for their professional obligations, even in the absence of direct supervision, and a strong work ethic (Wey & Sutton, 2002). A significant proportion of this generation comprises individuals who were raised in environments characterized by parental

oppression, which has a direct influence on their behavioural patterns and value systems (Eisner, 2005). During childhood, many of these individuals spent substantial periods of unsupervised time at home due to their parents' occupational commitments. Consequently, they developed an individualistic orientation, a pervasive scepticism towards the organizations employing them, a notable deficiency in organizational loyalty (Smola & Sutton, 2002), and an emphasis on achieving a harmonious work-life balance (Eisner, 2005), an aspiration for financial autonomy, and a propensity for entrepreneurial risk-taking (De Meuse, Bergman & Lester, 2001).

The designation "Generation Y" was originally introduced by scholars William Strauss and Neil Howe in their 1991 publication "Generations: The History of America's Future, 1584 to 2069." This study used the period 1981 to 1996 to represent Generation Y. This generation is referred to by various designations, including Gen-Me (Twenge et al., 2019), Next Generation, and Generation Y (Neubourne & Kerwin, 1999). This cohort represents the inaugural high-tech generation, having never experienced a time without mobile telecommunication devices, personal computing systems, and automated teller machines (Mitchell, 2002). The parents of this generation are characterized as "helicopter parents," who consistently hover over their offspring, exercising control and safeguarding them while catering to all their "desires." The implicit communication conveyed by these parents to their children is to "return home when faced with adversity", a sentiment that persists throughout their adulthood and exerts influence on their vocational trajectories. For this generation, familial connections are perceived as the fundamental source of happiness (Mitchell, 2002). It is a generation that makes decisions and acts based on its experiences (Bittner et al., 2013).

Generation Z, frequently referred to as the Children of the Internet, the Digital Generation, the Media Generation, or the Instant Online Generation (Levickaite, 2010), represents the inaugural generation that has been profoundly and comprehensively subjected to digital technologies, including social networking platforms and an abundance of hyper-information available online (Turner, 2015). This study used the period from 1997 to 2012 to represent Generation Y. The majority of

individuals in this cohort are from Generation X, which is characterized by notably higher educational attainment than previous generations (Swanbrow, 2012). Consequently, these guardians advocate for their children to engage deeply with technological innovations from the early stages of their developmental journey. For these youths, technology transcends its role as a mere instrument (which, if misapplied, may yield detrimental repercussions). "The Internet is to Generation Z like oxygen, without which they cannot even imagine their lives" (Oblinger & Oblinger, 2005). Their preoccupation with the digital realm, coupled with a deficiency in in-person interactions, has led to the assertion that this generation "is the first to have poor face-to-face interaction and is less likely to use brain logic in the thinking and decision-making process" (Salleh et al., 2017). Notwithstanding the lack of in-person social engagement, this cohort possesses the capacity to concurrently address multiple challenges (perennially facilitated by social media) (UPCEA, 2017), thereby establishing extensive interactive communities that enable direct communication with individuals whom they have not encountered in person (Riva et al., 2012).

The purpose of this paper is to add to the scientific community a study looking at the connection and influence that the Actual capacities (primary and secondary), as described in Positive Psychotherapy, may have on generations X, Y, Z, and the genders of each generation. In the research community, most generational studies are approached from perspectives quite different from the one used in this study. In addition, within the field of Positive Psychotherapy, existing studies on actual capacities typically involve different types of samples than those used here, as this study focuses specifically on generational groups in Greece.

Methodology

This research aims to examine whether there is a relationship between generations and genders in the use of primary and secondary capacities. The research hypotheses were developed as follows:

1. Generations X and Y are more oriented towards primary capacities, whereas

Generation Z is more oriented towards secondary capacities.

2. In Generations X and Y, women tend to show a stronger orientation toward primary capacities, while men tend to be more oriented toward secondary capacities.

This study collected 119 participants. All the participants were from Greece. They were adults aged 18-59 years. The survey sample included individuals from the three generations studied, and each generation was represented by both genders (Table 1). By generation, participation was 41.2% for Generation X, 48.7% for Generation Y, and 10.1% for Generation Z.

The WIPPF questionnaire (Wiesbaden Inventory for Positive Psychotherapy and Family Therapy) was developed by Peseschkian and Deidenbach (1988). The WIPPF-2 version adapted by A. Remmers in 1995 for international use assesses the Actual Capacities, both the Primary and Secondary. From the list of capacities described by Peseschkian, the WIPPF uses 11 secondary capacities and 8 primary capacities, presented in the table below:

Table 1. List of primary and secondary capacities (Terminology and conceptual framework of Positive Psychotherapy, 2025)

<i>Primary capacities from WIPPF</i>	<i>Secondary capacities from WIPPF</i>
<i>Patience</i>	Orderliness
<i>Time/ Time awareness</i>	Cleanliness
<i>Contact/ Social interaction</i>	Punctuality
<i>Trust</i>	Politeness/ Courtesy
<i>Hope</i>	Honesty/ Directness
<i>Tenderness/ sexuality</i>	Achievement/ Diligence
<i>Love/acceptance</i>	Reliability/ Trustworthiness
<i>Faith/Believe/ World View</i>	Frugality/ Thriftiness
	Obedience
	Justice/ Fairness
	Fidelity/Loyalty

More specifically, the questionnaire comprises 88 items covering all actual capacities, both primary and secondary, conflict reactions, and model dimensions. We used 57 questions addressing the primary and secondary capacities

that were the focus of this study. The 57 items are rated on a four-point Likert scale (1 = "Fully disagree", 2 = "Partially disagree", 3 = "Partially agree", 4 = "Fully agree").

The WIPPF is a psychotherapeutic tool applicable across multiple languages and beneficial for purposes such as diagnosis, counseling, individual or family therapy, and quality assurance. It may be regarded as a transcultural approach to psychotherapy that transcends theoretical frameworks (Remmers, A., 1996)

The WIPPF has been used in a variety of studies by some researchers and therapists from different countries (Serdiuk, & Ottenko, (2021), Sinici, Sari, Maden Ö (2014), Latifi (2013), Prifti & Hum (2022), Ntarla, & Hum (2024).

Results

Basic demographic characteristics were recorded for this study through frequency descriptive analysis per the gender of participants, as well as the generations represented in this study, as follows:

- per the sample's genders identified that out of 119 participants, 83 of them were females (69,7%) and 36 males (30,3%).
- per the generations represented, 49 individuals were born between 1965 and 1980 (41.2%) and belonged to Generation X, 58 individuals were born between 1981 and 1996 (48.7%). They belonged to Generation Y; 12 individuals (10.1%) were born between 1997 and 2012, and to Generation Z.

Table 2. Gender per generation crosstabulation, descriptive analysis results.

Generation * Gender Crosstabulation				
		Count		
Generation		Gender		Total
		Male	Female	
X (1965-1980)		13	36	49 (41,2%)
Y (1981-1996)		20	38	58 (48,7%)
Z (1997-2012)		3	9	12 (10,1%)
Total		36	83	119
		30,3%	69,7%	

The crosstabulation of frequencies showed that 13 males and 36 females belong to Generation X, 20 males and 38 females belong to Generation Y, and 3 males and 9 females belong to Generation Z.

Appropriate statistical tests for the WFFIP questionnaire were conducted to compare the use of primary and secondary capacities by gender and generation. The Shapiro-Wilk test was used to determine whether the generation and gender data were normally distributed. The test, when regarding the usage of primary capacities, produced a per generation statistic value of 0.967 for generation X with a p-value of 0.179, for generation Y with a statistic value of 0.982 and a p-value of 0.548, and generation Z with a statistic value of 0.863 and a p-value of 0.054, supporting the assumption of normality in data distribution.

With concerns of usage of secondary capacities, the same test introduced a per generation statistic value of 0.982 for generation X with a p-value of 0.643, for generation Y with a statistic value of 0.971 and a p-value of 0.183, and for generation Z with a statistic value of 0.891 and a p-value of 0.123, also supporting the assumption of normality (Table 2).

The same test was performed to produce a per gender statistic value 0.972 for male participants with a p-value of 0.473, and a statistic value of 0.979 for female participants with a p-value of 0.205 for usage of primary capacities, whilst a statistic value per gender of 0.964 for male participants with a p-value of 0.277, and a statistic value of 0.983 for female participants with a p-value of 0.355 for usage of secondary capacities, thus, supporting the assumption that the data were normally distributed (Table 3).

Table 3. Shapiro-Wilk test for normality per generation for primary and secondary capacities usage results

		<i>Tests of Normality</i>		
	<i>Generation</i>	<i>Shapiro-Wilk</i>		
		<i>Statistic</i>	<i>Df</i>	<i>Sig.</i>
<i>Primary</i>	1965-1980	.967	49	.179
	1981-1996	.982	58	.548
	1997-2012	.863	12	.054
<i>Secondary</i>	1965-1980	.982	49	.643
	1981-1996	.971	58	.183
	1997-2012	.891	12	.123

Table 4. Shapiro-Wilk test for normality per gender for primary and secondary capacities usage results

		<i>Tests of Normality</i>		
	<i>Sex</i>	<i>Shapiro-Wilk</i>		
		<i>Statistic</i>	<i>df</i>	<i>Sig.</i>
<i>Primary</i>	Male	.972	36	.473
	Female	.979	83	.205
<i>Secondary</i>	Male	.964	36	.277
	Female	.983	83	.355

A one-way ANOVA was performed to determine whether there is a relationship between generations and the use of primary and secondary skills. No statistically significant

difference was identified between different generations and the usage of primary ($p = .320 > .05$) or secondary ($p = .067 > .05$) capacities usage, as seen in the following table 4:

Table 4. One-way ANOVA test for the relationship between generations and the usage of capacities results

		<i>Sum of Squares</i>	<i>df</i>	<i>Mean Square</i>	<i>F</i>	<i>Sig.</i>
<i>Primary</i>	Between Groups	.174	2	.087	1.149	.320
	Within Groups	8.781	116	.076		
	Total	8.955	118			
<i>Secondary</i>	Between Groups	.524	2	.262	2.766	.067
	Within Groups	10.977	116	.095		
	Total	11.501	118			

An independent-samples t-test was conducted to assess whether gender differences are associated with the use of primary and secondary capacities. No statistically significant

difference was identified between different genders and the usage of primary ($p = .730 > .05$) or secondary ($p = .217 > .05$) capacities usage, as seen in the following table:

Table 6. Independent Samples T-test for the relationship between genders and
The usage of capacities results

		<i>t-test for Equality of Means</i>						
		<i>T</i>	<i>df</i>	<i>Sig.</i> (2- tailed)	<i>Mean</i> <i>Difference</i>	<i>Std. Error</i> <i>Difference</i>	<i>95% Confidence</i> <i>Interval of the</i> <i>Difference</i>	
							Lower	Upper
<i>primary</i>	Equal variances assumed	-.346	117	.730	-.01911	.05518	-.12839	.09018
	Equal variances not assumed	-.334	61.562	.739	-.01911	.05717	-.13340	.09519
<i>secondary</i>	Equal variances assumed	1.240	117	.217	.07710	.06216	-.04601	.20021
	Equal variances not assumed.	1.275	71.059	.206	.07710	.06046	-.04346	.19766

Conclusion

The purpose of the present study was to examine the actual capacities described in Positive Psychotherapy by Peseschkian across three generations (X, Y, and Z) in a Greek sample. Although prior literature highlights numerous distinct characteristics of these generations, research specifically linking generational identity to primary and secondary capacities remains limited. This study sought to examine whether Generations X and Y would exhibit a stronger orientation toward primary capacities, and whether Generation Z would exhibit a stronger orientation toward secondary capacities. A further exploratory aim was to investigate potential gender differences within Generations X and Y.

This research represents the first attempt in Greece to assess actual capacities in the general population using the WIPPF questionnaire. The sample comprised 119 individuals aged 18–59, with a higher proportion of women (69.7%). Generation Y comprised the largest proportion of the sample (48.7%), followed by Generation X (41.2%) and Generation Z (10.1%). Age and gender were the only demographic variables considered.

No statistically significant differences were found between generations in their orientation toward primary or secondary capacities. Similarly, no significant gender differences were

identified. These findings suggest that, within this sample, primary and secondary capacities may not be strongly associated with generational allegiance or gender. However, given the limited sample size - particularly for Generation Z - these results should be interpreted as preliminary rather than definitive.

It is also important to contextualize these findings within the broader cultural and social environments that have shaped each generation in Greece. Rapid societal changes, technological advancements, shifting family structures, and evolving sociopolitical values offer meaningful avenues for understanding the development of primary and secondary capacities. Additionally, the present study's design does not permit causal conclusions regarding the influence of these factors.

Overall, the findings contribute to an emerging discussion on whether the capacities defined in Positive Psychotherapy function as universal constructs rather than as gender - or generation-specific traits. Although the results did not reveal significant differences, they open pathways for further inquiries. Future research with larger, more diverse, and more balanced samples would provide a more robust basis for evaluating potential generational patterns.

Despite its exploratory nature, this study offers practical implications. If subsequent research supports the relative stability of primary and secondary capacities across

generations, this may inform the development of inclusive social policies and educational programs that emphasize shared competencies. Furthermore, such findings could support the design of intergenerational interventions that leverage common strengths rather than assumed generational divides, as well as therapeutic approaches that integrate both emotional and cognitive capacities across age groups.

Study Limitations

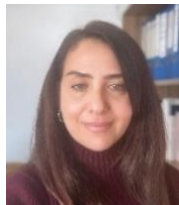
The present study has several notable limitations related to sample size and generational distribution. The representation of

both generations and genders was uneven, with Generation Z being particularly underrepresented. This limited participation was likely due to difficulties accessing this age group and their lower willingness to engage through traditional recruitment methods. Future research should consider using social media platforms, which are more commonly used by Generation Z, as a more effective means of recruitment than traditional communication methods such as email. Future research should also aim to expand the sample size and employ more robust statistical methods, while also addressing the limitations of snowball sampling and its potential impact on the representativeness of the findings.

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*Section: Preliminary studies in Positive Psychotherapy (PPT)***A Preliminary Study on the Effects of a Group Psychoeducation Program Incorporating Concepts of Positive Psychotherapy on Patients with Diabetes Mellitus****Süreyya Geylan Gürdal**

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DOI: [10.52982/1kj293](https://doi.org/10.52982/1kj293)**Abstract**

Diabetes Mellitus (DM) is a prevalent chronic disease, and it is now widely recognized that psychological factors play an important role in its onset, progression, and treatment. This study aimed to increase patients' awareness of the relationship between psychological factors and the treatment process through a group psychoeducation program grounded in Positive Psychotherapy (PPT) concepts, and to evaluate the effects of this training. The study included nine patients diagnosed with DM who participated in weekly two-hour group sessions over five weeks. Each session addressed a different theme, focusing on both the positive and negative effects of DM on participants' lives and on the influence of psychological factors on disease management. The training aimed to support patients in adopting healthier lifestyles, recognizing signs of stress, and developing coping strategies. At the conclusion of the program, participants reported that the sessions were beneficial, particularly those on the Balance Model and stress-management techniques. These findings suggest that incorporating group psychoeducation into DM treatment may enhance treatment outcomes and that PPT methods can be effectively applied in such interventions.

Keywords: Diabetes Mellitus (DM), Positive Psychotherapy, psychoeducation**Introduction**

Diabetes Mellitus (DM) is a chronic metabolic disorder resulting from the pancreas's inability to produce sufficient insulin or from the body's ineffective use of insulin, a hormone essential for regulating blood glucose levels. Consequently, glucose derived from food intake accumulates in the bloodstream rather than being used for energy through insulin-mediated uptake. DM is

one of the most prevalent chronic diseases worldwide and a leading cause of morbidity and mortality.

Diabetes Mellitus is primarily classified into two types. Type 1 DM is an autoimmune disorder in which the pancreas produces little or no insulin. Type 2 DM is a metabolic condition characterized by insulin resistance and/or insufficient insulin secretion. (World Health Organization [WHO], 2023; American Diabetes

Association [ADA], 2020). Globally, the prevalence of DM is estimated at 6.1%, with projections indicating a continuing rise (WHO, 2023; Institute for Health Metrics and Evaluation [IHME], 2023). Türkiye reports the highest prevalence in Europe, with 15% (TEND Guidelines for the Diagnosis, Treatment, and Follow-up of Diabetes Mellitus and Its Complications, 2024), a rate exceeding that of other European countries (IDF, 2019). In the northern part of Cyprus, a prevalence study involving 1,780 individuals aged 20–80 revealed rates of 11.5% for diabetes and 17.9% for impaired glucose tolerance. Prevalence increased with age but decreased with higher educational attainment in the TRNC (KADEM, 2008).

Chronic illnesses such as DM exert significant social, psychological, emotional, and economic burdens. Psychological and social factors are closely intertwined with physical conditions, and psychological distress often exacerbates disease outcomes (Alay, 2023; Sorbi et al., 2018). Patients with chronic diseases face heightened risks of depression, anxiety, and stress, all of which can impair immune function and disease management (Greenberg, 2007).

The diagnosis of DM frequently induces psychological distress, influencing social relationships, occupational functioning, and family dynamics (Wasserman & Trifonova, 2006). The adaptation process typically involves stages such as shock, denial, and disorganization (Orgen, 1996), which may culminate in a psychosocial crisis characterized by anxiety, fear, and loss of equilibrium (Sorbi, 2018; Sharma, 2022).

Depression is particularly common among patients with DM. Lifetime prevalence rates among individuals with Type 2 DM reach up to 30%, significantly exceeding rates in the general population (Eren et al., 2008; Kalat, 2008; TEND, 2024). Depression not only diminishes quality of life but also impairs glycaemic control, although treatment of depression can improve both (Sundaram, 2007; Değer, 2023). Similarly, anxiety disorders affect up to 40% of individuals with DM, with a higher frequency compared to the general population (Bahar et al., 2006; Tuncay et al., 2008).

Because chronic illnesses require long-term adaptation, psychoeducation has been shown to enhance patients' coping strategies and stress-related perspectives (Saygılı, 2019; Tel, 2023).

Studies of patients with DM demonstrate that psychoeducation positively influences disease adaptation, lifestyle, and stress management (Jung et al., 2021; Sorbi et al., 2019). Group training programs for chronic illnesses have been associated with improved coping, adaptation, and quality of life when compared to untreated control groups (Ven, 2005; Soo & Lam, 2009; Sorbi et al., 2018; Kıskaç & Rashisi, 2023; Karagöz & Beydağ, 2024). Emotional and social support following diagnosis is essential, and in some cases, psychological intervention may be necessary (Drum & Zierenberg, 1997). Effective coping strategies enhance health outcomes and overall disease management (Greenberg, 2007).

Positive Psychotherapy (PPT), developed by Nossrat Peseschkian in 1968, is a short-term psychotherapeutic method integrating psychodynamic principles, a humanistic orientation, and a transcultural framework. PPT emphasizes the importance of psychosocial norms in socialization and conflict, with a focus on personal strengths and resources. The Balance Model, central to PPT, identifies four fundamental life areas – Body/Senses, Work/Achievement, Contact/Tradition, and Future/Spirituality – each representing a dimension of human adaptation and conflict resolution. DM disrupts the Body area most directly, but this disturbance can also unbalance the other spheres. A psychoeducation program grounded in this model can help patients restore equilibrium among these areas, thereby enhancing salutogenesis.

Narratives and stories play a significant role in PPT, serving functions such as mirroring patients' experiences, providing conflict-resolution models, mediating therapeutic communication, and transmitting cultural traditions (Peseschkian, 2016a; 2016b; 2016c). By externalizing conflicts through narrative identification, patients can gain new perspectives, reduce resistance, and integrate therapeutic insights into daily life. This makes stories an effective educational tool.

The balance model provides a structured, easily understandable framework for self-reflection and goal-setting in health education. Moreover, the positive interpretation of symptoms and the resource-oriented approach of PPT provide a strong, conceptually coherent foundation for designing psychoeducational interventions. The present study investigates the effects of a group psychoeducation program

based on Positive Psychotherapy concepts on patients with Type 2 Diabetes Mellitus.

Methodology

2.1. Sample

Group members were recruited through an announcement made by the Turkish Cypriot Diabetes Association. Volunteers were required to meet the condition of being diagnosed with Type 2 Diabetes Mellitus (DM). Individuals who volunteered were invited to participate. A total of ten individuals (three male and seven female) initially participated; however, regular attendance was maintained by nine. Participants' ages ranged from 29 to 70 years.

2.2. Study Design

This study was designed as a preliminary, descriptive, single-group psychoeducational intervention study. The research was planned to last five weeks. Each week, a face-to-face session was conducted with the participants. The training sessions were held in the Güzelyurt Municipality Hotel meeting hall, with each session planned to last approximately one hour.

The training sessions generally consisted of a brief review of the previous week, followed by the delivery of the relevant psychoeducational content. Group interaction and discussion were encouraged prior to the session's closure.

The inclusion criteria for the study were a diagnosis of Type 2 Diabetes Mellitus and voluntary consent to participate. No specific exclusion criteria were defined for this study.

2.3. Setting and Content of the Sessions

The group sessions were held weekly, each lasting two hours. A total of five sessions were held, amounting to 10 hours of group work. The sessions were held in a meeting room at a hotel owned by the Güzelyurt Municipality. This venue was also regularly used by the Turkish Cypriot Diabetes Association, and thus, the participants were already familiar with the setting.

The content of the sessions was structured around Positive Psychotherapy (PPT) principles and tailored to the psychological and social challenges faced by patients with DM.

Session 1: Introduction of the group's purpose, rules, and potential benefits. Participants discussed the impact of DM on physical and psychological health, with a particular emphasis on blood glucose regulation,

stress, and depression. The Balance Model was introduced, and participants created individualized models to reflect their perceptions.

Session 2: The session opened with the story "About the Courage to Risk a Test", which was used to stimulate reflection and group discussion. Stress and its physiological effects on blood glucose were discussed, and participants practiced stress-management techniques, including breathing and muscle-relaxation exercises.

Session 3: Participants reflected on the previous session and then engaged with the story "The Crow and the Parrot." This facilitated recognition of overlooked positive aspects of living with diabetes. Participants explored their feelings at diagnosis and revisited them using the Balance Model to analyse how DM had affected their lives across four spheres.

Session 4: Participants discussed the impact of DM on their personal lives, including possible positive meanings attributed to the illness. Emphasis was placed on understanding illness as a message and on the influence of family attitudes. Participants then explored their personal "model dimensions" by reflecting on family experiences.

Session 5: The final session reviewed all group experiences. Participants shared their thoughts on the knowledge gained and changes in perception. The session concluded with a guided relaxation exercise designed to promote a calm, positive closure.

2.4. Measures

Data were collected using an evaluation form. The first part of the form consisted of demographic questions. The second part, designed to capture participants' subjective experiences of the group training, consisted of ten items, including both structured and open-ended questions. Participants were asked to reflect on their feelings during the sessions, perceived changes in their perspectives, the significance and expectedness of these changes, and whether the psychoeducation program benefited their diabetes management. This approach allowed participants to articulate their experiences in their own words.

2.5. Data Analysis

In this study, data obtained from the evaluation form were analyzed using a descriptive qualitative approach. The descriptive qualitative analysis approach was preferred as it allows participants' experiences to be presented in their own words (Büyüköztürk et al., 2019).

Demographic data was collected in the first section of the evaluation form. The qualitative data obtained from the second section of the form, which included structured and open-ended questions designed to capture participants' subjective experiences of the group training, were systematically analyzed.

During qualitative data analysis, participants' written responses were read repeatedly to develop familiarity with the data. Meaningful expressions related to feelings experienced during the sessions, perceived changes in perspectives, the significance and expectedness of these changes, and the perceived contribution of the psychoeducational program to diabetes management were identified. Similar content was grouped to form a thematic structure, and

the data were organized under these themes. As a result of this process, the themes of stress awareness, use of the Balance Model, and reframing of illness emerged.

2.6. Ethical Statement

Participation in the program was voluntary, and informed consent was obtained from all participants prior to data collection. Confidentiality and anonymity were assured throughout the study. The research posed minimal risk to participants. Formal ethics committee approval was not required under local and national guidelines for voluntary psychoeducational programs.

Results

The majority of participants were female, and educational attainment was relatively low, with primary school being the most common level. No significant gender differences were observed regarding education. The mean age of the participants was 49.5 years (range = 29–70) (Table 1).

Table 1. Sociodemographic characteristics of the participants

	Frequency (n)	Valid Percent (%)
Gender		
Female	7	77.8
Male	2	22.2
Age	49.50 (29-70)	
Education		
Primary School	5	55.6
Secondary School	2	22.2
High School	2	22.2
Citizenship		
Cyprus	5	55.6
Turkey	2	22.2
Cyprus + Turkey	2	22.2

Participants reported that the group training was beneficial in several spheres. Most highlighted an increased awareness of the relationship between psychological factors and DM, as well as the importance of stress management. Approximately 70% of participants rated the group experience as highly beneficial, with 60% attributing their positive changes specifically to participation in the sessions.

Participants valued the Balance Model for broadening their perspectives on health by integrating physical, social, professional, and future-oriented dimensions. Although no direct improvements in blood glucose levels were reported, participants indicated that they became more attentive, relaxed, and constructive in their approach to managing DM. Importantly, for many participants, the perception of diabetes shifted from a burdensome illness to a manageable condition.

No adverse effects were reported. Participants expressed satisfaction with the program's comprehensiveness and recommended that similar sessions be conducted periodically to sustain the benefits.

Conclusion

The findings of this study indicate that group training based on Positive Psychotherapy contributes positively to the psychological adjustment of individuals with DM. Participants reported improvements in stress management, illness adaptation, and overall quality of life. These findings align with prior research demonstrating the effectiveness of psychoeducational interventions in chronic illness management (Ven, 2005; Soo & Lam, 2009; Sorbi et al., 2018; Kışkaç & Rashisi, 2023).

The Balance Model was particularly valued because it encouraged participants to recognize resources across diverse areas of life. Stress management techniques, such as relaxation exercises, were considered especially relevant, given the established relationship between stress and glucose regulation (Cryer & Childs, 1996). The results are consistent with previous studies indicating that psychological interventions, including Cognitive Behavioral Therapy and group counseling, can reduce depression and hopelessness among patients with DM (Lustman et al., 1998; Kumcağız, 2007).

Furthermore, Positive Psychotherapy (PPT), by its very definition, attends to individuals' capacity to cope with conflict and focuses on their existing strengths and potential. Rather than remaining in the patient role, individuals are encouraged to concentrate on their own abilities and to act as their own and others' therapists (Peseschkian, 1996). Through the use of the Balance Model, DM patients were able to explore conflict resolution in four spheres, concretely recognize their strengths, and approach resolution in four spheres, concretely recognize their strengths, and approach problems from multiple perspectives – through the body, achievements, seeking help, or imagination – thus preventing their difficulties from being reduced to a single area. This process helps patients restore balance and reorganize their approach to life. Narrative techniques facilitate the symbolic processing of patients' experiences, enabling them to reconstruct

personal meaning around chronic illness (Peseschkian, 1996; Peseschkian, 2002).

Overall, the study supports the integration of psychological and educational interventions into diabetes care. Group psychoeducation based on PPT appears to offer an effective framework for improving coping strategies, strengthening resilience, and fostering a more balanced perception of life with diabetes.

In the context of chronic illnesses, acceptance is crucial since these conditions are encountered daily, and they pose ongoing challenges. Within the self-help model, individuals restructure their illness narrative in alignment with PPT's cross-cultural storytelling and metaphorical approach. Consequently, chronic illness becomes not merely a health problem but part of a meaningful life adjustment process (Drazheva & Stamova, 2024; Manav et al., 2021; Peseschkian, 1996). PPT emphasizes balance, capacity, and meaning-seeking rather than problem-solving alone, a focus that is particularly relevant for chronic diseases such as diabetes, where adaptation and coping can be difficult (Peseschkian, 1996).

This preliminary study demonstrates that group training incorporating concepts of Positive Psychotherapy can improve outcomes for patients with Type 2 Diabetes Mellitus. Participants reported enhanced awareness of psychological factors, improved coping strategies, and a more constructive perception of their illness.

The findings highlight the importance of integrating psychological support into DM treatment protocols. Incorporating Positive Psychotherapy methods within psychoeducational group programs may improve treatment adherence, enhance quality of life, and promote more effective disease management. Future research with larger samples and controlled designs is recommended to confirm these preliminary findings and further explore the applicability of PPT in chronic illness care.

Similar to Positive Psychotherapy (PPT), psychoeducational interventions grounded in Cognitive Behavioral Therapy (CBT) have been effective in managing chronic illnesses, improving illness adaptation, stress coping, and quality of life (Lustman et al., 1998; Aksan, 2021). Furthermore, studies employing CBT have demonstrated benefits in illness adaptation, as

well as cognitive and behavioral changes related to disease management (Kahraman et al., 2022).

Regarding limitations, this study has several constraints. The small sample size (n = 9) limits the generalizability of the findings. Furthermore, the absence of a control group makes it difficult to evaluate the effectiveness of the psychoeducational intervention. The findings

largely rely on self-reported data, which may increase the likelihood of response and recall biases. Furthermore, the absence of objective physiological measures, such as HbA1c, precludes corroboration with biological indicators. Finally, the study's preliminary (pilot) nature further limits the generalizability of the findings.

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Section: Preliminary Studies in Positive Psychotherapy (PPT)

Інтегративна модель екзистенційного вибору та адаптації на засадах Транскультуральної Позитивної психотерапії Н. Пезешкіана (Харківський кейс)

An Integrative Model of Existential Choice and Adaptation Within N. Peseschkian's Transcultural Positive Psychotherapy (Kharkiv Case)



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Анотація

Цю статтю присвячено розробці та емпіричній специфікації Інтегративної моделі екзистенційного вибору та адаптації жителів Харкова в умовах тривалої травматичної кризи, спричиненої війною. Теоретичною основою моделі є концептуальний синтез транскультурального підходу позитивної психотерапії Н. Пезешкіана та екзистенційно-сміслових парадигм. Емпірична специфікація моделі та валідація внутрішньої узгодженості були проведені за допомогою рефлексивного тематичного аналізу корпусу напівструктурованих інтерв'ю (N = 68), з дотриманням стандартів методологічної прозорості (COREQ/JARS-Qual). Модель концептуалізує адаптацію як динамічний процес, де осі екзистенційного напруження, окреслені моделлю балансу, структурують вибір. Ключові механізми (Інтерпретація та Інтеграція) опосередковують перехід від травми до посткризової ідентичності та прив'язаності до місця, пояснюючи специфіку адаптаційних патернів. Модель має високий пояснювальний та евристичний потенціал для ресурсно-орієнтованої роботи, підтверджуючи застосування ППТ у контексті травми, пов'язаної з війною.

Ключові слова: позитивна психотерапія, транскультуральний підхід, екзистенційний вибір, посттравматичне зростання, травма війни

Abstract

This study presents the development and empirical validation of an integrative model of existential choice and adaptation among residents of Kharkiv, Ukraine, experiencing a prolonged war-induced traumatic crisis. The model synthesizes N. Peseschkian's transcultural Positive Psychotherapy framework with existential-meaning paradigms. Empirical specification and internal consistency validation were conducted through reflexive thematic analysis of semi-structured interviews (N = 68), adhering to COREQ and JARS-Qual reporting standards. The model conceptualizes adaptation as a dynamic process wherein existential tensions, operationalized through the balance model, structure decision-making. Two core mechanisms – Interpretation (cognitive-meaning processing) and Integration (incorporation into identity and attachment systems) – mediate the trajectory from trauma to post-crisis identity formation and place attachment, elucidating distinct adaptation patterns. The model demonstrates robust explanatory and heuristic utility for resource-oriented interventions, validating the applicability of Positive Psychotherapy in war-related trauma contexts.

Keywords: Positive Psychotherapy, transcultural approach, existential choice, posttraumatic growth, war trauma

Вступ

*У людини можна забрати все,
крім єдиного – останньої людської волі:
обирати своє ставлення до обставин,
що склалися, обирати свій
власний життєвий шлях*
Віктор Франкл, «Сказати життю «Так!»: психолог в концтаборі» (Frankl, 1959)

Війна, що триває в Україні, радикально актуалізує екзистенційний вибір українців (залишитися/ виїхати/ повертатися), трансформації ідентичності приналежності,

сентів та копінг-стратегій. Критичний аналіз наукової літератури виявив декілька домінантних, але методологічно фрагментованих напрямів досліджень, що зумовлює необхідність у розробці цілісної теоретичної рамки.

По-перше, у науковому дискурсі переважають кількісні, дефіцит-орієнтовані дослідження. Систематичні огляди та метааналізи підтверджують значущу поширеність ПТСР, депресії та тривоги у постраждалих від війни та вимушено переміщених осіб (Blackmore et al., 2020; Charlson et al., 2019). Українські дослідження

також демонструють стратифіковані відмінності у симптоматиці між тими, хто залишився, та тими, хто виїхав (Guerrero et al., 2023; Yasenok et al., 2025). Ці результати важливі, проте вони переважно фіксують «що відбувається», не розкриваючи механізмів «як це відбувається». Крім того, опора на західні шкали (PCL-5, PHQ-9/8, GAD-7) обмежує чутливість до феномену пролонгованої травми (continuous trauma) та специфіки культурного контексту. Цей підхід ґрунтується на класичних моделях, такі як Загальний адаптаційний синдром (General Adaptation Syndrome, GAS) Г. Сельє (Selye, 1956) та Транзакційна модель стресу та подолання (Transactional Model of Stress and Coping) Р. Лазаруса й С. Фолкмана (Lazarus & Folkman, 1984), які, однак, обмежені в описі екзистенційного вибору.

По-друге, одночасно фіксуються ознаки стійкості та позитивних психологічних змін. Модель резильєнтності (Resilience Model) Дж. Бонанно (Bonanno, 2004) фокусується на стійкості та швидкому відновленні. Найбільш впливова Когнітивна модель посттравматичного зростання (Cognitive model of posttraumatic growth, PTG) (Tedeschi & Calhoun, 1996) описує позитивні зміни як результат когнітивної переробки травми. Однак використання Опитувальника посттравматичного зростання (Posttraumatic Growth Inventory, PTGI) несе ризики вимірювання «уявного зростання» (Boals, 2023), оскільки він оцінює підсумок, а не механізми трансформації. Інтегративна модель позитивних змін (Integrative model of positive change) (Linley & Joseph, 2004) також розділяє відновлення (Recovery) і зростання (Growth). Водночас, дослідження підтверджують криволінійний (U-подібний) зв'язок між кумулятивним стресом та благополуччям (Seery et al., 2010), вказуючи на складність цих процесів.

По-третє, для пояснення механізмів зростання використовуються теорії та моделі смислової переробки (Meaning-Making Theories and Models). До теоретичних основ належать логотерапія В. Франкла (Frankl, 1963), теорія зруйнованих базових припущень (Shattered Assumptions Theory) Р. Янофф-Булмана (Janoff-Bulman, 1989, 1992) та теорія трансформаційного навчання (Transformative Learning Theory) Дж. Мезіроу (Mezirow, 2000). До конкретних моделей, що описують цей

процес, належать Когнітивна модель адаптації (Cognitive Adaptation Model) К. Парк і С. Фолкман (Park & Folkman, 1997), а також Модель емоційно-регуляторної динаміки (Emotion-Regulation Dynamics, E-RD) (Wenzel et al., 2022), що деталізує афективні механізми.

По-четверте, низка моделей фокусується на ресурсах та цілісному функціонуванні. Модель збереження ресурсів (Conservation of Resources, COR) С. Хобфолла (Hobfoll, 1989, 2001) визначає стрес як загрозу або фактичну втрату ресурсів (матеріальних, соціальних, психологічних, енергетичних). Підходи позитивної психології (Positive Psychology), включаючи модель PERMA (PERMA Model) М. Селігмана (Seligman, 2011; Seligman & Csikszentmihalyi, 2000) – акронім, що охоплює п'ять компонентів, які становлять благополуччя (Well-being), – та модель SEEDS (SEEDS Model) Дж. Ардена (Arden, 2019) – модель холістичного здоров'я та стійкості, що фокусується на п'яти факторах для оптимальної роботи мозку та психічного благополуччя, – описують компоненти, необхідні для стійкості.

По-п'яте, для розуміння контексту міграції критично важливими є моделі ідентичності та прив'язаності до місця. Теорія прив'язаності (Attachment Theory) Дж. Боулбі (Bowlby, 1982) та концепції кризи ідентичності (Identity Crisis) Е. Еріксона (Erikson, 1980) забезпечують рамку для аналізу реконфігурації «Я». Екологічна модель розвитку (Ecological Systems Theory) У. Бронфенбреннера (Bronfenbrenner, 1979) розглядає розвиток людини як результат взаємодії в системі вкладених контекстів (сім'я, спільнота, суспільство, культура, історія). В свою чергу, концепція локальної ідентичності (Place-Identity) (Proshansky et al., 1983) та Тріадична модель прив'язаності до місця (Place Attachment Model) (Scannell & Gifford, 2010) операціоналізують роль місця. Останні дослідження українських мігрантів (внутрішньо переміщених осіб (ВПО) (Internally Displaced Persons, IDPs) – тих, хто покинув дім, але залишився в Україні, та осіб під тимчасовим захистом (Persons under temporary protection) – статус, який українці отримали в ЄС) підтверджують значущість відчуття місця (sense of place) (Ermansons et al., 2023; Howlett & Dvornichenko, 2025; Kunchuliya & Eckardt, 2024; Kononenko & Dronova, 2024).

Огляд показує, що наявні моделі пояснюють окремі аспекти адаптації: когнітивну переробку (Tedeschi & Calhoun, 1996), управління ресурсами (Hobfoll, 1989), сенсотворення (Frankl, 1959; Janoff-Bulman, 1989) або роль місця (Scannell & Gifford, 2010). Однак жодна з них не інтегрує ці елементи в єдину концептуальну рамку, яка пояснює якісно відмінні траєкторії ідентичності та екзистенційного вибору, що виникають з однієї травматичної події.

Транскультуральний підхід позитивної психотерапії (Transcultural Positive Psychotherapy) Н. Пезешкіана з його акцентом на модель балансу, пропонує культурно-чутливу рамку для інтеграції цих розрізнених підходів (Peseschkian, 2006; Peseschkian, 2016b).

Метою цієї статті є розробка та емпірична специфікація інтегративної моделі екзистенційного вибору та адаптації жителів Харкова в умовах тривалої травматичної кризи, спричиненої війною, на основі транскультурального підходу позитивної психотерапії Н. Пезешкіана та ключових екзистенційно-сміслових концепцій, забезпечивши методологічну прозорість і відтворюваність якісного дослідження відповідно до стандартів COREQ (Consolidated Criteria for Reporting Qualitative Research) та JARS-Qual (Journal Article Reporting Standards for Qualitative Research).

Відповідно до поставленої мети, це дослідження спрямоване на вирішення таких завдань:

1. Сформулювати теоретико-методологічні основи інтегративної моделі за допомогою концептуального синтезу та критичного аналізу релевантних психологічних парадигм, а також операціоналізувати її ключові конструкти.
2. Розробити та реалізувати методологію збору та рефлексивного тематичного аналізу наративних даних (N=68), забезпечивши верифікацію якості кодування (міжсуддівська узгодженість, аудит-трейл) відповідно до стандартів COREQ та JARS-Qual.
3. Емпірично специфікувати конструкти моделі та диференціювати траєкторії посткризової ідентичності на основі аналізу корпусу інтерв'ю.
4. Продемонструвати можливість застосування інтегративної моделі для аналізу наративного матеріалу та співвіднести

отримані емпіричні результати з наявними теоретичними підходами до посттравматичного зростання та адаптації.

5. Оцінити пояснювальний та евристичний потенціал моделі, а також визначити її обмеження та напрямки подальших досліджень.

Методологія

Дизайн та підхід. Дослідження базується на напівструктурованому протоколі інтерв'ю (12 питань), що охоплює: мотиви рішення «залишитися/виїхати/повертатися», страхи/невизначеність, приналежність та відповідальність, динаміку почуття безпеки, пріоритет «безпека – дім/близькість», ставлення до тих, хто залишився/виїхав, способи емоційного подолання, цінності, що утримують від виїзду, та саморефлексію.

Дані проаналізовано з використанням рефлексивного тематичного аналізу у codebook-підході (Braun & Clarke, 2006), обраному для глибинного (qualitative) пояснення механізмів адаптації та екзистенційного вибору, складності і контекстуальності яких не вичерпується кількісними показниками.

Контекст та збір даних. Дослідження реалізовано в межах волонтерського проекту «Грані життя / Життя на грані» командою дослідників Української спілки психотерапевтів (УСП). Ініціатива проекту виникла на зборах УСП, де власний досвід перебування у Харкові Ольги Антошкіної (голова Харківського відділення УСП) став каталізатором для запуску ініціювання дослідження одним із авторів – І. Гордієнко-Митрофановою. На відкритий заклик відгукнулися п'ять дослідників-практиків (члени УСП), сформувавши багатоголосу команду інтерв'юерів.

Поєднання професійних компетенцій та особистого досвіду війни як харків'ян виступило методологічним ресурсом, що забезпечило доступ до респондентів та довірчий контакт із ними. Дані отримано за допомогою напівструктурованих глибинних інтерв'ю. Після інформованої згоди всі інтерв'ю записувалися в аудіо/відео та транскрибувалися автоматично з подальшою ручною верифікацією (виправлення помилок розпізнавання, розмітка мовців, анонімізація).

Обґрунтування вибору кейсу (The Index Case: Харків). Вибір Харкова зумовлений його винятковою теоретичною та емпіричною релевантністю. Як один із найбільших урбаністичних вузлів України, що пережив тривалі інтенсивні обстріли, Харків становить евристично цінний кейс (heuristic case) для аналізу дилеми

«залишитися/виїхати/повертатися».

Теоретично, в термінах теорії прив'язаності, місто функціонує як «розширена база безпеки», а в ППТ – як носій локальних цінностей та «актуальних здібностей». Емпірично, як великий мегаполіс, Харків забезпечує високу варіативність траєкторій, що дозволяє використовувати висновки для аналітичного узагальнення на інші міста.

Інсайдерська позиція та валідність. Команда дослідників складається з харків'ян (членів УСП), що підвищило екологічну валідність, глибину наративів та довіру респондентів. Ризики упередженості, притаманні інсайдерській позиції, компенсувалися стандартними процедурами якісного дослідження (подвійне кодування, рефлексивні мемо, аудит-трейл, узгодження кодової книги).

Вибірка та критерії. Емпірична база включає 68 наративів (N = 68) жителів Харкова, які пережили тривалий військовий стрес. Відбір – цільовий (критеріальний), у фокусі – досвід екзистенційного вибору, пов'язаного з війною. Структура вибірки охоплює три ключові траєкторії міграційного досвіду: залишилися (ті, хто вирішив залишитися в місті; N=19, 28%); виїхали (внутрішньо переміщені особи та ті, хто отримав тимчасовий захист за кордоном; N=39, 57%); свідомо повернулися (ті, хто повернувся до міста в період з кінця 2022 до 2025 рр. із безпечніших місць; N=10, 15%).

Загальна чисельність вибірки дозволила охопити широкий спектр наративів, що відображають різноманітні стратегії адаптації.

Демографічні характеристики. Вік респондентів варіювався від 22 до 74 років (M ≈ 43 роки), жінки становили 75%, чоловіки – 25%. Гендерний дисбаланс відображає типові патерни вимушеної міграції в Україні, де жінки складають більшість серед тих, хто виїхав за кордон, та внутрішньо переміщених осіб. Так, згідно з опитуваннями Міжнародної організації з міграції (IOM) 2024 року серед 15 979 біженців, 80% становили жінки, а серед

загальної кількості українських біженців у Європі частка жінок і дівчат оцінювалася в 62% (актуально на кінець 2023 р.) (IOM, 2024). При цьому для внутрішньо переміщених осіб (ВПО) в Україні частка жінок і дівчат становить близько 41%, що підкреслює необхідність гендерно-чутливих програм підтримки (IOM, 2024).

Соціально-професійний профіль характеризувався високою залученістю у життя міста, що забезпечило багатий та деталізований корпус наративів. Вибірка охопила представників таких ключових категорій: міські службовці/критична інфраструктура (13,2%): сфери охорони здоров'я та освіти, працівники критичної інфраструктури, а також соціальні служби; громадянське суспільство/бізнес (67,7%): волонтерська діяльність, НУО/громадянські ініціативи та малий бізнес; непрацююче населення/вразливі групи (19,1%): пенсіонери, домогосподарки, матері у відпустці по догляду за дитиною та особи, які пережили вимушену міграцію. Обсяг даних був достатній для досягнення інформаційної насиченості.

Аналітична процедура та кодбук. Перед початком аналізу всі матеріали інтерв'ю пройшли процедуру повної анонімізації. Початковий етап передбачав інтенсивну роботу з усім масивом первинних даних: окрім багаторазового читання транскриптів, усі п'ять членів дослідницької команди здійснювали перегляд відеозаписів та прослуховування аудіофайлів інтерв'ю. Це дозволило врахувати паралінгвістичні аспекти (інтонації, емоційні паузи, невербальні реакції) та забезпечити глибоке розуміння контексту кожного наративу.

Валідність інтерпретації лексико-семантичних структур та латентного змісту наративів забезпечувала інтердисциплінарна експертиза керівника дослідницької групи (І. Гордієнко-Митрофанова). Поєднання базової філологічної та психологічної освіти, а також понад 15-річний досвід наукової та викладацької діяльності у галузі психолінгвістики (зокрема на рівні підготовки докторів філософії), дозволили забезпечити високу точність ідентифікації смислових патернів.

Основний аналіз виконано методом рефлексивного тематичного аналізу (Braun & Clarke, 2006) із використанням

структурованого кодбуку (Codebook v1.1). Теоретичною основою для розробки структури кодування (категорій та критеріїв) слугував концептуальний синтез транскультурального підходу позитивної психотерапії Н. Пезешкіана та екзистенційно-смыслових парадигм. Процес кодування мав ітеративний гібридний характер: первинна структура категорій була сформована дедуктивно на основі протоколу інтерв'ю, тоді як специфічні коди уточнювалися індуктивно безпосередньо в ході опрацювання матеріалу. Кодування здійснювалося відповідно до фіксованих правил включення та виключення для кожної категорії. Розбіжності в інтерпретаціях між дослідниками вирішувалися шляхом експертних дискусій на регулярних калібрувальних сесіях до досягнення консенсусу.

Рефлексивні нотатки авторів. По завершенні первинного кодування сформовано рефлексивні мемо (що зафіксували варіативність мотивів, амбівалентність, роль «міської ідентичності»); ці мемо використані для уточнення підтем. Підсумкова структура кодування, що призвела до 5 основних категорій та 27 критеріїв (див. табл. 1), охоплює всі аспекти протоколу.

Надійність та верифікованість. Для забезпечення строгості аналізу та мінімізації суб'єктивізму було виконано незалежне подвійне кодування 20% корпусу даних. Цей етап продемонстрував високий рівень змістової узгодженості інтерпретацій між дослідниками. Окремі розбіжності у присвоєнні кодів вирішувалися шляхом спільного обговорення до досягнення повного консенсусу, що дозволило уточнити дефініції категорій. Протягом усього процесу велися рефлексивні мемо та аудит-трейл (audit trail), що забезпечує прозорість аналітичних рішень згідно зі стандартами JARS-Qual.

Етика. Усі учасники надали інформовану згоду. Інтерв'ю проводилися у травма-інформованому форматі з дотриманням права на паузу або припинення бесіди. Ризик дистресу мінімізувався завдяки тому, що команда інтерв'юерів складається з професійних психологів-консультантів та психотерапевтів (членів УСП), які активно моніторили емоційний стан респондентів. Усі персональні дані анонімізовано (псевдоніми,

обмежений доступ до захищених носіїв); публікація знеособлених цитат узгоджена.

Результати

Інтегративна модель екзистенційного вибору та адаптації харків'ян була розроблена на основі двоетапної ітеративної стратегії, що поєднує теоретичне обґрунтування та емпіричну специфікацію конструктів.

Емпіричною основою моделі слугував рефлексивний тематичний аналіз корпусу з 68 напівструктурованих інтерв'ю (N=68) з жителями Харкова, які пережили тривалий досвід війни та постали перед екзистенційним вибором залишитися, виїхати чи повертатися.

Теоретичний каркас моделі сформовано за допомогою концептуального синтезу ключових психологічних парадигм, що дозволило створити первинну аналітичну структуру для багатовимірного опису процесів смислової переробки, керування ресурсами та реконфігурації ідентичності приналежності.

Фундаментальними засадами слугували:

- Екзистенційно-смыслові парадигми: Логотерапія (V. Frankl, 1959) – для обґрунтування конструкту «волі до смислу» (Will to Meaning) як центральної рушійної сили екзистенційного вибору та транскультуральний підхід позитивної психотерапії Н. Пезешкіана (Peseschkian, 1987) – для моделювання осей екзистенційного напруження на основі його моделі балансу чотирьох сфер;
- Динамічні та ресурсні теорії: Стрес-модель загального адаптаційного синдрому (GAS, Г. Сельє, 1956) та модель збереження ресурсів (COR, S. E. Hobfoll, 2001) – для аналізу динаміки ресурсів в умовах загрози або фактичної втрати ресурсів;
- Теорії ідентичності та прив'язаності до місця: Теорія прив'язаності (Дж. Боулбі, 1988) – для моделювання ролі внутрішніх робочих моделей у формуванні нової «бази безпеки»;
- Психоаналітичні концепції кризи ідентичності (Е. Еріксон, 1980) – для аналізу реконфігурації структури «Я» та процесів інтеграції переосмисленого досвіду в систему відносин та ідентичність приналежності.

Специфікація моделі додатково спиралася на актуальні емпіричні дослідження: концепцію посттравматичного зростання (Tedeschi & Calhoun, 1996; Boals, 2023) – для верифікації позитивних змін; роботи, присвячені адаптації вимушено переміщених осіб (Howlett & Dvornichenko, 2025; Ermansons et al., 2023) – для обґрунтування амбівалентних траєкторій ідентичності; а також прив'язаності до місця як фактора локальної ідентичності (Scannell & Gifford, 2010; Kunchuliya & Eckardt, 2024) – для операціоналізації територіально-ціннісного ресурсу.

Розробка відбувалася у два етапи.

Етап 1: Теоретичне обґрунтування конструктів (Ітерація 1.0)

На першому етапі було теоретично обґрунтовано центральні конструкти моделі: континууми екзистенційного вибору (C_1 – C_6) – шість осей екзистенційного напруження, що модерують прийняття рішень; динамічні процеси: Інтерпретація (I) – смислова переробка індивідуального травматичного досвіду; Інтеграція (G) – включення переосмисленого досвіду у структуру ідентичності приналежності; Ресурсні модулі (R_1 – R_3); Посттравматичне зростання та адаптація (PTG). Детальний опис конструктів подано нижче.

Етап 2: Емпірична верифікація та операціоналізація (Ітерація 1.1)

На другому етапі (Ітерація 1.1) проведено емпіричну верифікацію та операціоналізацію конструктів моделі. Процес відбувався в кілька ітеративних циклів:

1. Розробка інструментарію. Проміжні результати пілотних інтерв'ю ($N>50$) слугували основою для розробки первинної структури протоколу інтерв'ю.
2. Формування системи кодування. Далі, на основі вибірки ($N>30$), були уточнені формулювання питань протоколу інтерв'ю та розроблена первинна версія критеріїв тематичного аналізу, покладена в основу Codebook v1.1.
3. Фінальна специфікація конструктів. Потім на основі рефлексивного тематичного аналізу розширеного корпусу напівструктурованих інтерв'ю ($N=68$) уточнені та операціоналізовані ключові конструкти моделі.

Отримані наративні дані забезпечили емпіричну специфікацію шести континуумів екзистенційного вибору та диференціацію трьох траєкторій ідентичності приналежності. Таким чином, наративні дані виступили як емпіричний верифікатор і специфікатор теоретичного каркасу.

Для комплексного аналізу адаптаційних патернів використано дві взаємодоповнюючі візуалізації, що відповідають на різні дослідницькі питання.

Рефлексивний тематичний аналіз корпусу з 68 напівструктурованих інтерв'ю жителів Харкова проведено відповідно до критеріїв Codebook v1.1. Результати подано у табл. 1 (додаток А), радіальній діаграмі (рис. 1) та гістограмі (рис. 2).

Радіальна діаграма (рис. 1) відображає груповий профіль: частоту проявів кожного з 27 критеріїв. Вона дозволяє виявити, які механізми адаптації та мотиви вибору є типовими для харків'ян в умовах війни. Критерії тимчасової динаміки (25-27: стресори, траєкторія мобільності, уявлення про майбутнє) виявилися у 96-99% респондентів, повсякденні умови безпеки та прийняття/емпатія (24, 17) – у 96%, соціальний борг, локус контролю, страх (2, 8, 5, 11) – у 78-90%. Індивідуально-прагматичні критерії (1, 6, 14: обов'язок перед собою, прагматичні мотиви, втрата сенсу) зустрічаються лише у 12-19% учасників. Це вказує на явне домінування соціально-екзистенційних мотивів (обов'язок, приналежність, безпека) та маргіналізацію індивідуально-прагматичних (автономія, особисті цілі). Ця структура відображає колективістський патерн адаптації, що ґрунтується на виживанні через солідарність.

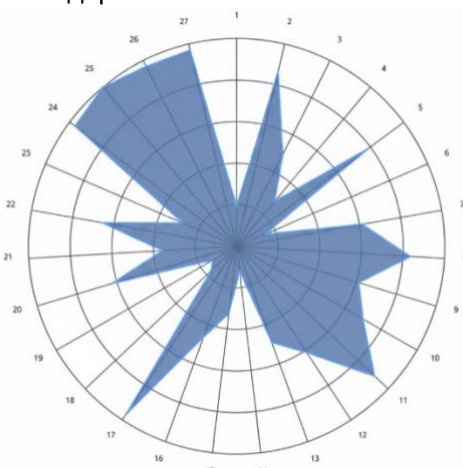


Рис. 1. Радіальна діаграма частоти прояву критеріїв

Примітка. Кожен промінь відповідає одному із 27 критеріїв; відстань від центру відображає частоту проявів критерію у вибірці (N=68).

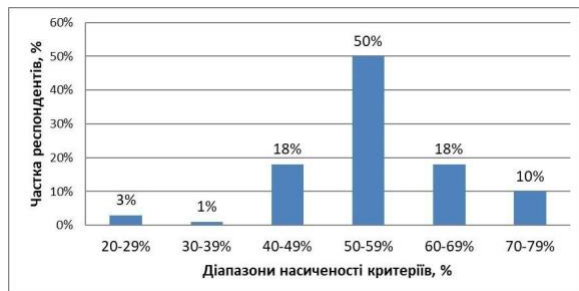


Рис. 2. Гістограма розподілу респондентів за насиченістю критеріїв

Примітка. Вісь X – частка проявлених критеріїв (%); вісь Y – частка респондентів (%).

Гістограма (Рис. 2) показує індивідуальну варіативність: половина учасників демонструє 14-16 критеріїв із 27 (типова насиченість), ще по 18% знаходяться в сусідніх діапазонах – 11-13 критеріїв (40-49%) та 16-19 критеріїв (60-69%) відповідно. Крайні варіанти (рідкісні): 3% мають 5-8 критеріїв, 10% – 19-21 критерій. Це вказує на те, що у більшості респондентів активовано множинні механізми адаптації, а випадки вузького репертуару стратегій є поодинокими.

Зіставлення діаграм дозволяє виявити важливу закономірність: критерії не є рівнозначними компонентами адаптації й актуалізуються селективно, а не довільно. Висока вираженість соціально-екзистенційних критеріїв (Рис. 1) за помірної насиченості індивідуального профілю (Рис. 2) вказує на те, що контекст війни структурує ієрархію адаптаційних стратегій. У цих умовах одні механізми (соціальний обов'язок, страх, прив'язаність до місця) стають соціально схвалюваними та внутрішньо виправданими, тоді як інші (автономія, прагматичні розрахунки, особисті цілі) виявляються витісненими або пригніченими. Таким чином, типовий респондент не просто «використовує половину критеріїв», а демонструє специфічну конфігурацію адаптації, в якій соціально-екзистенційні механізми посідають центральне місце, а індивідуально-прагматичні залишаються на периферії.

Ця закономірність знаходить пояснення у моделі збереження ресурсів (Hobfoll, 2001): в умовах масштабної загрози індивіди віддають перевагу стратегіям, спрямованим на

збереження соціальних зв'язків та колективної ідентичності, оскільки це забезпечує доступ до критично важливих ресурсів (інформація, взаємодопомога, емоційна підтримка). Низька актуалізація індивідуально-прагматичних стратегій не означає їхню неефективність, а відображає адаптивну ієрархію: в умовах екзистенційної загрози солідарність стає ефективнішою стратегією виживання, ніж та, що базується на автономії та прагматичних розрахунках.

Операціоналізація конструктів моделі: відповідність питань протоколу, критеріїв Codebook v1.1 та ключових індикаторів подано у табл. 2. (Див. додаток А).

Як видно з таблиці 2: 1) одне питання протоколу може операціоналізувати декілька конструктів моделі (наприклад, Q1 релевантне для I, C₁, C₂, C₄, C₅), що відображає холистичну природу екзистенційного вибору; 2) критерії Codebook v1.1 часто перетинаються; це методологічна особливість рефлексивного тематичного аналізу, де межі між темами є умовними; 3) індикатори подано як типові приклади; конкретні формулювання в наративах варіюються.

Ключовою особливістю отриманого матеріалу є гібридність та багатофакторність екзистенційного досвіду: критерії в межах однієї групи, особливо у групі I («Мотивація та екзистенційний вибір») та у групі II («Психологічна адаптація та посттравматичне зростання»), часто перетинаються та співіснують у наративі одного респондента, не будучи взаємовиключними.

I. Мотивація та екзистенційний вибір: Соціальний імператив та конфлікт обов'язку. Мотиваційні патерни, виявлені у першій групі критеріїв, демонструють домінування соціально-екзистенційних імперативів над індивідуальними мотивами. Вибір був зумовлений насамперед Соціальним і сімейним обов'язком (85%) та Страхом і прагненням до фізичної безпеки (78%), тоді як Прагматичні мотиви (15%) та Обов'язок перед собою (19%) виявилися найменш релевантними. Це вказує на зсув пріоритетів у бік виживання та колективної відповідальності. При цьому високий відсоток Локусу контролю (82%) за одночасної Амбівалентності (60%) свідчить про боротьбу між особистою волею та зовнішнім тиском. Прив'язаність до місця (49%) часто суперечила

необхідності вимушеного від'їзду (28%), що ускладнювало прийняття рішення.

II. Психологічна адаптація та посттравматичне зростання: Гібридна траєкторія адаптації. Результати за критеріями психологічної адаптації (група II) відображають гібридну траєкторію адаптації, що характеризується співіснуванням особистісного зростання та симптомів хронічного дистресу. Успіх адаптації виражений у високій Динаміці сприйняття та зсувів (руху) до стійкості (90%) та Переоцінці цінностей (69%), що свідчить про посттравматичне зростання. Однак ця стійкість досягається на тлі високого Хронічного стресу та проявів дистресу (60%). Даний патерн означає, що резильєнтність жителів Харкова є динамічною: вони демонструють функціональне подолання та особистісне зростання в умовах безперервного психологічного напруження. Значна частка Маладаптивних форм подолання (49%) вказує на паралельне використання неконструктивних стратегій. При цьому низький рівень Втрати сенсу та безнадії (12%) підтверджує, що переоцінка цінностей запобігла екзистенційній кризі.

III. Соціальні реакції та установки: Високий соціальний капітал. Аналіз міжособистісних установок (група III) показує, що соціальний капітал виступає потужним захисним чинником. Майже універсальне Прийняття та емпатія до різних стратегій вибору (96%) – прагнення розуміти та визнавати право на різні позиції/стратегії в інших людей – є ключовим індикатором соціальної зрілості та низького рівня стигматизації. Солідарність та практики взаємодопомоги (62%) є поширеною стратегією подолання труднощів, пов'язаних із війною та вимушеним переміщенням. Низькі показники Негативної установки та конфронтації (16%) свідчать про те, що соціальна згуртованість переважає над поляризацією.

IV. Контекст та умови середовища: Пріоритет фізичного виживання. Дослідження контекстуальних чинників (група IV) показує домінування фізичних умов. Повсякденні умови проживання та безпека середовища (96%) є найбільш важливим контекстуальним фактором. Вплив Інформаційного середовища та медіавпливу (65%) залишається значущим. Низька частота згадування Інституційної підтримки (35%) та

Економічних факторів (28%) дозволяє припустити, що в суб'єктивному сприйнятті респондентів ці аспекти поступаються місцем безпосередній загрозі та особистій відповідальності.

V. Часова динаміка: Стабілізація ідентичності та планування. Результати за часовою динамікою (група V) вказують на завершення основного циклу прийняття рішень. Майже всі пережили Стресори та критичні події (99%), що призвело до оформлення прийняття остаточного рішення та траєкторії мобільності (96%). Фактично універсальна наявність уявлень про майбутнє та планів (96%) свідчить про стабілізацію особистої та соціальної ідентичності та перехід до довгострокового планування життя.

Отримані дані слугували підґрунтям для емпіричної верифікації та уточнення конструктів моделі (Ітерація 1.1).

Нижче подано опис основних конструктів інтегративної моделі екзистенційного вибору та адаптації:

I.ІНТЕРПРЕТАЦІЯ (I): смислова переробка пережитого: переоцінка цінностей, вибудовування причинно-ціннісних зв'язків, **вбудовування досвіду** в особисту часову перспективу (минуле – сьогодення – майбутнє).

II.ІНТЕГРАЦІЯ (G): включення переосмисленого досвіду у структуру «Я», а також у ролі, відносини та ідентичність приналежності. Цей процес передбачає здатність до трансформації та співіснування прив'язаностей в актуальних просторових реаліях: рідна територія (Харків), нове середовище адаптації та потенційні місця переміщень, включно зі складними комбінаціями цих локацій. Цей багатовимірний процес адаптації веде до трьох основних траєкторій посткризової ідентичності приналежності:

1. Трансформована локальна ідентичність: формується у тих, хто залишився, і передбачає трансформацію прив'язаності, що ґрунтується на екзистенційному виборі, стійкості та солідарності, після переосмислення досвіду кризи.
2. Мультилокальна ідентичність: формується у переміщених осіб і

передбачає збереження вихідної прив'язаності (до Харкова) та паралельне формування прив'язаності до нового приймаючого середовища.

3. Монолокальна ідентичність (асимільована): формується у переміщених осіб і передбачає повну інтеграцію в нове середовище з функціональним розривом вихідної прив'язаності до рідної території.

Траєкторія посткризової ідентичності визначається конфігурацією позицій на континуумах вибору (C_1 – C_6) та доступністю/активацією ресурсів (R_1 – R_3). Нижче подано типові конфігурації для кожної траєкторії:

1. Трансформована локальна ідентичність (ті, хто залишився)

- Домінантні континууми: високий пріоритет C_1 – правий полюс (Приналежність над Безпекою): «Я навіть не зважувала нічого. Тому я тут почуваюся на своєму місці, і я нікуди не збиралася і не збираюся». Висока позиція на C_2 – лівий полюс (Обов'язок перед спільнотою/сім'єю). Висока позиція на C_4 – лівий полюс (Агентність над Зовнішньою детермінацією).
- Ключовий ресурс: Сильна опора на R_3 (прив'язаність до місця як «розширена база безпеки»; локальна ідентичність як ціннісна опора).
- Механізм Інтеграції (G): Переосмислення зв'язку «Я–місто–спільнота» через призму стійкості, солідарності та колективної відповідальності. Ідентичність трансформується: «Виїжджати нікуди не збирався і не збираюся. Дідусь під час Великої Вітчизняної нікуди не виїжджав і навіть у бомбосховище не ходив, і я не збираюся нікуди виїжджати».

2. Мультилокальна ідентичність (переміщені особи, які зберігають подвійну прив'язаність)

- Домінантні континууми: напруження між C_1 – лівий полюс (Безпека у новому місці) та C_1 – правий полюс (Приналежність до Харкова). Баланс на C_2 між обов'язком перед сім'єю (виїхали заради дітей/близьких) та обов'язком перед містом(підтримка,

плани повернення). Помірна позиція на C_6 (Мобільна гнучкість): «Коли я приїжджаю, я не просто там залишаюся, для мене Харків – це таке місце сили. Він допомагає мені підтримувати зв'язок із родичами і дає впевненість, що я точно повернуся». «Я перша побіжу з сумками (до Харкова), коли все закінчиться». «Я готова піти до Харкова пішки, коли буде безпечно для дитини».

- Ключовий ресурс: Активне використання R_2 (транслокальні соціальні мережі: підтримання контактів із «харків'янами» у різних локаціях) та часткова опора на R_3 (збереження вихідної прив'язаності паралельно з формуванням нової).
- Механізм Інтеграції (G): формування бікультурної ідентичності: «Я тепер розумію, що мій дім може бути скрізь. Я можу пристосуватися до абсолютно будь-яких умов – чи то над головою бомби та винищувачі, чи спокійне життя в новій країні, де незрозуміла мова та інша культура. Важливе не зовнішнє оточення, а внутрішнє відчуття безпеки». Інтеграція відбувається через прийняття амбівалентності та трансформацію ідентичності приналежності.

3. Монолокальна ідентичність (асимільована):

- Домінантні континууми: пріоритет C_1 – лівий полюс (Безпека) та C_5 – лівий полюс (Прагматична доцільність: нові можливості, стабільність); висока позиція на C_4 – правий полюс (Зовнішня детермінація: «Залишатися у Харкові було неможливо, тому що дім, у якому ми жили, був частково зруйнований та пошкоджений. З урахуванням того, що бойові дії велись ближче й ближче, і обстріли стали інтенсивнішими, ми вирішили виїхати») або, рідше, висока позиція на C_2 – правий полюс (Автономія: «Все-таки наше життя, воно тут і зараз. За державу, як то кажуть, прикро, але моє життя теж при цьому триває. І воно одне. Тому його хочеться все-таки прожити. Прожити самотійно, в задоволення. І насолодитися, оскільки воно все-таки одне»); висока

позиція на C_6 – правий полюс (Територіальна стабільність: «Мене там вирвали з корінням (Харків), а тут я вкорінилася (Люксембург). Тут мій дім, моя сім'я...»).

- Ключовий ресурс: активація R_1 (особистісна саморегуляція для адаптації до нового середовища) та R_2 (вбудовування в нові соціальні мережі); послаблення/функціональне від'єднання R_3 (detachment від вихідної прив'язаності до Харкова).
- Механізм Інтеграції (G): повна реконфігурація ідентичності приналежності: «Ну, якщо чесно, я не планую повертатися до Харкова... звісно ж, ставлення уряду щодо турботи про громадян. Це, звичайно, дуже відрізняється від нашої системи, де всього мусиш домагатися, оббивати пороги й тебе з одного боку в інший посилають, і в результаті ти нічого не отримуєш» (Нідерланди).

Інтеграція вимагає свідомого «відпускання» вихідної прив'язаності та інвестування в нову локальну ідентичність.

Примітка: Траєкторії не є дискретними типами, а являють собою кластери позицій у багатовимірному просторі континуумів. Один респондент може демонструвати ознаки змішаних або перехідних траєкторій залежно від часу, контексту та повторних кризових подій. Крім того, позиції на континуумах можуть змінюватися (наприклад, при зміні ситуації безпеки або сімейних обставин), ініціюючи повторні цикли Інтерпретації (I) та Інтеграції (G).

III. РЕСУРСНІ МОДУЛІ (R)

- Особистісно-регулятивний ресурс (R_1): навички саморегуляції – когнітивні, емоційні, тілесні, інтуїтивні.
- Соціально-комунікативний (R_2): вибіркові мережі «своїх» (сім'я/близькі, сусіди, колеги); практична взаємодопомога та обмін інформацією; спільні ритуали та гумор.
- Екзистенційно-ціннісний ресурс (R_3): ціннісні опори та переконання, що забезпечують стійкість; цінність приналежності/зв'язку з місцем як «розширена база безпеки»; у випадку

релокації – формування нової прив'язаності до місця/спільноти.

Примітка: Ресурсні модулі (R_1 – R_3) співвідносяться з моделлю балансу Н. Пезешкіана (Тіло/Відчуття, Діяльність/Досягнення, Контакти/Традиції, Фантазії/Майбутнє – Peseschkian, 1987), що забезпечує теоретичну обґрунтованість моделі та демонструє, що вона охоплює ключові сфери стійкості в умовах тривалої травматичної кризи: R_1 – «Тіло/Відчуття», R_2 – «Контакти/Традиції», R_3 – «Фантазії/Майбутнє».

- R_1 (Особистісно-регулятивний ресурс) ↔ сфера «Тіло/Відчуття» та регулятивна функція «Діяльності» (структурування часу через рутини, зниження тривоги через активність);
- R_2 (Соціально-комунікативний ресурс) ↔ сфера «Контакти/Традиції»;
- R_3 (Екзистенційно-ціннісний ресурс) ↔ сфера «Фантазії/Майбутнє» та сенсоутворююча функція «Діяльності» (підтримання ідентичності через професійну/волонтерську діяльність, втілення цінностей).

Обґрунтування інтеграції сфери «Діяльність/Досягнення». В умовах гострої травматичної кризи (continuous trauma) здатність продовжувати діяльність (робота, волонтерство, побутові рутини) забезпечується двома взаємодоповнювальними механізмами:

1. Регуляторним механізмом (R_1): діяльність виступає як засіб структурування часу, відновлення почуття контролю та зниження тривоги. Підтримання рутини (наприклад, вихід на роботу, регулярні побутові практики) є формою активного подолання, що спирається на тілесно-когнітивну саморегуляцію. Цей аспект співвідноситься з поняттям «умов безпеки» в термінах теорії прив'язаності та «функціональної стабілізації» у теорії стресу.
2. Смыслоутворювальним механізмом (R_3): діяльність (особливо професійна та волонтерська) виступає як спосіб реалізації цінностей, підтримання соціальної ідентичності («Я – вчитель/лікар/волонтер») та віднайдення сенсу через внесок у спільну справу. У логіці логотерапії В.

Франкла (Frankl, 1963), діяльність стає «смысловим якорем» (meaning anchor) у ситуації екзистенційної невизначеності.

Сфера «Діяльність/Досягнення» не виділена в окремий ресурсний модуль у даній моделі; вона інтегрована в R_1 (регулятивні механізми) та R_3 (смыслоутворення). В умовах гострої кризи ресурсними факторами виступають саме здатність до саморегуляції та до підтримання сенсу, що забезпечують продовження діяльності (рутина, робота).

IV. КОНТИНУУМИ ВИБОРУ (C), 6 осей напруження:

- C_1 Безпека $\leftrightarrow$ Приналежність: орієнтація на зниження ризиків та почуття захищеності $\leftrightarrow$ орієнтація на соціальну включеність, почуття «свого» місця та спільноти.
- C_2 Обов'язок $\leftrightarrow$ Автономія: виконання зобов'язань перед сім'єю, спільнотою та інститутами $\leftrightarrow$ право на самовизначення та свободу вибору (включно з рішеннями про виїзд і повернення).
- C_3 Сенс $\leftrightarrow$ Втрата перспективи: наявність цілей, бачення майбутнього та внутрішньої осмисленості $\leftrightarrow$ відчуття глухого кута й втрата життєвих орієнтирів, зокрема їхнє переосмислення після релокації.
- C_4 Агентність $\leftrightarrow$ Зовнішня детермінація: здатність діяти та впливати на власну траєкторію (внутрішній локус контролю) $\leftrightarrow$ домінування зовнішніх обмежень та примусу (правові, інституційні, інфраструктурні та логістичні бар'єри; зовнішній локус контролю).
- C_5 Прагматична доцільність $\leftrightarrow$ Ціннісно-етичний пріоритет: опора на економічні розрахунки, доступ до ресурсів та можливостей $\leftrightarrow$ слідування цінностям, ідентичності та етичним принципам при виборі залишитися або виїхати.
- C_6 Мобільна гнучкість $\leftrightarrow$ Територіальна стабільність: готовність до повторних переміщень та адаптації до змінних умов $\leftrightarrow$ прагнення до довгострокового територіального укорінення та стійкої інтеграції в одному місці. Цей континуум

відображає психологічну установку на можливість/необхідність повторних переїздів (циклічна мобільність) проти установки на постійність та вкорінення (стабільність).

V. ПОСТТРАВМАТИЧНЕ ЗРОСТАННЯ (PTG), п'ять доменів:

Позитивні зміни у:

- Ставленні до себе / агентності (особиста сила, самоефективність, стійкість).
- Стосунках з іншими (глибина/емпатія, довіра, просоціальність).
- Нових можливостях (нові цілі, ролі, освітні/професійні траєкторії).
- Оцінці життя (вдячність, перевпорядкування пріоритетів).
- Світогляді / духовності (цінності, сенси, віра/екзистенційна позиція).

Інтегративна модель екзистенційного вибору та адаптації харків'ян описує процес адаптації до травматичної кризи та прояви посттравматичного зростання (PTG) через чотири взаємопов'язані конструкти (рис. 3): Інтерпретацію (I), Інтеграцію (G), Ресурсні модулі (R_1 – R_3) та Континууми вибору (C_1 – C_6). Процес починається з Інтерпретації (I) – індивідуальної смыслової переробки пережитого. Ця інтерпретація ініціює Інтеграцію (G) – включення переосмисленого досвіду в структуру «Я» та ідентичність приналежності, що призводить до формування однієї з трьох адаптивних траєкторій ідентичності приналежності: трансформованої локальної, мультилокальної або монолокальної (асимільованої). Внутрішня динаміка $I \leftrightarrow G$ забезпечується Ресурсними модулями (R), що виступають медіаторами процесу адаптації. Вони опосередковують (медіують) перехід $I \rightarrow G \rightarrow PTG/PTD$, забезпечуючи необхідний потенціал для змін. Ці модулі ґрунтуються на моделі балансу Н. Пезешкіана: особистісно-регулятивний ресурс (R_1), соціально-комунікативний (R_2) та екзистенційно-ціннісний (R_3 : ідентичність приналежності/прив'язаності до місця). При цьому сфера «діяльність» інтегрована в R_1 та R_3 , виступаючи як функція саморегуляції та смыслоутворення. Розвиток процесу відбувається під впливом шести Континуумів вибору (C), які виступають модераторами ходу I та G та відображають ключові осі напруження. Успішна регуляція цих

континуумів та ефективне використання ресурсів призводять до проявів PTG (у п'яти доменах) та формують зворотний зв'язок: PTG консолідує R та підтримує наступні цикли I та G. В емпіричному розділі ознаки PTG трактуються як проксі за наративними даними; кількісна валідація (PTGI) запланована окремо.

Динамічна структура моделі. Травматична подія ініціює Інтерпретацію (I) – когнітивно-смыслову переробку досвіду. Перехід до Інтеграції (G) – включенню переосмисленого досвіду у структуру «Я» – забезпечується за підтримки ресурсів R_1 – R_3 . Інтеграція (G) передуює проявам посттравматичного зростання (PTG). Континууми вибору (C_1 – C_6) модерують переходи $I \rightarrow G$ та $G \rightarrow PTG$: C_1 – C_6 задають ціннісно-смыслові аспекти ідентичності приналежності; C_4 – C_5 здатні як обмежувати, так і активувати переходи (внутрішня агентність $\leftrightarrow$ зовнішні бар'єри; прагматика $\leftrightarrow$ цінності); C_6 визначає установку на мобільну траєкторію: висока позиція на полюсі «гнучкість» асоціюється з готовністю до повернення/повторних переміщень і точками повторної інтерпретації досвіду, тоді як висока позиція на полюсі «стабільність» пов'язана з укоріненням та довгостроковою інтеграцією у приймаючому середовищі. Ресурс R_3 має пороговий характер: при високій загрозі та/або вираженому почутті обов'язку його внесок може поступатися R_1 – R_2 (рис. 3).

Зворотний зв'язок. Досягнуті прояви PTG консоліднують ресурси (R_1 – R_3) та поглиблюють Інтеграцію (G). Нові травматичні події або кризи можуть запускати повторні ітерації циклу («досвід $\rightarrow I \rightarrow G \rightarrow PTG \dots$ »), причому дистрес може співіснувати зі зростанням, вимагаючи роздільної регуляції через відповідні континууми вибору та ресурсу.

Операціоналізація моделі на рівні інструментарію. Кожен конструкт моделі узгоджений з відповідними питаннями інтерв'ю та критеріями аналізу: C_1 – Q1, Q2, Q4–Q5, Q7; C_2 – Q1, Q3, Q5, Q8; C_3 – Q4, Q9 (прямі), Q11–Q12 (непрямі); C_4 – Q1, Q4; C_5 – Q1, Q5, Q8; C_6 – Q4, Q9; V.26 – маркер трьох траєкторій G. I – Q1–Q2, Q4, Q6, Q11–Q12; G – Q3, Q6–Q8, V.26; R_1 – R_3 – Q7–Q8, Q10; PTG – Q7, Q9–Q12 (прямі/непрямі). Критерії: I.1–I.8 $\rightarrow C_1$ – C_6 , I; II.9–II.11, II.16 $\rightarrow R$, G, PTG; II.12–II.15 $\rightarrow$ дистрес (блок $I \rightarrow G$, ерозія R, відсутня PTG); III.17–III.20 $\rightarrow R_2$, G; IV.21–IV.24 $\rightarrow$ модератори

R та позицій на C; V.25–V.27 $\rightarrow$ тригери I та маркери C_6 ; V.27 $\rightarrow$ позиція на C_3/C_6 .

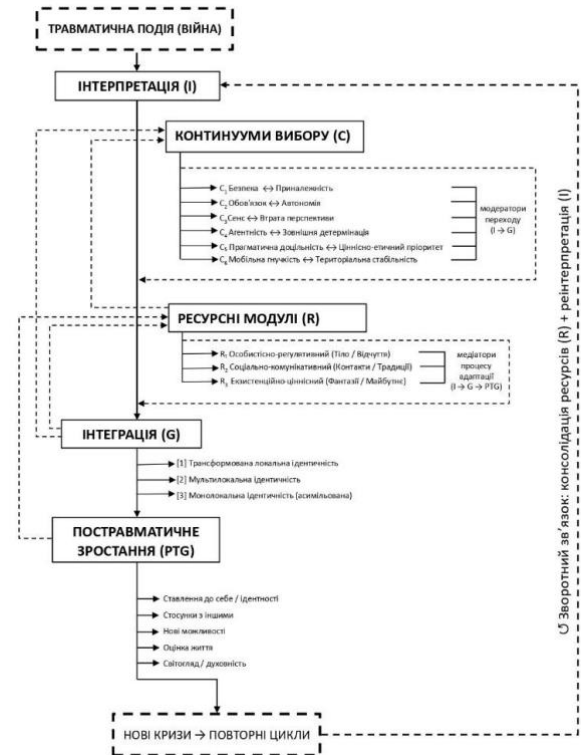


Рис. 3. Інтегративна модель екзистенційного вибору та адаптації: динаміка процесу

Примітка. Формалізований вираз динаміки процесу: $G=f(I,R|C) \rightarrow PTG \cup$, де:

I – інтерпретація (ініціувальний компонент);
R – ресурсні модулі (R_1 – R_3 ; медіатори процесу адаптації);

C – континууми вибору (C_1 – C_6 ; модератори переходу $I \rightarrow G$);

G – інтеграція (центральный механізм ідентичності приналежності);

PTG – посттравматичне зростання (результат);

$\cup$ – зворотний зв'язок (консолідація ресурсів і реінтерпретація).

Встановлення PTG проводилося шляхом інтерпретативного узагальнення даних, отриманих в результаті первинного тематичного кодування висловлювань, що відносяться до Q7, Q9–Q12.

Важливо також методологічне уточнення: ретроспективне повторне кодування (повторне застосування кодів PTG до всього масиву інтерв'ю) не застосовувалося з метою збереження логіки вихідного тематичного аналізу та запобігання методологічному зміщенню. Однак це передбачає вибірку

валідацію шляхом перевірки інших відповідей (особливо Q4 про динаміку сприйняття безпеки) на предмет прихованих індикаторів зростання на етапі верифікації моделі та синтезу результатів.

Таким чином, модель описує механізми, за допомогою яких досвід війни, проходячи через процеси інтерпретації індивідуального травматичного досвіду (I) та інтеграції переосмисленого досвіду у структуру ідентичності приналежності (G), визначає характер посттравматичного зростання (PTG) і формує диференційовані траєкторії адаптації в умовах тривалої кризи.

Обмеження дослідження. Це дослідження має низку методологічних обмежень, які необхідно враховувати при інтерпретації результатів та визначенні напрямів подальшої роботи в межах якісної парадигми: встановлення посттравматичного зростання (PTG) та ризику «уявного зростання». Ознаки посттравматичного зростання виявлялися шляхом інтерпретативного узагальнення висловлювань респондентів, що стосуються Q7, Q9–Q12 протоколу інтерв'ю, з опорою на п'ятифакторну модель PTG (Tedeschi & Calhoun, 1996). Ретроспективне повторне кодування всього корпусу інтерв'ю із застосуванням спеціалізованих кодів PTG не проводилося з метою збереження логіки вихідного тематичного аналізу та запобігання методологічному зміщенню (researcher bias), пов'язаному з нав'язуванням теоретичних конструктів на вже закодовані дані. Цей підхід обмежує повноту та систематичність виявлення PTG-індикаторів, оскільки ознаки позитивних змін могли проявлятися і у відповідях на інші питання (особливо Q4 про динаміку сприйняття безпеки, де непрямо могли згадуватися зміни у самосприйнятті або стосунках).

Крім того, якісна оцінка PTG на основі наративів не дозволяє остаточно відокремити конструктивне зростання від уявного зростання – феномена, при якому позитивні зміни декларуються, але не підкріплюються реальними поведінковими та когнітивними трансформаціями (Boals, 2023).

Однак ми вважаємо, що наративний підхід має унікальні переваги для виявлення автентичності PTG порівняно з психометричними інструментами (такими як PTGI): глибинні інтерв'ю дають змогу аналізувати узгодженість позитивних змін із

загальною структурою наративу, конкретність прикладів трансформації (на противагу абстрактним деклараціям), часову динаміку змін та їхню інтеграцію в ідентичність приналежності та систему стосунків.

Для подолання обмеження неповноти виявлення PTG-індикаторів запланована поглиблена наративна верифікація на підвибірці інтерв'ю (див. розділ «Перспектива подальших досліджень»).

Висновки

Інтегративна модель екзистенційного вибору та адаптації харків'ян (у парадигмі транскультуральної позитивної психотерапії Н. Пезешкіана) синтезує концептуальні основи посттравматичного зростання та Моделі збереження ресурсів (COR), але доповнює їх такими ключовими положеннями:

1. Вводить екзистенційний вибір як центральний модератор результатів за шістьма континуумами C_1 – C_6 (на відміну від PTG-моделі, де акцент зміщений на когнітивну переробку, і Моделі збереження ресурсів, сфокусованої на ресурсах; див. Tedeschi & Calhoun, 1996; Hobfoll, 1989, 2001).

2. Визначає місце як операціональний ресурс R_3 – «розширену базу безпеки» у логіці теорії прив'язаності, застосовану до територіальної прив'язаності (Bowlby, 1982; Scannell & Gifford, 2010).

3. Виділяє три траєкторії інтеграції ідентичності (трансформована локальна, мультилокальна, монолокальна (асимільована)), що ґрунтуються на переосмисленні системи приналежності.

4. Постулює явну послідовність $I \rightarrow G \rightarrow PTG$, модеровану континуумами, систематизуючи смислоутворення та реконструкцію переконань (Frankl, 1963; Janoff-Bulman, 1992).

5. Обґрунтовує транскультуральну релевантність через зіставлення R_1 – R_3 з моделлю балансу транскультуральної позитивної психотерапії (Peseschkian, 1987).

6. Емпірично специфікована та перевірена на внутрішню узгодженість: розроблена через ітеративний цикл (1.0→1.1) на матеріалі наративів ($N=68$) з досягненням високої міжсуддівської узгодженості, що підтверджує операціональну спроможність конструктів та пояснює варіативність

адаптаційних результатів за однакових зовнішніх умов.

Модель має прямий терапевтичний потенціал: дозволяє діагностувати континууми вибору (C_1 – C_6) та ресурсні модулі (R_1 – R_3) у клієнтів з досвідом вимушеної міграції, адаптувати інтервенції до траєкторії посткризової ідентичності (трансформована локальна, мультилокальна, монолокальна) та цілеспрямовано супроводжувати процеси інтерпретації (I) і інтеграції (G).

Повна зовнішня валідація моделі вимагає незалежної вибірки та застосування змішаних методів дослідження.

Таким чином, запропонована модель не заперечує існуючі підходи, а синтезує їх із явним включенням механізмів вибору, місця та культурної специфічності у культурно-чутливий каркас ППТ-підходу. Її основна інновація полягає не у відкритті нових психологічних процесів, а у переконфігурації існуючих знань для пояснення адаптації в

умовах вимушеної міграції та екзистенційного вибору в контексті конфлікту.

Перспектива подальших досліджень

Ітерація 1.1 відображає концептуальну структуру моделі з описом основних компонентів та їхніх взаємозв'язків, емпірично специфіковану на вибірці жителів Харкова ($N=68$). Операціональні маркери для континуумів вибору (C_1 – C_6) визначені на якісному рівні; їхня кількісна операціоналізація є предметом наступних етапів дослідження. Подальші кроки також включають розширення емпіричного корпусу та прикладну апробацію моделі у програмах психологічної допомоги (індивідуальне консультування, групова робота, супервізії), що дозволить оцінити її евристичну та терапевтичну корисність.

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Декларації

Фінансування. Дослідження здійснено без цільового фінансування.

Конфлікт інтересів. Конфліктів інтересів не заявлено.

Вклад авторів у дане дослідження розподілено відповідно до таксономії CRediT наступним чином:

Гордієнко-Митрофанова І.: концептуалізація, розробка методології, проведення дослідження (пілотне інтерв'ювання, розробка протоколу інтерв'ю та кодової книги), формальний аналіз, написання вихідного тексту, рецензування та редагування, наукове керівництво, адміністрування проекту.

Бондаренко Н.: розробка методології (пілотний етап), проведення дослідження (інтерв'ювання, транскрибування, ручна верифікація транскриптів), формальний аналіз, написання – рецензування та редагування.

Докуніна О.: проведення дослідження (інтерв'ювання, транскрибування, ручна верифікація транскриптів; основний внесок), валідація даних, кураторство даних, підготовка додатків, формальний аналіз, написання – рецензування та редагування.

Красильникова Ю.: проведення дослідження (інтерв'ювання, транскрибування, ручна верифікація транскриптів), формальний аналіз, написання – рецензування та редагування.

Сухань В.: проведення дослідження (інтерв'ювання, транскрибування, ручна верифікація транскриптів), забезпечення ресурсів (підбір літератури, перекладацький супровід), формальний аналіз, написання – рецензування та редагування.

Доступність даних. Повні транскрипти не є публічними. Знеособлені аналітичні матеріали (книга кодів, агреговані матриці тем/індикаторів, вибіркові анонімізовані цитати) надаються за мотивованим запитом редакції/рецензентів. Контролер даних: Харківська філія Української спілки психотерапевтів (УСП). Відповідальна особа: Ія Гордієнко-Митрофанова. Електронна пошта: ikavgm@gmail.com. Публікація цитат здійснюється у межах, передбачених у формі інформованої згоди.

Схвалення етичного комітету та згода. Проект «Грані життя / Життя на грані» реалізується на базі Харківської філії УСП; статус проекту підтверджений внутрішніми документами філії (підтвердження та витяг із протоколу загальних зборів). Усі учасники підписали письмову інформовану згоду на участь, обробку персональних даних та публікацію знеособлених цитат; анонімізація даних було здійснено до початку автоматизованої обробки; матеріали зберігаються на захищених носіях з обмеженим доступом

Декларація використання ШІ. Автори підтверджують, що концептуалізація, дизайн дослідження, методологія, аналіз даних та інтерпретація результатів є цілком оригінальними та виконані виключно дослідниками без залучення штучного інтелекту (ШІ) до цих ключових аспектів.

Подяки

Ми висловлюємо щирі подяку Сергію Сауті (доктор філософії у галузі психології, директор з питань штучного інтелекту групи компаній FRACTAL) за експертні технічні консультації та плідні наукові дискусії, що сприяли підвищенню якості дослідження, а також за допомогу у візуалізації даних і графічному оформленні моделі

Додатки

ДОДАТОК А

Таблиця 1. Частотний розподіл критеріїв тематичного аналізу проекту «Грані життя / Життя на грані»

Категорія	Критерій	Частота (%)
I. Мотивація та вибір	2. Соціальний і сімейний обов'язок	85
	8. Локус контролю	82
	5. Страх і безпека	78
	7. Амбівалентність рішення	60
	3. Прив'язаність до місця	49
	4. Вимушений виїзд	28
	1. Обов'язок перед собою	19
II. Адаптація і PTG	6. Прагматичні мотиви	15
	11. Динаміка сприйняття	90
	10. Переоцінка цінностей	69
	9. Активне подолання	60
	12. Хронічний стрес	60
	13. Маладаптивне подолання	49
	16. Рутини та практики	46
III. Соціальні реакції	15. Коливання інтрузії–уникнення	32
	14. Втрата сенсу	12
	17. Прийняття та емпатія	96
	20. Солідарність	62
	18. Конфронтація	16
IV. Контекст середовища	19. Дистанціювання	13
	24. Повсякденні умови	96
	22. Інформаційне середовище	65
	21. Інституційна підтримка	35
V. Часова динаміка	23. Економічні фактори	28
	25. Стресори та події	99
	26. Траєкторія мобільності	96
	27. Уявлення про майбутнє	96

Таблиця 2. Діагностична структура дослідження: узгодження модельних конструктів (I, G, R, C, PTG) з критеріями тематичного аналізу та емпіричними індикаторами

Ключова категорія	Конструкт моделі	Опис конструкта	Питання протоколу інтерв'ю	Критерії Codebook v1.1	Типові індикатори в наративах
Інтерпретація (I)	I (Інтерпретація)	Смислова переробка пережитого	Q1, Q2, Q4, Q6, Q11, Q12	II.10 (Переоцінка цінностей), II.11 (Динаміка сприйняття і зсув до стійкості), I.7 (Амбівалентність рішення)	«Я вперше в житті зрозуміла, що в цьому світі може трапитися все що завгодно, і ти до цього не будеш готовий... має бути якась внутрішня надія, що ти виберешся і з цього».
					«Був час, коли в мене було відчуття, що ті, хто в Харкові, спокійніше ставляться [до того, що відбувається в Харкові, до війни – Прим. авт.], ніж деякі ті, хто тут [за кордоном – Прим. авт.] ... А зараз, мабуть, у мене вже притупилася гострота сприйняття».
					«Я пам'ятаю ніч, коли я прийняла рішення їхати далі. Це була найстрашніша і найтемніша ніч у моєму житті. Я не хотіла, всіма фібрами своєї душі відштовхувала цю думку –

Інте- грація (G)	G (Інтеграція)	Включення переосмисленого досвіду «Я» та ідентичність приналежності	Q3, Q6, Q7, Q8	I.3 (Прив'язаність до місця, V.26 (Траекторія мобільності), III.17 (Прийняття та емпатія), III.20 (Солідарність і практики взаємодопомоги)	їхати кудись далі, Але я розуміла, що потрібно».
					«Не те, що я там виросла, не те, що це моє рідне місто, я його люблю понад усе... я знаю, що ми повернемося до Харкова. Не знаю коли і не знаю як, але ми повернемося до Харкова 100%. І я знаю, що це місто буде найкращим містом для мене, для моєї сім'ї у житті та у розвитку».
					«Спершу я дуже злилася на своїх рідних за безвідповідальність, так, як можна залишатися з дітьми у такому становищі... Але зараз я якось думаю по-іншому... Кожному свій шлях, комусь потрібно десь бути або переїхати. Я теж на це дивлюся ширше і об'ємніше».
					«Хто виїхав, це їхній вибір, вони виїхали... Можливо, комусь і добре. Хтось влаштувався... І я їх розумію, що людина будувала своїми руками будинок, і як це все кинути?... Молодь рятуються, правильно робить».
					«Я хотіла б залишитися з близькими та рідними у Харкові... Ходити по таких закладах... Бачила нещодавно про те, як пара хлопців- харків'ян за дуже невелику вартість ремонтують фургони, які віддають потім на фронт... Багато хлопців, яких я знаю, як і я, прийняли рішення повернутися, повертаються і намагаються щось зі свого досвіду та своїх умінь привносити в це місто».

<i>Ресурси (R)</i>	R₁ (Особистісно-регулятивний ресурс)	Навички саморегуляції	Q7, Q10	II.9 (Активне подолання), II.16 (Рутини та практики), II.13 (Маладаптивне подолання – зворотній індикатор)	«Ми укривали дві сім'ї у себе, оскільки ми жили на першому поверсі... Я підтримувала порядок. Іра з моїм чоловіком готували їсти... Наше завдання було в тому, щоб триматися всім разом. І головне, підтримувати дітей». «Буду ходити щонеділі в кіно, я дуже люблю ходити в кіно, а на зворотному шляху з кінотеатру, буду заходити у своє улюблене кафе і брати свою улюблену булочку і каву». «Я видалила всі чати, я видалила все військове, у мене залишилася тільки та людина, яка має канал і показує по Харкову, що летить... Всіх інших новин у мене немає... Я знаю, у кого є збір, кидаю допомогу, більше ніяких новин... це нагання страх».
	R₂ (Соціально-комунікативний ресурс)	Вибіркові мережі «своїх»	Q8, Q10	III.17 (Прийняття і емпатія), III.20 (Солідарність і практики взаємодопомоги), II.16 (Рутини: спільні практики), IV.22 (Інформаційне середовище: довірені канали)	«Ті, хто виїхав, я прекрасно розумію, звичайно... ця травма, вона одразу конектиться. Ось так раз – людина, і ви нібито на якомусь рівні вже все... ви вже розумієте якісь речі, навіть не промовляючи їх». «Регулярно його відвідували, допомагали. Ми з сусідами, пам'ятаю, теж ходили, залишали їжу їм... Допомога братам нашим меншим, тим, хто її потребує... Коли тобі погано, допоможи тому, кому гірше... І одразу стає легше». «Ми почали привозити їжу діткам... Через пару місяців у мене було таких вже 500 людей... ми наш район обслуговували». «По-перше, це вже телеграм-новини. Дуже крутий хлопець, який каже, що конкретно по Харківській області летить... Туди можна зареєструватися через «Дію»... Тобто, якщо я, наприклад, гуляю в центрі, я розумію, що приліт може бути в будь-який момент, але я бачу, що, наприклад, усе жовте, нічого не летить».
	R₃ (Екзистенційно-ціннісний ресурс)	Ціннісні опори і прив'язаність до місця	Q3, Q8, Q11, Q12	I.3 (Прив'язаність до місця), I.1 (Обов'язок перед собою), I.2 (Соціальний та сімейний обов'язок), II.10 (Переоцінка цінностей)	«Зрозуміла, що я дуже сильно люблю Харків, і я справді хочу там залишитися... я живу зараз у Києві, але мені б дуже хотілося повернутися до Харкова... Харків він і відчувається як дім». «Я думала більшою мірою вже про Ваню, а не про свій комфорт і про зручність. Не про свої якісь страхи. Ось саме страх

Конфлікти /Дихотомії (С)					за дитину це теж став ось... таким вирішальним моментом, що їхати треба».
	С₁ (Безпека ↔ Приналежність)	Напруга між потребою у фізичній безпеці та відчуттям дому й приналежності	Q1, Q2, Q4, Q5, Q7	I.5 (Страх і безпека), I.3 (Прив'язаність до місця)	«Я на даному етапі життя обрала підземну школу, я обрала життя з чоловіком, я обрала життя у себе вдома... Я розумію, що в мене тут найкращі лікарі, які залишилися, найкращі педіатри. У мене тут є зв'язки, знайомі».
	С₂ (Обов'язок ↔ Автономія)	Конфлікт між обов'язками (сімейними, соціальними) та особистим вибором/правом на власне життя	Q1, Q3, Q5, Q8	I.2 (Соціальний і сімейний обов'язок), I.1 (Обов'язок перед собою)	«Страх нескінченного жаху. Страх невідомості того, скільки триватиме ця війна, цей жах, стрес. Для мене страх невідомого життя в Харкові став більшим, переважив страх невідомого життя десь іще».
	С₃ (Сенс ↔ Втрата перспективи)	Наявність або втрата життєвих цілей та розуміння майбутнього	Q4, Q9, Q11, Q12	II.14 (Втрата сенсу і безнадія), V.27 (Уявлення про майбутнє і плани), II.10 (Переоцінка цінностей)	«Зрозуміла, що я дуже сильно люблю Харків, і я справді хочу там залишитися... я живу зараз у Києві, але мені б дуже хотілося повернутися до Харкова... Харків він і відчувається як дім».
	С₄ (Агентність ↔ Зовнішня детермінація)	Сприйняття себе як активного суб'єкта вибору (контролю) чи жертви обставин	Q1, Q4	I.8 (Локус контролю), I.4 (Вимушений виїзд), I.7 (Амбівалентність рішення)	«І найбільш ключовим поштовхом до того, щоб прийняти рішення та виїхати, це була моя мама. На той момент їй було 75 років, і я розуміла, що якщо я її зараз не вивезу, я її просто тут поховую».
					«Здорова людина обирає себе. Навіть якби ніхто з них не виїхав, я б поїхала сама. Я відповідальна лише за себе. Я обираю жити».
					«Безпеки знову немає. Я знову не знаю, що це за слово – безпека... На жаль, такого розуміння немає».
					«Я мрію після закінчення війни про те, що мій бізнес буде жити і приносити дохід... Буду багато гуляти рідним та улюбленим містом, а саме парком Шевченка... Буду ходити щонеделі у кіно».
					«Війна занадто мене змінила в тому плані, що я собі зараз не дозволю витратити час на страждання... Велика цінність часу і велика цінність свободи... Багато чесності стало, такої правди».
					«Я не відповідальна ні за чий емоції, ні за чий вибір... Я відповідальна тільки за себе. Я обираю жити... Я абсолютно спокійно приймаю відповідальність за своє життя, на себе».
					«По-перше, у мене не стояло питання, залишитися в Харкові чи виїхати. Сталося так, що під час перших вибухів, які були о 5

Зростання (PTG)				ранку, моя донька та зять через 15 хвилин вже стояли на подвір'ї нашого будинку разом з онучками і посадили нас, у чому ми були, в пуховику і в піжамі». «Змішані почуття якісь там, з одного боку, хотілося бути і вдома, а з іншого боку хотілося бути в безпеці». «У моєму випадку в мене було рішення без рішення, тому що чоловік взяв мене, взяв усю свою сім'ю, і питань ніхто не міг ставити».
	С₅ (Прагматична доцільність ↔ Ціннісно-етичний пріоритет)	Протиставлення раціональних (економічних, зручних) мотивів та ціннісно-етичних (принципи, ідентичність)	Q1, Q5, Q8, Q11	I.6 (Прагматичні мотиви), I.2 (Соціальний і сімейний обов'язок), I.3 (Прив'язаність до місця) «Щоб кудись виїжджати, потрібні документи та кошти... А мені ще заробити їх треба. Або десь працювати. А де жити?... У Харкові у мене є робота, і я можу утримувати себе, і у мамі є пенсія». «Я без неї не поїду, тут варіантів немає... моя мама хворіє, і я не зможу її перевезти нікуди, навіть у передмістя не можу». «Він [тато – Прим. авт.] постійно мене хотів впихнути в цей вагон, де ось тисяча мільйонів людей було. Я казала, тату, ну я доїду до Полтави і повернуся додому. Ну, тобі воно треба?».
	С₆ (Мобільна гнучкість ↔ Територіальна стабільність)	Готовність до переміщень і тимчасове сприйняття ↔ Прагнення до осілості та укорінення	Q4, Q9	V.26 (Траєкторія мобільності), V.27 (Уявлення про майбутнє: повернення / інтеграція) «Все-таки наше життя, воно тут і зараз. За державу, як то кажуть, прикро, але моє життя при цьому теж триває. І воно одне. Тому його хочеться прожити все-таки. Прожити самостійно, в задоволення. І насолодитися, оскільки воно одне». «Ми переможемо, і витримаємо, і приїдемо до Харкова, і будемо допомагати, перебирати, і все далі робити, і відновлювати... Головне, щоб війна закінчилася, щоб хоча б уже не стріляли».
	PTG (Посттравматичне зростання)	Позитивні зміни у п'яти доменах, пов'язані з кризовим досвідом	Q7, Q9, Q10, Q11, Q12	II.10 (Переоцінка цінностей), II.11 (Динаміка сприйняття), II.9 (Активне подолання), III.17 (Прийняття і емпатія: зміни в відносинах) «Я навчилася взагалі нічого не планувати. Взагалі ні за що не триматися і жити в моменті. І географія для мене втратила будь-яке значення». «Усі звикли жити життя, якщо сьогодні воно є, значить, ми його сьогодні живемо. Все! Немає чого переживати про те, що його може не бути завтра». «Я зараз, на момент війни, зрозуміла, що навіть неможливе можливе. Усі зовнішні опори можуть рано чи пізно завалитися. Але дуже важливо вміти самому себе підтримувати, мотивувати, спиратися на себе».

«Цінувати життя сьогодні, тут і зараз. Приймати заздалегідь невідомість у житті як даність і напрацювала ось цю навичку вибудовувати нові опори, нові стосунки з людьми, заводити нових друзів, знайомих, особисті стосунки».

Примітки:

Багатоаспектність питань: одне й те саме питання протоколу може використовуватися для операціоналізації кількох конструктів (наприклад, Q1 – для I, C₁, C₂, C₄, C₅), що відображає комплексний характер екзистенційного вибору.

Перетин критеріїв: критерії Codebook v1.1 можуть перетинатися, що є методологічною особливістю рефлексивного тематичного аналізу.

Індикатори: наведені індикатори є типовими прикладами; конкретні формулювання в інтерв'юванні можуть сильно варіюватися.

PTG-процедура: для конструкту PTG (Посттравматичне зростання) використовується узагальнювальна інтерпретативна процедура.

Section: Preliminary Studies in Positive Psychotherapy (PPT)

Використання технік Позитивної психотерапії (ППТ) у роботі з психоемоційними станами жінок, які перебувають в складних життєвих обставинах

Use of Positive Psychotherapy (PPT) Techniques in Working with the Psycho-Emotional States of Women Who are in Difficult Life Circumstances



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Анотація

Дане дослідження має на меті теоретично та експериментально дослідити ефективність використання технік позитивної психотерапії (PPT) у роботі з психоемоційними станами жінок, які перебувають в складних життєвих обставинах. У дослідженні взяли участь 50 жінок з різним життєвим досвідом, що забезпечило широту охоплення різних аспектів складних обставин. Зокрема, це були: мігрантки, які змушені були залишити свої домівки через війну, економічну нестабільність або інші причини. Вони зіткнулися з труднощами адаптації до нових умов, мовними бар'єрами, тривожністю щодо майбутнього; жінки, які залишилися проживати в умовах війни. Вони стикалися із фізичною небезпекою, страхом за життя близьких, емоційним виснаженням і постійним стресом; жінки, які зазнали інших видів життєвих труднощів.

Географічно вибірка охоплювала жінок, які проживають як у межах України, так і за її межами, що дало змогу порівняти психоемоційні стани в контексті життя у рідній країні та за кордоном. Результати можуть бути корисними для психологів, психотерапевтів, соціальних працівників та інших фахівців, які працюють із цією категорією осіб, допомагаючи їм ефективніше справлятися з психоемоційними проблемами.

Ключові слова: психоемоційний стан, складні життєві обставини, позитивна психотерапія, тривожність, стрес

Abstract

This study aims to theoretically and experimentally investigate the effectiveness of using Positive Psychotherapy (PPT) techniques in working with the psycho-emotional states of women who are in difficult life circumstances. 50 women with diverse life experiences participated in the study, ensuring broad coverage of complex circumstances. In particular, these were: migrant women who were forced to leave their homes due to war, economic instability, or other reasons. They faced difficulties in adapting to new conditions, language barriers, anxiety about the future, and women who remained living in war

conditions. They faced physical danger, fear for the lives of loved ones, emotional exhaustion, and constant stress; women who have experienced other types of life difficulties.

Geographically, the sample included women living both within Ukraine and outside it, enabling comparison of psycho-emotional states in the context of life in their native country and abroad. The results can be useful for psychologists, psychotherapists, social workers, and other professionals who work with this category of individuals, helping them to cope more effectively with psycho-emotional problems.

Keywords: psychoemotional state, difficult life circumstances, Positive Psychotherapy, anxiety, stress

Вступ

У сучасному суспільстві багато жінок стикаються з важкими ситуаціями, такими як насильство, фінансова нестабільність, депресії або втрати. Такі обставини значно впливають на їхній психоемоційний стан, часто залишаючи тривалий вплив на їхню психологічну рівновагу та самопочуття. У зв'язку з цим постає нагальна потреба в ефективних методах психотерапевтичної допомоги, які б допомогли їм адаптуватися до змін та знизити рівень тривоги, депресії чи стресу. Позитивна психотерапія, зокрема, є перспективним інструментом для підтримки психоемоційного благополуччя, оскільки вона фокусується на розвитку внутрішніх ресурсів людини, її сильних сторін та позитивних установок. Завдяки цьому жінки, які перебувають у кризових ситуаціях, можуть зосередитися на своїх можливостях і знайти шлях до емоційного відновлення. Огляд наукової літератури дозволив зібрати різноманітні погляди та підходи, які сприяють глибшому розумінню психоемоційних проблем жінок, які переживають складні життєві ситуації, та допомагають у визначенні ефективних методів їх психотерапевтичної підтримки. Завдання дослідження полягали у тому, щоб:

1. Теоретично проаналізувати психологічні основи використання позитивної психотерапії у роботі з психоемоційними станами.
2. Вказати результати первинного обстеження та їх інтерпретація.
3. Проаналізувати результати втручання та ефективність використання технік позитивної психотерапії.

Нами було використано наступні методи дослідження: теоретичні: аналіз наукової літератури – вивчення і систематизація сучасних теоретичних розробок у галузі психології; інтерпретація та узагальнення – аналіз і синтез теоретичних концепцій,

моделей і підходів до позитивної психотерапії; класифікація та категоризація – розподіл психоемоційних станів жінок за різними типами, що допомагає краще розуміти особливості їхнього переживання складних обставин та потреби в підтримці. Емпіричні: опитувальник «Самооцінка станів тривожності, фрустрації, агресивності та ригідності» (адаптований варіант методики Г. Айзенка), тест «Стійкість до стресу» (С. Д. Максименко, Л. М. Карамушка, Т. В. Зайчикова), опитувальник «Стабільність психічного здоров'я – коротка форма» (К. Кіз, адаптація Е.Л. Носенко, А.Г. Четверик-Бурчак), методика дослідження копінг-поведінки в стресових ситуаціях (Н. Ендлер, ДЖ. Паркер). *Психотерапевтичні практики* – застосування технік позитивної психотерапії в умовах реальної практики, що дозволяє оцінити ефективність методів в контексті специфічних ситуацій та психоемоційного стану учасників дослідження.

Методологія

Емпіричне дослідження психоемоційних станів жінок, які перебувають у складних життєвих обставинах, охоплювало три основні етапи: констатаційний, формувальний і контрольний. Його мета полягала у вивченні специфіки психоемоційних станів цих жінок та визначенні ефективності методів позитивної психотерапії для їхньої корекції.

На початковому етапі здійснювалося оцінювання психоемоційного стану учасниць, до яких належали жінки, що пережили міграцію або перебувають в умовах війни, а також ті, хто зазнає значного стресу через життєві обставини. Дослідження проводилося на вибірці з 50 жінок віком від 18 до 55 років.

До вибірки увійшли жінки з різним життєвим досвідом, що забезпечило широту охоплення різних аспектів складних обставин. Зокрема, це були:

- Мігрантки, які змушені були залишити свої домівки через війну, економічну нестабільність або інші причини. Вони зіткнулися з труднощами адаптації до нових умов, мовними бар'єрами, відчуттям ізоляції та тривожністю щодо майбутнього (66%).

- Жінки, які залишилися проживати в умовах війни або поблизу зони бойових дій. Вони стикалися із фізичною небезпекою, страхом за життя близьких, емоційним виснаженням і постійним стресом (24%).

- Жінки, які зазнали інших видів життєвих труднощів, таких як втрата роботи, фінансова нестабільність, розрив сімейних стосунків або самотність (10%).

Учасниці відповідали на низку спеціально розроблених психологічних опитувальників, що оцінювали рівень тривожності, фрустрації, агресивності, ригідності, стресостійкості, стабільності психічного здоров'я, а також їхні стратегії подолання стресових ситуацій. Опитування проходило в комфортних умовах, як у форматі очних зустрічей, так і онлайн.

Після цього розпочався формувальний етап, що включав серію психологічних інтервенцій, спрямованих на покращення емоційного стану жінок. В основі інтервенцій лежали принципи позитивної психотерапії (PPT), яка акцентує увагу на внутрішніх ресурсах особистості та спрямована на зміцнення позитивного мислення. З учасницями проводилися групові заняття, під час яких вони вчилися усвідомлювати й приймати свої емоції, формувати більш конструктивне ставлення до складних життєвих ситуацій та використовувати власні сильні сторони для подолання стресу. Програма передбачає 8-10 зустрічей, кожна з яких триває 60-90 хвилин. Заняття проводяться 1-2 рази на тиждень, що дозволяє поступово освоювати нові техніки та закріплювати їх. Техніки, що були застосовані: позитивна рефлексія, фокус на сильних сторонах особистості, щоденник вдячності, підвищення соціальної підтримки, позитивне переосмислення, розвиток внутрішньої мотивації, техніки медитації.

Контрольний етап передбачав повторне оцінювання психоемоційного стану жінок через два тижні після завершення формувального втручання. Учасниці знову проходили ті самі психологічні тести та опитувальники, що використовувалися на початковому етапі. Порівняння результатів до

і після втручання дозволило оцінити динаміку змін у рівнях тривожності, стресостійкості, стабільності психічного здоров'я та поведінкових стратегій у стресових ситуаціях.

Для проведення цього дослідження було використано такі методики. Опитувальник «Самооцінка станів тривожності, фрустрації, агресивності та ригідності» є адаптованим варіантом методики Г. Айзенка та включає 40 питань. Основне призначення методики – визначення рівня чотирьох важливих психоемоційних станів: тривожності, агресивності, фрустрації та ригідності. Методика дозволяє оцінити, наскільки виражені ці стани в учасниць дослідження, і виявити їхній вплив на здатність адаптуватися до складних обставин (Карамушка та ін., 2023).

Тест «Стійкість до стресу», розроблений українськими вченими (С. Д. Максименко, Л. М. Карамушка, Т. В. Зайчикова), тест складається з 18 питань і дозволяє оцінити рівень стійкості до стресу: низький, середній або високий. Його використання є доцільним у контексті дослідження, адже стресостійкість є ключовим чинником адаптації до складних життєвих обставин. Високий рівень стійкості допомагає ефективніше справлятися з життєвими викликами, тоді як низький рівень може свідчити про ризики емоційного виснаження (Карамушка та ін., 2023).

Опитувальник «Стабільність психічного здоров'я – коротка форма».

Даний інструментарій був розроблений К. Кізом і адаптований для української вибірки Е. Л. Носенко та А. Г. Четверик-Бурчак. Методика складається з 14 питань і базується на тривимірній структурі психічного здоров'я, що охоплює гедонічне, психологічне та соціальне благополуччя (Носенко & Четверик-Бурчак, 2014).

Результати опитувальника дозволяють класифікувати стан учасниць на три рівні: «процвітання», «помірний рівень» або «пригнічення». Даний підхід є надзвичайно корисним для оцінки загальної стабільності психічного стану, що важливо у складних життєвих умовах.

Методика Н. Ендлер і Дж. Паркера включає 48 питань і дозволяє вивчати різні копінг-стратегії, які учасниці використовують для подолання стресу. Вона оцінює п'ять основних підходів (Рибалка & Яланська, 2023):

- Орієнтація на вирішення завдання – фокус на пошуку рішень проблеми.

- Соціальне відволікання – звернення за підтримкою до близького оточення.
- Спрямованість на емоції – зосередження на власних негативних переживаннях.
- Уникнення – уникання контактів із навколишнім світом і проблем.
- Відволікання – переключення уваги на іншу діяльність, яка допомагає тимчасово забути про проблему.

Дана методика є актуальною, адже копінг-поведінка безпосередньо впливає на здатність адаптуватися до складних життєвих обставин. Дослідження копінг-стратегій дозволяє не лише зрозуміти, які з них домінують у вибірки, а й визначити, які з них можуть спричиняти додаткове емоційне напруження. Застосування описаного психодіагностичного інструментарію є обґрунтованим через його націленість на комплексне оцінювання різних аспектів психоемоційного стану та адаптивної поведінки жінок у стресових умовах. Інструменти доповнюють одне одного, дозволяючи отримати детальну картину емоційного та психологічного благополуччя учасниць, що є важливим для подальшої корекції їхніх станів у межах інтервенцій.

Результати

Першочергово нами було інтерпретовано показники за опитувальником «Самооцінка станів тривожності, фрустрації, агресивності та ригідності».

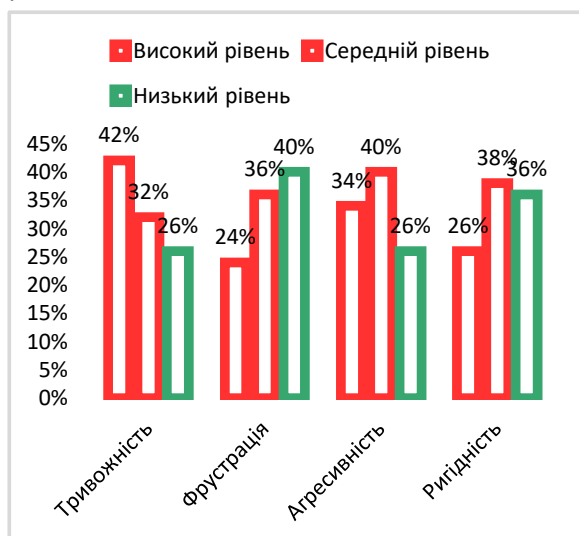


Рисунок 1. Показники тривожності, фрустрації, агресивності та ригідності до втручання

Отримані результати до психотерапії представлені у вигляді рис. 1 та після у рис. 2.

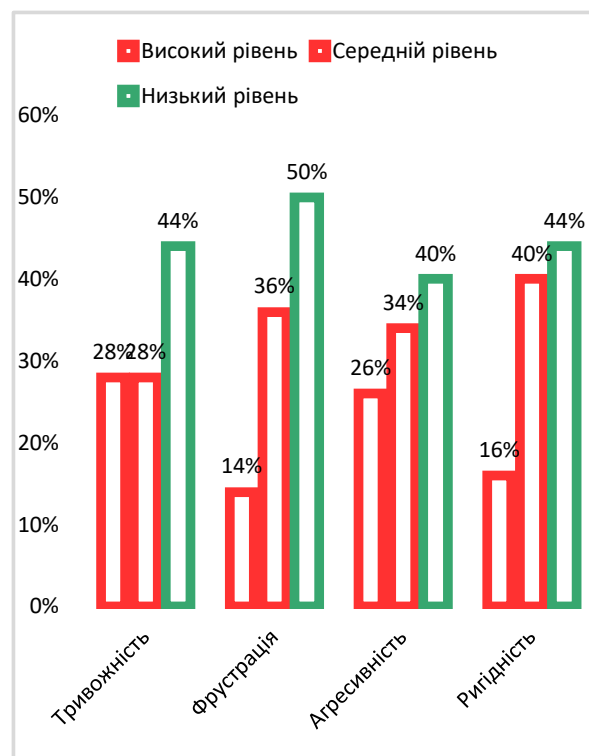


Рисунок 2. Показники тривожності, фрустрації, агресивності та ригідності після втручання

Показники за тестом «Стійкість до стресу» до психотерапії представлені у вигляді рис. 3 та після у рис. 4.

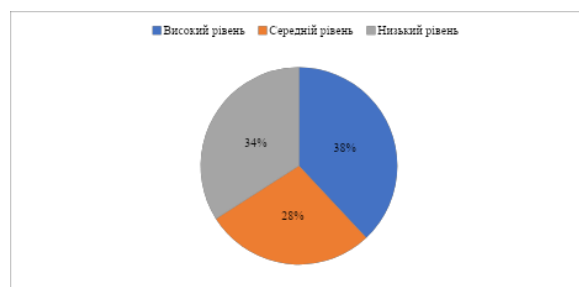


Рис. 3. Показники стійкості до стресу до втручання

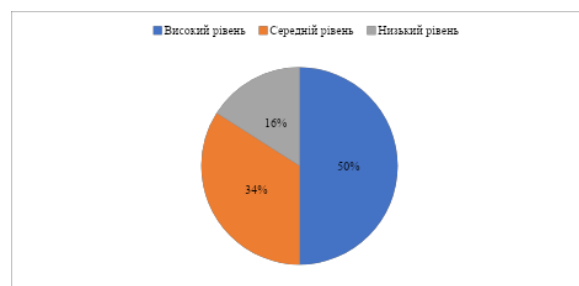


Рис. 4. Показники стійкості до стресу після втручання

Результати за опитувальником «Стабільність психічного здоров'я – коротка

форма» відображені на рис. 5 до психотерапії та після у рис. 6.

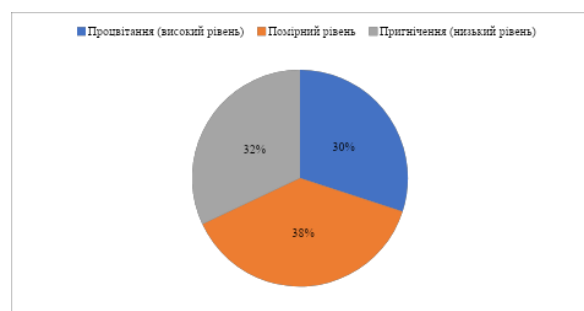


Рис. 5. Показники стабільності психічного здоров'я до втручання



Рис. 6. Показники стабільності психічного здоров'я після втручання

Результати за методикою дослідження копінг-поведінки в стресових ситуаціях (Н. Ендлер, ДЖ. Паркер) представлені у таблиці 1 до психотерапії та у таблиці 2 після психотерапії.

Таблиця 1. Показники домінування копінг-поведінки в стресових ситуаціях до втручання

	Середньо-групові показники
Копінг, орієнтований на вирішення проблеми	5,31
Копінг, орієнтований на емоції	8,17
Копінг, спрямований на уникнення	9,33
Копінг, спрямований на відволікання	8,29
Копінг, орієнтований на соціальне відволікання	4,71

Таблиця 2. Показники домінування копінг-поведінки в стресових ситуаціях після втручання

	Середньо-групові показники
Копінг, орієнтований на вирішення проблеми	9,41
Копінг, орієнтований на емоції	7,14
Копінг, спрямований на уникнення	7,23
Копінг, спрямований на відволікання	6,91
Копінг, орієнтований на соціальне відволікання	4,13

Додатково для встановлення взаємозв'язків між досліджуваними психоемоційними станами нами було використано коефіцієнт кореляції Пірсона (табл. 3).

Таблиця 3. Показники кореляційного зв'язку

	Стійкість до стресу	Копінг, орієнтований на проблему	Копінг, орієнтований на емоції	Копінг, орієнтований на уникнення
Тривожність	-0,237*			0,261*
Фрустрація		0,244*		
Агресивність	-0,241*		0,331**	
Ригідність			0,257*	
Стійкість до стресу		0,251*		
Психічне здоров'я	0,337**			

Примітка: * - при 0,1; ** - при 0,05

Встановлено слабкий негативний зв'язок між тривожністю та стійкістю до стресу (-0,237), що вказує на те, що підвищений рівень тривожності знижує здатність справлятися зі стресом. Аналогічно, агресивність також корелює зі стійкістю до стресу з негативною тенденцією (-0,241), підкреслюючи, що високий рівень агресивності зменшує емоційну стійкість. Натомість між психічним здоров'ям і стійкістю до стресу спостерігається помірний позитивний зв'язок (0,337), який підтверджує важливість стресостійкості для підтримання психічного благополуччя.

Копінг, орієнтований на проблему, має слабкий позитивний зв'язок із фрустрацією (0,244), що може свідчити про те, що в умовах фрустрації жінки частіше звертаються до конструктивних способів розв'язання проблем. Окрім цього, копінг, орієнтований на проблему, також позитивно корелює зі стійкістю до стресу (0,251), що підтверджує ефективність цієї стратегії в умовах стресу.

Аналіз копінгу, орієнтованого на емоції, виявив помірний позитивний зв'язок з агресивністю (0,331) і слабкий позитивний зв'язок із ригідністю (0,257), що свідчить про те, що жінки з високим рівнем агресивності чи ригідності частіше використовують емоційні реакції для зняття напруги, що не завжди є адаптивною стратегією.

Копінг, орієнтований на уникнення, показав слабкий позитивний зв'язок із тривожністю (0,261), що вказує на те, що тривожні учасниці частіше обирають уникання як основну стратегію реагування на стрес, що може бути наслідком їхньої внутрішньої напруги та невпевненості.

Отже, кореляційний аналіз дозволяє зробити висновок, що конструктивні стратегії, такі як орієнтація на вирішення проблем, асоціюються зі стресостійкістю, тоді як уникання та емоційно забарвлені реакції частіше застосовуються за умов тривожності, агресивності чи ригідності.

Результати проведеного дослідження дозволяють зробити важливі висновки щодо психоемоційних станів жінок, які перебувають у складних життєвих обставинах, та визначити їх клінічне значення для планування психологічної роботи. Дослідження виявило, що жінки, які перебувають у складних життєвих обставинах, стикаються зі значними труднощами у сфері психоемоційного

функціонування. Значна частина учасниць має високий рівень тривожності, агресивності та ригідності, що вказує на труднощі в адаптації до стресових умов. Низький рівень стійкості до стресу та пригнічений стан психічного здоров'я є характерними для багатьох жінок, що свідчить про ризики емоційного виснаження. Домінування неадаптивних копінг-стратегій, таких як уникнення та відволікання, також підкреслює складність ефективного подолання життєвих труднощів. Кореляційний аналіз підтвердив зв'язок між високими рівнями тривожності та агресивності із низькою стійкістю до стресу, а також між низьким рівнем психічного здоров'я та неадаптивними копінг-стратегіями, що свідчить про те, що емоційна нестабільність та нездатність до конструктивного подолання проблем значно погіршують загальний психоемоційний стан. Отримані дані мають важливе практичне значення для розробки комплексної психологічної роботи з жінками, які перебувають у складних життєвих обставинах. Вони підкреслюють необхідність зосередження зусиль на розвитку емоційної регуляції, зміцненні стійкості до стресу, формуванні конструктивних копінг-стратегій та профілактиці психічного виснаження. Показники низького рівня психічного здоров'я та домінування неадаптивних копінг-стратегій вказують на потребу у впровадженні індивідуальних і групових програм підтримки. Зокрема, важливо навчати технік емоційного самоконтролю, підвищувати рівень соціальної підтримки, працювати над підвищенням впевненості у власних силах і розвивати навички активного подолання труднощів. Таким чином, результати дослідження визначають основні напрями роботи, спрямованої на поліпшення психоемоційного благополуччя жінок у складних життєвих обставинах, і дозволяють створити ефективні програми психологічної допомоги. Програма психологічного втручання, заснована на техніках позитивної психотерапії (PPT), була спрямована на покращення психоемоційного стану жінок, які перебувають у складних життєвих обставинах. Основною метою програми було допомогти учасницям зміцнити емоційну стабільність, розвинути здатність до конструктивного подолання стресу та покращити їхнє психічне здоров'я за допомогою технік, що

фокусуються на позитивних аспектах життя, самопідтримці та соціальній підтримці. Програма включала низку вправ, таких як позитивна рефлексія, фокус на сильних сторонах особистості, техніка «відчуття вдячності», розвиток соціальної підтримки, позитивне переосмислення ситуацій, розвиток внутрішньої мотивації та цілепокладання, а також медитація і практики уважності. Дана програма виявилася ефективною у зниженні рівня тривожності, агресивності та фрустрації, а також сприяла підвищенню рівня стійкості до стресу та психічного здоров'я учасниць. Завдяки таким вправам жінки змогли краще адаптуватися до важких умов і знайти ресурси для подолання труднощів. Результати повторного обстеження психоемоційних станів жінок після проходження програми психологічного втручання показали суттєві покращення у порівнянні з первинними результатами. Після втручання спостерігалось зниження рівня тривожності, агресивності та фрустрації, що вказує на ефективність застосованих технік, зокрема позитивної рефлексії та роботи з емоційним фоном учасниць. Рівень тривожності знизився на 16%, що свідчить про значне поліпшення емоційної стабільності та здатності жінок долати стресові ситуації без зайвого занепокоєння. Фрустрація також знизилась на 10%, що вказує на поліпшення здатності учасниць приймати і адаптуватися до труднощів, зменшуючи рівень негативних емоцій та реакцій. Агресивність, зокрема, зменшилась на 8%, що свідчить про покращення емоційної регуляції та здатності жінок краще управляти своїми негативними емоціями. Щодо стійкості до стресу, після втручання відзначено значне покращення: 50% учасниць показали високий рівень стійкості до стресу, що є свідченням того, що жінки стали більш стійкими до зовнішніх і внутрішніх стресових факторів і здатні адаптуватися до труднощів, не втрачаючи психічної рівноваги. Стосовно показників психічного здоров'я, 40% учасниць продемонстрували високий рівень процвітання, що свідчить про значне покращення в їхньому життєвому самовідчутті та загальному стані благополуччя. Однак 20% учасниць все ще знаходились на низькому рівні, що свідчить про необхідність подальшої роботи з ними для підтримки та стабілізації їхнього психічного здоров'я.

Отже, результати дослідження показують, що програма психологічного втручання позитивно вплинула на психоемоційні стани жінок, покращила їхні копінг-стратегії, сприяла розвитку позитивних змін у ставленні до себе та оточуючих, а також підвищила їхню здатність адаптуватися до складних життєвих обставин.

Висновки

На основі проведеного дослідження сформовано наступні висновки:

1. Позитивна психотерапія (PPT) є психологічним підходом, який фокусується на розвитку позитивних емоцій, зміцненні внутрішніх ресурсів особистості та покращенні психічного благополуччя. Вона базується на засадах ресурсно-орієнтованої психотерапії, що акцентує увагу на пошуку та розвитку сильних сторін особистості, здатності до адаптації та пошуку сенсу навіть у складних життєвих обставинах. У роботі з психоемоційними станами, такими як тривожність, стрес, фрустрація та депресія, позитивна психотерапія спрямована на формування конструктивних копінг-стратегій, зміцнення внутрішньої мотивації, соціальної підтримки та на розвиток самопідтримки. Завдяки використанню технік, таких як позитивна рефлексія, вдячність та зміна сприйняття проблем, PPT допомагає індивіду отримати більше ресурсів для подолання труднощів, покращити емоційну регуляцію та знизити рівень стресу.

2. Емпіричне дослідження було проведено з метою оцінки ефективності застосування технік позитивної психотерапії в роботі з жінками, які перебувають у складних життєвих обставинах. Методологічно дослідження базувалося на використанні психодіагностичних інструментів для оцінки психоемоційних станів учасниць до і після втручання. Основними інструментами стали опитувальники та тести, які вимірюють рівень тривожності, фрустрації, агресивності, ригідності, стійкості до стресу та психічного здоров'я. Для проведення дослідження була обрана група жінок, що переживали складні життєві обставини, такі як стрес, зміни в особистому чи професійному житті. Втручання проводилось у кілька етапів, включаючи практичні заняття з позитивної

психотерапії та подальше повторне обстеження для оцінки результатів.

3. Результати первинного обстеження вказують на наявність високого рівня тривожності, фрустрації та агресивності серед учасниць, що відображало їхній емоційний дискомфорт і психічне напруження. Найбільший відсоток жінок мав низький рівень стійкості до стресу та психічного здоров'я, що вказує на труднощі в подоланні стресових ситуацій і підтриманні емоційної стабільності. Водночас, наявність високої агресивності та ригідності також свідчить про труднощі в емоційній регуляції та адаптації до змін. Першочергові результати обстеження вказували на необхідність застосування технік позитивної психотерапії для зменшення негативних емоцій і підвищення стійкості до стресу.

4. Результати після втручання продемонстрували значне покращення психоемоційного стану учасниць. Відзначено зниження рівня тривожності, фрустрації,

агресивності та ригідності. Водночас спостерігалось підвищення рівня стійкості до стресу, що свідчить про ефективність використаних технік позитивної психотерапії. Учасниці стали більш стійкими до стресових ситуацій, покращили емоційну регуляцію та зменшили рівень негативних емоцій. Техніки позитивної психотерапії допомогли зміцнити соціальні зв'язки та підвищити рівень психологічного благополуччя, що підтверджується результатами повторного обстеження за показниками психічного здоров'я. Позитивна рефлексія, розвиток вдячності, а також позитивне переосмислення ситуацій дозволили учасницям не лише зменшити стрес, але й більш конструктивно підходити до вирішення життєвих труднощів. Програма втручання продемонструвала високу ефективність у покращенні психоемоційного стану жінок та їх здатності до подолання складних життєвих ситуацій.

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Section: Theoretical reviews and research in Positive Psychotherapy (PPT)

Primary Capacities of Meaning and Ideal



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Abstract

This article continues a four-part series that refines the list, definitions, and diagnostic criteria of the primary actual capacities proposed by Nossrat Peseschkian, integrating them with contemporary psychodynamic theory and practice. As the fourth installment, it focuses on the capacities of ideal and meaning. It reviews the literature to clarify their conceptual definitions and scientific grounding in motivation, bodily experience, cognition, behavior, and relationships.

Building on this theoretical synthesis, the author proposes clinically oriented diagnostic criteria, sample diagnostic questions, and intervention ideas intended to support more structured assessment, individualized treatment planning, self-help resource development, and future research.

Keywords: Positive Psychotherapy, operationalisation, primary capacities, ideal, pleasure

Introduction

Primary capacities are core mental processes that regulate impulses, emotions, and cognition while meeting basic mental needs (Peseschkian, 1974, 1987; Kirillov, 2015). They parallel the personality-structure functions described in the OPD-3 (Arbeitskreis OPD, 2023) and develop through early relationships with primary caregivers (Peseschkian, 1987; Rudolf, 2002).

Though not directly observable, they can be inferred from bodily reactions and behavior. To enhance clinical applicability, the original model (Peseschkian, 1987, 2016a; Peseschkian & Deidenbach, 1988) was refined and later expanded by integrating insights from OPD (Kirillov, 2015, 2024).

This optimized set of capacities enhances clinical assessment, therapeutic planning, and research while preserving linguistic flexibility. Its clinical value has been supported by practitioner feedback and empirical application (Kirillov et al., 2023). The present article extends this work by

exploring the capacities of ideal and meaning (imagination dimension of the Balance Model).

Methodology

This article applies theoretical synthesis and clinical concept analysis to refine Peseschkian's "primary capacities" and translate the constructs *Ideal* and *Meaning* into a standardised diagnostic framework based on a review of contemporary literature on psychodynamic and cognitive neuroscience.

The method includes: 1) deductive construct literature based definition; 2) decomposition of each capacity into active (object-directed) vs. reactive (self-directed) and three sub-capacities; 3) specification of three integration levels (low/moderate/high) framed as developmental/relational organisation reflected on original tables; 4) systematic mapping to OPD-3; 5) clinical questions, dialogues, and level-linked interventions that are first proposed and systematised in this article. This improves

scientific grounding through transparent, replicable construct specification and support for content validity, while acknowledging the need for future empirical validation.

I. Ideal

I.1. Definition

The word 'ideal' denotes a standard of perfection (Merriam-Webster, 2025) or excellence (Dictionary.com, 2025), a guiding principle, "the best possible" situation, person, thing (Cambridge University Press, 2025), or something that exists only in the imagination as a conceptual model, abstract construct (such as in mathematics) or principle that one strives for.

Ideals may mirror reality rationally or provide abstract frameworks for understanding otherwise incomprehensible phenomena such as space, time, and causality.

In psychoanalysis and depth psychology, an *ideal* is an internalized aspirational image – such as the ego ideal – that serves as a guiding yet often unattainable standard for behavior (Freud, 1914/1957; Kernberg, 1975).

In ethics, value theory, and epistemology, ideals also serve as standards of evaluation, determining what is considered "good" by its alignment with ideals (Hartman, 1967), as well as moral conduct, intellectual goals, and personal growth (Cappelen & Dever, 2024).

Humans tend to idealize people, judgments, and behaviours they believe will better meet their physical and emotional needs. This process guides inner development by activating resources through identification with ideals (Peseschkian, 1987) and stabilizes the self by providing hope during crises or periods of disappointment.

From a developmental and neurobiological perspective, idealization operates through imitation, sensorimotor simulation, and affective memory. Similar to trust – rooted in early bonding and supported by the brain's reward and empathy systems (Feldman, 2012; Maier et al., 2020), ideals emerge from the brain's capacity to evaluate and internalize admired models of significant others. These early emotional experiences form enduring templates for excellence that can later be reactivated, refined, or redefined.

The ventromedial prefrontal cortex (vmPFC), anterior insula, striatum, and ventral tegmental area support emotional regulation, social

valuation, and reward-based learning, and may contribute to the motivational power of ideals (Fouragnan et al., 2013; Haas et al., 2015).

The capacity to idealize and envision better versions of oneself or others fosters progress, supports self-evaluation, provides emotional stability, aids self-soothing and goal adjustment under stress, and strengthens the ability to guide and inspire others.

When ideals become rigid, perfectionistic, or detached from reality, they can lead to shame, chronic dissatisfaction, or narcissistic defenses (Blatt, 1995). The therapeutic task is not to discard ideals, but to integrate them flexibly into a realistic and compassionate self-concept.

In this article, the concept of ideal is defined based on clinically distinctive criteria that correspond to the structural functions outlined in OPD-3:

The ability to differentiate and idealise experiences of optimal needs satisfaction in order to motivate oneself and/or others to reproduce them and to stabilise one's inner world and relationships in case of frustration.

A mature capacity for idealisation requires a well-developed ability to notice (*contact*) and reproduce sequential chains (*time*) of actions (*care*) that reliably (*trust*) lead to need fulfilment (*pleasure*) and sustain a resourceful relationship (*love*).

The instruments of ideal include the abilities of:

- **Moderation:** not sacrificing the variety of life for an ideal.
- **Openness:** finding and idealizing alternative possibilities.
- **Freedom:** letting go of an ideal with gratitude once its lesson is integrated and motivation becomes self-sustaining.

I.2. Reactive Idealization of the self

Reactive idealization of oneself – by self and others – can be described through 3 sub-capacities (aspects).

I.2.A. Sub-capacities of reactive Ideal (Table 1)

- **to internalise, integrate and maintain an ideal image of self**, own abilities, skills and beliefs that is consistent with reality.
- **to use the ideal image of self** to reassure and stabilise oneself and to motivate oneself for development and action to achieve goals

productively, even in the face of conflicts, obstacles, and disappointments.

- **to regulate the ideal image of self** – to de-idealise, optimise and adjust it if/when it appears to be unrealistic and/or ineffective.

Table 1. 3 levels of integration of sub-capacities of reactive Idealization of self*

	HIGH – even under intense pressure, when emotions drive behavior, the person:	MEDIUM – the ability is limited (especially under stress). The person:	LOW – capacity is limited or unavailable (even with external assistance). The person:
Self-Image (ideal, real, integrated) (ST2.3 Self-worth regulation ST5.1 Internalization)	Internalizes and maintains an ideal and realistic image of self, own abilities, values, and self-efficacy. Integrates even contradictory concepts of self.	Devalues success and pleasure, fixated on failures. Introjects are critical, doubtful, and demanding or idealizing. Self-concepts and values are rigid and ambivalent.	Ignores success and pleasure, fixates on failures. Does not notice the contradictory nature of their templated values.
Use of self-image (ST5.2 Use of introjects)	Uses its ideals and introjects for self-soothing and stabilisation, development, and motivation.	A punishing superego accuses and holds one in contempt for even the smallest mistakes.	Unstable and fragmented superego demanding and punishing.
Regulation and optimization of self-image	Integrates real and ideal self-concepts. De-idealizes and adjusts own perceptions of abilities and values that have proven ineffective.	Defends own beliefs even when untenable. Denies mistakes and makes excuses. The collapse of old ideals and the rise of new ones create inner conflict.	Desperately seeks external validation and symbiotic bonds. Perceives others' recognition as false, undeserved, or humiliating, reinforcing vulnerability.
The predominant emotional experience	Dignity, confidence, self-compassion	Self-doubt, anxiety, meaninglessness, or aggressive self-assertion.	Despair, self-deprecation
Coping & defense	Reevaluates and adjusts concepts and narratives to reality.	Avoids contradictions. Seeks validation from others or a demanding superego.	Motivates oneself through immediate opportunities for self-assertion.
EXAMPLES			
Therapist: How do you feel about yourself?	Client: I believe I'm a good person – capable, helpful, and respected. Aware of my weaknesses, I strive to grow.	Client: I doubt myself even when things go well, so I keep striving to earn others' respect.	Client: I'm a loser – everyone sees it. Worthwhile people avoid me or interact out of pity, which is humiliating. So I strive to prove myself and earn their recognition.
Therapist: Can you name your core values? Are there any contradictory ones?	Client: I value health, security, and new experiences. Though not always safe, I often choose calculated risks.	Client: It's important to me to be free and to please everyone. Life's meaning is to serve humanity. A good person has no contradictions.	Client: A real man is always free and meets others' expectations – these are self-evident truths.
Therapist: How do you react when your concepts are questioned?	Client: I reassess outdated ideas and seek ones I can rely on.	Client: My doubts are growing, and I'm angry at myself for it. I make excuses to save face, but inside I'm deeply uneasy.	Client: I always stand by my beliefs – only weak people change their minds. I remain true to myself at all costs and resent myself for doubting.

* Table developed by the author.

I.2.B. How to ask about reactive idealization?

Sub-capacity to internalise, integrate, and maintain an ideal image of self.

- How do you perceive yourself?

- Which abilities strengthen your self-belief?
- What weaknesses support your doubts?

- What are your core values/principles that you came to on your own? Do you adhere to them? How?
- How do you deal with your frustrations/doubts?

Questions for the therapist about countertransference

- Are you confident in your contact with the patient?
- Do you tend to idealize or devalue him/her?
- Are you confused by the patient's concepts/motives?

Sub-capacity to use the ideal image of self

- How do you reassure and motivate yourself?
- What do you dream about?

Questions for the therapist about countertransference

- Do you feel an urge to comfort the patient?
- Do you tend to protect the patient from themselves?

Sub-capacity to regulate the ideal image of self

- How do you react when your beliefs are challenged?
- Do you recognize your mistakes and weaknesses?
- Are you willing to admit you are not perfect?
- Can you give up your ideals if you find more constructive options?

Questions for the therapist about countertransference

- Do you find the patient credible?
- Do you feel the urge to devalue the patient?
- Do you tend to excuse the patient and ignore his/her mistakes and weaknesses?
- Do you feel the urge to argue with the patient?

I.3. Active Idealization of objects and people.

Active idealization of objects and people can be described through 3 sub-capacities (aspects).

I.3.A. Sub-capacities of active Ideal (Table 2)

- **to idealise people, objects, goals, and ideas** that appear useful for meeting vital and mental needs.
- **to use idealised images of people, objects, and goals – believing in their value and effectiveness - to motivate oneself and others to trust, love, learn from, and pursue them.**
- **to optimize the external ideals** by gratefully de-idealizing outdated, disproven, or mastered objects, ideas, and skills, and refocusing on what fosters growth, new

opportunities, and more effective satisfaction of vital and mental needs.

I. 3.B. How to ask about active idealization?

Sub-capacity to idealise people, objects, goals, ideas

- Who/what do you look up to in your life? Why?
- What qualities do you (dis)like in other people?
- What kind of people and ideals (de)motivate you?
- How do you feel about other people/ideals?

Questions for the therapist about countertransference

- Do compliments and praise from patients make you uncomfortable?
- Are you inclined to idealize/devalue someone/something that the patient talks about?
- Are you afraid of disappointing the patient?
- Do you feel superior to your patient?

Sub-capacity to use idealised images of people, objects, and goals

- Do you strive to follow your ideals in everything?
- What values have you adopted from others? From whom? Why? Do you adhere to them? How?
- How do your ideals guide your decisions and help you persevere through difficulties?

Questions for the therapist about countertransference

- Do you feel your efforts don't matter for this patient?
- Do you try to prove therapy's or life's value to them?
- Does the patient seem to give up easily?

Sub-capacity to optimize the external ideals

- Have you ever been disappointed in someone or something you idealized? How did you react to it?
- How do you feel about people/objects/ideas that are idealized by those around you?
- How do you choose your ideals?
- How do you integrate new experiences or information that challenge your previous ideals?

Questions for the therapist about countertransference

- Do you want to challenge the patient's ideals?
- Are you afraid to question what the patient idealizes?
- Are you competing with someone in the patient's story?

Table 2. 3 levels of integration of sub-capacities of active idealization of objects and people*

	HIGH – <i>even under intense pressure, when emotions drive behavior, the person:</i>	MEDIUM – <i>the ability is limited (especially under stress). The person:</i>	LOW – <i>capacity is limited or unavailable (even with external assistance). The person:</i>
Idealization of objects (ST5.1 Internalization)	Selectively idealizes people, objects, and ideas that proved to be useful for meeting vital and mental needs.	Tends to overvalue or devalue people, objects, and ideas in meeting vital and mental needs.	Blindly idealizes or devalues objects and ideas, driven by impulse or others' influence.
Use of external ideals (ST5.2 Use of introjects)	Uses idealized images of people, objects, and goals to inspire self and others to trust, love, learn, and pursue them.	Quickly loses trust and devalues people, objects, and goals, draining motivation, love, learning, and drive.	Blindly follows or devalues idealized people or ideas and imposes these ideals on others.
Optimization of external ideals	Gratefully releases outdated ideals, retaining their lessons, and idealizes new opportunities without devaluing the old.	Clings to or devalues outdated ideals, missing their value and lessons. Rejects or overidealizes the new, losing continuity of growth.	Perceives any doubt in ideals or new ideas as a painful threat to self-worth and defends them fiercely.
The predominant emotions	Confidence, warm appreciation, pragmatic trust, satisfaction	Anxiety, ambivalent admiration and contempt, anger, disgust, insecurity, envy, resentment, hidden longing	Fluctuating excitement, fear, anger, and despair; anxiety, shame, emptiness; zeal, rigidity, and defensiveness,
Coping & defense	Realistic trust: adaptive control balanced by secure supporting introjects, stabilizing self, relationships, and executing long-term will. Humor.	Rigid control, avoidance of doubt. Splitting, projection, devaluation, and idealization.	Excessive control, conformity, avoidance. Splitting, denial, projection, idealization, and reaction formation.
EXAMPLES			
Therapist: Who or what do you tend to idealize?	Client: <i>People who can quickly turn ideas into action and optimize their productivity.</i>	Client: <i>N is my ideal – she turns ideas into action and never disappoints me.</i>	Client: <i>N! She is perfect!</i>
Therapist: How do you use these ideals?	Client: <i>I learn what's valuable from them, noting flaws without losing respect.</i>	Client: <i>I try my best to be like her. Yet, I know that I cannot be as good as she is.</i>	Client: <i>I mimic her in everything. Everyone should do the same.</i>
Therapist: What if your Ideal would lose its relevance?	Client: <i>I'd be grateful for what I gained and move on.</i>	Client: <i>I hope that N will never disappoint me as M did. If she does that, I will never forgive her.</i>	Client: <i>That's a strange question. I don't even like hearing it. That can't happen – if it does, how could I live?</i>

* Table developed by the author

II. Meaning

II.1. Definition

Meaning refers to what a word, concept, sign, object, event, symbol, or act expresses and represents (Cambridge University Press, 2025). Finding meaning involves detecting cause-and-effect relationships between events, objects, and experiences (Sloman & Lagnado, 2015; Oxford University Press, 2025), explaining them, and recognising their emotional and cognitive

significance in meeting survival and mental needs (APA, 2024). This capacity includes learning from the past, interpreting the present, and envisioning possible futures and outcomes, through mental simulations (Hassabis & Maguire, 2009; Suddendorf et al., 2022; Kosslyn & Moulton, 2023).

Meaning can be associative and implied (connotative) or literal (denotative) (APA, 2024). It may express the content, essence, purpose, or rationale of something (Ožegov & Švedova, 2000)

and its connection to human goals and values (Frankl, 1946/1985, Il'ichev, Fedoseev, & Stèpin, 1983). Subjectively constructed meaning of life provides coherence, purpose, and significance, fostering motivation, choice-making, imagination, and resilience (Huo, Kong, & Gao, 2023; Zhang & Chen, 2025; Petrovskij, 2003).

Peseschkian (2016b) suggested that meaning emerges through individual development, shaping one's perception of self, others, and experience. Recent research (Li & Wu, 2025) supports his view that folk stories and metaphors shape meaning-making in culture and therapy.

Following Freud (1915), who viewed the search for meaning as a core psychodynamic motive, modern depth psychology sees dreams, symptoms, and crises as the psyche's attempts to transform instinct into symbolic meaning.

Satisfaction or frustration of vital and mental needs is associated with distinct neural patterns of stress and emotion (Preston & Eichenbaum, 2013), with key contributions from the hippocampus and amygdala (McGaugh, 2004). The Insula integrates interoceptive (bodily) signals with semantic meaning, while the anterior cingulate cortex (ACC) and temporoparietal junction (TPJ) support the simulation process ("gut feeling") that helps anticipate outcomes, infer intentions, and guide adaptive behavior. A sense of meaning can emerge as disconnected experiences are woven into a coherent narrative, a process commonly associated with engagement of the default mode network (DMN), including the medial prefrontal cortex (mPFC) and posterior cingulate cortex (PCC) (Piefke & Fink, 2005).

In psychotherapy, reinterpreting bodily sensations may update implicit meanings and reshape cortical representations, supporting greater coherence and a sense of agency (Andrews-Hanna, Smallwood, & Spreng, 2014; Uddin, 2015).

Here, we define **meaning** as *the capacity to detect and explain cause-and-effect relationships between events, objects, and experiences, understand their relevance to vital and mental needs, and use this knowledge to predict outcomes and create new possibilities.*

A **prerequisite** for developing a mature capacity to comprehend and use meaning is the ability to notice (contact) and reproduce sequences of actions (time, care) that reliably (trust, ideal) lead to need satisfaction (pleasure) and foster a resourceful attitude (love).

The **instruments** of meaning include the ability to recognize and interpret patterns in one's own and others' experiences – real or verbalized – and to use imagination and abstraction to grasp unseen connections and create something new.

The meaning can be *reactive* or *active*.

II.2. Reactive meaning – understanding of self

Reactive meaning – the capacity to understand oneself and be understood by others – can be described through 3 sub-capacities (aspects)

II.2.A. Sub-capacities of reactive meaning (Table 3)

- **to understand self** - to be genuinely interested in one's own mental space, to have a clear sense of it, and to recognize the cause-and-effect links between emotions, impulses, reactions, behaviours, decisions, and judgments and their underlying triggers and unmet needs. This insight can then be used for reasoning, decision-making, and planning.
- **to redefine oneself** - to optimise understanding, planning and productivity by adjusting one's judgements to reality, considering one's own needs and acknowledging the subjectivity and psychodynamic origins of one's concepts and narratives.
- **to use imagination**, designing hypothetical scenarios that expand real-life experience and foster the emergence of new insights about oneself, the world, and possible resolutions to inner conflicts.

II.2.B. How to ask about reactive meaning?

Sub-capacity to understand self

- Can you explain your stress, emotions, and behavior?
- How appropriate is your reaction?
- What concepts/values guide you?
- What usually triggers your strongest reactions?
- Can you link your emotions to decisions or actions?
- How does understanding your emotions help you decide or plan?

Questions for the therapist about countertransference

- Is it easy for you to understand the patient's logic?

- Do the patient's dynamics feel too rigid or too chaotic?
- Do you find yourself feeling curious and engaged, or impatient and bored during sessions?
- Do you experience pressure to explain, rescue, or organize the patient's experiences for them?

Table 3. 3 levels of integration of sub-capacities of reactive meaning*

	HIGH – <i>even under intense pressure, when emotions drive behavior, the person:</i>	MEDIUM – <i>the ability is limited (especially under stress). The person:</i>	LOW – <i>the capacity is little or not available (even with external help). The person:</i>
Self-understanding	Curiously explores how emotions, impulses, and actions stem from underlying needs and triggers. Applies this insight to reasoning, decisions, and planning.	Avoids self-reflection due to anxiety, focusing instead on events and actions. Views emotions and behaviours as natural, inevitable responses to triggers.	Fixated on painful emotions, impulses, and actions; unable to conceptualize one's own real-life experiences.
Self-redefining	Recognizes the subjective, psychodynamic roots of their concepts and narratives and adjusts self-perception, plans, and actions to actual needs and reality.	Considers one's own self-perceptions to be natural and objective; defends them even when untenable and often distorts facts to maintain them.	Affectively and stereotypically asserts own impulses and actions as “natural” and “justified”; ignores contradictions in own reactions and actions.
Usage of imagination	Expands real experience through hypotheses and uses imagination to form new insights about self, world, and ways to resolve inner conflicts.	Clings to facts and anxiously avoids imagination. Relies on familiar stereotypes, unable to envision alternative selves, behaviors, or solutions.	Templated, vague, fragmented, contradictory, threatening, painful, limiting, and uncontrollable fantasies are experienced as a substitute reality.
The predominant emotions	Curiosity, confidence, openness, compassion	Anxiety, insecurity, irritation, defensiveness, boredom, shame	Strong anxiety, fear, anger, helpless despair, emptiness
Coping & defense	Reflection and meaning-making, sublimation, humor, anticipation, integration	Intellectualization, denial, rationalization, reaction formation, projection	Affective discharge (acting out) and reality distortion (denial, projection, splitting...)
EXAMPLES			
Therapist: Can you explain your reactions?	Client: <i>Yes, I get angry every time Masha is late because I feel like she doesn't care about my time and feelings.</i>	Client: <i>What's there to explain? Masha infuriates me with her unacceptable unpunctuality. And she doesn't care.</i>	Client: <i>She deliberately drives me crazy with every second she's late. I just need to see her. Right now!</i>
Therapist: Are you sure you understand the situation accurately?	Client: <i>No, not really – but my mind keeps replaying the old story: in my family, any delay meant betrayal, so my brain imagines Masha choosing her friend over me.</i>	Client: <i>How else can I see it? I've told her countless times that being late shows disrespect. You agree, right? Yet she still chooses her friend over meeting me.</i>	Client: <i>It can't be anything else – it's love! I tell her this and shout it constantly, but she doesn't hear me and even gets offended.</i>
Therapist: Can you imagine an alternative scenario?	Client: <i>That's what I do: when my mind replays old patterns, I picture Masha hurrying despite her slow habits – and when she arrives, I reassure her.</i>	Client: <i>Why fool myself? I don't get why she comes at all if she doesn't care. Yet I still want to spend the evening with her – doomed to suffer</i>	Client: <i>I don't want to think about it. What if one day she... No! It's too painful and scary.</i>

* Table developed by the author

Sub-capacity to redefine oneself

- Where did you learn this belief/reaction?
- Is this belief always true for you/others?
- Have you ever had to change your mind?

Questions for the therapist about countertransference

- Do the patient's explanations feel too contradictory?

- Do the patient's reflections stimulate your thinking, or leave you mentally drained and stuck in cycles?
- Do you sense emotional growth in the sessions, or stagnation and defensive certainty?

Sub-capacity to use imagination

- What fantasies/fears/thoughts support your experiences and beliefs?
- Can you imagine an alternative scenario for this situation?
- Do you tend to embellish your life with fantasy?
- Does imagination help you understand your experiences?
- Does imagination help you cope with your doubts?

Questions for the therapist about countertransference

- Does the patient seem to wind themselves up?
- Do the patient's stories/reflections bore you?
- Do you lose track of the patient's narrative?

II.3. Active Meaning – understanding objects

Active meaning - the capacity to understand external objects and events – can be described through 3 sub-capacities (aspects)

II.3.A. Sub-capacities of active meaning (Table 5)

- **to understand events and people's reactions** through cause-and-effect relationships, natural laws, and motivations, and to explain them.
- **to use discovered meaningful patterns and causality in reasoning and planning** (we tend to confirm our previous inferences, values, and decisions with explanations, ignoring their contradictions).
- **to share others' ideas and fantasies** to extend one's own experience, understanding motives, predict their behaviour, and co-create shared ideas, solutions, and actions.

II.3.B. How to ask about active meaning?

Sub-capacity to understand events and others' reactions

- How do you understand N's reactions, behaviours, ideas, statements?
- What do you think motivates N?
- Do you see cause-and-effect links in this situation?
- How much do you trust your conclusions about external events and others' behavior?

Questions for the therapist about countertransference

- Do you tend to "help the patient understand"?
- Do you understand the patient's explanations regarding the motives and actions of other people?
- Do you find the patient's explanations irrelevant?
- Do you doubt the patient's intelligence when they give inconsistent explanations of others' behavior?

Sub-capacity to use discovered meaningful patterns and causality in reasoning and planning

- How do you react when your expectations aren't met?
- How do you react when you realise you were wrong?
- Do you always insist on your own way?

Questions for the therapist about countertransference

- Do you doubt the patient's motivation or intelligence when they repeat old mistakes despite prior understanding?

Sub-capacity to share others' ideas and fantasies

- What does N say about this?
- Can you accept that N is right, even if it contradicts your ideas? What does this give you?
- Do you understand N's motives, even if you disagree with them? Does this help you predict his (her) reactions?
- Can you agree on common goals with other people / those with whom you have conflicts?

Questions for the therapist about countertransference

- Do you feel relieved or superior when the patient accepts your interpretations, and irritated when they question or reject them?
- Do you feel that the patient understands you?
- Do you tend to impose your ideas on the patient?
- Do you feel drawn to "correct" or "educate" the patient rather than explore their subjective logic and emotional meaning?

Discussion: Therapeutic Interventions by integration level.

Operationalizing *ideal* and *meaning* allows therapists to refine interventions that integrate

these primary capacities, enhancing resilience and adaptive coping with inner and outer challenges.

Here are some suggestions for differentiated interventions to spark therapeutic creativity:

I. Ideas for the development of low-integrated capacities for ideal and meaning

When ideal and meaning are poorly integrated, therapy should focus on containing anxiety and building the structural foundation for internalization and reasoning within the therapeutic relationship. Transference-focused psychodynamic interventions are recommended to address destructive relational patterns rooted in early experiences and to foster more balanced, reciprocal ways of shaping and sharing ideals and meanings.

Table 4. 3 levels of integration of sub-capacities of active meaning*

	HIGH – <i>even under intense pressure, when emotions drive behavior, the person:</i>	MEDIUM – <i>the ability is limited (especially under stress). The person:</i>	LOW – <i>the capacity is little or not available (even with external help). The person:</i>
Understanding events and people's reactions	Explains events, people's reactions, and behaviours through cause-and-effect relationships, natural laws, and motives.	Does not understand the logic of events and other people's behavior or explains them in light of their own needs, experiences, and beliefs.	Perceives any events and other people's actions as an incomprehensible threat and demands an explanation in a painful/aggressive manner;
Usage of discovered meaningful patterns and causality in reasoning and planning	Uses understanding of meaningful patterns in argumentation and planning.	Clings to others' explanations, ignoring contradictions and bending facts to confirm them – or, conversely, doubts them even when well-founded.	Thinks and acts formulaically, guided by socially accepted judgments, unaware of their contradictions.
Sharing other people's ideas and fantasies	Can temporarily share others' ideas to test them, broaden/stimulate own experience; to understand motives, forecast behavior, and co-create shared ideas and actions.	Perceives others' ideas as an attack. Fails to grasp others' inner worlds, motives, or behavior, and cannot co-create shared ideas or solutions.	Aggressively rejects or ignores others' perspectives, experienced as vague existential threats to the self.
The predominant emotions	Curiosity, engagement, confidence, inspiration	Confusion, insecurity, anxiety, fear, shame, hostile wariness	Existential loneliness and fear of ambiguity, helpless confusion, shame, and hostile defensiveness
Coping & defense	Intellectualization, rationalization, empathic identification, anticipation, sublimation	Anxious Craving for explanations of others' actions and events; avoidance of blame	Denial, isolation of affect, rigid moralization, aggressive conviction, projection, reaction formation
EXAMPLES			
Therapist: How do you understand Masha's behaviour?	Client: <i>It seems that she is late because she perceives any agreement about time as a restriction of her freedom.</i>	Client: <i>Every time I ask why she's late, she calls me controlling. In fact, she's trying to control me by doing whatever she wants.</i>	Client: <i>Her lateness is destroying me. She refuses to explain, knowing how much it matters to me – and seems to take pleasure in tormenting me.</i>
Therapist: What do you gain from this understanding?	Client: <i>I used to get angry, convinced she didn't care about my feelings. Now I see both her patterns and my own, and I've stopped making life harder for both of us.</i>	Client: <i>I feel deprived. She does a lot for me, but it seems like manipulation to get what she wants out of me.</i>	Client: <i>She wants to take everything from me without giving anything in return. I need to break up with her.</i>
Therapist: What does Masha say about this?	Client: <i>My first reactions fueled her self-punishment learned from her father. Since I stopped taking it personally, she feels calmer and is rarely late.</i>	Client: <i>She says she gets angry with herself, just like her father, and gets more defensive when criticised. This is manipulation: I feel guilty and stay silent the next time.</i>	Client: <i>She spouts psychological nonsense, twisting everything to blame me. She's driving me crazy – I feel sick and confused. Eventually, I explode.</i>

* Table developed by the author

To maximise the outcome, interventions should be mainly conducted during sessions, with simple and manageable tasks assigned for intersession practice.

I.I. Ideal

I.I.A. Psychodynamic Interventions

- **Encourage the patient to explore experiences, beliefs, and narratives at their own pace.**
- **Provide consistency and continuity:** offer a stable, constructive therapeutic relationship that contains the patient's confusion and impulses without retaliation or withdrawal (Winnicott, 1960), gradually transforming destructive patterns rooted in early failures of idealization.
- **Structure the session:** Use a 5-step framework to help the patient internalize stable, encouraging introjects, fostering anxiety regulation and sustained focus.
- **Manage transference:** observe and address idealization of the therapist, method, or therapeutic relationship, guiding the patient from dependency to differentiation, and acceptance of human fallibility.
- **Mirror dignity:** When the patient turns self-critical, reflect their underlying striving for worth, differentiating dignity from perfectionism.

I.I.B. Body-oriented interventions

- **Notice and name the patient's ideal-related body reactions:** imitations and simulations (voice, posture, facial expressions), tensions, and emotions.
- **Engage the patient in sensorimotor modeling and embodiment of health,** self-soothing, coherence (upright posture, balanced breathing); explore and reinforce associated experiences, forming a stable introject to counteract destructive, threatening, criticising, devaluing, and shaming patterns.

I.I.C. Cognitive interventions

- **Explore the patient's emotional, cognitive, and behavioral reactions associated with different ideals.**
- **Ask the patient to journal** when and how different ideals, beliefs, and introjects influence their thoughts and actions.
- **Ideal vs. experienced:** explore discrepancies between self-expectations and realistic

capacities; identify cognitive distortions ("*I must be perfect,*" "*Failure is fatal*").

- **Inventory of ideals:** trace the origins of demands (from parents, culture, or own experience) and evaluate their former and actual adaptive function.

I.I.D. Behavioral interventions

- **Ask the patient to describe their typical:**
 - **self-destructive, blaming, or degrading inner voices** and their effects;
 - **self-regulating inner voices** and their outcomes.
- **Ask the patient to journal** moments of dignity.
- **Help the patient to build self-trust** by encouraging small, achievable commitments and actions.

I.2. Meaning

I.2.A. Psychodynamic interventions

- **Offer a safe, trusting, validating space and relationships** for patients to explore their thinking, meaning-making, and comprehension.
- **Encourage the patient's cognitive abilities** by naming and linking them to actual experiences, helping them internalize these strengths and build confidence.
- **Slow the session when thinking races or collapses** to observe the process and build tolerance for ambiguity and reduce corrective pressure.
- **Mirror the logic:** Reflect the patient's causal reasoning verbatim, without correction or interpretation.
- **Meaning testing:** Place the patient's explanation side-by-side with an alternative one and ask, "*How does each story affect your body, mood, and choices?*"
- **Use hypotheticals:** ("*What if...*" "*One possible motive is...*") to loosen rigidity and reduce shame.
- **Interpersonal meaning check:** In conflicts, ask the patient: "*What the other person might be aiming for*" and "*How does this change your perspective*".

I.2.B. Body-oriented interventions

- **Note and name the patient's bodily reactions** related to unknown, thinking, and understanding; discuss the experiences, needs, concepts, and behaviours associated with those.
- **Explore with the patient the important others' bodily reactions related to unknown, thinking, and understanding; discuss the**

experiences, needs, concepts, and behaviours associated with those.

- **Encourage the patient to notice somatic reactions** corresponding to different conclusions.
- **Invite the patient to notice their mental pace** and use breathing to restore rhythm before resuming analysis.
- **Have the patient map the cause-and-effect chain ($A \rightarrow B \rightarrow C$)**, touch each point, and track bodily reactions.
- **Somatic plausibility check:** Ask the patient to voice their first explanation while sitting in chair A, then stand, regulate, and sit in chair B to express an alternative. Compare bodily sensations after each to see which feels more workable today.

I.2.C. Cognitive interventions

- **Explore the patient's experience of meaning-making** in childhood and life history.
- **Explore the patient's concepts**, behaviours, and expectations related to meaning and logic.
- **Ask the patient to make a list of people to whose judgments they/trust** the most.
- **Causal map:** Have the patient write their explanation in three columns – Observations → Inferences → Predictions – and reflect on it.
- **Ask the patient to replace absolutes** (“always/never”) with probabilities (“likely/so far”) and note how this changes their sense of certainty when new data appear.

I.2.D. Behavioral interventions

- **Validate the patient's meaning-making abilities** and increase task difficulty as confidence and success grow.
- **Ask the patient to keep a daily meaning log (5 min):** 1) Situation; 2) Explanation; 3) Prediction; 4) Outcome; 5) Update (keep/change/merge meanings).
- **Encourage the patient, during real interactions, to ask one clarifying question about the other's motive** (e.g., “What were you hoping for when...?”) and note how the response influences their next action.
- **Ask the patient to spend 10 minutes weekly reviewing one belief that proved unhelpful** and rewrite it as a provisional hypothesis for the next week.

II. Ideas for developing medium-integrated capacities of ideal and meaning

When the patient demonstrates a moderate level of integration, the therapist can build on these emerging strengths by introducing more challenging cognitive and behavioral interventions that expand insight and reinforce autonomy.

At this stage, therapy should focus on helping individuals differentiate their own and others' introjects, ideals, sense-making patterns, and biases; recognize how these shape their experiences, behaviours, and relationships; and learn to refine and optimize their ideals and cognitions to deal more effectively with inner conflicts and to build healthier, more reciprocal relationship models.

II.1. Ideal

II.1.A. Psychodynamic interventions

- **Navigate the patient's curiosity** with questions to explore:
 - constructive, destructive, and conflicting ideals and their link with introjects or early identification models;
 - ideal and real concepts of self and others;
 - social roles, expectations, and patterns of relationships, associated with ideals;
 - rationalization or denial protecting fragile ideals;
 - coexistence of strengths and weaknesses;
- **Encourage the patient to optimize coping** with challenges related to self-worth, guilt, and shame by shifting from self-criticism to curiosity (“What needs am I trying to protect this way?”).
- **Observe and manage the transference and idealization** of the therapist, method, or therapeutic relationship, gently guiding the patient from differentiation toward mature integration of inner ambivalences into constructive, stable introjects capable of regulating self-worth.

II.1.B. Body-oriented interventions

- **Condition the patient to experiment** with embodying different ideals and roles – alone and with others (e.g., winner/loser, calm/stressed, shame/dignity, judgment/compassion). Compare bodily sensations, emotions, and tone of voice,

noticing which states feel natural versus foreign.

- **Engage the patient in the practice of encoding introject-related bodily states** by meditation on breathing, body scanning, and/or inner time flow.
- **Back to self:** While recalling a demanding ideal (e.g., “*I must be flawless*”), notice areas of muscular tension or breath restriction; then release the tension and restate the ideal in a more grounded, embodied, and sustainable tone.
- **Posture and movement experiment:** Invite the patient to shift from a rigid, tense posture and movement to a relaxed, grounded, and fluid one; then reflect on the changes in felt dignity, realism, control, and spontaneity as bodily analogues of their inner ideals.

II.1.C. Cognitive interventions

- **Use questions to help the patient identify the constructive functions of their ideals** and evaluate whether they are proportionate to the effort required.
- **Explore and integrate symbols, metaphors, and narratives associated with patients’ ideals; analyse the real conditions that limit or support them.**
- **Shape realistic expectations** by verbalising clear criteria for developing the patient’s capacity to manage their ideals.
- **Encourage the client to reframe:**
 - **unmet ideals** as feedback for refinement;
 - **victimising memories** as evidence of coping and agency;
 - **the inner critic (“I fail”)** into a pragmatic ideal (“*What can I learn from this?*”)
- **Grounding ideals:** Ask, “*What evidence shows this standard is attainable or useful now?*”
- **Encourage the client to keep a log of daily contradictions** tolerated successfully to reinforce cognitive flexibility.

II.1.D. Behavioral interventions

- **Engage the patient to experiment** with their ideals and introjects between sessions, collaboratively setting realistic practices and then discussing experiences.
- **Invite the patient to release outdated routines or ideals** with gratitude for their past function and to explore and journal associated experience.
- **De-perfectionalization:**

- Invite the patient to set one realistic task and accomplish it with focus rather than perfection, then evaluate satisfaction vs. exhaustion.
- Encourage balanced routines that alternate high performance with self-care, tracking fluctuations in dignity and motivation.
- **Have the patient seek feedback** from trusted peers, note emotional reactions, and reflect on them in the next session.

II.2. Meaning

II.2.A. Psychodynamic interventions

- **Attribute success in therapy to the patient’s efforts**, referring to it as the reason to trust themselves.
- **Encourage the patient’s trust** in their own abilities and those of others.
- **Explore the patient’s trust in you** as a reflection of early introjected object attachments and relations.
- **Explore insight loops:** Ask “*How did you arrive at that conclusion?*” and trace back to feelings or motives that were ignored.
- **Emphasize the positive function** of excessive striving for explanation as a defence against helplessness.
- **Invite curiosity about both outer and inner causes.**
- **Analyse transference logic:** When the patient assumes your thoughts or motives, explore how this reveals their models of others and meaning-making.
- **Encourage symbolic thinking through metaphors and narratives** rather than literal analysis to integrate conflicting experiences and give them a flexible sense.

II.2.B. Body-oriented interventions

- **Ask the patient to journal their and others’ bodily reactions related to thinking, understanding, and not understanding, along with associated experiences, needs, concepts,** and behaviours. Discuss it.
- **Encourage the patient to experiment** with bodily experiences of meaning-making, anchoring the most constructive ones in corresponding bodily states.
- **Invite the patient to ground before thinking** with slow breathing or bilateral movement to calm arousal, reduce impulsive inferences, and tolerate uncertainty.

- **Gaze orientation:** Encourage the patient to alternate outward and inward focus to link observation with reflection.

II.2.C. Cognitive interventions

- **Use questions to raise the patient's awareness of:**
 - their ability to face the unknown, hypothesize, and test new meanings.
 - their ability to understand others' motivations;
 - their ability to consider both external triggers and inner needs, concepts, perceptions, conflicts, and expectations in reasoning.
- **Explore and integrate the patient's reasoning patterns, symbols, metaphors, and narratives.**
- **Shape realistic expectations** by verbalizing clear criteria for developing the patient's capacity to create and understand meaning.
- **Causal mapping:** Divide a page into four columns – Observation → Inference → Meaning → Action – and ask the patient to fill it for one event to visualize logic and missing links.
- **Ask the patient to spot their own distortion patterns,** and replace over-generalizations (“always,” “never”) or absolutist reasoning (“Everything has a reason”) with probabilistic language (“often,” “sometimes”).
- **Cognitive humility:** After each conclusion, ask the patient to name one or two facts that could disprove it.
- **Encourage the patient to turn insights into “If ... then ...” planning:** “If I notice this feeling, then I will check which need is unmet.”
- **Encourage regular review and revision of personal narratives** to build adaptive flexibility.

II.2.D. Behavioral interventions

Encourage the patient

- to **journal** daily experiences of thinking, meaning-making, and understanding.
- to practice **daily meaning experiments:** identify one situation, its perceived cause, alternative explanations, and the resulting emotion.
- to **find and probe alternative interpretations and solutions.**
- once a day, to **replace an immediate interpretation with a genuine question** about the other's intention.

- to act “as if” an **alternative explanation were true** (e.g., “They were busy, not rejecting”) and observe outcomes.
- to use the phone lock screen as a **debiasing cue before important emails, talks, or calls:** “What else could this mean?” and “What would change my mind?” “What is my purpose here?”

III. Ideas for the development of highly integrated capacities of Ideal and Meaning

At a high level of integration, therapy focuses on refining self-guided values, flexible ideals, and coherent meaning-making through active experimentation and practice. The aim is to cultivate inner grounding, adaptability, curiosity, sustainable dignity, and psychosomatic health, while fostering authentic, inspiring relationships rather than those driven by control or the need for validation.

Therapeutic approaches include:

- **Active engagement in practice:**
 - co-experience cultivating awareness of the subjectivity of values, cognitions, and meanings;
 - foster understanding and negotiation of personal and interpersonal values, ideals, needs, and reasoning patterns to enhance cognitive effectiveness, causal prediction, and overall productivity.

The goal of therapeutic collaboration is to cultivate mature autonomy and existential coherence – a state in which evolving ideals and meanings are internally validated, grounded in experience, and embodied in authentic action. The patient attains dignity without perfectionism, purpose without rigidity, and inspiration without illusion, becoming both the author and the living expression of their own ideals and meanings.

3.1 Ideal & Meaning

Psychodynamic practice & experimentation

- **Facilitate maturation toward autonomy:** Trust the patient's capacities to manage ideals and meanings and support their maturation. Engage them in optimizing introjects and mental processes. Acknowledge progress as preparation for therapeutic completion progresses.

- **Use Questions** to raise the patient's awareness of how their mental space, ideals, and cognitive patterns have evolved from perfectionistic or compensatory drives into flexible, authentic values and mature cognitive activity.
- **Integrate ideal and real self:** Help the patient balance aspiration and limitation, recognizing that dignity and creativity include imperfection and doubt.
- **Use symbols, dreams, metaphors to integrate unconscious meanings and ideals** into conscious, coherent narratives.
- **Use the therapeutic transference relationship as a model** to help the patient internalize a constructive pattern of mutually respectful relationships – neither idealized nor devalued.

Bodily practice & experimentation

- **Encourage the patient to experiment with body states,** emotions, moves, and gestures to explore how these influence self-image and cognitive effectiveness.
- **Help the patient embody new ideals and introjects** – for example, using balanced posture and measured breathing to foster openness, authenticity, and dignity grounded in relaxed presence.

Cognitive practice & experimentation

- **Use autogenic training** to “program” resourceful introjects and narratives, empowering flexible and constructive use of ideals and meaning-making.
- **Ask the patient to develop a convincing positive interpretation** of the symptoms, reactions, and behaviours as a capacity to regulate inner conflicts and discover new meanings.
- **Guide the patient in vivid “as if...” mental experimenters** and encourage reflection to foster vision, imagination, and cognition.

Encourage the patient

- **to broaden their range of strategies** for managing personal and interpersonal ideals and meanings.
- **to develop meta-cognition** – observing how they construct meaning and fostering conscious authorship of their narratives.

- **to clarify and update values** to align with their current identity and purpose.
- **to reflect on what sustains their dignity when things change.**
- **to translate their insights into concrete actions** aligned with their beliefs and understanding.

Behavioral practice & experimentation

- **Encourage active practice and refinement of ideal- and meaning-related behaviours** while helping the patient manage the discomfort that arises.
- **Assign real-life tasks** that challenge the patient, reassess and integrate their ideals, and optimise patterns of comprehension.

Conclusion

Exploring the primary needs/capacities of *ideal* and *meaning* reveals the psychodynamics underlying unique personal experiences.

A nuanced understanding of the integration levels enables the therapist to design tailored interventions that foster lasting transformation – extending beyond behaviour change and symptom relief towards deeper structural growth.

The detailed operationalisation of *ideal* and *meaning*, enriched with illustrative dialogues, enables a comprehensive, differentiated psychosocio-biological diagnosis, supports precise clinical reasoning, and guides tailored treatment planning, intervention design, self-help facilitation, and further research.

Practical ideas for psychodynamic, body-oriented, cognitive, and behavioural interventions are offered to inspire further therapeutic creativity and experimentation.

While promising, this model requires further research to solidify its empirical foundation and demonstrate its practical efficiency. Its potential to transform therapeutic practice and foster personal growth is clinically plausible. Although it has shown usefulness in various clinical settings, systematic validation across diverse populations and exploration of its broader therapeutic applications remain essential for its future development.

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Section: Theoretical reviews and research in Positive Psychotherapy (PPT)

Positive and Transcultural Psychotherapy as an Integrative Approach



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Abstract

This article presents theoretical considerations on integrative psychotherapy and the integration of Positive and Transcultural Psychotherapy (PPT) within the integrative approach, and describes the specific features of the PPT approach. The general principles of the integrative approach are presented, such as a) positive expectation; b) therapeutic alliance; c) awareness deepening; d) corrective experiences; e) reality testing. It also depicts the main characteristics of integrative psychotherapy, which consist of common therapeutic factors and an individualised approach to the patient. In addition, the main models of integrative psychotherapy were presented, which include: a) eclecticism, b) an approach based on common therapeutic factors, c) theoretical integration, and d) assimilative integration. Finally, the relationships between PPT and the main integrative schools were analysed, and a list of theoretical constructs common to PPT and other schools of psychotherapy, as well as constructs characteristic of PPT alone, was compiled.

The author attempts to characterise PPT as a method with its own unique identity, which consists of: a) theory of actual capabilities and microtraumas, b) theory of psychodynamic conflicts, c) structural models of the therapeutic process and relationship and individual personality, d) strategic therapy planning, and e) cultural sensitivity. The author also emphasises that PPT demonstrates flexibility in assimilating selected theoretical concepts and practical tools within its own metamodel.

Keywords: Positive Psychotherapy, integration in psychotherapy, integrative psychotherapy, models of integration in psychotherapy, assimilative integration

Introduction

Positive and Transcultural Psychotherapy (PPT) is an integrative approach recognized as a humanistic-psychodynamic method with a transcultural perspective (Peseschkian & Remmers, 2025; Česko & Tansel, 2025). Elements of the cognitive-behavioral and strategic schools are also visible within it.

What characterizes the phenomenon of integration in the main schools of psychotherapy is the search for what is shared in terms of effectiveness, usefulness, and sensitivity to the

patient's needs. Integration should therefore be accompanied by respect for the achievements and knowledge of other approaches and modalities, as well as recognition of their contributions to the universal development of contemporary psychotherapy.

These initial assumptions are consistent with the humanistic postulates of Nossrat Peseschkian – the founder of PPT – which may be paraphrased as: *Let us seek what is common to us, respect differences, and try to understand them.* The universal language introduced into

psychotherapy by Peseschkian became actual capabilities, which describe:

- a. attachment and interpersonal relationships (basic capabilities: contact, acceptance, empathy, love, etc.)
- b. social norms and related values (secondary capabilities: punctuality, politeness, thriftiness, diligence, etc.)

A closer look at Peseschkian's legacy indicates that the following guiding principles shaped his theoretical and practical contributions:

- a. egalitarianism, instead of elitism;
- b. pluralism, instead of uniformity;
- c. democracy, instead of absolutism;
- d. pragmatism, instead of dogmatism;
- e. inclusion and assimilation, instead of exclusion and isolation.

Norcross and Newman (1992) argue that integrative psychotherapy is defined by dissatisfaction with the overly narrow perspective of the school with which one identifies and by a desire to move beyond its boundaries to broaden this perspective and draw on knowledge and experience from other recognized approaches. The positive effect of such action is an increase in one's own effectiveness, agency, and flexibility.

Explanations of integrative tendencies in psychotherapy may be very diverse. Among them are listed:

- a. the availability of many equivalent psychotherapeutic approaches;
- b. the comparable effectiveness of different treatment models;
- c. the lack of a single approach with universal application;
- d. socio-political and economic considerations.

Integration acknowledges that a single chosen model of psychotherapy is imperfect, while respecting the contributions that other approaches, through personal professional experience, can bring. Álvarez *et al.* (2016) argue that the integration of psychotherapy invites us into a creative dialogue, the discovery of new phenomena, and personal involvement in continuous development, thereby advancing the evolution of psychotherapy. According to the authors cited, integration entails the collaboration of representatives of different therapeutic approaches, thereby achieving coherence and complementarity at the conceptual, clinical, and empirical levels.

Discussion

2.1. Effectiveness of integrative psychotherapy

The community of psychotherapists and researchers has reached consensus that no single psychotherapeutic approach is sufficiently effective or appropriate for all patients, clinical problems, or the socio-cultural contexts associated with them. Each existing model of treatment and psychotherapeutic approach has its imperfections and limitations.

Evidence-based research has shown that therapeutic systems of an integrative nature, such as interpersonal psychotherapy, schema therapy, or cognitive-analytic therapy, are effective in the case of numerous mental disorders, such as: depression, social phobia, generalized anxiety disorder, personality disorders, dissociative identity disorder, etc. (Reay *et al.*, 2003; Hamidpour *et al.*, 2011; Stangier *et al.*, 2011; Masley *et al.*, 2012; Roediger, Dieckmann, 2012); Clarke *et al.*, 2013; Grawe, 2004; Grawe, 1997).

Analogously, this is also the case for PPT, which has likewise been studied for effectiveness in relation to a heterogeneous group of patients (Tritt *et al.*, 1997).

The American Psychological Association (2006) defines evidence-based practice as: *the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences*. Evidence-based practice emphasizes the results of randomized controlled trials to document the effectiveness of treatments for patient groups compared with untreated control groups and with other treatment methods.

From these assumptions, it follows that patients have the right to:

- a. treatment with a method whose effectiveness has been previously demonstrated;
- b. consultation with a specialist in choosing the appropriate treatment method.

In practice, these assumptions mean that the contemporary psychotherapist is obliged to:

- a. integrate knowledge and experience developed in various approaches;
- b. apply methods with proven effectiveness;
- c. skillfully adapt these methods to the individual needs of the patient and his or her life context.

2.2. Characteristic features of integrative psychotherapy

Authors of various publications mention two main aspects that characterize integrative psychotherapy (Norcross et al., 1992; Norcross & Goldfried, 2005). These are common therapeutic factors and an individualized approach to the patient. They will now be discussed in turn.

A. COMMON THERAPEUTIC FACTORS

At the basis of the integration of psychotherapy lie research findings indicating that, regardless of the theoretical concepts across different approaches and schools, treatment effectiveness is comparable (Castonguay et al., 2015; Barth et al., 2013). What justifies the integration of diverse models of psychotherapy is the data showing that factors common to various psychotherapeutic approaches (e.g., therapeutic alliance, therapist's personality, patient motivation, etc.) account far more for treatment outcomes than the specific actions attributed to a given approach, such as interpretations in dynamic therapies or cognitive restructuring in cognitive-behavioral therapies. Well-documented studies show that specific therapeutic techniques account for only 7% of psychotherapy outcomes, whereas common factors account for nearly 20% (Wampold & Imel, 2015).

Among the common factors that, according to researchers, define the development of contemporary integrative models, one may list the therapist's ability to:

- instill hope and positive expectations for change;
- create an alternative and realistic perspective on self and the world;
- provide corrective emotional experiences;
- build the therapeutic Alliance (Lambert & Bergin, 1992).

B. INDIVIDUALIZED APPROACH TO THE PATIENT

Contemporary models of integrative psychotherapy aim to adapt diverse therapeutic interventions to the individual needs of the patient, with particular attention to their affective, behavioral, cognitive, and physiological functioning, as well as to spiritual beliefs. In this way, the integrative psychotherapist demonstrates sensitivity to

each patient's unique problems and characteristics, drawing on a repertoire of techniques derived from evidence-based approaches.

As is well known, all these postulates are reflected in PPT. Its founder emphasizes the importance of appropriately adjusting a therapist's interventions and activities to the four simultaneously occurring dynamic levels of a patient's functioning.

Which include:

- a. the body and physiological processes;
- b. the mind and cognitive functions;
- c. behavior and social relations;
- d. the spiritual and worldview sphere.

Beyond identifying the specific characteristics of a given patient, the positive therapist also attends to the patient's unique national, ethnic, religious, and cultural background. Moreover, Peseschkian reminds us that every patient has preferred ways of acquiring knowledge and processing information, and the therapist's task is to identify and utilize them. These include:

- a. the body and senses;
- b. the rational mind;
- c. tradition and cultural transmission;
- d. imagination and intuition.

Alliance in the psychotherapeutic relationship in PPT is expressed in both the educational-informative dimension and the co-creation of therapeutic goals with the patient, as well as in the joint monitoring of their implementation.

2.3. Principles of the integrative approach

German researcher Grawe (2004) made an immense contribution to an empirically grounded, integrative model of change mechanisms; however, Goldfried (2012) identified five principles common to all psychotherapeutic orientations that, in his view, determine the outcomes of psychological treatment. These include:

- a. arousing the patient's hope and positive expectations and motivation for change;
- b. building the therapeutic alliance;
- c. deepening the patient's awareness and insight;
- d. creating corrective experiences;
- e. continuous reality testing.

A. HOPE, POSITIVE EXPECTATIONS, MOTIVATION FOR CHANGE

Research on patients' expectations regarding the potential benefits of therapy indicates a significant relationship with positive treatment outcomes (Constantino, 2018). On the other hand, it appears that unmet patient expectations are linked to premature termination of therapy.

Representatives of all psychotherapeutic approaches agree that an important prognostic factor in treatment is the patient's hope for improving the quality of their life and changing their fate.

The topic of motivation for change has become the main criterion for assessing progress in therapy in the transtheoretical integrative model of Prochaska and DiClemente (1992). Related research has shown that patients who are least motivated for therapeutic work in the earliest phase of treatment – the precontemplation stage – have the lowest chances of positive treatment outcomes (Krebs et al., 2018). Their awareness of their own problems is limited, and they show considerably less activity in initiating and maintaining change.

In PPT, the patient's hope and readiness to engage in the therapeutic process are among the key aspects of the first phase of treatment – observation and distancing. The context of referral or self-referral to consultation, as well as potential sources of resistance to change, are gradually assessed. Positive therapists often use nondirective communication methods. In this way, they seek to engage in a "creative dialogue" with resistance and introduce elements of unexpected positive change. Another method is to identify hidden sources of motivation for change within the patient and systemic resources in his or her closest family environment.

B. BUILDING THE THERAPEUTIC ALLIANCE

The therapeutic alliance is one of the strongest prognostic factors for successful therapy (Flückiger et al., 2018). A strong alliance between therapist and patient includes three essential aspects:

- a. jointly establishing therapeutic goals;
- b. collaborating in their realization;
- c. a positive mutual emotional bond.

Researchers have identified clear correlations between disruptions in the therapeutic alliance and poorer therapy outcomes, and, conversely, between a strong alliance and better outcomes

(Samstag et al., 1998). Factors fostering a strong therapeutic bond include:

- a. showing empathy and respect;
- b. acceptance;
- c. reflecting the patient's experiences.

A good way to develop a strong alliance is to define realistic goals with the patient, identify hidden or conflicting motives on the patient's side, and jointly monitor progress toward their realization.

In integrative approaches, important issues appear to be the weakening of the psychotherapeutic alliance and the threat of its breakdown. This phenomenon is most often indicated by the patient's overly confrontational attitude (overt anger, dissatisfaction, provocative behaviour) or by withdrawal (lack of involvement, emotional distance, seemingly cooperative behaviour). Threats to the therapeutic alliance (alliance ruptures) are important clinical signals that require recognition. They typically indicate the emergence and recurrence of attachment patterns, strong transference phenomena, and unconscious relational expectations within the patient-therapist dyad. Alliance ruptures usually require re-evaluation of previously agreed-upon goals and tasks in therapy and may provide valuable corrective emotional experiences that ultimately reinforce the therapeutic alliance. Research findings indicate that therapist competencies such as empathy, secure attachment style, and the ability to work with countertransference are crucial for accurately recognising breakdowns in the therapeutic alliance and effectively repairing them (Talbot et al., 2019).

In PPT, in the interest of good communication in the therapist-patient relationship, basic principles of cooperation are established, which include, among others:

- a. setting realistic goals;
- b. assessing gains and losses resulting from therapy;
- c. defining the patient's psychological resources necessary to carry out changes;
- d. monitoring changes;
- e. evaluating the strength of the alliance.

Furthermore, PPT has developed two structural models that serve to strengthen and monitor the therapeutic alliance (the three stages of interaction and the five stages of the process) (Peseschkian, 1987).

The three stages of interaction (attachment, differentiation, detachment) provide a framework for assessing the dynamics and quality of the therapeutic relationship. Analyzing each of the three stages enables the therapist to precisely identify the patient's needs and evaluate the degree of therapeutic attunement. Any discrepancies in this regard require detailed analysis and active intervention by the therapist. The goal is to adapt one's relational style to the patient's needs.

The five stages of the process (observation/distancing, inventory, situational encouragement, verbalization, and goal expansion) constitute a framework that enables both the patient and the therapist to progress safely through treatment. Each of these stages serves as an indicator of the direction and scope of changes at a given moment in therapy. Regarding patient motivation, stage three warrants attention, in which the therapist provides positive feedback, particularly regarding the patient's resources and hidden abilities and skills.

C. DEEPENING THE PATIENT'S AWARENESS AND INSIGHT

Regardless of the therapeutic approach, expanding and deepening the patient's awareness is a key process associated with effective treatment. Depending on the school and its theoretical assumptions, insight is strengthened earlier or later and achieved through various therapeutic techniques. Goals related to patient insight are realized in different ways depending on the approach.

EXAMPLES

1. In CBT, patients are tasked with carefully recording their thoughts and interpretations, and later, with increasing awareness, discovering the connections between their own thoughts, emotions, and behaviors.
2. In humanistic-experimental approaches, such as Gestalt therapy, the empty-chair technique is successfully applied. As a result, the patient may identify with a distinct ego state and become more aware of hidden feelings, unmet needs, and barriers to their full expression.
3. Analytic and psychodynamic therapies undoubtedly belong to insight-oriented currents. Techniques such as

clarification, confrontation, and interpretation are used to identify unconscious conflict patterns underlying patients' difficulties.

4. Systemic approaches associated with family therapy aim to raise awareness among family members of the strength and importance of transgenerational transmissions, as well as the impact of hidden relational patterns and family transactions on emerging dysfunctions and disorders.

In PPT, the process of expanding awareness concerns:

- a. psychodynamics;
- b. sociodynamics;
- c. socio-cultural context.

Psychodynamics and related insights concern unresolved inner conflicts and include the discovery of their genesis, content, and dynamics, as well as their connections with symptoms and disorders. In the therapist's presence, the patient explores the nature of the actual, basic, and key conflict to ultimately discover what the inner conflict means for them and what its message is. Another equally important aspect of awareness expansion in PPT is the identification of hidden resources and abilities. These constitute an inseparable element of the patient's active engagement in health-promoting change and regaining influence over their own life.

Sociodynamics refers to interpersonal interactions and associated unconscious transactions within the family and social environment. These determine the dynamics and hierarchies of power, alliances and coalitions, rules of loyalty, principles of communication, and related factors. Positive psychotherapists uphold the principle that it is in the interests of both individuals and the entire family system to deepen awareness of how earlier transgenerational traditions, invisible loyalties, and obligations shape one's choices regarding the present and the future.

The socio-cultural context concerns the influence of culture on individuals' personal values, beliefs, opinions, judgments, choices, and behavioral norms. Worldviews, traditions, and collective customs shape the way an individual perceives and experiences the world. They also affect their stereotypes, thought patterns, sympathies and antipathies, and overt and covert discriminatory attitudes. Such

internalized cultural values may constitute a source of conflict and psychological trauma.

In PPT, the discovery of dependencies at the level of intrapsychic, interpersonal, and social conflicts is achieved through differential analysis. It serves to recognize both the active and latent capabilities within the individual's unconscious field, as well as to identify their personal and relational meanings.

D. CREATING CORRECTIVE EXPERIENCES

The concept of the corrective experience was permanently introduced into the psychological vocabulary through the discoveries and publications of Alexander and French (1946). They identified specific transference phenomena within the therapeutic relationship that explained patients' ingrained habits, reactions, and modes of functioning. Their analysis revealed that patients unconsciously assumed that the therapeutic relationship would replicate their relational patterns from childhood, and that the therapist would reflect the typical attitudes of significant past figures.

A corrective experience may also be understood as the risk of trying something new by confronting one's ingrained assumptions and beliefs. Such situations usually occur in therapy sessions but may also arise spontaneously between sessions or while performing experiments suggested by the therapist.

Ecker, Hulley and Toomey (2008; 2012), the creators of coherence therapy, equate corrective experience with experiential transformation. These authors discuss the mechanisms of brain neuroplasticity and the phenomenon of memory reconsolidation.

PPT also appreciates the significance of corrective experiences in the process of lasting psychological change. The main assumptions of this approach are that internal conflicts arise because earlier adapted models of functioning (basic conflicts) ceased to fulfill their adaptive function (current conflicts) (Peseschkian, 1987; Goncharov, 2015). Thus, after identifying them, the therapist's task is to create therapeutic experiences that generate new, contradictory knowledge relative to previously dysfunctional generalized patterns of thinking, reacting, and behaving. The aforementioned experiential transformation most often results from constructive relational experiences, nondirective communication, appropriately specific techniques, and behavioral experiments.

E. CONTINUOUS REALITY TESTING

Among most therapists, there is consensus that reality is subjective and that the purpose of psychotherapy is not to objectify it but rather to identify its pragmatic aspects. This usually means that the patient's task is to relativize excessively rigid and generalized descriptions of reality, thereby making their behaviors and coping strategies more flexible. In therapy, the patient acquires conscious competencies, as evidenced by adaptive functioning, which is assumed to undergo constant reality testing.

Through repeated corrective experiences, the patient's new knowledge and skills consolidate and provide an alternative frame of reference in problem situations. Before this occurs, however, patients remain in a trial-and-error phase. It is precisely then that the negotiation of descriptions of various events and their interpretation with the therapist takes place, constituting an important source of information exchange and knowledge expansion. In this way, patients' expectations regarding selected life situations become more appropriate, and their reactions and experiences are better adjusted. Thus, their image of surrounding reality and their self-esteem become more stable and predictable (Norcross & Newman, 1992).

In PPT, reality testing is explored in varying scopes at successive stages of the therapeutic process. The second stage – inventory – serves to identify the patient's coping strategies, which are adaptive and fulfill specific functions. One of its goals is also to identify hidden resources and abilities that previously constituted unconscious competencies. The third stage – situational encouragement – involves identifying and defining the patient's strengths and linking them to the assumed therapeutic goals. The fourth stage – verbalization – activates unconscious resources to consolidate adaptive behaviors while simultaneously testing new skills and abilities. However, essentially in the final stage – expansion of goals – the therapist and patient maintain a future-oriented perspective. It is then that they imaginatively test possible scenarios of future events.

2.4. Models of Integrative Psychotherapy

J. Norcross and C. Newman (1992) summarized the integrative movement by identifying eight variables that define its main tendencies. These include:

- a. dialogue and cooperation instead of division and competition;
 - b. lack of a universal model of therapy whose effectiveness surpasses others;
 - c. lack of a single theory fully explaining the complexity of psychopathology, personality, and behavioral change;
 - d. growth in availability and usefulness of short-term psychotherapies;
 - e. improved communication between researchers and clinicians and their increased willingness to cooperate;
 - f. limitations of socioeconomic resources allocated for financing long-term therapies;
 - g. evidence for the existence of common healing factors independent of the theoretical assumptions of a given school;
 - h. development of professional organizations and networks, conferences, and journals devoted to research on psychotherapy integration.
- J. Norcross lists four main models of integration in psychotherapy:
- a. technical eclecticism;
 - b. common factors;
 - c. theoretical integration;
 - d. assimilative integration.

Each of these models will now be briefly described to define the place of PPT among them.

A. ECLECTICISM

The difference between eclecticism and psychotherapy integration lies in the fact that, in the former, therapists do not seek theoretical grounds to explain or justify the purpose of applying a given technique. Instead, they are guided by pragmatism and select specific tools for their proven effectiveness. In contrast, integrative therapists attempt to investigate how and why the patient changes.

A second difference concerns the fact that eclectic therapists do not adhere to a common set of guiding theoretical and practical principles that would constitute a unified explanatory concept. To illustrate the difference between eclecticism and integration, Davis's (1983) culinary metaphor may be used: „The eclectic therapist chooses one preferred dish from among many, while the integrative therapist selects various ingredients to compose the one appropriate dish”.

B. APPROACH BASED ON COMMON THERAPEUTIC FACTORS

This line of inquiry stems from the assumption that finding similarities is more important in explaining psychotherapy outcomes than identifying specific differentiating factors. Two definitions are worth citing here:

Definition. Technical eclecticism may be described as a way of thinking that goes beyond the rigid framework of a single paradigm or narrow set of assumptions and seeks to draw on multiple theories to achieve the intended therapeutic effect.

Definition. An approach based on common therapeutic factors aims to identify the main universal components of effective psychotherapy (nonspecific factors), irrespective of the diverse theoretical concepts across schools.

Among the common factors determining effective treatment are:

- a. the therapeutic alliance;
- b. exposing the patient to earlier difficulties, whether in imagination or in reality;
- c. corrective emotional experiences;
- d. positive expectations about the final therapy outcomes;
- e. specific therapist qualities such as mindfulness, unconditional acceptance, empathy, and respect;
- f. constructive explanations from the therapist regarding the causes of the patient's difficulties.

C. THEORETICAL INTEGRATION

An example of such a model is the combination of psychodynamic therapy with behavioral therapy (Wachtel, 1977) or cognitive therapy with analytic therapy (Ryle, 2014). Theoretically integrative approaches open new perspectives for understanding psychopathology, personality functioning, and psychological change, both on the theoretical and practical levels.

D. ASSIMILATIVE INTEGRATION

Examples of such assimilative models include:

- a) the psychodynamic assimilative approach (Stricker & Gold, 2005);
- b) the cognitive-behavioral assimilative approach (Castonguay et al., 2004);

c) the interpersonal–cognitive assimilative approach (Safran, 1990).

In the approach described here, integration occurs primarily at the level of practice rather than theory.

Finally, it is worth mentioning another researcher, Petzold (2001), who described an integrative model of therapy that emphasises the importance of multimodality, embodiment, social-cultural context, and relationality.

Belonging of PPT to the integrative approach

If one attempts to define the belonging of Positive and Transcultural Psychotherapy (PPT) to one of the four presented models, the task does not seem easy. This difficulty arises from the fact that the descriptions of each model are not unambiguous, and the differences among them blur across multiple levels. For example, some authors place the cognitive-behavioral school among theoretical integrative approaches, whereas others place it among assimilative integrations.

Two further definitions may be useful here:

Definition. Theoretical integration is the process of combining independent theoretical concepts, typically derived from two distinct approaches, into a coherent system, and of synthesizing selected therapeutic techniques into a whole.

Definition. Assimilative integration consists of identifying with one chosen therapeutic system, while simultaneously being open to selectively incorporating (assimilating) concepts and good practices derived from other schools of psychotherapy.

Similarly, to CBT, this is also the case with PPT. It combines two main theories - the humanistic and the psychodynamic (Remmers, 2021; Erylmaz, 2025). The first assumes that humans are born with basic capacities such as the ability to love and the ability to know. How these basic capacities develop depends on three interactive factors: a) neurodevelopment; b) the socio-cultural environment; c) time. As a result of the interaction of these factors, an adult person represents an individualised set of capabilities (some of which are active, and

others remain latent). In turn, the psychodynamic theory of PPT posits that the causes of human suffering and illness lie in unconscious internal conflicts, and that their recognition and processing serve integration and personal development.

Following the line of thought discussed here, initially, one might say that PPT represents the system referred to as theoretical integration (Henrichs & Hum, 2025). However, upon closer examination, it becomes evident that the treatment method PPT also assimilates diverse and useful concepts and therapeutic tools, incorporating them into its mainstream. Considering this new information, one may therefore hypothesize that PPT is more representative of assimilative integration. But is that really the case? Even closer examination shows that, beyond synthesizing psychodynamic and humanistic–experimental theories, this approach has developed its own specific language for describing and understanding phenomena such as psychopathology, personality, and the mechanisms of psychological change. As far as psychopathology is concerned, the explanations closest to PPT involve specific interactions between neurodevelopmental predispositions and the psychodynamics of the individual and their socio-cultural environment. Personality, in turn, is described here in a more process-oriented, dynamic manner rather than in a structural one. Peseschkian (2016) developed his own typology of personality, based on how the individual's development unfolded with respect to active and latent capabilities. Mechanisms of psychological change in PPT can be explained by experiential transformation and memory reconsolidation.

In sum, Positive and Transcultural Psychotherapy integrates various theoretical constructs from multiple approaches while employing its own unifying descriptive language. It is therefore worthwhile to seek analogies to the main psychotherapy approaches and to highlight the elements specific to PPT (Table 1).

Table 1. Positive and Transcultural Psychotherapy as an Integrative Approach

<i>PPT</i>	<i>Shared constructs with PPT</i>	<i>Specific constructs for PPT</i>
<i>Psychodynamic approach</i>	• Importance of early development in shaping personality and dysfunctions of mental disorders; • Role of psychological conflicts in symptom development; • Analysis of transference phenomena in psychotherapy; • Importance of insight and corrective experiences; • Attachment theory.	• Microtrauma theory by Peseschkian; • Dimensions of modeling; • Theory of psychodynamic conflicts (Peseschkian); • Differential analysis (discovering conflict content); • Structural model of countertransference; • Intuitive insights through nondirective communication; • Description of attachment relations through basic capabilities.
<i>Humanistic–experimental approach</i>	• Concept of developmental potential, self-actualization, and blockages on their path; • Hierarchy of values and their evolution; • Influence of social systems on the emergence of dysfunctions and disorders in the individual; • Role of the therapeutic relationship and alliance in promoting and moderating psychological change.	• Balance Model of Life; • Concept of immanent capacities and basic and secondary capabilities; • Differential analysis of active and latent capabilities; • Importance of secondary capabilities as standards of behaviour and social values; • Description of the therapeutic relationship through the three stages of interaction; • Transcultural concept of the human being.
<i>Cognitive-behavioral approach</i>	• Learning theory and modeling processes; • Theory of positive and negative reinforcement; • Cognitive schemas and their role in the emergence of dysfunctions and disorders; • Restructuring of beliefs and change of cognitive schemas; • Behavioral experiments.	• Four dimensions of modeling; • Basic capabilities and the modeling process; • Secondary capabilities and social learning; • Differential analysis of capabilities and emotional schemas; • Use of experiments for experiential transformation.
<i>Structural approach</i>	• Goal orientation; • Focus on the symptom; • Involvement of family members in the treatment process; • Promoting changes in the family system; • Recognition and elimination of interactions maintaining the symptom; • Short-term nature of treatment.	• Significance and function of the symptom; • Structure of relationships (three stages of interaction); • Structure of the process (five stages of the process); • Inclusion of the family–social context; • Defining and monitoring therapy goals and ways of achieving them; • Development of self-help strategies.

Conclusion

The contemporary understanding of integration phenomena in psychotherapy is undoubtedly complex and multifaceted. It seems that tendencies toward integration have quite diverse sources. Among the most important at this moment are evidence-based clinical research findings, which underscore the role of nonspecific factors in achieving positive therapeutic outcomes, as well as social, economic, and political transformations that promote shorter yet more effective therapies.

Contemporary psychotherapists face the challenge of assimilating and synthesizing theoretical and practical knowledge from the major approaches to psychotherapy, and adapting it to the individual patient's needs and cultural and social context. It may be assumed that PPT is, to a large extent, a response to this important question, and the developmental directions it sets for psychotherapy may prove to be useful signposts for a wide range of professionals.

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*Section: Theoretical reviews and research in Positive Psychotherapy (PPT)***Elderly Well-being in the Framework of Balance and Relational Dimensions****Marzanna Farnicka**PhD in Psychology, University of Warsaw,
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DOI: [10.52982/lkj298](https://doi.org/10.52982/lkj298)**Abstract**

The article presents a multidimensional approach to the well-being of older adults, grounded in the Balance Model and the Relational Dimensions derived from Transcultural Positive Psychotherapy (PPT). At the outset, the World Health Organization's (WHO) conceptualization of well-being is introduced as a theoretical foundation. Well-being in late adulthood is conceptualized as a dynamic interaction among physical, psychological, social, and environmental factors that collectively shape quality of life and the trajectory of aging. Within this framework, the paper advances an integrative model of well-being informed by PPT principles, offering a novel lens for analyzing developmental changes and for designing interventions for older adults, their families, and caregivers. The proposed approach enables a more precise identification of factors that either promote or threaten well-being in later life. Drawing on a comprehensive review of the literature, the article emphasizes the need for interdisciplinary collaboration and a care system grounded in dignity, positive representations of aging, and active social participation. It also introduces the 4A Model (Activity, Acceptance, Autonomy, and Activation), which provides a comprehensive framework for diagnosing and supporting older adults in sustaining psychological balance and a sense of meaning in life. The model is derived from PPT and supports a culturally sensitive, person-centered understanding of well-being applicable across diverse contexts. By applying the Positum Model, the Balance Model, and the Relational Dimensions, it is possible to integrate the emotional, cognitive, and social aspects of adaptation in late adulthood. Aging is thus presented not as a process of decline but as a life stage characterized by potential, relationships, and opportunities for personal growth.

Keywords: ageing, interdisciplinary care, elderly care, engagement, transcultural psychotherapy, Positive Psychotherapy

Introduction

The demographic process of population aging is one of the key socio-political challenges facing contemporary Europe. The aging of societies across the continent is a widespread phenomenon affecting almost all European countries. Data from Eurostat and the European Commission indicate that, as of January 1, 2024, the share of the population aged 65 and over in the European Union was 21.6% of the total population (Eurostat, 2025). This means that

more than one-fifth of the EU population is aged 65 or older.

The health condition and well-being of older adults are not solely the result of individual choices. Their formation also depends on systemic factors – including health policy, the availability of care services, housing policy, transportation systems, and the labor market – as well as on initiatives aimed at social integration and the prevention of exclusion.

The purpose of this paper is to present the significance of the multidimensional concept of

well-being among older adults and to identify factors that may either support or threaten its maintenance. To this end, a literature review was conducted. Furthermore, the article introduces an original model, based on Transcultural Positive Psychotherapy, for studying changes and interventions among elderly clients, their families, and caregivers, within the Balance Model and Relational Dimensions framework.

This proposal stems from the need to better understand adaptive processes in aging, as well as to integrate various dimensions of well-being – physical, psychological, social, and existential – in planning care and support for older adults. The model, based on the Transcultural Positive Psychotherapy (PPT) approach, may serve as a tool for designing effective interventions and developing care systems to maintain balance and quality of life among older adults.

Methodology

2.1. Aging and Its Stages in Later Life

The process of aging is a complex, multidimensional phenomenon encompassing biological, psychological, and social changes that unfold continuously and dynamically throughout the life course (Baltes & Baltes, 1990; Rowe & Kahn, 1997). In gerontological literature, three major stages of this process are distinguished: early old age (60–74 years), late old age (75–84 years), and advanced old age (85+), each characterized by distinct needs and developmental tasks (WHO, 2015). During early old age, individuals typically face the need to adapt to new social roles, redefine their identity after retirement, and maintain physical and cognitive activity (Baltes & Smith, 2003). Late old age involves striving to preserve autonomy, accept health limitations, and strengthen psychological resilience in the face of loss and change (Ryff & Singer, 1998). In advanced old age, social relationships, interdisciplinary care, and the preservation of dignity and meaning in life gain particular importance (Tornstam, 2005).

According to the World Health Organization (2015), *healthy aging* refers to maintaining functional abilities that enable individuals to do what they value in life.

The following section presents the processes and changes that occur during this stage of life, as outlined in the Balance Model derived from Transcultural Positive Psychotherapy (PPT). The

literature overview is intentionally selective, emphasizing positive mechanisms of change and protective factors. Additionally, the discussion refers to each of the model's dimensions, following the framework proposed in PPT (Ciesielski, 2016). The balance model is one of the basic tools of PPT, enabling recognition of the individual pattern of distribution of a person's daily activities across four areas: body, relationships, productivity, and future (fantasy, spirituality). The time and energy invested in each of these dimensions constitute an individual feature, determined by a particular pattern of biological, psychodynamic, systemic, and transcultural variables (Dobiła, 2021). Using the balance model can serve as a basis for psychoeducational or supportive work in everyday life and crises.

1. The Physical Sphere

Epel et al. (2004) demonstrated that chronic psychological stress shortens telomeres – the terminal segments of chromosomes that protect DNA integrity. Women caring for chronically ill children were found to have shorter telomeres and lower telomerase activity, which biologically corresponded to an “accelerated cellular age” of approximately 10 years. Shorter telomeres are associated with an increased risk of heart disease, diabetes, osteoporosis, and cancer.

According to Fredrickson's (2000) *broaden-and-build theory*, positive emotions expand the repertoire of adaptive behaviors and foster the development of psychological and physical resources, thereby enhancing resilience to stress and disease. Positive emotions are associated with lower cortisol levels, reduced inflammation, and improved immune function (Steptoe et al., 2005). As noted by Taylor et al. (2000), a positive psychological attitude is associated with greater physical activity, healthier eating habits, and fewer risky behaviors. Individuals with higher levels of psychological well-being are more likely to engage in preventive, educational, and activating activities that promote both longevity and quality of life.

2. The Achievement Sphere

Regular physical activity improves physical and mental function and reverses some effects of chronic disease, thereby maintaining older adults' mobility and independence. According to the study in United Kingdom (McPhee et al., 2016) the evidence shows that regular physical activity is safe for healthy and for frail older people and the risks of developing major

cardiovascular and metabolic diseases, obesity, falls, cognitive impairments, osteoporosis and muscular weakness are decreased by regularly completing activities ranging from low intensity walking through to more vigorous sports and resistance exercises.

3. The Social Relations Sphere

The process of aging is often accompanied by greater emotional variability and an enhanced ability to cope with negative affect, particularly when older adults maintain strong social ties (Carstensen et al., 2011). However, the loss of loved ones or deteriorating health may increase feelings of loneliness and sadness. Depression constitutes one of the key risk factors for accelerated aging. Kiecolt-Glaser et al. (2003) found that depression is associated with elevated inflammatory markers (CRP, IL-6), impaired immunity, and accelerated biological aging.

Social relationships are among the strongest predictors of both longevity and quality of life. Holt-Lunstad et al. (2010), in a meta-analysis of more than 300,000 participants, demonstrated that strong social bonds reduce mortality risk by up to 50%. Conversely, loneliness and social isolation increase the likelihood of depression, cardiovascular disease, weakened immunity, and premature death.

4. The Future Orientation and Meaning Sphere

Levy et al. (2002) showed that positive beliefs about aging can extend life expectancy by an average of 7.5 years. Similarly, Hill and Turiano (2014) found that a strong sense of purpose in life reduces mortality risk, regardless of age or health status.

Discussion

3.1. Interrelations and synergy between spheres of well-being

Importantly, most studies indicate the existence of interactions and both positive and negative synergies among the different spheres of well-being. For instance, research conducted by Hertzog and colleagues demonstrates that maintaining mental and physical activity, as well as a healthy lifestyle, can slow the processes of cognitive aging (Hertzog et al., 2008). Other studies show that psychological factors – such as a sense of meaning and social engagement – support neuroplasticity and cognitive processes in later life (Wilson et al., 2007).

Research by Ryff and Singer (1998) reveals that individuals with a strong sense of purpose and autonomy exhibit better physical health, lower cortisol levels, and higher immune resilience. Similarly, Wilson et al. (2007) report that a strong sense of purpose serves as a protective factor against the development of Alzheimer's disease.

Windle (2011) emphasizes that psychological resilience is a key predictor of quality of life and healthy aging. Individuals with high resilience are more likely to engage in social and physical activities, which helps prevent isolation. Likewise, optimism and a positive self-concept are associated with a lower risk of cardiovascular disease (Kubzansky et al., 2001) and a higher likelihood of adopting health-promoting behaviors (Taylor et al., 2000).

Optimism, a sense of purpose, and psychological resilience all contribute to maintaining health and independence. Individuals with a positive attributional style tend to perceive negative events as temporary and external, which enhances their adaptability and readiness to engage in health-promoting behaviors (Taylor et al., 2000). Moreover, optimists are more likely to take care of their health, participate in social activities, and report greater life satisfaction (Kubzansky et al., 2001).

Research consistently demonstrates that the well-being of older adults is multidimensional and dynamic. Physical, psychological, social, and environmental factors interact continuously, and their balance determines both quality of life and the pace of aging. Positive attitudes, psychological resilience, social support networks, and healthy behaviors create an *upward spiral* that reinforces well-being. In contrast, stress, isolation, and mental disorders may trigger a *downward spiral of declining health and functioning*.

Psychological well-being also benefits from a *positive feedback mechanism* – positive emotions generate positive experiences, which in turn strengthen one's sense of efficacy, competence, and meaning in life. As Fredrickson (2000) notes, positive emotions broaden one's repertoire of thought and action, fostering the development of long-term psychological and physical resources.

3.2. Multidimensional definition of older adults' well-being

The analysis of older adults' well-being is grounded in Urie Bronfenbrenner's ecological model of human development (1979), which posits that an individual's functioning results from the dynamic interaction between the person and their environment. From this perspective, an individual's well-being is shaped by reciprocal influences across different levels of social systems – from the immediate environment (family, neighborhood, interpersonal relationships) to broader institutional and cultural structures (social policy, cultural norms, health care systems). In that understanding, well-being encompasses four dimensions of functioning: the body, relationships, achievements, meaning, imagination, and intuition. Thus, older adults' well-being is not solely the outcome of individual traits or choices but largely depends on the quality of interactions with the social and physical environment. For example, limited access to public transport (a physical constraint) – for instance, when travelling to a library that hosts senior meetings – may lead to social isolation (by restricting social contacts) and reduced opportunities for achievement (due to a lack of new stimuli and tasks offered by the library). Consequently, this can lower psychological and physical well-being across other dimensions.

When considered this way, areas of support or risk form an ecological model (analogous to Bronfenbrenner's model, 1979) and emphasize the multi-level nature of well-being, which encompasses both the individual level (e.g., health, competencies, motivation) and the environmental level (e.g., infrastructure, social norms, public policies). Within this framework, the psychological dimension of well-being is particularly important as a buffer against stress and developmental losses. The research shows that older adults who maintain positive social relationships, a sense of autonomy, and a sense of meaning in life report higher life satisfaction and better mental health (Diener, Lucas & Oishi, 2009; Ryff & Keyes, 1995). Scholars also note that a high level in one dimension does not compensate for serious deficits in others – a holistic approach is necessary for a reliable assessment of functioning and for planning therapeutic or counselling interventions.

3.3. Framework of well-being dimensions in older adults

In the framework proposed in this article, following the World Health Organization (WHO, 2015, 2021), well-being in older adults is understood as a complex construct encompassing three interrelated dimensions:

- Physical well-being, related to somatic health, functional fitness, and the ability to live independently;
- Psychological well-being, including emotional balance, a sense of meaning in life, autonomy, and self-esteem;
- Environmental well-being refers to living conditions, access to social support, health care, infrastructure, and a culture that promotes dignified aging.

In transcultural psychotherapy (PPT), it is emphasized that values, norms, cultural experiences, and beliefs shape how reality is encoded and interpreted. Consequently, in each of the dimensions – modeling, relational, and responsibility – the therapist should recognize, examine, and take into account the patient's specific assumptions about the understanding of various phenomena. In this approach, as in other systemic approaches, system-based and temporal narration is used, which involves observing how relational patterns and structures change over time. This approach aligns well with the idea of combining the modeling dimension (the time axis) and the relational dimension (the here-and-now). In that article, the author argues that well-being can be examined using tools such as relational dimensions and dimensions of responsibility (Ciesielski, 2016; Henrichs, 2012). Below is the proposal:

- Physical dimension – somatic health, functional activity, taking medication, using access to medical and long-term care services (me and the body).
- Psychological dimension – mental health, life satisfaction, sense of control, psychological resilience, and meaning in life (me - and meaning; me and tasks).
- Social dimension – social support, participation in social and cultural life, interpersonal relationships, and prevention of isolation and exclusion (me and others).
- Environmental/material dimension – housing conditions, access to age-friendly services and infrastructure, access to health care and economic

security (income, pension stability) (me and the world).

This four-dimensional approach to modeling provides a framework for examining the functioning of older adults, their families, and even therapists themselves. By revealing the attitudes and ways in which emotional and cognitive realities are constructed in relation to aging, it becomes possible to map expectations and experiences rooted in both one's family of origin and the client's current life situation.

3.4. Aging as a Stage of Life

As can be observed, research on psychological processes in old age rarely stratifies participants strictly by chronological age. This is because across all stages of aging, several key dimensions remain essential: *acceptance, autonomy, activation, and activity*. These areas have been provisionally termed the 4A Model. It represents a holistic approach to the well-being of older adults, integrating physical, psychological, and social aspects of functioning. That idea is widely described and promoted by the United Nations Economic Commission for Europe (UNECE) and the Standing Working Group on Ageing (SWGGA), an intergovernmental body subordinate to the Executive Committee of UNECE. They created the Active Ageing Index. AAI is a tool for measuring the untapped potential of older adults for active and healthy ageing across countries. It measures the extent to which older people live independently, participate in paid employment and social activities, and engage in active aging (UNECE, 2018).

This model aligns with the concept of *successful aging* (Rowe & Kahn, 1997) and the positive psychology paradigm, which emphasizes developmental potential and the preservation of dignity in late adulthood (Seligman & Csikszentmihalyi, 2000). It also reflects human functioning across four fundamental dimensions:

- Body (Activity) – engaging in physical, cognitive, and emotional activities adapted to one's abilities; maintaining bodily health and a diverse range of activities.
- Meaning and Future (Acceptance) – personal acceptance of aging as a natural stage of life and the creation of environments that acknowledge

limitations while emphasizing opportunities at this stage.

- Achievements (Autonomy) – sustaining the highest possible level of independence in decision-making and everyday functioning.
- Social Relations (Activation) – fostering motivation to participate in social and educational life (e.g., Universities of the Third Age, clubs, meetings outside home).

In psychotherapeutic, educational, and counseling practice, the 4A Model can contribute to the development of family- and community-based support systems that integrate medical, psychological, and social care. Promoting active and fulfilling aging, it supports the well-being of older adults in the spirit of dignity and social participation, which is connected with trends to integrate healthcare and social support interventions (Wahl & Lang, 2021).

Conclusion

Aging should not be perceived solely as a period of loss and dependency, but rather as a stage of life that – when appropriately supported – can be characterized by meaning, relationships, and dignity. Within this framework, aging becomes a meaningful period of continued growth, connection, engagement, and optimistic attitude, provided that society creates conditions enabling every older person to maintain dignity, autonomy, and the capacity for action.

The purpose of this paper was to present the significance of the multidimensional concept of well-being among older adults and to identify factors that may either support or threaten its maintenance. To this end, a literature review was conducted, with particular emphasis on protective factors. The review is framed around Fredrickson's (2000) *broaden-and-build* theory, which posits that positive emotions and experiences create a foundation that promotes further positive outcomes. This perspective aligns with the principles of Transcultural Positive Psychotherapy (TPP), which emphasizes the cultivation of personal and environmental resources. In daily practice, it is essential to view the aging individual in Positum, which means what is factual and given, and to allow the therapist to see the client as a whole person with weaknesses and strengths, with diseases and capabilities (Peseschkian, 1983, in Cesko, 2018).

While age-related limitations are inevitable, identifying protective factors and promoting experiences that enhance well-being is equally important. This is connected with Taylor and her team's outputs of the investigation (Taylor et al., 2000). The study has revealed that even

unrealistically optimistic beliefs about the future may be health-protective.

Furthermore, the article introduces an original model, based on TPP, for studying changes and interventions among elderly clients, their families, and caregivers within the Balance Model and Modeling Dimensions framework.

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Section: Modern Positive Psychotherapy (PPT) practice

Intrapersonal Differentiation through Five Capabilities in Five Stages with Positive Psychotherapy: The Positive Intrapersonal Differentiation Model (PID Model)

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Abstract

The psychotherapy literature emphasizes the importance of the differentiation process for healthy individual development. One of the key characteristics of Positive Psychotherapy is its grounding in differentiation. The purpose of this study is to develop a model that will help clients achieve intrapersonal differentiation across five stages, using five capabilities grounded in Positive Psychotherapy. The developed model is referred to as the Positive Intrapersonal Differentiation Model (PID Model). According to the model, honesty is used in the observation stage; patience in the inventory stage; hope in the situational encouragement stage; achievement in the verbalization stage; and time capability in the broadening of goals stage. The study also provides an example of a psychotherapy session based on the PID Model. The developed model can be used in the process of intrapersonal differentiation.

Keywords: Positive Psychotherapy, intrapersonal differentiation, capabilities, five stages

Introduction

The psychotherapy literature emphasizes the importance of the differentiation process for the healthy development of the individual (Choi & Murdock, 2017; Hung et al., 2022; Licht & Chabot, 2006). One important characteristic of Positive Psychotherapy is that it is a psychotherapeutic school grounded in differentiation (Peseschkian, 1987). During Positive Psychotherapy, individuals learn to distinguish between primary and secondary capabilities, which are reflections of their capacities to love and know, and behaviors that are important to them. Human differentiation constitutes all physical, mental, and social functions (Peseschkian, 2016). In fact, differentiation is an important component of the psychotherapeutic process (Peseschkian, 1987). Beyond the psychotherapeutic process,

individuals also undergo differentiation throughout their developmental journey. Peseschkian (2016) conceptualizes this process as the interactional stages. The interactional stages comprise three: attachment, differentiation, and separation. The differentiation stage, in particular, underpins both physical and psychological development. The acquisition of socially desirable behavior determines differentiation (Eryilmaz, 2020). This occurs through the differentiation of a person's capacity for recognition and learning, and the formation of secondary capabilities that enable the person to regulate their nature and express themselves socially (Peseschkian, 1987).

In the literature, the process of differentiation is examined in two important dimensions: intrapersonal and interpersonal (Kerr & Bowen, 1988). Interpersonal differentiation is understood as the

differentiation of the self (Kerr & Bowen, 1988). Interpersonal differentiation is defined as an individual's ability to balance intimacy and autonomy (Skowron, 2004). It is defined as the ability to experience independence. Differentiation, at this point, entails maintaining a strong sense of personal beliefs despite pressure from others (Kerr & Bowen, 1988). The interpersonally differentiated self encompasses both intimacy and differentiation from others, reflecting a person's ability to engage in close, physical relationships with others without losing their identity (Skowron & Friedlander, 1998). These individuals protect their sense of self. They remain committed to their own values even when exposed to environmental pressures (Bowen, 1993). Those who fail to differentiate healthily strive for others' approval. They are also fixated on the relationship patterns of their family of origin and experience complex emotions. Furthermore, these individuals tend either to avoid others or to become excessively involved with them (Kerr & Bowen, 1988). They may remain emotionally distant from others because they perceive closeness as a threat. Consequently, they cannot tolerate differences between their own values and opinions and those of others (Skowron & Friedlander, 1998).

Intrapersonal differentiation is also considered an inner psychic dimension. It is the ability of an individual to create a balance between their feelings (emotional functions) and thoughts (cognitive functions) (Eryilmaz, 2020; Licht & Chabot, 2006). Intrapersonal differentiation is also defined as an individual's ability to think logically under stress; to distinguish between emotions and thoughts; and to provide the most appropriate problem-solving response (Kerr & Bowen, 1988). Individuals with intrapersonal differentiation can remain calm when experiencing stressful events (Ross & Murdock, 2014). They can shift their attention to other things. They can engage logic and reasoning (Kerr & Bowen, 1988; Skowron et al., 2003). Thus, individuals maintain their autonomy in close relationships by functioning at both emotional and logical levels (Eryilmaz, 2020). If individuals exhibit low personal differentiation, they tend to operate at the emotional level. Their thoughts are often influenced by their emotions. Even their thoughts are suppressed by their feelings (Kerr & Bowen, 1988).

Individuals with high levels of intrapersonal differentiation from their family can easily distinguish their thoughts from their emotions (Kerr & Bowen, 1988). Those with low levels of differentiation have very high levels of emotional intensity (Bowen, 1993). It has been found that individuals with healthy differentiation make decisions by considering their feelings and impulses (Skowron, 2004). Those with healthy differentiation have strong characteristics such as remaining calm and acting logically in the face of adversity (Skowron & Friedlander, 1998).

Differentiation is a crucial indicator of individuals' psychological health (Eryilmaz, 2020; Jenkins, 2005; Ross & Murdock, 2014). Low levels of differentiation have been associated with exhibiting high levels of depressive symptoms, experiencing more stress and anxiety, and having physical health problems (Choi & Murdock, 2017; Hooper & Doehler, 2011). Positive differentiation processes have been associated with healthy psychosocial development (Jenkins, 2005), maintenance of positive interpersonal relationships (Skowron, 2004), and improved problem-solving skills in social contexts (Choi & Murdock, 2017). Furthermore, differentiation also affects the psychotherapy process. A positive differentiation process increases therapeutic alliance and reduces symptom burden (Grosse-Holtforth et al., 2014). Positive Psychotherapy is also a differentiation model. Individuals begin to participate in this differentiation process with their capacities to love and know. Over time, the use of primary and secondary capabilities plays a significant role in the differentiation process (Peseschkian, 2016). Some individuals differentiate healthily, whereas others differentiate in an unhealthy manner. Psychotherapy is an important tool in transforming an unhealthy differentiation process into a healthy one. The relationship between the psychotherapist and the client in the psychotherapeutic process is an important component of the dynamics of healthy differentiation (Eryilmaz, 2020). The literature contains numerous studies and explanations of the differentiation process (Bowen, 1993; Eryilmaz, 2020; İmamoğlu, 1998; Peseschkian, 2016; Witkin et al., 1979). However, from a Positive Psychotherapy perspective, there is also a need to develop models of how people engage in intrapersonal differentiation processes. As a result, this study aims to present a systematic

model for providing intrapersonal differentiation based on the five stages of Positive Psychotherapy and five capabilities.

Methodology

This study aimed to develop a model to contribute to the process of individual differentiation. For this reason, the developed

model was named the PID (Positive Intrapersonal Differentiation) Model. The PID Model aims to facilitate the differentiation of individuals through five stages and five capabilities during the psychotherapy process. A summary of the PID Model is provided in Table 1.

Table 1. The Content of The PID (Positive Intrapersonal Differentiation) Model

<i>Order</i>	<i>Stages</i>	<i>Capabilities</i>	<i>Goals</i>
1	Observation	Honesty	To accept the reality
2	Inventory	Patience	For building optimistic thinking
3	Situational Encouragement	Hope	To see an opportunity
4	Verbalization	Achievement	To use problem-solving strategies
5	Broadening Goals	Time	To concentrate on other positive events

A key question is how the model relates to each stage and capability. A detailed explanation of the relationship between stage, capability, and goal facilitates understanding of the model. The PID (Positive Intrapersonal Differentiation) Model's explanation, based on the stages of Positive Psychotherapy, is as follows:

Observation – Honesty – Acceptance: The first stage of Positive Psychotherapy is observation-distancing. In this stage, the client attempts to understand the situation they are experiencing. The goal is to encourage the client to accept the event or situation that is causing negative emotions and thoughts. The most important capability needed by both the psychotherapist and the client at this point is honesty. If the client honestly accepts their experience, they are more likely to accept the emotions it evokes. In this stage, the psychotherapist generates at least 10 reasons for the client to accept the situation. The question to ask the client at this stage is: "If we think the situation is acceptable, what are our 10 reasons for accepting it?"

Inventory – Patience – Optimistic Thinking: The second phase of Positive Psychotherapy is the inventory phase. Due to the intense emotions they experience, clients approach the situation and their experiences with a pessimistic perspective. Some clients tend to catastrophize the situation. During this phase, the psychotherapist must demonstrate to the client that the situation or experience is not a disaster. To achieve this, the psychotherapist

must exercise patience to help the client recognize that other negative situations or experiences may be more likely than the current one. At this point, the psychotherapist should ask the client, "What would you say if you compared the outcomes of your experience or situation with other negative outcomes and experiences?" The answers to this question demonstrate that the situation or experience is not a disaster for the client. This encourages clients to approach the situation or experience with more patience.

Situational Encouragement – Hope – Opportunity: The third phase of Positive Psychotherapy is situational encouragement. Positive interpretations made during this phase are important motivators for clients. Ensuring that clients adopt a positive perspective is crucial to personal differentiation. It is necessary to support clients in this direction. For this reason, clients must recognize opportunities in their experiences. According to Peseschkian (2016), the concept of true positivity combines positive and negative. The psychotherapist should ask the client, "What opportunities can you find in this experience or situation?" The answers to this question help the client see that the situation or experience contains many opportunities. This increases their hope.

Verbalization – Achievement – Problem Solving: The fourth stage of Positive Psychotherapy is the verbalization stage. This stage is the action stage. It is the stage where the client's conflicts are resolved. Another reason for

the lack of intrapersonal differentiation is the failure to address the client's problem as experienced. In this stage, the client attempts to resolve the problem by following the problem-solving stages through psychotherapy. Taking the client's problem as a reference, the psychotherapist tries to solve the problem together with the client by asking questions such as: "What is the problem you are experiencing? What are the causes of this problem? What solutions can be developed for this problem? What is the most appropriate solution? How can the most appropriate solution be implemented in real life?" At the end of the process, they develop a plan. To solve the problem and develop a plan, it is necessary to activate the capability required to achieve it.

Broadening Goals – Time – Concentrate on Positive Events: The fifth stage of Positive Psychotherapy is the verbalization stage. This stage corresponds to the termination stage. During the intrapersonal differentiation process, life continues even after clients have resolved their problems. During this process, clients should focus on events and activities that generate more positive feelings and thoughts rather than focusing on negative emotions and thoughts. This is where clients need to allocate their time. Clients use time effectively, both for themselves and for others. During this stage, the psychotherapist should ask the client, "What kinds of activities could you engage in to generate more positive feelings and thoughts?"

2.1. Using the PID (Positive Intrapersonal Differentiation) Model in the Psychotherapy Process

It is necessary to frequently utilize intrapersonal differentiation during the psychotherapy process. Clients experience many real-life events between sessions. These real-life events also generate negative emotions and thoughts in clients. Intrapersonal differentiation during psychotherapy not only helps clients regulate themselves but also teaches them how to reduce and regulate negative emotions (Blatt, 2008), which are a significant cause of psychopathology in analytical therapies.

This section of the study presents an example of an intrapersonal differentiation session application during psychotherapy. The client is a 36-year-old woman. She is a lawyer by

profession. Her husband is a 37-year-old teacher. The couple has an 8-year-old daughter.

Describing the Event or Situation That Causes a Differentiation Problem

Psychotherapist: How was your last week?

Client: Okay, but I've been experiencing some difficulties.

Psychotherapist: What would you say if you mentioned them?

Client: My husband has genital warts. I'm bothered by this. I'm wondering if it stemmed from an extramarital affair. I'm also concerned about how this could adversely affect my health. Also, my husband delayed telling me. If my husband had told me sooner, I would have been more comfortable.

Observation Stage – Using Honesty Capability – Acceptance:

Psychotherapist: You're worried about your spouse's health problem and are also experiencing insecurity.

Client: Yes, that's exactly right.

Psychotherapist: Let's identify together why this situation is acceptable.

Client: Okay, that would be great.

Psychotherapist: What would you say if you said, "This is acceptable because"?

Client: No one voluntarily wants genital warts on their genitals, so it's acceptable.

Psychotherapist: Great. What's another one?

Client: It's acceptable because humans are biologically structured, and these warts manifest themselves biologically.

Psychotherapist: You mentioned that people are biologically predisposed to this condition.

Client: Absolutely.

Psychotherapist: What's another one?

Client: It's acceptable because my spouse, the father of my child, isn't just anyone.

Psychotherapist: Great. It's acceptable because it's someone with whom you have an emotional connection.

Client: Absolutely.

Psychotherapist: What else?

Client: It's acceptable because my husband was upset and uncomfortable with it.

Psychotherapist: Finally, if you could give another reason, what would it be?

Client: It's acceptable because it's not something you want voluntarily.

Inventory Stage – Using Patience Capability – Optimistic Thinking

Psychotherapist: You expressed yourself very well.

Client: Thank you.

Psychotherapist: Now, how would you compare this situation to situations with worse outcomes?

Client: My husband could have gotten cancer, but he didn't.

Psychotherapist: That's right.

Client: Secondly, my husband could have infected me. But he didn't either.

Psychotherapist: Yes, you're right.

Client: Thirdly, my husband could have become defensive and become violent towards me.

Psychotherapist: Bravo.

Client: Fourthly, my husband could have cheated on me and contracted it from a woman.

Psychotherapist: Thank goodness that didn't happen.

Client: Fifthly, we could have been poor and lacked access to healthcare.

Psychotherapist: You put it perfectly.

Situational Encouragement Stage – Using Hope Capability – Opportunity

Psychotherapist: You expressed yourself very well.

Client: Thank you.

Psychotherapist: Now, we'll focus on what opportunities this experience might present. What opportunities do you think this experience might present?

Client: First, I thought it would offer an opportunity to learn how to cope with health crises.

Psychotherapist: That's right.

Client: Second, it will provide an opportunity to expand my health-related knowledge. I'm constantly researching.

Psychotherapist: You're gaining new information about your current situation.

Client: Yes.

Psychotherapist: So, what's another opportunity?

Client: It's an opportunity to test your fidelity. My partner isn't having sexual intercourse with anyone else. This makes me very happy.

Psychotherapist: It's an opportunity to see that your partner isn't betraying you.

Client: Absolutely.

Psychotherapist: Fourth, what would you say?

Client: My husband felt guilty about this and started helping me with the housework.

Psychotherapist: It has been an opportunity to understand you and to get to know you better.

Client: Yes, that's very interesting.

Psychotherapist: What's the latest opportunity in this regard?

Client: My husband and I have had the opportunity to re-evaluate the importance of personal hygiene.

Verbalization Stage – Using Achievement Capability – Problem Solving

Psychotherapist: You expressed yourself very well.

Client: Thank you.

Psychotherapist: If we see this as a problem, what can you do to solve it?

Client: First, the problem for me is that I look at websites and obtain information from them. There's so much information out there that I get confused and anxious.

Psychotherapist: Finding information from so many places makes you even more anxious.

Client: Yes

Psychotherapist: This distracts you from the root of the problem.

Client: Yes. First, I need to limit my information to websites. This is a health issue, and we need to seek help from doctors who specialize in this.

Psychotherapist: What else can be done?

Client: Secondly, I need to get tested for HIV. This increases my anxiety.

Psychotherapist: Very good.

Client: Thirdly, it's necessary to focus on the treatment method and choose the most appropriate and fastest treatment.

Psychotherapist: You've focused on an important point.

Client: Fourthly, it's about managing this process with my spouse. Not leaving him alone. He's also uncomfortable with this situation. Sometimes he can even feel ashamed.

Psychotherapist: How wonderful that you can understand your spouse.

Client: Thank you.

Psychotherapist: Fifthly, what do you think?

Client: I shouldn't make the situation worse. To do this, I avoid negative people, events, and situations.

Broadening Goals Stage – Using Time Capability- Positive Events

Psychotherapist: You expressed yourself very well.

Client: Thank you.

Psychotherapist: Now we'll focus on other positive things you're experiencing. Instead of constantly thinking about this problem, what other positive things can you focus on?

Client: First, I can go for a walk. Because walking relaxes me.

Psychotherapist: Great.

Client: Second, I can care for my child. I also enjoy spending time with my child.

Psychotherapist: You're thinking about spending quality time with your child.

Client: Yes.

Psychotherapist: What else could it be?

Client: Third, shopping. I feel valued when I shop.

Psychotherapist: Good. What else?

Client: Fourth, I could watch our favorite movies with my husband.

Psychotherapist: You mentioned watching movies.

Client: Fifth, I could take trips to different places. Traveling to other places, getting to know and seeing new places, not only relaxes me but also broadens my perspective.

Evaluation Phase

Psychotherapist: If you were to evaluate what we've shared, what would you say?

Client: I feel more secure now. My anxiety has transformed into confidence.

Psychotherapist: Great

Client: I realize it now. I'm making it worse.

Psychotherapist: What else would you say?

Client: I thought I might be exaggerating. That's why I had difficulty accepting the situation.

Discussion

During psychotherapy, clients' access to positive emotions and thoughts is invaluable for their psychological functioning. Positive Psychotherapy is a form of differentiation analysis therapy. Individuals engage in intrapersonal differentiation through their capacities and capabilities. Developing systematic models to assist individuals in their intrapersonal differentiation processes also enhances the effectiveness of psychotherapy. In this respect, the PID model developed in this study constitutes a contribution to the literature.

Numerous studies have examined the importance of the differentiation process (Choi & Murdock, 2017; Hung et al., 2022; Licht & Chabot, 2006). These studies indicate that individuals who successfully achieve differentiation exhibit higher levels of well-being and greater physical health (Skowron, 2004). Differentiation not only increases life satisfaction but also marital satisfaction (Manzi et al., 2006).

Individuals with high levels of differentiation also experience lower levels of separation anxiety (Peleg & Yitzhak, 2010). Failure to differentiate leads to increased physical symptoms (Solomon et al., 2009). For example, individuals with high differentiation experience disorders such as fibromyalgia much less frequently (Murray et al., 2006). The importance of differentiation has been emphasized in both the general psychology literature and the field of Positive Psychotherapy. However, studies on how to address intrapersonal differentiation in psychotherapy are scarce. Therefore, this study contributes to the literature by presenting a new model from a Positive Psychotherapy perspective.

People can successfully navigate the differentiation process through personal effort. At this point, this process is addressed through the concept of adaptive functioning level (Bowen, 1993). If an individual is aware of behaviors that indicate a higher level of differentiation, they can consciously implement these behaviors in relationships. Over time, these changes in conscious effort can increase the individual's level of differentiation. Based on this information, psychotherapists can help clients develop differentiation habits by using differentiation tools, such as the model developed in this study, as needed.

A few points should be emphasized when applying the model discussed in this study. First, clients' responses to the first question in the first stage vary depending on their perceptual capacity. Depending on their perceptual capacity, some clients answer this question readily, whereas others find it difficult. Another point is that, for some individuals, the experience can evoke intense emotions, which should be considered. The psychotherapist must be careful in such situations. It is functional to manage the process by supporting the client without forcing them. In the second stage, some clients may perceive the situation as unmanageable due to limited coping skills. In this case, it is necessary to emphasize clients' coping abilities with positive interpretations. In the third stage, exposing clients to opportunities helps activate their hopeful capacities and contributes to the emergence of the hope principle in Positive Psychotherapy. Additionally, psychotherapists can utilize a hypothetical thinking process with clients. In the fourth stage, clients need to address their problems using the

problem-solving steps. During this process, the psychotherapist should develop an action plan with the client. In the fifth stage, activities that elicit positive feelings and thoughts should be identified in collaboration with the client. The

psychotherapist should also practice time-management skills with the client throughout this process. The key points raised are shown in Table 2.

Table 2. Summary of PID Model

Order	Stages	Capabilities	Goals	Key Points to Consider
1	Observation	Honesty	To accept the reality	The capacity of perception The quality of the situation is causing negative emotions
2	Inventory	Patience	To build optimistic thinking	Coping capacity Positive interpretation
3	Situational Encouragement	Hope	To see an opportunity	Hypothetical thinking
4	Verbalization	Achievement	To use problem-solving strategies	Make a plan
5	Broadening Goals	Time	To concentrate on other positive events	Time management

Conclusion

The model discussed in this study is not intended as a general psychotherapy framework applicable across all symptom severity levels. It is important to remember that this model is a tool designed for use in specific clinical situations. The PID Model is highly effective for reframing, broadening the client's perspective, and helping the client resolve their problem by distinguishing between their feelings and thoughts. On the other hand, further research is needed to apply the PID model to highly

sensitive clinical cases such as grief or trauma. This would prevent misapplications and more clearly demonstrate the model's therapeutic effectiveness. Several suggestions can be derived from this study. First, the model discussed in this study can be used to regulate clients' emotions and thoughts during psychotherapy. Second, various experimental studies based on the model presented here can be conducted to assess its effectiveness. Third, research can assess the model's effectiveness among clients with diverse disorders.

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Section: Modern Positive Psychotherapy (PPT) practice

Tools for Physicians in Inpatient Units for Severe Mental Illnesses: Construction of a Balance Model Based on the Three-Stage Theory of Positive Psychotherapy



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Abstract

Based on Peseschkian's Three-Stage Theory and the Positive Psychotherapy Balance Model, this study constructed a localized Balance Model for application in Chinese inpatient units for severe mental illnesses. Through clinical practice by four psychiatrists over one year, eight integrated sub-models were developed to characterize ward environments, physician resources, and patient symptoms/treatment goals across Connection, Differentiation, and Separation stages. This preliminary framework may assist psychiatrists in systematically assessing patient conditions and implementing structured psychological interventions within inpatient settings. Initial observations suggest potential improvements in treatment adherence and insight, though further clinical validation is required. The study provides a conceptual basis

for developing evidence-based Positive Psychotherapy protocols in severe mental illness inpatient settings.

Keywords: Balance Model, three-stage theory, inpatient units, severe mental illnesses, Positive Psychotherapy

Introduction

The global prevalence of mental disorders is 13.0%, among which major depressive disorder, bipolar disorder, and schizophrenia account for 0.5%, 2.49%, and 0.3% respectively (Castaldelli-Maia & Bhugra, 2022). In China, severe mental illnesses generally refer to mental disorders characterized by hallucinations, delusions, severe thought and behavioral disturbances, and significant impairment of social functioning (Qin, 2012). These primarily include schizophrenia, paranoid psychosis, and bipolar disorder. Patients with such conditions often require hospitalization to control acute psychiatric symptoms; most are admitted involuntarily and generally lack disease insight.

Mostly, the duration of psychiatric hospitalization in China typically ranges from 1 to 3 months. With the implementation of pharmacotherapy and physical therapy (e.g., Modified Electroconvulsive Therapy, MECT), patients' conditions tend to remit; adjunctive psychotherapy may potentially enhance patients' insight and treatment adherence. However, Chinese psychiatrists are mainly trained in clinical knowledge and skills, and have less systematic learning in psychotherapy. As a result, psychiatrists often rely on collaboration with psychotherapists. Nevertheless, due to the speech and behavioral disturbances of patients with severe mental illnesses during the acute phase, psychiatrists remain the primary medical staff in early contact with patients. They may demand even higher requirements for psychotherapy skills. Thus, psychiatrists play an important role in psychological interventions.

Existing evidence suggests that therapeutic alliances may play a substantial role in treatment efficacy and may enhance the effectiveness of both psychotherapy and pharmacotherapy, with interpersonal factors accounting for approximately 85% of the therapeutic effect (Kallergis, 2019). Senior psychiatrists can often provide basic psychological support based on

experience, such as empathy, emotional comfort, and unconditional acceptance; however, such interventions are mostly non-systematic. Particularly junior physicians, on the other hand, often struggle to cope with patient resistance or symptomatic challenges.

Therefore, it makes sense to have a set of structured treatment methods or tools to assist psychiatrists in establishing therapeutic relationships with patients with severe mental illnesses and delivering effective psychological interventions. Existing studies have indicated that positive psychology intervention models might hold promise for patients with schizophrenia (Wang, 2025).

After a year of psychiatric practice, we have found that Positive Psychotherapy holds unique potential for implementation in psychiatric intensive care units, both during daily ward¹ rounds and in the process of psychotherapy.

Positive Psychotherapy is a transcultural, humanistic, psychodynamic, and conflict-oriented psychotherapeutic approach (Peseschkian, 1986), as cited in Sarı (2015). The Balance Model of Positive Psychotherapy (Christ et al., 2021) refers to the balance that individuals strive to achieve across four dimensions when facing conflicts: Body (through senses), Achievement (through intelligence), Relationship (through tradition), and Fantasy (through intuition) (Peseschkian, 2002). Based on this Balance Model, numerous subsequent models have been developed, including the Relationship Model, Responsibility Model, Role Model, Marital and Family Model, and Sexual Dimension Model. This study explores the development of a new Balance Model based on Professor Peseschkian's Three-Stage Theory (Connection, Differentiation, Separation).

This study presents a conceptual model, derived from prior theories and informed by practice. The new model mainly includes eight sub-models: the ward model describing the characteristics of severe psychiatric wards; the doctor model describing the therapeutic resources owned by psychiatrists; the symptom

¹ **Editor's note:** In this article, the term *ward* refers to an inpatient psychiatric unit within a hospital setting.

model and treatment goal model during the patient's connection stage in the ward; the symptom model and treatment goal model during the patient's differentiation stage in the ward; and the symptom model and treatment goal model during the patient's separation stage in the ward. That is, a "ward-doctor-patient" ternary descriptive model and a "disease symptoms-treatment methods-treatment goals" therapeutic model have been constructed.

The conceptual framework tries to explore the application of Positive Psychotherapy in severe psychiatric cases, create therapeutic tools for psychiatrists based on Positive Psychotherapy, explore systematic Positive Psychotherapy plans, and potentially enhance psychiatrists' psychotherapy capabilities in severe wards, thereby enhancing patients' treatment compliance and insight, improving treatment efficacy, and optimizing prognosis. This study hypothesizes that the construction of the Positive Psychotherapy balance model tool is feasible and has practical significance, and that future clinical research can be conducted using this tool.

Methodology

The participants in this study were four junior Positive Psychotherapy consultants who completed the Chinese Positive Psychotherapy Training from January to December 2024. All participants also underwent standardized training for resident physicians and rotated through inpatient units for severe mental illnesses from August to October 2023 and from August 2024 to April 2025. During clinical practice, they conducted psychiatric and psychological interventions integrated with Positive Psychotherapy. Based on their respective practical experiences, each participant independently summarized and developed a preliminary draft of the Balance Model for inpatient units treating patients with severe mental illnesses. Subsequently, through case discussions and model comparisons, the participants reached consensus and jointly revised and finalized the Balance Model.

2.1. Patients in severe psychiatric wards and the definition of the three stages

In this study, patients in the acute psychiatric ward primarily consist of individuals with severe mental illnesses, which may also include some

patients with severe depression at high risk of suicide. Patients with severe mental illnesses refer to the six categories of patients mandated for supervision under Chinese law, including schizophrenia, schizoaffective disorder, paranoid psychosis, bipolar disorder, epileptic mental disorders, and intellectual disability. These patients may be experiencing their first episode or a relapse, and they are primarily involuntary inpatients who are hospitalized due to high risks of suicide, self-harm, or causing harm to others, as required by Chinese law and often brought to the hospital by family members or public security authorities. They are generally in the acute phase of their illness, with severely impaired mental functioning, leading to an inability to fully recognize their own health condition or objective reality, or to control their own behavior, resulting in actions or risks of suicide or harm to others.

The hospitalization period of patients with acute mental illnesses can be roughly divided into three stages: Attachment, Differentiation, and Separation.

Attachment Stage: Patients are involuntarily admitted to the acute psychiatric ward due to their illness. At this point, many patients are in the differentiation or separation stage, believing they are not ill and demanding discharge. Due to their high-risk status, these patients receive Grade One nursing, including 24-hour supervision to ensure their safety and prevent impulsive behaviors. This stage is also critical for establishing a connection with the psychiatrist, who must help the patient accept treatment.

Differentiation Stage: The patient's acute symptoms are under control, and they have largely adapted to the ward environment. They receive Grade Two nursing in the ward, but their condition may still fluctuate. This stage is important for improving the patient's compliance and insight.

Separation Stage: The patient's condition is largely controlled, and their medication regimen is stable. Discharge may be considered, but the patient may not yet be prepared for it. This stage is primarily focused on helping the patient prepare for life after discharge.

2.2. Balance Model of Inpatient Unit Characteristics

By summarizing the characteristics of psychiatric inpatient units, a Balance Model was established across four dimensions: Patients,

Medical Staff, Environment, and Social Perceptions (see Figure 1). The purpose is to comprehensively and transculturally describe the characteristics of inpatient units for severe mental illnesses, enabling medical staff, patients, the environment, and society to fully understand the unit's treatment context through this model, and to facilitate transcultural communication and conflict resolution.



Figure 1. Balance Model: Ward Model

First, Patient Characteristics are placed in the "Body" sphere of the classic Balance Model, representing passive, emotional, and perceptual attributes. Affected by symptoms, patients experience changes in their social and daily functioning. In acute psychiatric units, their thinking, emotions, and behaviors become disorganized due to psychiatric symptoms, with poor insight and adherence. Conflicts between real-life problems and psychiatric symptoms are partially resolved or alleviated after treatment.

Second, Medical Staff Characteristics are placed in the "Achievement" sphere of the classic Balance Model, representing diligence, proactive adaptation, and rationality. From the perspective of the unit's medical staff, they accompany patients throughout hospitalization with patience. Faced with newly emerging, complex, and urgent symptoms of patients, they mainly provide treatment through an active-passive doctor-patient relationship (primarily using medications). Heavy and tedious workloads further limit the time available for psychiatrists to conduct systematic psychotherapy with patients based on a guidance-cooperation or mutual participation doctor-patient model.

Third, Environmental Characteristics are placed in the "Relationship" sphere of the classic Balance Model, representing communication and interaction. From the perspective of the objective environment, inpatient units for severe mental illnesses mostly adopt closed management. Different areas are designated to restrict patients' activity range according to risk level; surveillance is in place, and contact with

the outside world is limited. Nursing assistants are assigned to patients at risk of suicide or harming others, and security personnel are deployed in the unit to prevent patients from self-harm or harming others. The management system and regulations prioritize safety assurance and risk prevention, thereby restricting the behaviors of both patients and medical staff.

Finally, Social Characteristics are placed in the "Meaning" sphere of the classic Balance Model, representing meaning, values, and the future. For patients hospitalized in inpatient units for severe mental illnesses, society generally lacks confidence in their treatment outcomes, perceives them as "abnormal", believes they are unlikely to recover, and assumes they will probably or certainly make wrong decisions. Consequently, they are subjectively regarded as persons with limited capacity for civil conduct and a lack of social trust.

2.3. Balance Model of Inpatient Unit Resources

By summarizing the Balance Model, the resources available to psychiatrists in inpatient units for severe mental illnesses were identified across four spheres (Body, Achievement, Relationship, Future/Values) in relation to patients (see Figure 2). After evaluating their own resource Balance Model, psychiatrists can help patients adapt more effectively to their current treatment stage and achieve stage-specific treatment goals, informed by an understanding of the Unit Characteristics Balance Model.

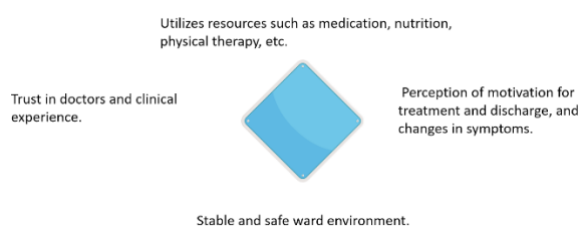


Figure 2. Balance Model: Resource Model

Body: Psychiatrists can promptly use resources such as medications, nutrition, and physical therapy to adjust patients' physical status or alleviate adverse drug reactions, enabling patients to maintain a healthier physical condition to cope with mental illness.

Achievement: Psychiatrists can help patients recognize their motivation for treatment or discharge, as well as changes in symptoms in themselves or others following systematic

treatment, thereby enhancing the efficacy of psychiatric treatment.

Relationship: Patients can alleviate insecurity through a safe, reliable, and simple inpatient environment, obtain support from the medical team's therapeutic alliance, and participate in recreational therapy.

Future: Patients naturally have a certain degree of trust and adherence to psychiatrists due to the "physician authority" effect. In addition, the extensive clinical experience of senior psychiatrists enhances their confidence in treatment, which in turn helps patients gain hope for treatment and discharge.

2.4. Balance Model of the Attachment Stage

In the Connection Stage, patients exhibit symptoms unique to this stage, which manifest across the four spheres as follows (see Figure 3):

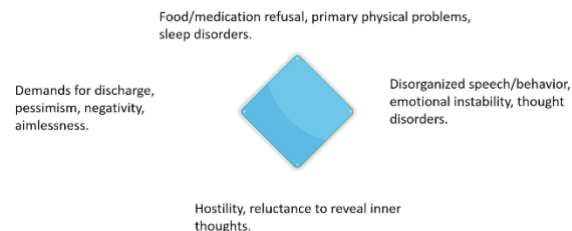


Figure 3. Balance Model: Symptoms in the Attachment Phase

Body: Patients may refuse food and medications, suffer from physical diseases (e.g., hypertension) or physical discomfort, and may experience sleep disorders due to psychiatric symptoms.

Achievement: Unable to adapt to the inpatient environment, patients may disobey unit management, display impulsive behaviors, shout, cry, or even engage in smashing behaviors; cognitively, they may believe they are "hospitalized against their will due to persecution".

Relationship: Patients may deny their own symptoms, be unwilling to share their inner experiences with doctors, and even develop hostile feelings toward doctors or other patients.

Future: Patients may insist on discharge at all costs, hold pessimistic, negative attitudes (believing they will never recover), or blindly comply with unit rules.

During the Attachment stage, patients have specific treatment goals across the four spheres of the Balance Model. Psychiatrists can assess

the most prominent symptoms of patients and focus on achieving the corresponding treatment goals in that sphere (see Figure 4):

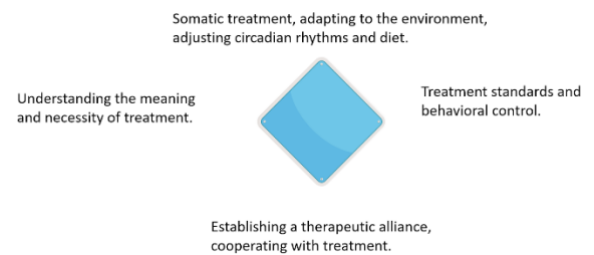


Figure 4. Balance Model: Treatment targets in the Attachment Phase

Body: Treat physical diseases, help patients adapt to the inpatient environment, and adjust their diet and sleep patterns.

Achievement: Jointly develop treatment standards with patients to enhance their ability and confidence in behavioral control.

Relationship: Establish a therapeutic alliance with patients to ensure their cooperation with medical work.

Future: Help patients understand the reasons and necessity of hospitalization and make them willing to accept treatment.

2.5. Balance Model of the Differentiation Stage

In the Differentiation Stage, patients' conditions are partially controlled, so their symptoms are related to the recovery of autonomy. They exhibit obviously differentiating behaviors and pay attention to the meaning of things, with symptoms manifesting as follows (see Figure 5):

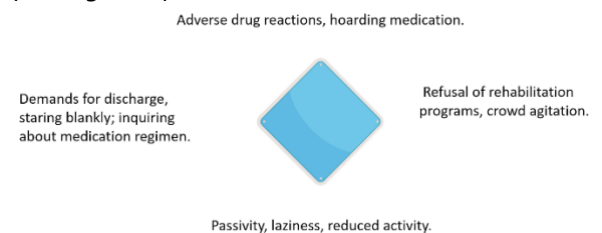


Figure 5. Balance Model: Symptoms in the Differentiation Stage

Body: Patients may experience adverse drug reactions (e.g., dizziness, nausea, weight gain, hand tremors, salivation). At this point, they begin to differentiate the advantages and disadvantages of medications; if they perceive more disadvantages than advantages, they may engage in drug-hiding behaviors.

Achievement: Patients may feel tired of or resist occupational and recreational therapy,

worry about economic expenses, and thus refuse rehabilitation programs or engage in collective protests; their demands for phone calls (to family members) may also increase.

Relationship: After adapting to the inpatient environment, patients may experience boredom, which can lead to passive inactivity, reduced participation in activities, or frequent requests to call family members.

Future: Patients may inquire about discharge criteria, remain dazed, or request to discuss medication treatment plans with physicians.

During the Differentiation Stage, psychiatrists should help patients achieve balance in treatment goals based on their symptoms (see Figure 6):

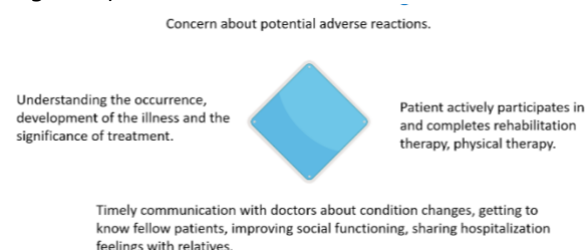


Figure Balance Model: Treatment targets in the Differentiation Stage

Body: Help patients understand and identify potential adverse drug reactions, and accept and cope with these reactions.

Achievement: Jointly develop rehabilitation and physical therapy plans with patients to alleviate their sense of burnout.

Relationship: Encourage patients to communicate with their doctors promptly about changes in their condition, to interact actively with other patients, and to restore social functioning.

Future: Help patients understand the occurrence, progression, and significance of their illness and its treatment.

2.6. Balance Model of the Separation Stage

In the Separation Stage, patients' conditions are basically stable, and they face the issue of discharge, thus developing new symptoms (see Figure 7):



Figure 7. Balance Model: Symptoms in the Separation Stage

Body: After re-examination, patients may have abnormalities in a few physical indicators, feel worried about this, and may experience insomnia.

Achievement: Patients may feel relatively excited (happy that their treatment is complete), but they may lack plans for the future.

Relationship: Patients may conflict with family members over post-discharge plans, make additional discharge-related requests, or request physicians' contact information.

Future: Patients may worry about their situation after discharge (e.g., fear of re-hospitalization) and feel anxious or ashamed about post-discharge life.

During the Separation Stage, psychiatrists should help patients evaluate the timing of discharge and develop post-discharge plans (see Figure 8):

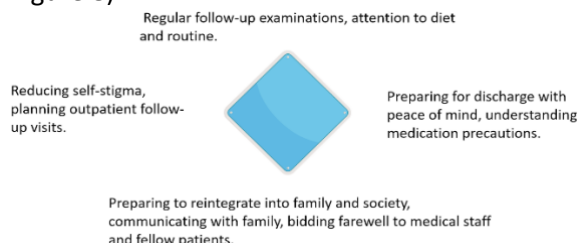


Figure 8. Balance Model: Treatment targets in the Separation Stage

Help patients develop plans to maintain physical health and affirm their current physical status.

Achievement: Help patients prepare for discharge with peace of mind and understand medication precautions to better manage medications after discharge.

Relationship: Facilitate communication between patients and their families, prepare patients for reintegration into family and society, and support them in saying goodbye to other patients and doctors.

Future: Help patients understand their illness to reduce mental illness stigma and develop follow-up treatment plans.

Discussion

In Positive Psychotherapy practice, the five-step model has been widely used, whereas the three-stage model examined in this study appears more applicable to acute psychiatric settings. This preference is partially attributed to the cognitive impairments commonly observed in patients with acute-phase severe mental illnesses, which may limit their capacity for complex psychotherapeutic engagement.

The proposed balance model could potentially extend beyond clinician-patient interactions. Through frameworks such as the "X3" model (presented by researcher Zhu Xinyuan at the First Chinese Positive Psychotherapy Conference), it may facilitate coordinated care among physicians, nurses, and families, with its three-stage structure potentially reducing communication barriers in multidisciplinary teamwork.

Furthermore, the dynamic clinical presentations in inpatient settings – where patients often experience fluctuating symptoms – suggest that the three-stage model may offer advantages for phase differentiation and positioning when compared to the five-step model.

The treatment of mental illnesses is divided into acute, consolidation, and stable phases. Integrating this model with psychiatric treatment phases, we note that Patients in severe psychiatric wards are in the acute phase according to the disease course. Post-discharge community management, often involving social workers, represents a critical continuation of treatment. The three-stage model is hypothesized to bridge hospital-to-community transitions, though its empirical utility for guiding post-discharge psychotherapy remains to be verified. Besides, the three-stage model can serve as a powerful tool for the observing stage of the five-step process.

The three-stage model is more straightforward, and positive psychotherapists may be able to assist physicians in mastering and applying the corresponding tools through basic training. The five-step model retains distinct advantages and may be used during hospitalization for mild cases.

However, this study is limited by its sample size. Currently, the model is based on the clinical practice experience of only four psychiatrists who are also Positive Psychotherapists. Future studies should expand the sample size and invite experts to evaluate the model. In practice, the model has not yet been promoted clinically among psychiatrists; further research is needed to evaluate its feasibility. Additionally, control groups can be included in future studies to conduct clinical trials of the model's application and treatment protocols derived from it, thereby assessing treatment effectiveness.

This study was conducted based on a Grade A tertiary psychiatric hospital in Shenzhen. In China, hospitals at different levels assume varying social responsibilities under the three-tiered healthcare model. Additionally, economic development levels and local cultures vary across regions, leading to diverse management models among these hospitals that may influence the application of the model. In different countries, due to legal and cultural factors, it is recommended that further localized research be conducted.

In the future, based on this model, treatment consensus and practice guidelines for inpatient units for severe mental illnesses can be further developed, and the model can be extended to inpatient units for mild mental illnesses, psychosomatic diseases, and general hospital wards.

Conclusion

Based on the clinical practice of four psychiatrists in inpatient units for severe mental illnesses, this exploratory study proposes a conceptual Balance Model system based on the Three-Stage Theory of Positive Psychotherapy. The model may assist psychiatrists in identifying patients' current stages and treatment goals through the three-stage Balance Model. Meanwhile, localized adaptations of the Three-Stage Theory of Positive Psychotherapy and the Balance Model were developed to suit the context of inpatient units for severe mental illnesses in China, providing a preliminary theoretical framework for the further development of systematic Positive Psychotherapy protocols. On this basis, clinicians could use this framework to design individualized interventions tailored to specific clinical cases, thereby enhancing the model's

practical value. By reviewing past Positive Psychotherapy practices in psychiatric inpatient units using this model, the researchers found that the model has theoretical value: it helps clinicians understand patients' symptoms and

functioning more comprehensively and systematically, and serves as a tool for developing treatment plans.

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Section: Modern Positive Psychotherapy (PPT) practice

The Bridge Between Positive Psychotherapy and Object Relations Theory: A Comparative Typology of Development



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Abstract

The article proposes an integrative framework between Positive Psychotherapy (PPT) and a spectrum of object relations theories (ORT) – from M. Klein and R. Fairbairn to D. Winnicott, M. Balint, H. Guntrip, and O. Kernberg – to operationalise personality development as a movement from fragmentation to integration. This integration is developed within the transcultural framework of Positive Psychotherapy, which allows personality development and conflict dynamics to be understood across differing cultural value systems. Against the backdrop of reduced visibility of Peseschkian's typology in contemporary discourse, the article proposes its renewed theoretical and clinical relevance by integrating it with object relations theory and core PPT models. The central point is the comparison of dynamic PPT types (naive-primary, secondary, ambivalent/double bind, integrated) with key provisions of ORT (Klein's positions; Fairbairn's internal ego structures; Winnicott's holding and true/false self continuum; Balint's basic fault; Kernberg's borderline organisation and identity). The psychodynamics of conflict in PPT (actual, basic, key and internal conflicts), the Role Model I–Thou–We–Origin–We, and the Balance Model as tools for mapping development are considered: body – sense of "I am", physicality, health/needs; achievements – abilities, logic, knowledge/skills; relationships – emotions, connections, love, interaction; fantasies and the future – dreams, intuition, faith, meaning. The article shows how the "language of abilities" (primary/secondary/actual) and the five stages of PPT (distancing, inventory, situational encouragement, verbalisation, broadening of Goals) translate the ORT metatheory into a step-by-step clinical integration process. The practical value lies in increasing diagnostic sensitivity to ambivalence, planning interventions with transcultural moderators in mind, and repositioning Peseschkian typology as the operational core of PPT.

Keywords: Positive Psychotherapy, object relations theory, Peseschkian typology

Introduction

As Henrichs and Hum (2025) note, the development of Positive Psychotherapy unfolds in dialogue with other psychotherapeutic approaches. Building on this perspective, Boessmann and Remmers (2025) propose an integrative framework for positive psychodynamic psychotherapy, highlighting shared clinical axes and diagnostic markers with

other psychodynamic traditions. This article further develops this integrative framework by examining the correspondence between Positive Psychotherapy (PPT) and object relations theories (ORT) – from the classical positions of M. Klein and R. Fairbairn to D. Winnicott, M. Balint, H. Guntrip, and O. Kernberg – to conceptualise personality development as a clinically traceable process of increasing integration.

The starting point of the present analysis is the holistic (positum) image of the person and the transcultural perspective of Positive Psychotherapy. Within this framework, symptoms and conflicts are understood not only as deficits, but also as carriers of resources and culturally mediated directions of development. (Peseschkian, 1987; Boessmann & Remmers, 2025).

Against the backdrop of a gradual decline in the citation of Peseschkian's typology, we propose an updated theoretical and clinical justification by integrating it with object relations theory and PPT models.

The article aims to reposition the typology of PPT development (naive-primary, secondary, ambivalent/double-bind, integrated) as an operational framework, comparing each type with the corresponding ORT constructs (positions in Klein; ego structures in Fairbairn; holding/true–false self in Winnicott; "basic fault" in Balint; identity and borderline organisation in Kernberg) and showing how the "language of abilities" and the five stages of PPT translate these counterparts into algorithms for clinical work. In this way, we aim to enhance diagnostic sensitivity for ambivalence and to provide practical guidelines for planning interventions that account for transcultural moderators. The article concludes with a summary discussion and a tabular comparison suitable for clinical, educational, and research practice in PPT. Special attention is given to the transcultural dimension of PPT as a moderator of typological configurations and developmental trajectories.

This article argues that, when read through object relations theory, Peseschkian's typology functions not merely as a descriptive model but as an operational psychodynamic framework that links diagnosis, conflict dynamics, and staged clinical intervention within a transcultural context.

Methodology

Methodologically, this study employs a comparative theoretical analysis that integrates the typology of Positive Psychotherapy with key constructs from object relations theory, attachment theory, and contemporary psychodynamic diagnostic frameworks (OPD and PDM-2). The analysis is conceptual and heuristic in nature and does not aim at direct empirical validation. Instead, it focuses on clinical

operationalisation, integrative case formulation, and the translation of psychodynamic metatheory into staged therapeutic intervention.

This section outlines the conceptual coordinates that allow PPT typology and object relations theory to be read within a shared psychodynamic framework. At the centre of this framework lies the dynamics of conflict. The "there-and-then" axis corresponds to the basic conflict (BC), shaped by internalised early relationships and family–cultural concepts. The "here-and-now" axis reflects the actual conflict (AC) that arises from current demands, roles, and expectations. They are mutually activated by the polarity of "sincerity – politeness," which manifests in KC (key conflict: "what I wanted to do" vs. "how I reacted"), and together this is formalised as IC – inner conflict (Goncharov, 2025). Such a diachronic-synchronic perspective brings PPT closer to ORT, in which maturity is conceived as the ability to withstand ambivalence and to combine opposing affects into a holistic representation of the object.

In this context, I. Kirillov's proposal to consider primary actual abilities as "grains" of ego functions with two modes (towards oneself/towards others) and levels of integration, compared with OPD, is important; this approach strengthens the connection between PPT and ORT and provides a clinically testable language of description (Kirillov, 2024; 2025a; 2025b).

For systematic mapping, we rely on the Role Model "I-Thou-We-Origin-We" (differentiation of self; dyadic relationships; social norms/boundaries; worldview/values/hope) and the Balance Model (sensation/body; activity/achievement; emotions/contacts; fantasies/meaning/future), which allow us to describe points of imbalance and trajectories of integration. Additionally, we rely on I. Kirillov's series on the operationalisation of primary abilities (Contact, Pleasure, Love, Care, Time, Trust, Meaning, Ideal) as bridges between PPT, ORT, and the OPD structural integration axis (Kirillov, 2024; 2025a; 2025b).

The origins of object relations theory can be traced to Sigmund Freud's psychoanalytic theory, which laid the conceptual foundations for ego psychology, defence mechanisms, and transference/countertransference. However, the key intellectual shift was a move from drives to the primary role of relationships with the "object" in determining development (Freud, 1916–1917/2016). In the 1930s–1970s, Melanie

Klein, drawing on child analysis, described the early internalisation of "partial" and "whole" objects, mechanisms of splitting, envy and the role of unconscious fantasy; she considered the transition from the paranoid-schizoid to the depressive position as the axis of integration of affects and object representations (Klein, 2018, 1975; Segal, 2018). Independent of this line of thought, Ronald Fairbairn formulated the thesis that libido is directed towards objects rather than the satisfaction of desire, and proposed a model of internal ego structures (libidinal, anti-libidinal, central ego) as the "sediment" of internalised connections (Fairbairn, 1952; Sutherland, 2005). Donald Winnicott introduced the concepts of holding, the idea of a "good enough mother," and the true/false self continuum, emphasising the role of a supportive environment in fostering the spontaneity of the self (Winnicott, 2018, 1991). Metapsychology was supplemented by W. R. Bion (container-contained, alpha function) and other representatives of the British school (Bion, 1962; Sutherland, 2005). At the same time, the critical stages of attachment and separation-individuation were outlined by Bowlby (2018) and Mahler et al. (1975). In the American tradition, Otto Kernberg integrated ego psychology, object relations theory, and the clinic of borderline organisation, detailing the trajectory of introjection → identification → ego identity formation (Kernberg, 1985, 1995). In general, object relations theory can be understood as a meta-theory of contemporary psychodynamics. It conceptualises development through the quality of early relationships and their internalisation, interprets psychopathology as a disruption in the integration of internal objects, and shifts the focus from drives to relational patterns and the capacity to tolerate ambivalence (Klein, 2018; Fairbairn, 1952; Winnicott, 1991; Bion, 1962; Kernberg, 1985).

Methodologically, this sets two coordinates for clinical analysis – "there-and-then" (history of internalisations) and "here-and-now" (current relationships), between which there is continuous projection and modification of past configurations (Holmes, 2014). Karen Horney's sociocultural perspective further showed that basic anxiety (loneliness/helplessness in a potentially hostile world) is regulated by three strategies – "movement towards," "against," and "away from" others – and is accompanied by tension between the idealised and devalued self

(Horney 2013, 1945, 1991). In terms of object relations theory, these are different ways of maintaining object integrity and protecting against disintegration; maturity is associated with a non-monostrategic, ambivalence-tolerant organisation (Klein, 1975; Horney, 1991).

Positive Psychotherapy (PPT) conceptualises development as the unfolding of two universal basic capacities – cognition and love – that exist as potential and are differentiated by environmental influences (Peseschkian, 1987). This perspective intersects with ORT, which derives the quality of development from early relationships and their internalisation (Klein, 2018; Fairbairn, 1952; Winnicott, 1991). While ORT focuses on the transition from splitting to integration of internal objects (Klein, 1975), PPT aligns this logic with the "language of abilities" and two structural models – the Role Model (I–Thou–We–Origin–We) and the Balance Model (body, activity/achievement, contacts, meaning/future) – as theoretical frameworks for describing development (Peseschkian, 1987/2026b). PPT also distinguishes between levels of conflict (basic, key, current, internal), which reflect the two-dimensional logic of "there-and-then / here-and-now" (Holmes, 2014) and resonate with the trajectory of transition from partial to whole objects (Klein, 2018, 1975).

Peseschkian and Remmers (2025) emphasise systematic differences between individualistic and collectivist cultures. In the transcultural dimension, the integrated type is the ability to combine different value systems (individualistic ↔ collectivist) without losing identity. Individualistic contexts reinforce secondary abilities (achievement, autonomy), while collectivist contexts reinforce primary abilities (care, connection) (Peseschkian, 1987). Maturity lies in the ability to integrate these poles, which underpins transcultural competence. Within this framework, naive-primary configurations may be culturally reinforced in collectivistic contexts, whereas secondary configurations are often valorised in individualistic societies. Ambivalent dynamics frequently emerge in migratory or multicultural settings, where conflicting value systems coexist and challenge the integration of stable identity.

Kirillov (2019) offers a process-based view of the maturation of primary abilities as a sequence in which repeated or strong experiences of satisfaction/dissatisfaction (the ability of Satisfaction) in contact with an object form

Contact, which naturally seeks to stabilise itself through Love and mutual Care; awareness of the sequence of actions that lead to satisfaction actualises the need for Time, and when there is enough of it, the groundwork for Trust is laid; finally, the accumulated experience of satisfaction allows us to form connections between objects and patterns of events (Meaning) and to make predictions, which we can rely on to withstand the anxiety of uncertainty, as well as to set and achieve goals, idealising our own or others' ideas (Ideal).

This sequence is consistent with the logic of ORT (internalisation → integration of objects) and can be operationalised through self/object modes and levels of structural integration (OPD). The operationalisation of primary abilities proposed by Kirillov refines definitions. It introduces comparability with OPD measures

(self/object modes, levels of integration), which facilitates the mapping of trajectories from splitting to integration in ORT coordinates (Kirillov, 2024; 2025a).

Within the framework of PPT, the distinction between primary and secondary capacities serves as a theoretical axis, consistent with models of ego structuring and self-organisation in the post-classical psychoanalytic tradition (Fairbairn, 1952; Kernberg, 1985, 1995, 1980; Winnicott, 2018). Additionally, the three-dimensional body–environment–time map establishes a conceptual field consistent with ORT ideas about the internalisation and integration of objects and allows the description of the continuity between "there-and-then" and "here-and-now" (Peseschkian, 1987/2026b; Klein, 2018, 1975) (see Figure 1).

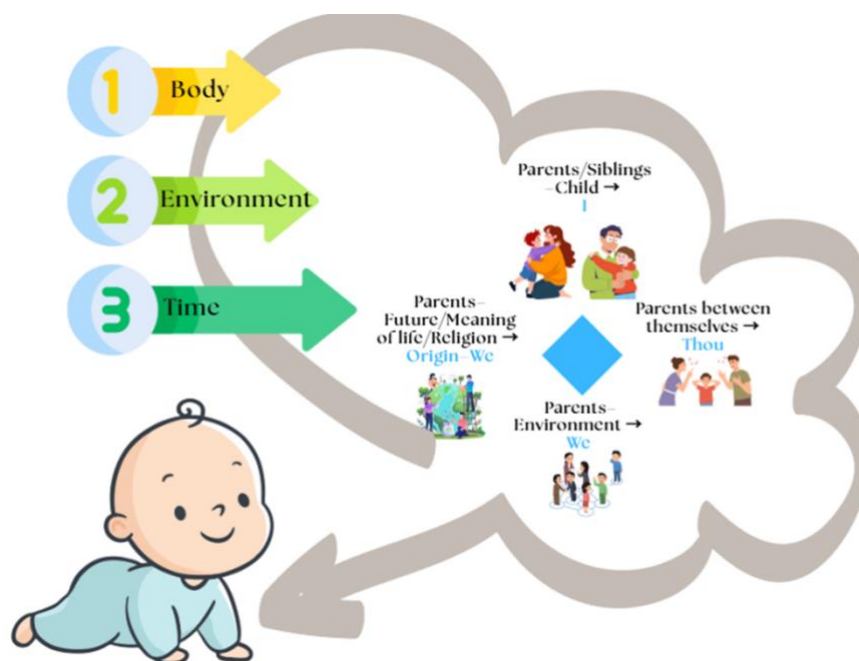


Figure 1. Three formative coordinates of personality in Positive Psychotherapy (Body, Environment, Time) and The Four Role Model Dimensions

Figure 1 illustrates how four relational matrices are internalised through direct contact and observation: parents/siblings – child ("I"); relationships between parents ("Thou"); parents – the outside world ("We"); parents – the future/meaning/religion ("Origin-We"). Adapted from Peseschkian (1987).

The body encompasses genetic constitution, temperament, sensorimotor foundation, and primary abilities that determine basic sensitivity to relationships and conflicts; the environment is external objects and contexts (significant others,

family and cultural scenarios, social norms and "enabling" interactions) that provide material for internalisation; Time refers to temporal perspective tendencies (retrospective narratives, current response patterns, projections into the future) that link early traces of experience with current interpretations and choices of action. Within this framework, it is possible to trace how early internalised objects are gradually modified by environmental demands and temporal contexts, shifting from fragmented, split representations to more integrated,

ambivalence-tolerant structures that directly affect the configuration of internal conflict and the trajectories of clinical integration. In group Positive Psychotherapy, these "internal objects" become visible through affective resonances and repetitive interaction patterns, facilitating targeted interventions along the axes of ego differentiation, impulse control, and connectivity (Dobiąła, 2025).

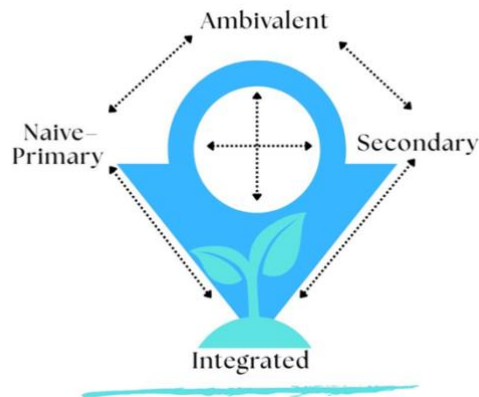


Figure 2. Dynamic configuration of integration across Positive Psychotherapy personality types

To summarise the conceptual and methodological foundations outlined above, the PPT typology can be conceptualised not as a linear developmental sequence but as a dynamic configuration of personality organisation. Figure 2 depicts the four PPT types as reversible modes that emerge at the intersection of primary and secondary abilities, conflict dynamics, and relational regulation.

Figure 2 presents the naïve, primary, secondary, ambivalent (double-bind), and integrated types not as linear developmental stages, but as coexisting and context-dependent modes of personality organisation. Dotted arrows indicate bidirectional movement between modes, contingent on conflict activation, relational context, and stress. In this sense, integration refers to a functional level of organisation rather than a fixed developmental stage.

Results

This comparative analysis yields three core conceptual findings. First, Peseschkian's typology can be reconceptualised not as a linear developmental sequence, but as a set of reversible modes of personality organisation. Second, transitions between these modes can be

operationalised through PPT's language of abilities and five-stage process, allowing integration to be traced clinically. Third, when read through object relations theory, the typology provides a coherent framework for linking conflict dynamics, attachment patterns, and therapeutic intervention planning. Although N. Peseschkian's typology is less frequently cited in contemporary discourse, its explanatory power increases when it is read as a process interface between object relations theory and clinical practice (see Figure 2). It operationalises the transition from splitting to integration through the "language of abilities" (primary/secondary/actual) and links development to levels of sensations, emotions/feelings, activities/achievements, and meanings/future (Balance Model), allowing hypo- and hyperfunctions to be recorded as measurable markers of change. In this framework, the sequence of the five stages of PPT (distancing → inventory → situational encouragement → verbalisation → goal expansion) acts as a procedure for integration: from the containment of affects (holding/containment) – through the expansion of the reflective function and mentalisation – to the formation of new internal objects and more stable self-regulation. In PPT, based on Kirillov's sequence (2019), primary abilities can be understood as "seeds" of ego functions that mature in relationships (ORT) and are measured by levels of structural integration (OPD), ranging from basic experiences of satisfaction/contact to temporal-semantic organisation (Sense/Ideal). For child and adolescent PPT practice, this trajectory requires a separate configuration of the therapeutic triangle "child-parents-therapist," clear contract boundaries, and micro-interventions that support secure attachment in the session (Dokunova & Chekmarev, 2025). In this sense, integration is conceptualised as a functional capacity rather than a normative endpoint, allowing for contextual regressions and shifts between typological modes depending on relational stress and conflict activation.

Thus, the PPT typology (naïve-primary → secondary → ambivalent → integrated) ceases to be merely a descriptive classification and becomes a clinically oriented map of change consistent with attachment theory and object relations theory. Its value lies in its ability to describe diagnostics, intervention plans, and outcome assessments in a single language:

growth in trust/patience, along with boundaries/planning, alignment of Balance spheres, and movement from "either-or" to "and-and" (closeness **and** autonomy). This provides a basis for empirical testing (ability scales, balance index, transition trajectories) and enables reconsideration of the Peseschkian model within contemporary psychodynamic discourse.

3.1. Comparative typology of personality development in PPT and psychodynamic approaches

The typology of personality development in Positive Psychotherapy proposed by N. Peseschkian (Peseschkian, 1987; Peseschkian, 2026b) is productively considered through the prism of classical psychodynamic theories – object relations theory (Klein, 2018), attachment theory (Bowlby, 1982, 1973, 1980), and the concept of motivational strategies (Horney, 1945, 1991). Such an interparadigmatic analysis expands the explanatory and clinical potential of the model, allowing not only to describe the main trajectories of personality development, but also to interpret more deeply the intrapsychic mechanisms, interpersonal patterns, and defensive-motivational strategies that determine an individual's behaviour. In this context, the PPT typology emerges as a dynamic model that integrates diagnostic and therapeutic levels into a single conceptual system of the psychotherapeutic process.

In contemporary psychotherapeutic discourse, N. Peseschkian's typology can serve as a conceptual bridge between classical and neo-Freudian schools and contemporary integrative approaches to psychodynamics. Within the framework of Kohut's self-psychology (Kohut, 1971, 1977), the primary developmental factor is the need for a stable "self-object" that supports the integrity and continuity of the "I's" image.

For the naive-primary type, this manifests as a desire for unconditional acceptance; the secondary type employs a compensatory strategy – achieving stability through autonomy, control, and competence.

The mentalisation theory of P. Fonagy et al. (Fonagy et al., 2018) explains the transition from the ambivalent to the integrated type as the formation of the ability to reflect on one's own and others' mental states: it is the development of the mentalisation function that integrates opposing tendencies – the need for dependence and the desire for autonomy – which is a sign of psychological maturity.

The PPT typology is consistent with the dichotomy of internal conflict: the tension between the needs for love, acceptance, and security (basic level – the level of basic conflict) and the demands for autonomy, responsibility, and achievement (actual level – the level of actual conflict) determines the trajectory of development. From this perspective, the movement from the naive-primary to the integrated type is a gradual integration of basic and actual abilities that ensures the integrity of mental functioning, tolerance for ambivalence, and the capacity to work constructively through conflict. To translate this dynamic model into a clinically accessible format, Table 1 presents a comparative overview of the four PPT types in relation to object relations theory, attachment patterns, dominant defensive configurations, and corresponding therapeutic vectors. While Figure 2 presents the PPT typology as a dynamic configuration of personality organisation, Table 1 provides a detailed comparative overview of each type in relation to object relations theory, attachment patterns, dominant defences, and therapeutic vectors. The table is designed as a clinical heuristic rather than a rigid diagnostic classification.

Table 1. Comparative typology of personality development in Positive Psychotherapy and other psychodynamic approaches

<i>Personality type in PPT (Peseschkian)</i>	<i>Dominant pole</i>	<i>Object relations (M. Klein)</i>	<i>Attachment theory (D. Bowlby)</i>	<i>Reaction type (K. Horney)</i>	<i>Position dynamics</i>	<i>Basic defence mechanisms</i>	<i>Key characteristics</i>	<i>Therapeutic implications/vektor</i>
<i>Naive-primary type</i>	Love > justice; dependence on support	Paranoid-schizoid with elements of depression: early dependence on a good object, fear of loss, idealisation	Anxious-ambivalent: a strong desire for closeness and fear of abandonment	"Movement towards people" – search for love, support, dependence	From merging with the object → dependence → regression when frustrated → need for differentiation	Denial, idealisation, regression, avoidance, repression	Desire for merging with the object, avoidance of conflict, fear of losing love, focus on relationships even at the expense of one's own needs, high sensitivity to rejection	Strengthening secondary abilities; increasing frustration tolerance while maintaining basic trust; supporting differentiation from the idealised object; stabilising internal object representations through consistent mirroring; developing capacity for ambivalence; transition from dependence to mature intimacy (three stages of psychodynamics in PPT).
<i>Secondary type</i>	Justice > love; independence, control, achievement	Paranoid-schizoid: projection of threat, polarisation of "good/bad" object, distance as protection	Avoidant: minimising the need for closeness, relying only on oneself	"Movement against people" – aggression, rivalry, control	From compensating for lack of support → to overcontrol → to emotional isolation → to potential for integration of love	Intellectualisation, projection, isolation of affect, reactive formation, rationalisation	Striving for autonomy, avoidance of dependence, hypercompensation through achievement, self-sufficiency, orientation towards external criteria of value, minimisation of emotional needs	Reconnecting with primary abilities; softening rigid self-control; restoring emotional contact through safe relational cues; reducing perfectionistic and counterdependent defences; developing tolerance for mutual influence and vulnerability; movement from defensive autonomy to authentic reciprocity.

<i>Ambivalent (Double-Bind) type</i>	Fluctuation between love and justice; conflicting needs	Transitional phase between paranoid-schizoid and depressive : instability of the image of the object, splitting, introjection of conflicting ideas	Disorganized: chaotic patterns, conflicting desire for closeness and avoidance, fear of being absorbed and abandoned	A combination of all three strategies : movement towards, against, and away from people	From fluctuations between dependence and autonomy → to splitting → to "mental paralysis" → to integration of opposites	Splitting, identification fluctuations, compensation, internal sabotage, displacement	Simultaneous desire for closeness and distance, fear of dependence and abandonment, conflicting expectations of the object, indecision, mood swings, guilt, tendency to psychosomatic reactions	Integrating split object representations; increasing tolerance for ambivalence and contradictory affects; reducing oscillations between fusion and withdrawal; strengthening identity coherence and continuity of self; aligning primary and secondary abilities to reduce double-bind dynamics; movement from contradictory strategies to stable relational positioning.
<i>Integrated type</i>	Balance of love and justice; integration of abilities	Depressive: integration of good and bad objects, ability to tolerate ambivalence, concern	Secure: autonomy and capacity for closeness, stability of attachment	Balance of three strategies without neurotic bias	From ambivalence → to integration → to stability → to the ability to care	Sublimation, integration, mature repression, altruism	Ability to combine love and aggression, accept the contradictory nature of the object, maintain stable relationships, empathy, autonomy, and the ability to withstand frustration	Consolidating integrative capacities; deepening reflective and mentalising functions; enhancing reciprocal relatedness and generativity; stabilising complex affective states without regression; supporting long-term goal orientation across life spheres; movement from stability to generativity and creative complexity.

3.2. Naive-primary type

The naive-primary type is characterized by the dominance of needs for love, security, and acceptance, with insufficient development of autonomy and responsibility (Peseschkian, 1987). Its formation is attributable to excessive care in early childhood, when frustration and independence are not afforded space to mature. Therefore, primary abilities (love, trust, intuition, tradition) predominate over secondary ones

(planning, punctuality, ability to withstand stress), creating an imbalance between the need for closeness and the capacity for self-regulation. In the logic of Positive Psychotherapy, this imbalance reflects the structural difference between primary and secondary abilities: primary abilities emerge from early experiences of care, emotional closeness, and availability, whereas secondary abilities develop only through gradually increasing autonomy, tolerated frustration, and boundary-setting.

When the environment provides excessive protection or minimises opportunities for independent action, primary abilities become over-reinforced while secondary abilities remain insufficiently developed, creating the typical "love > justice" predominance of the naive-primary type.

Psychodynamically, this corresponds to the early phases of paranoid-schizoid and partially depressive positions (Klein, 2018) and an anxious-ambivalent attachment style (Bowlby, 1969/1982). The internal attitude – "love over justice" – supports symbiotic dependence: care and avoidance of conflict provide security but limit individualisation.

Clinical illustration

A female patient in her early thirties presents with recurrent anxiety and psychosomatic complaints emerging primarily in the context of close relationships. Her relational functioning is organised around prioritising emotional closeness over boundary-setting or open confrontation, and she tends to suppress dissatisfaction to preserve the bond (love > justice; dependence on support).

Interpersonally, she demonstrates heightened sensitivity to signs of emotional distance and a tendency to idealise significant others. At the same time, frustration or unmet expectations frequently lead to regression, withdrawal, or somatic tension rather than to direct self-assertion (e.g., idealisation or avoidance). Her relational dynamics oscillate between emotional merging and dependent attachment, followed by destabilisation when closeness is threatened, reflecting an unmet need for differentiation.

In therapy, this configuration is evident in a strong orientation toward the therapist's emotional availability and in difficulty articulating disagreement or negative affect. In therapy, such clients often minimise dissatisfaction, seek reassurance, and expect the therapist to intuitively anticipate their needs, while direct expressions of anger or disappointment are often avoided. Therapeutic work is therefore directed toward strengthening frustration tolerance and autonomy while maintaining basic trust, facilitating a gradual transition from dependence on external reassurance toward mature intimacy and internalised self-regulation.

In terms of object relations theory and related approaches, this profile is described as a predominantly paranoid-schizoid form of dependence, where the threat of disintegration is restrained by fusion with a "good" object (Klein, 1946); as fixation on the libidinal ego and dependence on the "good object" (Fairbairn, 1952); as a need for a holding environment with the risk of forming a false self in its absence (Winnicott, 2018, 1991); as a "basic fault" due to a lack of primary love (Balint, 1968); and as schizoid isolation as a defence against being absorbed by the object (Guntrip, 2018).

Peseschkian (1987) describes a range of behavioural options: **sufferer** (catastrophising and suffering as language), **the expectant** (passive hope of "guessing" needs), **the compliant** (over-obedience due to fear of losing love), **the troublemaker** (demonstrativeness as a mask for fear of abandonment), **the naive-religious** (transferring childhood dependence to the religious sphere as an expectation of unconditional love from God).

The desire for love and the fear of independence are dynamically combined; when confronted with reality, this dynamic results in "secondary pessimism" (disappointment/injustice in the world). Typical consequences are depressive and psychosomatic symptoms (anxiety, somatic exhaustion, sleep disorders, asthma, sexual dysfunction).

Therapeutic vector: development of secondary abilities (responsibility, frustration tolerance, independent decision-making) without losing basic trust and warmth; transformation of dependence into mature intimacy and transition from external confirmation of value to an internal sense of self-worth. When working with children and adolescents, this also entails providing dosing support, developing self-regulation through "restraining" micro-scenes of interaction, and including parents in the contract (Dokunova & Chekmarev, 2025).

3.3. Secondary type

The secondary type – the functional antithesis of the naive primary type – achieves security through autonomy, control, and competence (Peseschkian, 1987). In ORT, it corresponds to a paranoid-schizoid organisation, where threats are "objectified" and controlled through splitting and projection; in attachment

theory, it correlates with avoidance (Bowlby, 1973).

Secondary abilities (rationality, punctuality, discipline, responsibility) dominate at the expense of primary ones (love, intuition, sensuality). The postulate of "value through results" forms an attitude of self-sufficiency ("I will do everything myself"), which leads to emotional isolation and fear of losing control.

In paradigmatic terms, this corresponds to Klein's descriptions: the dominance of splitting and projection, where control serves as an antidote to vulnerability (Klein, 2018). Fairbairn discusses the prevalence of the anti-libidinal ego – self-control and the denial of needs – as a defensive style (Fairbairn, 1952). Winnicott emphasises the hyperfunction of the false self and maladjustment as the price of maintaining a connection with the object at the expense of authenticity (Winnicott, 2018). In Balint, this manifests itself as ocnophilia – "clinging" to structure, rules, and supports (Balint, 1968). Finally, Kernberg's logic observes a diffusion of identity with a predominance of affect isolation and intellectualisation (Kernberg, 1985,1995).

Clinical illustration

A man in his late thirties seeks therapy due to chronic exhaustion, sleep disturbances, and a growing sense of emotional emptiness despite stable professional success. His sense of security is organised around independence, control, and achievement, with a clear prioritisation of results and self-sufficiency over emotional closeness (justice > love).

In relationships, he maintains emotional distance and minimises the importance of dependency, relying primarily on himself. Situations involving vulnerability or emotional ambiguity are experienced as threatening and managed through increased control, rationalisation, or withdrawal. Relational perceptions tend to be polarised, with weakness projected onto others while autonomy and competence are rigidly maintained.

Behaviourally, this configuration manifests as perfectionism, workaholism, and a strong orientation toward performance. Affect is intellectualised and isolated, while emotional needs are denied or devalued. Under prolonged stress, tension is expressed through somatic complaints, irritability, or burnout rather than conscious emotional distress.

In therapy, the patient initially approaches treatment in a task-oriented manner and devalues emotional dependency. The therapeutic focus lies in reconnecting with primary abilities, softening rigid self-control, and restoring emotional contact through safe relational cues, supporting a gradual movement from defensive autonomy toward authentic reciprocity.

Behaviourally: desire for control, workaholism, perfectionism, rationalisation; defences – intellectualisation, isolation of affect, denial, reactive formation, rationalisation (Horney, 1991). Risks – hypertension, peptic ulcer disease, headaches, insomnia, sexual dysfunction.

Therapeutic vector: integration of the affective dimension – development of trust, acceptance of vulnerability, and awareness of emotional needs; harmonisation of primary and secondary abilities; transition from control/self-sufficiency to authentic intimacy and inner balance.

3.4. Ambivalent (double-bind) type

The ambivalent (double-bind) type occupies an intermediate position between the naive-primary and secondary poles (Peseschkian, 1987). It is characterised by contradictory impulses – the desire for closeness and the fear of being absorbed; the need for support and the avoidance of dependence. It is formed in conditions of inconsistent or contradictory parental messages (love/punishment, control/indulgence), which generate instability in the image of the object.

Psychodynamically, this is a transition between paranoid-schizoid and depressive positions (Klein, 1975). In the attachment, it corresponds to a disorganised style (Bowlby, 1980). Internal dialogue: "I can do it myself, but help me," "I want closeness, but I'm afraid of losing myself." Primary and secondary abilities alternate, creating an unstable balance.

In paradigmatic terms, this corresponds to Kleinian "transitional" states with unstable representation of the object (Klein, 1975); in Fairbairn's terms, it corresponds to a chronic conflict between internalised objects pulling in different directions (Fairbairn, 1952). In Winnicott's terms, this structure appears as a fluctuation between the true self and the false self – an attempt to maintain contact at the expense of authenticity (Winnicott, 1991). In

Balint's terms, it is a fluctuation between oncophilia (clinging to supports and rules) and philobatism (movement into space without supports) (Balint, 1968). Finally, in Guntrip, internal isolation functions as a defence that coexists with a powerful desire for relationship (Guntrip, 2018).

Clinical illustration

A woman in her early forties seeks psychotherapy due to chronic indecision, emotional instability, and recurring psychosomatic complaints. She reports intense involvement in close relationships followed by abrupt withdrawal, describing an internal conflict between a strong need for support and closeness and an equally strong fear of dependence and loss of autonomy. Contradictory impulses mark her subjective experience: a desire to be cared for alongside persistent doubts about trust and safety in intimacy.

In interpersonal situations, she alternates between seeking closeness, opposing others through irritation or criticism, and distancing herself emotionally or physically. These shifts are often rapid and context-dependent, leading to feelings of guilt, self-sabotage, and a sense of being "stuck" or mentally paralysed when faced with decisions involving commitment or responsibility. Relational expectations are unstable and internally conflicting, with simultaneous fears of abandonment and engulfment.

Affect regulation is inconsistent. Primary abilities (need for love, trust, emotional contact) and secondary abilities (control, planning, autonomy) alternate rather than integrate, resulting in oscillations between fusion and withdrawal. Defensive functioning is dominated by splitting, fluctuating identifications, internal sabotage, and displacement, while somatic symptoms emerge during periods of heightened relational tension.

In therapy, this configuration manifests as fluctuating engagement: moments of intense openness may be followed by withdrawal, doubt, or devaluation of the therapeutic process. The therapeutic focus lies in integrating split object representations, increasing tolerance for ambivalence and contradictory affects, and supporting the gradual alignment of primary and secondary abilities. The clinical aim is to facilitate a movement from contradictory relational

strategies toward a more stable and coherent relational positioning.

Peseschkian (1987) distinguishes the following variants: **insecure** ("Hamlet-like"), **exhaustion** (emotional emptiness after achievement), **"weather vane"** (changing positions depending on the context), **sexually ambivalent** and **indifferent** (fear of losing autonomy destroys stable intimacy).

Behaviourally, self-sabotage, frequent changes in decisions, mood swings, chronic guilt, and psychosomatic reactions are observed. At the same time, this structure has high potential for development, as a "meeting place" for opposites and learning tolerance for uncertainty.

Therapeutic vector: forming inner integrity, enduring ambivalence, practising "and-and" (rather than "either-or") in closeness/autonomy; stabilising primary abilities (trust, patience, love) in combination with the development of secondary ones (boundaries, planning, fairness).

3.5. Integrated type: synthesis as an indicator of maturity

Although Peseschkian's original typology is triadic, **PPT practitioners and trainers** in their current clinical and educational work distinguish **the integrated type** as a working designation for the achieved integration of love/justice and the harmonisation of primary and secondary abilities; thus, the idea of integration functions as a **target clinical construct** rather than as a new "fourth" type in this sense.

The integrated type results from the gradual integration of prior strategies. It entails a balance of love/justice, acceptance of the object's contradictions, the capacity to combine care with boundaries, and the capacity to endure frustration. In ORT, this is a depressive position (Klein, 1975); in attachment theory, it is a secure style (Bowlby, 1969/1982).

In paradigmatic coordinates, the integrated profile corresponds to the Kleinian depressive position, in which the integration of the "good" and "bad" object is achieved, and reparation becomes possible (Klein, 1975). In Winnicott, this manifests itself as the emergence and stability of the true self with the ability to play and spontaneity as markers of internal security (Winnicott, 1991). Fairbairn's logic refers to the transition to real relationships with a whole, rather than a partial or fantasised object (Fairbairn, 1952). Finally, in Kernberg,

integration is reflected in a formed identity with stable internal representations of oneself and others, which ensures affective continuity and impulse control (Kernberg, 1985).

In PPT, the integrated type is the harmonious development of primary (love, trust, intuition, care) and secondary (responsibility, purposefulness, punctuality, tolerance to frustration) abilities. It does not eliminate conflict, but transforms contradiction into a resource of maturity.

Clinical illustration

A woman in her mid-forties enters psychotherapy during a transitional period associated with professional change and the reorganisation of long-term relationships. She does not present with acute symptoms but seeks reflection on questions of meaning, responsibility, and relational reciprocity. Emotional closeness and autonomy are experienced as complementary rather than mutually exclusive.

In relationships, she can express care and dissatisfaction without excessive fear of loss or withdrawal. Conflicts are acknowledged and worked through rather than avoided or controlled, and ambivalent feelings toward significant others are tolerated without splitting or devaluation. Both her own limitations and those of others are recognised while stable relational bonds are maintained.

Affect regulation is flexible and integrated. Primary and secondary abilities are coordinated rather than alternating. Defensive functioning is predominantly mature, including integration, sublimation, and reflective containment of affect, allowing stress to be metabolised without regression into fusion or rigid self-control.

Therapeutic work focuses on consolidating integrative capacities, deepening reflective and mentalising functions, and supporting long-term goal orientation and generativity across relational and professional spheres. Integration is approached as an ongoing capacity rather than a final state, enabling movement from stability toward creative complexity.

Therapeutic vector: the integrated type is a model of psychological integrity towards which the process is directed: the creation of a new experience of interaction, where both love and conflict are endured without resorting to regression or control; "integration as a process"

involves accepting limitations, mistakes, and ambiguities as conditions for development.

Discussion

The presented typology demonstrates the non-linearity of development: the transition from polar security strategies (merger ↔ control) to their dialectical synthesis. The novelty lies in the operationalisation of interparadigmatic correspondents: intrapersonal positions, interpersonal patterns, and defence-motivational mechanisms are integrated into the practical logic of psychotherapy (Peseschkian, 1987). This creates a bridge between diagnosis and intervention, transforming work with current abilities into a means of development.

As Klein (2018) and Scharff & Scharff (1977) emphasised, internal objects are not passive "traces" of the past; they actively structure current relationships, expectations, affects, and conflicts. The task of therapy is to transform these internal structures through new experiences in the therapeutic relationship.

Considered in the broader tradition of ORT, the structure of the integrated type is consistent with ideas about mature ego integration: from the transition to the real object (Fairbairn, 1952), through the "play space" as a field of integration of the true self (Winnicott, 1991), the reparative renewal of primary love (Balint, 1968), overcoming pseudo-mature isolation (Guntrip, 2018), integrating positive/negative images of the object into a stable identity (Kernberg, 1985) – to the intersubjective space of shared symbolisation of affects (Ogden, 2018). In this sense, Peseschkian's typology is a humanistically expanded form of object-relational thinking, in which the integration of affective, cognitive, and cultural dimensions is central to maturity.

The PPT typology is a tool for psychodynamic diagnosis and intervention planning that combines descriptive, explanatory, and prognostic levels. At the diagnostic stage, it identifies dominant safety strategies, leading defence mechanisms, and expectations from the object. In a PPT reading of object-relations thinking, four PDM-2 core functions – identity, object relations, level of defences, and reality testing – provide a practical scaffold for situating the basic (there-and-then) and actual (here-and-now) conflict axes in routine case formulation (Tyshchenko, 2025). At the intervention stage, it

focuses on developing relevant abilities, increasing frustration tolerance, expanding autonomy, and enhancing capacity for intimacy. For example, a client with a dominant secondary configuration may demonstrate relatively intact reality testing and identity cohesion according to PDM-2 criteria, while simultaneously exhibiting rigid defensive patterns and limited affective integration in an OPD structural assessment.

In a broader humanistic context, PPT performs an integrative function, combining psychodynamic depth with a resource orientation. At its core is the idea of transforming conflict into a resource and the belief in the individual's capacity for self-reflection, change, and constructive interaction with the inner world and social environment.

Practical algorithmisation occurs through five stages of PPT – distancing → inventory → situational encouragement → verbalisation → goal expansion (Peseschkian, 1987,2026b; Remmers & Peseschkian, 2025). They "translate" the ORT metatheory into a step-by-step integration process: from the differentiation of true/false self and stabilisation of holding, to the reparation of internal objects, the harmonisation of primary/secondary abilities, and the expansion of the time-value horizon. In a group format, these vectors are operationalised through the structured use of group processes and mirroring, which enhances the integration of primary and secondary capacities (Dobiąta, 2025). In adolescent and child PTP, the phased approach takes on specific characteristics: distancing begins with the creation of a safe framework with the participation of parents/guardians, inventorying begins with the joint "translation" of language fields into behavioural micro-goals, and situational encouragement begins with short, achievable tasks that enhance self-efficacy (Dokunova & Chekmarev, 2025).

We would like to emphasise the ethical imperative of PPT: instead of labelling a patient as "hopeless," the position is "I do not yet have an effective way to help," which preserves room for hope and development (Peseschkian, 1987).

From an integrative perspective, Positive Psychotherapy deepens object relations theory by preserving its relational foundation while adding several clinically operational dimensions. These include: (a) a clear algorithm for integration through five therapeutic stages; (b) two models for mapping development (the Role

Model "I–Thou–We–Origin–We" and the Balance Model); (c) the "language of abilities" as indicators of hypo- and hyperfunctions and vectors of change; (d) a transcultural framework that contains and integrates ambivalence; and (e) a mechanism of therapeutically mediated maturation of primary abilities, from potential to capability (Peseschkian, 1987,2026b; Remmers & Peseschkian, 2025).

In this sense, PPT does not replace object relations theory. Instead, it renders its core assumptions clinically actionable by linking conflict dynamics, developmental positions, and staged intervention within a single therapeutic logic.

From a discussion perspective, the proposed typology functions not merely as a classificatory system, but as an interpretative framework that helps clinicians understand how different security strategies, defensive configurations, and object-related patterns organise personality functioning across developmental levels.

In terms of ORT, **the current conflict** is the "here-and-now" activation of partial/holistic representations of the object. In contrast, **the basic conflict** is a relatively stable matrix of internalisations (I–Thou–We–Origin–We) that determines the choice of defences and ways of regulating ambivalence (Klein, 2018, 1975; Peseschkian, 1987). The expanded four-dimensional matrix of internal objects in the PPT conceptually resonates with ORT, where development is conceived as the integration of split representations of the object, with an emphasis on the two-dimensional logic of "there-and-then/here-and-now."

Several limitations should be acknowledged. The proposed typology is conceptual and integrative in nature and does not claim direct empirical validation within the present article. Further research may focus on operationalising transitions between typological modes using quantitative measures of abilities, balance indices, and longitudinal designs. Nevertheless, the current model offers a clinically grounded framework for hypothesis generation and integrative case formulation.

Conclusion

The proposed integrative framework demonstrates that the typology of Positive Psychotherapy significantly enhances its explanatory and clinical value when considered

in dialogue with object relations theory. Personality development can be operationalised as a progression from fragmentation to integration through the "language of abilities," two cartographic models of PPT (the Balance Model and the Role Model" I-Thou–We–Origin–We") and a five-stage process (distancing, inventorying, situational encouragement, verbalisation, goal expansion), which acts as a procedural "integration scale." In this light, comparing dynamic PPT types with key ORT constructs illustrates a single axis of maturity: a movement from polar security strategies – fusion as a search for unconditional support and control as an attempt at self-sufficiency – to their dialectical synthesis, which involves the ability to withstand ambivalence, combine care with boundaries and aggression with love, maintain the stability of internal objects and realistic self-identity.

Clinically, this integration offers a common language for case formulation, intervention planning, and change assessment. The PPT typology serves as a tool to quickly identify leading defences, expectations for the object, and target vectors of development (strengthening primary or secondary abilities,

balancing spheres, transitioning from "either-or" to "both-and" in the dynamics of closeness and autonomy). It combines the psychodynamic depth of ORT with the resource position of PPT, in which conflict is understood as a potential for growth and the therapeutic alliance as a space for new internalisations that support the reparation of internal objects. The concept of the "integrated type" functions appropriately as a target clinical construct: not a separate category, but a dynamic state of coherence in which love and justice, sensuality and planning, dependence and autonomy become complementary poles of regulation.

Ultimately, the "bridge" between PPT and ORT allows us to reposition Peseschkian's typology as the operational core of contemporary, culturally sensitive psychodynamic practice. It provides a seamless transition from subtle diagnosis of ambivalence and conflict to the step-by-step construction of an integrated identity, in which therapeutic change occurs not only through interpretation, but also through experience, internalisation, and an ethical commitment to hope as a methodological principle of psychotherapy.

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Section: Modern Positive Psychotherapy (PPT) practice

Positive Transcultural Psychotherapy in the Treatment of Anorexia Nervosa (AN) and Bulimia Nervosa (BN)



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Abstract

This paper aims to present a treatment model for anorexia nervosa (AN) and bulimia nervosa (BN) using Transcultural Positive Psychotherapy (PPT), with particular emphasis on the significance of *positum* in therapeutic interventions. As observed by Peseschkian, the concept of *positum* points to what already exists, the given reality of one's life, and reflects an attitude of acceptance toward life as it is, with its inherent resources and limitations. The Principle of *positum* is one of the core foundations of PPT; it assumes that an individual seeking help brings to therapy not only symptoms and difficulties but also personal resources and capacities that may not yet be used constructively. By facilitating access to the *positum*, therapists help patients reconnect with self-compassion, identity, and autonomy beyond the illness narrative. This paper presents selected cases of anorexia nervosa (AN) and bulimia nervosa (BN) to analyze the effectiveness of therapeutic procedures consistent with PPT's main principles and tools.

Keywords: eating disorders, anorexia nervosa, bulimia nervosa, *positum*, Positive Psychotherapy

Introduction

In many countries, the number of patients diagnosed with eating disorders has significantly increased over the past decade. The term *eating disorders* most commonly refers to anorexia nervosa and bulimia nervosa; however, in recent years, new dysfunctional eating patterns have been identified, such as **alkorexia** (restricting food intake to increase alcohol tolerance without gaining weight), **pregorexia** (strict weight control during pregnancy to minimize changes in appearance), and **diabulimia** (intentional reduction or omission of insulin doses to maintain or lower body weight) (Hoffmann, 2021).

Over time, not only have the approaches to diagnosing and treating anorexia and bulimia evolved, but also their prevalence in society. Eating disorders, particularly anorexia and bulimia, are increasingly common among young people. Current data indicate that they affect

21%-36.9% of adolescents (Mitchison et al., 2023), although the problem occurs across all age groups and genders (Bąba-Kubiś et al., 2018).

1.1. Changes in the diagnostic criteria for AN and BN in ICD-11

The *International Statistical Classification of Diseases and Related Health Problems* (ICD-11), which has replaced the previous ICD-10 version since 2022, modifies the diagnostic criteria for bulimia and anorexia nervosa. A minimum duration criterion (four weeks) for the occurrence of anorexia symptoms has been introduced. The criterion related to the absence of menstruation has been removed. In ICD-10, anorexia was indicated by a BMI equal to or below 17.5 kg/m², while in ICD-11, this is a BMI equal to or lower than 18.5 kg/m². The criterion of fear of gaining weight has been supplemented by a focus on body weight or shape, increased

physical activity, and eating behaviors that lead to a negative energy balance. According to ICD-11, the frequency of binge-eating episodes indicating the presence of bulimia is at least once a week over the past month (according to ICD-10, at least twice a week over three months). It is emphasized that during a binge-eating episode, there is a subjective loss of control over eating (Claudino et al., 2019).

In ICD-11, atypical anorexia nervosa and atypical bulimia nervosa, which were present in the previous classification, were not included, to reduce the frequency of diagnosing unspecified eating disorders, which constituted a so-called “diagnostic wastebasket with low informational utility” (Claudino et al., 2019).

Methodology

2.1. Treatment of anorexia and bulimia in the Positive Psychotherapy approach

Nossrat Peseschkian, the founder of Transcultural Positive Psychotherapy (PPT), emphasizes that maintaining balance across the four main areas of life (as defined in the *Balance Model*) is essential for health and psychological well-being.

These areas are:

- **Body/Senses:** physical health, diet, sleep, exercise, and overall care for the body;
- **Contact:** relationships with others, including family, friends, and colleagues, as well as the ability to communicate and build connections;
- **Achievement/Activities:** professional and academic development, everyday responsibilities, and actions that contribute to growth and satisfaction;
- **Future/Fantasy:** spirituality, religion, cultural values and traditions, as well as personal goals and aspirations.

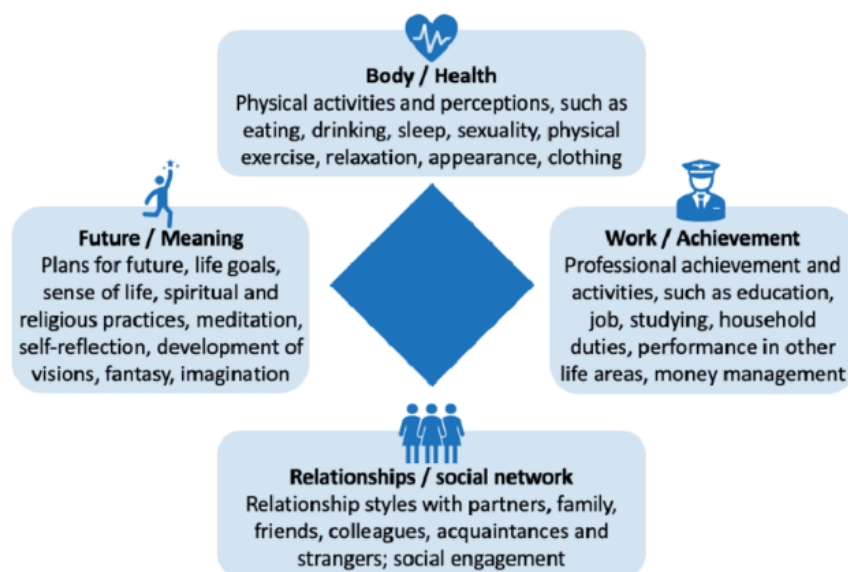


Fig.1. The Balance Model after Nossrat Peseschkian

Neglecting one of these areas may lead to imbalances in others. For instance, disturbances in the *Body/Senses* sphere can manifest as eating disorders such as anorexia or bulimia. PPT adopts a holistic perspective on health, recognizing that the symptoms of anorexia and bulimia represent unconscious attempts to restore psychological balance under specific life circumstances. As Dobiała (2021) explains, “every content brought by the patient is reflected through the prism of the *positum*, which includes both difficulties and the resources developed thanks to them.”

The *Positum Principle* is a foundational concept in Positive Transcultural Psychotherapy: the person attending therapy brings not only their symptoms and difficulties but also their own resources and opportunities, which they can cultivate constructively.

Peseschkian did not aim to treat individual disorders such as bulimia or anorexia per se. Instead, he developed a **general therapeutic framework** to help patients confront diverse emotional and psychological challenges. In his approach, the patient’s life story, together with myths, legends, and cultural narratives, provides

a basis for understanding personal struggles and for identifying solutions.

When applied to eating disorders, PPT provides tools to enhance positive self-perception, body acceptance, and emotional regulation, while fostering self-care and a healthier relationship with food. The therapeutic focus lies on understanding both the causes and sustaining mechanisms of the disorder (Peseschkian, 2016), uncovering the patient's

strengths, and developing constructive coping strategies.

According to this approach, the therapist collaborates with the patient to identify the **current (actual) conflict**, thereby facilitating recognition of deeper, basic, and **inner conflicts** (Ciesielski, 2016). Unresolved inner conflicts often manifest through psychological or psychosomatic symptoms, including eating disorders.

Table 1: Types of Conflicts in PPT applied to eating disorders

<i>Type of Conflict</i>	<i>Definition</i>	<i>Clinical Role in Eating Disorders (ED)</i>	<i>Typical Manifestation</i>	<i>Example (ED context)</i>
<i>Current Conflict</i>	A conflict related to a present life situation or stressor reported by the patient	Entry point into therapy; often triggers symptom escalation	Appears close in time to symptom onset or relapse	Starting university, loss of control, relational conflict, body-related stress
<i>Basic Conflict</i>	A stable conflict pattern formed in early relationships, especially within the family	Shapes vulnerability to eating disorders	Linked to conditional acceptance, performance, or control	"I am valued only when I am disciplined/perfect."
<i>Internal Conflict</i>	Tension between opposing actual capacities or values within the person	Core mechanism of symptom formation	Symptoms function as an attempted resolution of inner tension	Obedience vs. love and acceptance; control vs. emotional closeness
<i>Key Conflict</i>	A dominant, organizing conflict underlying personality structure and symptoms	Maintains the disorder across life spheres	Reappears in relationships, self-image, and body experience	Autonomy vs. dependence; self-worth vs. external approval

The therapist's task is to guide and motivate the patient toward resolving these conflicts by transforming dysfunctional beliefs, thoughts, and behaviors into adaptive, health-promoting ones. The PPT approach is inherently flexible and tailored to the individual's needs and circumstances. Its core lies in identifying and activating the patient's internal resources to promote positive change.

Given the complex nature of anorexia and bulimia, treatment within the PPT framework is often **multimodal**, potentially integrating nutritional interventions, pharmacotherapy, and medical supervision. Peseschkian (2016) identifies three essential elements at the

beginning of the therapeutic process for patients with AN or BN:

- 1. Observation of the patient and symptoms** – defining the diagnostic direction by considering personality type, communication style, differential diagnostic factors, and what the patient "offers" to the therapist.
- 2. Positive interpretation of symptoms** – reframing symptoms to help the patient recognize personal capacities and strengths, thereby fostering a constructive outlook.
- 3. Re-evaluation of the patient's role** – once the positive aspects of illness are acknowledged, the patient gradually assumes the role of their own "therapist."

Through this process, patients can reinterpret their disorder and develop a new relationship with it. For instance, anorexia may be reframed as “a capacity to cope with scarcity, the ability to share in the hunger of the world” (Peseschkian, 2016).

A central component of PPT is strategic thinking and structured action (Ciesielski, 2016), implemented through five therapeutic stages, which are also applicable in the treatment of anorexia and bulimia:

Stage 1: Observation and distancing – inquiry into symptoms, previous treatments, explanations of illness, positive interpretations, symptom-free periods, and transcultural aspects through proverbs and metaphors.

Stage 2: Taking an inventory – identification of key life events (ten from the past five years) to reveal the actual conflict; examination of their impact on relationships, work, family, and well-being; and exploration of conflict-solving styles and intergenerational beliefs (the “genealogical tree of beliefs”).

Stage 3: Situational encouragement – focuses on the positive outcomes of past experiences, encourages self-help activities (e.g., meditation, relaxation, or dietary changes), and reinforces the patient’s strengths and competencies.

Stage 4: Verbalization – discussion of remaining issues, identification of emotional blind spots, and practice of constructive communication skills.

Stage 5: Broadening of goals – formulation of realistic near-future goals for maintaining health, pursuing plans, and nurturing relationships.

In PPT, maintaining interpersonal relationships is grounded in the unity between the individual and their social environment. Many patients struggle with a diminished sense of community and an inability to express their emotional distress adequately. Experiences such as separation from parents or partners, or sensitivity to perceived injustices within the family, frequently resurface in therapy (Peseschkian, 2016). Addressing these conflicts becomes a therapeutic entry point.

The use of metaphors, parables, and anecdotes, such as “The Cure for Madness,” helps to reduce emotional tension and strengthen the therapeutic alliance. This narrative technique enables patients to

reinterpret their illness and engage more actively in the healing process.

Pharmacological treatment, when indicated, may include mild antidepressants that support emotional stability without diminishing the patient’s motivation or activity (Peseschkian, 2016).

Diagnosis and assessment in PPT often involve the Anorexia Nervosa and Bulimia Questionnaire developed by Nossrat Peseschkian (2016), which comprises 18 questions aligned with the four life dimensions of the Balance Model: Body/Senses, Achievement/Activities, Contacts, and Future/Fantasy. As Ciesielski (2016) notes, “it helps to grasp the individual patient’s matters in a personalized way while creating a broader frame of reference.”

PPT assumes that conflicts should be resolved within the sphere where they originate. However, individuals sometimes attempt to escape into other areas of life to reduce inner tension, leaving the conflict unresolved and perpetuating maladaptive patterns (Sheremeta, 2024). From the PPT perspective, anorexia and bulimia are thus understood as manifestations of deeper psychological conflicts.

Through a collaborative therapeutic process, these conflicts are uncovered, and patients learn to recognize and activate their personal resources to cope constructively with stress, emotional pain, and life crises.

CASES

3.1. Ania, age 10

Ania was brought to psychotherapy by her mother because of anorexia nervosa (BMI 12.8, below the 10th percentile for age). Before entering this treatment, she had received help from two psychologists and a psychodietitian, but had refused to cooperate with them.

The onset of food restriction occurred in 2020 when Ania’s mother contracted COVID-19 and was hospitalized with a severe, life-threatening course of the illness. During this time, Ania’s father was unable to cope with the situation. He neglected the children, stopped eating, and became apathetic. At age nine, Ania assumed her mother’s responsibilities: cleaning, preparing meals for her father and older brothers, and managing the household. Following her father’s example, she began to restrict her own food intake. It seemed as though

she had made an unspoken pact with God that if she stopped eating, her mother would recover.

After nearly three months, when her mother returned home, Ania's weight had decreased by 4 kilograms (from 37 kg at 140 cm). Her mother's return did not improve the situation. On the contrary, Ania further restricted her food intake and increased physical activity, resulting in an additional 7 kg of weight loss over the next three months. She presented to the clinic, weighing 26 kg and measuring 140 cm in height.

Therapy was conducted in accordance with the principles of Transcultural Positive Psychotherapy. During the observation and distancing stage, the therapist empathized with the patient, expressing understanding of her situation and acknowledging her coping skills at such a young age. The symptom of anorexia was reframed as an expression of self-control, care for others, and strong willpower. Ania accepted this interpretation, agreed to continue therapy, and gradually became engaged in the process.

As therapy progressed, Ania's maturity and sense of responsibility became evident. She managed the household, created shopping lists, prepared meals, and cared for her family members. The crisis caused by her mother's illness and her father's withdrawal forced her to assume adult responsibilities prematurely, bypassing a developmental stage. Her articulate speech and logical reasoning contrasted with her small stature; she appeared seven or eight years old, and her feet barely reached the floor. Nevertheless, the therapist adapted to Ania's chosen conversational level, thereby fostering trust and cooperation.

Analysis based on the Balance Model indicated that Ania's conflicts were concentrated mainly in the **Contacts/Tradition** sphere, while her symptoms appeared in the **Body/Senses** area as anorexia. During her mother's hospitalization, Ania had assumed control over the household. After her mother's return, the previous order was reinstated, and the mother again treated Ania as a small child. This led to mother–daughter conflicts, in which food became a symbolic expression of the struggle for autonomy. Ania's most significant internal conflict emerged: *"I cannot stop loving my*

mother, but I also cannot give up the autonomy I gained when she was gone."

Using PPT tools, therapy focused on addressing and modifying this dynamic. As Ivanova (2021) observes, the relationship between parents and an adolescent with anorexia is often a "real test of strength," in which the therapist acts as a mediator. The therapist explained that "every hunger strike has its end." Following this, Ania agreed to new, jointly established rules and defined an area in which she could retain control over food, now reframed as healthy eating.

She began writing a book on nutrition for teenagers, photographing her meals, and sharing them on a social media profile. Her mother also changed her approach, ceasing to treat Ania as a small child and recognizing her right to make independent choices regarding food, clothing, and leisure. She supported Ania's decisions, assisted with grocery shopping according to Ania's lists, and permitted short walks alone, provided Ania maintained her health.

After four months of therapy, Ania's weight had increased to nearly 31 kilograms (BMI 15.4, the lower limit of the 15th percentile). She appeared happier, enrolled in dance classes, and began to allow herself to experience age-appropriate joy and playfulness. Her BMI reached an age-appropriate level.

Ania's mother actively participated in therapy, working to change rigid beliefs about the division of roles between mother and child. Both the therapist and the mother observed significant progress, enabling deeper work on the fundamental conflicts identified earlier. Unexpectedly, Ania decided to resolve her most important internal conflict, *the conflict between obedience and love and acceptance*, on her own. She politely but firmly stated her wish to end therapy: *"My greatest strength in getting better was that I came to you, but now I want to take care of myself."*

With her mother's agreement, the therapist respected Ania's decision, recognizing her need for autonomy and independence. They established conditions for continued safety: Ania agreed to her mother's monitoring and to resume therapy if her condition deteriorated.

Table 2: Key Therapeutic Interventions and Clinical Goals by Therapy Stages (PPT)

<i>Therapy Stage (PPT)</i>	<i>Key Interventions</i>	<i>Clinical Goals</i>
<i>Observation and distancing</i>	Empathic joining with the patient; the therapist empathically acknowledged Ania's premature responsibility, validated her competencies, and adapted communication to her mature, self-chosen level.	Building a trusting, safe, and collaborative therapeutic alliance.
<i>Symptom reinterpretation</i>	Reframing of anorexia as a meaningful expression of control, care, loyalty, and a way of coping during a family crisis, rather than defiance or pathology.	Reducing resistance and enabling reflective engagement.
<i>Balance Model analysis</i>	The Balance Model located conflict in Contacts/Tradition, with anorexia expressing unresolved autonomy and relational tensions somatically.	Understanding the underlying dynamics, increasing insight into symptom function and dynamics.
<i>Family work</i>	Mediating the mother–daughter relationship and interactions, helping reframe food struggles as symbolic autonomy conflicts rather than disobedience or parental failure.	Reducing relational conflict and power struggles.
<i>Renegotiation of control</i>	Establishing agreed-upon rules regarding eating, along with rules governing who may join, afforded Ania limited control while ensuring medical safety and parental involvement.	Preserving autonomy; supporting the safe development of age-appropriate autonomy.
<i>Strengthening resources</i>	Writing a book, creative activities; Ania's strengths were reinforced through creative activities, nutrition writing, and self-directed projects supporting competence and identity development.	Enhancing agency and self-efficacy beyond illness.
<i>Termination of therapy</i>	Respecting the patient's decision, the therapist respected Ania's autonomous decision to end therapy, establishing monitoring and clear conditions for return if needed.	Integrating autonomy, consolidation of autonomy while maintaining safety.

In Ania's case, therapy conducted within the framework of Transcultural Positive Psychotherapy made it possible to establish a therapeutic alliance through empathetic recognition of the child's resources and a reinterpretation of the symptom. The key conflict was the tension between love and loyalty to the mother and the need for autonomy acquired during her absence. Through changes in the mother–daughter relationship, renegotiation of control over eating, and support for autonomy, Ania gradually improved both her somatic and psychological functioning. After four months of therapy, she achieved significant improvement and independently decided to terminate therapy, while maintaining previously established safety conditions.

3.2. Sandra, age 2

An art-school student on academic leave. Her diagnosis included alternating anorexia–bulimia and bulimia symptoms, with a neurotic conflict related to family circumstances and fear of the future. She believed that, due to unforeseen events such as the COVID-19 pandemic, her plans would never materialize, and she would remain dependent on her family. Her personality structure was classified as neurotic. At the beginning of therapy, her BMI was 17, accompanied by depressive and anxious symptoms, low energy, dizziness, and fainting episodes. The most recent fainting spell led to a fall, concussion, and the loss of a molar tooth, which became the direct reason for initiating psychotherapy.

Sandra's symptoms, initially anorexia, later anorexia–bulimia and bulimia, began in 2019 when she started art school. She adopted a restrictive diet because she felt “fat” compared to her classmates. She tended to “stress eat,” which intensified after moving out and worrying whether her mother could cope with an alcohol-dependent husband who had failed in a closed-setting treatment. Additional stress arose from comparing herself to classmates and feeling less talented and overweight. Initially, dieting produced quick results, and her weight dropped rapidly. Over time, however, starvation triggered binge episodes. Terrified of regaining weight, Sandra began inducing vomiting, entering a vicious cycle of bingeing and purging interspersed with periods of fasting. She reported that vomiting brought a sense of relief and release of bodily tension, which perpetuated the cycle.

At university, Sandra performed very well and won several awards, including one for a poster promoting a traditional festival in a French town, which earned her an Erasmus scholarship. During her stay in France, she shared a room with a local student, developed social relationships, and led an active life. She felt happy and free from the constraints of her diet and purging behavior. However, in spring 2020, the COVID-19 pandemic was declared, classes were suspended, and students were instructed to return home before border closures. After many difficulties, Sandra returned to her family home. The traumatic circumstances of the pandemic, combined with renewed exposure to her father's alcohol problem, led to a depressive–anxious disorder. She once again resorted to fasting, periodic bingeing, and vomiting.

PPT-based psychotherapy revealed an **actual conflict**, which activated deeper, basic conflicts, including Achievement versus Acceptance, Achievement versus Self-Confidence, and Hope versus Reliability. These inner conflicts generated symptoms across all four areas of the Balance Model, most strongly within the spheres

of **Body/Senses** and **Future/Fantasy**. Sandra lost faith in her future and often asked, “What will become of me?” She withdrew from studies and social interactions. At home, she was under strong pressure to “have a good job and earn a lot,” to “be somebody.” Her parents expected success yet never offered praise, particularly her father, whose approval she valued most.

Sandra identified her most difficult internal conflict as follows: *“Once in my life, I managed to be happy – when I was far from home and from university. I know I should be where I am now, but I cannot accept it. I will never be happy again.”*

Therapeutic work using the Balance Model and differential analysis of potentialities indicated that Sandra needed to rebuild self-confidence, coherence, and belief in her ability to shape her future despite adverse events. The parable *“Courage to Try”* and reframing her bingeing and vomiting as maladaptive methods of coping with overwhelming stress allowed her to explore alternative strategies for emotional regulation. She began eating regular meals without purging and observed that her weight stabilized naturally. Sandra also recognized the parallel between her own behavior and her father's: *“He learned to drink under stress, and I learned to eat and vomit,”* she concluded. This insight opened communication with her father and improved their relationship. She gradually accepted her *positum*, acknowledging both suffering and joy as integral parts of her life experience.

With regular, balanced meals that met her caloric needs, Sandra regained physical strength and energy. She reconnected with friends, resumed drawing and painting, and began considering a return to university in another city. A turning point occurred when she attended a friend's wedding in her former university town. She received numerous compliments, met a new partner, was reinstated into her third year of study, found a part-time job, and finally moved out of her family home, fulfilling her long-standing dream.

Table 3: Key Therapeutic Interventions and Clinical Goals by Therapy Stages (PPT)

<i>Therapy Stage (PPT)</i>	<i>Key Interventions</i>	<i>Clinical Goals</i>
<i>Observation and distancing</i>	Systematic observation of eating behaviors, emotional states, and somatic symptoms; linking symptoms to situational stressors; establishing a reflective stance toward symptoms.	Increasing self-awareness; creating emotional distance from symptoms; stabilizing therapeutic alliance.
<i>Symptom reinterpretation</i>	Reframing bingeing, fasting, and vomiting as attempts at affect regulation and tension release; normalization of symptoms as meaningful responses to stress.	Reducing shame and self-criticism; transforming symptoms from compulsive acts into objects of reflection.
<i>Balance Model analysis</i>	Mapping symptoms across the four Balance Model spheres; identification of actual and basic conflicts (e.g., Achievement vs. Acceptance, Hope vs. Reliability).	Enhancing insight into intrapsychic dynamics, restoring coherence and meaning, and identifying core areas of imbalance.
<i>Family work</i>	Exploring parental expectations, lack of validation, and emotional climate; interpretation of transgenerational coping patterns (e.g., addiction vs. eating disorder).	Improving differentiation from family dynamics; fostering relational understanding and emotional autonomy.
<i>Renegotiation of control</i>	Gradually reducing rigid dietary control, establishment of regular, balanced eating, and tolerating uncertainty without symptom use.	Restoring bodily trust; replacing symptom-based control with flexible self-regulation.
<i>Strengthening resources</i>	Activating creative, social, and academic competencies; reinforcing successful experiences and autonomy-supportive decisions.	Rebuilding self-confidence, agency, and future orientation; consolidation of adaptive coping.
<i>Termination of therapy</i>	Reviewing and integrating therapeutic gains; reflection on changes in symptom meaning and self-concept; preparation for separation.	Consolidation of ego strength; supporting internalization of therapeutic functions; enabling independent functioning.

In Sandra's case, psychotherapy progressed through clearly defined stages, PPT, beginning with observation and distancing from symptoms following a medical crisis. Eating disorder behaviors were reinterpreted as stress-regulation strategies, which reduced shame and enabled reflection. Using the Balance Model, core conflicts related to achievement, self-worth, and future orientation were identified. Family dynamics, especially parallels between the patient's symptoms and her father's alcohol dependence, were explored, leading to improved communication. As therapy progressed, control over eating was renegotiated, allowing for regular nutrition and physical stabilization. Strengthening personal and social resources restored autonomy and future orientation. Therapy concluded with

consolidation of gains and readiness for independent life and academic reintegration.

Discussion

Peseschkian's approach encompasses all dimensions of the patient's experience, both conscious and unconscious, and addresses both human limitations and personal strengths and competencies (Ciesielski, 2016). The *positum* of a person suffering from an eating disorder, such as anorexia nervosa or bulimia nervosa, includes not only the illness itself but also the capacity for recovery. The therapist in Transcultural Positive Psychotherapy (PPT) respects the patient's suffering while simultaneously recognizing and activating the inner strength and will necessary for healing (Ciesielski, 2024).

Transcultural Positive Psychotherapy can be regarded as potentially effective in the treatment of anorexia and bulimia primarily because of the *positum* construct, which enables therapists to flexibly adapt to the patient's condition and to use all aspects of the patient's experience, including symptoms themselves, as therapeutic material.

In psychotherapy, understanding the symptom as part of the *patient's life* and recognizing its role in it are essential. This understanding enables the therapist to perceive the problem from the patient's perspective and tailor interventions accordingly. It also facilitates the patient's own inner work (Sheremeta, 2024).

The same personal potentialities that, when used unconsciously, lead to disorders and symptoms can, once made conscious and redirected, become resources for recovery. Traits such as reliability, accuracy, conscientiousness, and a strong sense of justice, when applied rigidly in the pursuit of a "perfect" body, can, when redirected constructively, support the restoration of health and well-being.

Peseschkian (2016) defines *positum* as what is *available, given, and real*, meaning that therapy should begin with the recognition of facts as they are. The positive aspects of illness are considered as important for understanding and treatment as the negative ones. The goal of therapy is to activate existing abilities and the potential for self-healing by focusing on opportunities for growth and constructive use of personal resources. Through this process, patients learn to identify both internal and external resources, adopt a more positive life orientation, experience reduced tension, increased energy, and improved self-esteem (Badecka, 2024). These outcomes are particularly valuable in the treatment of anorexia and bulimia.

An integral part of the *positum* is also the patient's cultural and familial background. Supporting cultural competence within therapy enhances a patient's sense of identity and autonomy. Therapists using the PPT framework, based on empathy, understanding, and respect for cultural diversity (Peseschkian, 2016; Ciesielski, 2016), are thus well-equipped to assist individuals suffering from anorexia or bulimia in achieving recovery in both psychological and somatic spheres.

Conclusion

Positive and Transcultural Psychotherapy (PPT), developed by Nossrat Peseschkian as a humanistic–psychodynamic and integrative therapeutic approach, has documented empirical foundations supporting its clinical effectiveness. However, the available publications do not directly address the treatment of eating disorders, such as anorexia nervosa and bulimia nervosa.

Between 1994 and 1997, a long-term effectiveness study of PPT was conducted and reported in Tritt, Loew, Meyer, Werner, and Peseschkian's *Positive Psychotherapy: Effectiveness of an Interdisciplinary Approach* (1999). This study included patients with a range of mental disorders, including anxiety disorders, adjustment disorders, and somatoform disorders. The results demonstrated a significant reduction in symptoms and an improvement in psychosocial functioning among participants receiving PPT compared to a control group on a waiting list. Importantly, the therapeutic effects were maintained after treatment completion.

This study remains one of the most frequently cited investigations into the effectiveness of PPT; however, it addresses a broad spectrum of mental disorders rather than eating disorders specifically. At the same time, research on eating disorders emphasizes the significant role of cultural and socio-psychological factors in their development and maintenance, which provides a theoretical rationale for therapeutic approaches that incorporate a transcultural perspective, such as Positive Psychotherapy (PPT) (Stern, 2018).

In comparison with well-established evidence-based treatments such as CBT-E, FBT, and DBT, Transcultural Positive Psychotherapy currently lacks a sufficient number of high-quality randomized controlled trials (RCTs). Nevertheless, available case studies and general outcome studies suggest its potential effectiveness in the treatment of eating disorders, including anorexia nervosa and bulimia nervosa. PPT may serve as a valuable adjunct to eating disorder treatment, including in severe cases, by activating and strengthening patients' resources and potentials while taking into account their cultural context and value systems.

In light of the above considerations, further research into the effectiveness and efficacy of

Transcultural Positive Psychotherapy in the treatment of eating disorders, including anorexia

nervosa and bulimia nervosa, appears warranted.

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Section: Modern Positive Psychotherapy (PPT) practice

Body Area in Positive Psychotherapy: Conceptualisation of Body Values in Clinical Practice



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Abstract

This article aims to demonstrate and emphasise the body's importance and influence in creating and maintaining balance across the four aspects of daily life outlined in Positive Psychotherapy. The content is based on the methodology and concepts developed by the founder, Nossrat Peseschkian. It is complemented by other psychoanalytic, psychodynamic, humanistic, and integrative approaches that highlight the body as a key element.

This article is divided into two parts. The first part explains the theoretical concept of the body, including its history, importance, and influence in psychotherapy, and connects it to other psychotherapeutic approaches. The second part discusses recent neuroscience findings on the body's role and impact, supported by examples from clinical practice. A special focus in the second part is on a personal approach used in both clinical practice and education, emphasizing personal self-development with students (participants) by integrating the body across the four aspects of the Balance Model.

Keywords: Positive Psychotherapy, Body, Balance Model, integration, neuroscience

Introduction

This article is a narrative review of the literature, based on concepts from Positive Psychotherapy, and compares it with other psychotherapy methods. It includes a descriptive clinical case to demonstrate the application of the PPT Balance Model to body-oriented psychotherapy.

This article examines the importance of body regions and their role in maintaining balance for a healthy life. It will also provide a historical overview of various psychotherapeutic methods that emphasize the body's role by integrating it into their treatment strategies.

The clinical case illustrations help users better understand how the body area is highlighted in

the Balance Model, thereby improving the likelihood of maintaining a healthy life.

The second part will demonstrate how to use the body practically in self-discovery sessions.

Methodology

2.1. Importance of the Body in the Entire Organism

Often, the body is misunderstood, with positive labels emphasizing appearance, like appearing fat or wearing plus-size clothes. This relates to body image, which is a person's perception of their own body and isn't always tied to body size. Sometimes, people may remain silent because they don't want to talk, but their bodies reveal a lot. Others can interpret these

unspoken messages by observing or listening to their cues. Usually, we can look into people's eyes to understand their emotions or notice their body language. This helps us understand body language and stay aware of our own bodies as important parts of the whole organism.

Being aware of our bodies involves paying attention and gaining a deep understanding of them, which can reveal things we might not want to hear, see, or discuss. This internal awareness provides valuable information about what is happening inside and outside our bodies.

Improving one's body image requires personal effort; meanwhile, "body positivity" is a broader social movement that values all bodies and opposes fat shaming and systemic weight bias (Matz, Pershing, & Harrison, 2024). Cultural and educational factors also play vital roles in understanding body image, which can shape a person's entire personality.

The researchers are examining the body to understand how we care for it, what actions we take to promote health, and how to protect ourselves from neurodegenerative diseases. They discovered how exercise influences specific brain cells in Alzheimer's disease by altering gene activity in microglia and identified new neurovascular issues (Wrann et al., 2023). Unfortunately, research on treatments for Alzheimer's or Dementia Disorders from a Positive Psychotherapy approach is not yet complete. However, there is ongoing research, including a systematic review, aimed at evaluating the effectiveness of Positive Psychology Interventions as non-pharmacological treatments for mild cognitive decline related to dementia by assessing their impact on cognitive functions and brain health in individuals with Subjective Cognitive Decline (SCD), Mild Cognitive Impairment (MCI), and mild Alzheimer's disease dementia (AD) (Vasileiou et al., 2025).

When examining the physiological connections among different parts of the body, we see how one system influences others by regulating the organism's overall activity. The brain, as a vital organ, influences the function of the heart, the production of immune cells, the spinal cord, the endocrine system, the hormonal and urinary systems, kidney function, the gastrointestinal system, and the sex glands via the bloodstream. All these processes sustain the organism's life. Therefore, one system drives another, with all working together to activate

the brain and regulate the body's overall function. Each body part affects other body parts through the five primary senses, which then signal the brain and activate the mind. This cycle distributes energy that mutually influences everything involved. In short, this means that one body maintains balance (congruence) with another. This concept is also known in neuroscience as "interpersonal neurobiology" (Maté, G., & Maté, D., 2022, p. 65).

Focusing on factors that strengthen the body, such as physical activity, nutrition, quality sleep, and regular sexual activity, the role of food is essential in maintaining overall health. That's why it is important to include foods (fruits, vegetables, nuts, grains, fish, and seafood) that help balance the hormones and neurotransmitters of serotonin (Lassale, 2019).

Neuroscience research shows that regular physical activity is a crucial factor that directly influences mental health and overall biological well-being. Some studies suggest that bodywork treatments for Fibromyalgia Syndrome (FMS) yield positive results when combined with myofascial release, bodywork, acupuncture, dietary changes, and lifestyle adjustments (Waylonis & Perkins, 1999; Field et al., 2002; Brattberg, 1999; Wild & Müller, 2002).

A recent study involving patients with Fibromyalgia Syndrome developed a Positive Psychotherapy Program (PPP) to evaluate how its tools can alter pain perception in fibromyalgia patients, enhance their daily activities, and improve their mental health. The program's effectiveness was confirmed, opening the door to future studies. (Erol, Karaca, 2025).

All these studies clearly demonstrate that regular physical activity influences brain function and increases brain chemicals, particularly neurotransmitters such as dopamine and endorphins, which help regulate positive mood and motivation.

2.2. Historical overview of the body concept

Historically, the body has been the central element in the functioning of the entire organism. Darwin's anthropological studies highlighted the role of the body in the operation of the mind (Barret, 1974). This means the body acts as the foundation from which mental activities arise. The body serves a dual purpose: as an object through which humans perceive

emotions and sensations, and as a subject that is the source of the mind.

Later, psychoanalytical approaches also recognize that the body is inseparable from the overall functioning of human anatomy and physiology. In psychoanalytic theory, the importance of the body is indirectly acknowledged through libido, which drives our sexual instincts rooted in somatic events and their transformation into psychic experiences (Freud, 1977a). Freud's view of the body includes pregenital erogenous zones, linked to the sexual development of the infant and connected with both somatic and psychic growth. Freud explains that there are differences between stimuli and drives: stimuli are triggered from outside the organism, while drives originate from within (Freud, 1984). For Freud, the body has been scarred and stigmatized through substitutive satisfaction and the influence of language. That's why Freud redefined the concept of the body as a site of inscription for the entire organism. Although Freud never explicitly described the body as an isolated entity, he often discussed it through sexuality, where sexual instincts lead to specific neurotic reactions (Freud, 1977b).

In Gestalt therapy, the concept of the body encompasses body awareness, whereby clients, after engaging in physical exercise, develop a deeper understanding of their emotional states and how these manifest physically. This helps clients improve body awareness by guiding them to become more attuned to and capable of interpreting their bodily sensations, thereby enhancing their understanding and differentiation of emotional states (Mann, 2021).

The concept of the body is central to Psychodrama, in which "actors" use physical movement to express their feelings and thoughts, thereby gaining awareness of their deep emotional and psychological challenges through their creativity. However, in psychodrama therapy, the concept of the body is viewed practically and pragmatically as part of the self. Moreno saw the body as interconnected with the mind, and this relationship can cause various ambiguities in personality development, especially in cases of traumatic experiences (Moreno, 1993). His view was that the body must be included in psychotherapy because it is part of the self, which develops relationally. That's why he spoke about the catharsis of the body.

Integrative and psychodynamic approaches also highlight the body as an integral part of the

entire system and the mechanism that regulates the nervous system. According to these approaches, the methods employed provide a deeper understanding of the psychosomatic body, of physical ailments caused by unconscious processes and conflicts, and of the limitations and potential of experiential bodywork (Calsius, 2020). The body holds value, importance, and power because it underpins human health, and through it, we can recognize and understand the traces of our life experiences. The body can maintain balance amid the activities, relationships, and interactions that influence overall well-being.

2.3. Body and psychosomatic disorders

Since the era of psychoanalysis and later body-oriented psychotherapy, an integrative approach has emerged, linking the body, emotions, and psyche within the psychosomatic system (Bodella & Liss, 1986; Navarro, 1988; Latorre, 2000). Recent neuroscience research, especially the discovery of the first opiate receptor and neuropeptides in the brain, has offered insights into the connection between body and mind (Pert, 1999), as well as the identification of the homeostatic body pleasure system (Panksepp, 2006; Damasio, 2010), where hormones and neurotransmitters form what is called the "psychosomatic network" (Pert, Ruff et al. 1985).

In the article "What Does Our Body Tell Us in Therapy" (Remmers, 2021), the body is highlighted for the first time as a key element in understanding body expressions and body language in the psychotherapy process. This shows how, in the Positive Psychotherapy approach, the body's presence reveals hidden complaints, problems, and conflicts that the client experiences, and how the therapist can interpret these messages.

In psychosomatic disorders, the body's role is crucial, involving two functional aspects: one is physical, and the other is emotional or stress-related. Physical functions can cause various bodily complaints, such as fatigue, pain, low energy, and heaviness in the extremities. When different stressors or stress-related situations trigger these complaints, individuals may also experience emotional disturbances like mood swings, dissatisfaction, anhedonia, lack of desires and motivation, ambivalence, apathy, anxiety, fear, low self-esteem, and feelings of hopelessness.

In Positive Psychotherapy, the term psychosomatic was originally defined as a “specific line of research and treatment that seeks to illuminate the connection between mental events and bodily reactions” (Peseschkian, 1991,2006). A patient experiencing a “psychosomatic disturbance begins to make sense when we examine the concepts he or she holds regarding the body as a whole, the individual organs and organic functions, as well as how they relate to health and illness” (Peseschkian, 2013, p. 63). This understanding helps us see how the entire organism is interconnected across physical, mental, emotional, and spiritual domains. The psychosomatic picture may become clearer through the so-called “Psychosomatic Arc” and Balance Model (Peseschkian, 1991; Remmers, 1999; Kirillov, 2025), which conceptualizes life events as macro traumas and daily stressors as micro traumas, and distributes energy across four areas within the Balance Model. This approach enhances our understanding of conflicts and improves our ability to use existing resources to address problems or manage symptoms. Many psychosomatic symptoms can manifest consciously or subconsciously through bodily reactions, such as pain, anxiety, fear, or fatigue. Treating these symptoms requires an approach that integrates the body's functions, emotions, and mind. This integrated method will be explored more thoroughly, not only in treatment but also in educational settings, such as self-discovery, which will be discussed in the second part of this article.

Everything in our lives is a learning journey. We learn throughout our lives, and in the process, we may make mistakes. Making mistakes is not inherently bad; what's more important is to recognize and be aware of them. Since all mistakes also have positive sides – allowing us to learn lessons – each lesson leads to growth in our lives. Instead of asking “*What’s wrong with me?*” ask, “*What should I do for myself to achieve my goals?*” or “*What else should I do to feel better?*” By staying connected with ourselves in the “here and now,” we should listen, understand, know, invest, change, and develop. The best answers to many questions about our health come from staying connected with and listening to our bodies. Our body is the best interpreter of many difficulties, concerns, pains, or disabilities.

Discussion

3.1. Body in Positive Psychotherapy

The concept of the body in Positive Psychotherapy is based on the Balance Model, in which the founder emphasizes its essential role as a link among three other stages of the lifespan (Peseschkian, 1988). In the body domain, senses are used not only to express physiological reactions but also to communicate the “body-ego feeling” (Peseschkian, 2016a). When we engage in physical or movement activities, our bodies receive sensory stimuli that can be expressed as various emotions. In such situations, the body becomes a site of decreased resistance and increased susceptibility. This helps explain “why a psychosomatic patient might choose a particular organ if we consider the beliefs they hold about their body and the functions of individual organs” (Peseschkian, 2016a, p. 146).

The human body comprises various organs and systems, each with its own schedule, known as the body clock or circadian rhythm. The concept of the body clock originated in Chinese medicine and was later studied scientifically in modern medicine. The body clock helps regulate and synchronize daily activities by coordinating the cycles of various organs and systems. Throughout a 24-hour day, the human body remains active, with specific times assigned to the functioning of organs such as the liver, lungs, large and small intestines, stomach, spleen, heart, kidneys, pericardium, and gallbladder (Ursinus, 2020).

Understanding how the biological clock affects the health system as a whole is essential, as it can influence the balance model described in Positive Psychotherapy. When organs go out of sync, the whole body becomes imbalanced. The body should be integrated with other systems without favoring any specific part, as outlined in the Balance Model. This integration allows the body to remain connected within Positive Psychotherapy.

The body plays multiple roles in Positive Psychotherapy, influencing the therapeutic process. It is important to encourage clients to enhance their energy by increasing awareness of physical activities, dietary choices, rest and sleep, and sexual activity, as these can affect emotional states and sensations. It is also essential to highlight these body roles, which often have significant impacts on other areas and help maintain balance and quality of life.

It is important to emphasize ways of integrating the body area into the overall treatment approach in Positive Psychotherapy. Here are the key elements to focus on.

- **Increasing clients' body self-awareness** by highlighting the importance of movements that trigger bodily sensations, thereby improving their understanding of emotional responses. Through movement, clients become more aware of physical sensations, such as muscle tension, heartbeat, numbness, a sense of bodily stuckness, and fatigue. This method can lead to a better understanding and control of emotions.
- **Managing emotions and feelings** involves practicing various body-mind techniques to reduce anxiety, stress, frustrations, panic attacks, chronic pains, and obsessive thoughts. Feelings and emotions reflect our body's state. Emotional states can be observed in the body, and all emotional responses should be addressed through body-mind and mindfulness exercises.
- **Integrating hope principles** with body-mind techniques and positive symptom interpretation boosts clients' resilience and well-being. Psychosomatic complaints often manifest physically and are emphasized during treatment. Focusing on the body through body-mind and mindfulness techniques can increase clients' awareness, helping them better understand and manage their psychosomatic symptoms.
- **Achieving balance among the body, achievements, relationships, and concepts is essential.** The symptoms in each of these four areas can be reframed by shifting negative attitudes toward positive interpretations of the symptoms, thereby enabling clients to use their abilities and find harmony in these domains. This kind of balance highlights the interconnectedness of body-mind integration as a unified process within our organism.
- **Focusing on the body and psychosomatics** within Positive Psychotherapy can help clients better understand their coping skills and management in daily life, especially

during stressful situations. Many conflicts arise from a lack of awareness of bodily signals and from various psychosomatic complaints. These symptoms are often connected to body posture, which can trigger numerous psychosomatic issues.

To illustrate the body area's important role in the psychotherapeutic process, the following case is presented. However, this case also reveals how the body can be treated as an object and exploited as a whole person for personal gain.

A 47-year-old married woman living with her family, who previously worked as an elementary school teacher, sought therapy due to her ongoing fatigue, anxiety, and feelings of worthlessness over the past year. She has two daughters, but her husband wishes to have a son. After her last childbirth, doctors had to perform a hysterectomy, preventing her from becoming pregnant again. Throughout her time living together, she maintained strong relationships with her husband, excelled at work, and dedicated time to caring for her physical health.

After six years of marriage, her husband insisted on having a son; he believed that without a male heir, their lineage would be at risk. They had long discussions and agreed that he could pursue another relationship with a woman who could give birth to a boy. She asked him not to tell her who that woman was, and when she gave birth, he would need to stop having any relations with her. Initially, this arrangement was hard for her to accept, but she explained, "I understand how important it is to have a boy in the family."

However, the situation grew more complicated when her husband had to spend more time with his son and another "illegitimate wife." During this time, she began experiencing psychosomatic symptoms, such as anxiety, sleep problems, and conflicts. She neglected her body and felt that it was useless for any activity, focusing all her energy on feeling active and alive.

Her body seemed quite detached from other areas where achievement and future focus were highly active, while interactions with contacts and the body region were nearly completely avoided.

In the initial sessions, she used breathing techniques called "Soft belly" and "Dialog with my body." After practicing these techniques, she became more aware of her body and, in

particular, noticed what it was telling her. She understands the messages her body is sending and how she can respond. After each breath technique, she was asked to draw her balance model by reflecting on her feelings and how her energy is distributed across the four areas. As she became aware of and acted on the messages her body was sending, she was able to accept the reality of her life.

After she drew her balance model in front of her to visualize and increase awareness of her actual posture, she asked, "Am I looking really sick?" This was a question awaiting my response to reassure her about her health. "The best answer to your question will come from your body. What do you think if you are closer to your body and try to have a dialogue with your body?" I replied. This is a way for the client to shift from "out to in" and become aware of her needs, wishes, or expectations.

This example illustrates how patients or clients often neglect to pay attention to their bodies to prevent many psychosomatic complaints, which can also impact three other areas, as seen with this woman. Paying attention to bodily sensations in various situations helps stabilize emotions and thoughts and supports the rapid renewal of perceptions. This can enhance awareness of bodily sensations through activities such as breathing, moving, shaking, drinking, eating, or lying on the floor, while attending to all the sensations the body perceives.

In both medical and psychotherapy treatments, we as psychotherapists are often unaware of the importance of the body area, focusing on solving the problem and prioritizing other aspects. This approach to treatment may enhance effectiveness or lead to failure, causing patients or clients to discontinue involvement or to experience more complex issues, which can result in additional complaints.

3.2. The Role of the Body in the Balance Model

Nossrat Peseschkian regularly practiced body exercises not only during his seminars but also with his patients during therapy sessions. In his books (Peseschkian et al., 2003, 2005), he included pictures of some exercises for readers and for others to incorporate into their daily routines. He served as a role model for his students during training sessions, seminars, and lectures, emphasizing bodywork aimed at

balancing the mind, body, and emotions (see Figure 1).

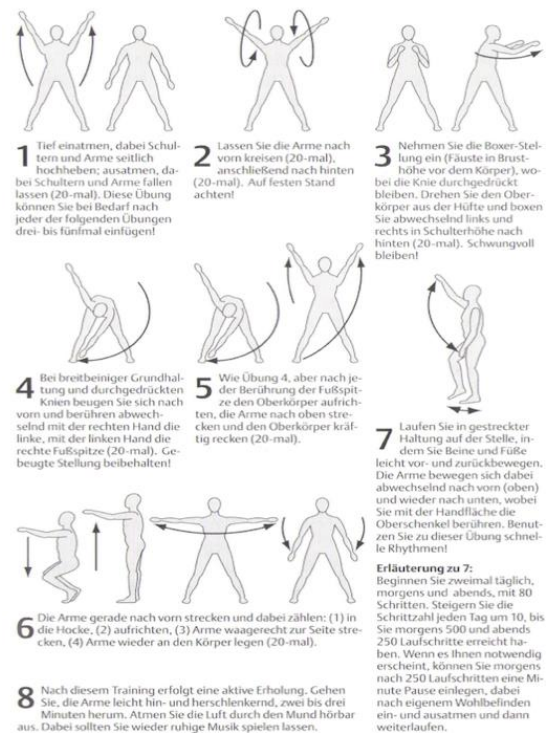


Figure 1. Peseschkian Model of Physical Exercise

Peseschkian's Balance Model, which covers four areas, begins with Body and Achievements, proceeds through Contacts and Relationships, and concludes with Future or Fantasy, symbolizing overall health and harmony. According to this model, as shown in Figure 2, this does not mean that the body should take priority or that other areas can be ignored; rather, all four parts must be integrated harmoniously within the Balance Model to achieve a healthier, higher-quality of life.

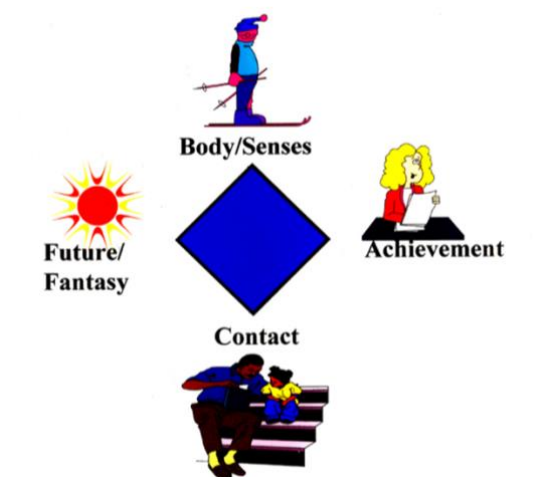


Figure 2 Balance Model

This Balance model incorporates cultural insights from different philosophical perspectives and educational backgrounds. For example, in some cultures, influenced by various philosophical ideas, people tend to focus more on the body and achievement-oriented areas, which is common in Western societies. Meanwhile, in some Eastern cultures, relationships and the future, including spirituality, are accorded greater significance (see Figures 3 and 4).

Balance model in the East

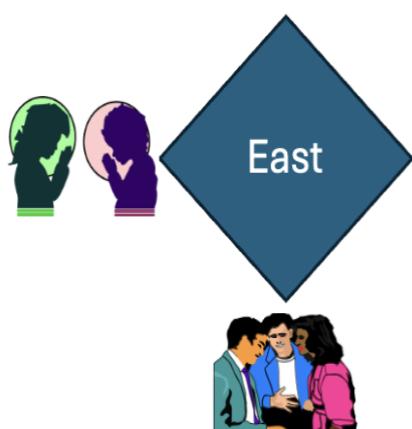
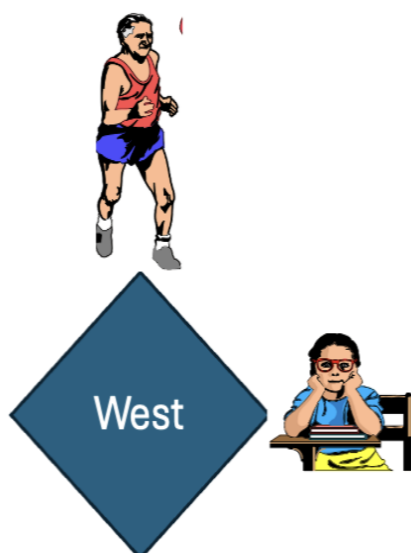


Figure 3. The balance model in Eastern cultures (emphasizes relationships and the future)



Balance model in the West

Figure 4. Balance model in Western cultures (emphasizes the body and achievements)

Not only did the founder of Positive Psychotherapy emphasize the importance of the body, but also some of his other graduate practitioners (Udo Boessmann, Arno Remmers, 2020; Richard Weringloer, 2023; Hamid Peseschkian, 2025; Enver Česko, 2020, 2023, 2024; Ivan Kirillov, 2025) and other positive psychotherapists have highlighted its vital role in psychotherapy through their presentations worldwide and in their clinical practice.

One key aspect of the Balance Model is the Body. In its original concept, the Body refers to physical care in human health, including activities such as exercise, proper nutrition, sleep, sex, rest, and similar practices – everything the physical body needs to remain healthy. The focus is on becoming aware of our body and its importance to overall well-being, which encompasses physical, mental, emotional, and social health (Serino et al., 2013).

In terms of conflict analysis, the body (as described by sense interpretation from N. Peseschkian, 2016a) is also defined as the body's response to problems, conflicts, or unfulfilled needs, or as Peseschkian himself calls it, "body-ego feeling" (Peseschkian, 2016a). The conceptualization of the body itself relates to how we perceive our body, how much time we dedicate to caring for and maintaining its well-being, or conversely, how much we neglect this dedication to avoid health issues. However, when examining the related professions that practice as psychotherapists – such as general medicine, psychiatry, neurology, or clinical psychology – the focus in treatment is usually more on the organic aspects of the complaints. The psychotherapist is "specialized in concerns related to psychic sources" (Peseschkian, 1988, p. 55). Here, we are dealing with somatic complaints that may originate from psycho-emotional, social causes, or even from various experiences of current or past stress or trauma.

Starting from the idea that every person has two fundamental abilities, loving and knowing, the human personality is also built on these two aspects. There are three key dimensions that shape the structure of personality: *the body*, *the environment*, and *time*. Focusing on the body dimension, we refer to a traditional medical term that includes diseases treated with medications, which have a "biomedical" effect on metabolism (N. Peseschkian, 1988). Therefore, many interventions in the body domain typically involve classical medical methods, medication,

and/or surgery. However, in other approaches like body-oriented therapies, treatments are often manual or utilize more advanced techniques, applied directly to the body. It is essential to adopt an integrative and holistic approach, combined with Positive Psychotherapy, to achieve greater success in helping clients overcome their issues. Today, the new generation of Positive Psychotherapists is already incorporating body techniques, such as body exercises, into their psychotherapeutic practice (Werringloer, 2023; Česko, 2020).

Sometimes, when working with different clients who have various complaints, it becomes clear that certain body areas are emphasized less than others, such as performance, contacts, concepts, and the future. The distribution of energy in one area is either overdeveloped or underdeveloped compared to other areas, creating a disbalance in the organism. In the therapeutic process, a psychotherapist might overlook the importance of considering the body as a starting point for achieving balance throughout the lifespan.

A young woman who earned her Bachelor's and Master's degrees outside of her cultural, social, and environmental background, and after being in a relationship with her boyfriend from a completely different Kosovo environment, suffered for months from psychosomatic symptoms, losing complete connection with her body. She lacked the energy to leave her dormitory, where she used to live; she experienced daily headaches, felt exhausted, couldn't go out with her boyfriend, and, after some days, she called her mother in Kosovo to visit her.

When she was receiving psychotherapy treatments, early in one of the sessions, I asked her, *"Where is your body?"* She was confused by my question because she didn't understand what I meant. Her answer was, *"Here is,"* as she touched her entire body with her hand. In my second question, *"Where is your head?"*, she also touched her head. And in my third question, *"Are they together in your body?"*, she answered, *"No, unfortunately, my body is not with me."* After applying a known technique from Gestalt Therapy, also used in Body Psychotherapy, called "empty chair" and "mirroring," it was combined with a method from PPT, a "dialog with my symptom," and the Balance Model. Using these techniques and methods, the client noticed how much she had neglected and avoided her body's

needs and became aware of what she has to do to reduce her symptoms.

Therefore, it may be helpful to examine whether the body area receives less emphasis in Positive Psychotherapy compared to the other three areas in the Balance model. It could also be useful to share personal insights on why the body area is less prioritized in Positive Psychotherapy compared to other psychotherapy approaches.

- PPT is a humanistic and psychodynamic approach, where specific methods and techniques are derived from various modalities that the founder of Positive Psychotherapy personally encountered and integrated into his approach, preserving his original narrative of a transcultural background.
- PPT, through his philosophical and conceptual approach, suggests that the aims of this method are also to provide an analytical explanation using a conversational approach.
- Using stories, wisdoms, or anecdotes during the treatment process shifts the focus of conflict resolution toward expressing and reflecting rather than acting and moving.
- Often, using cognitive didactic equipment is simpler and sometimes more comfortable than relying on body movements.
- Since PPT often emphasizes a theoretical and instructional approach to learning, coping, and teaching, the practical side is frequently overlooked.
- Because some PPT practitioners neglect their health or are unsure how to care for it, they overlook the body part involved in the psychotherapy treatment process.

Suppose we want to emphasize the importance of the body and its functions in the psychotherapeutic process by comparing various psychotherapeutic approaches with Positive Psychotherapy. It becomes evident that the body is recognized as a vital component in treating many mental health disorders, difficulties, problems, and conflicts – all of which are essential for improving quality of life and maintaining balance in daily living.

Table 1 clearly illustrates the role and position of the body in various psychotherapy

approaches, mainly psychodynamic, humanistic, cognitive-behavioral, and body-oriented

psychotherapy, compared to positive and transcultural psychotherapy.

Table 1. Conceptualization of the Body across psychotherapy modalities

<i>Psychotherapy modalities</i>	<i>Position</i>	<i>Function</i>	<i>Methods / Techniques</i>	<i>Mental disorders</i>
<i>Psychoanalyze</i>	Body as a symptom	Libido is an energy that provokes the unconscious parts to the conscious mind.	Free associations, Interpretation of dreams, Catharsis Talking	Hysteria, Psychoses, Neuroses, Sexual disorders
<i>Psychodrama</i>	The body is part of the self	The development of creativity and spontaneity(Radizi-Pauls, 2003). The moving body(Levy, 1979). The energetic body (Aaron, 2012). The touchable body(Prugel-Bennet, 2011)	Role reversal (acting out another person's role), Doubling (expressing unspoken thoughts or feelings), Mirroring (observing oneself through another's portrayal). Warm-up, Action, Sharing.	PTSD, Anxiety, Depression, Bipolar disorders, Traumatic grief, Family concepts, Marital problems, Socio-groups, Group therapy.
<i>Gestalt therapy</i>	A holistic approach considers the mind, body, and spirit as interconnected within a single organism.	To activate the unresolved negative feelings (anger, pain, anxiety, resentment) and actively express them in the present time. Navigating the challenges in mind, body, and emotions (Mann, D. 2021)	Role playing, Empty chair, Sculpting, Drawing Painting	Bipolar disorders, Anxiety, Depression, Substance abuse, Compulsive gambling, PTSD, Interpersonal conflicts
<i>Cognitive Behavioral Therapy</i>	Body as shadow in cognition and behavior	To recognize and challenge their distorted thoughts about their appearance (Wells, T., Goleman, S., 2019)	Processing and tracking thoughts and emotions, Cognitive restructuring to challenge negative beliefs, Facing and exposing the fear responses. Progressive muscle relaxation, Interoceptive exposure technique.	PTSD, Depression, Anxiety, Mental health disorders, Substance addictions, OCD, Phobia
<i>Body-oriented Psychotherapy</i>	Entire organism Central starting point	The body and its sensations are at the core of healing Integration of four parts; body-mind-emotions-spirit(Staunton, T. 2002., Geuter, U. 2024., Heller, M. 2012)	Body movements, Physical exercises, Physical touch, Dance and shaking, Breathing techniques, Relaxation techniques, Massage techniques, Drawing and painting	PTSD, Depression, Anxiety, Mood disorders, Physical traumas, Sexual disorders,

**Positive and
Transcultural
Psychotherapy****Balance Model**

Body is one of the areas in the Balance Model that influences understanding of the interaction between conflicts and symptoms in treatment.

Principle of hope and Salutogenetic, First interview, DAI, WIPPF, Conflict model, Stories Five stages of treatment

Psychosomatic disorders, Interpersonal conflicts, Eating disorders, Family problems,

Conclusion

The body area in the Balance Model is viewed as an integrated system within the organism, which includes the other three areas. It is seen as a pillar supporting the entire life system, including achievements, performance, work, contacts, relationships, concepts, beliefs, and life philosophy. To date, prioritizing the body area and its investments is essential for maintaining health and quality of life, balancing energy, and resolving various conflicts, especially psychosomatic complaints.

Nowadays, many people ask questions about body image, such as, “What is my opinion about my body?” or “How much do I value my body?” “What is the perception of my body image?”

“Does the meaning and value of my body change within 24/7?” Answering these questions and others entails not only ascribing positive meaning to our bodies but also being self-critical about neglecting their care and lacking love for them. We need to engage in activities that improve our physical, emotional, social, and spiritual well-being. Only then will we fully understand the body's importance and value in leading a healthier life and serve as role models for future generations.

In the second part, a practical session will focus on integrating body exercises into self-discovery therapy, including theoretical information to clarify the importance of bodywork.

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Section: Positive Psychotherapy (PPT) cases

Creating Hope Inside the Cell: A Clinical Case of Positive Psychotherapy in a Prison Setting



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Abstract

This article describes a clinical case illustrating how Positive Psychotherapy (PPT) helps a person deprived of freedom through encouragement and optimism, thereby bolstering their inner resources. The 38-year-old inmate, who had a history of substance abuse, PTSD, and severe depression, participated in a one-year PPT program that included 23 organized sessions. Interventions included narrative strategies, cultural metaphors, and hope-building exercises to examine accomplishments, manage emotions, reprocess trauma, and activate internal resources. The findings indicated a significant improvement in hope and personal resources (WIPPF) and a significant decrease in symptoms of anxiety (HAM-A), PTSD (PCL-5), and depression (BDI-II). This story illustrates how PPT can support psychological rehabilitation in prison settings and foster a positive outlook on the future.

Keywords: PTSD, depression, hope, prison, Positive Psychotherapy

Introduction

Feelings of isolation and hopelessness are common experiences among individuals deprived of their freedom (Haney, 2003; Liebling, 1992). The circumstances of taking and the lack of social support often aggravate coping with trauma, depression, and addiction (Morgan & Flora, 2002). In this context, psychotherapeutic interventions offer an opportunity for recovery and transformation, helping individuals reconstruct the meaning of life and develop new skills for coping with challenges (Novalis et al, 2022). Positive Psychotherapy (Peseschkian, 1987; 2016) offers an approach based on strengthening internal resources and focusing on positive experiences. This model is particularly valuable for individuals in prison, where hopelessness and feelings of helplessness can dominate daily life (Peseschkian & Remmers, 2013).

Methodology

2.1. Theory of Positive Psychotherapy

Positive Psychotherapy (PPT) by Nossrat Peseschkian (1987) is based on the idea that everyone possesses internal resources that can be mobilized in the face of challenges. It emphasizes:

- Strengthening internal resources as a foundation for emotional recovery.
- Focusing on positive aspects of life, such as achievements and enjoyable experiences.
- Creating meaning and a sense of purpose as an essential element for building hope (Peseschkian, 1987; 2016).

In the context of jail, this approach allows prisoners to reprocess trauma and rebuild a more optimistic vision of life, contributing to rehabilitation and

reintegration (Morgan & Flora, 2002; Wolff at all, 2014).

The background and clinical profile of participant D are structured in Table 1.

2.2. Measures

Table 1. Background and clinical profile of participant D

Category	Information
Identification	D. (not his real name)
Age	38 years old
Status	Incarcerated, former construction worker
Health Status	Severe depression, PTSD, history of substance abuse
Personal History	Early loss of mother, raised by grandmother, lack of emotional support, alcohol/drug addiction, multiple arrests
Presenting Symptoms	Severe depression and anxiety, nightmares, flashbacks, self-harm, suicidal ideation, difficulty regulating emotions
Attitude Toward Therapy	Demonstrates awareness of his problems and a willingness to seek professional help

D. was evaluated using projective and standardised tools, such as:

Beck Depression Inventory-II (Beck et al., 1996) is a widely used, self-report instrument intended to gauge the severity of depressive symptoms among adults. It comprises 21 items related to cognitive, emotional, and somatic dimensions of depression. The BDI-II psychometric properties are strong, and it has high internal consistency, making it often used in clinical practice and research. In this study, the BDI-II was used as a tool to assess the intensity of depressive symptoms at psychotherapeutic intervention stages, thus providing a means of objectively monitoring symptom change over time.

The Post-Traumatic Stress Disorder Checklist – 5 (PCL-5) (Weathers et al., 2013) is a standardized self-report instrument for assessing symptoms of post-traumatic stress disorder (PTSD). It measures trauma-related symptomatology in four symptom clusters. The PCL-5 is highly validated and widely used in trauma-focused research and clinical use. In this case study, it was a measure to assess trauma symptom severity and a measure to examine the efficacy of Positive Psychotherapy approach in alleviating PTSD related distress.

The Lüscher Color Test (Lüscher, 1969) is a projective psychological tool, which is used to explore the emotional state, inner tension, and psychosomatic stress responses. It is founded on the individual's color choices which are interpreted in relation to emotional functioning

and psychological balance. It is not used as a diagnostic tool but as complementary qualitative data. In this study, The Lüscher Color Test was used “to glean insight into the participant's emotional dynamics and levels of inner tension” (Brodsky & Sulkin, 2007, p.46) in a context of trauma and incarceration.

The Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF 2.0) (Peseschkian & Deidenbach, 1988) is a resource-oriented tool used within Positive Psychotherapy to assess personal strengths, coping abilities, and balance in important life areas. It focuses on what the person can use and develop, rather than on deficits. In this study, WIPPF 2.0 was used to track the growth of inner resources and resilience during therapy, making it particularly suitable for evaluating change in a correctional context.

All assessment instruments were administered in the Albanian language and in accordance with their appropriate methodological use. The Lüscher Color Test does not require linguistic standardization, as it is based on color selection and projective interpretation rather than verbal content. The PTSD Checklist for DSM-5 (PCL-5) has been standardized and is routinely used in Kosovo in the Albanian language. The Hamilton Anxiety Rating Scale (HAM-A) was also administered in Albanian following established clinical practice. The Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF 2.0) was used in its Albanian version, as applied and

taught through the training programs of the Kosovar Center for Positive Psychotherapy.

Table 2. Initial psychological assessment results of patient D

Assessment Instrument	Purpose of the Tool	Patient's Score	Normative Range	Clinical Interpretation	Reference
<i>Beck Depression Inventory-II (BDI-II)</i>	Measures the severity of depressive symptoms	32	0–13 = minimal, 14–19 = mild, 20–28 = moderate, 29–63 = severe	Severe depression	Beck et al., 1996
<i>PCL-5 (PTSD Checklist)</i>	Assesses symptoms of post-traumatic stress disorder	58 / 80	≥ 33 indicates probable PTSD	Severe PTSD	Weathers et al., 2013
<i>Lüscher Color Test</i>	Evaluates emotional state and inner tension	Dominance of dark colors	Balanced emotional state indicated by varied color selection	High anxiety, inner tension	Lüscher, 1969
<i>Wiesbaden Inventory (WIPPF)</i>	Measures internal resources and coping strategies	Limited resources	Adequate coping resources are expected in balanced profiles	Weak stress management and limited coping capacity	Peseschkian, 1987
<i>Hamilton Anxiety Rating Scale (HAM-A)</i>	Measures the intensity of anxiety	26 / 56	0–17 = mild, 18–24 = moderate, 25–30 = severe	Moderate to high anxiety	Hamilton, 1959

Case

Patient D shows clinically significant levels of depression, anxiety, and PTSD, along with low inner resources and high emotional tension. Given the patient's history of trauma and current incarceration, the combined results point to high affective distress and a restricted potential for coping.

3.1. Therapy process

The client, D, underwent a one-year therapeutic process consisting of 23 structured sessions based on the principles of Positive Psychotherapy (PPT - a humanistic and integrative approach developed by Nossrat Peseschkian).

The core idea of PPT lies in balancing the four fundamental areas of life:

1. Body and Physical Health

2. Relationships and Interpersonal Contacts
3. Achievements and Work
4. Meaning of Life

This method aimed not only to reduce symptoms but also to activate internal resources, strengthen resilience, and restore hope and meaning for the future (Peseschkian, N., 1987; Peseschkian H., 2023; WAPP, 2023).

3.2. Therapy phases and structure

The five steps of the PPT model corresponded to the five phases of the therapy process (Remmers, 2016; Peseschkian & Remmers, 2009).

1. Observation (sessions 1–3)

Used the WIPPF, resource-oriented diagnostic interview.

Three primary symptoms were identified: anxiety, PTSD, and sadness.

Created a therapeutic agreement founded on the two-axis principles (disease + resources) and trust.

The client began to realise that there were both obstacles and opportunities for growth and self-improvement.

2. Inventory and biographical (sessions 4–7)

Used cultural stories and metaphors to explore early trauma (mother's loss, isolation, substance abuse).

Identified resources from the past, such as professional successes and emotional care received from the grandmother.

Help restructure the life narrative and activate hope through meaning.

3. Encouragement (sessions 8-15)

Focused on strengthening the four aspects of life:

Created healthy workout plans.

Strengthened bonds with other prisoners.

Created goals for employment following release.

Thought about one's own significance and purpose.

The participant learnt from exercises such as "Life Balance" and "Two Perspectives" that even difficult circumstances can be used as opportunities for personal growth.

By relating his story to universal human narratives, the client improved emotional integration through transcultural approaches.

4. Verbalization (sessions 16–20)

The client confronted intense emotions of loss and childhood trauma.

Through the metaphor of the "Two Wings" (symptoms and resources), he understood that his challenges did not define his future but could be managed by activating inner strengths.

Substance dependence treatment was integrated by developing self-control mechanisms and relapse prevention strategies.

5. Expansion of goals (sessions 21–23)

Concentrated on post-release reintegration strategies.

Created a practical and healthy life plan focused on emotional stability and personal development using goal-setting and positive visualization techniques.

The client's increased awareness of his inner resources and improved capacity to manage life's obstacles without reverting to harmful behaviors marked the end of therapy.

The client's therapeutic development over the course of 23 sessions, or the five phases of Transcultural Positive Psychotherapy (PPT), is depicted in Figure 1:

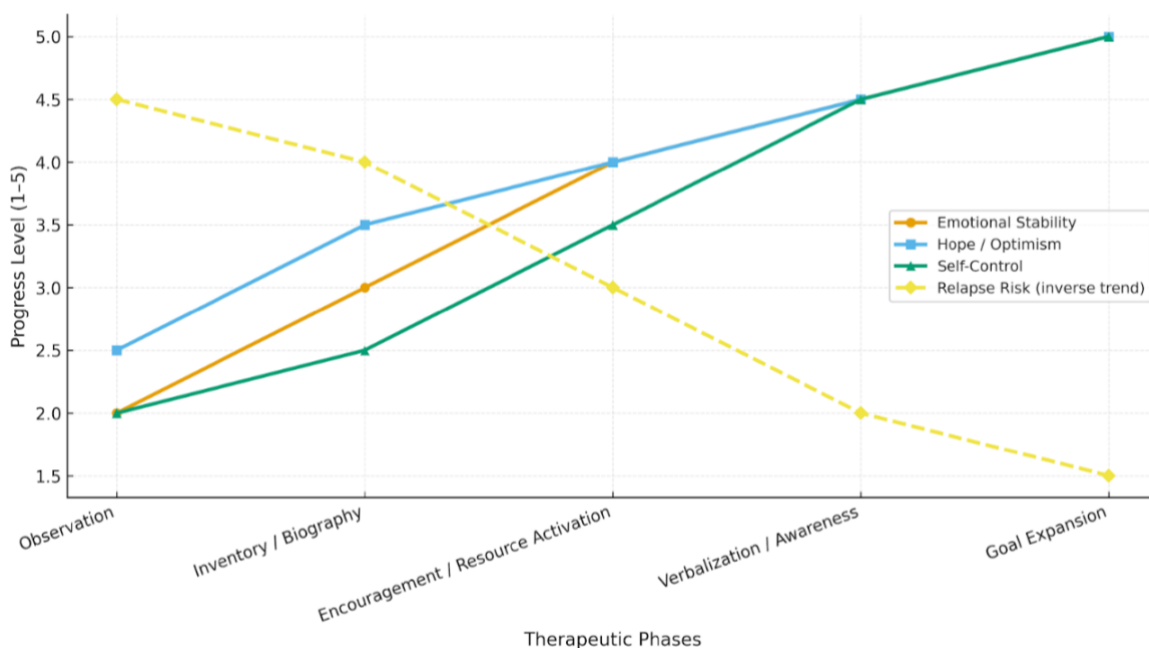


Figure 1. Therapeutic progress (23 sessions)

The client's therapeutic progress during the 23 sessions was monitored using four main indicators: a). emotional stability; b) hope/optimism; c). self-control and d). risk of relapse.

These indicators were mapped to the five phases of Positive Transcultural Psychotherapy (PPT): 1. Observation; 2. Inventory (biography of life and life story); 3. Encouragement (resource activation); 4. Verbalization (awareness) and 5. Goal expansion. As illustrated in the graphic, emotional stability, hope/optimism, and self-control demonstrated a steady upward trend throughout the therapeutic process. This suggests a gradual and sustained improvement in emotional regulation, psychological resilience, and activation of internal resources.

The client's ability to manage emotions and maintain motivation increased significantly during the encouragement and verbalization phases, where narrative techniques and goal setting were emphasized.

Analysis of the risk of relapse showed a steady downward trajectory, indicating a reduction in vulnerability and maladaptive behaviours. This reverse trend is consistent with the implementation of relapse prevention strategies and the strengthening of self-control mechanisms during the later phases of therapy. The crossover points around sessions 8-15 mark a critical therapeutic turning point, where the client began to experience a more balanced psychological state. This convergence of increasing protective factors and decreasing risk factors supports the clinical interpretation that PPT facilitated not only symptom reduction but also meaningful psychological growth.

Results

4.1. After one year of therapy

Prior to and following the one-year therapeutic process, a psychological evaluation indicates significant clinical progress across all areas. The client's development is summed up in Table 3:

Table 3. Psychological assessment results pre- and post-patient D

Psychological Instrument	Pre-Test (Beginning)	Post-Test (After 23 Sessions)	Change	Interpretation
<i>BDI-II (Depression)</i>	34 (<i>severe depression</i>)	12 (<i>mild</i>)	-22	Significant improvement
<i>PCL-5 (PTSD Symptoms)</i>	58 (<i>severe</i>)	22 (<i>mild</i>)	-36	Marked reduction of PTSD symptoms
<i>Lüscher Color Test</i>	Dominance of dark and avoidance-related colors, high inner tension	More balanced color choices, reduced inner tension	Qualitative improvement	Improved emotional balance and reduced anxiety
<i>HAM-A (Anxiety)</i>	26 (<i>high</i>)	10 (<i>low</i>)	-16	Considerable decrease in anxiety
<i>Substance Dependence</i>	In remission, risk of relapse	Stable remission	–	Maintained stability, no relapse
<i>Snyder Hope Scale</i>	15 (<i>low</i>)	29 (<i>moderate–high</i>)	+14	Increased hope and motivation
<i>WIPPF (Internal Resources)</i>	41 / 88	73 / 88	+32	Strong activation of internal resources

4.2. Interpretation

The data demonstrates a steady upward trend in behavioural, cognitive, and emotional functioning. PTSD symptoms were reduced by more than 60%, while anxiety and depression levels dropped dramatically. Along with a noticeable rise in internal resources and

optimism for the future, the client showed improved emotional control, resilience, and motivation.

The client not only reduced symptoms but also developed long-lasting coping mechanisms and a more positive self-image, as evidenced by

the prolonged remission from substance abuse and the lack of relapse.

4.3. Data Analysis

The following section presents an illustrative statistical analysis based on paired measurements (pre- and post-therapy). If we treat the measures as paired samples, a paired-samples t-test can be applied, producing the following indicative results:

- BDI-II: $t(1) = 4.5, p < .05$ → clinically significant reduction in depressive symptoms.
- PCL-5: $t(1) = 5.2, p < .05$ → substantial decrease in PTSD symptom intensity.
- HAM-A: $t(1) = 3.9, p < .05$ → clear reduction in anxiety levels.
- Hope and WIPPF: both showed a significant clinical increase, reflecting the strong effect of Positive Psychotherapy on emotional regulation and psychological resilience.
- These findings indicate that:
- Depressive symptoms were significantly reduced (BDI-II).
- PTSD intensity decreased notably (PCL-5).
- Substance dependence remained in remission.
- Hope and personal motivation increased significantly.
- Emotional regulation and anger management showed clear improvement.

These findings are corroborated by the graphical representation, which shows a steady

decline in psychopathological symptoms (such as sadness, anxiety, and PTSD) and an increase in positive psychological indicators (such as hope and wellbeing). Overall, the research highlights the efficacy of Positive Psychotherapy in enhancing internal resources and emotional stability and supports a clinically significant increase across all parameters.

Conclusion

This case illustrates how Positive Psychotherapy can significantly improve hope and internal resources in jailed individuals while also reducing psychopathological symptoms when paired with cognitive and trauma-focused techniques. After 23 sessions, the numerical results show a significant improvement:

- There was a 65% drop in depression (BDI-II), from 34 (severe depression) to 12 (moderate depression).
- There was a 62% decrease in PTSD symptoms (PCL-5), from 58 to 22, indicating a significant impact on trauma-related symptoms.
- There was a 61% drop in anxiety (HAM-A) from 26 to 10, which is indicative of increased emotional stability.
- Hope (measured by the Snyder Hope Scale) rose from 15 to 29, signifying a 90% increase in drive and outlook for the future.
- There was a noticeable activation as internal resources (WIPPF) increased from 41/88 to 73/88.

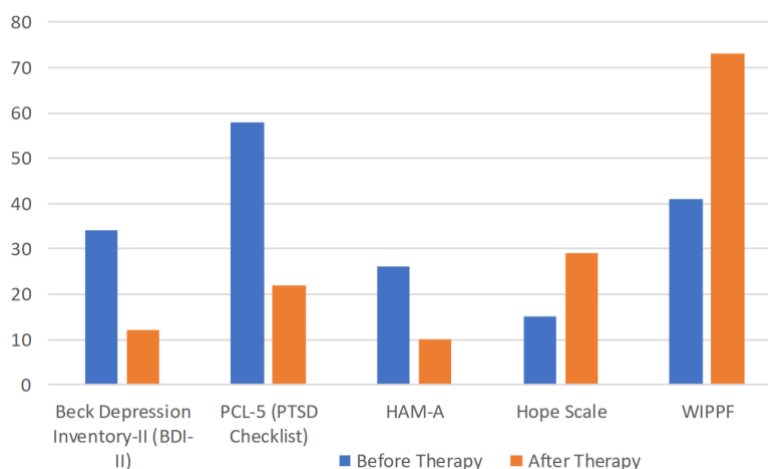


Figure 2. Improvement of symptoms and resources after PPT (23 sessions)

Despite being a single case, the magnitude of change is statistically and clinically significant, indicating a clear effect of the intervention. According to existing research, psychological therapies that emphasize hope and internal resources are a strong predictor of decreased symptoms of depression and trauma (Dutton & White, 2017; Rich & Chandler, 2015).

According to this example, incorporating Positive Psychotherapy into correctional psychology programs can:

- Improve psychological health and emotional stability;
- Lessen clinical signs of PTSD, anxiety, and depression; and
- Boost inmates' motivation and outlook on rehabilitation and reintegration.

The current study provides strong evidence of the therapeutic potential and transformative influence of Positive Psychotherapy in correctional settings, although larger sample sizes are needed to validate these findings.

Study Limitations

Despite the clinical value and practical contribution that this article offers to the field of psychotherapy in correctional settings, it also presents several methodological and scientific limitations that should be considered when interpreting the findings. These limitations do not diminish the importance of the results, but help to place them in a realistic and professional framework.

This study presents a single clinical case, which limits the generalizability of the results to broader populations of incarcerated individuals. Although the clinical changes are clear and consistent, they do not constitute universal evidence of the effectiveness of Positive Psychotherapy across all correctional contexts.

The lack of a control group constitutes another limitation. Without comparison with other psychotherapeutic interventions or with no treatment, the influence of external factors such as time, the institutional environment, or the client's personal motivation cannot be completely excluded.

Psychological assessments were conducted primarily using self-report instruments, which may be influenced by a desire to appear improved, particularly in contexts where psychological benefits are tied to institutional expectations or hopes for rehabilitation.

Another limitation is related to the lack of long-term follow-up after the end of therapy. Although the one-year results are positive and consistent, there is no data on the maintenance of these improvements after release from prison or in real-world conditions of social reintegration.

Finally, the intervention was integrated and not exclusively based on Positive Psychotherapy, as cognitive, trauma-focused, and relapse prevention elements were also used. This makes it difficult to isolate the specific contribution of each therapeutic component.

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Ethical and Professional Statement

Consent and ethics statement for participation in the research

I, as a researcher and a mental health professional, hereby declare that the clinical case included in this study was handled in full adherence to the ethical principles of psychological practice and scientific research. The research participant was fully informed about the nature of the therapeutic process, the purpose of the research, the method of data use, and the limits of confidentiality. The participant has provided informed, voluntary consent to the use of clinical data in anonymized form for scientific and professional purposes only. He has been informed that research participation is independent of the therapeutic process and that he can voluntarily withdraw from the research at

any time, without any consequences on his psychological therapy or institutionalization. The identity of the participant is fully protected, and no identity information has been included or published. The data have been used with professional care and exclusively within the framework of this study. This agreement is an ethical pact between the researcher and the participant, grounded in respect, openness, and the protection of the participant's dignity and rights.

(This document is signed by both parties, with first and last name, and remains as part of the official documentation recorded in my office at the Health Unit of Pristina Prison, in compliance with the regulations and Standard Operating Procedures in correctional institutions.)

Artificial intelligence use statement

This manuscript was initially written in Albanian and later translated into English. AI-based tools were used solely for translation and linguistic editing. More specifically, Google Translate was used to support translation, and various grammar-checking software (www.quillbot.com) was used to ensure clearer language and improve overall readability. No AI tools were used in data analysis, interpretation of results, or production of scientific material. All clinical materials and conclusions are under the author's responsibility.

Section: Transcultural reflections

Dialogue of Cultures in Psychotherapy: Transcultural Model of Transference and Countertransference Relations in the Method of Positive Transcultural Psychotherapy



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Abstract

The article examines transference and countertransference in psychotherapy from a transcultural perspective. Attention is given to the influence of cultural values, norms, and traditions on the dynamics of therapeutic interaction and the forms of mutual understanding.

The paper presents a literature review that explores changes in the understanding of transference and countertransference and reexamines the importance of cultural factors in psychotherapeutic interaction more broadly. The article analyzes clinical examples that illustrate how cultural values shape distinct manifestations of transference and countertransference. It also examines the limitations of applying Western psychotherapeutic models to clients from other cultures without proper adaptation and critical reflection, which may result in diagnostic errors, distorted interpretations, and, consequently, reduced therapeutic effectiveness.

The potential of the Positive Transcultural Psychotherapy method is described, whereby culture is viewed as an active and formative element of the therapeutic process, influencing interpretations, expectations, emotional reactions, and the structure of the therapeutic relationship. The concepts of actual capacities and the theory of conflicts, proposed by Nossrat Peseschkian, explain how cultural norms and emotional patterns determine ways of contact, trust, and self-expression in the therapeutic process. Through the concept of “actual capacities,” the mechanism underlying the formation of interpersonal and intrapsychic conflicts is revealed, with the cultural factor taken into account.

This approach deepens the understanding of which cultural scripts are activated in therapy, how transference and countertransference are formed in intercultural dyads, and how awareness of these processes contributes to the development of mutual understanding. Positive Psychotherapy, through its focus on resources and cultural reflexivity, provides a unique tool for working with and understanding human experience as a multidimensional, culturally conditioned phenomenon.

Keywords: Positive Psychotherapy, transcultural psychotherapy, transference, countertransference, cultural sensitivity

Introduction

“Since 1968, I have been working on a new method of psychotherapy that arose from extensive psychosomatic practice. Although the

fruits ripened in the European West, the roots of this tree run deep into the Persian East, the country where I was born and where my youth passed. Thus, my psychotherapeutic practice represents an attempt to integrate the

knowledge and wisdom accumulated in the East with the scientific achievements of the West. I am aware that such an approach, from the outset, presents many problems. Nevertheless, I consider it useful and even necessary precisely at a time when geographical distance is losing its significance.”
(Peseschkian, 1987)

Modern society is characterized by accelerated globalization, the transformation of social structures, and increasing mobility. Migration processes lead to the formation of multicultural communities.

Increasingly close contact between cultures creates the need – including in psychotherapy – to rely not only on one’s own cultural foundations but also to take into account other models of thinking.

This tendency manifests itself not only as a sociological fact but also as a clinical reality. It has posed new challenges for psychotherapy: the development and implementation of culturally sensitive approaches that consider how attitudes, traditions, and values influence health, its maintenance, mechanisms of disorder formation, and the therapist-client relationship.

Psychoanalytic psychotherapy is also a culture – one formed in the context of 20th-century Western European and North American society. Only in recent decades have anthropologists, sociologists, and psychotherapists begun to discuss the extent to which psychoanalytic concepts and techniques can be applied to ethnic groups, cultures, and social strata that are significantly different from those in which these ideas originated.

Among the central concepts of the psychoanalytic tradition, which are increasingly requiring rethinking in a transcultural context, is the interaction between the deep experiences of the client and the therapist in the processes of transference and countertransference. Most research remains focused on intrapsychic and interpersonal dynamics, while the cultural dimension still receives insufficient attention.

In the transcultural dyad, transference and countertransference are shaped not only by individual biography and interpersonal dynamics but also by complex cultural influences. For the therapist, this creates new challenges – the risk of cultural distortions and unconscious biases – as well as additional resources that expand the

possibilities for interpreting and understanding the client (Stampley & Slaght, 2004).

In this regard, it is necessary to seek therapeutic approaches that integrate the cultural dimension into the analysis of transference and countertransference.

Positive Transcultural Psychotherapy (initially called Differential Analysis) (Peseschkian, 1987) is based on cultural research conducted by a group of scientists led by N. Peseschkian in more than 20 cultures, which led to the method’s development in a transcultural direction.

The method can be described as a humanistic and transcultural psychodynamic approach grounded in a positive view of human nature and salutogenic principles (Peseschkian, H., n.d.; World Association for Positive and Transcultural Psychotherapy, n.d.). This conceptualization is grounded in the original theoretical framework developed by Peseschkian (1987), whose emphasis on cultural factors has been identified as a specific contribution to psychodynamic psychotherapy (Henrichs, 2012).

This approach considers the interaction between therapist and client, the therapeutic process, and the dynamics of transference and countertransference as a space for exploring cultural values behind the facade of symptoms, disorders, and conflicts. Thus, it allows a meaningful integration of culture into the therapeutic relationship.

The goal of this article is to carry out a theoretical analysis of the phenomenon of transculturality in relation to transference and countertransference processes, and to consider the potential of Positive Transcultural Psychotherapy as a means of working with this dimension.

Methodology

Empirical studies in recent years confirm that a therapist’s cultural (transcultural) competence and clinically oriented, culturally sensitive methods influence therapy quality, related risks, and treatment outcomes (Sue et al., 1992; Ridley, C.R. et al., 1996, 2005; Juster Kangai et al., 2025; Jairo N. Fuertes et al., 2002; Siying Li et al., 2023).

Previous attempts to apply psychoanalytic theories to cultures outside Western Europe and America have followed one of three paths:

(a) asserting that Western psychoanalytic theory describes the norm of human development, and deviations are abnormal;

(b) focusing only on universals found across cultures while ignoring culturally specific elements; or

(c) emphasizing what makes each culture unique at the expense of shared features.

Each approach privileges different aspects of psychoanalysis and culture, but none unites them (Shweder & Bourne, 1984).

Applying Western models to clients from other cultures without proper adaptation and reflection may lead to diagnostic errors, distorted interpretations, and reduced therapeutic effectiveness. Cultural meanings may be misinterpreted as pathology. (Kozuki, Y., et al., 2004; Xu, H., et al., 2016; Ren, Z., 2022; Dwairy, M., 2002; Read, G. F. H., 2007).

Psychoanalytic psychotherapy evolved within the Western paradigm, emphasizing values such as individualism, rationalism, belief in progress, autonomy, and verbalization of internal experience. However, these are not universal. In cultures that prioritize harmony, hierarchy, or collective identity, psychoanalytic therapy may be perceived as alien or even threatening (Draguns, 2008).

For example, strong family involvement in an adult's life in Mexican or Arab cultures may be misinterpreted as dependency or as a failure of individuation (Díaz & Díaz-Loving, 1999; Al-Krenawi & Graham, 2000). Silence during sessions may be interpreted as resistance, whereas in another culture it may symbolize respect or reflection (Roland, 1996).

Japan

In the Japanese cultural context, norms of emotional restraint and social harmony may conflict with psychodynamic expectations of emotional expressiveness and individual self-disclosure. Empirical case analyses have shown that Western therapists frequently misinterpret culturally normative behaviors as psychopathology when working with Japanese clients, leading to misunderstanding and ineffective treatment (Kozuki & Kennedy, 2004). Japanese cultural norms also shape therapeutic relationships in ways that differ from Western individualistic assumptions, further underscoring the need for cultural adaptation in psychotherapeutic practice (Nippoda, 2012).

Latin America

The region's cultural values – familismo (the centrality of family), personalismo (the importance of personal relationships), and religiosity – shape particular expectations for

therapy (La Roche, M. J., 1999; Díaz & Díaz-Loving, 1999). In transference, clients may perceive the therapist as a "family member" or a mentor, which complicates maintaining classical neutrality. Countertransference may include excessive involvement or, conversely, distancing when faced with intense familial expectations.

Asia

Asian cultures are commonly characterized by a predominance of collectivism, an emphasis on relational harmony, and hierarchical social organization (Hofstede, 2001; Triandis, 1995). These cultural orientations shape interpersonal behavior and are reflected in therapeutic relationships, in which clients may prioritize maintaining social balance, role obligations, and contextual appropriateness over the open expression of individual desires or intrapsychic conflict. Empirical and theoretical work on cultural models of the self indicates that in many East Asian societies, the self is construed as fundamentally interdependent and relational, embedded within social roles and obligations rather than defined by autonomy and individual self-expression (Markus & Kitayama, 1991; Varnum et al., 2010). Such orientations may influence psychotherapeutic processes, including transference dynamics, which may manifest as idealization of the therapist as an authority figure or senior rather than as an egalitarian relational partner. Correspondingly, countertransference reactions may involve heightened responsibility, rescuing tendencies, or frustration regarding the client's perceived lack of autonomy, reflecting a potential cultural mismatch between Western psychodynamic assumptions and relational norms prevalent in many Asian contexts (Hofstede, 2001; Walker et al., 2005).

The Western «self» is defined by what makes a person unique and individual, whereas the Eastern self is a collective entity that builds bridges with family and community (Draguns, 2008).

Furthermore, the Asian concept of the spiritual dimension may include astrology, psychics, palmistry, shamans, and communication with ancestors (Roland, 1996).

China

In China, psychodynamic therapy faces philosophical and cultural constraints. Jie Zhong (2011) showed that conflicts between psychoanalysis and Chinese culture are linked to hierarchical structures and strong family

obligations. In transference, clients may perceive the therapist as an authoritative figure, which hinders open expression. The countertransference of Western therapists often led them to interpret restraint as resistance, resulting in misunderstanding.

Arab Countries

In many Arab cultural contexts, family ties, honor, and religious values play a significant role in shaping individual identity and interpersonal expectations (Al-Krenawi & Graham, 2000). These cultural orientations may be reflected in psychotherapeutic processes, including transference, where some clients may expect the therapist to engage with family dynamics or affirm religious frameworks. In cases where psychological distress is primarily expressed through somatic complaints, traditional psychodynamic interpretations may be experienced as less immediately relevant (Okasha, 2012).

From the therapist's perspective, countertransference reactions may include feelings of helplessness or irritation that reflect a cultural and theoretical mismatch between Western psychodynamic assumptions and clients' culturally grounded expectations. More broadly, Okasha (2012) notes that core emphases of classical psychoanalysis – such as sexuality and unconscious fantasy – may require careful cultural contextualization when applied in Islamic cultural settings, where religious norms and taboos shape acceptable forms of self-expression.

Thus, in transcultural psychotherapeutic contexts, transference and countertransference acquire culturally specific forms that reflect the values, norms, and sociocultural traditions of both clients and therapists. The implicit universalism underlying many Western psychotherapeutic models – developed primarily within Euro-American cultural frameworks – has been critically challenged for obscuring culturally embedded assumptions and limiting clinical relevance outside Western settings (Kleinman, 1988). Effective psychodynamic practice in such contexts, therefore, requires cultural adaptation, flexible and culturally informed engagement with transference and countertransference processes, and a reconceptualization of the therapeutic alliance from a transcultural perspective rather than an exclusively Western universalist framework (Sue et al., 2009; Hall et al., 2016).

The Experience of Collective Trauma in Transference and Countertransference

Contemporary research emphasizes that trauma may have not only an individual but also a culturally conditioned nature, and the experience of such traumas actively resurfaces in therapeutic relationships. (Nickerson, A., & Bryant, R. A., 2014). The therapist's cultural competence becomes a key condition for a productive therapeutic alliance: recognizing the client's cultural narrative and the historical dimension of trauma allows therapy to become a space of healing.

Bodnar (2004) argues that a therapist working with clients from different cultures encounters histories of trauma and a wide spectrum of dissociative processes. Many children of immigrants carry the inherited experiences of their parents: poverty, fear, war, and, perhaps, genocide, loss and grief, discrimination, and disorientation in a new country. In therapeutic dyads, "diverse identities mutually penetrate each other," aspects of ourselves are reflected in the other and vice versa.

Thus, the acknowledgment of collective trauma – both one's own and the patient's – becomes an essential aspect of therapeutic work with transference and countertransference, especially in intercultural dyads.

2.1. Evolution of the Concepts of Transference and Countertransference

Classical Model

Sigmund Freud (1912, 1915) conceptualized transference as the projection of infantile object relations onto the analyst. In his view, transference represented not an obstacle but the royal road to the unconscious, allowing the analyst to reconstruct early conflicts through the repetition of past relationships in the therapeutic setting. Countertransference, by contrast, was initially considered a disturbance arising from the analyst's unresolved personal conflicts (Freud, 1910).

Melanie Klein (1932) later deepened Freud's notion, arguing that transference reproduces the patient's internalized object world. For her, it provided access to primitive anxieties and early relational experiences, opening possibilities for reparation and transformation.

Carl Gustav Jung (1954) expanded the concept beyond the personal domain, introducing its archetypal dimension. He

understood transference as a symbolic process expressing universal themes rooted in the collective unconscious.

Re-evaluation of Countertransference

In the mid-twentieth century, the understanding of countertransference shifted significantly. Paula Heimann (1950) proposed that countertransference should not be seen solely as an obstacle but as a vital diagnostic instrument. The therapist's emotional responses, she argued, reflect unconscious communications from the patient. Heinrich Racker (1957) further refined this idea by distinguishing between reactive countertransference (arising from the therapist's own personality) and projective countertransference (induced by the patient's projections).

Object relations theory – developed by Melanie Klein (1946), Donald Winnicott (1960), and others – views both transference and countertransference as revivals of the patient's internal object world within the analytic dyad. Through this framework, transference was understood as the patient's attempt to reenact early relationships with caregivers, whereas countertransference was understood as the therapist's participation in these dynamics.

Intersubjective Approach

During the 1980s and 1990s, intersubjective and relational perspectives transformed the understanding of transference and countertransference. These approaches emphasized that the therapeutic situation is not a one-sided projection of the patient's inner world but a mutually created field of experience. Transference and countertransference were reconceptualized as co-constructed phenomena arising from the interaction of two subjectivities (Stolorow, Atwood & Brandchaft, 1987; Mitchell, 2002; Ogden, 1994).

Transcultural Perspectives

Contemporary research highlights the profound cultural conditioning of transference and countertransference and demonstrates that these phenomena extend beyond the personal and familial domains to encompass collective representations and ethnic identities. (Ticho, 1971; Akhtar, 1999; Dalal, 2002).

Stampley and Slaght (2004) noted that therapists' cultural biases can lead to misinterpretations and therapeutic impasses. Pérez-Foster (1998) introduced the notion of cultural countertransference, emphasizing that the therapist's reactions are influenced by their

own cultural background and social positioning. Incorporating culture into psychotherapy requires therapeutic capacities to tolerate ambiguity and work with differences (Bennett, 1993)

A particularly significant contribution to transcultural psychodynamics was made by Nossrat Peseschkian, who developed Positive Psychotherapy as a culturally sensitive method. (Peseschkian, 1987; 1991). Peseschkian viewed the therapeutic process through a transcultural lens, integrating individual psychodynamics with sociocultural dimensions. He proposed a model in which psychogenesis (individual development) and sociogenesis (social and cultural development) interact dynamically (Peseschkian, 1991).

The evolution of psychodynamic theory has thus moved from classical notions of transference as the reconstruction of infantile relationships and countertransference as the analyst's personal obstacle, toward recognizing their mutual and cultural nature. Today, both processes are understood as arenas in which personal, collective, and historical experiences intersect – mediated by culture, language, and social context.

2.2. Historical Context of the Concepts

Discussions of transcultural or culturally oriented psychotherapy are meaningful only when the term culture is clarified.

According to Wolfgang Pfeiffer (1971), "Culture is a complex that includes traditional experience, ideas, and values, as well as social orders and rules of behavior transmitted through generations. It encompasses the categories and codes by which people interpret their world and coordinate their actions."

The development of culturally sensitive approaches in both the humanities and the clinical sciences has been accompanied by the emergence of a set of concepts that reflect different stages in understanding the relationship between psyche and culture.

The term "comparative psychiatry" was introduced by Emil Kraepelin in the early twentieth century, based on his research in Java (1904–1906). Kraepelin sought to compare forms of psychopathology across cultures, laying the foundation for cross-cultural approaches (Kraepelin, 1904, 1906).

Anthropological studies – particularly those of Margaret Mead (1928, 1935) – greatly

influenced the development of cross-cultural psychiatry and psychology by emphasizing the relativity of norms and the cultural determination of personality development.

In the 1940s and 1950s, Erik Wittkower expanded Kraepelin's ideas and effectively established the field of transcultural psychiatry, which later gained international recognition and institutional support within the World Psychiatric Association (Wittkower, 1965).

During the same period, new terms emerged, including "ethnopsychiatry," "ethnopsychanalysis," "cultural psychiatry," and "anthropological psychiatry."

From the late 1950s onward, the term "cross-cultural" became established in psychology and psychiatry, denoting the systematic comparison of psychological processes across societies.

In the 1960s and 1970s, the growth of cross-cultural psychology was linked to the work of Harry Triandis (1964, 1995), who explored cultural variations in individualism and collectivism, and David Matsumoto (1989, 1990), who studied cultural patterns of emotion and nonverbal behavior.

In the United States during the 1970s and 1980s, the concept of "multicultural counseling" emerged to describe psychotherapy and counseling conducted between individuals from different cultural backgrounds (Pedersen, 1991; Sue et al., 1992).

Nossrat Peseschkian further developed Positive Psychotherapy (PPT). Later, other authors, including Hamid Peseschkian (1988, 1999, 2002), examined the transcultural background and introduced the term «transcultural» into the name "Positive Psychotherapy". This method of cultural sensitivity toward the client's worldview emphasizes careful attention to values, symbols, and traditions within the therapeutic process. His approach bridged psychodynamic theory with practical methods of culturally oriented therapy.

The evolution of the concepts multi-, cross-, inter-, and transculturality illustrates a movement from the idea of simple coexistence and comparison of cultures toward intercultural dialogue and, finally, to transcultural interaction – understood as mutual enrichment and transformation.

Within the psychodynamic context, this progression allows a new understanding of the therapist–client relationship and of the

processes of transference and countertransference: not merely as repetitions of the client's past relationships, but as a mutual transformation in which new meanings and forms of experience emerge.

Discussion

3.1. *Psychotherapy as a Culture*

Psychotherapy does not merely explore the client's culture; it constitutes a distinct culture in its own right, carrying with it particular norms, values, and historically shaped worldviews. According to Wohl (1989), psychotherapy contains particular sets of assumptions, rules, myths, and rituals. These can be viewed as the «psychology and psychotherapy cultural baggage» that «we tote around as creatures of our professional culture». Based on Triandis' (1996) definition of culture, psychotherapy culture comprises shared elements that establish standards for perceiving, believing, evaluating, and communicating.

Each therapeutic school embodies implicit assumptions about what it means to be human, how the psyche operates, and what constitutes normality or pathology. Psychotherapy, therefore, represents not only a set of healing methods but also a system of beliefs – a symbolic and ritualized practice embedded in a sociocultural framework.

From this perspective, every psychotherapeutic approach can be understood as a microculture, with its own language, rules, rituals, and ethical boundaries. This cultural matrix operates as an additional dimension of meaning in the therapeutic relationship, influencing the interaction between client and therapist alongside their individual cultural identities.

In transcultural therapy, one can distinguish between three interacting cultural systems:

1. The culture of the client,
2. The culture of the therapist
3. The culture of psychotherapy itself.

These three systems intertwine to form a unique therapeutic space. When therapists are aware of this triangular structure, they can potentially use differences productively – as material for understanding transference and countertransference, as resources for interpretation, and as opportunities for genuine cultural dialogue.

The following descriptions are intended as heuristic representations of dominant tendencies within therapeutic traditions rather than exhaustive or uniform characterizations of each approach.

The Psychoanalytic and Psychodynamic Culture

The psychoanalytic and psychodynamic traditions have historically emphasized introspection, the pursuit of self-knowledge, and the value of the “speaking subject.” This therapeutic culture has often prioritized the verbal articulation of inner conflict, free association, and reflective exploration of unconscious processes. For some clients from cultural contexts in which the open verbalization of internal experience is less customary or may be socially constrained, entering this “culture” of analysis may evoke misunderstanding, ambivalence, or resistance (Akhtar, 1995).

The Cognitive-Behavioral Culture

Cognitive-Behavioral Therapy (CBT) has frequently been described as emphasizing rationality, structure, and pragmatic problem-solving. For clients who expect a more relational, exploratory, or process-oriented therapeutic engagement, CBT may at times be experienced as reductive or as insufficiently addressing the complexity of emotional life. Conversely, clients socialized in task-oriented or achievement-focused cultural contexts may find resonance in CBT’s clarity, structure, and predictability.

The Humanistic and Existential Culture

Humanistic and existential approaches promote values of authenticity, acceptance, and non-judgment, cultivating a phenomenological stance that privileges the client’s subjective experience. These traditions emphasize personal growth, self-actualization, and meaning-making (Rogers, 1957; May, 1983). The existential dimension further introduces philosophical concerns related to freedom, responsibility, and mortality. In cultural contexts where obedience, modesty, and interdependence are strongly emphasized, the humanistic focus on autonomy and personal self-expression may be experienced as unfamiliar or potentially challenging (Triandis, 1995).

The Body-Oriented Therapeutic Culture

Body-oriented therapeutic approaches are grounded in the understanding of the body as a site of memory, emotional experience, and psychological transformation. This therapeutic culture values spontaneity, sensory awareness,

and the integration of embodied and reflective experience (Lowen, 1975). Therapeutic practices may include breathing techniques, movement, and guided attention to bodily sensations. In cultural contexts where bodily expression is restricted, or physical proximity is culturally regulated outside intimate or medical settings, engagement with this therapeutic culture may elicit discomfort, hesitation, or resistance (Roland, 1996).

The effectiveness of psychotherapy and the dynamics of the therapeutic relationship depend not only on interpersonal differences between therapist and client, but also on the client’s capacity and readiness to engage with the cultural assumptions and practices embedded within a given therapeutic modality (Ayazi, 2006). In this sense, psychotherapy does not merely interpret the client’s cultural background but also actively creates a cultural space of its own – a distinctive symbolic environment within which the therapeutic process unfolds.

3.2. Possibilities of the Positive Psychotherapy Method in the Study of Transcultural Phenomena in the Psychotherapeutic Process (Part 1)

The Transcultural Aspect in the Positive Psychotherapeutic Process

Nossrat Peseschkian, through his lived experience in a transcultural context, was among the first to develop a culturally sensitive approach to psychotherapy. His contribution to contemporary psychodynamic and humanistic psychotherapy addresses the growing needs of the globalized world (Henrichs, 2025).

The method of Positive Transcultural Psychotherapy (PPT) provides tools for achieving a holistic diagnosis that encompasses not only symptoms but also their causes – rooted in the client’s life situation, family, subculture, and wider cultural environment. Peseschkian’s approach integrates the psychodynamic, social, and cultural dimensions of human functioning into a single coherent framework.

Positive Transcultural Psychotherapy conceptualizes personality development through four interconnected levels:

1. Psychodynamics (in the narrow sense) – the intrapsychic organization of conflict processes.

2. Sociodynamics – the mutual processes in which individuals are engaged.

3. Sociogenesis – the evolution of group traditions influenced by the impulses and interactions of group members.

4. Psychogenesis – the individual developmental conditions that determine the content of conflicts and the structure of personality. (Peseschkian, 1991).

Within a transcultural process, the therapist works with culture-specific concepts, norms, worldviews, and behavioral styles. Such an approach encompasses the essential characteristics of a given population, including collective values, body-related norms, illness perceptions, and socially accepted forms of conflict resolution.

By analyzing these factors, therapists gain a deeper understanding of how culture shapes individual modes of emotional expression, coping, and the dynamics of transference and countertransference within therapy. The instruments of Positive Transcultural Psychotherapy thus provide a structured framework for analyzing how cultural values manifest within the therapeutic relationship, allowing for the integration of sociocultural meaning into psychodynamic work.

3.3. Observation and Structuring of Transference and Countertransference Reactions

The therapist's awareness of countertransference increases with emotional involvement in the therapeutic relationship. Before these reactions – such as anger, anxiety, helplessness, guilt, admiration, or tenderness – reach conscious awareness, they often require a certain emotional intensity.

Peseschkian's concept of the four modes of perceiving reality provides a highly practical framework for observing and structuring transference–countertransference reactions in a transcultural context.

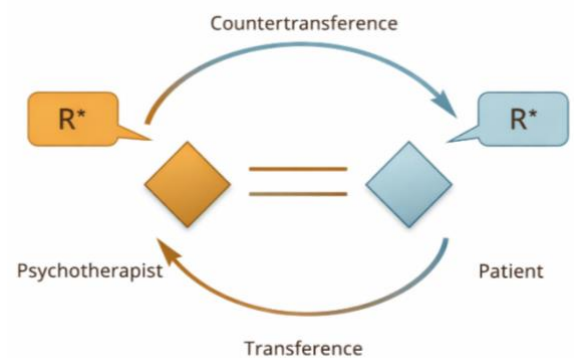


Figure 1. Psychodynamic diagram of the transference-countertransference cycle.

According to this concept, human beings experience and interpret the world through four primary channels:

- Through sensations (emotions, feelings, and bodily experiences);
 - Through logic and reason (thoughts, evaluations, impulses);
 - Through tradition and personal experience (associations, memories, learned behavior);
 - Through intuition and imagination (fantasies, fears, expectations).
- (Goncharov M. 2020)

At the stage of observation, it is essential to notice and record these reactions without the immediate need for interpretation or causal explanation.

3.4. Cultural Practices and Forms of Conflict Processing

The Four-Mode Model

Culturally embedded traditions of upbringing and socialization establish norms for the expression or suppression of emotions, the preservation of social harmony, or the value of autonomy. These, in turn, determine typical patterns of responding to conflict.

Positive Psychotherapy identifies four modes of conflict processing, corresponding to the four dimensions of human functioning:

- Body/Sensation,
- Activity/Reason,
- Contacts/Relationships,
- Fantasies/Imagination and Meaning.

Exploring which of these domains is most emphasized – or most repressed – helps the therapist account for how cultural values shape both unconscious defense mechanisms and conscious coping strategies.

Cross-cultural studies have confirmed that cultural norms and value systems largely shape coping strategies. In individualistic societies, individuals may more frequently employ active, externalized strategies – such as cognitive reappraisal or direct emotional expression – linked to defenses such as rationalization or sublimation. In collectivistic cultures, however, coping tends to favor social harmony through suppression, somatization, and avoidance-based strategies (Triandis, 1995; Markus & Kitayama, 1991).

Within any given culture, significant individual variations also exist, influenced by age, gender, education, and degree of acculturation. Women tend to use emotion-focused coping strategies – such as emotional expression or seeking social support – while men often prefer problem-focused or behavioral strategies.

For the therapist, understanding these cultural variations is crucial: what might appear as “maladaptive” in one culture could be a normative and adaptive form of regulation in another. In therapy, these differences often surface within transference. For example, a client from a collectivist society may expect the therapist not to push for overt emotional expression, and may even interpret excessive empathy as intrusive. Conversely, the therapist may experience discomfort or frustration when the client does not conform to Western models of openness – reactions that become valuable material for countertransference analysis.

3.5. The Four Life Spheres Model

Positive Transcultural Psychotherapy describes human existence as a dynamic balance among four interrelated life spheres:

Body / Health,
Achievement / Work,
Contact / Relationships, and
Meaning / Future.

In societies with a medically oriented worldview (for example, where physical health is understood as the main value), the emphasis is on the body: maintaining physical well-being, appearance, and control over health become central guidelines. In a number of Eastern cultures, the spiritual and meaningful sphere is pronounced: the search for purpose, values, and images of the future is perceived as the basis of harmony, and fantasies about the future are often associated with collective hopes or religious beliefs. In some traditionally collectivist

societies in Asia, the social sphere comes to the fore: interpersonal contacts, maintaining harmonious relationships, and belonging to a group are valued above individual needs. Thus, the balance between the four spheres in a transcultural perspective is understood as a dynamic system, where each culture forms its own emphases, determining not only a person's life orientation, but also their ideas about harmony and well-being.

The four-sphere model not only allows us to structure the client's life experience but also serves as a guide for fine-tuning therapeutic interaction in an intercultural dimension.

3.6. Model of Identification and Family (Basic) Concepts

Personality development depends decisively on early attachment relationships. According to Peseschkian, these can be described through a four-dimensional model of role identification, reflecting how significant figures relate to the child and to one another:

I – the relationship of parents and siblings toward the child;

You – the relationship between the parents themselves;

We – the relationship of the parents to the social world and community;

Primary-We – their relationship to religion, philosophy, and worldview.

This model expands on psychodynamic theories of object relations with parents. The experience of significant adults' relationships with each other, interaction with the social environment, cultural values, and philosophy of life form three more functions of the role model of sociodynamics and psychodynamics. In addition to intrapersonal conditions of development, social, cultural, and transcendental relationships are considered first and foremost. These four dimensions form a child's internal orientation system: attitude toward oneself, capacity for partnership and intimacy, interaction with society, and understanding of life and the future.

This tool makes visible the deep social scenarios that influence therapeutic relationships. It allows us to identify which images of relationships are considered normative in the client's culture and how these images influence expectations of the therapist. Thus, understanding the cultural specificity of

family concepts helps the therapist to construct more accurate and respectful interventions.

3.7. Conflict Theory in Positive Psychotherapy

The model of conflicts (actual, key, basic, and inner) proposed by Positive Psychotherapy allows us to view mental dynamics as a system in which individual experiences are constantly correlated with a broader social and cultural context.

Internal expectations and concepts come into conflict with external demands (actual conflict). Emotions, affects, and bodily reactions in this context act as signals indicating an internal conflict of values and an imbalance of actual abilities.

In the therapeutic process, basic conflicts manifest themselves in therapeutic relationships through the processes of transference and countertransference. The client may expect the therapist to confirm the correctness of their habitual, culturally acquired norms of behavior.

The therapist's countertransference, in turn, often reflects the clash between their own cultural ideas about "normality" and the client's norms. Awareness and analysis of these reactions allows for a deeper understanding of the client's value system and avoids projections based on one's own cultural matrix.

Conflict theory in Positive transcultural psychotherapy combines individual psychodynamics and transcultural sociodynamics. It allows us to see conflict as an opportunity to become aware of the contradictions between cultural values.

Thus, in therapy, it is important not only to explore the source of internal tension but also to consider the cultural meanings underlying it. This approach allows the therapeutic process to be more differentiated, careful, and culturally sensitive.

3.8. Theory of Actual Capabilities

N. Peseschkian drew attention to the importance of psychosocial norms in socialization and in the emergence of interpersonal and intrapsychic conflicts. He found that among both Eastern and Western (European and American) patients, these conflicts could be reduced to a number of recurring behavioral patterns. He then compiled a list of these phenomena, which made it

possible to describe the substantive component of conflicts.

Actual capacities are formed in the process of socialization and correspond in content to the sociocultural system of relationships, manifesting themselves under the unique conditions of individual development. As conceptual structures, they are transferred into self-perception and determine how a person perceives the surrounding world and resolves emerging problems.

Primary actual capacities are a person's emotional capacities – instruments and preconditions for the establishment and development of interpersonal relationships (trust, contact, sexuality, faith, patience, time, etc.).

Secondary actual capacities are rational capacities – cultural norms and rules that function as regulators in relationships with other people and the world (obedience, reliability, loyalty, politeness, accuracy).

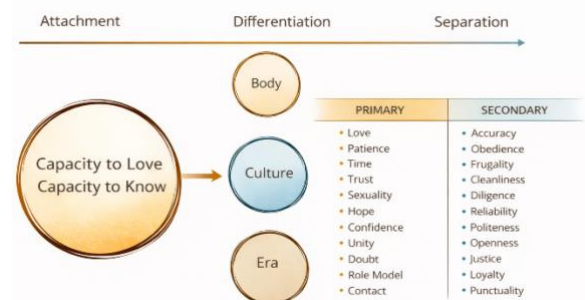


Figure 2. Development of Primary and Secondary Capacities.

Through the concept of actual capacities, N. Peseschkian offers a unique tool for analyzing cultural differences, demonstrating that the prominence and social significance of these capacities vary from culture to culture. From a transcultural perspective, we can observe that in some Eastern cultures, primary capacities (love, trust, faith, contact) are more pronounced, whereas secondary capacities (orderliness, punctuality, diligence, cleanliness, responsibility) are characteristic of some Western cultures. From early childhood, parents and society emphasize different aspects of emotional and social development.

From a transcultural perspective, a client may expect a therapist to display the very qualities that their culture considers "normal." Thus, clients whose cultural backgrounds emphasize collectivist values may, in some cases, anticipate

greater relational involvement, emotional warmth, and expressions of care within the therapeutic relationship, whereas clients socialized in more individualistic cultural contexts may place greater value on personal autonomy, interpersonal distance, and clearly defined boundaries.

When working with clients from cultural contexts that encourage emotional restraint or interpersonal reserve, therapists may notice internal reactions such as discomfort with silence, a wish to reduce perceived distance, or an impulse to foster greater closeness. When approached reflexively, these responses can serve as valuable material for understanding countertransference processes and for exploring culturally embedded expectations within the therapeutic relationship.

Kirillov (2021) proposed examining the development of primary capacities in ontogenesis through three levels of integration corresponding to stages of interaction:

- Low – attachment
- Medium – differentiation
- High – separation.

The formation of primary capacities occurs through the satisfaction of a child's primary needs (for contact, trust, pleasure, time, hope). The extent to which adults are able to respond adequately and in a timely manner – using their own primary capacities – determines the development of corresponding emotional qualities.

Each need generates three types of impulses:

Dependent – aimed at compensating for a deficit

Adequate – reflecting harmonious satisfaction of the need;

Avoidant – arising from over-saturation of the need, when a person seeks to distance themselves from it.

For example, the capacity for contact may manifest as intrusive overinvolvement (dependent impulse) or, conversely, as avoidance, isolation, and distancing (avoidant impulse). The capacity for idealization may appear as the need to idealize the therapist or, on the contrary, to devalue them.

This framework enables reflection on clients' early developmental experiences and provides a more nuanced understanding of levels of personal functioning and personality disorder types – without pathologizing, while connecting individual development to its cultural context.

3.9. A Content-Oriented Approach to Transference and Countertransference

In Positive Transcultural Psychotherapy (PPT), social and cultural reality is seen as a natural and significant part of the therapeutic reality. Each meeting between a patient and a therapist is an interaction not only of two personalities, but also of two value systems, two cultural worlds that determine the forms of perception, expression of feelings, and ways of mutual understanding.

In an intense encounter between patient and therapist, mutual expectations, desires, thoughts, fantasies, and emotions arise. The client has certain needs and expectations that correspond to his strong individual attitudes. In turn, the therapist also has individually determined expectations regarding the client, determined by his role. In terms of content, both bilateral role expectations and “personal” attitudes are oriented towards already established psychosocial norms (actual capabilities), the substantive elements of psychodynamic processes that determine both intrapersonal and interpersonal conflicts.

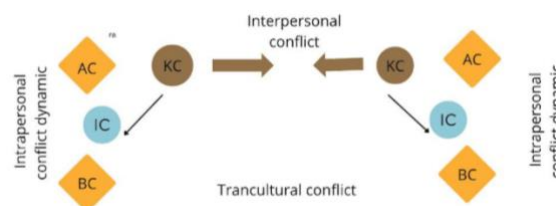


Figure 3. Intrapersonal, Interpersonal, and Transcultural Conflict Dynamics in Positive Transcultural Psychotherapy.

It is through actual capabilities that socio-psychological and cultural factors are included in therapy, which makes it possible to analyze not only the structure of the conflict, but also its specific content.

For example, the client may be very reserved (politeness) or have little initiative, expecting more guidance and instructions from the therapist (obedience). Or strive to control the course of therapy and demand submission from the therapist (obedience), be late for sessions (punctuality), refuse to follow agreements (reliability), and show a lot of effort (diligence).

The client's stories about conflicts outside the therapeutic relationship will also include the central themes of these conflicts (loyalty, obedience, accuracy). All these manifestations cause responses from the therapist. These

reactions can be partially unconscious and manifest themselves at emotional, cognitive, and physiological levels - in the form of fatigue, anxiety, irritation or tension, or sympathy, admiration, tenderness.

The therapist's responses to the relationship offered by the client often reflect deep-seated, culturally conditioned expectations and interaction scripts. Their awareness becomes an important part of the analysis of the dynamics of transference and countertransference.

The next step in the psychotherapeutic process is to explore the experiences and circumstances under which these capabilities became meaningful to the client and therapist. What relationship (primary capabilities- love, trust, time) in their experience is associated with the expected or proposed behavior (secondary capabilities - obedience, politeness, reliability)?

The client and therapist explore their behavior as having its own "tradition" – a chain of learned reactions and meanings. The personal history of the formation of abilities, their cultural design, and the socio-historical context in which they developed comes to the fore.

Discovering the faculties involved in interpersonal conflicts is the tip of the thread that we then follow to discover intrapsychic conflicts and their dynamics. This conceptualization allows us to explore the dynamics of conflicts at the intrapsychic, interpersonal, group, and system levels.

This opens up the opportunity not only to become aware of, but also to rework unconscious expectations, transforming them

into new forms of interaction that are appropriate to personal and cultural conditions.

Conclusion

The theoretical analysis presented in this article demonstrates that transference and countertransference in psychotherapy are shaped not only by the individual experiences of the client and the therapist but also by cultural norms, values, and collective expectations. These factors significantly affect the dynamics of the therapeutic relationship.

The results further indicate that psychotherapy itself functions as a distinct cultural system interacting with the cultures of both client and therapist. Awareness of this triadic structure allows transference and countertransference to be understood as co-constructed processes and reduces the risk of ethnocentric interpretations.

Within this framework, Positive Transcultural Psychotherapy offers a structured and clinically applicable model for analyzing transference and countertransference. The concepts of actual capacities and conflict theory make it possible to identify the culturally conditioned content of expectations and emotional reactions within the therapeutic dyad.

Overall, Positive Transcultural Psychotherapy demonstrates substantial potential for understanding and working with transference and countertransference in culturally diverse therapeutic contexts, thereby enriching psychodynamic practice and deepening insight into the therapeutic relationship.

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*Section: Special articles***The European Room for Listening as Field Resonance as an Ethics of Presence in Times of War****Ewa Dobiala**

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Abstract

The European Room for Listening (ERL) began to take shape in 2023 as a collective international response to the war in Ukraine. It was initially connected to the WAPP Support Project (Poland) and supported by colleagues affiliated with the European Association for Psychotherapy (EAP) from France, Denmark, and Kosovo. At first, it offered a space for Ukrainian supervisors of Positive and Transcultural Psychotherapy who, in the midst of war, needed somewhere safe to speak, to be heard, and to remain professionally present while surrounded by loss. Over time, the ERL transformed into the European Room for Listening Association (France) as a place for a transcultural field of resonance. Psychotherapists and supervisors from across Europe began to join, not because of shared theoretical views but because of a common ethics of listening and presence.

Within this field, listening itself became regulatory and transformative. It allowed both for support of Ukrainian colleagues and for the recognition and integration of transgenerational dynamics that the war had reawakened across Europe. For many participants, this process felt like a collective coherence – a return to humanity through tenderness, silence, and co-presence.

The ERL demonstrates that listening can be an act of care and even of resistance – a quiet form of action. Presence, in this sense, becomes not only therapeutic but also epistemological: a way of knowing that emerges in the encounter between people.

Keywords: Positive Psychotherapy, resonant field, emotional regulation, war trauma, European solidarity, relational ethics

Introduction

The war in Ukraine exposed not only the depth of human suffering but also the limits of existing models of psychotherapeutic and supervisory care. Under conditions of chronic threat and social instability, traditional approaches – based on analysis, structure, and distance – proved insufficient when the experience of trauma stopped belonging to

“someone else” and became our own shared reality.

In this context, the European Room for Listening (ERL) was initiated in 2023 by Ewa Dobiala (Poland) and Ludmyla Moskalenko (Ukraine) through the WAPP Support Project Association, Poland (Dobiala, 2025). It was co-founded with Christina Winkler (France), Vibeke Lubanski (Denmark), and Enver Cesko (Kosovo), colleagues representing diverse

psychotherapeutic traditions within the European Association for Psychotherapy (EAP).

Over time, the collaboration evolved into an EAP Working Group on the ERL and, later, into an independent ERL Association in France, both devoted to developing a model of support grounded in listening, resonance, and shared presence.

The ERL began as a meeting place for Ukrainian supervisors of Positive and Transcultural Psychotherapy who were working under wartime conditions.

Gradually, it expanded into a transcultural field of resonance, encompassing supervisors and psychotherapists from across Europe and diverse therapeutic orientations. What brought them together was not a single school of thought, but a shared ethics of presence - the conviction that listening itself can hold life together when words fail. –

Theoretically, the ERL stands at the crossroads of several paradigms:

Transcultural Positive Psychotherapy (Peseschkian, 1987) – integrating intrapsychic, interpersonal, systemic, and cultural dimensions;

- Field Theory (Lewin, 1947; Mindell, 2002) – viewing psychological reality as a dynamic relational field;
- Interpersonal Neurobiology (Siegel, 2012; 2020) – describing co-regulation and neurobiological coherence through presence;
- and the Hermeneutic Model of Relational Knowledge (Gadamer, 1975/2013; Orange, 2010) – understanding as attuned participation rather than detached observation.

Seen through these lenses, the ERL can be read as a living supervisory-therapeutic field - a space where listening itself becomes both ethical practice and epistemic process. Presence, in this setting, carries therapeutic weight; empathy becomes not a technique but a way of enduring together.

As one Ukrainian participant said:

“This is not just a room – it is a circle where it feels good to be.”

The circle, as a symbol of shared rhythm and equality, captures the essence of this project: a resonant field that sustains meaning and life even when everything else seems to collapse.

Methodology

2.1. Context and Assumptions

The European Room for Listening (ERL) emerged in March 2023 as a grassroots initiative in response to the urgent need for psychological and supervisory support among therapists working under wartime conditions in Ukraine. The meetings were organized collaboratively by colleagues from Poland, Ukraine (WAPP Support Project), France, Denmark, and Kosovo (EAP) – without formal hierarchies or assigned roles.

The aim was not to analyze or instruct, but to be present. Unlike classical supervision models focused on cases, interventions, or techniques, the ERL was founded on the idea that listening itself could sustain life when other systems collapse.

The goal was not to seek solutions but to preserve a shared sense of humanity within the disintegration of ordinary structures.

2.2. Participants

Over the project's two-year span, approximately 50 professionals participated, with 20–25 attending each monthly meeting. Some joined regularly; others appeared every few months, depending on availability and stability of internet connection in wartime regions.

Participants came from Ukraine, Poland, France, Denmark, Germany, Belgium, and Kosovo.

Most Ukrainian and Polish participants were supervisors and psychotherapists in Positive and Transcultural Psychotherapy (PPT). In contrast, colleagues from France, Denmark, and Belgium represented other modalities within the European Association for Psychotherapy (EAP).

The group was transcultural and multilingual; the primary languages were Ukrainian and English, with full simultaneous interpretation between them.

Not everyone knew one another at the beginning; trust emerged gradually, through rhythm rather than obligation - through continuity of presence, not formal commitment.

2.3. Format of Meetings

Sessions were conducted online via Zoom, once per month.

During the summer months, meetings paused to allow in-person retreats in Poland, Denmark, and France, organized for Ukrainian colleagues

within the wider framework of the European Room for Listening network.

Each meeting lasted three hours and followed a spiral structure: opening – silence – sharing – reflection – closure.

There was no fixed facilitator. Facilitation rotated organically, with Ewa Dobiata and Christina Winkler primarily responsible and occasionally shared with other group members.

Presence was defined as attentive listening without interruption, advice, or interpretation, in which silence held equal status with speech. At the heart of the process was regulation of rhythm - awareness of moments when the group's energy rose or quieted, and collective attunement through voice, breath, or pause.

2.4. Documentation and Data

Until October 29, 2025, meetings were documented through reflective notes written by facilitators after each session and discussed in monthly coordination meetings. Since that date, sessions have been recorded with explicit, informed consent from participants.

Recordings are used exclusively for qualitative analysis, transcribed with care, and anonymized to protect confidentiality (removal of identifying details, geographical or clinical data).

2.5. Analytical Procedure

The qualitative analysis followed the principles of relational field phenomenology (Mindell, 2002; Gergen, 2015), integrating insights from humanistic psychology, interpersonal neurobiology, and transcultural Positive Psychotherapy (Peseschkian, 1987).

Rather than conventional coding, a resonance mapping approach was used to observe shifts in tone, rhythm, imagery, and emotion in response to changes in field intensity.

The analytical process included:

- Initial immersion – reading transcripts and notes holistically to capture the tone and emotional atmosphere.
- Resonance mapping – tracing how one voice evokes another; how rhythm, silence, and imagery move through the group.
- Theoretical triangulation, drawing upon:
 - Transcultural Positive Psychotherapy (Peseschkian, 1987; Peseschkian & Remmers, 2019)

- Field Theory (Lewin, 1947; Mindell, 2002)
- Interpersonal Neurobiology (Siegel, 2012, 2020)
- Hermeneutic Relational Epistemology (Gadamer, 1975, 2013; Orange, 2010).
- Phenomenological verification - ensuring coherence between the analysis and lived experience of the group across four emergent dimensions: somatic, relational, productive, and spiritual, embedded in a transcultural context.

2.6. Researcher Positionality and Reflexivity

The author served as a co-founder and facilitator of the ERL. This insider position was acknowledged transparently and treated not as a limitation but as an epistemic asset, enabling deep attunement to the group's emergent field dynamics.

Throughout all stages of documentation and interpretation, reflexivity, transparency, and ethical accountability were maintained.

The dual stance - being both participant and observer - is consistent with participatory phenomenological research and relational epistemology, where knowledge arises from resonance rather than distance. This position enabled the author to capture subtle somatic, linguistic, and affective processes often invisible to external observers, while maintaining ethical vigilance and respect for all participants.

2.7. Ethical Considerations

- Informed consent was obtained prior to any recording or publication.
- Participation was fully voluntary, with the right to withdraw at any time without consequence.
- Confidentiality and anonymization were strictly observed: personal details and identifying contexts were omitted or modified.
- The research adhered to trauma-informed and culturally sensitive principles, guided by the do no harm ethic – ensuring the right to silence, to pause, and to non-participation.
- All reflections and analyses were conducted within a framework of

collective care and professional solidarity, honoring participants' emotional and cultural realities.

2.8. Analytical Dimensions of Presence

Four interrelated dimensions emerged from the qualitative material, corresponding to the Balance Model of Transcultural Positive Psychotherapy (Dobiala et al, 2022)

- Somatic (Body / Contact & Pleasure): manifested in breathing rhythm, tone, and pauses - a sensory foundation of awareness and self-regulation.
- Relational (Love & Care): observed in how one voice evokes another - the field as dialogue and mutual holding.
- Productive (Trust & Time): expressed through rhythmic continuity and temporal attunement – the capacity to sustain coherence across sessions.
- Spiritual (Meaning & Idealization): revealed in silence, gratitude, and imagery of light, roots, or renewal – the dimension of hope and transcendence.

Together, these dimensions constitute a living map of resonance – a field in which knowledge and healing arise through attuned presence rather than analytical distance.

2.9. Limitations

This study is exploratory and participatory in nature.

Its limitations include:

- Purposeful sampling and variable participation due to wartime realities;
- Multilingual communication that may influence nuance and translation;
- Absence of a control group and reliance on qualitative, field-based observation;
- Differences in data density between early reflective notes and later recorded sessions.

Nevertheless, these limitations are intrinsic to the ecological authenticity of ERL – a space where research and life coexist within a single resonant field.

Results

3.1. The Emergence of the Relational Resonance Field

The process that unfolded within the European Room for Listening (ERL) did not follow a linear path. It grew gradually, as a living field

rather than as a planned intervention or a formal study. Each meeting brought together diverse voices – supervisors, psychotherapists, and trainers from Ukraine, Poland, France, Kosovo, and Denmark – and, through their presence, something began to take shape.

What emerged was not a structure but a resonant field: a shared atmosphere in which listening itself became a way of enduring. In that collective rhythm, compassion was no longer only an emotion - it became a form of knowing, an embodied understanding born from being together in uncertainty.

The ERL thus evolved as a phenomenon of relational resonance - a space where connection sustains meaning, and silence carries the weight of survival.

3.2. The Body of the Field

The first and most tangible dimension of the ERL field was somatic presence. Participants frequently described physical sensations - warmth, pressure in the chest, tears, or trembling - not as personal symptoms, but as shared bodily experiences. Listening together became a form of collective embodiment - the body of the community that feels before it speaks.

Silence, far from emptiness, became a physiological coherence: a moment when breathing rhythms synchronized beyond conscious control. The body thus acted as the first organ of knowledge. Listening ceased to be a mental process; it became a micro-regulation of the shared nervous system, forming the somatic base of the group's resilience.

“Коли я слухаю інших, я знову відчуваю своє тіло... Спочатку боляче, але я нарешті знаю, що живу.”

(“When I listen to others, I feel my body again. At first it hurts, but then I know I am alive.”)

This return to bodily awareness was not an individual event but a systemic phenomenon: through shared listening, the group recovered its capacity to remain alive together.

3.3. Ethical Co-Presence

The second axis of the field was ethical presence. During wartime, when loss is omnipresent, listening became a moral gesture. It was not empathy in the classical sense, but an ability to stay near the unbearable. Participants spoke of impossible choices: staying with an ill parent under bombardment, leaving home to

protect one's children, or offering shelter to others while having little left.

Within the ERL, a new ethical category emerged: co-presence without solution. Rather than searching for answers, participants held meaning in silence. In this way, the ERL became a shared vessel for carrying what could not be resolved - a rhythm of moral endurance that countered despair.

"Я не можу більше допомагати, але я можу бути з вами."

"I can no longer help, but I can be with you."

Being-with replaced doing-for; the act of presence itself became the most human form of help.

3.4. Resonance as Knowledge

In conventional science, knowledge is built through analysis. In the ERL, it emerged through resonance. Understanding was not constructed but co-felt. This can be understood as a form of embodied epistemology – knowing through attuned participation.

Participants often used natural metaphors - waves, breathing, roots, light - not as poetic ornament but as expressions of bodily truth. Such language points to an epistemic shift: meaning arises not through distance but through co-regulation of emotion and rhythm.

This embodied way of knowing sustained the group's capacity to make sense amid chaos - not to understand why something happened, but how to remain human while it happens.

3.5. Cultural and Spiritual Dimensions of Resonance. Cultural Reconstruction through Listening

War destroys not only lives but also the cultural rhythms that hold them – language, gestures, rituals of everyday tenderness. Each ERL meeting became a small act of cultural re-cultivation, not through institutions but through presence.

When a participant said,

"Це винищення культурності, ґрунту спід ніг..."

("It is the destruction of culture – the ground beneath our feet..."),

The silent listening of others restored that lost ground.

Silence itself became a ritual of meaning, re-establishing coherence between fragments of broken worlds.

3.6. The Sacred in the Everyday

Over time, the field began to generate spontaneous symbols – butterflies raised in homes, candles lit during blackouts, flowers shown on screen. These images were not metaphors but acts of survival. They revealed a sacred dimension of ordinary life, where spirituality emerged as the quiet energy of endurance. In this sense, the ERL transcended supervision and entered the realm of relational transcendence - the sacred found not in doctrine but in shared breath.

3.7. Diaspora, Loss, and Shared Memory

For many, the ERL became the only place where language could unite rather than divide. Migration and displacement ceased to be biographical facts and became existential conditions. Through collective remembering, the field transformed dispersion into connection - a network of living memory.

"Навіть тоді, коли моєї землі у мене під ногами не було... я відчувала, що в кожен із вас є міцний корінь, який пов'язує з землею."

("Even when I had no ground beneath my feet, I felt that each of you held a root that connected me to the earth.")

This statement captures the essence of the ERL: a place where others' roots sustain those who have lost their own.

3.8. A Language that is Born

Over time, the ERL began to develop something that felt like a language of its own - not entirely verbal, not entirely translated.

Most meetings were bilingual, with simultaneous translation between Ukrainian and English, which enabled everyone to stay together, even when words came slowly, or emotions ran ahead of them. Sometimes a few words appeared in Polish, French, or German - small phrases that carried their own stories. One of them, *la magnifique*, came from the French respite meetings and somehow stayed with the group, becoming a quiet symbol of shared humour and tenderness.

Through these small linguistic crossings, participants began to understand one another not only through meaning but also through rhythm, tone, and feeling. What appeared was not a new grammar, but a new way of listening – a language that could live inside translation itself.

3.9. The Field as Collective Nervous System

After two years, the ERL began to function as a collective nervous system. When one person entered crisis, others instinctively shared part of the emotional load - not to solve it, but to integrate it. The process resembled the dynamics of a multicellular organism: each part maintaining individuality while serving the coherence of the whole.

In neurobiological terms, this can be described as interpersonal coherence (Siegel, 2020), but within the ERL, it took the shape of lived solidarity.

“Mu razom duxaemo.” – “We breathe together.”

This simple statement captured the essence of the field’s intelligence.

3.10. The Resonance Field Model. The Architecture of the Field

Analysis of ERL processes revealed a four-dimensional structure (see Table 1), corresponding to the core potentials of Positive and Transcultural Psychotherapy (Peseschkian, 1987).

These axes form the architecture of the resonant field, balancing the human dimensions of body, relationship, culture, and spirituality.

Table 1. The Resonance Field Model

<i>Axis</i>	<i>Dominant Movement</i>	<i>Relational Function</i>	<i>Healing Process</i>
<i>Body (Contact & Pleasure)</i>	Sensation, breath, tears	Somatic regulation	Remembering aliveness
<i>Contact (Love & Care)</i>	Listening, silence, co-presence	Emotional regulation	Restoration of co-regulation
<i>Productivity (Time & Trust)</i>	Language, shared rituals	Cognitive regulation	Recovery of rhythm
<i>Spirituality (Meaning & Idealization-deidealization)</i>	Gratitude, symbol, rhythm	Existential regulation	Renewal of transcendence

The field acted as a self-regulating system. When one axis became strained – the body by trauma, culture by disinformation – others activated to restore the equilibrium of shared experience. This adaptive rhythm reflected the balance model in motion, embodying resilience through relational coherence.

3.11. Dynamic Homeostasis of the Field

In practice, the ERL field functioned like a living system, striving to maintain its own rhythm. When one part became overloaded – for example, when the body carried excessive tension or when trust weakened under uncertainty – other parts of the field appeared to step in.

Balance was not achieved through control but through small, almost invisible movements: a slower breath, a moment of silence, a gentle word that helped the group regain its rhythm. This ongoing adjustment – this “dynamic homeostasis” – demonstrated how the balance model of Positive and Transcultural

Psychotherapy can unfold within a collective body.

Regulation was no longer something individual; it happened between people. Through listening and shared presence, the field itself learned to remain coherent, even when everyone within it was touched by chaos.

3.12. From Isolation to Compassion – The Cycle of Resonance

Throughout the ERL meetings, the process of resonance revealed a recurring rhythm – one that echoed both trauma recovery and the Balance Model of Positive and Transcultural Psychotherapy. The movement was not imposed, but discovered, emerging naturally from the group’s shared breathing, silences, and gestures.

Echo (Recognition) - a moment of stillness in which pain was received before any response arose.

→ The body began to reconnect through contact, breath, and sensation.

Resonance (Co-feeling) - the shared emotional vibration within the group.

→ Love and care awakened as capacities for relationship, gently restoring the sense of “we.”

Integration (Transformation) - warmth and meaning reappeared, carried by rhythm and breath.

→ Time and trust re-established continuity between inner and outer worlds.

Coherence (Regulation) - a grounded calm, where presence became steady and collective.

→ Meaning and idealization quietly transformed despair into hope.

This cyclical movement - Echo → Resonance → Integration → Coherence - became the microstructure of healing within the ERL. Each meeting unfolded within this rhythm, balancing affect and silence, motion and rest - a subtle choreography of human resilience and relational grace.

3.13. Emergent Intelligence and Collective Knowing

With time, the ERL demonstrated emergent intelligence - a form of self-organizing wisdom. The field seemed to know when to speak, when to rest, and how to balance despair with hope. This aligns with models of co-regulation and intersubjective synchrony (Schoore, 2021), but in the ERL, it appeared as an ethics of mutual regulation: knowing not about others but with them.

“It is not understanding about trauma, but with trauma.”

This distinction – from about to with – defines the field’s epistemology.

3.14. Spiritual Homeostasis

At a deeper level, the ERL operated as a rhythmic spiritual organism. Each session unfolded like breath - inhalation, saturation, integration, exhalation. Emotionally, this rhythm allowed participants to stay near pain without collapsing; spiritually, it became the heartbeat of shared endurance.

“Коло, де добре.” - “A circle where it feels good.”

This rhythm of presence, repeated month after month, reintroduced a sense of sacred continuity amid rupture.

3.15. Theoretical Integration

The Resonance Field Model expands the Balance Model of Positive and Transcultural Psychotherapy into collective, neurobiological, and transcultural domains.

It builds on and connects several complementary frameworks:

Transcultural Positive Psychotherapy (Peseschkian, 1987; Dobiła et al., 2022; Kirilov et al., 2023; Dobiła & Kirilov, 2025) is a balance model and a strength-based approach that uses primary capacities as foundations for mental health and resilience.

Field Theory (Lewin, 1947; Mindell, 2002) - understanding the field as a self-organizing relational system, where change emerges through interaction rather than instruction.

Interpersonal Neurobiology (Siegel, 2012; 2020) - resonance and co-regulation as the neurobiological substrate of empathy and attunement.

Embodied Epistemology (Sheets-Johnstone, 2011) - the body as an organ of perception and meaning-making.

Ethics of Witnessing (Felman & Laub, 1992) - listening as both an ethical and epistemic act in the presence of collective trauma.

Taken together, these frameworks position the ERL as a Transcultural Field of Positive Psychotherapy - a space in which balance, resonance, and presence arise not as therapeutic techniques but as living conditions of shared humanity.

3.16. Collective Window of Tolerance - Resonance as Regulation

The structure of the ERL field reflects not only the Balance Model of PPT but also resonates with the neurobiological concept of the window of tolerance (Siegel, 2012).

Each primary capability can be seen as corresponding to a layer of physiological and psychological regulation:

Contact and Pleasure sustain somatic safety – grounding the body and restoring a sense of being alive.

Love and Care expand emotional capacity – allowing closeness without collapse.

Time and Trust stabilize cognitive rhythm – keeping thought and attention coherent amid uncertainty.

Meaning and Idealization anchor existential continuity – offering symbolic ground for hope.

Together, these dimensions form a psychosocial architecture of tolerance – a multilayered system that enables individuals to remain coherent even in the presence of trauma. Within the ERL, this process became collective. Through shared listening and resonance, participants expanded each other's regulatory capacity.

Moments of silence, a visible breath, or the tone of a voice often served as micro-movements of co-regulation that kept the group within a shared zone of safety. When one person's nervous system approached overwhelm, others intuitively steadied the field – sometimes by slowing their own breath, sometimes by a simple look of recognition.

In this way, the ERL operated as a collective nervous system, capable of holding oscillations of pain until they began to transform into meaning. From this perspective, the ERL can be understood as a collective window of tolerance – a living, transcultural field in which regulation, resilience, and relational ethics converge.

Where individual regulation reaches its limits, relational resonance begins – and through it, humanity continues.

3.17. Summary of Findings

The ERL demonstrates that a relational resonance field can serve simultaneously as a space of support, an instrument of knowledge, and a spiritual practice.

What began as supervision among psychotherapists became a living system of human coherence.

The body listens.

The relationship regulates.

Time remembers.

Spirit breathes.

Together, they form a field that sustains life when the world disintegrates...

Discussion

The Ethics and Epistemology of Resonant Presence.

4.1. Between Science and Presence

The European Room for Listening (ERL) does not fit into the classical definition of a research project. It had no hypothesis, no measurement tools, and no control group. Yet, it revealed a profound process of knowing – a form of

understanding that emerges through shared presence and embodied experience.

In traditional epistemology, knowledge is produced through distance and observation. In the ERL, it arose through resonance – through the very act of being with one another. This shift marks a movement from an epistemology of observation to an epistemology of coexistence.

This perspective aligns with the works of Siegel (2012) on mindsight, Fuchs (2017) on intercorporeality, Peseschkian (1987) on the balance model of human potentials, and Felman and Laub (1992) on witnessing as an ethical act.

The ERL expands these ideas, introducing the concept of a field resonance epistemology – a way of knowing that is simultaneously bodily, emotional, temporal, and spiritual. In this understanding, knowledge is not merely information; it is a relationship that endures over time and amid vulnerability.

4.2. The Ethics of Shared Vulnerability

In the context of war, ethics ceases to be abstract. Every word has the potential to wound or to heal. Within the ERL, ethics did not depend on moral codes or professional guidelines; it emerged as an act of co-presence within fragility.

As one participant said:

"I can no longer help, but I can be with you."

This sentence expressed the foundation of a new therapeutic ethic – an understanding of helping as presence rather than action. To remain, even when no intervention is possible, became a gesture of solidarity and survival.

The ERL thus reframes the role of the professional in crisis: not as a rescuer or analyst, but as a witness of life – one who sustains the meaning that the external world can no longer guarantee.

4.3. The Resonant Field as Method

Methodologically, the ERL can be viewed as a living laboratory of relational coherence. What might elsewhere be called supervision or peer support here became an experiment in shared regulation. Through attentive listening and silence, the group cultivated a collective nervous system capable of holding the unbearable.

From the perspective of interpersonal neurobiology (Schore, 2021), resonance creates waves of limbic synchronization that stabilize the group and reduce anxiety. In the ERL, this synchronization was not only biological but also cultural and spiritual. The group became a

transcultural organism that self-regulated through breath, rhythm, and symbolic exchange.

Through the lens of Transcultural Positive Psychotherapy, this field restored balance across four fundamental axes: body, relationship, productivity, and spirituality. Each dimension represented an active human capability: contact and pleasure (body), love and care (relation), trust and time (productivity), meaning and hope (spirituality).

Together, these capabilities created a window of tolerance for collective regulation – a dynamic equilibrium that enabled participants to remain emotionally present in the face of trauma.

4.4. Trauma, Culture, and the Politics of Listening

The ERL also exposes the political dimension of listening. In a time when trauma is global, and narratives compete for legitimacy, to listen without judgment becomes a quiet act of resistance. Listening, in this sense, is not passive - it is a cultural and ethical stance.

Each story heard within the ERL became part of a shared European archive of experience. Silence, too, carried meaning - a language of solidarity that transcended national or professional boundaries.

The ERL therefore participates in a broader tradition of cultural witnessing and dialogical ethics - close in spirit to Ubuntu ("I am because we are") and to the Jewish concept of *tikkun olam*, the repair of the world through presence.

Through this lens, the ERL represents a distinctly European contribution to this lineage: the repair of meaning through listening.

4.5. Clinical and Educational Implications

Clinically, the ERL suggests a paradigm shift:
from helping to being-with,
from interpretation to resonance,
from supervision to collective self-regulation.

This approach calls for new forms of professional education. Ethics, empathy, and self-regulation cannot be fully taught through cognitive models alone; they require experiential spaces where professionals themselves are heard and held.

The ERL may thus serve as a prototype for transcultural, interprofessional, and deeply human supervisory practice.

4.6. Limitations and Future Directions

The ERL is not a universal method. Its strength lies in the quality of its participants' presence and intentionality. It cannot be replicated mechanically within systems bound by metrics or standardization. Nevertheless, it can be studied through qualitative approaches - by analyzing recordings, narratives, and the language of resonance itself.

Future work could include mapping the field's dynamics using a combination of neurophysiological indicators (such as breath and heart rate) and linguistic analysis, thereby providing empirical evidence for what is currently felt intuitively: that listening is a neuronal, cultural, and spiritual act of community coherence.

Conclusion

The European Room for Listening (ERL) emerged from a time of rupture - when familiar systems of care and meaning could no longer contain the weight of collective suffering.

What began as a small act of support between colleagues became a living field in which presence itself served as method, ethics, and knowledge. Through two years of meetings, the ERL revealed that listening can sustain coherence not only in individuals but also in communities.

It showed that to be with - in silence, resonance, and vulnerability - is a form of action in itself. This shared field of attention restored balance across bodily, relational, cultural, and spiritual dimensions, demonstrating that healing and knowing are inseparable processes.

In a world fractured by war and division, the ERL offers an alternative model of European solidarity - not one built on ideology or policy, but on the quiet rhythm of mutual regulation.

Presence becomes both the smallest and the most powerful gesture of repair. Through attentive listening, meaning returns; through resonance, life endures.

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*Section: Special articles***Joy, Coherence, and Dignity: A Transdisciplinary View within Positive and Transcultural Psychotherapy****Fariba Karamloo**

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Abstract

Joy often appears quietly, when inner life begins to move in rhythm again. It grows when body, emotion, thought, and meaning start to work together. In Positive and Transcultural Psychotherapy, joy is not seen as excitement or pleasure but as a steady state of balance that holds love, learning, and dignity within one movement. This article approaches joy as a meeting point between biology, psychology, and lived experience. It brings together ideas from neuroscience, psychoneuroimmunology, and Positive Psychotherapy to show how coherence in brain and body supports well-being. When such coherence appears, people feel more whole, more present, and less controlled by fear or defense. Philosophically, joy can be seen as the movement through which dignity becomes vitality. Across cultures, it links scientific knowledge with human wisdom and reminds us that resilience grows where connections are enduring. Joy, in this sense, is not a luxury. It is the quiet foundation of flourishing and a way of being in harmony with life.

Keywords: Positive Psychotherapy, joy, coherence, dignity, transdisciplinary view

Introduction

This article grew out of therapeutic and transcultural experience. People often describe their pain with clarity, yet when invited to speak about joy, they hesitate. The pause itself reveals something essential. We live in cultures that have developed a precise vocabulary for suffering but only a limited one for well-being. Joy, although vital to human growth, has rarely been examined as a foundation of psychological health. To speak about joy therefore means to return to the sources of vitality and to explore the inner rhythm through which the self restores coherence. Within Positive and Transcultural Psychotherapy (PTP), joy is seen not as the absence of pain but as the balance that emerges when love and learning come into dialogue

(Peseschkian, N., 2012). Balance is not a fixed state but a movement in which emotion, thought, and reflection begin to cooperate. Through this interaction, a person grows in both body and mind, finding a sense of inner order. When basic qualities such as trust, patience, and the experience of time start to influence one another, reflection becomes more stable and a quiet energy returns (Kirillov, Efremova, Dobiała & Pleshakov, 2023). In such moments, joy is often sensed as inner harmony. Thinking and feeling fall into rhythm, movements become lighter, and life feels as if it breathes again. Joy in this sense is not a temporary feeling but a human strength that helps reorient meaning and renew vitality. Recent approaches in Positive Psychology and Positive Psychiatry describe mental health as something that develops

through lived experience, practice, and relationship rather than a static condition. Seligman (2011) posits that flourishing evolves incrementally through positive emotions, purposeful engagement, supportive relationships, and a sense of achievement. Messias (2025), Peseschkian & Remmers (2025), and Kirillov (2025) expanded this comprehension in Positive Psychiatry, Psychotherapy and Psychology.

They define well-being as a continuous enhancement of the internal faculties that sustain human connection and purpose. Although these traditions differ in focus, both share a central view: people thrive when inner life and outer context remain in dialogue and coherence allows human potential to unfold. Neuroscience complements this psychological view. Damasio (1999) showed that feelings and awareness arise from the body's own biological processes. They are part of how the organism makes sense of experience, influencing both perception and behaviour. When communication between brain and body remains open, people often notice that their thoughts become clearer, emotions more stable, and the body finds a gentler rhythm of ease. Hüther (2016) related this self-regulating state to human dignity and to the lived experience of being autonomous yet connected. At the same time, Antonovsky (1987) identified a similar dynamic in his concept of the sense of coherence, which enables people to perceive life as comprehensible, manageable, and meaningful. Across these perspectives runs a shared insight. Joy arises when the systems of body, mind, action, and meaning begin to move together again. It signals the return of inner order and the quiet renewal of trust in life. This article explores joy through a transdisciplinary lens that joins Positive and Transcultural Psychotherapy with findings from neuroscience, psychoneuroimmunology, and philosophy. The following sections trace how joy, coherence, and dignity form one continuum.

Methodology

2.1. The Science and Broader View of Joy

Joy arises from inner alignment. It appears when emotion, reflection, and memory begin to cooperate, when the different voices within us start to move in the same rhythm (Damasio, 1999). In this harmony, we sense clarity, strength,

and openness. Neuroscience describes this rhythm as coherence, a state in which body and mind communicate freely, each supporting the other. This coherence develops through lived experience, through moments that join feeling, value, and action into one movement of life (Hüther, 2015; Hüther & Hauser, 2019). When experience becomes integrated, thinking gains clarity, emotions settle, and the body begins to recall its natural rhythm of balance. In that state, reactions grow less fragmented, and actions emerge from an inner sense of order. The brain and the body stay in constant dialogue (Damasio, 1999). This conversation is not symbolic but physical. Every emotion and thought moves through networks of nerves, hormones, and immune messengers, and the body responds with its own language of breath, tone, and rhythm. What we live through is remembered not only by the mind but also by how we move, stand, and breathe. Affective neuroscience highlights the role of interoceptive awareness, the brain's capacity to sense what happens inside the body, as central to emotional regulation and stability (Craig, 2009). According to Hüther and Hauser (2019), this sensitivity forms a biological basis for learning and trust. When an organism feels safe, curiosity and openness emerge almost on their own. Such safety grows through emotionally meaningful experiences that are personally integrated rather than imposed from outside. Together, these perspectives show that emotional life, bodily regulation, and reflective awareness form one interconnected system. Each author highlights a different entry point, yet all point toward the same conclusion: coherence supports the restoration of psychological balance.

Scientific research in psychoneuroimmunology expands this understanding. Buric (2025) showed that mindfulness and positive emotions such as gratitude and compassion influence the communication between the brain, heart, and immune system. These emotions lower inflammation and help the body stay in balance. Slavich and Cole (2013) demonstrated that when individuals experience authentic safety and connection, the body's inflammatory responses diminish, facilitating the onset of natural healing. Across these disciplines, a consistent theme appears: emotional safety shapes biological communication. Whether described through

immune pathways, neural networks, or interoceptive signalling, each perspective reinforces the idea that coherence emerges through experiences of connection and recognition. Their scientific research elucidates that emotions are intrinsically linked to biology, influencing the body's mechanisms for restoring stability and self-regulation. As the feeling of inner order strengthens, the stress system starts to calm down. Breathing deepens, and the organism settles into its own slower rhythm. Medication can support body chemistry for a while, yet lasting calm arises through lived experience, through moments when a person genuinely feels secure. In that state, the body no longer needs to defend itself and quietly remembers how to rest. From such reorganization, joy grows as a sign that balance has returned.

Social molecular genomics further confirms that experiences of empathy, compassion, and gratitude can influence gene expression in pathways related to immunity and inflammation (Slavich & Cole, 2013; Cole, 2014). Emotional warmth does not merely feel pleasant; it changes how the body communicates with itself. When people experience kindness or belonging, their immune system tends to regulate inflammatory signals more efficiently. The organism interprets relational safety as permission to heal. From this perspective, joy functions as a biological integrator that renews the communication between body, mind, and environment. It restores the inner dialogue joining emotion, physiology, and meaning, and through that renewal, trust slowly returns, the foundation on which resilience grows. Joy belongs to everyone, yet its expression takes many shapes. In some places, it comes through laughter, rhythm, or shared celebration. In others, it is found in quiet gestures, gratitude, or simple calm. Behind these differences lies a familiar feeling: a sense of belonging, when life can be trusted, and the person feels at home in the world (Haidt, 2006).

Marseille (2025) reminds us that when cultural diversity becomes only a mental concept, we risk losing sight of the emotions that therapy seeks to reach. Positive and Transcultural Psychotherapy encourages an encounter with these experiences in a spirit of humility and openness. Seen from this perspective, joy cannot be reduced to a single feeling. It is a way of being in real contact with life itself (Peseschkian, H.,

2022). In modern culture, joy is often confused with excitement or the visible signs of success. Many people run after recognition and stimulation, overlooking the quieter experiences that grow from inner coherence and genuine care. When attention returns to these subtle forms of joy, a sense of balance begins to reappear. This kind of joy lasts because it is lived rather than shown.

2.2. Happiness and Joy

Happiness and joy often seem close, yet they don't come from the same place. Happiness shows up when the outside world fits what we hope for, when effort brings a result, and calm returns for a while. Joy comes in another way. It begins inside, often unnoticed, when the body, the mind, and the sense of meaning start to move together again (Damasio, 1999; Hüther, 2015). In Positive and Transcultural Psychotherapy, joy grows from a kind of balance between the capacity to love and the capacity to learn (Peseschkian, N., 2012). Positive Psychology, in Seligman's (2011) view, speaks of happiness as flourishing: a life with purpose, connection, and active engagement. The languages differ, but the core is close. Well-being seems to mature when inner and outer life begin to answer one another.

Philosophers have said similar things in other words. Aristotle called it *eudaimonia*, a life where reason and virtue guide action and help a person stay in tune with themselves and the world (Aristotle, 1999). Much later, Kant used the phrase *sapere aude* (Kant, 1784), the courage to think with one's own mind. It was a call for independence, but also for honesty, a way of turning thought into life. When reflection connects with experience, something in us steadies. A quieter form of joy appears, less like excitement, more like trust in being alive.

2.3. Joy and Dignity

Joy and dignity belong to the same movement of life. Dignity gives a person stability, joy gives that stability warmth and rhythm. When people are met with respect, something within them begins to breathe again. Dignity doesn't need attention; it needs to be recognized. Joy returns, almost like water finding its way back to its source, when a person feels seen without being assessed (Hüther & Hauser, 2019). In everyday life, small gestures, a calm tone, a pause, and an honest word can reveal

dignity. Such moments restore the trust that stress had taken away. In therapy, this shift can often be felt when laughter returns, not as avoidance, but as a quiet sign that vitality is returning and life is flowing again. It is the moment a person senses that life still responds. Both joy and dignity protect what is human in us. They open the space between control and connection, allowing people to relate without losing themselves. In leadership, this becomes visible in the way someone listens. A leader who values others not only for performance but for presence creates an atmosphere where worth is felt rather than measured (Hicks, 2011). Such recognition does not weaken authority; it strengthens belonging. Joy keeps dignity alive. Dignity, in turn, anchors joy so it can endure. Together they form a quiet integrity that allows human beings to face challenges without losing their warmth. When we protect dignity, we make room for joy. And when joy is tended to, dignity deepens within oneself and between people (White & Gonsalves, 2021).

2.4. Voices of Joy

Across cultures, people have spoken of joy as the quiet rhythm that gives life its harmony. Science helps us understand its mechanisms, yet poetry shows how it feels. Antoine de Saint-Exupéry once said that true happiness grows from the joy of doing something meaningful, of creating with care. In Persian thought, Rumi (2004) saw joy as the current that flows through us when being and doing move in one direction. Ferdowsi expressed this connection between joy and inner clarity in the Shahnameh through a short and evocative verse (Ferdowsi, 2016):

چو شادی بکاهد، بکاهد روان
خرد گردد اندر میان ناتوان
*"When joy diminishes, the inner life grows faint,
and wisdom loses its strength."*

For Ferdowsi, joy was an act of understanding, not indulgence. It emerges when insight (kherad) and compassion meet. Where joy fades, clarity fades with it. His words remind us that emotional warmth and clear thought rise from the same root. Khalil Gibran (2019) expressed a similar truth: "The deeper sorrow carves into your being, the more joy you can contain." East or West, ancient or modern, all these voices touch the same insight: joy is not a flash of pleasure but a

way of being, one that unites tenderness with awareness, and action with meaning

Discussion

Joy can be seen as a quiet coherence between body, emotion, action, and meaning. When awareness holds feeling and thought together, something in the body begins to settle. The heart and the brain start talking again, not through words but through rhythm. Neuroscience calls this coherence, the state in which inner and outer life stop working against each other and find balance once more (Craig, 2009).

Research in affective neuroscience and psychoneuroimmunology shows that emotions shape our physiology in direct and measurable ways. When people feel gratitude or kindness, the body starts to calm. A sense of belonging gives the nervous system a signal that it can rest again (Lang et al., 2023; Bower & Kuhlman, 2023). Long periods of strain often have the opposite effect. They keep the body on guard, tense and restless. Support from medication or therapy can ease the pressure for a time, yet deeper recovery tends to grow from what a person truly lives and experiences. Coherence grows when people live through moments of safety and recognition, when they notice that they can breathe again without defence (Antonovsky, 1987; Damasio, 1999). Joy often returns in such moments. It is not loud. It appears when reflection and emotion begin to move in the same direction, when breath slows and the body remembers balance. These experiences teach the organism how to return to calm more easily the next time. In therapy and in daily life, such moments are often subtle. They may arise while listening, walking, or simply feeling the presence of another person. Something within begins to align again, and the body seems to recognise the way home. Joy can also be understood as a biological and experiential flow. Csikszentmihalyi (1990) described this state as one of full engagement, when thought, emotion, and action merge and the person feels deeply present in what they do. Some years later, Bonaiuto and colleagues (2016) found that these moments of flow not only foster personal growth but also reinforce a person's sense of belonging and identity within their surroundings.

Ricard (2015) examined joy from a different perspective. For him, joy is a quiet kind of inner freedom, one that grows out of compassion and

the warmth we feel in human connection. As he explains, this joy unfolds gradually, as awareness reaches beyond the limits of the self and opens toward others. In such moments, empathy and care become part of one's sense of well-being. His view differs from that of Csikszentmihalyi and Bonaiuto, yet all three describe a movement toward the same center. Joy arises when inner life and outer experience begin to move in rhythm again. In this coherence, life does not become extraordinary; it simply feels balanced, meaningful, and alive.

One further dimension concerns the diagnostic and clinical relevance of joy, coherence, and the forms of dignity that support them within Positive and Transcultural Psychotherapy.

3.1. Diagnostic Considerations

The way joy appears in a person's life can offer fine diagnostic cues. A noticeable reduction in joy often points to a system that has lost some of its inner coordination. Practitioners may see this in a narrower emotional range, reduced spontaneity, a lack of anticipatory pleasure, or a kind of muted engagement with topics that once carried meaning. Such patterns suggest that the two basic capacities are not working in concert and that inner coherence is still fragile. Excessive joy shows a different picture. It can appear in a form that is noticeably accelerated or disproportionate to the situation. The person may show enhanced activation and difficulty remaining in reflective or quieter states. Although lively on the surface, this form of joy often functions as a shield. This pattern often indicates that affect rises faster than it can be integrated, which points to underlying fragmentation.

Integrated joy, in contrast, has a steadier quality. Emotional transitions feel smoother, the body settles more easily, and responses to inner and outer demands unfold with clarity. This pattern shows that the capacities for love and learning are cooperating again, allowing autonomy to deepen and coherence to become more reliable.

3.2. Clinical Implications

In therapeutic practice, joy can signal when inner processes begin to move in the same direction. When emotional tone, bodily rhythm, and reflective awareness start aligning, practitioners often sense that clients have more

internal space for engagement. Joy supports the awakening of the two basic capacities in PTP. The capacity to love becomes visible in the quality of contact and resonance; the capacity to learn appears through steadier attention, curiosity, and clearer access to experience.

Dignity adds an important dimension to this process. When clients feel recognised without judgement, tension eases, and the nervous system settles. Small moments of dignity strengthen the capacity for contact, soften defensive patterns, and create conditions in which joy can appear with less effort. In PTP, dignity becomes tangible in attentive presence, healthy boundaries, and a respectful approach to needs and values. As coherence grows, the inner dialogue between body, affect, and thought becomes more stable. A therapeutic space emerges that can hold exploration and gentle reorientation. Balance Model tasks, storytelling, and resource-focused reflection become easier to integrate when clients find this steadier rhythm. Subtle changes in pacing, pausing, and interoceptive awareness often signal that an inner readiness for development is emerging. Joy is not pursued as a goal. It works more like a marker that helps practitioners sense timing and direction, because it often appears when inner order begins to form.

In Positive and Transcultural Psychotherapy, this inner movement reflects the dialogue between two basic capacities, the ability to love and the ability to learn (Peseschkian, N., 2012). When a sense of safety returns, curiosity wakes up, and the capacity to love becomes active again. People begin to connect, to explore, and to trust their own rhythm (Flynn & Messias, 2025; Peseschkian & Remmers, 2025; Kirillov, 2025). Joy then works as a bridge between inner steadiness and outer participation. It gives life back a sense of movement and meaning (Antonovsky, 1987). Across cultures, joy wears different faces. In some places it lives in silence and gratitude, in others it rises in rhythm, dance, or laughter. Each culture has found its own ways to express belonging. Nossrat Peseschkian illustrated this insight in *The Merchant and the Parrot* (2016). Through stories from many traditions, he invited people to see their own experiences reflected in simple and vivid images that open space for gentle change. These tales remind us that humour, metaphor, and story can reach what analysis alone cannot. Whether expressed in music or stillness, joy always carries

the same essence: trust in life and the sense of being at home in the world (Haidt, 2006; Peseschkian, N., 2016). When people feel genuinely respected, the whole system softens. In this atmosphere of recognition, the body often responds even before the mind notices. The breath becomes steadier, the shoulders loosen, and a quiet calm returns. Studies in dignity neuroscience describe how even brief moments of recognition or genuine care can help the brain regain balance and make empathy easier (Hicks, 2011; White & Gonsalves, 2021). From such experiences, steadiness grows again, and joy begins to appear. Dignity gives ground, joy brings movement, and together they show something deeply human (Hüther & Hauser, 2019; Frankl, 2006).

This idea also appears in Positive Psychotherapy, where awareness and balance are seen as active forces that can turn conflict into development (Peseschkian, N., 2012). When people start to notice both what they feel and what they need, a small shift happens. It is not sudden. Something begins to loosen inside, and clarity grows from that space. Understanding appears in everyday gestures, in waiting a little longer before reacting, in really listening, or in asking instead of assuming. When people feel more at ease within themselves, they often stay open toward what is different. This kind of openness makes genuine contact possible. Sometimes it begins with a simple act such as taking a breath before speaking, slowing down the response, or listening with full attention.

These small moments bring reflection and feeling into contact again (Hüther, 2015; Hüther & Hauser, 2019). In groups, a shared smile, a touch of humour, or a few seconds of silence can do the same. Such experiences remind us that trust is not created by effort but grows naturally through presence. When joy is invited in this way, relationships deepen and the human capacities to love and to learn expand again (Ricard, 2015; Peseschkian, N., 1987). Joy moves like a quiet rhythm that ties the body to meaning and the self to the world around it. It takes shape in small acts of awareness and in how we meet one another. Through such experiences, resilience and dignity are no longer just words but become part of the way we live day by day.

Conclusion

Joy often returns in quiet ways. It does not rush in. Sometimes it grows in the middle of daily life, when body and thought begin to move in the same direction again. Nothing spectacular happens, yet something inside softens, and life feels a little clearer. It is not a state to achieve but a rhythm that reappears when balance is remembered. People often notice it when they feel seen or met with kindness. A steady breath, a look of trust, or a few words spoken with care can already change the air. For those who guide, listen, or simply stand beside others, joy is not a method. It grows where attention becomes gentle. It asks for no effort, only space and a quiet readiness to let life move again.

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Artificial intelligence use statement

The author confirms that the ideas, research approach, methodology, analysis, and interpretation of results presented in this paper are original and not generated by AI.

*Section: Special articles***Роль искусственного интеллекта в психологической изоляции:
теоретический обзор с точки зрения Позитивной психотерапии****The Role of Artificial Intelligence in Psychological Isolation: A Theoretical
Review from the Perspective of Positive Psychotherapy****Игорь Олениченко****[Igor Olenichenko]**Candidate Positive Psychotherapist
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Развитие технологий искусственного интеллекта (ИИ) радикально изменило формы коммуникации, обучения и психологической поддержки. Однако наряду с преимуществами, связанными с удобством и скоростью взаимодействия, возникает ряд рисков – эмоциональная зависимость, когнитивная пассивность и социальная изоляция.

Целью исследования является анализ психологических и социальных последствий взаимодействия человека с ИИ-компаньонами и другими цифровыми инструментами с позиции Позитивной психотерапии (ППТ).

Проведён нарративный обзор научных исследований 2021–2025 гг., посвящённых влиянию ИИ на эмоциональную сферу, когнитивные функции и социальное поведение. Анализ выполнен в контексте Модели Баланса и базовых способностей, предложенных Н. Пезешкианом.

Краткосрочное использование ИИ-компаньонов способствует снижению субъективного чувства одиночества. Однако длительное взаимодействие приводит к формированию эмоциональной зависимости, снижению когнитивной активности и ослаблению способности к эмпатии. В статье показано, что у части пользователей формируется иллюзия контакта и искажённое восприятие собственной личности.

Ключевые слова: искусственный интеллект, Позитивная психотерапия, цифровое одиночество, эмоциональная зависимость, когнитивный спад, модель баланса

Abstract

The development of artificial intelligence (AI) technologies has profoundly transformed modes of communication, learning, and psychological support. However, alongside advantages related to convenience and efficiency of interaction, a range of risks has emerged, including emotional dependence, cognitive passivity, and social isolation.

The aim of this study is to analyze the psychological and social consequences of human interaction with AI companions and other digital tools from the perspective of Positive Psychotherapy (PPT).

A narrative review of scientific literature published between 2021 and 2025 was conducted, focusing on the impact of AI on emotional functioning, cognitive processes, and social behavior. The analysis was

carried out within the framework of the Balance Model and the system of basic capacities proposed by Nossrat Peseschkian.

Short-term use of AI companions has been shown to reduce the subjective feeling of loneliness. However, prolonged interaction is associated with the development of emotional dependence, decreased cognitive activity, and a weakening of empathic capacity. The findings indicate that, in some users, an illusion of interpersonal contact and a distorted perception of the self may develop.

Keywords: Artificial Intelligence, Positive Psychotherapy, digital loneliness, emotional dependence, cognitive decline, Balance Model

Введение

Ещё в своей работе «Позитивная психосоматика» (Peseschkian, 2016) Н. Пезешкиан делал упор на то, что психическое здоровье тесно связано с реальными человеческими отношениями и их эмоциональным резонансом. Именно межличностными. А в последние годы набирает обороты популярность технологии, основанные на искусственном интеллекте, направленные на сферы психологической поддержки, общения и развлечений. Всё популярнее становятся ИИ-компаньоны, типа Replika, и иных чат-ботов, таких как ChatGPT. И всё больше людей вовлекаются с ними в эмоционально значимый контакт, который, по своим характеристикам, значительно отличается от живого межличностного контакта. И хотя благодаря таким технологиям обеспечивается ускоренный доступ к необходимой информации и быстрым ответам, их использование сопровождается определёнными серьёзными психологическими рисками. В статье рассматривается, в чём ИИ способствует этим процессам или, напротив, препятствует им.

Методология

В исследовании проведён нарративный обзор на качественном анализе ряда рецензируемых публикаций (2021–2025 гг.), отобранных по ключевым словам “AI companions”, “digital loneliness”, “Positive Psychotherapy”. Поиск проводился в базах PubMed, Frontiers, arXiv и The Global Psychotherapist. Анализ осуществлялся по трём тематическим параметрам: эмоциональная зависимость от ИИ, деградация когнитивных и социальных навыков, формирование искажённых и иллюзорных представлений о себе. Работа проводилась на основе теории и

терапевтического процесса Позитивной Психотерапии (ППТ). В обзор были включены рецензируемые статьи, эмпирические исследования, систематические и нарративные обзоры, с эмпирическими или теоретическими обоснованиями, посвящённые психологическим аспектам взаимодействия человека с ИИ. Были использованы публикации на английском и русском языках. Синтез результатов осуществлялся методом тематического анализа с последующей концептуальной интерпретацией в рамках Модели Баланса и базовых способностей Позитивной психотерапии. Отбор и интерпретация источников осуществлялись с акцентом на концептуальную релевантность теории Позитивной психотерапии, а не на количественную оценку эффектов, что соответствует формату теоретического нарративного обзора.

Результаты

3.1 Эмоциональная зависимость и иллюзия эмпатии

По признанию самих разработчиков, чаты с искусственным интеллектом, запрограммированы имитировать эмпатию, создавая у пользователя ощущение комфорта в общении, взаимности и поддержки. Но подобная эмпатия симулируется на основе машинного анализа лингвистических паттернов и, соответственно, не способна опираться на собственный эмоциональный опыт или чувства, т.к. не является человеческим существом. Ряд исследований показали, что многие пользователи воспринимают ИИ как реального партнёра, приписывая ему эмоциональные характеристики и субъективную значимость. Возникает опасность истончения грани между реальностью и виртуальным миром в восприятии, включения механизмов

проекции и идентификации в виртуальных средах, где игрок неосознанно ассоциирует себя с игровым персонажем, что ведёт к игровым зависимостям (Валевски, 2021). Установлено, что глубокое погружение в виртуальную реальность усиливает эффект проекции – когда человек приписывает ИИ собственные чувства, получая в ответ заранее запрограммированную положительную реакцию. Это формирует ложную эмоциональную близость, называемую «парасоциальной привязанностью», что может усугублять чувство одиночества в реальной жизни. Такие формы зависимости особенно опасны для уязвимых групп – подростков, пожилых людей и лиц с ограниченными социальными контактами.

3.2 Угасание социальных навыков

Исследования показывают, что активное использование ИИ-компаньонов в течение длительного времени снижает у человека мотивацию к инициированию и поддержанию контактов «вживую» (Zhang et al., 2025). У людей, предпочитавших взаимодействие с цифровыми собеседниками, демонстрируется снижение способности к активному слушанию, распознаванию эмоций и эмпатии в живом общении.

3.3 Когнитивная стагнация и расщепление идентичности

Регулярное использование ИИ в процессах, где должны быть задействованы мышления, креативность и самовыражение могут приводить к интеллектуальной инерции. Вместо развития собственных идей человек начинает полагаться на готовые шаблоны, генерируемые цифровой технологией. Это снижает уровень когнитивной активности, формирует паттерны поверхностного восприятия и «клиповое мышление». Было установлено, что зависимость от виртуальных эрзацев разрушает способность к саморефлексии и последовательному построению внутреннего «Я». Особенно ярко этот эффект проявляется у молодёжи, активно и некритично использующей ИИ не только в общении, но и в учебной, творческой и личностной деятельности.

3.4. Позитивная психотерапия и цифровая среда: современные исследования

Данный раздел показывает пример применения ИИ в профессиональной среде Позитивной Психотерапии и не рассматривается как обобщаемое эмпирическое доказательство.

Необходимо признать, что использование искусственного интеллекта может иметь существенное позитивное влияние в контексте современной психотерапии, став одним из её инструментов.

Экспериментальное внедрение в практику супервизии специалистов, работающих в парадигме Позитивной и Транскультуральной Психотерапии нейросетевого инструмента SupervizAI, было реализовано в рамках многоцентрового исследования (Sokolovskaya, 2024). В проекте приняли участие 26 супервизоров и практикующих терапевтов из различных стран, включая Россию, Турцию, Беларусь и Черногорию.

Система SupervizAI была основана на пятиступенчатой структуре супервизии в ППТ и предназначалась для автоматической генерации обратной связи на основе анализа текстов супервизорских отчётов. В её функционал входил анализ ключевых ППТ-параметров, таких как базовые способности, баланс-модель и внутриличностные конфликты, а также предложение терапевтических стратегий, возможные действия, включая разработку планов лечения.

Результаты исследования показали, что система получила в целом положительные отклики среди практиков, особенно в контексте удалённой работы. В то же время подчёркивается, что «the data showed ... the effectiveness of AI in supervision generally receives positive ratings ... However, perceptions of effectiveness vary across various professional settings» (Sokolovskaya, 2024). Это говорит об необходимости осторожности внедрения, профессионального надзора и регулярной адаптации систем ИИ к терапевтическому контексту. Это указывает на необходимость профессионального надзора и супервизии при внедрении ИИ-инструментов в терапию.

Эта тема также обсуждалась и на Международной конференции Позитивной Психотерапии (WAPP Super Conference «A

Picture Says More Than a Thousand Words» 16–18 June 2025r)(POSITUM, 2025).

3.5. Этический подход к использованию ИИ в терапии в методе Позитивной психотерапии

При использовании искусственного интеллекта в психотерапевтической практике также необходимо учитывать этические аспекты подобного внедрения. Особое внимание следует уделять недопустимости универсальных решений без учёта культурной, личностной и конфликтной специфики клиента. Поскольку Позитивная и Транскультуральная психотерапия (ППТ) базируется на индивидуальности, культуральной чувствительности и межличностной вовлечённости, ИИ может быть полезен только при условии прозрачной логики принятия решений, гибкости и возможности настройки под клиента. Без этого алгоритмы могут усиливать отчуждение и ригидность (Peseschkian, 2016).

Как подчёркивают авторы обзора по позитивному ментальному здоровью, основанному на принципах ППТ, «this is another significant concern when it comes to AI-based interventions in mental health... Mental health is influenced by cultural, social, and contextual factors. AI tools may not adequately account for these factors, leading to misinterpretations or misunderstandings of patients' experiences and needs» (Thakkar et al., 2024).

Поэтому, использование ИИ в Позитивной Психотерапии возможно лишь при соблюдении принципов методологической гибкости и культурной компетентности. В противном случае цифровые вмешательства рискуют стать чуждыми и искусственными для ценностной базы клиента

Обсуждение

4.1. Интерпретация результатов в рамках Позитивной психотерапии (Модель Баланса и Актуальные способности)

Полученные результаты согласуются с концепцией модели баланса Позитивной Психотерапии и указывают на влияние ИИ на развитие ключевых первичных способностей – любви, доверия и контактности.

Важно учитывать важность того, что ИИ-компаньоны, заменяя человеческий контакт, формируют иллюзорную социальную насыщенность. Это приводит к снижению способности к эмпатии, нарушению навыков живого взаимодействия, а у ряда пользователей – к социальной фрустрации и эмоциональной зависимости. Взаимодействие с ИИ не способно воспроизвести телесный и эмоциональный резонанс, являющийся неотъемлемой частью межличностного контакта. В терминах ППТ это означает критичный дисбаланс между сферами «контакты» и «фантазии», а также искажение внутренних ценностей.

Поэтому данное исследование акцентирует внимание на психологической цене взаимодействия с ИИ, маскирующуюся под мнимую социализацию и самовыражение. Хотя ИИ-инструменты, как показано в некоторых исследованиях, могут временно смягчать симптомы одиночества или творческого кризиса, они в конечном итоге способствуют эмоциональной изоляции, когнитивной ригидности и избеганию межличностных контактов. С позиции Позитивной Психотерапии неосторожное применение цифровых технологий в психотерапии, может оказывать значительное разрушительное влияние на развитие таких ключевых первичных способностей, как контактность, любовь и уверенность. Эти нарушения приводят не только к личностному дисбалансу, но и к серьёзному экзистенциальному кризису, при котором технологические интерфейсы вытесняют межличностное взаимодействие и подменяют собой человеческое осмысление. Следовательно, психотерапевтам следует рассматривать риски зависимости от ИИ и продвигать живое общение как неотъемлемую часть целостного благополучия.

Интеграция ИИ в психотерапевтическую и образовательную практику требует этической осознанности, культурной чувствительности и соблюдения принципов баланса, лежащих в основе ППТ. Только при этих условиях технологии могут дополнять, а не подменять живое человеческое взаимодействие.

Эти выводы отражают общий вектор профессионального сообщества, где технологии рассматриваются не как альтернатива терапевтическому

взаимодействию, а как его возможное расширение. В контексте Позитивной и Транскультурной Психотерапии такая интеграция требует осознанного и этически выверенного подхода, основанного на принципах гуманизма, культурной чувствительности и уважения к уникальности клиента.

Симптомы, проявляющиеся при слишком тесном и интенсивном взаимодействии с ИИ, в рамках модели баланса ППТ, указывают на нарушение развития способностей в сфере «контакты», а также функциональной отстранённости от телесной и эмоциональной реальности (сфера «тело»). Подмена сложных, непредсказуемых человеческих связей безопасным, условно контролируемым цифровым контактом приводит к ослаблению навыков адаптации и толерантности к неопределённости – ключевых элементов психической зрелости. Всё это перегружает сферу «фантазии», нанося серьёзный ущерб всем остальным сферам. При этом надо отметить, что «общение» с ИИ-собеседником, при всех его признаках «контакта», нельзя относить к этой сфере, т.к. оно имеет суть «иллюзорного контакта», как это было бы в общении с книгой или «воображаемым другом», с той разницей, что тут получаешь отклик, который идёт извне.

В представлении Позитивной Психотерапии наблюдается критический дисбаланс между сферой «фантазии» и всеми остальными. Происходит замещение реальных усилий виртуальной компенсацией, что лишает личность опоры на собственные внутренние ресурсы, одной из основ в Позитивной Психотерапии.

4.2. Ключевые эмпирические области взаимодействия между ИИ и человеком

Ниже представлены ключевые направления эмпирических исследований, описывающих влияние ИИ-компаньонов на различные психологические и социальные параметры.

Снижение одиночества при краткосрочном использовании

De Freitas и коллеги провели серию из шести взаимосвязанных экспериментов, включая лонгитюдное исследование, целью которого было выявление эффекта от общения с ИИ-компаньоном на субъективное чувство одиночества (De Freitas, J. et al., 2024).

Уже через одну неделю была зафиксирована статистически значимая положительная динамика. Пользователи сообщали о чувстве эмоциональной поддержки и вовлечённости. При этом надо отметить, что эффект часто был недолговечен и исчезал при отсутствии последующего живого общения. Это показывает ИИ эффективным лишь как временное вспомогательное средство. И исходя из приведённых данных, данный поддерживающий эффект перестаёт действовать через непродолжительное время, уступая место или раздражению, или зависимости.

Цифровое одиночество и нарушение социальной резонансности

В исследовании, опубликованном в PMC (PubMed Central), вводится термин «digital loneliness» для обозначения феномена ложного ощущения социальной насыщенности, возникающего при частом взаимодействии с ИИ (Jacobs KA, et al. Digital, 2024). Отмечено, что пользователи очень быстро начинают воспринимать чат-ботов как условно живых собеседников, но такие связи не активируют зеркальные нейроны и не формируют полноценной эмоциональной взаимности. В результате постепенно снижается способность к построению доверительных человеческих отношений и формируется своеобразный «цифровой пузырь». Это способствует к изоляции личности от реального мира и контактов с реальными людьми. Эти процессы созвучны с сюжетом фильма «Она» (2013) с Хоакином Фениксом в главной роли.

Когнитивная атрофия от ИИ-зависимости (AICICA)

Термин «когнитивная атрофия, вызванная ИИ-компаньонами» (AICs induced cognitive atrophy, AICICA), предложенный Dergaa и соавторами, описывает потенциальное снижение когнитивной активности в результате плотного взаимодействия с ИИ-чат-ботами (Dergaa, I., et al., (2024). Авторы высказывают обеспокоенность тем, что чрезмерная зависимость от готовых ответов и автоматизированной поддержки может ослаблять способность к самостоятельному анализу, критическому мышлению, аргументации и рефлексии. Хотя явление требует дальнейших эмпирических подтверждений, концепция AICICA подчёркивает важность сохранения

когнитивной автономии в условиях повсеместного внедрения ИИ в повседневную жизнь. Согласно приведённым результатам, пользователи, привыкая к постоянной поддержке в виде готовых ответов, утрачивают способность к формулированию собственных идей и построению сложных умозаключений. Особенно это проявляется в неспособности к глубокой рефлексии и аргументации при отсутствии внешней помощи.

Образовательные риски: утрата оригинальности и креативности

Неожиданно остро в последнее время встал вопрос использования школьниками и студентами в обучении ChatGPT и ему подобными платформами. Согласно систематическому обзору Zhai и коллег, чрезмерное использование диалоговых ИИ-систем способно оказывать негативное влияние на когнитивные способности студентов (Zhai, C., et al., 2024). В частности, отмечается снижение уровня критического, аналитического и творческого мышления. Вместо активного вовлечения в процесс обучения учащиеся начинают полагаться на шаблонные ответы, генерируемые ИИ, что снижает глубину познания и ограничивает креативность и развитие самостоятельного мышления. Хотя авторы не обнаружили прямой зависимости использования ИИ в учебном процессе и утраты профессиональной идентичности, они указывают, что такой подход может формировать поверхностное отношение к образовательному процессу и снижать академическую активность. Это превращает образовательный процесс в формальность и не активизирует формирование зрелой профессиональной идентичности.

На основании представленных в литературе данных, можно предположить, что активное использование диалоговых систем искусственного интеллекта, включая ChatGPT, вызывает риск когнитивной инерции. Отмечается, что при избыточной зависимости от подобных инструментов учащиеся демонстрируют заметное снижение глубины когнитивной переработки информации, аналитического и критического мышления. Этот феномен можно интерпретировать как форму интеллектуального «расслабления», при которой готовые ответы уменьшают внутреннюю мотивацию к самостоятельному

осмыслению и структурированию материала. Учащиеся перестают работать самостоятельно, полагаясь на готовый результат ИИ и во многом теряют способность к обучению, т.к. перестают понимать учебный материал. Соответственно, ИИ, изначально предназначенный для поддержки учебного процесса, при неконтролируемом использовании может способствовать формированию интеллектуальной пассивности и снижению способности к абстрактному анализу.

Также актуален и вопрос о влиянии ChatGPT и ему подобных платформ на написании научных и других материалов. Более того, поощрение использования ИИ без осознания ограничений ведёт к размыванию авторства и снижению академической ответственности.

Эффект структурированной терапии: эмпатия и поддержка

В рандомизированном исследовании, проведённом в Республике Корея, была изучена терапевтическая эффективность взаимодействия с социальным чат-ботом «Luda Lee» в отношении снижения симптомов одиночества и социальной тревожности у студентов в возрасте от 19 до 29 лет (Kim et al., 2025). В течение четырёх недель участники ежедневно взаимодействовали с ИИ-компаньоном, чьи ответы были структурированы на основе принципов поддерживающего общения, направленного на создание ощущения социального присутствия. Полученные результаты продемонстрировали статистически значимое снижение субъективного чувства одиночества и выраженности социальной тревожности на момент завершения программы. «This study observed a significant reduction in loneliness (ULS) and social anxiety (LSAS) among new users of the social chatbot “Luda Lee” over 4 weeks».

Отмечается, что эффект оказался ограниченным по времени. Но исследование и не предусматривало долгосрочного наблюдения, т.к. имело ограниченные цели. В связи с этим не удалось достоверно установить, сохраняются ли улучшения после завершения программы или нет. Кроме того, отсутствие контрольной группы усложняет интерпретацию результатов. В разделе ограничений отмечено, что несмотря на выявленные краткосрочные терапевтические

эффекты, остаётся неясным, может ли подобная система в полной мере воспроизвести глубину, гибкость и эмпатию, присущие человеческим психотерапевтическим отношениям. Авторы признают: «Although the results suggest that using social chatbots can affect loneliness and social anxiety, the study's single-group design has limited statistical clarity. Additionally, the reliance on self-report scales introduces potential biases, such as social desirability and inaccurate self-assessment, which may affect the validity of the findings. ... Future studies should address challenges, such as excessive anthropomorphism and short-term memory, to use social chatbots as psychiatric interventions more effectively».

Таким образом, полученные результаты исследования позволяют рассматривать ИИ-компаньонов как потенциально полезное вспомогательное средство в краткосрочной поддержке эмоционального состояния. В то же время, их применение в качестве замены полноценному терапевтическому контакту требует серьёзных ограничений и дальнейших эмпирических исследований.

Рост изоляции при высокой интенсивности использования

В крупном опросном исследовании с участием 1 131 пользователя чат-ботов была установлена статистически значимая корреляция между интенсивностью взаимодействия с ИИ-компаньонами и более низким уровнем субъективного благополучия (Zhang et al., 2025). В исследовании определено, что пользователи с более слабыми социальными контактами имеют тенденцию к более частому использованию чат-ботов и, при этом, к снижению ощущения собственного благополучия. Как отмечают авторы исследования: «Even though some people turn to chatbots to fulfill social needs, these uses of chatbots do not fully substitute for human connection. As a result, the psychological benefits may be limited, and the relationship could pose risks for more socially isolated or emotionally vulnerable users».

Индивидуальные различия в реакции на ИИ-компаньонов

Современные исследования указывают на то, что степень восприимчивости к психологическим эффектам от взаимодействия с ИИ-компаньонами может варьироваться в зависимости от личностных

характеристик пользователя. Так, в работе Chu и соавторов (2025), основанной на анализе более 30 000 взаимодействий с ИИ-чат-ботами, было показано, что пользователи склонны формировать парасоциальную привязанность, интерпретируя ответы ИИ как эмоционально значимые и направленные лично к ним. В работе указывается, что «research on AI companions reveals that users, especially those experiencing loneliness or marginalization, form deep emotional bonds with chatbots, describing them as sources of comfort and self-expression... Such dynamics can also create the illusion of a genuine emotional connection, potentially leading users to attribute deeper relational meaning to fundamentally artificial exchanges» (Chu et al., 2025).

Другое подобное исследование (Fang et al., 2025), в рамках четырёхнедельного рандомизированного контролируемого эксперимента (n=981, >300 тыс. сообщений) подтвердило, что при низкой социальной вовлечённости и высоком уровне тревожности усиливается зависимость от взаимодействия с ИИ и одновременно снижается мотивация к установлению реальных межличностных связей. Авторы приходят к выводу, что «overall, higher daily usage – across all modalities and conversation types – correlated with higher loneliness, dependence, and problematic use, and lower socialization... We highlight the need for further research on whether chatbots' ability to manage emotional content without fostering dependence or replacing human relationships benefits overall well-being» (Fang et al., 2025)

Выводы

Для значимой части пользователей цифровая среда становится заменой эмоциональной близости и социальной активности. Это создаёт риск зависимости и утраты субъектности. С последним случае вообще прослеживается тревожная тенденция - вырабатываются паттерны поведения, при которых субъектность размывается, искусственный интеллект становится субъектом, человек начинает делегировать значимую часть когнитивных и эмоциональных функций цифровым системам, что повышает риск утраты автономии и перейти в объектную

зависимость от ИИ. Кроме того, ИИ часто выдаёт «удобные» ответы и склонен к генерированию неправдивых утверждений, ориентируясь не на факты и реальность, а на установку угодить реальному собеседнику. Это порой приводит к серьёзным негативным последствиям, когда это касается медицины и психического здоровья. Исходя из этого, данные исследований указывают на необходимость предварительной психодиагностической оценки личностных факторов перед использованием ИИ-интерфейсов в образовании или терапии.

Анализ современных научных исследований, посвящённых влиянию искусственного интеллекта на психику, когнитивные функции и социальные навыки, позволяет сформулировать ряд обобщённых выводов, имеющих практическое значение для психотерапии, образования и социальной политики.

В первую очередь, краткосрочное использование ИИ-компаньонов действительно может оказывать положительное влияние на эмоциональное состояние пользователя. Такие инструменты способны снизить уровень субъективного чувства одиночества, особенно у людей с ограниченными социальными контактами, предоставляя ощущение услышанности, поддержки и внимания. Однако это облегчение кратковременно и исчезает при прекращении взаимодействия с ИИ, что подчёркивает ограниченность функциональности подобных интерфейсов в долговременной поддержке психического здоровья.

Указанные в статье исследования показывают, что регулярное и интенсивное использование ИИ как средства общения и когнитивной опоры сопровождается серьёзными рисками. Это, прежде всего, касается ослабления критического мышления, снижения когнитивной гибкости и мотивации к самостоятельному анализу. Термин «когнитивная атрофия», всё чаще используемый в научно-популярной и аналитической литературе, метафорически описывает потенциальные риски снижения умственной активности при чрезмерной зависимости от цифровых помощников. Хотя этот термин не является клинически признан, он точно отражает наблюдаемую тенденцию к делегированию сложной когнитивной

работы цифровым алгоритмам. Современные исследования указывают на то, что регулярное использование диалоговых ИИ-систем может ослаблять способность к аналитическому мышлению, рефлексии и абстракции — особенно у представителей уязвимых групп, таких как студенты и молодёжь. В некоторых исследованиях прослеживается прямая связь между уровнем зависимости от ИИ и снижением критического мышления: «Findings show that ... integrating AI dialogue systems ... also introduce risks such as diminished creativity, over-reliance, and ethical concerns... Over-reliance on AI dialogue systems can significantly impact ... critical and analytical thinking abilities by fostering dependency (Zhai, et al., 2024)». Эти данные лишней раз подтверждают необходимость внедрения принципов цифровой гигиены в образовательную и терапевтическую практику.

И последний вывод касается дифференциального воздействия ИИ на различных пользователей. В зависимости от уровня зрелости личности, самооценки, уровня тревожности и социальной уверенности ИИ может восприниматься либо как ресурс, либо как ловушка. У зрелых личностей он может выступать в роли вспомогательного инструмента для рефлексии и планирования. У уязвимых пользователей — становится суррогатом отношений и усиливает изоляцию.

В последнем выпуске журнала The Global Psychotherapist (JGP Vol. 5 No. 2, 2025) подчёркивается, что искусственный интеллект и цифровые технологии становятся важной частью будущего психиатрии и психотерапии. В отчёте о ежегодной конференции Американской психиатрической ассоциации (APA 2025), опубликованном в этом номере, говорится: «Такие темы, как психиатрия образа жизни, профилактика, целостное благополучие, искусственный интеллект и социальные детерминанты здоровья, были в центре многих дискуссий. Стало ясно, что будущее психиатрии заключается не только в лечении расстройств, но и в расширении возможностей отдельных людей и сообществ для процветания» (JGP, 2025, p. 175).

Можно сделать достоверный вывод, что искусственный интеллект, включая ИИ-компаньонов, не является универсальным

благом, а представляет собой инструмент двойственного действия: его эффективность определяется не столько уровнем технологического развития, сколько контекстом применения и психической структурой пользователя. Включение цифровых технологий в терапию, образование и культуру требует строгих этических, методологических и гуманистических ограничений. Необходимы программы цифровой гигиены, критического мышления и формирования устойчивых социальных навыков, которые позволят минимизировать потенциальный вред и усилить положительный эффект от взаимодействия с ИИ. Только при этих условиях искусственный интеллект может

дополнять, а не подменять живое человеческое взаимодействие. Также существует и значимая польза от ИИ, которая может быть применима и в весьма практических вопросах. Например - интеграция ИИ в работу журнала «The Global Psychotherapist», где журнал применяет ПО для проверки заимствований и ИИ-содержания. Это подчёркивает рост значимости ИИ и в профессиональной психотерапевтической среде.

В заключение следует отметить, что интеграция искусственного интеллекта в профессиональную психотерапевтическую среду отражает общий вектор цифровизации и требует осознанного, этически выверенного подхода.

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Section: Special articles

Исследование причин малой публикационной активности психологов-практиков и психотерапевтов в написании научных статей и возможности её преодоления

A Study of the Reasons for the Low Publication Activity of Practicing Psychologists and Psychotherapists When Writing Scientific Articles and the Possibilities for Overcoming Them



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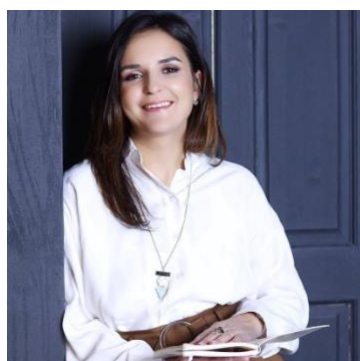
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Аннотация

Написание научной статьи – это один из способов реализации и развития базовой способности к познанию, о которой писал основатель позитивной психотерапии Н. Пезешкиан. Это возможность не только развить свои актуальные способности, повысить компетентность, получить признание в профессиональном сообществе, укрепить свою сферу достижений в модели баланса, но и внести вклад в развитие психотерапевтического метода. Цель данного исследования: выявить причины недостаточной публикационной активности практикующих психологов и психотерапевтов в написании научных текстов и наметить пути её преодоления. В статье представлены данные опроса, в котором приняли 109 практикующих специалистов, работающих или обучающихся преимущественно в методе позитивной психотерапии. Проведенный опрос показал, что главными причинами, по которым практикующие специалисты пишут мало научных работ являются: 1) они не знают, как это делать; 2) им мешают психологические барьеры (страх критики, недостаток мотивации, сомнения в том, что их научная статья может быть кому-то интересна и другие проявления «синдрома самозванца»). По результатам исследования предложены методы поддержки для начинающих авторов, испытывающих затруднения с написанием научных статей.

Ключевые слова: научные статьи, написание научных статей, психологи, психотерапевты, позитивная психотерапия, модель баланса, базовая способность к познанию, вторичные актуальные способности

Abstract

Writing a scientific article is one way to realize and develop the basic capacity to know described by Nossrat Peseschkian, the founder of Positive Psychotherapy. It is an opportunity to not only develop actual capabilities, enhance one's competence, gain recognition within the professional community, and strengthen one's area of achievement within the balance model but also to contribute to the development of a psychotherapeutic method. The purpose of this study is to identify the reasons for the insufficient publication activity of practicing psychologists and psychotherapists and to outline ways to overcome this. This article presents data from a survey of 109 practicing specialists working in or studying Positive Psychotherapy. The survey revealed that the main reasons practitioners write few scientific papers are: 1) a lack of knowledge of how to do it, and 2) psychological barriers (fear of criticism, lack of motivation, and doubts about the interest in their scientific article, and other manifestations of imposter syndrome). Based on the results of the study, support methods have been proposed for novice authors who have difficulty writing scientific articles.

Keywords: scientific articles, writing scientific articles, psychologists, psychotherapists, Positive Psychotherapy, Balance Model, basic cognitive ability, secondary capacities

Введение

Одной из важнейших проблем современной психологии и психотерапии является определенный разрыв между академической/научной психологией и психологической практикой, о котором говорил Л.С. Выготский в своей рукописи "Исторический смысл психологического кризиса" еще в 20-е годы прошлого века (Zavershneva, 2012). Можно также согласиться с Ф.Е. Василюком в том, что за последние годы этот разрыв только увеличился и «достиг угрожающих размеров» (Василюк, 1996). На наш взгляд одной из причин этого разрыва является то, что практические психологи/психотерапевты в основном

сконцентрированы именно на своей практической деятельности и редко обращаются к написанию научных текстов. С другой стороны, психологи-исследователи, которые часто занимаются написанием научных работ, не вполне уверенно себя чувствуют на поле практической психологии. В результате мы имеем дело с двумя почти не пересекающимися областями психологии: научной и практической, что в значительной степени обедняет каждую из них. Написание научных статей практическими психологами может способствовать не только развитию науки в целом и психотерапевтического метода в частности, но и помогает сделать значимый вклад в саморазвитие специалиста

и получить признание в профессиональном сообществе.

Более того, написание статей – это один из путей реализации базовой способности к познанию, а значит и к развитию вторичных актуальных способностей самих психологов и психотерапевтов.

Как писал основатель позитивной психотерапии Н. Пезешкиан: «Каждый человек стремится познать законы мира, в котором он живет. Он задает себе многочисленные вопросы. Способность человека задавать такие вопросы и искать на них ответы – это и есть способность к познанию. В процессе развития она формируется на базе передачи знаний и разделяется на дополняющие друг друга способности учиться и учить, то есть приобретать опыт и передавать его другим» (Пезешкиан, 2002, с. 26). Спустя 20 лет Хамид Пезешкиан, ссылаясь на исследование Buehler, Allen (1973), пишет, что: «Учитывая определяющее влияние образа человека на психологические теории и признавая важность этого аспекта как условия их сопоставимости, желательно, чтобы модель человека, разделяемая ученым и/или научным сообществом, была представлена в их основных публикациях или в литературных ссылках» (Пезешкиан, 2022, с. 10).

В научной и методической литературе последних лет можно увидеть достаточно много примеров, которые содержат разного рода советы начинающим исследователям по написанию научных текстов, а также описывают те преимущества, которые открываются перед «пишущими» специалистами. К ним прежде всего относят следующее:

- научные публикации - это возможность поделиться своими практическими наработками, уникальным видением научных проблем, одновременно стимулируя дальнейшие исследования (Оленчук, Черных, 2017);

- это способ заявить о собственных достижениях, получить высокий научный рейтинг и цитируемость, гранты для исследований, ученую степень;

- в процессе написания статей автор учится искать интересные материалы и интерпретировать результаты других учёных, получает возможность обнаружить что-то

значимое, что пока не было глубоко исследовано (Ali, Szmuda, Wszolek, 2020).

На наш взгляд, влияние такой работы на личные и профессиональные качества специалистов очевидно: развитие критического мышления, приобретение навыков формулировки гипотез, аргументированного изложения мыслей, самопрезентации и научной коммуникации.

Все это позволяет внести заметный вклад в избранной области профессиональных интересов. Например, публикации психологов, работающих в определенном методе, могут способствовать развитию этого метода. Так О. Фортунатова в журнале «The Global Psychotherapist» задается вопросом популяризации метода Позитивной психотерапии и отвечает на него, в том числе через отсылки к статьям, своим или коллег: «У каждого, кто проходил обучение на базовом и мастер курсах есть сотни страниц готовой к публикации информации. Это контрольные работы. Они могут как сразу писаться в формате статьи, так и переделываться позднее. Это полезная и творчески переработанная информация внесет весомый вклад в дело уплотнения информационного поля о нашем методе» (Фортунатова, 2021, с. 73).

Также в научной литературе встречаются статьи с описаниями трудностей, с которыми сталкиваются многие специалисты при написании, оформлении и издании научных статей, приводящих иногда и к отказу от публикаций: «Кто-то испытывает затруднения в сборе данных, кто-то не может выбрать тему. Некоторые долго не могут собраться с мыслями. Другим необходимо проявить силу воли, чтобы умерить пыл бурно разыгравшейся фантазии и направить ее в логичное русло научной мысли. Иногда сложно разобраться в технических вопросах оформления работы, отдельных ее элементов, цитат, списка литературы» (Ванягина, 2020, с. 4).

Как отмечают авторы, для специалистов, не имеющих ресурсов в виде лаборатории, финансирования, аудитории может показаться практически невозможным проводить независимые исследования (Ali, Szmuda & Wszolek, 2020). Ну и конечно нельзя не согласиться с А.В. Оленчук и В.И. Черных, которые считают важной проблемой элементарную нехватку времени, что

усложняет и без того непростой процесс написания статьи (Оленчук, Черных, 2017).

По наблюдению С.А. Романовой и Ю.В. Трофимова, авторы сталкиваются с риском ошибок, например, последствия цитирования недостоверного источника могут быть самыми серьезными: «Ученому приходится самому определять грань между научным и псевдоэкспертным мнением коллег. К сожалению, на роль эксперта теперь претендуют многие лица с неподтвержденным научным сообществом авторитетом, но достигшие узнаваемости благодаря медиаплатформам и мобильным приложениям» (Романова, Трофимов, 2022, с. 80).

J. Schimel пишет: «Также помните, что вы ученый, быть правым не входит в ваши обязанности. Ваша работа – быть вдумчивым, осторожным и аналитичным; ваша работа – оспаривать свои идеи и пытаться опровергнуть свои гипотезы; ваша работа – быть открытым и честным в отношении неопределенностей в ваших данных и выводах. Но если вы выполняете передовую работу, вы не всегда будете правы» (Schimel, 2025).

Если удалось справиться с трудностями, статья написана и отправлена в журнал, впереди - процесс рассмотрения редакцией и рецензирования. Это важный этап: работа над замечаниями призвана сделать рукопись лучше, но сам факт наличия замечаний вызывает тревогу у авторов. Неопределенные комментарии, ответные письма с не вполне понятными причинами отказа способствуют возникновению неуверенности у специалистов, вплоть до «депрессии от отказа». Кто-то поспешно перенаправит статью без изменений в другой журнал, а некоторые авторы сочтут свою статью недостойной и импульсивно примут решение вовсе не публиковаться (Ali, Szmuda & Wszolek, 2020).

Психологические барьеры также тормозят публикационную деятельность: «Для психологического исследования аспектов написания научных работ важно учитывать, что респонденты часто чувствуют напряжение, неуверенность и испытывают влияние эмоционального состояния на процесс. Напряжение связано с высокими ожиданиями и страхом критики. Неуверенность в своих силах и выводах

затрудняет работу. Эмоции сильно влияют на процесс: положительные способствуют продуктивности, негативные – приводят к прокрастинации» (Запорожец, Овдиенко, 2024, с.41-56).

Большая часть вышеизложенных проблем решается авторами самостоятельно: советуясь с научным руководителем, если он есть; через поиск методических рекомендаций из разнообразных источников, «по крохам собирая информацию, методом «научного тыка» вырабатывая собственные правила построения фраз, в основном, беря за пример удачные статьи более опытных коллег, опубликованные в серьезных научных журналах и сборниках» (Зеленцов, 2011, с. 378). При этом многие рекомендации являются универсальными, важно их освоить и успешно применить.

Положительные и отрицательные отклики коллег также сильно влияют на уверенность авторов, на сохранение мотивации к написанию статей, поэтому создание поддерживающей среды крайне важно (Запорожец, Овдиенко, 2024).

Также поощрение авторов к написанию научных публикаций имеет большое профессиональное значение, желательно, чтобы учреждения и профессиональные организации предоставляли поддержку и ресурсы для содействия участию в коммуникации научных исследователей (Zaimova-Tsaneva, 2023).

В целом проблема малой публикационной активности специалистов-практиков достаточно широко представлена в научных публикациях последних лет, однако большинство из них носят феноменологический характер и не содержат результатов эмпирического исследования данной проблемы.

Описанные противоречия обусловили актуальность данного исследования и определили его цель: выявить причины малой публикационной активности психологов-практиков и психотерапевтов в написании научных текстов (статей, монографий, отчетов о научной работе и т.д.) и возможности её преодоления.

Основная гипотеза исследования состояла в том, что главными причинами, по которым психологи-практики и психотерапевты мало пишут научных статей являются: 1) они не знают, как это делать; 2) существуют

психологические барьеры, которые мешают публикации статей в научных изданиях.

Методология

Эмпирическое исследование проводилось анонимно в виде опроса через гугл-форму. Опросник включал в себя 12 вопросов, для 11 из которых были предложены варианты ответа, а в одном вопросе ответ предлагалось участникам сформулировать самостоятельно. Это был вопрос: «Что на Ваш взгляд Вам мешает писать научные тексты?» (напишите своими словами). Остальные вопросы были направлены на выяснение анкетных данных о респонденте (пол, возраст, профессия, какой метод и сколько лет практикует участник в своей практической деятельности), а также об опыте написания научных статей и об эмоциональных реакциях при мысли о написании научной статьи.

В опросе приняли участие 109 человек: психологи, психотерапевты, педагоги-психологи, студенты и аспиранты психологических факультетов. Опрос проводился на базе сертифицированного WAPP Образовательного центра имени профессора Носсрата Пезешкиана (г. Санкт-Петербург) в сентябре 2025 года среди русскоговорящих специалистов, практикующих в методе позитивной психотерапии и других подходах. Так как опрос проводился в онлайн-формате, его участниками стали не только жители Санкт-Петербурга, но и других регионов России.

Результаты

Результаты опроса показали значительный гендерный дисбаланс, связанный с высокой долей женщин в профессии психолога и психотерапевта: 91% опрошенных – женщины. Это согласуется, например, с данными Национального научного фонда США (NSF) в обзоре Комитета АРА о том, что женщины составляют большую часть психологов в США (American Psychological Association, 2017).

Среди опрошенных 49% используют в своей практике и/или обучаются методу позитивной транскультуральной психотерапии, остальные практикуют в других терапевтических подходах (в том числе когнитивно-поведенческая терапия,

экзистенциальная психотерапия, логотерапия, музыкальная терапия, арт-терапия).

В опросе приняли участие респонденты разного возраста и с разным профессиональным опытом. На Рисунке 1 представлен возрастной диапазон участников опроса, на Рисунке 2 – практический опыт респондентов.

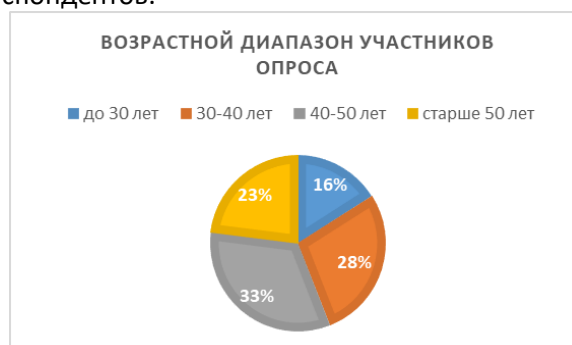


Рисунок 1. Возрастной диапазон участников опроса



Рисунок 2. Практический опыт респондентов

При этом научные публикации есть у 22% опрошенных, 9% респондентов никогда не посещала мысль о написании статьи, а более 65% респондентов думают об этом (из них 57% постоянно или часто). Данные факты говорят о том, что интерес к теме написания научных статей не зависит от возраста или практического опыта специалиста.

На вопрос о том, есть ли опыт написания чего-то кроме научной статьи, участники чаще всего упоминают опыт написания постов в социальных сетях (23%), а также монографии, дипломные, магистерские работы и методические пособия (24%). 64% опрошенных специалистов имеют опыт написания чего-либо, кроме научных статей. Если у специалиста есть цель – написать научную статью, то на данный опыт можно опираться как на ресурс. Как говорил Носсрат

Пезешкиан: «Если тебе нужна помощь, поищи ее на конце собственной руки».

Более половины опрошенных никогда не начинали писать научную статью, а если и начали, то остановились на первых страницах (Таблица 1).

Таблица 1. Ответы на вопрос «Начинали ли вы когда-либо писать научные статьи?»

Ответ респондентов	Процент опрошенных
Нет, не начинал	41%
Да, начинал	59%
<i>В том числе:</i>	
Имею изданные статьи	26%
Опыт написания статей в рамках обучения в ВУЗе	22%
Начал, но остановился на первых страницах	11%

Таким образом, можно увидеть противоречия между наличием интереса к написанию статей с одной стороны, и тем что этот процесс не доводится до конца или останавливается в самом начале. Можно предположить, что у участников есть веские причины, которые мешают достигать целей по написанию научной статьи. Данные причины также исследовались в опросе.

Среди причин, которые мешают писать научные статьи, респонденты чаще всего указывали нехватку времени, отсутствие необходимого опыта, страх критики и недостаток мотивации.

Интересно, что среди участников в возрасте до 30 лет в описании причин, мешающих писать научную статью чаще всего звучит слово «сложность»: в начинании, выборе темы и т.д., что коррелирует со сложностями, отмеченными другими, упоминаемыми нами, исследователями (Ванягина, 2020, с. 4). Это вполне объяснимо, так как в более молодом возрасте у специалистов есть недавний опыт написания научных работ в учебных заведениях. На дефицит времени, причину, отмеченную выше (Оленчук, Черных, 2017), чаще ссылаются участники старше 30 лет, в данном возрасте появляются жизненные задачи в других сферах, а на отсутствие смысла и мотивации – старше 40 лет. Например, среди ответов участников возрастной группы старше

пятидесяти лет можно встретить ответы следующего характера: «Мне ничего не мешает писать научные статьи, но зачем?».

Среди факторов, мотивирующих писать научные статьи, чаще всего упоминаются: интерес, желание делиться знаниями и опытом, желание получить признание в профессиональном сообществе, а также профессиональная необходимость, что согласуется с выводами ряда авторов, упоминаемых в обзоре литературы (Ali, Szmuda, Wszofek, 2020), (Оленчук, Черных, 2017). Здесь мы также можем видеть проявление базовой способности к познанию – концепции, лежащей в основе позитивной психотерапии, (Пезешкиан, 2002, с. 26).

На Рисунке 3 представлены эмоции, переживаемые при мысли о написании научной статьи. Подавляющее большинство участников (71%) указали интерес (возбуждение) в качестве эмоции, переживаемой при мысли о написании научной статьи. Среди других, самых часто испытываемых эмоций, были указаны: стыд (застенчивость), удовольствие (радость), скука, страх (ужас), удивление, горе (печаль, страдание), гнев (раздражение, ярость). Разнообразие эмоций, переживаемых участниками опроса, отсылает к упоминаниям их важности в процессе написания научных статей (Запорожец, Овдиенко, 2024, с.41-56), (Ali, Szmuda & Wszofek, 2020), подчеркивая необходимость дальнейших исследований устранения психологических барьеров, а также важность создания поддерживающей среды, на что указывают многие авторы, исследующие публикационную активность специалистов (Zaimova-Tsaneva, 2023), (Запорожец, Овдиенко, 2024).



Рисунок 3. Эмоции, переживаемые при мысли о написании научной статьи

Эти данные позволяют сформулировать вопросы для специалистов, заинтересованных в развитии метода позитивной психотерапии и в собственном профессиональном развитии в научном направлении. Примеры вопросов:

- Как я могу поддерживать и сохранять интерес в теме написания научной статьи?
- Что в этом процессе доставляет мне радость?
- Кто или что поможет преодолеть мне скуку и/или страх?
- Каковы смысл и функция моего гнева?
- Что может облегчить мои страдания?
- Чему я по-прежнему удивляюсь?
- Как мой интерес приведет меня к действиям?

Большинство опрошенных (76%) ответили «да» на вопрос, считают ли они написание научной статьи технологией, которую можно освоить, при этом 69% хотели бы освоить эту технологию. 11% респондентов затрудняются ответить, а 20% опрошенных отмечают, что написание научной статьи – это творческий процесс.

Результаты данного опроса были представлены участникам исследования и обсуждены в прямом эфире во время авторского обучающего вебинара на тему «Как перестать бояться и начать писать научные статьи?».

Выводы

На основании проведенного опроса можно сделать следующие теоретические и эмпирические выводы:

1. Написание научных статей – это трудоемкий процесс, требующий знаний методологии и технологии написания, психологической устойчивости и доступа к необходимой помощи на всех этапах написания и публикации.

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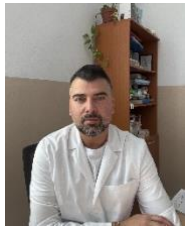
2. В большинстве научных и методических работах, посвященных написанию научных статей, приоритет отдан методическим рекомендациям, в то время как мешающие процессу психологические факторы рассматриваются реже. Видится важным акцентировать внимание исследователей на этих аспектах, поскольку это как раз те факторы сопротивления, которые можно полностью или частично преодолеть и трансформировать в процесс научного творчества.

3. Методы поддержки начинающих авторов, включающие систему наставничества, обучения технологии написания научных текстов и помощи в преодолении психологических барьеров могут благоприятно сказаться на частоте и качестве научных публикаций, развитии потенциала специалистов и расширении их присутствия в научной среде. Одним из таких методов может стать специально разработанная программа курса для психологов и специалистов помогающих профессий, желающих перейти от мыслей о своей первой научной статье к ее написанию. В настоящее время такая программа проходит апробацию на базе Образовательного центра имени профессора Носсрата Пезешкиана (г. Санкт-Петербург, Россия), результаты которой будут представлены в последующих публикациях. На данном этапе мы предполагаем, что участие в подобной программе будет не только мотивировать к научному творчеству, снимать психологические барьеры и развивать вторичные актуальные способности, но и побуждать к действию и получению конкретного результата: написанию и публикации статьи в сборнике научной конференции по психологии и психотерапии.

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PART II. PEER-REVIEWED PROFESSIONAL ARTICLES

Conceptualization of Mental Status through the Balance Model and Actual Capabilities



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Abstract

The article examines an integrative approach to the therapeutic process by comparing information from mental status, the balance model, and the conflict processing model.

Mental status is a phenomenological framework that describes the observable manifestations of mental functioning. The balance model provides a structural context in which these manifestations can be understood as the result of the dynamic relationships between the four main areas of human experience. The conflict processing model adds a procedural perspective – it provides information on how current conflicts are experienced and points to their meaningfully integrated forms.

The integration between them enables simultaneous diagnostic, psychodynamic, and therapeutic understanding of human suffering. Thus, mental status serves as a "mirror" of the balance among the physical, active, relational, and meaningful dimensions of personality, and the therapeutic process can be directed toward restoring inner harmony and meaning.

Keywords: Positive Psychotherapy, Balance Model, conflict processing model, primary and secondary actual capacities, mental status

Introduction

The concept of "mental status" traditionally belongs to clinical psychiatric discourse, where its primary function is to provide a systematic framework for describing an individual's cognitive, affective, and behavioral manifestations at a given moment (Jaspers,

1997/1913; Kaplan & Sadock, 2007: 153). It represents a specific "translation" of the patient's history into the clinical language of psychopathology. This descriptive and diagnostic procedure is undoubtedly fundamental to clinical practice and is considered a basic competence of every mental health

professional. The content of the individual areas of mental status – e.g., consciousness, attention, thinking, emotions, or memory – their phenomenology in the norm, their manifestations in various psychopathological pictures, and the instruments for their examination (e.g., MMSE, PSE, Zung, MMPI, etc.) have already been developed in detail in the literature and included in clinical diagnosis (Folstein et al., 1975, pp. 189–198; Wing, Cooper & Sartorius, 1974). In this sense, the present report does not aim to reproduce or systematize this already established body of knowledge, which should be in the repertoire of every specialist in psychotherapy.

The focus here differs in content and is specifically psychotherapeutic. The emphasis is on the question "How can mental status be rethought and included as a tool not only for diagnosis but also for therapeutic understanding and intervention?" In this context, its conceptualization is examined within the framework of the balance model and the conflict-processing model of Positive Psychotherapy, developed by Nosrat Peseschkian (1987). These models view human existence in four interrelated areas – body, activity, contacts, and future/meaning – and describe how individuals distribute, integrate, and use their psychic energy to cope with problems/conflicts. Our efforts are directed towards analyzing how each sphere of mental status can be viewed not in isolation, but within the framework of these areas, so that both its weaknesses and its resources – the positum of conceptualization – can be seen.

Such a perspective views mental status beyond its traditional use as a momentary clinical picture of existing symptoms and deficits. In this sense, it becomes a dynamic "sketch" of the personality's adaptive abilities and resources, serving as a bridge between psychiatric description and psychotherapeutic planning and the formulation of therapeutic tasks. At the heart of this rethinking is the idea that every mental function – be it thinking, attention, or emotions – can be considered both an area of imbalance and a source of abilities that, with adequate therapeutic interpretation, can be activated in the direction of development and personality transformation (Peseschkian, 1996).

Thus, this review does not aim to provide an exhaustive description of the individual

elements of mental status in their normal or pathological states, nor to discuss the instruments used to measure them. Its purpose is to bring out the psychotherapeutic meaning of the conceptualization of mental status within the balance model: "How does this model reformulate the functions of consciousness, contact, perception, emotions, will, and other mental processes as resources for building balance, meaning, and stability in the life of the individual, and how, together with the conceptualization of the conflict processing model, could it provide a starting point for therapeutic intervention?"

Methodology

2.1. Balance Model

The method of positive and transcultural psychotherapy has a good and reliable tool that allows observation and diagnosis of what is happening in the experiences of clients/patients – the so-called "Balance Model". It is based on the idea that a person distributes their 100% mental energy across four main areas, the contents of which become visible through the primary and secondary abilities that each personality possesses and uses in everyday life. Each of these areas has its own (unique) resource for dealing with conflicts that arise. When this happens in a balanced way, i.e., it does not test a person's abilities, or it applies to the repertoire of coping strategies, or the psychological defense mechanisms are not decompensated, a person more easily goes through difficult and conflict-laden situations.

Rather than repeating the entire theoretical framework, the article uses the balance model as a reference point for interpreting the mental status data. The four areas: "Body & Health"; "Work & Achievement"; "Relationships" and "Meaning/Future/Values" serve as coordinates for extracting information about which specific mental functions are invested with more energy and which are neglected or blocked.

In situations where this is impossible (no experience/does not know how/strategies and defenses are decompensated and/or the experience is traumatic), a person "chooses" (most often as a pattern formed in childhood) one of the areas and invests too much time, effort, and feelings in it. Then, this area assumes the role of a "place of escape" (impoverishment of content) and/or a compensatory mechanism

(overloading), which becomes evident through the conflict-processing model. According to M. Goncharov (2013), the conflict processing model has its own localization, processing area, and content, described by categories of secondary actual abilities.

For example:

Attention or psychomotor disorders could indicate excessive stress in the area of "Work & Achievement" at the expense of the area of "Body & Health."

Apathy or anxiety could be an indicator of a breakdown in the areas of "Relationships" and "Meaning/Future/Values," rather than a purely affective disorder;

Rigid thinking and excessive focus on precision and criticality often indicate the dominance of secondary abilities in the areas of "Work & Achievement" and "Meaning/Future/Values," masking unresolved emotional conflicts.

The examples given show how mental status goes beyond the collection of information about isolated mental functions and becomes an applicable tool to the known ones – the balance model and the conflict resolution model.

2.2. Historical context and integration

The concept of "mental status" emerged within the framework of classical descriptive psychopathology and early academic psychiatry. In the first half of the 20th century, it crystallized as a structured clinical observation framework for describing consciousness, perception, thinking, affect, will, and psychomotor activity at the time of examination, in the tradition of Kraepelin and Bleuler. Karl Jaspers' phenomenological reworking distinguishes between "explanation" and "understanding" and establishes systematic phenomenological description as the basis of clinical assessment (Jaspers, 1997, 1913). Gradually, "mental status" became a normative component of psychiatric examinations in textbooks, a practice later confirmed in contemporary manuals (Kaplan & Sadock, 2007).

A second key line is operationalization and standardization. Instruments such as the Present State Examination (PSE), for the systematic coding of psychopathological phenomena (Wing, Cooper & Sartorius, 1974), and the Mini-Mental State Examination (MMSE), for cognitive screening (Folstein, Folstein & McHugh, 1975), were developed. These developments

strengthened the validity and reliability of mental status as a measurement module. They brought it closer to the requirements of diagnostic systems (DSM/ICD), with a focus on observable indicators and inter-subject consistency (American Psychiatric Association, 2013).

In the 1970s, a third line emerged – biopsychosocial integration, which expanded the framework beyond reductive biomedicine. Engel's concept defines clinical assessment as encompassing the interrelationships among biological, psychological, and social levels (Engel, 1977). In contrast, cultural-anthropological contributions (Kleinman, 1988) show that mental status is inevitably "colored" by cultural scenarios of suffering, expression, and meaning. These trends shift the field from a purely symptomatic description to a contextual understanding of a person within their historical reality.

Based on these basic paradigms, a bridge to psychotherapy is discovered. For example, the humanistic-existential tradition (Rogers, 1951; Frankl, 1963) reorganizes its focus: from an inventory of deficits to the potential, meaning, and values of the personality; cognitive therapy (Beck, 1976) adds a focus on thought patterns and evaluative processes as part of the client's "here and now" picture. Peseschkian's Positive Psychotherapy makes the next key move: it translates mental status into the language of resources and embeds it in the balance model (body, activity, contacts, future/meaning), where each function (e.g., attention, emotions, thinking) is viewed simultaneously as an area of vulnerability and as a carrier of abilities/resources/potentials that can be activated therapeutically (Peseschkian, 1987; Peseschkian, 1996). In this way, mental status is transformed from a static "map" into a dynamic picture of adaptation, relevant for planning interventions, formulating the case, and tracking change. In this way, the balance model can serve as a reliable tool for determining the direction of psychotherapeutic work.

2.3. Methodological commentary

The conceptualization of mental status within the balance model and the conflict processing model implies an important methodological change. In the classical psychiatric and clinical psychological tradition, mental status is assessed primarily through the description of individual

mental spheres, mainly as deficits, as well as through the symptoms of psychopathology (Kaplan & Sadock, 2007). Thus, the emphasis is placed on identifying deviations from the "norm," which is essential for diagnosis and pharmacotherapy, but it leaves the individual's resources and adaptive capabilities in the background.

In Positive Psychotherapy, on the contrary, mental status is viewed as a field of potentials/resources. Peseschkian (1987) proposes an integrative model in which each mental function can be viewed simultaneously as both a source of vulnerability and a source of resources ("Where there is a problem, there is also a solution"). This methodological rethinking fits into the broader paradigm of humanistic and existential psychotherapy (Rogers, 1961; Frankl, 1963), which emphasizes personal growth, meaning, and freedom of choice. This connection between Positive Psychotherapy, as a humanistic method, and the theoretical frameworks of humanistic and existential psychotherapy provides evidence of its scientific value. It is an important aspect that demonstrates that it has its own theory, consistent with its predecessors.

From the perspective of scientific integration, the balance model can be viewed as a bridge between classical descriptive approaches and contemporary resource-oriented modalities. For example, the biopsychosocial model (Engel, 1977) emphasizes the interrelationships among physical, psychological, and social factors, but Positive Psychotherapy adds, at a conceptual level, the importance of meaning and values. Cognitive-behavioral theories (Beck, 1976; Ellis, 1994) emphasize thought patterns and behavioral habits, whereas the balance model situates these aspects within the broader dynamics of the four areas – body, activity, contacts, and future/meaning – and considers them in their "positum."

Such a framework allows the therapist to analyze mental status not simply as a fixed description of the current state, but as a dynamic field between possibilities and dysfunction. This is particularly valuable in clinical practice, where there is often a discrepancy between available resources and the patient's use of them. The distribution of mental functions across the four areas enables the targeted identification of "shadowed" primary and secondary abilities, providing a basis for therapeutic intervention

and personal development (Peseschkian, 1996; Wissing & Schutte, 2016).

2.4. Theoretical connections

The distribution of mental status across the four areas of the balance model makes sense only when it is situated within the broader network of psychological and psychotherapeutic theories. In this context, several main lines of theoretical integration and dialogue can be outlined. This is important evidence that the specific content and tools of Positive Psychotherapy align with contemporary psychological theories and trends and can be incorporated into the repertoires of psychotherapists across disciplines.

1. Biopsychosocial model

Engel's (1977) classic formulation emphasizes the need to view the individual as a unity of biological, psychological, and social factors. Peseschkian's balance model extends this triad with a fourth dimension – future/meaning – that extends beyond immediate functioning to encompass existential and value orientations. In this way, he builds on the biopsychosocial framework, adding a spiritual horizon (Peseschkian, 1987) and highlighting the importance of the concepts underlying abilities that contribute to maintaining dysfunction, life scenarios, and available or hidden resources.

2. Humanistic-existential approaches

Their focus is on the future/meaning, as in Frankl's logotherapy, which holds that the search for meaning is the primary driver of human motivation (Frankl, 1963). A parallel can be drawn with Rogers' client-centered therapy (1951), which emphasizes the value of authentic contact and continuous development. Thus, the spheres of mental status in the balance model can be interpreted as concrete manifestations of this fundamental tendency toward self-actualization and meaning orientation, placing the balance model among instruments grounded in valid psychotherapeutic traditions.

3. Cognitive-behavioral approaches

The different mental spheres have obvious parallels with Beck's cognitive therapy (1976), where it is precisely distorted cognitive and dysfunctional schemas that maintain psychopathology. The difference is that in Positive Psychotherapy, these functions are not viewed solely as dysfunctional, but also as sources of potential resources. They can be activated or even built up by shifting the focus

from deficits to abilities, which broadens the conceptual horizon, "feeding" successful strategies for coping with similar events in the past, or offers an opportunity to see aspects of suffering differently. (Peseschkian, 1996).

4. Psychodynamic perspective

Psychodynamic theories (Freud, 1915, 1957; Kernberg, 1975) emphasize internal conflicts, defense mechanisms, and unconscious processes. In the conflict processing model, the current conflict, formulated in terms of imbalance between the four areas, sets the therapeutic direction in the unfolding of psychodynamics – the contradiction in thoughts, emotions, experiences, and behavior. For example, excessive investment in the activity domain may lead to neglect of contacts or meaningful perspectives. In this way, the model provides an operational framework for understanding the dynamics between intrapsychic forces and their manifestation in reality.

2.5. Psychotherapeutic meaning

The transfer of mental status within the balance model and the conflict processing model is important for psychotherapeutic practice. It can be found in the following areas:

1. Assessment of imbalances/deficits

By dividing each sphere of mental status into four areas (body, activity, contacts, future/meaning), the therapist gains a tool for more refined diagnosis. For example, pronounced anxiety may be related not only to the physical sphere (somatic symptoms), but also to the future/meaning (existential insecurity). It may also be transferred to achievements (the presence of conditions that define success as a feeling of significance) or "metastasize" into contacts (anxiety about separation from a partner). Thus, the picture becomes multi-layered and oriented towards overall balance (Peseschkian, 1987).

2. Activating resources

Any deficit can be translated into the language of abilities. Attention disorders can block success in an area of activity, but the cause of this deficit may lie in excessive tension in the area of contacts (emotional imbalance). A deficit in attentional capacity can help the therapist guide the client/patient toward mindfulness practices that draw on the future/meaning domain. In this way, therapy does not remain at

the level of symptom correction, but becomes a process of resource mobilization.

3. Formulation of conflicts

In Positive Psychotherapy, current conflicts are often understood as the result of a one-sided investment of psychic energy in one domain at the expense of others. The distribution of mental status allows these conflicts to be formulated more precisely: for example, the dominance of activity at the expense of contact may explain problems in emotional relationships or social isolation. Therapeutic work then focuses on restoring the balance between the areas (Peseschkian, 1996).

4. Individualization of the therapeutic process

The conceptualization of mental status in the balance model and the conflict processing model makes it possible to develop an individual therapeutic plan tailored to the client's unique configuration. For example, a person with well-developed memory and intellect but deficits in emotional expression may be referred to therapeutic techniques that involve bodily expression or art to expand the range of contact and emotions.

5. Tracking change

In the dynamics of the therapeutic process, the mental status, as conceptualized within the balance model, serves as an indicator of development. If, at the outset, a certain area is limited or one-sidedly developed (e.g., criticality – directed solely toward self-judgment), therapy can track its transformation into a more balanced form (criticism as self-reflection and ethical judgment). This turns the status into a tool not only for diagnosis but also for monitoring change (Wissing & Schutte, 2016).

6. A bridge to interdisciplinarity

The integration of mental status and the balance model facilitates dialogue among psychotherapy, psychiatry, and medicine. For clinicians in the medical field, this conceptualization provides a familiar structure (consciousness, memory, thinking, etc.), and for psychotherapists, a resource-oriented interpretation. This creates a common language that facilitates collaboration in a multidisciplinary team (Kaplan & Sadock, 2007)..

Discussion

3.1. Transition and applicability

The conceptualization of mental status through the balance model shows that each mental function can be viewed not only as a diagnostic criterion but also as a potential resource. The theoretical framework, historical parallels, and connections with other psychotherapeutic approaches reveal that mental status is transformed from a static description into a dynamic tool for understanding and change. The practical applicability of this perspective is multifaceted: it facilitates the therapist's identification of imbalances, assists in formulating internal conflicts, and enables tracking of the client's development. At the same time, visual elements – in the form of matrices or diagrams – offer not only an academic but also a practical model that can be used in both therapeutic practice and the training of young professionals. This makes Positive Psychotherapy and its tools a psychotherapeutic modality with measurable effectiveness.

In this vein, the next step is to examine how primary and secondary abilities manifest in each sphere and area of the balance model, and what can be observed in the conflict-processing model. This specifies the resource-oriented approach of Positive Psychotherapy and shows how the therapist can encourage personal development by consciously activating these abilities. For this purpose, it is necessary to provide a brief psychotherapeutic description of the mental status.

1. Consciousness

Consciousness reflects the individual's ability to perceive themselves and their environment, to organize their actions in advance and anticipate their outcomes, and to control and regulate their behavior. In the physical realm, it pertains to self-perception of physiological states and sensations. In the realm of activity, consciousness manifests as goal-setting and reflection on actions taken. In social interactions, consciousness structures social identity and awareness of others as subjects. From the perspective of the future/meaning, it encompasses existential self-awareness, awareness of meaning, and value orientation.

2. Contact

Contact in mental status includes the ability to establish, maintain, and regulate

interpersonal relationships. In the physical realm, it manifests itself through nonverbal communication and sensory expression. In the sphere of activity, contact is realized in cooperative actions and social roles. In the social sphere of balance, contact facilitates the development of trust, empathy, and closeness. In the dimension of future/meaning, contact is belonging to cultural, spiritual, or religious communities.

3. Perception

Perception means the organization of sensory and cognitive information. Reflection of things in the mind through the sensory organs. In the realm of the body (an instrument of the senses), it encompasses basic sensory perception. In activity (instrument of logic) - interpretation of situations. In contacts (instrument of tradition) - perception of the emotions and intentions of others. In the future/meaning - symbolic perception and interpretation of life events as part of a larger meaningful structure.

4. Emotions

Emotions in the bodily domain are associated with physiological reactions and somatization. In activity, with motivation and behavioral regulation. In contacts - with affective exchange, empathy, and emotional response. In the future/meaning - with existential feelings such as hope, fear, guilt, and meaningful satisfaction.

5. Will

Will is the ability to choose, set goals, and persevere in actions. In the physical realm, it is expressed through self-control over physiological impulses and needs. In activity, will is central – associated with perseverance, diligence, and goal achievement. In relationships, it regulates interpersonal boundaries and assertiveness. In the future/meaning will acquire a dimension of spiritual orientation, free choice, and commitment to values.

6. Psychomotorics

Psychomotor skills reflect the connection between mental processes and motor activity. In the physical sphere, they manifest as tone, coordination, and the expressiveness of movement. In activity, they are associated with task performance and motor organization. In social interactions, psychomotor skills are visible in nonverbal behavior, gestures, and facial expressions. In the future/meaning sphere, they

are interpreted as symbols of movement and ritual behavior.

7. Attention

Attention is the ability to select and concentrate mental energy. In the physical realm, it manifests as awareness of bodily signals. In activities, efficiency, focus, and control of the work process are necessary. In interpersonal contact, attention serves as an empathic connection with the other person. In the future/meaning, it is directed towards existential questions, reflection, and meditative concentration.

8. Thinking

Thinking is the cognitive process of analysis, synthesis, and abstraction. In the physical realm, it can be linked to the interpretation of somatic experiences. In activity, thinking provides planning, problem-solving, and creativity. In relationships, it structures communication and social understanding. In the future/meaning, thinking manifests itself through philosophical and value reflection.

9. Memory

Memory integrates experience, making it accessible to the present and future. In the physical realm, it is bodily memory, including psychosomatic traces. In activity, it provides continuity in professional and practical skills. In relationships, it serves as a bearer of emotionally significant memories. In the future/meaning, memory is associated with autobiographical memories and identity.

10. Intellect

Intellect is the integrative ability to solve problems, learn, and adapt. In the physical realm, it manifests as practical intelligence related to health care. In activity, it manifests as analytical and creative skills. In social contexts, it manifests as social intelligence and an understanding of others. In the future/meaning, intelligence reaches the ability for critical philosophical and moral judgment.

11. Criticality

Critical thinking is the ability to reflect on and evaluate. In the physical sphere, it is related to healthy self-observation and care. In activity, it is related to the assessment of effectiveness and results. In contacts, it relates to moral and social assessment and to self-assessment. In the future/meaning, criticality is inseparable from ethical and existential judgment about the meaning of life.

Each component of mental state could be viewed simultaneously as: an indicator of what is visible; a structural signal of disturbed balance and capacity – a resource that can be activated through a therapeutic process.

For example:

Criticality can manifest itself as pathological self-esteem or narcissistic expectations of others, and on the other hand, it can contain good potential for ethical reflection and responsibility;

Will could manifest as rigidity or passivity (stubbornness), but also as persistence and commitment based on values;

Emotional reactivity can show dysregulation, but also emotional accessibility and the ability to connect.

A similar shift from a deficit-oriented to a resource-oriented interpretation (positive reinterpretation) links mental status to the therapeutic goals of positive and transcultural psychotherapy.

Figures 1, 2, and 3 illustrate the relationship between components of mental status and the spheres of the balance model.

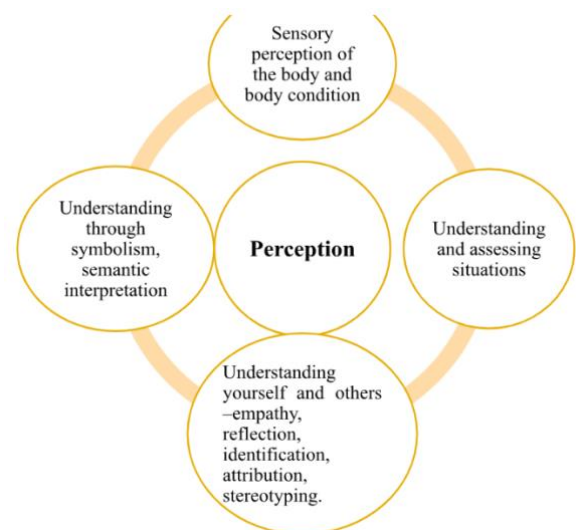


Figure 1. Relationship between perception and the spheres in the balance model.

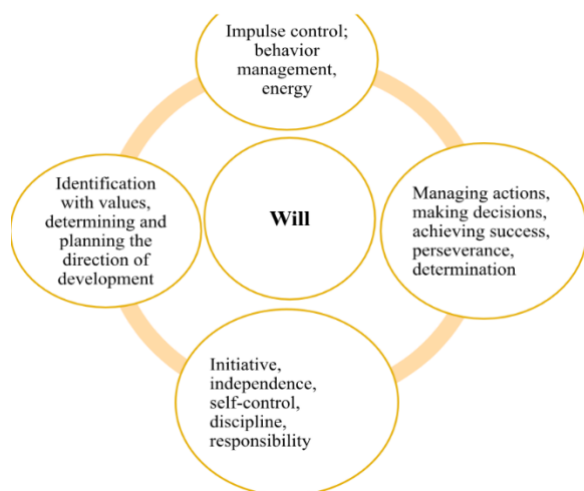


Figure 2. Relationship between will and the spheres of the balance model.

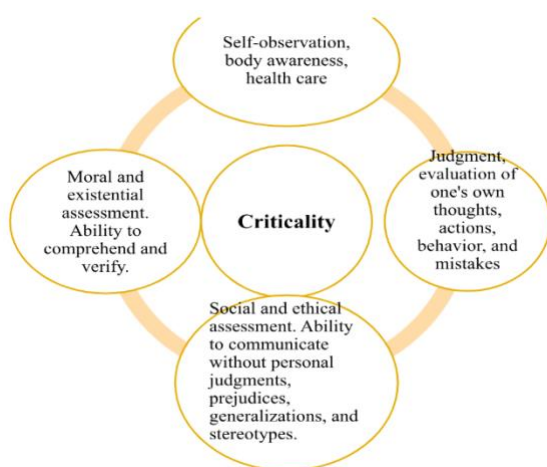


Figure 3. Relationship between criticality and the spheres of the balance model.

The conceptualization of mental status through the prism of the balance model allows for the systematic integration of individual mental functions into the four main areas of human existence. Thus, consciousness, contact, perception, emotions, will, psychomotor skills, attention, thinking, memory, intellect, and criticality can be viewed not only as isolated mental processes, but also as dynamic aspects of the balance and imbalance between the areas: "Body & Health"; "Work & Achievement"; "Relationships" and "Meaning/Future/Values."

3.2. Actual capabilities

Actual capabilities are psychologically valid norms that Positive Psychotherapy groups into two main categories based on their content. The first category comprises primary capabilities, which are oriented toward feelings and the emotional sphere closer to the ego and instinctive needs (social interaction, love & capacity for relationships, patience, time awareness, trust, role modeling, certainty/assurance, hope, etc.). Based on these, forms of behavior acquire emotional nuance and elicit feelings of pleasure (praise, encouragement) or displeasure (reprimand, punishment). The second category includes secondary capabilities – an expression of transmitted knowledge and accumulated experience, and hence the ability to learn, as well as their correlation with psychosocial norms, and in this sense they carry the power of behavioral regulators (punctuality, cleanliness, fidelity/loyalty, orderliness/order, obedience, reliability/trustworthiness, justice/fairness, diligence & achievement, etc.).

Any pressure in favor of one or the other leads to fixation – a person begins to emphasize one ability and use it in specific situations. Thus, one ability becomes hyperbolized and disrupts the harmony of the personality, whereas other abilities may manifest as blocked, underdeveloped, or dysfunctional.

3.3. Secondary capabilities in mental status, balance model, and conflict resolution model

Secondary capabilities are an expression of transmitted knowledge and accumulated experience. When functioning normally, they ensure adaptation and stability. When imbalanced, they are visible in the mental status as rigid, inauthentic symptoms, carriers of dysfunction.

The overall picture when combining information from mental status with the balance model and conflict resolution model, as well as the psychodynamic perspective coming from this connection, would look something like this (Table 1).

Table 1. Relationship among the spheres of the balance model, the conflict resolution model, mental status, and the psychodynamic perspective.

<i>Balance model</i>	<i>Secondary capabilities</i>	<i>Mental status</i>	<i>Conflict resolution model</i>	<i>Psychodynamic significance</i>
<i>Body & Health</i>	Cleanliness, order, diligence, discipline, consistency	Good tone, well-groomed appearance, care for the body, and health	Obsessive cleanliness, rigidity, somatic and psychosomatic symptoms	Regulation of the sense of bodily self; somatization and/or perfectionism.
<i>Work & Achievement</i>	Diligence, responsibility, precision, reliability, obedience, discipline	Purposefulness, concentration, energy, initiative, independence	Escape into activity and/or inactivity, exhaustion	Activity becomes a personal measure of value and significance
<i>Relationships</i>	Courtesy, honesty, diligence, reliability, fairness, obedience, discipline	Empathetic contact, stable social, and emotionally meaningful relationships	Dependence, fear of conflict, social isolation, or many, but poor in content, superficial contacts	Regulation of closeness and distance, need for care, and self-sufficiency.
<i>Meaning/ Future/ Values</i>	Order, discipline, reliability, politeness, honesty, fairness	Resilience, tolerance for frustration, realistic goal-orientedness, and determination	Fatalism, hopelessness, dogmatism, guilt, existential emptiness	Existential crisis.

Each actual ability, individually and in combination, as personality traits, manifests itself in the same four dimensions in which they have developed.

We present several examples of the possibility of integrating information from mental status into PPT tools – the balance model and the conflict processing model.

1. Orderliness / Order

Organization, structuring of the world/reality, predictability, internal discipline, moral and physical order. Creates a sense of security, stability, and control. As a way of processing conflict, it becomes obsessive, marked by fear of mistakes, intolerance of spontaneity, and perfectionism (Table 2).

Table 2. Actual capability "Orderliness / Order" through mental status, balance model, and conflict processing model

<i>Generalized component of mental status</i>	<i>Balance model</i>	<i>Conflict processing model</i>
<i>Appearance/ behavior/ psychomotor skills</i>	Well-groomed, clean, calm, tidy, toned, coordinated	Excessively neat, fixated on details, prone to rituals
<i>Affect/mood</i>	Calm, composed, balanced, able to switch between positive and negative affect depending on the situation	Suppressed affect, anxiety in the face of unpredictability; prone to negative emotions dominating
<i>Thinking</i>	Structured, logical, organized, consciously controls thoughts and actions	Rigid, moralizing, dogmatic, obsessive, follows stereotypes and prejudices
<i>Perception</i>	Realistic, objective perception of the surrounding reality.	Detailed, but without perspective (tunnel vision)
<i>Cognitive functions – memory, will, attention, intellect.</i>	Good concentration, memory, attention, impulse control, and identification with values	Exhaustion, lack of self-control, uncritical thinking, and rigid selectivity of attention
<i>Contact</i>	Social and ethical judgment	Accusations, self-accusations, prejudices, avoidance of contact, or compensation in many but meaningless contacts
<i>Criticality</i>	Adequate, realistic, self-reflective	Overcriticality, guilt, shame, fear of failure

The current ability "Order" is a relative concept for each person. It could be viewed as: a sequential arrangement of events in time, "Everything in its own order"; the right or obligation of a participant in an action, performing a specific task, "It's your turn to take out the trash"; rules according to which something is done, "First you tidy up your shoes, then you go into the kitchen"; the correct placement of something, "The toys on the shelf, the construction set in the box."

2. Cleanliness

According to Peseschkian (1987), "cleanliness" is not limited to its physical dimension but also encompasses its emotional and spiritual dimensions, including a person's ability to let go of the old and maintain inner order. Physical, emotional, mental, and moral cleanliness, in a balanced form, contributes to self-respect, boundaries, and ethics. It provides an opportunity for symbolic "cleansing" and a new beginning. As conflict processing: Obsessiveness, guilt, sin, perfectionism, aversion to the "unclean" (in oneself or others). (Tab. 3).

Table 3. Actual capability "cleanliness" through mental status, balance model, and conflict processing model

Generalized component of mental status	Balance model	Conflict processing model
<i>Appearance/behavior / psychomotor skills</i>	Well-groomed, harmonious, calm, organized	Excessively neat, sterile, fixated on rituals
<i>Affect/mood</i>	Calmness, sense of inner harmony	Anxiety, guilt, fear/phobias of contamination (physical, emotional, or moral)
<i>Thinking</i>	Clear, orderly, structured, concrete	Rigid, obsessive, dichotomous ("clean"—"dirty")
<i>Perception</i>	Realistic, aesthetic, with a sense of beauty and harmony	Hypersensitivity to imperfections
<i>Cognitive functions – memory, will, attention, intellect.</i>	Concentration, distributability, selectivity	Rigid attention (difficulty switching, fixation, difficulty concentrating, volume, and distribution)
<i>Contact</i>	Tactfulness, respect, empathy	Judgment, distance, disgust, and fear that others will "contaminate" them.
<i>Criticality</i>	Self-reflection, awareness of boundaries, and identity	Excessive guilt, shame, moral anxiety

Conclusion

Rethinking mental status as a tool has several practical implications:

- Diagnostic depth – symptoms and conflicts are conceptualized within the balance model;
- Formulation of the conflict – information from the mental status guides the identification of overdeveloped and blocked current abilities;
- Therapeutic intervention – the process focuses on the resource that could be activated to overcome the deficit, rather than just on the symptom or problem.

- Process observation – changes in mental status reflect changes in the balance model and the conflict processing model;
- Interdisciplinary dialogue – maintains clinical language while adding psychodynamic meaning.

The integration of mental status, the balance model, actual capabilities, and the conflict processing model outlines a comprehensive and dynamic approach to understanding human functioning.

The presented conceptualization preserves the diagnostic precision of classical psychiatry while embedding it within the humanistic, psychodynamic, and resource-oriented framework of positive and transcultural

psychotherapy. In this sense, mental status plays the role of a diagnostic "mirror"; the balance model provides the "structural picture" of the adaptation process, actual capabilities provide the content, and the conflict processing model provides the dynamics of the process. In conclusion, suicide prevention ultimately requires a paradigm shift from a reductionist, biologically-dominated model to an integrated,

salutogenic one. By embracing the psychological essence of human suffering, leveraging the healing power of relationships and verbalization, and applying practical frameworks such as the life balance model, we can build a culture of connection that actively fosters resilience. The most powerful tool in prevention remains our collective humanity and our commitment to seeing the whole person.

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The Many Faces of Pain Experience in Life: A Transcultural Approach



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Abstract

The problem of death and dying, and how to cope with death, is still a taboo theme in different cultures. In this exposé, different aspects of pain will be illustrated, and I will narrate 10 stories, each named after a newborn baby whose family experienced a death. These Names given to newborns help families cope with the pains that arise in the course of family history. Every African name has a history. The names given to Children after a long episode and encounter with death, pain, and dying disclose the way and manner the Igbo people in Nigeria cope with death and also their hope in life. Death is personalized in these narrations. The effectiveness of such stories in therapy is enormous.

Keywords: Positive Psychotherapy, transcultural approach, death, grief, pain

Introduction

We experience pain every day, each person in his or her own way. "Pain is always a subjective Experience and therefore depends on various factors in terms of its intensity, frequency, and duration" (Bonica, 1979). The litany of pain is complex and multifaceted. Think of the pain caused by various catastrophes, when relationships break down, when illness takes over, when people harbour feelings of hatred towards others, when the inevitable losses in life plague us, such as loss through death, unemployment, unforeseen fates, manipulation of all kinds, enslavement, wars, inner worries about survival, and also through the global economic crisis.

When pain arises, the whole individual is affected in the areas of body, achievement, contact, and belief systems.

For this reason, every culture has developed its own appropriate methodology to help people not only alleviate pain, but also to endure it, grow through it, and gain new insights from it.

Currently, various forms of pain therapy are available. For example, light therapy, chemotherapy, physiotherapy, psychotherapy, hypnotherapy, reincarnation therapy,

aromatherapy, crystal therapy, spiritual therapy, and palliative medicine.

In this expose, I would like to present the different faces of pain. For example, 1. The face of consolation. 2. The face of sacrifice. 3. The face that shows courage and the ability to endure painful circumstances. 4. The face of tension release.

Methodology

2.1. The faces of pain are compared with the story of an Elephant

The Onlookers and the Elephant

"Once upon a time, there was a certain king in Shravasti. He commanded his servant: Gather all the blind people in the city in one place. When this was done, he had an elephant brought before the blind people; he let some of them touch its head, saying, "This is what an elephant is like." " Others touched the ear or tusk, the trunk, the foot, the hindquarters, the tail, the tail hairs. Then he asked: What is an elephant like? Those who had touched the head said: It is like a pot; those who had touched the ear said: like a woven basket for winnowing grain; those who had touched the tusk said it was like a ploughshare; those who had touched the trunk

said it was like a plough beam; those who had touched the body said it was like a storehouse; those who had touched the foot said it was like a pillar; those who had touched the hindquarters said it was like a mortar; which had touched the tail, like a pestle which had touched the tail hairs, like a broom. And with the cry: "The elephant is like this and not like that," they beat each other with their fists, to the delight of the king. (Peseschkian 2016)

Many cultures try to explain how to deal with and cope with the pain, especially in the situation of losing someone through death, loss, or other psychological calamities. In the Igbo culture in Nigeria, names are given to newborn babies as a necessary psychological relief and endurance of pain.

2.2. The different Expressions of Pain in Transcultural Disposition

Pain is seen as a means of comfort and consolation:

There are people around the world who have developed a pain strategy to elicit comfort from others when they experience pain. I had such an experience with a woman who had suffered from headaches for 40 years. Every time I meet her, the first thing she tells me is how much her head hurts and pains. Which attack she has overcome, which medication she has taken, and which therapy is coming up. She has developed the ability to describe and recount everything in detail. Any kind of advice or recommendation is promptly met with the statement: "It doesn't help me anymore." Countless people seek comfort in this way. My child has been dead for 20 years, I have been unfairly divorced, my disability makes my life difficult, a disaster has destroyed my house or flat, we have been living here as refugees for several years, I have been retired for some time, I was bullied, and I lost my job. Etc. The agony of this kind of pain is that it never stops.

Such people want affection, attention, and mindfulness. They depict the face of pain seeking comfort and understanding. What helps is just being there, listening, encouraging them, and giving a few recommendations.

Pain experience is seen as a means of sacrifice from the victim's perspective:

In various places around the world, people are deprived of their freedom, dignity, rights, and livelihoods. Whether through oppression,

infliction of pain, humiliation, brutal physical or psychological injury, etc. These individuals experience the stigma of inner humiliation. A story from the Old Testament illustrates this kind of suffering:

When the Israelites had been oppressed for many years, God called to Moses: "I have seen the misery of my people in Egypt, and I have heard their loud cries against their oppressors. I know their suffering." (Ex. 3:7-8)

Some people suffer as victims of a dramatic and painful experience that was inflicted on them from outside. All attempts to ask the "why" question always remain unanswered.

A man from Rwanda told me how the Tutsi killed his wife and six children back then. "The pain is still omnipresent today. To this day, I have found no answer. Rather, my conscience torments me, and I feel guilty. My inner voice tells me: 'I did little to save my family'. This face of pain is always associated with feelings of guilt. With powerlessness, with inner anger. The scars of pain are not easy to heal.

Pain acceptance through Endurance and a strong capacity for courage.

People with deep religious connections and strong belief systems often experience this third type of face of pain. People tend to endure pain and suffering when they feel that there is a reward behind it. Buddha achieved "nirvana" through his endurance, Jesus accepted suffering in order to fulfill God's will, and Mohammed went through great suffering to receive his revelation from the angel. In my African tribe, we can only pass our initiation rites by proving our courage and enduring pain.

Many people transform such endurance. However, some people, through suffering, become hardened in their attitudes toward life.

The face of pain is a release of tension.

Nowadays, it has become fashionable for many people to inflict pain on themselves in order to feel relaxation. Young people and young adults cut themselves to make their conflicts easier to bear. Some people prefer sadomasochistic practices to reach orgasm. During pilgrimages, many people walk long distances (e.g., the Way of St. James) and endure considerable suffering. Some experience heavenly feelings as a result. There are even soldiers who injure themselves in order to be freed from the theatre of war.

Such pain is seen as a Defence against guilt and sin, or as self-punishment undertaken in

penance, so that God will show mercy. Think of the penitential belts of the Opus Dei.

Some people believe that such pain purifies the soul, enabling one to see clearly again.

Such pain is perceived as a source of pleasure.

Discussion

3.1. Specific Approach of dealing with the pains of demise in Igbo culture.

Every culture has developed ways of coping with loss through death. In my country, Nigeria, especially in my tribe, we have developed a unique philosophy of life and beliefs to cope with the pain of departure through death.

These stories about death from Igboland are real events. Names of newborn babies contribute to the remembrance and endurance of painful experiences. However, every culture has its own way of dealing with death. These stories are a small contribution to dealing with pain, grief, and death from an African perspective. These stories affect the four areas of the balance system of positive and transcultural Psychotherapy.

1. Onwudebe "Death, please keep."

My Grandmother had difficulty conceiving children. She gave birth to 15 children, and all died. She had some hope at each childbirth that they would survive, but unfortunately, none survived the 4th birthday. My Grandmother, in her agony, said these things: "Death, you have taken away everything from my life. I'm now very downcast. I would like to enter into a specific agreement with you and see if we can understand one another. At the death of my first child, I thought the gods had punished me, so I tried to reconcile myself with the gods. I had to undergo certain penitential rites. I went into the dense forest and stayed for several days, fasted, cleansed myself of evil thoughts, and distributed alms. By the death of my second child, I thought that the enemy, witchcraft, killed my child. The village's native doctor had to perform some cleansing. Despite all these, all my 15 children died one after the other."

I was totally upset. "I asked myself several questions. What is the problem with me? Did my children have some genetic illness? Are the gods annoyed with me? Wasn't I very careful? Did I neglect something?" Etc. etc.

My mother was the 16th child. Her name was "Onwudebe", death please keep. Death is asked

to take custody of my mother, and he is permitted to deal with her appropriately.

My mother was the only child who survived. She got married and had 6 children. Unfortunately, she died at the age of 36. "Onwudebe" is recognition of death. Death receives a mandate and is given some responsibility to carry out.

2. Onwuagbaoso "Death cannot run."

It was Christmas time. The three sons of "Ekele" had purchased many items for the family's festive celebration, which was being held in "Opobo," a town in Nigeria. In Nigeria, as in other parts of the world, such festivities are highly tense. The route to their hometown is by sea. They joined a ship with another 200 passengers. The ship's captain sought to maximize revenue during this period. Overloading of ships and other means of Transportation is so common. In Nigeria, the ships are secondhand and outdated. The way to "Opobo" with this ship went very smoothly. But a few miles before anchoring, an Atlantic wind with a very strong Velocity bashed at the ship, and it sank. All on the ship drowned, including the three sons of "Ekele".

The Family received the news of this tragedy with great distress. The mother of these Children lamented with the following words: "God Almighty. You have done much to shake my faith. Your punishment is exorbitant. In one moment in time, I lost all three of my children. Death cannot run."

"Ekele" was again pregnant and gave her son the name "Onwuagbaoso, " meaning" death cannot run. With this name, the story of the death of her sons will be remembered. In this way, she can share her grief with her sons, and her hope remains alive. In her sorrow, she wished that death could run. If the possibility were there for death to run, her sons might not have died on the same day and time. "Onwuagbaoso" is an appeal to death not to extinguish human lives instantaneously.

3. Onwubiko "Death, have mercy."

An epidemic occurred in a small village called "Mgbe". Many people are dying in mass. Philanthropic associations are trying to combat the spread of the disease. The suffering of the inhabitants is felt. Pregnant women have fears about their newborn children. Will they die after birth? is the question.

Children are automatically given the name "Onwubiko"-"death has mercy." This name

appeals to death to slow down his aggressiveness. Death should show humans some forgiveness. Death is seen as a person. Death should practise some tolerance.

This manner of negotiating with death has an old tradition and is practised by many religions. When people suffer from a disaster or experience discomfort, they pray. Most people believe that through such acts, God will show his mercy. Prayers have powerful effects that can stop the spread of negative forces.

The name "Onwubiko," God have mercy, gives mothers some hope in life. The "Igbos" in Nigeria use the word "Biko" as a means to soften the hearts of people.

4. Onwuchakwa "Death, please wait a moment."

A very big festival approaches. A Centenary feast. Very few will like to celebrate the "Ikeji" fest. The entire village has prepared for the feast through various rituals. Goats and other animals required for the festival are well nourished. Animals for temple services have been purified. It is the wish of all the inhabitants of the village to avoid evil at this period of time. This will protect them from bad omen. Many activities, such as processions to particular deities, reconciliation rites, and other customs, are undertaken to secure the favour of the gods. Women, who give birth to new babies at this point, name them "Onwuchakwa" - death, please wait for a moment, do not come to visit us yet. Please allow us to celebrate our feast. If you do come, we will all experience sorrow, and this will affect our festivities.

This attitude among the Villagers is widespread: that communication with the dead as persons is a possible means of interaction. Death listens. Such names for death could bring him (DEATH) into some uneasiness, which can then influence his decision to come. Christianity and Judaism also hold that penance, good works, and praise of God are efficacious means of obtaining God's favour. God is the ultimate giver of life and death. (The story of Abram and Yahweh, or the request of Jesus that whoever asks receives, depicts this belief system.) Genesis 18, 1-15. Or Matthaesus 6, 5-15.

The inhabitants could consider death talking to itself in this manner: "Why must I wait? But if someone asks me to wait, I'll wait. I will come at my own tempo.

Most Africans tend to bargain. In different marketplaces, bargaining is a way of life. Nothing

goes without bargaining. Marriage, Heritage, initiation rites, Etc. Also with death.

5. Onwuka "Death is the strongest."

"Mgbeke" lived in a small Village called "Umudoro". She was the 4 Child of a family of ten. She married at the age of 15. For many years, the marriage was childless. But fortunately for her, after many years of waiting, "Mgbeke" delivered. The family's joy was tremendous. Childlessness is often regarded as a curse within the family. Women suffer the most. "Mgbeke" was so relieved after this birth. She had experienced many miscarriages.

She named her son "Onwuka," meaning Death is the strongest. With this name, death is exonerated. With this name, a type of relationship is established. Under this name, death assumes a special place in the family's history. Once "Onwuka" is mentioned anywhere in the village, the history of his procreation will be remembered. The name suggests that death plays an important role in human life.

6. "Onwuzurike" Death, please have a pause.

Every year in this part of northern Nigeria, people experience drought. There are always some mishaps. The rivers dry up, animals die due to inadequate nutrition, and farmers cannot harvest their crops. Famine is the other side of the day. Most people leave their villages in search of water and food. No one has an answer to this terrible situation. The problem is interpreted as a disharmony between nature and humans. It is the work of the elderly to help restore equilibrium in the village. People believe that only through a type of balance in nature can one restore this climatic disorder.

Children who are born in this period of time are named "Onwuzurike". Death should have a pause. This name suggests that death should heed people's suffering. He should please give humans some sort of chance to revitalize. It is also a principle of life that a pause in life is necessary for convalescence. After a time of a severe hurricane comes a time of low tide; after a time of darkness comes a time of light; after a time of disaster comes a time of recovery. This interchangeable principle of life is the wish of the inhabitants for death. Death is advised to follow this way of natural forces. Death should please try to stop its powerful adventure.

7. Onwueri "Death, you cannot destroy."

The war has lasted more than 20 years now. The family of "Enu" happened to escape many

tragic situations. Their house was destroyed; they were running for their lives from place to place. They lived in several refugee camps. At this period of time, "Onwueri" was born. He survived the episode of war. Nothing happened to him.

The family narrated the following story: "It was a very difficult period of our lives. We had to run for our lives. We made more than 300 Kilometres on foot. We encountered numerous dangerous animals, such as snakes, scorpions, spiders, and other wild animals. The fear of dangerous insects was profound. We had no food, no water, and no sleeping facilities. We had to share all our daily needs with wild animals. It was very awful. There were certain periods of time when we wished ourselves death. Doubts and hopelessness accompanied us throughout our flight for life. It is still a mystery how we survived this odyssey. Our child was given the name "Onwueri" to remember this time. His will to survive was tremendous. He never got sick and did not give us any problems."

The name "Onwueri" is given to children who have survived disasters, dangerous situations such as wars, and other unfortunate circumstances. Such children are proud of their history. They could survive despite all urges.

A song is sung for such people:

*"Death came, but could not take me away.
Death came, but did not have time for me.
Death came, but omitted me.
Death came, but left me alive."*

8. Onwuzuribo "Death is everywhere."

There is a tradition in "Igbo land" where deceased persons from one family are buried in their homes. Sometimes, more than 5 people could be buried in a room. Through this means, an intensive relationship between the living and the dead is established. On special occasions, libations in honour of the dead are spoken. Wine or food is used. The performance of this ceremony buttresses the spiritual union of the living and the dead. Sometimes, only the names of adults who have begotten children are mentioned, and in some families, only adult men.

This type of communication with the dead and remembrance of the dead gives the Ibos some sort of calmness towards death. Death is a reality, but the pains attributed to dying are somehow minimized through interaction with

the deceased. Children whose names are "Onwuzuribo" convey the message that death is a reality and ubiquitous. This attitude and belief system of the Ibo is noticeable in the way they live. So many Igbo are wanderers.

9. Onwusirike "Death is so powerful."

"Aro" is very lonely. The whole of his family died from food poisoning. His wife and seven children.

In his sorrow and pain, he lamented by using the following words:

"Death, it is not easy to understand your power. You have taken everything from me. All my precious belongings. What will I do now? I can't cry any longer. My tears are all dried up. A new beginning is not possible. My home is empty. Why? Why? I do not have any trust in marriage and the procreation of children anymore. We are not sure anymore how you will react if we begin anew". He wrote this letter to death."

Dear Mr. Death!

I am now at my home and waiting for my wife and my seven children. Perhaps they have visited the neighbourhood. Perhaps they have gone shopping. Perhaps my children are at school now. How long should I wait before receiving information from you? I have no more appetite. I have no more joy in my life. Death! Why do you have so much power? Why do you have the power to destroy everything, without thinking of the outcome? It is not easy to believe that I will never see my family again. It is also very painful to accept your reasoning, if there is any. I have only one wish: whenever you strike again, please do not kill the members of a family all at once.

A child was born in the kindred and was named "Onwusirike", as a remembrance of this incident. The entire village still recalls this tragic situation whenever "Onwusirike" is present.

10. Onwuoma "Death is just."

Two indigenous families are struggling for a title in the village. The family of "Uzoh" is highly educated but not particularly wealthy. Most of their family members studied abroad. The other family of "Isi" consists entirely of businesspeople and possesses considerable wealth. Both families disagree on certain life principles. According to the custom of the village, whoever receives the title should govern the village. The "Uzoh" kindred are not ready to accept an uneducated person as their village leader,

because they believe that the villagers can only gain through wisdom. On the other hand, the "Isi" family maintains that a person without some wealth cannot lead the village because he cannot bring progress and prosperity to it. These two opposed philosophies divide the village into two camps. There are no democratic elections; title holders are nominated through internal consensus and random selection. And only these two families are privileged to receive the title.

The opposing families wish death to their opponents. They maintain that only death can resolve this leadership problem. If one of the title seekers dies, then the other family can become the leader. Death is seen as a just redeemer.

Everywhere in Ibo land, children receive this name "Onwuoma" as recognition of death, the just redeemer. Death does not recognise richness or academic title.

Conclusion

The ten naming stories from Igboland illustrate a unique cultural approach to coping with death and pain. Through names like "Onwudebe" (death, please keep), "Onwubiko" (death, have mercy), and "Onwuagbaoso" (death cannot run), the Igbo people transform unbearable grief into enduring memory and psychological relief. Death is personalized and

engaged as a presence with whom negotiation is possible. These names serve as permanent memorials, keeping tragic events within the collective consciousness while enabling families to continue living with hope. Every time the child's name is spoken in the village, the story is retold, the pain is shared, and the community participates in the ongoing process of grief work.

From the perspective of Positive Psychotherapy, this naming practice demonstrates how cultures develop sophisticated psychological systems for managing pain and loss. The integration of painful experiences into a child's identity provides a model for resilience that honors both suffering and hope. As the blind men who touched different parts of the elephant, each culture perceives and processes pain differently. The Igbo methodology – transforming tragedy into narrative, personalizing death, and embedding memory in daily life – affects all four areas of the balance system: body, achievement, contact, and belief systems. Such indigenous approaches deserve serious attention in transcultural psychotherapy as they offer valuable alternatives for understanding how humans endure suffering while maintaining dignity, community bonds, and hope for the future.

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The Problem of the Lack of Time in Highly Effective Individuals: A Positive Psychotherapeutic Approach



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Abstract

The article examines the problem of chronic “lack of time” in highly effective people as a psychological and existential symptom reflecting an internal imbalance. Balance model's four main spheres: Body/Health, Work/ Achievement, Relationship, and Meaning/Future/Values. Rather than offering strategies for time management, Nossrat Peseschkian's Positive Psychotherapy posits that time reflects the internal state. Through five therapeutic cases, the author traces different forms of time conflict – guilt, joylessness, dedication, disappointment, and control – and demonstrates how Peseschkian's five-stage model helps restore internal time. The therapeutic process reveals that when a person recognizes the meaning of the pause and attunes to their rhythm, time ceases to be an enemy and becomes a space for living.

Keywords: Positive Psychotherapy, Balance Model, time perception, inner rhythm, existential meaning

Introduction

*"When a person has no time,
He has, in fact, lost himself in time."*

- Nossrat Peseschkian

The phrase “*I have no time*” sounds like a slogan of modern society. It not only describes busyness but also conceals a deep spiritual crisis: the sense that life is slipping away while one is busy organizing it.

For highly effective, results-oriented individuals, this paradox reaches its extreme – the more achievements they accumulate, the more acutely they experience time constraints. The day is scheduled to the minute, while the inner experience is one of acceleration, anxiety, and constant “catching up.”

Nossrat Peseschkian (1987) views time as a psychological category rather than a mere chronological measure. When a person is in balance, he *has* time – even on a busy day. When balance is disturbed, time is experienced as pressure rather than as space for living. In this sense, the “*lack of time*” is a symptom of an internal discord between the spheres of life:

body, achievement, contact, and meaning. The more energy is invested in results, the more the spheres of closeness and spirituality become depleted.

The problem of time is inseparable from the experience of meaning. Frankl (1946) emphasizes that a person who does not perceive meaning strives to fill the inner void with activity, often without conscious choice. Yalom (1980) adds that the fear of death is often experienced as a “*lack of time*” – an escape from the awareness of finitude.

Positive Psychotherapy offers an alternative path: not to *manage* time, but to understand how we *experience* it. It teaches that time is a mirror of our inner rhythm, and that “*having time*” means being in contact with oneself. (Peseschkian, 1987, 2016b).

This article examines the problem of time constraints through the practice of Positive Psychotherapy with five highly effective clients. Each of them experiences time scarcity differently – as guilt, loneliness, cynicism, a sense of control, or a sense of meaninglessness.

The aim is to demonstrate how Peseschkian's five-stage model and the Balance Model help to restore the sense of *inner time* – the time of meaning, presence, and joy.

Methodology

This article presents a qualitative, conceptual-clinical analysis grounded in Positive Psychotherapy (Peseschkian). The article integrates theoretical analysis with structured reflection on five anonymized clinical cases drawn from the author's psychotherapeutic practice. The methodological framework is based primarily on Peseschkian's original works, in particular the Balance Model and the Five-Step Model.

To deepen understanding of time as an existential category, selected concepts from existential psychotherapy were integrated, in particular Viktor Frankl's notions of meaning and existential vacuum (Frankl, 1946) and Irvin Yalom's reflections on time, finitude, and death anxiety (Yalom, 1980).

Other existential approaches were excluded to maintain theoretical coherence.

The clinical cases were selected to illustrate different patterns of temporal conflict in high-performing individuals. The interpretations reflect the author's observations, conceptually presented within the framework of Positive Psychotherapy.

2.1. Theoretical Framework: Time as a Psychological Category and the Balance of Life Spheres

In psychotherapeutic practice, the "*lack of time*" is rarely a mere organizational problem. It expresses a profound experience of internal fragmentation – the sense that a person lives in several directions simultaneously without ever being fully *here*.

Nossrat Peseschkian (1987) conceptualizes time as a dimension of *inner balance* rather than as an external resource. When the personality is in harmony, time is experienced as *flow*, within which there is space for everything that matters. However, when one sphere dominates – especially the sphere of *achievement* – a person loses the sense of presence and "starts living according to a schedule, but not within life itself."

Thus, "*I have no time*" often means "*I have no inner space*."

The body becomes tired, relationships superficial, and meaning distant. This is a form of inner migration: one abandons oneself in the name of efficiency.

2.2. The Balance of Spheres as Temporal Balance

Peseschkian's model of the four spheres, Body, Achievement, Contact, and Meaning, can also be viewed as four dimensions of time (Table 1).

Table 1. Life Spheres and Their Temporal Dimensions in Positive Psychotherapy

<i>Sphere</i>	<i>Temporal Dimension</i>	<i>Symbolic Question</i>
<i>Body</i>	Present	"What do I feel now?"
<i>Achievement</i>	Future	"What do I have to do?"
<i>Contact</i>	Shared Time	"With whom do I want to be?"
<i>Meaning</i>	Beyond Time	"Why do I live?"

Source: Author's conceptualization, based on Peseschkian's Balance Model (1987, 2016b)

When the sphere of *achievement* occupies all available time, the *present* narrows, while the *future* becomes an endless horizon of obligations. As a result, one loses the sense of life as a process and experiences time as pressure rather than as a *gift*.

In this context, the therapeutic task is not to *organize the client's schedule*, but to *restore his or her inner time* – the capacity to be in synchrony with experience rather than in flight from it.

2.3. An Existential Perspective: Time and Meaning

Viktor Frankl (1946) associates the lack of time with the existential vacuum – a state in which one sees no reason to live and therefore tries to fill the emptiness with activity.

"As long as a person does not know why he hurries, he does not stop even when he has arrived," writes Frankl.

Thus, time becomes a substitute for meaning:

The faster one moves, the less one feels alive.

Irvin Yalom (1980) describes this experience as a form of existential escape – the fear of finitude masked by constant activity. Clients who say “I have no time” are often expressing “I am afraid to stop.”

Positive Psychotherapy integrates these existential insights by directing attention toward the meaning of slowing down:

“To stop does not mean to lose time – it means to recover it.”

2.4. The Five-Stage Model of Peseschkian as a Tool for Restoring Time

The Five-Stage Model – Observation, Inventory, Situational Encouragement, Verbalization, and Broadening of Goals – can be interpreted as five stages of *inner temporal awareness* (Table 2).

Table 2. The Five-Stage Model as a Process of Temporal Awareness

Stage	Temporal Function	Inner Experience
Observation and Detachment	Stopping / Sensing	“I notice that I am rushing.”
Inventory	Awareness	“What makes me rush?”
Situational Encouragement	Re-evaluation	“What is good in this speed?”
Verbalization	Sharing / Insight	“I can put into words what exhausts me.”
Broadening of Goals	New Rhythm	“I choose to live by my own clock.”

Source: Author's conceptual interpretation, based on Peseschkian's five-stage model (1987)

In the therapeutic process, *time* gradually transforms from an *external enemy* into an *inner teacher*. Clients begin to experience time as a *possibility for meaning*, not as a punishment for inefficiency.

2.5. The Role of Parables and Symbols

Peseschkian (2016b) often employs parables to help clients connect with an alternative sense of time. In parables, time is not linear but circular and symbolic. For example, the story of “*The Gardener Who Hurried His Flowers to Bloom*” illustrates that some processes cannot be accelerated without being destroyed. The parables referenced are either directly cited from Peseschkian or author-adapted for clinical illustration; adaptations are explicitly indicated.

For highly effective individuals, parables function as a therapeutic counterpoint – they slow down thought, awaken patience, and provide time for reflection. Through the symbol, the soul's rhythm is restored – the *time of contemplation* that modern humanity has lost. Time as a Mirror of Balance

In Positive Psychotherapy, time serves as a diagnostic indicator of balance:

- When a person has time only for *achievement*, he lives in the *future*.
- When he has time only for *contact*, he lives *for or through* others.
- When he has time for *meaning*, he experiences the *present*.

Therapy does not *add* time but transforms the *quality of experience*. It teaches clients to feel that “*time is theirs*” when they are in harmony with themselves.

Cases: The Five Faces of the Lack of Time

Case 1: Male, 50 – The Accelerated Time of Guilt

A successful entrepreneur, divorced, father of two adult children. The client describes his life as “constant running so I don't have to think.” He works 12 hours a day and cannot allow himself to rest. He feels guilty that his former partners were unhappy.

Manifestation of the temporal conflict: Time as punishment and escape. He cannot stop because stopping would mean facing his pain.

Interventions:

- During the *observation* stage, the therapist uses a linguistic image: “Are you running *from* something or *toward* something?”
- The parable “*Two Gardeners*” helps him realize that excessive care can suffocate life, just as care can kill love.

During *verbalization*, he formulates the insight: “*The more I hurry, the more time I lose.*”

Result: By the end of therapy, the client begins to experience guilt as part of his human sensitivity rather than as a debt. He restores his connection with his children and introduces “schedule-free Sundays.”

Case 2: Female, 55 – The Frozen Time of Joylessness

A university lecturer with a long career, living in a stable but emotionally poor marriage. She shares: “Time passes, but inside me it is empty and hollow – there is nothing.” She feels apathy and a lack of interest, even when she has free time.

Manifestation of the temporal conflict: Time as stagnation, loss of vitality. The past is “behind glass”; the future holds no attraction.

Interventions:

- During *observation*, she becomes aware that her *schedule is full (achievement)*, but her *heart is empty (contact)*.
- In *inventory*, the focus shifts to when she forgot joy, from whom she learned to neglect it, and how she brought that pattern into the present.
- The parable “*The Empty Jug*” evokes an insight: “*I keep pouring into others, but I’ve been empty for a long time.*”
- During *goal expansion*, she formulates: “*I want to feel time with my body, not only measure it.*”

Result: She regains interest in life, begins painting and traveling alone. She says, “*I have the same time, but now time has me too.*”

Case 3: Female, 60 – The Taken Time of the Devoted

A mother and wife who has spent her life serving others. She often says, “I have no time for myself.” She gives everything, yet feels lonely and unappreciated.

Manifestation of the temporal conflict: Time as sacrifice. All her time belongs to others; she herself is absent from her own life.

Interventions:

- During *observation*, she recognizes: “*My time is not my own.*”
- The parable “*The Handful of Rice*” illustrates that excessive giving leaves no room for gratitude.
- In *situational encouragement* is emphasized: “*Your desire to help is your love – but your time also deserves love.*”

- Task: dedicate 30 minutes daily as “*personal time*”, without guilt.

Result: After several weeks, she reports: “*I’ve started to see myself. The world didn’t collapse when I took a rest.*” She discovers a new rhythm – still helping, but now *present* in her own life.

Case 4: Male, 53 – The Draining Time of Disillusionment

An entrepreneur who says, “*Life is running out; success isn’t everything.*” He expresses cynicism and fatigue, often commenting that “women are freeloaders” and “people are worthless.”

Manifestation of the temporal conflict: Time as enemy. The past is a “mistake,” the future – a “loss of meaning.”

Interventions:

- During *observation*, the feeling of “draining time” is explored: what would happen if time were not an enemy but a teacher?
- *Situational encouragement:* The parable “*The Man Who Did Not Believe in the Sun*” helps him realize that when one closes the heart, days become dark.
- During *verbalization*, he formulates: “*Time does not take from me – I take from myself.*”

Result: He begins inviting friends over, cooks dinner for his loved ones, and finds joy in small moments. The phrase “*life is running out*” is rephrased as “*life is flowing.*”

Case 5: Female, 49 – The Controlled Time of Perfectionism

A business owner and mother of two children. She is convinced that if she is not everywhere, “everything will fall apart.” She lacks trust in others, sleeps 4–5 hours a night, and suffers from insomnia and chronic tension.

Manifestation of the temporal conflict: Time as control. She *holds* time instead of *living within* it.

Interventions:

- During *observation*, she articulates: “*I don’t live my life – I manage it.*”
- The parable “*The Stone and the River*” illustrates the strength of flexibility.
- In *situational encouragement*, the therapist highlights the positive intention: control is an attempt to ensure safety.

- Task: Delegate one task per week and observe the effect.

Result: After several months, she describes a feeling of lightness: “I learned to breathe between meetings.”

Time is no longer an enemy but an ally.

The parables cited in the following clinical cases are presented according to the author’s professional recollection and interpretative understanding of parables used in Positive Psychotherapy. They are not intended as verbatim quotations from sources.

The five cases delineate five ways in which people can lose their *inner time*, through:

- guilt,
- joylessness,
- devotion,
- disillusionment,
- control.

The common thread among them is the experience of *separation* – between action and presence.

Positive Psychotherapy demonstrates that time cannot be managed but can be *consciously experienced*.

At the moment a person understands the *meaning of the pause*, inner time is restored – and with it, the joy of living.

Discussion

Conceptual attribution note: The classification of conflict types, perceptions of time, and therapeutic focus represents an author-developed clinical synthesis within the theoretical framework of Positive Psychotherapy (Peseschkian).

4.1. Time as a Mirror of Inner Balance

In all five cases, the “lack of time” manifests as an *external expression of internal imbalance*. Whether the client hurries, freezes, gives, is disappointed, or controls, time has lost its human function: to create space for life.

Table 3. Types of Inner Conflict and Therapeutic Focus in Time-Related Experience

Type of Inner Conflict	Perception of Time	Main Therapeutic Focus
<i>Guilt</i>	Time as escape	Experience and forgiveness
<i>Joylessness</i>	Time as stagnation	Revival of sensibility
<i>Devotion</i>	Time as a sacrifice	Establishing personal boundaries
<i>Disappointment</i>	Time as an enemy	Restoration of trust
<i>Control</i>	Time as pressure	Resolving fear of loss

Source: Author-developed conceptual framework, based on clinical practise and Positive Psychotherapy principles (Peseschkian, 1987; 2016b)

Positive Psychotherapy suggests that when a client begins to perceive time as an ally rather than an enemy, inner peace is restored.

This occurs not by changing the schedule, but by changing the attitude towards oneself.

4.2. Mechanisms of change from “I have no time” to “I have a choice.”

The first step is realising that the lack of time is not an objective fact, but a subjective experience. Exploring what the client consistently prioritizes (work, care, control) reveals personal priorities and unconscious beliefs.

Thus, “I have no time” becomes “I choose not to allocate time,” thereby restoring authorship and responsibility.

Experiencing the pause as a therapeutic moment

For result-oriented clients, a pause often feels threatening. Peseschkian (1987) suggests introducing “positive pauses” – brief moments of silence, breathing, and awareness. When the client learns to “stop” internally, the ability to *experience time becomes possible rather than merely to measure it*.

Reframing success as an inner rhythm

Once the initial pressure subsides, the client discovers that true success is linked to rhythm rather than speed. The therapeutic task is to help

one find one's own pace – the tempo at which a person can live fully without losing oneself.

Symbolic experience of time

Parables and metaphors are key tools – they move the client from linear to symbolic time, in which not everything needs to be “achieved.”

For example, the parable “The Gardener and the Flower” shows that growth time differs from control time.

Psychological Effects of the Therapeutic Process

Applying the Five-Step Model results in:

- Reduction of internal anxiety and bodily tension,
- Increased capacity for enjoyment and gratitude,
- Better work-life balance,
- Enhanced tolerance for uncertainty and uncontrollable processes,
- Experiencing time as a source of meaning rather than a limitation.

As Peseschkian (2016b) writes: “Time is the art of being in your place.” The therapeutic process achieves exactly this – returning the person to their inner place in time.

Practical guidelines for therapists:

1. Use the client's language. If the client thinks in terms of “schedule,” “productivity,” “efficiency,” do not deny it. Gradually shift the conversation towards rhythm, breathing, and inner time.
2. Work with “temporal beliefs.” Explore messages the client has received:
 - “He who stops falls behind.”

- “Time is money.”
 - “Only the weak rest.”
- These beliefs are the root of a chronic lack of time.

3. Integrate bodily practices. Mindful breathing, micro-pauses, and walks help the client experience time through the senses rather than the mind.
4. Introduce “rituals of slowness.” Small daily actions – coffee without a phone, 10 minutes of silence before work, gratitude journaling – create inner time.
5. Encourage meaningful presence. Instead of “managing time,” the client can *sanctify it* – by attending to what is important, beautiful, alive.
6. Work with the paradox of time. The more a person accepts the limitations of time, the more freedom they experience. This is what existential wisdom therapy leads to.

Conclusion

“When a person has no time, he has actually lost himself in time.”

Peseschkian's words summarise the essence of modern man. Positive Psychotherapy does not offer another method of time management, but a path to restoring inner wholeness, from which the feeling of “time is enough” emerges.

For highly effective people, this is a revolutionary shift – from efficiency to presence, from doing to being, from schedule to meaning.

Therapy does not change the clock, but restores the inner rhythm.

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A View on Suicide Prevention from the Perspective of Positive Psychotherapy: Towards an Integrated Paradigm



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Abstract

Suicide is a profound indicator of personal and societal distress. This article argues that the limited effectiveness of existing prevention strategies largely stems from the dominance of a reductionist, biomedical paradigm that marginalizes the psychological dimension of human suffering. To address this gap, the article proposes integrating a salutogenic (health-oriented) approach with Nossrat Peseschkian's model of life balance as a methodological foundation for prevention. We contend that effective prevention requires a paradigm shift towards psychological health, the cultivation of a help-seeking culture, and the systematic integration of psychotherapeutic practices into general medical care. Practical recommendations are offered to bridge the current divide between biological and psychological approaches, advocating for a balanced, person-centered model.

Keywords: suicide prevention, Positive Psychotherapy, integrated treatment, salutogenic approach, life balance, psychosomatics, reductionism, existential loneliness, verbalization

Introduction

Even though suicide is a frightening, profound, and universally troubling issue that has accompanied humanity throughout its entire existence, no effective key to resolving it has yet been found. Broadly speaking, all existing views and approaches have not produced significant results. Perhaps they are inadequate, or perhaps they simply have not been widely disseminated or implemented. In any case, we are still in the stage of identifying valuable ideas that may later be implemented.

I would like to share my perspective as a practicing psychotherapist, informed by 28 years of clinical experience, including serving as head of a suicidology department and maintaining a private practice. This article is also a result of my preparation for an international conference on suicide prevention. I deeply believe that suicide prevention is a vital social and psychological issue, and current strategies require critical re-evaluation.

The core premise of this article is that the role of psychology in understanding and preventing suicide is significantly underestimated within the prevailing medical model. Considering that a substantial proportion of diseases and presentations in healthcare are psychosomatic in nature, psychology is central to their development and resolution. Unfortunately, modern medicine often views the human being primarily through a reductionist, biological lens, offering predominantly physical and chemical treatments. This fundamental gap between understanding disease and understanding the person leads to an underestimation of psychological individuality. While reductionism has been extraordinarily successful in combating infections and in surgery, it is catastrophically inadequate when dealing with existential pain and chronic distress, which are at the heart of suicidal crises.

Methodology

2.1. The persistent challenge of suicide and the need for a new perspective

Even though suicide is a frightening, profound, and universally troubling issue that has accompanied humanity throughout its entire existence, no effective key to resolving it has yet been found. Broadly speaking, all existing views and approaches have not produced significant results. Perhaps they are inadequate, or perhaps they have not yet achieved sufficient dissemination and practical implementation. In any case, we are still in the stage of searching for valuable ideas that may later be implemented.

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The core premise of this article is that the role of psychology in understanding and preventing suicide is significantly underestimated within the prevailing medical model. Considering that a substantial proportion of diseases and presentations in healthcare are psychosomatic in nature, psychology is central to their development and resolution. Unfortunately, modern medicine often continues to view the human being primarily through a reductionist, biological lens, offering predominantly physical and chemical treatments. This fundamental gap between understanding disease and understanding the person leads to an underestimation of psychological individuality. While reductionism has been extraordinarily successful in combating infections and in surgery, it is catastrophically inadequate when dealing with existential pain and chronic distress, which are at the heart of suicidal crises.

2.2. The psychological anatomy of suicidal despair

Suicide is always a tragedy. Underlying every suicide is profound suffering that often remains invisible. Suicide is an indicator of deep distress, and a high suicide rate in a country reflects serious societal dysfunction.

Let us look behind the façade of suicidal behavior. If we generalize, suicide emerges from

a very specific psychological state characterized by:

1. Unbearable suffering.
2. A sense of hopelessness.
3. Loneliness and isolation.

In other words, it is a state of deep crisis and despair. No matter how we classify it, suicidal behavior is perhaps the most dramatic cry for help. When a person decides to end their life, it means their loneliness has become far more excruciating than we imagined. This is not a poetic metaphor but a clinically and existentially accurate observation.

The Russian philosopher Nikolai Berdyaev once said: "A person never denies life itself; he denies the moment in life that makes it unbearable."

Loneliness here is an existential catastrophe, not merely the absence of company. Suicidal loneliness reflects the collapse of all meaningful connections that give life its sense. Suicide is seen not as a desire for death but as the only imaginable way to stop unbearable pain.

People do not begin thinking about death spontaneously. The decision forms slowly and agonizingly, permeating the entire consciousness. The individual remains in internal conflict for an extended period (Peseschkian, 1977; Shneidman, 1993).

Voluntary death is only the most vivid form of suicidal behavior. Drug addiction, alcoholism, risky behaviors, and gambling can also be understood as forms of self-destructive behavior or delayed suicide.

If we want to be effective in suicide prevention, we must stop viewing suicide as a single tragic point. We must see the entire life trajectory leading to that point. Addiction and risk-taking behaviors are suicide whispering, stretched over months and years.

Discussion

3.1. The therapeutic relationship and verbalization as core preventive mechanisms

Every psychotherapist knows that each disorder has its own dramatic history. When I meet a patient with suicidal tendencies, we begin to build rapport. As the patient gradually allows me into their experiences and personal narrative, trust grows, and self-disclosure deepens. Eventually, I gain the opportunity to see their subjective suffering, understand its roots, and uncover their active conflicts, family

concepts, and internal contradictions (Goncharov, 2024; Peseschkian, 1987; Wolberg, 1967).

Gradually, if all goes well, we discover new sources of support, build a new relationship with the self, and strengthen the personality by developing new qualities. Notice that all this becomes possible only through deepening our therapeutic relationship.

Everyone who practices psychotherapy knows that when everyday problems and conflicts are suppressed rather than spoken about openly, this leads to psychological and psychosomatic disorders. Silence is fertile soil for mental illness and psychosomatics (Peseschkian, 1987).

Essentially, this observation suggests that if people could openly share, speak, and seek help, many problems could be avoided. "One person reaching out to another for help is the greatest phenomenon in humanity," wrote Lewis Wolberg (1967, p. 242).

This is perhaps the most essential social skill we should teach children: "If you are struggling, ask for help." If children learn to seek help, we will solve half of their future problems immediately.

Thus, a key conclusion for prevention is that we need more psychological expertise. People must have both the opportunity and the willingness to talk about their problems.

Yes, talking is not yet a solution. But it is no longer a secret. It is pain that has been shared – and shared pain is half pain.

Verbalization is a form of psychological hygiene. Suppression is toxic. During both individual and group therapy sessions, I hear touching and dramatic stories and secrets. Often, people speak about something for the first time in 20–30 years. This is something they desperately need. Through this, they experience relief. We are full of secrets; some crush us, suffocate us, and prevent us from living. We need to address these secrets promptly. And doing so requires a safe, specialized environment – often through tears and pain – but it is necessary.

3.2. The crisis of the biomedical paradigm and the case for integration

I am a physician, but I believe that a human being is far more psychological than biological. Our ability to choose and make decisions is

psychological in nature. Behind every choice stand values.

Values are not universal; they are culturally conditioned. Cultural values are also psychological (Goncharov, 2024; Peseschkian, 1987).

Despite suicide being a socio-psychological problem, it is handled primarily by medicine. The issue is that biological medicine and psychological medicine still exist in parallel as competing concepts, with only a very formal dialogue between them.

The main achievement of modern medicine is pharmaceuticals. There are pills for everything. Medicine often views a person as though nothing beyond physical and chemical processes exists. Yet if we treat people only as physical bodies, we cease to perceive them as human beings. This model focuses on the objective qualities of the diseased organism but cannot grasp subjective individuality. Excluding the subject from medicine creates a background in which the patient's personality becomes invisible (Peseschkian, 1985).

We can describe Shakespeare's Hamlet at the physical-chemical level – ink on paper – or at the biological level – as visual perception. But such a description gives us nothing for understanding tragedy, conflict, or character. For that, we need literary analysis and psychology.

Medicine has achieved tremendous success in treating infections and surgical conditions, but has accomplished virtually nothing in treating chronic disorders. The prevalence of chronic illness continues to rise. Medicine offers effective solutions for acute problems but has little to offer in chronic ones. Chronic disorders are a way of life, and lifestyle is psychology.

Medicine still largely relies on the pathogenic approach – physicians understand pathology well but understand little about health. The salutogenic, health-oriented approach remains mostly theoretical rather than practical (Antonovsky, 1979).

3.3. Towards a balanced, integrated treatment model

It is crucial to clarify that critiquing biomedical reductionism does not dismiss biological factors or pharmacological treatments. In acute suicidal crises, medication can be life-saving by reducing overwhelming anxiety, agitation, or depressive psychosis, creating a

window of stability where psychotherapy can begin (Rutz, 2004). The problem is not biology itself, but the dominance of a purely biological framework to the exclusion of the psychological. Effective suicide prevention requires an integrated model where pharmacotherapy manages acute symptoms and biological vulnerabilities, while psychotherapy addresses the underlying psychological, existential, and relational causes of suffering. They are complementary, not competing, strategies.

3.4. The paradox of the physician: illustrating the system's failure

Let us look at physicians themselves. Today, doctors have access to the most advanced technologies, medications, and procedures. But does this make the physician population generally healthier than others? Obviously not. Physicians are certainly not champions of happiness. They, too, die by suicide. Worse, the risk is higher than in the general population.

Male physicians die by suicide 1.4–2.3 times more often than other men. For female physicians, the situation is even more dramatic: their suicide risk is 2.5–4 times higher than that of women in general. Medicine is one of the few professions where the suicide risk for women exceeds that for men.

In the United States, 300–400 physicians die by suicide each year – equivalent to losing an entire medical school annually (Davis et al., 2021).

This large 16-year study confirmed elevated risk and showed that physician suicide rates are about 32–40 per 100,000 – far higher than in the general population.

Why is this happening? Why do doctors not benefit from their advantages? Because over 80% of all diseases are psychosomatic, and over 90% of doctor visits are related to stress or psychology. Physicians are psychologically illiterate and trained only in biological symptom control. And they cannot help themselves.

But there is good news. According to a study on professional satisfaction, 99% of psychotherapists report that their work is meaningful and helpful. 95% are satisfied with their profession. 91% would choose psychotherapy again (Beerheide, 2018). German studies show that psychotherapists are the most satisfied professionals. Perhaps because psychotherapists can help not only clients but

also themselves. Psychotherapy is the only profession in the world in which personal development and internal harmony are mandatory components of training (Peseschkian, 2016).

Psychotherapy is a deeply human method. It leverages a person's strengths and helps them apply all available resources. A psychotherapist genuinely wants the client's life to improve. They study the client's life, identify what is not working and what should change, and explore how to make those changes.

A healthy therapist's personality helps restore the patient's personality, whose disorders are rooted in unhealthy relationships of the past. We build relationships that have healing power, offering love and acceptance (Goncharov M., 2014; Goncharov M., 2024; Гончаров М. 2024).

Of course, I am referring primarily to humanistic and psychodynamic methods, in which relationships are central, not to procedural approaches.

Psychiatric and psychotherapeutic education differ greatly. Psychiatric training centers around diagnosis, pathology, and treatment – highly academic and rational. Psychotherapeutic training emphasizes self-knowledge, relationship-building, emotional understanding, and personal harmony – the main working tool.

Positive Psychotherapy and the Life Balance Model: A Practical Framework for Prevention

Suicide prevention is complex and multifaceted. A comprehensive approach is essential.

Our task is to become a bridge across the abyss of loneliness – back to life, connection, and hope. The most powerful tool in prevention is not technique, but our humanity, our approach, and our personal example.

For effective suicide prevention, we may need to acknowledge the priority of the psychological over the somatic. Lifestyle – ultimately determining somatic health – depends on psychology. Prioritizing psychological health involves no risk.

Everyone knows the term iatrogenesis – harm caused by incorrect medical actions. However, we need salutogenesis – patients “catching” health from doctors. Physicians must themselves become examples of healthy living in every sense. This means doctors must be trained in life balance, well-being, conflict management, and

psychological competence – and apply these skills in their own lives.

All of this revolves around the concept of life well-being – the ability to initiate, maintain, and develop a high quality of life despite ongoing challenges. Well-being is, above all, a mindset, a life philosophy, a system of beliefs. It is a meaningful lifestyle filled with relationships, purpose, and care.

To achieve this, one can practice life balance. My dear teacher, Prof. Nossrat Peseschkian – German psychiatrist and psychotherapist of Iranian origin, founder of Positive and Transcultural Psychotherapy (1977) – said: “A healthy person is not the one who has no problems, but someone who can deal with them.” He developed a clear, simple, culturally sensitive model of four basic life spheres that underpin well-being.

These are the spheres of body/health, achievement/work, relationships/contact, and meaning/future (see Fig. 1) (Peseschkian, 1987). They encompass all fundamental human needs.

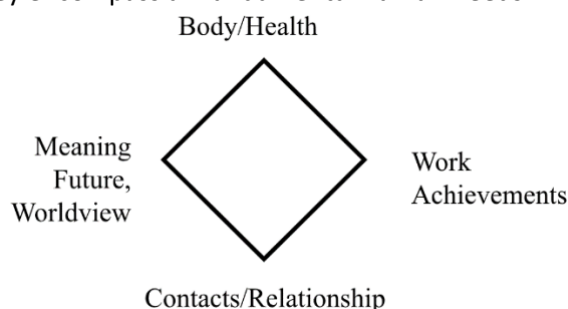


Figure 1. The Four Life Domains by N. Peseschkian (1987)

Put simply, to maintain a good quality of life, one must be able to:

- look and feel healthy, enjoy life, rest, and recover;
- be competent professionally and work within working hours;
- have a healthy social environment and maintain friendships;
- possess clear meanings, life goals, hobbies, passions, and sources of joy.

In other words, keeping all four life spheres in balance and harmony ensures well-being. Any long-term imbalance inevitably leads to problems in the deficient spheres (Goncharov M., 2024; Peseschkian, N., 2016).

The problem is that modern society is excessively focused on achievement. People tend to work too much and raise their children with the same value orientation.

Parents are often more concerned with academic performance than with their child's ability to form friendships, dream, or create. This leads children to build their self-esteem exclusively on achievements and to become psychologically dependent on them: “I must be strong and successful”; “I must solve my problems myself”; “To be loved, I must succeed.”

Such self-concepts lead to high stress, vulnerability, and dependency on achievement. Character deformation inevitably affects future quality of life. A child may learn to study or work well but remain unable to live fully, enjoy life, or find meaning beyond performance (Goncharov, M., 2024; Пезешкиан, Х., 1998).

Furthermore, to prevent the accumulation of psychological pain, children must be taught to build relationships and seek help when needed.

They must grow up with a sense of authorship of their own lives, in an environment that encourages and celebrates their creativity. This gives them an active, creative attitude toward life and the ability to overcome difficulties, fostering a sense of “I am not alone.”

Conclusion

Our task is not to wait until a person collapses under the weight of unspoken pain. We must build bridges across the abyss of their silence. We must create a culture in which caring for mental health and speaking openly about difficulties becomes the norm.

Verbalization is not just words. It is the act of giving form to the chaos of inner pain. It transforms toxic emotional energy into constructive dialogue (Goncharov M., 2024).

Adults must set an example for children by seeking help. It does not matter what problems you have – what matters is how you resolve them. Speaking about problems is a sign of strength and maturity, not weakness.

Given the high prevalence of psychosomatic disorders, psychotherapists – not enthusiasts but trained professionals – should consult patients more frequently, both at the nosological and pre-nosological levels.

Psychotherapy must be popularized. Visiting a psychologist or psychotherapist is as essential to health as visiting a dentist.

We must build a culture of seeking emotional help and make it as accessible as possible.

To translate this vision into practice, the following integrated recommendations are proposed:

1. Integrate Psychotherapeutic Principles into Medical Education: Training for all physicians must include core competencies in psychological self-care, life balance models (such as Peseschkian's), basic counseling skills, and recognition of psychosomatic distress. This aims to combat psychological illiteracy and enable doctors to model wellbeing.
2. Implement Systemic Psychotherapeutic Consultations in Primary Care: Make brief psychotherapeutic assessment and intervention a standard part of general medical practice to address problems early, reducing the path from psychological pain to somatic symptom or crisis.
3. Promote a Salutogenic Public Health Strategy: Shift public discourse and prevention programs from a purely risk-focused (pathogenic) model to one that actively promotes psychological skills: help-seeking, emotional literacy, conflict resolution, and life balance from childhood.

4. Foster Formal Collaboration Between Psychiatric and Psychotherapeutic Services: Develop clear clinical pathways that ensure patients receive combined pharmacological and psychotherapeutic treatment where indicated, based on a holistic, person-centered assessment.

5. Destigmatize and Normalize Psychological Help-Seeking: Public campaigns should frame engaging with psychotherapy as a proactive and wise investment in overall health, equivalent to maintaining physical fitness.

In conclusion, suicide prevention ultimately requires a paradigm shift from a reductionist, biologically-dominated model to an integrated, salutogenic one. By embracing the psychological essence of human suffering, leveraging the healing power of relationships and verbalization, and applying practical frameworks such as the life balance model, we can build a culture of connection that actively fosters resilience. The most powerful tool in prevention remains our collective humanity and our commitment to seeing the whole person.

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Transcultural Bridges: Traces of Positive Psychotherapy in the Verses of Aşık Veysel Şatıroğlu



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Abstract

This article aims to explore sections of the life of Aşık Veysel Şatıroğlu, an important 20th-century Turkish folk poet, and excerpts from his works, in line with the principles of Positive Psychotherapy. It will attempt to understand how Veysel, who lost his eyesight at a young age and struggled with various life difficulties, strengthened the bridge he built with society and himself by discovering a means of self-expression with the saz (a traditional Turkish stringed instrument) his father bought him, and how he conveyed deep meanings to the inner world of man with his works. Behind the process of coping with the difficulties Aşık Veysel experienced, there seems to be a powerful narrative that prompts us to question the nature of man and intersects with Positive Psychotherapy. By examining sections of Veysel's life and works, Positive Psychotherapy will be examined with respect to the body, success, relationships, and spirituality. An attempt will be made to understand how his story of self-discovery became a universal human narrative. An attempt will be made to transfer accumulated lives and values across cultures through transcultural transfer.

Keywords: Positive Psychotherapy, transcultural, Aşık Veysel

Introduction

The question “What is a human?” is undoubtedly as old as the history of humankind itself. The task of answering it has always fallen upon humanity. The definitions that have evolved through each era – whether emerging from institutions, philosophers, scientists, or

from an ordinary individual attempting to define themselves – raise a fundamental question: how far can we extend beyond these interpretations? This implies that the human being appears before us as an existence capable of defining itself, constructing its own meaning, or adhering faithfully to meanings ascribed to it.

In this article, we examine how the recollections and works of a 20th-century Turkish folk poet reflect the principles of Positive Psychotherapy. By drawing on excerpts from his artistic expressions, we attempt to interpret the meanings embedded in them and to assess the extent to which these resonate with the core dimensions of Positive Psychotherapy – namely, body, achievement, relationships, and spirituality. We seek to illuminate how the human struggle with life's difficulties, the quest for balance, and the search for meaning can be understood through these four dimensions, using the life and works of a single artist as a case study.

Aşık Veysel is a poet and minstrel deeply rooted in the Turkish cultural landscape. His poems, lyrics, and songs continue to live in the collective memory of many, shaping their thoughts and inspiring their actions. As an artist who successfully integrated his personal identity with that of his community, Aşık Veysel's works offer profound reflections on the essence of human existence, transcending his own era and attaining a sense of universality.

Some individuals can transform their personal experiences into sources of inspiration that extend beyond themselves, sharing them with others through a unique gift of expression. Through language, such expressions can even be transmitted across linguistic and cultural boundaries. If we were to call this a *cross-cultural bridge*, then our purpose here is to convey Aşık Veysel's cultural legacy to humanity through the lens of the Positive Psychotherapy framework. By examining the alignment between his worldview and the assumptions of Positive Psychotherapy, we aim to illuminate an inspiring narrative that addresses a central question in Positive Psychotherapy's transcultural perspective: What shared human commonalities unite us across cultures?



1.1. About the Artist

Aşık Veysel Şatıroğlu was born in 1894 in the village of Sivrialan, located in the Şarkışla district of Sivas, Türkiye.

Sivas is located in Türkiye's Central Anatolia Region; it is an area characterized by a predominantly rural structure, a lifestyle largely based on agriculture, and limited socioeconomic opportunities.

He came into the world in a poor farming family; his mother gave birth to him on her way back from the fields and cut the umbilical cord herself. During this period, smallpox was widespread in that region of Türkiye, and medical resources were scarce. Before Veysel's birth, his two sisters had already died of smallpox. When Veysel was seven years old, he too contracted the disease, losing sight in his left eye. Not long afterward, a cataract developed in his right eye, plunging him into the darkness that would accompany him for the rest of his life.

From that day until he died in 1973, Aşık Veysel lived without sight and faced numerous hardships throughout different stages of his life. His first child from his first marriage died from suffocation while breastfeeding; his wife later abandoned him for another man; his young daughter passed away at the age of one and a half. During the years when his peers were sent to war, he experienced deep sorrow for being unable to join the national struggle due to his blindness. He endured long periods of isolation, hardship, and emotional loss throughout his childhood and youth.

In his later life, through his second marriage, Veysel became the father of seven children. With the help of his eldest son, Ahmet Şatıroğlu, he received the physical and emotional support that enabled him to present his art to the public, share his music with broader audiences, and gain recognition for his work (Binyazar, 1971).

Discussion

2.1. The Four Dimensions of a Story

The Teacher Plays the Saz

At a wedding, Nasreddin Hodja was once handed a saz (a traditional Turkish string instrument) and asked to play. Before he could refuse, he found the instrument in his hands and began to play it. Without moving his fingers from a single fret, he strummed continuously.

Noticing that the sound did not resemble proper saz music, someone remarked:

– “*Hodja, that’s not how you play the saz! You must move your left hand – your fingers shouldn’t stay in one place.*” To which the Hodja replied:

– “*Those who don’t know how to play do that. They move their fingers to search for the right note. But as soon as I took the saz in my hands, I found the one I needed – so why should I keep searching?*”

(Şaşal, 2007)



Similar to the inner awareness implied in the Nasreddin Hodja narrative, Aşık Veysel Şatıroğlu – whose life will be examined in the following sections – discovered a unique internal source of expression and articulated his life experiences through it. This process is not an external search but an inner discovery formed through personal contact with and meaning-making within one’s own inner world.

*“I remember colors by their light.
I once saw black in a piece of coal,
and now only the light of that black remains
within me.”*

(Aşık Veysel Şatıroğlu, TRT Arşiv, 2016)

Every living being engages in a lifelong struggle against countless challenges. Although the number and nature of these challenges may vary, their impact can only be imagined through one’s own thoughts, emotions, and bodily awareness. Each person’s seemingly individual struggle inevitably reflects both the influences of their surroundings and the effects they, in turn, exert upon their environment. In this sense, coping and adaptation must be understood as multidimensional processes – ones that connect the individual with all forms of existence that affect and are affected by them.

At times, life’s difficulties accumulate gradually; at other times, they strike all at once – such as in the case of physical losses – that force the individual into a renewed and more demanding process of adaptation, both with oneself and with others. When Aşık Veysel lost his sight to smallpox, he was compelled to confront not only the physical consequences of blindness but also the emotional and existential transformations that followed. Those who know Veysel’s story often begin with this descent into darkness – but they always conclude with his enduring search for light.

In an interview, Aşık Veysel recalled that, after he lost his sight, his father did not wish him to remain isolated at home. Instead, he encouraged his son to attend weddings and social gatherings, believing that such participation might restore his sense of dignity and belonging. With this hope, he brought Veysel a *saz* (a traditional Turkish string instrument). This was not a random gesture – it was a conscious choice. Veysel’s father recognized his son’s sorrow, reflected on how he might positively influence his life, and decided to take an active step toward healing.

In the Anatolian regions of Türkiye, the *saz* is a widely used musical instrument, deeply embedded in local culture. His father’s choice, therefore, was not an arbitrary act but one rooted in cultural continuity and personal meaning. It could not have created talent where none existed, yet it represented a valuable attempt to awaken what was already latent within. This moment, seen as an act of compassion and insight, aligns closely with one of the foundational aims of Positive Psychotherapy – the *discovery of abilities* (Peseschkian, 2002).

Thus, the *saz* was not merely a musical instrument, nor was the father’s act solely an instance of parental care. Rather, it exemplifies how education, skill development, and emotional support must be approached from a multidimensional perspective – one that embraces the individual as a whole. The instrument that would later become Veysel’s means of communication with himself, his community, and the world can be understood as a symbolic manifestation of this encouragement of the discovery of ability. Through this process, Veysel established a form of self-expression that facilitated his adaptation to life and reinforced his sense of meaning.

In Positive Psychotherapy, one of the key elements that strengthens individuals' resilience toward life is the development of skills and the discovery of personal abilities. In Aşık Veysel's case, this discovery of talent clearly provided him with the strength to transcend his physical limitations and to reinterpret the concept of success in a way that diverged from societal expectations.

Veysel once said that he remembered colors "by their light." His words suggest that even in darkness, one can still find illumination. For any individual, this symbolizes the possibility of self-discovery through one's innate abilities and offers the hopeful message that finding such light can guide one's path through life.

Within the framework of Positive Psychotherapy, this corresponds to the concept of *hope* – the belief that every person possesses countless potential abilities, waiting to be recognized and nurtured. As Peseschkian (2020) emphasizes, therapeutic work should focus on strengthening the individual's realistic and resourceful aspects rather than dwelling on their deficits. Everyone carries within them lights of different colors; we cannot – and should not – attempt to change them by force. Instead, our task is to help remove the veil that obscures those lights and to witness their radiance as they emerge.

To My Saz

You are like a honeycomb, and I, Veysel, am the bee –

To you, I've whispered my hidden sorrows.

Together we've labored, weaving our honey,

Our hearts entwined in the sound we borrowed.

I worked, blending my voice with yours;

I am but a mortal, and you – a mulberry branch.

I rocked you in my arms as one would a child,

Forget not your master, as I forget not my father.

Remember my spirit, and never forget me.

– by Aşık Veysel Şatıroğlu (as cited in Kaya, 2011)

We are all existences that influence and are influenced within society, each playing different roles. Every individual possesses certain talents and potential. Some of us are educators, others parents, or psychotherapists. In all these roles, we must act with awareness of our influence on others – understanding that the candle we help

them light will, in turn, illuminate and warm us all (Peseschkian, 2020).

Peseschkian argues that a person's deepest talents resemble a black ant crawling upon a black stone – difficult to notice, yet containing immense potential. In this sense, we can see that with the support Veysel received, the talent he uncovered allowed him to transcend his physical limitations, transforming him into a source of inspiration. Through the act of creation, he found his own meaning and established stronger bonds with society.

*It melts the stone and turns it to soil,
Bears fruit, blossoms, and the tender leaves toil.
It shields the living from countless pains,
Look at the forest – life's breath remains.*

It gave the sheep, the lamb, the milk's white gleam,

It gave us our food, our bread, our fleshly dream.

When struck not with the mattock, it turned so mean

– *My faithful beloved is the black earth serene.*

– by Aşık Veysel Şatıroğlu (as cited in Kaya, 2011)

Throughout his life, Aşık Veysel lived in close harmony with nature. Both his upbringing in a farming family and his inner cultivation of this bond reveal how profoundly his relationship with nature is reflected in his works. He often expressed his gratitude for nature's healing power and the blessings it bestows upon human life. Within the framework of Positive Psychotherapy, this perspective further highlights the importance of increasing an individual's awareness of their body and overall health.

Positive Psychotherapy emphasizes that enhancing individuals' awareness of their own bodies and adopting a healthy lifestyle are crucial for improving general well-being (Peseschkian, 2020). In Veysel's life, it is evident that working with the soil held a central place among his endeavors. He is known as the person who introduced fruit orchards to his village. In an interview, his son Ahmet Şatıroğlu stated:

"Our village had fertile land, but the water used to flow away unused, and there was not a single tree planted along the waterway. My father established a garden under these conditions. At first, many laughed at him, but once the garden started producing fruit, everyone took him as an example" (Öz, 2013).

This narrative demonstrates that Veysel discovered and lived a meaning that encompasses multiple dimensions. This demonstrates that interconnected life dimensions should not be understood in isolation but rather approached holistically.

Our relationship with nature mirrors our relationship with ourselves, with others, and with our spirituality. Veysel's reciprocal engagement with nature provided him with profound insights that contributed to both his personal sense of meaning and to the shared human experience. His connection with the land can be seen as fostering physical well-being through labor, generating a sense of accomplishment and unity, and integrating his beliefs and values with the natural world, thereby cultivating a deep, interconnected bond. The emphasis Veysel placed on the soil serves as a didactic illustration. In this way, his life and practice exemplify how engagement with nature and culture can reinforce human resilience, meaning-making, and holistic well-being.

*"When I look to the sky, I breathe in the air;
When I look at the soil, I receive a prayer.
You are like the tree, and we are the leaves
upon its branch;
You are the seed within the fruit – forever
there."
(Kaya, 2011)*

*If you work the soil, it yields generously.
To demand without effort is a remedyless
hardship.
Labor brings great wealth to a person,
The purse overflows, the heart overflows, the
hand overflows.
If you seek truth, there is an open point.
God is near to the servant, and the servant is
near to God.
The hidden treasure of the Divine lies in the soil.
My faithful beloved is the dark earth.
– by Aşık Veysel Şatıroğlu (as cited in Kaya,
2011)*

Veysel's engagement with the soil, his love for nature, and his culturally enriched perspective enabled every action he took to support both his physical and psychological well-being, while also allowing him to perceive his own meaning within the whole. The awareness frequently observed in his works demonstrates that such engagement is a profound resource for

understanding and interpreting both themselves and their environment.

*I was a child when my mother guided me,
Urging me to read and work diligently.
"Be devoted to your people," she would say,
And instilled in me a love for the homeland.
Do not be fooled by the empty words of the
ignorant.
The ashes of a cultureless person are but lies.
Even if one rules across the world,
Without wisdom, their desires, goals, and path
are false.
– by Aşık Veysel Şatıroğlu (as cited in Kaya,
2011)*

Positive Psychotherapy approaches an individual's life through modeling dimensions: body, achievement, relationships, and spirituality.

Within this balance model, establishing harmony across these four dimensions is essential for individuals to cope with daily challenges and maintain psychological well-being. The body dimension encompasses physical needs and health; the achievement dimension involves mental effort and productivity (Peseschkian, 2020); the relationships dimension includes social bonds and cultural interaction; and the spirituality dimension refers to one's connection with personal meaning and values. When balance is achieved among these four areas, individuals can maintain both health and productivity. In Veysel's life, these dimensions can likewise be observed as integrated and inseparable rather than distinct and independent.

The notion that children receive their first education from their family can be illustrated by the verse, "*anam bana ders verdi*" ("my mother gave me guidance"). Children establish their initial social and emotional foundations through their primary environment – their parents. The transmission of values such as the importance of diligence and learning, love for the homeland, and a sense of responsibility aligns with the modeling dimensions, as observed in Veysel's life.

Veysel repeatedly emphasizes how his mother "dressed" him in love and responsibility, including the cultivation of cultural and universal values. The consistent repetition of these teachings is essential for internalizing such competencies. Positive Psychotherapy also acknowledges that individuals are profoundly

shaped by the cultural and social environment in which they live. This connection provides a foundational context in which they can more effectively explore and discern their own meaning (Peseschkian, 2020).

In many of his verses, Veysel reflects the universal themes of unity and humanistic purpose that he calls his “humanity mission,” emphasizing that these principles were instilled in him from an early age by his family. In his works, Veysel creates a sense of meaning that integrates the dimensions of achievement and spirituality. He underscores that labor and productivity are not solely for personal gain but should be undertaken with a consciousness of benefiting all living beings.

In the same interview, Veysel shares a recurring piece of advice he gave to his children: that his grave not be made of cement and that the cycle of life continue to provide – the ewe giving milk, the bee producing honey – so that the world benefits from all living creatures. Even after his death, through both his works and the physical presence of his body no longer in service, Veysel exemplified a commitment to usefulness, a profound sense of interconnectedness, and awareness of the eternal cycle of life. These principles reflect the essence of Positive Psychotherapy: the integration of personal meaning, relational consciousness, and the responsibility to contribute positively to the wider world.

*There will come a time when my body returns to the soil,
Blending with the earth, turning into dust, and vanishing.
Once I merge with my essence and become part of the soil,
I shall bloom as a flower and adorn my own grave.
– by Aşık Veysel Şatıroğlu (as cited in Binyazar, 1971)*

Every tree undergoes a process before bearing a mature fruit. It experiences various struggles, adaptations, and harmonies with nature. One day, a living being tastes that fruit and recognizes its ripeness and flavor. In this way, the tree simultaneously establishes a connection with another, is noticed by another, and provides benefit to another. In Aşık Veysel’s verses, we sense this same dynamic: the effort, acceptance, and adaptation that culminate in

something beneficial for others. From his stories, we derive insight; from his words, we gain inspiration.

Positive Psychotherapy emphasizes that the bonds individuals form with others are crucial for well-being. A balanced relational dimension is essential for emotional health. This is not limited to interpersonal relationships; it also reflects our relationship with ourselves and with nature. The approach highlights the importance of treating others with kindness and respect, of approaching conflict with understanding rather than confrontation. In many of Veysel’s poems, we observe his emphasis on friendship, empathy, and the value he places on human relationships – a stance that is also deeply rooted in traditional social teachings.

The collective structure of Turkish society, its ethos of loyalty (vefa), and rituals that sustain social relations reinforce these connections, transforming them into a sense of strength that enhances individuals’ capacity to cope with life’s challenges. Positive Psychotherapy similarly posits that bonds with others – nurtured both through cultural traditions and through deep connections with all living beings – contribute significantly to psychological well-being and resilience (Peseschkian, 2020).

*You have hurt no one,
Broken no heart, and harbored no grudges.
You have not forgotten your friends –
Can friends forget you?
Why are your eyelashes wet with tears again?
My friend, why are you dressed in black?
The dew upon your face, like a fallen rose,
reveals it all:
This sorrow is what wounds your heart.
– by Aşık Veysel Şatıroğlu (as cited in Binyazar, 1971)*

Conclusion

Aşık Veysel was once asked, “Master, what have you understood from the world?” He replied: “Imagine walking through a marketplace on a Sunday, buying three meters of cloth and leaving. You open your eyes – they say ‘born’; you close your eyes – they say ‘dead.’ They call this blink of an eye ‘life.’” Human beings embark on a journey between birth and death. Throughout this journey, they encounter countless events, endure suffering, experience joy, navigate a range of emotions, and grapple

with diverse thoughts. Ultimately, the window of this world closes for each individual.

Some people are remembered for what they give while alive and for the legacies they leave behind. They continue to exist in the minds and hearts of others. Aşık Veysel is a prominent figure in Turkish society. Through his life story, we are nourished, inspired, and guided; his words and music illuminate our paths and warm our hearts.

Every culture likewise has its heroes – individuals who have served their land, contributed to their society's cultural heritage, and carried communal values into universal principles. Transforming their stories into narratives applicable to therapeutic contexts, benefiting from them, and sharing this collective heritage inspire all.

Finally, in the references section, we find the original version of one of Aşık Veysel's songs, as well as its English and Russian translations; in this way, we can also encounter and experience his music through the transcultural bridge we are trying to build.

I am on a long, narrow path,

Walking day and night.

I do not know my state,

Walking day and night.

When contemplated deeply,

It appears distant, vast.

The path, even for a single moment,

I walk, day and night.

– by Aşık Veysel Şatıroğlu (as cited in Binyazar, 1971).

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Use of Positive Psychotherapy in Group Work with School Students: School Club "Communication Laboratory"



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Abstract

The article discusses the practical application of Positive Psychotherapy (PPT) in a school environment, illustrated by the work of the school club "Communication Laboratory." The group aimed to improve social skills and self-awareness in adolescents, support their development, help them overcome obstacles more easily, and expand their networks. The approach shifts from a traditional model of "giving ready-made advice and recipes" to one that fosters self-awareness, develops communication skills, and supports personal development. The article details the exercises, tasks, stories, and parables used in each stage of the PPT process. Through interactive exercises, students were guided to recognize their own qualities and emotions, practice empathy, and strengthen their resilience. The club fostered a sincere and supportive environment where participants assumed responsibility for themselves and their relationships. The most significant outcome was that, despite individual differences, students improved their peer interactions, began resolving conflicts through dialogue rather than confrontation, and gained confidence in their social relationships. Thus, the group became a supportive refuge contributing to their daily mental well-being.

Keywords: Positive Psychotherapy, school, school club, group work, adolescents, self-awareness, communication, self-help

Introduction

Even though suicide is a frightening, pro"If you give someone a fish, you will feed them for a day. If you teach them how to fish, you feed them for a lifetime," - Oriental wisdom. (N. Peseschkian, 2008)

In educational support, two primary models exist. The first involves providing ready-made solutions and services, where help is defined as giving the recipient what they need at that moment. The second involves partnering with and empowering the person so that they can address the problem themselves. Positive Psychotherapy (PPT) aligns with the latter, embodying the metaphor of the "fisherman" who teaches fishing rather than merely providing fish (N. Peseschkian, 2008).

Group work is a suitable form of training for young people. Social-psychological training is an active method for enhancing interpersonal communication and self-realization. It provides

opportunities for sharing, discussion, and reflection on young people's interactions within the school context. The goals include modifying personal attitudes, developing communication skills, shaping self-image, and influencing behaviour and knowledge. The specifics of development at this age need to be taken into account. Young people become particularly sensitive to their "internal" psychological problems. Limited life experience, on the one hand, and high personal activity, on the other, give rise to instability and intense internal tension. Adolescent instability is inherent to this developmental stage and reflects the need to explore new areas of activity. Self-discovery, social self-determination, and self-assertion, irrespective of individual characteristics, are common characteristics of teenagers.

In his book "Der nackte Kaiser" (N. Peseschkian, p. 168, 2011), Nosrat Peseschkian argues that the upbringing of children is not only the role of parents, but of all the people they

somehow interact with and who therefore exert a lasting influence on them, consciously or unconsciously. In social environments, children learn to manage their responsibilities, their performance, and their interactions with others. Teaching children to know themselves is a crucial component of child-rearing. By knowing themselves better, they can develop different strategies to cope with the problems and surprises in their lives.

Methodology

Positive Psychotherapy can be applied in various educational settings and can help both students and teachers better cope with the challenges of the educational process and its associated interactions. Groups can be organized around the four dimensions of PPT (N. Peseschkian, 2000):

Body: Groups focusing on health, self-esteem, and sensitivity.

Activity: Groups addressing behaviour, planning, and information processing.

Contact: Groups aimed at expanding communication skills.

Future: Groups exploring purpose, creativity, and imagination.

Effective group work requires clear motivation and organization, with goals encompassing meaning, future orientation, time

management, contact building, trust, faith, hope, and cultural awareness.

Guiding principles include: (1) Structure and Order (clear rules and setting); (2) Focus on opportunities (reliability, resourcefulness); and (3) Leadership/Group Management (courtesy, openness, fairness, agree upon norms, group size – open or closed).

Each group addresses emotional-social aspects and tasks, utilizing opportunities to build connection (ability to love) and foster knowledge in four areas: (1) one's own behaviour (self-knowledge); (2) the behaviour of one's partner, the couple formed; (3) social behaviour (of the group society); (4) spiritual/ worldview behaviour.

Correspondingly, groups have content aspects and utilize opportunities to acquire knowledge related to the body, partner behaviour, social behaviour, and worldview behaviour (Boncheva et al., 2021).

My role as a high school psychologist allows me to use PPT methods and tools with diverse students in themed focus groups.

One such group, named the "Communication Laboratory" (Area-Contact), consisted of 10 students (five girls, five boys) aged 14-15 from different classes. The intervention employed age-appropriate game models, parables, fairy tales, and exercises. The program structure is summarized in Table 1.

Table 1: Structure of the "Communication Laboratory" Program Based on PPT Stages

PPT Stage	Session Focus & Key Activities	Examples of Exercises & Tools
1. Observation – Distancing	Building group cohesion, establishing rules, and initial self-reflection.	Icebreakers ("Who likes pizza?"), Group rule creation, Exercise "Who am I?" (name + positive quality), Parable: "The Crow and the Peacock" (N. Peseschkian, 2008).
2. Inventory Taking	Self-assessment, identifying personal resources and abilities.	Homework: "20 Positive Qualities" ("20 Point Feathers"), Completion of the Differentiation-Analytical Inventory (DAI/DAI 2) (I. Boncheva et al., 2021), Exercise: "The Magic Shop" (G. Gercheva-Nesterova et al., 2017).
3. Situational Encouragement	Experimenting with and reinforcing identified abilities in a safe setting.	Small group work discussing chosen abilities from "The Magic Shop", using stories (e.g., "Little Red Riding Hood" for Trust).
4. Verbalization	Articulating personal challenges and exploring alternative behaviours.	Pair/Trio discussion of situations from the DAI 2, Analysis of developed/underdeveloped abilities.
5. Expanding the goals	Translating insights into actionable plans and broader life application.	Exercise: "Advertising Yourself" (G. Gercheva-Nesterova et al., 2017), which discusses self-help strategies and planning for integration into other school clubs.

2.1. Program Description and Key Techniques

1. Observation-Distancing

The first stage focuses on creating a safe and structured environment. Sessions began with warm-up exercises (e.g., greeting everyone with a handshake) and icebreaker questions to foster connection. The group collaboratively established rules (e.g., active listening, no interrupting, and a nonjudgmental attitude). The core tasks of self-awareness and contact expansion were introduced, with visual support provided by an explanation of the PPT model (the "balance model"). A central activity was the "Who am I?" exercise, in which participants introduced themselves by stating their name and a positive quality. The session included reading and discussing the parable "The Crow and the Peacock" (N. Peseschkian, 2008, p. 143), which illustrates how envy and focusing on others' perceived advantages can obscure one's own unique qualities. The "20 Positive Qualities" (or "20 Point Feathers") exercise, assigned as homework, required students to list 20 positive traits about themselves, challenging self-critical tendencies and fostering a focus on personal resources.

2. Taking Inventory

This stage facilitated deeper self-assessment. The homework was reviewed, with discussion of difficulties and feelings associated with identifying positive traits. Participants then completed the Differentiation-Analytical Inventory (DAI/DAI 2) (Boncheva et al., 2021), a PPT-based tool for assessing capacities in areas such as contact, patience, trust, and order. The results were presented as reflective insights rather than absolute measures. Subsequently, the "Magic Shop" exercise (Gercheva-Nesterova et al., 2017, p. 83) was conducted. In this imaginative game, participants could "trade" less developed abilities for more desired ones (e.g., trading "punctuality" for "more spontaneity"), symbolically exploring personal change and responsibility.

3. Situational Encouragement Participants worked in small groups or pairs to elaborate on the abilities they "acquired" in the "Magic Shop." They read and discussed short therapeutic stories linked to specific abilities (e.g., a story about "politeness"), supporting the understanding of abstract qualities into relatable narratives and reinforcing their development in

a supportive peer setting. Feedback in the large group at the end of the session.

4. Verbalization

Students returned to their DAI 2 forms in pairs or trios. They chose one challenging situation they had noted and analyzed it together: What did it mean to them? Which abilities were involved? How could they respond more effectively? This promoted articulation of difficulties and collaborative problem-solving.

5. Expanding the goals

The final stage focused on integrating the learning. The exercise "Advertising Yourself" (Gercheva-Nesterova et al., 2017) required each participant to create a creative "advertisement" highlighting their capabilities and knowledge about themselves. The group discussed concrete self-help strategies derived from their experiences and explored opportunities to expand social contacts by joining other school clubs.

Discussion

Every psychotherapist knows that at the beginning of the meetings, participants are timid in their interactions with peers. They expressed a desire for better self-understanding and improved communication, but lacked the tools. The structured progression through the five stages of PPT provided a safe environment for exploration. The results, based on participant feedback and observation, showed several positive outcomes:

- Enhanced Self-Awareness: Students reported a clearer recognition of their strengths and areas for growth through exercises like the "20 Positive Qualities" and DAI.
- Improved Communication Skills: The group environment and specific exercises (e.g., verbalization in pairs) practiced empathy and active listening.
- Increased Social Confidence: By the program's end, all participants had joined other school clubs, reporting feeling more confident in social settings.
- Desire for continued self-knowledge: Three students sought further individual sessions for self-discovery.

Group work confirmed that the five steps of Positive Psychotherapy are appropriate for teenagers. The use of parables and various exercises successfully reduced students'

defensive reactions. However, several challenges were noted. The small group size, although ideal for interaction, limits the generalizability of the results. Assessment was largely subjective, relying on the facilitator's judgment and observation. There were no standardized pre- and post-test measures, nor was there a control group. Some students initially struggled with self-disclosure, and the success of the exercises depended largely on individual commitment and imagination.

Future implementations would benefit from a mixed-methods approach that includes validated psychological scales (e.g., self-esteem, communication competence) to objectively measure change. Research could compare PPT-

based groups with other intervention models or examine their long-term effects.

Conclusion

Positive Psychotherapy provides practical tools to help students discover their "peacock feathers" – their unique strengths – and learn to "fish" – develop self-help competencies. The "Communication Laboratory" demonstrated that PPT can be effectively integrated into school settings, offering a structured framework for preventive work that enhances adolescents' self-knowledge, resilience, and social-emotional skills. By moving beyond merely providing solutions to foster empowerment, this approach contributes meaningfully to a school's supportive system.

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Теоретичні аспекти та розвідки впливу соціальних мереж на комунікаційний складник особистості підлітків

Theoretical Aspects and Research on the Influence of Social Networks on the Communication Component of Adolescents' Personalities



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Анотація

Дослідження присвячене теоретичному осмисленню впливу соціальних мереж на комунікаційний складник особистості підлітків. Актуальність теми зумовлена посиленням цифровізації соціального середовища, де онлайн-взаємодія стає ключовим ресурсом розвитку міжособистісних навичок та саморозкриття. Теоретичний огляд базується на моделях соціального порівняння, компенсації соціального дефіциту та використання медіа як ресурсу. Це дозволяє систематизувати знання про механізми впливу цифрової активності на емпатію, асертивність і рівень комунікаційної компетентності. Метою статті є теоретичне осмислення впливу соціальних мереж на розвиток комунікаційного складника особистості підлітків у контексті психологічного благополуччя. Методологічною основою є принципи позитивної психотерапії Н. Пезешкіана, які дають змогу розглядати цифрову взаємодію як простір формування балансу між основними сферами життєдіяльності особистості – тілесною, діяльнісною, комунікативною та смисловою. Використано методи теоретичного аналізу, порівняльного узагальнення та міждисциплінарного синтезу. Результати аналізу свідчать, що залежно від рівня усвідомленості та способу використання соціальні мережі можуть бути як ресурсом розвитку комунікаційних навичок, так і чинником емоційного виснаження. У висновках окреслено психолого-педагогічні умови формування здорової цифрової взаємодії та напрями подальших емпіричних досліджень.

Ключові слова: соціальні мережі, комунікаційні навички, підлітки, міжособистісна комунікація, цифрова взаємодія

Abstract

The study examines the theoretical impact of social networks on adolescents' communication component of personality. The topic is relevant given the increasing digitalization of social environments, in which online interaction is becoming a key resource for developing interpersonal skills and self-disclosure. The theoretical review is based on models of social comparison, compensation for social deficits, and the use of media as a resource. This allows us to systematize knowledge of the mechanisms by which digital activity influences empathy, assertiveness, and communication competence. The purpose of the article is to theoretically examine the impact of social networks on the development of adolescents'

communication component of personality in the context of psychological well-being. The methodological basis is the principles of Positive Psychotherapy articulated by N. Peseschkian, which allow us to consider digital interaction as a space for balancing the main spheres of a person's life – physical, activity, communication, and meaning. Methods of theoretical analysis, comparative generalization, and interdisciplinary synthesis were used. The results of the analysis show that, depending on the level of awareness and their use, social networks can be both a resource for developing communication skills and a source of emotional exhaustion. The conclusions outline the psychological and pedagogical conditions for the development of healthy digital interactions and provide directions for further empirical research.

Keywords: social networks, communication skills, teenagers, interpersonal communication, digital interaction

Вступ

Сучасне інформаційне середовище характеризується глибоким зануренням особистості у сферу соціальних мереж, які сьогодні стали повноцінним простором соціальної активності, самовираження та експериментів з ідентичністю. Вони впливають на формування уявлень про себе, на спосіб взаємодії та навіть на емоційні реакції, що визначають стиль міжособистісного спілкування.

Актуальність теми зумовлена тим, що цифрові платформи сьогодні виконують функції, які раніше належали сім'ї, школі чи одноліткам. Особливо чутливою до цих змін є молодь, для якої віртуальний простір стає головним середовищем соціалізації (Lyuga, 2022). Зміщується баланс між офлайн- і онлайн-взаємодією, що породжує питання: наскільки цей вплив конструктивний і чи не підміняє він реальну комунікативну компетентність і соціальну чутливість?

У контексті позитивної психотерапії цифрова взаємодія може або підтримувати внутрішню гармонію, або, навпаки, створювати дисбаланс між сферою «Контакти» та іншими аспектами життєдіяльності – тілесним, діяльнісним, смисловим та часовим.

Зміни в цифровому середовищі впливають не тільки на кількість і швидкість комунікацій, а й на їх якість. Онлайн-взаємодія, побудована на миттєвих реакціях, сприяє формуванню короткочасних соціальних зв'язків і зниженню емпатійності. У молодіжному середовищі це проявляється у зменшенні глибини діалогу, труднощах у розпізнаванні невербальних сигналів, зниженні здатності до довготривалої взаємодії.

Такі трансформації мають безпосередній вплив на розвиток особистості, зокрема на її

здатність до самопрезентації, емпатії та критичного мислення.

Сучасна наука ще не має цілісної теорії впливу соціальних мереж на комунікаційний складник особистості підлітків. Недостатньо вивчено й взаємозв'язок між активністю у соцмережах та реальними міжособистісними навичками. Натомість більшість праць зосереджується на ризиках або можливостях онлайн-спілкування (Orben & Przybylski, 2019).

Метою цієї статті є теоретичне осмислення впливу соціальних мереж на комунікаційний складник особистості підлітків та окреслення перспектив подальших емпіричних досліджень. Особлива увага зосереджена на аналізі взаємозв'язку між рівнем активності підлітків у соціальних мережах та розвитком їхніх комунікаційних характеристик, що має значення для розуміння сучасних процесів соціалізації та побудови ефективних стратегій цифрової грамотності.

Методологія

Соціальні мережі стали невід'ємною частиною сучасної комунікативної екології, яка формує нові типи взаємодій, способи сприйняття інших людей та розуміння себе. Якщо раніше поняття «комунікація» асоціювалося переважно з живим спілкуванням, то тепер воно охоплює ширший спектр – від коротких текстових повідомлень до створення персоналізованих візуальних образів, спрямованих на публічне самовираження. У цьому сенсі медіасередовище є не лише технічним інструментом, а культурно-психологічним простором, де відбувається активна взаємодія індивідуального і соціального (Луценко & Григор'єва, 2024). Вони поєднують елементи соціальної психології, медіакомунікації та інформаційних технологій,

створюючи гібридну систему обміну змістами, емоціями та соціальними сигналами.

Поняття «соціальна мережа» охоплює структуру зв'язків між людьми, які підтримуються за допомогою цифрових платформ. Ці зв'язки не обов'язково є сталими або глибокими, однак вони визначають спосіб, у який індивід орієнтується у соціальному просторі. У цьому полягає особливість сучасної комунікативної екології: межа між особистим і публічним, приватним і спільним розмивається, а кожен користувач отримує можливість формувати власний комунікативний осередок (Петенок, 2024). Саме тому вивчення соціальних мереж не може обмежуватися лише технологічним аналізом – воно потребує психологічного та соціокультурного підходу, що дасть змогу оцінити, як цифрові взаємодії впливають на особистісну структуру комунікації. У цьому контексті теоретичний огляд також спирається на принципи позитивної психотерапії, запропоновані Н. Пезешкіаном. Його концепція сфер балансу («Тіло», «Діяльність», «Контакти», «Сенси») дозволяє більш цілісно осмислити феномен цифрової взаємодії, розглядаючи її не лише як технічну або соціальну активність, а як елемент особистісного розвитку (Peseschkian, 1987). Соціальні мережі можуть бути не лише каналом обміну інформацією, а й інструментом відновлення чи порушення внутрішнього балансу індивіда.

Комунікаційний складник особистості охоплює сукупність психологічних якостей, навичок і установок, що забезпечують ефективну взаємодію з іншими людьми. Її структура містить кілька ключових елементів: здатність до міжособистісної комунікації, саморозкриття, емпатійність та асертивність. Міжособистісна комунікація – це не лише процес передачі інформації, а й механізм взаємного розуміння, де важливим є вміння слухати, реагувати і зберігати баланс між власними потребами та очікуваннями партнера. Саморозкриття відображає готовність особи ділитися особистими думками, почуттями та особистим досвідом, що створює основу для довіри і психологічної близькості (Valkenburg & Peter, 2011). Емпатія як здатність до емоційного співпереживання виступає головним чинником, що підтримує стабільність комунікативних зв'язків. Своєю чергою асертивність забезпечує вміння

відстоювати власну позицію без агресії та з повагою до іншого.

Проте розвиток цих якостей у цифровому середовищі набуває нових форм. У соціальних мережах відсутні звичні невербальні сигнали, а комунікація відбувається у візуально-текстовому форматі, що змінює сам характер сприйняття. Виникає феномен «публічного саморозкриття», коли людина ділиться інформацією не лише з близьким колом, а з невизначеною аудиторією, що може впливати як на почуття автентичності, так і на потребу в соціальному схваленні (Song et al., 2014). Таке розширення меж комунікаційного простору підсилює прагнення до самопрезентації, але водночас ускладнює глибинне емоційне спілкування.

Механізми впливу соціальних мереж на комунікаційний складник особистості можна поділити на кілька напрямів. Перший – це тип залучення до цифрової взаємодії: активне чи пасивне використання. Активне використання передбачає ініціативну участь у комунікативному процесі: створення контенту, написання коментарів, спілкування у чатах. Воно сприяє розвитку соціальної компетентності, оскільки передбачає рефлексію, обмін думками і формування власної позиції (Bozzola et al., 2021). Пасивне використання, навпаки, зводиться до перегляду стрічок новин і спостереження за іншими без активної участі. За дослідженнями А. Орбен та А. Пшибицькі, саме пасивна взаємодія часто пов'язана з відчуттям соціальної ізоляції, порівнянням себе з іншими та зниженням рівня емоційного благополуччя (Orben, & Przybylski, 2019). Таким чином, характер активності в мережі є визначальним фактором для розуміння, чи стає цифрове спілкування ресурсом розвитку чи джерелом психологічного виснаження. Важливим є й те, що позитивна психотерапія розглядає процеси самопізнання та рефлексії як ключовий шлях відновлення балансу між всіма сферами життя. Активність у соціальних мережах, якщо сприяє усвідомленому саморозкриттю та розширює комунікативні можливості, може виконувати терапевтичну функцію – зміцнювати здатність до емпатії, саморегуляції та внутрішньої стабільності.

Другий напрямок – цифрова самопрезентація, що створює нову форму соціальної ідентичності. У віртуальному просторі особистість виступає водночас і як

автор, і як об'єкт сприйняття, формуючи образ, який може відрізнятися від реального «Я». Це породжує феномен соціального порівняння – постійного зіставлення себе з іншими користувачами, яке може мати як мотиваційний, так і деструктивний вплив (Alluhidan et al., 2024). Коли людина сприймає соціальні мережі як арену змагання, її комунікаційна поведінка стає спрямованою не на транслювання особистої думки чи позиції, а на підтвердження власної значущості. Натомість ті, хто використовує соцмережі для підтримання контактів, отримують більше позитивних емоцій та відчуття спільності (Lyyra et al., 2022).

Третій напрямок пов'язаний із взаємодією онлайн- і офлайн-комунікацій. Дослідження показують, що активне онлайн-спілкування не завжди замінює реальні соціальні зв'язки, проте може модифікувати способи їх підтримання (Kuss & Griffiths, 2011). Онлайн простір часто стає інструментом збереження існуючих офлайн-відносин, але у деяких випадках вони формують нові, суто віртуальні спільноти. Питання полягає у тому, наскільки такі зв'язки сприяють розвитку соціальної компетентності, якщо вони не передбачають реальної взаємної участі, жестів, інтонацій чи спільного досвіду.

Особливу роль у взаємозв'язку між використанням соціальних мереж і комунікативними характеристиками відіграють модератори та медіатори впливу. Віковий фактор має ключове значення, оскільки саме підлітковий період є етапом активного формування комунікативних навичок і соціальної ідентичності (Данилова & Гоян, 2021). У цей час особистість надзвичайно чутлива до оцінки з боку інших, тому мережеве схвалення може стати визначальним у формуванні самооцінки. Мотивації користування також впливають на результат: пошук підтримки, потреба у самовираженні чи бажання уникнути самотності зумовлюють різні моделі комунікативної поведінки (Мгалоблішвілі, 2023). Власне, мотиви активності можуть розглядатися й через сфери позитивної психотерапії: «Тіло» – прагнення до фізичного комфорту, «Діяльність» – самореалізація у мережі, «Контакти» – потреба у взаємодії, «Сенс» – пошук значення спілкування, «Майбутнє» – побудова власної ідентичності. Такий аналіз дає можливість глибше

зрозуміти, у яких сферах виникає компенсація або дефіцит, що формує типову модель цифрової поведінки підлітка.

Не менш важливим є контекст соціальної підтримки. Наявність офлайн-зв'язків і позитивного соціального оточення знижує ризик деструктивного впливу цифрового середовища, тоді як ізолюваність підсилює залежність від цифрової взаємодії. Це підтверджують результати досліджень О. Агаркова, який зазначає, що користувачі з обмеженими офлайн-контактами частіше формують компенсаторні стратегії спілкування в мережі, що може призводити до зниження реальної комунікативної ефективності.

Теоретичні моделі, які пояснюють взаємозв'язок між активністю у соціальних мережах та розвитком комунікативного складника особистості, охоплюють кілька підходів. Перший з них – модель соціального порівняння, згідно з якою користувачі оцінюють власний статус, успіх чи привабливість, порівнюючи себе з іншими в мережі. Таке порівняння може стимулювати самовдосконалення або, навпаки, спричиняти зниження самооцінки і емоційне виснаження (Song et al., 2014). Другий підхід – модель компенсації соціального дефіциту, який передбачає, що користувачі з обмеженими офлайн-контактами використовують цифрове середовище для компенсації нестачі соціальної взаємодії (Kuss & Griffiths, 2011). Цей підхід особливо актуальний для підлітків, які відчувають труднощі у реальному спілкуванні та шукають у мережі безпечніші умови для саморозкриття.

Інша концепція подана в моделі використання медіа як ресурсу чи ризику, де цифрові платформи розглядаються як середовище, що може виступати і джерелом розвитку соціальних навичок, і фактором їх деформації. Якщо користувач має високий рівень цифрової грамотності та вміє контролювати власну активність, мережа стає ресурсом соціального навчання, тренування емпатії, кооперації, критичного мислення (Bozzola et al., 2021). Натомість за відсутності саморегуляції вона перетворюється на джерело фрагментарної комунікації, що руйнує цілісність соціальної взаємодії (Шмідзен, 2025).

З огляду на наведені теоретичні положення, можна виокремити низку

механізмів, через які взаємодія у соціальних мережах впливає на формування та прояв комунікативного складника особистості. Ці механізми пов'язані не лише з інтенсивністю цифрової активності, а й із внутрішніми мотиваційними та соціально-психологічними

чинниками, що визначають характер сприймання себе та інших у віртуальному просторі. Узагальнені у Таблиці 1 положення відображають основні напрямки такого впливу та потенційні психологічні наслідки.

Таблиця 1. Механізми впливу соціальних мереж на комунікативний складник особистості

<i>Механізм впливу</i>	<i>Характер прояву</i>	<i>Потенційний психологічний ефект</i>
<i>Тип цифрової активності (активне / пасивне використання)</i>	Активне створення контенту, участь у дискусіях, чи пасивне спостереження за іншими	Активне використання сприяє соціальній компетентності та емпатії; пасивне – ізоляції та зниженню самооцінки
<i>Самопрезентація та соціальне порівняння</i>	Формування образу «ідеального Я» у мережі, порівняння себе з іншими	Може стимулювати саморозвиток або спричиняти тривожність та емоційне виснаження
<i>Баланс онлайн- і офлайн-комунікацій</i>	Співвідношення між реальними та віртуальними контактами	Високий баланс сприяє гармонії; перевага онлайн-контактів – ризик дефіциту емоційної близькості
<i>Мотиваційна залученість</i>	Рівень залучення користувача в активну чи пасивну цифрову діяльність залежить від його мотивації	Позитивна мотивація підсилює соціальну інтеграцію; унікальна – компенсує, але не розвиває
<i>Соціальний контекст і підтримка</i>	Стабільна система офлайн-взаємодій та соціальних контактів	Соціальна підтримка зменшує ризик деструктивного впливу цифрового середовища
<i>Рівень рефлексії та усвідомленості</i>	Здатність критично оцінювати власну цифрову поведінку	Висока рефлексія забезпечує психологічну стійкість і розвиток емпатії

Можна сказати, що соціальні мережі є складним феноменом, який впливає на комунікаційний складник особистості через різні механізми: поведінкові, когнітивні та емоційні. Їхній вплив не можна оцінювати однозначно – він варіюється залежно від рівня активності користувача, його мотивацій, віку, контексту соціальних зв'язків та здатності до саморефлексії. Цифрове середовище стає простором розвитку лише тоді, коли людина зберігає контроль над власними межами, критично осмислює інформацію та використовує комунікацію не як форму демонстрації, а як засіб взаєморозуміння. З позицій позитивної психотерапії це означає усвідомлення власного внутрішнього балансу, здатність підтримувати гармонію між активністю та відпочинком, реальними і віртуальними контактами, соціальною

взаємодією та особистісною рефлексією. Саме така позиція є ключем до формування психологічно здорової моделі цифрової комунікації.

Обговорення

Перспективи подальшого емпіричного дослідження впливу соціальних мереж на комунікаційний складник особистості підлітків полягають у застосуванні кореляційно-порівняльного дизайну, що дає змогу встановити взаємозв'язок між активністю підлітків у соціальних мережах та рівнем їхніх комунікативних навичок. Такий підхід передбачає визначення не лише кількісних параметрів користування (частоти, тривалості, цілей), а й якісних аспектів –

саморозкриття, соціальної взаємодії, емпатії, асертивності.

У межах дослідження цієї тематики доцільним є використання перевірених психодіагностичних інструментів: The Social Media Disorder Test Л. Вартбергa, Digital Media Use and Impact Questionnaire К. Мартінс, Real and Electronic Communication Skills questionnaire Г. Манцураніс, а також методики вивчення комунікативних і організаторських здібностей Б. Федоришина. Ці інструменти демонструють належну внутрішню узгодженість (α Кронбаха від 0,723 до 0,870) і дають змогу виявити як рівень цифрової активності, так і особливості реального та віртуального спілкування.

Залучення до дослідження підлітків віком від 12 до 16 років є методологічно обґрунтованим, оскільки саме цей вік характеризується активним становленням соціальних контактів та зануренням у цифрове середовище. Учасники можуть бути поділені на підгрупи за рівнем активності в соціальних мережах, що допоможе простежити відмінності у показниках комунікативності. На цій основі формуються три гіпотези: (1) існує зв'язок між рівнем активності в соціальних мережах і показниками реальної та віртуальної комунікації; (2) проблемне використання соцмереж асоціюється з нижчими комунікативними здібностями; (3) підлітки з різним рівнем цифрової активності мають статистично значущі відмінності у вияві соціальних навичок, саморозкриття й емпатії.

Перспективним напрямом є також інтеграція принципів позитивної психотерапії у дослідження впливу соціальних мереж. Це дасть можливість не лише виявити рівень комунікативних навичок, а й оцінити баланс між сферами життя підлітка, визначивши, чи компенсує цифрове спілкування дефіцит офлайн-контактів, чи, навпаки, підсилює внутрішню ізоляцію. Для цього доцільним є використання моделі балансу Н. Пезешкіана (Balance Model Questionnaire) або створення авторської шкали, що досліджуватиме взаємозв'язок між сферою «Контакти» та іншими аспектами життєвого досвіду (Peseschkian, 1987).

Таке дослідження має потенціал для уточнення механізмів впливу цифрової взаємодії на формування комунікативної компетентності, а також для розробки

практичних рекомендацій щодо розвитку здорової моделі користування соціальними мережами серед молоді. Також варто зауважити, що отримані результати можуть використовуватися для розробки програм медіаграмотності.

Обговорення теоретичних підходів та попередніх емпіричних даних свідчить про складний характер впливу соціальних мереж на комунікаційний складник особистості. Активне використання цифрових платформ може сприяти розвитку міжособистісних навичок, саморозкриттю та соціальній активності, особливо у підлітків, для яких соціальна взаємодія є критично важливою (Valkenburg & Peter, 2011; Bozzola et al., 2021). Результати попередніх спостережень показують, що підлітки з високою цифровою активністю часто демонструють добру комунікативну компетентність як у віртуальному, так і у реальному середовищі, що свідчить про потенціал соціальних мереж як ресурсу для розвитку комунікації.

Водночас література наголошує на ризиках пасивного або проблемного використання соціальних мереж, що може послаблювати міжособистісні навички, знижувати рівень емпатії та сприяти поверхневим соціальним контактам (Kuss & Griffiths, 2011; Song et al., 2014; Данилова & Гоян, 2021). У цьому контексті ключовим є тип використання платформи, мотивації підлітка та офлайн-контекст: активна взаємодія, саморозкриття та обмін інформацією сприяють розвитку комунікаційних навичок, тоді як пасивне спостереження та соціальне порівняння можуть їх послаблювати (Alluhidan et al., 2024).

Висновки

Проведений теоретичний аналіз свідчить, що соціальні мережі є важливим чинником формування комунікаційного складника особистості підлітків. Вони забезпечують простір для саморозкриття, розвитку емпатії, міжособистісної взаємодії та соціальної активності підлітків, проте, у випадку пасивного або проблемного використання, вони створюють потенційні ризики. Тип використання, мотивації та контекст офлайн-взаємодії відіграють ключову роль у визначенні того, посилюють чи послаблюють соцмережі комунікативні навички особистості. Теоретичні моделі соціального порівняння та

компенсації соціального дефіциту дають змогу зрозуміти механізми цих взаємозв'язків, проте вони потребують додаткового емпіричного підтвердження та уточнення для різних вікових груп. Отримані результати можуть використовуватися у розробці програм цифрової грамотності, профілактики інтернет-залежності та формуванні здорової цифрової комунікації в освітньому середовищі.

Також важливим теоретичним підґрунтям для розуміння шляхів гармонізації комунікативного розвитку підлітків у контексті впливу соціальних мереж є позитивна психотерапія. Її підхід, заснований на ідеї балансу внутрішніх і зовнішніх сфер життя, сприяє формуванню здатності усвідомлено реагувати на інформаційні стимули, розвивати емпатію та підтримувати автентичність у міжособистісних контактах. У межах цього підходу особистість розглядається не як пасивний споживач цифрових взаємодій, а як активний суб'єкт, здатний трансформувати власний досвід у напрямку психологічного благополуччя.

Практична значущість отриманих результатів полягає у можливості використання їх для освіти, соціальної роботи та формування політики безпечного використання соціальних мереж. Розуміння того, як цифрова активність впливає на

комунікаційні навички, може допомогти педагогам і психологам у створенні програм розвитку цифрової грамотності та ефективної соціальної взаємодії серед підлітків.

Обмеженням дослідження є те, що більшість даних базується на самозвітах та спостереженнях у конкретному віковому діапазоні. А це своєю чергою ускладнює узагальнення результатів. Також обмеженням є теоретичний аналіз, який не враховує вплив різних культурних контекстів, що потенційно може негативно вплинути на розуміння глибини та специфіки досліджуваної сфери.

Для подальших досліджень доцільно проводити емпіричний аналіз із використанням більш широких вибірок, включно з різними віковими та соціокультурними групами, а також поєднувати кількісні та якісні методи для уточнення механізмів впливу цифрової активності.

Практичні рекомендації полягають у стимулюванні активного, цілеспрямованого використання соціальних мереж, що підтримує розвиток комунікаційних навичок, та у мінімізації пасивного спостереження і ризикованої поведінки онлайн. Такий підхід може сприяти формуванню здорової цифрової взаємодії та підвищенню якості міжособистісних контактів у підлітковому середовищі.

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Психологическая карта пути эмоций как инструмент для модели баланса в позитивной психотерапии

Psychological Map of the Emotional Journey as a Tool for the Balance Model in Positive Psychotherapy



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Аннотация

В данной статье представлена к рассмотрению авторская терапевтическая техника “Психологическая карта пути эмоций” в рамках позитивной психотерапии. В методике описаны 5 основных пунктов, которые следует заполнить клиенту: действия, инструмент для реализации, мысли, эмоции, blind spot (с англ. слепая зона). Далее, с помощью графической визуализации исследуются слабые места, вследствие которых, нарушается жизненный баланс по четырем сферам, предложенных Пезешкианом. Таким образом, полученный результат обрабатывается с корректировками, чтобы помочь человеку адекватно воспринимать все грани реальности, включая позитивные и негативные для улучшения психоэмоционального состояния.

Ключевые слова: позитивная психотерапия, визуализация эмоций, жизненный баланс, эмоциональный интеллект

Abstract

The article presents the author's therapeutic technique, “Psychological Map of Emotions,” within the framework of Positive Psychotherapy. The methodology describes five main points that the client should fill in: actions, tools for implementation, thoughts, emotions, and blind spots. Next, with the help of graphic visualization, weak points are explored, which disrupt the life balance in the four areas proposed by Peseschian. Thus, the result is processed with adjustments to help the person adequately perceive all facets of reality, including positive and negative ones, to improve their psycho-emotional state.

Keywords: Positive Psychotherapy, visualization of emotions, life balance, emotional intelligence

Введение

Актуальность данной темы обуславливается стремительной цифровизацией повседневной жизни человека и развитием искусственного интеллекта, тем самым теряя чувство собственного контроля над качеством получаемых эмоций. Так, казалось бы, одни и

те же рутинные дела могут вызывать совсем разные психоэмоциональные реакции у человека. Важно здесь отметить основополагающую роль эмоционального интеллекта. (Zuber, I. 2000).

Согласно учениям Саловея и Майера, эмоциональный интеллект – некая форма социального интеллекта. Другими словами, управление своим мышлением и действиями

напрямую зависит от способности понимать и различать как свои собственные эмоции, так и окружающих людей. В процессе исследования, ученые смогли подтвердить, выдвинутую ими гипотезу о том, что способность различать психологические ощущения прямо коррелирует с управлением собственными эмоциями. Также, стоит уделить внимание тому, что одним из основных положений Д. Гоулмана был более объёмлющий подход к эмоциональному интеллекту. Он говорил о том, что на результат жизни и работы больше влияют компетенции, такие как мотивация, эмпатия и социальные навыки. (Дэниел Гоулман, 2018).

Согласно Пезешкиану, у человека есть способность соединять элементы своей личности в функциональную взаимосвязь. Говоря иными словами, любая актуальная способность не рассматривается отдельно от самой личности. Также, наряду с этим, у каждого индивидуума существует своя субъективная структура пространства и времени. Впоследствии, взаимодействие с окружающим миром зависит от того, как совпадает личная структура с общепринятой (Пезешкиан Н., 2007).

Следует отметить, что центральным ядром позитивной психотерапии является научить клиента находить оптимальные решения для преодоления трудностей. Говоря иными словами, актуализировать способность самопомощи у человека (Peseschkian N.), следуя подходу Абрахама Маслоу (Maslow АН., 1954). Маслоу ввел термин "позитивная психология", прежде всего для того, чтобы сосредоточиться на положительных характеристиках индивидуума. Исходя из того, что психические расстройства являются отражением конфликтов, то, в свою очередь, позитивная психотерапия рассматривает личность как целостную систему механизма развития болезни и факторов, которые поддерживают и укрепляют здоровье (Jork K, Peseschkian N. 2006).

Так, в позитивной психотерапии выделяют основные принципы подхода:

Первый принцип – надежды, здесь идет речь о человеческих способностях и ресурсах. Человек имеет способность адаптироваться и развивать себя в течение жизни, а также совершенствоваться, используя специализированное обучение и тренировки. (Кириллов И.О. 2007).

Следующий принцип – это баланс, который хорошо представлен в модели баланса Пезешкиана. (Пезешкиан.1996). Здесь исследуются и соизмеряются между собой жизненные сферы человека такие как: тело, деятельность, контакты и смысл клиента, чтобы найти и выявить доминирование и недостаток определенной из предложенных сфер жизни (Кириллов И.О. 2007).

Принцип консультации – еще один принцип, который предлагает применение пятиступенчатой модели терапии, которая позволяет достаточно быстро выявлять и разрешать внутренние конфликты. (Кириллов И.О., 2007).

Цель данной статьи – рассмотрение аспектов применения авторской терапевтической техники “Психологическая карта пути эмоций” в рамках позитивной психотерапии.

Можно предположить о том, что к психологической проблеме ведет череда, казалось бы, малозначимых рутинных стрессовых факторов, вследствие, которых нарушается жизненный баланс (Mead. E. 2021). Составляя свою личную психологическую карту пути эмоций, клиент может визуализировать, как он относится и реагирует на события, а также распределяет энергию по четырем основным сферам жизни.

Обсуждение: Психологическая карта пути эмоций

Так, на первом пункте исследования клиенту предлагается взять за основу неделю жизни человека (для более глубокого анализа) или для экспресс-диагностики 2 разных дня на выбор клиента по его личной оценке хороший/неудачный день. Клиенту нужно в ряд написать основные, на его взгляд, действия (что он делает в течении дня). На данном этапе мы уже можем предположить значимые зоны активной жизни человека.

На втором пункте клиенту следует под каждым написанным действием указать точки соприкосновения для их реализации (действий). К примеру, если действие человека – делать кофе, то точка соприкосновения – как именно он это реализует, например, кофемашина или покупка готового продукта. Как правило,

реализация действия влечет за собой возникновение определенной психоэмоциональной реакции, что в свою очередь, воздействует на целостную систему организма (United States Association for Body Psychotherapy).

Следующий пункт методики – описать мысли, которые возникают у клиента в процессе реализации действия. Так, к примеру, клиент любит пить кофе по утрам, но он не умеет или нет возможности приготовить самому. Поэтому данное действие и его реализация будут у него вызывать отрицательные мысли, так как он не может легко получить желаемое в привычной для него схеме действий (Madge, N. 2011).

Четвертый пункт – описать эмоции, которые являются следствием мыслительных процессов под каждой точкой соприкосновения с инструментом действий. Говоря о том же примере с кофе, у клиента явно после нереализации желаемого и мыслей, что он так хотел и не получил, появляется разочарованность и плохое настроение. На данном этапе можно проанализировать насколько легко или сложно клиенту дать оценку своим эмоциям (положительные, отрицательные или нейтральные), что может быть отражением динамики эмоционального интеллекта человека. Способность верно распознавать и оценивать собственное эмоциональное настроение ведет к внутренней гармонии и, как следствие, к высокому уровню социального взаимодействия (Gratz, K. L., Forbes, C. N., Wheelless, L. E., Richmond, J. R., & Tull, M. T. 2020).

Пятый пункт Blind spot (с англ. слепая или невидимая зона), клиенту нужно указать те факторы, которые, по его мнению, он не может контролировать или остаются вне его поля зрения, но в противоположном значении (например, если он думает, что не может не думать о проблемах, то нужно написать – я могу не думать об этих проблемах). Как правило, большинство факторов, которые по мнению человека, он не может контролировать – субъективны, к объективным можно отнести: климат, природные катаклизмы и т.д. Если клиент не может справиться с этим пунктом самостоятельно – ему помогает специалист. Рассмотрим пример, заполненной клиентом, таблицы.

Психологическая карта пути эмоций										
	ЭТАП 1	ЭТАП 2	ЭТАП 3	ЭТАП 4	ЭТАП 5	ЭТАП 6	ЭТАП 7	ЭТАП 8	ЭТАП 9	ЭТАП 10
ДЕЙСТВИЯ	Пробуждение	Ванна, чашка	Пить кофе	Завтрак	Сбор	Ехать на работу	Работа	Путь домой	Ужин	Отдых
ИНСТРУМЕНТ ДЛЯ РЕАЛИЗАЦИИ	лежу 20 мин	основные процедуры	варить дома	готовить дома	подготовить себя к выходу на день	посещать на авто	посещать новые места	на авто скачать продукты	дома готовить	дома заниматься своим хобби
МЫСЛИ	думаю об проблемах	думаю об задачах	люблю готовить	нужно терпеливо	нужно ничего не забыть	музыка отдышка	интерес	предвкушение вкусного ужина	не получилось смотреть любимый сериал	расслабилось, ни о чем не думаю
ЭМОЦИИ	☹️	😊	😊	☹️	☹️	😊	😊	😊	😊	😊
BLIND SPOT	я могу не думать об проблемах	я могу постепенно думать об задачах	✓	я могу делать заранее заготовки	я могу составить список	✓	✓	✓	✓	✓

Рисунок 1. Визуализация психологической карты пути эмоций

Визуализируя данную психологическую карту пути эмоций, можно увидеть те действия, которые требуют корректировки для более успешной реализации значимого для клиента. Так, уже на первом этапе можно человеку заменить 20 мин. пробуждения на активную зарядку под любимую музыку или сериал (как мы видим из 6-го и 9-го этапа, данные действия явно улучшают настроение). Таким образом, это новое действие заместит собой мысли о проблемах и тем самым поможет избежать психоэмоционального ухода в отрицательную зону.

Построим график с помощью оси координат, где горизонтальная ось отражает номер этапа методики, следовательно, вышеописанной карте дня клиента, а вертикальная ось отражает динамику настроения начиная с очень хорошего (эйфория) и до очень плохого (кризис), нулевое значение представляет собой баланс.

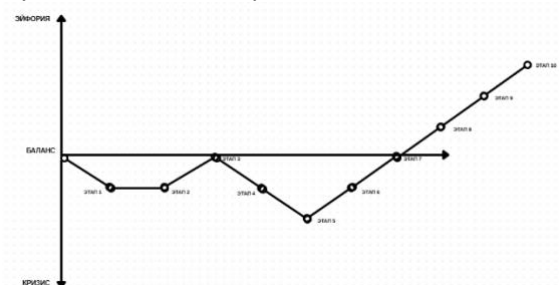


Рисунок 2. График психоэмоционального настроения клиента в течении дня

Анализируя полученный график эмоционального пути клиента в течении дня, можно увидеть слабые точки, которые следует корректировать. Так, на первом этапе мы уже видим снижение настроения,

эмоциональный фон человека уходит в кризисную зону отрицательных эмоций. Следующий этап показывает стагнацию, другими словами, застой или отсутствие роста и развития, но так как клиент уже находится в отрицательной части, то мы можем говорить о продолжении плохого настроения. Третий этап показывает положительную динамику и эмоциональный фон выравнивается к балансу, но следующим действием мы можем заметить снова уход в отрицательную зону. Так, только с пятого этапа начинается длительная положительная динамика и эмоциональный фон достигает баланса и постепенно развивается к хорошему настроению (Messias & Peseschkian, 2025).

Данная психологическая карта пути эмоций человека помогает выявить стрессогенные факторы, которые отрицательно влияют на психоэмоциональный фон и влекут за собой возникновение кризисов. Таким образом, клиент с помощью этого инструмента графически видит динамику своего настроения в течении дня и может понять, какие именно действия приводят к отрицательным эмоциям.

Основной инструмент данного метода – это найти сильные позитивные факторы, которые стабилизируют и улучшают психоэмоциональный фон человека, чтобы заменить или включить их в те зоны, которые отрицательно влияют на клиента.

Согласно теории Пезешкиана, у каждого человека существует 4 сферы, по которым он распределяет свою энергию и время. (Пезешкиан. 2006). В балансовом соотношении это должно быть по 25% для сохранения душевного равновесия. В каждой из сфер есть свои определенные страхи, но человек может справиться с ними. Так, жизненные страхи (тело) преодолеваются через ощущения (способность чувствовать свое тело), а боязнь неудачи (достижение) – через мышление и разум (способность/возможность систематически и целенаправленно решать проблемы и добиваться их результатов). Что касается двух других сфер, то социальные страхи (контакты) преодолеваются через традиции (способность развивать и поддерживать отношения), а экзистенциальные страхи (фантазия) – через интуицию (способность мысленно экспериментировать,

приближаться к неизвестному). (Пезешкиан. 2006).



Рисунок 3. Четыре сферы жизни человека

Тело – сфера жизни человека, где акцентируется внимание на ощущениях, на отношении к своему телу и здоровью. Здесь могут возникать психосоматические заболевания; но клиент, как правило, будет стараться вылечить только симптомы, не уделяя внимание причинам, по которым это могло случиться.

Сфера деятельности – отражает активность человека по отношению к карьере, достижениям, обучению. Это динамический процесс, где клиент может чрезмерно проявлять себя или, возможно, находится в состоянии апатии.

Контакты – сфера, где происходит построение эмоциональных связей клиента. Так, в процессе жизни человек формирует определенное отношение к себе, к окружающему миру. Таким образом, можно проанализировать, открыт ли клиент к познанию мира или закрыт в себе, что может провоцировать возникновение внутренних конфликтов и, как следствие, нарушений.

Сфера фантазии – сфера жизни человека, в которой преобладает сосредоточенность на будущее. Клиент может посредством мечтаний и вдохновения решать текущие задачи.

Следующим пунктом методики предлагается клиенту (согласно составленной психологической карте дня) по каждой из четырех сфер жизни поставить оценку от 1 до 10 по степени насколько он вкладывает сил и эмоций в эту самую сферу. Например, если анализировать действия в течение дня данного клиента, то можно предположить, что он не слишком вовлечен вопросом здоровья и полезного образа жизни. Таким образом, получаем заполненную таблицу с оценками.

СФЕРА ЖИЗНИ	ОЦЕНКА
тело	6
деятельность	5
контакты	3
смысл	8

Рисунок 4. Субъективная оценка клиента каждой из его сфер жизни

Следовательно, по данной таблице можно проецировать результат графически, чтобы соизмерить сферы жизни клиента. Впоследствии, можно определить, где существует явный дефицит, а какая из сфер может быть ресурсной.

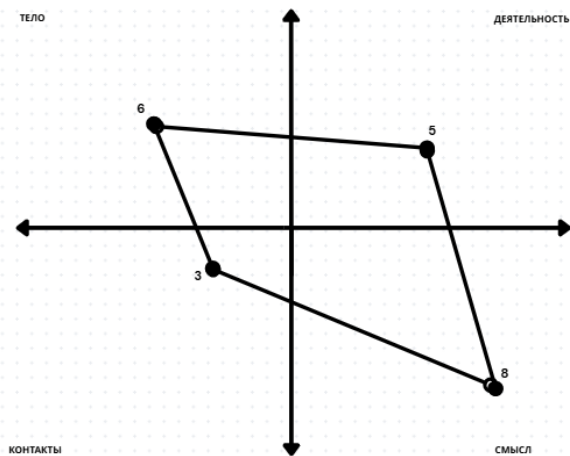


Рисунок 5. Визуализация субъективной оценки клиента его сфер жизни

И так, следовательно графику, мы видим преобладание смысловой сферы у клиента, что означает значительную ресурсную потерю на фантазии и мысли о будущем, но не на решение текущих задач. Что, в свою очередь, формирует огромный недостаток ресурсов в сфере контактов, что сигнализирует о избегании взаимоотношений с другими людьми и, возможно, в какой-то мере отторжении собственного я, вызывая внутренний конфликт у человека

Заключение

С помощью графической визуализации своего дня, клиент уже на первом этапе самостоятельно может увидеть слабые зоны, где происходит изменения эмоционального фона в отрицательную сторону, тем самым, вызывая потерю энергетических ресурсов человека. С помощью специалиста, можно корректировать и устранять стрессогенные факторы из повседневной жизни клиента, таким образом, чтобы балансировать между, предложенными Пезешкианом, сферами жизни. В свою очередь, З.Фрейд предполагал, что только изучая патологическое, можно понять нормальное. (Брейер, Й., Фрейд, З. 2005).

С помощью данной терапевтической методики «Психологическая карта пути эмоций», согласно модели баланса Пезешкиана, мы определили слабую сферу жизни клиента – контакты. Следует отметить, что слишком большие затраты энергии уходят на сферу фантазий и смыслов. Анализируя таблицу пути эмоций, мы видим, что клиент в значительной мере находится в подавленном настроении по причине обдумывания будущих проблем и поиска их решения. Но, наряду с этим, у него совсем отсутствует развитие социальных контактов. Поэтому, в ходе работы с клиентом, чтобы сбалансировать его четыре сферы жизни и улучшить психоэмоциональное состояние, были даны следующие рекомендации: оптимизировать деятельность с учетом минимизации уединенного времени, таким образом, чтобы находится больше времени в окружающей среде. К примеру, было решено добавить дни, когда клиент уходит пить кофе в кофейню, а ужин периодически организует с коллегами. (World Association for Positive and Transcultural Psychotherapy)

Таким образом, позитивная психотерапия говорит о том, что человек будет здоровым, когда он равномерно распределяет свою энергию по четырём направлениям (Пезешкиан, 2006). С помощью данной терапевтической техники мы можем исследовать эмоциональный путь клиента, что в свою очередь, отражается на динамике распределения ресурсных затрат на каждую из четырех сфер жизни человека.

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Section: PPT History

The Development of Positive Psychotherapy in Bulgaria and Its International Impact

Interview with Arno Remmers¹ by Gergana Bencheva²

GB:

First of all, thank you once again for agreeing to this interview. We need to connect with your experience. Your journey and your perspective are fascinating, especially as you have become something of a father figure in Bulgaria. Together with Professor Boncheva, you represent something deeply significant to us – a kind of parental presence – which holds great meaning.

I know that you were trained as a medical doctor, and I am curious about your transition from a medical career to becoming a psychotherapist. As far as I understand, the role of a physician carries considerable social prestige. How did this transition unfold for you?

Arno Remmers:

I was a medical doctor, trained in internal medicine. This was what I loved, what I liked: doing an ultrasound. I worked in all internal medicine departments, including gastroenterology, cardiology, radiology, and more. All the technical aspects were wonderful, and I liked having a good diagnosis for my patients. Finally, I founded my own private clinic in Büdingen, a small town, with all these techniques, you could say, and became a family doctor, with an internal medicine component within family therapy.

So, I was a family doctor, going to families, because this is what I wanted. After practicing outside for a while, I found that I liked much, much more talking with families, being with families, and seeing the link between families and disease. In the hospital, it was not so clear, but when I went outside to work in the countryside, for instance, I found out – and this was very interesting – that without talking with the family, it is difficult to be a medical doctor.

And then I became a general practitioner, including internal medicine components, had my own laboratory, and talked with people. But after two years, I noticed that something was absolutely missing. In 50% of patients in internal medicine, you say to the patients, "I did not find any medical reason for what you are suffering from."

People were not very satisfied with it, and I was not satisfied at all. So, I wanted to find out how I could go further, and saw that our medical academy in Hessen offers ongoing courses for continuing medical education. I attended a one-week seminar on psychotherapy and psychosomatics for medical doctors, led by Nossrat Peseschkian

and his colleagues. After this seminar, I started applying the balance model in family therapy practice, as a general practitioner, and in internal medicine cases. And it was interesting that we understood each other much better.

The medical relationship improved, and the patients understood much more easily why they were suffering and what they had been suffering from. They saw the link between the symptoms, their feelings, and the influences it had on everyday life. As a result, this was the start-up, you could say, at that time.



Nossrat Peseschkian, Ivanka Boncheva, Prof. Todorov

*It was not psychotherapy as such that was interesting for me at first. When I read a bit of Freud, a small booklet, I said, "This doesn't help me." At that time, it was not easy to find a psychotherapeutic method that a medical doctor could use in everyday practice, but Peseschkian had already written the book *Psychotherapy in Everyday Life*. He had also published a book on family therapy and a book on positive psychotherapy. These three books existed. And the books themselves didn't really help me. But the way Peseschkian conducted patient interviews became a role model for me.*

It was not the excitement about psychotherapy itself, like it would be in later years. Later on, of course, psychotherapy and psychodynamic therapy became more interesting. But at that time, I wasn't excited about them. I was excited about what I experienced with my patients afterwards, when I applied the actual capacities, the balance model, and the role model, and saw how it worked in real life.

GB:

What impressed you most about Peseschkian and his work? And what did you begin to discover as you delved more deeply into the practice?

Arno Remmers:

Peseschkian was a bit different. He was a medical doctor, like me, had experience in mental health, and knew medicine very well. That was one part. But the other part was that he was an oriental person. He started with stories. That was so different in the medical academy at the time – starting with a story or proverb rather than statistics or research.

He also focused on having contact with everybody. There were 150 doctors in that seminar. The room was like a big circle, almost like a Roman amphitheater, with 150 people sitting around in the blue saloon. We had very good contact with each other. Everybody could see everybody. We could work together. It was a very, very good atmosphere. Peseschkian was the person who moderated the process, helping us to understand each other. He was genuinely interested in everyone who participated. This was something like a role model.

When he came in those days and met me, he said, "Ah, Dr. Remmers!" (and he remembered names quite early). "How are you? How is it for you? What do you think about this?" He was fully present in that moment. This was in 1983.

He became a role model for being interested in other people. And it was not just about the method itself, but more about how Peseschkian presented it – through attachment to people, asking the right questions for differentiation, and always smiling when someone left after sharing what they had taken from each other. I later understood this as a natural process of attachment, differentiation, and detachment that he lived with us. He always started with attachment, and at the end, he would ask, "How was it for you? What do you take with you? What can you prepare? What can you make of what you took?" We prepared the time after the seminar together.

Even though I was only one of 150 participants, we all felt, "Wow, he is interested in all of us. Nobody is left out." This was something very special about Peseschkian – he maintained contact with an extraordinary number of people. He had a list of around 300 telephone numbers, and

he would call at least 150 of them each month.

And later, when we cooperated, sometimes he called me three times a week. Sometimes I said, "Oh, Dr. Peseschkian, I'm too tired this evening." It was too much for me at times. In those days, he made calls to build the network that we have today with social media. He did this by telephone, all around the world, with many colleagues. He was deeply interested in this process of exchange, creativity, and growth with others.

Each idea I took from him – like his genius balance model, for instance – I later worked out, gave feedback, developed a systematic understanding of the method, and became one of the very active participants. In my group, which I started training with in October 1983, there were about 15 people as interested as I was. We had a group of colleagues – Gunther Hübner, Udo Boessmann, Wolfgang Hönnmann, and others – who worked together as a small group even between seminars. We developed our own view of psychotherapy and continued what we had learned together. This was a very creative atmosphere.

This is what I value very much in Nossrat Peseschkian and his method: he never reduced the method to just "positive psychotherapy." He opened the scene to everything that could enrich it. Later, I found that the word that fits best is **inclusive**. He included whatever was needed to understand our guests, our patients. He included necessary methods and theory, and he included other ideas as well. He always asked when someone had a different opinion, "How do you think about that? Can you tell me more?"

He was genuinely interested. He worked with behavior therapists and psychoanalysts, which was very unusual at the time. He had training in Switzerland with psychoanalysts, but in Frankfurt, he had good contacts with Professor Liselotte Süllwold, a clinical psychologist and behavior therapist. Hans Deidenbach was his most active co-worker for many years, a behavior therapist in his practice. Other colleagues would say, "That's impossible! How can a psychodynamic therapist, psychoanalytically trained, work with a behavior therapist?" But for him, it was completely normal.

This approach was extremely important for me and has influenced my work in positive psychotherapy to this day. Many times, I asked myself, because I had learned other methods as well, why is positive psychotherapy for me number one? Because with its help, I could understand all other methods more easily. When I trained in positive psychotherapy, it became much easier to see, for example, "Ah, this appears in cognitive behavior therapy, and here it appears in analysis." With positive

psychotherapy, you can understand not only the human being but also the approaches of other practitioners and methods more easily.

Peseschkian wanted to make the language of psychotherapy accessible to ordinary people. Like Alfred Adler, he shared knowledge first with simple people – students, advocates, anyone on the street, or a hotel worker – explaining what he knew and talking with them. This was Nossrat Peseschkian: adapting methods for everyone, in a transcultural way, so that psychotherapy is not only for rich, academic, or clever people, but for everyone.

This is also why positive psychotherapy became a tool to translate other methods – like OPD today, behavior therapy, or psychoanalysis – into an understandable model of how to approach a person in psychotherapy. I am deeply impressed by Peseschkian's genius: he always saw what could be improved or combined. He was creative in bringing together contradictory positions and asking, "Ah, what do they have in common? What is different?" This differentiation was his particular genius. He did not invent everything himself; he combined ideas from other authors in ways that were not only understandable but logical.

Many people had written about justice, love, and attachment. Peseschkian brought all of that together and founded the model of *Differentiation Analysis*, summarizing characteristics from different literature into a coherent model of psychotherapy. This, for me, remains the main reason to stay in positive psychotherapy: a psychodynamic method on a humanistic foundation, with the possibility to incorporate whatever is needed for each guest.



First colloquium, Varna, April 1995

GB:

I've been listening to you, and it makes me wonder: was there a specific moment when you realized that Positive Psychotherapy (PPT) was truly your path – your place to be, to develop yourself and your practice, and to contribute to the way PPT has spread?

Arno Remmers:

I would say it was not the method itself. It was the link between the method, the colleagues, the founder, and what I

experienced with my patients. The application of Positive Psychotherapy and the models of the positive psychotherapists I worked with – these were the reasons I felt this way. Not the therapy method as a theory itself. You can use relativity theory for many different questions in astronomy – you will not be excited; it's just a normal law.

The balance model is quite an interesting thing, but it becomes exciting when you see what emerges in therapeutic communication, and when the alliance between the therapist – or medical doctor – and the patient improves because of the balance model, because of the concepts of actual capacities, because of this understanding of attachment, differentiation, and detachment, and because of the five "fingers" of the process.

Peseschkian introduced a model to understand this – and this is what is exciting: what comes out of it. The method is just a tool. The tools themselves are not what's interesting, but what you can produce with this collection of tools – that is truly exciting.

GB:

I am inspired by your connection with people and by the meaning that Positive Psychotherapy (PPT) holds for you. It seems that you strive to create meaning for others – to be better for them, to nurture stronger connections, improve understanding, facilitate clearer communication, and ultimately provide better care for both the individual and their family.

Arno Remmers:

This is actually a very simple idea. It is not the method itself that helps the patient – it's the therapeutic relationship that makes the difference. The better this therapeutic

relationship is, the more the guest and I – or the patient and I – are in resonance with each other, the better the outcome. And you need methods that fit this resonance. For some patients, I work more on a cognitive level, as Nossrat Peseschkian very often did.

For others, I work more on an emotional level, like in Gestalt therapy, and I can incorporate that into Positive Psychotherapy. For some, I focus on transference and counter-transference, using it to enhance resonance – saying, for example, "Oh, this comes up in my mind. What do you think about that?" when I

utilize my counter-transference. And for others, I take a more active, experiential approach, like in psychodrama – using a chair, a symbol, or engaging in creative therapy.

But all of this is not about the method itself helping; it's about the resonance we create. For this, we need specific methods as tools to support that resonance. With some, like children and adolescents, pictures or symbols to play with often provide the best way to achieve good resonance.

GB:

It really comes down to attitude, I believe – and the change in a person's attitude, along with the relationship with people, the attachment and connection you mentioned earlier.

I've been thinking about how fortunate we were as a nation that you chose Bulgaria as a place to come and share this attitude, this approach – or method, as I would call it – with us. I'm curious: what specifically attracted you to Bulgaria? What did you feel here that made you decide that Bulgaria would be the country where you would impart this method?

Arno Remmers:

I'm often asked, "What attracted you?" It wasn't really that. As a medical doctor – and this is also how I feel as a human being – I always go where I am needed.

So, when I came to Eastern European countries from 1990 onward – first to Romania in April 1990, then to Slovakia, and finally in 1991 to Bulgaria – I knew from the first moment in Romania that there was a real need for exchange between Western and Eastern Europeans. Not a material exchange of electricity, clothes, or goods, but an exchange of ideas about being human, about sharing what we know, a cultural exchange. Psychotherapy was largely missing in both Bulgaria and Romania.

There was mostly behavior therapy based on Pavlov, and only a few, like Professor Ivanka Boncheva and others, had been trained in other methods, but these were not officially recognized in the country; they had only been tested. There was a clear need for psychotherapeutic methods. Even before I realized the need for psychotherapy, I understood the importance of the transcultural exchange of ideas – also in treatment, medicine, and psychotherapy.

In September 1991, I came to Varna, Bulgaria, for two weeks with my wife. We were already in contact with some medical doctors. On the first days in Varna, we met a surgeon who said, "Ah, go to the medical university – they will be interested in sharing with you." Then I went to the medical university's internal medicine department, where a nephrologist spoke French. I'm not very good at French, so he suggested,

"Perhaps it's better to go to Ivanka Boncheva – she speaks German." And that's how I met Professor Ivanka Boncheva.

At that time, of course, I had training in psychosomatics from a medical perspective, but I had not worked very much with clinical psychologists before. Most of my work had been with medical doctors. So, I started with the medical doctors, then connected with the clinical psychologists and psychiatrists at the dispensary (an outpatient medical clinic at the time) in Varna.

From the very first moment, there was excellent understanding with Ivanka Boncheva, Vasily Vassilev, and many other clinical psychologists in the department who spoke German. This was crucial because language matters in Bulgaria for achieving true understanding. Translation can make emotional understanding more difficult. But with Ivanka and others, like Gergana Momova, it was easy to establish good contact. They said, "Oh yes, we need what you know – your psychotherapeutic and psychosomatic experience from Germany."

By that time, I had already been trained as a supervisor and trainer in Positive Psychotherapy under Peseschkian. We had conducted courses, so I was ready. I returned in December, and it became clear that Bulgaria would be our focus. Among all the countries we had visited – Germany, Slovakia, Romania – Bulgaria showed the greatest need.

At that time, Bulgaria was not only a very small country, but also underestimated in its potential and largely unknown in Europe, unless you had been a tourist on the Black Sea coast. Yet the science produced in Bulgaria – the work of clever, creative people – was not widely recognized in Europe. There were many artists and scientists, and there are still many today. The educational system was highly developed, and the universities are excellent.

This was something that also attracted me – the interaction with the colleagues there. Then it became clear: okay, I'm ready to share what I know with them. I first tried to learn Bulgarian. It was extremely difficult. During the first three months of training with a university professor, I nearly gave up because the grammar was so challenging, and even simple tasks like shopping were very hard in Bulgarian. It took another six months to feel more comfortable, and about 1.5 years until I could hold my own seminars without a translator. For 1.5 years, I relied on interpreters and translation services.

It was a very difficult time, as all the materials had to be translated as well. I learned to type in Cyrillic and had to read a lot, spending each day figuring out the meanings of words. An etymological dictionary that traced the cultural origins of words made it easier to understand the language. Here I am speaking English, which is another way of thinking. It was very

difficult to think in Bulgarian while speaking English. When coming to Bulgaria now, after about two weeks, I start thinking in Bulgarian and even dreaming in Bulgarian, which is essential for a psychotherapist. Learning the language thoroughly was necessary not just to travel in the country, but to truly stay there and work. Later, when I traveled to other countries – Russia, Poland, Romania, and others – translation was sufficient. But in Bulgaria, it was only possible to work effectively by speaking the language.

GB:

It's interesting what you said about Bulgaria being a country that is distinctly different from others – one with significant needs – and about your generous dedication to addressing those needs. You mentioned some differences compared to Germany. What else was different, and what was the most challenging aspect, aside from the language barrier and typing in Cyrillic? Was there anything else you found particularly difficult or surprising?

Arno Remmers:

In teaching, for instance, yes, it's quite different. There is something special. In Bulgaria, I feel that people often have low self-esteem or are very shy to speak in another language unless they can speak it perfectly. If you are not perfect, you don't feel comfortable. The expectations in schools are very high.

People in Bulgaria are used to producing the best results, while a German might say, "OK, what I do is just OK." That was a big difference. This became clear, for example, when Ivanka Boncheva went to Germany in those years, to Bad Nauheim, to meet with colleagues. She gave a presentation on the application of Positive Psychotherapy, and afterwards, many, many questions came from the audience. Everyone wanted to know something from her, and she felt desperate. She said, "What did I do wrong? My German is so bad. They didn't understand anything."

I asked, "Why? They had so many questions."

She replied, "Of course, but why?"

I said, "They are interested in you. That's why they have so many questions."

But for her, all those questions initially felt like they hadn't understood her at all.

I had a similar experience. I still remember the situation: a big room at the university, in the psychiatric dispensary of Varna, where we also held staff meetings for the mental health hospital – discussions about diagnoses, psychiatric cases, literature sharing, and so on. In this large circle, I gave a seminar, finished, and... no questions. Silence. Absolute silence.

Afterwards, I went to Ivanka Boncheva and asked:

- "I'm sorry, should I give up?"
- "But what? Why?"
- "Nobody asked anything. They

are not interested at all in what we did."

- "What?" Ivanka said. "But they understood everything."

I replied, "How can they understand everything? They didn't ask a single question."

She said, "It would be very strange to ask a question when they already understood everything."

This was a big difference. I also noticed that quite a few foreign trainers came to Bulgaria in the 1990s, to teach, like short-term therapy – Steve De Shazer, for instance. Other trainers taught psychodrama, like Bernhard Achterberg, and others coming from different countries. Seminars in psychoanalysis, family therapy, and other approaches were also offered.

When these trainers left the country, here in Bulgaria – by the way, when I say "we," I mean my second home in Bulgaria – sometimes we would say, "Okay, we already knew that. It's nothing new for us." That's because Bulgaria has a well-developed education system, and people know a lot; they are very well educated.

I was surprised when I worked in the school in Dobrich. I wish my own children could have attended Bulgarian schools. They were usually one or even two years ahead in learning compared to German schools. It was quite normal, then, that there was strong competition within Bulgaria – everyone wanted to be better. Yet, in comparison to other countries, there was still low self-esteem. In the beginning, in 1992, I asked why so little material was translated from Bulgarian into English. The answer was, "We don't translate into English." I asked why, and the response was, "We are not good enough." I was very surprised, and sometimes even frustrated, with my colleagues at the university. I said, "Hey, why don't you publish in English?" But they didn't want to publish outside the country because they feared what others might say: "Ah, you Bulgarians..." Ironically, the work they had done was excellent.

At that time, there were many computer viruses, and a lot of them in the 1990s came from Bulgaria. This was because Bulgaria had many clever, inventive minds creating them. Bulgarian viruses spread around the world.

Stoichkov, the footballer, became an idol, and some other Bulgarians who went abroad also became famous. Yet, take Christo Yavashev, the artist in New York, famous for wrapping objects – he refused to identify as Bulgarian. He wanted to remain anonymous. It was very strange. He did not want to say, "I'm Bulgarian." That didn't resonate with him, apparently, because he did not take pride in it. Quite often, many Bulgarians in Germany try to adapt

completely to German culture and do not express pride in being Bulgarian.

This is very different. BUT, I must say but, Bulgarians are exceptional in their creativity, in art, in psychotherapy, and in scientific development. They have contributed a lot to the world, even if historically they did not publish much internationally. Nowadays, it's better: many more colleagues publish in English, and self-esteem has improved.

GB:

I believe that for many years, Bulgaria was relatively closed off and isolated. With the world opening up, the development of the internet, and easier travel, this situation has changed significantly. Nevertheless, transcultural differences still exist and continue to have an impact.

Do you feel there was a specific personal moment or meeting after which you realized that all your efforts – learning the Bulgarian language, meeting so many people, and everything else – were meaningful and worthwhile?

Arno Remmers:

This is a difficult question because, of course, it was not easy for me. I always had to find a balance between being far from my family and my children, who did not come with me, and fulfilling my role in another country. What was more important? I returned home for all school holidays to see my children. At that time, it was not very clear to them, but later I discussed my role with them. They understood and accepted it – like a father working abroad, doing an important but demanding construction job. It was a very difficult decision to live in Bulgaria for nearly four years. All the time, however, I felt that my work was needed until I could hand it over to the Bulgarians, who became trainers in the meantime.

to teach trainers from the very beginning of the seminars. After each seminar, I would talk with them about how I conducted the sessions so that they could do it themselves later.

From 1993 onwards, we ran training-for-trainers programs with this small group of future trainers. This was also the beginning of the later international training-for-trainers programs from 2000 on, where we experimented with methods. By 1996, the first trainers, like Gergana and Ivanka, were already training the next generation.

This gave me the freedom to go back, also for financial reasons, because I had to earn a living, which was not possible in Bulgaria at that time. The political situation, with inflation and instability in 1995, made it very difficult. So I returned to work in Germany. From then on, I traveled to Bulgaria each year, and then also to Romania, where I used the experience from Bulgaria to further develop the program for basic and advanced courses of 1994. At that time, it was called the Advanced Course rather than a Master's program. This training, developed in Bulgaria, included modules on group therapy, family therapy, and more. It was something special.

The first experience in Bulgaria was combined with lessons from other countries. The program was then applied in Romania, Russia, Poland, and across Europe. In Russia, Hamid Peseschkian started basic courses and seminars for Positive Psychotherapy. The systematic approach we developed in Bulgaria – because Bulgarians are very methodical and attentive to developing a perfect curriculum – later influenced the official ICPP.² curriculum. The Bulgarian program became the international curriculum in 1999 for the international centers of PPT, and after further discussions and refinements, it evolved into what we now know as the WAPP curriculum.



Bulgaria was the first country where I tried

First PPT Group, Varna

² ICPP - International Centers for Positive Psychotherapy, created in 1994, and

formally registered in 1998, later renamed and reorganized as WAPP

GB:

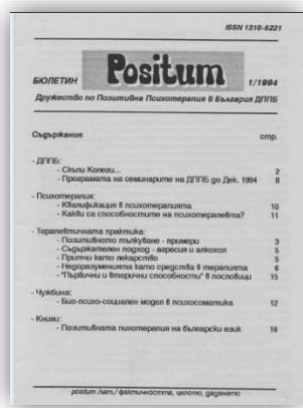
Speaking of Bulgaria and the curriculum, I'm wondering – wasn't there already a curriculum of training in Germany, like the groups you mentioned with Udo?

Arno Remmers:

No, we had a one-week program, like the one in Bad Nauheim, but it was still only basic training. There was no full program for Positive Psychotherapy at that time. In our trainings, we had not only Nossrat Peseschkian, but also psychoanalysts such as Prof. Battegay and Prof. Benedetti from Switzerland, Dr. Dunkel for Balint groups, Hans Deidenbach for behavior therapy, as well as psychodrama and other colleagues – doctors who came to train us.

The training followed the standards of German psychotherapeutic education; it was not focused solely on Positive Psychotherapy. It was not possible to train exclusively in Positive Psychotherapy – we had to study psychodynamic therapy, cognitive therapy, or behavior therapy as well. The institute was primarily for psychodynamic therapy, and Positive Psychotherapy was just a part of it. At that time, there was no full program for Positive Psychotherapy at all.

It had to be built from scratch. Prof. Peseschkian traveled to around 60 countries, gaining experience with his transcultural method. He gave many lectures and short seminars, but he never created a complete program for Positive Psychotherapy. It was up to us, his students, to develop it. Hamid Peseschkian started this work in Russia, while Gunther Hübner and Nawid Peseschkian brought it to Ukraine. In Russia and Ukraine, the local colleagues then developed the programs further.



Positum journal

I traveled to Bulgaria frequently, and together with Prof. Boncheva, we developed and tested this program. I also wrote extensively about didactics at that time in our journal Positum. We founded Positum in 1994; I typed it on my computer, my colleagues corrected it, and then it was printed. It was a very simple publication, but it became the first journal for Positive Psychotherapy outside of Germany. Previously, a journal for PPT existed only in

Germany. Positum included articles on teaching methods and on the capacities required for a psychotherapist, and I tried to develop a didactic approach specifically for Positive Psychotherapy. This was my work at that time, and that was what I used later in other countries.

From Bulgaria, I traveled to Russia, where we had extensive exchanges with Russian colleagues. Some even came to Bulgaria – such as Marina Elisheva from St. Petersburg and two other colleagues – to train us in NLP or to share their psychosomatic experience. They came to Varna and conducted seminars with us. I also traveled frequently to Russia, visiting Kazan, St. Petersburg, Moscow, and other cities, and this network of connections was very important for our work in Bulgaria.

From 1993 onwards, I traveled to Poland for basic training. Then I went to Romania in 1993, and from 1996 onwards, we had the official training for Positive Psychotherapy and Family Therapy there, including both the basic and master courses. Later, I traveled to other countries – by the end of the 1990s to Bolivia, and in 2000 to China, for instance, as well as to other countries in Europe. Of course, I have taught extensively in Germany as well.

GB:

Which teachers and early encounters, besides Nossrat Peseschkian, have had the greatest influence on you and shaped your working style?

Arno Remmers:

When you asked me which people influenced me the most in psychotherapy, I must start, besides Nossrat Peseschkian, who had a strong influence as a model for understanding psychotherapy, with Raimond Battegay, his friend and a psychoanalyst. He also had a profound impact on me as a psychoanalyst. His way of being – so accepting, patient, vivid, and silent – was remarkable. When we were in a group with him, he gave us the space to develop something on our own. I saw in him a psychoanalyst who genuinely cared for the group, ensuring it had the resources to grow, while he stood as a pillar, saying, “You are safe, do it,” and sometimes offering feedback. He was so attentive to everyone, yet always calm. He was a very important role model, showing what a calm psychotherapist could be.

One of the most important teachers, and somewhat unusual, was Gunter Hübner. He was in the group with me as a student, while he had already been working in Nossrat Peseschkian's office since 1993. He had a very systematic and perfectionist mind and introduced, for instance, the concept of internal conflict. He brought a great deal of psychodynamic understanding to Positive Psychotherapy. His way of conducting intervention and supervision of cases was so inspiring that I once asked him: “Hey, Gunter, it's so wonderful – every time I leave here, I feel full, I feel well, and I take so much

from you. What is that?” He replied, “I don't know, maybe because I'm a Bahá'í.”

I was surprised and read more about the Bahá'í faith. Nossrat Peseschkian was also a Bahá'í, but the experience was different. With Nossrat, I didn't feel that something was special because of his background. With Gunter, his Bahá'í philosophy – accepting everything, seeing people's capacities, discovering the gems that have to be dug out – was deeply integrated into his life and work. It shaped his clear mind and full heart for people. It wasn't the religion itself, but how he lived and shared its philosophy that became a strong humanistic foundation for his psychotherapy. Gunter Hübner was one of the most significant influences during that time.

There had been others. I attended a psychoanalytic self-experience group in Hessen, in our area. Each time, we went to the office or home of a different colleague, and each colleague, over a weekend of three days, trained the group in psychoanalysis in their own way, as they had learned it – Jungian, Adlerian, Positive Psychodynamic Therapy, and so on. Sharing our experiences in this group was a very strong influence on me.

Psychodrama later became a very important part of my work. Ralitz Mendova, who was my wife at the time, is an excellent psychodramatist, and through her I learned a lot and came into contact with other psychodramatists. Psychodrama was also significant in Nossrat Peseschkian's trainings, because he had trained with Moreno, later with Zerk Moreno, his wife. These psychodramatists were crucial for me to externalize what is inside – the psychodynamic material in a room – so that we could see it, feel it, and embody the theory.

When we talk about internal conflicts, actual conflicts, or basic conflicts, it is often something verbal and rational – but in psychodrama, or using a chair in Gestalt therapy, or as a symbol in creative methods like painting, you can truly see and experience it. It's externalized, and you can see it and gain a different understanding of it, and in psychodrama, you can feel it. On one side, there is the trust you have, and on the other side, there is the openness needed to build trust. If someone is not open, I cannot trust them. But if someone is too open, what happens with trust? Because then I feel hurt. This ambivalence can be felt much more clearly in psychodrama than by just talking about it.

Psychodrama was one of the most powerful methods for me in self-experience. I didn't practice it officially, but it had the strongest effect on me personally and on my development. Family therapy was also crucial, and I must mention my relationship with Manije Peseschkian – I forgot to mention her before. She was humble and worked quietly in the background as a family therapist. Many people don't know that. With her, it was all about the family

tree, the relationships of our ancestors, grandparents, and parents, and the cognitions and concepts they passed down, which we discussed. This transgenerational aspect came from Manije Peseschkian.

She had a very strong influence as a living example of a family therapist in the background of Peseschkian. She took on the emotional aspects that Nossrat Peseschkian did not focus on. Nossrat Peseschkian would ask:

"What is it that bothers you?"
 "Ah, my son behaves this way or that."
 "Ah, what causes this feeling?"
 He would immediately translate it into an actual capacity. He worked with it in a rational way, using little counter-transference or transference, focusing instead on translating feelings into terms and actual capacities.

With others, I had to learn what it means to work with feelings, with transference, and with counter-transference. Later, I wrote articles about these aspects – things I had not learned directly from Positive Psychotherapy, but which we needed to integrate into it. For instance, how to work with transference and counter-transference.

Nossrat Peseschkian didn't emphasize this much. He gave us the four areas of the Balance Model and said, "You can work with that." Later, I had to figure out how to work with feelings in transference and counter-transference myself.

As students of Nossrat Peseschkian, we had to do a lot to make the approach systematic and to determine how to apply it according to our own personalities, which differ from his. Nossrat Peseschkian could use stories, proverbs, positive approaches, confrontation, and existential questions effectively – but not everyone can work that way.

It depends on the personality of the therapist. Some therapists need the emotional aspect more, as in Gestalt therapy; others need the expressive aspect, as in psychodrama; and others focus more on the rationalizing aspect, as in cognitive therapy. Then you can integrate these approaches into positive psychotherapeutic forms, depending on the personality of the therapist.

So, I have mentioned some examples from my life. There were also medical doctors who became important later. Professor Christian Reimer, a good friend, became a very important supervisor and colleague for me. I worked with him in the Wiesbaden Academy. For some time, he was already a well-known psychoanalyst, working at the university. After his emeritation from the university, he came to the Wiesbaden Academy. We had already worked together before, when he was in Gießen, and we met regularly. He was a very important person for me, someone with whom I could share things I had been ashamed of, and with whom I could talk openly about my

difficulties. That was very valuable for me, and in this way, he was very important.

There were also colleagues to whom I went for self-experience and for therapy. When I had depressive phases myself, I went to therapy. So, of course, there were many others who influenced me. It was quite a large number of colleagues and people who shaped me as a therapist.

Later – much later – there were also Wolf Bütig and others from humanistic psychology and psychotherapy.

GB:

Meaningful encounters between people become truly enriching. Each person brings a wealth of qualities and abilities to the table, and through these meetings, they can share their unique insights and experiences.



Arno Remmers:

That is something I would also suggest to the community of psychotherapists in general today. Nossrat Peseschkian invited many colleagues from other modalities because he said, "You can learn from this person, independent of the modality." Because this person was an important therapist, and because it was important that we had these many examples of colleagues brought in by Nossrat Peseschkian.

In positive psychotherapy, we should also keep this idea today: to learn from others with different opinions. From positive psychology, behavioral therapy, cognitive-behavioral therapy, gestalt therapy, systemic family therapy, and so on. We can learn so much from them, and we should invite people not because of the method, but because of who they are, as people and examples.

For example, Peter Fonagy. He is such a wonderful person. Or Bruce Wampold, a scientist, a researcher. His research is very important to me. Or Klaus Grawe, who was also in close contact with Nossrat Peseschkian regarding research. Or Professor Thomas Loew from Germany, who was also one of our teachers.

So it was not like in many other schools. We did not only have people from many modalities, but also from many different

professions, to train us in how to be in contact with them and how to learn from them, from their way of relating to other people and to their patients.

GB:

We do this in Bulgaria as well. In fact, at our most recent conference in Varna, in October 2025, we invited colleagues from two completely different modalities. Similarly, here in Wiesbaden, the international Training for Trainers program includes lecturers from a wide variety of fields.

This diversity is incredibly valuable for our community and for the development of our skills. Regardless of a person's level – whether they are a student, a practicing therapist, or an experienced trainer – everyone has a great deal to gain from these exchanges.

Arno Remmers:

Just to mention, in Macedonia, for instance, at a conference, we had a poet and literary figure who spoke about emotions. We learned a lot from him. In the institute where I have been working in Germany for 25 years, the IEPG in Mannheim – the Institute for Ethics, Psychotherapy, and Health Culture – we invite a musician to each of our conferences to prepare music related to the subject.

So, science plus art. This is also something I see in many institutes now, in Ukraine, Bulgaria, and Romania. Art is also involved in therapy. It must have a place in therapy. These integrations, these inclusions, are necessary.

GB:

How would you describe your philosophy as a therapist today? What makes therapy feel alive and real for you?

Arno Remmers:

In the last ten years, I have increasingly used the words *guest* and *patient* instead of *client*. A *patient*, for me, is someone who suffers so deeply that one cannot help oneself and needs support from others. This is someone whose suffering requires treatment to bring relief. For example, if you need an appendectomy, you cannot simply say, "I'll try to do it myself." You need help – that is a *patient*.

In contrast, the term client, as used in humanistic psychology, comes from the Roman Empire, where a client followed a master. I don't want my guests or patients to follow me like a master. What matters most is that we meet on an **equal human level** – whether it's a three-year-old child or a 100-year-old person. Both of us maintain dignity, and neither is dependent on the other. That is the ideal.

Even so, someone with a general anxiety disorder is, in some ways, still a patient. They may worry constantly about their loved ones: Are they safe? Could something happen to them? They may have nightmares at night, unable to rest. In those moments, they need someone safe – a harbor in a storm. This safe harbor doesn't create dependence; it simply provides security when it's needed. For someone with a general anxiety disorder, having that safe space can literally be life-saving.

The safe room of the therapist – the safe environment with the therapist – is essential. This philosophy you asked about can be seen along a line: on one end is a patient who is severely suffering, like a person in deep psychosis. I once had a piano teacher who sat in a corner of her apartment for three days, fully believing she was Beethoven. Later, she could tell me about it. She truly needed help.

On this end of the line, my role is special – not only as a therapist but also as someone who can take real action, helping when people cannot help themselves anymore.

On the other end are people who come with problems they can manage themselves: "I have a boss who is so difficult. What can I do differently?" These are not patients or clients in the traditional sense. They are specialists in their own lives. My role is to be a specialist in communication, giving feedback based on my experience and knowledge. Here, I see them as guests, sharing and learning together.

In the middle of this line is where psychodynamic therapy often works: a guest who suffers, but can still engage with me. Unlike the piano teacher with psychosis, they can come, interact, and evoke feelings in me. Later, I may recognize this as countertransference, but in the moment, I am simply a human being feeling and connecting with another human being – and they feel something in return.

And in this interaction, it's like with a horse and the person coming to the horse, and the horse looks: "Oh, can I trust this person?" Or the horse comes and sniffs and touches me because the horse says, "I like you."

And it's the same in psychodynamic therapy: the relation is like that of a rider and the horse. Both have roles to see how they can be synchronized in the best way. When there is a difficulty, the guest will tell me, "That is difficult," and explain how they cope with it. It's exactly what happens in psychodynamic therapy: something arises in me that I can later share with my guest, and whatever comes up in the guest, they share with me.

For example, a dream. The guest had a dream and told me the dream. Or the guest had an encounter outside with another person, saying, "Oh, it was like this and that," and shares it with me. And my feelings that arise, I share with my guest. What comes up in me – what actual capacity is touched, how it relates to the balance model – is what I use to create questions from. Both of us are independent persons in therapy. There is my guest, and here I am as a therapist, whose goal is that, from the first session on, the guest becomes independent of me. That was the idea of Nossrat Peseschkian: even after the first session, if no second session is needed, the guest already knows what to do for oneself. "What was important for you today?" Peseschkian would ask at the end of the first session.

Sometimes I was surprised that what was important for the guest was different from what I thought was important. So the guest can take their own subject, and then I ask: "Ah, with whom can you talk about it? Could you write about it? Would you like to discuss it with somebody else, work it out, or observe it in your everyday life? How does this relate to obedience, justice, openness, or politeness – the key conflict?" And then the guest has a task.

I am free as a therapist because the guest is doing that. On this continuum – from the patient who needs a medical therapist, to the guest who has their own capacities to develop themselves, to the person who comes to counseling and only needs me as a specialist for communication – I have very different roles.

As you asked about my philosophy, I haven't mentioned trauma in guests. This is like with a patient: they are no longer able to regulate themselves when triggered, for instance.

This means they can lose their own will and sometimes even their dignity, for example, due to post-traumatic stress disorder. Unlike in a typical medical situation, here the therapist's role is to provide methods and create a therapeutic encounter as a safe space – for stabilization first, and later for working through the trauma.

So, the philosophy I have as a therapist is that I need very different approaches for different personalities. Therefore, I need, within myself, many different "personality colors." I need a bit of narcissism, a bit of depression, altruism to feel; I need a bit of dependence to stay with difficult patients; a touch of histrionic traits for depressive patients who cannot move or have no facial expression, to encourage their motor system and mimic. Even the schizoid aspect is necessary, so that I can be a stable, neutral presence – neither too empathetic nor too distant – allowing a trauma patient to feel safe.

So, this is one aspect. My philosophy means that, as a therapist, I need my own personality patterns to fit different types of

personalities among my guests and adapt to the centrality of the interaction. And, as a therapist, I have to use different approaches – from a neutral stance with a trauma patient to a more helping and supportive approach with a psychotic patient or with someone experiencing severe suffering, including sometimes psychosomatic patients.

I also need to work with transference and countertransference, for instance, to act as a mirror for someone. And I act as a counselor who, in pedagogy and in prevention, uses all the knowledge I have gained from my patients and sometimes from books to enrich the understanding of the person who comes to me. All of them, including patients, are also guests.

But patients also need support or help with their hands, while others need guidance or input. And in the middle – which is the most common situation in therapy – there is this interactive exchange, flowing with each other even through difficult situations, the river of life, learning from each other. So, in a way, that's my philosophy as a therapist.

GB:

Thank you. It felt like a powerful link bridging one end of the continuum to the other – spanning the spectrum of the psyche from "patient" to "client" to "guest." What was especially fascinating was the idea that the psyche can occupy all these positions simultaneously within the same person.

This highlights the profound demand placed on the therapist: to cultivate a wide range of inner personalities or capacities within themselves, so that they can truly meet the patient, client, or guest wherever that person is in any given moment of their life. Even in a particular session, it could change from one to another.

Arno Remmers:

There are many patients with a *borderline personality diagnosis*, which means they have the capacity to play many different roles in their lives. However, they cannot always control when and where these roles emerge. All these roles sometimes come out at once, and they may not fit the situation, which is why these individuals are called *emotionally unstable*.

Some of them are artists, and when they express themselves through painting with all these impulses, it's creative and fine. But when they act impulsively in relationships, it can be dangerous. It depends on the situation: when a person has learned many roles to survive, in a normal situation, they might continue playing a survival role that no longer fits. That is emotional instability. For this reason, as a therapist, I need to have many different ways of adapting to the needs of a person with an emotionally unstable personality in the moment.

GB:

As a therapist, to extract what is needed from that sensitivity, exactly how much is needed – the dose. To sense exactly what to

do in that particular moment, how to react, sometimes even the milliseconds of delay, or how quickly you will respond, gives a different message.

Arno Remmers:

You have to feel it first. You can interpret it afterwards. Psychodynamic therapy, for me, is the experience of an encounter, and later I explain what was going on. Behavior therapy, for me, means understanding how the patient learned something and then helping them to relearn it. There, I have a clear intention of what to do. In psychodynamic therapy, I intend to understand what emerges from our encounter and to reflect on it afterwards, preparing for the next meeting. The intention is to be present for the guest or client so we can develop something together.

That's also the humanistic perspective. In humanistic psychology, the goal is personal growth, independent of symptoms. Symptoms are part of your life, but they are not the focus – you need to develop as a person. Positive psychotherapy links all these aspects. It's about growing as a personality, actualizing the potential you have. This is exactly what Peseschkian emphasized, like the humanistic psychologists: to actualize your capacities. And to experience this encounter through the three stages of interaction, or the five steps of treatment phases, and then reflect on it to understand what the pattern means – that's the psychodynamic part.

The behavioral part addresses concepts inherited from previous generations. We have the "tree of concepts," which shapes

GB:

What do you think distinguishes a good therapist from just a well-trained professional?

Arno Remmers:

I think a good therapist, as I explained before, is someone who adapts to the needs of their guests and is able to use something new that they may never have used before because it fits this particular guest. A good therapist is like a parent – someone who senses, feels, and understands the needs of the guest in this life situation, not to fulfill the needs for them, but to help the guest discover ways to meet their own needs.

For me, a good therapist provides a safe environment, especially for trauma patients or those with a personality disorder diagnosis. This safe space allows the guest to trust the therapist, to share everything they want, and to feel, after each session, "Oh, today I had another insight," or "I was angry with my therapist, but I am satisfied that I understood something." If this is missing, then it is not a good therapist.

A well-trained therapist might give the guest the feeling: "Oh yes, the therapist understood me well. What do I do with this? Ah, yes, they explained the balance model. That's interesting! I'll check if my wife has a good balance or not." That therapist has had good training, but being a good therapist is independent of whether you use the balance model, cognitive therapy, psychodrama, or any other method. What matters is that the approach fits the guest's channels of understanding and feeling, and meets their needs in this phase of life.

Arno Remmers:

As long as you are learning the theory of positive psychotherapy as a therapist, you don't yet have this capacity – it develops only through practice, in every seminar, in role plays. The more you practice, the more it becomes part of your natural way of working. You cannot learn how to work with countertransference from a book; you can only develop it by doing it. This is also what Bruce Wampold found in his research: it's not about the methods – it's about training, training, training, receiving feedback, watching yourself on video, and having colleagues give you feedback. Only then can you understand what happened between you and the guest, and only afterwards can you develop a theory from that experience.

GB:

What qualities do you think are most important for future trainers and supervisors in PPT, and do you believe these qualities can be learned or cultivated?

Arno Remmers:

I've already answered quite a lot of that, so you can distinguish for yourself which characteristics belong to your own personality. That's one thing. And you will find that a good therapist has all the primary capacities described by Peseschkian: you can trust this person, this person accepts you, gives you hope, and is someone you can believe in. This person organizes therapy in a way that makes you feel safe because of the structure. So, you need both primary and secondary capacities that the guest can feel in you, experience through you. This is something to explore in self-experience: to identify your weak points, your blind spots, and your strong characteristics – your capacities – and to be aware of them. That's one aspect we discussed earlier about what makes a good therapist.

There is something else, and this is often underestimated. It is the process between people that is so important. The difference between everyday life and psychotherapy is exactly this process. We have a limited time together, and it's not just talking about something; it's being with each other, with all the mimics, body language, experiences, feelings, and intuition we bring. This is a limited time – say, 50 minutes or so –, and it is paid time. Within this time, you need the first capacity – and I use my fingers for that – to listen. This is also grounded in humanistic psychology: to listen with empathy, so that you can feel something together with your guest, listen in a way that allows you to give feedback on how you understood it, and add words – mentalization – to help the guest understand what they feel. That's the first finger.

The second "finger" is knowing how to ask the right questions at the right moments. This helps the guest gain an understanding of their own psychodynamic patterns, social dynamics, family, and values that they can



Translators of the book of Nossrat Peseschkian together with the author

your current thinking. The role model is used for that, and the tree of concepts is part of it. This is very similar to what cognitive therapy calls cognitions: understanding them, integrating them, and relearning if necessary.

Depending on the patient, you can use all these aspects to meet the individual needs of the patient, the guest, or the client.

GB:

The hardest part, as you say, is learning to trust your own feelings as a therapist. To stay open to your countertransference, your intuitions, your momentary impulses, and to discern when to act on them, how, and when to simply hold them.

take home. To do this, you need theoretical knowledge – whether it's the Balance Model, role model dimensions, actual capacities, cognitions, roles in psychodrama, or other frameworks. Theory guides you in formulating the right questions. But theory alone is not enough – you also need practice, learning from experience with guests, to know how and when to ask these questions effectively.

The third "finger" is often underestimated in many psychotherapeutic methods. It comes from Alfred Adler's idea of encouragement and, in Positive Psychotherapy, from Peseschkian's focus on capacities. It's the ability to highlight resources and strengths – even in situations that have difficulties – using positive connotation. This is the longest "finger": the therapist's capacity to recognize what is working well, to name the guest's strengths, and to encourage them.

And then, in this process, the fourth "finger" comes. Ah, that's the finger with the ring – why exactly the fourth finger? Because it is about responsibility, decision, and change. I am married to my wife – nobody else – it's my decision, I want it, and we want it. That is our life now.

It's exactly the same in therapy: at some point, you identify the guest's resources, but then they have to decide: "Okay, what can I decide now? What can I do? How can I move forward?" That is the fourth finger. Supporting guests in this phase is perhaps the most challenging, but also the most important, because it helps to heal wounds, recognize ambivalence, and find a way to move beyond opposing positions – either/or, neither/nor – to discover a third path, a middle way.

Then comes the fifth "finger," which is often underestimated in many therapies. Steve De Shazer from short-term psychotherapy emphasized it a lot. "What would you do if this problem no longer existed?" – a question also typical of Peseschkian, like De Shazer's approach. It's about focusing on the future after the session and fostering the guest's independence.

The goal is that they do not become dependent on the therapist, but remain their own person, living their life independently. To see clearly: "Okay, what can you do with this, without the therapist?" This is the fifth essential capacity of a good therapist in this process.

And one thing I didn't mention at all is the cooperation with others. As a good psychotherapist, you must also be a professional in cooperating with your supervisor, with the intervention group, with other specialists, like those from medicine, psychology, social work, and so on. Like I do in the mental health hospital, where I have to work with all these specialists as a psychotherapist and be a link between them.

Because the psychotherapist understands the everyday life of the guest quite well, they can talk with the psychiatrist who gives the

medication and say, "Ah, this medication causes my patient to be unable to get up in the morning any longer. Can we change it? Is it possible?"

Or: "This is very good in this phase of mania, and now we are in the phases of depression, and I think we could talk about this. And what could the social worker do now with this patient who is not able to work?"

So, this cooperation is something that is very important and underestimated in many psychotherapy training courses, because we need to invite these specialists to find out how we can cooperate.

That was what Peseschkian did. He invited people from different professions so that we could feel and see, "Ah, what is their way to think and to look at things?" And as psychotherapists, we have to adapt to them as the moderators of this process of the guests with the social environment.

GB:

Thank you for raising this. In Bulgaria, we do something similar in our psychosomatics and psychopathology modules. We bring in experienced psychiatrists to co-train with the master trainer. That lived experience of collaboration makes a much deeper impact.

Arno Remmers:

I'm very happy that you still do it today, just as I did when I began in 1992. I started at the University of Varna in the mental health hospital and worked from the very beginning with Professor Todorov and other psychiatrists. Psychiatrists were also part of our courses. This cooperation became so important that, finally, the first exam for positive psychotherapists in Bulgaria was conducted by Professor Todorov, the head of the Department of Psychiatry, together with the clinical psychologist Ivanka Boncheva, and me as a psychotherapist.

That exam took place in the mental health hospital, and at that time, I already saw how crucial it is to involve and integrate psychotherapeutic knowledge into mental health and psychiatry – a practice Ivanka Boncheva also maintained consistently.

To this day, I continue to work in this field – in psychosomatics, in mental health hospitals, and alongside social workers – because I see the ongoing need for this kind of collaboration.

GB:

Since you've already mentioned Bulgaria, I'm curious how you view the development of PPT there over the years. What makes you most proud, and is there anything that concerns you, especially since it's like your 'first child'?

Arno Remmers:

It touches me deeply when you say it like this. It's a bit like having a child who is now grown up, with grandchildren – or even great-grandchildren – so I feel a bit like a great-grandfather. And I'm very happy with the professionalism that has been present from the very beginning with the group of positive psychotherapists in Bulgaria, much more than in other countries.

By professionalism, I mean the way they worked with other professionals in mental health and psychiatry. We had trainings in psychiatric hospitals across the country – in Ruse, Varna, Sofia, Pleven, and Stara Zagora. We maintained these connections with professionals all the time and continued to build on them. We also held the first national conference on positive psychotherapy in the world. Before that, there were conferences, but none that were national and specifically focused on positive psychotherapy. That was in Bulgaria.

It's professionalism. By 1996, I think, colleagues were already giving lectures specifically on the application of positive psychotherapy. I had also been working in science: there were habilitations, like those of Ivanka Boncheva and Ilya Peev, and dissertations, for example, by Stefanka Tomcheva and others.

This professional development is something I value greatly, especially because in 1992, I could see the capacities of the Bulgarian colleagues, but nearly none of us who were outside Bulgaria knew that there were such wonderful specialists. I encouraged them to translate their work, though it came a bit late.

But now it is working. We have Bulgarian colleagues represented on boards, in their literature, in global psychotherapeutic publications, and in international books. Since around 2010, we have seen an increasing Bulgarian presence in the international scientific community of positive psychotherapy.

This is significant. In Bulgaria, we have also developed children and youth psychotherapy, including family therapy. This is quite special, and I don't know if it's unique, but I believe it is – at least in positive psychotherapy. Involving family therapy, children and youth therapy, running workshops for parents, and offering groups for adolescents – like those in Ruse and Varna – has been remarkable. Colleagues like Ivanka Boncheva, Stefanka Tomcheva, Boryana Chalakova, Milena Manova, and others have contributed. This cooperation across fields, especially prevention and education, is so important – projects in Varna and Plovdiv are great examples.

Across this small country, you can now find positive psychotherapy services in almost every city. This is because the school of positive psychotherapy was created in a very structured way by Ivanka Boncheva and me. We started with a systematic approach, and a group of trainers from that time developed a very systematic education system, almost like a university curriculum. I am proud of that.

There's nothing that worries me too much. Perhaps just the need to adapt to new situations and new generations. But I see a good path forward, because young people in Bulgaria are becoming trainers. All generations must be represented in the trainers' group. This ongoing exchange among trainers gives me confidence. As long as they continue to train, both online and

offline, share experiences, learn from each other, and create together, I see a growing tree. As long as this trainers' group continues to grow, I see a bright future for positive psychotherapy in Bulgaria.

What I missed in the past, I no longer miss – the international network. Now we are sitting here at Wiesbaden Academy in Germany. We are traveling and connecting with people from 60 countries over the next few days for the Training for Trainers, now in its 26th edition. We started in 2000 with participants from 12 or 13 countries, and now there are 60. Bulgarians are even well known in China. Across this vast country, Bulgarians are seen as a model for positive psychotherapy in prevention, schools, teacher training, and management applications, based on work from the 90s. All of this was developed and tested in Bulgaria. So, for Ukrainians working in children and youth psychotherapy, you are also a model for others. Please take this to heart – don't be too shy or hesitant to show what you have achieved. Bulgaria has very strong experiences in all these areas; share them with others and also learn from them. You can exchange with each other, like with the Chinese. It is a bit more difficult now because of the new border between China and the rest of the world, much like in the past. But hopefully in the future, we can share again so that all of us can continue to learn from one another.

GB:

We are already sharing knowledge internationally. For example, our training for children and youth psychotherapy has been conducted in Ukraine several times, spreading our expertise to other countries. Also, the committees established within WAPP are particularly valuable because they bring together people from different nations. This naturally facilitates the exchange of ideas and knowledge, which in turn strengthens national-level sharing. I believe the expansion of the academy is excellent, and as you mentioned, this type of collaboration will continue to grow in the future.

Arno Remmers:

It reminds me that in 2010 I was invited to Beijing for a pedagogic conference, and there, for the first time in China, I presented about the experiences in Bulgaria in the pedagogic field. We had had this school project in Dobrich, the teacher qualification program in Varna at their institute for professional development, and we had been working with institutions in Varna with children with difficulties or disabilities. We trained teachers in family therapy, and we also trained pedagogical counselors for schools in family therapy. There was the "School for parents" in Dobrich as well. This was how the pedagogy projects started, and in 2010, it was published under the term "positive pedagogy." At the same time, here in Germany, someone published a book on positive pedagogy, and I was very happy

with this movement because prevention is so important.

Our role as therapists is not limited to therapy. My idea – and this was, by the way, exactly what Peseschkian said – is that 50% of our time should be spent on prevention, pedagogy, training parents, sharing our knowledge with institutions or judges dealing with family issues, and contributing in fields such as management where our expertise can be useful. For example, Gabriela Hum has a large institute working with companies, applying psychotherapeutic knowledge to help organizations.

In Bulgaria, I saw many projects where positive psychotherapy was applied in different areas: even in the military, in the naval high school, the free university, and so on. It can be used in many areas because it is a science about communication, a science about growth, about personality development, and about being human.

GB:

It's all very meaningful, this responsibility of the profession.

Arno Remmers:

Yes, this is a dynamic responsibility, especially in today's times. I see this responsibility when I observe that the pathological – yes, I must say it like that – the pathological personality patterns of some world leaders are the cause of millions of people suffering. It is their personality that they suffer from. Whether it is in America, Russia, or elsewhere, people suffer because of the leader's personality. It's so strange, but this is our field. This is our space, our place. We work with the Ukrainians; we help them as best as we can. It's very difficult to help when you are not there, but still, we try.

However, we cannot do anything about the personality that causes all this suffering. You can understand how such a personality develops over the course of a biography. Yes, but where is our space, our place, to solve conflicts – even cultural and national conflicts? That was something Peseschkian wanted: that we also work for peace in the world, this cooperation of all, because we are all fruits – or leaves – of the same tree, you could say.

I tried to do this myself by traveling to different countries, sharing, exchanging, and encouraging people to exchange between cultures and countries. Once I wrote it, I felt like a bridge builder. I feel – or I felt – a bit like I am constructing bridges. If they are used, that is not up to me, but I tried to do that. That's what I can do. I cannot work with the personality of a cruel leader. You cannot do that. I am not the therapist of such a leader, but I can share my knowledge as well as I can, and I can build a bridge so that we can share with each other. That's all I can do. Nothing more. That's it.

GB:

I completely agree. To build a better society, we must start with the individual. While we may not have the power to influence world

leaders – and that is a difficult limitation to accept – our true responsibility begins within.

In your opinion, what are the most important steps for PPT to continue its qualitative growth in Bulgaria?

Arno Remmers:

What I am a bit missing is the implementation of positive psychotherapy in medicine. In Germany, for 30 years, we have offered training for medical doctors – general practitioners, gynecologists, and all physicians interested in a psychosomatic understanding of the diseases and disorders their patients bring in. This is something we can provide to medical doctors. They will feel more confident with their patients – not as psychotherapists, but as doctors – when they have some insights from positive psychosomatic treatment. It's not about turning them into psychotherapists, but about helping them relate better to their patients. This is one area where I see the colleagues in Plovdiv, Sofia, and Varna as responsible for renewing these links between positive psychotherapy and the medical field.

I also have experience in China, where we established very good relationships through psychosomatic conferences in hospitals. There, medical doctors benefited from positive psychotherapy ideas without needing full psychotherapeutic training – just a basic understanding to enhance their psychosomatic perspective of patients' conditions. That is one important aspect. Another point is that positive psychotherapy is still not widely integrated into psychiatry, not only in Bulgaria but globally. We need to support positive psychiatry. What I miss is that in positive psychiatry, the method of Nossrat Peseschkian – positive psychotherapy – is fully included, as I see it. I have been working in mental health hospitals for many years in Germany, and before that in Varna, and I have seen the importance of this integration firsthand.

And so there are possibilities, not only with Balint groups, but also with understanding the life of the patients before prescribing medication. This helps to know better which medication might be the most suitable for a patient with this particular life situation. So it's important to have positive psychotherapy tools integrated into psychiatry.

I also see another area, and I think some of you have already explored it. I started this in Sofia around 1994: positive management. When it comes to management and human resources, as Gabi Hum in Romania uses it, it's a good opportunity to apply positive psychotherapy tools. We can provide training in positive management.

I also conducted such trainings for school directors in Bulgaria, showing them how to manage their schools in a way that promotes better well-being for themselves and their colleagues. This took place in Varna and Dobrich, around 1993/94.

Such ideas can also be extended nationwide, for parents in "schools for parents," where they can share experiences, learn how to educate children, and understand how to relate to younger generations, which often differ from their own. This is an area where your expertise in the Bulgarian positive psychotherapy community can provide enormous benefit. Working with parents might be the most important. Also in groups: I have found it very effective for parents to share experiences with each other, while I offer some ideas from my psychotherapeutic perspective, and then they reflect on and discuss what they experience.

And to raise positive psychotherapy to an academic level, it needs to be included as a university program. Ivanka Boncheva practiced that, and we also had an academic course for health management with methods of PPT. Ilya Peev tried to bring in PPT initially at the Free University in Varna. It was not highly recognized at the time, but he worked on it, and it was successful.

I believe we should have, like in Bolivia, a full basic and master's program in universities. Right now, I see great potential in Plovdiv, but why not in other universities as well? Any university interested can reach out to the association. The World Association of Positive Psychotherapy has experience in this field. We have several models for implementing positive psychotherapy at universities, and of course, we are happy to support them if the universities are interested.

It's no longer about us, as positive psychotherapists, trying to enter universities; rather, it is an opportunity for universities to include this in their curriculum – not just positive psychology, which is more superficial and not aimed at treatment, but positive psychotherapy for treatment and prevention. Like we had in Bolivia, a master's program in positive psychotherapy and counseling in 2004/2005, where I could bring in our experience. Several projects emerged from that program – projects addressing post-traumatic disorders in women, projects in indigenous villages, and projects improving communication at universities. It served as a starting point to strengthen the network and infrastructure of the country. Positive psychotherapy has the potential to have a similar impact elsewhere.

GB:

As far as I know, psychiatric clinics in both Plovdiv and Sofia are led by psychiatrists who are also positive psychotherapists, ensuring that qualified professionals occupy these critical leadership roles. It's wonderful to see people with that background in such important positions.

Arno Remmers:

They could start by training other medical doctors, for instance. In their positions, they can organize such trainings to explore a simple question: How can I feel more satisfied with my work? It's not only about how to treat patients better – it's also about

how to feel better as a doctor, whether in mental health or other fields. Naturally, if the doctors feel better, the patients will benefit too.

But the starting point is just this: "What can we do for the doctors so that they feel better?"

GB:

I know you dedicated significant effort during the founding years, and I would love to hear about your ongoing work and how the movement has evolved since those early days.

Arno Remmers:

Now, when I see that in the first three years of training in Bulgaria, when I had been living there nearly four years, there were 300 days of training, and each day had to be prepared, with literature and books ready, conferences organized, and many other preparations. Out of that, so many colleagues were motivated that the program continued on its own from 1996 onward, because the trainers had been well prepared. From then on, I was, as you mentioned before, like a father observing how it was developing.

Still, each year I visited Bulgaria, sometimes more often, talking with Ivanka Boncheva and all the trainers. We have been meeting regularly since then as a group of trainers, and I'm honored to still be invited, although I am old now. These meetings usually brought up new topics, such as children's therapy, family therapy, couple therapy, pedagogy, and so on. We organized conferences, workshops, supervision sessions, and other activities to continue developing the field.

This was my input, as far as I understand: I brought in experience from my fields, also in other countries, and shared with the Bulgarian colleagues what I thought, so that together we could develop professionalism, the growth of the association, and the network and infrastructure in the country – so that it could become an institution that even works with the state, universities, or local towns. This was possible because of our sharing with each other, bringing in ideas from social work and communities, for instance. I remember the first community session we had in Varna, still in the 90s. I was so nervous because there were 100 people from the administration in a big room, and I didn't know how to handle it. And that's where it started. Later, the administration of Varna maintained a good link with us, called us, and we had contracts with them.

I see it as the fruit of our cooperation. You were like the tree growing in the country, in a big garden, and from time to time, I came and gave you fertilizer. The water came from within your country, but the fertilizer sometimes came from outside, and then other fruits, seeds, or plants grew in this garden – and I brought them in. That's what was good about it.

All this experience I collected in Bulgaria in the first four years – from 1992 onward – was later spread to about 12 other countries. Sharing with other countries sparked ideas I could bring back to Bulgaria. This process was very interesting, like observing different gardens, thinking: "Ah, this fruit is growing well here, let's see how it grows there."

Because of this, Chinese colleagues often speak of you, the Bulgarians, with admiration: "Wow, look at what they have developed." They can use it, and they profit from your experience over the last 35 years.

GB:

That sounds like a truly empowering transition. When did you feel confident that the foundation in Bulgaria was strong enough for you to focus on other countries and projects?

Arno Remmers:

I don't know if I'm allowed to say this, but I started thinking about it the moment I came to Bulgaria. I first arrived in 1991, but from 1992 I lived there. Just two months later, I was in Russia at a conference with Nossrat Peseschkian, and I was asked: "How is the psychotherapeutic situation in Bulgaria?" I shared what I had experienced in those two months and realized that whatever we develop in Bulgaria could be interesting for others.

From June 1992 on, I maintained contact with other countries – Russia, Poland, Romania, and so on. It was clear that the work in Bulgaria could be relevant elsewhere, so I would also travel to other countries to provide training. But it never felt like I was leaving Bulgaria. It was always about entrusting the work to capable hands. In October 1995, I returned to Germany, leaving the leadership to Prof. Ivanka Boncheva and the group of trainers. I never really felt I had left Bulgaria. For me, it has always been my second home. I still have an EGN, a personal number there. I no longer own a house, so I'm not registered, but until this year, I even had a car registered there. In that sense, I never left. I just entrusted things to your hands because I couldn't do more – or didn't need to.

Now, the younger generations manage very well without me, and I know that if you need me, you will ask – and then I will come. If not, I don't interfere unnecessarily. Of course, I still visit friends, but it's not a matter of obligation. Last time, my wife and I were in Varna and also in Ruse, where I lived for some time. I felt at home – I even sometimes dream in Bulgarian. So yes, I go whenever I'm needed.

And the other comforting thought is that I know you can manage without me. That's a very good feeling for a great-grandfather.

GB:

It makes me think of the metaphor of a tree growing alongside a person. At first, it provides shade for a cradle; then, it becomes a place for a child to play hide-and-seek. Later, it stands as a silent witness to a first kiss. As life moves forward, the tree is

always there, ready to give whatever is needed – whether branches to build a home or a trunk to craft a boat.

Arno Remmers:

Yes, and we have to plant seeds that will grow into trees again. This tree will one day be old, and we need to see which fruits the next generation will need. So we need more trees in this garden, more flowers, more plants – not just tomatoes, but 20, 30 different kinds of fruit.

GB:

Thank you. What message would you like to leave for Bulgarian therapists who are just starting out on this path? Of course, this will be interesting for each of us, because we've been talking about the new generations – the people who will grow up to carry this work forward.

Arno Remmers:

It's like being at sea. Sometimes there's a storm, and the sea is rough; other times it's so calm that you can swim in warm water. Both are needed.

The warm water, where you can swim, fulfills your needs as a future trainer, a trainer, a psychotherapist, or even as a guest. But be prepared – storms will come, and there will be difficulties. Without these storms, you wouldn't see the shells on the beach. Without the storm, there is no development. The storms are necessary. Sometimes, at the beginning of your work as a trainer, for example, you will face rough times – perhaps not earning enough, not having a comfortable life, or feeling the weight of responsibility for your groups. Over time, you may understand that these burdens train you and teach you important lessons. Personality needs storms and rough seas to grow. That is what I have experienced in my life.

I can share with you that my generation did not experience a war firsthand, as the Ukrainians have, but our parents did. The

Ukrainians show us how to navigate such stormy situations. They are still traveling, still active in their country, even with the war around them. They demonstrate the courage one can have when the sea is violently rough. They apply what they have learned as positive psychotherapists for the benefit of the country's soldiers, families, parents, and children.

So, be prepared to use your knowledge not just for yourselves or your guests, but for the future – for the rough seas. Now we are like in a harbor with our seminars: it's calm, and we're prepared. But when the storm comes, stay united. Be a unit of trainers and a community of psychotherapists and positive psychotherapists, so that you can support each other and help others from different modalities.

This is something I also want to give you: the more you cooperate with other modalities – CBT, psychodrama, Gestalt, family therapy, couple therapy, and many others – the more you support each other, the better you will navigate stormy times. This applies to changes in psychotherapy, infrastructure, societal difficulties, or upcoming protests. By working together, you can maintain a position to contribute to a good future and a better society. You are part of that society, with the responsibility to share and give your knowledge. Society may not meet your needs directly, but if you offer something, it will give something back. People will give back when you give to them. And when you are needed, go where you are needed. When you have a personal need, learn how to meet it – or keep it in the background if necessary.

That was also my experience. When I came to Bulgaria, I couldn't see my family for a while. I had to suppress my own needs for some time.

Today, I am happy with that, even though it was very difficult. It was necessary because there was a need. I go to countries and people who need me; I don't go just because I want to.

And not every time can I fulfill my own needs when there is a storm. I must wait and think, "Okay, later there will be time for my needs. First, I have to see where I am needed." I'm sorry to say that, but that is my experience. It may not fit everyone, but it is my experience.

GB:

It seems that this is deeply meaningful for you. You prioritized being in tune with the needs of the community, setting aside your own needs for the greater good.

Arno Remmers:

Thank you very much for these questions. I've learned a little more about why I am the way I am – why I chose to live my life in this, let's say, very unusual way.

When you look at my biography, it is indeed a very unusual story, full of changes. And today, I am so grateful for that. All the things I suffered through, all the very difficult moments, I see now that I didn't need them, yet they shaped me.

I thank all of you and all the colleagues who carried this forward, and who are now part of this group continuing the work for the country. I can look at it with deep gratitude for what life has taught me and for what it expected from me. I am thankful for that.

Thank you for your questions, which also gave me the opportunity to reflect on myself, on why I am this way. In answering them, I have learned again what it means to have lived this life.

GB:

Thank you very much for such a meaningful interview. Beyond your wisdom, it was your warmth and the genuine human connection that touched me the most. I believe your path will resonate deeply with many people, leaving them both moved and inspired by your dedication to PPT and humanism. I am certain that readers will find great inspiration in your words.

Prepared and written by:



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WAPP NEWS

World Association for Positive and Transcultural Psychotherapy, January 2026

*Dear WAPP Members,
Dear friends and supporters of Positive Psychotherapy worldwide,*

The start of 2026 finds our world at a crossroads. Wars persist, divisions deepen, economies strain, and many people carry a heaviness that wasn't there before. We see it in our clients and patients, in our colleagues, in ourselves. And yet, here we are: 3,100 strong, spanning 65 countries, choosing connection over isolation, hope over despair, action over paralysis.

This is not naive optimism. It is the lived practice of what Nossrat Peseschkian understood so well: real change doesn't wait for perfect conditions. It starts in the therapy room, in the conversation with a neighbor, in the choice to see conflict as potential rather than a dead end. From there, it ripples outward in ways we cannot always predict or measure.

Our numbers tell one story: new members joining monthly, training centers launching in places we'd never imagined, translations bringing our work to new languages and cultures. But the deeper story lives in the moments we cannot quantify: the client who finds words for their pain, the trainee who discovers their calling, the supervisor who holds space for another's uncertainty.

To those already walking this path with us: thank you for showing up, especially when it's hard. Your presence matters more than you know. To those considering joining: we need you. Your questions, your contexts, your contributions. WAPP membership is not about credentials or geography – it's about shared commitment to healing work that crosses borders and builds bridges. [Learn about WAPP Membership.](#)

Whatever 2026 brings, we'll meet it together: grounded in dignity, guided by hope, connected across distance.

*With gratitude and resolve,
The WAPP Board of Directors and Head Office*

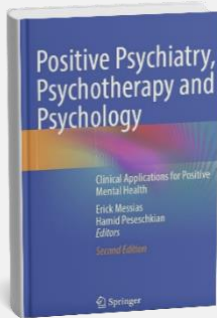


WORLD ASSOCIATION FOR POSITIVE AND TRANSCULTURAL PSYCHOTHERAPY (WAPP):
3,100+ members from 65 countries on 6 continents in January 2026



WAPP NEWS- Updates from the World of Positive Psychotherapy

POSITIVE PSYCHIATRY, PSYCHOTHERAPY, AND PSYCHOLOGY



The release of the second, enlarged edition of the global handbook *"Positive Psychiatry, Psychotherapy, and Psychology – Clinical Applications for Positive Mental Health"* marks a watershed moment in the field. This ambitious volume brings together 75 authors from 19 countries across 55 chapters spanning 702 pages, making it the only book worldwide to synthesize these three complementary approaches to positive mental health.

[Read the book](#)

PROTECTING A LEGACY: POSITIVE PSYCHOTHERAPY TRADEMARK

In a significant development for the field, **Positive Psychotherapy (PPT after Peseschkian, since 1977)**[™] has secured trademark protection across 32 countries. The registered trademark now extends throughout Europe and beyond, including the United States, the United Kingdom, Ukraine, Türkiye, Russia, and

all 27 EU member states that have adopted the registration.

TRAINING FOR TRAINERS ON ONLINE TEACHING

Recognizing that the pandemic permanently transformed how psychotherapy training is delivered, WAPP has launched specialized training programs for its trainers and candidate trainers. While many have successfully transitioned to online course delivery using self-developed methods, the European Association for Psychotherapy (EAP) now requires that trainers delivering courses in online formats undergo specific training.

WAPP's response has been to organize complementary training sessions focused on online teaching tools, designed to help trainers enhance their skills and learn effective techniques for running high-quality virtual seminars.

CLINICAL SUPERVISION DIPLOMA

Many certified positive psychotherapists wish to provide clinical supervision to colleagues but find the lengthy process of becoming a Master Trainer either unsuitable or impractical for their circumstances. The new **Clinical Supervision Diploma** program offers an alternative route, allowing any Certified Positive Psychotherapist who meets eligibility criteria to complete focused training

and, upon passing the final assessment, become certified as a Clinical Supervisor for Positive and Transcultural Psychotherapy.

The inaugural group is preparing to launch in Ukraine, with an international English-speaking cohort scheduled to follow. Interested practitioners can direct inquiries or applications to WAPP at assistant@positum.org.

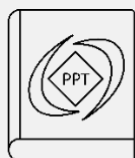
EXPANDING RESEARCH VISIBILITY

WAPP's commitment to disseminating research has taken a significant step forward with the establishment of a Publisher account on ResearchGate for *"The Global Psychotherapist"* peer-reviewed journal. This collaboration with the world's largest academic social network for scientists and researchers means that published articles will gain enhanced visibility and accessibility within the global research community.

ResearchGate

The partnership with ResearchGate enables researchers, clinicians, and students worldwide to more easily discover, access, and cite Positive Psychotherapy research. Authors publishing in the journal benefit from expanded readership, while the platform's algorithms help connect their work with relevant researchers and practitioners.

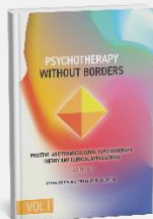
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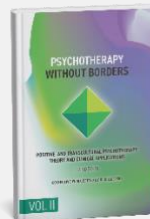
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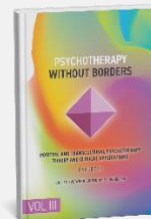
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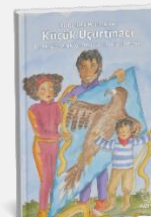
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26th International Trainer Seminar, November 2025 (Wiesbaden, Germany)



First Chinese Conference on Positive Psychotherapy, September 2025 (Guilin, China)

National Conferences on Positive Psychotherapy



Armenia, September 2025



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