THE GLOBAL PSYCHOTHERAPIST

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

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WELCOME BY WAPP PRESIDENT

DR. HAMID PESESCHKIAN

"I believe that a different therapy must be constructed for each patient because each has a unique story."
Irvin D. Yalom

Dear Reader,

In your (virtual) hands you are holding the first issue of *"The Global Psychotherapist"*, the international journal of Positive and Transcultural Psychotherapy. Like everything, it has a past, present and – hopefully – a bright future.

The Past:

Five years after Nossrat Peseschkian (1933-2010) founded Positive Psychotherapy (PPT) and published the first of his 29 books in 1974, he decided to form the German Association of Positive Psychotherapy in 1977, and to publish a regular journal. The first issue of the German Journal of Positive Psychotherapy (Zeitschrift für Positive Psychotherapie) was published in November 1979 and mentioned four themes as the main purpose of the journal: education, self-help, psychotherapy, and transcultural problems. As Nossrat Peseschkian explained further in his editorial: *"These four aspects of Positive Psychotherapy are important elements of a psychotherapy, which has a preventive function and understands human-beings in their social and economic environment"* (1).

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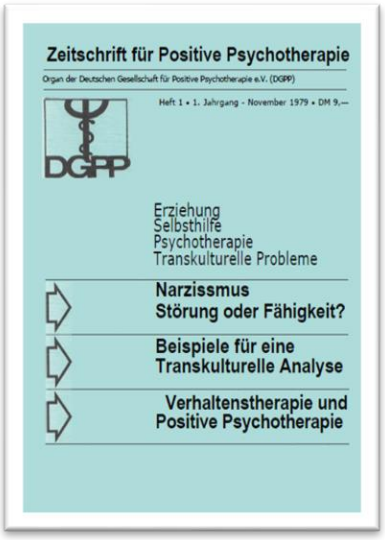

The first issue of the German Journal of PPT from November 1979

The inclusion of a transcultural viewpoint into the everyday work of psychotherapy was not only a central concern of Nossrat Peseschkian from the very beginning, rather transcultural questions had a political-social dimension for him: *"The transcultural approach runs like a red thread through the whole of Positive Psychotherapy. We consider it especially because the transcultural point of view also offers material useful for the understanding of individual conflicts. Furthermore, this point of view possesses extraordinary social significance: Problems of guest workers [immigrants], of help with development, problems which arise in dealing with people from other cultural systems, problems of transcultural marriages, prejudices and overcoming them, alternative models which originate from another cultural framework. In this connection we can also address political problems which originate in a transcultural situation."* (1).

With the expansion of PPT, especially to Eastern Europe, journals in other languages and countries followed in the 1990s.

The Present:

Today, Positive Psychotherapy has become an international movement: The World Association for Positive and Transcultural Psychotherapy (WAPP) has more than 1,600 members in 35 countries and five continents; Training Centers of Positive Psychotherapy are active in more than 20 countries; more than 150 trainers are teaching hundreds of PPT training courses every year; some leading books were published; dozens of theses on PPT have been written and defended; the first National Association and PPT-Center on the African continent was established; the 7th World Congress was held in 2019; and Positive Psychotherapy (PPT after Peseschkian, since 1977) was registered as a trademark.

Our world has changed a lot since 1979, but the message of Positive Psychotherapy is getting even more and more important every day. Not only, because PPT as a humanistic psychodynamic psychotherapy method integrates approaches of the four main psychotherapy modalities: a humanistic conception of human-beings, a psychodynamic understanding of disorders, a

systemic approach towards culture, work and environment, and a practical, goal-oriented approach with some cognitive-behavioural techniques (2). But this conflict-centred and resource-oriented short-term psychotherapy can be applied in different areas of human endeavour, and thus bring psychotherapeutic insights into daily life.

With this expansion and firm foundation of PPT during the past decade, it was a logical step that the WAPP Board of Directors decided to re-launch its international journal. With Professor Olga Lytvynenko and Professor Erick Messias as the main editors, assisted by an experienced international editorial and advisory board, the Journal is in good and very capable hands.

The Future:

Scientific papers and journals are often boring, but this must not be the case (3, 4). The publications of Positive Psychotherapy have shown over the past 50 years, that it is possible to publish exciting, refreshing and stimulating papers, which are at the same time very deep and thought provoking.

It is the hope of the WAPP Board that this Journal will offer an international platform, and – in the words of Nossrat Peseschkian – "*Our aim is to offer both: high quality scientific articles and information and an opportunity for international dialogue and friendship"* (5). As an integrative and transcultural method, this PPT-Journal offers unique opportunities to exchange professional experiences from all over the world. Young professionals will find here the possibility to combine scientific and practical work, and to become future experts in both. Positive Psychotherapists all over the world have developed an identity as *global psychotherapists* and want to share their experiences with like-minded colleagues.

Now, dear reader, the Journal is – in many ways - in your hands. Your papers and contributions will keep it alive and attractive. It is my hope that *The Global Psychotherapist* will contribute to a deeper understanding of a global society, and can find an answer to the question: *"What do all people have in common?"* (5).

***Dr. Hamid Peseschkian**, MD, DM, DMSc, IDFAPA*
WAPP President
Medical and Academic Director,
Wiesbaden Academy for Psychotherapy

References:

[1] Zeitschrift für Positive Psychotherapie. Heft 1, 1. Jahrgang, November 1979.

[2] **PESESCHKIAN H., REMMERS A.** (2020) *Positive Psychotherapy: An Introduction*. In: Messias E., Peseschkian H., Cagande C. (eds) Positive Psychiatry, Psychotherapy and Psychology. Springer, Cham.

[3] **SAND-JENSEN K.** (2007) *How to write consistently boring scientific literature*. Oikos 116. pp.723-727

[4] **CHAPMAN, P.** (2014). Scientific papers should not be boring. *Marine Pollution Bulletin*. 87. 10.1016/j.marpolbul.2014.08.020.

[5] **PESESCHKIAN, N.** (2011). Former President´s Message. Posthum published editorial for the first issue of the International Journal of Positive Psychotherapy and Research, p. 3.

WELCOME BY THE EDITORIAL BOARD OF

THE PPT JOURNAL
"THE GLOBAL PSYCHOTHERAPIST"

Dear Reader,

It is with great pride and delight we are able to present to you the first edition of *"The Global Psychotherapist"* - International Journal of Positive Psychotherapy. As you will discover, *The Global Psychotherapist* has been put together by an outstanding group of editors who are responsible for selecting and arranging the articles that make up its content. All articles have been blind peer reviewed by scholars with Positive Psychotherapy expertise in the medical and counseling fields. We thank you for all for the in-depth work, focus and time commitment to bringing this journal to full publication.

The Global Psychotherapist aims to inform, stimulate debate and assist the profession of psychotherapy to develop across boundaries and continents. The journal's goal is to inform about the transcultural benefits of Positive Psychotherapy (PPT) and its unique approach to healing, increasing the evidentiary basis for PPT's effectiveness and to share its immensely practical application in various domains and fields including medical, educational and social.

Positive Psychotherapy was originally founded in 1968 by our beloved Nossrat Peseschkian (June 18, 1933 – April 27, 2010) who authored more than 26 different psychotherapeutic books, as "differential analysis," an ode to how people develop and refine their innate capacities. By 1977, it formally become Positive Psychotherapy. Positive Psychotherapy is an inherently transcultural form of psychotherapy that is one part psychodynamic and one part humanistic. It is designed to help clients reorient and advocate for themselves by using their inner resources to overcome challenges, understand and recognize areas of growth, and focus on working towards resilience and developing a greater sense of self.

Our long-term goal for "The Global Psychotherapist" Journal is to help expose PPT to a world that is rapidly modernizing and transcultural and in real need for a model of psychotherapy that is sensitive to these dynamics and is easy to learn, practice, and apply.

We hope you will find in these pages a very accessible overview of what Positive Psychotherapy offers today. In this, we also hope that it will help you discover new and exciting ways to understand psychotherapy and how it may be useful in your own practice and work.

Therefore, this journal is essential reading for informed psychological, medical and educational practitioners, trainers and students who recognize the value of transcultural approaches to healing and wish to develop a greater understanding of developments in psychotherapy world-wide.

Finally, we trust that you will enjoy reading these papers and be intrigued enough to come to our next World Congress in 2022, to join the World Association of Positive Psychotherapy and to become a certified Positive Psychotherapist.

The Editorial Board

"The Global Psychotherapist",
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POSITIVE PSYCHOTHERAPY IN THE TIME OF GLOBAL CRISIS

by PROF. DR. NOSSRAT PESESCHKIAN, M.D., WIESBADEN, GERMANY

First published in
International Journal of Positive Psychotherapy and Research. Issue 1 (2011)

Introduction

Transcultural difficulties – in private life, work and politics – are growing increasingly important today. Given the way society is developing now, the solution of transcultural problems will create one of the major tasks of the future. While people of differing cultural circles used to be separated by great distances and came into contact only in unusual circumstances, technical innovations have dramatically increased the opportunities for contact in our time. Just by opening the morning paper, we step out of our own living space and make contact with the problems of people from other cultural circles and groups. Generally we interpret these events in ways that we've grown up with. We are ready to criticize, damn or make fun of them because of their supposed backwardness, naiveté, brutality or incomprehensible lack of concern. In the transcultural process we deal with the concepts, norms, values, behavioral patterns, interests and viewpoints that are valid in a particular culture.

Methods

Characteristics for a time of globalization with its positive and constructive consequence:

1. What have all people in common and by what do they differ? (Principle of hope).

Our world has changed. For the first time in history of mankind a global, interconnected society is emerging whose characteristic feature is its cultural diversity. The process of globalization – not only at a political level, but first of all at a mental level – does not take place without challenges. We face the task of giving a new direction to our fields of specialization in order to enable them to adequately cope with the demands of the modern world. This, however, requires a shift in deliberation – from a monocultural and monocausal consideration to a multicultural and multicausal one.

These changes and challenges affect each individual, and, above all, individual health.

2. Existing problems of the world **(Stage of observation – distancing).**

It is a fact that our communication today is stricken with a worldwide crisis that is reaching the extent of an epidemic. In their conjugal communication partners are facing the pain of mutual misunderstanding and disregard, families are suffering from an almost missing or merely superficial way of communication between parents and children.

Likewise, the communication between governments and their peoples shows a state of mutual distrust, of invectiveness, deception and animosity. Moreover, there was an unprecedented crisis of communication between the super powers - a situation that easily could have resulted in the annihilation of the entire life on this planet.

3. Different meanings of the same behaviour in diverse cultures **(cross-cultural aspects)**.

This relativization of the concept of illness is especially important for the dynamics within the family. It gives the illness a definite function and sets the tone for the relationships between family members. This is the case

regardless of whether the illness is psychic, psychosomatic, psychotic or somatic.

We investigate how the same disorder or illness is perceived and assessed in other cultures, how the people in a particular culture or family face the illness, what particular meaning the conflicts have for the individual, and which contents they address.

4. Eradication of racial and national prejudices in some countries of the world. Reduction of religious prejudices in the world, interaction and dialogue between different religions are favorable signs of this development **(capacity to know - capacity to love)**.

5. The active role of so many non-political, humanitarian institutions (for example NGOs) which employ themselves for realization of world peace, protection of minorities and abolition of poverty. International and national associations such as „Doctors without Borders" (Ärzte ohne Grenzen), Red Cross etc. are improving. The involvement of ever greater numbers of people in the quest for peace is vital and their readiness to help each other in times of crisis and natural catastrophes is important as well as in matters of mutual concern **(Positive Psychotherapy in comprehensive sense).**

6. The spread of youth movements for the interest to investigate about foreign cultures, and their endeavor to have understanding and confidence in them as well as their involvement in active work in developing countries. The inter-racial and inter-cultural marriages between people from Africa, Asia, Europe, Australia, and Americas indicate the means by which the practical problems of humanity may be solved **(future of family and culture)**.

7. Increased calls for an honest acknowledgement that materialistic ideas have failed to satisfy the needs of mankind and a fresh effort is now made for family life, spirituality and other qualities of human life **(Principle of Balance Model**).

8. Increased number of rich people, who believe that disparity between rich and poor keeps the world in a state of instability and try to use their wealth for bringing changes in the society, for example through the establishment of foundations for education, health, abolition of poverty etc. **(first maturity and then wealth)**.

9. Increased activity and partnership of women in all fields of human endeavors (economic, social, political etc.). Through this development the goal of the emancipation of women and the achievement of full equality between the sexes is a new motivation in politics, economy and science **(equality of women and men).**

10. Our world is coming closer to a comprehensive globalization (world peace, global economic model, standards for a world monetary policy, environmental issues, education standards etc). It happens through the engagement and activity of world citizens.

11. This transcultural view is evident throughout all of Positive Psychotherapy. We give it such great importance because it helps us understand the individual's conflicts. It can also be important in dealing with such social issues as the treatment of illegal immigrants and refugees, foreign aid for the Third World countries, problems in dealing with members of other cultural systems, interracial and transcultural marriages, prejudices, and alternative life-styles adopted from other societies. It can also be applied to political problems brought about by transcultural situations.

12. The European Union is an example for 27 countries working together. Mass media like television, radio, newsletters, internet etc. are building a global information network **(stage of broadening of goals)**.

Instrumentarium of Positive Psychotherapy:

1. Three principles of Positive Psychotherapy.
2. Nine Theses.
3. 20 Techniques.
4. The questionnaire of Positive Psychotherapy.

Conclusion

In the same way that there are cultural circles, there are also educational circles within which a person develops his own cultural system, which then collides with other systems. The principle underlying transcultural problem thus becomes the principle for human relationships and the processing of inner conflicts. It thereby becomes an object of Positive Psychotherapy.

In that Positive Psychotherapy deals with elementary human capacities, it is in a position to speak to people of all languages and social state and to cope effectively with transcultural problems. Therapeutically, Positive

Psychotherapy offers an effective five-stage short therapy which activates the patient's indwelling therapeutic capacities. In other words, the patient is not only the sufferer of his illness, but also is employed as a therapist himself.

THE UKRAINIAN-LANGUAGE ADAPTATION FOR THE WIESBADEN INVENTORY FOR POSITIVE PSYCHOTHERAPY AND FAMILY THERAPY (WIPPF)

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Abstract

The article presents adaptation and verification made for the psychometric characteristics of the Wiesbaden Inventory for Positive Psychotherapy and Family Therapy. The psychometric characteristics and other approbation results for the offered Ukrainian-language version of the examined Inventory are shown. The data on the Inventory diagnostic are described and its prognostic capabilities to determine factors of an individual's self-determination, psychological well-being and psychological hardiness are assessed.

Keywords: approbation of the inventory, positive mental health, Positive Psychotherapy, actual capacities, psychological well-being.

Introduction

The Positive Mental Health Movement which comprises positive psychology, positive psychotherapy and positive psychiatry is a new promising direction around the world. The fundamental feature of this direction is a change in the focus of approaches to a person from the symptoms' and deficits' orientation on the development and support of his or her internal resources (Messias et al., 2020). In this positive sense, mental health is the basis of well-being and effective functioning of a person, in which he or she can realize his/her own potential, effectively overcome difficulties, and work productively and fruitfully. Empirically based, it is necessary to develop and improve diagnostic tools for measuring the constructs of positive human mental health to develop this direction. Therefore, the study of the possibilities of using the few existing effective diagnostic tools is a significant task of modern psychology, psychotherapy and psychiatry.

The Wiesbaden Inventory for Positive Psychotherapy and Family Therapy is an original tool that examines self-assessment of characterological and personal characteristics (primary and secondary abilities), the content of conflict reactions manifested in four areas of the balance model,

sources and psychodynamics of conflict underlying basic personality concepts.

The Inventory was developed by N. Peseschkian in collaboration with H. Deidenbach (Peseschkian, & Deidenbach, 1988). The modern English version of the Inventory (WIPPF 2.0), revised and supplemented by A. Remmers, is intended for use in different cultures and for translation into other languages (Remmers, 1996)

The Inventory consists of 88 statements, providing four levels of their evaluation: fully agree, partially agree, partially disagree or completely disagree. For data processing, these verbal estimations are translated into the appropriate points: fully agree - 4 points, partially agree - 3 points, partially disagree - 2 points, completely disagree - 1 point.

The authors have identified 27 inventory scales, assessing subjective significance for an individual of their personal characteristics in the following three areas: 1) actual abilities (secondary to their own behaviour; primary in relation to themselves); 2) manifested conflict reactions in four areas of the balance model; 3) subjectively perceived parameters of the model of relations.

The Inventory is intended to use mainly in psychotherapy, so clients, through reflection and self-assessment, start understand their internal resources, the content of conflicts they are involved, their conflict reactions and psychodynamic origins of such reactions.

For WIPPF application for research purposes, the standardization of research data is important; in particular, the normative values for the Inventory scales should be determined.

Methods and organization of the research

The adaptation of WIPPF was a part of a comprehensive study at the Laboratory of Psychology of Personality, Kostiuk Institute of Psychology, the National Academy of Educational Science, Kiev, Ukraine.

The modern version (WIPPF 2.0) of the Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (Peseschkian, & Deidenbach, 1988; Remmers, 1996) was used for translation into Ukrainian and subsequent adaptation. The translation into Ukrainian was made by professional translators and adapted to the socio-cultural norms of the Ukrainian language.

In addition, an adapted version of S. Maddi's Hardiness Scale (Leontev, & Rasskazova, 2006); adapted Ryff's Scales of Psychological Well-being (Ryff, 1995; Shevelenkova, & Fesenko, 2005); the General Causality Orientation Scale of E.Deci & R.Ryan adapted by O. Dergachova, L. Dorfman and D. Leontiev (Deci, & Ryan, 2002; Dergacheva, Dorfman, 2008) were used in the empirical research to determine the competitive validity of WIPPF, as well as its diagnostic and prognostic capabilities. The methods of descriptive statistics, correlation analysis, regression, comparison of averages were used for data processing and statistical analysis.

The empirical data processing was carried out using the statistical software package SPSS 21.0 for Windows.

Participants of the research. The sample for Ukrainian-language version adaptation consisted of 384 people, including 96 men and 288 women, aged 19 to 62 years. The average age was 37.7 ± 11.1. By their main activities, they were: students attending the advanced training in Positive Psychotherapy methods, working specialists (teachers, engineers, managers of different levels, lawyers, economists, psychologists, doctors, social workers, rehabilitation specialists, etc.). All respondent can be described as psychologically well, somatically healthy, without visible personality disorders.

Results

The research carried out using the Ukrainian-language inventory has shown a fairly high internal consistency. We calculated the internal consistency of the scales by Cronbach's alpha (the consistency of inventory three statements determining a scale value). Internal consistency scores assessed using the Cronbach's alpha were quite acceptable and ranged from 0.73 to 0.86 for different WIPPF scales.

The retest study was conducted 1.5 months after the first testing. We re-interviewed 157 people aged 19 to 53 years (average age 34.8 ± 8.4 years), 44 men and 113 women. There were no statistically significant differences in age and gender (Mann-Whitney test, $p < 0.05$) between the test and retest samples.

Correlations were calculated between the WIPPF test and retest scales for each scale (Pearson's method, $p < 0.05$, $p < 0.001$). The Inventory retest reliability after the period of 1.5 months was quite high (mean $r = 0.78$, $p < 0.001$). That is, the test showed fairly high retest reliability.

The sample classification by age was made on the basis of psychosocial developmental stages proposed by Eric Erickson (from 19 to 35 years - youth; from 35 to 60 years - adulthood). There were small, but statistically significant differences between different age groups (Mann-Whitney test, $p < 0.05$) for the scales of Trust (the average value for young people was 8.6 ± 1.4; the average value for adults was 9.3 ± 1.7) and Hope (the average value for young people was 8.8 ± 1.7; the average value for adults was 9.6 ± 1.5).

There were no statistically significant differences for the WIPPF scales between men and women. Obviously, the inventory scales are not gender specific. But since the number of men in the sample is much smaller, this issue can be investigated in more depth in the future.

As for the respondents' activities, there were no statistically significant differences.

The normative values for the Inventory scales, obtained initially on the basis of mean points and standard deviations for the general sample (the test study), showed strong overestimation of Sincerity, Trust, Hope and an underestimation of Thrift.

To determine the WIPPF normative values that are characteristic for a psychologically mature personality, we used as a main criterion for respondents' selection the indicators of psychological hardiness (the respondents showed values above average or high for this indicators). This is justified by the fact that hardiness is a disposition that helps to overcome internal stress in difficult life situations through hardy coping with stresses. Since psychological hardiness is closely related to indicators of psychological well-being and self-determination (Serdiuk, Danyliuk, & Chykhantsova, 2019), these indicators were two additional criteria for selection.

The normative values were determined with the 3σ rule, according to the Gaussian normal distribution law: 99.6% of the general population data are within 3 σ, 94% are within 2 σ and 68% are within 1σ. Therefore, the statistical normative values will be defined as a mean ± standard deviation (μ ± σ).

Thus, the standard values for the Inventory scales are presented in Table 1.

Table 1.

Normative values for WIPPF scales (n=315)

	WIPPF Scales	Mean	Std. deviation	Norms
Secondary capacities	Orderliness	7.8	1.7	6.1 – 9.5
	Cleanness	7.9	1.7	6.2 – 9.6
	Punctuality	8.1	1.9	6.2 – 10.0
	Politeness	7.5	1.6	5.9 – 9.1
	Sincerity	8.2	1.3	6.9 – 9.5
	Activity	8.5	1.5	7.0 – 10.0
	Seriousness	9.1	1.2	7.9 – 10.3
	Thrift	6.2	1.8	4.4 – 8
	Obedience	7.5	1.5	6.0 – 9.0
	Justice	9.1	1.4	7.7 – 10.5
	Fidelity	9.0	1.3	7.7 – 10.3
Primary capacities	Patience	9.2	1.3	7.9 – 10.5
	Time	8.5	1.5	7.0 – 10.0
	Contacts	9.0	1.5	7.5 – 10.5
	Trust	9.6	0.9	8.7 – 10.5
	Hope	9.7	1.2	8.5 – 10.9
	Sexuality	9.5	1.3	8.2 – 10.8
	Acceptance	9.2	1.0	7.2 – 10.2
	Faith	8.6	1.7	6.9 – 10.3
Conflict reaction	Body	7.5	1.9	5.6 – 9.4
	Achievement	8.1	1.9	6.2 – 10,0
	Contacts	7.3	1.8	5.5 – 9.1
	Future	8.2	1.8	6.4 – 10.0
Model dimension	I – mother	8,0	2.6	5.4 – 10.6
	I – father	8.0	2.9	5.1 – 10.9
	I – others	6.6	2.9	3.7 – 9.5
	You	8.1	2.6	5.5 – 10.7
	We	8.3	2.4	5.9 – 10.7
	Primary I	7.0	2.4	4.6 – 9.4

Checking of the Inventory competitive validity presented a certain difficulty, since there were no adequate diagnostic tools for this. For this purpose, correlations with personality constructs were investigated to distinguish between people with different levels of self-determination, psychological well-being and hardiness. Table 2 shows the correlations between actual abilities and other personality constructs characterizing a self-fulfilling personality.

Table 2.

Correlations between WIPPF scales and the indicators of psychological well-being

	Positive relations	Autonomy	Environmental mastery	Personal growth	Purpose in life	Self-acceptance	Psychological well-being	Self-determination	Commitment	Control	Challenge
Order-liness	-.25	-.16	-.08	.18	-.09	-.15	-.14	-.05	-.28	-.25	**-.39***
Clean-ness	-.26	-.21	-.27	.04	-.09	-.26	-.29	-.38	-.24	-.26	**-.45****
Punctua-lity	**-.51****	-.25	-.18	-.07	-.19	**-.38***	-.32	-.09	**-.45***	**-.39***	**-.48****
Polite-ness	-.07	-.15	.08	.45**	.19	.16	.18	.28	.16	.01	.04
Since-rity	.26	**.53****	**.26**	**.57****	**.55****	.39*	**.48****	**.39***	**.34***	.21	.19
Activity	.04	-.24	-.07	**.46****	.18	.13	.05	-.03	.16	.09	.06
Serious-ness	.07	.24	.07	.26	.27	.29	.26	**.45****	.26	.13	.28
Thrift	**-.41***	-.32	-.28	-.17	-.19	**-.33***	**-.38***	-.25	-.17	-.26	-.26
Obedi-ence	-.06	-.08	.05	.29	-.06	-.06	.04	-.19	-.18	-.07	-.19
Justice	.13	.09	.13	**.44****	**.33***	.27	.27	**.48***	**.39***	.19	.15
Fidelity	.07	.05	.09	.29	.25	.19	.18	**.59****	.28	.12	-.06
Patience	-.07	.07	.18	.16	-.15	.08	.07	.25	-.18	-.07	-.06
Time	.14	**.38***	.27	.29	.19	.05	.27	.14	.18	.07	.07
Contacts	**.41***	.25	.26	**.66****	**.58****	**.39***	**.58****	**.35***	**.59****	**.48****	**.44***
Trust	**.55****	**.38***	**.42****	**.46****	**.49****	**.55****	**.58****	**.65****	**.53****	**.43***	**.36***
Hope	**.56****	**.43****	**.53****	**.58****	**.69****	**.63****	**.72****	**.57****	**.79****	**.74****	**.55****
Sexua-lity	**.47****	.19	.11	.32	**.39***	**.47****	**.38***	**.33***	**.56****	**.44****	**.41***
Accept-ance	.31	.17	**.48***	.24	**.33***	**.36***	**.34***	.29	**.44****	**.49****	**.44****
Faith	.14	.15	-.14	**.59****	.27	.02	.16	.27	.13	.08	-.04

*Note: * - correlation is significant at the level 0.05; ** - correlation is significant at the level of 0.01*

The data presented in Table 2 show: first, the consistency of significant relationships; secondly, the

possible ways of psychological assistance to achieve positive life priorities.

The findings suggest that contacts, trust, hope, sexuality contribute to a positive relationship, while overestimated punctuality and thrift, on the contrary, make a bad contribution. Autonomy and self-determination are promoted by sincerity, time, seriousness, acceptance, justice, trust, hope, etc. Personal growth is associated with politeness, sincerity, justice, contacts, trust, hope and faith.

In general, we should note the special importance of primary abilities in achieving of positive life priorities, which correlate with almost all diagnosed indicators.

The described correlations, in our opinion, are very logical and reveal an individual's psychological resources, which development will contribute to life satisfaction in all areas of the balance model.

Conclusion

1. The performed empirical study of the WIPPF psychometric characteristics showed a fairly good internal consistency of scale statements, the inventory sufficient reliability and validity in relation to such constructs as psychological well-being, psychological hardiness and self-determination.

2. The correlations revealed at competitive validity testing show an individual's psychological resources that help to achieve positive life priorities and psychological health.

3. The Ukrainian-language version of the Inventory fits well into the conceptual circle of Positive Mental Health Sciences and can be used as a research method in Personality Psychology.

4. The research tasks at the nearest future should include identification of a predictive validity of the examined Ukrainian-language version regarding indicators of psychological health, life quality and life satisfaction.

References

[1] **ANTONOVSKY, A.** (1993). The structure and properties of the Sense of Coherence Scale. *Social Science and Medicine, 36,* 725–733

[2] **DECI E.L., RYAN R.M.** (2002). Self-determination research: reflections and future directions. *Handbook of self-determination research.* Rochester, NY, 431-441.

[3] **DERGACHEVA, O, DORFMAN,, L, & LEONTEV, D.** (2008). Русскоязычная адаптация опросника каузальных ориентаций [Russian-language adaptation of the General Causality Orientation Scale]. *Vestnik Mosk. Un-ta. Ser. 14. Psyhkologia, 3,* 91-106.

[4] **LEONTEV, D., & RASSKAZOVA, E.** (2006). *Тест жизнестойкости [Test of psychological hardiness]*. Moscow: Smysl.

[5] **MADDI, S., & KHOSHABA, D.** (1994). Hardiness and mental health. *Journal of Personality Assessment, 63(2),* 265-274.

[6] **MESSIAS, E., PESESCHKIAN, H, CAGANDE, C**. (editors) (2020). *Positive Psychiatry, Psychotherapy and Psychology - Clinical Applications.* Springer International Publishing, Cham.

[7] **PESESCHKIAN, N., & DEIDENBACH, H.** (1988). *Wiesbadener Inventar zur Positiven Psychotherapie und Familientherapie WIPPF*. Berlin, New York: Springer Verlag.

[8] **REMMERS, A.** (1996). WIPPF 2.0 int. Transcultural Adaptation of the Psychotherapeutic Questionnaire WIPPF for the International Use. Theoretical and Practical Aspects. WIPPF 2.0 int. - Транскултурална обработка на психотерапевтичния въпросник WIPPF за международно приложение / теоретически и практически аспект. *Journal Positum, Varna, Feb. 1996,* 13-28.

[9] **RYFF, C.** (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69,* 719-727.

[10] **SERDIUK L., DANYLIUK, I., & CHYKHANTSOVA O.** (2019). Psychological factors of secondary school graduates' hardiness. *Social Welfare. Interdisciplinary Approach, 1,* 93-103. DOI: https://doi.org/10.21277/sw.v1i9.454

[11] **SHEVELENKOVA, T. & FESENKO, T.** (2005) Психологическое благополучие личности [An individual's psychological well-being]. *Psihkologicheskaya diagnostika*, *3*, 95-121.

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THE BALANCE MODEL IN RUSSIAN AND CHINESE CULTURE: PRELIMINARY STUDY AND COMPARATIVE ANALYSIS

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Abstract

This article focuses on the transcultural aspects of the Peseschkian Balance Model. The goal was to conduct a preliminary study of the balance models of Russian and Chinese respondents, to carry out quantitative characteristics of the balance model of the two groups and to compare out quantitative characteristics of the balance model of the Russian and Chinese sample group. Object of research: settlements in Russia and China according to N. Peseschkian 's balance model. Objectives: to form two control groups for the study; create a questionnaire in Russian and Chinese for conducting research; study the population model of China (Group 1) using a questionnaire; study the model of the population of Russia (Group 2) using a questionnaire; to carry out a comparative analysis of quantitative indicators of Group 1 and Group 2 in four areas of the balance model N. Peseschkian. It was measured the quantitative parameters of the four spheres of the balance model of Group 1 and Group 2 and compared the quantitative parameters. It was found that the sphere of meanings and the sphere of contacts are quantitatively differ little in Group 1 and Group 2, and in the spheres of activity and the sphere of the body there are significant quantitative differences Group 1 and Group 2. Detailed results of the study were displayed in tables and diagrams.

Keywords: Positive Psychotherapy, Balance Model, Russia, China, transculturality.

Introduction

Finding balance in life is recognized by many authors as crucial to psychological well-being and quality of life for different groups and individuals. Living in Blagoveshchensk, Russia, which is right on the border with the Chinese city of Heihe, and inspired by Peseschkian's (2016) idea of a balance model, the author became interested in preliminary exploring the content of the balance model of Russians and Chinese and comparing the quantitative differences between them to provide a preliminary basis for a deeper study of the specifics of the balance model and the separate areas of BM of these two cultures, which undoubtedly has significance in the development of transcultural research.

Methodology

The method of comparative analysis was chosen as the most versatile and convenient for preliminary research of the topic of the article, in order to gain a deeper understanding of the common features and differences in the areas of the Balance Model of the two Groups and preliminary compare their quantitative indicators. The object of this study are the 4 spheres of life in Nossrat Peseschkian's Balance Model (Peseschkian, 2016) as applied to residents of Russia and China. It was created a questionnaire (Appendix 1, 2) in Russian and Chinese for this research, where participants answer the questions about how they experience each of the areas of the Balance Model (Body, Achievement, Contacts, Meaning/ Future) in their daily lives and to estimate how great a percentage of their

vital energy and time falls on each sphere of the Balance Model. For this purpose the participants was divided into two groups.

Group 1 - residents of China, 20 people from Beijing, Shenyang, Jinan, Zhengzhou, working in: trade/services, foreign languages, education, IT, equipment manufacturing, born 1980 to 1996, 10 men, 10 women.

Group 2 - residents of Russia, 20 people from Moscow, St. Petersburg, Barnaul, Blagoveshchensk, Korsakov, working in: IT, trade/services, geology, media, energy, construction, foreign languages, born 1980 to 1996, 10 men, 10 women.

Group 1 and 2 are identical in age and gender. Then it was explored the Balance Model of participants from China and Russia using the questionnaire. Then conducted a comparative analysis of the quantitative indicators of Group 1 and Group 2 in the 4 areas of the Balance Model.

Results

Average Values of the Balance Models in Groups 1 and 2 (Tab.1).

Table 1.

Average values of the Balance Model. Group 1

Body %	Achievement, %	Contacts, %	Meaning/ Future, %
35	26	21	18

For convenience, the study data was combined into a diagram:

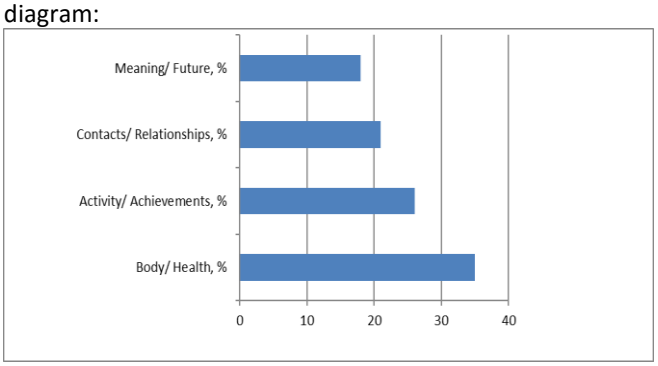

Fig. 1. Average values of the Balance Model. Group 1

As if is illustrated in the graph, the sphere that receives the most time and attention in China is the sphere of the Body (35%), followed by the sphere of Activity (26%), then Contacts (21%) and Meanings (18%). Comparing the Balance Model results according to gender for Group 1, was find (Tab. 2):

Table 2.

Balance Model results. Group 1

	Body, %	Achievement, %	Contacts, %	Meaning/ Future, %
Women	41	21	22	16
Men	28	32	20	20

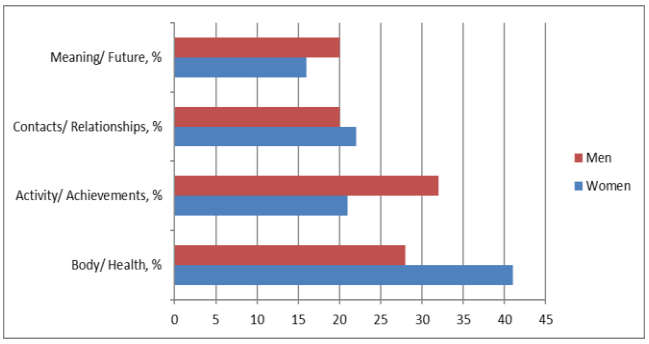

Fig. 2. Average values of the Balance Model according to gender. Group 1

Women pay 13% more attention and time to the Body area than men, and men give 11% more than women to the field of Activity. In the field of Contacts, the differences are minimal, women pay 2% more attention to the field of Contacts than men. In the sphere of Meanings, differences are also small, men pay 4 percent more attention to the sphere of Meanings than women.

Table 3.

Average values of the Balance Model. Group 2

Body %	Achievement, %	Contacts, %	Meaning/ Future, %
17	46	22	15

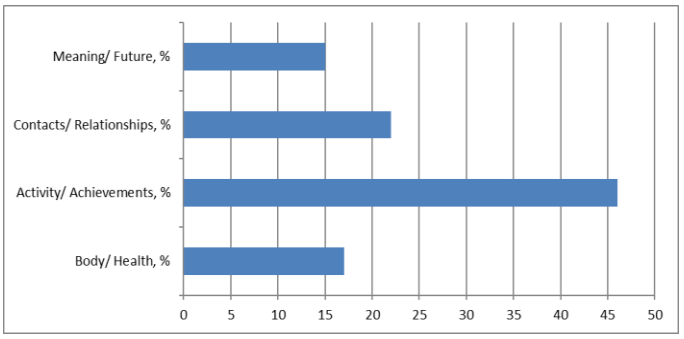

Fig. 3. Average values of the Balance Model. Group 2

As if is illustrated in the graph, the sphere that receives the most time and attention in Russia is the sphere of Activity (46%), followed by the sphere of Contacts (22%), then the sphere of the Body (17%) and Meanings (15%). Comparison of the Balance Model results according to gender (Tab. 4).

Table 4.

Balance Model results. Group 2

	Body, %	Achievement, %	Contacts, %	Meaning/ Future, %
Women	15	53	20	12
Men	19	38	24	19

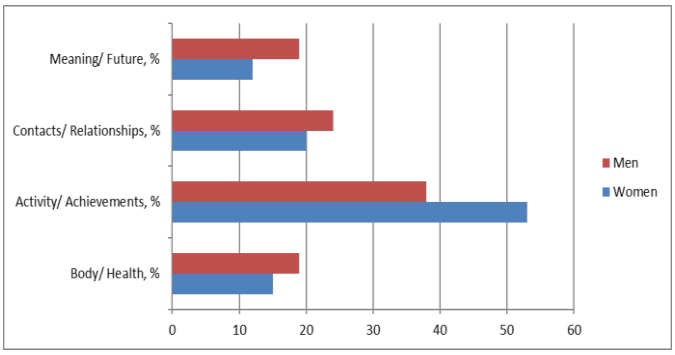

Fig. 4. Average values of the Balance Model according to gender Group 2.

Men pay 4% more attention and time to the Body than women, and women pay 15% more attention to the field of Activity than men. In the area of Contacts the differences are minimal, men pay 4% more attention to Contacts than women. In the sphere of Meaning, men pay 7% more attention than women.

2.1. Comparative analysis of engagement in the sphere of the Body/ Health.

The sphere of the Body in Group 1 contains 35% of the total, in Group 2 - it is 17% of the whole. Was found that in Group 1 the sphere of the Body shows 18% more, almost 2 times as much; the gap is quite impressive. Through detailed analysis of the content of the sphere of the Body, we will try to understand the similarities and differences between both participant groups in this sphere and why the quantitative difference is so great.

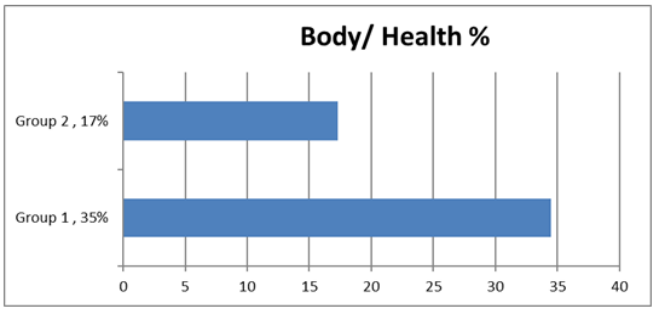

Fig. 5. Diagram. Comparison of the quantitative values of the engagement with the sphere of the Body in Group 1 and Group 2

The diagram below shows how the figures for engagement with the Sphere of the Body are distributed according to gender in each participant group. The diagram shows that the men in Group 1 are 13% less engaged in the area of the Body than the women in Group 1. this difference is contrasted by the men in Group 1, who spend 11% more time and energy in the sphere of Activity than the women in Group 1. As for Group 2, the difference in engagement with the sphere of the Body between the men and women is not as great as in Group 1, showing that the men have 4% more engagement in the area of the body than do the women.

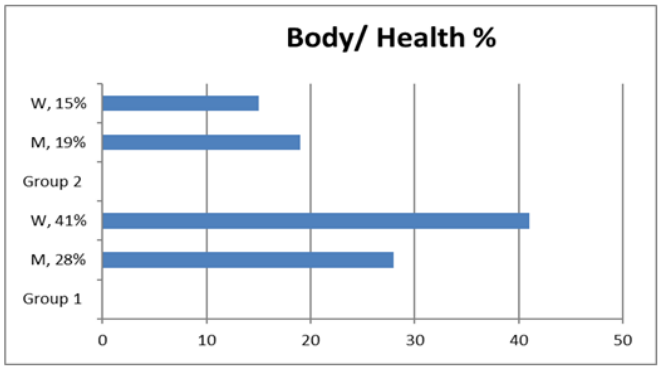

Fig. 6. Diagram. Comparison of the quantitative values of the level of engagement with the sphere of the Body for men and women in Group 1 and Group 2

The diagram shows the aggregation in numerical terms of the engagement of the men and women in groups 1 and 2 with the body. Below presented the options at the specific activities and behaviors which comprized these aggregations of engagement with the Sphere of the Body in each participant group. For this, will examined specific answers to the individual questions in the questionnaire. An analysis of these responses revealed the frequencies and tendencies of the specific behaviors queried in the questionnaire.

Group 1: Responses from residents of China. All 20 respondents wrote that they go to bed early and get up early in the morning. 17 people noted that they walk on foot regularly, go to the park in the morning or ride a bike to and from work. 6 people noted that they ensure that their food is balanced and try to eat on time, they eat a lot of fruits and vegetables. 9 people said they play sports (football, basketball, jog, swim), go to the gym, dance or exercise.

Group 2: Responses from residents of Russia. 7 people from Group 2 noted that they usually rest passively at home. 11 people complained about poor sleep; no one boasted a good sleep. 10 of the respondents said they look at beauty, celebrate visits to the beautician and perform active daily beauty care at home (SPA, moisturizing the skin). 5 out of 20 respondents reported that they regularly monitor their health and visit doctors. 6 people walk in the open air, while 3 respondents said they go out into nature to rest. Another 3 people relax while fishing and 2 while hunting, 3 go to the vaporarium, 11 do sports (volleyball, gym, yoga, skiing, biking and snowboarding). 8 said that they did no sports at all. 1 person noted that he watches his diet, and 1 person answered he loves tasty food. 1 person periodically takes massage. 2 people relax by playing computer games and 1 person relaxes with intellectual games. 1 person noted relaxing by watching movies, doing handicrafts and playing with a child.

2.2. Comparative analysis of engagement in the sphere of Activity/ Achievement

The sphere of Activity in Group 1 comprises 26% and in Group 2 it makes up 46% of the total of the participants' time and energy, the difference in the balance means that Group 2 devotes 20% more time and effort to the field of activity than Group 1; visually the difference is slightly less than 2 times. This is quite a lot, despite Group 2 being close to 50% and Group 1 being in the Balance Model's optimal position of equal distribution of energy and time in the four spheres of life.

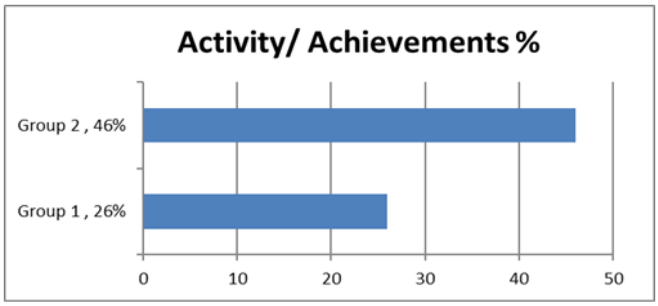

Fig. 7. Diagram. Comparison of the quantitative values of the level of engagement with the sphere of Activity for men and women in Group 1 and Group 2

The diagram below shows how the figures for engagement with the Sphere of activity/achievement are distributed according to gender in each participant group. The men in Group 1 work 11% more than the women in Group 1 (almost 1/3). In Group 2, the rate of achievement is higher for the women - women work 15% more than men. I can assume that this is due to the workload of women in Group 2, household chores and raising children. It is not possible to analyze this disparity in more detail and discover the reasons for such a large difference within the framework of this study.

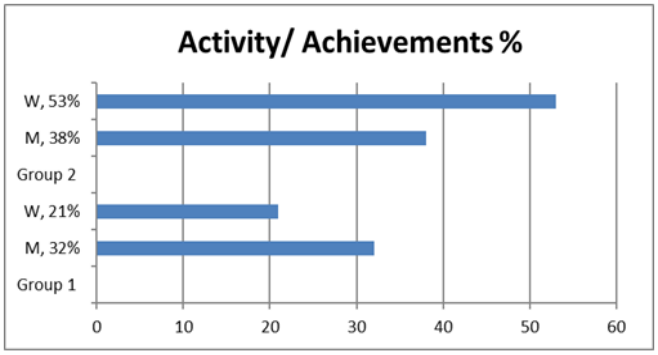

Fig. 8. Diagram. Comparison of the quantitative values of the level of engagement with the sphere of activity/achievement for men and women from Group 1 and Group 2

Group 1. 5 people from Group 1 noted that their work involves periodic or daily overwork, two of them work for 10-12 hours (overwork by 2-4 hours), two people work 9-10 hours a day, and 1 reported working enough hours during the week to equal a 6th working day. 13 people from Group 1 noted that they work without overwork, 8 hours for 5 days a week.9 people from Group 1 are engaged in raising children.

Group 2. In Group 2, 13 people overwork, 4 of them have a 6-day working week, two work 12-14 hours a day and 4 people regularly linger at work for 30-90 minutes. 6 people from Group 2 noted that they work without overwork, 8 hours for 5 days a week. 11 people from Group 2 are engaged in raising children. 2 of them said that they are engaged in raising young children almost around the clock. 9 out of 10 women in Group 2 noted that they regularly do household chores. 6 out of 10 men in Group 2 noted that they regularly do household chores.

2.3. Comparative analysis of the levels of engagement in the sphere of Contacts/ Relationships

The sphere of Contacts in Group 1 comprises 21% and in Group 2 22% of the total of the participant's time and energy. There is no significant difference find in the levels of engagement in this area as a whole between the two groups.

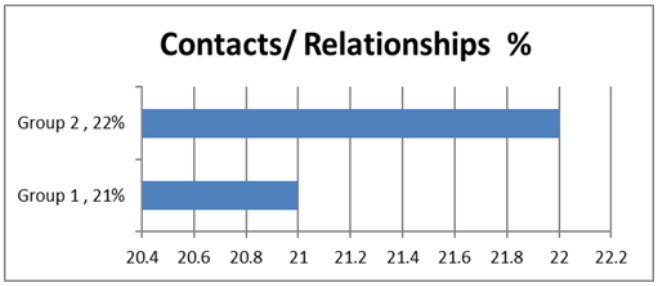

Fig. 9. Diagram. Comparison of the quantitative values of the levels of engagement in the sphere of contacts in Group 1 and Group 2

The diagram below shows how the figures for engagement with the Sphere of Contacts/relationships are distributed according to gender in each participant group. At first glance can be seen the differences between women and men in both groups are small. In Group 1, women show 2% more engagement in the area of contacts than men. In Group 2, men show 4% more engagement in this area than women.

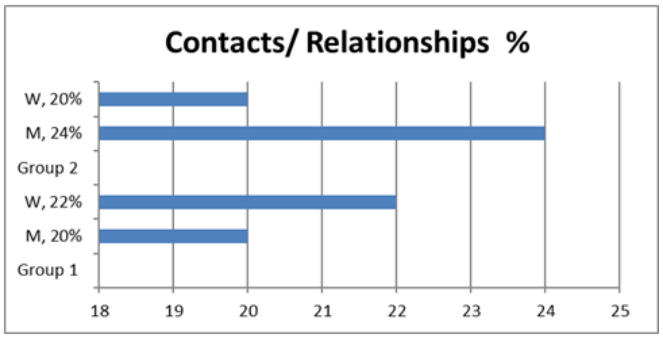

Fig. 10. Diagram. Comparison of the quantitative values of the levels of engagement in the sphere of contacts for men and women in Group 1 and Group 2

Group 1. For Group 1, it is common to meet with friends for a meal. 12 out of 20 people noted that they often meet with friends and eat together. This is an integral part of the sphere of contacts in China. I will cite several quotes from a study on the engagement in the sphere of contacts, translated from Chinese. "I don't have so many friends, real friends - only a few people, but I am very pleased. Every evening I return home and communicate with friends, we all are very well and happy together, I spend the weekend with my family. " "I have friends but I usually communicate with family members, especially with my wife. On the weekends I usually go somewhere to have fun with my wife. " "I have friends, we often organize joint dinners, we watch movies." "Usually we gather with friends to eat, or we communicate by phone."

Group 2. For Group 2, I selectively present quotations from a study about how the members of this group actually engage in the sphere of contacts. "I have friends, we meet several times a week, I give my daughters 1-2 hours a day." "My circle of friends is sharply limited. I spend almost all my free time with my family." "I am with friends 2-3 times a month and on holidays, with the family daily." "I have friends whom I do not meet very often. I spend almost all my free time With my family, my wife and child." " I have only a few friends, but it seems that these friendships are of some serious quality. Sometimes we meet with relatives, sometimes with friends, we correspond a lot. I spend a lot of time with my family. We like to lie around, moan and do nothing."

2.4. Comparative analysis of the levels of engagement in the sphere of Meaning/Future

The sphere of Meaning in Group 1 comprises 18% and in Group 2 15% of the total of the participants' time and energy. In this area of life, the difference of 3% between the two groups is small.

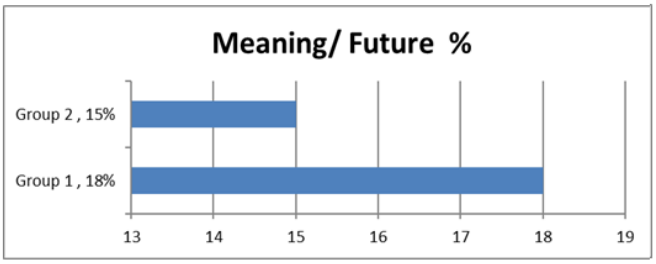

Fig. 11. Diagram. Comparison of the quantitative values of the levels of engagement in the sphere of Meanings for men and women in Group 1 and Group 2

The diagram below shows how the figures for engagement with the Sphere of Meaning are distributed according to gender in each participant group. At first glance can be seen the differences between women and men in both groups are small. In Group 1, men show 4% more engagement in the area of Meaning than women. In Group 2, the differences are slightly more significant - men show 7% more engagement in the sphere of meaning/future than women.

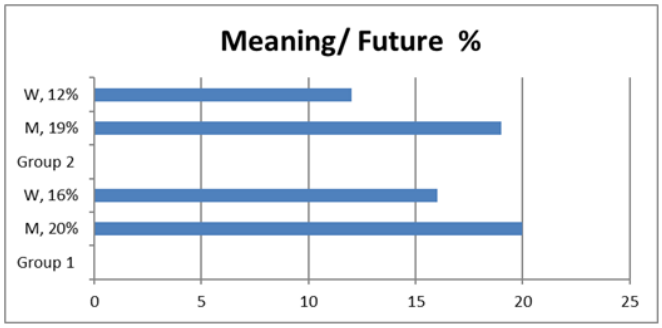

Fig. 12. Diagram. Comparison of the quantitative values of the levels of engagement in the sphere of meaning/future for men and women in Group 1 and Group 2

Group 1. 1 person noted that he considers himself religious. 13 out of 20 people make plans for the future. 14 of the 20 people in this group have hobbies, among which are: volleyball, dancing, reading, watching TV shows, football, basketball, fitness, ping pong, badminton, watching movies, computer games. I will present several quotes from a study on engagement in the sphere of meaning, translated from Chinese. "I have a hobby. My hobbies - Latin-American dancing, gymnastics and reading. I am not religious. my plan for the future is to purchase commercial insurance for myself and my child, I am already implementing it. I dream that in the future I will be able to leave China to see other countries. " "I read books. I'm not religious. I have no specific plans for the future." "My hobby - football. I'm not religious. My plan for the future is to open a travel agency. I dream of visiting every corner of China or many different foreign countries."

Group 2. 3 people said they consider themselves religious. 10 people out of 20 are making plans for the

future. 15 people have a hobby, the rest have either no hobby or no free time for one. Among the hobbies are: hunting, fishing, sports, reading, music and playing musical instruments, trips to nature, computer and intellectual games, photography, various handicrafts. I will present several quotes from a study on the engagement with the sphere of meaning in Group 2. "My hobbies are Computer games, intellectual games, drawing, raising my child, fishing, mushrooming. I am religious. " "I have a hobby, I like to knit, sew, read books. I am not religious. I make plans." "My Hobby is music (performing). I am indifferent toward religion. I am interested in reading. I no longer make plans. My engagement with the sphere of meaning is in computer games".

Conclusion

As a result of the responses to the questionnaires in the appendices to this article, was obtained the quantitative results of the levels of engagement with the four areas of life in Nossrat Peseschkian's Balance Model in two groups of participants, one from China and the other from Russia, and conducted a comparative analysis of indicators. Can be seen the results of this comparison in the diagram below:

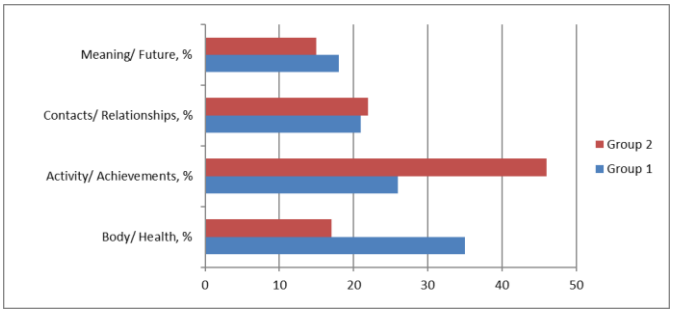

Fig. 13. Diagram. Comparative Diagram of the 4 Areas of the Balance Model in Group 1 and Group 2

As if is illustrated in the final diagram, the most significant differences in levels of engagement in the Balance Model are between the spheres of Body and of Activity/Achievement. In Group 1, the Sphere of the Body occupies 35%of the whole, in Group 2 the Body takes only 17% - with Group 1 showing almost twice as much engagement in the sphere of the Body as Group 2. Conversely, the sphere of Activity in Group 1 makes up 26% of the whole, while Group 2 shows 46%. This difference in balance shows that Group 2 devotes 20% more time and energy to the field of Activity than Group 1. Can be seen that the people of China pay more attention to the Body than Russians, and the people of Russia devote more time and energy to the field of Activity. Quantitative indicators in the field of contacts and meanings in Group 1 and Group 2 differ slightly. The sphere of Contacts in Group 1 occupies 21%, and 22% in Group 2. Engagement with the sphere of Meaning also shows only a small difference between two groups, with Group 1 showing 18% and Group 2, 15%. The participants from Russia and China devote the same proportion of their time/effort to the Contacts and Meaning.

Therefore, a preliminary study was carried out and on the basis of a survey of two groups and a quantitative comparison of the data, it was preliminary found that in the spheres of the balance model of Russia and China there are both significant quantitative differences in the sphere of activity and body, and minor quantitative differences in the spheres of meaning and contacts.

References

[1] **DAMIAN, O.** (2019). Life in camphill communities: a balance model approach: conference paper. *World Congress for Positive and Transcultural Psychotherapy (Kemer/Antalya, Turkey).*

[2] **PESESCHKIAN, N.** (2016). *Positive Family Therapy: Positive Psychotherapy Manual for Therapists and Families*. AuthorHouse UK, Bloomington, USA

[3] **SINICI, E.** (2015). A Balance Model for Patients with Post-Traumatic Stress Disorder. *International Journal of Psychotherapy 19(3).*

Appendix 1. 您好！我是心理学学生，我叫达尼娅，做我的毕业论文，这个是欧洲德国心理学研究方法平衡模式。请您帮我请填调查表帮我做我的毕业论文研究，谢谢！

问题 出生年： **性别：** **城市：** **工作(学习)领域：**	*四中生活质量说明: **躯体， 感觉**- 您生活中多少%力量供给你的身体健康，吃饭，情绪 **成就** - 您生活中多少%力量供给你的工作（学习，您孩子保育）？ **交往** - 您生活中多少%力量供给与您家人和好朋友交往？（您最喜欢的交往，工作领域的交往不属于这种交往，只家人和朋友） **约想，未来** - 您生活中多少%力量供给您梦想和计划安排，业余爱好和宗教。

2. 四中生活质量（四中生活领域）2.1.请填写您的每种生活质量具体内容，请介绍一下您生活经验怎么样 *（在这请你有多少就写多少）

躯体，感觉: 您一般做什么为你身体健康？好不好睡觉？做不做早操什么的？跳舞、散步吗？去不去美容馆和理发店？**请填写一下：**	**成就** 你做什么工作（学习））？一天工作（学习）多长时间？一个星期工作学习）几天？累吗？您是不是保育孩子吗？**请填写一下：**
约想，未来 您有没有业余爱好？什么业余爱好？有什么宗教信仰？您有没有具体未来计划？喜不喜欢梦想？ **请填写一下：**	**交往** 你有朋友吗？你尝尝和家人和朋友交流？一般想做什么？ （比如说去一起吃饭，还是在家说话，去公园玩一玩，别的方式请填写）**请填写一下：**

2.2.请填写每种生活质量你生活中有多少%? * 一共要有100%

躯体， 感觉 ____%	成就____%
约想，未来____%	交往____%

非常感谢您的帮助！

Appendix 2. Hello! My name is Tatyana, I am a psychologist, I invite you to take part in my graduate research, I ask you to answer a few questions. Thank you for your participation!

1. Year of birth： Sex： Place： Sphere of work / study：	* explanation of 4 areas of the balance model: 1) Sphere of Body/ Health: health, nutrition, sleep, sport, dancing, yoga, gym, jogging in the morning, fitness, beauty and personal care, trips to the hairdresser and massage therapist, healthy lifestyles, rest, walking, sexuality, and also emotionality - that is, everything about the body and caring for it. 2) Sphere of Activity/ Achievements: work, business, training, professional development, raising children, social activity, household chores. 3) Sphere of Contacts/ Relationships: relationships with close people with whom you like to communicate, for the purpose of emotional exchange, meeting with friends, Sunday trips to grandmother for pies, (business communication is not here, communication with your beloved girlfriend / friend is here, and walk with a friend will affect the sphere of the body and the sphere of contacts). 4) Sphere of Meaning/ Future: your religious, philosophical, political views, hobbies, reflections on the meaning of life, dreams and fantasies, goals, creativity, making plans for the future, reading books, etc.

2. The four spheres of the Balance model.

2.1.Please fill in the table below, based on your personal experience. Comment on what matters is filled in each of the areas of your balance model?

Body/ Health: How do you relax? Do you sleep well? Do you follow health and beauty? What are you doing for this? Do you play sports? How do you take care of your body? What else do you fill your body sphere with? Your Answer:	Activity/ Achievements: Do you work / study? How many days and hours per week? Is there any recycling? Doing household chores? Raising children? What else do you fill in your field of activity? Your Answer:
Meaning/ Future: Do you have a hobby? Which one Do you consider yourself a religious person? Do you read books? Do you make plans for the future? What else do you fill your sphere of meanings with? Your Answer:	Contacts/ Relationships: Do you have friends? Do you often meet with friends and relatives? How much time do you spend with your family? What do you like to do with friends / family? What else do you fill in your contact sphere? Your Answer:

2.2. Please mark how much % of your life energy and time is in each sphere? * the amount should be 100%

Body/ Health____%	Activity/ Achievements____%
Meaning/ Future____%	Contacts/ Relationships____%

Many thanks for your help and participation!

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PRELIMINARY STUDY OF THE "SEPARATION ANXIETY" PHENOMENON THROUGH THE EYES OF THE METHOD OF POSITIVE AND TRANSCULTURAL PSYCHOTHERAPY

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Abstract

The article presents the results of a preliminary study which forms part of the preparation of a dissertation titled: "Influence of parental behavior on separation anxiety in children aged 1.5 to 5 years." This article discusses the relationship between the symptoms and problems of children manifesting separation anxiety when starting to attend kindergarten and the experiences of their parents. The preliminary study included 38 parents and their children manifesting anxiety upon separation. The study used the tools of Positive psychotherapy, which offers the opportunity to diagnose parent-child relationships and supportive intervention.

Keywords: Positive Psychotherapy, separation anxiety, parent-child, current abilities.

Introduction

One of the family crises that puts parents to the test and directs their search for psychotherapy clinics is related to their children's starting to attend a nursery / kindergarten. September is the time when psychotherapy rooms used to be filled with parents and children who had made an unsuccessful attempt at separation when the children were starting and adapting to a new place. The anxiety that the children feel is sometimes so strong that it causes experiences of guilt in the parents, who in turn blame the kindergartens, the law, teachers, etc. and finally turn to specialists.

According to Freud [7], anxiety arises when there appears a threat of breaking the closeness between a child and its mother. It is a manifestation of protest against a possible separation, which is essential for the existence of the little man. Harry Sullivan (according to R. Stamatov [6]) defines anxiety as an interpersonal emotion that manifests itself in the frustration of a relationship between a child and the mother. Emotion arises as a result of the experience of loss, being associated with a loss of security and love, which brings a sense of helplessness and hopelessness. Anxiety is an existential problem related to the contradiction between security and insecurity, between intimacy and separation.

E. Erickson [4] in turn makes a connection between anxiety and fear of losing identity. Anxiety and love are the main motives for identification, and parental love is internalized in the child in the form of trust, security and acceptability, which is the basis for positive self-esteem. When such behavior is maintained by the parents, it becomes a sustainable model. By the same token, anxiety could be internalized and become a sustainable experience for a child.

The onset of anxiety is associated with the emergence of two experiences:

- Experience of separation, respectively loss;
- Experience associated with loss of love (rejection).

Every day the child faces moments of approval or disapproval. The mother's reactions, which are related to disagreement, anger, punishment, can be perceived by the child as a loss of love of his/her significant figures and this can affect the child's self-esteem. The experience related to eventual loss of love is a variant of the experience of separation afterwards.

According to John Bowlby [1], maternal care in early childhood is as important to mental health as vitamins and protein are to physical health. This forms an inseparable, symbiotic and coherent "parent-child" system, in which the two main parties (usually mother-child) are interdependent in their needs.

For a child, separation is not only the severance of an external bond, the destruction of that bond is the experience of losing a part of the child itself.

In summary of the above, it is clear that when examining a child's anxiety, we must take into account the experiences of its parent, because the child's behavior is closely related to the parent's presentation as a reference person. Often, when a parent brings a child to the psychotherapy clinic with a problem of separation anxiety, the parent's focus is only on the child, and the expectation is that the therapist will work only with the child to stop him/her worrying.

The literature review shows that the topic of separation anxiety and the relationship between a child's experiences as presented by the child's reactions and those of the parent is a topical area for research. At the time of the study, information about the observed phenomenon was found in Dallaire, D., Weinraub, M. [9]. Their research proved that the model of attachment is fundamental for understanding the development of separation anxiety in 6-year-old children, which on the one hand does not affect problems related to psychological and social development of children, and on the other covers a group different than that studied by us (1, 5 - 5 years of age). There are no sources of data found on the topic in Bulgaria.

Methodology

The object of the study is the relationship between mother (parents) and child upon admission to kindergarten/ nursery.

Subject of study: Separation anxiety in children aged 1.5 to 5 years when separated from parents on the occasion of admission to kindergarten / nursery

The aim of the study is the relationship between children's anxiety at separation and the parent's reaction.

Methods of study:

1) Content analysis of the data on the Conflict processing model – areas: body, activity, contacts, future / fantasy and the data from the Differential-analytical inventory (DAI);

2) Processing of individual information in aggregate on the basis of percentages.

The study is of a preliminary nature, and as part of my dissertation titled: "Influence of parental behavior on separation anxiety in children aged 1.5 to 5 years." and continues with the expansion of the experimental sample.

The study was conducted with the parents of 38 children aged 2 years up to 4 years, 20 boys and 18 girls, exhibiting separation anxiety.

Results

The model of conflict processing provides a good field for diagnosis of what is happening in the parent-child dyad, where the discrepancy in expected and actual behavior in both parties becomes the basis for the deployment of conflicting experiences (anxiety, frustration, fear, sadness, dissatisfaction, etc.). A parent describes well their reaction to the daily recurring situation – bringing and leaving their child in kindergarten or nursery, in more than half (65%) the localization of the conflict is in the area: "Future / Fantasy", there is doubt, mistrust and fears present, and in 35% - area: "Contacts", shown through irritation and dissatisfaction. Children, in turn, respond to the onset of "separation" through a symptom ("Body"), refusal of activity ("Activity") and reluctance to communicate with others ("Contact"), together with 38 parents of children showing separation anxiety. age from 2 years up to 4 years, 20 boys and 18 girls.

Figure 1 summarizes the data on how an event affects both children and their parents.

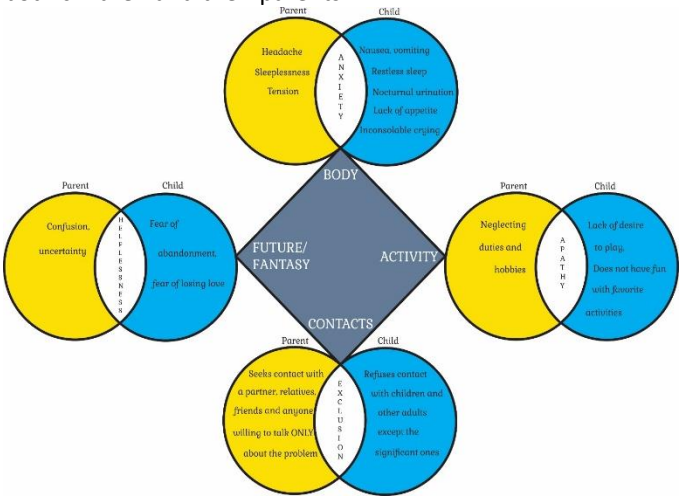

Fig. 1 Balance Model

In the "body" area 73% of children express their anxiety through crying (pay attention to me, you hurt me), nocturnal urination (crying from below), nausea and vomiting (I want to get rid of this feeling, to be free of it), insomnia (I'm on the alert), reluctance to eat (I do not want and can not take anything), on the other hand, 70% of mothers express their anxiety through headache (feverish thoughts about what is happening and seeking a solution),

insomnia (more time to attempt at problem solving and fear of the coming day) and tension (it all depends on me). It becomes clear that the feeling in both parties is strong anxiety.

In the "Activity" field in 80% of the surveyed parents and children the main feeling in both parties is apathy. The manifestation of this feeling is the child's reluctance to play and participate in favorite activities, and the mother's loss of desire to do housework and practice favorite hobbies.

In the field of "Contacts" for 81% the main thing is that both parties are excluded from the outside world, but merge with each other, because only this brings peace to both. The child does not want to be in contact with adults other than its mother, and the mother in turn makes contact with others (teachers, psychologists), only based on comments related to the child's anxiety. Apart from not making good contact with others, the mother is also unable to make contact with herself (to see her own involvement in the situation), but believes that the only problem is with the child.

in the "Future / Fantasy" field for 69% of the interviewees, the common thing for both parties is the helplessness, which in the child is expressed through fear of losing love, "Mom does not love me anymore!", Fear of abandonment, "Mom will not come to take me back!", the parent has strong feelings of confusion and insecurity", Am I doing the right thing?", "Am I a good parent?"

The use of the differential analytical approach, where the areas of behavior (real or expected) described by secondary actual abilities (accuracy, obedience, discipline, diligence, reliability, etc.) and areas of attitude (to oneself, the other and the environment) described by content through the primary actual abilities (time, patience, trust, model – sample, attention, love, etc.), allowed the disclosure of conflict readiness.

At the heart of the trigger that accompanies separation anxiety in children is the question of parental behaviour and how parental patterns directly or indirectly affect children's anxiety and the onset of attachment disorders. The study showed the following results in terms of primary actual abilities in parents. (Fig. 2)

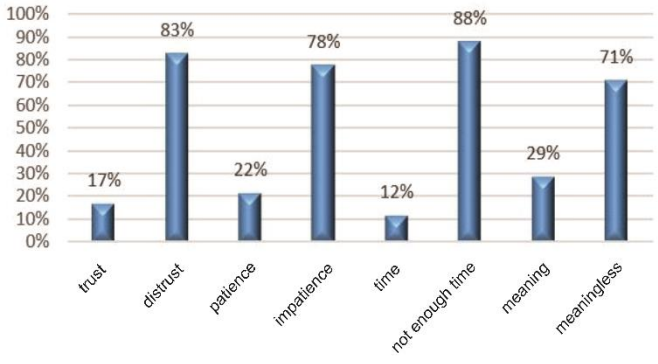

Fig. 2. Primary actual abilities in parents

For 80% of parents it is extremely difficult to trust an institution or another adult for the care of their children and they approach this with expressed distrust. In 78% there is strong impatience in both in the situation (the child gets used to it and stops crying) and to oneself (I can no longer bear the situation). 88% of parents are pessimistic that time is crucial and that over time the child will get used to it, as well as not showing a willingness to give time. For 71%, the separation of children is meaningless and they consider it a "robbery" of childhood.

Data on secondary actual abilities showed that 65% of parents lack respect for authority (obedience, discipline), and 77% are indifferent to the recommendations of employees in the kindergarten and challenge the rules introduced there (responsibility, order).

Both the parents and the children have identical experiences related to the separation process.

The child actively seeks the mother's presence and demands that she constantly shares each of its new experiences or feelings. Although the child is no longer as dependent and helpless as in the previous stages of its development, with its behavior it seems to strive to be just the opposite. To the mother, this behavior seems confusing and contradictory. Some mothers cannot accept the constant demanding and requiring behavior of their child, while others cannot tolerate the gradual separation of the child from them and cannot accept the fact that their child is becoming more independent and separate and is no longer part of them. At the same time, the child becomes more and more aware of its autonomy, but cannot completely separate from the mother, as shown by the child's constant attempts to do something with her or to imitate her.

An in-depth analysis of the information shows that often parents do not even suspect how they project their own traumas on their children: "I have very bad memories from the nursery!", "It is normal for him to cry, I used to cry, too.", "My parents still tell unpleasant stories from my time in kindergarten." The difficulties they themselves had were easily passed on to their children and brought to the surface the trauma of their own experiences.

The derivation of strong (resourceful) topical abilities such as: diligence, love, security, consistency, reliability in both the child and the parent normalize the experience and allow them to see the situation from another angle:

· 93% of parents show their love;
· 90% of the interviewees show tenderness to the child;
· 87% show perseverance in child care and self-sacrifice.

Here it is very important for the mother to be supported in recognizing and accepting the child as an individual, without trying to subordinate it to her own preferences and desires. Verbal communication and empathy are abilities that are important in a parent's relationship with a child. According to Margaret Mahler [10]; [11], if the mother shares the child's experiences and calmly accepts them, the

child builds a loving image of her and of what is happening, begins to imitate her and the child becomes her "shadow" and her presence and emotional participation is predictable. . When the mother is overly caring and anxious, intervenes rudely in the child's world and is extremely attached to it, she becomes its "shadow", which hinders the normal process of individualization and exit from the symbiotic relationship with the child. Excessive care for the child by the mother maintains the illusion that the child can only function in a symbiotic relationship. The mother may be emotionally distant to respond primarily and rationally to the child's urges, which will cause the child to focus much of his/her energy and skills on trying to win her love, instead of investing that energy in his/her own development which would lead to autonomy.

Non-acceptance and denial of separation in time leads to a pathological dependence on the object and an inability to tolerate the frustrations coming from the external reality. How much a child will suffer anxiety during separation depends on three variables that are subject to support during the therapeutic process.

The **first** is regarding the development of the "I" feeling of a child – to what extent he/she perceives him/herself as an independent human being and to what extent he/she builds a concept of him/herself as autonomous, how does it rely on the abilities which he/she has already developed in contact with the parent and how does he/she connect them to reality?

The **second** variable is related to the experiences arising in connection with separation, namely the extent of frustration and how it is experienced by the child in terms of primary actual abilities (I expect from mom: love, attention, security) and by the parent in terms of secondary current abilities (I expect from the child: obedience, order, discipline).

The **third** variable is related to the child's ability to integrate primary and secondary actual abilities into relationships involving several people.

In the developmental stages, the child must give up some things in order to acquire others. Going to kindergarten is a key moment in a child's existence, which he/she will tolerate well if the parents manage to show the child support, not to spare the child. It is important to clarify not only the socializing role of kindergartens, but also their importance for the psychological development of children. It is through the five-step model for intervention of Positive and Transcultural Psychotherapy that parents become acquainted with the need to "dose" love and set flexible boundaries in contact with the child. For example: In the observation / distancing phase, the therapist teaches the parents to observe with curiosity what is happening to their child, how he/she is changing, what is attracting his/her attention, what is interesting to this child, etc.

In the inventory phase, the parent, with the help of the positive psychotherapist, learns to find out what is difficult for the child at this stage of his/her development, what it is coping with without a problem, etc. During this first separation, the parent and the child both undergo a fundamental change in their inner worlds and these changes require mental preparation for this move toward autonomy, which is experienced emotionally, especially on the part of the mother.

Three stages are of particular importance. In the language of Positive and Transcultural Psychotherapy, these are attachment - differentiation - separation. The process of separation occurs without conflict only after successful differentiation. In terms of good differentiation, a positive parental attitude towards leaving their child in kindergarten would sound something like this: "**You** are dressed and ready for kindergarten, **I** am ready for work. Today **you** will play with the other children, you will sleep in the kindergarten, and **I** will work at my job." and to suggest to the child that what is happening is not a separation but a detachment (preparation for a new connection), the parent could react like this, for example: "**You** stay here with the other children and the **nurse**, I am going to work. When you sleep and have breakfast, **I** will come and pick you up."

Conclusion

The anxiety which occurs when a child starts attending a kindergarten is significant for both the child and the parents. Children in this age group are characterized by strong curiosity and desire to explore the world on their own, here these characteristics of the age crisis give way to fears of abandonment, loss of their parents' love and of the unknown. Parents know and realize that this moment of separation will come. Think that they are prepared for this step, but they discover that they also must face their own fears. Positive and transcultural psychotherapy provides an opportunity to develop the overall picture of the process and to support the parent-child system in order to help them go through this challenge more easily, smoothly and without conflict.

References

[1] **BOWLBY, J.** (2005) *A secure base*. Routledge. 224 p.

[2] **ДОЛТО, Ф. [DOLTO, F.]** (2012). *Когато се появи детето* [When the child appears]. София: Colibri. 448 с.

[3] **ДОЛТО, Ф., [DOLTO, F.] (2005).** *Несъзнаваният образ на тялото* [The unconscious body image]. София: Център-за-психосоциална-подкрепа. 320 с.

[4] **ЕРИКСЪН, Е. [ERIKSON, E.] (1996).** *Идентичност: Младост и криза* [Identity: Youth and crisis]. София: Наука и изкуство. 340 с.

[5] **PESESCHKIAN, N.** (2016). *Positive Psychotherapy of Everyday Life: A Self-Help Guide for Individuals, Couples and Families with 250 Case Stories*, Bloomington, USA: AuthorHouse UK

[6] **СТАМАТОВ, Р. [STAMATOV, R.]** (2008). *Детска психология* [Child psychology]. Пловдив: Хермес. 407 с.

[7] **ФРОЙД, З. [FREUD, S.]** (1991). *Психология на сексуалността* [Sexuality psychology]. Христо Ботев. 198 с.

[8] **ЦИРКОВА, Д. [TSIRKOVA, D.]** (2007) *Психологично консултиране на деца, юноши и родители.* [Psychological counseling for children, adolescents and parents]. София: Център-за-психосоциална-подкрепаю 126 с.

[9] **DALLAIRE, D., WEINRAUB, M.** (2006). Predicting children's separation anxiety at age 6: The contributions of infant–mother attachment security,maternal sensitivity, and maternal separation anxiety. *Attachment & Human Development.* 7(4). pp. 393-408

[10] **MAHLER, M.** (1979). The Selected Papers of Margaret S. Mahler: Vol. 1: Infantile Psychosis & Early Contributions 1st Edition. NY: Jason Aronson Inc; 1st edition. 306 p.

[11] **MAHLER, M. S., F. PINE & A. BERGMANN**. (1975) *The Psychological Birth of the Human Infant. Symbiosis and Individuation.* New York: Basic Books, Inc., 1975. 308 p.

РАЗВИТИЕ ПЕРВИЧНЫХ СПОСОБНОСТЕЙ У ДОШКОЛЬНИКОВ С ПОМОЩЬЮ МЕТОДОВ ЭКОЛОГИЧЕСКОЙ АРТ-ТЕРАПИИ (НА ПРИМЕРЕ КОРРЕКЦИННОЙ ПРОГРАММЫ ПО СНИЖЕНИЮ УРОВНЯ ТРЕВОЖНОСТИ)

DEVELOPMENT OF PRIMARY ABILITIES IN PRESCHOOLERS USING ECOLOGICAL ART THERAPY METHODS (ON THE EXAMPLE OF A CORRECTIVE PROGRAM TO REDUCE ANXIETY LEVELS)

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Abstract

This article focuses on using art-therapy and nature based therapy in dealing with anxiety in preschool children and developing primary capacities. Emotional disorders detection, as well as prevention and intervention, can help children to sustain their mental health. Nature based therapy alongside with expressive arts could be very efficient in helping children to learn about their emotions, to express themselves and to develop self-confidence.. Art-therapy program (nature based therapy approach) aimed at lowering the anxiety level in preschoolers was implemented in a private kindergarten “Deborah” (Shenzhen, China).

Keywords: anxiety, pre-school age, primary capacities, art-therapy, Positive Psychotherapy.

Аннотация

Данная статья посвящена исследованию воздействия методов экологической арт-терапии в коррекции тревожности у детей старшего дошкольного возраста и в развитии первичных способностей. Выявление эмоциональных проблем у дошкольников, их коррекция и профилактика способствует гармоничному развитию детей, поддержанию их психологического здоровья. Применение средств арт-терапии подходит для этих целей - занятия экспрессивными искусствами в сочетании с положительным влиянием природной среды могут помочь детям отреагировать свои эмоции, снять эмоциональное напряжение, развить уверенность. В частном дошкольном образовательном учреждении «Дебора» (г.Шеньчжень, КНР) была реализована программа занятий, направленная на снижение уровня тревожности с помощью методов арт-терапии в экологоческом подходе.

Ключевые слова: тревожность, детский возраст, первичные способности, арт-терапия, Позитивная Психотерапия.

Вступление

Носсрат Пезешкиан (2016) основал свой метод опираясь на выводы из масштабного исследования, в котором принимали участие люди из разных стран. Одним из важных столпов Позитивной и Транскультуральной Психотерапии является концепция Актуальных Способностей. В соответствии с ней, каждый человек, независимо от своего происхождения, вероисповедания или же возраста, обладает ими. В тоже самое время, эти способности не являются врожденными – мы развиваем их только посредством отношений с другими людьми, учась у них, перенимая их опыт взаимодействия с окружающими (Peseschkian, 2016). Старший дошкольный возраст – наиболее сензитивный период для формирования эмоциональной сферы, а значит и для формирования первичных способностей. Последние играют важную роль для налаживания и поддержания отношений с людьми. Появление новых технологий и активное их внедрение в повседневную жизнь ускоряет темп городских жителей и привносит, с одной стороны, удобства, но с другой – является факторами стресса. Жизнь в современном мегаполисе сопровождается переработкой огромного потока различного рода информации и многозадачностью. В связи с этим, на фоне агрессивного воздействия урбанизированной техногенной среды на соматическое и психологическое здоровье городских жителей, использование природной терапии приобретает все большую актуальность. Дополнительной психической нагрузке подвергается не только взрослое население крупных городов. В условиях современного развития общества, с увеличивающимся количеством используемых технологий, ростом увлечения виртуальными играми и онлайн общением, у детей все меньше возможностей исследовать природу. В крупных городах данная тенденция может быть связана и с тревогой о небезопасности окружающей среды, где с детьми может случиться что-то неприятное или опасное для их жизни и здоровья. Негативные переживания взрослых, нехватка времени на качественное общение с детьми, подавленное состояние родителей – могут сказаться на эмоциональном и психологическом состоянии детей. Одновременно с этим, трансляция обществом установки на «успех» заставляет родителей отправлять детей на дополнительные занятия, что сокращает время для игры, не говоря уже о прогулках на свежем воздухе и подвижных играх с друзьями на улице. В современном быстроменяющемся мире обращение к ресурсам естественной среды может стать помощником в решении определенных эмоциональных проблем.

Методология

Тема тревожности давно исследуется специалистами в разных областях. Почти все они сходятся во мнении, что определеный уровень тревожности свойственен всем людям и несет в себе положительную функцию – привлекает внимание к возможным трудностям, препятствиям для достижения цели, содержащимся в ситуации, и позволяет мобилизовать силы, тем самым помогая достичь наилучшего результата. То есть, нормальный уровень тревожности рассматривается как необходимый для эффективного приспособления к действительности (адаптивная тревога). Таким образом, когда ребенок испытывает беспокойство по поводу грядущего экзамена, или выступления на сцене перед публикой, мы говорим о реакции приспособления к нестандартным для него ситуациям. В то же самое время, нежелание посещать детский сад, игровые площадки, быть в людных местах без объективных на то причин (например, буллинг или физические травмы, полученные ранее), частые ночные кошмары – могут свидетельствовать о повышенном уровне тревожности. Внешними ее проявлениями у детей являются избыточность жестов, скованность, напряжение, повышенная суетливость, беспокойство, или же, наоборот, повышенная застенчивость. (Лютова, Монина, 2011) Также возможно нарушение сна, аппетита, преобладание негативных эмоций над положительными.

Тревожность имеет тенденцию к самоподкреплению и самоподдержанию, что оказывает негативное влияние на успешность деятельности детей различных возрастов (Прихожан, 2000). Данное эмоциональное расстройство чаще всего может быть вызвано длительной внешней стрессовой ситуацией, подкрепленной частым переживанием тревоги, или же особенностями психофизиологического развития. Часть исследователей видят источник тревожности в нарушенных в раннем детстве отношениях со значимыми взрослыми и говорят о прямой зависимости уровня тревожности ребенка от уровня тревожности родителя (значимого взрослого). Так, например, Салливен (1999) говорил о тревожности как о межличностном феномене, который формируется в отношениях между матерью и младенцем, имея в виду, что имеющееся у матери напряжение тревоги индуцирует тревогу младенца. Он также отмечал, что потребность в устранении тревожности, по сути, равна потребности в межличностной надежности и безопасности, создание которой в раннем детском возрасте может предотвратить развитие тревожности (Салливен, 1999). М. Боуэн, в свою очередь, определял «передачу тревоги» от матери к ребенку как основной

механизм поддержания общей эмоциональной системы в детско-родительских отношениях, при котором ребенок принимает тревогу матери и беспокоится потому, что беспокоится она (Варга, 2017). Хорни (1997) выделяла неодобрение значимых людей как основной источник тревожности и подчеркивала роль среды в ее возникновении. Если в раннем опыте ребенка существует любовь и поддержка окружающих, то у него развивается чувство безопасности и уверенности в себе. В том случае, когда значимые взрослые ведут себя по отношению к ребенку чрезмерно требовательно, безразлично, или же они могут быть излишне тревожными, доминирующими, гиперопекающими, тогда это может вызвать у него «переживание глубокой ненадежности и смутной озабоченности, для которой я использую понятие «базисная тревожность». Это чувство изолированности и беспомощности в мире, который он воспринимает как потенциально враждебный себе» (Хорни, 1997). В связи с этим особую важность представляет потребность тревожных детей в чувстве надежности и безопасности.

С точки зрения Позитивной Психотерапии, детская тревожность может быть обусловлена негармонично развитыми первичными способностями. Например, недостаточной уверенностью в себе, своих силах; отсутствием доверия другим людям; избытком сомнения в определенных ситуациях; недостаточно развитой способностью к контакту с собой или окружающими; слабо сформированной способностью к надежде, как ощущению безопасности мира вокруг; сложностями, связанными с несформированной способностью к терпению (возрастная особенность).

В программах профилактики и коррекции эмоциональных и поведенческих расстройств у детей успешно применяются методы арт-терапии. Одновременно с этим, занятия арт-терапией могут помочь сбалансировать четыре сферы жизни ребенка: сферу тела и здоровья, деятельности и достижений, сферу контактов, и сферу фантазии и смыслов. Использование в работе с детьми арт-терапевтических занятий позволяет высвободить негативные эмоции, невербально выразить эмоциональные переживания, в том числе и страхи. Творческая работа, созданная в процессе занятия, является неким «посредником» между арт-терапевтом и ребенком, что облегчает процесс взаимодействия для тревожного или замкнутого дошкольника: это позволяет делиться своими эмоциями и переживаниями не напрямую, говорить порой иносказательно, не от своего лица, а от лица персонажа, изображенного на бумаге или упомянутого в истории. Подобный «иносказательный» смысл мы находим и в использовании притч и сказок, которые также могут быть успешно использованы в рамках занятий. Набор техник и средств арт-терапии очень разнообразен, что позволяет ребенку также выбрать наиболее комфортный способ самовыражения, который соответствует его потребностям и возможностям. Для занятий арт-терапией, независимо от модальности (будь то лепка, сочинение истории, рисование, коллаж) не требуются специальные навыки. Это, в сочетании с безусловным принятием арт-терапевтом любых форм творческой активности, может способствовать укреплению веры в свои силы и развитию уверенности в себе. Создание терапевтом атмосферы безопасности и доверия может также внести свой положительный вклад в коррекцию уровня тревожности. В ходе занятий арт-терапевт использует различные приемы вербальной и невербальной обратной связи, которые могут включать активное наблюдение, перефразирование высказываний, фиксирование отраженных в рисунке поступков или мимики эмоций и чувств, сообщение о своих чувствах и ассоциациях с работой ребенка (Мартинсоне, 2017). Все это способствует налаживанию механизмов саморегуляции и улучшению способности к контакту с собой и другим, к эффективной адаптации, что часто является задачами терапевтического процесса.

В последнее время применение экологического подхода в арт-терапии становится все более популярным. В данном подходе природа рассматривается как важный фактор формирования терапевтического пространства и терапевтического процесса, а также как дополнительное условие повышения эффективности процессов лечения. Копытин (2016) рассматривает экологический подход как частный аспект средового. Он связан с изучением влияния человеческой деятельности на природные процессы и среду обитания, а также воздействия природной среды на состояние и функционирование человека. Средовой и экологический подходы в арт - терапии основаны на представлениях средовой психологии, экопсихологии и экологии здоровья. Экопсихология составляет общетеоретическую базу для методов эко-терапии, используемых с целью лечения и профилактики различных заболеваний, в частности расстройств психической деятельности и нарушений адаптации, а также для повышения качества жизни людей на основе укрепления их позитивных связей с природой. Бергер (2016) говорит о том, что в процессе взаимодействия человека с природной средой происходит активизация разных сфер опыта и психических процессов, что является важным условием повышения адаптивности и стрессоустойчивости. Другой

важной функцией является совершенствование навыков саморегуляции в результате активного контакта с природой и ее здоровьесберегающими ресурсами. Кроме того, совместная творческая активность группы людей в природной среде может способствовать сплочению и улучшению коммуникативных навыков (Копытин, 2013). Занятия в рамках экологического подхода могут полностью или частично проводиться вне помещения. Прогулки на свежем воздухе обостряют работу сенсорных систем организма, способствуют развитию наблюдательности, стимулируют воображение, одновременно с этим оказывая расслабляющее действие. Природа, в свою очередь, может выступать неким «ко-терапевтом» в процессе эко-арт-терапевтических занятий и внести свой важный вклад в процесс гармонизации личности ребенка.

Некоторые специалисты, работающие с детьми, например, Кортни (Courtney, 2017), подчеркивают важность использования природной среды и природных элементов в работе для решения их эмоциональных проблем. Она так же выделяет потенциальные функции природы, которые проявляются при взаимодействии детей и природной среды и/или природных объектов. Часть из них связаны с эмоциональной регуляцией, например, успокаивающее воздействие объектов природы при тактильном взаимодействии (особенно, если есть возможность подержать объект в руках), снижение уровня беспокойства и страхов, создание ощущения безопасности и защиты, а также предоставление некоего пространства для выплеска эмоций. В то же самое время взаимодействие со средой дает толчок к проявлению внутренних ресурсов ребенка, способствует повышению уверенности в себе, и, что особенно важно в работе с детьми, стимулирует воображение и магическое мышление в процессе оздоравливания.

Результаты

Реализация программы

Для отбора детей в группу коррекционных занятий была проведена комплексная диагностика группы старших дошкольников (возраст детей 5-6 лет) из 26 человек, в результате которой было установлено, что 8 человек (около 30 % класса) испытывают средний и высокий уровень тревожности (были использованы тест тревожности Тэммл (Головей, 2002) и опросник Лаврентьевой (1992) «Уровень тревожности ребенка»). Свое согласие на участие в занятиях дали 6 семей.

Один из участников, проявляющий максимальное количество признаков тревожности в группе по результатам опросника тревожности (11 признаков из 20) часто выражает несогласие, спорит с родителями и учителями, в то же самое время боится новых видов деятельности, нерешителен и робок с незнакомыми людьми. Участник, чей уровень тревожности определен как самый высокий в группе по результатам теста тревожности (78,6%), очень боязлив, стеснителен в общении, легко краснеет. Он плохо засыпает, ему часто снятся кошмары. У еще одного участника с высоким уровнем тревожности нет сложностей в общении со взрослыми и детьми, однако ему очень сложно фокусироваться и завершать начатые дела, следовать правилам. Во время выполнения различных заданий часто вносит изменения, исправляет работу.

Предположительно, одной из причин тревожности детей являются сложности в отношениях с родителями или же иными членами семьи. В связи с тем, что некоторые специалисты связывают тревожность детей с нарушенными отношениями со значимыми взрослыми, был проведен проективный тест Э. Клессман «Три дерева» (Обухов, 2005), который выявил сложные взаимоотношения в семьях четырех детей. Другим потенциальным фактором, оказывающим влияние на уровень тревожности, и о котором также говорят специалисты, может быть тревожность матерей дошкольников. В рамках программы матерям участников был предложен для заполнения переведенный и адаптированный для данных целей опросник тревожности Спилбергера – Ханина (Дерманова, 2002). Он продемонстрировал высокий уровень тревожности у 100% испытуемых.

По результатам диагностики в программу коррекционных занятий по снижению уровня тревожности было решено включить совместные занятия с родителями. Программа рассчитана на 12 занятий, с периодичностью 3 занятия в неделю. Длительность одного занятия 40-50 минут.

В ходе реализации программы решаются следующие задачи:

- Развитие у детей способности оценивать свое эмоционального состояние и выражать свои чувства (налаживание контакта с собой и с другими; развитие первичной способности к контакту).
- Укрепление веры в свои силы и рост уверенности (способность к уверенности).
- Снижение уровня эмоционального напряжения (сфера тела).
- Улучшение коммуникативных навыков (сфера контактов).
- Развитие творческих навыков (сфера фантазии и сфера деятельности).

- Создание безопасного пространства для свободного выражения чувств, эмоций и творческих идей (пример безусловного принятия).
- Содействие укреплению детско-родительских отношений (развитие сферы контактов).

Методические приемы, используемые в занятиях программы:

1. Игры на распознавание своих и чужих эмоций (сфера контактов)

2. Дыхательные упражнения и релаксация (сфера тела)

3. Свободное и тематическое рисование (сфера смысла и фантазий)

4. Создание истории (перефразирование, рефлексия своего опыта)

5. Создание амулета / помощника (активация внутренних ресурсов для восстановления)

6. Семейная прогулка с фокусировкой внимания на отдельных предметах (практика осознанности и улучшение контакта внутри семьи)

В соответствии с программой каждое занятие начиналось с определения эмоционального состояния участников с помощью «карточек настроений» и упражнений на релаксацию. Если занятие проводилось в кабинете, то использовались аудиозаписи звуков природы - шум дождя, звуки прибоя, пение птиц. Первые два занятия были направлены на знакомство с ходом занятий арт-терапией и занятий в экологическом подходе, во время которых дети исследовали свойства художественных материалов, знакомились с площадкой, на которой планировалась часть занятий. Третье занятие включало в себя взаимодействие со средой, а также создание рисунка и истории к нему на основе впечатлений от прогулки.

Темой четвертого занятия, и первого совместного занятия с родителями, была семейная фотопрогулка в парке. После упражнений на знакомство и фокусировку внимания было озвучено задание: исследовать окрестности парка в течение 30 минут и фотографировать объекты, привлекшие внимание. Дети и родители должны были выбирать объекты самостоятельно. Почти все взрослые отметили, что им было сложно не отвлекаться на социальные сети, мессенджеры, звонки, разговоры. По их словам, было довольно трудно «замедлиться» и полностью присутствовать в моменте. После окончания занятия мама одной из девочек в личной беседе сказала о том, что благодаря этому занятию поняла, что она может взять паузу, остановиться и провести время с дочерью, насладиться природой и ее красотой.

Второе совместное занятие с родителями было также проведено в парке. После приветствия и упражнений на релаксацию, участникам было озвучена тема занятия и задание – сбор природных материалов для создания коллажа на тему «Семья». Участники поначалу были робки, возвращались к месту сбора только с листьями. Однако постепенно стали обращать внимание и на другие предметы вокруг: ветки, палочки, раковины улиток, камни, цветы, детали от потерянных кем-то в парке игрушек. Данное занятие выявило некоторые паттерны взаимодействия родителей и детей во время их деятельности. Так, например, на вопрос, является ли одна из девочек центром семьи (фото ребенка было помещено в центр коллажа), ее тетя ответила, что это само собой разумеется – в Китае это типичная модель семьи. На высказывание о том, что остальные работы участников не похожи, и дети не занимают в них центральное место, и что, скорее всего, это личная модель их семьи, женщина задумалась. Для мамы одного из мальчиков визуальный раздел совместной работы вызвал удивление и огорчение. Мама другой участницы использовала 5 элементов вокруг иероглифа «счастье» по количеству членов семьи, и обратила на это внимание только после комментариев участников группы. Она была также очень тронута высказыванием дочери о старшем брате (сестра участницы нарисовала портрет семьи, включая старшего брата, который живет отдельно от девочек, и сказала, что очень надеется, что он сможет ходить). Маме другого участника пришлось уступить ему в том, как он хотел видеть свою работу (сначала мама настаивала на своем), а в некоторых моментах они смогли найти компромисс.

Во время одного из занятий было проведено упражнение «Мое безопасное место», во время которого дошкольники искали место на игровой площадке, в котором их игрушки смогли бы почувствовать себя спокойно и комфортно. После расположения в безопасном месте ребята успокаивали свои любимые игрушки, принесенные из дома, и объясняли, почему выбрали то или иное место.

Другим важным занятием было завершающее занятием программы. Детям было предложено создать свой личный амулет либо помощника. Во время занятия была использована аудиозапись звуков природы. Для изготовления амулета ребята могли использовать природные материалы (деревянные кружочки и шарики, шишки, веточки, листья, камни), а также и художественные материалы.

Один из мальчиков выбрал деревянный кружок, веточку от дерева, камень и шишку. Он создал переговорное устройство для связи со своим другом, который не был на занятии. Мальчик добавил, что поставит его у себя в комнате на шкафчик и будет использовать его.

Одна из девочек использовала деревянный кружок для своей работы и сказала, что это для улучшения настроения. Она добавила, что, когда ей будет грустно, она будет на него смотреть. Девочка решила создать второго помощника. Для этого она взяла второй

деревянный диск, камень, добавила к нему шишку, веточку и листочки, которые нашла на улице, и сказала, что этот амулет для тех случаев, когда она будет злиться - она будет держать его в руках из её злость будет проходить.

Второй мальчик создал картину с изображением гор и этапов сложного пути. Он также соорудил некое подобие тоннелей из деревянных кружков и лент, добавил поезд из камня, нарисовал под ним дорогу. После он взял ветку, поставил и превратил в фонарь уличного освещения, который освещал всю картину. Ребенку очень понравилось его работа, он несколько раз с восхищением смотрел на неё и говорил «какая же она красивая». И добавил, что она его очень радует.

Вторая участница взяла деревянный кружок и прикрепила к нему два деревянных шарика. Затем добавила к ним веточку и шишку. Сказала, что первый шар – это радостный шар, а второй шар от скуки. Она заметила, что что шишка похожа на цветок, а затем начал разрисовать шарики. После разрисовывания второго шара сказала, что это её подруга и она очень рада ей. Еще один участник группы приготовил множество материалов для своей работы, однако долго не мог собраться с мыслями и решить, что он хочет сделать. Сначала он создал некое подобие тоннеля. Затем взял камень и превратили его в поезд. После окончания работы мальчик сказал, что ему очень нравится его поезд, а когда он с ним играет, это делает его счастливым. Последняя участница группы прикрепила на лист бумаги материалы с разнообразными поверхностями: камень, шишку, деревянный кружок, а сверху приклеила на него листик, который она принесла с улицы. На своей работе она изобразила дверь: ее можно открывать, заходить в этот чудесный мир с разными поверхностями и дотрагиваться до них. Девочка сказала, что ей очень нравится её работа, а также очень нравится прикасаться к разным предметам, чувствовать их поверхности.

Дети были очень вовлечены в процесс изготовления своих амулетов, и в основном выбирали природные материалы. Итоговым занятием стало создание того, в чем они нуждались: для двух из них это потребность в общении с друзьями, а для одной из девочек что-то, что может помочь ей справиться со сложными переживаниями. Для двух мальчиков это потребность в успешном завершении замысла без помощи взрослого, потребность в создании чего-то, что может их радовать, поднимать им настроение. Для еще одной девочки было важным спроецировать свой волшебный мир, в который она может погрузиться в любой момент, притронувшись к предметам на листе. Все дети создали помощников для саморегуляции, к которым они смогут обратиться в любой момент. Это занятие - пример активации восстановительного потенциала человека с помощью средств природы и искусства. Дети смогли выявить свои потребности и постарались сделать все, чтобы удовлетворить их. Заключительное упражнение было важным для развития способности контакта с собой и роста уверенности в своих силах - дети самостоятельно определяли, что они хотят смастерить, и как они хотят это сделать.

На завершающем этапе программы был проведен опрос родителей с помощью анкеты и опрос воспитателей группы о результатах их наблюдений, а также повторное заполнение опросника Лаврентьевой «Уровень тревожности ребенка».

Результат заполнения опросника Лаврентьевой (1992) показал, что количество наблюдаемых признаков тревожности у всех участников коррекционных занятий снизилось, и уровень их тревожности определяется как «низкий».

Родители одной из участниц отметили улучшение настроения, качество сна, физического состояния. Они также добавили, что девочка стала чаще делиться своими переживаниями с близкими (способность к контакту с собой и с другими). В группе она стала чаще общаться с детьми, легче идти с ними на контакт и меньше смущаться при общении с воспитателями (уверенность, способность к контакту). Мама другой участницы отметила улучшение настроения и отношений с сестрой, с которой она стала чаще разговаривать и играть. Мама также заметила, что у девочки появилось больше друзей в группе детского сада (способность к контакту).

На это же обратили внимание и воспитатели. В ходе занятий она стала чаще идти с ними на контакт, инициировать его, а также стала «проситься на ручки» для того, чтобы поговорить или обнять их (избегала физического контакта до начала коррекционных занятий). У одного из мальчиков, по словам мамы, улучшилось настроение, как и аппетит. В группе начал стараться заканчивать задания (развитие терпения), стал меньше исправлять свои работы (снижение полюса “сомнение” и рост уверенности), а также чаще слушаться воспитателей, выполнять какие-то просьбы и задания без споров (доверие ко взрослому). В проявлениях третьей участницы мама не заметила разницы. Однако, по наблюдению воспитателей, в группе девочка начала чаще инициировать общение, меньше смущаться при ответах перед всем классом (уверенность).

Что касается второго участника коррекционной группы, чей уровень тревожности был определен как самый высокий, мама отметила его большой прогресс: раньше в сложных для него эмоциональных ситуациях мальчик плакал и отказывался говорить о причинах расстройства. После курса занятий он начал говорить о том, что его печалит или беспокоит (способность к контакту), интенсивность и длительность плача снизилась. Она также сказала, что с ним легче общаться и договариваться, и что мальчик стал более свободно

выражать свое мнение (уверенность, доверие ко взрослому, безопасность среды). Прогресс также отметила и мама третьего участника: мальчик стал чаще общаться с отцом, с ним стало гораздо проще находить общий язык и договариваться (способность к контакту), чем раньше, когда он упрямо настаивал на своей точке зрения (доверие ко взрослому). По поводу плохих привычек сына мама сказала, что они по-прежнему есть, однако это также и задача родителей - следить за своими привычками и изменять их вместе с сыном. Она также добавила, что эти занятия, включая опросник на уровень тревожности, дали ей понять, что она не уделяла достаточно внимания сыну в силу своих личных проблем и что она будет над этим работать

Выводы

Проведение коррекционно-развивающих занятий с использованием методов экологической арт-терапии позволило снизить уровень тревожности у детей с высоким уровнем тревожности и помочь им развить некоторые первичные способности. По мере реализации программы дошкольники смогли укрепить веру в свои силы, начать больше доверять взрослым, меньше сомневаться в принятии самостоятельных решений, и почувствовать дружелюбность окружающей их среды. Опыт взаимодействия семьи в новых условиях со-творчества был полезен для развития способности к контакту не только для детей - родители смогли иначе взглянуть на внутрисемейные отношения и наметить пути к позитивным изменениям.

Несмотря на то, что во многих традиционных культурах Востока взаимодействие человека и природы является неотъемлемой частью жизненного уклада, современные условия жизни накладывают свой отпечаток. В городах Китая очень развита парковая культура, семьи часто проводят время вместе. Однако, с развитием новых технологий, популярностью социальных сетей и высокими темпами развития мегаполиса, людям становится все сложнее фокусироваться на том, что происходит здесь и сейчас. Занятия экологической арт-терапии помогли детям развить некоторые первичные способности, а их родителям обратиться к природе не только как к рекреационному ресурсу, но и источнику вдохновения, взаимодействие с которым может служить основой для налаживания отношений с детьми.

Использование методов эко-арт-терапии специалистами помогающих профессий обладает потенциалом для коррекции детской тревожности, равно как и развитию первичных способностей. Описываемая программа не включает в себя встречи для установления контакта, и подразумевает взаимодействие с детьми, с которыми у специалиста налаживаются доверительные отношения. Это стоит учитывать при планировании работы с тревожными детьми.

Список использованных источников

[1] **БЕРГЕР, Р.** (2016). Природная терапия: теоретические основы и опыт применения в образовательных учреждениях Израиля. Арт-терапия и арт-педагогика: новые возможности для развития и социализации личности. *Сборник материалов всероссийской научно-практической конференции*. Санкт-Петербург. 2016. № 1. С. 83-87

[2] **ВАРГА, А.Я**. (2017). *Введение в системную психотерапию*. Москва: Когито-Центр.182 с.

[3] Исследование тревожности (**СПИЛБЕРГЕР, Ч. Д.**, адаптация **ХАНИН, Ю.Л.**). Диагностика эмоционально-нравственного развития. Ред. и сост. Дерманова И.Б. СПб. 2002. С.124-126.

[4] **КОПЫТИН, А. И., КОРТ Б.** (2013). *Техники ландшафтной арт-терапии*. Москва: Когито-Центр.104 с.

[5] **КОПЫТИН, А.И.** (2016). Целебное взаимодействие со средой: экологический и средовый подходы в арт-терапии и арт-педагогике. Арт-терапия и арт-педагогика: новые возможности для развития и социализации личности. Сборник материалов всероссийской научно-практической конференции.Санкт-Петербург. 2016. № 1. С.75-83

[6] **ЛАВРЕНТЬЕВА, Г.П., ТИТАРЕНКО Т.М.** (1992). *Практическая Психология для Воспитателя*. Киев. 29 с.

[7] **ЛЮТОВА, Е. К., МОНИНА Г. Б**. (2011). *Тренинг эффективного взаимодействия с детьми*. СПб: Речь.

[8] **МАРТИНСОНЕ, К.** (2014). *Искусствотерапия*. СПб: Речь. 352 с.

[9] **ОБУХОВ Я.Л.** (2005). *Диагностика внутрисемейных отношений при помощи проективной методики Три дерева*. Москва. 10 с.

[10] **ПРИХОЖАН, А. М. (2000).** *Тревожность у детей и подростков: психологическая природа и возрастная динамика*. М.: Московский психолого-социальный институт; Воронеж: МОДЭК. 304 с.

[11] **САЛЛИВАН, Г. С.** (1999). *Интерперсональная теория в психиатрии*. М.; СПб. С. 229–285.

[12] Тест тревожности **(ТЭММЛ, Р., ДОРКИ, М., АМЕН, В.**): приложение к «Прауктикуму по возрастной психологии под ред. Л.А.Головей, Е.Ф.Рыбалко». СПб.: Речь, 2002.

[13] **ХОРНИ, К.** (1997). *Собр. соч. в 3 томах*. М.: Смысл. Т.2. С. 174-180

[14] **COURTNEY, J. A.** (2017). *T*he art of utilizing the metaphorical elements of nature as "co-therapist" in ecopsychology play therapy. In A. Kopytin & M. Rugh (Eds.), *Environmental expressive therapies: Nature-assisted theory and practice* (p. 100–122). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9781315310459-7

[15] **PESESCHKIAN, N.** (2016). *Positive Psychotherapy of Everyday Life: A Self-Help Guide for Individuals, Couples and Families with 250 Case Stories*. Bloomington, USA: AuthorHouse UK

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FAMILY DYNAMICS IN PSYCHOTHERAPY IN ADOLESCENTS WITH ANOREXIA

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Abstract

The article represents the question of the relationship between family dynamics and the emergence, development and treatment of eating disorders in adolescents, through the eyes of the psychodynamic and positive approaches in psychotherapy. The main conclusion is that without taking into account the dynamics of family relations, the function of the symptom cannot be understood.

Keywords: anorexia, family, adolescent, Positive Psychotherapy.

Introduction

Psychodynamic theories postulate that through appetite and refusal to take food, unconscious oral and aggressive stalking is prevented. Fasting was seen as an unconscious protest and punishing reaction to parents (Loch, 1971, Alexander, 1971). With their appearance and behavior, the sick display emotional hunger. Many of the therapeutic strategies are based on understanding the influence of inter stock inside the family (Rosman, 1976). The main conflict in the families of the anorexic sick is associated with the so-called " "intact" families with financial relationships. According to Peseschkian (2016), typical in these families is emphasis, in one of the parents, on the importance of order, purity, courtesy, success, and in terms of religion, attention is also paid to abilities such as obedience. Attitudes towards the body and sexuality are pushed out and a markedly one-way approach to " spiritualization" is present. In this regard, these families are also called " ascetic"- limitations of pleasure and sensuality do not exist, nor joy from sensual chases, chases and tenderness. Love is deserved by children through success and good behavior. There are few or no contacts outside the family. Again, according to Peseschkian (2016), adolescents make a demonstration of autonomy through a dramatic act of denial of food, in a conflict between what they have learned in the home and their own desires and attitudes. Psychogenic weakness provides an external expression of the problem in the family, it is a disease of the whole family, where the sick person is only a carrier. Through his illness, he expresses the suffering of the whole family, which no one dares to pronounce out loud. Risking his life, the teenager makes family problems visible. Peseschkian describes several cases of anorexia in which the girl identifies with her brother, as evidenced by the preservation of the body as boyish, a refusal of femininity.

Patterns of family bonding of people with obsessive-compulsive personality structure, such as personality specialty rather than diagnostic category, are described in research by Nancy McWilliams (2018) as incorporating parenting figures who create high standards of behavior and await their early, strict and consistent adoption. The style of education is focused on the motivation for achievement. Caregivers have unreasonable expectations, too early they start demanding things that the child is not able to do because of his age. They strictly reject not only unacceptable behavior, but also the accompanying emotions and feelings, thoughts and fantasies. From the perspective of object relations, the question of control in the family is raised, from which eating disorders and,

accordingly, obsessive-compulsive personality structures are derived. Common fears of infection, present in people with eating disorders, are associated with separation anxiety and parental overcommittance and excessive protection. McCullough stresses that it is important to take into account the function of the control parents exert when dealing with modern obsessive and compulsive psychopathologies, such as eating disorders, to take into account the function of the control that parents exert, to plant obsessive and compulsive patterns by shaming, and not so much by ingesting guilt, which has been described in earlier studies. The author also describes another type of family environment, fundamentally opposed to the over-controlling and moralistic atmosphere described so far, in which children are deprived of family standards, with a lack of supervision and careless ignorance. In this case, the child tries to be the opposite of the distracted, unfinished parent by creating an overly strict and idealistic standard that is not humanized, has no human face, because it is not related to the behavior of real parents, and this makes it even stricter and more abstract. These children have to model themselves in a parental image of their own invention. In his analysis of the problem, Delarosch (2004) defined the disease as "a form of slow suicide disguised in numerous ways and liable to others." For this reason, the author believes that anorexia is a wayward interruption of the development process. If the adolescent can realize that he or she refuses the process of adolescence, it gradually leads to a return to this process. It's about a conflict that can only be expressed through drama. Delarosch (2004) calls it a "hunger strike" and control over parents, an ongoing illusion of omnipotence that is an indicator of a failure of the word in the family that needs to be restored. In the beginning, the family adopted the adolescent diet as part of the media-imposed model - a banal adolescent problem. Then a real loss of appetite occurs, and then relatives try to force the sick to eat, which at this stage of the disease is already very difficult, and then come the conflicts. However, Delarosch (2011) believes that if the anorexic has solved her conflicts through the symptom, then she does not do so by negotiating with words. For this reason, a struggle to measure the forces between the girl and the parents begins. The author refers to the knowledge of the relationship between orality and female sexuality, with anorexia becoming for the girl a " triumphant denial of the Oedipus Complex". Anorexia challenges the father, especially his inelessness,*** his castration from his wife. In other words, anorexia is a function of impaired emotional and sexual relations between parents. Delarosch (2011) also emphasizes the girl's reluctance to resemble the mother caused by disharmony of a different type between parents, the obviousness of the Oedipus complex. The author brings out four characteristics of anorexia in a family environment: "The Hunger Strike", in anorexia the adolescent sees her possibility of a rematch, until then pressed by the conflicts in the family, discovers the power she possesses over parents by refusing to eat.

There is a "real test of strength" between parents and adolescent, in which often the doctor is in the role of mediator, who seeks to explain to the adolescent that each strike has its end. " Omnipotence"- the need of the anorexic sick to place themselves above others intellectually and spiritually, to experience themselves as highly spiritual beings, elevated above prosaic and petty household needs, such as nutrition and sexuality – these can all be observed in their speeches. The third characteristic described by Delarosch is precisely the refusal of sexuality, denial of the body as sexual - it remains a body of a child's shapes, without the distinctive marks of the female, a refusal of the idea of sexual communication, the cessation of menstruation is a physical expression of this refusal. The fourth characteristic raises the question of the " shadow of death", although often the sick do not realize the suicidal nature of their behavior and are supported by an illusory sense of immortality and omnipotence, of the one who can live without eating, only on air and water. Delaros describes anorexia as a failure of speech in the family, and during psychotherapy, this exchange of speech must be restored, between the child and the parents, even before the start of psychotherapy with the child. At its heart, anorexia is a denial of sexuality, of being a woman, like her mother-refusal to identify with the mother, often due to an unauthorized Oedipus situation in which female sexuality makes insula anxiety unbearable. Lacan (2008), in "The Family Complexes," talks about the deliberate de-ation as a nonviolent suicide, in which the subject is condemned to repeat endlessly the effort to break away from the mother. First among the causes of neurosis, it puts parental neurosis. " The psychological fate of the child is, first and foremost, conditioned by the relationships that parents show each other. Lacan (2008) says that with anorexia, "what the child eats is nothing," which he says happens because the anorexic has been trampled on in terms of his need for food, she is now struggling to maintain her desire by refusing to meet that need.

Dolto (1995) in " In the Game of Desire" puts the desire to communicate with the other, from birth, through the gaze, the hearing, as more essential than the instinct for food. It is this communication that is disturbed in the family of anorexic children.

In "Teenagers", Dolto (1995) writes that disagreements between parents are tolerated by the child until the age of 11, but then the maturing problem becomes apparent. The author develops the problem of family dynamics going beyond the hypothesis that refusal of food is directed only against the mother, Dolto believes that this behavior has to do with the mother, but not necessarily the native one, but the woman who is the subject of identification by the girl.

Understanding anorexia, Dolto (2005) goes through her theory of body image (as revealed in the analytical dialogue with the child). The root of the problem relates to what happened in the period before Oedipus, between three and six years. Anorexia brings us back, she writes, to what happened in the so-called primary narcissism phase, when a girl comes to know her gender, as a future woman, as her mother, and to the narcissistically rewarding pride of becoming a woman like her mother. Of course, here Dolto talks about the organization of the girl's sexuality around a man who is valuable to her, the father. Dolto (2005) writes in his book, "Unconscious Body Image": " The girls who took at the time of primary castration, at the age of three, postponed their sex life to adulthood, but who were convinced of the value of their personality as the daughter of this man and this woman, these young girls rarely or almost never get anorexia."

Gaining weight is a word unconsciously related to pregnancy, the girl obeys the desire to please herself in front of the mirror, erasing all feminine curves, even the most discreet ones. The desire for the father is masked, disguised in a complex, conflicting love, and her problem is in the conflict between love, affection and desire for her father and in such with the mother and rivalry and struggle with her. In other words, according to Dolto, the girl "experiences completely autonomous unconscious conflicts dating from three to six years of age", having very little to do with the current situation and the behavior of her parents towards her at the moment. Anorexia is a reaction to what it was like for a little girl between the ages of three and six. Bernard 2016 in The Body links anorexia to maternal depression, with digestive disorders linked to her identification with the mother's suffering, in which case the relationship between mother and child is one that needs to change so that the child no longer needs to be sick.

In a study of family dynamics and anorexia, Secondo Fassino, Dragan Svrakic, Giovanni Abbate-Daga (2002) found evidence of immature relationships between parents living in symbiosis and found evidence of the important role of parental personality patterns and temperament in describing fathers of anorexic girls, more likely to have a passive, dependent temperament, with high levels of personal anxiety and fears. The authors recommend as an optimal approach to treatment, one that takes into account family characteristics and the characteristics of parents and family relationships.

In the concepts of PPT we can describe anorexia as the ability to achieve many things with activity and achievements. We are concerned with the topic of the meal, but without prejudice to the topic of nutrition. (Peseschkian, 2016)

In the PPT psychotherapy we work with self-assessment and importance, the role of the woman from the little girl to mom and dad, to the little woman and the fears to becoming "a woman like my mom." Consciously, the therapist avoids discussing the topic with the mother. The therapist is careful not to become a demanding, controlling mother, but continues to connect cordially. The affective dimension is imported through transcultural nursing, images, symbolism and artistic communication and, of course, fairy tales. In the concepts of PPT we suppose that the conflict is only externally in a body area, only the current conflict is there, the internal conflict is in the area of contacts, and the main conflict in the field of meaning and problematic is the issue of death.

Peseschkian wrote about the motive for the eternally living relationship between the adolescent and the family, regardless of how old he is. Therapy of the individual always includes the elements of family therapy, even when working only with the adolescent. n ? these girlsshow reference to secondary abilities such as accuracy, purity, order of magnitude, obedience, diligence, achievements. They use their bodies to rebel against an overly controlling but remote and cold relationship with the mother, a relationship in which the girl does not have her own space, not recognized as a person and subject.

Methodology

For our study we use the "Thematic Apperception Test" and make content phenomenological, qualitative analysis. The Thematic Apperception Test, or TAT, is a projective psychological test. Proponents of this technique assert that a person's responses to the TAT cards can provide information about his or her views of the self, the world, and interpersonal relationships. 30 protocols of girls aged 12-18 years were analyzed.

The TAT is popularly known as the *picture interpretation technique* because it uses a series of provocative yet ambiguous pictures about which the subject is asked to tell a story. The subject is asked to tell as dramatic a story as possible for each picture presented.

The research procedure is conducted by the author who works as a clinical psychologist and psychotherapist, in the Child and adolescent psychiatric clinic in Varna, Bulgaria.

Results

For the needs of the research we have used qualitative assessment methods:

- content analysis
- interpretive phenomenological analysis
- analysis of feelings through lexical analysis

Qualitative analysis of data is a descriptive method. It works with texts in the form of verbal and written speech. The content of the text is of paramount importance in this analysis. But apart from the directly expressed content, the speech also translates the emotional state of the speakers, the attitude to what the partner says, the unconscious

contexts. Interpretive phenomenal analysis is a method that is used when we are interested in the way a person experiences a phenomenon and, accordingly, the psychological interpretation of that experience. Content analysis is a method of empirical analysis of the content of text. It is characteristic of the frequency of certain speech units or mental categories and, on this basis, an assessment of the back-to-back mental concepts.

Initially, the individual thematic units of the following segments are summarized:

- aggression towards the mother;
- death;
- guilt;
- dependence;
- riot.

Table 1.

Basic thematic units in TAT stories

Basic thematic units in TAT stories	Frequency
Aggression towards the mother	86%
Father figure	3,3%
Death	83%
Guilt	80%
Dependence	78%
Riot	75%

The comparative analysis of the summarized data from the 30 cases (Tab. 1) shows the following significant trends: unconscious aggression towards the mother is projected in 26 of the 30 protocols, and this is accompanied by feelings of guilt and self-punishment. The image of the father is idealized and less represented than that of the mother (in 10 out of 30 protocols). absent, etc.). The perception of oneself is like that of a little girl, under the power of a strong female figure, with the desire for escape and independence mixed with the horror of separation and differentiation. At the same time, the mother-daughter relationship is over-controlling and anxious, but emotionally cool. The lack of stable emotional attachment and connection makes the stage of differentiation problematic. The main conflict of these girls is between the need for bonding and love and the need for differentiation and rebellion. By controlling their food and body, they try to show the symptom to the family, risking their own lives.

Researchers of familial pathology point to different types of problems in the family, Beavers (2000) points out that families with a diseased member are usually those in which there are no clear boundaries, specified roles. At the heart of the communication difficulties, the researcher uses the so-called double blind, it consists of a disproportion and discrepancy between the content of the verbal message addressed to the child and the way the message is expressed. From the point of view of a systemic approach, the other form of pathological family behavior is non-acceptance of change, lack of flexibility to change, which creates conflict dynamics, often different coalitions in the family, functional of personal neuroses of those who make them up.

In the case of girls, the interest in the relationship with the mother and sexual desire in the broadest sense of the word are completely pushed out, without being changed into interpersonal relationships with the mother and women. Dolto shares that her clinical experience shows that the parents of these girls often live in an infantile way, in a pleasant or not climate, but one in which the idea of possible pregnancy and childbirth in the girl is completely unbearable for these girls and all symbols of fertility. - Breasts, female body shapes are destroyed by the compulsive thought of avoiding gaining weight. This fact does not need to be analyzed, Dolto continues, because it is a "disturbance in the real relationship between the girl and the mother, between the girl and the food, between the girl and her father, between her imaginary femininity and her inexperience with boys, between the girl and his mirror".

Conclusion

In the words of the girls, the main problem at the moment is the separation from the mother, against the background of a contradictory connection, as the subject seeks to separate, showing through her body that there are unspoken things in family relationships. Seemingly conflict-free, family relationships in the projections carry a hidden and constant tension, and the child's suffering is an expression of the unspoken in the whole system. Anorexia is also a symbolic protection of the subject who strives to remain free and differentiated. The rejection of the female body, associated with broken relationships with significant others, leads to a regression that stops the natural process of adolescent farewell to childhood, it is important that this process be brought to consciousness to continue the growth from girl-boy to woman body.

References

[1] **BEAVERS, W. R. & R. B HAMPSON** (2000). The Beavers System Model of Family Functioning. *Journal of Family Therapy*. No. 22. pp. 128–143.

[2] **FASSINO, S., SVRAKIC, D., ABBATE-DAGA, G., LEOMBRUNI, P., AMIANTO, F., STANIC, S., ROVERA, G. G**. (2002). Anorectic Family Dynamics: Temperament and Character Data. *Comprehensive Psychiatry.* 43(2). pp. 114-20. DOI: 10.1053/comp.2002.30806

[3] **WESTEN, D** (1991) Clinical assessment of object relations using the TAT. *Journal of Personality Assessment*, p. 56.

[4] **БЕРНАРД, Ф. [BERNARD, F.]** (2016). Цялото [The body]. София: Център-за-психосоциална-подкрепа

[5] **ДЕЛАРОШ, П. [DELAROCHE, P.] (2004).** *Юношеството* [Adolescence]. София: Център за образователни програми и социални инициативи.

[6] **ДЕЛАРОШ, П. [DELAROCHE, P.] (2011).** *Проблемите на юношеството* [The Problems of Adolescence]. Център за образователни програми и социални инициативи. София: Център-за-психосоциална-подкрепа. 200 с.

[7] **ДОЛТО, Ф., [DOLTO, F.] (**1995). *Тийнейджърите. Най-после отговор на вашите въпроси* [Teenagers. The last answer to your questions]. София: Наука и изкуствою 320 с.

[8] **ДОЛТО, Ф., [DOLTO, F.]** (2005). Несъзнаваният образ на тялото [The unconscious body image]. София: Център-за-психосоциална-подкрепа. 320 с.

[9] **ЛАКАН, Ж. [LACAN, J.]** (2008). *Семейните комплекси* [Family Complexes]. София: СИЕЛА. 176 с.

[10] **МАКУИЛЯМС, Н., [MCWILLIAMS, N.]** (2018). *Психоаналитична диагностика. Разбиране на структурата на личността в клиничния процес* [Psychoanalytic diagnosis, understanding the structure of personality in the clinical process]. София: Издателство "Леге Артис". 456 с.

[11] **МИХАЙЛОВА, К. [MIHAILOVA, K.]** (2004). МИХАЙЛОВА, К. *Жени, секс, анорексия* [Women, sex, anorexia]. София: изд. Весела Люцканова. 144 с.

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

TO BE OR NOT TO BE – HAMLET AND THE PSYCHOTHERAPEUTIC TECHNIQUE: ABOUT THERAPEUTIC ALLIANCE, GROWTH AND EFFECTIVE THERAPY

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Abstract

It is possible to construct a helping alliance for the best results in therapy by keeping in mind this helpful process of therapy, starting with building an attachment which will be needed for the interactive differentiation of the therapy contract, goals, and the client's own activity between the sessions, and finally using feedback at the end of each session. The therapeutic alliance will grow by changes, in crisis situations and thresholds within therapy. It is essential that we know the partners of the clients and let them know about us, in order to facilitate our clients' growth and to lessen side effects, and that we include the interaction with the social environment of the clients, and finish with the feedback about the therapy process.

Keywords: therapeutic alliance, stages of interaction, Balance Model, Positive Psychotherapy

Introduction

As workers in a healing profession, we have to care about the existential questions in our patients' lives. They suffer from these, whether it is in a panic attack, feeling that they are going to die, in a depression with a lack of feelings altogether, or in a compulsive obsessive disorder with the feeling that they must always do something meaningless. The patients usually have high expectations and get hope in the moment they make an appointment with us. We have the task to cope with their existential questions, how to live with depressive phases, how to survive a borderline personality diagnosis, or how to cope with life as unpredictable and with its finite nature.

Methodology

As a therapist, who mainly did not have the experience of such symptoms as my patients experience, but has had long years of training in specific treatment methods, I wonder: Who am I in this encounter with my patient? Whom could I be for my client? How am I in this relation with my client? What is it that really counts in psychotherapy, what is it that really helps?

Surprisingly enough - it is not the method or theory that is the healing aid, its influence is not more than 15% on the outcome of therapy. Such data is supported by the newest publications such as Bruce Wampold's in the Conference on Systemic Research on 8.-11. March 2017 in Heidelberg. It might disappoint us as therapists learning or even teaching psychotherapeutic methods, that it is not the psychotherapeutic method which we identify with, but the patients' factors, patients' expectations and the therapeutic relation that have the strongest effect on the outcome in treatment (Norcross, 2009). The 'best method' or the 'excellent technique' are not what they seem to be - they are not the most important basis on which to help our clients to have a better life. Still, the psychotherapeutic

method as such seems to be necessary in any case; for me, myself, as a therapist I feel the need to develop an identification with one of the theoretical models (Kernberg, 2005), to understand myself and the clients' world better by means of a clear, logical, and 'empirically based' theory.

After passing the psychotherapeutic school, experiencing psychotherapy, applying interventions, learning from our patients how to act or what to do, as therapists, we soon come to Hamlet's question - To be or not to be, or as formulated for therapists: To be, or how to be? In order to survive as therapists. The question brings me back to reflect on the real person I am, playing therapeutic roles, back to the therapeutic relations we have, to the patterns we create with each other, to the meaning we find together in a therapeutic setting. I might be identified with a method I like, with a theory I believe in, and still - research has been showing for a long time that it is not very important to my clients which theory I apply to their disorders. Rather, it is important if I have a healing personality. Still, it helps me to survive when I can identify with a specific method of psychotherapy.

A psychotherapeutic school with its theory and teachings of interventions can help me to grow as a therapeutic personality. A theoretical explanation of disorders gives me an inner working model. The methodology helps me to reflect myself, using terms from the methods I believe in, and gives me a belief that it is useful for us and the clients. The methods become inner working models. In this way, I can understand, can see a meaning, and can manage a situation, concerning the salutogenetic principles of Antonovsky (Antonovsky, 1997). In the spectrum between facts and religion, we can either see our method as a nice, empirically-based, logical theory or as a problem-management tool, "nice to have". It might provide a strong basis for what we experience with each other in a therapeutic process, and an aid in finding out what helps my clients to organise themselves better. We might become believers in a psychotherapeutic faith and identity so as to be united with others who believe in the same idea. It will give us a strong feeling of being on the 'right side'. So, we might feel safe and separated from dangerous others, being members of a strong community of the 'best psychotherapists ever' united with the label of the best method ever found, as in a religious community.

So I come back to the question: To be, or how to be as a therapist? The real medicine in psychotherapy is the therapeutic alliance, at least the recent research does not show other results.[1] The psychotherapist, as a person, as a human, is in interaction with the client. The alliance with each other is the helpful ingredient, valid for all kinds of methods, as Michael Balint quoted 1973: "...the most frequently-given medicine is the doctor himself. This is not medicine in a package, but an atmosphere in which the patient perceives another medicine" (Boncheva, 2004).

Results

The "person" - in Latin: *per - sonare*, means "to sound through the mask of the actor on the stage" in theatre,on the ancient Greek background πρόσωπον/prosopon = face. Carl Gustav Jung (1971) defines the "Persona" as "the mask or face with which the human shows himself to the world."

So, let us reflect on the question: What are the real influences of our trainings, the psychotherapeutic methods, of the therapist's personality, experience and training, the influence of the patients themselves, and that of the environment of the clients on the outcome of treatment?

Extra-therapeutic factors seem to play the biggest role in good results from therapy, that means, the nature of the patient's disorder as such, the severity of symptoms, the readiness for changes, the characteristics of the individual personality, the social environment, together these make up some 40%. This is what family therapy works with - to involve the family as the most important part of the social environment, and Positive Psychotherapy also includes the family and the wider social environment as much as possible.

The **quality of the therapeutic relation**, in a broader sense, the therapeutic alliance and the person of the therapist, has an influence of around 30% in all modalities. Psychodynamic methods explicitly focus on the patterns of therapeutic relation, the contents and dynamics, and resistance as a field of therapeutic training in conflict management. In Client-Centered Therapy (C. Rogers) the therapeutic relation is seen as the healing agent. Also in CBT, the therapeutic relation plays this important role but usually is not reflected as such. The **therapeutic alliance** is considered the most robust process variable, much associated with positive therapeutic outcome in a variety of psychotherapeutic models, as was stated by Alexander, L. B.&Luborsky, L. (1986) Gaston, L.&Luborsky, L. (1993), the alliance is found to be the predictor of the efficacy of

[1] „The well-known "common factors model of psychotherapy" postulates that in order to explain treatment success of different approaches to psychotherapy or counselling, a set of common factors (such as clients' social and biographical context, life events during therapy, strength of clients' motivation, therapists' personal qualities and the therapeutic relationship) are much more responsible as compared to particular methods or techniques for specific problems and disorders (e.g. systematic desensitization for phobic disorders)..." http://www.isr2017.com/news_events/

counselling and therapy, also by Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Shedler and Leichsenring found the same (Mellado et al., 2017).

The **hope of the client**, a perspective of help soon to come, the belief in healing, ca. 15%, and therapy techniques and methods have an influence of ca. up to max. 15% on the outcome of therapy, all these results are cited by Hubble, Duncan, and Miller 2001 (Hubble et al., 2009). The hope of the client is focussed on interventions, in Humanistic Therapy, in Positive Psychotherapy, in Systemic Therapy, or in Positive Psychology. In Cognitive Behaviour Therapy the frequent reflection of the goals of the therapy has the indirect function of focusing on a symptom-changing orientated future, so it might create hope, depending on the way it is reflected as a feedback in the therapeutic relation.

In one of the biggest meta-studies of that time, Grawe (1994) described as the main factors of a good outcome in psychotherapy: **Active help in problem solving, motivational clearing** (concerning values and goals), and again - the quality of the **therapeutic relation**. It seems that the personal influence or the **personality of the therapist** is linked to one of the strongest factors in the outcome of psychotherapy.

All this is the therapist's perspective. What do **patients** say? What were their expectations and what did actually help them? Sloane et al found (1975):

"The helpful person or personality of the therapist," (as when patients say "My therapist!")

"Help me to understand my problem," (see understandability of Antonovsky, or clearing of Grawe)

"Encourage me, help me to do something, to encounter the difficulties" (active help in problem solving)

"Give me the possibility to talk with an understanding person" (quality of the therapeutic relation)

"Help me to understand myself" (interactive encounter with an emotionally important person in the therapeutic alliance)

To summarize the most important factors in psychotherapeutic treatment:

- Quality of the Therapeutic Relation
- Understanding and Clearing
- Aid in Constructive Conflict-Solving
- Optimism to Find and to Give Help
- Motivation and Active Participation
- Personality and Maturity of the Therapist
- This is valid for all Methods (Grawe et al., 1994)

How can we reach this quality and alliance in our own therapies? What does this mean, as my personality as a therapist is as it is, and it will not change much? And: What does all that has been mentioned mean for our own practice? What do psychotherapeutic modalities offer for that?

A **therapeutic alliance**, the "helping alliance" (Luborsky 1976), is reached and supported in **different methods**:

- Personality orientated Psychodynamic Therapy by being a Model, by Parenting (Rudolf), Transference Focussed (Kernberg, 2005), or Ressource Orientation (Wöller).

- Conflict orientated psychodynamic therapies work with countertransference and resistance as part of founding the alliance, overcoming difficulties together and creating in that a way to solve inner and interpersonal conflicts.

- In Gestalt Therapy equality of patients' and therapists' feelings and positions are an important part of constructing a strong alliance.

- The Humanistic therapies focus on empathy, authenticity, being yourself.

- Positive Psychotherapy uses the same fundamental humanistic understanding of the therapeutic relation, and adds interactivity, self-help orientation, an understandable language and theory.

- Cognitive Behavioural Therapy uses goal orientation and encouraging active patient-s exposition and confrontation to support the working alliance.

What does it mean to create a "therapeutic alliance"? Rudolf (1991) answered this question already, and as research, it seems to be valid today: "...both partners need to **develop the belief, that they** themselves and the counterpart **are suitable** for the common therapeutic enterprise, and that they might/can lean on a **personal appreciation** for the other. The patient needs to come to the **conclusion, that the therapist can help** him because of his means; on the other side, the therapist needs to leave the impression that the patient is someone whom **he can help** and whom he **is able to accept** so far, furthermore that he is **motivated** to give therapeutic help. After all, both partners must develop the **same view of the problem** and the **same perspective for solutions**." (Rudolf, 1991)

As I have been working for 3 decades as a psychotherapist and teaching psychotherapy since 1992 in Germany and in other countries, working in psychosomatic medicine, in mental health, in hospitals and with outpatients, I asked myself the question: **what is common, what is different** in these different **settings and therapeutic relations**, and in founding a **good therapeutic alliance**? I want to show you how I like to work to reach a good therapeutic alliance as a family therapist, a psychotherapist and counsellor, a medical doctor or in psychiatry:

Four situations show the different positions of a family therapist, counsellor and psychotherapist, medical doctor, and in psychiatric treatment:

- a family with child behaviour problems,
- a depressive patient,
- a medical doctor's patient with a sleeping disorder,
- a paranoid psychosis.

As a therapist or doctor I have in mind my role, how to be, how to work with

- my feelings as a therapist, i. e. to be neutral and to hold in my feelings as a doctor, or to use them in psychodynamic psychotherapy to work with counter transference
- how I understand the contents of conflicts as a family therapist, or how I need to act as in psychiatry, not feeling understood by the psychotic patient,
- how to moderate a psychotherapeutic process or how to guide the patient in medicine or psychiatry,
- how to be sensitive for intuition in psychodynamic therapy, or how to plan for the suffering patient in medical treatment and CBT.

There result four areas of the therapist's mind sets:

- feelings vs neutrality
- contents understanding and self help vs treatment planning, psychoeducation and active help
- listening, interacting vs guiding and acting
- to open oneself for intuitions vs. to have clear plans, tasks and duties

For different patients I will need flexibility on a continuum between these attitudes, relative to the personality and situation of the client/patient. They are different in conflict management, psychotherapy, social work, health care, or medical treatment. I have to adapt to the severity of depression, anxiety disorders, or to the level of integration in personality disorder or psychosis, giving room or being active, feeling or being neutral, acting or letting the client think and change. We will give the emotional safe space and setting to the patient, being interested mindfully to understand the hidden links as a psychotherapist. "The medical doctor, in the role of communicator, has an intensive contact with the disorder or disease. The subjective information coming from the experience of the patient in contact with the doctor and the disease does not (usually) have a communicative value [for the medical doctor]" (Boncheva, 2004).

A constructive path for a therapeutic alliance is to see the patient as the specialist for his feelings and experience of the disorder, while the doctor will be the specialist to make the experience understandable. As medical doctor I will give my knowledge about disorder and treatment to the patient, in psychotherapy I will use my knowledge about communication and contents of problems. The feedback quality in our encounter will be more around the effects of treatment and the patient's activity, in medicine and psychiatry. Feedback is effective for a helpful alliance when we do it regularly, concerning the therapeutic relation[2]. Especially in times of thresholds or changes in consultation and psychotherapy. This will support the client's making good progress.

To work with the Social Environment of the clients:

Especially in children's therapy, we need the family therapy approach as a helpful alliance with the family, not just treating the child. In Youth therapy persons from the social environment of the adults also can be invited, if the client wishes. Christian Reimer suggested that, in therapy, we should "get to know the unknown third" (Reimer&Rüger, 2012) - the partner or family of the client should know about us or meet us, if the client wishes, and the therapist should get to know the partner of the patient, to lessen the side effects of therapy, and to broaden the therapeutic alliance.

The development of interaction in our therapy sessions follows **three Stages of Interaction**:

Attachment - differentiation - detachment, in a process of interaction, understanding and cooperation. They are the natural way of human encounters in many languages, as "hello!, how are you?, see you later!", or like our attitudes in phases of treatment:

1. Attachment: The patient's feeling of a person taking time for her or him and the patience in listening and really being interested in his or her problem is the starting point to have trust in you as a person and hope for the future and the outcome.
2. Differentiation is the phase of learning from each other and to clear the unknown: What is it about, what is the problem content, what is needed?
3. Detachment means looking forward, means the feedback about the session (Engster & Wampold, 1996), and preparing for the time after therapy, self help and future goals

An example to help us analyse the stages of interaction: Sometimes patients come and ask me immediately for diagnosis or for a prescription of medical drugs, or a plan for therapy. Then I remind the patient of the proverb "If you give somebody a fish, you feed him once, if you teach him fishing, he can feed his family a whole life long." I will go back to attachment, to have a human link first, to give the patient a space in which to feel free, to have time, to feel my patience, before we start with the subjects and contents of therapy. Lievegoed said: "A talk, or a talking culture, include, that a human encounters oneself in the self of the other."

To start and moderate the therapeutic process with **attachment**, to go through **differentiation** of contents and dynamics, to organise a good **detachment**, introducing the client's self help, seems to me important in all kinds of therapeutic encounters, and seems to be important to have a fruitful therapeutic alliance. Three phases of therapist - patient relations and interactions have already been described by V. von Gebsattel (1954) and V. Frankl (1953),

[2] „1. Create a „Culture of Feedback", 2. Integrate alliance and outcome feedback into clinical care, 3. Learn to „fail successfully" in: Evidence Based Practice/Medicine (EBM) vs. Practice Based Evidence (PBE). Feedback as the main important tool. Scott D Miller, International Center for Clinical Excellence: The Heart and Soul of Change: What Works in Therapy p. 21. http://www.scottdmiller.com/

later put into practice in Positive Psychotherapy as "the three stages of interaction" by their student N. Peseschkian (1977).

As you saw before, I must be clear about my role in creating a good therapeutic alliance, and need instruments to help the client and me to get a better understanding of the client's situation, of the function of the symptom, of the resources, and of myself in therapeutic encounters. For this I use the **Balance Model** (Peseschkian, 1977, similar to Jung, 1971) for reflecting the therapeutic alliance:

- Feelings and Observations,
- Knowledge and Action,
- Relation and Relational Pattern,
- Expectations and Imaginations.

With the Balance model, the patient and I can describe in a visualised way

- the symptom areas, better understand the everyday life of the client, and how the energy of this client is balanced,
- the influence of the symptoms on these areas of life, so to say, the function of the symptoms,
- resources and how to encourage them,
- goals and plans of self help for the patient,
- personality capacities (like the structural capacities of personality, OPD-2),
- finally the goals and objectives of therapy.

I usually start this balance model together with my client so as to have a clear understanding, to encourage the patient, to prepare self help, and to understand the environment of my client. This provides a simple but effective way to help construct a strong helping alliance. In addition, I can use the Balance Model for myself as a therapist, to understand the therapeutic relation as a mirror of the patient's unconscious contents, when I describe in the four areas, **how I feel with the client**, to find out what it means:

- feelings and emotions,
- rational thoughts,
- relational patterns with the client,
- intuition, fantasy.

The balance model helps me to understand my own countertransference in psychotherapy, to understand the contents of the inner conflict dynamic, to co-operate as "partners, that are on the same level of being" (Gebsattel, 1954). Within the four areas of my countertransference, described in the Balance Model, I can go to supervision after treatment and share with my supervisor what I experienced with my client.

After clearing the situation, the symptoms and their functions, the resources, and the goals, we can continue with a positive connotation of the function of the symptom, with language pictures, or transcultural comparisons of the family concepts, and we will go to the contents of resources, concepts and conflict ambivalence.

The contents of resources and of conflicts can be described psychodynamically according to the OPD, or in Positive Psychotherapy as "Actual Capacities" to work with the clients in understandable terms. Differentiation of contents and capacities of the behaviour, perception and interaction is now possible. The work with the subconscious contents and concepts is easily understandable for the client with the terms defined as actual capacities such as trust, politeness, openness, punctuality or hope. This is taught in seminars for Positive Psychotherapy in order for both client and therapist to have a better therapeutic relation and greater satisfaction during and after the therapy.

In psychotherapeutic trainings we can train therapists to gain **five main competencies** to create a helpful therapeutic alliance concerning feelings, contents, resources, therapy cooperation and self help with

The Five Steps of Building a Helpful Alliance in Treatment[3]

1. Observation, Distancing

... to listen with patience, empathy and to add different points of view

2. Differentiation and Verbalisation

... to ask exactly to define contents, history, dynamics and possibilities

3. Situative Encouragement

...to accompany the patient and to encourage his self help

4. Verbalisation

...to focus on conflicts by consultation and to mediate responsibility for the consequences of changes

5. Broadening of the goals

...to see the future after conflict solving is no longer in the center

To train the capacity for observation and distancing, so to be able to listen with patience, empathy and to add different points of view, we need to train to be sensitive to our own emotions. We can reflect on them by being open to our own associations, thoughts, fantasies and feelings, as in the psychoanalytic freedom of free association. Combined with the courage to accept the different and perhaps strange feelings of fantasies, this will help us to change the points of view in therapy and to understand better our countertransference experience.

To train the capacity to differentiate, to ask exactly to define contents, patients and family history, the dynamics and possibilities, we need to understand the contents in episodes, description or countertransference. Theory of the psychotherapeutic methods we have learned will offer the terms for that, such as terms for conflict and structure in psychodynamic therapy (OPD), schema, cognition or

[3] see also Peseschkian N: Psychosomatik und Positive Psychotherapy, 1991; Remmers A: 1997, Boncheva I: 2004

patterns in CBT, or actual capacities and the balance model in Positive Psychotherapy, and these terms can be easy for the clients to understand.

The step of situative encouragement, a term close to Alfred Adlers way of treatment, means to accompany the patient and to encourage his self help. We can train therapists to become stronger models for the patient in interacting and understanding, relation and balance.

The capacity to focus on conflicts by consultation and to mediate responsibility for the consequences of changes in the step of verbalisation means to be emotionally open for changes and conflicts in the therapeutic encounter as such, representing the reality outside of therapy. Therapists need to be trained for this by finding out their own inner conflicts in self-discovery, in training groups, and after therapy sessions in supervision.

Broadening the goals of the client, it is not possible to see the future after conflict solving has been removed from the center of my perspective if I only have relief from the symptoms in mind. This also means that therapists must be able to learn continuously, to be open to new ways, to learn from each feedback from the client. Feedback culture needs to be installed early in therapy to have a good and fruitful therapeutic alliance and to learn from each other. This is what we are doing here in our conference - to learn from each other. In each new therapy I start to learn again from this individual patient, as well as in the discussions with you now.

Conclusion

It is possible to construct a helping alliance for the best results in therapy by keeping in mind this helpful process of therapy, starting with building an attachment which will be needed for the interactive differentiation of the therapy contract, goals, and the client's own activity between the sessions, and finally using feedback at the end of each session. The therapeutic alliance will grow by changes, in crisis situations and thresholds within therapy. It is essential, in order to facilitate our clients' growth and to lessen side effects, that we know the partners of the clients and let them know about us, that we include the interaction with the social environment of the clients, and finish with the feedback about the therapy process.

References

[1] **ANTONOVSKY, A**. (1997). *Salutogenese. Zur Entmystifizierung der Gesundheit. Deutsche Herausgabe von Alexa Franke* [Salutogenesis. To demystify health. German edition by Alexa Franke]. dgvt-Verlag: Tübingen.

[2] **DUNCAN, B.L., MILLER, S.D., WAMPOLD, B.E., & HUBBLE, M.A. (eds.)** (2009). *The Heart and Soul of Change (2nd Ed.): Delivering "What Works."* Washington, D.C.: APA Press.

[3] **ENGSTER, S. L., WAMPOLD, B.** (1996). Systematic Effects of Participants Role on the Evaluation of the Psychotherapy Session. *Journal of Consulting and Clinical Psychology, 64, pp. 1020-1028.*

[4] **GEBSATTEL, V. I.** (1954). *Prolegomena Einer Medizinischen Anthropologie: Ausgewählte Aufsätze* [Prolegomena of a Medical Anthropology: Selected Articles]. Springer.

[5] **GRAWE, K**. (1994). Psychotherapie im Wandel. Von der Konfession zur Profession. Hogrefe

[6] **GRAWE, K**., **DONATI, R., BERNAUER, F**. (1994). *Psychotherapie im Wandel Von der Konfession zur Profession 5. Auflage* [Psychotherapy in Transition From Denomination to Profession 5th Edition]. Göttingen: Hogrefe 2001 Erstausgabe: 1994.

[7] **JUNG, C. G.** (1971). *Psychological Types. Collected Works of C.G. Jung, Volume 6. Princeton University Press*. ISBN 0-691-09774.

[8] **KERNBERG, O. F.** (2005). *Psychoanalyse — Prinzpien, Anhängerschaft und persönliche Entwicklung. In O. F. Kernberg, B. Dulz & J. Eckert (Hrsg.), WIR* [Psychoanalysis - Principles, Followers, and Personal Development]. Stuttgart: Schattauer

[9] **MELLADO, A., SUÁREZ, N., ALTIMIR, C., MARTÍNEZ, C., PÉREZ, J., KRAUSE, M., HORVATH, A.** (2017). Disentangling the change-alliance relationship: Observational assessment of the therapeutic alliance during change and stuck episodes. *Psychotherapy Research, 27:5, 595-607, DOI: 10.1080/10503307.2016.1147657*

[10] **NORCROSS, J.** (2009). *The Therapeutic Relationship. In: B. Duncan, S. Miller, B. Wampold, & M. Hubble (eds.): The Heart and Soul of Change*. Washington DC: APA Press.

[11] **PESESCHKIAN, N**. (1977). *Positive Psychotherapie*. Frankfurt: Fischer TB-Verlag.

[12] **REIMER, C., RÜGER, U.** (2012). *Psychodynamische Psychotherapien* [Psychodynamic psychotherapY]. Springer-Verlag Berlin Heidelberg.

[13] **RUDOLF, G.** (1991). Die Beziehung zwischen Psychotherapie-forschung und psychotherapeutischer Praxis [The relationship between psychotherapy research and psychotherapeutic practice]. In: Buchheim P., Cierpka M., Seifert T. (eds) *Psychotherapie im Wandel Abhängigkeit. Lindauer Texte (Texte zur psychotherapeutischen Fort- und Weiterbildung) p.113-129.* Springer, Berlin, Heidelberg. https://doi.org/10.1007/978-3-642-84473-7_9

[14] **БОНЧЕВА, И. [BONCHEVA, I.]** (2004). *Психологически параметри на комуникацията "Лекар-Болен"* [Psychological Parameters of the Communication "Medical Doctor – Patient"]. Habilitation, Faculty for Clin. Psychology, Univ. Sofia (Bulg.). p 164.

INSTRUMENTS OF POSITIVE TRANSCULTURAL PSYCHOTHERAPY AS A MODEL FOR SYSTEMIC CONSTELLATIONS

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Abstract

The article is dedicated to methodological features of constellations in the positive psychotherapy method. Models of Positive Transcultural Psychotherapy determine the structure of personal differentiation, which could be used in constellations. According to the three levels of work in positive psychotherapy (situational, notional and basic), we could discuss constellations on the three different levels. This article represents a generalization of practical experience of using the constellations on the three levels of work in positive psychotherapy in group and individual psychotherapy as well

Keywords: constellations, phenomenology, constructivism, systems theory, Positive Psychotherapy

Introduction

N. Peseschkian's Positive Transcultural Psychotherapy, being a metatheory of psychotherapy, integrates well with other psychotherapeutic approaches and methods. The psychodynamic component is presented in the conflict model. A positive view of a person with his/her innate abilities for love and cognition points to Positive Transcultural Psychotherapy's humanistic roots. Cognitive-behavioral methods are widely used in work with actual capacities. The systemic approach is also obvious in so-called "Peseschkian's Circles":

I (Self) —> Family —> Society —> City —>
Country —> Humankind

These are examples of theoretical integration, built into the foundation of Positive Transcultural Psychotherapy by its founder. Technical integration is also possible alongside theoretical. It would allow the use of specific techniques of various psychotherapeutic methods within the structure of Positive Psychotherapy (PPT).

Nossrat Peseschkian wrote about the connection of PPT with other methods in his book "Positive Family Therapy". According to the author (Peseschkian, 2016): "Positive Psychotherapy is not just one of the methods among others. It offers tools to assess which methodological approaches can be applied in specific cases and how these methods can be alternated." "Short-term Positive Psychotherapy is universal because it can explore specific elements of a particular case and purposefully apply any specific approach within the framework of the Positive Psychotherapy concept." (Peseschkian, 2016).

Methodology

This article is about integrating constellations into Positive Transcultural Psychotherapy and is a generalization of the practical experience of using constellations both in group and in individual psychotherapy.

While studying in the method of Systemic family therapy, I acquired the skill of participating in constellations based on the systemic-constructivist paradigm, which in its philosophical and theoretical foundations is very close to the philosophy and worldview of Nossrat Peseschkian's Positive and Transcultural Psychotherapy. I use the term

"constellation" not as the name of Bert Hellinger's method, but as a designation of one of the techniques of systemic family psychotherapy. In this regard, I see the need to separate these two concepts: constellations as Hellinger's approach and constellations as one of the techniques used within the framework of systemic family psychotherapy.

The key differences come from the different philosophical and methodological principles on which these methods are based: phenomenology in one case and constructivism in another.

Constructivism (from Latin "Constructio" - construction) is one of the directions of modern philosophy of science, which appeared in the late 70s - early 80s of the twentieth century. In a broad sense, this term refers to certain aspects of worldview and self-awareness: organizational, structural, formative and figurative. Supporters of constructivism believe that there is no reality other than that created by a person, i.e. there is no identical objective reality independent of people's perception. (Lebedev, 2004).

There are also notable differences in purposes of the techniques applyed, in the psychotherapist's position, in specific technical aspects and their interpretations, as well as in the final goal of therapy (Dobrodnyak, 2010).

Results

If we explore the history of constellations, we can conclude that they appeared as a result of the mutual influence of the following three components:

1. The First Component — is the Systems Theory, which developed from the mechanistic understanding (first-order cybernetics) under the influence of biological models (Maturana, Varela) and Luhmann's social systems theory to the modern understanding (second-order cybernetics).

2. The Second Component — is the technique of using representatives instead of family members, elements of larger systems or even abstract concepts. The first example of such a technique in Western psychotherapy was Jacob Moreno's psychodrama.

In the 1960s, Virginia Satir combined these two components into her Family Sculpting approach.

3. The Third Component — is phenomenology. Phenomenology (from the German "Phänomenologie" - the study of phenomena) is a direction of philosophy of the 20th century. It defines its objective as a self-evident description of cognitive experience of consciousness and identification of its essential features.

Phenomenological psychology is a direction of psychology based on the ideas and methods of phenomenology. It pursues a descriptive study of consciousness, subjectivity and human experiences.

Philosophical basis of phenomenological psychology is rooted in the ideas of Edmund Husserl, as well as his students and followers: Alexander Pfänder, Martin Heidegger, Jean-Paul Sartre, Maurice Merleau-Ponty, Alfred Schutz, etc. (Spiegelberg, 2002).

These historical roots are common for both constellations within the system-constructivist approach, and constellations within the framework of Hellinger's approach. Now let us explore the differences.

1. The Understanding of the System

A system is a construct, therefore the therapists relies on the client's expertise in choosing participants of a constellation. The facilitator might have his/her hypotheses about a usefulness of specific participants within the constellation, but it should be discussed with the client and it iss ultimately the client's decision.

In Hellinger's understanding, interactions within the system are determined by rules ("the orders of love"), which, according to the author, are universal. Therefore, the participants in a constellation are determined by the right to belong to the system.

2. The Purpose of a Constellation

In a systemic approach, the purpose of a constellation is to expand one's understanding of a problem situation, providing an ability to perceive it more resourcefully, to see solutions. At the same time, it is accepted that there is not just one correct solution and that someone is able to direct the client towards it. The work enhances the client's own resources to resolve a problem situation.

In Hellinger's approach to constellations, the orders dictate the "correct constellation" and the purpose of the constellation work is to find it.

3. The Choice of Representatives

During the constellation work, representatives often experience feelings (sensations, emotions, impulses and even symptoms) which bear striking resemblance to the experiences of those whom they stand in for. This raises questions and gives constellations an air of mysticism. However, these phenomena have rather logical explanations. The idea of representatives belongs to Jacob Moreno, who explained such "knowledge" without the concept of "tele-". Moreno defined it as "the process of people sensing each other, which, like cement, binds the entire group" (Moreno, 1945). In other words, "tele-" refers to the phenomena of group dynamics and embodies the process of exchange of empathy. Moreno considered the ability to look at the world through the eyes of another person to be a basic ability.

Hellinger attributed the phenomena of striking coincidences during constellations to getting into the morphogenic field of the system. Such explanations appear to be mystical.

4. The Position of the Facilitator

The therapist's position in the systemic family approach has evolved from rather authoritarian (strategic direction) to the position of cooperation and partnership. The idea of the

"competent client" currently prevails, which eliminates any pressure on the client by the therapist.

Hellinger's phenomenological approach dictates the best (from the therapist's point of view) solutions for clients through correct placement within the constellation.

Thus, we can conclude that the use of constellations in the system-constructivist approach and in Hellinger's method is based on different philosophical and methodological foundations, which leads to differences in explanations and in the position of the therapist (Dobrodnyak, 2010)

As a positive psychotherapist, I use the Constellations as one of the techniques within the structure of Positive Transcultural Psychotherapy and I would like to share with you the methodology of such an approach, as well as practical experience of conducting constellations in group therapy settings.

The Systems Theory is universal. It offers a unified, interdisciplinary, theoretical language for phenomena of any level - from a cellular organism to society as a whole (Shlippe & Schweitzer, 2007).

PTPT offers such a systemic approach via so called "Peseschkian Circles". These represent an ever expanding identity system: from "I" to "the Universe". "Family" is just one of these circles, it follows the individual/personality level ("I"), which itself is a system: personality subsets, various roles, the unity of body, soul and spirit, a unique structure of actual capacities, etc. Positive Transcultural Psychotherapy models provide a structure for personality differentiation, which can be used in Systemic Constellations. The three levels of work in PTPT (situational, contextual and basic) offer three levels of Constellations.

I. Situational (Symptomatic) Level

This level offers participants a possibility to work with an exploratory Constellation based on the Balance Model (a request for an exploration without an Actual Conflict, hereafter — AC). If there is a request for work with an AC or a symptom, then it is advisable to consider the system of the AC/problem, which includes various objects of interpersonal conflict. Inclusion of the symptom into the Constellations gives an opportunity to comprehend its function/meaning in interpersonal interactions (positive reinterpretation of the symptom), to receive feedback from the representatives (cross- cultural aspect) and to shift attention to the conflicts, which stand behind the symptom.

II. Contextual Level

This level can offer a possibility to work with the Constellation using Actual Capacities (hereafter — ACP), for instance, after completing Differentiation-Analytic Inventory (DAI) or other ACP-related exercises. Another option is to explore manifestations of the Key Conflict (KC) within various relationships. If internal conflict (IC) contents and conflict dynamics are discovered, they too can be utilized in the Constellation, in search of possible resolutions of IC.

III. Basic Level

Basic or identity level involves work with basic concepts, established in the client's parental family. Thus, the Constellation of the parental family (family of origin) can be useful. "Five Summits of Fate" This concept by Vladimir Karikash is also suitable for Constellation work on this level (5 existential identities: I-Son/Daughter, I-Man/Woman, I-Father/Mother, I-Human, I-Part of the Universe) (Karikash, 2009).

Constellation Work Based on Peseschkian's Five-Stage Model

Below is an example of the Constellation process structure based on the Five-Stage Model of treatment.

1. Distancing.

Prior to the Constellation work, it is important to have a preliminary conversation with the client (protagonist): hear his/her problem, figure out his/her needs and request and establish through a dialogue what kind of figures he/she sees in the Constellation (people, spheres of the balance model, actual capacities, identities, etc.) The therapist should suggest that he/she should choose representatives, assign their roles and positions in a given space. Then the client is encouraged to watch the complete Constellation and concentrate on his/her feelings and thoughts (observation).

At this point in time, the client assumes metaposition and observes the Constellation of his/her situation from outside, thus distancing him/herself from it. The Constellation itself represents a visual, kinesthetic metaphor, which also contributes to distancing.

2. Taking Inventory

At this stage the client listens to the feedback of all the representatives. The therapist instructs representatives to voice their corporeal sensations, feelings and impulses without explanations or rationalizations. The protagonist is in charge of the order in which representatives give their feedback, thus receiving additional information about the situation. It is important at this stage to figure out whether the feedback resonates with the protagonist. Usually, everything said by the representatives produces client's "yes"-reaction".

3. Situational Encouragement

At this stage it is important to highlight positive aspects of the Constellation, asking resource-oriented questions and questions focusing on positive reinterpretation:

- Which resources can you see in this Constellation?
- What do you gain from this kind of balance (interaction)?

4. Verbalization

This stage of the Constellation work gives the client a chance to see pathways and means towards conflict resolution, as well as new opportunities for growth and balance. After the client confirms his/her readiness to see prospects for change, the representatives are granted the

opportunity to move freely and find more comfortable positions in the Constellation. They then provide feedback about their sensations in their new spots. The protagonist observes this dynamic and notes his/her reactions. When the Constellation acquires its final structure, the therapist suggests that the protagonist trade places with his/her representatives and stand in this "good place". Often, this results in an emotional reaction and deep awareness, which can facilitate decision making. The client is then encouraged to verbalize his/her conclusions and complete the Constellation by releasing the representatives from their assumed roles.

5. Broadening of the Goals

However, this is not the end of Constellation work. The group process should end with sharing: the representatives are asked to separate their sensations and feelings that appeared during the Constellation process, from sensations and feelings connected to their own lives. It is also important to hear out those observers who did not take part in the Constellation, but can share their emotional reactions and alternative perceptions. Once the entire group have completed its feedback, the protagonist should report what he/she found useful from the Constellation work and the feedback of the participants.

Conclusion

The Constellations provide a valuable opportunity to see existing dynamics within the family system or personality, which are often not fully realized by the client. The protagonist is thus given an access to unconscious information via the participants in the Constellation group, their sensations and feedback. Their physical reactions provide further input about dynamics, which the client is not aware of and cannot see (Franke, 2007).

Thus Positive Transcultural Psychotherapy, which is usually highly structured and operates on a conscious level, is complemented by an unconscious (irrational) component.

It should be noted that constellations are only part of a large complex psychotherapeutic work. The material raised during the constellation process can be explored over many sessions. Therefore, it is important that the psychotherapist has a complete education in one of the recognized psychotherapeutic methods and can use more than just constellations in his/her work. It is also important to realize that it is impossible to study constellations by reading books, watching films or even completing several seminars with a recognized master. Learning constellations, first and foremost, happens through personal experience in a group form: by observing, participating as representatives and creating one's own constellations.

The first experimental training project on constellations in Positive Transcultural Psychotherapy took place in 2018-2019 in Poltava, Ukraine under the supervision of the Ukrainian Institute of Positive and Transcultural Psychotherapy.

I see the effectiveness of integrating constellations into Positive and Transcultural Psychotherapy.

References

[1] **ДОБРОДНЯК, О. [DOBRODNYAK, O.]** (2010). Використання консультування у рамках системно-конструктивістського підходу Системної сімейної психотерапії (короткий зміст навчальних семінарів, проведених в рамках Української спілки психотерапевтів у 1994 - 2010 рр.). Порівняння з оригінальною моделлю Хеллінгера [The use of constellations within the system-constructivist approach of Systemic Family Psychotherapy (the summary of the training seminars conducted within the Ukrainian Union of Psychotherapists in 1994 - 2010). Comparison with the original Hellinger model]. *Журнал "Системна та сімейна психотерапія". Київ: "Системний погляд".* Подвійний випуск №1-2.

[2] **КАРИКАШ, В. [KARIKASH, V.]** (2009). Пять вершин на жизненном пути [Five Summits of a Lifetime: Therapy through Transformation of Existential Identity]. *Позитум Украина*. Черкасы. No 3.

[3] **PESESCHKIAN, N.** (2016). *Positive Family Therapy: Positive Psychotherapy Manual for Therapists and Families,* Bloomington, USA: AuthorHouse UK

[4] **ФИЛОСОФИЯ НАУКИ. СЛОВАРЬ ОСНОВНЫХ ТЕРМИНОВ (**2004**) [**Philosophy of Science: Dictionary of Basic Terms**].** Составитель: С.А. Лебедев [Lebedev, S. A.]. М.: Академический проект.

[5] **ФРАНКЕ, У. [FRANKE, U.]** (2007). "*Когда я закрываю глаза, я вижу тебя" Семейная расстановка в индивидуальной терапии и консультировании* ["When I Close My Eyes I See You" Family Constellation in Individual Therapy and Counseling]. М.: Издательство: Институт консультирования. 182 с.

[6] **ШЛИППЕ, А. Ф., ШВАЙТЦЕР, Й.** [**SCHLIPPE, A.F., SCHWEITZER, J.**] (2007). *Учебник по системной терапии и консультированию* [Systemic Therapy and Counseling Textbook]. М.: Институт консультирования и системных решений. 363 с.

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

ADOLESCENT BETWEEN THE TWO SHORES. PRESENTING A CASE OF PSYCHOTHERAPEUTIC PRACTICE

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Abstract

A case of psychotherapeutic practice for an adolescent between identity, symptom and balance. Individual identity is essential for mental health. Identity development is a basis of self-acceptance and good self-esteem. As Erikson (2013) pointed out, subjective sense of identity must continue to be rediscovered and developed in a never-ending process. Erikson emphasizes that the term of identity has different but generally interrelated meanings. In many situations it can be attributed to a conscious sense of individual identity, in the others - to "an unconscious battle" for continuity between tradition and individuality, in the third - to the stability of the self, and in the fourth – as a mechanism for maintaining internal balance with group (traditional) ideals and group (traditional) identity.

Keywords: identity, symptom, balance, Positive Psychotherapy, 5 stage model

Introduction

In my work as a children and youth psychotherapist constantly I am encountering one or another parent's requests - "You're a psychologist - do something," "Talk to him / her a little," "Look .. tell him / her couple of words ..."

What is the question about here? What the parents expect?

I am sharing this case from my practice as a psychotherapist as an illustration for a professional response to such parental requests.

Results

Case presentation

The mother on her phone, directed by her GP, contacted me. Her 17-year-old son (who I will call Alex) has nausea and vomiting. The problem started when he was 12 years old and has deepened over the years. (much earlier, as we will see). No physiological reasons have been found for it. A number of medical analyses have been performed on him, including hospitalizations within three years. The mother insists on seeing me before the meeting with her son. Usually for adolescents aged 16 to 19, I encourage and support parents to motivate their child to come to see me alone. Sometimes I also do this for younger adolescents – 13 to15 years. As for the parents' point of view, I talk with them by phone, then after the meeting with the adolescent, I invite the parent in for a conversation and it usually works. But in this case, with the mother speaking in an angry tone of voice, I felt her anxiety, helplessness and fear (lack of trust in everyone and everything) and I invited her to a meeting before I had seen or spoken with her son.

What did I learn from the mother except for the medical history of the condition)?

Alex, 17-years old, the first born of two children (has a brother 14-years old), the family is formed of a mixed marriage - the mother is a Bulgarian, the father is of Turkish origin, not from the Turkish ethnic group in Bulgaria (who are born and live in Bulgaria). The mother watches over her son (and his symptom) like an eagle, while the father, who

was initially irritable, developed intolerance about three years ago toward his son's crises of nausea and vomiting. Alex had a very difficult birth (the mother remembers it as a long battle), but actually the real battle began when Alex was at least seven years old and the father's family requested him to be introduced in the Islamic Religion with the ritual of "circumcision". According to the Islamic legal system, there is no definite age in which circumcision must be performed, but it is acceptable to have the children circumcised between 7 and 10 years old. The mother's family opposes this strongly and stormily. The mother and father made a good family at first, and they actually have the ability to support it if their parents do not interfere. In Bulgaria these mixed marriages are often problematic because of cultural and religious differences between the two ethnic groups, one can imagine what the family is when it comes from two nationalities. The emphasis on these differences usually begins with the grandparents or someone else in the parent's family. The situation is similar here, but much more strongly emphasized – tension has grown between this mother and father and although they had initially decided to leave the choice of religious and ethnic identity to their children, later both sides started to "pull the carpet" to their own religious Identities. At this time Alex began to go to school and thus spent most of the year in Bulgaria and school vacations in Istanbul. At the same time, he began to be sick increasingly often: Sore throat, stomach pain, vomiting (symptoms of difficult adaptation to school), then when he was about 10 years old, the nausea and vomiting stops to return later as a clear-cut symptom. When he was 12-13 years old, he started to insulate himself and two years later (when he was15 – 16 years old) he no longer wished to go out to meet friends, to communicate (with the exception of online communication). Nor did he want to go to school. This caused his performance in school to drop and decreased his chances of entering a prestigious university in either Turkey or Bulgaria. This provoked his father to behave even more harshly with him.

First meeting with Alex - **Stage of Observation and Distancing**

The 17-year-old boy entered my office and presented himself. Apparently calm in behavior, but it gave me a feeling of anxiety, fear and somehow a seeming hidden hope. It was a first meeting for him with a psychologist/psychotherapist. He did not know what to do, how to start and from where to start. Until now, he had experienced a number of visits to doctors for disease symptoms. He suffers from insomnia, tension, nausea, vomiting, and as I have understood later in the course of our conversation - painful thoughts with aggressive contents.

Prepared to "report" about his complaints (because of the many medical visits), Alex proved to be surprised at my question "What happened to you that was important or significant, just before the appearance of the first unpleasant symptoms?" There was a pause. Then, apparently, he went back in time and started to sort out the first events:

The Actual situation at the onset of the symptom

12-year-old, already a student in a Mathematical High school, after months of preparation for the competitive entrance exam, still in the period of adaptation to the new school and among new people, gladly accepted his parents' decision to go on Holiday to the seashore in Antalya. Amid the pleasant events surrounding the arrival on the beach, he began to vomit, which had also happened at home, but now the reaction of the parents was different: they appeared shocked and quickly cleaned up the mess and he also faced the glances of people around looking at him. He subsequently saw this as reproach from the parents and ridicule on the part of the other people who were there. He captured himself in an attempt to deal with these feelings and began to justify himself. His father said in Turkish, so as to be understood by those around them: "Dribbler! You embarrass yourself! You embarrass us also. It's one thing to do this at home to escape your responsibilities, but here …"" His mother's passivity during this time blocked his ability to produce a good explanation or justification for himself and provoke him to begin another struggle - whether it was better only to stay at home in order not to embarrass anyone .

How does a psychotherapist react after such a story about the actual situation that unlocks the illness? The positive psychotherapist goes looking for the function of the symptom, its positive reinterpretation and reflection of the relation between the symptom and psychological (emotional) problems. In this case, my positive reinterpretation of the symptom - nausea and vomiting was: "It seems you have an ability to possess a fine sensitivity to what is happening around you and easily dispose of what is unnecessary!"

Alex appeared astonished when I seemed to take his side. He also seemed perplexed and resisted accepting my reading of the experience he had undergone 5 years before.. I realized that until now, no one had considered his internal anguish. Who would have understood it?

1. Himself? – Certainly not! Otherwise, it would not be a disease symptom. The human mind does not accept content that runs contrary to the appropriate attitude and patience, which he had learned at home.

2. The friends? – They would reject him. Moreover, they might decide that he embarrasses them also.

3. The parents? – Even more certainly not! They had not yet found a reason and an explanation for what is happening.

This was my understanding of what was going on unconsciously in Alex's head. It had motivated him to make a decision to isolate himself from the social environment and to use the symptom if he was forced to make contact.

For years Alex had been musing over the questions, "Who am I?"; "What am I, What do I belong to?" "Who / what should I follow - myself or others?" In terms of Positive and Transcultural Psychotherapy, this is the content of his Key Conflict (Fig. 1) He continues learning, goes to language and math courses, but always feels he is "standing between two shores". He is constantly afraid that he will vomit again and embarrass himself in front of everyone.

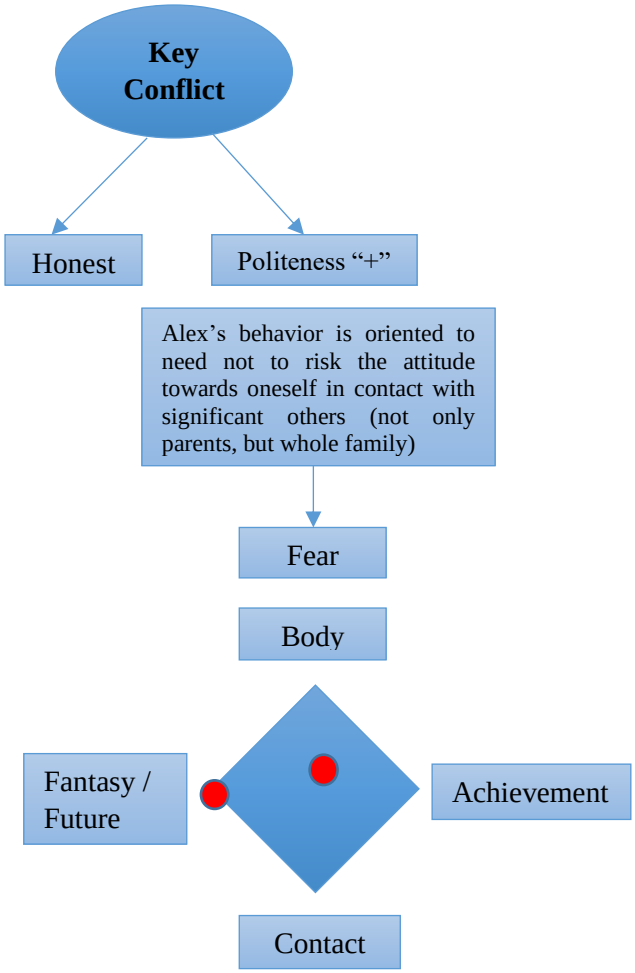

Fig. 1 Client's key Conflict Model

What I learned about him - Stage of **Inventory**?

4.Since childhood, the brothers have done sports, Alex's brother plays football and Alex plays volleyball. The volleyball was not Alex's decision or desire, it was his father's decision. Alex did not want to go there, but he was not able to say, "No" or "I do not want!"

5.Mother and father (especially father) made the decision that Alex should start to study at school with profiled sports classes. It means he must participate in competitions. Before these competitions, he has stayed awake all night with painful thoughts about failing. On the playground, he has been worried, nervous and frozen by fear.

6. After several failures at competitions, the parents decided that he will not have success in sports, and he has been moved to a school with profiled biology and chemistry classes without his agreement (the father's words were: "let's even become a doctor"). He attends school regularly and prepares his lessons and homework, always thinking that he must not embarrass his parents.

7. During the period of his growing up, he has learned that the parents must be listened to and that the father's will is law. He is convinced that they all rely on him (the Turkish grandparents inculcate in him that the first-born son must take the hope of the whole family upon himself) and he must fulfill their expectations not only about educational success and obedience, but also in every other aspect. Typical of that kind of family is the importance of order, politeness and success. As for the religion, the attention there is toward obedience.

8. Then followed math lessons and Alex's applying to the Mathematical High school chosen by the parents again.

9. With this family background, he has experienced many disappointments connected to the idea that his brother is much more loved (according to his experience) and much more successful according to relatives and the circle of acquaintances. He is well aware that his brother, like a "Free Bird," follows his own desires and intentions, while he always respects others.

10. What worries him, he does not share with anyone. To this day, at night he is unable to sleep and is tormented with thoughts of failure. As a young man with a high intellectual level, he has the ability to over-control himself and behave mostly politely, which helps him to stand aside from the chaotic and indiscriminate contacts with others (as some adolescents are able to do), he seems pleased with himself, mentally balanced and successful. It is because,…

As the Stage of **Situative Encouragement** has shown,

11. He is a man of reason, obedient, consistent, seeking success at any price.

He can handle himself and his emotions by "gulping and swallowing" - in fact, he turns them off and minimizes them.

Stage of **Verbalization**

Somehow the connection between what I had told Alex at the beginning and his own story about himself appeared spontaeously in his head. In the beginning of our meetings, I had told him that he has the ability to turn attention in a noticeable way into something within himself or something

around himself and I told him that something which is not shown during the day comes out at night with a stormy force. It is those emotions which he does not allows himself because he does not know how to use them as strengths.

He replied: "I've never heard such good things about myself in my life until now." In his verbalization Alex himself presented our therapeutic task as his own problem. I realized that Alex did not know himself in the light of his own abilities, but only as a "shining with reflected light" from the abilities of the others.

In a series of 20 therapeutic meetings, we went through a number of life situations and topics. The first, important for me as a therapist and for him as a patient, was to understand the logic of the appearance of the aggressively-charged thoughts that he swallowed politely. We dealt with this subject for 4 meetings.

In the next group of sessions, we moved through the struggle for change, with Alex taking the lead and me providing psychological support. Our tasks had been conscious until now, to develop new behavior, which requires tenacity (he holds it as a strong ability). The other task was openness in sharing the ability we had just developed in our contact, and later he would bring it in his polite form of expression to the relatives.

We have also handled a number of life misunderstandings:

13. The form of parental affection - to deal with the painful experience that he is not loved because he does not fulfill their expectations, that he is still not noticed and therefore it is better to be "crouched behind a computer", "a silent letter";

14. What does it mean to follow the religious rules and what is the place of faith? What is the meaning of faith?

15. What do I lose but also what do I gain when I behave in a certain way.

For example: When I am only the obedient child, correct, attentive, respecting the others, how will they know what I am thinking about and how I experience things differently - that is a presentation of the power of negative emotions.

16. What do I give to myself when I am doing the thing for the others? For example: When I rush to do something, but actually in this instance, nobody expects anything from me. Even so, I think I am doing it for others, without a chance to realize that I use this way as a defense of my norm of justice and my vision of success.

Gradually, the first changes in his behavior appeared:

17. The ability to distinguish "what others want" from "what I want" in the same situation gave him the right to choose the way to deal with the situation.

18. Instead of trying to realize his fantasy of "winning behavior", he developed the ability to produce emotionally-motivated, free behavior.

19. Instead of extreme perfectionism in order just to be accepted - he expanded his spontaneous potential.

Satisfied with what we had achieved, we made our detachment with the following balance sheet:

Stage of **Goals expanding**

He gave a report that if before, he had wanted to be successful in his activities just for the approval of the others, now, it is more important for him to feel himself satisfied. In this direction, he is now an active young man, secondarily by upbringing, but emotional by nature, and already knows what to do with his daily life without the symptoms and the sense of dependence on the approval of his relatives. The great test of his achievement came during his participation in the Biology Olympics,– when he felt himself surprised, calm and without symptoms- and this had never happened before.

Why am I sharing this case with you?

This adolescent is in a psychological (and emotional) stage of separation. In the stage when he actively attempts to synthesize his experience to form a stable sense of personal identity. Eriksson emphasizes the role of accurate self-knowledge and realism, but here this adolescent felt himself - and thus behaved himself as 3 – 4 years old when the "battle was for autonomy". Every mother knows how plastic a child could be if it decides to do what the others expect from it, but it is impossible to make it do only this.

Conclusion

The presence of strong external control and overly rigid and secondary education deprives the child of his involvement in learning to control and express himself according to his own will and free choice. The long-standing suspicion and shame comes and leads to an inevitable sense of loss of self-esteem and a sense of parental over-control.

References

[1] **БОНЧЕВА, И. [BONCHEVA, I.]** (2013). *Психологична психотерапия* [Psychological psychotherapy]. „Славена", Варна. 228 с.

[2] **ЕРИКСЪН, Е. [ERIKSON, E.]** (1996). *Идентичност: Младост и криза* [Identity: Youth and crisis]. С.: Наука и изкуство. 340 с.

[3] **PESESCHKIAN, N.** (2016). *Positive Psychotherapy of Everyday Life: A Self-Help Guide for Individuals, Couples and Families with 250 Case Stories,* Bloomington, USA: AuthorHouse UK

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

[5] **PESESCHKIAN, N.** (2016). *Positive Family Therapy: Positive Psychotherapy Manual for Therapists and Families*, Bloomington, USA: AuthorHouse UK

HEALING AND SPIRITUALITY: PSYCHOTHERAPEUTIC CASE

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Abstract

This article is an invitation to reflect on how we can handle the spiritual, existential aspects described by Nossrat Peseschkian in his method of Positive and Transcultural Psychotherapy. The existential aspect was analyzed during the process of therapy and used as a strong resource. According to the Role model, and related with Basic Conflict, author looks at the patient's relationship with God. The resources offered by religion in psychotherapy can be: hope, acceptance, the meaning of life (useful in depression, death), prayer (which reduces anxiety), meditation exercises and rituals. It is determined that where the patient is facing existential problems, the resources offered by religion are indisputable.

Keywords: Positive Psychotherapy, spirituality, religion, mental health.

Introduction

Concerning religion, parents can become a model/anti-model for their children. So, children will take over or reject the religious norms of parents and/or adhere to other norms (primary we). Man, from the point of view of positive psychotherapy is good by nature and composed of 4 areas: physical, mental, social and spiritual. To preserve health is necessary for a harmonious development of all these areas. We have to give, time and energy equally to each side.

Where there is faith, religious values can become resources in the therapeutic process.

Depending on how the divine is interiorized: as good, loving, supportive or, on the contrary, bad, authoritarian, judgmental; the patient will be oriented to use, to gain access to resources or to put religious perceptions in perspective. How is the relationship with God, based on love or fear?

The resources offered by religion in psychotherapy can be: hope, acceptance, meaning of life, prayer, meditations, and rituals. Where the patient is facing existential problems (illness/death, lack of sense/emptiness) the resources offered by religion are undeniable.

"In God we trust" is printed on the American money. It looks like Americans felt the need to put this on their money in order to keep in mind what gives them a stronghold.

Methodology

According to Nossrat Peseschkian (Peseschkian, 1977), "trust" is a capacity which is developed in early childhood in the symbiotic relationship "I-Thou". Spiritual trust, and trust in the future and culture is developed by the model of the parents relation to the world, the "Origin We". An infant will learn to accept oneself by being accepted and loved in the relation with the parents first. When the "I" and "Thou" differentiation occurs, trust and faith can be developed in a wider relation with other people to form the "We", a representation of the I in relation to others. The "capacity to love" (Peseschkian, 1977) represents the capacity to accept oneself and others. Through development of the capacity to love, connections to other capacities are made. The basic "capacity to know" means differentiation concerning social norms. The two basic capacities are the foundation upon which the capacity for faith develops. The balance between religion and science in many ways expresses the two basic capacities of to know and to love. Science stands for the

capacity to know and religion for the capacity to love. Belief is developed from the capacity to love and becomes understandable in its contents through the capacity to know. Nossrat Peseschkian looks at religion as giving meaning, and faith as searching meaning (Peseschkian, 1985).

As positive psychotherapists I come in contact with the existential topics such as religion, spirituality, philosophy of life. In my work experience, I have found that for some patients these are important resources while for others they can become obstacles or complicate their lives. The principle of balance helps me to understand and work with this aspect.

Thus, the question was born: with what and how religion, culture, philosophy of life can help in healing, or, on the contrary, can accentuate disorders. How can religion help with in healing, how exactly does it support healing? Or, what aspect of religion can lead to disorders?

Many sayings and proverbs referring to God exist in every country and culture. Some examples: God helps those who help themselves; God gives everyone a song; God moves in mysterious ways; help yourself to help God help you; God works through us, God sees you; God be with you, God is everywhere; God help us; Trust in God and tie your camel; he has caught God by the leg. What do these countless proverbs actually mean, also in therapy?

God still for most of our clients is a part of our culture, of our tradition, of our daily life. In other words, faith is part of our collective unconscious that nourishes our conscious life. In any culture, religious beliefs have inspired the educational system, art, literature, the existence of humanity itself. Religion gives us rules that govern the way we live together and define the human being's position and the perspective he has on life. Nossrat Peseschkian distinguishes in his book "In Search of Meaning" (Peseschkian, 2016) the terms "faith", "religion", and "church". This helps in therapy to clarify and understand the specific meaning for the clients. In the word "religion", he said, grows a lot of misunderstanding. He refers to the human capacity to find meaning while religion can give meaning, science supports to find this meaning.

God is differently perceived in cultures, countries, families and individuals, according to N. Peseschkian. "Religion is like a medicine that works appropriately for the essence of man. When a falsely-understood religion leads to disturbance, fixation, inhibition in development, and rigidity in intellectual defenses, it must be nonsense. Feuerbach labeled it pathology instead of theology; Marx and Engels spoke of religion as the opiate of the masses, and Freud caricatured it as an insurance company" (Peseschkian, 2016).

Theory and spiritual background. Nossrat Peseschkian describes science and religion as two wings that man can use to progress. One cannot fly with only one wing. If people try to fly with the wing of religion only, they will end up in dogmatism, superstition. If one uses the wing of science only, one will fly in the despair of materialism.

To be useful, religion and psychotherapy must be in balance. Peseschkian said: Psychotherapy helps us live; spirituality opens the ability to understand life. "The purpose of an ideology of a conception of the world as a religion is to consciously acknowledge the human values, aim and meaning of life, while the exact sciences seek and find explanations for the legalities. If religion and science really are intended to be of use for human beings, they should be complete and form a unit. Religion does not replace psychotherapy and psychotherapy is not a substitute for religion."

Thus, we return to our question: with what and how can religions, spirituality help us in our activity as therapists, in healing or on the contrary, confuse us, keeping the disturbances, the imbalance.

What we certainly know as psychotherapists is that religious concepts or religious norms become internal beliefs. As we know from positive psychotherapy, through their relationship with religion, parents can become role models or anti-role models for their children. Thus, children will take over or reject the religious norms of their parents by keeping them, or adhering to others by rejection (Primary We).

The human being, from the point of view of positive psychotherapy (according to the principle of balance) is good by nature and consists of 4 areas: body, mental, social and spiritual. In order to preserve health and promote the harmonious development of all areas, we must give equal time, attention and energy to each part. Here it is good to see if the area of religion, philosophy of life is over or under represented. If the area of religion, philosophy of life is over represented or too developed, then an imbalance occurs and the other areas are not covered. If I pray all day and stop working, I will have nothing to support myself with, I will have nothing to help me live. If I don't invest time and energy in relationships, the contact area, I can wake up alone one day, without support from those around me. If I just look at God and don't take care of my body, I can get sick. The over representation can become more flexible in counseling and therapy.

Results

Therapeutic application. According to role model, and related with basic conflict, I can look at the patient's relationship with God. What is the relationship with God based on? Fear or love? How did the patient develop a relationship with God? Here we can investigate what the patient's representation of God is, is he seen as a friend or foe, do I love him or not? How do I feel about him? And I am trying to find out which of the parents had the same relationship with God. And, what they asked, waited for the patient in order to give him acceptance, love.

Where there is faith, religion can become a resource in the psychotherapeutic process. The resources offered by religion in psychotherapy can be: hope, acceptance, the meaning of life (useful in depression, death), prayer (which reduces anxiety), meditation exercises and rituals. Obviously, where the patient is facing existential problems, the resources offered by religion are indisputable.

Case presentation

Ovidiu (name was changed), shows up at the office visibly tense and tormented. The problem he faces is about his marital relationship. He has been married for 17 years. The relationship began with respect and appreciation, without love or affection from the patient.

Currently, the relationship with his wife is very deteriorated. In this context, he falls in love with a colleague at work. He develops a romantic relationship with her, but they remain at a platonic level, because he considers it a sin to have sex outside of marriage. Feelings of guilt are very high and developed also due to his catholicism. He also shows an emphasis on the representation of secondary capacities. Secondary abilities and strong adherence to the norms of the Catholic Church lead to the presence of a strongly represented superego. He is a great representation in the religious area at the same time with a strong desire, due to the fear of respecting the rules imposed by the church, of obeying them, as he did in his relationship with his father. Obedience is represented to the maximum. This is where the basic conflict appears, I obey my father, I am afraid of him, I only do what I am allowed to do. What is currently being transposed into the actual conflict, I submit to the church and do only what the church and its norms allow me to. Otherwise, I will be punished and burn in hell forever. God (father in the past) will not forgive me and I will be forever punished.

He explained to me that in the Catholic religion divorce is not accepted and if you divorce you go to hell.

The relationship with his wife is very dysfunctional, often leading to physical violence from both sides, which has ended only with police intervention. "Hell on earth", from my point of view. He is dominated by his wife, obeying her too, he feels guilty about her because in the past he was helped by his wife's father to complete his higher education. Due to these studies he currently has a good job. He prays to God day and night for his wife to leave him, this being seen as the only way for him to be free and exonerated from guilt before God.

This is what his life looked like when he came for therapy.

The predominant emotion is fear, embodied in the present in the fear of God (in the past the fear of the father). Psychodynamically, at the basic conflict, we see a buzzy and violent relationship with the father and with many requirements oriented towards secondary capacities' (obedience, punctuality, seriousness). The relationship with the mother was also characterized by requirements oriented towards secondary capacities, but without aggressively (obedience, seriousness).

Totally devoid of love, support, acceptance, he goes to the Catholic Church where he feels a divine love, an acceptance to which he reacts unconsciously by offering the blind obedience required by his father in the past.

In therapy, we worked a lot on this differentiation between father and God and on the way the two relationships overlapped (submission to father / submission to God, religion; fear of father / fear of God). And we worked out the distinctions between God an church Institutions.

In the absence of positive representations, the relationship with religion with the religious norms that have been internalized, the relationship with God has greatly developed. He, accepts himself, only when is following religious norms.

His actual conflict was: "I do not divorce, because I will be punished forever and burn in hell". In this point, being aware that near the spiritual problem also lay his ability to make decisions, procrastination, I told him that he could also consult a Catholic priest to take the route of annulment of the marriage.

We worked also at the key conflict, in order to be less polite with his wife and be more honest with her; and he was able to verbalize this in the process of therapy. In therapy, he was able to verbalize the actual conflict: if I do not submit to God, he will no longer love and save me. And, also, the basic conflict, if I don't obey my father, he will punish me and hit me.

I worked with the transcultural model of other religions where husbands can have multiple wives, as in Islam. He verbalized that thinks could be different if he had had a different religion. Sometimes I used humor, with reflection such as: "you are more Catholic than the pope "and he was able to make fun of it.

Finally, he got the strength to move out of the house where he lived with his wife, but without an official divorce.

He was living on his own and continuing the relationship with his girlfriend.

His final solution was still to avoid confrontation with his wife (avoidance being one of the frequently used defense mechanisms), and to go on a mission abroad for one year.

Until then, he will leave the decision in God's hands, and maybe, who knows, before he returns, his wife will find someone else.

Conclusion

As human beings, we need a spiritual orientation, values, a philosophy of life for a harmonious experience and a balanced mental health and need to be conscious about our own spiritual model as therapists. In positive psychotherapy, this existential aspect is analyzed during the process of therapy and also used as a strong resource.

The case presented was one in which there was not enough time to find a final solution. The patient "had to" discontinue therapy because he would start a service mission outside the country.

We can heal only in interaction with our clients and with their readiness and courage to work with their potential. Sometimes, we could refer patients also to the priest when this kind of approach is needed.

As N. Peseschkian said: "Religion does not replace psychotherapy and psychotherapy is not a substitute for religion." As psychotherapists, we can collaborate with doctors, social workers and at other times with priests, considering that the human being consists of 4 areas: body, mental, social, and spiritual.

References

[1] **OKORO, J.** (2019). Spirituality. Presentation at 7th Word congress for Positive and transcultural psychotherapy (Antalya, Turkey). Retrieved from: https://www.positum.org/files/spirituality.pdf

[2] **PESESCHKIAN, N.** (1977). Positive Psychotherapie: Theorie und Praxis einer neuen Methode. Frankfurt am Main: Fischer.

[3] **PESESCHKIAN, N. (**2016). *In Search of Meaning: Positive Psychotherapy Step by Step.* Bloomington, USA: AuthorHouse UK

HEALTH - ILLNESS FROM THE PERSPECTIVE OF POSITIVE PSYCHOTHERAPY

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Abstract

Health and illness are to be understood as two sides of the same coin. The human being is neither healthy nor sick, rather there is a constant effort for a balance, only then can one speak of an approach to health. In this context, symptoms take on an informative character and indicate longings (needs) that have not been fulfilled.

Keywords: health, illness, balance, Positive Psychotherapy, needs

A person suffers from an average of 20 life-threatening, 20 serious and two hundred moderate illnesses in 20 years of life.

Stefan Heim

Introduction

The onlookers and the elephant

An elephant had been brought into a dark room for exhibition at night. People flocked in droves. Since it was dark, visitors could not see the elephant, so they tried to grasp its shape by touch. Since the elephant was large, each visitor could only grasp part of the animal and describe it according to his tactile findings. One of the visitors who caught one of the elephant's legs explained that the elephant was like a strong pillar; a second, touching the tusks, described the elephant as a pointed object; a third, grasping the animal's ear, said it was not unlike a fan; the fourth, stroking the elephant's back, claimed that the elephant was as straight and flat as a couch. (Peseschkian 2016)

We should ask ourselves: what is health? In the above story we learn that each person can only discover and describe a part of the animal through his tactile findings, but he only sees a part of the whole at a time. The conclusions drawn from this distort the view of reality or, in other words, we experience a reality that we subjectively distort. Similarly, this story can be understood as a synonymous example when we ask about understanding health and illness. We each experience the expression of symptoms in the disease, but these can only be understood as part of the whole.

Since people in general are constantly at risk of illness in their lives, this fight against the disease requires the mobilization of enormous energies and justifies a high cost without ultimately clarifying the question of what health is. Since health cannot be sufficiently defined with the absence of illness, a holistic concept in the sense of a philosophy of health is necessary. Health can therefore not be a lack of individual aspects of the disease. As a result, a symptom cannot be determined only in the context of the disease, because the unexplained or missing role of health (as the opposite) has not yet been satisfactorily explained.

Methodology

Requirements for Understanding of health

We know health as soon as we lack it. (Andrew Weil). Trying to define health by 'not being sick' expresses a similar helplessness as trying to declare peace as 'not being at war'. This unsatisfactory definition of health is based on a multidimensional problem: The individual is asked to

become aware of the limits of his/her own individual, interactional, institutional and ideological reference, because between health and illness on the one hand, and the social environment on the other (transcultural reference), there is an interdependence because each definition of health or illness takes on a different meaning within the respective level. The decision as to when there is a 'disorder' that fulfills the conditions of an illness and when an individual has enough pathological components, depends on the definition of health and understanding of disease.

Fig. 1. Four Qualities of life = health

Another difficulty in determining health is the beliefs and worldview of people who make decisions about them. Like health, illness (symptoms) is to be understood as an attribution of interpretation, in which beliefs and world views are expressed and constructed as a diagnostic definition.

The medical understanding of somatogenic diseases has been fundamentally changed by the development of "psychosomatics". The theoretical and methodological explanatory concept of psychosomatics is of psychoanalytic and deep psychological provenance, and therefore a domain of the individual-interactionist level. From these levels, psychopathological approaches played a major role in the theoretical and methodological explanatory concepts of psychosomatics.

Results

New explanatory and healing approaches with different understandings of theory and methods were added (primarily systemic and transcultural approaches). Despite all the variety of theoretical and methodological approaches, commonalities can be found for many clinical pictures. Diseases, disorders and problems are increasingly being given a hidden or unconscious message with information content. By interpreting these diseases or disorders, they become the subject of communication and thus 'meaningful', 'conscious 'and treatable. In general, there is a tendency in the classification of psychosomatic processes to differentiate them from somatic processes (diseases) or to justify them based on differential diagnosis (see, for example, "ICD 10" coding). With such a separation between somatic and psychosomatic illnesses it is implied that not every illness / symptom correlates with a deeper human problem and therefore not every form of illness is granted an 'information content'.

There is also generally no scientific agreement to give all symptoms a psychological correlation with psychosocial factors. Where diseases and symptoms experience an attribution that is contrary to the understanding of 'conventional medicine', the derogatory title of "psychologization" threatens, which means an unnecessary complication. Any method that wants to interpret symptoms psychologically and meaningfully and sees them as an unsolved psychological problem, but whose explanatory approach is outside the recognized "nomenclatura", will not avoid the need to provide evidence of the relevance of postulates made.

Healings or the elimination of symptoms are not sufficient scientific justification, since so-called "spontaneous healings" or "placebo effects" draw attention to the fact that there are other active factors that either require a new explanation or are manifestations beyond the currently "explainable" (Jaspers 1913).

A separation of somatic and mental illnesses without consideration of interactions (interdependency), harbors the risk of an apparently causal link between cause and effect, whereby essential aspects of the wholeness (reality) are excluded or denied. In the traditional pathogenetic explanations of illness, a reductionist thinking can be seen. One remains in the exact diagnosis and consideration of symptoms from an etiological point of view (e.g. bacterial infestation as the cause of physical symptoms) without paying attention to the coherence of the whole. The connections between the symptoms and the appearance of a disease as well as the interactions of disease signs with the social and communicative conditions are insufficiently considered.

Simon (1995) explains this idea as follows: "If illness is seen as a change within the physical space, it does not mean that the deeper explanation for it - i.e. the mechanism generating it - is localized within the body. The processes taking place in the body, which explain the formation of symptoms, in turn require an explanation that fits into the logic of the everyday world view applied".

Somatic medicine also interprets the causes of illness in connection with the symptoms and certain symptoms are assigned to certain causes, e.g. infectious diseases require viruses or bacteria. It is also undisputed that a weakening of the immune system is postulated at the onset of the disease.

However, an individual's illness is rarely associated with an individual's personality structure and its social role and reality (macro- and meso- systems). As is well known, humans are constantly confronted with bacteria without necessarily reacting with manifest illness.

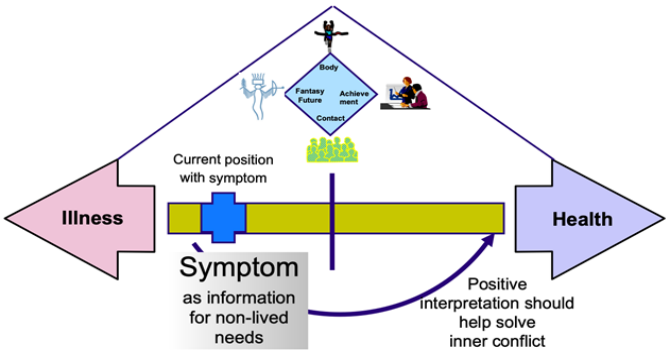

Fig. 2. Illness – health in balance (by Author)

The problem of health / illness is therefore not easy to explain in terms of a cause and effect principle. On the one hand, there is the question of when and why symptoms appear and what meaning of the disease can be attributed to them, and on the other hand, what conditions / factors the individual brings with them so that illness (e.g. burnout) can manifest itself.

If "organic medicine" cannot determine any organic findings with a defined symptom, the condition is unsatisfactory not only for the doctor, but also for the patient. Organic medicine then shows the tendency to shift the causes of these to an imaginary space somewhere without "diagnosis" (Simon 1995), which cannot be explained, but nevertheless appears in effect due to its effects. The acceptance of the imaginary space corresponds to the assumption that 'some 'mechanisms are involved that have not yet been explained (researched, found, etc.), but must exist. This brings the intolerable state of "ignorance" into a comprehensible concept for a doctor / psychologist / scientist, even though the causes of the phenomena are outside the of the communication.

The patient's imagination can therefore take up a lot of space, that he is not really sick (only simulating) or punished for socially deviant behavior. In other words, the patient interprets his symptoms according to his individual explanations, because somehow and in his subjective way he tries to reconcile the observable symptoms and phenomena with his understanding of reality (concept).

Simon explains (1995): „When explaining, from the perspective of the outside, objective observer, a generating mechanism for the phenomenon to be explained is constructed. In understanding, on the other hand, the observer uses the similarity between himself and the observed system (a human being, a cat, a god, a machine ...); he identifies with him, goes, so to speak, into the inner perspective of the subject standing in a certain communicative context in order to (re) construct his feeling, thinking and acting in its meaningfulness ... The unobservable area, in which the explanation for the symptoms of the disease to be localized is modeled on normal human communication. There are certain social rules of good behavior, compliance with which is correlated with well-being. And, conversely, it is concluded that the loss of well-being is an indication of a lack of good behavior."

The understanding of symptoms, even if their explanatory approaches are not within a markable and understandable ("unobservable", Simon 1995) area, because they elude comprehensible observation and traditional categorization, are nevertheless treated as a "source of information". Subjective experiences and intuitions form a subjective knowledge which, together with the individual personality profile, opens up its own "sense provinces" (Berger / Luckmann 1969) and "reality claves" (Müller 1991).

From this it can be deduced that symptoms are to be understood as a message and are given a subjective meaning both intra- and interpersonal. This subjective and collective process of interpretation assigns meaning to symptoms, which makes them accessible for communicable understanding. The reference to objective reality plays a minor role.

Symptoms become messages and can influence further steps; e.g .: Pain is assigned a meaning that does not interpret it as hostile and directed against the individual, consequently it does not have to be combatted. In this context, burnout can be given information or a message that is meaningful in the context of health and wholeness, for example to indicate a deficiency that overwhelms the individual in certain situations. If no countermeasures are taken or the correct conclusions are not drawn, there is a risk of a disorder, symptom, or illness.

Such a process draws attention to a general phenomenon. One can speak of a construction of reality by the individual communicating and explaining his subjective understanding (attribution of meaning) about his reality to the outside world with his interpretation of the symptom.

If the interpretation of symptoms is based on a subjective understanding, the question of the context within which the subjective understanding develops develops at the same time. For this purpose Peseschkian (2016) uses the terms meaning and finding meaning, to which he assigns the

domain of religion (meaning) and science (finding meaning). This use of terms by Peseschkian (2016) implies an interaction of different domains, which, however, form the background for a subjective understanding and can be found in every attribution.

If one assumes that the meaning of symptoms and events is a subjective construction, then it is accepted that the individual has his/her implicit orders, ideas, norms and values communicated to the outside world in a subjective way.

Hypothetically, two sources of information can thus be tapped:

a) the interpretation of the symptom makes the construction of reality of the person concerned or observer transparent and at the same time it becomes clear what meaning the symptom has for the person concerned and

b) The interpretation reveals a subjective and situation-shaping reality of expectations, which determines the further action of the individual and his learning experiences for new situations.

Health as Understanding of wholeness

In the following, a basic understanding of health is assumed, which is influenced by a certain idea of wholeness, which should enable the individual to integrate his symptoms into everyday life. In the further course of the chapter, this model, as well as the use of the term wholeness, will have to be explained in more detail because it means health is synonymous to the sense of 'being healthy'.

Heil comes from Middle High German and has the following meaning according to the Dudens' dictionary of origin (Duden's dictionary of origin 1963):

Luck"; (lucky coincidence; Health; Healing, salvation, assistance ... Under the influence of Christianity, the word salvation also took on the meaning "redemption from sins and the granting of eternal bliss" …

The use of 'wholeness 'and 'being healed 'means a balance that is not static but dynamic, and whose balance creates a state that can be translated as health. As a result, illness is a condition that exhibits a 'loss' or 'lack' of wholeness (according to the meaning: hopeless = "without luck, welfare or health, therefore, miserable; hideous, wicked; ibid.).

We find the meaning of salvation both in medicine and in religion (holy). Common to both is the understanding of a unity consciousness as an overcoming of a split-off or a fragmented perspective. It also means learning to integrate what exists outside of a subjective reality or has been suppressed outside of this subjective reality.

Sickness and health are not simply physical conditions that will sooner or later be fully analyzed and understood through the methods of science. They are rooted in the deepest and most mysterious layers of being ... The idea that one has to accept and incorporate the dark side of existence, even illness and death, if one wants to achieve wholeness and perfection, is an impressive train of thought that is reflected in numerous systems of practical magic and esoteric philosophy. (Weil, 1997)

Health can therefore also integrate illness if illness is understood as a phenomenon that shows that necessary aspects for the wholeness are missing, and consequently no health has yet been achieved.

If one starts from this concept of health as a whole, the elimination of a symptom does not mean a cure, because only the symptoms were cured, that is, illness was treated.

Healing is therefore largely conceptualized as eliminating the causes of illness, but not as creating health conditions. (Simon, 1995)

In order to clarify the content and form, the explanation by Detlefsen and Dahlke (1990) should be used to differentiate between symptoms, illness and health. Detlefsen and Dahlke use a picture in which they compare the body / organism of the individual with a stage (form) on which a tragedy is performed. Although the tragedy is performed on the stage, the stage cannot be tragic, only the piece (content) can be tragic. But the piece (content) appears on the stage (form), within the scenes, using the costumes, the music, the actors etc. These are only the formal aspects that express something, but not the content itself.

Capra (1983) tries to formulate health approximately as follows: "Health is a subjective experience, the quality of which can be intuitively known, but can never be exhaustively described or quantified". But perhaps we can begin our definition by stating that health is a state of well-being that arises when the organism functions in a certain way. The description of this type of functioning will depend on how we describe the organism and its interaction with its environment ...The term "health" and the associated term "illness" therefore do not refer to precisely defined units, but are an integral part of limited and approximate models that reflect the relationship between several aspects of the complex and flowing phenomenon of life.

Once one has recognized the relativity and subjective nature of the term health, it also becomes clear that the experience of health and illness is strongly influenced by the cultural context in which it arises ... In addition, the cultural context also influences the specific way people behave when they get sick.

In Capra's understanding, health is the expression of a multiple interaction of the individual with his social reality (macro- and meso- systems) and the resulting generating mechanisms, as well as his subjective view.

In this sense, health is understood with the Peseschkian balance model as a whole, in which complex and heterogeneous contents and expectations are to be integrated in dependencies of the multidimensional realities

in order to provide individual satisfactory answers to the diverse requirements, conditions and situations.

The Peseschkian balance model is a metaphor for wholeness and health. In this way, complex interrelationships such as health become accessible visually and intuitively, which is not satisfactory enough with communication alone. At the same time, this model remains ambiguous and can nevertheless summarize different and complex areas from the point of view of similarities.

To be healthy, people need flexibility and the willingness to do something actively. He/she needs the knowledge of the possibility of shaping and making decisions. The more dynamically a person has learned to use and develop his/her energies within the four areas of the balance model, the greater that person's flexibility and alternatives to react to problems and new challenges. As a result of this dynamic balancing act, Peseschkian sees health as a subjective feeling of well-being, which gives the helper the opportunity to experience his physical (body), psychological (performance, contact) and intellectual (imagination / future) abilities, which work together positively with the natural (animals, plants, etc.) and social environment (contact). This would enable this individual to accept phases of crisis as natural life intervals - as a valley between two mountains. Peseschkian (2016) assumes that the ability of individuals to help themselves is more likely to be expected when people know how to use their energies and needs.

In this context, the balance model can help people orient themselves and get a health compass to organize their self-help.

Conclusion

Health can be understood as a subjective construction that is shaped by the process of socialization. In addition, cultural habits refine the development of personality. This leads to a self-evident view of yourself. But it is actually only habits based on relative repetitions in the cultural-social-individual living space that become a kind of strict law as to how I understand what I should do and what I shouldn't do in order to be myself. This process takes place largely unconsciously, in the sense of habit.

The understanding of health and illness is also shaped by the individual constructions of realities. This development becomes problematic when the individual understands habits as the only way to be himself, even against his emotions and needs, just because he believes it has to be. As a result, the individual reduces his creative process of thinking of new possibilities that have so far still existed outside of their own reality, but have so far been thought of as not allowed by my conception of myself.

If, however, desires and needs cannot be reconciled with the creative possibilities, symptoms are, on the one hand, the expression of the non-lived needs and, on the other hand, information about the lack of creativity, insufficient use of new possibilities. The result is an unconscious self-reduction of the possibilities to stay in habits that do not reconcile the needs of the individual.

Understanding the balance model in positive psychotherapy is therefore also an invitation to think "outside the box" of previous reality and the request to reconcile one's needs with oneself, from which health and life satisfaction would indirectly derive.

References

[1] **ANTONOVSKY, A.** (1979). *Health, stress an coping: [New perspectives on mental and physical well-being]*. San Francisco, Calif.: Jossey-Bass.

[2] **ANTONOVSKY, A.** (1984). *The sense of coherence as a determinant of health. In: Matarazzo, J.D. e.a.: Behavioral Health: A handbook of health and enhancement and disease prevention.* New York. pp. 114-129.

[3] **ANTONOVSKY, A.** (1993). *Gesundheitsforschung versus Krankheitsforschung* [Health research versus disease research]. In: Franke, A./ Broda, M. (Hg.): Psychosomatische Gesundheit. Versuch einer Abkehr vom Pathogenese-Konzept. Tübingen. S. 3–14.

[4] **BECKER, P.** (1995). *Seelische Gesundheit und Verhaltenskontrolle* [Mental health and behavior control]. Wahlstedt: Hogrefe.

[5] **BERGER, PETER L., & LUCKMANN, T.** (1963). "*Sociology of Religion and Sociology of Knowledge." In Sociology and Religion*: A Book of Readings, edited by Norman Birnbaum and Gertrude Lenzer, 410–418. Englewood Cliffs: Prentice-Hall.

[6] **CAPRA, F.** (1983). *The Tao of Physics*. Boston: Shambhala Publications.

[7] **DAMASIO, A. R.** (2000). *The feeling of what happens - Body and Emotion in the making of consciousness.* New York: Mariner Books.

[8] **DENEKE, F.-W.** (2001). *Psychische Struktur und Gehirn - Die Gestaltung subjektiver Wirklichkeiten* [Mental Structure and Brain - The Verlag. 286 s.

[9] **DETHLEFSEN, T., DAHLKE , R.** (1990). *The Healing Power of Illness: The Meaning of Symptoms and how to Interpret Them*.Element Books Ltd. 288 p.

[10] **DÖNER K., PLOG U., BOCK, T, BRIEGER, P., HEINZ, A., WENDT F.** (2017). *Irren ist menschlich: Lehrbuch für Psychiatrie und Psychotherapie* [To err is human: Textbook for Psychiatry and Psychotherapy]. Psychiatrie Verlag, Köln 1978, 1984, 2002, 2017.

[11] **JASPERS, K.** (1913). *Allgemeine Psychopathologie. Ein Leitfaden für Studierende, Ärzte und Psychologen.* [General psychopathology. A guide for students, doctors and psychologists]. Berlin: J. Springer. 338 s.

[12] **JORK, K., / PESESCHKIAN, N.** (2006). *Salutogenese und Positive Psychotherapie. Gesund werden - gesund bleiben* [Salutogenesis and Positive Psychotherapy. Get healthy - stay healthy]. Bern: Hogrefe AG; 2., aktualisierte und ergänzte Edition. 297 s.

[13] **KRAUSE, R.** (1992). *Psychodynamik der Emotionsstörungen - eine psychoanalytische Perspektive* [Psychodynamics of Emotional Disorders - A Psychoanalytic Perspective]. Stuttgart: Kohlhammer. 276 s.

[14] **PESESCHKIAN, H., REMMERS A.** (2020). *Positive Psychotherapy: An Introduction*. In: Messias E., Peseschkian H., Cagande C. (eds) Positive Psychiatry, Psychotherapy and Psychology. Springer, Cham. https://doi.org/10.1007/978-3-030-33264-8_2.

[15] **PESESCHKIAN, N.** (2016). *In Search of Meaning: Positive Psychotherapy Step by Step,* Bloomington, USA: AuthorHouse UK.

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

[17] **PESESCHKIAN , N.** (2016). *Oriental Stories as Techniques in Positive Psychotherapy*, Bloomington, USA: AuthorHouse UK

[18] **SIMON, H. A.** (1995). Rationality in Political Behavior. *Political Psychology 16 (1). pp. 45-61.* DOI: 10.2307/3791449.

[19] **THE OXFORD-DUDEN GERMAN DICTIONARY**: German-English, English-German (1963) edited by the Dudenredaktion and the German Section of the Oxford University Press Dictionary Department ; chief editors, W. Scholze-Stubenrecht, J.B. Sykes.; Oxford : Clarendon Press; New York: Oxford University Press.

[20] **WATZLAWICK, P.** (2005). *Wie wirklich ist die Wirklichkeit?: Wahn, Täuschung, Verstehen* [How real is reality?: Delusion, deception, understanding]. Piper Taschenbuch; 19. Edition. 256 s.

[21] **WEIL A.** (1991). *Healthy Living (Ask Dr. Weil*): Ivy Books; 1st ed. 85 p.

SUICIDAL PERSONALITY STATES: RESEARCH AND SCIENTIFIC PERSPECTIVE

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Abstract

This article is written on the basis of dissertation material for the scientific degree of candidate of psychological sciences (PhD), on the basis of handwritten material. The topic of the dissertation is "Social and psychological correction of suicidal conditions in persons of mature age". Theoretical-methodological analysis of approaches to the problem of the suicidal condition in adults, was carried out in a modern, scientific environment. It is substantiated that the suicidal condition means temporary, situational or internally-conditioned disintegration of a personality which arises when one sees it as impossible to overcome obstacles in achievement of vital goals by using methods formed on the basis of previous life experience. It is indicative that the suicidal condition can be manifested by signs of decrease and inflexibility of social integration that leads to violations in interpersonal, social and professional spheres of the personality. The analysis as conducted allowed identifying characteristic features of suicidal conditions at the current stage of development of social and economic relations and identifying characteristic features of such conditions that indicate suicidal intentions. An important point is that in order to determine the real suicide risk in adults, it is necessary to take into account not only factors that contribute to suicide, but also predictors that deter suicidal states and act as protective factors against suicide.

On the basis of the research carried out in the dissertation material marks the connection of actual abilities of the person and ways of processing the conflict, which can lead to the formation and manifestation of behavioral reactions, in consequence of which there can be irreversible consequences in the form of suicide. As a result, the article analyzes the topic of the actual abilities of the person, which help cope with the oppressive situation, seemingly unsolvable. Special attention in the article is paid to the fact that due to actual abilities it is possible to form new views on the conflict leading to suicidal thoughts and to form a new vision of an "intolerable" conflict situation. The characteristic features of the PPT method being conflict-centered are highlighted and described; by applying a positive interpretation of the symptom arising from a highly stressful situation, it becomes possible to change the human condition from "intractable" to "solvable" and deactivate the intensity of suicidal thoughts, consequently lowering the risks and probability of suicidal thoughts to be carried out. Despair and the desire to end one's life recede, which gives hope for a change in the life situation, through newly developed skills.

The principle of hope, is extremely important and is one of the fundamental concepts of PPT. In the article it is traced that through the use of situational encouragement and goal enlargement it becomes possible to identify the individuality and uniqueness of a given person, to clarify the life prospects of the future that will inevitably lead to the discovery of creative potentials inherent in this person, which were displaced or suppressed by situations of acute (macro) or chronic (micro) stress and trauma, resulting in "tunnel thinking", which created a sense of "hopelessness" and no way out of the current situation

On the basis of the study, it was found that the use of the PPT method in work with suicidal people, gives great prospects for changes in the cognitive abilities of the personality, its perception and reaction to stressful situations, as well as the acquisition of new meanings of life and other ideas about its quality.

Keywords: personality, suicidal states, suicidal behavior, suicidokinesis, Positive Psychotherapy

Introduction

Relevance of the research topic. The presence of suicidal conditions and the frequency of completed suicides are among the most objective indicators of poor mental health, social well-being and quality of life. At the same time, research into the problem of suicidal conditions, must be interdisciplinary in nature and becomes possible only if it is recognized that such conditions are the result of a number of socio-cultural and psychological factors that characterize the space called "society - microsocium - person". This means that despite their "individuality", suicidal conditions cannot be disregarded as having been influence by social factors.

It is noted that only a quarter of people who complete suicide has suffered from mental illness, which means that the share of non-pathological suicides is growing.

In this regard, it is important to optimize the system of socio-psychological support to the personality, aimed at overcoming the factors stimulating its suicidal activity.

It has been noted that the set of empirical studies of socio-psychological factors of suicidal states is mainly focused on studying the peculiarities of the system of close relations between a suicidal person and his sphere of value and meaning.

The socio-psychological stratum of studies of suicidal conditions concerns to a greater extent the microsocium, i.e., the immediate environment of the suicidal person, most often the family. At the same time, psychological analysis of a personality is impossible without analyzing the system of its significant relationships and structural research in the sphere of motivation and need, because the motives for suicidal behavior and suicide attempts largely depend on the state of socio-political and economic processes taking place in society.

Methodology

As the analysis showed, the problem of timely diagnostics of suicidal conditions in adults is extremely topical.

Especially threatening is the period of the next year, as a result of which persons prone to suicide should be placed in the highest risk group. This requires effective professional supervision and targeted social and psychological correction of suicidal relapses, based on an individual forecast of the crisis. Meanwhile, the results of special psycho-diagnostic studies of this kind are practically absent (Kudryavtsev, 2010).

In this regard, it is of particular importance to identify and assess the features, personal factors, and prognostic signs of suicidal conditions in adults according to psychodiagnostics-studies to develop psychological markers - predictors of the risk of suicide and effective socio-psychological means to correct such conditions. The main psycho-diagnostic methods of identifying social and psychological markers of suicidal conditions were used:

- motivational interviewing, which revealed the main stimuli and verbalized meanings of suicidal behavior in adulthood, the level of awareness of the motive components, and attitude toward the suicidal trend (Kudryavtsev, 2012);
- methods of determining the level of motivational and personal conflict;
- the scale of depression (Beck, Ward & Mendelson, 1961);
- the scale of anxiety (Beck &Steer, 1993);
- the scale of hopelessness (Beck, 1974; 1975);
- the scale of suicidal thoughts (Beck, 1988);
- suicide risk assessment test (Patterson, 1983);
- methods of diagnostics of coping and protection strategies (Libina, 1998);
- the scale of subjective evaluation of life satisfaction (Libina, 1998);
- the temperament structure questionnaire (Rusalov, 1990);
- the M. Lucher test (1985; 2010);
- the Mass Media technique (Sobchik, 2000).

The purpose of the study was to identify and assess the socio-psychological factors and regularities of suicidal conditions of adults according to the data of a psycho-diagnostic study to determine the socio-psychological factors of suicide risk and measures of socio-psychological correction.

To achieve the goal, the following objectives were set at the stated stage of the research:

- Practical validation and selection of the most effective psychodiagnostic methods that reveal the mechanisms of suicidal conditions of adults and the leading directions of their socio-psychological correction
- Discovering the prognostic value of test results, identifying criteria of increased suicide risk and mechanisms of its implementation in adults with suicidal conditions.

Methods of psychological diagnostics were aimed at obtaining data on features of emotional, motivational and communicative spheres of personality, the presence of which could be important for forming suicidal conditions in respondents.

The research procedure consisted in measuring on one and the same sample of three rows of variables - coping and protective strategies, temperament characteristics, and

subjective assessments of satisfaction with life, self, and relationships with others.

In order to conduct the experimental part of the research, a set of methods was compiled, which were adequate for the purpose of the work - to study the socio-psychological specifics of suicidal conditions of adults and to discover individual differences in strategies of respondents' interaction with complex life situations. Thus, at the research establishment stage, the social psychological specificity of suicidal conditions in adults was determined. Voluntary participation in the study and guaranteed anonymity of the results ensured the most optimal form of psycho-diagnostic experiment and excluded such factors as social pressure and social desirability. Thus, the organization of the conditions of the experiment met the criteria necessary for the validity of the scientific study.

The empirical research was carried out at the Scientific and Practical Center of Medical-Social and Psychotechnologies, Center for Restorative Treatment and Rehabilitation of Veterans of War, Center of Mental Health, Ukrainian Northeast Institute of Applied and Clinical Medicine.

The sample consisted of 132 respondents (72 (54.5%) men and 60 (45.5%) women) aged 35 to 56 years with suicidal conditions (with non-psychotic disorders) that emerged as a reaction to a stressful (psycho, socio - or somatogenic) situation. Participants had different levels of education, family and financial status, length of professional experience.

Given the nature of suicide kinesis and its staged nature, the findings were analyzed within two types (models) of suicidal activity: pre-suicide (suicidal thoughts) and post-suicide (incomplete suicidal attempts).

When using the scale of suicidal thoughts (Beck, 2003), the most informative was to discuss the topic of deterrents (family, religious beliefs, possibility of disability in case of unsuccessful attempt, irreversibility of action, etc.), the descriptors of which reveal the level of control over suicidal tendencies. In discussing it, the significant statements made by most of the suicidal individuals surveyed were assessed as indicating that they have reduced control over suicidal behaviors. The suicide risk marker was a lack of reference to personal values that could deter suicide. Only the actual blocked (frustrating) meanings responsible for the suicide attempt or those that formed serious suicidal intentions were addressed. Some deterrents were assessed as features formally inherent in other people, but not significant to respondents. All this means that semantic barriers to carrying out the suicide were not present in the minds of the subjects (Kudryavtseva, 2016).

It should be admitted that application of A. Beck's scale (Beck, 2003) markedly shows the denial of suicidal thoughts. Its results make it possible to establish the absence or semantic insufficiency of personal factors deterring suicide, i.e., to objectify the latent threat of relapse into suicidal activity (I. Kudryavtsev 2016). It is shown that application of generally accepted scales of suicide risk A. Beck and W. Patterson has a number of constructive limitations (Kudryavtsev, 2012).

Indicators of subjective risk assessment of such conditions as a state of hopelessness cannot fully and reliably differentiate the high level of suicidal risk.

It should be noted that the methodology of diagnostics of coping and protection strategies (Libina, 1998) is based on the differential and psychological classification of mastering strategies with complex life situations.

For the analysis of quantitative indices of protective and copying behavior, the values of scales measuring the severity of each of 18 protective and 18 copying behavior strategies were used. The expression of strategies was estimated on a five-point scale, where 1 point corresponds to the minimum and 5 points - to the maximum value of the scale.

M. Lucher's test was used in the study as a method to determine the emotional and motivational state of mature individuals with suicidal conditions, their level of activity, determination, dominant needs and attitudes, as well as to determine the stress state. As is known, the Lucher test belongs to a fairly reliable methodological tool that can be used to determine the emotional and motivational states, the level of their activity, determination, and personal attitudes.

Given the nature of adult suicidokinesis and its stages, the data were analyzed within two models of suicidal activity: pre-suicide (suicidal thoughts) and post-suicide (incomplete suicide attempts).

The results of motivational interviewing to identify the main motives for suicidal behaviors and to determine the level of awareness of their components by respondents in both groups were used for meaningful analysis of the psychotraumatic factor.

The use of existential analysis of the content of psychological trauma for scientific consideration also made it possible to reveal the level of violations of unconscious mechanisms of perception and conscious mechanisms of its processing. This, in turn, revealed the system of interaction of protective antistress mechanisms, knowledge of which further defined the content of the program of social-psychological correction and measures of secondary

psychological prophylaxis of suicides of mature persons with suicidal conditions.

It was also found that, with an increase in the severity of depressive disorder, there is a tendency for the number of suicides with a high level of personal anxiety to increase (with severe depression 54.3% with a high level of anxiety) (Tsygankov, 2012), which may indicate its importance in the diagnosis of increased suicide risk.

As it has already been noted, the most important topic of diagnostic interviewing was finding out the possibility of the respondent's awareness of a different, more constructive (non-auto-aggressive) reaction to a psychotraumatic event. The degree and quality of such reflexion is considered a criterion of suicidal risk (Kudryavtsev, 2012). Analysis in this direction showed that 66.7% of individuals in the pre-suicide groups do not see any other opportunity to prolong life, at the time of interviewing. They link the decision to commit suicide to their illness - 28.6%; fear of losing control - 71.4%.

In order to understand the sources and mechanisms of suicidal activity of the mature adults surveyed, significant importance was given to examining the level and sources of psycho-emotional tension and analyzing the characteristics of mature respondents with suicidal conditions.

Higher levels of anxiety with prevalence of somatic components were found in the group of women with somatic non-localized sensations.

The cognitive-behavior markers of increased suicidal risk in the group of pre-suicides also include avoidance of satisfying needs (in severe cases, underdevelopment of the needs formation system); coping strategy of avoidance, which is especially typical for the strategy of behavior in conflict; underdevelopment and/or exhaustion of resources, flexible system of the realization of needs. Autoagression is based on a rigid system of blocking and freezing in frustrating situations. The leading frustrating need - internal desire for comfortable relations - is not manifested actively; the content of intra-personal conflicts - inability to influence changes in relations that do not satisfy.

The psychogenic-psychotic (deep maladaptation) symptom complex included emotional disorders, psychosomatic fixations, phenomena of mental activity exhaustion, presence of intra-personal conflict, non-adaptive and inadequate reactions to the psychotraumatic situation, severe disorders of the personal system of relations, inadequacy of cognitive and behavioral systems.

Data analysis shows a connection between suicidal activity and conditions of deep depression. Severe depressive episodes were not only the most frequent causes of suicide attempts, but also had the greatest preponderance in the suicide group, determining the dominance of suicidal thoughts in the minds of adults.

Informative and significant results were obtained using predictive indicators of the hopelessness scale (Beck, 1961;1988), and the suicide risk scale (Patterson, 1983).

The results obtained did not reveal any significant differences between the groups of pre- and post-suicide on the indicators of subjective risk assessment as a state of hopelessness. This indicates that the indicators of the hopelessness scale cannot reliably differentiate between mature individuals with a real risk of suicide.

Thus, the application of the suicide risk scales has a number of constructive limitations. The application of these scales provides valuable orientation in the suicidal state, allows us to determine its presence and severity, but does not reveal the essence of semantic meaning. Application of the scales is possible only if the respondent agrees to cooperate informally with a psychologist and is suitable mainly for preliminary evaluation orientation of a specialist, both in building a program of socio-psychological correction and in monitoring the resulting psychologically corrective effect.

It should be recognized that the use of A. Beck's scale of suicidal thoughts (Beck, 1961;1988) shows the denial of suicidal thoughts most markedly. Its results allow us to establish the absence or semantic insufficiency of personal factors deterring suicide, i.e., to indirectly objectify the latent threat of recurrence of suicidal activity.

It should be noted that the most informative marker of suicidal conditions in adulthood is the results of the discussion of restraining factors in A. Beck's method. The advantage of this method is the ability to work directly with the semantic value content of intra-personal factors that reduce the risk of suicide.

Thus, the results of the analysis of psycho-diagnostic data on individuals with attempted suicides make it possible to identify and rank psychological markers of the risk of recurrent suicides, to evaluate the most dangerous combinations of these personal symptom complexes, and to reveal the associated significant mechanisms of the genesis of suicide. The data obtained allow us to identify general principles and specific methods (methodological tools) of socio-psychological correction both in the early post-suicide period of the suicidal state and in its remote stages - when monitoring prognostic indicators.

A study of suicidal behavior abroad over the past few years has shown that the risks of suicidal behavior depend on many factors, including gender, age, and racial differences, but there are common factors inherent in the modern development of society.

N. Peseschkian (2016) writes in his book "Psychosomatics and Positive Psychotherapy" in the section "Suicidal Attempts" that the largest number of suicides in the world was registered in 1988 in Hungary, Finland in second place and France in third place. In the United States, about 30,000 people commit suicide every year. There is a high number of suicides in Japan. The lowest rates of suicide are in Greece and Saudi Arabia.

Suicides are not found among indigenous people of Australia and Tierra del Fuego. In India, suicide is found in the form of self-sacrifice in holy places (self-immolation of sati widows). Suicide is often found in Eskimos when they reach old age or have chronic diseases. (Peseschkian, 2016).

Results

If we consider suicidal behavior through the prism of Positive Psychotherapy, the balance model is well embedded here, and we can see what changes in the distribution of energy in the spheres of life and the deficit area of the model itself are found in the meanings mentioned above. Lost or distorted meanings lead to a gradual deformation of the personality in the following areas of activity, contacts and in conclusion, such changes occur in the body, sometimes reversible, that a "suicide plan" is formed as to how to end it all. Using the balance model in the therapeutic process, I see an opportunity to draw a person's attention to the areas of his life from a different perspective, to consider opportunities available in his life, to find a positive interpretation of situations and events that can show resources to improve the quality of life, thus acquiring new visions and meanings in what seems impossible to solve in the moment of the here and now. I also see as an especially important moment the use of current abilities in working with the patient. Most often, a person, not only a suicidal person, is not aware of the potential and resources available, and it is very important to emphasize that by applying their exclusivity and individuality it is possible to change life by adding joys and colors, to acquire new meanings and a more complete content of life.

Positive psychotherapy is a conflict-centered, ability-oriented method of psychotherapy with a humanistic approach to the individual. In this connection, work with suicidal behavior is oriented toward finding the conflict that results in suicidal thoughts, as life becomes unbearable and the client "wants out of it." The individual's disorder is labeled as a conflict with his or her own life, which is his or her reaction to the challenge of the external environment.

In positive psychotherapy, the actual abilities of the person whose conflict has caused the disorder as well as those that help to cope with it are in focus. The symptom which the individual displays while under a severe stress which has led to suicidal thoughts, is his only possible and available reaction to the conflict with his environment and his experiences. By analyzing the actual abilities that lead to this reaction and the specifics of their emergence in the course of life, it is possible to change these abilities in the therapeutic process by forming new attitudes and skills. As a result, the reactions to the events change and the symptom goes away.

Most important in PPT analysis is:

1 Determining the scope and content of the conflict (the presence and frequency of micro-trauma is important).

2 Positive interpretation of the symptom.

3 Identifying the underlying conflict.

4 Verbalization.

5 Changing the habitual script that recurs in stress response.

6 Building self-help skills for when stress occurs.

The positive interpretation of a symptom in positive psychotherapy describes an attitude toward illness that differs somewhat from the traditional interpretation in medicine and tries to discover in the various symptoms and illnesses a certain meaning and function that they carry. That is, it puts the person, the personality and the individual in the focus, rather than a mechanism that has malfunctioned and needs to be treated according to a certain pattern. (Пилявская, 2016) The main goal of positive psychotherapy is to change the patient's perspective on his illness and to provide new opportunities to find reserves in the fight against the ailment. And since positive psychotherapy is based on the fact that many psychiatric and psychosomatic illnesses are based on conflict, changing the perspective of symptoms or syndromes allows the therapist (and the patient) to approach the conflict in a more differentiated way.

For a more holistic understanding of diseases and ailments, the questions must be answered:

- Why and for what purpose did this or that disorder of functioning appear?
- What is behind the symptom?
- What does the symptom want to tell us?

Fundamental to the PPT method is its focus on the resources, abilities and needs behind a person's suffering.

By analyzing the urge to deprive oneself of life, through the lens of positive interpretation, one can see the person's desire to change his life and outlook on it. Also hypothetically possible are:

1.Searching for an opportunity to cope with the situation that led to suicidal thoughts

2.Finding an opportunity to be noticed and draw attention to oneself.

3.Finding an opportunity to distance oneself from the difficult situation.

4.Finding an opportunity to overcome fear.

5.Finding an opportunity to get rid of distressing physical or mental pain.

6. A way to get rid of loneliness.

Frequent areas of conflict:

1.Health conditions (physical and mental illnesses).

2.conflicts in professional activities.

3.Family conflicts.

4.Conflicts related to asocial behavior (alcohol, drugs).

5.Material and everyday conflicts (lack of finances, credits).

6. Existential crisis (not understanding the meaning of one's own life and its further perspectives).

These spheres can be distributed according to N. Peseschkian's balance model. The balance model shows an imbalance in the 4 spheres of life and it becomes apparent which spheres are in deficit and which are given special attention, and although the location of the conflict becomes visible, the content of the conflict has not yet been established.

The balance model is a universal tool that can be used to rework a conflict situation. Although everyone is individual, unique, there is a common model of behavior that most people resort to when dealing with conflict.

If there are problems, people are often angry, quarreling, feeling misunderstood, not seeing the meaning in life, all of these difficulties can be expressed in 4 forms of conflict processing, which correspond to the 4 dimensions of people's cognitive abilities. This model can clearly show how the world around us is perceived and in what ways it is mastered. When disharmony arises in any of the vertices of the balance model, all energy from the other positions is withdrawn to restore harmony in it.

A distinctive feature of positive psychotherapy is differential analysis, which regards actual abilities as an effective potential for personal development and conflict resolution (Гончаров). Peseschkian referred to actual abilities as those behavioral norms which are constantly in effect in our daily interpersonal relations and therefore always retain an actual meaning. Although actual abilities begin to form as early as the prenatal period, they are not inborn or hereditary. Actual abilities form and manifest themselves in a person's behavior depending on the influence of three developmental factors: the characteristics of the body, the environment, and the spirit of the times. (Пилявская 2016)

The concept of positive therapy is based on the view that every person has two basic abilities: the ability to cognize and the ability to love. Depending on the inner workings of the individual and his environment, these abilities are differentiated and form a distinct character structure. That is, all actual abilities grow out of these basic abilities and their development, which can be divided into two categories: primary and secondary. Primary actual abilities grow out of the ability to love, they arise on the basis of emotional relations. It is the ability to love, to have patience, to give time to something, to be able to establish contacts, to show and accept tenderness and sexuality, to be able to trust, to hope, to be able to believe and be able to doubt, to gain confidence. Secondary actual abilities develop from cognitive abilities that relate to the ability to act in the world, such as punctuality, cleanliness, neatness, obedience, courtesy, honesty/openness, loyalty, fairness, diligence, thriftiness, obligation, accuracy, conscientiousness. Actual abilities represent the essence, the content of education. They are taught in accordance with the needs of society. Depending on the family, the environment in which the person grew up, some actual abilities are emphasized, while others are developed less. (Гончаров)

The imbalance of the expected and actually existing, can become a subject of conflict, trauma, contradictions, resulting in irritation, anxiety, aggression, disturbed sleep. The reason for many interpersonal conflicts and, as a consequence, the emergence of possible suicidal thoughts is the difference in the degree of development of different people's actual abilities. It is also possible to predict possible conflicts by understanding the degree of development of actual abilities.

Four directions of behavior in a conflict situation are distinguished, four models to follow, which are described in the form of a basic conflict:

"I" – If from early childhood the needs of the child were not taken into account, ignored, frustrated, then an attitude of "I am not good enough" is formed, there is no formation of the person's own value and significance for the close environment, as a consequence, formation of basic trust is broken.

"You" – The model of behavior of parents and close people, their relations with each other, ideas about marriage, determine stereotypes of behavior of the child who has grown up in this family. Hence, different concepts of life.

"We" – The model of behavior is formed according to the image of the parents' opinion of the people around them.

"Pro-We" – Behavior is determined by the formed worldview, religion, traditions.

The principle of self-help corresponds to the 5-step model used as a strategy of harmonization, adaptation and development of the personality, - first in the process of psychotherapy itself and then in the further process of self-help of the person to himself/herself and his/her surroundings. I want to note that repeated suicidal actions continue to be a problem; therefore, an important step in psychotherapy is the development of self-help skills.

1.Observation.

2.Inventory.

3.Situational reassurance.

4. Verbalization.

5.Extension of purpose.

The final stage of psychotherapy is goal expansion, when the interaction between psychotherapist and patient is directed toward the realization that the energy of life needs to be invested not only in conflicts, but also in other areas of life. "The other person" often brings conflicts, difficulties, problems and crises. At the same time, it also provides a chance for further personal development and adequate resolution of these conflicts.

The advantages of positive psychotherapy are:

1. Conflict-centered therapy (as opposed to symptom-centered therapy).

2.Short-term (10 sessions in counseling and 50 sessions in therapy).

3.Universal application to problems.

4.Transculturality.

5.Treats the individual as a holistic system.

6.Use of metaphors, parables as a tool.

7.Gives the client an active role.

8.Focuses on the future.

9.Deals with the problems of the therapists.

9.Deals with the problems of the therapists in their supervision sessions.

The results of the analysis in my dissertation (which are reflected in the article) showed that the degree of reflection, the depth of understanding of the relationship between the psychologically traumatic event and the subsequent mental and behavioral acts is the most important criterion for suicidal risk at the social and psychological level.

The material in the dissertation draws attention to the fact that one of the marginal variants of neuropsychiatric instability is a propensity for auto-aggression (Zotov, 2002). The complexity of this problem is that suicidal behavior is extremely difficult to diagnose, because the main diagnostic tools are interviews and self-reporting methods (Popov, 2009). At the same time, many individuals carefully conceal their suicidal thoughts and experiences in an effort to escape from life with minimal prior publicity.

In this regard, I would like to note that the main principle of assistance to mature persons who are suicidal should be an individual choice of direction and method of socio-psychological correction with a reasonable combination or step-by-step advantage of its various methods, as well as the consideration of any specific suicidal condition. At the same time, knowledge of peculiarities of the dynamics of suicidal behavior and of the individual psychologically-important elements of suicide kinesis allows us to carry out better-differentiated and effective individual work that is important in prevention of suicidal conditions.

Conclusion

The analysis of conditions and causes of suicidal conditions in adults provided an opportunity to differentiate socio-psychological factors of such conditions by taking into account the level of suicidal risk in the specified age period of ontogenesis. It was established that the most important interindividual factors are: psychosis and borderline psychiatric disorders; suicidal statements, repeated suicidal actions, early post-suicidal period; extreme, especially marginal conditions (in particular, imprisonment), loneliness; loss of social prestige; decrease of social status, level of material well-being; conflict and psychotraumatic situations; loss of loved ones, a reference person; burdened or dependent behavior. Intra-individual factors include: age-related changes in the body with increased suicidal influence of somatic factors; prevalence of epileptoid and cycloid types of character; reduced tolerance for emotional stress, depression, inferiority of communicative contact systems; inadequate self-esteem of personal capabilities; absence or loss of attitudes that determine the values of life; limited life prospects.

References

[1] **BECK, A., KOVACS, M., WEISSMAN A.** (1975). Hopelessness and suicidal behavior. An overview. *JAMA*. Vol. 234. pp. 1136-1139.

[2] **BECK, A., WEISMAN, A., LESTER, D., TREXLER, L**. (1974). The measurement of pessimism: the hopelessness scale. *Journal of Clinical Psycholo*gy. Vol. 42. pp. 861-865.

[3] **BECK, A.T., FREEMAN, A., DAVIS, D. D**. (2003). *Cognitive Therapy of Personality: Disorders*. The Guilford Press. 412 p.

[4] **BECK, A.T., STEER, R.A.** (1993). *Beck Anxiety Inventory Manual.* San Antonio, TX: The Psychological Corporation Harcourt Brace & Company. pp. 12 – 80.

[5] **BECK, A.T., STEER, R.A., RANIERI, W.** (1988). Beck Scale for Suicide Ideation (BSS). *Journal of Clinical Psycholo*gy. Vol. 44. pp. 499-505.

[6] **BECK, A.T., WARD, C.H., MENDELSON, M.** et al. (1961). An inventory for measuring depression. *Arch. Gen. Psychiatry*. Vol. 4. pp. 561-571.

[7] **LÜSCHER, M.** (1985). Der Lüscher-Test. Persönlichkeitsbeurteilung durch Farbwahl. Rowohlt: Reinbek. 171 p.

[8] **PATTERSON, W.M., H.H. DOHN, J. PATTERSON** et al. (1983). Evaluation of suicidal patients: the sad person's scale. *Psychosomatics*. Vol. 24, № 4. pp. 343-349.

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

[10] **ГОНЧАРОВ, М.А. [GONCHAROV, M.A.]** Дифференциальный анализ в терапии суицидального поведения [Differential analysis in the therapy of suicidal behavior]. Центр позитивной психотерапии СРР. Retrieved from: http://www.cpprussia.ru/ru/center/science/science2

[11] **ЗОТОВ, М.В., ПЕТРУКОВИЧ, В. М. [ZOTOV, M. V., PETRUKOVICH, V. M.]** (2002). Внимание к мотивационно значимым стимулам как основа методического подхода к исследованию мотивации и его реализация на примере оценки суицидальных тенденций [Attention to Motivation-Significant Stimuluses as Basis of Methodical Approach to Research of Motivation and Actualization Thereof on the Example of Suicide Trends Assessment]. *Современная психология:*

состояние и перспективы» (тезисы докладов на юбилейной научной конференции Института психологии РАН, М. Т.1, С. 264-266.

[12] **КОВАНДА, О. В. [KOVANDA, O. V.]** (2020). *Соціально-психологічна корекція суїцидонебезпечних станів особистості зрілого віку*: *дисертація на на здобуття наукового ступеня кандидата психологічних наук* [Social-Psychological Correction of Suicide Hazardous Conditions of Adult Personalities: dissertation for the degree of PhD in Psychological sciences]. Сєвєродонецьк: Східноукраїнський національний університет імені Володимира Даля. 238 с.

[13] **КОЛМОГОРОВА, В. В., ЛУГОВЫХ Н. А., ЗАБОЗЛАЕВА И. В., ПИЛЯВСКАЯ, О. И. [KOLMOGOROVA, V. V., LUGOVYKH N. A., ZABOZLAYEVA I. V., PILYAVSKAYA, O. I.]** (2016). Позитивная Психотерапия: учебное пособие для слушателей системы дополнительного профессионального образования врачей и смежных специальностей [Positive Psychotherapy: a textbook for students of the system of additional professional education for doctors and related specialties]. ГБОУ ВПО ЮУГМУ Минздрава России, кафедра психиатрии. С. 12 - 17.

[14] **КУДРЯВЦЕВ, И.А. [KUDRYAVTSEV, I.A.]** (2016). Психодиагностика суицидального риска как критерий недобровольной госпитализации психически больных в системе профилактики их общественно опасного поведения [Psychological Diagnostics of Suicide Risk as Criterion for Involuntary Hospitalization of Sick Persons in the Preventive Treatment System Based on Social Behavior]. *Суицидология: научный и практический журнал*. No. 4 (25). С.10-22.

[15] **КУДРЯВЦЕВ, И.А., ДЕКАЛО, Е. Э. [KUDRYAVTSEV, I. A., DECALO, E. E.]** (2012). Психологические факторы и механизмы суицидогенеза как критерии суицидального риска и направленной профилактики [Psychological Factors and Mechanisms of Suicide Genesis as Criteria of Suicide Risk and Aimed Preventive Treatment]. *Суицидология: научный и практический журнал*. No. 2. С.3-11.

[16] **КУДРЯВЦЕВ, И.А., ИВАННИКОВА, Н. М. [KUDRYAVTSEV, I. A., IVANNIKOVA, N. M.]** (2010). Психодиагностика постсуицида [Post-Suicide Psychological Assessment]. *Российский психиатрический журнал*. M. No. 6. С.11-15

[17] **ЛИБИНА, Е. В., ЛИБИН, А. В. [LIBINA, E. V., LIBIN, A. V.]** (1998). Стиль реагирования в сложных ситуациях [Style of Reacting to Complicated Situations]. В кн: Либин А. В. (Ред). Стиль человека: психологический анализ [Human Style: Psychological Analysis]. М.: Смысл.

[18] **РУСАЛОВ, В. М. [RUSALOV, V. M.]** (1990). *Опросник структуры темперамента* [Temperament Structure Survey]. M., IPRAN. 55 с.

[19] **СОБЧИК, Л. Н. [SOBCHIK, L. N.]** (2000). *Введение в психологию индивидуальности. Теория и практика психодиагностики* [Introduction to Individuality Psychology. Theory and practice of psychodiagnostics]. M. IPP-ISP. 512 с.

[20] **ЦЫГАНКОВ, Б.Д., ВАУЛИН, С.В. [TSYGANKOV, B.D., VAULIN, C.B.]** (2012). *Суициды и суицидальные попытки (клиника, диагностика, лечение): монография* [Suicides and Suicidal Attempts (Clinic, Diagnostics, Treatment): monograph]. Смоленск: СГМА. 232 с.

BOOK REVIEW

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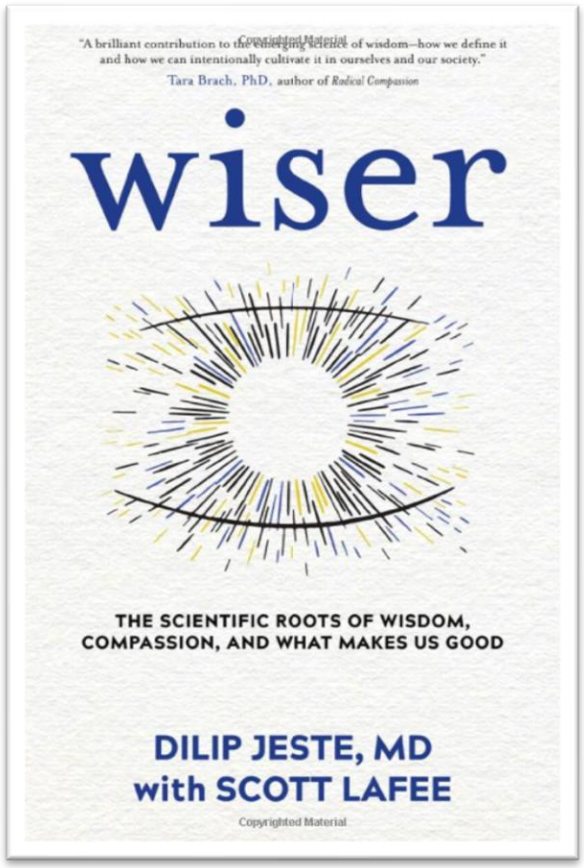

WISER: THE SCIENTIFIC ROOTS OF WISDOM, COMPASSION, AND WHAT MAKES US GOOD

Dilip Jeste, MD
& Scott Lafee

Sounds True, 2020
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Over ten years ago Dr. Dilip Jeste – recognized as the founding father of Positive Psychiatry - published a scientific article comparing the conceptualization of wisdom in the ancient Indian text Bhagavad Gita to modern ideas about wisdom (Jeste and Vahia, 2008). In that initial incursion found several similarities including knowledge about life, emotional regulation, insight and compassion along with differences in the emphasis on control over desires and renunciation of materialistic pleasures. That comparative study was followed by a review on the neurobiology of wisdom in which the prefrontal cortex figures prominently as regulating limbic and striatal regions (Meeks and Jeste, 2009) . In the following year Dr. Jeste coordinated an expert consensus on the characteristics of wisdom that listed agreements on statements such as being a "personal quality", "rare", "experience driven", "learned", "a form of advanced emotional/cognitive development" and importantly as being measurable (Jeste et al., 2010). A few years later the work continued by proposing individual wisdom as a mechanism to explain the paradox of increased well-being despite worse physical health in old age (Jeste and Oswald, 2014). The measurement of wisdom was explored by Dr. Jeste in two further works, first by developing a shorter version of the 39-item Three-Dimensional Wisdom Scale (3D-WS) into the 12-item version 3D-WS-12 (Thomas et al., 2017); and second with the development of the San Diego Wisdom Scale (SD-WISE) (Thomas et al., 2019). All this outstanding body of work is now available to general audiences, and mental health practitioners, in the book "*Wiser: the scientific roots of wisdom, compassion, and what makes us good"* (Jeste and LaFee, 2020). The book is organized in three parts: "What is Wisdom?", "Components of Wisdom", and "Enhancing Practical and Societal Wisdom".

In the first part of the book the authors recognize German psychologist Paul Bartes, and collaborators, as one of the first to develop a theory of human development with respect to wisdom in creating the Berlin Wisdom Project – a model that, according to the authors, placed great emphasis on knowledge and cognition. That work was followed by work in the US and Canada that lead to more insight into wisdom and

its many components. Eventually this body of work pointed to these many components as: prosocial attitudes and behaviors – like empathy and compassion; emotional regulation; decisiveness while recognizing the uncertainty of life; insight and self-reflection; and social-decision making based on pragmatic knowledge of life; with spirituality being added upon further consideration. This chapter on the definition of wisdom and its components is followed by a chapter on the neuroscience of wisdom, then the relationship between wisdom and age and finally a chapter on the its measurement. This final chapter on Part 1 is important as it includes the items of the San Diego Wisdom Scale – which may also be accessed at sdwise.ucsd.edu

Part 2 devotes a chapter to each proposed component of wisdom: compassion, emotional regulation, decisiveness in the face of uncertainty, self-reflection, and spirituality. All these chapters follow a similar structure: background, including historical, social, and scientific context; definitions; measures; and biology; followed by specific interventions designed to manipulate and boost each component. These chapters are information-dense while weaving stories and anecdotes that make the reading much easier and enjoyable.

The third part of the book is dedicated to practices to enhance practical and societal wisdom and includes two chapters: "becoming wiser faster", "wisdom boosters: drugs, gadgets, and artificial wisdom?" and "The Future of Wisdom: moving from individual to societal wisdom." These final chapters make clear the ambition of this project which in final measure points to making society wiser. Here the authors use the aging of societies to speculate about whether these extra years of life have contributed to wiser societies. The jury is still out on that question.

One potential limitation for the book is the authors focus on English language references and Western societies. Work remains to be done to apply these concepts of wisdom to the fullest extent of humanity today, including the large contingents living in China, Japan, and in many African nations, along with Latin America.

This short book builds on an enormous body of work and functions as a ticket to the dense world of functional neuroscience and the study of happiness. Overall, the reading experience is fluid, the book is well researched, and provides a large list of references for further study. There is likely nothing else to say but to affirm that one finishes the book wiser – and there is no better reason to recommend it without reservation.

REFERENCES

[1] **JESTE, D. V., ARDELT, M., BLAZER, D., KRAEMER, H. C., VAILLANT, G. & MEEKS, T. W**. (2010). Expert consensus on characteristics of wisdom: a Delphi method study. *Gerontologist,* 50**,** 668-80.

[2] **JESTE, D. V. & LAFEE, S.** (2020). *Wiser: the scientific roots of wisdom, compassion, and what makes us good.* Boulder, CO: Sounds True,.

[3] **JESTE, D. V. & OSWALD, A. J.** (2014). Individual and Societal Wisdom: Explaining the Paradox of Human Aging and High Well-Being. *Psychiatry*.

[4] **JESTE, D. V. & VAHIA, I. V.** (2008). Comparison of the conceptualization of wisdom in ancient Indian literature with modern views: focus on the Bhagavad Gita. *Psychiatry,* 71**,** 197-209.

[5] **MEEKS, T. W. & JESTE, D. V.** (2009). Neurobiology of wisdom: a literature overview. *Arch Gen Psychiatry,* 66**,** 355-65.

[6] **THOMAS, M. L., BANGEN, K. J., ARDELT, M. & JESTE, D. V**. (2017). Development of a 12-Item Abbreviated Three-Dimensional Wisdom Scale (3D-WS-12): Item Selection and Psychometric Properties. *Assessment,* 24**,** 71-82.

[7] **THOMAS, M. L., BANGEN, K. J., PALMER, B. W., SIRKIN MARTIN, A., AVANZINO, J. A., DEPP, C. A., GLORIOSO, D., DALY, R. E. & JESTE, D. V**. (2019). A *new scale for assessing wisdom based on common domains and a neurobiological model*: The San Diego Wisdom Scale (SD-WISE). *J Psychiatr Res,* 108**,** 40-47.

OBITUARY

MRS MANIJE PESESCHKIAN

(15 July 1940 – 3 March 2020)

by the German Association for Positive and Transcultural Psychotherapy (DGPP) and the Peseschkian Foundation

Dear friends and colleagues,

With sad hearts, deep solidarity and gratitude, we say goodbye to our Honorary President, Manije Peseschkian, who left this world on 3 March 2020 after a brief, but serious illness. Although her health had been impaired for several months, she continued working for everyone, even up until a few weeks before her death, as the "mother of Positive Psychotherapy".

Manije Peseschkian was born on 15 July 1940, the second of three children of the Eghrari family in Tehran. She attended grammar school, completed her science-oriented high school as the best in her year and then began to study biology. To this she said herself: "In this phase of my life, only gaining knowledge counted - until 1961 when Nossrat appeared". In December 1961, the couple married and then, in 1962, they moved to Frankfurt, and finally to Wiesbaden. Their sons, Hamid and Nawid, were born in 1962 and 1964 respectively. Manije Peseschkian completed an apprenticeship as an EEG assistant and worked for many years at Nossrat's practice. She reached her actual professional goal of 'pedagogy and family therapy' shortly before her 40th birthday and then worked for many years as a family therapist.

Their third child was Positive Psychotherapy (PPT). We can only approximate Manije Peseschkian's contribution to the development of Positive Psychotherapy. The expression of the teamwork of this couple can be found in the formation of the many centers at home and abroad, and also in managing the publishing of more than 30 books around the world in as many as 26 languages! In the face of the stories and sayings, one learned again and again in personal meetings how the Peseschkian couple were co-creative in the development of the PPT. Manije Peseschkian was

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soon perceived as the "mother of Positive Psychotherapy". In an interview in November 2019, however, she described herself as the "midwife of positive psychotherapy" and she also made this child known in numerous lectures and seminars. It was important to her throughout her whole life; her strength and commitment belonged to it.

Together with her husband, she founded the 'Prof. Peseschkian Foundation', in which she worked until the end as Chair of the Board. After Nossrat Peseschkian's passing in 2010, she made a significant contribution to the continuity and unity of Positive Psychotherapy - both in Germany and worldwide. With the maintenance of the foundation archive, she ensured a strategic positioning, and with the organisation of advanced training events (not only) for counselors and therapists in Germany and Ethiopia, she ensured the dissemination and deepening of PPT, and finally with the courses for teachers in Hesse, she ensured the use of PPT in other social fields.

She has always had a particularly close relationship with the DGPP. Through her constant presence, her advice, her contributions to various events and, last but not least, her hosting, she has repeatedly strengthened, encouraged and, to our delight, accepted the honorary presidency in 2018. We all remember the warmth of her heart, and after direct contact with her, you immediately felt noticed by her and that you were important.

Manije Peseschkian was a loving mother and grandmother, a committed member of the Bahai community in Wiesbaden. She used to meet everybody with warmth, open-mindedness, extraordinary kindness and humour, be it in encounters with professional or voluntary collaborators - essentially in all her contacts with others. Manije Peseschkian had a rare and special ability to make everyone feel welcome and comfortable. Her faith shaped her perception of people and the world ever since childhood and gave her strength and basic trust. In 2003, she reported on her special encounters with the Angel of Death and added that "through such experiences I have become more tolerant, patient and humble. The years I have left are a bonus. I cherish life, infinity and the mystery of God and hope that I can duly accept the inevitable end of life".

It could be like that. A few days before her death, she wrote the following message for us:

> *"Dear family and friends,*
>
> *2020 was my 80th year on planet earth. I really enjoyed this journey because I was able to travel to all 5 continents and saw more than 70 countries and regions. Each of you, personally, were an important part of accompanying my journey through life, for which I am infinitely grateful. Now is the time to begin the longest journey of my life. A few months ago, I reserved a ticket for my last adventure in the Abha Kingdom."*

Manije Peseschkian is survived by two sons and four grown grandchildren. Our thoughts are with her family. May they find sufficient strength, calm and courage during this time.

The funeral took place on 13 March 2020 in the cemetery in Wiesbaden-Sonnenberg. She is buried besides her husband.

Board of Directors, Advisory Board, Board of Trustees and Head Office of the DGPP and Peseschkian Foundation

Report on the funeral of Mrs. Manije Peseschkian by Larisa Schicker from Kyiv (Ukraine)

"Dear friends, let me confide my inmost soul to you and share my impressions of the farewell ceremony for our beloved Manije Peseschkian. Today, I'm filled with sweet sorrow, faith, love of life, responsibility for life and the moment of

transition to the other world.

Manije was the perfect role model for me. She managed to finish all the things she intended to do on this earth and arranged for everything, including the nomination of a successor to her lifetime project. My narration might be of interest to all the friends who were eager to go to Wiesbaden but did not manage to go. The Peseschkian family arranged a farewell ceremony in accordance with the traditions of the Baha'i Faith. All the friends who came to pay their last respects to Manije Peseschkian received memorial booklets which contained the farewell message of Manije to her beloved family and friends, and some Baha'i prayers.

All those present were touched by the insightful farewell speeches of Manije's sons - Dr. Hamid Peseschkian and Dr. Nawid Peseschkian - as well as the prayers and music. It wasn't mourning - it was instead an occasion to cherish the memory of our dear Manije and express the sublime love which everyone had for her.

After the spiritual ceremony we proceeded to the burial place where we saw the closed coffin covered with fresh flowers as a symbol of eternal life. The coffin was entombed as the following Baha'i quote was chanted: God is sufficient unto me, He is the Al-sufficing! Let the trusting trust Him, let the trusting trust! All those present, one after another, approached the basket filled with rose petals and threw a handful of petals into the grave. We bid our final farewell to our beloved Manije with our rose petals of love. The photo of the burial place, which was taken by Dr. Hamid Peseschkian, showed the flowers covering both the graves of Manije and her husband, Dr. Nossrat Peseschkian. As their bodies are resting side by side, so their souls are now together in the Abha Kingdom.

The celebration of the life of Manije Peseschkian took place from 3 p.m. until 8 p.m. in the beautiful hall of the "Dorint" restaurant. All those present enjoyed delicious food, a cordial atmosphere and divine music. Every family member shared personal stories, memories and photos. We were immersed in the ocean of love and gratitude that they had towards their great Mother, loving Granny, faithful Wife, Scientist, Chairperson of the Board of Directors of the World Association of Positive Psychotherapy, Chairperson of the Nossrat Peseschkian Foundation; our beloved Manije Peseschkian. This event united one and all, strengthened us in our faith and love, so that we would strive to continue serving people as our angel Manije did throughout her life.

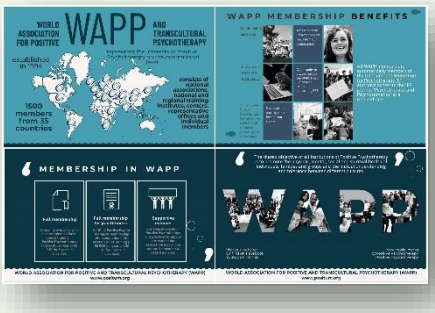
We will always cherish her memory in our hearts. My colleagues - Natalia Ruda and Yanina Danish - and I, on behalf of all those who knew and loved her from the positive psychotherapists of the Eastern region, left a record in the Memorial Book and expressed our sincere condolences to the family members.

We are grateful to Dr. Hamid and Catherine Peseschkian, their children Leyla and Farid, Dr. Nawid and Shida Peseschkian, their children Tara and Samira, to all the relatives, close friends and colleagues of the Peseschkian family for their attention, care, and the atmosphere of love and friendship throughout the day. With love and respect to the dignified life of Manije Peseschkian. In loving memory. Manije's legacy will be continued".

WAPP NEWS

WAPP Annual Review 2020

Dear WAPP members,
Dear friends and supporters of Positive Psychotherapy worldwide,



The year 2020 was an extraordinary year with changes one would not have imagined 12 months ago. The pandemic was the major theme of this year, but it was amazing to witness how all of you took this crisis as an opportunity to raise to a new level. Our worldwide community of PPT has become stronger and more united than it was one year ago. It has really become a global movement. Today, we wish to share with you some highlights and events of 2020, but this is only a small part of all the activities which happened all over the world.

Due to the pandemic, almost all presence modules of psychotherapy trainings had to be cancelled and changed to online seminars. And also psychotherapy and counselling sessions with patients and clients oftentimes had to be altered to the online format. Now, after nine months of this practice, we gained much experience with it and are happy to see that it works well. Especially, continuing therapy with patients in these uncertain times of pandemic was necessary and a good option to keep in contact and to not interrupt treatment.

Online encounters by Zoom or other providers even offered us new opportunities to meet and exchange. Our International Training Seminar (ITS) was conducted as an online conference seminar for the first time in August, and it was well received by about 120 participants from 15 countries.

We also had other plenary online meetings and conferences, like a Zoom meeting open for all members of WAPP, meetings with trainers only, meetings with working groups, and online conferences were organized by different organizers, trainers, national organizations and interest groups. Before the pandemic, the WAPP Board was meeting only twice per year, now there are monthly meetings. This makes decisions much faster.

A new WAPP Board was elected in August for the years 2020-2022. The election was conducted online, too. The members of WAPP received an individual link and code to make their votes. The members of the new Board are: Hamid Peseschkian (president), Ewa Dobiala, Maksim Goncharov, Gabriela Hum, Ivan Kirillov, Olga Lytvynenko, Richard Werringloer, and Tinia Tober (as a representative of the Peseschkian Foundation).

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This year, we engaged two new co-workers to assist and help with the work of our association: Dr. Kateryna Lytvynenko from Ukraine as WAPP assistant and Dr. Dorothea Martin from USA/Albania for English language editing. We are very thankful for their valuable help.

In the past 12 months since our last World Congress in Kemer (Turkey), our association has quickly moved on to another stage. Many new impulses were set, our members inspired us with young and contemporary ideas, such as **designing official information material, initiating a YouTube channel**, and - which is one of the most important steps - we revived the Electronic Journal for Positive Psychotherapy. From now on it will be known as **"The Global Psychotherapist"**, and its first issue you are reading now.

At present our association has 1,600 members in 36 countries. Among them are 144 Basic and Master Trainers of Positive Psychotherapy, 8 of them received their trainer license this year.

A big project this year is and was the re-certification of trainers, which started in Ukraine. 39 trainers needed to undergo an online interview examination. Furthermore, from this year on trainer applicants need to do a similar interview examination. Currently, 16 candidate Basic Trainers and 13 candidate Master Trainers have done this interview. The examiners are quite satisfied with the results of these interviews. Almost all candidates passed the examination.

The trademark "Positive Psychotherapy (PPT after Peseschkian, since 1977)" was registered in the United States of America in June 2020. This was an important achievement for us to stake our claim and protect our name in the USA.


United States of America
United States Patent and Trademark Office
Reg. No. 6,082,225
Registered Jun. 23, 2020
Int. Cl.: 16, 41, 44
Service Mark
Trademark
Principal Register

This year also brought us some sad news:
The passing of Mrs. Manije Peseschkian on 3 March 2020. The "mother" of Positive Psychotherapy has left this mortal world to be re-united with her husband and the founder of PPT. Since August last year she did not feel well, but it was very important for her to participate at the World Congress in Kemer. A few weeks later, she was diagnosed with cancer and the last weeks of her life she spent with her family and close friends at home. We will keep her in loving memory and continue her lifework.
We are also thinking of our colleagues who suffered from Covid-19 or are still suffering and wish them to become healthy soon again.

The Board of Directors would like to thank each and everyone for his or her support during the 2020 year. It is so encouraging to see that there are active Positive Psychotherapists worldwide who are contributing to the mental health of their fellow citizens. It makes us proud to be part of the worldwide professional family of Positive Psychotherapists.

We wish you all the best for the year 2021.

WAPP Board of Directors and Head Office

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INFORMATION AND GUIDELINES FOR AUTHORS

Full and up-to-date "Information and Guidelines for Authors" are on the JGP website: https://www.positum.org/182-0-PPT-Journal.html

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

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

Review Process: All manuscript submissions - except for short book reviews - will be anonymised and sent to at least 2 independent referees for 'double-blind' peer-reviews. Their reviews (also anonymised) will then be submitted back to the author.

Submissions can only be sent by an email attachment in Word format to journal@positum.org.
Each article should be between 3 – 10 pages in length, including key words, abstracts, and references (Times New Roman, font size 12, and line spacing 1.5).

Structure: Title, abstract with keywords, introduction, methodology, results, conclusion, references.

An author can publish only one paper per issue.

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

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

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

Here are three basic examples:

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

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

[2] For books:

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

[3] For non-English resources:

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

[4] For chapters within multi-authored books:

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

Frequency and Copyright

The journal is published twice a year. The copyright of all published articles is with the World Association of Positive and Transcultural Psychotherapy. The Editorial Board of the Journal reserves the right to proofread the articles, submitted for publishing.

Further Information and contact details are available on the JGP website:
https://www.positum.org/182-0-PPT-Journal.html

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