Positive Psychiatry, Psychotherapy and Psychology

Clinical Applications

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The editors dedicate this book in gratitude and admiration to the three "founding fathers" of the contemporary Positive Mental Health movement.
May their concepts continue to improve the life of people around the globe and inspire young professionals to follow their footsteps.

Positive Psychotherapy
by Nossrat Peseschkian
(1977)

Positive Psychology
by Martin E.P. Seligman
(1998)

Positive Psychiatry
by Dilip V. Jeste
(2012)

Foreword: Positive Mental Health

I am honored to write the Foreword for this wonderful book edited by three esteemed friends and colleagues: Erick Messias, Hamid Peseschkian, and Consuelo Cagande. At the annual meeting of the American Psychiatric Association (APA) in May 2018, there was a symposium on positive psychiatry, positive psychology, and positive psychotherapy in which the main speakers were the three editors of this book and myself. The symposium was well attended and generated considerable interest. The present volume can be considered a positive and lasting outcome of that symposium. A unique feature of this book is its global nature, with authors of the chapters coming from various continents and countries across the world as well as highly varied backgrounds.

The topic of this book is close to my heart. In 2012–2013, when I was the president of the APA, an important task for me was to ensure the finalization and publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. I devoted a considerable amount of time to it and was happy that the task was accomplished. At the same time, I knew the limitations of the DSM. DSM is often called the Bible of psychiatry. I did not agree with that characterization. While the DSM is necessary for reliable diagnoses of psychiatric disorders, I felt that psychiatry was much more than a collection of mental illnesses. I take exception to the standard dictionary definition of psychiatry as a branch of medicine that focuses on diagnosis and treatment of mental illnesses. I believe that the definition must be broadened to also include study and promotion of mental health. While we must treat mental illnesses and prevent them when possible, the scope of psychiatry needs to extend beyond reducing psychopathology to emphasizing promotion of well-being and happiness.

Yet, I was struck by the fact that mainstream psychiatry had paid little attention to the positive aspects of mental health. In 2012, when I googled the term positive psychology, I got thousands of citations, but when I did the same for positive psychiatry, I did not get a single one. In the medical and other health-related literature, there were numerous papers on resilience, optimism, social engagement, and other positive traits. Yet very few of these were published in psychiatric journals – they were mostly in psychology, sociology, internal medicine, family medicine, and pediatrics. Psychiatric textbooks were mostly restricted to mental disorders and risk factors, rarely mentioning wellness and protective factors. I made positive psychiatry my APA Presidential Theme. Positive psychiatry was defined as the science and

practice of psychiatry that seeks to understand and promote well-being through assessments and interventions aimed at enhancing positive psychosocial factors and mental wellness. In my 2013 APA Presidential Address, I highlighted the journey from DSM-5 to positive psychiatry.

I was unsure how the concept of positive psychiatry would be received by others in our field. While there was some (expected) criticism and dismissals ("is this opposite of negative psychiatry?"), many more people supported the idea. Since then, there have been a number of symposia on this topic at various conferences, and these have often attracted standing-room-only crowds. In 2015, we published the first handbook on positive psychiatry, which became one of the best sellers for the APA Publishing. The formation of an APA caucus on positive psychiatry was soon followed by the development of a section on positive psychiatry in the World Psychiatric Association.

The notion of positive mental health is not new, of course. In modern times, it dates back to the early 1900s. During his Presidential Address to the American Philosophical Association, the philosopher/physician/psychologist William James proposed the notion of a "mind-cure," conceptualized as the restorative powers of positive emotions and beliefs. Half a century later, this construct was expanded by Abraham Maslow and colleagues in the form of humanistic psychology. These psychologists believed that measuring and cultivating overall health and creativity was the best approach to improving outcomes in people with mental illnesses. The World Health Organization (WHO) has long advocated for a conceptualization of health that extends beyond symptom alleviation and absence of illness to a state of enhanced biological, psychological, and social well-being. In recent years, spiritual wellness has been added to the construct of health.

Positive psychotherapy (1977) was proposed by Nossrat Peseschkian, an Iranian-born, German-trained neurologist, psychiatrist, and psychotherapist. It integrates Maslow's humanistic approach with therapeutic alliance, psychodynamic understanding of mental illnesses, and a consideration of culture, work, and environment. It is practical, self-help, and goal-oriented short-term psychotherapy based on transcultural observations in varied cultures. The term "positive" emphasizes mobilizing existing capacities and the potential for self-help.

Martin Seligman's 1998 Presidential Address to the American Psychological Association famously launched the modern positive psychology movement. Positive psychology is the study of positive emotions, positive character traits, and enabling institutions. Over the past two decades, the field of positive psychology has grown enormously and has provided a refreshing approach to mental healthcare as well as businesses and other areas of life. The term positive psychology is now a part of the common lexicon.

This book seeks to address three connected themes: positive psychology, positive psychotherapy, and positive psychiatry. There are several commonalities among them, including a focus on well-being, happiness, and meaning or purpose in life. The book is divided into five parts. *Part 1* provides basic concepts, background, and history of each of these areas in separate chapters on positive psychiatry, positive psychotherapy, and positive psychology. *Part*

2 includes chapters on positive interventions and approaches for well-being across the life span. *Part 3* is dedicated to psychiatric and psychosomatic disorders including depression, anxiety, schizophrenia, substance use, and other mental illnesses. *Part 4* contains chapters on special settings and populations such as family and couples' therapy, pedagogy, organizations, and group therapy. Finally, *Part 5* is comprised of chapters on theoretical basis of positive psychotherapy.

At the core of positive mental health are positive or strength-based psychosocial factors like resilience, optimism, wisdom, social support, purpose or meaning in life, spirituality, self-efficacy, personal mastery, and coping ability in people with mental illnesses or physical disabilities as well as the in community at large. These factors mediate the trajectory toward improved mental health outcomes including well-being, happiness, life satisfaction, low perceived stress, posttraumatic growth, successful aging, recovery, and prevention of psychopathology. Importantly, empirical data have supported this perspective as the positive traits have been repeatedly shown to be associated with healthy biomarker levels and greater longevity.

A positive trait that is as ancient as humanity but is relatively new to empirical research is wisdom. Since the 1970s, scientific literature on wisdom has been growing progressively. A complex trait that includes self-reflection, emotional regulation, prosocial behaviors like compassion and altruism, decisiveness amid uncertainty, and spirituality, wisdom seems to have evolutionary roots. The postulated wisdom neurocircuitry involves prefrontal cortex and limbic striatum. We have found a significant inverse correlation between wisdom and loneliness, suggesting a possible means of reducing loneliness, a modern epidemic. Wisdom has also been shown to be associated with well-being, life satisfaction, and physical and cognitive function. One investigation included a three-dimensional wisdom scale (with cognitive, affective, and reflective dimensions) completed by adult outpatients with chronic psychotic disorders. Reflective wisdom, representing personal insight and ability to engage in perspective taking, was positively correlated with mental health in people with schizophrenia and schizoaffective disorder. Patients who scored higher on the wisdom scale had better overall functioning than those with lower wisdom scores.

In the discussion below, for the sake of brevity and avoidance of redundancy, I have used the term positive psychiatry as encompassing all the three themes of this book. The principles underlying positive psychiatry are that there is no health without mental health and that mental health can be improved through preventive, therapeutic, and rehabilitative interventions to augment positive psychosocial factors. Positive psychiatry is not a naïve, feel-good pseudoscience that views the world through rose-colored glasses. Rather, it is an evidence-based approach to understanding normal behavior as well as psychopathology and to improving well-being by evaluating and enhancing positive psychosocial factors in people with and without psychiatric or physical illnesses and disabilities.

Positive traits and positive outcomes are measurable. It is worth stressing that both researchers and clinicians already have access to a large armamentarium of self-report inventories with excellent psychometric properties as

well as a few objective measures that can be used in their research participants and patients. Self-report scales or inventories are sometimes criticized as lacking in reliability and validity. However, it should be noted that for evaluating internal states like happiness, well-being, and subjective recovery, there are no valid objective measures. These constructs are inherently tied to an individual's introspective feelings rather than an external biological or historical proxy. For instance, should we determine someone's level of happiness by collecting cerebrospinal fluid and measuring biomarkers of pathology or by simply asking that individual about her or his current inner experiences? The answer is obvious.

While serious mental illnesses are typically thought to have poor prognosis, there are subsets of patients who experience recovery or sustained remission. There have been several impactful qualitative investigations of coping strategies that facilitate such a positive outcome. Compared to closed-ended multiple-choice inventories, this approach confers much more flexibility and autonomy to the participants in the disclosure of their subjective experiences. In one study, we interviewed older adults with schizophrenia about the longitudinal course of their symptom expression and their overall quality of life and wellness. Most participants endorsed trouble managing the initial symptom onset, leading to confusion and interpersonal isolation. However, a majority of these people bounced back later in life due to improved coping techniques, resulting in reduced levels of symptoms and much higher levels of functioning. Similarly, a study from the UCLA involved interviews of people with schizophrenia who had achieved a high degree of occupational attainment despite their illness. These individuals reported employment of several successful coping strategies including maintaining a routine, cultivating spirituality, using recovery-oriented language, and focusing energy on school and work. These are real-life examples of positive psychiatry in practice!

Psychiatry, as a branch of medicine, is biologically based. The same applies to positive psychiatry too. Empirical evidence supports links between measures of positive psychiatry and biomarkers including allostatic load, telomere length, inflammation, and specific genes, although the literature on the impact of these factors in seriously mentally ill people is sparse. Children and adults with higher perceived self-efficacy, optimism, empathy, spirituality, and engagement with pleasant activities have less systemic inflammation (e.g., lower levels of pro-inflammatory cytokines interleukin-6 and C-reactive protein).

It is not surprising that people with serious mental illnesses tend to have lower levels of positive psychosocial factors possibly due to a bidirectional relationship between psychosocial adversity and psychopathology. Yet, several studies in recent years have demonstrated that these positive factors may serve to neutralize the adverse impact of negative psychosocial factors in these patients.

One of our studies measured the level of happiness in outpatients with chronic schizophrenia and healthy comparison participants. Although the healthy group had (as expected) higher mean scores on the happiness scale compared to the schizophrenia group, the latter showed considerable variability in happiness. Notably, the level of happiness was negatively cor-

related with perceived stress and positively associated with other positive traits like resilience, optimism, and personal mastery. Another research project assessed the degree of resilience and mental and physical health in people with schizophrenia and healthy comparison participants. We also retrospectively measured childhood emotional abuse/neglect, physical abuse/neglect, and sexual abuse using a well-validated scale. The most notable result was that, among people with a history of childhood adversity, resilience during adult life seemed to protect against the negative mental and physical health effects of childhood abuse and trauma. In contrast to those who were low in resilience, participants who had high levels of resilience displayed better mental and physical health as well as healthier levels of metabolic biomarkers than persons with low levels of resilience, despite similar histories of childhood adversity. This suggests that resilience serves as a buffer against early and severe psychosocial stress in schizophrenia.

Other researchers have reported similar findings. One group recorded suicidal ideation, hopelessness, and positive self-appraisals in individuals with psychotic disorders. Statistical analyses revealed that positive self-appraisals moderated the relationship between hopelessness (a predictor of self-harm) and suicidal ideation such that the patients who were high in hopelessness but who also possessed positive self-appraisals were significantly less likely to endorse suicidal ideation. Another group of investigators measured subjective recovery – or perceptions and inner experiences related to meaning-making in the face of psychiatric illness – as well as clinical symptoms and quality of life in veterans with psychotic disorders. The subjective recovery seemed to mitigate the deleterious impact of positive psychotic symptoms on quality of life such that participants with high degrees of subjective recovery were nevertheless able to attain high levels of experiential and external quality of life.

All these studies suggest that the enhancement of positive traits capable of overcoming the negative factors and enabling positive outcomes should be a top priority in future research and clinical interventions in psychiatry. Fortunately, the literature on positive interventions has been growing. Mindfulness interventions have been shown to improve the body's physiological response to stress by promoting acceptance and nonreactivity toward potential stressors, thereby facilitating constructive reframing. Neuroimaging studies suggest that mindfulness enhances neurocircuitry associated with increased empathy and emotional processing. Although there has been some historical concern about the possibility of meditation leading to symptom exacerbation (and potentially even an acute psychotic episode) in schizophrenia, recent studies show moderate positive effects of mindfulness interventions on negative symptoms in schizophrenia.

Self-compassion meditation training has wide-ranging positive effects including reducing anxiety and improving physiological responses to social stressors. Compassion mediation has also been reported to decrease social stress-induced inflammation. Increased spirituality is associated with improved decreased risk for depression and some other mental disorders and increased purpose in life, gratitude, and posttraumatic growth. Some data suggest that spirituality and religiosity can be protective in people with schizophrenia.

An important caveat to the theory and practice of positive psychiatry and positive psychology is there can be "too much of a good thing." The relationship between several psychological traits and overall functioning or well-being exists in a nonmonotonic inverted U shape – i.e., enhancing these characteristics leads to functional improvements until a threshold is reached (the middle of the inverted U), at which point, continued increases can have adverse consequences. For example, excessive optimism can precipitate risky medical- and health-related choices, ultimately leading to negative outcomes. Similarly, extreme happiness has been associated with a lack of attention to prophylactic health behaviors, leading to increased morbidity, traumatic injuries, and even mortality. However, most individuals with serious mental illnesses are likely to have lower rather than higher levels of positive factors, including optimism, resilience, and happiness, compared to people without these disorders. Consequently, enhancing these traits is important for a majority of people with mental illnesses.

The future of psychiatry is positive psychiatry. Rising costs and challenges such as obesity, opioid epidemics, and increasing suicides have overextended the healthcare system and shortened the average life span in the United States during the last 3 years. In response to this changing scenario, preventative medicine may be the most powerful and cost-reducing method for maximizing quality of life in the general population. A focus on enhancing overall wellness, and positive psychosocial factors in particular, is necessary as optimal degrees of positive traits can buffer against the negative impact of mental or physical disorders and disabilities.

Positive psychiatry has the potential to revolutionize the assessment and treatment of people suffering from psychopathology, particularly those afflicted with severe mental illnesses. There already exist a wide array of psychometrically sound instruments to measure the core facets of positive psychiatry – positive traits and outcomes. Moreover, cognition is closely tied to functional outcomes in schizophrenia, and there are empirically supported interventions for enhancing cognition in this population. Finally, research in successful aging strongly suggests the potential for enhancement of positive traits even in older adults, mediated by continued neuroplasticity.

There is an urgent need for promoting further research in positive psychiatry. On the clinical side too, assessment of symptoms and functional impairment needs to be complemented by evaluation of positive psychosocial factors. To bring about an effective change in psychiatric practice, we need development of a training and administrative infrastructure to support positive psychiatry assessments and interventions. The future of positive psychiatry is bright as the field of psychiatry slowly but surely embraces its theory and practice. This superbly written book of international significance will help accelerate the forward progress of the field of positive mental health.

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Preface/Introduction by the Editors

Nothing is as strong as an idea whose time has come.
—Victor Hugo (French poet of the nineteenth century)

The Challenges and Promises of a Global Textbook

Despite the growing integration created by global communication networks, much of human activity remains locked within national or language borders. This isolation allows for the creation of islands where the lessons learned by one group of people are not transmitted to other groups sometimes facing the same problems. Thus, solved problems in one land remain haunting other islands, and instead of heaping the benefits of living in one continent of human civilization, we continue to linger in the archipelago of tribes and parochial resentment.

This book is an attempt to build bridges linking three islands: positive psychology, positive psychotherapy, and positive psychiatry. This connection is needed because these efforts aim to reach similar goals through different means, namely, to help people achieve their highest potential, find meaning in life, and be happy.

This impulse to help human beings achieve their full potential, overcome their darkest instincts, and achieve happiness is not new. In fact, in founding history, Herodotus (c. 484–425/413 BCE) talks about the encounter between the Greek sage, Solon, and the king of Lydia, Croesus, as revolving around the question "who is the most happy?" (1). Different religious traditions also aim at providing guidance on that fundamental question. Finally, philosophers tackled the question, with Aristotle writing his *Nicomachean Ethics* on the very question of happiness (2). These seeds gave us the roots of positive psychology, which as a contemporary effort emerged as Martin Seligman's legacy when president of the American Psychological Association (3).

One branch of the positive mental health tree, however, is older than the tree, that is, positive psychotherapy. The idea of focusing on the capacities not on the symptoms, on the future not on the past, and on balance not on imbalance started in Germany in the late 1960s with psychiatrist and psychotherapist Nossrat Peseschkian. From his psychotherapeutic work, there emerges a positive psychotherapy model (4) that is now organized by the World Association for Positive and Transcultural Psychotherapy (WAPP) in over 25 countries (5).

The budding fruit of this tree is positive psychiatry. As a branch of medicine, psychiatry has traditionally been associated with diagnosis and treatment. With the evolution of medicine, more and more attention has been given to prevention and wellness. So, it is in psychiatry. That's why psychiatrists need a positive psychiatry model and why this model is informed by the theory of positive psychology and the practice of positive psychotherapy. As of the writing of this book, positive psychiatry itself is less than a decade old having had its launch at Dilip Jeste's charge as the president of the American Psychiatric Association (6).

This book provides a clear and visible link through these three traditions: Seligman's psychology, Peseschkian's psychotherapy, and Jeste's psychiatry. In that sense, it is in itself a transcultural effort. This transcultural nature is emphasized by the authors themselves: they come from 13 countries in 5 continents. The effort to edit and revise these chapters was not intent to erase their respective cultural accents. So, we ask the reader to understand that this is a global effort, so at times, one will hear a strong Slavic accent and at times a soft Polish whisper. These accents speak of the varieties of the human experience in the world today. This book should be read like a large family reunion on a planetary scale. We see these relatives we have only heard about, we meet someone we have not seen in years, yet we know we all belong to one human family, striving in this lonely planet to survive, flourish, and be happy. And we can only do so if we help and support each other in the process.

Overview of the Structure

The book is divided into five parts.

Part 1: Basic Concepts, Background, and History provides a short introduction to each separate approach: positive psychiatry, positive psychotherapy, and positive psychology. Here, the groundwork for each tradition is laid out, and a short history about how the ideas came together is presented.

Part 2: Staying Positive Through Life includes five chapters on positive interventions and approaches for well-being, from child and adolescents to the midlife crisis, to well-being at work, and to successful aging; this part closes with a chapter on applying Peseschkian's balance model to move from work-life balance to life balance.

Part 3: Psychiatric and Psychosomatic Disorders contains eight chapters, each centering on a psychiatric diagnostic category: depression, anxiety, schizophrenia, substance use, eating disorders, posttraumatic stress disorder, psychosomatic illness, and disorders usually first diagnosed in infancy or adolescence.

Part 4: Special Settings and Populations includes eight chapters with the application of positive psychology and psychotherapy in a variety of settings and to different populations. Examples of these settings include family and couples' therapy, pedagogy, organizations, and group therapy. Special populations include minorities, athletes, and psychotherapeutic work with men.

Part 5: Theoretical Foundations and Training includes ten chapters on the theoretical basis of positive psychotherapy, its training, and special

characteristics, such as its roots and foundations, the first interview in PPT, the conflict model, the use of stories and humor, supervision, spirituality, existentialism, its relation to other methods, meaning in life, and positive interpretations.

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Acknowledgments

It took more than 3 years from the conception until the "birth" of this textbook. It was quite a challenge that required a plethora of expertise and dedicated authors.

Preparing a book with 34 chapters by 48 authors from 13 countries and 5 continents, as in this *global textbook*, requires teamwork, cooperation, and perseverance. First and foremost, we are indebted to the many authors who contributed their expertise and time to writing original and innovative chapters for no financial reward. It is the collective work of many individual authors that have brought this comprehensive *global textbook* into fruition.

We also want to acknowledge three professors who were instrumental in inspiring and motivating us before and throughout the process.

Professor Shridhar Sharma, one of the fathers of psychiatry and psychotherapy in India, established the first contacts with other colleagues during the 2016 Annual Meeting of the American Psychiatric Association (APA) in Atlanta, Georgia. This resulted in the first joint symposium on "Positive Psychiatry, Positive Psychotherapy, and Positive Psychology" ever held in 2017.

Professor Dilip Jeste, the founder of positive psychiatry, supported the idea of this book from the very beginning and agreed to write the Foreword to this book. We are most grateful to him for that and also for chairing the above mentioned symposium.

Professor Rama Rao Gogineni, from Cooper Medical School of Rowan University/Cooper University Hospital, was immediately excited about this project and introduced the idea of this book to Springer Publishers and assisted the editors in finding some of the authors.

Finally, we also want to acknowledge the strong support we received from the publisher, Ms. Nadina Persaud, editor, *Clinical Medicine*, and Mr. Prakash Jagannathan, project coordinator (Books). Without their strong and continuous support, and their patience, this book would have not seen the light of the day. Despite the challenges of different time zones and authors from different cultural and language backgrounds, they kept the train on the track.

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Part I

Basic Concepts, Background, and History

This part *Basic Concepts, Background, and History* includes three chapters.

In the first chapter, Positive Psychiatry is defined as the application of Positive Psychology principles and tools, which include Positive Psychotherapy, to those with mental disorders or at risk of developing them and examples of how it applies to schizophrenia, depression, and posttraumatic stress disorder are given.

The second chapter encompasses the history of Positive Psychotherapy (PPT) as developed by Nossrat Peseschkian in Germany since the early 1970s and the main characteristics of its theory and practice. PPT is a transcultural psychodynamic approach based a positive image of human beings and working to restore balance to their lives. The PPT practice is structured in a five-stage process starting with "acceptance, observation and distancing" and concluding with "broadening of the goals."

The third chapter defines and articulates the current field of Positive Psychology based on the work of Martin Seligman and others. Here the elements of the PERMA model – Positive Emotion, Engagement, Relationships, Meaning, and Accomplishment – are articulated as the basis of the Positive Psychology approach.

Positive Psychiatry: An Introduction

1

Erick Messias

Introduction

Mental disorders are among the leading causes of disability worldwide [1]. Those millions of people living with mental disorders want more than finding a medication to alleviate their symptoms; they want to flourish and find satisfaction and happiness, like all human beings. For its first 200 years, the medical specialty of psychiatry has focus on the first goal of symptom control with significant successes along the way [2]. With the evolution of medicine and psychology, preventive and health-enhancing interventions are expected to be developed and implemented to go beyond treating disease and toward maintain health and well-being. The same is happening in psychiatry with the development of Positive Psychiatry combining the tools of positive psychotherapy and the theoretical framework of positive psychology.

While psychologist Martin Seligman's 1998 presidential address for the American Psychological Association is known for launching the modern positive psychology movement [3], psychiatrist Dilip Jeste's 2012 presidential address to the American Psychiatric Association did the same to Positive Psychiatry [4]. In Jeste's address he urged psychiatry to aim beyond managing symptoms and identifying psychopathology to create tools that will help "patients grow, flourish, develop, and be more satisfied with their lives". These factors overlap significantly with those cited by Seligman 14 years before that included: optimism, courage, work ethic, future-mindedness, interpersonal skill, the capacity for pleasure and insight, and social responsibility.

A third contribution in the development of these approaches preceded these initiatives by a few decades, when positive psychotherapy was proposed by psychiatrist Nossrat Peseschkian as a "new treatment for psychiatric and psychosomatic illnesses" in Germany [5].

These three sources may be articulated in a more concise definition of *Positive Psychiatry as the application of Positive Psychology principles and tools, which include Positive Psychotherapy, to those with mental disorders or at risk of developing them*.

Definitions

Positive Psychiatry can also be described as the science and practice of psychiatry seeking to understand and promote well-being, through assessments and interventions aimed at enhancing Positive Psychosocial Factors (PPSFs) among those who have, or are at risk of developing mental or physical illnesses [6]. PPSFs include

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Table 1.1 Contrasting clinical and positive psychiatry perspectives

	Clinical psychiatry	Positive Psychiatry
Target population	Those with mental disorders and behavioral symptoms	Those with, and at risk for, mental disorders
Immediate goals	Cure, management of symptoms, and return to baseline functioning	Improvement above baseline level of functioning
Long-term goals	Relapse prevention	Recovery in mental illness
Treatment approaches	Psychotherapy and psychopharmacology	Positive psychotherapy, executive coaching
Focus of attention	Symptoms, dysfunctions	Strengths, capabilities, talent
Theoretical foundation	Psychopathology and phenomenology	Positive psychology and resilience

psychological traits and environmental factors – see below. *Positive Psychiatry has four main goals*: achievement of positive mental health outcomes, fostering PPSF, study of biological factors underpinning positive mental health, and development of positive psychiatry interventions [6]. These definitions of Positive Psychiatry contrast with the classic definition of the specialty, in which clinical psychiatry has been focused on symptoms, disability, diagnosis, and treatment – see Table 1.1. Looking through a lifespan perspective, clinical and positive psychiatry offer different approaches addressing different issues and problems – see Table 1.2.

Positive Psychosocial Factors (PPSFs) include psychological traits and environmental factors that mediate positive outcomes such as well-being, growth, and flourishing. The work of Seligman and Petersen validated a group of six virtues containing a total of 24 character strengths [7]. Their research looked into virtue traditions throughout history including Confucian, Taoist, Buddhist, Hindu, Athenian, Judeo-Christian, and Islamic cultures. The resulting list of six major virtues includes: wisdom, courage, humanity, justice, temperance, and transcendence. The character strengths components of each virtue are listed in Table 1.3. In order to be included in this list, a character strength had to fulfill the majority of the following criteria:

- Criterion 1: a strength contributes to various fulfillment that constitute the good life, for oneself and for others. Although the strengths and virtues determine how an individual cope with adversity, the focus is on how they fulfill an individual.

Table 1.2 Contrasting clinical and positive psychiatry across the lifespan

	Clinical psychiatry	Positive Psychiatry
Children	Reducing disruptive behaviors	Enhancing learning and development
Teenagers	Early detection of symptoms and early intervention	Promoting healthy coping skills and growth
Young adults	Relapse prevention and return to baseline functioning	Career development, promoting social engagement
Mid life	Maintenance of baseline, independent living skills	Overcoming baseline, achieving full potential
Elderly	Early detection and intervention, symptom management	Successful aging strategies

- Criterion 2: although the strengths can and do produce desirable outcomes, each strength is morally valiant in his all right, even in the absence of obvious beneficial outcomes.
- Criterion 3: the display of strength by one person does not diminish other people in the vicinity.
- Criterion 4: being able to phrase the opposite of a punitive strength in a felicitous way counts against regarding it as a character strength.
- Criterion 5: a strength needs to be manifest in the range of an individual's behavior, including his or her thoughts, feelings, actions, and such a way that it can be assessed. It should be trait-like in the sense of having a degree of

Table 1.3 Virtues and their components according to Peterson and Seligman

Virtue	Character strengths components	Definition
Wisdom	Creativity	Thinking of novel and productive ways to conceptualize and do things
	Curiosity	Taking an interest in an ongoing experience for its own sake
	Open-mindedness	Thinking through and examining things from all sides
	Love of learning	Having positive feelings about acquiring skills, satisfying curiosity, building on existing knowledge, and learning something new
	Perspective	Having ways of looking at the world that makes sense to oneself and to other people
Courage	Bravery	Not shrinking from threat, challenge, and difficulty
	Persistence	Capacity to stay the course despite obstacles
	Integrity	The quality of being honest and having strong moral principles
	Vitality	The state of being strong, energetic, and active
Humanity	Love	A great interest and pleasure in something
	Kindness	The quality of being friendly, generous, and considerate
	Social intelligence	Being aware of motives and feelings of other people and oneself
Justice	Citizenship	Working well as a member of a group or team
	Fairness	Impartial and just treatment or behavior without favoritism or discrimination
	Leadership	Organizing group activities and seen that they happen
Temperance	Forgiveness	Ability to stop feeling angry or resentful toward someone for an offense, flaw, or mistake
	Humility	Ability to acknowledge one's mistakes, imperfections, gaps in knowledge, and limitations
	Prudence	Cognitive orientation to the future in taking the form of practical reasoning and self-management
	Self-regulation	Optimal control over one's own thoughts, emotions, behaviors, and impulses
Transcendence	Appreciation of beauty	Ability to find, recognize, and take pleasure in the existence of goodness in the world
	Gratitude	Sense of thankfulness and joy in response to a gift or experience
	Hope	Positive cognitive and emotional stance towards the future
	Humor	Playful recognition and enjoyment of incongruity, including views on adversity, that leads to the ability to make others smile
	Spirituality	Beliefs and practices that recognize a transcendent – beyond ones' existence - dimension in life

generality across situations and stability across time.

- Criterion 6: the strength is distinct from other positive traits in the classification and cannot be decomposed into them.
- Criterion 7: a character strength is embodied in consensual paragons.
- Criterion 8: there exist prodigies with respect to this strength.
- Criterion 9: there are people who show the total absence of a given strength.
- Criterion 10: the larger society provides institutions and associated rituals cultivating strengths and virtues and then for sustaining their practice.

Other positive psychological traits include resilience, optimism, personal mastery and coping self-efficacy, and social engagement [6].

Positive Translation of the conventional illness terminology has been proposed as a way to reframe disease and symptoms from deficits into

capacities [8]. *Depression* can be positively translated from "feeling of being despondent, with a prevailing passive attitude" to "ability to react to conflict with deep emotion". *Mania* can be interpreted not as "a mental illness" but also as "capacity to see the glass half-full, to experience one as powerful, and to disregard the minutia of life". *Existential anxiety* moves from being "fear of the future" to being the "ability to prepare for the future and not give in the illusion of security" [8]. These interpretations are not necessarily more realistic but are ways to expand the view and experience of illness beyond a mere reductive dysfunction and handicap. This process of translation can also help link mental disorders to specific virtues or strengths of character.

Translating Mental Disorders to Strengths of Character

Mental disorders are associated with specific strengths of character and this association holds promises of ways to translate these disease states into more positive capacities. Patients with Bipolar Disorder, for examples, have been known for their creativity and originality; patients with obsessive traits and symptoms are known for integrity and honesty; patients with depression can show prudence and humility; and finally persons dealing with mental disorders in general display significant elements of courage, like persistence and bravery, in facing their challenges and following up with treatment.

Recovery in Mental Illness has been defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" [9]. There are *four dimensions* that support life in recovery:

- Health – managing symptoms and diseases;
- Home, a stable and safe place to live;
- Purpose, daily activities that provide meaning and independence; and,
- Community, relationships, and social networks that provide support, friendship, love, and hope.

The ten guiding principles of recovery, as delineated by the Substance Abuse and Mental Health Services Administration (SAMHSA), are as follows:

1. Recovery emerges from hope.
2. Recovery is person-driven.
3. Recovery occurs via many pathways.
4. Recovery is holistic.
5. Recovery is supported by peers and allies.
6. Recovery is supported through relationship and social networks.
7. Recovery is culturally-based and influenced.
8. Recovery is supported by addressing trauma.
9. Recovery involves individuals, family, and community strengths and responsibilities.
10. Recovery is based on respect.

Resilience is defined by the American Psychological Association (APA) as the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress – such as family and relationship problems, serious health problems or workplace and financial stressors. It means "bouncing back" from difficult experiences. Since having a mental disorder is one significant source of stress, the positive psychiatry perspective works to enhance and foster that trait. Among the ways to build resilience are: making connections, accepting change as part of living, taking action, using opportunities for self-discovery, and keeping things in perspective. Mental health promotion and human flourishing become then a natural outcome of resilience education and training [10].

Historical Background

Religious texts that are foundational to several civilizations contain the seeds of positive psychological traits and ways to foster them. As stated above, there is overlap on these traits across traditions and they form the basis of a universal theory of human strengths. At the source of Western – European-based – civilizations, in the works of Plato and Aristotle one finds extensive discussion on these virtues and

character strengths. In his monumental classificatory effort, Aristotle organized not only biological specimens but also worked on a theory of virtues.

Aristotle's Nicomachean Ethics

Through the ten books composing the *Nicomachean Ethics*, Aristotle builds his theory of virtues around the doctrine of the mean. In it, virtues occupy the space between extremes of behavior in that courage stands between cowardice and recklessness, confidence between timidity and arrogance, generosity between miserliness and vulgarity and so on. With the fall of the Roman Empire, Aristotle's manuscripts were preserved in libraries through the Middle East, and returned to Europe in the 1200's when they were assimilated in Catholic theology by the hands of Thomas Aquinas.

With the development of clinical psychiatry in 1800's Europe most of its intellectual effort was dedicated to delineating conditions, establishing its border with neurology, and developing therapeutic interventions. In the mid 1900's American psychologist Abraham Maslow started a program to develop a theory of motivation initially based on five sets of goals in a hierarchy of needs [11]. Those five needs were: physiological, safety, love, esteem, and self-actualization. Maslow's work originated interest in human potential and motivation leading to interest in Creativity and Flow, as framed by Mihaly Csikszentmihalyi, the proposal of positive psychotherapy (PPT) by Nossrat Peseschkian, and eventually to Martin Seligman's push for the development of Positive Psychology.

Applications of Positive Psychiatry: First Episode Psychosis

Several principles and tools from positive psychiatry were used in the Early Treatment Program (ETP) study, part of the National Institute of Mental Health's (NIMH) Recovery After an Initial Schizophrenia Episode (RAISE) initiative. RAISE aimed to develop, test, and implement person-centered, integrated treatment approaches for first-episode psychosis that promote symptomatic and functional recovery. In line with these objectives, RAISE-ETP developed a comprehensive recovery-oriented, evidence-based intervention for first-episode psychosis that has been shown to be effective and statistically better than standard community-based treatment [12]. The full manual for the Individual Resilience Training (IRT) modules is available at http://navigateconsultants.org/materials/

In summary, IRT involves weekly, or biweekly, structured sessions lasting between 45 and 60 minutes. The standard modules take 4–6 months to complete followed by individualized modules – both sets including sessions on resilience development. Among the individualized modules there are sessions specifically focused on "having fun", "connecting with people", and "improving relationships." A key message in the IRT process is that *recovery is possible in psychosis and that many persons with psychotic disorders live happy and productive lives*.

These applications of positive interventions in First Episode Psychosis corroborate the use of such perspective in what's traditionally known "severe mental illness", or SMI, and will be further explored in the chapter on schizophrenia.

Applications of Positive Psychiatry: Post-traumatic Stress Disorder

The positive perspective and translation of post-trauma reaction beyond trauma to growth has been a key contribution in the development of positive psychiatry. Studies with military population have confirmed that negative response to trauma, in particular Post-Traumatic Stress Disorder (PTSD), are not the only possible outcome and that promoting post-traumatic growth may be beneficial for well-being, both in military populations [13] as well as civilians [14]. These elements will be further developed in the chapter on Trauma.

Applications of Positive Psychiatry: Depression and Anxiety

Positive interventions, including gratitude, acts of kindness, and optimism, have been shown to decrease negative affect, anxiety, and depressive symptoms in persons showing clinically impairing symptoms [15]. These interventions appear to have potential to not only decrease depressive and anxiety symptoms but also to increase well-being in clinical populations [16]. Finally, a meta-analysis of 51 positive psychology interventions concluded that they both enhance well-being and also decrease depressive symptoms [17] Specific application of positive interventions in depression and anxiety are discussed in their respective chapters.

Future Directions in Research in Positive Psychiatry

Research in Positive Psychiatry will mirror and expand the research portfolio in neurosciences. As such, the biological underpinnings, including genetics and neuroimaging, of positive psychological traits among those with mental disorder remain to be delineated. Initial efforts in understanding the neurobiology of wisdom show great promise in that approach [18]. The role of positive environment and social support in buffering life changes and disease stages also remains to be determined [19].

The study of effectiveness of positive interventions for specific diagnostic groups will also be needed, with calls for their application to those with psychotic disorders [20] and depression [21] already on the way. The expansion of positive interventions toward addressing physical health needs and conditions is another area where research is active and promising [22].

Finally, applications of Positive Psychiatry principles in the prevention and early detection of mental disorders is a future step of this process, when we move from individual-based interventions toward populational health promotion.

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Positive Psychotherapy: An Introduction

2

Hamid Peseschkian and Arno Remmers

Introduction and Summary

> Give a Man a Fish, and You Feed Him for a Day. Teach a Man to Fish, and He Will Feed Himself for a Lifetime.

Positive Psychotherapy (PPT)[1] is a form of *humanistic psychodynamic psychotherapy* developed by Nossrat Peseschkian (1933–2010) during the 1970s and 1980s [28, 29, 34] (Peseschkian 1991). This method integrates approaches from the main modalities of psychotherapy: a humanistic conception of human beings and therapeutic alliance; a psychodynamic understanding of disorders; a systemic approach toward culture, work and environment; and a practical, self-help and goal-oriented five-step process of therapy in which techniques of different other methods can be integrated. As a conflict-centered and resource-oriented short-term psychotherapy method, it is based on transcultural observations in more than 20 cultures, which subsequently led to its development.

From the beginning, the *intention* of Nossrat Peseschkian was *twofold*: to develop an understandable, easily applicable, conflict-centered short-term therapy that professionals (psychotherapists, physicians, and psychologists) could use in their daily clinical work, to make psychotherapeutic and psychosomatic concepts accessible to interested laypersons, and at the same time provide them with instruments for self-help. Stimulated by his own transcultural life situation (Iran – Germany), Peseschkian was inspired to develop a method that could be applied without distinctions of culture or class.

Positive Psychotherapy pursues *several goals and can be applied in the following areas*:

- Psychotherapy and treatment of psychosomatic and mental disorders (therapeutic approach).
- Counseling, prevention and education (preventive-pedagogic approach).
- Promotion of transcultural understanding (transcultural-societal approach).
- Cooperation and integration of different therapeutic methods (interdisciplinary approach).

The term "positive" in Positive Psychotherapy means that the aim of this therapy is not primarily

[1]Positive Psychotherapy (PPT after Peseschkian, since 1977) is a registered trademark in the European Union (registration no. 014512578 and 014512537). Registrations in the United States of America (registration no. 1343592) and Canada (registration no. 1748288) are being processed.

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to eliminate an existing disturbance but rather to try at the outset to mobilize existing capacities and the potential for self-help. Rather than with the disturbance, PPT begins with the possibilities for development and the capacities of the people involved (Peseschkian [34], pp. 1–7), following Maslow [17] who first used the term "positive psychology",[2] as he saw "...the importance of focusing on the positive qualities in people, as opposed to treating them as a 'bag of symptoms'" [8] in humanistic psychology. Symptoms and disorders are seen by Peseschkian as a capacity to react to conflicts and the therapy is called "positive" because it proceeds from the concept of the wholeness of the persons involved as a given. The pathogenesis of illness, conflict, deficit, and suffering is part of that wholeness as well as the salutogenesis with the joys, capacities, resources, potentials, and possibilities of those involved (Jork and Peseschkian [11], p. 13).

Here, the term "positive" is to be understood in the sense of the "positive sciences" (based on Max Weber, 1988) as the judgment-free description of that which is observed. The Latin term "positum" or "positivus" is derived from the Latin "ponere," meaning "to place, put, lay down" (Merriam-Webster Online). Nossrat Peseschkian uses the above-mentioned term "positum" in a broader sense as an expression of that which is available, the given, the actual. This positive meaning confronts the patient (and the therapist) with a lesser-known aspect of the illness, but one that is just as important for the understanding and clinical treatment of the affliction: the function of the illness, its meaning, and consequently a connotation as given and positive aspects [35].

Based on a positive image of human beings, *the concept of "capacity"*[3] runs throughout this method, such as viewing an illness as the expression of the capacity to react to a conflict, for example, as the capacity to be unique; as the capacity either to return to health or to be overcome by this illness; or as the specific capacities that are hidden in the conflict. A feature of this method is that the concepts that are used as well as the explanatory models can be easily understood by all patients.

Positive Psychotherapy fulfills the criteria of both humanistic psychotherapy and psychodynamic psychotherapy. We consider Positive Psychotherapy a psychodynamic method that is based on a humanistic image of humankind. In this sense, the method can be described as a form of *humanistic psychodynamic psychotherapy* (Peseschkian and Remmers [27], p. 13–15).

Brief History of the Origin of Positive Psychotherapy

> During the time that the Prophet Mohammed was born, King Anoshirvan, whom the people also called "The Just," traveled through his kingdom. On a sunny slope, he saw a venerable old man bent over, hard at work. Followed by his courtiers, the king came nearer and saw that the old man was planting year-old seedlings. "What are you doing there?" the king inquired. "I'm planting nut trees," replied the man. The king asked in amazement, "You are already quite old. Why are you planting seedlings when you won't see their foliage, won't rest in their shade, and won't eat their fruit?" The old man looked up and said, "Those who came before us planted, and we were able to harvest. Now we plant so that they who come after us can harvest."
>
> (From Peseschkian [36], p. 151)

The concept of PPT is closely connected to the life history and the personality of its founder Nossrat Peseschkian, an Iranian-born, German-trained neurologist, psychiatrist, and psychotherapist. His biographer referred to him as a "wanderer between two worlds" (Kornbichler and Peseschkian [14], p. 17). It was not without reason that Peseschkian's biography was subtitled, "The East and the West."

Nossrat Peseschkian describes the origins of his method as follows: *"An important motivation*

[2] Nossrat Peseschkian mentions the term 'positive psychology' in his book on Positive Psychotherapy in 1987, p. 389, but not going further.

[3] similar to Kurt Goldstein (1939), who saw self-actualization as "the tendency to actualize, as much as possible, [the organism's] individual capacities"

for the employment of Positive Psychotherapy may have been that I find myself in a transcultural situation. As a Persian (Iranian), I have lived in Europe since 1954. In this situation, it was very clear to me that many forms of behavior, customs and attitudes did not have the same value in the two cultures. This was a discovery that I could already make during my childhood in Tehran. This concerned religious customs above all else, something which I could observe quite clearly. As Bahá'ís, we were always in the middle between our Moslem, Christian and Jewish classmates and teachers. This stimulated me to reflect upon the connections the religions have with one another and the relationships of people to one another. I had experience with the families of my classmates and learned to understand their attitudes as coming from their worldviews and family concepts. Later I was to witness similar confrontations during my medical specialization showing how tense the relationship was between psychiatric, neurological and psychotherapeutic positions and with what vehemence the psychiatrists and psychotherapists collided with one another. I learned that these prejudices must be discarded. This way I could also feel comfortable in the West. The equality of men and women, for example, was and still is a given for me" (Kornbichler and Peseschkian [14], pp. 62–63 [translated by the authors from the German original]).

The origin of PPT traces back to the development of humanistic psychology and psychotherapy, pioneered by Kurt Goldstein, Abraham Maslow and Carl Rogers. Personal encounters with leading psychotherapists, such as the psychoanalyst Heinrich Meng (Switzerland), Viktor Frankl (Austria) and his existential psychology or Logotherapy, Jacob Levi Moreno (United States) as the founder of group therapy and psychodrama, and training experiences with some of them left a lasting impression on Nossrat Peseschkian. As for the quarrels between the various schools and methods, Nossrat Peseschkian describes his observations in Germany, where psychoanalysts and behavior therapists sometimes even refused to have lunch together. Additionally, the strong prevailing influence of psychoanalysis and its Neo-Freudian, psychosomatic and focus orientated (Balint) developments at that time also made an impression on Nossrat Peseschkian. He hoped to construct a metatheory that would be a bridge between these methods.

At the same time, some principles of the Bahá'í Faith, such as the harmony between science and religion, the Bahá'í image of human beings as *"a mine rich in gems of inestimable value"* (Bahá'u'lláh [2], CXXII, pp. 259–260), and the vision of a global society, fascinated and inspired Nossrat Peseschkian throughout his life. Continuing medical education; experience with patients in a psychotherapeutic and psychosomatic practice; contacts with people from different cultures, religions, and value systems; and the diversity and heterogeneity of the methods of psychotherapy were the sources of what gradually developed as "Differentiation Analysis" from 1969 on, presented at conferences, into Positive Psychotherapy in 1977.

The title of the first book "Psychotherapy of Everyday Life" [31] (in 1974), and of the book "In Search of Meaning" [32] (in 1983) show the influence of psychoanalysis and the existential schools of psychotherapy on the development of Positive Psychotherapy,[4] and the title "Positive Family Therapy" (in 1980) shows the common development with systemic family therapy in the 1970s. There are 29 books and hundreds of articles on this method by the founder himself.

Main Characteristics of Positive Psychotherapy

The application of PPT as a form of integrative, transcultural, and humanistic psychodynamic psychotherapy will be explained in the following chapters of this book. The main principles and characteristics are as follows:

[4] In recent years, some North American authors have published the clinical applications of positive psychology and named it Positive Psychotherapy (Martin E. P. Seligman, Tayyab Rashid, Acacia C. Parks, Positive Psychotherapy. November 2006, American Psychologist, 774–788) [43] .

Positive Psychotherapy as a Metatheory

From the beginning, Nossrat Peseschkian's purpose was first, to develop a method that would be understandable and practicable for patients, and second, to offer PPT as an agent of mediation among the different schools of psychotherapy. In his early book "Positive Psychotherapy" (1977 in German, 1987 in English), he devotes an entire chapter to this challenge: "Positive Psychotherapy and Other Psychotherapies" (pp. 365–400). He often referred to that chapter as the most difficult one in the book and the one that required the most work.

> "Positive Psychotherapy is not to be understood as one method among others. Rather, it offers an instrumentarium by means of which one can select the methodological approaches appropriate in a specific case and how these methods can be alternated. Positive Psychotherapy is thus a metatheory of psychotherapies. We understand psychotherapy to be not just an established method to be applied to certain symptom profiles, but at the same time as a reaction to existing societal, transcultural, and social conditions" (Peseschkian [34], p. 372). "Positive Psychotherapy itself is not to be understood as an exclusive system, but rather attributes a particular value to each of the various psychotherapeutic methods. Thus, psychoanalytic, depth psychological [psychodynamic], behavior therapeutic, group therapeutic, hypnotherapeutic, medicamentous, and physiotherapeutic forms of treatment are considered. Positive Psychotherapy thus represents an integral method, in the sense of a multidimensional therapy" (Peseschkian [34], p. 400).

Nearly 20 years were to pass before Klaus Grawe and his colleagues (Switzerland) published a meta-analysis about the effectivity of the different approaches and founded a general method that would go beyond the schools of psychotherapy [7]. In the United States, Jerome Frank published a scheme for integrated psychotherapy [6], but this plan was also met with controversy and was not accepted. The movements for eclectic and integrative psychotherapy, which have found increasing acceptance since that time, have nonetheless skirted the core goal of theoretical integration and largely settled for the peripheral function of employing techniques from various schools [16, 20]. Today grows an agreement that the common factors and the influence of the therapeutic alliance, empathy, expectations, cultural adaptation, and the person of the therapists are more important than the methods and techniques as such [47].

The Transcultural Approach

The inclusion of a transcultural viewpoint in the everyday work of psychotherapy was not merely a central concern of Nossrat Peseschkian from the very beginning; rather, transcultural questions had a sociopolitical 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"* [34].

The consideration of cultural factors and the unique characteristics of every treatment leads not only to a broadened area of application for PPT but also to its effective use in multicultural societies [25]. PPT has been learned and applied by psychotherapists in more than 60 countries, and it can be understood as a transcultural method of psychotherapy. Consequently, the principles of PPT serve as the basis of the definition and construction of the new scientific discipline of transcultural psychotherapy, particularly important for psychotherapy education, for continuing education and for the recognition and implementation of new disciplines in psychotherapy.

The term "transcultural" in PPT means (a) the consideration of the uniqueness of the patient when the therapist and the patient come from dif-

ferent cultural backgrounds (intercultural psychotherapy, or "migrant psychotherapy"), and (b) the consideration of cultural factors in every therapeutic relationship in the sense of broadening one's own repertoire, as a therapeutic attitude, and consequently a sociopolitical dimension of our thinking and behavior. This consideration of the uniqueness of each person, of the relativity of human behavior and of "unity in diversity" is an essential reason why PPT cannot be characterized as a "Western" method in the sense of "psychological colonization" [19]. Rather, this approach is a culture-sensitive method that can be modified to adapt to a particular culture and life situation. Referring to this assertion of the social dimension of PPT, Nossrat Peseschkian writes:

> When we carry over these considerations into the whole realm of social relationships, including the interrelationships among groups, peoples, nations, and cultural groups, a bold social theory may be developed in accordance with Positive Psychotherapy, a theory which places great emphasis upon both difficulties in interaction and the human capacities as well as upon economic conditions. (Peseschkian [34], p. 7).

In this sense, transcultural psychotherapy must be understood as an all-embracing concept and not merely as a comparison between different cultures. This form of psychotherapy is essentially a matter of the cultural dimensions of human behavior, asking: *How are people different? What do all people have in common?* (Peseschkian [34], p. 4). Furthermore, examples from other cultures are given to the patient to help him or her relativize his or her own perspective and to broaden his or her own repertoire of behavior. In PPT, the use of stories and tales, social norms (actual capacities), and the Balance Model were found to open a transcultural approach toward a transcultural perspective. In 1979, Nossrat Peseschkian used the term "transcultural psychotherapy" to which he dedicated a chapter in his work "The Merchant and the Parrot: Oriental Stories in Positive Psychotherapy": "*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"* (Peseschkian [36], p. 21). He explains further that the principle of transcultural problems thereby becomes the principle of relationships between people and of dealing with inner spiritual conflicts, finally becoming the object of psychotherapy.

The Use of Stories, Tales, Proverbs, and Anecdotes

A special technique of PPT is the therapeutic use of tales, stories, and proverbs, which was introduced in the earliest works of Nossrat Peseschkian, such as "Oriental Stories as Tools in Psychotherapy – The Merchant and the Parrot" (in 1979). The therapeutic effect of surprise produced by these Eastern stories, which at first seem "strange" in European culture, is clearly intended. The use of unfamiliar stories has also proven effective in other cultures.

Because of the models that stories present, they can have *various functions* in therapy (Peseschkian [36], pp. 24–34). On one hand, stories create norms against which readers or listeners can measure themselves; on the other hand, they pointedly call norms into question and invite people to view them as relative. In therapy, these stories can be the means of a change in point of view, which is the goal of the first stage of therapy and is then used in the other stages. Such narratives can free up the feelings and thoughts of the listeners and often are key moments in therapy. The mirror function of storytelling leads to identification. In the narratives, the reader or listener recognizes him or herself as well as his or her needs and situation. He or she can reflect on the stories without personally becoming the focus of these reflections, and he or she can remember his or her own experiences. Stories present solutions that can be models against which one's own approach can be compared but that also leave room for broader interpretation. Storytelling is particularly useful in bringing about change in patients who are holding fast to old and outworn ideas.

The long-term effect of these narratives can also be seen in therapy. Many patients do not react to them at first. The authors have known many people who have come back to a story sometime after they had first reflected upon it, producing a "prolonged effect." Storytelling also aids rational people in regression. Patients recall their unconscious childhood encounters inspired by pictures, fairy tales, and stories. Passed down from one generation to the next, fairy tales and other stories and narratives have always served as transmitters of culture and tradition. Even when repeated many times, stories always acquire a new meaning for each listener. In PPT, the patient is asked about favorite fairy tales and identification with their figures or actions. The answers often give clues regarding the basic concepts or conflicts that are at work.

The stories function as transcultural communication by mirroring the behavior and thinking of people in other cultural circles. The fascination with the foreign causes the person's own rules to be viewed relatively. Some stories have the effect of direct provocation: they present an alternative concept that the patient must come to terms with. Above all, stories belong to the fourth stage, with its conflict-laden verbalization and confrontation. Laughing over a story in therapy changes the view, unties the "neurotic" knots. *"Humor is like salt in the soup of therapy"* (N. Peseschkian, personal communication); it opens up insight and relativizes fixed concepts. In psychodynamic therapy, humor is regarded as one of the most important, effective means of overcoming challenges, even in the most difficult and most tense situations (Mentzos [18], p. 48).

Resistance in therapy can also be understood as a capacity to hold onto the past and to oppose change. Stories and proverbs are among the most effective means of overcoming resistance. The triangle of the patient, the therapist, and the story provide an additional dimension of transference to explore. The characteristic of a psychodynamic method is shown clearly here: stories are aids in association that lead the way to the deeper, unconscious core. Early experiences with stories that were told by the primary educators during the so-called "magic phase" of 3–6 years of age are significant in the understanding of the relationship between good and evil. These experiences build the basis for the development of conscience. The stories contain figures with whom the children can identify and whom they learn to trust, which help them in their own experiences. Children can understand stories told to them by close persons even when their objective understanding is not yet developed.

The Positive Image of Human Beings and the Positive Interpretation of Disorders

The concept of PPT is based on a humanistic conception or image of human beings[5] in which people are essentially good by nature and endowed with many capacities [26]. In PPT, one speaks about the two basic capacities: to love and to know (see Fig. 2.1). Within biological limitations, the development of a person's capacities will, through education, cause him or to develop a unique personality. In this sense, education is a lifelong process of maturation; in such a context, therapy can be viewed as presenting the possibility of further maturation and of broadening the education of the patient and his or her family.

From this positive perspective, illnesses can be seen as a means of developing and managing conflicts in a way that was often learned early in life. Disorders are then understood as one-sided reactions to the dilemma between available concepts and capacities that are insufficient and not yet developed. By broadening the concepts and developing the capacities into abilities, new internal models develop that broaden the former one-sided perceptions, thinking, expectations, and behavior into new possibilities.

Thus, *disorders are interpreted in a positive way*. Depression, for example, can be seen as "the ability to react to conflicts with deep emo-

[5]In German language, there is a very exact word for worldview, philosophy of life, or image or conception of human beings: *Menschenbild*. This concept plays a very important role in philosophy, medicine and psychotherapy.

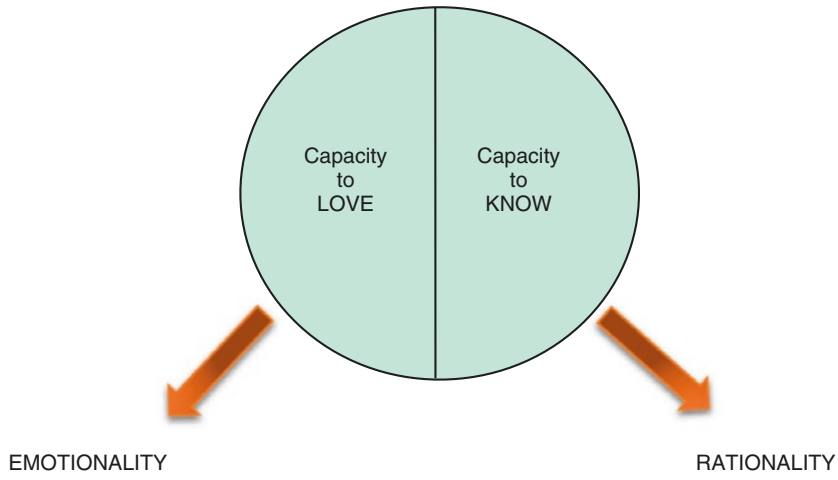

Fig. 2.1 The Basic Capacities in Positive Psychotherapy in their function

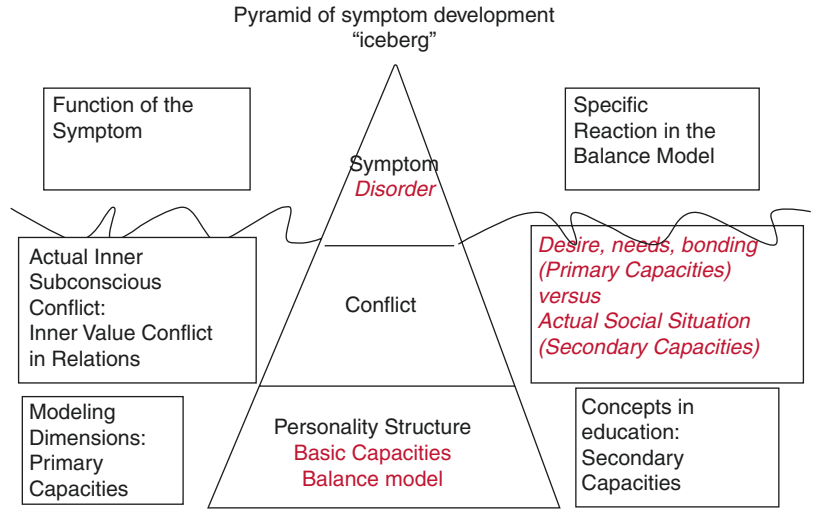

Fig. 2.2 The iceberg concept: from symptom to conflict

tionality"; fear of loneliness is understood as "the desire to be with other people"; alcoholism becomes "the capacity to supply oneself with that warmth (and love) which is not received from others"; psychosis is viewed as "the capacity to live in two worlds at the same time"; and cardiac disorders become "the capacity to take something very close to one's heart" [35].

The positive process brings with it a change in perspective in all those concerned: the patient, his or her family and the therapist/physician. In this way, one moves from the symptom to the conflict (see Fig. 2.2). This process also helps us focus on the "true" patient, who often is not our patient. The patient who comes to us functions as a symptom carrier and can be seen as the "weakest link" in the family chain. The "real patient" is often sitting at home [23]. The positive interpretation of illnesses confronts the patient with the possible function and the psychodynamic meaning of his illness for him- or herself and his or her social milieu, encourages the patient (and his or her family) to see his or her abilities and not merely the pathological aspects.

The Concept of Balance

Based on the humanistic image of human beings and the resources every patient or client brings

with himself or herself, a core concept of PPT is the importance of balance in one's life. Nossrat Peseschkian's concept of the Balance Model (see Fig. 2.3) [33] [other terms being the "four areas, qualities or dimensions of life"] is known as the very core of Positive Psychotherapy and is applied in different settings – clinical and nonclinical.

The Balance Model is based on the concept that there are essentially four areas of life in which a human being lives and functions. These areas influence one's satisfaction in life, one's feelings of self-worth and the way one deals with conflicts and challenges and are the hallmarks of one's personality in the here and now. This model describes and connects the biological-physical, rational-intellectual, socio-emotional and imaginative-spiritual spheres and capacities of human beings in everyday life. Although the potential for all four areas and capacities is present in every human being, some will be especially emphasized and others neglected through differences in education and environment. Life energies, activities, and reactions belong to these four areas of life:

1. Physical activities and perceptions, such as eating, drinking, tenderness, sexuality, sleep, relaxation, sports, appearance, and clothing;
2. Professional achievement and capabilities, such as a trade, household duties, gardening, basic and advanced education, and money management;
3. Relationships and contact styles with partners, family, friends, acquaintances and strangers; social engagements and activities;
4. Future plans; religious/spiritual practices; purpose/meaning; meditation; reflection; death; beliefs; ideas; and development of vision or imagination-fantasy.

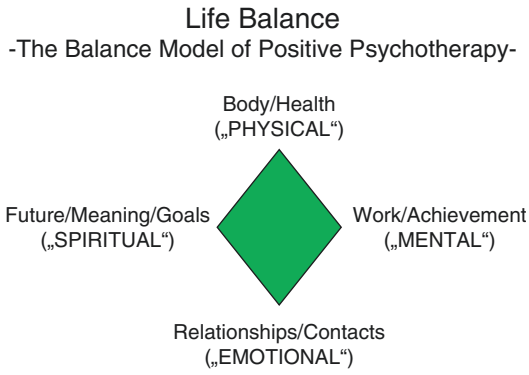

Fig. 2.3 The Balance Model of Positive Psychotherapy

The goal is to recover balance among the four areas. A goal of psychotherapeutic treatment is to help the patient recognize his or her own resources and to mobilize them with the goal of bringing them into a dynamic equilibrium. In particular, this goal places value on a balanced distribution of energy (25% to each area), not of time. One-sidedness that continues for too long can lead to conflicts and illnesses, among other things.

The positive image of humankind becomes particularly obvious when seen in the interpretation of an individual's life balance. Instead of pointing out a deficit to the patient or those close to him or her and advising the patient to lower his or her ambitions, the positive aspects of the one-sidedness are emphasized. The patient is encouraged, and his or her weak feeling of self-worth is strengthened to create a basis for analysis of the areas with the deficits.

For example, a person who places a high value on achievement and so works long hours every day is not confronted at an early stage with the fact that he or she should spend more time with family. At the outset, his or her inclination for achievement and motivation to work are observed and identified as a capacity. This experience is constructive for the patient and is both important and fruitful for building the relationship between the therapist and the patient. At the same time, the focus goes away from sickness or family problems to neglected other areas of life to develop them – a practical application of salutogenic principles [1].

At the same time, the Balance Model embodies the four spheres of life that potentially give self-esteem to a person. Usually, only one or two areas give self-esteem, but a patient can learn in the therapeutic process to uncover the neglected

areas so that his or her self-esteem will have additional pillars of support.

The Conflict Model of Positive Psychotherapy

Nossrat Peseschkian's psychodynamic conflict model (see Fig. 2.4) presents the differentiation of the content that is the point of contention and its internal evaluation. This model differentiates between the *actual conflict* that appears in an overburdened situation, the pre-existing *basic conflict,* and the unconscious *inner conflict* which causes physical and/or mental symptoms. "Conflict" (confligere, Lat., clash, fight) presents the apparent incompatibility of inner and outer values and concepts or an inner ambivalence. Emotions, affective states, and physical reactions can be understood in this context as signal lamps that indicate an inner conflict of values and the distribution of actual capacities. Therefore, in PPT, a question is asked about the content: what causes or triggers this emotion?

As an example of the translation of emotion into the content of a conflict, we can imagine the almost proverbial tube of toothpaste that is crushed against the glass while lying in the holder every morning or any similar everyday situation. Some such thing triggers a feeling of displeasure in one partner. Another person might react to the same situation with disappointment, tension, or even envy according to which conflict content is consciously or unconsciously significant to the person at hand. Is it the feeling of orderliness that is disturbed ("I will not have such disorder in my bathroom")? Is it a matter of thrift ("Now the tube cannot be squeezed to the end, and we must buy a new one before it is time")? It may be a perception of injustice ("Every day, I am upset that you people have it so good. Must I also clean up after you?"), or it may be a matter of diligence with the secret wish to leave everything as it is for once, but for the habit of doing everything ("I would like to have it so good that someone takes care of me"). There is always strained patience ("It's been a long time of no confidence and dashed hopes. We have talked about it so often, but nothing ever changes."). These are examples of subjective evaluations that have appeared so often in everyday life that they have come to function as unresolved inner conflicts that undermine the patient's health, just as *"constant dripping wears away the stone."*

The repetition of these many small psychic injuries, the "always" and "again!" with the microstress that is received from them, is what

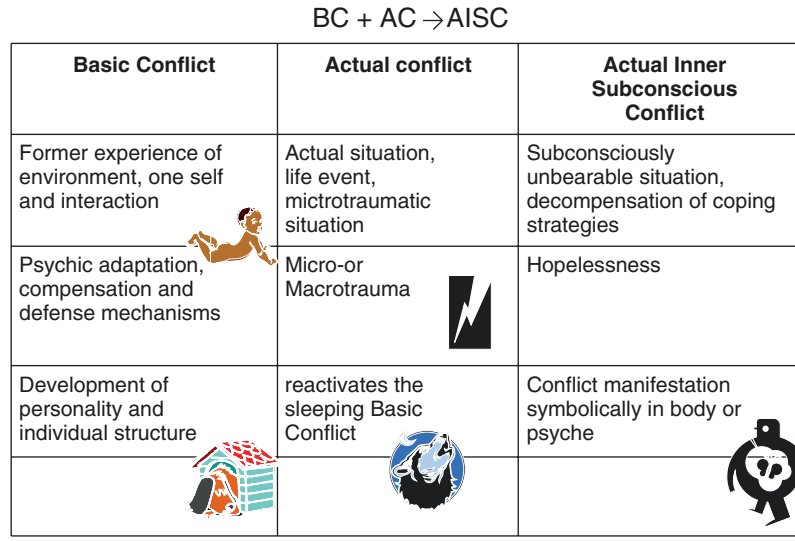

Fig. 2.4 The concept of the three main conflicts in PPT

Nossrat Peseschkian calls **"microtraumas**," the so-called "trivia, or trifles" (Peseschkian [34], P. 80), in contrast to single, major life events, which are *macrotraumas*. Nossrat Peseschkian described these microtraumas, which bear conflict content, in terms of *actual capacities*. They facilitate and form relationships and, on the other hand, are poised to become conflict content under specific conditions. The capacities attain this function in an *actual conflict*, a triggering situation that places too much demand on the previously effective coping mechanisms. Such a situation wakes up an old, unconscious *basic conflict*, as the patient is trapped between his or her primary emotional needs on one side, which are represented by primary capacities, like trust, hope or tenderness, and evaluations on the other, which are described as secondary capacities or social norms like orderliness, punctuality, justice or openness. The compromise that had worked out the basic conflict before does not longer function; an *inner conflict* is the result, standing between two values in a dilemma. This evokes symptoms that can be viewed as attempts at a solution. The conflict reactions can be presented using the Balance Model. Although such reactions cannot bring about a solution, they still have influence.

> The actual conflict situation does not usually appear like a bolt out of the blue. In part, it develops very slowly, finally reaching an intensity whereupon what would otherwise be a less problematic conflict situation suddenly becomes a psychological or psychosomatic disturbance. To make this clearer: disturbances of the soul resemble water which is slowly heated and finally, when a certain temperature has been reached, begins to boil. For this reason, one looks beyond the actual conflict and investigates the course of development of the inward and outward conflict situation; in so doing, the person's childhood and the milieu in which he was brought up become the foci of psychotherapeutic inquiry. Here we come upon domains in which we are concerned with relatively constant, i.e. stable characteristics and attitudes, which are labeled personality traits. The conflict situation which appears at this level of analysis is called the basic conflict. In the basic conflict are included evaluations and weightings, as well as the lion's share of individual development with regard to the modes of the capacities to know and to love. These are just as much prerequisites for basic conflicts as is the pattern of actual capacities acquired in the course of a person's lifetime. The basic conflict need not be a one-off event, such as the death of a reference person. Rather, all our experiences which we have had regarding the actual capacities and the modes of the basic capacities, and which play a part in the shaping of the actual conflict situation, are inputs into what we sum up as the basic conflict. (Peseschkian [34], p. 129).

Disorders can occur when these capacities, virtues, concepts, or values are now repeatedly applied in a one-sided way without the modification appropriate to the present situation. The continuing repetition of family (basic) concepts that were appropriate at an earlier stage of development or of compromises made with them at an early stage (basic conflict) leads to an unconscious inner conflict. Psychic, psychosomatic or bodily disturbances then occur and become the unconscious expression of the inner conflict. These manifestations fulfill an important function in the conflict by acting as the speech of the body or the spirit. Thus, the disorders have the function to help the client to express something subconsciously and have a specific meaning for the particular patient. PPT proceeds so that areas that have previously been neglected, capacities that have seldom been used and must be developed, are strengthened both within the therapeutic relationship and in the stress of the everyday environment to enable patients to resolve conflicts constructively and to restore inner and outer balance.

The Four Model Dimensions

One of the most important and challenging tasks in psychodynamic psychotherapy is the assessment of the effect of early childhood on a patient. One tool in PPT is the concept of the Model Dimensions (see Fig. 2.5). One could also call it 'example' or 'role model'. This model describes the pattern of family concepts in which the individual grows up in a way that reflects the individual's experience of them. One's upbringing and the environment during early childhood lead to a certain unique development and presentation of the basic capacities which Nossrat

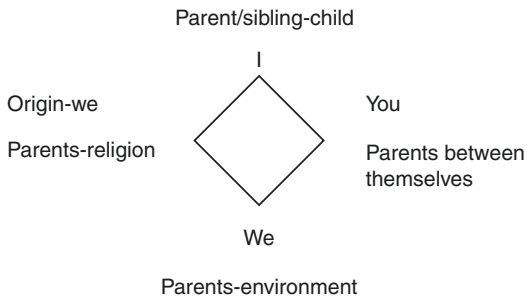

Fig. 2.5 The four model dimensions of Positive Psychotherapy

Peseschkian called the capacity to love and the capacity to know. The means of the capacity to know are described in the section on the Balance Model; the means of the capacity to love will be described below.

Positive Psychotherapy proceeds from four typical basic relationships which every human being experiences or can experience in some form. We may also speak of them as four levels or types of emotional relationship. We distinguish among four modes or means of the capacity to love. They characterize typical basic relationships into which every person enters in one way or another. These basic relationships are the relationships to the I, to the You, to the We, and to the Origin-We. A characteristic model dimension influences the development of each of these relationships. The structure of these relationships can be asked about and presented graphically during therapy. Nossrat Peseschkian has put questions for each of these spheres together which can be used in therapy, and also given to a patient as some kind of homework until the next session [33].

Dimension "I" The model dimension for the relationship to myself and life-long issues such as self-esteem, self-confidence, self-image, basic trust versus basic distrust, depend to a great extent on the relationship of my parents (and siblings) to me when I was a child. Here the child learns to assume a relationship to himself, which especially depends on how his wants and needs are satisfied. The basic question "Am I accepted or rejected?" is decisive. The answer to this question is provided directly by the reference person-child relationship, and indirectly by the comparison with the treatment of the siblings, for example. In the process a first discovery is made, which, to a certain degree, can become a reference system for later developments. It may be presumed that this initial discovery influences the later techniques of determination of self-worth: "Am I accepted on the grounds of my personality or on the grounds of my achievements?" Here lies the cause for the origin of basic conflicts. Later problems of self-esteem are essentially traced back to a conflictual, deficit-laden development in this area of the "I". This is also true for the capacity to bond and relate, early development of trust as opposed to mistrust, the basic attitude toward life, identity, and self-image as man or woman. Above all, the primary actual capacities are developed in this area in mutual interactions which demonstrate the modeling functions of the primary reference person. This is equivalent to the experience of the self-object [13] and the development of self- and object-representation in psychoanalytical theory [5]. The grandparents also come in here in their independent role as trans-generational transmitters of tradition and preferred primary capacities and in the widening triangulation they play a significant role in their grandchild's development of self-esteem because of their special form of acceptance of him or her.

Dimension "You" "The preeminent model for a person's relationship to the "Thou/You" is the parents' example, i.e., the parents' relationship to one another. It is through the parents' example that the possible ways of behaving in a partnership are suggested. Most importantly, it is through it that behavioral forms of tenderness are imprinted" [33]. Concepts and conflicts such as fidelity, the capacities to have a relationship, to advise someone, intimacy, togetherness, give and take, the capacity to be or to choose a partner, the self-image as man or woman, or the capacity to conflict – all these have their origin mainly in the healthy or deficit-ridden development in this area. The three-cornered relationship of father, mother, and child have special influence in the identity as man or woman, the

duality of love or justice or the perception of rivalry and solidarity [33]. This dimension plays an important role in couple therapy and/or marital problems.

Dimension "We" A person's relationship to the "We" is modeled to a great degree by his parents' relation to their social surroundings. With socialization, characteristic attitudes toward social behavior are transferred, in addition to achievement norms. The attitudes and expectations are related to social ties outside of the nuclear family. They include the relation to relatives, colleagues, social reference groups, interest groups, compatriots, and also humankind as a whole. Here one develops less of a relation with a personal You and more relationships with social groups. As a social being, a person adheres to the group, which offers him or her a series of essential assurances, but which can be experienced as threatening, for through confrontation with others one's own values can be called into question. For some people, this is sufficient grounds for only seeking contact where they can count on assent, and where the same patterns of actual capacities and modes prevail. A group demands of its members recognition of certain norms which are conventional for the group, and thus, in some cases, a relinquishing of one's natural inclinations. Representative social groups comprising the "We" are institutions, i.e., social establishments such as societies, professional associations, churches, sport clubs, and political parties, and also psychotherapeutic groups, and in general all such establishments as make it possible for a person to speak of a "We" [33]. Concepts and conflicts such as the capacities to have social relationships, to be part of a group, to accept the conventions of the group, the need for contact, involvement in hospitality, need for emotionality, the need for peace, relationships with people from other backgrounds, withdrawal versus sociability – all these have their origin mainly in the healthy or deficit-ridden development in this area. Role models develop and group identity gives support when the rules of the group are accepted, the value of which have been pre-determined in the area of the "We."

Dimension "Origin/Primal-We" A person's relationship to the Origin-We depends, in the first instance, on his parents' attitude toward meaning, purpose, spirituality/religion, and worldview. Thus, the Origin-We is not only based on formal membership of a religious community, but is also fundamental for the question of meaning which is asked later. Even if religion is rejected, the Origin-We remains the basis for other systems of orientation which are expected to provide meaning contents. As such systems we have the society (and more frequently a determined societal form), a certain way of life, the family, a chosen model, or the achievement or pleasure principle. These ideational contents can become an idol or a substitute religion. Even more determinant than the handed-down contents seem to be the conviction and consistency with which the parents defend those contents [33].

Concepts and conflicts such as doubt, hope, materialism, moral attitudes, fanaticism, crises of faith, life after death, meaningfulness versus meaninglessness, these basic values have their origin mainly in the healthy or deficit-ridden development in this sphere. The parents' relationship to each other and the attitude of more distant relatives with regard to questions about the philosophy of life, for example, religious norms are also significant. The later valuation of actual capacities as moral norms, as motto or ideal, and with them the formation of conscience take their point of departure mainly from the "Original-We."

A Semi-structured Approach

As a method that finds itself between manualized cognitive behavior therapy and process-oriented analytical psychotherapy, PPT pursuits a semi-structured approach in diagnostics (first interview), treatment, post-therapeutic self-help, and training (self-discovery).

The First Interview in Positive Psychotherapy

"Clinical interviewing is the single most important skill required in psychiatry" ([41], p. 7). The first interview in PPT holds a special place and represents a distinctive feature in the psychodynamic process. This semi-structured and half-standardized "First Interview of Positive Psychotherapy" [22] allows us to recognize the particular psychodynamic and biographical characteristics and resources important to the origin and development of the patient's state of health or illness, and it also serves as a systematic starting point for brief therapy. To our knowledge, this first interview is one of the few existing in psychodynamic and humanistic psychotherapy (in chapter 26, the first interview of PPT is published for the first time in the English language).

The psychotherapeutic first interview is central to the success of the therapy and is comparable to the medical history and the physical examination in somatic medicine. The first interview has a diagnostic, therapeutic, prognostic, and hypothesis-formulating function [39]. The first interview in PPT includes the diagnostic approach of the (psycho)somatic medical history as a means of inquiry. The interview considers relationship factors [15] as well as aspects of the therapeutic alliance [10]. The effects of expectation are recognized [15], particularly the hope for effective therapy (Snyder [44], 193–212, Frank [6]). Above all else, because of the semi-structured nature of the interview and the concepts it employs, it is useful in many different settings, in therapy with individuals, children, youth, couples and families, in counseling and coaching, and is practiced in different cultures.

The first interview in PPT consists of obligatory main questions and optional subordinate questions, which can be addressed or not, depending on the answers given to the main questions in each situation. There are open-ended as well as closed questions (Peseschkian [22], p. 31). We generally think of the first interview as being used during the first meeting or during the early sessions that form the preliminary phase, but it is possible to begin the first interview during the first session for the purposes of orientation and then go into greater depth in particular areas during the following sessions.

The Five Stages of Positive Psychotherapy

A structure of communication is employed within the *three stages of interaction* (attachment, differentiation, detachment), which involves a *5-stage process* that is used both within each session and throughout the therapy.

1. The first stage in the process is *acceptance, observation and distancing,* which involves a change in point of view.
2. The second stage is the taking of an *inventory* in which the content of the conflict and the patient's strengths are *differentiated*.
3. In the third step, called *situational encouragement*, self-help and resources are developed.
4. The conflict is subsequently worked through in the fourth step, that of *verbalization.*
5. The fifth step, called *broadening of the goals,* includes a future-orientated reflecting on, summarizing, and testing the new concepts, strategies, and perspectives.

This therapeutic process is predominantly oriented toward the future and toward change, and it involves understanding the past through concepts that are effective for the present. In this way, these adapted concepts are used, as well as those from other disciplines of psychotherapy when appropriate (integrative experience). The patient and his or her surroundings play an active part in the understanding of the process of illness (self-help).

The 5 stages provide a structure for the process of communication within a single session, or during the whole therapeutic process, which would spontaneously come to an end without it. The therapist facilitates the stories by means of an appropriate attitude, leading questions, stories, association triggers, and revisiting themes previously mentioned. The 5-stage process in PPT provides both the therapist and the patient with a starting point as well as a sense of security and prepares the patient to work with conflicts and to engage in self-help, particularly after the end of therapy.

Stage 1. Observation and Distancing

The patient begins with an emotional supposition; a concrete inventory is made, and a new perspective is established. The patient is led from an abstract stage of suffering to a concrete, descriptive point of view. He or she is brought to an understanding of the functions and effects of his or her symptoms in the four areas of life, with the use of figures of speech and transcultural comparisons. As part of the therapy, the patient is asked to observe the situations he experiences and his own emotions, particularly with conflicts, and to write them down as spontaneously as possible without changing anything. Viewing his own conflicts from the position of an observer helps the patient attain a growing distance from his own conflict situation. The patient becomes an observer of him- or herself and his or her environment. An important effect of this stage is the high level of unburdening in a conflict situation. Often, by the time a patient comes to therapy, he is "at the end of his rope," and therapy is "the last stop." It does no good to comfort the patient with the hope of successful therapy in 6–12 months. He is looking for help in the moment and for relief. In the same way, the stage of observation is helpful from the beginning of treatment in interpersonal relationships such as between life partners or in the workplace because the patient becomes much less critical and all conflicts and pain are obviated. Tense situations are defused, and time is gained. The patient is informed that he will be able to talk about everything during the fourth state (verbalization) and that he will prepare for this step during the next three stages, with his conflict partner if appropriate. The broadening of what is at first a one-sided perception, a "neurotic narrowness," provides the preparation for the next stage in the process, making an inventory of events.

Stage 2. Making an Inventory

This stage introduces the paramount task: to recognize the connections to clarify the prehistory of the individual's actual capacities and the preparation for the conflict, as well as to put the background of the concepts and misunderstandings into order so that the patient can develop a means of understanding them for him- or herself. The positions (attitudes) that, as a rule, the patient sees as being unchangeable personality characteristics will now be viewed as relative according to their meaning in his or her life history. The significance of the actual capacities is summed through association by means of an inventory of the actual capacities (the Differentiation-Analytic Inventory, DAI). The Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF) questionnaire provides a complete summary of the areas of behavior in which the patient and, if appropriate, his partner or conflict partner possess positively or negatively evaluated characteristics and where there are strengths, microtraumas, or examples of conflict reaction. The WIPPF also facilitates access to role models.

Patients with psychosomatic disturbances find the Balance Model, which appears in the second stage, to be of particular assistance, as the visualization helps clarify issues and prepare patients for self-help. These patients are often astonished when they put the events that have happened in their lives in the past few years into the four areas of the Balance Model, see them as catalysts, and understand the influence they have had in changing their lives.

Stage 3. Situational Encouragement

This stage emphasizes the development of specific resources. The most important aspect of the therapeutic relationship is the reflection of strengths. This aspect keeps the focus on the available capacities of the patient and his or her reference person in order to build a new relationship with the conflict partner. In any case, the patient and therapist look together at those capacities that correspond to this relationship with the conflict partner, and work through the meaning of these capacities. Rather than criticism of the partner, situational encouragement and appreciation are used based on what has been learned during the first and second stages. The patient and therapist organize the resources previously established in the Balance Model as well as areas that have been touched upon only briefly as well as potentialities and desires

which have not yet been fulfilled. In this context, the relationship to the reference person is particularly valuable, whether it is discussed actively or only indirectly, especially in working toward the use of self-help. Psychoeducational information about the specific disorder and ways to address it, such as the use of medications, relaxation methods, and counseling services, are typical supportive tools during this third stage of the process. Nossrat Peseschkian emphasized that in the third stage, the conflict partner was being prepared to withstand the criticism that he or she would face during the following stage of verbalization.

Stage 4. Verbalization

In order to move on past the speechlessness or the outpouring of speech so common with a conflict, the newly established communication must be carried over step by step into the social environment. In the fourth stage, the therapist and patient discuss both the positive and the negative characteristics of the experiences after which a relationship of trust was constructed during the third stage, which makes open communication possible. This stage is also when feelings and actual capacities are revisited and early experiences are remembered, organized according to themes and made conscious. Together, the therapist and patient investigate the transference of wishes, expectations, and fears that were experienced with persons earlier in life or feelings that the therapist recognizes as signals indicating painful content. This process demands that the therapist be open and ready to be a confrontation partner and that he or she show a respectful attitude when the patient experiments with changes in behavior within the therapeutic relationship at this early stage. The therapist supports the patient in achieving a balance between politeness and openness and in taking the responsibility for change. The focus on the themes of the central conflict, the work on the key conflict, the politeness-honesty tradeoff, and the active involvement of the reference persons in the therapy through the patient are the tasks that belong to the fourth stage. The therapist presents the concept of the family group and, if appropriate, brings the family into the therapy. The family concept and unconscious basic conflicts are worked through at this time. Verbalization means that the time has come for an open discussion after which each recognizes the strengths of the other through observation of the situation, analysis of the contents of the conflict and mutual encouragement. The conflict partner is now in a position to accept criticism or, at the least, to be able to speak about it. Experience shows that many people are inclined to speak about a problem immediately and to hurt the other person by so doing, after which the other person must be strengthened through many hours of encouragement.

Stage 5. Widening of the Goals

The patient is advised to consider the following question: "What will I do when I no longer have this problem?" This stage accompanies the patient from the beginning. This goal setting helps prevent relapse, leads to development that is more proactive than reactive, and prevents the patient from resuming the use of symptoms as a means of relief after the completion of successful therapy. The patient is therefore guided to detach him- or herself from the therapist and to develop new capacities that he or she had neglected in the past. The patient will develop micro- and macroscale goals together with the therapist. Goals for the near future can be determined using the Balance Model.

Fields of Application of Positive Psychotherapy

To understand both the individual fields of application of PPT and its breadth, we must begin with the assertion and vision of Nossrat Peseschkian about its goals. He saw it as a special challenge to be able to treat people from all classes and cultures psychotherapeutically and therefore to recognize and make use of the uniqueness and the capacities of each person. This aim required the selection of concepts that would be useful for short-term therapy and understandable to everyone. Self-help would be placed in the foreground with every therapeutic step, and the connections

that lay behind the complaints would be transparent to the persons involved.

> In other words, the patient is not only the sufferer of his illness but also is employed as a therapist himself…The essential difficulty of many patients is less a question of inadequate motivation to seek out a psychotherapist than of uncertainty about which psychotherapist is competent to deal with which kind of disturbance. This question can only be answered on the basis of a more comprehensive system which can bring together the multitude of existing psychotherapeutic orientations and assign them weights in accordance with their strong points. We present such a system in Positive Psychotherapy, which is not only a psychotherapeutic method but also a metatheory... It is not the patient who must adapt to a methodology he happens to be presented with, but vice versa: the methodology is selected in accordance with the changing psychotherapeutic needs of the patient. This flexibility permits the handling of all psychological and, in a broader sense, psychosomatic illnesses and disturbances. (Peseschkian [34], p. 4f).

In keeping with the emphasis on transcultural understanding, this form of psychotherapy is notable for combining traditional Eastern applications with current psychotherapeutic methods of the "Western" world. Peseschkian combines with a theory and therapy both systematic and structured in the Western sense the employment of proverbs and stories from different cultures, which can be used for association, support, or confrontation to broaden the patients' viewpoints about their own stories, to relativize their conflict situations and to facilitate their psychodynamic understanding.

> One of my concerns in writing this book was to unite the wisdom and intuitive thinking of the East with the new psychotherapeutic knowledge of the West. Not only the contributions of the great religions which are of psychotherapeutic importance, but also the wisdom of Oriental and Western philosophers and scientists are considered in the light of Positive Psychotherapy. Our intention in so doing is to address not only the intellect but also the capacities for intuition and fantasy, for emotion and sense perception, and the ability to learn from the experiences of tradition. (Peseschkian [34], p. 5).

Along with the main indication for PPT as a method of therapeutic and clinical treatment, it is also applicable in counseling, education, and prevention (the educational-preventive application of Positive Psychotherapy). In this context, the particular strong points associated with this method are a) working with death and bereavement, b) psychodynamic stress therapy based on PPT, c) working with burdensome life events and psychological traumas, d) preparation for partnership and marriage, e) positive psychodrama (PPD), and f) its application in general medicine and psychosomatic medicine. These uses give PPT a broad applicability for doctors, psychologists, and pedagogues.

By 1979 [30], four main fields of application had been formulated: psychotherapy, education, self-help, and transcultural problems. Based on these fields, the applications of PPT can be subdivided into three main categories:

Psychotherapy and Treatment

PPT is applied for the treatment of mood (affective), neurotic, stress-related and somatoform disorders; behavioral syndromes (ICD-10, chapters F3–5), and, to some extent, personality disorders (chapter F6). PPT has been employed successfully side by side with classical individual therapy in the settings of couple, family, and group therapy.

There is experience with the application of PPT to psychiatric disorders. Specifically, the use of stories and anecdotes has proven very effective in working with (post)psychotic patients and in group settings in psychiatric hospitals.

Self-Help

The greater part of Nossrat Peseschkian's books is intended to be used by laypersons for self-help. Among those books are "The Psychotherapy of Everyday Life" (1977 German, 1986 English), about dealing with misunderstandings; "In Search of Meaning" (1983 German and 1985 English," about coping with life crises; and "If You Want Something You Never Had, Then Do Something You Never Did" (2013), about interpersonal conflicts, as well as several books not

yet translated from the German. Through courses for counselors, professional counselors can study and be certified to apply Positive Psychotherapy in conflict moderation and to stimulate self-help in conflict situations.

Outside of Psychotherapy

PPT has been applied in numerous and varied situations: in education and schools [40]; in management training [24]; in coaching; in various counseling settings; in seminars for preparation for partnership or marriage; in recruiting; in trainings for teachers [40], officers and politicians[21]; in mediation for jurists and mediators; in intercultural trainings; in time management [42]; in naturopathy and order therapy [also known as mind-body medicine] [3]; in stress management and coping [38]; in burnout prevention [9]; in the armed forces and society [21]; in the psychology of religion [4, 23, 45]; and in supervision [12]. Other areas include coaching, family counseling, and general counseling.

Development of Positive Psychotherapy and Its Current Organizational Structure

The *history of the development* of Positive Psychotherapy can be divided into four periods that roughly correspond to decades.

In retrospect, one can identify *the 1970s* as the decisive years in the development of the method and of its structure as we know it today. The fundamentals of PPT took shape during these years. These fundamentals were used with many patients and their families at this time and were tested and presented at international lectures both inside and outside Germany. Four of the five basic books of PPT were published during this period: "Psychotherapy of Everyday Life" (originally "Schatten auf der Sonnenuhr," 1974); "Positive Psychotherapy" ([original German] 1977); "Oriental Stories" ([original German] 1979), about the application of Eastern stories in Positive Psychotherapy, and "Positive Family Therapy" ([original German 1980).

The same period saw the first postgraduate trainings in PPT with the founding of a training organization in 1974 (the forerunner of the WIAP Academy), its recognition by the Medical Chamber of Hesse for the psychotherapy residency training in 1979, and the founding of the German Association for Positive Psychotherapy in 1977 – the first association for PPT in the world.

The development continued *during the 1980s*, and more books were published, such as "In Search of Meaning" (German 1983, English translation 1985b). The method was systematized further in collaboration with some young colleagues. Hamid Peseschkian's dissertation, presented in 1988, was the first dissertation dealing with PPT. The first interview in PPT was first structured in this dissertation; a questionnaire for this first interview was presented, and a psychodynamic study of it was undertaken. This first-interview questionnaire was published shortly thereafter in 1988 (with minor modifications) together with the questionnaire in PPT, the WIPPF [37]. This precursor of the later semi-structured psychodynamic first interview was one of the first in psychodynamic psychotherapy. The last of the basic works of Nossrat Peseschkian, "Psychosomatics and Positive Psychotherapy" [35] (1991 German and 2013 English translation), also belongs to this period. The book presents a structured, psychodynamic model of illness and the treatment of different psychic and somatic disorders.

Nossrat Peseschkian began his travels for seminars and continuing education in PPT during the 1980s, predominantly in the developing countries of Asia and Latin America. This period coincided with the translation of the most important works of PPT into English. In addition, Nossrat Peseschkian undertook seminars in management training and in coaching, which provoked a great interest in the comprehensibility and applicability of PPT to these contemporary fields.

The international spread of PPT during the 1980s received a great impetus due to the radical

political changes in Central and Eastern Europe *during the 1990s*. PPT attracted great interest in these cultures, which lie not only geographically but also psychologically between East and West. The organized working methods and the thirst for knowledge of Eastern European colleagues led to the systematization of seminars beyond Germany. More than 30 centers, beginning in 1990 in Kazan, Russia, and the first national associations for Positive Psychotherapy were established outside of Germany in Bulgaria (1993), Romania, and Russia.[6] PPT was further internationalized through the founding of the International Center for Positive Psychotherapy in 1994, the forerunner of today's World Association for Positive and Transcultural Psychotherapy (WAPP). These events occurred simultaneously with the founding of the European Association of Psychotherapy (EAP) in Vienna in 1990, which established the profession of psychotherapy and the appropriate legal framework. Representatives of PPT have been involved in this association from its beginning.

In the German-speaking countries, a lively discussion was sparked at least in part by a publication by Klaus Grawe [7] (1994) and the debate regarding the law for psychotherapy, a discussion about the broad questions of the effectiveness of the various methods of psychotherapy. Nossrat Peseschkian followed the spirit of the time and undertook an exhaustive "Effectiveness Study of Positive Psychotherapy" with his colleagues (1999), which was distinguished by receiving the Richard Merten Prize [46] . This study was able to demonstrate the practical effectiveness of PPT.

In the *new millennium*, the influence of the generations of students who themselves took up teaching began to be evidenced. In 1999, a first international training curriculum for advanced studies in PPT was published on the experiences in different countries before. In 2000, the first International Training for Trainer in Positive Psychotherapy started. This broader development was formalized so that in Germany the Wiesbaden Academy for Psychotherapy (WIAP) received governmental recognition for the education of psychological psychotherapists as well as child and youth psychotherapists. The German law for psychotherapists (in 1998) led to increased developments in the curriculum and systematization of both basic and advanced training in PPT, which was also reflected beyond Germany. Seminars at the basic level have been taking place in eastern Europe for several years, and new concepts have been developed. In particular, PPT has moved into areas outside medicine, primarily school and university education as well as management training and coaching.

As of 2019, national associations for PPT exist in Germany, Russia, Bulgaria, Romania, the Baltics, Kosovo, Ukraine, Turkey, and Ethiopia. PPT is also active through additional local or regional training centers in Albania, Armenia, Austria, Northern Cyprus, the Czech Republic, Poland, the Netherlands, Latvia, North Macedonia, Russia, China, and the UK. Seminars and lectures on PPT have taken place in more than 80 countries to date. The first university graduate program (Master's degree) in PPT was completed in 2005 at UTEPSA University in Santa Cruz, Bolivia. PPT is also included in curricula for psychology and psychotherapy at universities in Bulgaria, Russia, Ukraine, and Turkey.

WAPP has established international standards and guidelines for a four-stage education: basic and master training, and basic and master trainer (see http://www.positum.org/). Since 2000, annual International Training Seminars and since 1997 seven World Congresses have taken place. The Peseschkian Foundation (International Academy of Positive and Transcultural Psychotherapy [IAPP]), founded in 2005 by Manije and Nossrat Peseschkian, promotes international activities and administers the International Archives of Positive Psychotherapy.

The WAPP, as the international umbrella organization of PPT, is registered as a nonprofit organization under German law. PPT is an officially accepted modality of the European Association

[6]The two authors of this chapter supported this development with extended stays in Eastern Europe: Hamid Peseschkian in Russia from 1991 to 1999 and Arno Remmers in Bulgaria from 1992 to 1995, in Romania 1996.

for Psychotherapy (EAP). The European Federation of Centers for Positive Psychotherapy (EFCPP) is a European Wide Organization (EWO), a European Wide Accrediting Organization (EWAO) and, through the IAPP, a European Accredited Psychotherapy Training Institute (EAPTI) of the EAP. Trainees can receive the European Certificate of Psychotherapy (ECP) in the modality of Positive Psychotherapy.

Research and Publications

The first publications in the area of PPT date back to 1974. Since then, this method has been presented in numerous books, scientific works, and other publications.

Research

PPT fulfills the four principles postulated by Grawe [7] for the effectiveness of psychotherapy: (i) activation of resources, (ii) actualization and (iii) management of problems, and (iv) therapeutic clarification. According to Grawe's model, PPT is a classical, integrative form of therapy (Jork and Peseschkian [11], p. 9). Substantiating this idea was the purpose of a wide-ranging effectiveness study that was carried out between 1994 and 1997 under controlled conditions. Thirty-two members of the German Association for Positive Psychotherapy undertook this study of effectiveness and quality assurance of PPT under the leadership of Nossrat Peseschkian, Karin Tritt, and Birgit Werner. This study was the first of its kind [46].

This longitudinal effectiveness study investigated the effectiveness of PPT under the conditions of daily clinical practice and compared recipients to a control group of patients with somatic illnesses who were on a waiting list for therapy. The recipients were treated by 22 therapists trained in PPT (15 physicians, 3 degree-holding psychologists, and 4 degree-holding teachers) with a median age of 45 and median professional experience of 7.7 years, all of whom were members of the German Association for Positive Psychotherapy. For a determined period of time, all patients taken into therapy were added to the sample. A total of 402 male and female patients were included: 23.6% with depressive disorders, 19.8% with anxiety and panic disorders, 21.2% with somatoform disorders, 20.5% with adjustment disorders, 8.2% with personality disorders, 3.4% with addictions, and 3.4% newly diagnosed with somatic disorders. In the design of this longitudinal study, 110 patients and a comparable control group of 771 other persons were questioned at the beginning and end of the study. A second part of the study contained a retrospective interrogation of the patients after the termination of PPT at intervals of 3 months to 5 years in three groups of 84, 91, and 46 patients. The choice of the battery of psychometric tests (SCL-90R, VEV, Gießen-Test, WIPPF, IPC, IIP-D, GAS, BIKEB) was arrived at by collaborating with the participating university in consultation with Klaus Grawe and other researchers.

The patients who were treated with PPT showed a clear reduction in symptoms and an improvement in their emotions and behavior. Significant improvements ($p \leq 0.005$) in the symptoms of patients treated with PPT can be demonstrated by comparing the results of the Symptom Checklist (SCL)-90 before and after the treatment. A control group drawn from patients on the waiting list showed no significant change in their symptoms ($p \geq 0.05$). The calculated mean effect size of the study, $e = 0.476$, is a good indication of the positive effects of the treatment when performed under controlled conditions as presented in this study. The stability of the effect of the therapy can be seen through the comparison between the catamnestic and poststudy measurements, which indicate no significant difference ($p \geq 0.05$; VEV: $F = 1179$; SCL-90-R: $F = 2473$) [46].

The discussion touched on the dilemma between an experimental design with high internal validity and a study pursued under controlled conditions with high external validity. The researchers suggested that in consideration of the unfortunate lack of such effectiveness studies, the experimental design devised for this study can be considered one of its strong points [46].

This computer-aided quality assurance study of PPT was awarded the Richard Merten Prize in 1997. The Richard Merten Prize is one of the best-endowed prizes in the health care sector in Europe and has been awarded by its trustees since 1992. The foundation's intention is to recognize outstanding work that leads to the improvement of medical/pharmaceutical/nursing treatment and that represents an important contribution to medical, social, sociopolitical, or economic progress in the health care sector.

Academic Works (Dissertations, Theses)

The basis for the multifaceted applicability and the cultural compatibility of PPT consists of the many colleagues who are stimulated and encouraged to undertake scientific work. Additionally, after coming into contact with PPT, many practitioners, no longer encumbered by the limitations and requirements of school, find their interest in publishing revived. According to available information, some 5 postdoctoral dissertations and approximately twenty doctoral dissertations have appeared on PPT, mainly from Germany, Russia, Bulgaria, and the Ukraine. Some 30–40 Bachelor's and Master's theses have also been written on the subject.

The major focus has been on the psychosomatic, medical, psychiatric, psychological and pedagogic aspects of PPT and applications to these fields, which can provide a foretaste of future scientific work. A survey of the themes of these academic works shows the multifaceted clinical and nonclinical areas of applicability of PPT and the emphasis on certain models. Alongside works dealing with psychosomatics in various organ systems, we find comparative transcultural research. Distinctive features of the therapeutic relationship and its portability into educational contexts had been focused. Some of these scientific studies are based on the social-pedagogic context, thus bringing out the applications and possibilities of "Positive Pedagogy."

Publications

Publications on PPT consist of the wide-ranging source material written by its founder, Nossrat Peseschkian, and of the work of his students. These scholarly publications have been joined by works of popular science that have appeared in diverse periodicals and do not appear in lists of scientific literature.

Nossrat Peseschkian, as the founder of Positive Psychotherapy, wrote 29 books that have been translated into as many as 23 languages. The most widespread book is "Oriental Stories as Tools in Positive Psychotherapy: The Merchant and the Parrot." Other core books are "Psychotherapy of Everyday Life," "Positive Psychotherapy," "Positive Family Therapy," and "Positive Psychotherapy in Psychosomatic Medicine." In his final years, Nossrat Peseschkian published a number of self-help books dedicated to various areas of life.

Starting with the founding of the German Journal of Positive Psychotherapy in 1977, colleagues in PPT have been encouraged to publish the results of their research and share their cases. Additionally, the source publications of Nossrat Peseschkian began to accrue secondary publications beginning in the 1990s. As new national associations for Positive Psychotherapy have been formed in various countries during the last 20 years, journals of PPT have been founded in Russia, the Ukraine, Bulgaria, and Romania.

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Positive Psychology: An Introduction

3

Tuğba Sarı and Alan Daniel Schlechter

Introduction

> Psychology isn't just about medical science or curing negative things. It is about education, work, marriage and even sports. What I want to see is that psychologists try to help people empower themselves in all areas [33].

When the history of psychology is examined, it is seen that the first personality development theories approach the human from a pessimistic perspective or treat the individual as a passive organism shaped by external influences.

While the etymology of the term "clinical psychology" comes from the Greek word *klinike* meaning "medical practice at the sickbed" and *psyche* meaning "mind," in reality the field has its roots in a philosophical quest that is more closely aligned with the tenets of positive psychology than is broadly understood contemporaneously [40]. The first to consider the theories of the mind, the ancient Greeks, certainly understood this, and the concept of *eudaimonia*, translated as "flourishing" was a central concept in Aristotle's *Nichomachean Ethics,* and represented the pursuit of what was meaningful in life, including excellence and "the full development of our potentials" [17].

The Positive Psychology movement gained momentum with Martin Seligman's speech when he was elected as the president of the American Psychological Association in 1998. In this speech, Seligman emphasized the need to reshape the trajectory of pathological-oriented psychology [33]. In the following periods, the Board of Positive Psychology was established under the chairmanship of Seligman, followed by the establishment of the Positive Psychology Network and the first Positive Psychology Summit was held in Washington DC. Subsequently, Seligman established the Center for Positive Psychology at Pennsylvania State University. In 2005, the first positive psychology graduate program was opened at Pennsylvania State University. The Journal of Positive Psychology, the first positive psychology journal, started its publication in 2006 [11].

According to Seligman and Csikszentmihalyi [35], two important pioneers of positive psychology, the field of psychology was mainly focused on abnormal behaviors and their efforts to reduce them. Especially after the Second World War,

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psychology workers have tried to understand and eliminate behaviors arising from mental disorders as health professionals. With the emergence of humanistic psychology and the introduction of Maslow and Rogers' views of human nature in the 1950s, the psychopathology-oriented approach was replaced by a focus on positive human characteristics. As a matter of fact, by the end of the 1990s, a positive psychology approach developed as a new psychology movement that examines the strengths of human beings. There are several definitions of positive psychology by different scientists. For instance, according to Seligman and Csikszentmihalyi [35], positive psychology is a scientific discipline that examines human functioning and development in a multidimensional way in a biological, personal, relational, cultural, and global context. In this context, psychology is not considered just a science of pathology, weakness, and damage; it is also about strengths and virtues. Similarly, according to Sheldon and King [38], positive psychology is nothing more than examining the strengths and virtues of an ordinary person. Peterson [24] mentioned that positive psychology is a scientific approach to studying human thoughts, feelings, and behavior, with a focus on strengths instead of weaknesses, building the good in life instead of repairing the bad. Gable and Haidt [14] stated that positive psychology is an area that contributes to the study of the conditions and processes necessary for the maximum functioning and development of not only people, and groups and institutions as well. As can be understood from the definitions mentioned above, positive psychology deals with the strong characteristics, virtues, and potentials of individuals.

In this context, the most basic assumptions of positive psychology regarding human nature can be listed as follows: (1) human is an active entity capable of directing his/her own development, (2) human has the intrinsic power necessary to regulate and change human behavior, (3) the individual develops behavior in the desired direction and at the same time activates the motivation to connect to life [1]. Acting on these assumptions about human nature, the positive psychology movement examines how and under which conditions positive characters, positive emotions are formed, and tries to present the findings in scientific ways. On the other hand, it does not deny the negative characteristics of the individual. However, it emphasizes that it is as important to build life on the traits that make the individual strong as it is to repair the bad thing.

Positive psychology does not reject people's problems, does not ignore the stress of people and does not oppose people's attempts to understand what good life means. On the contrary, it aims to complement and not replace ordinary psychology by expanding studies on human growth and development [22]. In contrast to traditional psychology, positive psychology has been primarily concerned with the strengths and positive personal characteristics of human nature and has sought to draw attention to improving the quality of life [35]. Positive psychology brings together research findings that provide good living [23].

Health Model

The main purpose and functions of the traditional approach using the disease model have been to solve problems, eliminate negative effects, and treatment [15]. The health model focuses on health protection and development. In understanding human personality, positive psychology uses the health model in contrast to the disease model used by traditional psychology. The perspective of positive psychology on human nature coincides with World Health Organization (WHO)'s definition of health. According to WHO, health is defined not only as the absence of disease and weakness, but also as a state of complete physical, mental, emotional, social, and spiritual well-being. Similarly, mental health is defined as being aware of one's own abilities, overcoming the stress that occurs in life, being productive and useful in business life and contributing to society in accordance with their abilities [39]. In positive psychology, the aim is to reveal the characteristics that improve the well-being and joys of individuals by searching for things that make life valuable and worth living

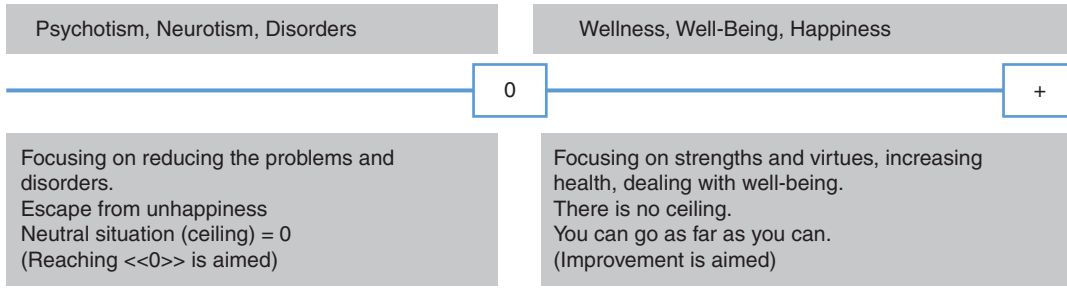

Fig. 3.1 Health model in the context of positive psychology

[20]. In this context, positive psychology focuses on the adoption of the health model by moving away from the disease model. The following figure presents the proposed health model in the context of positive psychology (Fig. 3.1).

When the literature on psychology is examined, it is seen that besides the theories explaining the pathological aspects of human behavior, models related to positive characteristics such as hope, optimism, well-being, happiness are limited, and the development of these models is neglected. In this context, it has been tried to develop various models related to the positive experiences and characteristics mentioned in positive psychology studies and to understand the structure of well-being in a nutshell.

From this point of view, there are many positive characteristics that are discussed within the framework of positive psychology approach. Psychological resilience, subjective well-being, self-efficacy, psychological well-being, hope, commitment to school, job satisfaction, relationship satisfaction, character forces, self-esteem, optimism, gratitude, post-traumatic growth, meaning of life, self-compassion, conscious awareness as examples of these characteristics shown. Positive psychology deals with many concepts that affect individual happiness and psychological well-being. In this section, subjective well-being, life satisfaction, psychological well-being, and optimism which are the most researched concepts in positive psychology, are discussed as the basic building blocks. First, the concept of well-being, which tries to explain the various aspects of human happiness, is emphasized.

Well-Being

What is well-being? Being happy in life is an important expectation of people. In the field of positive psychology, people's happiness is examined with the concept of well-being. Well-being is conceptualized as self-realization and fully functioning from an eudemonic perspective. On the other hand, hedonic perspective is considered as self-assessment of the individual's own satisfaction and happiness [9]. The concept of well-being is considered in two basic dimensions: psychological well-being and subjective well-being. The concept of psychological well-being is represented by the concept of *eudemonic* and subjective well-being is represented by the concept of *hedonic* [27]. Subjective well-being is not considered as the equivalent of psychological well-being and being healthy. Some people with mental health problems may say that they are happy. Looking at these statements, it cannot be concluded that such people are healthy [8]. Therefore, it should not be forgotten that subjective well-being is the only one aspect of psychological health.

Subjective Well-being

According to Diener [4], who made preliminary studies about subjective well-being, subjective well-being is the both cognitive and affective self-evaluations of the individual for their lives. The situation reached as a result of the assessment of the individual gives information about the well-being of the individual. Since the

cognitive and affective evaluations of the individual are based on self, this concept is described as subjective well-being. There is life satisfaction in cognitive dimension of subjective well-being and positive and negative affect in affective dimension [3]. *Life satisfaction* is the evaluation of an individual's own life in general about whether it is good or bad [21]. According to Diener et al. [7], life satisfaction includes satisfaction from life, satisfaction from the past, satisfaction from the future, and the views of one's relatives about that person's life.

Positive affect is the feeling of positive emotions such as eager, energetic, cheerful, calm, peaceful, lively, and grateful. *Negative affect* includes the feeling of bored, sad, anxious, worthless, angry, and guilty. Intensive positive affect includes the individual's positive attitude toward other people and life activities and positive mood. Intense negative affect causes the person to perceive his/her life as bad [5]. From this point of view, when individuals feel more positive emotions and less negative emotions, it may mean that they have high subjective well-being [4]. In fact, negative emotions such as anger, hate, and fear have evolutionary advantages and functions. They are developed to take the necessary measures to survive in life-threatening situations. The problematic situations are the frequent and intense experiences of these emotions, and the positive emotions are less and unnoticed.

As a matter of fact, especially laboratory studies conducted by Fredrickson [13] reveal that positive emotions extend individuals' thoughts and actions repertoire, reduce the effects of negative emotions, and improve psychological soundness. Positive emotions help the individual to recognize and develop internal resources. The constructive effect of experiencing positive emotions is shown in Fig. 3.2.

From this point of view, individuals with high subjective well-being are generally expected to have more positive emotions, and experience less negative emotions such as sadness, anxiety, and anger. Although subjective well-being plays an important role in assessing a person's well-being, there is a point to note: Subjective well-being alone is not sufficient to define mental health. In other words, subjective well-being is not synonymous with psychological health [8].

Although not universally considered, there are some factors that affect subjective well-being. According to Diener [3], these variables are divided into three groups as demographic, personality, and social variables. There are many studies investigating the relationship between demographic variables such as age, gender, educational status, income status, and subjective well-being. Most of these studies show that these characteristics explain only a small part (10%) of subjective well-being [21]. In terms of personality traits, many researchers argue that personality is one of the most powerful influential factors of subjective well-being. Self-esteem, optimism, and frequently felt positive emotions in personality traits were found to be associated with life satisfaction and therefore subjective well-being [8]. It is stated that personality traits have a 50%

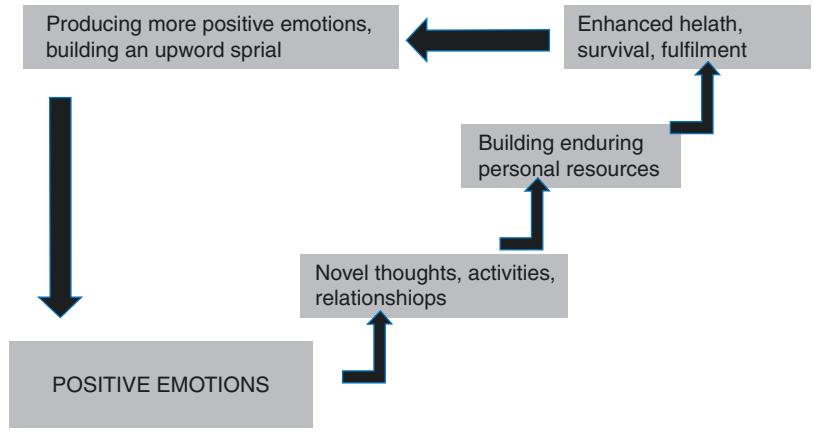

Fig. 3.2 Table showing the widening effect of positive emotions. (Adapted from Fredrickson's [13] Broaden-and-Build Theory of Positive Emotions)

effect on subjective well-being [21]. In the context of the culture considered as social variables, it is stated that individuals with individualistic cultures have higher levels of subjective well-being in individualist cultures because they can pass their interests and wishes to their lives more [8]. Research in the context of being associated with other social variables, other people, indicates that happy people have more social relationships; however, unhappy people have less social relationships [6, 19].

Psychological Well-Being

As mentioned earlier, subjective well-being is based on hedonism and psychological well-being is based on functionality. According to Ryff [28], which provides a comprehensive perspective on psychological well-being, psychological well-being cannot be explained by not only having mental disorders and not having a certain problem. Psychological well-being requires the ability to perform certain life functions.

Accordingly, for an individual to be psychologically good, he/she must have self-esteem, good relationships with others, discovering the meaning of life and living in this direction, autonomy, and ongoing growth/development. Starting from this, psychological well-being model consists of six structures. These are: (1) Self-acceptance (having a positive attitude toward oneself and past life), (2) Positive relationships with others (establishing warm and reliable relationships with others), (3) Autonomy (feeling of making your own decisions, freedom, (4) Environmental mastery (capacity to create a suitable environment according to the individual's personal and mental conditions), (5) Individual development (having the sense that the individual develops and grows as an individual), and (6) The purpose of life (having a sense of finding meaningful life) [29]. According to this model, psychological well-being is related to better performing of human functions and therefore to individual development and self-realization [30].

Many factors are effective in achieving psychological well-being in individuals. According to a study, psychological well-being increases with extroversion, education, and honesty [17]. In another study, psychological well-being was found to be negatively associated with depression, anxiety, and anger [31]. It has also been shown that psychological well-being has a protective effect against negative conditions such as depression [16] and neuroticism [17]. In parallel, it is seen that individuals who use negative coping strategies less have a higher level of psychological well-being [18]. As a result, studies show that psychological well-being is associated with many positive conditions.

Seligman [34] introduced the concept of *authentic happiness* which has three basic elements: (1) High level of positive emotions and life satisfaction (2) Quality of life including continuous assimilation and flow; providing meaningful life, and 3) A meaningful life that allows the individual to serve something greater and stronger than himself. The first dimension is explained by hedonistic approach (subjective well-being) and the second and third dimensions are included in the functionality approach (psychological well-being). While engaging in activities in the first dimension produces positive emotions in the individual, engaging in activities in the second and third dimensions adds meaning and value to an individual's life. From this point of view, it is possible to say that individuals' experiences that increase both their subjective well-being and psychological well-being increase their happiness and prepare the basis for living in totality and balance.

Martin Seligman expanded his definition of well-being to include five core measurable and buildable elements: Positive Emotion, Engagement, Relationships, Meaning, and Accomplishment (PERMA). In his book, *Flourish*, Seligman emphasizes that no one component can independently define well-being. Seligman postulates that each component of PERMA has three core elements: it contributes to well-being, it is pursued for its own sake, and it is defined and measured independently of the other components ([41], p. 18). Seligman believes that only by fostering each of the PERMA elements can we work toward a true sense of well-being.

The importance of nurturing each component could be compared to training for a triathlon. Just as the odds of winning a triathlon are highest when you train in swimming, running, and cycling, the odds of achieving well-being are highest when you train in all five components. Gander et al. conducted a positive psychology intervention study on 1624 adults aged 18–78 investigating how enhancing the five components of well-being impact affect [42]. The study confirmed that focusing on all five components rather than just one increased positive affect and reduced negative affect more effectively. These results are in line with previous studies examining well-being theory [42]. Understanding the components of **PERMA**, how they can be applied, and how to measure them are integral to working towards a sense of well-being and have become a cornerstone of the field of positive psychology.

P – Positive Emotion

> The days that make us happy make us wise." –John Masefield [43]

Positive emotions have historically been a central focus of positive psychology. A subjective measure of how we think and feel, positive emotions can be divided into activated emotions such as excitement and joy and the inactivated positive emotions like tranquility and serenity. Not only has the balance of positive and negative emotions been shown to contribute to levels of life satisfaction, but positive emotions have also shown to impact people's thinking and actions [44]. Many studies have shown the beneficial effects of positive emotions including self-efficacy, sociability, activity and energy, immunity and physical well-being, effective coping with stress, and flexibility [45]. Fredrickson developed the broaden-and-build model, which suggested that positive emotions help prepare the individual for future challenges. She presented the idea that positive affect predicted improved broad-minded coping, which would subsequently increase positive affect [46, 47]. She described broad-minded coping as utilizing constructive cognition and behavior when in distress. Over time, this can also lead to a broader range of psychological resources [47]. For example, experiencing happiness can lead to psychological broadening which will increase the odds of finding positive meaning in challenging events going forward. Positive affect can produce an upward spiral towards enhanced well-being. A study of U.S. college students in the aftermath of September 11th suggested that experiencing positive emotions in the wake of a stressor buffers resilient people against depression and helps fuel thriving. This is consistent with the broaden-and-build theory [48]. Positive emotions also contribute to physical well-being [49]. In one of the Pittsburgh common cold studies, Cohen et al. illustrated that experiencing more positive emotions is associated with greater resistance to the common cold [50]. Positive emotions do much more than make us feel good – they change the way our brains and bodies operate. They are a crucial part of PERMA, but not the sole driver of well-being.

E – Engagement

> The best moments in our lives are not the passive, receptive, relaxing times… The best moments usually occur if a person's body or mind is stretched to its limits in a voluntary effort to accomplish something difficult and worthwhile. –Csikszentmihalyi 1990 ([51], p. 3).

Seligman describes engagement as principally being about achieving flow. Mihaly Csikszentmihalyi, sometimes called the grandfather of positive psychology, conceptualized the term "flow" in his seminal 1975 book, *Flow: The Psychology of Optimal Experience*. Flow is described as the mental state of an individual immersed in an activity with optimal enjoyment, concentration, and involvement. He describes flow as an "optimal experience" that can occur in any situation or activity where there are clear goals, ongoing activity, immediate feedback, and ideally the challenge is just beyond the skill level of the individual [51–54]. For some, this could

occur during a sport or hobby, or while absorbed in a new work assignment. It is important to note that if the skill level is far greater than the challenge it may lead to boredom, and if the mismatch is reversed, this can be very stressful [55]. A vigorous hike can lead to feelings of invigoration, but a hike up the Himalayas might be overwhelming.

Another route to engagement is through the use of character strengths. A character strength is a positive trait embodied in our thoughts, behaviors, and feelings. Importantly, an individual cannot have too much of one character strength [23]. An assessment of character strengths can be completed free online through the Values in Action (VIA) character strengths assessment [23, 56]. Studies have shown that love, gratitude, curiosity, hope, and zest are the five character strengths that have the highest correlation to well-being [23, 26, 57]. This is likely due to their particularly significant contribution to engagement, pleasure, and meaning – key components of PERMA [26]. In his book, *Flourish*, Seligman discusses a questionnaire developed by Christopher Peterson, one of the first people to work with him on defining the field of positive psychology, that evaluates participants' signature strengths ([41], p. 39). Signature strengths are an individual's five character strengths that are most essential to they are and which, if used in a new way on a daily basis, are found to significantly increase well-being ([41], p. 40). Seligman encouraged participants to capitalize on these strengths to achieve, among other things, more flow. For example, if your signature strength is creativity, you may choose to allocate an hour to painting two times a week. This highlights the importance of identifying areas in which the individual can achieve flow to maximize its contribution to well-being.

R – (Positive) Relationships

> Shared joy is a double joy; shared sorrow is half a sorrow. –Swedish Proverb

According to Christopher Peterson, the core principle of positive psychology is that, "other people matter" [58]. Most of life's positive emotions, meaning, and accomplishment occur in the context of other people. Whether this is in the form of sharing success with a colleague or experiencing excitement with a friend, relationships are a central part of well-being. Human beings have evolved to pursue positive relationships as a means of survival and flourishing. Being part of a group historically increased survival rates, making relationships a vital part of natural selection ([41], p. 23). Some research has shown that the presence and quality of social connections are correlated with health outcomes including longevity and the development and progression of a disease [59]. Marriage and similar intimate relationships were found as a central element of these findings [59]. Another study conducted by Stanton et al. in 2019 looked at 1208 individuals from the National Survey of Midlife Development in the United States and demonstrated that perceived partner responsiveness (including change in responsiveness over time) predicted all-cause mortality through mediating effects on negative emotional reactivity to stressors [60]. These benefits make the importance of relationships clear; however, this stands in contrast to trends in how much time people are spending together. A 2014 study of UCLA freshmen showed that freshmen are spending less time with friends than did previous generations. The percentage of freshmen students spending fewer than 5 h a week socializing has more than doubled since 1987, going from 18% to 39% [61, 62].

The rise of social media has been targeted as a culprit in the declining amount of time people are spending with each other. An emerging area of focus has been the study of phubbing. Phubbing is when someone inadvertently snubs the person they are physically with when distracted by their cellular device. Chotpitayasunondh and Douglas explored these phenomena and revealed that phubbing negatively affected relationship satisfaction and perceived communication quality [63]. As cellular mobile devices continue to saturate interpersonal communication, it will be important to appreciate and be mindful of their potential impact on relationships and in turn, well-being. Though forming relationships is partially a biological

drive, research supports the value of increasing the motivation to act in a prosocial manner. Among other tools to do this, Lyumbomirsky et al. demonstrated that having subjects consciously commit to acts of kindness contributed to building better relationships, feeling more confident in their abilities to enact changes, and triggering an upward spiral of positive emotions and positive interpersonal exchanges. They postulated that these improvements were due to the acts producing a sense of interdependence, cooperation, gratitude, being better liked by others, and most importantly, prosocial reciprocity [45].

M – Meaning

> To live is to suffer, to survive is to find some meaning in the suffering. –Friedrich Nietzsche [64]

Human beings want meaning in life [65]. Michael Steger provides a concrete definition, a meaningful life is experienced as understandable, purposeful, and significant [66]. Going one step further, Baumeister described four requirements for meaning: purpose, values, sense of efficacy, and a basis of self-worth [67]. He describes satisfying these as a way of achieving meaning. It is important to recognize that meaning can come from multiple sources such as work, religion, or family and that fostering multiple sources is protective against a meaningless life. Seligman emphasizes the importance of clarifying the differences between meaning and positive emotions as their subjective components are similar at times [41]. For example, an extraordinary theatrical performance that made you contemplate your life direction could be seen as "a meaningful experience," yet this is a subjective experience that may lose its meaning with time. While positive emotions are entirely subjective, meaning has a subjective and an objective component. For example, Ruth Bader Ginsburg, an associate justice of the Supreme Court of the United States, may have had days in law school that were frustrating or that seemed mundane; however, this does not make the arc of her career any less meaningful. Despite the experience of subjective negative emotions, meaning remains. A study of 1807 adolescents in Hong Kong looked at how meaning in life affects well-being. Ho et al. demonstrated that increased meaning led to increased multifactorial satisfaction and a reduction in psychosocial concerns [68]. Furthermore, meaning has been shown to increase happiness, increase positive affect, decrease stress, and to be negatively correlated with depression [69, 70]. Meaning also has been demonstrated to increase resilience and increase interpersonal appeal [71, 72]. To help nurture the benefits of a meaningful life, studies have shown that writing about what is meaningful and keeping physical reminders of those things are ways to enhance meaning [61, 73]. A meaningful life, a clear sense of purpose and self-worth, is crucial to well-being.

A – Accomplishment

> It had long since come to my attention that people of accomplishment rarely sat back and let things happen to them. They went out and happened to things. –Elinor Smith [74]

Seligman describes accomplishment as coming in two forms: the momentary form and the extended form. Both forms of accomplishment were added to PERMA to help account for the role that mastery, competence, and achievement play in well-being. Though accomplishment often has overlap with other elements of PERMA such as positive emotions and meaning, Seligman highlighted that accomplishment completes what people choose to pursue for its own sake. Accomplishment is what allows us to look back on our lives and think that despite obstacles, we achieved and persevered [41]. "Grit" is a concept introduced by Angela Duckworth that examines the ability to persevere and accomplish in times of adversity [75]. There are countless examples of accomplished individuals who have had to overcome failure. Van Gogh was a talented painter who was both underappreciated as a painter throughout his life and suffered from schizophrenia. Despite these challenges, he produced incredible works of art that were ultimately only appreciated after his death. This is an example of perseverance leading to accomplishment

for the sake of accomplishment. Research has shown that having significant goals and achieving these goals are positively correlated with well-being [76, 77]. Importantly, if there is too much discrepancy between goals and reality, this can negatively impact well-being. As such, goal revision is an important tool to reduce this discrepancy when pursuing accomplishment as a path toward well-being [78]. In a 10-year longitudinal study of 5693 adolescents, Messersmith and Schulenberg demonstrated that goal achievement and continued goal striving lead to a greater sense of well-being [79]. This highlights the long-term impact of accomplishment on well-being, in particular during the important transition from adolescence to adulthood. Accomplishment can take different forms in the different life stages. According to Erik Erikson, each stage of psychosocial development presents a unique set of goals. During young adulthood, Erikson's Identity vs Role confusion, environmental mastery, and autonomy are a source of accomplishment. In late life, Erikson's Ego Integrity vs Despair, a key accomplishment is self-acceptance [29]. Goal revision is vital to maintaining accomplishment's impact on well-being.

The field of positive psychology is constantly evolving and so is our understanding of the many facets of PERMA. Scales, such as the PERMA Profiler, will continue to help deepen our understanding of PERMA and the future directions of positive psychology [80]. Though it is clear that fostering each of the elements of PERMA individually has tremendous benefits, it is crucial to appreciate that it is the combination of these elements that will lead to a true sense of well-being.

Learned Optimism

In Seligman [36], foundations of the concept of "learned optimism" are based on the concept of learned helplessness. Therefore, in this section, the concept of learned helplessness will be included before the concept of learned optimism is explained.

Seligman developed the *learned helplessness* hypothesis during his experiments with dogs in the 1960s. In the experiments conducted by Seligman and Maier in 1967, it was observed that the dogs did not react to shock evasion when shocked. In these experiments, Seligman divided dogs into two groups: one group was given the opportunity to escape from the shock, while the other group showed no response regardless of the shock. At the end of these experiments, it was observed that the dogs in the second group were unresponsive to the shock given after a while and did not attempt to escape. After many experiments in the following years, Seligman explained this unresponsiveness in dogs with the concept of learned helplessness. According to this, learned helplessness means that the organism does not show and passive in similar situations where it cannot establish a relationship between a behavior that occurs and the result of this behavior. Starting from here, Seligman and Gilliham [37] conducted various experiments with people who thought that learned helplessness could be generalized to human behavior. For example, in an experiment, individuals were given some riddles to solve. Individuals were divided into two groups, as in experiments with dogs. A group was given riddles that were difficult to solve and sound waves disturbing the ear were given to the environment unless individuals could solve the riddle. These people have experienced that there is no way to avoid negative stimuli, just like in experiments with dogs. The other group of individuals were given questions that they could easily solve and the annoying sound was withdrawn as they solved the riddles. Individuals in both groups were given new riddles again in the second part of the experiment after this part of the experiment ended. Although these riddles were easy, in the first part of the experiment, the individuals in the failed group did not attempt to solve the riddles.

Similar to the learned helplessness model, in the framework of the learned optimism model, optimism is handled by the individuals' way of explaining the events. It was found that individuals with an optimistic loading style had physical

health, motivation, high morale, and low level of depression symptoms. Based on the findings of this research, he developed the idea that a transition from pessimism to optimism is possible. For the realization of this change, he proposes to use the Inverse-Thought-Result model developed by Alber Ellis and Beck's ideas [25].

The four elements that an individual should be aware of in the process of developing optimistic way of thinking are evidence, alternatives, implications, and usefulness [32]. Evidence is to look for proof of distorted or unrealistic thoughts in negative explanations. Alternatives include screening for all negative causes. Implication is the discussion of the consequences of the negative/pessimistic explanation. On the other hand, the usefulness of the individual is to question whether the negative thinking about the reverse is destructive. If the individual realizes that the thought is destructive, he/she can easily oppose this thought or try to make it less destructive. For example, an individual who interprets the indifference of one of his/her friends as being worthless can look for evidence for this idea, try to develop alternative thoughts instead of this idea, realize the results of this idea, and finally discuss how destructive this idea is. At the end of this study, instead of pessimistic point of view, it can gain energy by reaching a more optimistic way of explanation.

As a result, Seligman argues that individuals can reduce their pessimism and increase their optimism by working on pessimistic thoughts that they have shown against unfavorable events. In this direction, he developed the concept of learned optimism and explained how to improve optimism. It is believed that the attribution of the individual to the events, in other words, the manner of explaining the events, is important. In a study conducted on the effectiveness of the optimism development program [2], it was concluded that the eight-session learned optimism development program was effective in increasing the level of optimism as a loading form.

Excellence

The study of excellence and accomplishments can be seen as a logical and relevant part of understanding positive psychology. Peterson describes that, "If our interest is in people at their best, we should study the most talented people, and we should study them in settings and circumstances that have allowed them to do their best" [24]. Just as we have studied illness to develop treatments, positive psychology seeks to put excellence under the microscope to potentially enhance the abilities of all people.

While an expert is seen as reaching a particular destination or level of mastery, excellence is found in the act of doing and action. Those that we consider experts almost always have a manifestation of excellence, the artist has their masterpiece and the professional athlete astounds with their high levels of physical prowess. In the study of excellence, it is also important to notice the ways in which the pendulum of theory and research have moved away from a purely intrinsic view of excellence based on inborn traits and more toward deliberate actions taken by the individual [81]. A meaningful example of this transition in the dominant thinking can be seen in the work of Sir Francis Galton. In the mid-1800s, he began an investigation into the origins of excellence and initially attributed excellence to hereditable factors. However, after considering work by others, such as Darwin, he came to see the importance of environmental factors and moved away from genetic predestination [81].

Anders Ericsson's work on expertise and excellence provided important contributions to our understanding of the development of high levels of performance. He described a theoretical framework called deliberate practice to describe the process leading to expertise and excellence and sought to clearly characterize this process. Deliberate practice involves investing significant amounts of time and energy on the part of the individual as well as receiving external support, e.g., training materials, appropriate facilities [82]. In addition to deliberate practice Ericsson also referenced the work of Simon and Chase and their study of chess experts and the idea of the "10-year rule." They found that in order to reach an international level of chess ability, there is a requirement of 10 years of consistent experience and preparation. The finding of the "10-year rule"

has been duplicated in other domains including intense competitive sports and music performance [81, 82]. The concepts of deliberate practice and the 10-year rule both recognize the importance of not just putting a certain amount of time into a pursuit but the highlight that there is a "right" way to spend that time in preparation in pursuit of high levels of performance.

Examining concepts related to excellence as they relate to positive psychology and promoting well-being can be useful. In his thesis Daniel Lerner explored this exact topic and coined the term "positive excellence" defined as "roads to excellence that are both effective and healthy, paths that lead toward success and well-being" [81]. There are countless examples in history, from the arts to politics to sports, of individuals who achieved high levels of expertise and performance at great personal cost. There are multiple paths to excellence and expertise, and not all are healthy, and it is important to identify this distinction when helping individuals develop positive excellence in their lives. This distinction involves understanding that striving for high levels of performance in an activity is an admirable pursuit, but attention must also be paid to the process of engaging in one's interests and not just the output.

Passion

To understand the field of what "interests" people, positive psychology turns to the study of passion. Passion has been defined as "a strong inclination toward an activity that people like, that they find important, and in which they invest time and energy" [83]. Robert White introduced the idea that we are drawn to certain interests or activities based on a basic human need for competence (as cited in [24]). We are attracted to our areas of passion because of the opportunity for improvement, growth, and development of skill [24].

Vallerand's work links the field of positive psychology and excellence through the study of passions. He posits that there are two types of passion: harmonious and obsessive. Harmonious passion is characterized by an internalized motivation to participate in the activity willingly and freely, occupying a significant but not all-consuming part of an individual's life, and operating in harmony with other parts. Conversely, obsessive passion is characterized by an internalized pressure to engage in an activity, compelling the individual to engage in the activity and eventually taking up a disproportionate amount of the person's time and identity [83].

While spending large amounts of time engaging in the activity is characteristic of both types of passion, obsessive passion can be associated with persistent rigidity that can cause someone to continue the activity, "even in the face of important personal costs such as damaged relationships and failed work commitments" [83]. Harmonious passion has been linked with promoting well-being and positive affect [84]. Harmonious passion is associated with less anxiety and pressure and as a result may lead to higher levels of performance [83].

The study of excellence and passion can be seen as a logical extension of positive psychology, beyond the human fascination with outstanding achievements. Harmonious, healthy passion may lead to individuals reaching personal levels of excellence and by extension greater well-being. The desire to have a passion is fairly ubiquitous though many feel unsure as to what their passions are or how to develop them. Understanding the ways in which people have successfully pursued passions may allow others greater self-efficacy in the development of their own.

Conclusion

Positive psychology is a discipline that focuses on protection and development of positive characteristics of individuals, positive experiences, and their mental health through programs that increase their subjective well-being [35]. Within the framework of the positive psychology approach, researches on the above-mentioned concepts of well-being continue to be conducted and studies are carried out to understand and develop the positive aspects of human personality. In this context, according to Seligman and Csikszentmihalyi [35], the positive psychology approach conducts research in three important

areas: (a) Working on what positive experiences of individuals are, (b) Working on what are the positive characteristics of individuals, (c) Working on positive institutions.

One of the criticisms to positive psychology is that positive psychology is more research-based in methodological terms, it gives more space to cross-sectional and correlational studies, whereas it gives less space to theoretical explanations. It is true that positive psychology focuses more on research and quantitative studies, but it should not be overlooked that there are studies of subjective well-being, such as adaptation theory, top-down and bottom-up theory, goal theory, and flow theory [12]. Positive psychology has also brought a different perspective to the science of psychology in general. Now, researchers do not only conduct studies on burnout in industrial psychology as well as work satisfaction; in addition to divorce and marriage problems in marriage, they also investigate marriage satisfaction. In this respect, positive psychology could be considered to have led to a paradigm shift in the world of psychology.

Another criticism is related to whether positive psychology is a new approach or not. As noted above, there are researchers and theories in the history of psychology that deal with the positive characteristics of man. Positive psychology seems very similar to the humanistic psychology put forward by Maslow (1971) in the 1970s, but it differs in various ways. Humanistic psychology is a qualitative method based on a phenomonological approach, examining human and its behavior. Positive psychology, on the other hand, can be used in experimental and quantitative methods just like natural sciences [10].

Question such as "What is good life?," "what is happiness?," and "what is well-being?" have been tried to be answered by different disciplines such as theology, philosophy, economics, and psychology. But even today, these issues are still an enigma. The positive psychology approach seems to be the youngest discipline seeking answers to these questions. To date, what has been put forward in this direction has shown a positive contribution of positive psychology to human well-being.

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Part II

Staying Positive Through Life

This part *Staying Positive Through Life* includes four chapters that follow the lifespan – child and adolescent, midlife crisis, professional wellbeing, and successful aging – followed by a concluding chapter on life balance from a Positive Psychotherapy (PPT) perspective.

Chapter 4, Staying Positive in Youth, identifies Rettew's twelve domains of wellness in positive child psychiatry and makes the case for the use of Positive Psychology Interventions to support youth wellbeing.

Chapter 5 centers on the Midlife Crisis, a period of high density of life events, and explores seven factors associated with resilience during this period.

Chapter 6, Staying Positive at Work, discusses the challenge of professional burnout and the need for interventions to achieve professional wellbeing.

Chapter 7 defines and summarizes the body of knowledge around the concept of Successful Aging – including recent findings on the studies of centenarians.

Chapter 8 uses the Balance Model from PPT to make a case for life balance instead of life-work balance.

Positive Child and Adolescent Psychiatry

4

Consuelo Cagande and Salman Majeed

> You're braver than you believe, and stronger than you seem, and smarter than you think.
> — Christopher Robin

Introduction

We learn from the Adverse Childhood Experiences Study (ACES) that persons who experience four or more adverse events in childhood have higher risks for several of the leading causes of death in adults. Researchers have studied significant factors for youth at risks for mental illness [3, 7, 13, 17] as well as factors that can promote positivity in youth [12]. While there is a paucity of research on positive psychiatry in children and adolescents, there is a plethora of literature on wellness. Cultivating wellness and positivity among youth have been essential in promoting resilience in youth. Child and Adolescent Psychiatrists and Psychologists have the skills in preventing and intervening earlier when this population has a lot more demands at home, school, work and social arenas, including the media. Decades ago our focus was diagnosis and treatment but now we are preventing and screening which in this generation is vital for resiliency. Resilience in children and adolescents can be greatly enhanced by paying attention to the value of cultural, sporting, and other activities, sensitive mentoring to build self-esteem and strengthen mental health, and open new social relationships.

Positive psychology seeks to understand and promote well-being through assessment and interventions involving positive psychosocial characteristics (PPCs) in people who suffer from or are at high risk of developing mental or physical illnesses. In their clinical handbook on Positive Psychiatry, Jeste and Palmer highlighted four main components:

1. Positive mental health outcomes (e.g., wellbeing),
2. Positive psychosocial characteristics that comprise psychological traits (resilience, optimism, personal mastery and coping self-efficacy, social engagement, spirituality and religiosity, and wisdom-including compassion) and environmental factors (family dynamics, social support, and other environmental determinants of overall health),
3. Biology of positive psychiatry constructs, and.
4. Positive psychiatry interventions including preventive ones. There are promising empiri-

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cal data to suggest that positive traits may be improved through psychosocial and biological interventions [6].

Rettew [11] identified 12 domains of wellness in positive child psychiatry:

1. Positive attributes and traits,
2. Nutrition,
3. Physical activity and exercise,
4. Involvement in structured activity,
5. Music and the arts,
6. Reading and limiting screen time,
7. Parenting behavior,
8. Parental mental health,
9. Spirituality and religious involvement,
10. Compassion and giving back to others,
11. Mindfulness,
12. Sleep.

Applications

Positive psychiatry is increasingly gaining the attention it deserves. But is there evidence of significant outcome when applying positive exercises, especially in youth? How are they applied? There are many components of positive psychiatry that have been applied and studied.

A study ventured in replicating Seligman's Positive Psychology Exercises (PPEs) study and its long-term benefits. Mongrain et al. added a "positive placebo" which was the cognitive access of positive information about the self. They concluded that PPEs do lead to lasting increase in happiness in both control and placebo groups. However, changes in depression over time did not exceed the control condition. Activation of positive, self-relevant information rather than through other specific mechanisms seems to be an effective method with brief positive psychology interventions to enhance happiness [9].

Given negative self-evaluation is prominent in adolescents with depression, positive self-reflection may be a protective factor. One would expect positivity in this aspect would be low. Wiley et al. studied the specificity of positive and negative self-evaluation in adolescent depression. They concluded that positive self-endorsements were not impaired nor associated with the severity of depressive symptoms [11].

Life satisfaction (LS) is an attribute one tends to measure themselves at times. In adolescents, subjective life satisfaction can impact their academic performance. A study sought to find evidence for reciprocal association of life satisfaction and academic performance and how the relations may be shaped by positive and negative affective experiences in school. The results showed positive reciprocal causal relations between students' LS and grades. Therefore, LS is synergistic with better school grades and should have a role in positivity in the school curriculum [10]. This can further boost one's confidence and competence.

Rosenberg's study on "Promoting Resilience in Stress Management" (PRISM) on adolescents and young adults with cancer showed improvements in hope and benefit finding which are two adaptive coping skills that may mitigate long-term psychosocial risk. This was a randomized study comparing those in PRISM to usual care. PRISM taught stress-management, goal-setting, cognitive-framing, and meaning-making skills [14].

Interpersonal relationships can be precipitating factors for youth with depression and anxiety. Herres studied emotional reactivity in youth with anxiety disorders. Negative parent and teacher events can cause more negative affect reactivity. Negative peer events can cause less positive affect reactivity. Emotion regulation associated with negative events involving adults and addressing barriers to developing and maintaining positive peer relationships should be goals in therapy [5]. Self-control has shown to be effective in accomplishing goals. The science and practice of self-control study by Duckworth and Seligman demonstrated that self-control "outdoes" talent in predicting academic success during adolescence [2]. Furthermore, family is the core unit that can either promote or demote positive thinking. The application of the constructive approach, not destructive, of "functional rehabilitation of the family" must be strongly emphasized in treatment [16].

Grebosz-Haring studied the effects of music, mainly singing versus listening, in hospitalized children and adolescents with mental illness. This pilot studied the efficacy of music-related interventions by measuring potential neuroendocrine (cortisol), immune (IgA), and psychological (mood state, health-related quality of life (HRQOL), well-being). Their finding was significant in demonstrating that singing led to a larger mean drop in cortisol and in HRQOL than those listening to music. Those listening, though, led to a higher mean positive change in calmness and improvement in well-being than singing [4]. Music therapy has been part of most inpatient setting but a larger study replicating this and having objective measures of the efficacy of music therapy would be ideal.

A cross-sectional study examined the predictive value of mindfulness and self-compassion for depressive symptoms, negative affect, and positive affect in adults. The Five Facets of Mindfulness Questionnaire (FFMQ) was used as a measure of mindfulness and the Self-Compassion Scale (SCS) as a measure of self-compassion. The study found harsh attitude toward oneself had a great value in predicting the presence of psychological symptoms. Four of the five FFMQ facets (observe, describe, act with awareness, and non-reactivity) were significant predictors, suggesting that mindfulness is a more important predictor of positive affect than self-compassion, as measured by the FFMQ and SCS [8]. Mindfulness is not just for the adults anymore. Applications of relaxation techniques such as mindfulness and yoga are now ubiquitous and effective. For example, relaxation therapy compared to watching relaxing videotape improved anxiety, including anxious behavior and fidgeting, in hospitalized children and adolescents with adjustment and depressive disorders. They also measured cortisol level and found it to decrease in the relaxation therapy group but no change in the video group [15].

Social media, internet, and screening time have received negative connotations, such as behavioral problems. Limiting screen time and more reading can improve language development, self-regulation, and academic achievements [12]. But applying innovative techniques using the internet can be effective for those who are not able to access mental health treatment timely. Internet-delivered cognitive behavior therapy (ICBT) has actually been around for approximately 20 years. Although a study by Andersson et al. found ICBT to be more effective than a waiting list and tends to be as effective as face-to-face CBT, it has not really been positively accepted by some patients who prefer using modern information technology as an adjunct to face-to-face therapy [1]. This is an area that earns itself for more innovated techniques and applications.

Outcome studies have shown positive psychology concepts are promising in pediatric oncology, promotion of sexual health and HIV/STD, pregnancy, and unprotected sex. Positive coping appraisals have been found to buffer the relationship between life stress and suicidality.

A psychiatrist can apply comprehensive assessments to include the strengths, weaknesses, interests, coping mechanisms, and interpersonal relationships of the child and adolescent. Furthermore, youth self-evaluations and life satisfaction assessment should be performed. Psychiatrists in training (residents), therapists, counselors, and institutions such as schools should implement aspects of positivity into their curriculum and training.

Summary

Positive psychiatry allows the clinician to promote resiliency in youth. There are many components to positivity. Obtaining comprehensive information on the youth's self-regulation, life satisfaction, and self-evaluation in addition to the traditional clinical assessment can aid the psychiatrist in formulating a meaningful and individualized positive treatment plan (PTP). Additionally, the PTP should emphasize and target positive interpersonal relationships and emphasize family formation.

Key Points

- Positive mental health thinking promotes resilience in youth.
- Positive psychology exercises (PPEs) in various forms (e.g., relaxation therapy, mindfulness, music therapy, stress management, self-evaluation, life satisfaction, innovative internet CBT) are applicable to youth.
- Including PPEs in a patient's treatment plan is crucial to fostering resilience and improvement in youth depression and anxiety and other behavioral problems.

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Positive Psychiatry in Midlife

5

Samidha Tripathi and Erick Messias

Introduction

The term "midlife crisis" was first used by psychoanalyst Elliot Jaques on a paper looking at prominent artists, among them Raphael and Dante, who experienced critical periods in their mid-30s and thus had what he called a "midlife crisis" [1]. Dante himself alludes to being in the middle of life in the majestic opening lines of the Divine Comedy:

> Midway upon the journey of our life.
> I found myself within a forest dark,
> For the straightforward pathway had been lost.

Indeed, the trajectory of psychological well-being when plotted over age has a U-shaped curve with its nadir at about the age 50 (Fig. 5.1) [2].

Similarly, the lifetime prevalence and risk of depression seem to peak between the ages 46 and 49 [3]. Taken together, these findings seem to confirm the notion of a midlife crisis occurring between the ages of 45 and 55. Interestingly, there is evidence for a similar "midlife crisis" among great apes [4] suggesting mechanisms beyond social and cultural pressures contributing to this phenomenon.

Midlife is also a pivotal age standing at the intersection of the decline in physical health, speed of processing, and working memory and the acquisition of knowledge, wisdom, and emotional regulation [6]. This convergence can foster a period of consolidation of life experience before the challenges of aging take hold.

The importance of understanding this key period in life led to the large epidemiological study Midlife in the United States (MIDUS) supported by the National Institute on Aging and available here: http://midus.wisc.edu/ [7].

The longitudinal findings on life satisfaction from the MIDUS study tell a somewhat different story than the U-bend. It shows that a majority of middle-aged adults are satisfied with their life and stay that way or even improve over a 10-year period. One possible explanation for the lower scores often reported in cross-sectional studies is that those in midlife have not yet met their goals and aspirations, and they see room for improvement and growth. In contrast, older adults may be closer to their peak in terms of goal attainment. Indeed, whereas present satisfaction is on the rise, and has not yet reached its peak in midlife, projected satisfaction about the future is on its way down, and has not yet reached the nadir which does not occur until old age [6, 8].

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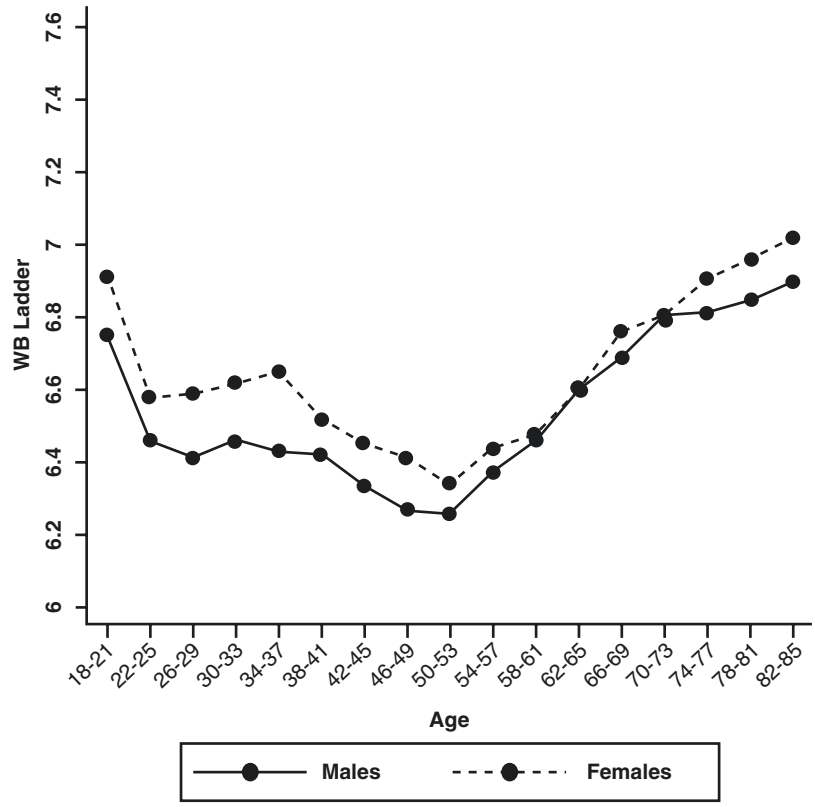

Fig. 5.1 Well-being through the lifespan. Note the nadir around age 50 followed by a gradual increase from 55 to 85. (Source for Fig. 1: Stone et al. 2010 https://www.pnas.org/content/107/22/9985. "WB" stands for well-being)

Definitions

Midlife is usually defined as the central period of a person's life, commonly thought of as between the ages of 45 and 55. Some studies extend the concept to early midlife 45–55 and late midlife 55–65.

A *life event* is defined as an important happening in someone's life with an impact in several areas of their being. Midlife is a period with high density of life events, the most prevalent being:

1. Close family death;
2. Family health issues;
3. Major financial difficulties;
4. Major job changes;
5. And moving to a new place of residency [5].

Midlife crisis is described as an emotional crisis of identity and self-confidence most commonly observed in early midlife.

The notion that midlife crisis is a phase that most adults go through has been rejected. Predisposing factors include a history of psychological crisis and personality type [9].

Factor associated with resilience in midlife include [5] the following:

1. Growth and purpose.
2. Managing uncertainty.
3. Spirituality.
4. Emotional objectivity.
5. Adversity level.
6. Humor.
7. Changing philosophy.

Growth and Purpose

One menacing emotion of midlife is the sense of stagnation at times associated with actually mastering a craft or profession. Erik Erikson's

life stage of generativity vs. stagnation represents the mature conflict of adulthood and coincides with the idea of mid-life crisis. Generativity involves guiding the next generation and the concept is meant to include productivity and creativity. In a healthy family, parents show generativity through interest and care for their children. In an organization, leaders with generativity are able to better care for both the mission and their employees [10]. Success leads to feelings of usefulness and accomplishment, while failure results in shallow involvement in the world.

By failing to find a way to contribute, one may become stagnant and feel unproductive. These individuals may feel disconnected or uninvolved with their community and with society as a whole.

Managing Uncertainty

Individuals in midlife may experience both physical and psychological changes, including changing physical appearance, decreased stamina, loss of family or friends, divorce, and altered vision. Midlife can be termed a bridge age with disruptions in or leveling of employment goals, children leaving home, and parents needing more care, as well as the realization that less time remains to fulfill dreams [11].

Anderson [12] compared the feelings associated with changes in physical appearance and stamina and facing mortality to the stages of mourning identified by Kubler-Ross. These stages, developed to describe the emotional reaction following a loss, include denial, anger, bargaining, depression, and acceptance [13]. Introspection guides individuals toward acceptance of changes in midlife thereby leading to positive change in relationships and employment [14]. Inability to accept mistakes made while managing difficult situations, focusing on too many aspects of difficult situations, and demoralization from personal failures can amount to difficulty coping with changes in midlife [5].

Spirituality

Spirituality is important to a large percentage of the older adult population and serves as a promoter of healthy aging. A growing body of literature suggests that people often turn to religion when coping with stressful events. However, studies on the efficacy of religious coping for people dealing with stressful situations have yielded mixed results [15]. The study on resilience in midlife by McGinnis also concluded that many participants considered religious and/or spiritual strategies to be an important component of managing challenges; however, for a subset, spiritual strategies were not necessarily effective [5]. Spirituality is also a strength of character identified by Seligman and Peterson and along with the appreciation of beauty, gratitude, hope, and humor, constitute the virtue of Transcendence.

Emotional Objectivity

An individual's ability to set aside emotional reactions when dealing with distressing situations and solving life's problems also contributes toward resilience in midlife. This is in line with the emotional dysregulation model for anxiety and mood disorders, which views such disorders as the result of emotional dysregulation of negative emotions coupled with deficiencies in positive affect [36].

Adversity Level

Current literature suggests that early traumatic experiences and early childhood adversity (ECA) have long-lasting repercussions influencing our health as adults, incidence of chronic disease, and quality of life indicators [16]. Life satisfaction is a common outcome of interest in research about successful aging [17, 18]. Life satisfaction involves an assessment of how well desired goals and actual outcomes have matched. Previous studies have established the effect of cumulative adversity, which included childhood

experiences as well as adult adverse experiences, on life satisfaction [19, 20]. Life satisfaction is negatively associated in particular with early adversity [21, 22].

In addition, individuals with low socioeconomic status (SES) are at risk and vulnerable to accelerated aging. Yet, the biggest advantages with psychosocial resources and adaptive behaviors have been found for those at greatest risk, i.e., low SES couple with ECA [23]. "Differential susceptibility" refers to individual differences in the response to adversity (National Institute on Aging, 2012) [24]. It suggests that the same attributes that make an individual particularly sensitive to adversity may also make him or her more responsive to supportive interventions designed to offset the effects of adversity [6].

Humor

Humor plays an important role in resilience toward stress and trauma. Increased humor can contribute to the enhancement of positive life experiences, and lead to greater positive affect and psychological well-being [25]. Humor is also a character strength that contributes strongly to life satisfaction [26] and another strength of character component of the virtue of Transcendence. However, a major concern with some of the positive psychology work on humor and resiliency is the exclusive focus on a singular positive construct of humor. In contrast, the humor styles model recognizes not only the positive or adaptive aspects of humor, but also the maladaptive or negative aspects. Self-enhancing or affiliative humor can yield the expected resiliency effects, whereas self-defeating or aggressive humor may not [27, 28].

Changing Philosophy

With each stage of development our responsibilities continue to evolve and change. One's ability to adapt to these changes and demands of life and society affects one's life satisfaction. Individuals may experience restlessness as they evaluate their goals in earlier years and compare them to accomplishments, leading to a crisis. Those who remain in a stable personal and professional environment are able to derive greater satisfaction as the meaning of work and their role shifts, and the concept of generativity becomes noticeable [14].

One important predictor of well-being in midlife is education – where years of education acquired before age 25 has a lingering effect in helping foster a lifelong learning pattern along with better management of adverse life events in midlife [5].

Time volunteering and charitable donations in midlife seem to have a significant positive effect in psychological well-being later in life [29].

Conclusion

There is some evidence that stresses involving multiple role demands, or financial pressures, may cluster in midlife or take a greater toll in middle age [30]. Yet still today, there are many misconceptions about midlife, with the most common myth centered on the midlife crisis.

The stereotype of midlife crisis as portrayed in the media is depicted as a middle-aged man purchasing a sports car or acquiring a new hair color or style in an effort to defy the aging process. In reality, midlife is a critical juncture of growth and decline pathways. The salient issues of midlife involve balancing work and family responsibilities and demands in the midst of physical and psychological changes associated with aging.

The MIDUS survey shows that a crisis is not a typical midlife phenomenon. In a recent study in the United Kingdom, the reports of crises were higher, in the 40–60% range, although the incidence was comparable across adulthood [31]. About the same number said they experienced crises at other points in life. Of those who said they had a midlife crisis, about half said it involved inner turmoil or angst associated with getting older. For the rest, it was tied to events such as divorce, job loss, or health problems, which can occur at any period [32]. Those who did experience a crisis in midlife were usually those who had upheavals at other times in their

lives, and these individuals seemed to be driven more by a neurotic personality than advancing age [33, 34].

On the positive side, the MIDUS study found that those who had supportive social relationships, exercised regularly, and had positive attitudes about control in midlife were better able to maintain their functional health and cognitive skills over a 10-year period, and more of these positive factors was better [35].

Midlife also is a prime period for connections across earlier and later periods of the life course. Despite its challenges, midlife is a time to learn from stressful experiences, find meaning and experience growth in the face of adversity.

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Professional Well-Being

6

Victoria Flynn and Erick Messias

Introduction

Most people in the world will spend a third of their adult lives at work, making well-being at work a key component of their overall well-being [1]. Positive interventions hold significant promise in helping prevent burnout and promote human flourishing both in the workplace and in general. Positive psychology and psychiatry are approaches to mental health, rather than mental illness, with an emphasis on enhancement of positive psychosocial traits, promotion of positive change, and development of well-being [2–5]. The focus on one's mental health, well-being, and both personal and professional success involves further developing positive coping, best practices and shifting to this positive approach.

Transitions throughout training, job search, and a career can be both exciting and challenging, with the potential for self-doubt and imposter syndrome, burnout, turnover, and early career transition. While there are many exciting opportunities, there are also new responsibilities and challenges that may seem both daunting and insurmountable to young professionals. These challenges are more easily navigable by fostering specific virtues in each phase of professional development, from initial curiosity and optimism to informed perspective and gratitude and ultimately to an appreciation of excellence in one's late career. Professional burnout is another challenge for professionals at each stage of their career. Professional burnout is a syndrome of emotional exhaustion, depersonalization or cynicism, and low sense of personal accomplishment in response to chronic occupational stressors [6]. Professional burnout affects one's ability to successfully navigate the unique challenges at various stages of professional development, especially those during periods of role transition from learner to apprentice to early career professional. This is an increasing concern for human service professions, including first responders, teachers, and healthcare providers where burnout affects one's ability to be successful in their profession. Professional burnout has become a profound concern for the institution of healthcare, as rates of burnout exceed 50% in students, trainees, and early career professionals [7–13].

With the guidance and direction of a professional coach, these transitions throughout one's professional development may be more easily traversed without these negative consequences [14, 15]. The International Coach Federation (ICF)

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defines coaching as "partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential" [16]. A positive psychiatry approach, with an emphasis on further developing one's strengths and the positive psychosocial factors of optimism for personal mastery, perceived self-efficacy, consciousness, social engagement, and resilience, may help encourage and guide young professionals through their career and shift from an emphasis on preventing burnout to promoting wellness.

Key Positive Psychological Traits

Positive psychosocial factors (PPSF) include positive social and environmental influences as well as internal positive psychological traits (PPT). PPTs originate from the positive psychology movement which focuses on circumstances and processes that yield successful and optimal functioning in individuals, groups, and institutions. Enhancement of PPTs is necessary for both personal and professional development. While most PPTs are beneficial for personal growth, we will focus on a select few proposed to be most beneficial throughout various stages of one's professional and career development (Table 6.1). Figure 6.1 shows these key character traits and virtues, alongside opportunities and challenges faced at progressive stages of development in one's career.

Erik Erikson, a prominent psychoanalyst of the twentieth century, formulated a psychosocial development model identifying developmental stages throughout the lifespan. This model illustrates sequential development and identity formation [17]. His theory has primarily been used as a model for the development of children and adolescents. Darling-Fisher has focused on its

Table 6.1 Opportunities, challenges, and key character traits throughout stages of development in a professional career

Stage of career	Opportunities and challenges	Erikson developmental phase	Associated virtue
Student	Knowledge acquisition; test-based performance evaluation	Autonomy vs. shame and doubt	Curiosity and optimism
Apprenticeship	Learning to apply acquired knowledge; supervised application of acquired knowledge; skill-based performance evaluation	Industry vs. inferiority	Love of learning
Early career	Transition to young professional; independent application of knowledge; skill-based performance evaluation	Professional identity vs. role confusion	Vitality and zest
Mid-career	Professional mastery and wisdom; leadership and mentorship development	Intimacy vs. isolation	Social and emotional intelligence
Late career	Expert professional mastery; knowledge and skill transfer to trainees	Generativity vs. stagnation	Perspective and gratitude
Retirement	Transition from professional life; evaluation of personal and professional life accomplishments	Integrity vs. ego despair	Appreciation of beauty and excellence

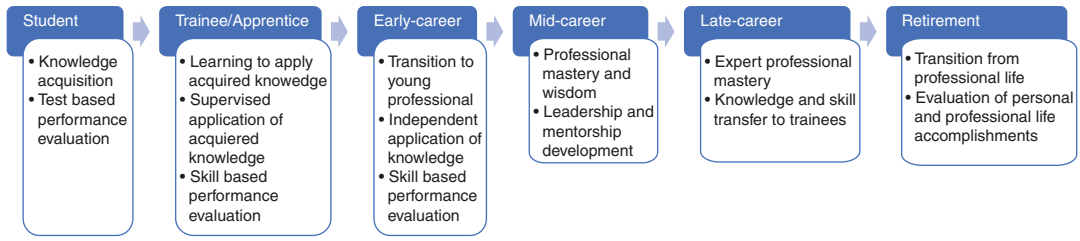

Fig. 6.1 Opportunities, challenges, and key character traits throughout a professional career development

application to adulthood and has shown that mastery of late developmental crises (generativity vs. stagnation and ego integrity vs. despair) in critical developmental periods is largely affected by advancing age [18, 19]. Here, the changes and challenges of professional development throughout a career from learner to retiree are likened to these developmental stages from childhood to old age, with advancing age and experience assisting in mastering these crises. There are various challenges and opportunities at each phase of one's career that when surpassed lead to further growth and mastery. In the above figure and in the sections to follow a proposed model is provided for pairing Erikson's psychosocial stages of development to phases of career development with associated opportunities and challenges and specific character traits and virtues identified to foster.

Curiosity and Optimism

Point in career	Developmental stage	Character trait or virtue
Student and trainee	Autonomy vs. shame and doubt	Curiosity and optimism

Curiosity and optimism are important aspects of nearly every stage of one's professional development, especially those periods with prominent growth and transition. In the learner and trainee stages, an individual is struggling with the developmental challenge of knowledge acquisition and attempting to overcome self-doubt and increase autonomy. Peterson and Seligman describe curiosity as a positive emotional-motivational state where individuals "initiate and sustain goal directed behaviors in response to incentive cues" [20]. Those in the earliest stages of their profession experience learning curves where large amounts of knowledge and skill must be acquired in order to ready oneself for future stages of one's career. An increased level of curiosity and optimism may serve students and trainees in knowledge acquisition and application. In fact, meta-analyses show curiosity accounts for 10% of the variance of learning and performance [21] with greater curiosity associated with greater learning, engagement, and performance [22]. Fostering the curiosity of students and trainees may keep them interested and engaged in the field for further occupational pursuits.

Optimism reflects the extent to which individuals expect favorable outcomes to occur and continue their effort toward obtaining goals and desirable outcomes [20]. Individuals with high levels of optimism tend to attribute positive outcomes to internal, stable factors and negative outcomes to external, temporary factors [2]. Optimism is an important trait for professional development and growth mindset as individuals with higher levels of optimism may be more likely to take on challenges, tackle new problems, and collaborate with others. Duckworth, a proponent of positive and well-being education, is dedicated to teaching character development and describes "grit" as the most reliable predictor of success. Grit, which she defines as passion and perseverance, is closely associated with Seligman's early studies on optimism [23]. In Seligman's research on depression, learned helplessness was viewed as the belief that one's actions did not influence outcomes. Grit and optimism are quite the opposite with an emphasis on internal motivators and influences.

Optimism and hope are essential for the ability to think about different possibilities and find the best course of achieving a more desirable future [3]. In their 2018 Positive Psychotherapy Clinician Manual, Rashid and Seligman describe a systematic process for building hope and optimism through their "Doors Opening" worksheet which illuminates optimism or pessimism through one's explanation for missed opportunities and "doors closing." An individual who describes the process of one door closing as external, temporary, and situationally dependent (rather than personalized, permanent, and pervasive) has increased optimism and more adaptive functioning in the wake of negative consequences. By pairing this activity with reflection and discussion with a professional coach, therapist or mentor, unhelpful and overly critical perceptions can be altered for progression toward a more optimistic and flexible mindset considering work [3].

Love of Learning

Point in career	Developmental stage	Character trait or virtue
Apprenticeship	Industry vs. inferiority	Love of learning

Lifelong learners, with their zest for advancement, individually excel as well as profoundly influence their surrounding community. These lifelong learners are cognitively engaged and have a love of learning that is described as a "way in which a person engages new information and skills generally and/or the well-developed individual interest with which he or she engages a particular interest" [20]. These individuals typically have positive feelings regarding learning new material and acquiring new skills [24]. They are the individuals who "learn for the sake of learning" rather than for an immediate or extrinsic motivation [20]. Individuals in the apprenticeship phases of their career transition from learning material to learning the application of this material to various occupational situations. In this phase of development, an individual is striving for industry but is at risk for feelings of inferiority. Peterson and Seligman suggest individuals with love of learning as a strength would strongly endorse statements that suggest they "like to learn new things" and that despite current difficulty or inability to perform tasks they have confidence that they will be able to master the material and/or skills in the future. These individuals are able to "self-regulate efforts to persevere, despite challenge and frustration" [20]. This skill is becoming increasingly beneficial for those life-long learners in nearly every field – healthcare, business, education, finance – as advancements in technology rapidly change processes of day-to-day operations as well as communication avenues for exchange of information.

Love of learning is described as a character strength with strong intrinsic motivation. Even without love of learning as a primary strength, individuals can foster its development after gaining specific interests. The process of developing love of learning as a strength as one develops specific interests and has increased opportunities to further develop knowledge in this area leads to an individual to gain value from learning by increased confidence, competence, and an optimistic sense of possibility [24]. Peterson and Seligman emphasize the roles of teachers and parents in supporting children in building a love of learning. In the professional domain, a coach or mentor may support an individual by connecting them to various topics of interest as well as encouraging them through periods of challenge and frustration.

Vitality and Zest

Point in career	Developmental stage	Character trait or virtue
Early career	Professional identity vs. role confusion	Vitality and Zest

A vital person infectiously energizes those with whom they come into contact [20]. The word "vitality" is derived from vita, or life, and one who is vital can be described as having vigor, enthusiasm, and spirit. This vitality, or life force, is a positive energy from within that energizes and motivates the self and others. The concept of vitality is far from new, with origins in ancient Eastern philosophies and healing practices. The Chinese describe *chi*, a vital force or energy that is the source of life, creativity, right action, and harmony. The Japanese concept of *Ki*, or energy and power one can draw upon, is related to physical, emotional, and mental health. Balinese healers work to bring together *bayu*, a vital spiritual or life force underlying growth and resistance to illness [25]. Each of these descriptions emphasizes the role of vitality in holistic growth and health. Ryan and Frederick developed a measure of subjective vitality, or a positive feeling of aliveness and fullness of energy which can identify differences between individuals' report of vitality as well as changes within an individual over time given various situations and factors [25]. Early career professionals focus on the development of a professional identity and once this identity is formed their enthusiasm and vitality is nearly palpable.

Individuals who are vital, or full of life, are internally motivated for positive influence and change. Several studies have attempted to mea-

sure and or enhance vitality. Nix et al. showed that while success in completing tasks can lead to happiness, only autonomous tasks maintain or enhance vitality [26]. Thus, those activities that are self-motivated and conclude with a perceived internal locus of causality have a greater influence on vitality. Exercise and a healthy lifestyle have been shown to improve vitality [27]. Jakobson et al. showed that physical exercise, performed with colleagues during working hours, is more effective than other exercises at improving vitality at work [28]. Interestingly, when individuals are asked to monitor and report the amount of time they spend sitting in a day, over time they report significant decreases in sitting time and significant increases in vitality at work scores [29]. Hendrikson et al's Workplace Health Promotion Program which included training, workshops, and individual coaching significantly improved workplace vitality, performance, self-management, and sickness leave [30]. Ryan et al. have experimentally shown that contact with nature positively affects vitality [31]. In these studies, vignettes describing being in nature, 15-minute walks in nature, and being shown photographs of nature scenes all increase vitality. This illustrates that any nature-related sensory input – auditory, physical touch, and visual – enhances an individual's sense of vitality. Additionally, a sense of autonomy and increased social contacts improves vitality [32, 33]. Workplace vitality may be increased by incorporation of several of the previously mentioned interventions – schedule informal meetings as walking meetings to increase exercise and reduce sitting time; have lunch meetings or work gatherings in an outdoor relaxation or garden spaces; have team building activities outdoors to include a nature component; and allow team members to work on committees or projects they can find passion for.

Social and Emotional Intelligence

Point in career	Developmental stage	Character trait or virtue
Mid-career	Intimacy vs. isolation	Social and emotional intelligence

Intelligence, the ability to think abstractly, can be divided into cognitive intelligences and the *hot intelligences* which encompass signals concerning motives, feelings, and relationships [20]. Social and emotional intelligence are two of the hot intelligences and individuals with high social and emotional intelligence are skilled in: identifying emotion in faces, voices, and designs; using emotional information to facilitate cognitive activities; understanding what emotions mean in various relationships; managing and regulating emotions of the self and others; using social information to facilitate group cooperation; and identifying social relationships and hierarchies among groups [20]. Individuals in the midpoint of their career have successfully traversed the initial challenging transitions of a career. These individuals focus on fostering relationships with trainees through coaching or mentoring and relationships with peers through membership and leadership in local, national, and global organizations. Goleman argues successful, effective leaders stand out because of their emotional intelligence. Emotional intelligence is valued equally, if not more so, than IQ in his concept of successful leaders [34, 35].

Emotional intelligence involves the basic skills of self-awareness, self-regulation, motivation, empathy, and social skill. These skills can be strengthened through practice and feedback from colleagues or coaches. David and Congleton have worked with leaders in various industries to build emotional agility, an emotional intelligence skill which enables people to approach their inner experiences in a mindful, values driven way rather than attempting to ignore, suppress, or alter these thoughts and emotions. They encourage four practices, based on Acceptance and Commitment Therapy, which include recognition of thought and emotion patterns, labeling of thoughts and emotions, accepting ideas and emotions with an open attitude, and acting based on individual and organizational values. Strengthening emotional agility and social-emotional intelligence can alleviate stress, reduce errors, increase innovation, and improve performance [34, 36].

Perspective and Gratitude

Point in career	Developmental stage	Character trait or virtue
Late career	Generativity vs. stagnation	Perspective, kindness, gratitude

Gratitude is a sense of thankfulness and joy in response to receiving a gift. Individuals late in their career may look back on their professional life and reflect on how others have positively influenced their professional development by investing time and energy into their success. A sense of gratitude arises from the belief that one has benefitted because of the actions of another person, the acknowledgement of this gift, and appreciation and recognition of the value of that gift [20]. Late career individuals who have benefitted from the assistance of another person often work to give back to other trainee and early career individuals. Their generativity and inclusion positively affects the development of those trainees and early career professionals.

Gratitude interventions often include a daily gratitude journal in which an individual reflects on people or experiences for which they are grateful. Cheng et al. showed that just two work-related diary entries per week decrease perceived stress at work [37]. Stegen and Wankier illustrated that generating gratitude in the workplace through various gratitude interventions increases job satisfaction [38]. Seligman showed that even a one-time letter of gratitude written and delivered sustains significant decreases in depressive symptoms and increases happiness ratings for 4 weeks [4]. Increasing opportunities for gratitude may positively affect the individual, the community at work, and work performance.

Appreciation of Beauty and Excellence

Point in career	Developmental stage	Character trait or virtue
Retirement	Integrity vs. ego despair	Appreciation of beauty and excellence

Individuals with an appreciation of beauty experience self-transcendent emotions like awe and admiration when encountering perceived beauty and excellence in their surroundings. Aesthetic sensitivity and responsiveness allow one to more fully appreciate the world around them and to forget one's own concerns and attachments. Appreciation, when associated with a loss of ego and openness to others, enables self-transcendence [20]. Individuals who have reached the later phases of their career and retirement theoretically reach what Maslow would describe as the "peak experience" of one's career. These peak experiences capitalize on a gained appreciation and include a selfless attitude, receptive and humble cognition, enhanced ability to see, hear, and connect with others, and a view of the world as good and beautiful despite conflicts and suffering [39]. An individual in the retirement phase of their career, who has reached the developmental phase of self-integrity, sees the workplace as "all of a piece and that one has his place in it" [39].

The developmental course of appreciation remains unclear. It is thought to be highly heritable and that openness to experience plays a role [20]. Searching for excellence in others and modeling that excellence throughout one's career may help one better appreciate the excellence around them. Fryer-Edwards et al. took advantage of this notion in their Committee on Continuous Professionalism Improvement program which emphasizes appreciative inquiry and celebrates excellence in their community, with the goal of further increasing positivity and excellence [40].

The Problem of Professional Burnout

Individuals often state their motivation for entering healthcare, human service, and educational fields is to connect with others, make a difference, and improve the lives of others. This empathic approach energizes individuals to become fully invested in their clients and work goals, often

working long hours giving up personal time in order to assist with a student or client in need. Higher levels of humanistic characteristics – generosity, compassion, altruism, social and emotional intelligence – are important for fostering interpersonal relationships [20]. Unfortunately, a higher level of these humanistic characteristics, specifically empathy, has also been associated with increased levels of professional burnout [41]. Professional burnout is a psychological syndrome of emotional exhaustion, depersonalization or cynicism, and a low sense of personal accomplishment or lack of professional efficacy in response to chronic interpersonal and occupational stressors [6, 42–44]. Due to the emotional and systemic/administrative demands of the profession, human service professionals may be at an increased risk for burnout.

The development and sequelae of burnout is not a universal process and individuals are not uniformly affected [45]. Various conceptual models have been created to describe the process, most of which involve imbalances between individuals and their workplace or job demands [43]. The transactional model of burnout describes sequential stages of stressors with individual and job imbalances – from an imbalance in job demands and individual capabilities, to individual strain, and finally defensive coping manifested as disengagement or cynicism [46]. This model describes a cause and effect process where increased stress leads to increased strain and stress, similar to an elastic stretched thin. The Job Demands-Resources Model and Conservation of Resources models describe a reactionary process to persistent job demands. In these models, unrelenting demands and stressors lead to either liquidation of resources or the perception of impending loss of resources and a resultant attempt to maintain any remaining resources (e.g., time, energy, etc.) [47, 48]. These conceptual models of burnout are similar to a car with an empty gas tank. The Areas of Worklife model identifies six key areas in which there are person-job mismatches leading to burnout. These six areas include workload, control, reward, community, fairness, and values [49]. In this model, a mismatch between goals of an individual and that of the workplace in one or more of these areas leads to burnout. Interestingly, rewards and compensation are helpful in keeping symptoms of disengagement and emotional exhaustion at bay but monetary rewards are not the most incentivizing strategy to increase productivity and enjoyment at work [47].

Significant time and energy have been invested in identifying an individual's burnout, an organizational prevalence, and key influences because there are very real consequences to this phenomenon. In the healthcare field, burnout has been associated with professional consequences of increased medical errors, decreased quality of care, reduced patient satisfaction, and decreased patient compliance with treatment plans [11]. Additionally, personal consequences of burnout include broken relationships, maladaptive coping (e.g., alcohol and substance use), depression, and suicide [11]. Several studies have examined the relationship between burnout and depression [50–52], with the current understanding that there is a complex relationship between these distinct entities [43, 53–56]. Burnout has an identified negative association with professionalism, altruism, and what often lead individuals to the human service fields, their sense of calling [57, 58]. The financial well-being of an organization is also affected as burnout is associated with the expressed intent to leave one's job, higher rates of turnover, and productivity losses [12]. These professional and personal consequences of burnout are of concern for patients, providers, and the institution of medicine.

Interventions

Given the many consequences of professional burnout, there are multiple budding solutions for reducing professional burnout, increasing employee engagement, and improving workplace well-being [11, 13, 59–63]. Interventions have been shown to reduce overall burnout moderately, some studies estimating reductions of 10% [13]. These interventions can be classified as

individual, organizational, or leadership-based (Fig. 6.2). Interventions must be developed to meet the needs of the individuals and organizations involved rather than application of a universal, one size fits all solution [11].

At the individual level, common interventions include mindfulness training, meditation, gratitude exercises or reengagement with hobbies [37, 38, 53–56, 64, 65]. Significant improvements in perceived stress and professional satisfaction are gained by reflecting on one's thoughts, emotions, and biases during challenging interpersonal encounters [66]. Small group curriculum on mindfulness, reflection, and shared experience leads to statistically significant and sustained improvements in feelings of empowerment and engagement at work. It also has significant improvements in finding meaning, emotional exhaustion, depersonalization, and overall burnout [61]. Interventions focused on improved communication increase satisfaction and decrease intent to leave one's job while interventions focused on workflow changes and targeted quality improvement reduce overall burnout [60].

At the organizational level interventions often involve workflow restructuring and improving workplace practices, providing occupational training, and developing workshops to reduce mental stress. Individuals with minimal, or no, burnout often participate in these programs but individuals with high degrees of burnout have been shown to be less likely to voluntarily participate in these organization-driven interventions [62]. Shanafelt et al. suggest nine organizational interventions to promote well-being. This list includes (1) acknowledging stress and burnout with leadership-driven open dialogue and assessments of burnout over time; (2) harnessing the power of leadership to enhance leadership skills and to recognize the unique talents and motivations of members of their team; (3) developing and implementing interventions which target-specific driver mismatches in individual work units; (4) cultivating community at work through debriefing after errors, providing feedback, and celebrating achievements; (5) using caution with productivity incentives that may encourage decreased

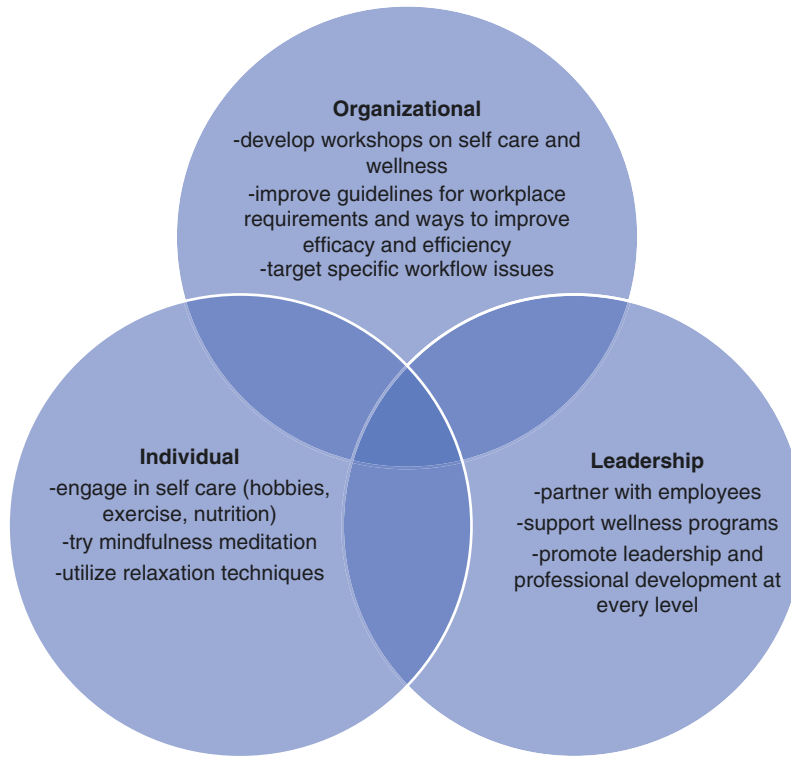

Fig. 6.2 Organizational-, leadership-, and individual-based interventions to improve engagement and performance and prevent professional burnout

quality of care (shorter appointments, increased work up, etc.) or increased work hours leaving employees susceptible to burnout; (6) aligning values to show that the team and organization are working toward a common goal and improve community at work; (7) promoting flexibility with work schedules and encouraging work-life integration; (8) providing resources to promote resilience (skills training, narrative medicine, mindfulness, positive psychology exercises) and self-care (exercise, diet, sleep, financial health, relationships, hobbies); and (9) facilitating and funding organizational science [11]. These nine interventions target nearly every one of their proposed drivers for engagement or burnout in work – values and culture, meaning, flexibility, community, resources, workload, and work-life integration. Other programs suggest addressing the psychological needs of employees, cultivating organization-employee relationships, and sponsoring leadership development in order to develop comradery and excellence [67].

Executive Coaching Approach to Professional Development

Professional coaching is a results-oriented method of "enhancing self-awareness, drawing on individual strengths, questioning self-defeating thoughts and beliefs, examining new perspectives, and aligning personal values with professional duties" [68]. As described above, the International Coaching Federation (ICF) defines the goal of coaching as partnering with a client and inspiring them to reach their full potential through a thought-provoking, question-driven, creative process [16]. Despite sharing attributes with mentoring, therapy, and consulting, coaching has specific goals, methods, and training making it a separate category of intervention that is suitable for professional development – see Table 6.2 for the differences between these modalities. Professional coaches engage clients with their present challenges and encourage them to think of alternative perspectives and self-identified action-oriented solutions. This process ultimately assists clients in the self-directed process of achieving their goals [14, 15, 68, 69].

A professional coach is most often confused with the role of a mentor. A mentor has a desire to share knowledge and experience and develops a personal and professional relationship with a mentee. Mentors are described as having multiple roles: advisor with career experience and desire to share knowledge; supporter who gives emotional and moral encouragement; tutor who gives specific feedback; sponsor who shares information and aids in opportunities for growth; and a model who demonstrates their own as well as guides the development of their mentees professional identity [70].

According to the ICF, coaching has several core competencies which range from establishing an agreement, being an active and present listener, engaging powerful questioning and maintaining communication, assisting with goal setting, and holding clients accountable [15, 16]. The core competencies, according to the ICF, are listed in Table 6.3.

Different coaching certifications require a variety of standards, training, supervision, and practice. Several tools applied in coaching have their origins in positive psychology, neurosciences, and traditional forms of psychotherapy, in particular Cognitive Behavioral Therapy (CBT) [68, 69, 71]. Positive psychiatry's emphasis on expanding on strengths and developing positive psychological traits (PPT) align nicely with the core competencies of coaching. PPTs focus on attributes that determine healthy outcomes and greater functioning in the face of normative transitions and adversities. PPTs of personal mastery, perceived self-efficacy, and resilience, are significant for coaching through one's professional development [7]. Developing and nurturing PPTs in a professional coaching relationship may lead to positive attitudes, increased work effort, and ultimately professional success. As a coach, it is usually more productive to focus on a client's strengths rather than weaknesses and to enhance skills and behaviors that have previously been helpful for a client [20]. Per Polly and Britton's executive coach case description in the recently published Positive Psychiatry: A Casebook, coaches who draw on positive psychology often emphasize client's strengths, growth mindsets, and self-efficacy [54].

Table 6.2 Differences between coaching, consulting, mentorship, training, and therapy modalities

Modality	Coaching	Consulting	Mentoring	Training	Therapy
Goal	Achieving goals and reaching full potential	Implementing programs	Modeling	Knowledge transfer and acquisition	Managing symptoms and relapse prevention
Expertise	Coaching	Subject matter experts	Experience	Implementation	Psychotherapy modalities
Focus	Present goals, consistent directed action, future results	Past processes applied for future outcomes	Past successes modeled for present success	Past knowledge applied to present circumstances	Past determinants and current symptoms
Techniques	Powerful questioning, client-directed exercises, challenges	Observation, implementation, testing	Advising, modeling	Case studies, skill building, systems, planning	Vary from supportive, to behavioral, to insight-oriented
Services	Pragmatism, accountability	Proven methods for success	Proven path for success	Practical strategic plans	Group and individual sessions

Positive psychology coaching uses one's strengths to emphasize engagement, meaning, and accomplishment [68]. Palamara et al. created a strengths-based coaching program for resident physicians with the goal of establishing a safe environment for support and guidance through internship. Coaches were trained in positive psychology exercises that guided each session – including the Best Reflective Self, Values in Action Signature Strengths Survey, GROW (goal, reality, options, way forward), and PERMA (positive emotions, engagement, relationships, meaning, accomplishment). At the conclusion of the program, 96% of interns reported they either definitely or probably would recommend this coaching program. Interns also reported statistically significant improvements in reported opportunities to reflect on performance and communication with their coach. While not statistically significant, there were lower reports of emotional exhaustion, a component of resident physician burnout [56].

As previously discussed, professional burnout is a syndrome of emotional exhaustion, cynicism and depersonalization, and a decreased sense of personal accomplishment [6, 42–44]. Coaches who emphasize enhanced self-reflection and awareness can improve a client's flexibility and resilience in the face of workplace stressors [72]. In fact, studies have suggested fostering this self-awareness may help identify one's values and find meaning in their work [61]. West et al. capitalized on this by designing facilitator lead small group discussions on mindfulness, reflection, shared experience, and group learning. They explored topics relevant to the physician work experience, including meaning in work, balance, mistakes, community, and caring for patients. The results of this work showed improvement in empowerment and engagement as well as decreased rates of depersonalization, both of which were sustained at 1 year [61].

Table 6.3 International Coaching Federation core coaching competencies

Coaching core competencies
Meeting ethical guidelines and professional standards
Establishing the coaching agreement
Establishing trust and intimacy with the client
Having coaching presence
Exercising active listening
Engaging in powerful questioning
Maintaining direct communication
Creating awareness
Designing actions
Setting plans and goals
Managing progress and providing accountability

Professional coaching is an emerging approach for the professional development of medical practitioners [61, 73]. Examples of dialogue between a client and coach can be reviewed to gain insight into the potential client-coach experience [68]. By

increasing engagement at work and inspiring recovery of personal interests, coaches encourage resilience and a sense of meaning [68]. There are many potential positive results of professional coaching including improved self-awareness, insight-oriented behavioral changes, decreased burnout, increased resilience, retention, and engagement in work and community.

Summary

Most adults spend the majority of their time at work, making well-being at work a major factor in overall well-being. Professional burnout affects one's ability to maintain engagement and productivity at work as well as successfully navigate the unique challenges at various stages of one's career. There are both personal and professional consequences to burnout and unfortunately the rate of burnout in human service professions is increasing. An emphasis on positive psychosocial factors and enhancement of various character strengths and virtues may counter the negative response to burnout and professional development challenges. With the help of a professional coach or mentor, professional developmental can be navigated for personal, professional, and leadership success.

Key Points

- Individuals face unique challenges and opportunities as they progress through various stages of their profession.
- These challenges can be viewed through a developmental lens, similar to Erikson's psychosocial development model, and traversed by enhancement of various character strengths and virtues.
- Professional burnout is a threat to today's organizations and society at large. With increasing emotional exhaustion, depersonalization, and decreasing self-efficacy come personal and professional consequences that affect work-life satisfaction and workforce sustainability and turnover.
- Interventions for improving satisfaction and reducing burnout by promoting wellness show promise. These interventions may be at individual, organizational, or leadership levels and should target the specific needs of individuals involved.
- With the help of a professional coach or mentor, professional developmental challenges can be navigated and personal, professional, and leadership development successfully guided.

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Successful Aging

7

Paulette Mehta, Romika Dhar, and Erick Messias

> The greatest thing in life is to die young as late as possible.
> — George Bernard Shaw

Introduction

People are aging in the United States (U.S.) and around the world. Whereas the median age in the U.S. was 47 years in 1900, it is now 76 years for men and 81 years for women [1]. In 1900 the number of people over 65 years of age was 1 in 25, now it is 1 in 8. Furthermore, the population over 85 years is now the fastest growing segment of the American population. The number of people over 65 years of age was three million in 1994 and is expected to be 19 million by 2050. The causes of morbidity and mortality have also changed from primarily infectious disease in the early 1900s (pneumonia and tuberculosis) to chronic diseases for which the underlying causes are now primarily psychosocial problems, i.e., obesity, smoking, physical inactivity, poor diet, addictions (opioid and others substances), suicide, and homicide [2]. These changes in demographics and in causes of disease will change public health needs and offer opportunities for interventions for decades to come. Psychiatrists will have an important role in shaping response to this public health upheaval and in promoting techniques for successful aging for patients with and at risk for mental disorders, for responding to the underlying psychosocial issues of our time, and for expanding and disseminating the wisdom of elders to the young.

Normal aging is usually associated with some decline in physical functioning and health while pathological aging is associated with premature decline in physical functioning, disease, and disability. In contrast, successful aging has been generally considered as living a long life with minimal disability and disease, with good function and social engagement, although its precise definition is still elusive [3].

There are many longitudinal studies on aging which began in the mid-1900s (see Table 7.1). Early studies were purely biomedical and focused on survival, causes of death, risk factors for disease, and protective influences mitigating the risks. Later studies added cognitive, behavioral,

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Table 7.1 Major longitudinal studies on aging

Year	Study name or cohort	Comments
1948	Framingham heart studies	Longest ongoing study of CV health, defined role of smoking, lipids, BP, psychosocial factors, family history, CHF and genomics
1955	Duke longitudinal studies of Normal aging	Evaluated cardiac, vascular, neurologic, psychosocial factors and aging
1958	Baltimore longitudinal study of aging	Showed variability of aging trajectories and relationships to CV disease and dementia
1961	Kansas City stud of adult life	Longitudinal study identifying aging trajectories and hierarchical goals
1976	Nurse health study	Studied married nurses from 11 states re birth control, smoking, cancer, CV disease, lifestyle factors, behaviors, personal traits in relation to CV and >30 other diseases
1984	MacArthur studies	Rowe and Kahn established the MacArthur studies and evaluated new biopsychosocial model of aging in 1000 elders; showed importance of social engagement, vitality, and resilience in successful aging
1991	Manitoba elderly study	Elders evaluated in 1971 and 1983, of >100 parameters, the only factors related to successful aging were age, 4 measures of health status, 2 of mental health and not having spouse die or enter nursing home
1993	MacArthur studies	Using biopsychosocial model, successful aging related mostly to non-smoking, exercise, volunteer activity, psychological health
1995	Nuns' Study (aging and cognitive function)	Long-term study of Roman Catholic nuns, evaluated physical, mental, cognitive, writing, and autopsy studies; found that education and social involvement could mitigate against early Alzheimer's disease symptoms
1995	Honolulu Asia aging study	Goal was to determine if there were differences in neuropathic disease and mortality in Japanese-American men in Hawaii. They identified 5 types of brain lesions independently associated with dementia
1998	Predictors of SA in men with high life expectancies	Evaluated men of Japanese heritage; predictors of successful aging: Clinical disease, impairment
1999	Canadian study of health and aging	Elders over 85 years; 79% felt well despite functional impairments
1999	Aging successfully until death in old age	High physical activity associated with two-fold greater chance for dying without disability
1999	Berlin study of aging I (BASE-I)	Study showed variability of aging trajectories and relationships to CV disease and dementia
1999	New England centenarian study	Identified many new genetic variants associated with long life and resistance to diseases of aging
2000	SAGe study (successful aging evaluation study, UCSD)	UCSD, study of 1800 randomly selected, representative, community-dwelling people in san Diego CA focusing on cognitive and emotional factors
2001	CV health study	Predictors for successful aging were physical activity, non-smoking, optimal weight, and no uncontrolled diabetes, blood pressure, lipid abnormalities
2001	Successful aging over a lifetime	2 cohorts of boys with and without college education studied for 60 years or until death; identified 8 variables affecting survival, all controllable
2006	Alameda County study	Evaluated elders born between 1895 and 1919, 20% healthy; successful aging related to race, family income, blood pressure, arthritis, back pain, smoking, weight, and alcohol.
2010	NuAGE (nutrition and aging), Quebec	Evaluated 1741 women, 68–82 years for 3 years; decline was related to age, physical capacity, and depression

Table 7.1 (continued)

Year	Study name or cohort	Comments
2011	MacArthur studies	Evaluated 499 people from original cohort, APOE-E4 related to worse baseline cognitive function for which B vitamins did not help
2014	Women's health initiative	Very large study on women >80 years, physical function found to be related to demographics, psychosocial, behavioral health, psychosocial support. Optimism mitigated depression
2014	Berlin study of aging I (BASE-II)	Expansion of BASE I study with additional 1600 people from 60 to 80 years and 600 younger subjects, 20–35 years; ongoing
2014	IDEAL study (insight into determinants of exceptional aging and longevity)	Recruiting subjects now for continuation of Baltimore longitudinal aging studies; will focus on aspects of successful aging in normal healthy subjects over 80 years of age
2015	SAGES study (successful aging after elective surgery)	Study assesses long-term impact of delirium and other late effects after elective surgery in the aging
2015	Veterans affairs normative aging study	Assesses impact of cherished vs. hostile vs. ordinary childrearing on late life satisfaction and successful aging
2015	Uppsala longitudinal study of adult men	Assesses predictive factors for late life independence. Optimal BMI and non-smoking are predictive
2015	National Health and resilience in veterans study	Successful aging in veterans is related to health behaviors, social engagement, and disposition
2016	Longitudinal aging study (Amsterdam)	Large Dutch study of elders 55–85 years evaluated over 16 years. Successful aging was related to education, income, occupation, SES, and emotional resilience
2016	Vanderbilt memory and aging project	Ongoing long-term evaluation of cardiovascular and brain health in people with mild cognitive impairment
2016	Women's health initiative	Most rated health as good or better despite disability/ disease, often self-rated with high levels of resilience, self-control, and self-mastery
2017	ACHIEVE-P (aging and cognitive National Evaluation in elders pilot program	Pilot program to study impact of hearing loss and cognitive decline in the elderly
2018	Occupational determinants of successful aging in older physicians	Large study of occupational and personal aging in physicians which was related to age, gender, depression, cognitive state, anxiety, and work. Work centrality was very high and many physicians never retire possibly because they do not know what else to do

psychosocial, and economic factors. Some studies have focused on patients with psychiatric disease, mostly anxiety, depression, and schizophrenia. More recent studies are focusing on positive psychological and psychiatric factors such as optimism, resilience, and wisdom with age. These qualities may take a lifetime to fully develop and may enrich one's personal life as well as the larger community and world.

Methodological Issues

Studies on aging share common obstacles, mostly lack of precise definitions. Depp, in his seminal review of aging literature, noted that there were 29 different definitions of successful aging in his review of 28 studies which had been published prior to 2006 [3]. Thus, successful aging may still be an elusive concept [4].

Similarly, there is not a single definition of elder age or how to distinguish biologically young-old from old-old, and oldest-old [5]. Although chronological age is easy to calculate, biological age is not, and biological age may be more important than chronological age in survival and in successful aging.

Another methodological problem is that subjects being studied and scientists studying them have different perceptions of any one person's quality of aging [6] . Elders almost always rate their aging as much better than do their investigators. One's person's perception of successful may be very different than another's. Successful aging, like beauty, may thus be in the eye of the beholder making any single definition non-generalizable.

Phelan and others were among the first to realize that elders often felt much better than their providers imagined [6]. The reasons for this is that despite functional impairment and limitations, people can overcome such limitations with optimism, resilience, spirituality, and wisdom [7–10]. Although this is a methodological problem, it is also potentially a resource with which to discover methods of overcoming physical limitations allowing for more successful aging.

Thus, there is no single subjective or objective measure to define successful aging. A biomarker for age and for successful aging would be useful but is not available. Jeste et al. have suggested that telomere length may be a biomarker for age. This possibility is under investigation [11]. Other investigators have suggested that markers of chronic inflammation (e.g., IL-6, TNF-a, CRP, ESR) may be better markers [12]. Some investigators claim that radiologic studies, in particular brain fMRIs, PET and SPECT scans may be even better markers for brain health and early detection of degenerative diseases of the brain prior to clinical manifestations [13]. These scans then could diagnose brain disease early and help to begin experimental treatments at the first sign of radiologic detection, even before any clinical manifestation of disease.

Longitudinal Studies on Aging

From Biomedical Model to Biopsychosocial Economic Models

Table 7.1 lists key clinical trials but there are many other trials around the world. Early studies focused on lifespan, causes of morbidity and mortality, identification of risk factors for disease and protective factors mitigating the risks. Early studies initially used a strictly biomedical model and emphasized disease and disability as limitations to successful aging. Gradually over time, this pure biomedical model evolved to incorporate cognitive, psychosocial, behavioral, and economic factors, creating a much more robust and comprehensive model.

The focus in aging research has consequently changed from a single disease focus to a more multimodal systemic approach [14]. Most recent aging studies are now organized by teams of specialists including geriatricians, internists, cardiologists, physiologists, psychologists, psychiatrists, and others. This is especially important since most age-related diseases involve multiple organs, although the underlying mechanisms of disease in each of these organs may be similar. Thus, factors which are dangerous for the heart such as high blood pressure, overweight/obesity, smoking, excess cholesterol and triglycerides are also dangerous for the brain.

As attention has turned to a cognitive-behavioral-biopsychosocial-economic model, so too has attention turned to the brain as a co-equal to the heart, which had previously taken center stage as a single focus of aging studies. This shift probably occurred due to a variety of reasons.

First, some of the most dangerous diseases of the 1960s were becoming more manageable and no longer needed the same single focus of attention. In particular, mortality from coronary artery disease began to decline in the 1980s [2] and beyond as a result of healthier lifestyles and more effective medications.

Second, it was clear that psychosocial factors modulated physical functioning such that patients

were often quite happy and content despite physical limitations and despite their researchers' presumptions. These psychosocial parameters needed to be included in medical models to close the gap between subjects' experiences and researchers' assumptions.

Third, the 1990s became the "Decade of the Brain" which brought attention to the brain and its impact on health and aging, as well as increased national funding [15]. Many discoveries arose during this period of time including new generations of antidepressants and antipsychotics. More striking however was the discovery that the brain could heal itself and that brain growth and remodeling occurred throughout life. Remodeling could occur through the regeneration of tissue from endogenous brain stem cells, stimulated by brain-derived neurotropic and other growth factors. This was in direct contrast to the previously prevailing belief that development or regeneration of the brain could not occur after early adulthood [16]. This neuroplasticity could also result in rewiring of neural connections and thus trauma pathways could be mitigated, and regeneration could occur well into late life. Some qualities arising from the brain could even blossom at the end of life, notably resilience and wisdom, natural antidotes to anxiety and depression [17–19].

Fourth, it is possible that interest in psychosocial parameters in aging may have related to the coming of age of the baby boomer generation. Baby boomers like to control their destiny and to try novel therapies; moreover, they often had already experimented with psychedelic and psychotropic drugs and may have also leaned on psychologists and psychiatrists in stressful times. As such they may have been more receptive to psychosocial studies and treatments. Of course, many baby boomer investigators were also coming of age, subject to the same dynamics and may have been more interested in studying psychosocial factors for the same reasons as the study subjects.

Thus, there is no surprise that cognitive, behavioral psychosocial-economic aspects became a part of the successful aging model as the first wave of longitudinal studies gave way to subsequent waves. Table 7.1 depicts many but not all of the major longitudinal aging studies from the mid-1900s until now. Below are a description of some of the more influential studies.

The Framingham Study

The largest of the early longitudinal studies is the Framingham study which started in 1948 and is still ongoing [20]. This study enrolled more than 5000 people between 30 and 62 years of age initially and has gradually expanded to involve three cohorts consisting of children of the original cohort as well as other cohorts with increasingly more diverse ethnic and racial composition. The emphasis from the very start was on the cardiovascular system especially coronary artery disease, congestive heart, and atherosclerosis.

More than a thousand papers have come out of this very long and distinguished study and form the basis of much of our current knowledge of risk factors for coronary artery disease. For example, investigators defined the role of hypertension, poor diet, lack of exercise, high blood pressure, diabetes mellitus, lipid abnormalities, and others in exacerbating heart disease. It also established the salutary effect of exercise, diet, optimal weight, and drugs such as aspirin and others.

Later studies in the Framingham Study focused on psychosocial findings and found, for example, that social contacts determine to a large extent whether an individual will become overweight/obese and that poor memory was more likely if their parents had dementia.

The Baltimore Longitudinal Study of Aging (BLSA)

Another very famous early and long-lasting longitudinal study is the Baltimore Longitudinal Study of Aging [21]. More than 3000 people between the ages of 60 to late 90s were entered into this study and were evaluated on a yearly basis for their aging trajectory. The major aims were to establish the types of aging trajectory and link them to physical and cognitive, mental, psychosocio-economic factors. These studies had a focus on physical strength, energy expenditures with

different types and intensities of physical activity, muscle strength, balance, bone mineralization, proprioception, and others. Brain imaging and PET scans were routinely done to identify the role of brain physiology in aging and to identify the earliest possible evidence of Alzheimer's disease.

A major feature of the study was comparing patients to themselves rather than comparing old to young people. The study generated more than 800 papers with several general conclusions that aging is very individualized, there is no specific pattern trajectory for all people and that aging did not necessarily cause disease. However, people do lose muscle mass and muscle strength over time and this can be partially overcome through vigorous physical activity. They also identified waist circumstance with body mass index (BMI) as better than BMI alone for predicting coronary artery disease. They also showed that physical activity can prevent problems even when begun late in life, that balance exercises can reduce falls, that strength exercise can build muscles and prevent osteoporosis and that flexibility exercises keep bodies limber.

The IDEAL Study

In 2014, the Baltimore Longitudinal Aging Study evolved into the IDEAL (Insight into Determinants of Exceptional Aging and Longevity) study [22]. This study sought to identify characteristics of successful or more-than-successful aging. Requirements for entry into the study are age over 80 years, good health, no major disease, no medications, normal cognitive function, and high physical activity. It is being conducted by the same investigators as those who conducted the Baltimore Longitudinal Aging Study. Study subjects are required to return every year for extensive studies and results are pending.

The Nurses' Health Study

Another noteworthy early large longitudinal study focused on women is the Nurses' Health Study [23] The Nurses' Health Study was started in 1976 and is now in its third generation of studies. Overall, more than 250,000 women have been a part of his study which has been continuously funded from the National Institutes of Health. Initially the main purpose was to evaluate the long-term effects of oral contraceptives, but it has evaluated many other aspects of health. Women who were married, registered nurses between 30 and 55 years of age and who lived in one of 11 of the most populated states were invited to join the study. The study focused on contraceptive use, smoking, heart disease, cancer, lifestyle, psychosocial behaviors, and personal characteristics as related to more than 30 different diseases. Nutrition was analyzed, and laboratory studies were performed regularly on all study subjects.

The Nurses' Health Study II was started in 1989 from the same funding source and also sought to study contraceptives, diet and psychosocial risk factors as well as physical activity. Women recruited into this second cohort were younger than those in the earlier cohort, 25–42 years of age.

There is now an ongoing Nurses Health Study III study which was started in 2010. It is entirely web-based, includes men as well as women, different types of health care workers, and focuses on diet, lifestyle, occupational resources, and other factors on health.

The Women's Health Initiative

This study was begun in 1991 and was also funded by the National Institutes of Health [24]. Its focus was on postmenopausal women and cardiovascular disease, cancer, and osteoporosis. More than 150,000 women between the age of 50 and 79 years were registered over 15 years. The study consisted of one observational study and three clinical trials. The intervention trials evaluated different types of hormone replacement including estrogen plus progestin versus estrogen alone, dietary change, and calcium and vitamin D supplementation. The major findings were that hormone therapy increased the risk of stroke and did not change risk of coronary artery disease and

that the estrogen-progestin combination increased the risk of breast cancer. Dietary modification showed that it lowered the risk of breast cancer in women who had a higher percentage of energy coming from fat only, but not in others. Calcium and vitamin were shown to improve bone mineral density slightly and had no effect on the risk of colorectal cancer as had been hypothesized.

The MacArthur Studies on Successful Aging

Rowe and Kahn were among the first investigators to add a psychosocial component to the definition of successful aging [25]. They assembled a group of 16 investigators from different subspecialties and vantage points and together to initiate the MacArthur Network on Successful Aging in 1984. The group concentrated on studies related to age trajectories of people entering and moving through old age. They confirmed the role of physical activity and social interaction as essential for successful aging, similar to findings from other studies. They also showed that vitality and resilience offset negative factors. They brought successful aging to the forefront of research on aging, showing that aging could be associated with positive growth,

The Berlin Aging Study

The Berlin Aging Study was one of the first major combined cross-sectional and longitudinal studies on aging using randomly selected people living in Berlin, Germany [26]. More than 500 people were selected and were studied in a holistic, multidisciplinary fashion using specialists from internal medicine, psychology, psychiatry, and others to explore physical, mental, cognitive, psychosocial-economic determinants of the population over time. The population was divided into six distinct age subgroups, each one corresponding to a 5-year increment. The study is ongoing, and two cohorts have been followed: the first cohort was selected in 1989 and the second in 1993 and each has been re-evaluated at least several times.

Major findings have been low rates of dementia before age 95 (<10%) but high rates after 95 years of age (50%). There were relative similarities in these data regardless of wealth for those people who survived into the high age groups, although poorer people were less likely to survive. Subjects had relatively good health over time with 90% of the cohort over 75 years of age reporting successful aging (i.e., cognitively aware and leading an active life) or at least average aging (i.e., relatively healthy, independent, and satisfied with life). Even at 95 years of age, 30% of the people studied still had good or average heath. A notable finding was that with age, subjects developed increasing spirituality and serenity. The most important predictors for successful aging were a high level of education and an extended family network.

The Nun Study

The Nun Study was focused on cognitive health in Roman Catholic nuns, all living similar lifestyles [27]. The study focused on cognitive impairment with aging, in particular but not only in Alzheimer's disease. It was started in 1986 under the direction of David Snowdon. It was originally housed at the University of Minnesota and followed him to the University of Kentucky when he transferred universities and has since moved back to Minnesota after he retired.

A total of 678 American Roman Catholic nuns constituted the study subjects and were homogeneous in that they drank very little alcohol, they lived together, had similar lifestyles, similar backgrounds and had no children, husbands, or family responsibilities. They were compliant with study protocols which included regular histories and physical examinations as well as laboratory studies. The study also included review and analyses of writing exercises and autopsy of their brains after death. The studies gave rise to numerous publications about Alzheimer's disease including the possibility of

remaining cognitively well despite pathologic lesions given sufficient stimulation and sufficient educational attainment. Those patients who did better were those who had altered circulation in the affected areas of the brain, a component of plasticity in which the brain can remodel itself to heal and limit damage.

The SAGe Study

Jeste and his colleagues, pioneers in positive psychiatry, direct the **S**uccessful **Ag**ing **e**valuation study (SAGe) in which 1300 randomly selected people from San Diego ranging in age from 50 to 99 years are under evaluation for types of aging [28]. The subjects are followed with phone interviews, questionnaires, saliva samples, and in-person examinations on a regular basis. In this study, the investigators have found that even as the physical component of quality of life, as measured by the SF-36 survey, declines after 70 years of age, the mental health component appears to improve. Similarly, even as the percentage of people with no disability, decreased after 60 years of age, successful aging improved after this time as measured by self-reports.

The Centenarian Studies

Centenarian studies on people over 100 years of age are ongoing throughout the U.S. and around the world including Hungary, Italy, France, Finland, Denmark, and China. Centenarians are the fastest growing group of people in the world and these studies may hold the key to long life. The New England Centenarian Study, started in 1995, is the largest study of centenarians in the world and invited subjects who had already reached the age of 103 years, or 100 years if they have siblings who were willing to participate in the study [29]. The study has resulted in more than 140 published peer-reviewed papers. The studies so far have shown that longevity is related to family history and decline does not necessarily start until the 1990s. Many of the subjects have genes which slow aging and reduce the risk for disease ordinarily related to old age like cancer, heart disease, and Alzheimer's disease. They found 281 genetic markers which could predict living until about 100 years of age.

Other Longitudinal Aging Studies

Table 7.1 lists other longitudinal studies including the Duke Longitudinal Studies of Normal Aging [30], the Kansas City Study of Adult Life [31], the Manitoba Elderly Study [32], the Honolulu Asia Aging Study [33], the Predictors of Successful Aging Study [34], the Canadian Study of Health and Aging [35], the Aging Successfully Until Death Study [36], the Cardiovascular Health Study [37], the Successful Aging over a Lifetime Study [38], the Alameda County Study [39], the NuAGE Study [40], the Successful Aging After Elective Surgery Study [41], the VA Normative Aging study [42], the Uppsala Longitudinal Study [43], the Helsinki Business Study [44], the National Health and Resilience Veterans Study [45], the Amsterdam Longitudinal Aging Study [46], the Vanderbilt Memory and Aging Project [47], the ACHIEVE-P Study [48], and the Occupational Determinants of Successful Aging in Older Physicians Study [49].

Successful Aging in Adults with Psychiatric Disease

People with psychiatric disorders have shorter lifespans and more difficulty in successful aging than their counterparts. Patients with untreated depression have a life expectancy of 7–10 years less than the general population [50] and patients with schizophrenia have a life expectancy which is 10–30 years less than that of unaffected age-matched people [51].

Major depression and schizophrenia interfere with quality-of-life by virtue of lower social involvement, greater physical impairment and decreased life satisfaction, the very factors that decrease the chance for successful aging.

Positive psychiatrists are needed not only to treat patients with these diseases early and

aggressively, but to continue treatment beyond return to baseline. Returning them to higher than baseline levels can provide a psychologic buffer, enhance life satisfaction, quality of life, and chances for successful aging [52].

The highest risk period for depression in the elderly is at the time of life events such as loss of family members, disability, and impairment of mobility. Such events can cause or deepen depression and can result in cycles of despair unless treated quickly and effectively.

Jeste et al. have studied aging in more than 1000 patients with schizophrenia and have shown that their health and survival improved with adequate treatment. With age, as their physical health declined, their quality of life by self-report improved, as did their adherence to treatment, number of psychotic symptoms, and number of relapses [53].

Of these patients with schizophrenia, 145 were older and approximately 10% of them remained in long-term remission. Whether patients remained in remission related mostly to the amount of social support they received, whether they were married or not, their level of cognitive reserve and early initiation of treatment [54]. The treatments that were most effective were training in cognitive behavioral social skills, adaptation, and cognitive remediation. Given these data, it behooves the internist and geriatrician to refer their patients with schizophrenia to psychiatrists as quickly as possible to enable them to have a chance at healthy and successful aging.

Not only do patients with severe mental illness often not get the psychiatric care they need, they often do not get the primary care they deserve and are often excluded from clinical trials where they could be offered early access to new effective treatments [55].

Another obstacle to effective and quick therapy is the shortage of psychiatrists nationwide and globally [56]. This shortage is acute in the aging population where attention to mental health may appear to be a secondary goal. Messias' group has suggested that more medical students could be recruited into general psychiatry through focusing on those whose lifestyle and other characteristics best match those of others already entering the field [57]. They also suggested that students be exposed to geriatric and geriatric psychiatry clerkship rotations since such student are more likely than others to express interest in eventual careers in geriatrics or geriatric psychiatry [58]. Alternatively, psychiatry extenders like nurse practitioners and others can help to provide care especially in rural areas. Finally, psychiatrists may also need to train front-line internists, geriatricians, and others to be able to quickly recognize and treat the most commonly encountered mental health issues, or at least refer for specialized services as soon as possible.

Interventions for Successful Aging

Diet

There is only one proven effective method for improving survival and that is dietary restriction. Animal studies have shown that life expectancy can be extended by approximately 50% or more by calorie restriction [60] and certain early human studies have shown benefit of calorie restriction. Witte et al. studied 50 healthy elderly people and subjected them either to a 30% restriction in calories, or a diet enriched in unsaturated fatty acids, or no change. Those people who underwent the 30% restriction had improvement in memory by 20%, whereas the people in the other groups had no change in cognitive function [61]. In a comprehensive review of the literature, Manchishi and others similarly showed that calorie restriction could improve symptoms and signs of depression [62]. Major benefits may have been due to increased insulin sensitivity, less metabolic syndrome, and less inflammation.

There is much controversy about the optimal diet to promote long and healthy life. The Mediterranean diet is replete with vegetables and fruits, a high percentage of unsaturated fat, and low carbohydrates; this diet may be associated with less depression and less risk for cognitive decline compared to other diets [63]. Petersson et al. evaluated the literature on Mediterranean diets and cognitive function [64]. They evaluated

32 studies of which 5 were randomized controlled trials, 25 were cohort studies, and 27 were observational only. People who followed the Mediterranean diet had better cognitive function, less risk for Alzheimer's disease, and less cognitive decline over time compared to their peers. Despite this association however, it is not clear that the diet *caused* the symptomatic improvements. What may be more important than the actual components of the diet may be the reduced calories, relaxed mood, good company, and slow digestion associated with a good meal.

Physical Activity

Physical activity has been shown to be beneficial for cardiac and for brain health. The Framingham studies clearly established a benefit to regular physical exercise at least three times per week [65]. Later other studies have shown that what is good for the heart is good for the brain [66], and that physical exercise is associated with improved cognitive function, especially as pertains to verbal memory, attention, cognitive function and attention [67].

Several pilot studies have provided "proof of principle" that exercise can improve cognitive function. In one large study, elderly subjects over 50 years of age with mild cognitive impairment as manifested by memory problems were randomized to exercise intervention compared to non-intervention [68]. Cognitive function improved significantly in those people doing the exercise program compared to the others.

Physical exercise has been studied in patients with mental health disorders, notably anxiety, depression, and schizophrenia. Wegner et al. reviewed meta-analyses exercise effects on anxiety and depression. They identified 37 meta-analyses, encompassing more than 40,000 patients. They found that exercise improved symptoms in both conditions, but more so in patients with depression than those with anxiety [69]. Josefsson and his colleagues reviewed the literature and data on effects of exercise in depression [70]. They found 13 high-quality studies and concluded that exercise improved symptoms, especially in the highly controlled studies and especially in patients with mild to moderate depression. However, the quality of the studies was very variable.

Similarly, Firth et al. studied existing meta-analyses of studies about exercise and cognitive outcome in patients with schizophrenia [71]. In all, they reviewed ten studies covering 385 patients. They found that exercise improved global cognitive function and it was directly related to the amount of exercise. Also, exercise was more effective when done in a supervised manner and worked especially well on memory, social cognition, attention, and vigilance.

Erickson and others showed that exercise can increase the size of the hippocampus and improve memory [72]. Ordinarily, the hippocampus shrinks in late adulthood and this decreases memory and increases risk for dementia. Exercise increased hippocampal volume by 2%, reversing approximately 2 years of age-related deterioration. The increase in hippocampal size was associated with increases in circulating brain-derived neurotropic factor (BDNF) which mediates neuronal growth and recovery.

Cognitive Stimulation

Castel and his investigators evaluated 176 people randomized to one of two groups to either receive cognitive stimulation or not [73]. Those who partook in the cognitive stimulation program had improvement in psychological well-being whereas the others did not. In support of this, Kelly and his colleagues reviewed all the literature and did meta-analysis of then existing cognitive training and stimulatory programs [74]. In all they evaluated 31 randomized, controlled trials encompassing more than 1800 people in training compared to more than 350 controls. Overall, people receiving cognitive stimulation had improvements especially in working memory, processing speed, composite cognitive function, and face and name recall.

It seems that cognitive stimulation can be incorporated into a leisure program rather than a formal training session, which may make the

training more palatable to some. In this regard, Grimaud et al. showed that patients doing cognitive stimulation work either in a standard training program, or integrated into their leisure activities did equally well in improving speed of processing, working memory, and self- esteem [75].

These programs may work best in patients with mild cognitive impairment and less well with marked impairment. In studies on patients with clinically significant dementia, Bailey and others showed little improvement with stimulation. They randomized patients to ten sessions each of cognitive stimulation or none. There were no differences in outcome in patients randomized to either ten sessions of cognitive stimulation or no stimulation. This suggests a "point of no return" after which patients will no longer respond to stimulatory activity.

Combining Physical Activity, Cognitive Stimulation and Fun through Exergaming

Exergaming is a way of exercising with an internet-based game platform such as Nintendo to combine sensory, motor and cognitive input, thereby increasing physical tone and motor skills [76, 77]. Exergaming using these platforms with TV and sports equipment can be done to play virtual golf, tennis, soccer, football, or other games. It builds stamina in a fun and progressive manner, is inexpensive, easily accessible and easy to set up in one's own home. Data are not available to compare different types of exergaming to each other or to actual gaming.

Social Participation and Engagement

Loneliness is one of the major risk factors for adverse physical functioning and one of the major impediments to successful aging. Lee et al. evaluated loneliness in 340 elders living in San Diego, CA. Subjects were 27–101 years of age (mean age 62) [78]. Of these residents, 76% had moderate to high amounts of loneliness and this was related to worse mental health. Three factors only influenced this problem: wisdom, living alone, and mental well-being.

Loneliness then is a key obstacle to successful aging but also a key point at which to intervene. There are many ways to combat loneliness. Any social meetup, time with others, volunteering, or involvement in synagogue, church or mosque activities helps to break down isolation. Similarly, caring for a pet or even for a plant is beneficial for connecting with the outside world. Whether interaction with robots, or artificial robotized animals and people would similarly be effective is not known; however, there is a huge developing industry for creating such toys with the hope that they will compensate for loneliness in the elderly [79].

A new and very promising concept is that of the age-friendly community (AFC) initiative [80, 81]. In these communities, elders live together in communities and age-in-place together with as their physical function declines. The most prominent of these types of living communities are within the World Health Organization's Global Age Friendly Communities (AFC) network [80]. This network has 287 communities in 33 countries. A similar model is that of the AARP network of AFCs with more than 50 communities throughout the U.S. [81] Each of these communities has affordable housing, safe green space, senior friendly environments, easy and inexpensive transportation options, activities, and health and wellness services.

Some of these homes for the elderly are armed with sensors which can indicate when elders are in need, when they fall, get lost or develop medical problems [82–84]. These sensors can then mobilize an internet-controlled device such as a robot to intervene, help, call for help, give medication, provide support or alert Alexa, Siri or other internet messenger to call someone. This machine-to-machine interaction to control the outside environment and make it safer constitutes an internet-of-things platform.

This type of platform can also be used to connect one's environment with a hospital setting through augmented intelligence digital health systems. In this set-up [82], biomedical and psychosocial information can be sensed, transmitted

to the health center, interpreted, and response can be returned through internet-controlled communication or robot systems.

Reinforcing Positive Psychological Traits

The main psychological traits associated with successful aging are optimism, resilience, and wisdom. Optimism is associated with better quality of life, better survival, and more successful aging trajectories. In one study, optimism in elderly men was shown to remain stable over time and was inversely and directly related to loneliness and risk of cardiovascular disease.85 Resilience is also associated with less depression and better aging [18]. In the Successful Aging evaluation (SAGe) study, Jeste et al. found that higher scores on a self-reported measure of resilience were associated with low levels of depression [18].

Wisdom seems to be a quality that ripens with time and is also associated with less depression [19, 86–88]. There is no simple definition for wisdom, rather it has many components and varies by culture. Qualities of wisdom include but are not limited to emotional regulation, altruism, empathy, reflection, tolerance, and insight [87].

Despite the disparate components of wisdom, its site can be mapped on the brain [17]. Jeste et al. have shown that this function resides in the dorso-lateral prefrontal cortex, the anterior cingular cortex, the ventromedial prefrontal cortex, and the amygdala [17]. Knowing its location in the brain and being able to find it may help in monitoring its growth and development over time before and after interventions.

Jeste and his colleagues have suggested that wisdom is a particularly important personality characteristic that is fostered with age and has even suggested that the purpose of long life after reproductive capability may indeed be to develop – and share – this quality. Wisdom offsets the negative impact of physical and mental decline inherent in aging, death and dying and offers benefit to one's community, society, and world. A world with wisdom would be less prone to hatred, violence and war and would be a better place to live.

Of course, the major challenge would be to channel wisdom generated from the aging population into the younger population at large. Difficult as this appears to be, it may actually be possible to pair young people with old people in social networks such as school systems. Thus, the University of Arizona has an "optimal aging program" in which students are paired with older adults as their mentors [89]. Students thus hear about challenges of aging as well as lessons of a lifetime while seniors feel useful, connected, and valued.

A similar project is "The Experience Corps," sponsored by the American Association of Retired Persons (AARP) [90]. This program teaches seniors over 50 years of age how to tutor children and then pairs their volunteers with children throughout the U.S. mostly in poor inner-city neighborhoods. Seniors then work with these children on a one-to-one basis or in small groups. To date, more than 300 senior volunteers have been trained. These volunteers have helped more than 4500 children; conversely the children have helped them by giving them a sense of altruism and usefulness.

Another more recent project is the "Nones and Nuns Project" in which young millennials who have no religious affiliations (i.e., religion affiliation = "none") have paired with Catholic nuns [91]. Together they meet at Catholic churches and monasteries around the country to dialogue and for "nones" to learn wisdom and spiritual practice from nuns. Nuns benefit too, from sharing their wisdom and from feeling useful and valued.

Meditation

Meditation may have a role to play in successful aging but has not yet been well defined.

Sperduti studied compared elders with long histories of meditation and compared them to age-matched people with no experience in

meditation [92, 93]. In this cross-sectional study, the non-meditators had significantly lower executive function, especially memory and attention, compared to their peer group who were experts in meditation.

This study concords with work by Luders et al. comparing brain age of people who meditate compared to those who do not. In this study, the investigators studied 50 elders with long histories of meditation compared to 52 age-matched subjects without a history of doing meditation [94]. At 50 years of age, brain age of the meditators was approximately 7.5 years less than that of the non-meditators, using BRAINAGE index, a radiographic procedure validated to measure age of the brain [95]. Similarly, Chetelat et al. evaluated six long-term meditators compared to 50 control subjects and found that the meditators had higher amounts of gray matter in their brains and higher glucose metabolism compared to the non-meditators [96].

It therefore appears possible that meditation may be able to slow aging of the brain. In order to study this more directly, some investigators have studied the effects of meditation on telomere length before and after mindfulness meditation as well as before and after stress. Epel has recently reviewed his and other studies to show telomere shortening with stress and promotion of telomere stability with meditation, evidence of slowing of the aging process with meditation [97].

Some investigators have evaluated different forms of meditation on telomeres, a marker of overall biological age and health. For example, Nguyen and colleagues studied mindfulness meditation compared to loving-kindness meditation on telomere length, each compared to controls of people who do not meditate [98]. In their pilot study of 12 weeks of mindfulness versus loving-kindness versus no meditation, only the people doing loving-kindness meditation preserved telomere length, while the others had telomere shortening over time.

These studies suggest a possible benefit to meditation on aging. More studies are needed to determine optimal type and timing of meditation and a plethora of related other issues.

Medication: New Psychiatric Treatments

Positive psychiatrists also have psychiatric drugs to use in their pursuit of bringing meaning and joy to their patients with, or at risk for developing, mental health issues and others. In particular, psychedelic drugs are now being rediscovered [99, 100]. Thus, psilocybin (from "magic mushrooms"), mescaline (hallucinogen from cactus plants), MDMA (3,4-methylenedio xymethamphetamine, or "Ectasy") are now being evaluated for mental health disease and to augment response of the brain to behavioral and other psychotherapies. Ketamine and esketamine are other drugs which have now been approved for patients with severe depression refractory to other treatments [101]. Such therapies could help positive psychiatrists to reprogram their patients with healthy, positive messages to promote successful aging.

Ongoing research into stem cell regeneration of the brain, brain-derived neurotrophic growth factors and superficial and deep brain stimulation also hold promise too for better treatment of patients with mental health issues [102]. There are also dozens of new drugs which are advertised to help slow and/or reverse the aging process, many of these however are currently unproved therapies and should be used only in clinical trials.

Others

Other interventions, nutritionals, pharmaceuticals, psychotropics, and even psychedelics have been advocated for successful aging and are listed in Table 7.2. Many of these therapies however have not been and adequately tested and many are being developed as quick snake oil type products.

Table 7.2 Interventions to foster successful aging

Intervetions	Outcomes
Calorie Restriction	Improves blood pressure and lipid profile
	Increases median and maximal longevity
	Improves memory
	Increases metabolic efficiency and insulin sensitivity
Exercise	Reduces anxiety, depression, and risk for dementia
	Improves executive function
	Reduces functional decline, preserves physical functioning, may prevent disability
Cognitive stimulation	Brain training games improve cognitive function
	Games can improve memory, attention, driving skills, balance, among other skills
	Can be combined with smart technology (i.e., exergaming)
	Exergames increase physical activity, fine and gross motor skills
	Widely available, easy to set-up, inexpensive, can be done at home
	Exergames include tennis, golf, rowing, shooting, stretching, yoga, cycling, and many more
Social engagement	Loneliness is a major factor for unsuccessful aging
	Social engagement mitigates depression, cognitive impairment
	Age-friendly communities (AFC) provide resources to engage socially
	World Health Organization maintains AFC network
	AARP maintains network
	Many programs (i.e., experience corps, Nones, and nuns project) engage elders in the community which may be sponsored by universities, AARP, cities
Promoting personal traits	Optimism, resilience and wisdom mitigate against loneliness, depression, despair
Meditation	Unproven, but interesting initial results
	Mindfulness meditation may improve relaxation, perceived control
	Transcendental meditation may improve cognitive and behavioral flexibility and learning
Medication	Psychedelic drugs are being rediscovered (psilocybin, mescaline, MDMA)
	Stem cell infusions for regenerative brain structure; brain-derived growth factor
	Anti-aging industry has many new products but most are unproven
	Brain stimulation with transcranial direct current may stimulate selected areas of brain and may
	Be useful when paired with psychiatric care
	Hormones (testosterone, estrogen, growth hormone, oxytocin, etc.): Unproven
On the horizon	Smart homes equipped with real-time monitoring of vital signs, EKG, mobility
	Internet of things can connect sensor with internet assistant (e.g., Siri, Alexa), robot, or hospital

Implications for Positive Psychiatry

Successful aging from the bio-cognitive-behavioral psycho-socio-economic standpoint is not genetic but is most rather mostly related to attitudes, beliefs, behaviors, and lifestyle [103, 104]. The most important psychological traits for successful aging are optimism, resilience, social engagement, and wisdom [104]. Harnessing these traits can overcome much suffering. Successful aging can thereby be possible, even in patients with serious mental health illness. However, underlying mental health conditions need to be treated early and aggressively for patients to age successfully like their counterparts.

Successful aging is a complex process in which biomedical, cognitive, behavioral, and psychosocial factors are all important and are all interconnected. With the aging population, more resources will be necessary to care for elders and

to help them derive as much satisfaction from life as possible. Positive psychiatry has much to offer in reinforcing positive traits to cope with the challenges of aging, and to restore function through diet, exercise, cognitive stimulation, meditation, and medication.

Positive psychiatrists are especially needed to help people with mental health disorders or at risk for developing them in overcoming the negative impact of their disease and for improving their lifespans and health spans. The goal must be to bring patients with mental health issues not only back to their baseline but to a much higher level so as to provide a buffer and to offer enhanced meaning and quality of life [52].

Most of the underlying reasons for actual cause of death in these days arise from psychosocial issues including smoking, obesity, poor nutrition, physical inactivity, opioid and other addictions, suicide, and homicide [59]. These issues require prevention, early detection, treatment, rehabilitation, and maintenance programs. Positive psychiatrists can develop such programs and help restore health and meaning to affected people, either as culprits or as victims.

Perhaps most interesting for the positive psychiatrist is the possibility of enhancing and spreading the positive aspects of aging. With aging comes gifts of experience, kindness, wisdom, serenity, and others [103]. If these gifts can be enriched and disseminated, they would become treasures not only for seniors themselves but for everyone, making the world a kinder, gentler, happier, safer place.

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8 Life Balance with Positive Psychotherapy

Hamid Peseschkian and Arno Remmers

> Many people seem to think that success in one area can compensate for failure in other areas.
> But can it really?... True effectiveness requires balance.
> — Stephen R. Covey [2]

Introduction

Inspired by a concept in the Bahá'í Writings about "The Four Criteria of Comprehension" Nossrat Peseschkian developed the balance model as an integral part of his psychotherapeutic method [1]. Here, the influence of the positive view of man is seen to be renewed, a concept of a healthy person is presented and the ways through which such health can be attained are shown. This means that a health-oriented conceptualization can proceed from concepts of salutogenesis rather than pathogenesis. It was important for Nossrat Peseschkian to tell patients not only what they had done wrong, but above all to offer them a concept of life for their own orientation. Peseschkian's concept of the balance model [8] is known as the very heart of positive psychotherapy (PPT after Peseschkian) and is used in different settings. It is also known as the "rhombus model", the "four qualities of life", the "four ways or medians of the capacity of recognition," the "four areas of life," the "four ways of conflict resolution," or the "diamond model" (see Fig. 8.1).

The balance model is based on the concept that there are essentially four areas of life in which a human being lives and functions. These areas influence one's satisfaction with life, one's feelings of self-worth, and the way in which one deals with conflicts and challenges. They are the hallmarks of one's personality in the here and now. This model describes and connects the biological–physical, rational–intellectual, socio-emotional, and imaginative–spiritual spheres and capacities of human beings in everyday life. Although the potential for all four areas and capacities can exist in every human being, some are emphasized and others neglected through differences in culture, family, education, time, and environment. The four areas of life, energy, activities, and reactions are:

1. *Physical activities* and perceptions, such as eating, drinking, tenderness, sexuality, sleep, relaxation, sports, appearance, and clothing
2. *Professional achievement* and activities, such as a job, studying, household duties, gardening, basic and advanced education, and money management

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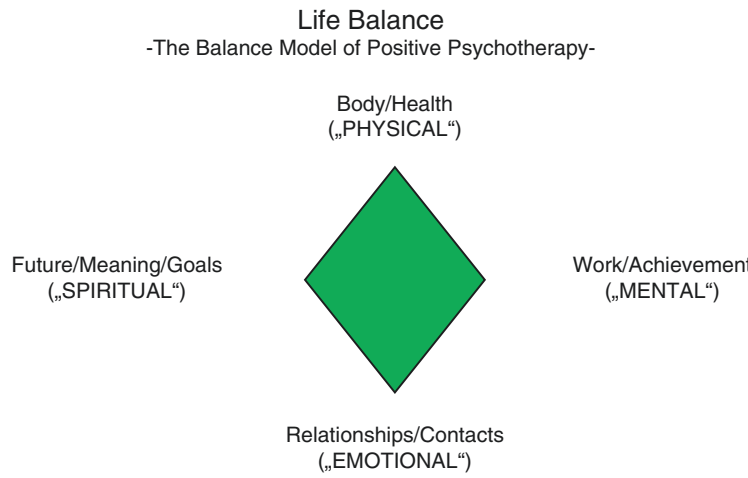

Fig. 8.1 The balance model of positive psychotherapy

3. *Relationship styles* and contact with partner, family, friends, colleagues, acquaintances, and strangers; social engagement
4. *Future plans* include religious/spiritual practices, purpose/meaning, life goals, meditation, self-reflection, death, belief, and the development of vision or imagination–fantasy

Nossrat Peseschkian sees a balance of the energy of life distributed among the four areas as favorable conditions for health and resilience: *"According to the concept of Positive Psychotherapy, a healthy person is not one who has no conflicts, but rather one who has learned to deal adequately with these conflicts. Here "adequately" means not to neglect any of the four areas of life, but to distribute one's energy (not necessarily time!) approximately evenly into the four areas of life."* ([4], p. 99). The goal is to achieve balance in the four areas. Accordingly, one objective of psychotherapeutic engagement is to help the patient to recognize his own resources and mobilize them with the goal of bringing them into a dynamic equilibrium. This places particular value on a balanced distribution of energy (approximately 25% to each area), not an equal distribution of time (see Fig. 8.2).

One-sidedness that goes on far too long can lead to conflicts and disorders, among other things. *"The four areas call to mind a rider who, being motivated toward achievement (Achievement), strives to reach a goal (Meaning/Future). For this he needs a good horse which is well-groomed (Body), and just in case the horse should throw him off, helpers who will assist him to remount (Relationships). This means that therapy cannot deal only with one area, for example, the rider, but must consider all related areas."* [8].

Consideration of the uniqueness of the patient is important so that he/she can reach an equilibrium within the framework of the "four areas," that are agreeable to him/her. To put it simply: every person should be in balance by not neglecting any area of life for a long time; however, the manner of this balance is specific to individuals, families, and cultures. For example, although individualistic cultures such as Western Europe and North America value the areas of body/health and achievement/job more importantly, in collectivistic cultures such as the Near East, the area of relationships (family, friends, relatives) and questions about the future, the meaning of life, and about one's worldview (area of future/meaning) are more significant to them (see Fig. 8.3):

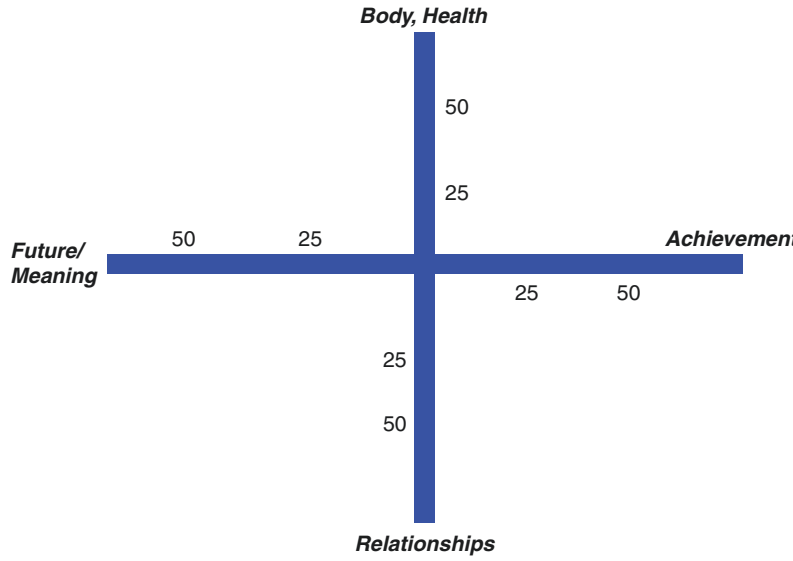

Fig. 8.2 Energy distribution in the balance model

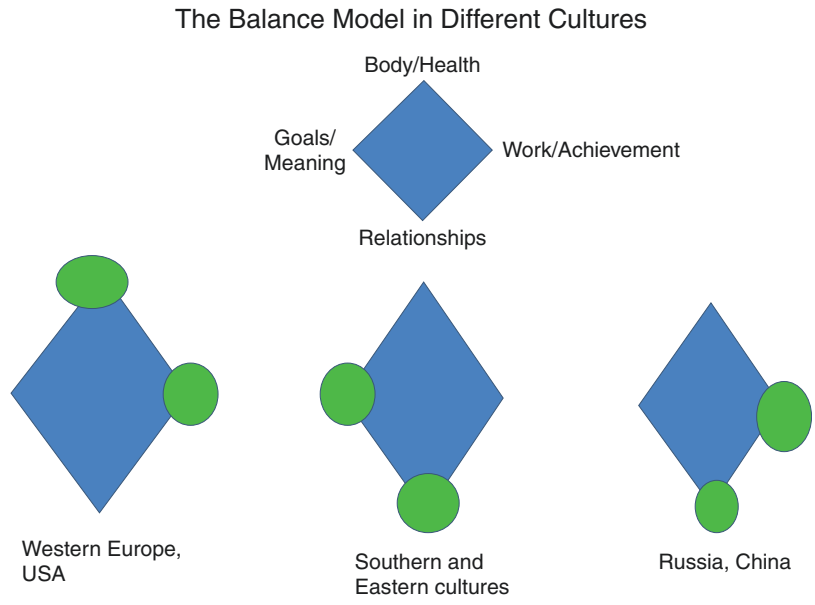

Fig. 8.3 Balance model in different cultures [6]

From Work–Life Balance to Life Balance

The positive conception of human beings becomes particularly obvious when seen in the interpretation of the individual life balance. Instead of pointing out a deficit to the patient or his/her family, and giving some immediate advice, the positive aspects of the one-sidedness are emphasized and encouraged. His/her weakest feeling of self-worth is strengthened to create a basis for the analysis of the areas with deficits. For example, a person who places a high value on achievement and works long hours every day is not confronted at an early stage with the fact that he or she should spend more time with the family (see Fig. 8.4). At the outset, his inclination for achievement and his motivation to work are seen

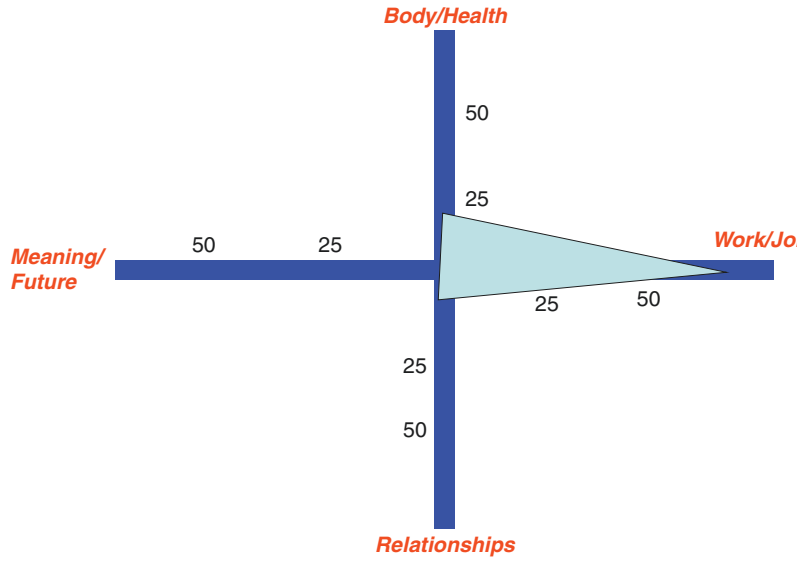

Fig. 8.4 Life balance of a work-oriented person

and identified as a capacity. This is an encouraging experience for the patient and is important and fruitful for building the relationship between the therapist and the patient. At the same time, the patient and his family are told that the patient is not suffering because he/she works so much, but rather that he/she has neglected other areas of life and not developed them. Often patients and clients are very surprised and say, "You are the first one who tells me that working so much is a capability and not only negative."

In this context, a positive image of human beings means a resource-oriented process, which means that this patient has the capacity for balance, but, owing to his/her socialization and the circumstances of his/her life, he/she has not developed certain areas of life until now. This process also prevents the phenomenon that in psychiatry is called relief depression. Thanks to the therapy, he/she reduces his/her workload, goes on forced leave with his/her partner and children, paces back and forth the whole day at the beach, and spends the whole day on the cellular phone or the computer until his/her partner cannot stand it anymore and sends him/her home early.

Areas in which we have invested a great deal are generally our greatest sources of self-worth and affirmation. When such an area is diminished before another one has been positively filled in, the patient falls into a deep hole. There is too much energy that cannot be invested; thus, it goes into full-blown inner unrest. A feeling of low self-esteem ("nobody needs me") is only one of its consequences, but perhaps the most important.

During the past 25 years, the term "work–life balance" has become part of society's daily conversation and goal in life. Thanks to this concept, people started to give importance to other areas of life. Unfortunately, the term "work–life balance" itself causes stress, as it suggests that there might be work and that there might be life. In many countries, it is neither possible nor desirable to separate between work and other areas of life, owing to technology, home office, different settings, etc. Many patients report that they feel guilty and are under enormous pressure not to think or speak about work at home. Therefore, we use the term "life balance" in positive psychotherapy instead of "work–life balance." The goal is to integrate all spheres of life into one's life. After all, the two are parts of one person. Thus, we need more work–life integration than work–life balance.

In positive psychotherapy, the therapist draws the attention of the patient to his/her strong areas and to those not yet developed. While the patient continues with his/her old lifestyle, the background of his/her one-sidedness is worked on.

New areas are being filled with desire, so that they can affirm his/her self-esteem.

The following *questions* may help one to reflect on one's own balance:

1. How much energy do you use for your body, for example, for sports, clothes, relaxation, rest, sexuality? How important to you is this area and how much of your self-esteem is obtained from it?
2. How much energy do you use each day for education, profession, homework or other capabilities? Could you imagine a life without work, if you were financially secure? How much of your confirmation do you obtain from your profession?
3. How much significance do family, acquaintances or friends have in your life? How great is your need for contact? Do your partner or children give you confirmation of your self-worth or do you receive your confirmation from other areas of life?
4. How much space does fantasy take up, for example, reading, music or painting, or just thinking about life, beliefs, your own future or humanity? Do you occupy yourself much with these questions or only with specific events? Do you think often about the meaning of your own life?

Four Ways of Coping with Conflicts and Conflict Resolution

Despite all cultural and social differences and the uniqueness of each person, we can observe that all people resort to typical forms of working through conflicts to cope with their problems. When we have a problem, we feel angry, burdened or misunderstood, we feel stressed all the time, or can see no meaning in our lives. We can find expression for these difficulties in the four forms of working with conflicts according to how they are mapped out in the balance model. They let us know how we perceive ourselves and the world around us and also through which method of acquiring knowledge the reality check succeeds.

Each person develops his own preferences consciously, or mostly unconsciously, as to how to deal with conflicts that appear.

> The model of the four qualities of life also presents the basis for the conceptualization of typical conflict models. We flee into illness (somatization) or excessive body-building, into activity and achievement (rationalization in the sense of disturbances of overburdening and adaptation), into refusal to perform, into loneliness or gregariousness (accompanied by idealization or deprecation, which lead to affective disturbances and changes in social behavior) and into fantasy and the world of thought (denial in the sense of anxieties, phobias, panic attacks and disturbances of illusion, addictive behavior, for example, into lack of imagination. ([4], pp. 99 ff).

Which form of conflict resolution one chooses depends largely on one's experiences, especially those from one's childhood. The balance model is used in such a way in the presentation and differentiation of the four areas of conflict reaction as to describe disturbances of illness and symptoms. In this way, Nossrat Peseschkian differentiates between those areas that are over-emphasized and over-differentiated in dealing with conflicts from those that have been pushed into the shadows in an effort to deal with the conflict.

The Balance Model in Practice

The balance model can be applied in a variety of areas, such as psychotherapy, coaching, counselling, mediation, professional assessment, prevention, personal and professional goal setting, management training, stress management, psychotherapy education, and in choosing a partner and marriage preparation.

Here is an example of how the symptoms, conflict reactions and resources can be documented using the balance model during an interview (see Fig. 8.5):

- The patient's individual goals, available resources and developed areas can be allocated to the areas of the balance model and discussed with the patient. This also promotes insight into correlations and the motivation to change. Negatively formulated goals, such as "not

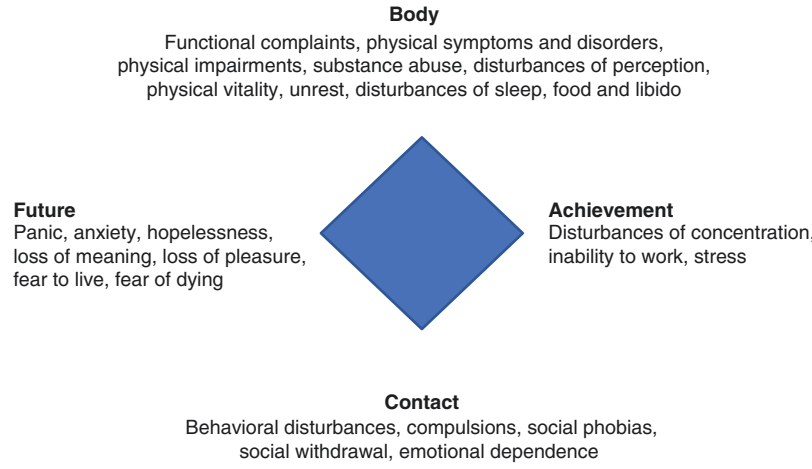

Fig. 8.5 Example of a documentation sheet during the first interview

wanting to have anxiety anymore," are turned into positively formulated realistic goals.
- The balance model is also used by therapists to describe their countertransference: what they think and feel about the patient, specific experiences of interaction with the counterpart, and the therapist's fantasies can be put into the balance model and used to understand the material gathered during the sessions.
- We can record symptoms, conflict reactions, and resources into the balance model during the therapy session. Eventually, the patient will thereby attain an understanding of his/her life situation and of the effects of his/her disorder.

Case Example and Application

Here is an example of a 45-year-old female patient during the first session (see Fig. 8.6):

– *Body/Health*: The patient's current and previous illnesses and complaints, in addition to her physical resources, are documented. Goal-oriented questions in the first interview concerning nutrition, sports, sexuality, relaxation, and sleep complete the spontaneously provided data.
– *Work/Achievement*: We enter spontaneously-given and elicited data about the following aspects—profession and the ability to work, other capabilities, housework, relevant compulsive symptoms, difficulties at the workplace, date when hired or when the job was lost, or financial burdens such as housing construction.
– *Relationships/Contacts*: Here, we find a brief overview of relationships and social resources, which include problems, dealings, friendships, data on the social environment, associations, etc.
– *Future/Purpose*: She has concerns about the philosophy of life, about that which gives support in life, about anxieties, dreams, beliefs, religion, politics, goals, desires and creative activities, the goals in life, and of therapy.

Besides symptoms and disorders, patients suffer a lot with regard to their influence on daily life. In addition to the report of the patient, the following questions can be asked about the effect of the *complaints* and disorder in the four areas:

- What are the effects of your complaints on your physical constitution?
- How have your sleep, sexuality, eating or pleasure changed during this time?
- How do your complaints affect your ability to work and your present job?
- How does your partner (your family) react to your complaints?

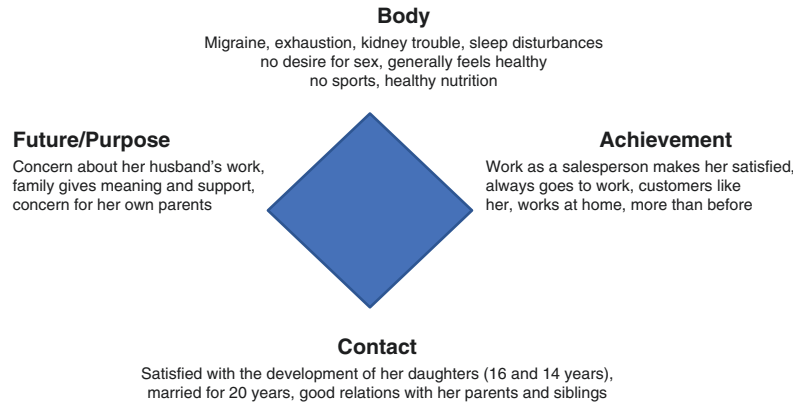

Fig. 8.6 Symptoms of a patient in the four areas of the Balance Model

- How have your relationships in the family or with friends changed because of your complaints?
- Who shows an understanding attitude toward your suffering?
- Who acts differently toward you than before?
- Which contacts have been most badly affected by your complaints?
- How do you see your future and that of your family being influenced by your illness?
- What gives you support and what makes you anxious?
- What goals or desires do you have now that you did not have before?

In the case of this patient, the balance model was presented in its function of describing the effects of the symptoms. Through this half-structured approach with questions, unexpected ideas, conflict reactions, experiences, and resources come to the surface in the four areas, particularly in the second stage of therapy. The comparison of the patient's balance model with that of his/her partner provides the means through which to differentiate the social resources, conflict reactions, and conflicted areas.

Questions for the Assessment of Life Balance

There are questions used to effectively assess the balance of the patient. These questions [7, 8] can be given to the patient as homework and reviewed at the next session(s). For example, "How do you see your own balance among these four areas?" with reference to distribution of energy by using Fig. 8.4. Working with the balance model leads to further stages of therapy. Often in these discussions, not only the contents of conflicts but also typical conflict reactions, basic concepts, mottos, and model dimensions become clear.

Questions for the Area of Body/ Health

- How do you judge your appearance?
- Do you view your body as friend or foe?
- Which of your organs reacts to anger, anxiety or fear?
- How do you sleep?
- Are you satisfied with your sex life?
- Do you do some sport? What kind of sport? How intensively?

Questions for the Area of Work/ Achievement

- Are you satisfied with your present job and your learned profession?
- What profession or job would you like to practice?
- Which professional activities are giving you a hard time?
- How do you feel when you have nothing to do? Can you do "nothing"?

- Would you still continue working, if you had enough money?
- What role does money play in your life?
- How do you react when a supervisor or a colleague criticizes you?
- Which of your parents put more emphasis on achievement?

Questions for the Area of Relationships/Contact

- How do you feel when you are in a gathering of many people?
- Do you like to invite guests (family, friends, colleagues)?
- How often do you go to the movies, theatre, concerts or other events? With whom?
- Are you a member of an association? Do you participate actively?
- Are traditions (family, religious, cultural, political) important to you?
- Which of your parents was more sociable and liked contact?
- In your childhood, to whom could you turn when you had a problem?

Questions for the Area of Meaning/Future

- Do you consider yourself an optimist or a pessimist?
- Do you sometimes think about the future? About your future, that of your family, your country, the world?
- Do you believe in life after death?
- What gives you support in your life?
- What is the purpose of your life?

A Brief Comparison of the Balance Model with Similar Concepts

A comparison of the balance model with the models presented by other authors shows similarities between this anthropological approach and other therapeutic orientations. What Nossrat Peseschkian calls the "energy of life" is approximately equivalent to "libido" or a general energy, as described by Carl Jung or Alfred Adler. Jung also presents as the goal of therapy and the way of life a balance among the four areas of "function types": thinking, feeling, perception, and intuition. When all four of these functions have been brought to the conscious level, the entire crisis can stand in the spotlight; thus, we can speak of a "rounded" person ([3], p. 21; [11]).

The operationalized psychodynamic diagnosis (OPD-2) includes four observable basic capacities of the personality structure, which are similar to the "four means of the capacity to know" ([9]), as described by Remmers [10]:

- The "means of the senses" is comparable with the structural capacity to perceive oneself and others, as described in the OPD-2. In the foreground, there stands the body—the self—the feeling.
- The "means of reason" serves in Peseschkian's balance model as the reality check through which problems can be resolved systematically, and it directs our activities. It is related in OPD-2 to the structural capacities that direct our inner and outer impulses.
- The "means of tradition" serves as the capacity to take up relationships and to flee from them. In OPD-2, the analogy to this is the emotional communication with oneself (internal dialogue) and with others as the structural capacity for empathy, and the anticipation of relating to and thinking about others.
- The "means of intuition" is described by Nossrat Peseschkian as the fourth area, that of meaning, future, and fantasy. He defines it as the capacity to imagine something in one's thoughts. It can allow for the sudden appearance of the vision of a painful separation from a partner. Intuition and imagination can go beyond immediate reality and take in whatever we can depict as the meaning of an action, the meaning of life, desires, pictures of the future or utopia. In the OPD-2, the fourth capacity of the personality structure is the "capacity to form attachments" [5]. Included in this is the imagination of objects that provide support, the connection to an ideal and

the external connections with persons. In Nossrat Peseschkian's scheme, we understand this as the capacity for imagination. With its help, the small child can imagine his/her mother, so that after a short period of being alone, just imagining her can quiet him/her, in contrast to those with structural disturbances, who often find it impossible to summon up such an imagined image. In this sense, the distribution of the four areas of the balance model present a forerunner of the structural models in OPD-2 (English translation, [5]).

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Part III

Psychiatric and Psychosomatic Disorders

This part *Psychiatric and Psychosomatic Disorders* includes eight chapters, each dealing with a diagnostic category.

Chapter 9 applies Positive Psychology Interventions (PPIs) to the management of depression.

Chapter 10 discusses the findings on the use of PPIs for anxiety disorders.

Chapter 11 makes the case for the use of PPIs to help persons with schizophrenia and other psychotic disorders achieve a better quality of life. This chapter includes a discussion on the use of Positive Psychotherapy – after Rashid – to support persons with psychosis in the WELLFOCUS-PPT trial which found significant effects on symptoms, depression, and well-being according to the Positive Psychotherapy Inventory.

Chapter 12 discusses the use of PPIs in managing substance use disorders.

Chapter 13 discusses the application of PPT – after Peseschkian – to the management of care of patients with anorexia nervosa, bulimia, and binge-eating disorder. The three leading concepts of PPT – balance, conflict, and capabilities – are here applied to eating disorder treatment in an interdisciplinary team approach.

Chapter 14 bridges the Positive Psychology concept of Posttraumatic Growth with the Positive Psychotherapy – after Peseschkian – balance model. Here the five stages of PPT and the use of stories are also exemplified.

Chapter 15 concentrates on Somatic Symptom and Related Disorders (DSM-5), or as Somatoform Disorders (ICD-10), and the application of the PPT concepts of conflict, balance, and the Psychosomatic Arc.

Chapter 16 discusses the uses of PPT to help children using the conflict and the balance models. These concepts can be thus applied in individual, group, and family settings.

9 Positive Interventions in Depression

Fayez El-Gabalawi

Depressive Disorders: Definition and Prevalence

Depressive disorders consist of a group of psychiatric disorders in which pathological moods and related vegetative and psychomotor disturbances dominate the clinical picture. Previously, they were part of mood disorders, affective disorders, manic-depressive disorder, dysthymic and cyclothymic disorders, and they are better conceived as syndromes rather than discrete disease categories [1]. Before discussing the concept of major depression from the historical and developmental point of view, let us examine how pervasive it is as a major public concern in the United States and in the world in general.

According to the National Institute of Mental Health (NIMH), major depression is one of the most common mental disorders in the United States. For some individuals, major depression can result in severe impairments that interfere with or limit one's ability to carry out major life activities. The past year prevalence data presented here for major depressive episode are from the 2016 National Survey on Drug Use and Health (NSDUH). The NSDUH study definition of major depressive episode is based mainly on the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Box 9.1: Depression Prevalence

1. Past year prevalence of major depressive episode among U.S. adults in 2016 was 6.7% (female 8.5%, male 4.8%).
2. Age groups differed in their prevalence (age 18–49 was 7.4%, age 50 and older was 4.8%).
3. Race and ethnicity (Hispanic 5.6%, White, 7.4%, Black 5%, Asian 3.9%).
4. Sixty-four percent of all adults with major depression had severe impairment (Box 9.1).

In fact, the Global Burden of Disease has ranked depression as the second leading cause of disability worldwide and also a contributor of burden allocated to suicide and ischemic heart disease [2]. Although direct information on the prevalence and correlates of major depression does not exist for most countries, the available data reviewed below indicate that there is wide variability in prevalence estimates, but that other aspects of descriptive epidemiology (e.g., age-of-onset, persistence) are quite consistent across countries. As such, a number of consistent sociodemographic correlates have also been found across countries [3]. Prevalence of DSM-IV/CIDI major depressive episodes in the 18 countries participating in the WMH surveys showed a lifetime prevalence of major depression among high income countries as listed in Box 9. 2.

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Box 9.2

France 21%, United States 19.2%, Netherlands 17.9%, New Zealand 17.8%, Belgium 14%, Spain 10.6%, Israel 10.2%, Germany 9.9%, Italy 9.9% and total was 14.6%. Among low-middle income countries lifetime prevalence of major depression showed the following: Brazil 18.4%, Ukraine 14.6%, Colombia 13.3%, Lebanon 10.8, South Africa 9.8%, India 9%, and Mexico 8%.

From the above survey, we see that major depression is a commonly occurring disorder in all countries where epidemiological surveys have been carried out; however, lifetime prevalence estimates of major depression vary widely across countries, with prevalence generally higher in high income versus low-middle income countries, and the age-of-onset distributions show consistent evidence for a wide age range of risk with median age-of-onset typically in early adulthood, while the course of major depression is often chronic-recurrent. Interestingly, women consistently across countries have lifetime risk of major depression roughly twice that of men; in the meantime, other socio-demographic correlates are far less consistent. Major depression is associated with a wide range of indicators of impairment and secondary morbidity, although some of these individual-level associations are stronger in high income than low-middle income countries.

Historical Perspective of Depression

Mental sufferings had been known to afflict humans since ancient times, and one of the common pervasive conditions was known as Melancholia (depression). Until the Greco-Roman period, the condition was frequently attributed to demonic possession, for which many harsh measures, such as exorcism – and possibly trepanation in prehistorical times – were used to rid the person of the evil spirit. However, during the fifth century B.C., Hippocrates had explained mental illnesses as resulting from imbalanced body fluids (the four humors were: yellow bile, black bile, phlegm, and blood) and that depression was caused by excessive black bile in the spleen. In the seventeenth century, Robert Burton wrote his monumental work "Anatomy of Melancholy" in which he described multitudes of clinical symptoms of Melancholia from the sufferer's perspective that seemed to resonate with our current understanding of depression. And interestingly he proposed Burton's six non-natural things that referred to such environmental factors as diet, alcohol, biological rhythms, and perturbations of the passion such as intense love.

The modern conceptualization was introduced by the French psychiatrist Jean-Philippe Esquirol (1772–1840) who suggested that a primary disturbance of mood might underlie many forms of depression and related paranoid psychoses and the symptoms were the expression of the disorder of affections (affective disorders), the term was coined by the British psychiatrist Henry Maudsley (1835–1918). However, Emil Kraepelin (1856–1926) described manic depression illness and he believed that endogenous affective disorders are somatically caused, yet he conceded that occurrence of psychogenic states of depression (due to loss or misfortune) is psychologically caused. It was Adolf Meyer (1866–1950) who bridged the gap between psyche and soma, emphasized the individual personal history and biographical factors, and introduced the term "psychobiology" emphasizing both biology and psychological causes of depression and other mental illnesses. So finally a conceptual shift from reductionist to pluralistic causation of depression was achieved [1].

The Contemporary Etiological Models of Depression

Etiological frameworks for depression included the biological models – including genetic and evolutionary, psychoanalytic, and psychodynamic behavioral, and cognitive models.

Biological Models

The biological model hypothesizes a connection between depletion or imbalance of biogenic amines such as catecholamine (norepinephrine), indoleamine (serotonin), and clinical depression. Current genetic evidence indicates a possible predisposing factor, however it is not known exactly what is inherited. An evolutionary model to explain depression proposes that our brains have evolved with a negative-event bias that overestimates threats as a strategy to avoid dangers and enhance survival chances.

Psychological Models

Psychological models include aggression turned inward model (Abraham-Freud), object loss model (Freud-Bowlby), and a loss of self-esteem model. Cognitive model (Aaron Beck) hypothesizes that negative attributional styles such as thoughts of being helpless, unworthy, and useless can generate biased interpretations of life events. Learned helpless model (M. Seligman) proposes that depressive disposition can develop as a result of repeated past experiences of uncontrollable helplessness.

The Role of Positive Psychiatry

From the above discussion, it is evident that the etiological models of psychopathology of depression are inconclusive, and there is not yet a clear genetic, biological, or psychological/social marker for depression. Moreover, the rapid rise and widespread use of antidepressant treatment of depression, based on the biological model of depression, has not been without controversy. Antidepressants are helpful in about half to two thirds of cases, especially with severe depression, however in most cases the effect is modest [4]; and in many cases especially in youth with major depression the antidepressant effect is close to a placebo effect. It is important to point out that clinical studies of antidepressants have primarily focused on reducing the symptoms of depression and not on a broader range of potential outcomes (such as changes in everyday functions, cognitive abilities, quality of life, etc.).

An integrative model is most likely the approach to understand and treat depressive illnesses. Thus, positive psychiatry opens the possibility that psychopathology is not the driving force to understand and treat depression, instead it emphasizes hope, optimism, character strength, and gratitude, among others, which can act as powerful protective factors against genetic vulnerability and precipitating stressors of depression.

A study on the effectiveness of six internet-based Positive Psychology interventions concluded that two – *using signature strengths in a new way* and *three good things* – increased happiness and decreased depressive symptoms for 6 months. The other effective interventions *The Gratitude Visit* led to positive changes for 1 month [5]. In a large placebo-controlled clinical trial, where a quarter of the treated sample had depression, Positive Psychotherapy was shown to be an effective interdisciplinary approach with long-term symptom reduction [6]. Finally, a meta-analysis looking at Positive Psychology Interventions concluded that they enhance wellbeing and decrease depressive symptoms and recommended clinicians incorporate positive psychology techniques "particularly for treating clients who are depressed" [7].

Clinical Application

A.R. is a 39-year-old white female attorney, married with one child. She was referred to outpatient treatment following her 3-week hospitalization on inpatient psychiatric unit for the treatment of severe recurrent major depression with suicidal ideation. That was when she met her current outpatient psychiatrist in the year 2014. The psychiatrist learned that the hospitalization was her third one, and that her history of clinical depression started during the year of 2011 and that she had been hospitalized approximately once a year since the onset of the illness. Her hospitalizations were always ushered in by

sleep disturbance characterized by difficulty staying asleep, lack of motivation, decreased energy level, decreased appetite, and a sense of hopelessness and helplessness associated with fleeting suicidal ideation without intention or plan. She had never attempted suicide and considered it to be unfair to her child and her supportive husband. She had been tried on many antidepressants at different times alone and sometimes in combination with mood stabilizers as augmenting agents with varying results. The last medication regimen included Bupropion extended release, Lamotrigine, and Trazodone.

In our first session, AR conveyed clearly that she had been tired of all those medications that seemed partially effective and frequently associated with side effects. She was a strong believer in modern pharmacology and the power of medication to correct the "chemical imbalance" that she believed it to be the cause of her depression. Her disappointment and disillusionment in the curing power of medications was increasing. AR was convinced that her depression is hereditary, since her mother also suffered from major depression and mother's response to antidepressant treatment was generally favorable.

AR grew up in a small town in Pennsylvania, the oldest of three children, a sister 3 years younger, and a brother 5 years younger than her. Parents had frequent marital and financial problems due to father's drinking problems and they were eventually divorced when AR was a junior in high school. She put all her energy in excelling in school and tried to help her mother raising the two younger siblings. Due to the difficult financial situation, she had to work part time while finishing college and went on to study law. She graduated from law school with a large debt, yet was motivated to start working immediately to pay her loans and to help her family financially. She joined a financial law firm in which the work environment was stressful and demanding, she worked long hours and always felt that she could not keep up with supervisor's expectations. She met her husband shortly after joining the law firm and had her only son who was 7 years old in 2014. AR described her husband as a caring and very supportive person. Because of the stressful work and the long hours AR had to spend working, her husband, who worked in computer business, began to do most of his work from home, which made him available for child-care. She was the main bread winner of her family and always felt obligated to work hard to secure a decent life to her immediate family; however, it was at the expense of the time spent with her husband and son.

In addition to the hospitalizations, AR had occasional therapy sessions with different therapists and was seen by psychiatrists for medication follow-ups; however, the outcome was not favorable since she continued to struggle with periods of depressive symptoms and three admissions.

In reviewing the history of treatment and medication with AR, it became obvious that the focus of most treatment modalities had been on addressing her psychopathology and deficits and attempting to correct them. Whether the problem is a chemical-imbalance that needed to be corrected by antidepressants and other somatic agents, or the problem is negative and dysfunctional thoughts that needed to be corrected through cognitive behavioral therapy sessions. Or the problem stemmed from her early formative years when she was exposed to parents' frequent discord due to father's drinking problem that culminated into their divorce and father's final abandonment of the family, which may have left AR with a deep feeling of poor self-worth and low self-esteem. Although those were legitimate issues that probably played a role in her depression, and convinced AR that she is somehow a deficient person, and she became even more despondent that all those treatments had never achieved the goals of correcting the problems.

It was clear that AR history of psychiatric evaluations and treatments, that was based on psychopathology and deficits will always recommend specific treatments, such as medications and individual therapy, while an evaluation that is based on the principles of positive psychiatry and wellness will produce different treatment recommendations that enhance the quality of life [8, 9]. It seemed that another side of AR as a person was never explored or utilized and that a whole different

mental state and way of thinking had to be adopted and tapped on, which could drastically change the direction of treatment and lead to a positive outcome.

Positive Psychiatry Treatment Approach

Assessment and Opening Sessions

The initial phase of the treatment consisted of first, addressing certain beliefs about what it meant for AR to have depressive illness; second, involving the husband to some degree in her treatment; and finally, identifying positive traits and strength that she had. A discussion ensued regarding AR conviction of having a hereditary chemical imbalance, in which the psychiatrist explained that the term "chemical imbalance" could be misleading and inaccurate, and it is only a hypothesis, no chemicals are routinely measured. The relationship between the chemicals (neurotransmitters) and depression is very complex –discussion continued – and it is not a causal relationship, meaning the presumed deficiency could be a cause or, in some cases, an effect of depression, also the effect of antidepressant on brain chemicals is most likely through several intermediary steps which are not fully understood. In terms of hereditary, the psychiatrist explained, it is not known what exactly that is inherited in addition, genes are not operating in isolation, genetics are in constant interaction with the internal and external environment, genes can affect behavior and behavior can affect genes expression (epigenetics). And it is better to conceive of hereditary as only a possible vulnerability that can be reduced through modifying stressful factors.

Building a Support System

The second step was to involve the husband in her treatment, since her depression had affected the family and her stressful work had limited the time the family can spend together. AR agreed for the husband, who is a caring and supportive person, to join in every other session for the first year.

Identifying and Using Character Strengths

Identifying strengths was the third step, AR was encouraged to take VIA survey available online, in which she showed high character traits such as kindness, judgment, and gratitude; she also showed a reasonable level of zest, a modest sense of hope, and a good level of love. She was encouraged to be cognizant of her strength and to nurture her sense of hope and optimism during most of her daily activities.

Addressing Stressors

During several sessions that included her husband, and after long discussion regarding her stressful work environment, AR reached a decision to quit her job and work as a part-time lawyer in a low-stress firm and to accept the less income yet she will enjoy more time with her husband and son and time for wellness. That also allowed her to volunteer a few hours per week as a legal advocate for mentally ill patients, an activity she always wanted to do but could not due to her busy schedule in the past. The advocacy for patients made her highly conscious of the value and the power of *optimism and hope* that she began to instill in her clients. AR had been interested in mindful-meditation in the past but could not find the time to practice, now she joined a group for mindful-meditation, and began to do her reading and meditation practices for 20 min daily. She added to her activities regular walking daily for half-hour. Within few months from adopting a positive psychiatry approach, sleep normalized, mood has improved significantly her outlook on life has changed positively. Medication regimen has been simplified, no mood stabilizers or sleep medication were required, and she only needed half of the dose of bupropion antidepressant. She had achieved a

remission for longer than 2 years and most importantly, her quality of life and well-being have been enhanced.

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Positive Interventions in Anxiety Disorders

10

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Introduction

Ancient Greek and Roman physicians and philosophers differentiated anxiety from other negative affects and labeled it as a medical disorder [1]. In the collection of Greek medical texts known as Hippocratic Corpus (dominant from 460 BC to 370 AD), a phobia of a man named Nicanor is described. Nicanor experienced severe persistent anxiety on hearing the voice of the flute at night time [2]. This typical phobia was labeled as a medical disorder.

Roman Stoic philosophers Cicero and Seneca described the clinical features and the cognitive treatment of anxiety that have much overlap with modern cognitive psychotherapy. In the *Tusculan Disputations*, Cicero (106 BC to 43 BC) classified affliction, worry, and anxiety as disorders, and made a distinction between pathological anxiety and sadness [3]. He also distinguished between trait anxiety (*anxietas* – the predisposition to anxiety), and state anxiety (*angor* – current anxiety). Seneca (4 BC to 65 AD), in his book *Of Peace of Mind (De tranquillitate animi)*, discusses the need to focus on the present rather than the future in the treatment of anxiety disorders – which is a foundational principle of modern Mindfulness practice.

Epicurean Philosophy founder, Epicurus (341 BC to 270 BC), also similarly noted that to reach the state of tranquility and to be worry free (Ataraxia), one needs to place attention on the present rather than having negative thoughts about the past or future.

In 1621, Robert Burton published a comprehensive review of the literature from Classical Antiquity up until the seventeenth century in *The Anatomy of Melancholy*. In this work, Melancholia included both depression and anxiety; the diagnosis would be applied to individuals with negative affect or internalizing symptoms. Boissier de Sauvages (1706–1767) worked on classifying diseases and published the first major French medical nosology. He used the term Panophobia to describe anxiety. His further subdivisions of Panophobia overlap with our current anxiety disorder subtypes. In 1869, George Miller Beard describes neurasthenia, which continues to be a diagnostic term today. Neurasthenia includes symptoms of anxiety and depression in addition to weakness, dizziness, and fainting. Freud initially considered anxiety to be the physiological buildup of libido but later redefined anxiety as a signal of threat in the unconscious.

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Box 10.1 All of the Anxiety Disorders Have a High Lifetime Prevalence

- Panic disorder 5.7%.
- Generalized anxiety disorder 6.2%.
- Agoraphobia 2.6%.
- Social anxiety disorder 13.0%.
- Specific phobia 13.8%.
- Obsessive-compulsive disorder 2.3%.
- Post-traumatic stress disorder 1.3–12.2% [4, 5, 6].

Current Understanding of Anxiety

Anxiety is a universal, evolutionary, and adaptive phenomenon. With a radar-like threat detection system, the thalamus and the amygdala can activate the autonomic nervous system, hypothalamic-pituitary-adrenal (HPA) axis, leading to the release of adrenaline and cortisol which maximize the fight or flight response for survival. In anxiety disorders, this threat detection system is sensitized to various fearful stimuli and gets activated in the absence of objective threats to survival.

Anxiety disorders constitute the most common psychiatric disorders, affecting almost one in five adults in the USA [7]. Estimates are that 25–30% of the population experience an anxiety disorder at some point in their lifetime, leading to an enormous disease burden and high healthcare costs [4, 7]. According to the National Comorbidity Survey (NCS), the lifetime prevalence rate for any anxiety disorder was 30.5% for females, vs. 19.2% for males [7]. The prevalence of self-reported anxiety has been increasing as well [8] (Box 10.1).

Furthermore, anxiety disorders have a chronic course of illness [9].

Biological Etiology

The survival value of anxiety facilitates genetic selection of anxiety genes because of evolutionary advantage and genetic inheritability; this can explain the significant genetic predisposition of anxiety disorders. Inheritance of shorter alleles for Serotonin *ss* (two short alleles) is directly involved in the genetic inheritance. A study on young rhesus monkeys showed that brain function and metabolism is passed on to the offspring from anxious parents, giving the progeny a higher risk of stress-related psychopathology [10]. Also, disruptions in neuroendocrine and neurotransmitter pathways have been associated with anxiety disorders, which have provided great implications for the psychopharmacological treatment of these diseases [11].

Genes often interact with their environment to make phenotypes appear, and some of these epigenetic changes are transmitted to the next generation as well.

Psychosocial Etiology

Ancient Greek philosopher Epicurus, and in modern times Freud, noted that seeking pleasure and avoiding pain drives human behavior [12]. Anxiety disorders, through their repetitive, intrusive, and unwanted activation of the threat detection system forces one to avoid fearful stimuli, no matter how irrational it might be. These psychological processes start from infancy and continue as we grow to make sense of the world and develop various mental schemas. As the infant individuates into their self and realizes their separate existence, developmentally normal separation and stranger anxiety starts. The brain detects danger when the caregiver disappears, or an unfamiliar person shows up. At age two or three, most children outgrow separation and stranger anxiety as they realize that either condition by itself does not pose any danger. Those born with a genetic predisposition, or through a combination of Nature and Nurture, continue to experience significant clinical anxiety. Bowlby [13] argued that children who suffered neglect and uncertainty develop an anxious-ambivalent attachment with the caregiver and do not overcome the fear of separation or abandonment [14]. Bowlby also noted, on the other spectrum, overprotection also led to anxiety disorders [13].

Within the normal developmental range, children continue to experience anxiety from various real or imagined objects, for example: being alone, dark, animals, thunder, monsters, etc. through misattribution and projection.

All around the house is the jet-black night;
It stares through the window-pane;
It crawls in the corners, hiding from the light,
And it moves with the moving flame.
Now my little heart goes a-beating like a drum,
With the breath of the Bogie in my hair;
And all around the candle, the crooked shadows come,
And go marching along up the stair.
The shadow of the balusters, the shadow of the lamp,
The shadow of the child that goes to bed --.
All the wicked shadows coming, tramp, tramp, tramp,
With the black night overhead.
ROBERT LOUIS STEVENSON, *A Child's Garden of Verses.*

Through the psychodynamic lens, clinicians might be able to identify various deep-rooted anxieties. Disintegration anxiety indicates excessive fear that the self will fragment because others are not responding with needed validation. Persecution anxiety refers to fear that self is getting invaded and annihilated by an external evil force. Fear of loss of the object, or the loss of the love/approval of an object (parent), or guilt from harsh superego of not living up to the internalized standards constitute other anxieties.

Behaviorists, on the other hand, explain anxiety as (1) a conditioned response to previous painful experiences, e.g., past trauma inducing horror from the perpetrator and resulting overgeneralized difficulty in developing trust, or (2) to result from overprotective anxious parenting as indicated by Social Learning theory. Anxious parents can often enable anxious behaviors in children by inadvertently teaching them that the world is dangerous and that it is better to stay home and not to take any risks. They may also learn to mimic the behavior of their parents and others after observing them according to the social learning theory [15].

Existential theorists indicate the anxiety to stem from (1) the fear of annihilation, (2) experiencing a void in existence and meaning of life, or (3) a guilt or condemnation that one has not lived to the moral standards [16].

The Cognitive Model describes anxiety as stemming from certain faulty cognitive processes that make the person experience heightened vulnerability [17]. Through fearful information processing/appraisal, anxious individuals overestimate the threat and underestimate their ability to cope with it. Common cognitive processing errors include:

1. Catastrophization (thinking that mistakes would have a disastrous outcome).
2. Magnification (viewing shortcomings to be significant flaws).
3. Selective attention (over scanning the environment for threats while missing the safety cues).
4. Personalization (wrongly blaming themselves for adverse events/outcomes).
5. Discounting the positive (not taking credit for excellent results).
6. Overgeneralization (generalizes an adverse event to oneself or the environment).
7. "Should" statements (overly self-critical)
8. Control fallacies (believing one has no control or complete control of everything).
9. Minimization (underestimating one's resources).

When faced with the fearful situation and stimuli, anxiety increases significantly with an automatic fight, flight, or freeze response and resulting physiological symptoms. Withdrawing or avoiding the trigger removes that painful anxiety response which is behaviorally reinforcing. Over time, avoidance behaviors perpetuate the vicious cycle of worsening anxiety and decrease the ability to cope with the fears [18].

Larger community also provides positive and negative social experiences. For racial minorities, exposure to discrimination leads to a higher risk of anxiety, but nativity is protective [19]. Other negative interpersonal experiences, for example, bullying also increase the vulnerability for anxiety disorders. Crime in the community leads to fear, resulting in a high likelihood of anxiety as well [20].

Box 10.2 To Treat Anxiety Disorder, Positive Mental Health Clinicians Must Understand, Assess, and Strengthen the Positive Psychosocial Factors (PPSFs) of the Following

- Optimism.
- Resilience.
- Perseverance.
- Positive emotions.
- Positive appraisal.
- Positive selective attention.
- Positive internal coping skills.
- Problem-solving skills.
- Humor.
- Emotion regulation.
- Facing one's fears.
- Spirituality.

Positive Psychiatry Applications

Positive Psychiatry does not replace the existing treatment, and instead broadens the scope of practice to health promotion and centers the treatment framework to identify and strengthen Positive Psychosocial Factors (PPSFs) Box 10.2.

Positive psychiatry extends beyond an individual approach and involves family and community work. For example, a Child & Adolescent Psychiatrist providing an individualized plan (with strengths and challenges) to the child, family, and school models the Positive Psychiatry approach. Parent training work, family meetings, and discussions with school counselor/teacher not only treats the identified child patient but also benefits other siblings and students.

Positive Psychiatry approach helps clinicians utilize the client's strengths to facilitate optimal exposure.

Therapeutic Relationship/Stance

Positive Mental Health practitioner indeed approaches the patient as a person gifted with unique strengths. Clinician actively elicits and listens to the existing strengths which will be utilized to treat the client's vulnerabilities and adversities. Provider actively communicates the acceptance, respect, and belief in their patients' capabilities. Therapist and patient jointly co-investigate the identified problems through collaborative empiricism [21], as in two scientists collaborate to solve a problem. The patient retains rather strengthens their sense of agency in the treatment.

It is important to highlight that this therapeutic stance is not neutral and is rooted in positivity instead. Also, it is not a forensic or investigative stance to regularly scan if the patient is telling the truth. Instead, clinicians listen to the client with an accepting and believing position. If there is a discrepancy between one's account or through a collateral source, clinician frankly discusses that in a matter of fact tone to understand the situation better. The therapist is not searching for a confession and instead facilitates their patients to start experiencing their authentic self in that relationship without fearing judgment.

Here, we represent a few tools that clinicians could use in treating anxiety disorders. Many of these tools have been described through various psychotherapeutic and philosophical traditions, some like mindfulness from the time of Stoics.

Exposure

> Each of us must confront our own fears, must come face to face with them. How we handle our fears will determine where we go with the rest of our lives. To experience adventure or to be limited by the fear of it. –Judy Blume

Whether some therapeutic approaches start with exposure or get there overtime, in the end, one overcomes fears by facing them. Gaining an understanding of the pain and purpose of exposure will be productive in overcoming anxiety through the development of the ability to persevere.

Mindfulness

Anxious ruminations involve either replaying the past negative situations and interactions or dreading the future occurrences. Mindfulness allows

one to be in the present moment. From the time of Stoic and Epicurean philosophers, mindfulness has been described as a way to achieve happiness and tranquility in life. Current research has validated the effectiveness of mindfulness for the treatment of anxiety [22].

Mindfulness is a non-judgmental and accepting awareness of the present. One could observe thoughts in a de-centered and non-attached manner [23].

Cognitive Restructuring

Cognitive therapy teaches how to correct the cognitive errors responsible for anxiety. Understanding that anxiety centers on experiencing heightened vulnerability, with more attention to threats, and less to the safety cues and resources, cognitive restructuring helps reappraise the risk more accurately and improves the confidence on internal and external resources.

Reflective Thinking

Anxiety reduces rational, reflective thinking as more primitive centers of the brain (Amygdala) take over. Engaging in more reflection, description, and writing activates more rational parts of the brain (Cerebral Cortex) which helps to challenge one's negative thoughts and enhances strategic thinking.

The Sense of Agency

Anxiety disorders, with a sense of heightened vulnerability, induce the feeling of helplessness. Self-efficacy and outcome expectancy are directly correlated with the ability to handle anxiety [24]. Individuals with an internal locus of control perceive life circumstances to be under their control, vs. those with an external locus of control think outside forces control them – hence increasing the sense of helplessness. Patients could train themselves to experience improved perceived self-efficacy.

The related concept of Personal Mastery – the power of "I can" empowers and motivates one to face and overcome threats. A fundamental assumption is that human beings need the motivation, perseverance, expectation of success, and positive attitude to make a specific behavior happen. Both Personal Mastery and perceived self-efficacy correlate positively with positive mental health outcomes.

Letting Go

With increased helplessness, anxiety forces one to control as many variables as possible. Contrary to this anxious pressure, treatment targets letting go of control and negative emotions. Learning to live without the safety of having control of the environment would significantly reduce the amount of anxiety experienced, preparing individuals for situations where they cannot obtain control. Mindfulness could help achieve this skill of letting go of negative emotions.

Letting go of perfectionism and particular validating statements from others would also reduce significant pressure. The University of British Columbia Cognition Inventory – "Letting Go" provides a useful measure of the process of letting go. Its advantage over other scales is that it measures multiple negative thought themes separately, accounting for the fact that different people do not fixate on the same things [23].

Resilience

Resilience is the ability to bounce back from adversity. Resilience competencies could be improved and taught. Resilience has an inverse correlation with the risk of PTSD [25, 26, 27]. The concept of resilience can thus be incorporated into the treatment of PTSD [28]. Some individuals become stronger when they experience adverse events in their lives, exhibiting posttraumatic growth.

Resilience includes six core competencies:

1. Self-Awareness (awareness of one's thoughts, emotions, and behaviors).
2. Self-regulation (ability to regulate one's thoughts, feelings, and behaviors).

3. Optimism (hope, positive outlook).
4. Mental Agility (cognitive flexibility, taking others perspective, adapting).
5. Character strengths (identifying major strengths and using them to overcome weaknesses).
6. Connection (healthy connecting with others, compassion, seeking/offering help).

Optimism is a particularly important skill for treating anxiety. With more sensitive threat detection, anxiety biases one to anticipate the high risk of various choices. When patients do not achieve the desired outcomes from a treatment plan within a short amount of time, they may experience discouragement if they do not have optimism to support them.

Self-regulation could be taught through various methods. Biofeedback could also be utilized to help patients learn to control previously involuntary body processes [29]. For those with anxiety, patients would monitor their heart rate, respiration rate, skin surface temperature, and heart rate variability as they control their sympathetic arousal [30]. With this concrete and visible information, patients could learn to regulate themselves more easily. In a four-week study of anxious graduate public health nursing students, biofeedback has been shown to reduce stress and anxiety [31].

People who identified and used their character strengths reported greater vitality, self-esteem, and positive affect as well as reduced perceived stress [32].

Healthy Sleep

Sleep can contribute to and worsen mental health issues, including anxiety disorders [33]. Improving sleep on its own makes a significant impact on quality of life. Regular circadian rhythm affects physiological processes in the body, including metabolism and hormone regulation which leads to improved sleep and higher energy levels through the day [34]. Ways to promote healthy sleep include decreasing alcohol, caffeine, and nicotine consumption, keeping the bedroom dark and free of distractions, only using the bed for sleep and sexual activity. In more severe cases of insomnia, medications may be utilized as well. Furthermore, providers can work to improve patients' circadian rhythms through light therapy and the utilization of melatonin.

Exercise/Physical Activity

Through the involvement of biological as well as psychosocial processes, healthy exercise helps reduce anxiety. Jayakody et al. conducted a systematic review to examine eight randomized controlled trials for the effectiveness of exercise in reducing anxiety symptoms [35]. It revealed that exercise does help to alleviate symptoms to an extent, and would likely work best as an adjunctive treatment. Anaerobic and aerobic exercise did not differ in terms of their results, and the type of intensity did not change the outcomes of the exercise as well. Both physiological and psychological mechanisms explain the reason why exercise can help with anxiety disorders [36]. Aerobic exercise, when performed regularly, has been shown to decrease sympathetic nervous system and hypothalamic-pituitary-adrenal axis reactivity; both of which have been implicated to be relevant in the pathophysiology of anxiety disorders. Exercise also provides exposure to physiological changes that can promote anxiety, increasing tolerance for these symptoms. Furthermore, exercise helps to build self-efficacy; it creates the perception of having control over potential threats. Similar to meditation, exercising can act as a distraction technique for reducing anxiety.

Spirituality and Religiosity

Religious and spiritual practices have an association with improved health outcomes and reduced anxiety [37]. With his systematic review, Koenig concluded religion and spirituality were associated with significant mental health benefits, including a reduction in anxiety. Perhaps, tran-

scendent beliefs provide hope and a deeper meaning of life or the presence of a higher being. The benefit may also come from social support or the sense of belonging that often comes from organized religion [33].

Family Engagement/Parenting

Family therapy is highly effective and yet underutilized for the adult population. Engaging the family and parents as allies in treatment increases the success rate. Rather than discussing anger on parents and their shortcomings for months to years, it is far more useful to bring them in the session and help them connect as therapist mediates those conflicts. Clinicians must be sensitive to parental guilt of anxious parents who commonly blame themselves for their child's anxiety. Anxious parents have the unique strength of the first-hand experience of their child's illness. While anxious parents cannot control the transmission of specific susceptibility genes, they can help minimize the increased psychosocial risk factors (as noted above) for their children. Child's anxiety could be a strong motivation for parents to seek their treatment. Extensive psychoeducation for the anxious parent and child should include the purpose of going through the pain of exposure and long-term cost of the avoidance behaviors. Involving the non-anxious parent or family member in a supportive manner could reduce marital conflict and increase the chance of treatment success.

Social Support

Secure, healthy interpersonal relationships significantly increase one's ability to cope with anxiety and prevent isolation. Types of social support include: emotional (listening and validating), instrumental (providing tangible help), informational (giving advice), and feedback [38]. A cross-sectional study revealed a significant association between perceived social support and decreased anxiety; the support can come from spouses, family members, friends, and healthcare workers [39]. Also, in a primary care setting, a study showed that increased perceived social support amplified the effects of treatment [40]. Social and interpersonal skills could be taught to anxious patients. Healthcare providers themselves act as a source of support through active listening and appropriate validation, giving emotional support to the patient.

Social-emotional curriculum at schools, bullying prevention programs [41], and racial/ethnic/religious tolerance can be global community-level prevention efforts.

There is a significant need for more research to expand our understanding of mental health promotion and utilizing positive psychiatry approaches.

Clinical Case

Veronica is a 21-year-old college student in her senior year, with a perfect academic record, and is well-liked by most classmates. The college counselor has referred her to the psychiatrist for further assessment. Veronica has been dealing with severe anxiety for years that she has successfully masked from everyone, without ever asking for help. She has always been a "perfect" student with no complaints from anyone. Veronica worries excessively to not "mount to anything," and be an embarrassment for her family. Recently, her classmates have noticed her hands shaking, and highly aware of her shakiness and palpitations; she has been finding it even more challenging to interact with others. Veronica fears to make serious mistakes and appearing incompetent in front of others. Despite her perfect grades, she perceives any small corrections or suggestions by teachers as gross incompetence. She describes feeling exhausted by these constant worries to the point she wishes she "just disappears." She denies any suicidal thoughts and finds suicide to be against her religion. She feels helpless to stop her anxiety and is skeptical if treatment would be useful.

Veronica avoids social interactions and small talk. She finds it more comfortable to stay by herself despite her desire to connect with others.

Veronica finds it hard to stop thinking about any negative interactions, sarcastic jokes, and passing remarks. She tends to apologize excessively, which seems almost involuntary for her. Veronica has had trouble sleeping and frequently feels exhausted. She tends to worry about her family and her parents' health. She has been excessively worrying about not getting desired internship or entry-level job that "everyone else in her class has already gotten by now."

Her father is a computer software engineer, and mother an accountant. Their jobs keep them busy so they do not socialize much. However, they tend to stay quiet even if they are outside the home as a family. Veronica believes her mother has anxiety, but she has not been diagnosed or treated. Veronica is the youngest of three children; her siblings are successful professionals and were also high achievers at the top of their classes through the school. Her parents have always reviewed her grades rigorously and compared her performance with others. While Veronica has always made it onto the honor roll, she does not feel that her parents have ever been proud of her.

Veronica does not recall any significant traumatic incidents. She had three close friends in school, but she did not socialize outside of school and has lost contact with them after graduating from high school. She has not had any romantic relationships.

On strength assessment, Veronica exhibits *high persistence, kindness, and self-regulation*.

A therapist and a psychiatrist collaboratively treat Veronica for Generalized Anxiety disorder and Social Anxiety disorder. They appreciate her perseverance and pushing through the challenges over the years by herself, how despite constant dreads and fears, she has excellent academic achievements – successes that Veronica does not think much of.

With this accepting/appreciating stance, they provide her with extensive psychoeducation about her anxiety and its physical symptoms of palpitations and tremors associated with neuroendocrine connections. She can now connect these details with her previous awareness of adrenaline and fight or flight response. The team provides her with realistic optimism and collaboratively devise a biopsychosocial treatment plan with her. Although interventions at all start together, below (non-chronologically) we break down the process.

For the biological component, the psychiatrist explained her physiological symptoms of tremors and palpitations. Also, Veronica routinely missed the breakfast and most days she only at one meal with a couple of snacks other times. The team discussed the need for healthy and balanced nutrition. She did not have specific eating disorder cognitive distortions but did not give much importance to regular meals. She agreed that she would start at least two meals and will have two snacks regularly.

The psychiatrist discusses the circadian rhythm and the importance of healthy regular sleep with her. During the discussion of bedtime, Veronica shared that many nights she studies until 2–3 am. Together, they discuss planning her day differently so she could get healthy sleep.

Veronica was already thinking that she should start exercise but felt anxious that others would judge her in the gym. The team discussed the value of exposure and the long-term benefit of facing these fears of judgment to overcome the anxiety.

The psychiatrist discussed the risks, benefits, and alternatives of SSRI's and provided her with printed material to review as well as talk with her parents if any family member has responded better to any of these medications. To her surprise, Veronica learns that her mother has been managed successfully on Sertraline. As patients with anxiety disorders typically respond to the higher dosages, but side effects/tolerability is better managed through titration, the plan was discussed with Veronica. She is also well informed of the delay in the therapeutic effects and multiple choices available, so she does not prematurely lose hope in the treatment.

Psychological interventions start from the moment of history gathering. Veronica understood the importance of exposure and viewed small talk and social interactions that she used to dread as more purposeful. Veronica had briefly learned about meditation yoga in her classes, but

found it hard, "I can't keep my thoughts focused." The therapist normalized the floating of thoughts and encouraged to observe them floating, and bring the attention back slowly each time. Veronica found it helpful that "there is no wrong way of doing mindfulness," and the whole practice involves acceptance and non-judgment.

The therapist helped her understand the anxiety as an internalizing disorder and ways to challenge anxious thoughts. She also introduced the concept of cognitive distortions. Through her curiosity and love for learning, Veronica started identifying the instances where she tended to process information from the anxious standpoint and was able to engage in more strategic reflective thinking. She was proud to show her journal where she had challenged her initial response and shifted her fearful reactions in a more thoughtful deliberate manner. The therapist deeply appreciated her courage, and Veronica laughed that "I'm not discounting my positives" and was able to take the compliment.

Veronica experienced distress in expressing her opinions to others, notably in case of a conflict. The therapist provided her with education about assertiveness and various methods of communication. She was afraid to offend anyone. The therapist did a few role-play exercises during the meeting and encouraged Veronica to find opportunities for assertiveness during the sessions with her. Veronica's inhibited communication also appeared closely linked with her perfectionism and fear of making mistakes. Together they worked on letting go, being imperfect, and the inevitability that like everyone else, she will – and can – make mistakes, and that will be alright.

Veronica engaged in significant social changes herself, as she also enrolled in volunteer work for the freshman class. She was able to observe other anxious students, and the same compassion that she experienced for them, she was able to extend to herself.

One day, Veronica asked the therapist that her parents are coming into town next week and if they could join her session. The therapist welcomed the idea. The family session turned out to be highly productive, as her parents for the first time opened up about their own vulnerabilities and emotional communication difficulties. Veronica was in tears to hear that they have always been proud of her and from their standpoint they were taking an interest in her education and peers. Both parents grew up in traumatic environments and were focused on providing safety for their children. They became tearful while expressing their guilt in not understanding their daughter's emotional states. With her oozing compassion, Veronica jumped to comfort them as she made a different sense of years of experiencing falling short of their expectations.

Summary

Anxiety disorders have been recognized since ancient times. Over the centuries, we have learned to conceptualize these disorders from its biopsychosocial aspects. As through the traditional disease model, we have extensively studied the challenges and problems, as a field, we had largely ignored the study of normal, healthy, and stable individuals. Including the study of healthy individuals within our scope would help prevention efforts as well as increase the treatment success rate. Clinicians bring out and enhance the patient's strengths, who then face their challenges through mastery and resilience. Treatment plans work to improve the positive psychological traits, including courage, optimism, positive emotions, positive appraisal, positive selective attention, positive internal coping skills, problem-solving skills, humor, resilience, emotional control/regulation skills, and willingness to approach fears. Positive psychiatry also includes direct work on improving family dynamics and social support. Starting from a positive perspective, mental health provider communicates the acceptance, respect, and belief in their patients' capabilities. Rather than discussing anger on parents and their shortcomings for months to years, clinician engages them in the treatment and mediates their conflicts. There has been emerging evidence for the effectiveness of positive psychiatry on mental illness, and still, significant research is needed in this field.

Key Points

- Positive psychiatry broadens the scope of the traditional approach with a high reliance on patient's resourcefulness.
- Positive mental health provider and patient co-investigate and collaboratively solve the problems through shared strengths and expertise.
- Positive psychiatry not only identifies and targets the biological, psychological, and social problems but also recognizes and utilizes strengths in each domain.
- Providers focus on keeping the patient's sense of agency and use more training and teaching to increase their self-efficacy and Personal Mastery.
- Resilience, optimism, and letting go could be learned with practice.
- There is a significant need for more research in the field of positive psychiatry.

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11 Positive Interventions in Schizophrenia and Psychotic Disorders

Narsimha R. Pinninti and Walter Rhoades

Introduction

Positive psychotherapy (PPT) stems from the positive psychology movement recently spearheaded by Seligman and his colleagues [1] and preceded by the work of Nossrat Peseschkian in Germany. In this chapter, PPT will be applied to Seligman's approach, while Peseschkian's approach is described in others (see Chap. 2 for clarification). In PPT the psychological interventions are focused on clients' positive resources, such as positive emotions, personal meanings, and strengths (including existential and spiritual meaning), and utilizing these to help the individuals address their psychopathological symptoms and emotional distress. The mnemonic PERMA captures the essence of PPT. It stands for positive affect, engagement, positive relationship, meaning, and accomplishment. The essence of PPT is building and maintaining a positive relationship through which other interventions are provided (Rashid and Seligman 2013). Traditionally psychotherapies follow the biomedical model in diagnostic evaluation followed by interventions that target most distressing symptoms and deficits. For example, cognitive behavior therapy (CBT) of depression focuses on the negative cognitive triad (negative view of self, the world, and the future), and interventions are designed to change the dysfunctional cognitions [2]. Identifying and increasing self-awareness of strengths is part of CBT, but that is not the central focus, and majority of the therapy time is spent in developing cognitive conceptualization of the individuals' psychopathology and helping the individual gain this understanding [3]. Improvement takes place through the individual developing more adaptive cognitions, coping skills for physiological reactions, and behavioral patterns [4]. Recent work of CBT for psychosis has focused less on the deficits and more in enhancing recovery through engendering hope and enhancing self-concept [5]. PPT differs from CBT and other therapies in that the majority of time in therapy is spent on unearthing positive strengths and generating positive affect and utilizing these to mitigate psychological distress and reduce symptoms. PPT was initially utilized for depression and subsequently a variety of conditions that are the focus of this book. There has been some work in utilizing PPT for individuals with schizophrenia and other psychotic disorders, and the field in this area is still evolving [6].

Psychosis is the defining feature of schizophrenia spectrum disorders, a common but variable feature of mood and substance use disorders,

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and a relatively common feature of many developmental, acquired, and degenerative neurologic and medical conditions [7]. This chapter covers all psychotic disorders including schizophrenia. Psychosis has traditionally been viewed in categorical terms with psychotic experiences considered essentially pathological. This categorical view of psychotic experiences as pathological contributed to the significant stigma associated with psychotic disorders and has been reported by clients as a barrier to recovery [8]. Recent evidence points to a more dimensional nature of psychosis with a continuum of psychosis ranging from self-reported infrequent psychotic symptoms in the general population to schizotypal traits, to schizotypal personality disorder, and finally to full-blown psychosis resulting in a diagnosable primary psychotic disorder [9]. In this chapter, psychosis is viewed as a spectrum with individuals who are at higher risk for psychosis at low end of the spectrum than those with prodromal symptoms, psychotic experiences, and psychotic disorders including first episode of psychosis, through either a relapsing or chronic course [10]. Positive psychotherapy (PPT) interventions can and should address the entire spectrum and prevent individuals from moving into the deeper end of the spectrum while helping them on their recovery journey.

Traditionally the mental health system and society viewed schizophrenia as an illness without recovery, and goals of treatment were symptom reduction and preventing hospitalization [11]. However currently recovery from mental illnesses including psychotic disorders is considered an expectation and reasonable goal by individuals who have recovered, families, mental health systems, and even the governments that ultimately foot the bill for mental health services [12–14]. Along with a change in the expectations for better outcomes, there is also a change in moving away from relying primarily on biological treatments of psychosis. Increasingly psychosocial interventions are given a well-deserved and more important place in their management of psychotic disorders. Current standard of care is that every individual diagnosed with schizophrenia is offered psychotherapy such as cognitive behavior therapy for psychosis (CBTp) along with pharmacotherapy as part of treatment [15]. Clients and their families also prefer psychosocial treatments to biological ones, but the current reality is that psychosocial treatments are labor-intensive and not widely available for individuals suffering from psychosis [16].

One relatively recent shift in the thinking and treatment of individuals with psychosis is paying attention to the experience and perspectives of individuals who have suffered from psychotic disorders including schizophrenia [17] . These individuals who are called “Experts by Experience” describe the importance of a trusting relationship with a professional as critical in their recovery. The relationship provides connection and containment during crises and high degree of autonomy in personal decisions during periods of stability and thereby promotes recovery and personal growth (Saks 2007). Recovery from psychosis is viewed as a journey, and there are several facilitators and barriers on this journey. Many clients describe stigma and discrimination, negative experiences from mental health services, and negative effects of medication as barriers to recovery [8]. The traditional model of psychiatric care termed the “medical model” focuses on the symptoms and deficits of the individual, and individuals with lived experience consider this perspective as a barrier to the recovery journey [18]. Positive psychotherapy for psychosis (PPTp) on the other hand by its focus on healthy aspect of the individual makes the healthcare experience a positive one for the clients and removes one of the current barriers in the recovery journey. The interventions for schizophrenia and psychotic disorders are still evolving and requiring more clinical and empirical fine-tuning. The interventions can be divided into two categories: (a) intensification of positive affect and experiences and (b) enhancing strengths of character. The first step in PPTp is building a positive therapeutic relationship that is mutually respectful, and the power differential in the relationship is minimized. It is important to recognize that there is normally a power differential in the relationship between client and therapist contributing to the stigma that can be addressed by the thera-

pist explicitly expressing that there are two experts in the room. One is an expert through knowledge and degrees, and another is an expert through lived experience [19]. All decisions about the therapy direction as well as different therapeutic decisions during the course of therapy are made in a collaborative manner with the involvement of client. It is extremely affirming for the client to have a physician or therapist listen to their intimate experiences without judgment and treat them as an equal partner [20, 21]. Experiencing positive affect in the session and learning to generalize this into real life through skill building helps in mitigating psychotic symptoms, improving affect, and countering the anhedonia that is part of negative symptoms. Positive affect in session is generated by establishing a meaningful therapeutic relationship through techniques such as engaging in casual or water cooler conversation, building on previous positive experience, identifying common interests, validation, and humor of laughing with patient [22]. Internet access provides an opportunity to enhance client's interests by helping them engage through those interests while in session. For example, an individual who hardly spoke due to negative symptoms was interested in rap music. When the author brought up his favorite song on YouTube in the session and played it, he became energized and rapped with the song and even began dancing. Music became a regular topic of conversation with him in their sessions subsequently, and many times he would just want to talk about music and in the end spent a few minutes on medication. The positive experiences in the sessions are then used as the foundation to identify more activities at home that can generate such affect. An activity and pleasure schedule can be developed in session, and client can keep track of their pleasurable activities. The first author has a list of pleasurable activities that he utilizes to jog clients' memory of activities that clients have previously engaged in or can get interested in. The second group of interventions is enhancing the strengths of character of the individual, and this has the effect of instilling hope in dealing with existing challenges and building resilience to deal with future challenges. The first author utilizes a technique to review life story while identifying the strengths and attributes that helped the individual in dealing with the traumas and challenges in life. See the chart enclosed (see Fig. 11.1). Usually after completing the chart, clients get to see the number of challenges and traumas that they have dealt with in their life and the strengths that they brought to bear in dealing with those challenges. The outcome of this intervention is that clients see themselves as survivors and are more aware of their strengths. In those situations where clients have difficulty identifying their strengths, they can recollect what people who know them best would consider as their strengths or even do a homework assignment to ask what people who know them well think of their strengths. Many times, clients are very surprised to hear the positive things that they hear from their family and other care providers when they specifically ask for feedback.

Empirical Evidence

Positive psychotherapy programs developed so far for persons with schizophrenia vary in content, procedure, and specific goals for interventions, but all are geared toward improving life satisfaction in a lasting and functional way [6]. Overall the evidence from controlled trials for the efficacy of PPTp is limited and is covered here. PPTp has been provided in individual and group format with more evidence for group format.

Johnson et al. developed a secular version of Buddhist meditation called loving-kindness meditation (LKM) and evaluated it in an open-label study of 18 participants with schizophrenia spectrum disorders and significant negative symptoms. Their conclusions were that the intervention was feasible and associated with decreased negative symptoms and increased positive emotions and psychological recovery [23]. Kim et al. (2017) randomized 57 subjects with schizophrenia into PPTp group and controlled group who received treatment as usual in community setting. The PPTp group received ten sessions of individual therapy in 5 weeks. Results showed that interpersonal relations ($F = 11.83$, $p = 0.001$) and

Strengths: My internal strengths that helped me deal with the stress and traumas below. Also, the people in my life and other circumstances that helped me deal with the challenges/traumas.

Strengths:

People:

Circumstances:

Age : <5	10	20	30	40	50	60

Year :

Symptoms:

Life events: Stressors/Trauma/ Losses

What did I learn about my strengths, ability to deal with challenges in life completing this chart?

Fig. 11.1 Timeline of Life and Strengths chart

resilience ($F = 9.62$, $p = 0.003$) significantly increased in the PPTp group compared to the control group showing the efficacy of PPTp in this study. However there was no change in positive affect with PPT interventions [24]. More studies on efficacy of individual therapy format for PPTp are needed to recommend this therapeutic modality more widely.

Positive emotions program for schizophrenia (PEPS) is a specific, short, group-based intervention to improve pleasure and motivation in schizophrenia [25]. In a pilot study, 31 subjects with schizophrenia, or schizoaffective disorder, participated in an 8-week PEPS, and the results were statistically significant reductions in the total scores for avolition-apathy and anhedonia-asociality on the Scale for Assessment of Negative Symptoms with moderate effect sizes. Furthermore, there was a statistically significant reduction of depression on the Calgary Depression Scale for Schizophrenia, with a large effect size. Emotional blunting and alogia remained stable and did not improve during the intervention [26]. Riches et al. used an evidence-based theoretical framework to modify 14-session standard PPT into a manualized intervention, called WELLFOCUS PPT, which aims to improve well-being for people with psychosis. The modification was undertaken in four stages, qualitative study, expert consultation, manualization, and stakeholder review, and was informed by systematic review and qualitative data. The resulting WELLFOCUS PPT is a theory-based 11-session manualized group therapy [27]. WELLFOCUS PPT was tested as an 11-week group intervention in a convenience sample of people with psychosis in a single-center randomized controlled trial involving 94 people with psychosis. ANCOVA showed no main effect on well-being according to the primary outcome scale (WEMWBS) but showed significant effects on symptoms ($p = 0.006$, ES = 0.42), depression ($p = 0.03$, ES = 0.38), and well-being according to the Positive Psychotherapy Inventory ($p = 0.02$, ES = 0.30) [28]. Client's feedback about the group experience was positive throughout. Components found helpful included learning to savor experiences, identifying and developing strengths, forgiveness, gratitude, and therapist self-disclosure [29].

Applications

Typically, psychotherapy assumes a dyadic relationship between the therapist and the individual

receiving therapy, but the existing reality is that an individual with psychosis has several members of a treatment team working with them at any point in time. A comprehensive way of applying PPTp principles and practices is to include all the members of treatment team in this endeavor, and together the treatment team can provide these interventions. Where possible it can be helpful to bring the family and social connections of the individual into the orbit of the therapeutic circle so they are working hand and glove with the treatment team toward the individual's recovery. This concept has been utilized in a method called open dialogue in Finland, and they report significant reductions in the use of medication, reduced psychiatric symptoms, and most individuals recovering their life roles [30].

Vignette HP is a 51-year-old African-American man with a diagnosis of schizoaffective disorder and post-traumatic stress disorder going back to his early 20s. He was enrolled in assertive community treatment team due to history of medication nonadherence and repetitive verbal as well of physical aggression in other settings such as partial hospitalization program. In his last partial hospitalization, he flipped a table causing fracture to a staff member and was put on probation with the possibility of doing jail time for repeat aggression. He was on depot haloperidol 150 mg IM every 4 weeks and sertraline 50 mg AM to help with persecutory delusions, ideas of reference, depressed mood, and angry outbursts. First author (NP) did medication monitoring at four weekly intervals, while the rest of ACT team members saw him on a regular basis to help him with his instrumental, vocational, and relational needs. He was given the option and choice to be seen earlier than 4 weeks if he so chose. The symptoms that bothered the client were:

(a) Ideas of reference that people were judging him.
(b) Paranoia that people are against him.
(c) Depressed mood and beliefs that he is worthless.

These beliefs when triggered would lead to verbal aggression including threats to harm staff. His developmental history was relevant for enduring severe physical and emotional abuse by his mother that lasted most of his childhood, his two brothers ended up in jail, and the daughter he had through a relationship was given in adoption without his knowledge, and he did not know her whereabouts. In essence the ACT team was his only professional and personal support system.

Clinical Issues and Interventions The main issue with HP was repeated angry outburst and sometimes being depressed and hopeless with suicidal thoughts. We saw his anger and depression as being linked with stress pushing him into one or other, and he could easily move from anger to becoming very depressed and hopeless. Positive interventions were utilized when he presented with these symptoms. The first focus was on building a positive relationship with client. This was done by allowing him to define his own short- and long-term goals, validating his emotional reactions to various situations, and normalizing the emotions but at the same time identifying his behaviors such as verbal outbursts as barriers to his life goals. The relationship was strengthened when the focus in some sessions was on identifying client's positive values, attributes, and decisions and bringing them to the attention of the client. A typical session would start with client reporting his problems. Then therapist would validate clients' thoughts and emotions, and together they would review:

(a) Recent positive things that client did.
(b) Positive decisions that client made over a period of time.
(c) Clients' positive attributes and values that have been discussed and agreed on before.
(d) The adversities that client faced and skills he used to overcome them.

About 80–85% of the session would be spent in these interventions, and typically that would bring about a change in his affect from anger and irritability to depression at first and then of relaxation and cheerful affect. The therapist would then point out to the client the change in his affect and how this affect makes the client a fun person

to be with. Most of the time, these positive interventions would be adequate for the client to feel much better about himself and go back with increased self-assurance and with increased motivation to continue his treatment. At other times, he would also ask for some adjustment in medication. All medication decisions were made collaboratively with complete involvement of client, and unless there was a real reason not to, the psychiatrist would go along with client request. This was with explicit understanding that client would inform us in case the change made him worse. On several occasions, he would reduce the dose of medication and a week later call to go back on higher dose. This way of allowing him the opportunity to make trial and error medication decisions made him feel empowered and contributed to improved self-worth. On several occasions, client left the meeting saying "I am better when I come and talk to you" or "You make me feel good or I do not know what I would do without the ACT team. You are the only family I have got." While the first author met with client infrequently, the rest of the team saw him at least once or twice a week. The first author described his interventions and what was effective to the entire team, and they adopted the same approach of positive interventions to help him overcome his symptoms. The above is a snapshot of some positive psychotherapy interventions, and in addition he received a variety of services that included vocational housing support, budgeting, vocational counseling, and relationship counseling by different ACT team members [31]. While enrolled in ACT, he was able to make progress in every aspect of this life. He completed probation without any problems and never had another episode of physical aggression. Thus, he avoided incarceration and maintained his own apartment, working part time. He also entered into a relationship and maintained a relationship for a period of 8 years.

Positive Interventions in a Team-Based Approach to Address Physical Health Crisis

AJ is a 36-year-old African-American man with diagnosis of schizophrenia, moderate cannabis use disorder, and medical problems including obesity, type 2 diabetes mellitus, and hypertension. He lived in a supported housing facility with case management and was scheduled to attend partial hospitalization program three times a week. His main issues were partial medication adherence, paranoid thinking, and thought disorder of mild degree leading to nonadherence with medical care. During a routine med visit, he was found to have significant hypertension for which he was sent to emergency room and was hospitalized. He was diagnosed with chronic renal failure and recommended dialysis. This was a crisis for him, and he reacted to this crisis in physical health by becoming paranoid about the doctors, refused to cooperate with any investigations, and wanted to sign against medical advice (AMA). At this time, his regular psychiatrist coordinated care with psychiatric consultant on medical floor to come up with a plan that AJ as well as medical team was comfortable with. AJ was willing to meet the team half way and get some investigations such as ultrasound in the hospital, but he would not undergo a shunt for dialysis. He agreed to follow up with his PCP soon after discharge. This plan was also acceptable to the nephrologist, and he was discharged with this follow-up plan. When he returned to partial hospitalization program, the psychiatrist coordinated interventions with his case manager in supportive housing program and counselor at partial program to strengthen the relationship with the team. While the case manager worked with client in the community and his residential settings, the psychiatrist and the counselor worked with him in the partial hospitalization program. Within the framework of strengthened relationship, the team focused on identifying the adversities that AJ has faced before and the adaptive ways in which he coped with them. The team also identified the strengths he has exhibited both here in the program and the group home, as well as his emotional experience while in program. When different team members were able to shine light on his strengths in different situations, there was visible change in his affect from one of anxiety to being more relaxed, positive, and hopeful about this future. He was able to acknowledge this positive change and did verbalize that speaking to and being with team members was positive for him.

Every small decision he made such as getting labs done, going to PCP, filling his scripts in pharmacy, and coming to program regularly was highlighted, and these were reframed as facing him showing courage to face normal and expected fears. These actions were also highlighted as helping him work toward his long-term goals. With these interventions done, AJ agreed to get a shunt placed in his arm for dialysis as first step and followed it with starting dialysis. He has so far kept up with his dialysis schedule 3 days a week while coming to program 2 days a week, and he no longer has any fears about the dialysis. His labs that were reaching potentially critical levels are now improved. He reports feeling better physically and reports that color returned to his skin. His mental state showed improvement in that the thought disorder and paranoia disappeared and anxiety came down. AJ continues to be medication and treatment adherent at this time.

Both these vignettes show the use of PPTp interventions for individuals with psychosis in naturalistic ACT team and partial hospitalization setting. While it is important to have the efficacy of PPT demonstrated in controlled trials in one-to-one or group sessions, most individuals are treated in community health-care settings such as partial hospitalization. In these settings, it is difficult to have the luxury of resources where in individual clients can be seen for 8–15 sessions on a weekly basis. What is needed is to fit the interventions into the normal workflow of the existing treatment teams so that more people can receive these interventions. These two case vignettes show that PPTp interventions can be incorporated into the routine workflow and by involving the entire team in providing these interventions, meaningful outcomes can be achieved.

Areas that Need More Research

PPTp belongs to an emerging generation of therapies and is a promising therapy approach for individuals with psychotic disorders. However, there are several areas that need further research and clarification. First is that there is limited research evidence for PPTp delivered in an individual format and more research is needed with rigorous methodology. For the group therapy format, there is more evidence, but there is not one standardized protocol that most groups of researchers follow. As a result, it is difficult to compare different studies that use different interventions. What is required is the scientific community being able to coalesce around a single protocol which can then be tested in multicenter trials to demonstrate efficacy. Second issue with PPTp is an overlap between CBT for psychosis, mindfulness-based CBT for psychosis, and PPTp. Positive psychotherapy for psychosis interventions have to be delineated clearly so that same or similar therapies are not studied under different names. The third issue is that we do not have adequate effectiveness data. We need more studies on the effectiveness of PPTp interventions in real-world situations as the success of this therapy modality will ultimately be determined by feasibility and effectiveness in real-world situations. A fourth issue is that staff from different disciplines such as psychiatrists, advanced practice nurses, registered nurses, therapists, counselors, case managers, and peers are involved in treating individuals with psychosis and future studies need to be done to show which of these staff can best utilize PPTp intervention. Similar studies have been done in cognitive behavior therapy for psychosis [32, 33]. Families of individuals with psychosis face enormous burden, and future research on PPTp can evaluate whether family members can be taught interventions that help them interact with their loved ones effectively and if they can utilize these techniques to reduce their own burden.

Summary

To summarize, psychotic disorders are more common than we recognize, and many individuals do not discuss their symptoms due to significant stigma. PPT is very well suited to address psychotic symptoms and improve functioning through relationship building and engagement. PPT interventions are best viewed as central to a dyadic relationship between staff member and the client. This is complimented by client's social and professional circle being made part of the therapy process through education and skill building so

that the experience of clients in dealing with the most meaningful relationships in their lives generates positive affect and helps them gain meaning and thereby enhances quality of life.

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12 Positive Interventions in Substance Use Disorders

Christopher Milburn

Introduction

As the PP movement has advanced, there has been minimal overlap between its study and the very similar movement that has existed within the field of substance use, the recovery movement. Positive psychology has existed as a better-defined academic venture blossoming over the past 20 years. The recovery movement, on the other hand, has been present in some capacity since the beginnings of addiction treatment and has existed outside the realm of medical treatment and at times found itself at odds with medical treatment [1]. Nonetheless, the recovery movement exists within the medical paradigm, and in much the same way that PP supplements "psychology as usual," it exists adjunctively within the realm of addiction treatment. The growth in peer recovery and peer specialists, recovery coaches, and recovery support specialists represent a shift from pathology-focused to a solution-focused recovery paradigm [2] that has occurred in parallel to PP and, until recently, with minimal research overlap. In fact, a recent review by Krentzman in 2013 noted that the Research Society on Alcoholism's 34th annual scientific meeting in 2011 had no discussion of PP and the Second World Congress on Positive Psychology, also in 2011, had only one poster dedicated to patients with substance use disorders [3].

Given the overlap between PP and recovery, it is worth asking to what extent substance use counselors are already engaged in PP interventions, even if these interventions are not formally described as such. A recent study attempted to answer this question. In a qualitative and quantitative study of substance use counselors, they established that all of the questioned counselors were using some form of positive psychological intervention. Gratitude exercises were quite common, and the Miracle Question from Solution-Focused Therapy was very similar to the Best Future Self intervention. Further encouragement of acts of kindness and having patients consider their own strengths were also common elements of current treatments [4].

Before continuing, it must be stated that several terms commonly used in the domain of substance use disorder treatment lack well-established definitions, including that of recovery. The concept of recovery is complex, and the definitions of recovery are not always agreed upon among treatment providers and those in treatment. There are several approaches that have been used to guide the conceptualization of recovery. The first is the medical model of categorizing behavioral disorders as disease concepts with clearly defined symptoms. It is via this model that most substance use disorders are diagnosed. Please see Table 12.1 for a definition of a substance use disorder based upon the signs and symptoms outlined in the *Diagnostic and Statistical*

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Table 12.1 Criteria for a substance use disorder

1. The individual may take the substance in larger amounts or over a longer period than was originally intended
2. The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use
3. The individual may spend a great deal of time obtaining the substance, using the substance or recovering from its effects
4. Craving as manifested by an intense desire or urge for the drug
5. Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home
6. The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
7. Important social, occupational, or recreational activities may be given up or reduced because of substance use
8. Recurrent substance use in situations in which it is physically hazardous
9. The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
10. Tolerance, by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed
11. Withdrawal, as characterized by the specific substance's withdrawal syndrome

Adapted from [5]

Manual of Mental Disorders, Fifth Edition. Based on this model, a specific set of behaviors can be used to define an addictive disorder. These behaviors are discrete and observable, and in the event of their remission, one can be designated as "in remission." The notion of remission, sometimes used interchangeably with sobriety, is used medically and is separate from the less clinically defined "recovery," which generally includes the notion of establishing a healthy and productive lifestyle and maintaining personal health as well as phenomenological concepts such as spirituality and finding meaning in life.

Definitions of Recovery

The definition of recovery as it pertains to substance use disorders has varied and has eluded precise definition. The American Society of Addiction Medicine (ASAM) in 1982 differentiated between recovery and addiction. Recovery was described as "a state of physical and psychological health, such as his/her abstinence from dependency-producing drug is complete and comfortable," and remission was defined as "freedom from the active signs and symptoms of alcoholism, including the use of substitute drugs during a period of independent living." ASAM has described recovery as long-term and ongoing process involving changes in physical, psychological, spiritual, behavioral, interpersonal, sociocultural, familial, and financial domains [6]. Per the Betty Ford Institute Consensus Panel, recovery is defined as "a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship" [7].

In an attempt to develop a more inclusive definition of recovery, White [2] notes that recovery is an experience and as such can occur gradually or rapidly and also exemplifies that it is a deeply personal phenomenon. He argues for the following definition:

> Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.

He posits the inclusion of individuals, families, and communities in the definition helps to ensure external validation of recovery, while the use of the term "voluntarily" reflects the impairments in free will evident in the behaviors associated with substance use disorders [2].

The requirement for abstinence is not central to all people's definitions of recovery. A separate analysis of the "What Is Recovery?" data further divided the respondents into five typologies, which can be found in Table 12.2 [8]. These groups differ primarily in the level of importance they place on both abstinence and spirituality in their views of recovery.

Recovery can be understood in its relation to positive psychology, by comparing it to the term reflected in the DSM, which is remission.

Table 12.2 Group definitions of recovery

1. 12-Step traditionalist: This group was strongly abstinence based, declaring that there be no alcohol, use of non-prescribed drugs, or abuse of prescribed medication. This group strongly endorsed the spirituality elements of recovery and felt recovery involved a process of growth and development and leading a life that contributes to others
2. 12-Step enthusiast: This group is similar to the 12-Step traditionalists, with a strong abstinence base. However, although spirituality was ranked highly, it was less strongly endorsed than the 12-Step traditionalists
3. Secular class: Members of this class are more forgiving in regard to abstinence, although greater than 50 percent still felt this should belong in the definition of recovery. There was much less emphasis on spirituality. Those belonging to this group were younger and tended to have fewer years in recovery
4. Self-reliant class: This class was strongly supportive of abstinence being included in a recovery definition and a majority supported the inclusion of spirituality elements, although to a lesser extent than the 12-Step traditionalists. This group was distinguished by its low endorsement of relational elements in recovery such as learning to obtain support, helping others, giving back, and being able to have relationships
5. Atypical class: This class was less concerned with abstinence and mixed in regard to support of spirituality elements, though largely tolerant of them. Members in this class were intolerant of describing recovery as being "religious in nature." this group was also less likely to endorse relational elements of recovery

Witbrodt et al. [8]

Remission refers to absence of the behaviors that define addiction. In this sense, if the person is no longer using the substance and is no longer suffering from its consequences such as ill health, family conflict, legal and other psychosocial difficulties, etc., a person can be described as being in remission. This describes the negative things that have been removed from a person's life. Recovery refers to this but with the addition of the positive things that are added to one's life in the realms of physical, emotional, relational, and ontological health.

As the 12-Step programs, which began in 1939 with AA, have provided a foundation for addiction treatment in the United States and for many peoples' conception of recovery, the elements of the 12 Steps and their positive psychological elements will now be reviewed (for additional information on the efficacy of 12-Step programs, please see Box 12.1).

Box 12.1 Does AA Work?

Given the omnipresence of AA and 12-Step treatments within the field of addiction treatment and its centrality to the discussions within this chapter, one must evaluate its efficacy. This is challenging on several levels, largely because it is diffuse and anonymous. However, many investigations into its efficacy have been undertaken, with mixed, though generally positive, results. Several meta-analyses have been undertaken. An analysis by Kownacki [9] found that the results of randomized trials found AA to be at best no better than alternative treatments and in some cases worse. They noted that a limitation of these randomized trials was that the participants had been coerced into treatment via the legal system [9]. An earlier meta-analysis found that AA participation was more strongly related to positive outcomes such as drinking outcomes and improved psychosocial function in outpatient versus inpatient settings [10]. A Cochrane review of eight trials involving 3417 people found that AA may help to keep people in treatment more effectively than alternative treatments. They noted that the study supporting this was small and the results were inconclusive and this difference in retention rates was not found in other studies. Further, studies combining AA with other interventions found no difference in amount of alcohol consumed or the number of drinking days. The review ultimately concluded that that experimental studies did not demonstrate the effectiveness of either AA or 12 Step facilitation, but that more robust and large-scale studies were necessary to better assess these treatment programs [11]. A review in 2009 found that rates of abstinence are twice as high for those who attend AA versus those who do not (although this cannot be definitively attributed to AA attendance), that higher levels of attendance are correlated to higher rates of abstinence, and that prior AA attendance is predictive of subsequent

(continued)

relapse [12]. There is also data to suggest that active participation, such as reading AA literature, as compared to simple attendance is better correlated with decreased substance use. Other factors such as whether attendance is voluntary or if individuals have psychiatric comorbidity may also have a role in determining which people will have improved outcomes with 12-Step treatment. Clinician encouragement to attend and follow-up on that encouragement can also increase participation [13].

A separate comment regarding Narcotics Anonymous (NA) is necessary as the literature for this group specifically denotes that attendees of their program are not considered "clean" while taking medication-assisted treatments (i.e., methadone and buprenorphine/naloxone (Suboxone®)) for opioid use disorder [14]. Anecdotal evidence also suggests that patients attending NA while on medication-assisted treatments (MAT) are at times not welcome to participate or speak and are often encouraged to discontinue MAT. This can create particular challenges for these individuals and potentially put them at greater risk for relapse given the proven efficacy of MAT in preventing accidental overdose and death [15]. Although the impact of the NA position on MAT has not been adequately investigated, patients should be encouraged to research NA groups in their area and advised that they may not wish to disclose their use of MAT until they have a clearer sense of their group's stance on MAT.

Positive Psychology and the 12 Steps

Although treatment of addiction is multimodal and inclusive of a wide array of services, the 12-Step recovery model is one that has been in use and in study for what is approaching a century. Its tenets are well-known in popular and academic culture. Treatments such as 12-Step facilitation, in which patients are encouraged to actively engage in AA meetings and explore their AA experiences with their therapist, are an integral part of addiction treatment and have a fundamental evidence base [16]. Study of the effects of 12-Step treatment are limited, largely due to the fact that AA and NA are heterogeneous, have no formal requirements, maintain no records, are not standardized, and are based on a principle of anonymity. Nonetheless, it is worthwhile to examine the 12 Steps and review the literature linking them to several of the theoretical constructs of positive psychology. For reference, the 12 Steps are outlined in Fig. 12.1.

Positive psychology studies human strengths such as optimism, meaning and purpose in life, gratitude, and well-being. In a similar vein, the 12 Steps encourage people with addiction to examine their own character traits and to develop and enhance their positive characteristics. Positive psychology helps to provide a theoretical framework with which to understand some of the benefits proffered by the AA and 12-Step process. AA encourages the development of personal strengths, to live a happy and productive life and contribute to the betterment of society as a whole.

Perhaps no better description of the confluence of positive psychology and 12-Step philosophy can be found than in the ninth Step of AA promises (often referred to as the promises of AA), outlined in Fig. 12.2. These promises embody the central themes of positive psychology including finding meaning and purpose, discovering hope and gratitude, attaining spiritual transcendence, and a sense of well-being.

Perhaps one of the strongest explorations into the parallels between the 12 Steps and positive psychology comes from the work of Zemansky, who provided a detailed accounting of several of the Steps and how they promoted optimism, gratitude, meaning and purpose in life, well-being, and spirituality [17] which will be briefly reviewed.

Optimism is noted to be associated with physical and psychological well-being. Although a person's degree of optimism has multiple influential factors including genetics and early life

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him,* praying only for knowledge of His will for use and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs [3].

Fig. 12.1 The 12 Steps

experiences, cognitive-behavioral therapy can promote an increasingly optimistic outlook. The 12 Steps also are quite optimistic, with a constant affirmation that long-term sobriety can be attained and with it a change in outlook on life. Through observation of the success of others, continued engagement in the AA community can provide a constant reminder of the positives available in maintaining sobriety. In much the same way as CBT, AA emphasizes a focus on defining problems, establishing solutions, exploring faulty thought patterns, and focusing on strengths [17].

Gratitude is described as a thankfulness and appreciation for life and strengthens social bonds. Gratitude does not exist in a vacuum and is often associated with positive emotions including joy, happiness, contentment, and hope. The prosocial power of gratitude is well-documented [18]. Gratitude is commonly expressed and encouraged in the AA setting and is integral to several of the stories in the Big Book, and gratitude lists are encouraged. AA is known for its many sayings, one of which is that AA members are to develop an "attitude of gratitude." Further, the tenth Step demands a constant moral accounting, which is similar to Shelton's proscription for increasing gratitude and moral development, which requires daily self-examination and reflection on personal growth [17]. A small study by Akhtar [19] inves-

1. We are going to know a new freedom and a new happiness
2. We will not regret the past nor wish to shut the door on it
3. We will comprehend the word serenity
4. We will know peace
5. No matter how far down the scale we have gone, we will see how our experience can benefit others
6. That feeling of uselessness and self-pity will disappear
7. We will lose interest in selfish things and gain interest in our fellows
8. Self-seeking will slip away
9. Our whole attitude and outlook upon life will change
10. Fear of people and of economic insecurity will leave us
11. We will intuitively know how to handle situations which used to baffle us
12. We will suddenly realise that God is doing for us what we could not do for ourselves [2]

Fig. 12.2 Promises as excerpted from *Alcoholics Anonymous*

tigating application of group positive psychotherapy intervention in adolescents with alcohol and other substance use disorders showed the interventions with the greatest benefit were those focusing on gratitude. Gratitude interventions had the strongest impact on happiness, were most frequently associated with experiencing positive emotions, and were the most likely to be used by participants after the intervention [19]. In a study of a web-based gratitude exercise, participants were found to have positive impact on affect, cognition, and attitudes toward recovery [20].

The ability to assign meaning, particularly meaning to events generally viewed as negative, has been shown to be associated with improved long-term outcomes. In the setting of terminal or life-threatening illness, the ability to remain optimistic, even unrealistically so, is associated with a slower clinical deterioration. In fact, a realistic assessment of one's disease progress is associated with a more rapid course of illness, suggesting that positive emotion and establishing meaning in adverse experiences is physiologically protective [21]. Although AA leaves the individual meaning in life up to the individual, meaning and purpose are frequently referenced in the literature. These references generally take the form of offering service toward others as exemplified in Step 12 [17].

A sense of well-being is central to the study of positive psychology. Studies of patients in long-term recovery have shown that those people who are actively involved in AA have increased feelings of well-being and self-acceptance, contrast-

ing to those in early recovery who tend to be depressed and poorly adjusted [22]. Studies have also indicated that increased time in sobriety is associated with an increased sense of well-being as measured on scales of subjective well-being [23]. The philosophy of AA encourages a shift in attitude and a constant reflection on how things have improved in the recovering person's life [17].

Spirituality

Spirituality is a core principle of the 12 Steps, and of all of the psychiatric disorders, substance use disorders and their treatment are most associated with spirituality [24]. The first Step requires an acceptance of powerlessness, and nine of the subsequent Steps make reference to a higher power, god, or spirituality. Further, spirituality, much like optimism, is associated with improved outcomes in situations involving mental health, stressful life events, and chronic or life-threatening disease [32, 25]. Because of spirituality's particular role in the recovery process, as well as its elusive quality and definition, it is worth exploring in greater detail.

Elkins et al. [26] had posited nine components of spirituality. The first of these components is that of a "transcendent dimension" which refers to a belief in an unseen dimension to which connection is deemed beneficial. This unseen dimension may take multiple forms including a more traditional view of god, extension into the unconscious, or connection to a "greater self." The second identified component was that of meaning and purpose in life which is conceptually closely related to their third component of mission in life. Their fourth component is that of sacredness and a sense of reverence or wonder and a discovery of sacredness in the ordinary. The fifth component is that of understanding the role of material values, recognizing that they have function but cannot provide ultimate satisfaction. The sixth component identified is that of altruism and a sense of connection to the community and common humanity. The seventh component is that of idealism and a commitment to bettering the world. The eighth component is awareness of the tragic and acceptance that pain, suffering, and death are inherent in human existence. The last concept they proposed was that of "fruits of spirituality" which they described as a recognition that spirituality in and of itself has enhanced the relationship with nature, others, and self.

Cook reviewed the concept of spirituality and its relationship to addiction through a review of 265 books and papers on the subject and also found lack of definitional clarity. They noted 13 core concepts in descriptions of spirituality: relatedness, transcendence, humanity, core/force/soul, meaning/purpose, authenticity/truth, values, non-materiality, non-religiousness, wholeness, self-knowledge, creativity, and consciousness. Based upon these concepts and definitions, they proposed the following provisional definition of spirituality ([27], 99):

> Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values.

Beyond the lack of an agreed-upon definition, there is conceptual overlap between several proposed components of spirituality and other human strengths enhanced through both positive psychology and the 12 Steps. The ability of religion to provide a sense of meaning, purpose, and coherence has been shown to be the greatest predictor of religiously conferred improvements in health status [28]. Religious and spiritual practices can increase positive emotional states such as joy, hope, optimism, and compassion [29]. Religion and well-being are also correlated [30]. Additionally, studies of prayer (although this is distinct from spirituality, but closely linked to religion) have shown that it is linked with increased degrees of gratitude [31]. It appears that there is an overlap between these various phenomena, making a study limited to only the effects of spirituality challenging. However, there

are decades' worth of research on this topic and how it impacts 12-Step outcomes, which will be summarized.

Research has associated increased 12-Step involvement with greater spirituality and spiritual change. In fact, individuals who reported a spiritual awakening in the context of 12-Step involvement were four times more likely at year 3 to report total abstinence than those who did not report such an awakening [32]. Further data shows that spirituality increases after recovery and that greater levels of spirituality are associated with longer recovery. A lagged mediational analysis of Project MATCH participants also showed an increase in spiritual practices through AA attendance, which was greater for those endorsing lower amounts of spirituality or religiosity at initial intake. This analysis also found that improved outcomes were associated with increases in spirituality [33].

Evidence also suggests that it may be the experience of an "awakening" which portends improved recovery outcomes. Zemore studied a longitudinal group of 733 patients entering residential and partial hospitalization programs and assessed their baseline spiritual involvement using the Religious Background and Behaviors Scale. They also asked them a single question to assess if they had experienced a spiritual awakening as a result of their 12-Step involvement. Their results showed that 82% of those who had reported such an awakening were remained abstinent at the 12-month end point of the study as compared to 55% of those who had not reported an awakening. Their study also indicated that baseline measures of religiosity were not predictive of abstinence outcomes [34], which is consistent with previously described literature [32].

Religion has been shown to have a protective effect against the development of substance use disorders, and rates of substance use are lower among those who identify as highly religious or spiritual. Alcohol use disorders are less prevalent among those who identify as Jewish, Muslim, or conservative Protestant when compared with those identifying as Catholic or liberal Protestant. Evidence also suggests that accommodation of spiritual and religious practices is effective. Some patients have also expressed a preference for inclusion of spiritual and religious preferences in the facilitation of substance use treatment.

Assessing patients' spirituality is recommended, and there are several tools available for the assessment of spirituality. Although these tools were designed for the general healthcare practitioner, they are general enough to be adapted to the setting of addiction treatment and provide a framework through which to broach this topic with patients. One tool is the FICA which is an acronym that is designed to guide providers through a series of questions that assess a patient's spiritual beliefs and the impact of those beliefs on ongoing care. It assists practitioners in remembering the core elements of a spirituality history (Table 12.3) [35].

Anandarajah and Hight proposed an approach to be used in a formal spirituality assessment called the HOPE. It is an acronym to help guide clinicians through the spirituality assessment, and its meaning is outlined in Table 12.3. Several questions were proposed by the authors to assess each aspect of the HOPE acronym. Some of their proposed questions are outlined in Table 12.4 [36].

Saguil and Phillips also proposed a tool they referred to as the "Open Invite" mnemonic. This tool encourages to open the door to a conversation about spirituality with very general ques-

Table 12.3 FICA spiritual history tool

Faith and belief	Do you consider yourself spiritual or religious?
	Is spirituality something important to you?
	Do you have spiritual beliefs that help you cope with stress/difficult times?
Importance	What importance does your spirituality have in your life?
	Has your spirituality influenced how you take care of yourself, your health?
	Does you spirituality influence you in your healthcare decision-making?
Community	Are you part of a spiritual community?
	Is this of support to you and how?
Address in care	How would you like me to address these issues in your healthcare?

Adapted from [35]

Table 12.4 The HOPE questions for spiritual assessment

H: Sources of **h**ope, meaning, comfort, strength, peace, love, and connection
O: **O**rganized religion
P: **P**ersonal spirituality and **p**ractices
E: **E**ffects on medical care and **e**nd-of-life issues

Adapted from [36]

Table 12.5 The Open Invite mnemonic

Open	May I ask your faith background?
	Do you have a spiritual or faith preference?
Invite	Do you feel that your spiritual health is affecting your physical health?
	Is there a way in which you would like for me to account for your spirituality in your healthcare?

Adapted from [36]

tions about spirituality and faith. Following this, questions are elicited that invite patients to discuss their spiritual needs and the impact those needs have on their ongoing medical care. Some of the Open Invite questions are outlined in Table 12.5 [37].

The Psychological Makeup of Patients Successful in Recovery

There is a paucity of literature on the psychological characteristics which promote long-term recovery. As previously noted, this is partially related to the lack of a well agreed-upon definition of recovery. Furthermore, literature which specifically examines different substances of abuse is limited further still. Much of the research that is available has focused on patients struggling with alcohol use disorder and often on the 12-Step process of recovery. Only recently has research into other substances of abuse started to build a more substantial evidence base [38].

It is worth noting that definition of addiction, according to ASAM, is as follows: "Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry" [39]. It is agreed that the course of addiction is chronic, wrought with relapse and multiple treatment attempts [40], with relapses occurring commonly even after years of sustained sobriety. Not all substance use or addictive disorders follow the same natural history and that results from studies of addiction may not be fully generalizable to all addiction types.

Despite the acknowledgment of the chronicity and relapsing nature of addictive disorders, much of the research has followed patients entering into treatment such as those entering into a detoxification and rehabilitation program, outpatient program, or medication-assisted treatment (MAT) program. The research examining sustained sobriety and recovery is less robust. It is known that the factors that promote behavior maintenance differ from those that promote behavior change. Similarly, the psychological factors that motivate entry into treatment may be, and likely are, separate from those that motivate long-term abstinence and recovery [38].

Most of the literature focuses on substance use outcomes and lapse/relapse to the substance of use. However, other outcomes such as assuming valued social roles, improving diet and physical activity, and engaging in leisure activities are often secondary outcomes or not investigated. This is in contrast to the criteria for diagnosing a substance use disorder, which relies almost entirely on failures in behavioral and social domains. Investigators have researched a concept known as recovery capital, which operationalizes several factors in a person's life including social supports, spirituality, life meaning, religiousness, and 12-Step affiliation. As our understanding of the natural history of substance use disorders has grown, there has been a greater recognition that maintaining stable abstinence and recovery is a process that is supported by the development and growth of personal, social, environmental, and cultural resources. Recovery is not an event, but rather a dynamic, transformational process or journey occurring over an extended period of time. This is exemplified by the work of Compton, who examined a group of eight individuals with between 16 and 27 years of sobriety from alcohol and found that they consistently described a belief that long-term recovery requires an ongoing effort and they persisted in some of the same

recovery-oriented activities that they had from the beginning. Recovery was not viewed as a single event [41].

Around the same time as the birth of PP, the concept of "recovery capital" had come into existence in the substance use treatment community. This term was first introduced by Granfield and Cloud in 1999 and, although also lacking a formal definition, has many parallels to the concepts in PP. Recovery capital was conceptualized as comprising the following four components [42]:

1. Cultural capital, reflecting the ability to integrate in a community.
2. Physical capital, reflecting material resources.
3. Human capital, defined as skills, knowledge, and positive physical and mental health attributes.
4. Social capital, reflecting relationships available in the community.

Ultimately, recovery capital describes the internal and external resources that can be brought to bear in order to initiate and sustain recovery.

Concepts of recovery capital have continued to expand, and several attempts have been made to further define and measure recovery capital. Groshkova developed the first measure of recovery capital in the Assessment of Recovery Capital (ARC), which is a 50-item questionnaire across 10 domains of recovery capital [43]. These domains include substance use and sobriety, global psychological health, global physical health, citizenship, social support, meaningful activities, housing and safety, risk-taking, coping and life functioning, and recovery experience. This questionnaire has been validated with quality of life measures and has been demonstrated to predict stable recovery of greater than 5 years [44]. Due to its limited broader potential for clinical use in busy and overwhelmed treatment centers, a shorter version of the scale called Brief Assessment of Recovery Capital (BARC-10) was developed and demonstrated high correlation with the longer version. It uses Item Response modeling, reducing the questions to one psychometrically validated question from each of the 10 domains each answered on a six-point Likert scale [42].

Further research on the ARC has also suggested that this instrument can be used as a measure of recovery capital but is limited in its ability to adequately assess the impact of the different subdomains [45]. Rettie also had concerns about the use of a Likert scale in the BARC-10, which was to measure quality of life, an area where the use of Likert scales has been questioned [46]. They therefore developed a scale using ten-point, end-defined scales with the goal of having greater measurement across different domains of recovery capital. The instrument they developed, termed the Recovery Strengths Questionnaire (RSQ), used end-defined scales and showed significant correlation with length of time in recovery. It also was able to distinguish between "within-group" recovery strengths such as "meaningful activities" and "actively learning" and "externally generated recovery strengths," such as family and finances. They demonstrated that "within-group" strengths could significantly predict time in recovery as compared to "externally generated" strengths. This is consistent with the earlier findings from White, which suggested that internal factors, rather than external factors such as social support, show greater correlation with length of time in recovery [38].

The Future

Research on the application of positive psychology to treatment of substance use disorders remains limited. Although there is a clear overlap between positive psychology and the recovery movement, particularly as it pertains to the 12-Step treatment strategy, this relationship needs further understanding. Preliminary research also suggests that positive psychology interventions are already engrained in addiction treatment, but this relationship needs to be better quantified. The limited investigations of formal positive psychology interventions in the sub-

stance-using population are promising and invite greater study.

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Positive Psychotherapy and Eating Disorders

13

Maksim Chekmarev

Introduction

There are two main eating disorders in ICD-10: anorexia (AN) and bulimia (BN). There are marked variations in prevalence across cultures. Several diagnostic manuals reasonably add binge-eating disorder (BED) to this group. These presentations are described in the sixth chapter of ICD-10 F5 "Behavioral syndromes associated with physiological disorders and physical factors." This category shows the syndrome-oriented and biologically oriented ideology of a large number of psychiatrists instead of focus on the cause approach. Meanwhile, comparing the national recommendations for the treatment of eating disorders, the importance of psychotherapeutic and socio-therapeutic approaches and the relatively small contribution of pharmacotherapy are noticeable [4]. The empirical nature of the recommendations strengthens the idea that the leading causal factors of these disorders are psychogenic, and, therefore, different modalities of psychotherapy are needed to offer a clinical understanding of eating disorders. We will try to outline a range of approaches to overcoming eating disorders from the point of view of positive psychotherapy (PPT after Peseschkian).

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General Description of Eating Disorders

Eating disorders can be understood from three main perspectives: appetite; attitude toward food; and episodic nature [5].

The first is appetite, or the desire to eat. On the one hand, there is anorexia, with an inhibited desire to eat. On the other, bulimia and BED are linked with normal appetite and can be periodically intensified.

The second is attitude toward food. Is it good or bad, dangerous and painful, or useful and enjoyable? In anorexia, food is an enemy; in severe forms, the rejection of food is seen. Patients dream about freedom from the need to eat; they can accept eating only for a basic level of living. For BED sufferers, food is a pleasure, but within the episode of compulsive eating, pleasure can be lost. Complaints from patients are focused not on the food but on the loss of self-control, the increase in body weight, and the feeling of shame. Bulimia has an intermediate position. Appetite is normal, as is the capacity to achieve pleasure from eating, but food is perceived as something bad, especially when it has already been eaten. Patients with BED are able to feel pleasure during eating, but begin to feel aversion to the state of satiety and filling of a stomach.

The third perspective is the episodic versus chronic nature of each disorder. Bulimia and BED are cyclic disorders. The usual style of eating

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is normal, but periodically, episodes of a disorder occur. Anorexia entails more chronic inhibition of the appetite.

Definition of Terms and Particular Description of Eating Disorders

Anorexia nervosa is a psychic disorder with a distorted perception of the body as esthetically unpleasant, imperfect, even disgusting. This distorted perception is connected with inadequate feelings with regard to weight and other parameters of the body. Patients use extreme methods to attain the perfect (from their point of view) body: refusal of food or severe limitation of it, increase in physical activity, and use of drugs (diuretics, laxatives, lipase inhibitors). These practices lead to significant weight reduction and its consequences may include oligo- or amenorrhea, myocardial dystrophy, and/or decrease in blood pressure. High demands on oneself extend not only to the body, but also to other spheres of life—work and study, personal relationships, intellectual and spiritual development. Patients may achieve a lot, but are not satisfied with it, there is always the idea that efforts are insufficient and achievements are ordinary. It is very difficult to recognize yourself as being good enough because of the fear of ceasing to develop; experiencing shame and guilt is typical and it is also linked to feeling that anorexia causes suffering to loved ones. On the other hand, the patient's perception of her/himself as underdeveloped may be associated with rejection of the role of a typical "adult." A similar pattern takes place in bulimic disorders. This is finely described in Ray Bradbury's story "Once upon a time in the days of eternal spring". The protagonist of is a boy who considers that food is a poison because it promotes adulthood. The character eventually overcomes his conflict through love. Several patients with eating disorders long for love, but consider themselves unworthy. Refusal or restriction of food is often associated with greater ethical considerations: the idea that there are countries in which children are starving; the rejection of violence associated with the use of meat and another animal products; the benefits of asceticism, which can be perceived as a method of self-improvement; and a way of purifying through punishment. Ideological motives can make the patient unready for cooperation during a long course of psychotherapy, especially adolescents, for whom solving the problem of nutrition means fulfilling the requirements of parents or the adult world.

Bulimia is an eating disorder characterized by cyclicity: periodically, there is a difficulty in controlling the desire to eat, the patient eats a lot of food, often high-calorie food, rich in fats and carbohydrates, and then because of psychological and physical discomfort, induces vomiting to empty the stomach. The described eating behavior is observed in patients with high demands for success in all spheres of life, with a very narrow path to self-acceptance that the patient allows only in the case of extraordinary achievements. Bouts of overeating with the consequent stomach-emptying are usually linked to a complex range of feelings, in which need and pleasure are mixed with a sense of guilt, fear of losing control, and shame.

Persons with bulimia may resort to the use of medications to control weight, including laxatives, emetics, diuretics, and lipase blockers. Vomiting may be induced mechanically as well. In that process, patients sometimes intentionally or unintentionally inflict damage to the mucous membrane of the pharynx and oral cavity.

It should be noted that the vast majority of patients are well adapted at work or in school, and other people often perceive them as being highly functional to the point of arrogance.

However, failures in love and friendship, suffering in a close relationship, are among the typical reasons that cause the greatest suffering to patients. They are desperately trying to satisfy their hunger for love, affection, and meaning.

The function and meaning of the symptoms in bulimia can be described as follows. On the one hand, the symptom complex includes quenching physical and symbolic psychological hunger, as an attempt to fill oneself and one's life, to find joy and acceptance. On the other hand, encouragement is often followed by punishment in the form of physical discomfort and vomiting. As a consequence of this, a feeling of control over the patient's life is achieved. The patient feels the

need for love, attention, pleasure, and meaningfulness, but does not believe that he, or she, is worthy of them as a result of high achievements, the bar of which rises higher and higher. Overeating helps to achieve temporary satisfaction, and inducing vomiting helps to restore the status quo, getting rid of guilt and shame. Behaviors associated with bulimia allow the temporary satisfaction of the needs that the patient unconsciously refuses to meet.

Some authors speak of a bulimic form of anorexia, or bulimorexia, characterized by the dominance of the theme of refusal of food, the perception of food as malicious, and the formation of a developed system of self-restraint. In this presentation, excessive anxiety about food may cause spontaneous nausea and vomiting. The loss of body weight becomes the most noticeable symptom, and among the psychological features, there is an excessive need for self-requirements and maximalism. Self-assessment is often built on the principle of "or–or": "I am either successful or worthless." A very strong theme of guilt, lack of acceptance, and thrift bring this form closer to anorexia.

Binge-eating disorder is an eating disorder with attacks of increased appetite, followed by abundant absorption of food. The patient finds these attacks difficult to control.

The pattern of relationships between the person and the body can be different. Dissatisfaction with their appearance, being overweight, and self-condemnation for overeating are typical, but the patient usually does not take active consistent actions to address these problems. Food is perceived as a pleasure for which you have to pay by being overweight and having related health problems. Very often, food becomes a way of relieving anxiety, filling empty time, and/or coping with boredom. Eating is a fast and reliable way of feeling satisfaction, of rewarding yourself. The patient often does not receive expected rewards in various spheres of life, for example, he or she does not feel appreciated at work, there is no activity on the part of the partner in the sexual sphere, and he or she does not feel interest from other people in friendships. Sometimes, overeating is associated with the collapse of expectations and the despair of getting, or feeling, anything.

The choice of food reflects this attitude. Choices of enjoyable and useful products associated, in the culture of the patient, with good social status, indicate a fairly intact self-perception and capacity to care about the self. Other times, patients eat harmful food, which may indicate a sense of despair and problems with the perception of their own personality.

In either case, the patient goes through a phase of stress accumulation associated with a specific stress, and then, when the stress level exceeds the threshold, food excess follows.

The function and meaning of the behavior of compulsive overeating can be characterized as the ability to achieve rapid satisfaction of needs under conditions of disbelief in the ability to receive acceptance, pleasure, and attention under the usual circumstances of human relationships.

As thus understood, eating disorders are not directly related to nutrition. They are associated instead with the symbolic meaning of food in our lives [3] [2]. Thus, the unique pattern of symptoms of each disorder becomes a support for us in understanding the meaning and function of what is happening with the client. This understanding helps the client and the process of psychotherapy to get away from the approach of overcoming the disorder as a struggle. We have already found out, characterizing the three perspectives of clinical manifestations, that hostility to oneself overwhelms the inner world of the client, and should be overcome. It is appropriate to assume that such a hostile perception creates a vicious circle of feelings, supporting clinical manifestations and eventually strengthening them. What is the center of these experiences? What position of the therapist is able to create a "lever of action" to make changes necessary to overcome the disorder in the life of the client?

General Psychotherapeutic Considerations for Eating Disorders

The position of the therapist, which helps to find a foothold for the patient and start effective internal work, is directly related to the ability to rely on the positive concept of the person, which indicates the presence in the client of the two

basic capacities: to love and to know [1, 10] (see Chap. 2).

When working with disorders affecting physiological needs, therapy relies on self-knowledge through the perception of oneself as the field of study. This means the need to move in the client's self-perception from reflex to the reflexivity, from reaction to introspection.

This reflex, in fact, is one of the key features in the vicious circle of eating disorders. It is associated with an immediate and often unconscious response to a stimulus. There are at least two circuits of such reflexes: to external circumstances that provoke an exacerbation of the symptom, and to the symptom itself, which becomes the reason for the reaction. For example, the client feels an irresistible urge to overeat before an exam, which helps to drown out the anxiety, but after an episode of overeating, s/he experiences an acute sense of shame that s/he was not able to restrain him/herself. This shame can also be associated with the fear of getting fat, becoming unattractive, feeling desperate that the condition is out of control again and again, and will never get better. Emotional chains then branch out, pointing to the frustration of significant needs: on the one hand, in self-confidence, the ability to cope with the exam or other difficulties, and, on the other hand, in acceptance and self-love, which are impossible for the client outside of the conditions of success and control of their physical form. However, in the process of activation of the symptom, these emotional processes are not visible, become conscious only post factum, and, sometimes, are not realized at all. The reflex pathway is the path of action, which is carried out in line with the concepts already available to the client. Strictly speaking, the behavior itself is a product of the reflex pathway, which is a reaction to the current problem, but does not offer a resolution [12]. The theory of PPT connects it with the processing of the actual conflict, which, owing to the severity and significance of the symptom itself, is in the shadows and is not realized. The client's focus shifts to his/her reactions, s/he begins to strive to suppress them, failing time after time, because the main source of tension is not eliminated, and periodically capitulates before the symptom, which causes aggravation of the experiencing of the problem and the occurrence of secondary painful reactions and disorders, makes him/her look for extreme and unnatural ways to solve the problem, such as excessive restriction of nutrition to starvation, exhausting exercise, surgical interventions on the gastrointestinal tract or removal of adipose tissue. The reflex pathway creates a feeling of powerlessness, because the client perceives him/herself as an object of suffering. S/he perceives the disorder as inseparable from him/herself, despite all attempts to fight. Thus, all the ways of fighting against the disorder are a struggle in themselves.

Moving from reflex to reflexive activates our ability to know ourselves. The very ability to reflect that is inherent in human beings from birth is a basic element of self-knowledge, representing an opportunity for consciousness to use its own psyche as an object of knowledge, becoming a subject, i.e., an active personality [11]. This position creates a synergy with the psychotherapist, who is able to catalyze the process of self-knowledge, being an external participant in human relations with him/herself. A reflexive position is not healing itself, but it is a necessary condition for healing to begin. Its main essence lies in the ability to experience impulses from the position of the observer, paying attention to the processes behind them. The client moves from identifying him/herself with the problem to considering it as part of his/her present and past life history, from the problem history to the possibility of perceiving it as real and multifaceted, in accordance with the PPT model. A reflexive process starts to take place between the trigger and the reaction. It needs a gradual expansion to enable the client to create a thinner and clearer picture of his/her inner world. However, for the client, this observation can be unbearable and painful if the reflexive process is not connected with the acceptance–actualization of the basic capacity to love.

The basic capacity to love in the process of differentiation becomes the source of an expansion of our capabilities to build relationships. The distortion of the image of one's own body and of

the perception of physiological needs indicates a lack of acceptance, alienation of a part of oneself, the inability to treat this part with emotional warmth and acceptance. Most eating disorders are characterized by a feeling of insufficiency and wrongness of the desire to get rid of or drown out these "wrong" parts. The client comes to therapy at times, flooded with these self-perceptions. Without understanding the reasons for such emotional pain, s/he refuses to accept something inside her/himself, and therefore feels an irresistible need to do something, which is implemented in the field of eating behavior. Impatience provokes the patient to hurry, to seek advice and direct recommendations from the therapist, to be more in the sphere of "doing" rather than "being." It is easy to see that we have met with the second part of the vicious circle, leading us away from the very essence of the client's experiences. But we cannot go further if the client is not there. We cannot accept what the client her/himself has not yet accepted. It is logical that the therapist himself becomes a donor and an example of acceptance. We start by accepting the client's rejection of himself. This acceptance potentiates the work in the reflective position; it would validate those experiences that the client sees in his inner world. True love is far away, but the starting goal is to develop the forces of "being" with problematic experiences. Therefore, we gradually get the opportunity to touch the root causes of eating disorders. The client's ability to meet emotional pain and see it as part of the internal and external context is expanding [7].

Thus, by implementing the presence and development of basic abilities in the client's problem situation, we are able to see the experiences behind the symptom and not reject them too quickly. We stay with the client in the field of his inner world to clarify the conflicts behind the disorder and develop relevant abilities that can become a resource in the process of overcoming. Now, the client with the help of a psychotherapist is able to dive into the safe space of therapy in communication with a specialist to the level of critical experiences, which allows this process to be life-changing [14].

The general principles of the approach to the treatment of eating disorders focus on three areas, corresponding to the leading concepts of PPT:

1. Balance: an integrated approach to therapy affecting all spheres of human life, the analysis and harmonization of all spheres of life.
2. Conflicts: the study of conflict dynamics and psychogenic causes of the disorder at all levels—actual, key, basic, and internal conflicts. The work is aimed at understanding the causes of the disorder.
3. Capabilities: includes diagnostics of the actual capabilities of the client, understanding of the opportunities for development of those capabilities, which are involved in the formation of problem situations. The assessment of resources and deficits of the client, the updating of resources, and the overcoming of deficits through development.

The principle of balance calls for the need for an integrated approach toward eating disorders that requires the participation of a team of mental and somatic health specialists at the different stages of treatment [13].

The Importance of the Interprofessional Team

Most of the national guidelines for the treatment of eating disorders are based on an integrated approach, including and sometimes centered around psychotherapy.

Despite our opinion on the predominantly psychogenic origin of eating disorders, considering the idea of balance, we believe it is important to coordinate different professionals, which will make the team most effective. This also reflects the holistic approach of PPT. Therapy affecting all spheres of human life creates a special psychotherapeutic environment that becomes a support for the client during the entire period of work with him or her.

A few clarifications for the following sections: it is assumed that the coordinator of the therapeu-

tic process is a psychotherapist, working with a general practitioner, and, if necessary, a gastroenterologist, endocrinologist, and nutritionist. Group therapy is useful and it is highly desirable to gain the support of the family and, if the client is religious, of a community of believers.

During psychotherapy, we should provide changes in each sphere of patient's life: body, activities, contacts, and meaning (for the Balance Model, see Chap. 2).

Sphere of Body

- Exploration of the experience of the disorder, the somatic consequences of the disorder, especially with its long-term persistence (damage to the teeth and oral cavity, esophagus, stomach, endocrine glands, nervous system, etc.)
- Assessment of the main parameters of the physiological sphere; if necessary, the implementation of the necessary somatic treatment
- Investigation of the nutrition status; its gradual correction

Sphere of Activities/Achievements

- Activities to improve the client's knowledge about her/his disorder
- Assessment of the impact of the disorder on the educational and work activities of the client, as well as the impact of his/her educational and professional activity on the disorder itself.

Sphere of Contacts

- Assessment of the influence of family and social environment on food behavior, the course of the disorder, and the psychological state of the client; the involvement of the social environment in the care system, if necessary
- Participation in a support group or the opportunity to meet people who have overcome an eating disorder

Sphere of Meaning/Future

- Clarifying the client's ideas about his/her goals in therapy. How does s/he see his/her optimal state? Discussion of this image, maintenance of its implementation
- Construct a phased plan for life change
- Enhance the understanding of the impact of the client's value system on his/her condition
- Gain support from the spiritual community

The general principles of psychotherapy also affect the role model, the conceptual field of the client, focusing on the past, present, and future, which means the importance of studying the client's position in three directions [8]:

- *What was the attitude toward food in my parents' family?*
- *How do I feel about food now?*
- *How do I see a healthy attitude to food in the future?*

Particular Characteristics of a Positive Approach to the Treatment of Eating Disorders

Nossrat Peseschkian (2016) classified eating disorders as psychosomatic disorders [3]. This fact means that the very nature of the disorders is linked to manifestations of psychological dysfunction through the body. In the process of psychotherapy, we should use actual symptoms, and current conflicts, and move forward to address the internal conflict. The positive interpretation of the symptom helps to clear up the actual conflict behind the symptom.

The path from the actual conflict to the basic conflict—from the external behavior to the psychological roots—is carried out through the search for frustrated need or frustrated value behind the actual conflict [9]. The framing of an internal conflict is based on searching for the concept that confronts another concept that has become dysfunctional in a basic conflict.

In the case of psychosomatic disorder, the key conflict resolution usually tends toward politeness. But sometimes we can see an exception that occurs after long attempts to handle psychological stress in the internal space, when the patient finally snaps and briefly shows powerful aggressiveness.

In the following, we describe the typical options for each eating disorder.

Anorexia

From Symptom to Conflict Through Positive Interpretations

Anorexia is the ability to achieve goals by extreme methods, reaching the ideal by will and through excessive effort. Realization of the goal is usually tied to the capability for achievement that supports a person's sacrifice and self-restraint.

Anorexia is often accompanied by feelings of failure, lack of effort, and it often arises and intensifies during life periods when external evaluation is especially important, such as school exams, development or end of a romantic relationship. Anorexia is a disorder that other people notice; it is visible. And it becomes a way to show other people one's zeal, to mark boundaries and values.

From Actual Conflict to Needs and Values

Showing extreme zeal for the goal, from the one side a person seeks love but from the other—and it is often crucial—a person needs trust and expects others to find him/her worthy enough to rely on, to recognize his or her autonomy. Thus, the basic conflict is expressed by attempts to gain love and trust by showing extreme zeal in achieving the ideal.

From External to Internal Conflict

Usually the need for love and trust faces the inability to speak of desires and values openly. Openness is associated with the risk of losing relationships with those who are important. Instead of openness, a person chooses politeness and obedience, creating a dual reaction. It means that the need for autonomy and hope of relying on someone's opinion to obtain security go hand in hand.

Bulimia

From Symptom to Conflict: Positive Interpretation of the Symptom

Bulimia can be described as the ability to obtain pleasure and love that a person wants, but of which considers himself unworthy. Symptoms include encouragement and punishment, love and shame. Usually, the appearance of a patient with bulimia does not change; in the case of this disorder, suffering is applied to a person him/herself. He or she does not feel good enough and vicious; the person chooses extreme measures to curb the effects of his/her cravings.

From Actual Conflict to Needs and Values

In a conflict, and in the case of anorexia, there is a certain feeling that achievements are not enough; a person hopes to feel loved by others and to allow him/herself to be loved.

But at the same time, he/she is afraid to lose relationships with others, afraid that they will turn their backs if he/she is going to be less perfect. Thus, a person seeks love and contact by showing zeal.

From a Basic Conflict to an Internal One

The basic conflict in bulimia is linked to high standards, not only for oneself but also for others.

Justice is a more developed ability than love.

A person, therefore, is so desperate for communication and other people's attention, but at the same time rejects many of the people around because they are not well-suited for communication. This increases fear and loneliness.

A person wants to be loved, but in fact is ready to accept love from a very limited number of people.

Bulimia is often characterized by a paradoxical solution to a key conflict. Although showing a lot of politeness to significant people, customers can be very open and even aggressive toward those who are not considered good and successful enough.

Binge-Eating Disorder

From Symptom to Conflict: Positive Interpretation of the Symptom

The symbolic meaning of food may be different; thus, the subtle meaning of a symptom may also differ, but in general food brings pleasure and takes the edge off.

Tension and anxiety are reactions to the unreliability of people and the world around. The need for pleasure is linked to the desire for approval.

Thus, binge eating is a way of pleasing oneself and of alleviating concern under insecure conditions and lack of self-confidence.

The effects of overeating are visible to people around, and the impact usually make a person less attractive to others. There is an opportunity to verify that other people will stick around even for unattractive person, will support him/her, will consider him/her good enough and sexy.

From Actual to Basic Conflict

Checking the reliability of relationships helps to find out if there are reasons to worry.

In the process of exercising due diligence, a person is fueling self-confidence.

Binge eating helps to fix an injustice, to evaluate oneself if feeling underestimated.

From Basic to Internal Conflict

The contradictory nature of overeating causes the uneffectiveness of just improving eating habits and increasing physical activity.

A person is not seeking confidence in an attractive body; he/she tries to establish self-confidence, to be important to others.

The frequency of overeating episodes is reduced in a supportive, careful, and safe environment.

But the client himself usually does not show a strong resolve to set boundaries and release his sphere of contacts from difficult people.

He is afraid to stay alone as a result of choosing with whom to communicate and whom not. At the same time, weight normalization means returning to a competitive environment in which physical attraction is very important, but clients usually do not feel confident under conditions of competition.

Important Elements in the Psychotherapeutic Treatment of Eating Disorders

We conducted a survey of clients who had undergone treatment for eating disorders with the help of specialists who practice PPT. Clients were asked to answer exactly what they found to be most valuable in the psychotherapy.

Here is a list of items that were noted by patients with each form of eating disorder.

Anorexia

1. Less fixation on food, especially reducing the degree of nutrition monitoring by relatives. This reduces anxiety and leaves individuals with a feeling that they are trusted.
2. The chance to share your anxieties and beliefs about food and nutrition with a psychotherapist, and the chance to discuss it in a climate of acceptance and security.
3. Better understanding of links between one's psychological state and the current state of anorexia.
4. Growing ability to cope with life problems through the concept of moderation.
5. The chance to see oneself differently through the eyes of a therapist—with less self-criticism, greater acceptance, and through the prism of resources but not shortcomings and weaknesses.
6. Expanding the idea of attractiveness

Binge-Eating Disorder

1. Therapist's faith in the possibility of healing. Accepting even after failures but without connivance.
2. Expanding the variety of life pleasures, finding the ability to see joy and value in things that have not been perceived in such way. Growth of the ability to value oneself.
3. Assignments that the therapist gives and that help to organize work on oneself.

4. Shaping a more optimistic attitude to one's life, understanding how to cope with anxiety.
5. Expanding ideas of attractiveness.

Bulimia

1. The realization that bulimia is only an effect, but the reasons are distorted self-perception and low self-esteem.
2. Chance to accept oneself, one's current weight and figure as they are.
3. Improvement in self-esteem.
4. Escaping from the "excellent student syndrome."
5. Normalization of nutrition as a result of doing the psychotherapist's homework. Doing the right homework gave a chance to feel that one can live without vomiting.
6. Using not food, but psychological means to manage stress.
7. It is possible to more easily take an episodic weight gain because it is a natural process that depends on the menstrual cycle, the amount of water in the body, and other factors.
8. The realization that it is possible and it is necessary to love oneself not because of a good figure, but in principle because of who he/she is.

Summarizing the main points of the patients' feedback, we can determine a plan for psychotherapy as meeting three main challenges—emotional, rational, and behavioral—and this allows us to use the theory of three stages of interaction of PPT as a framework for the plan [1].

In psychotherapy, we go through three stages of interaction with the client step by step, and these are repeated in each session as far as in the general course of psychotherapy, and this reflects the dialectical principle of development as a spiral.

First phase: attachment the client is dominated by emotional needs: he/she has a lack of acceptance, trust, confidence, he/she is faced with feelings of guilt and shame, fear of not adapting to all the expectations. Secondary complications are associated with the deterioration of relations with the people who often demonstrate misunderstanding, if they are aware of client's disorder, who turn away from him/her or build a system of excessive control.

The patient wishes to gain people's acceptance but faces rejection. The second part of the complications is usually linked to the area of the body and health problems. At the moment, it is important for the client to get a new experience of relations with the therapist, the experience of being understood and accepted, to find himself in the atmosphere of empathic active listening, to feel an interest in his personality. This allows the client to touch his/her experience with greater courage, to verbalize his/her own feelings in the safe space of therapy, increasingly aware of the fact that psychological problems are indeed the reason for eating disorders.

The focus is shifting from disorder to a personality; we begin to analyze a client's conflicts instead of his/her struggle concept, we look for resources and find out the vision. Work at the first stage is crucial; it gives those customers who are focused on secondary capabilities the opportunity to find themselves under conditions where actual primary capabilities play a major role.

It is difficult for a client to accept that love, time, trust, and confidence in his abilities can be acquired without extraordinary efforts, but step by step, he/she feels more comfortable, resistance decreases, and the client begins to admit he/she has the right to satisfy emotional needs simply because they are the basis of any close relationship.

The development of this feeling usually coincides with the possibility of at least temporarily avoiding the existing pattern of disorder; the client is ready to expand his repertoire of ways of coping with stress.

Second phase: differentiation Reflects the work in line with the rational needs of the client.

First of all, we can talk about the progressive development of his/her ability to see the mechanism that triggers the disorder. The client learns to notice causality between life circumstances and nutrition problems. He/she expands his/her vocabulary to describe his/her own inner world,

to verbalize emotional needs. An important field to explore in therapy is a set of a client's ideas of physicality, attractiveness, their origin, and development.

This is the area where a person meets a cultural environment, and where it is very important to obtain an expanded vision of oneself in keeping with transculturality, to understand the non-absolute nature of standards of attractiveness, their artificiality.

We explore a wider framework of concepts: the client's view of her/himself, which forms his/her "I-concept" and the manner of his/her self-perception, noting contradictory and narrow concepts. The differentiation phase helps one to start questioning one's usual beliefs and ways of life, giving the client an active role and running self-help mechanisms.

Third phase: separation Extends ways of coping with problems and helps to satisfy the client's behavioral needs. At the same time, the client him/herself turns into an active player, who creates both strategy and tactics to overcome his/her problems hand in hand with the therapist. It is very important to develop openness, which increases the client's ability to resolve interpersonal difficulties, as well as the ability to see his/her own resources. The client knowing the causes and functions of his/her disorder can begin the search for those mechanisms that will help him to achieve the same goals in a healthy way. Clients also note the importance of homework that the therapist gives at this stage: they organize work on themselves, become a source of a new vision and new ways of responding in the life of the client. Homework is individual, but often follows the principle formulated by Nossrat Peseschkian: "If you want something you've never had, you've got to do something you've never done"; it helps to expand the system of goals and values of the client.

A good, stimulating way to correct self-perception is to keep a diary of the client during the psychotherapy process. It is important to note that this is a psychotherapeutic diary, centered on the inner world; it is a counterweight to fixation on the outside world and physicality, helping to achieve a balance between attention to the body and attention to the inner life.

Additional Comment

Most of the national recommendations are unanimous on the importance of involving the client's immediate environment in therapy. In the case of working with children and adolescents, family psychotherapy is necessary. The immediate environment creates a context in which there is a patient with his/her disorder; thus, the elimination of micro-traumatic circumstances in this context helps to overcome the disorder. It is important to make the family a resource, not an enemy.

The average course of psychotherapy lasts for about 1.5 years and at least 50 sessions. The prognosis depends on the associated conditions, the duration of the course, the resources of the client's personality, and the possibility of creating an interprofessional team of specialists [6]. Eating disorders may recur, although the course of psychotherapy in the case of relapse is usually much shorter. In addition to individual therapy, it is reasonable to consider adding group psychotherapy, usually close to the end of the individual course. Support groups can be very useful because they provide the opportunity to meet those who have overcome eating disorders. These meetings help the client to broaden conceptions about him/herself, to inspire hope, and to feel unity with those who have already coped with the problem.

Conclusion

In PPT, eating disorders are categorized as psychosomatic. The three main forms of disorders—anorexia, bulimia, and BED—result from the processing in the body of problems arising in other spheres. Most often, the actual conflict is situated in the sphere of contacts. The emphasis on therapeutic relationships is central to the psychotherapeutic process. This is reflected in the importance of the development of the actual primary capabilities of the client and in expanding the system of relations that supports the client,

both through the involvement of the family in therapy, and through the creation of an interprofessional team of specialists. The general vector of psychotherapy provides the transition from symptom to conflict through the understanding of the meaning and function of the disorder through positive interpretation, from the actual conflict to the basic conflict through the understanding of the dominant needs frustrating the life situation of the client, from the basic conflict to the internal conflict through the clarification and elimination of internal dissonances arising between the concepts of the client of him/herself, images of attractiveness, conditions of self-acceptance, and ways of coping with problematic situations. If these conditions are met, the approach of PPT becomes an effective way of helping the patient.

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Positive Psychotherapy in PTSD and Post-traumatic Growth

14

Tuğba Sarı and Ali Eryılmaz

Introduction

In the history of psychology, there have been many approaches to interventions for psychological disorders. One of these approaches is the positive intervention approach [19]. Positive Psychotherapy, founded by Nossrat Peseschkian (1977), has the characteristics of positive interventions mentioned in the literature [36]. The symptoms of clients are interpreted in a positive way, and their abilities – and capabilities – are studied in Positive Psychotherapy. This section first discusses trauma and post-traumatic growth. Then, the positive intervention side of Positive Psychotherapy (after Peseschkian) is emphasized.

Today, many individuals may experience one or more traumas in their lives. It has been found that 75% of people experience a traumatic life event during their life [38]. Traumatic events include a wide range of experiences, including terrorist attacks, wars, natural disasters, accidents, casualties, harassment, rape, bombing, wounding, and technological attacks. The word trauma, from ancient Greek, means "injury" or "to pierce." The word trauma was used to express the injuries that soldiers in ancient Greece receive from punctures in their armor [37]. For an event to qualify as traumatic, it has also been stated that it should have low controllability, be sudden and unexpected, create permanent or chronic problems, and have similar characteristics [41]. In the literature, traumas have been divided into two groups: micro (small) and macro (big) traumas [29, 35].

Traumas that cause a shock to the individual, such as sexual or physical attack, are considered macro traumas, whereas traumas such as humiliation, loss of life, and neglect are characterized as micro traumas. There may be significant differences between people's responses to traumatic events. In some cases, particularly after severe traumas, syndromes such as anxiety, depression, and post-traumatic stress disorder (PTSD), may emerge. Focusing only on the negative consequences of trauma can lead to a biased understanding of post-traumatic reactions [20]. Recent studies of traumatic events have shown that trauma has positive effects as well as negative effects [4]. For example, despite experiencing the same event in a traffic accident that results in an injury, each individual's reaction to the incident may vary. Some individuals continue their normal daily life in a matter of weeks and state that it was an empowering experience, while some

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individuals may have various symptoms that affect their daily life and experience, such as mental illness.

In published articles, many clinicians and researchers have suggested that not only negative changes but also positive changes could occur from traumatic events [41]. Tedeschi e al. [42], for the first time, used the term post-traumatic growth to describe changes that have behavioral consequences due to highly challenging life events. Difficulties and suffering may find a relevant place in many belief systems and religions, such as branches of art, Christianity, Islam, Hinduism, and Buddhism. In these belief systems, the contribution of suffering to human life has been noted in many places. Parallel to this idea, existential philosophers such as Kierkegaard and Nietzsche emphasized that a traumatic experience is an experience in which people question the meaning of life [40]. Professionals in the field of practice stated that when working with trauma victims, their clients felt that they were now closer to people, they also started to help other people more, and they were trying to receive more help from people [15].

The construct of post-traumatic growth (PTG) suggests that that survivors of traumatic events can not only heal from their trauma but may actually grow into stronger, more driven, and more resilient people because of their trauma. According to the latest research in positive psychology, enormous growth and development have been observed after unimaginable suffering, trauma, and pain [15]. It was observed that practitioners and researchers working in the field of positive psychology and positive psychotherapy focus on post-traumatic development. Nossrat Peseschkian [29] introduced the theory of micro and macro trauma to Positive Psychotherapy (PPT), which was developed in Germany in the 1970s. PPT provides a five-step intervention method in which the trauma is positively interpreted and rebalancing the life of the individual is aimed at empowerment and growth. Parallel to Nossrat Peseschkian, practitioners working in the field of positive psychology, which was developed in the most recent century in the USA, have started to develop emerging models to prevent negative post-traumatic consequences [15, 25]. The aim of this section is to introduce interventions and examples based on Positive Psychotherapy after Peseschkian. The main focus of PPT is based on the principle of hope and finding the positive aspects of the client and the situation, reinterpreting the trauma, and, ultimately, helping bring balance to the client's life.

Definition of Key Terms

Post-traumatic Stress Disorder (PTSD) PTSD is one of the most common psychological disorders following traumatic experiences. The symptoms of PTSD listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5) published by the American Psychiatric Association are divided into four categories: (1) relieving the traumatic experience – intrusive symptoms; (2) avoiding reminders of trauma; (3) negative alterations in cognition and mood; and (4) hyperarousal and sensitivity [2]. To be diagnosed with PTSD, the individual must be experiencing the following symptoms for at least 1 month: (a) at least one intrusive symptom, (b) at least one avoidance symptom, (c) at least two cognition/thinking and mood symptoms, and (d) at least two arousal or reaction symptoms. Not everyone who experiences a traumatic event develops PTSD, but it is certainly not an uncommon diagnosis. According to the National Center for PTSD [24], approximately 7 or 8 people out of every 100 experience PTSD at some point in their lives, including approximately 10% of women and approximately 4% of men.

Post-traumatic Growth (PTG) The positive changes following trauma have many names in the literature. These names include post-traumatic growth [40], personal growth [39], perceived benefits [21], positive reappraisal [22], and positive changes [16]. At its core, post-traumatic growth is basically a concept that points to an increase in individual functionality after a traumatic situation. PTG has been operationalized by five major positive changes that manifest in the individual: (a) improved interpersonal relationships, (b) openness to new possibilities, (c) a greater appreciation of life, (d) an increased sense

of personal strength, and (e) spiritual development [40]. According to the Posttraumatic Growth Research Group at the University of North Carolina at Charlotte [33], PTG can be conceptualized as positive change resulting from an individual's struggle with a major life crisis or traumatic event. This positive change typically manifests in one (or more) of five areas: (1) a sense of new opportunities or possibilities in life, (2) improved relationships with others, (3) increased mental and/or emotional strength, (4) greater appreciation for life in general, and (5) spiritual deepening (2014). Research has shown that PTG has numerous benefits, including lower levels of PTSD and higher levels of emotional maturity [1]. The theory has provided hope to countless people and spawned multiple resources and methods of facilitating healing and growth.

Balance Model of Positive Psychotherapy According to PPT [31], there are four dimensions of life: body, achievement, contact, and meaning/spirituality. Individuals cope with conflicts in their bodies, achievement, social contacts, and meaning in life/spirituality. The purpose of PPT is to help the client reach a balance in these four areas and to widen the opportunities through which he or she copes with conflicts (see Chap. 2 for further discussion).

Five Stages of Positive Psychotherapy PPT involves a five-stage process with clear psycho educational features [29]: (1) observation, (2) inventory, (3) situational encouragement, (4) verbalization, and (5) broadening of goals. This process gives structure to the therapy and can be learned by clients so that they can become their own "therapist" when the therapy ends (see Chap. 2 for further discussion).

Applications

Reestablishing Balance

While people are adapting to their lives, they face constant threats to their own balance. Piaget [26] states that people incorporate new knowledge and situations through assimilation into schemas. Thus, adaptation takes place and individuals reach equilibrium. The balance between assimilation and adaptation helps individuals to mature psychologically. In traumatic situations, individuals have difficulty incorporating the new situation they face. For this reason, traumas prevent individual development [22]. Coping with trauma also means that individuals might need to create a new level of balance.

In terms of approach, PPT focuses on the balance creation process. In the process of creating balance, there are many tools available in PPT. The most important of these tools is the balance model ([31]; see also Chaps. 2 and 8). The balance model proposes people use resources to deal with conflict in a balanced way. Traumatic experiences disrupt the individuals' balance and narrow their resources for coping with conflict. In the psychotherapy process, it is an important objective to expand individuals' sources of coping with conflict [11, 27].

The post-traumatic growth process [41] is actually the process of rebalancing in terms of PPT. Individuals enter into a new balance of body, achievement, relationships, and spirituality. The dimension of *spiritual change* in post-traumatic growth corresponds to the fourth sphere of the balance model which is future/fantasy. A *character strengthening change* in post-traumatic growth corresponds to the body dimension as a source of conflict in PPT. *Relationships with people* in post-traumatic growth correspond to the relationship dimension in Positive Psychotherapy. The new possibilities in post-traumatic growth may correspond to other dimensions of the balance model and the success dimension.

Positive Interpretations of Symptoms

In the therapeutic process, one of the most important factors that foster this rebalancing process and increase post-traumatic growth is the positive interpretation of symptoms. Positive interpretation of symptom means the expression of reality. In reality, there can be positive features or situations as well as negative features or situations [27, 34]. For example, *depression* is not considered to merely be a feeling of demoralization with a pas-

sive attitude. Depression also reflects the ability to react with profound sensuality. Similarly, *fear of loneliness* is not only inadequacy of self-management but also a strong expression of the need to engage with other people. In PPT, specific positive comments are suggested for some specific problems [29, 34]. In this way, determining the symptoms and problems individuals experience positively changes the perspectives of the clients in the PPT process. Clients feel themselves to be stronger at the end of this process. The level of acceptance of problems is increasing. Thus, this process uses the resources of coping with conflict more effectively [7, 8, 30, 31]. The following is an example of the process of creating balance by making positive interpretations to a client who witnessed the death of his father as he fell from a roof.

- *Therapist:* What makes you miserable?
- *Client:* Since I learned that my father fell from the roof, I can't go into the street. There's a revival/flashback.
- *Therapist:* Could you tell me a little about your experiences and feelings?
- *Client:* As I said, I left the house where my father fell from the roof. I never liked our house. It was too far away from the bazaar. It's been 2 months since we moved. If we had not moved, I would have constantly thought about it. My brother said I'm leaving this house, leaving the memories. Grandma said you don't like your dad. We've worked to overcome things. After my father's death, I left home and went to school. It was on the roof, it was in the house, and it was going bad on the street. We moved out. What my grandmother told us was that she left my father. However, we're away from my father's pain. It's weird how they stand. My grandma told us not to get over it.
- *Therapist:* To overcome this situation, what else can you do instead of being constantly upset?
- Client: In fact, I think to overcome the situation means to continue where it left off. Our new home is close to the bazaar and my brother's school. Even when my father was alive, we had to move out of that house. It's wrong when I think of my grandmother's attitude. Although we loved that house so much, we left the memories and continued our lives. This means we have overcome this situation. This house was my grandfather's house and was entrusted to us. No one can live in a house where his father died. To cope is to put aside all experiences and to move on from where you left off.
- *Therapist:* We talked about you constantly blaming yourself for what was happening and repressing your feelings. In fact, if you think of your situation as an opportunity for your development, what do you think?
- *Client:* I have to be careful about my father. You should not suppress emotions but use them correctly. Be a master of your emotions!
- *Therapist:* You better manage your emotions and make more sense.
- Client: Yes certainly. My father's fall and death were unexpected. Maybe I've been overly emotional. It's ridiculous not being able to overcome the situation in regard to these feelings. These emotions are feelings that suddenly occur. I've actually had a condition. Death has a reason. Death occurred as a result of an accident. Searching for the perpetrator of death, the roof, no one is guilty. We've lost my father. We can't stop what's going to happen. Nobody is guilty.
- *Therapist:* The biggest indicator of this is the intensity of emotion. I think even attending your father's funeral is a sign of coping for you.
- *Client:* Yes, it made me feel better.
- *Therapist:* I mentioned earlier about the balance model. What do you say is something that will empower you if you interpret this situation in terms of spirituality?
- *Client:* According to my belief, we cannot prevent what should be. When death comes, it can come for a small reason. Allah decides who will die, when, and how. The only thing that can be called upon is prayer when my father comes to mind. My father won't come back if I blow the house up with dynamite. The best thing I can do is make a fountain.
- *Therapist:* What else can you say?
- *Client:* We have already lost my father. Everyone knows that. It means nothing is permanent. My father is not the only person who died in this world. Nothing should be considered permanent. I know the value of life. I realized there was a death. Now, when I think of my father's loss, I will be more comfortable.
- *Therapist:* Very nice. So, what do you say will empower you if you interpret this situation in terms of the body dimension of the balance model?
- *Client:* I have all my memories in that house. I was born in that house, and I had a lot of memories with my father. This is nothing but an overcoming. We didn't go where we left off. We changed our house. Most of the things we have done, for example, to rent a new home, to move from that home with a disturbing event. We relax when we stay away from stimulants. Emotions are erased when acceptance is needed. I can think of them. To commemorate, the event ends here. When I mention my father, I can think of his jokes and not his fall from the roof. I can control my emotions. We're injured in this case. If we do not dress this wound, there will be inflammation. This wound can progress to death. If we

think of good things instead of remembering my father's death, we will heal the wound. From the positive point of view, the location of our house is very close to the bazaar and close to our relatives. Good things continue to happen. This is the missing part of humanity. We can't look at the big picture.
- *Therapist:* I noticed that the negative thoughts you experience are from the intensity of emotion.
- *Client:* These are intense emotions. I get used to them. I don't put my feelings on the object, and it's a childish situation.
- *Therapist:* You said very important things. Instead of negative emotions and thoughts, you can think of positive emotions and thoughts. So, you see the big picture better.
- *Client:* Certainly, I will do this.

Five Stages of Positive Psychotherapy in PTSD

The contribution of psychotherapeutic processes to individuals cannot be denied. Practices based on many psychotherapy approaches contribute to individuals' post-traumatic growth [12–14, 44]. PPT is one of these approaches. The practice of PPT in accordance with the consultation principle contributes to individual post-traumatic growth. One of the important meanings of the consultation principle is to carry out the psychotherapy process in five steps. These five stages of treatment are the observation/distancing phase, inventory phase, situational encouragement, verbalization stage, and expansion of goals [5, 7, 8, 11, 29, 34].

Trauma studies based on psychotherapies emphasize the importance of post-traumatic growth and underscore an important point. Post-traumatic growth has two important dimensions: adaptive and non-adaptive. In psychotherapy studies, too much focus on growth may mean that individuals escape from the consequences of an actual trauma [13, 17, 18, 44]. On this point, a strong side of PPT is emerging. PPT is a psychodynamically oriented psychotherapy. Although PPT contains positive elements, its main purpose is to eliminate pathologies [7, 8, 10, 11, 27, 29, 34]. At this point, the five stages of PPT provide opportunities to work on post-traumatic growth and on other trauma outcomes. In this section, the five stages of PPT and examples of working with trauma are included.

Stage One: Observation/Distancing: The main purpose of this step is to understand the client's situation and problems. The psychotherapist listens objectively to the client about his or her trauma experience. The therapy focuses on the client's needs and problems. Once the client's problem has been identified, the client's symptoms are examined within the framework of the balance model. An example of a psychotherapist's examination of the symptoms of trauma is given below.

- *Therapist:* Can you tell me about your problem?
- *Client:* When I was 4.5 years old, there was a major earthquake. Although I cannot remember exactly what I experienced during this earthquake, what it left me still affects me. I am 22 years old now. I can say that I've been experiencing the effects of trauma since my elementary school years. Especially when I sleep at night, I can leap to fear even when someone comes near me. There is a residual effect from that time. I'm afraid of tall buildings. However, this fear usually hits me when I sleep at night. I also think that every night I can live through the same things again.
- *Therapist:* How does this affect your body?
- *Client:* When I'm afraid, my body twitches and I feel like I can't move. I cannot speak. I close my eyes. My eyes open too much. In some cases, I feel cold and breathe. After some time, my head hurts.
- *Therapist:* How does this affect your perspective of the future?
- *Client*: I start worrying about the future. I'm even worried about where I'm going to sit. I start to be restless, and I get bored a lot. I feel like there's going to be something going on for a few days, and I can't make plans for the future. I can't plan where I will live. I can be uneasy when I think my loved ones may have the same problem.
- *Therapist:* How does this problem affect your relationship with people?
- *Client:* Generally, this problem does not affect my relationships because it appears at night. At night, when the trauma comes to mind, I can't sleep until the morning and I'm sleepless for days. I cannot communicate in a healthy way

with people during the day. I wonder if they are around me. I can't explain exactly, so sometimes I get bored. I also don't want to talk when I'm badly affected. It affects me negatively when I cannot communicate with people in a healthy way.

- *Therapist:* How does this affect your success?
- *Client:* It doesn't affect my performance much. If I've been very busy, I'm going to be absent-minded because it can influence my exams on that day. I'm very pensive when I'm doing homework and I can't be myself.

During this process, clients are given various assignments. One of these assignments is writing a letter to their symptoms. This assignment is intended to create a motivation for clients to respond to their symptoms and to ask them to better understand the function of their symptoms. The following is an example of a letter to a client's symptoms:

> I don't know how to describe you. I've learned to live with you, or you're still trying so hard, I don't know. I experience you when I see you with trauma triggers. When I met you, I was very small, but I remember you like the first time. Who was crying, who was shouting, all in a corner of my mind? The sound of dripping water that I still don't know where it comes from still annoys me more. When I hear the sound of water choked in the quiet place, in a silent place, I still remember you. You impress me a lot. When I meet with your triggers, my body twitches and I feel like I can't move. I don't often talk. Either my eyes open like a fortune cookie or they're tight. I'm cold, and my breath shrinks. After a while, my head hurts a lot. People around me wonder what I'm going through. I can't tell people about it, and I'm bored. I also don't want to talk when I'm badly affected. This affects me negatively because I cannot communicate with people in a healthy way. You don't affect my achievements much. If I live very intensely, I will be absent-minded because you can influence my exams on that day. I'm very pensive when I'm doing homework, and I can't be myself. I start worrying about the future. I'm even worried about where I'm going to live. I'm starting to become restless. I'm bored. I feel like something's going to happen. Sometimes it feels like I can't make plans for the future. I can be uneasy when I think that my loved ones may have the same problem. Natural disasters can happen anywhere in the world. I can live like this all the time. Everyone can live. I need to remain calm and natural. I need to pray to Allah to be protected from you. God will make the most auspicious thing about me. I pray.

Stage Two: Making an Inventory In this process, the balance model is used to inform the client about what he or she has been experiencing in the last 5 years. It is used to try to understand how the client has solved the problems he or she faces related to the trauma and which dimension of the balance model he or she uses more. The levels of primary and secondary capacities are investigated. In this process, the client's micro-traumas are also examined. At this stage, the therapist begins to formulate hypotheses about the actual conflict (the traumatic event that happened recently) and the basic conflict (the traumatic event that happened in early childhood).

Figure 14.1 illustrates the state of the client in terms of capacity. The client states the situation: "When I think of my traumas or when I meet with their triggers, I feel helpless and fearful. In this process, my ability to hope comes into play and reminds me that I am not helpless and that I am safe. My faith also supports my ability to hope. In this process, ability to love creates fear in me because it makes me think that I can lose my loved ones due to a possible earthquake. As I meet the triggers, I am trying to cope with them with patience and faith."

Stage Three: Situational Encouragement Situational encouragement is of central importance in PPT. Since the client focuses only on his or her problems, he or she cannot realize the positive aspects and opportunities. In this context, the client is encouraged on the positive aspects of the situation from a more realistic perspective. An attempt is made to help the client find new alternative ideas to expand his horizons. Below are positive interpretations from group members in a PPT group for a member who experienced a traumatic experience.

- *Therapist:* What are the positive features you see in our friend?
- *Feedback from the group members:* She is patient, calm, friendly, beautiful energizing, and also knows how to listen. She is also funny, remains calm, helpful, clean, mature, acts according to place, and a compassionate mother.
- *Therapist:* What kind of emotions and thoughts did your friends' feelings give you?
- *Client:* My friends' list of positive qualities made me feel good.

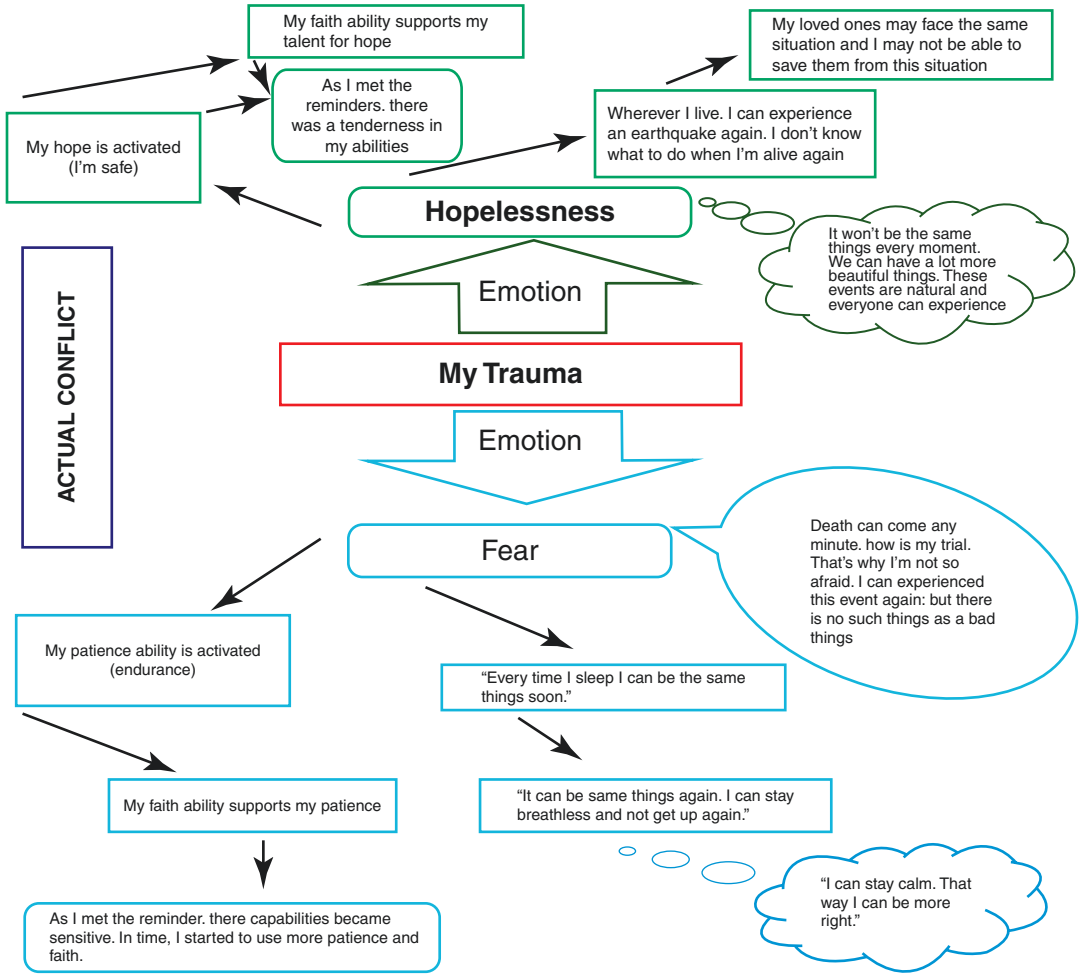

Fig. 14.1 An example from a client's actual abilities to cope with trauma

- *Therapist:* Very nice. Now give feedback about what our friend's problem contributed to her?
- *Group members' feedback:* It has changed her perspective on life. She increased her religious belief. She understood the importance of being safe. She understood the value of their relationship. It didn't affect her relationships.
- *Therapist:* What kind of emotions and thoughts did your friends' feelings give you?
- *Client:* I am strong. When my friends spoke, I realized my positive qualities once again. I'm a woman who can stay calm and think maturely. I can stay calm when I think about my trauma. I can remember how to cope with mature thinking. I'm a patient. I can deal with my trauma using this trait. I think it's the best way to handle patience. I have this property. I have the power to deal with my trauma. God has always been with me and has given me many positive features. I'm dealing with my trauma by using them.

Stage Four: Verbalization In previous stages, after creation of the necessary therapeutic environment, the basic conflict (the trauma happened in early childhood) of the client is studied in this period. An attempt is made to help the client solve the actual and basic conflict by using the balance model and its four dimensions. The main purpose of this circuit is to focus on the ways in which the client can balance the four dimensions of his life. This period is the longest in the consultation process and continues until the basic conflict is resolved. The following is an example of an action plan used in the verbalization step when intervening after a trauma. An example from a client's action plan is shown in Table 14.1.

Table 14.1 Example of an action plan used by the client to deal with trauma

	My activities according to the action plan									
Days of weeks	Scenario (I'm worried/I'm comfortable)	Behavioral control technique intervention	Balance model	Letter of separation suggestion	Dealing with faith	Editing cognitive distortions	Upload meaning to triggers	Edit my basic conflicts	I don't carry my trauma with me (story of the traveler)	Situational encouragement (positive suggestions)
Monday	X					x				
Tuesday		x	x							
Wednesday				x						x
Thursday							x			
Friday					x			x		
Saturday									x	
Sunday					x					

Stage Five: Broadening of Goals This stage focuses on how the client wants to live in the future (in the short to medium-long term) after reaching the objectives. The main purpose of the psychotherapeutic relationship in this circuit is to provide information to the client about self-help. In this way, the person can be equipped with a self-help method to accompany him/her during his/her life after ending therapy. In this stage, the client learns to reconsider the goals he or she pursues before he or she begins his or her life again. In doing so, he or she takes the four dimensions of life in the balance model and plans how to maintain balance in his or her life. This stage usually includes short-term therapy of one to two sessions and then long-term therapy that lasts four to five sessions.

Usage of Stories

Another original intervention of PPT is the usage of stories in the therapy process (see Chap. 22). Stories in proverbs, wise sayings, and metaphors are used as mediators between the client and the therapist. Story use has many functions in the therapeutic process. These functions include being a mirror and identifying and transferring the past to the future ([28], p. 7; [6]). The aim of the stories is for the client to look at the trauma or the problem through a new frame and a new spectacle with the help of the story. In the example given below, the therapist presented the story of a traveler [28] to the client and asked him to write down his thoughts about the story.

> ***I do not carry my trauma with me.*** There is no requirement that I will always experience positive things. Sometimes I have to experience negativities. I may have had a trauma. I may have had a hard time coping with my trauma. That's perfectly normal. I've been carrying it all the time with me because I didn't know how to handle it. I'm traumatized. However, I know how heavy it was. I couldn't afford it. I was always worried, and I was on top of it. At home, at school, the fear that I would live the same everywhere I went was wearing me out and I was getting tired. On the other hand, I knew that it was a test. Why am I carrying it then? Why I was persecuting myself? It was an unnecessary burden for me. I shouldn't have moved it anymore. That was much better. I don't move you anymore. You haven't left me for years, but I grew up with you and I don't want you anymore. I don't want to be scared or anxious anymore. However, now that you've lived, you stayed in August. I leave you there. And I'm on my way. I'm happier like that without you. When I don't think about you, I'm enjoying more of my experiences. You're not with me anymore even the main challenge. Allah knows best, and he will give me strength. I'm on my way now without you. Not happy with you. I've carried you as a burden so far. However, you're heavy now. I'm leaving you on a roadside in the heat of August. Hope to not meet again.

Summary and Key Points

Positive Psychotherapy (PPT after Peseschkian) is a therapy model that has proven to be effective for many psychological disorders [7–9, 11, 29, 30, 32, 34, 43]. This therapy model can be used effectively both for individual and group psychotherapy for post-traumatic stress disorder. In a study of positive group psychotherapy with a heterogeneous structure, individuals who had trauma problems were found to be able to solve these problems [9]. Trauma is a psychological problem that can be experienced by individuals of all age groups and by those who are psychologically strong and weak [3]. At this point, while trauma symptoms are common, individual differences are observed in traumatized individuals. These differences are also reflected in the psychotherapy process. In this part of the chapter, suggestions are given for the five stages of therapy for practitioners who will work with trauma.

Observation/Distancing Stage When working with individuals with trauma problems at this stage, it is necessary to explore the problems and needs of the clients. Subjective questions such as what, how, where, when, and who are used to understand the trauma and the individual in detail. At the same time, the trauma experiences of individuals with behavioral control techniques are examined as pre-event, during the event, and post-event feelings, thoughts, and behaviors. The client's symptoms are recorded. A letter can be given as an assignment to the client.

Making an Inventory Stage The therapist applies the Differentiation Analysis Inventory. The client's trauma is examined in terms of sources of coping with conflict. At the same time, the client's trauma is evaluated in terms of model dimensions. Micro-traumas they have experienced in the last 5 years are discussed. The client is asked to find a history related to his problem, or a story is recommended by the therapist.

Situational Encouragement Stage Trauma is made of red flag symptoms that are given a positive interpretation. The positive characteristics of the client are emphasized. In particular, the client's situation can be evaluated in terms of post-traumatic growth dimensions at this stage.

Verbalization Stage With the client, action plans are prepared for intervening in the trauma problem. These action plans can be techniques from other therapy models. The therapist has an educational role in the process of creating and implementing the action plan.

Broadening of Goals Stage The expansion phase focuses on the client's aims, in which a life without trauma symptoms is made. Clients determine various goals in the areas of body, success, relationships, and spirituality after solving the trauma problem. The therapist works with clients on how to convey these life goals.

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Positive Psychosomatics

15

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Introduction

Despite all inspiring developments of the psychosomatic field within recent decades [7], there are still three significant challenges [30] to meet:

1. Excessive fixation on "physical suffering," a despairing urge to take it under control, helplessness, and fear of new suffering drive psychosomatic patients to anxiously sabotage any attempt to engage them in the psychotherapeutic alliance while precious time is passing without the "real" diagnosis and the "real" treatment.
2. Absence of the systematic description of the somatization process.
3. Absence of the systematic strategy of diagnostic and treatment planning for psychosomatic disorders.

Positive psychotherapy effectively addresses all three challenges. Nossrat Peseschkian used the salutogenic concept [3] and positive[1] approach to understand any psychosomatic symptom as a capacity to discharge the inner tension of the inner and/or external conflicts. He suggested innovative operationalization tools to describe the psychodynamics of conflict genesis and somatization. The five-stage psychotherapeutic strategy establishes a systematic framework to effectively engage psychosomatic patients in the psychotherapeutic process, to labialize their neurotic fixation on physical symptoms, and to help develop their impaired capacities of mentalization.

Definition of Key Terms

Psychosomatics Nossrat Peseschkian defines psychosomatics as a "specific line of research and treatment that strives to illuminate the connection between the mental events and bodily reactions" [21].

Psychosomatic disorders are "bodily ailments and functional disorders of the organism, the etiology of which and course of which are largely dependent on social psychological circumstances" [21]. Psychosomatic disorders are now classified as Somatic Symptom and Related Disorders (DSM-5) or as Somatoform Disorders (ICD-10).

- *Dissociative (F-44 [300.11] Conversion) disorders (the capacity to express and discharge the tension of the inner conflict):* dissociative

[1]Positive /ˈpɒzɪtɪv/:consisting in or characterized by the presence rather than the absence of distinguishing features (https://en.oxforddictionaries.com/definition/positive).

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amnesia, fugue, stupor, motor disorder, convulsions, anesthesia and sensory loss, involuntary movements, trance and possession disorder—cannot be explained by any physical dysfunction. The conversion is the physical form of regression due to the highly intense anxiety and compulsion arising from unconscious conflicts and therefore acquiring a symbolic significance. The preliminary results of neuroimaging studies show that during conversion, the primary perception remains intact, yet the activation of the insula [25], orbitofrontal and anterior cingulate cortex [10, 15] and limbic system act via inhibitory basal ganglia–thalamocortical circuits to reduce the conscious sensory or motor processing [4].

- *Functional psychosomatic disturbances (F-45.3 Somatoform autonomic dysfunction) (the capacity to indicate the inner conflict and tension of the autonomic nervous system)* result from arousal in the autonomic nervous system and hormonal chain reactions. These nonspecific stress reactions are manifested in at least six symptoms from at least two of the following groups: cardiovascular, respiratory, gastrointestinal, genitourinary, skin, and pain. The connection of those symptoms with psychological life has been known for so long that it is already reflected in famous sayings such as: "Anger hits you in your gut!" "That gets my gall," "I cannot breathe without you," "You give me a headache" ...
- *Organic psychosomatic dysfunction (the capacity to indicate the suppressed or unattended inner conflict and exhaustion)* appears when "the anger has, so to speak, eaten into the organ, leading to objective, pathological modifications" [21]. In other words, the long-lasting tension of the autonomic nervous system due to chronic stress exhausts the physiological resilience, causes noticeable changes in the structure and function of the cells, tissues, and neuro-immune system, such as gastric and/or duodenal ulcer, Basedow's disease, Hashimoto syndromes, type 1 diabetes, functional heart disorders, headaches, intestinal disorders, rheumatic problems, asthma, etc. The specificity of the organs to suffer is defined by the general stress reaction, genetic predisposition, and by specific life conditions (lifestyle, nutrition, physical activity, environmental factors), rather than the psychological content. Yet the retrospective interpretation of the symptom's meaning allows the patient to reintegrate somatic experience by working through the conflicts to discharge them [1].
- *Hypochondriacal (F45.2 [300.7] Illness Anxiety) disorder (the capacity to look for the more profound problem in health instead of the psyche)* is a persistent (at least 6 months) distressing preoccupation of the physically healthy person with (1) the fear of a serious, often life-threatening illness, such as cancer or heart disease, or (2) presumed deformity or disfigurement (body dysmorphic disorder).
- *Psychological factors affecting other medical conditions (F54 [316]) (the capacity to deal with the anxiety related to illness)* are the psychological and behavioral reactions that affect the course and treatment of physical illness, such as avoiding care, demanding extra-care, etc.
- *Factitious disorder (F68.10 [300.19]) imposed on self or another (the capacity to attract attention, even without apparent benefits)*, interestingly, triggers the same changes on neuroimaging as conversion and hypnotically induced paralysis [11].

The key conflict (see chap. 27 on the conflict model details) between *straightforwardness (openness)* and *courtesy* regulates the processing of the tension of the inner conflict and therefore plays an essential role in the process of somatization. The key conflict can be resolved in four different ways: constructive; straightforward; polite; and ambivalent.

(a) *Constructive* solution of the *key conflict* became possible if in the basic situation the primary caretakers were capable: (a) of providing the baby with secure attachment; (b) of mirroring, naming, and converting the infant's emotional arousals into psychic elements so that they can be thought about and regulated [8, 29] to protect oneself and others

from one's own impulses and to manage the external physical and emotional consequences of one's own behavior; (c) of managing the secure detachment process; (d) of managing and explaining their [parent's] own affects so that the child learns to tolerate, notice, and understand them, to negotiate and establish a mutually beneficial relationship. By such means, the child develops mature primary capacities to regulate one's own affects and symbolic structures, ego functioning, and mentalization in addition to an object relationship. Well-developed primary capacities constitute the mature structure of personality [19] that allows one to integrate sensory, visceral, and motoric excitations with images and words, and in this way expand existing emotional schemas internally and in relationships with others.

(b) *Straightforward.* If the primary caretakers were only able to mirror and name the emotional states and needs of the baby, and yet failed to regulate those affects and to consider external physical and emotional consequences, then one's primary capacities will not be developed enough to solve the inner conflicts sufficiently by one's own inner means and to protect others from one's own impulses. Then, the growing inner tension [2] will be redirected toward an external object to release otherwise unbearable emotional stress.

Straightforwardness is the capability to follow one's impulses and needs to discharge the tension of the inner conflict outwardly, overcoming the fear of external conflicts and aggression from others whose needs would probably be violated. If the external resolution is impossible because of objective conditions or insufficient communicative skills, then the stress of inner conflict will grow and eventually deplete the body's resources, causing the mental or physical disorder.

Physiologically, straightforwardness is supported by the predominance of impulses of the limbic structures [6, 23] and sympathetic tone, the release of adrenaline [21], and open manifestation of anger.

(c) *Courteous*. If the primary caretakers failed to regulate the baby's emotional impulses and yet demanded obedience and politeness, then the child will not only be unable to deal sufficiently well with their own inner conflicts but will also suppress the external discharge of the growing inner tension because of the fear of losing contact, pleasure, love, care, trust, idealness *("I cannot talk about it," "I do not want to upset anyone," "I cannot do it")*.

Courtesy is the capability to remain in contact with other people by avoiding external conflicts, considering the external conditions and needs of other people, suppressing one's interests, impulses, and aggression toward the external requirements. Physiologically, courtesy is related to fear and is governed by the activity of the cortical structures of the brain, especially the prefrontal lobes [6, 23], resulting in parasympathetic tone [21].

When insufficiency of the primary capacities does not allow the inner conflict to be solved employing the primary capacities of ego, and yet the external resolution is impossible because of excessive courtesy, then internal stress builds-up, becomes chronic, and sooner or later leads to the exhaustion of physical resources and consequently to illness.

(d) *Ambivalent* mode results from the inability of primary caretakers to provide the baby with the secure closeness and secure detachment. Often the parents of such patients treated them as their narcissistic possession and either overwhelmed or ignored the child's needs [9]. They failed to regulate and organize the child's experiences so that the infant may not have developed the capacity to modulate its affective arousals [17] and to manage the external consequences of his/her own behavior to build mutually beneficial relationships. To compensate for those deficiencies, one may develop an split Ego, presenting pseudo-normal functioning and even success in isolated areas of life, yet denying unprocessed affects and inner conflicts that were never symbolized [26].

An ambivalent person can recognize, understand, evaluate, and regulate neither

his/her own needs nor those of others. The capacities for fantasy, associating, and mentalization are limited. Instead, those patients tend toward "operational" or "concrete" thinking [16]. They make no use of metaphors [1] and tend to describe events mechanically, in an emotionally empty manner, rather than reflect on them. Only those objects that can be touched or seen are perceived as important. Such patients experience emotions as events happening to them, rather than as their own responses to life situations [13, 14, 28] so that they are often described as depressive and alexithymic, and have severe difficulties in emotionally empty, painful, and exhausting relationships.

Such a "speechless mind" cannot make sense of growing unpleasant internal stimulation or describe it. The building anxiety and ambivalent impulses tend toward spontaneous discharge in the form of regression (conversion) and/or in over- or under- functioning of the physical systems (constipation or diarrhea, increased or decreased blood pressure, etc.) that would temporarily relieve the overloaded psyche, giving the patient a chance to recover if the stressor is discontinued [1]. If recovery is not possible, the functional disorders tend to progress into more severe illnesses (autoimmune diseases or cancer) [27].

Psychosomatic arc was first introduced by Nossrat Peseschkian in 1988 [24] to help both the patient and the therapist to visualize and thus to understand the process of somatization to find the best way of intervention to cure psychosomatic disorders.

The psychosomatic arc was further developed [5, 12, 24] in line with new findings of neuroimmunology and neurophysiology within recent decades (Fig. 15.1).

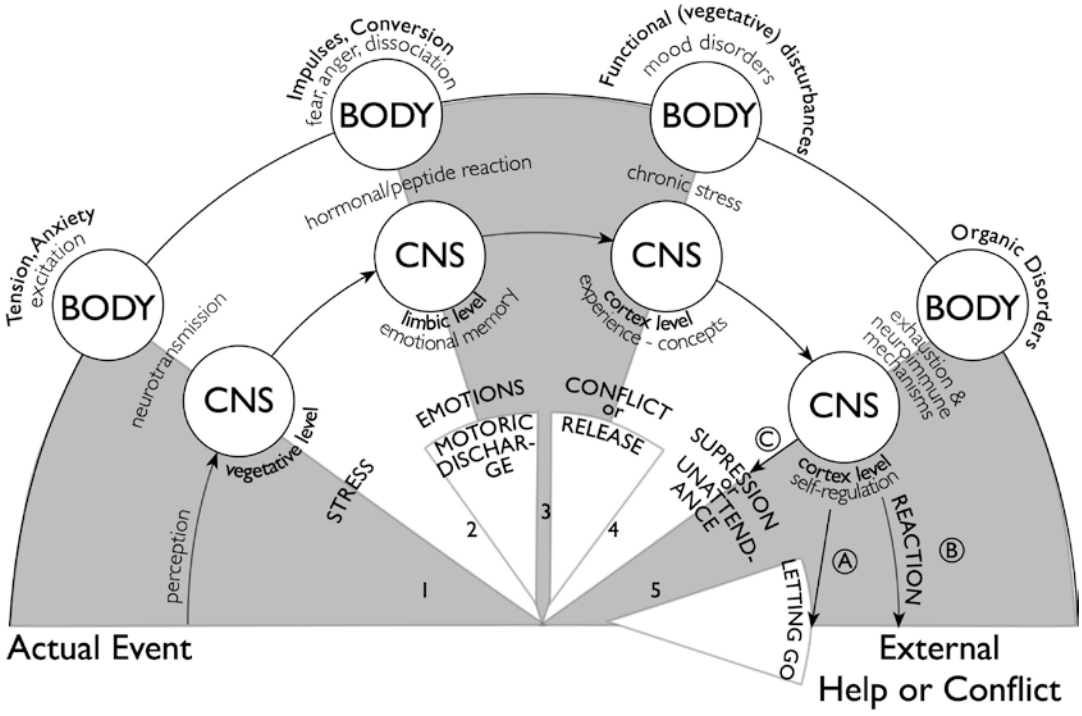

Fig. 15.1 The psychosomatic arc modified by I. Kirillov after N. Peseschkian, A. Remmers, I. Boncheva

The process starts with the actual event.

1. The central nervous system (CNS) receives information about the external or internal changes from the sensory receptors within 0.5 s and responds with the stress.
2. The primary reaction of the brainstem's reticular formation (*vegetative level*) "turns on" the sympathetic nervous system by releasing adrenaline into the synapses. The general arousal, aggravation of attention, vasoconstriction, increasing heart rate and respiration prepare the body to fight, flight, or freeze.
3. Almost simultaneously, the *limbic system* compares the data obtained with the personal "emotional memory" modeled in the basic conflict to determine the level of subjectively perceived danger and to activate the corresponding emotion to channel the energy of stress into the impulse that can be quickly discharged by the involuntary motoric reaction.
4. The evolutionarily new *cortical structures* of the brain, especially the prefrontal lobe, work a little more slowly [6, 23] to analyze the perceived actual event and one's emotional reactions to compare them with existing conscious and subconscious experiences. There are three possible results of this comparison:
   (a) *The inner conflict:* if the situation familiarly triggers one of the *pre-existing concepts* modeled in the *basic conflict,* then it is subjectively perceived as a threat or chance for the satisfaction of the primary needs *("I'm afraid to make a mistake, because then nobody will love me," "this is so unpleasant, but as a good person I have to do this"*). Such a perception reinforces the emotional impulse to protect the activated primary needs, conditions chronic stress, and therefore causes mood disorders and functional disturbances.
   (b) *The search engine and thinking* (*What? How? Why? When?*) are activated if there is not enough information or if it is all new and unknown.
   (c) *The release* (*"it is OK")* discharges the impulse if the situation seems to be safe and unpromising.
5. The emotional impulse generated by the *inner conflict* or *search engine* activates the *key conflict,* and depending on its resolution, initiates one of the four above-mentioned scenarios:
   (a) *Constructive* usage of the *primary capacities* to notice, understand and re-organize the inner conflict discharges the tension and all systems are restored to normal functioning.
   (b) *Straightforward* redirection of unprocessed tension of the inner conflict outside into the attempt to meet one's own inner needs employing external objects.
   (c) *Courteous* suppression or
   (d) *Ambivalent* unattendance of unresolved inner conflict continually builds up the chronic stress, that, in the case of genetic predisposition, can cause the neuroimmune system to reduce the immune activity opening up the possibility of infections or, in contrast, of triggering the excessive or one-sided immune reaction that might start to attack the tissues of different organs such as the thyroid (Basedow's disease and Hashimoto syndrome), pancreas (type 1 diabetes), connective tissues (Bechterew's disease), and others.

Applications

The five-stage strategy of positive psychotherapy for psychosomatic disorders structures the therapeutic efforts to address all critical processes of the above-described pathogenesis sequentially and systematically.

Stage One: Observation/Distancing

Facilitation of engagement To establish initial trust, the therapist generates a vivid interest in the patient's essential experiences. The best way to facilitate this process is a systematic sequence of questions structured by the *balance model* (Fig. 15.2) [20]. Those questions are focused on immediate experience of the symptom *(How do you experience your symptom physically? What do you do at such moments? How do others react toward your suffering? What do you hope for/are afraid of?)* and on the long-term influence of the

Fig. 15.2 The balance model

psychosomatic disorder *(Since you have had this problem how has it affected your general physical conditions/productivity/relationships/perspectives?)*. Such nonjudgmental interest helps the patient to feel understood and taken seriously.

By answering systematic questions, the patient engages in use of the balance model to explore the symptoms, their contexts, and influences on daily life. Thus, he/she re-organizes self-reflection, memory, and overall perception of the experience.

To strengthen the rapport, the therapist can utilize the patient's verbal expressions and symbols used to describe suffering to construct the questions and reflections.

Labialization of fixation The systematic examination of the symptom, recollection of important life events (*macro traumas*), and daily stressors (*micro traumas*) help the patient to distance his/herself from his/her own intense experience and to build the awareness of its connection with the life burdens, social relationships, psychological content, and behavioral models.

Focus on capacities The therapist helps the patient to identify what *actual secondary capacities* (norms and behaviors) trigger his/her stress and inner conflicts again and again, weakening physical resources and conditioning the psychosomatic reaction. Thus, the client switches his/her attention from the somatic symptom to the behavioral and psychological content of the daily stressors.

Psychodynamic focus The positive psychotherapist engages in an ongoing mental experiment trying to understand the symptom as a patient's subconscious attempt to discharge the suppressed impulses of inner conflict and to stabilize or develop existing social systems. Such a *positive* focus of attention helps the therapist to keep a distance from the neurotic experiences of the patient, and from one's own countertransference.

The positive attitude of the therapist provides the patient with the alternative psychodynamic experience of the symptom: *curiosity* vs. *avoidance, understanding* vs. *shame, developing capacities* vs. *anxiety, hope* vs. *despair*. Such a change of emotional experience affects the immediate reactions of the brain stem and therefore has the potential to reorganize the emotional memories if such an experience were to continue long enough (approximately 6 weeks).

To help the client to gain the new perspective of his/her disorder, the therapist offers, if appropriate, an alternative viewpoint borrowed from folklore, different cultures, and general positive interpretations suggested by N. Peseschkian (*heart attacks—the ability to take burdens and risk factors to heart; impotence—the ability to withdraw from the arena of sexual conflict*, etc. [21]).

Self-Help Tool-Kit

- Self-observation: *list your daily stressors, describe your actual reaction and suggest a desirable alternative reaction to each of them.*
- *List your capabilities and strong points.*
- *List important life events that you experienced and measure them against the Social Readjustment Rating Scale (SRRS)* [18].
- The balance of life: *how do you distribute the 100% of your life energy among the four areas of the balance model?*

- The balance of reactions: *reflect your reactions toward your symptoms in four areas of life.*

Social Adjustment Interventions

- *How do the other people in your life react to your somatic conditions?*
- *How do the other people in your life cope with similar situations in their own lives?*

Stage Two: Inventory

The therapist asks questions about relationships with the primary caretakers in the basic situation of the patient's childhood in *four model dimensions* (Fig. 15.3) to bring to the patient's consciousness the psychodynamic of inner motivations and conflicts causing the chronic stress and somatization.

I Relationship

How did your parents/siblings treat you in childhood?

What role did [actual secondary capacity] play in the attitude of your parents/siblings to you in childhood?

YOU Relationship

How did your parents treat each other?

What role did [actual secondary capacity] play in your parents' relationship with each other?

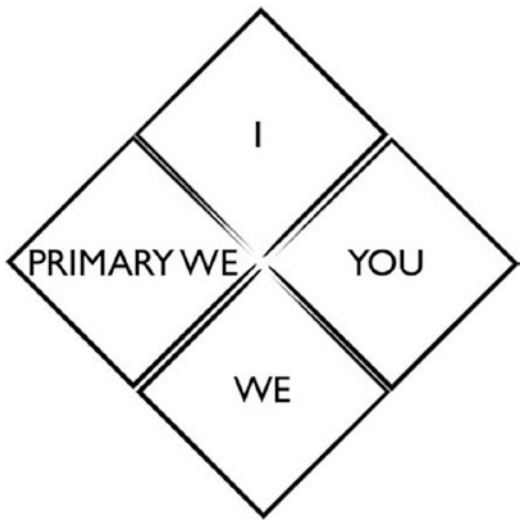

Fig. 15.3 *Four model dimensions*

WE Relationship

What were your parents' relationships with the social environment?

What role did [actual secondary capacity] play in your parents' relationships with the social environment?

PRIMARY WE Relationship

What did your parents believe?

What role did [actual secondary capacity] play in your parents' belief system?

The therapist helps the patient to restore his/her personal psychodynamic of modeling the individual resources and coping strategies:

- The *subjective concepts attributing the emotional value* to the secondary capabilities (identified as triggers on the stage of observation), especially the *straightforwardness and courtesy* and physical symptoms, depending on how they helped or hindered the satisfaction of vital and primary needs in a *basic conflict*.
- The *primary physiological reactions (stress and emotions)* aimed at surviving and the satisfaction of vital and primary needs.
- The sufficiency level of *primary capacities* to regulate the inner psychological processes and conflicts to meet corresponding primary needs.

Such an inventory supported by the *Differentiation Analytical Inventory (DAI)* [21] helps the patient to realize that his/her conflicting attitudes that appeared to be immutable and personality-bound are indeed historically conditioned attempts to solve some inner or social conflicts that can be more painful than the physical suffering.

Psychodynamic focus The therapist uses his/her primary capacities and structured inventory to help the client to differentiate the contents and dynamics of the inner conflicts leading to the psychosomatic disorder and to develop his/her capacity for mentalization.

Self-Help Tool-Kit

- *Differentiation Analytical Inventory* (DAI) [21]
- Wiesbaden Inventory for Positive and Family Therapy (WIPPF) [22]

- Stress surfing journal *(identify triggered primary needs by behavioral reactions)* [12]

Social adjustment interventions
- *What does the [symptom] mean for you/for your partner, friends, people from different cultures?*
- *What functions does the [symptom] perform in your life/in the life of your partner?*

Stage Three: Stimulation (Situational Encouragement)

At this stage the therapist uses:

1. *The paradoxical encouragement of the symptom* by the verification (following the client's capacity for mentalization) of the understanding of its positive function:
   (a) For clients with developed mentalization:

> *"Am I getting it right, that you perceive any requirement of obedience [situation described in terms of secondary capabilities] as the threat for your contact with yourself [primary need] and react with the intense anger and impulse to rebel [level of stress, emotion, behavioral impulse] to protect/meet your contact with yourself [primary need]?*

If the client confirms this, then continue if appropriate:

> *"It seems that you perceive your impulse to rebel [description of the impulse] as the threat for your need to be a good (ideal) son [primary need] and suppress your impulse (courtesy) to protect/meet your need to be good (ideal) son [primary need].*

If the client confirms this, then continue if appropriate:

> *"And then your body continues to generate the energy to protect your needs and discharge it through the asthmatic attack [somatic symptoms]?"*

(b) For clients with poor mentalization:

> *"Am I getting it right, that your asthmatic attack [symptom] is your capacity to:*
>
> - *Protect your contact with yourself and still be a good son [primary need]?*
> - *Tell your parents that you cannot do what they ask [implicit message]?*
> - *Ask for freedom to stay in contact with yourself [needed help]?*

This intervention is meant to condition the client's insight into the inner conflict and function of the symptom; to discharge defenses and to condition the motivated, active search for an alternative reaction.

2. *Situational encouragement*: regular positive attention to capacities/capabilities revealed in life situations and during the session focuses the client on what is already achieved and available as an active resource and generates confidence and an impulse to act.
3. *Psycho-serum* can be used to facilitate the "inscription" to the automatic subconscious memory of newly gained positive perception of the symptom in addition to positive counter-concepts. Technically, it can be done by hypnotic suggestion, autogenic training, guided imagery, stories, metaphors, humor, etc.

Psychodynamic focus The therapist provides the patient with the model of finding resources and trusting them, encourages self-help, conditions the inspiration and curiosity to experiment.

Self-Help Tool-Kit
- *What positive influence do your symptoms have on your life?*
- Breathing and relaxation exercises
- Autogenic training

Social Adjustment Interventions
- *What positive influence do your symptoms have on your environment?*
- *How can you establish trust with the conflicting partner?*
- *Which of his/her capabilities can you encourage? How?*

- *How can you show him/her the understanding of those behaviors that disturb you?*
- *Who can help/encourage you? How can you ask for this?*

Stage Four: Verbalization

Focus the discussion on explored and overlooked conflicts to *ensure the patient's clear understanding of the inner conflict*, its origins, and role in the development of the psychosomatic symptoms.

Address the key conflict by noticing its manifestations in the therapeutic relationship and discussing its origins and role in the development of chronic stress and psychosomatic symptoms.

Condition the constructive resolution of the key conflict by:

- Listening and questioning while the patient is emotional.
- Being straightforward, clear, and sensitive to the patient's lexicon and level of understanding in your questions and comments.
- Focusing the questions and comments not on the person, but instead on actions and capabilities to stimulate the natural impulse to develop his/her capabilities and to test new behaviors.

Ask the patient to come up with *alternative practices* that can:

- Optimize his/her concepts and perceptions.
- Help him/her to meet the triggered needs without inner or external conflicts.
- Develop vulnerable primary capacities to become self-sufficient.
- Encourage the patient's responsibility for future physical, emotional, social, and behavioral development.

Psychodynamic focus The therapeutic relationships serve as an active model of the balance between *straightforwardness* and conscious responsibility for one's own emotional reactions (*courtesy*).

Self-Help Tool-Kit

- *How often does the conflict of straightforwardness vs. courtesy arise, and with whom?*
- *Which of your needs and those of your partner does it trigger?*
- *How can you now explain your problems/needs to your partner?*

Social Adjustment Interventions

- *How can you verify your understanding of the problems/needs of your partner?*
- *What mutually beneficial solutions can you offer your partner?*
- *How can you agree with your partner that inconsideration hurts you and your partner more than a frank conversation at the right time?*

Stage Five: Broadening of Goals

At this stage, the therapist focusses on the:

1. Feedback of the patient to activate the impulse to act.
   - *What have you already achieved with the therapy?*
   - *What was important for you?*
   - *What will you do now?*
   - *What do you want to bring to your colleagues, family, friends?*
   - *What would you like to discuss at the next session?*
2. Developing the patient's underdeveloped capacities, especially the primary ones.
3. Building the life balancing plan (one to three objectives supported by three to five specific activities) using the balance model and four dimensions of relationship responsibility (I, You, We, Primary We) for 5 years, 1 year, 1 month, 1 week, 1 day.

Psychodynamic focus: to strengthen the new ideas, "installing" them into the client's inner "story" to balance the vision of a healthy future, making it more realistic.

Self-Help Tool-Kit

- *What would you do if you had no more symptoms?*

Social Adjustment Interventions

- *What would you do with your partner if you had no more symptoms?*

Summary

Positive psychotherapy effectively addresses all three challenges of contemporary psychosomatic medicine.

1. A positive understanding of psychosomatic symptoms as a capacity to physically discharge the inner tension of the underlying inner conflicts, accompanied by the balanced questioning, helps to engage the patient into the therapeutic collaboration, gain his/her trust, and labialize the excessive somatic fixation.
2. The psychosomatic arc offers the *systematic description and visualization of the somatization process* to optimize its understanding, treatment planning, and facilitation.
   (a) *Transmissio*n of the organically perceived information to CNS
   (b) *Energy generation* and preparation for action (vegetative level)
   (c) *Emotional impulse* (limbic level)
   (d) *Conceptual regulation* (cortical level):
      (i) "Threat" and/or "inner conflict"
      (ii) Questioning and thinking
      (iii) Dismissal
   (e) *Impulse regulation* by the *key conflict:*
      (i) *Constructive* resolution
      (ii) *Straightforward* externalization
      (iii) *Courteous* suppression of it or *ambivalent* disregard reinforcing the chronic stress and further somatization.
3. The five-stage psychotherapeutic strategy provides a systematic framework to effectively and sequentially address every critical point of somatization:
   (a) Stage One: *(to engage the patient in therapy and to reorganize the patient's perception).*
   (b) Stage Two: *(to differentiate the contents and dynamics of the inner conflict underlying the psychosomatic symptoms).*
   (c) Stage Three: Stimulation (Situational Encouragement) *(to find resources of self-trust, conditioning the inspiration and curiosity to experiment).*
   (d) Stage Four: *(to optimize the resolution of the key conflict).*
   (e) Satage Five: Broadening of goals *(to develop capacities supporting a healthy balanced life after therapy).*

Key Points

1. Positive psychosomatics based on positive psychotherapy addresses symptoms as a capacity to physically discharge the inner tension of the underlying inner conflicts.
2. The psychosomatic arc offers the *systematic description and visualization of the somatization process*.
3. The five-stage psychotherapeutic strategy addresses every critical point of somatization systematically, sequentially, and effectively.

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Positive Child and Adolescent Psychotherapy

16

Roman Ciesielski

Only seeds

A man had a dream, in which he went to the greengrocer. He was greeted by an elderly man standing behind the counter. The young man asked with a strong voice: "What can you offer me?" The shop assistant replied in a friendly way: "It depends on what you wish for". Hearing that the client started to enumerate with no further hesitation: "If so, I would like world peace and unity of the world, abolition of all the prejudice and poverty, unification of religions, equal rights for women and men." At that moment the old man interrupted and said: "Just a moment young man, most probably there has been some misunderstanding between us. I do not sell fruits here, only their seeds."

Citied in: Peseschkian [1]

Introduction: The Importance of the Family and Social Context

For a comprehensive understanding of child or adolescent issues it is of particular importance to know the environment in which they live, develop, and learn every day. A child rarely reports a problem of a psychological or psychosomatic nature of their own initiative. Their limited insight into the nature of their own experiences, in addition to subjective or objective obstacles, makes it difficult. Usually, it is the adult who recognizes specific symptoms that may manifest as psychological suffering in the child. Depending on developmental age and sense of safety, the young patient confirms or denies the perceptions of adults.

Presentations where the parents directly share their worries and observations about the child are more beneficial. This enables the therapist to gather the most important data from the caregivers, and at the same time allows the assessment of the dynamics of mutual relations in the family and build the initial alliance with the parents. The prognosis is much worse when the disturbances in the child's functioning are observed by persons from outside the family, such as tutors, counselors, or teachers. This may indicate neglect by the closest family members and presage difficulties in building a therapeutic relationship with the family.

The positive psychotherapist should obtain information about their juvenile patient from various potential sources. This creates an opportunity to compare the child's ways of reacting in a variety of social surroundings. It should be considered that symptoms presented by the child are strongly related to explicit and implicit family conflicts, in addition to the level of stress experienced by the family and their coping styles. The presence of family members, both at the stage of making a diagnosis and during the process of a child's treatment, seems to be a key to the success of further therapy.

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Key Definitions

Developmental Phases in the Life of the Child and Its Family

The individual therapy plan should be preceded by a thorough clinical diagnosis. To make such a diagnosis, it is essential to have extended knowledge in the field of children's psychomotor development and the stages of family development. For the first issue, the stages of psychosocial development described by Erikson and Erikson are particularly useful [2]. They define normative developmental crises, which, if solved properly, provides the child with new skills and at the same time starts a new stage in their life. On the other hand, unsolved crises cause inhibition and remaining fixed at that developmental stage. This leads to recurring conflicts later in life, e.g., basic mistrust, sense of inferiority, or the feeling of shame. The author of PPT also gives special meaning to ego development in a social context; however, he explains the nature of conflict connected with this process in a different way. This subject will be discussed in the next section.

The second important point of reference in the working out of the clinical diagnosis in PPT of children and adolescents are cycles of family development, as described by Duvall [3]. According to this author's observations, families grapple with specific tasks at particular stages of the child's life, which requires specific resources and adaptation skills. In the absence of those resources, the family system reacts with resistance to expected changes. Then it is the child who unconsciously develops symptoms of illness, which perform a homeostatic function for the whole family, e.g., separation anxiety at the stage of going to nursery school or juvenile depression at the stage of the empty nest.

Attachment and Basic Capacities

A lot of clinically useful knowledge on the subject of child development was brought about by the theory of bonding by Bowlby [4, 5], later broadened by Ainsworth [6, 7]. It emphasizes the fundamental importance of a bond between a child and a basic object of attachment, most commonly the mother. This bond is decisive for the proper emotional, cognitive, and social development of every human being. What guarantees optimal development is a secure bond, in which the mother is fully in tune with the physical and emotional needs of her child. Experiences of a safe relationship bear the fruit of trusting oneself and others. As stems from practice, there are also unsecure attachment styles, among which the anxiety-ambivalent and anxiety-avoidant styles can be mentioned. Prospective observations indicate that relational schemas from early childhood are being unconsciously reproduced at further stages of a person's life and that this may lead to numerous disturbances and dysfunctions (unsecure attachment styles).

Nossrat Peseschkian described attachment relationships with constructs, which he called basic capacities. Among them he mentioned trust, contact, time, patience, and others—see Chap. 2 for an introduction to the Positive Psychotherapy model. According to the model, basic capabilities, which are implicitly present in the child–caregiver relationship, constitute a kind of matrix that enables the child to satisfy their specific biological and psychological needs [8, 9]. Peseschkian especially emphasizes the role of modeling, that is, unconscious identification with the adult model. In his opinion, in the first 2 years of life, children embody some of basic capacities that in the future will determine their attachment style. What models the family environment and what dimensions of the relationship are being reinforced is dependent, among other things, on transgenerational transmissions and on the sociocultural context in which the family lives.

Social Education and Secondary Capacities

The older a child becomes, the more visible are the influences of the broader social environment and cultural context. The child starts to assimilate specific norms of behavior that are necessary in the process of social adaptation. Peseschkian defines

them as secondary capacities (conscientiousness, politeness, punctuality, diligence, and others) [8, 9] and stresses the fact that the child internalizes them throughout education, starting in nursery school. One may easily notice that from that moment, satisfying a child's emotional and relational needs will be conditioned by reinforcement or by suppressing selected secondary capabilities. It will promote individual unconscious compromises, according to the rule: if I am honest, then my parents will be proud of me, or if I am obedient, then my parents will show interest in me.

Conflicts

Above-mentioned unconscious compromises on one hand are decisive for survival, and on the other hand they shape a child's personality and limit their repertoire of resources for reaching happiness or self-actualization. It can be said that the unconditioned need of love is transformed into individual compromises between basic capacities (differentiated equivalents of love) and secondary capacities (differentiated norms of social behaviors). Peseschkian names these compromises *basic conflicts*. Stemming from previous chapters, when they are aroused in a child, then an internal conflict is developed that externalizes itself through the agency of mental or psychosomatic symptoms.

Estimation of Resources

In the case of the dysfunctions of a child, which have psychological or neurobiological bases, very often it is their limitations that remain the focus of attention of its family and the social environment. Adults, and sometimes also peers, openly express their disapproval toward the child's reprehensible conduct. As can easily be suspected, such negative marking disrupts the child's self-esteem and leads to social exclusion. To a great extent, this phenomenon applies to children diagnosed with attention deficit hyperactivity disorder (ADHD) or oppositional-defiant disorder (ODD).

In PPT, the therapist aims to reverse this process as early as possible. Particularly useful are meetings with parents, family members, tutors, and teachers. Every one of them may recall descriptions and images of the child that go beyond negative schemas. Recognition and naming hidden resources of the child promotes the establishment of secure and open relationship with them. It also seems useful to search for an answer to the question about the child's capacity that owing to reasons independent of them could not fully develop and thus how their development could be stimulated during the course of the therapy.

A useful way to engage the family is to reformulate the child's behaviors from those that are difficult to accept to those that serve the family and protect its values and principles. Owing to positive connotations, the child regains its previous position in the family system instead of being excluded. Moreover, mutual accusations and criticism are replaced by attempts to reach mutual understanding and to search for solutions.

Particularly good are positive reflections on the family as a whole and its individual members from an outside perspective, seen with eyes of friendly and attentive observers.

The process of discovering psychological resources, both from the individual and from the family, is included in the conception of *positum*, which has been described in previous chapters. This assumes that every person is good by nature and that to be able to realize their potential, they need optimal conditions. If some unfavorable circumstances have brought this process to a halt, it is the aim of the PPT to remove these obstacles and give the young patient an impulse to develop.

The Process of Modeling in Positive Psychotherapy in the Development Period

Many contemporary scientific works and clinical observations indicate the fundamental role of the therapeutic relationship in the process of treatment [6]. This sort of relationship creates a secure model of attachment for the child and gives space

for corrective experiences, which in turn enable the development of a more mature and integrated ego. PPT, while systematizing the knowledge gained from direct observation of interactions in the family and from the interview (see Chap. 2 for the model and Chap. 26 for the first interview), defines these basic capacities, which are necessary for the child for the fulfillment of further development, making them directly accessible in the relationship, all the time consciously modeling this process. Depending on concrete needs, it can be authenticity, acceptance, patience, hope, and others. However, you should not forget that in the majority of cases, individual contact of the therapist with the young patient is like the sourdough in the process of healing. After the therapeutic session is ended, the child returns to their environment of everyday life and is subject to its various influences. Because of this, positive psychotherapists seek allies in the closest milieu of their patients. Their active participation in therapy enables them to directly activate the desirable capacities in their clients through identification with the selected therapist's attributes, and on the other hand, the patients can develop new and more healthy attachment styles in contact with the therapist. This way a child may use new relationship patterns that are given to her/him by the therapist and the primary support group.

Therapeutic Contract

In PPT, the arrangements concerning the therapeutic contract are arranged with the child's caregivers in the presence of the child. The discussion encompasses the location of the sessions, their frequency, the anticipated duration of the therapy, assumed therapeutic goals, and the plan of therapy. Moreover, the therapist, depending on the child's age, should negotiate the range of activity in the therapeutic process of the parents and other family members. The younger the child, the more advisable the presence of adults in the sessions. In the case of adolescents, it is recommended to separate individual sessions from consultation sessions, in which the patient's caregivers, other family members, or the whole family take part. This division corresponds with the natural process of individuation and separation occurring at this stage of family development. Furthermore, it enables at the same time the young person's needs for autonomy and dependence to be respected. In such situations, issues of confidentiality are discussed, which include information shared in the individual therapy with an exception for circumstances that are life-threatening the patient or others.

Forms of Psychotherapy in the Development Period

In the PPT of children and adolescents, the following forms of therapy can be applied, both independently and simultaneously:

- Individual psychotherapy
- Group psychotherapy
- Family psychotherapy

Group and family psychotherapy are described in Chaps. 22 and 20; thus, we shall now concentrate exclusively on individual therapy in the presence of the child's caregiver or caregivers, or with family consultations taking place from time to time.

In both cases, the individual therapy is in the foreground and the presence of adults in the sessions serves the achievement of therapeutic goals.

Therapeutic Techniques in the Development Period

Working with a child or an adolescent within the framework of PPT requires flexible adjustment of therapeutic tools and techniques, depending on the age and developmental stage of the child. This encompasses the method of work using:

(a) Imagination
(b) Tales and stories in the development period
(c) Expression in the form of art therapy
(d) Games and sports
(e) Dolls and puppets, etc.

Examples of techniques **in the development period** of such work are included in the next chapter and in the case description.

Therapeutic Process While Approaching Children and Adolescents

Positive psychotherapy is originally a strategic activity and the process itself has been described by its author of five subsequent steps [10, 11]. Each of these stages constitutes a clear frame of reference for all parties engaged in mutual interactions and serves to monitor the progress of the therapy.

Five stages of positive psychotherapy consist of:

1. Observation and distancing
2. Making an inventory
3. Situational encouragement
4. Verbalization
5. Broadening of goals

Stage 1: Observation and Distancing

This initial phase of therapy is aimed at gathering basic diagnostic information, in the clinical and descriptive sense of the word, expressed in the language of the child and their family. The reported problem is discussed from various perspectives of each of the persons taking part in the consultation.

The differentiation of perspectives enables the problem to be redefined and positive reformulation to be used, e.g., "Maggy, because you are unable to go to the kindergarten due to your anxiety, mother and father together are thinking about the ways to outwit it." In other words, we try to give another meaning to the reported problem and put it in the context of family relations and events. In PPT, we concentrate on careful observation of the socio-dynamics of the family system. Thanks to this observation, one can better understand both explicit and implicit norms of the family's functioning, as well as its structure, hierarchy, and patterns of communication, e.g., consent to express negative emotions by the child or lack of such consent. When the family consultation with a small child takes place, it is possible to describe the problem from the child's perspective by means of a story. Children create the stories willingly if they are instructed in simple wording, e.g., "Johnny, tell us the story of a little animal whose parents went off on a journey and they were left home alone…". Another useful form of making contact with a child and encouraging them to name their worries would be using role-play, when the therapist plays with a child with puppets, e.g., "*this puppet is Mary, who nobody likes in the class. Mary has just come back home from school and she doesn't want to talk to anybody." She doesn't know that a surprise awaits her and she will be visited by Aunt Lucy, who loves Mary very much. And that is her (Lucy), Mary can you act as Aunt Lucy for now and ask Mary how is she today and what has happened at school?"*

To sum up, during the stage of observation and distancing, the task of the positive therapist is to formulate the initial diagnosis concerning conflicts being experienced by the child and to discover the function of presented symptoms in the context of family relations.

Stage 2: Making an Inventory

At this stage, the therapist pays attention to the child's previous ways of dealing with difficult experiences or symptoms identified as problematic. The child's social skills, the capacity to articulate and to have insight are evaluated, in addition to both the availability and the range of support offered by the adult. In this way, the child's psychological resources are identified, in addition to their limitations and appropriate skills that need to be developed.

Detailed narrations of the child and their family concerning the genesis and the development of the symptoms enable the therapist to recognize the sources and conditions of their exposure. At this stage of therapeutic work, techniques such as discovering the patient's *line of life* and the *four dimensions of modeling* are useful.

In the first of above-mentioned techniques, the task of the child is to illustrate their line of life by means of a colored piece of rope and

place on it selected objects such as shells, stones, etc. These objects represent important life events of a child and their family. Discussing these episodes one by one may give valuable information and at the same time help the therapist to reconstruct the emotional climate that accompanied them, such as when we found that the stuttering of a 13-year-old boy was connected with a threat he had heard from an old man who was wearing a hat. That threat was: "If you do not listen to your father, the devil will come to you at night." As it turned out, this boy had been suffering from nightmares for several months and started to stutter after his mother had told him he was becoming rebellious toward his parents. The object that was associated with the man with a hat was a toy trumpet and the impulse to recall and share this experience with a therapist was evoked by the therapist's request to play on the trumpet.

The second technique is called *four dimensions of modeling*. They become the point of reference for the child's self-image in addition to their image of a partnership relationship, social relations, the view of the world, and the future. Adequate self-esteem, trusting close ones, hope, having the sense of agency toward forthcoming events, and their sense of meaning remain in close connection to basic models of interpersonal relationships that were internalized by the child. They influence the child's coping style in problematic situations and their ability to use their social support. The diagnostic and therapeutic repertoire in this field is broad, starting from the drawing of the family tree and going through the use of boards with figures and hand puppets. Special attention is given to reading and interpreting with a child fairy tales, stories or other works taken from various cultures, in which analogy to the current situation of the young patient can be found.

The second stage of PPT of children and adolescents presented above is helpful for a better understanding of both family and social sources of difficulties experienced by a child. In addition, during this stage, the patient's actual capacities can be recognized, which serve as their resources, but may also lead to psychological conflicts.

Stage 3: Situational Encouragement

During previous stages of therapy, the reported problem and its function have been defined and the genesis of conflicts, together with the actual capabilities involved, have been discovered. Now it seems important to recognize and strengthen the psychological resources of the child and their family environment in the context of formulated needs and therapeutic goals. Thus, the attention is intentionally directed at those life events that have been the source of strength for the family members and the role of the positive psychotherapist is to moderate the family communication style so that the unconscious resources of the family are more easily available. This is facilitated through various activities performed during the sessions, and in the form of homework, e.g., *"Mark, could you please finish at home a story that starts like this: Jack was a very impatient boy and would often speak at the wrong time. This caused him a lot of trouble until he spent vacations with his grandfather who helped him to find out many new things about himself…"*. By analogy, children are often interested to hear a story with an unexpected change of plot, when the main character, seemingly at a dead end, suddenly discovers new talents in himself or recognizes admirable qualities in other people.

If it turns out that it is the parents or the whole family that require therapy (marital conflicts, domestic violence prevention, addiction treatment, etc.), such a recommendation must be clearly expressed at this stage and their realization becomes decisive for the therapist's decision regarding individual therapy in a child. An extended and often suggested form of treatment might be group psychotherapy carried out in a peer group, in addition to socio-therapeutic activities.

Summing up, it must be pointed out that at this stage of therapy both the patient and the whole family system are being prepared to accept permanent psychological change, which often requires personal engagement, determination, and courage.

Stage 4: Verbalization

Revision of therapeutic goals in the context of the child's individual needs and the whole family

system takes place during the stage of verbalization. Such goals are accomplished both in the sessions and in the social context of life. As was previously mentioned, the older the child, the more probable it is that family consultations are separated from the individual therapy sessions. Then it is of particular importance for the family to support the contracted goals of the individual therapy and respect the needs of autonomy and privacy of the adolescent. It should also be stressed that the family system is an important source of support, not only for the child but for the positive therapist as well.

The patient's self-knowledge, enriched at this stage, helps to discover the nature of individual conflicts and opening oneself up to new experiences, facilitating psychological development. Interventions of the therapist enable the excessively rigid beliefs to be relativized and help to change the child's tenacious patterns of reaction. In PPT, the process of discovering what internal and interpersonal conflicts contain is called differentiation analysis. Because of this analysis, it becomes more understandable to the child that, for example, the need for love and acceptance she or he solely satisfies through obedience toward the parents comes at the cost of not completely fulfilling their own desires. In other situations, the child can realize that to advocate the implicit family norms, she or he concentrates excessively on the need for achievement, which takes the form of obsessive behaviors. In other examples, the adolescent's need to experiment with drugs or alcohol turns out to be their only way of inducing their parents to openly talk about closeness or intimacy in their mutual relationships. Identifying the key elements of internal conflicts and contradictory values, attitudes, and tendencies that are connected with them makes it possible to externalize them, better understand the nature of their dynamics, and finally work out their positive resolution.

Case Example

One of my patients started therapy at the age of 14 because of his self-injuries. His autoaggressive behaviors evoked a lot of tension in himself, his family, and in his school environment. After some time, during one of the sessions, he realized that for many years he felt unfairly treated by his parents and grandparents, who in the boy's opinion preferred his two older siblings. When the patient was separated from his best friend who had moved with his family to another country, he started to injure himself with a sharp instrument. His parents were concerned about this and tried to establish some contact with him, but his deep-rooted grudging feeling made it very difficult for them. On the one hand, he longed for their appreciation and emotional support, but on the other hand, he was unable to take it. As he was unable to tolerate the tension evoked by this situation, he resorted to acts of self-harm.

When the patient discovered during the therapy that his desire for love was in opposition to his sense of justice, then he could better recognize his denied needs and finally expose them. He invented "Mr. Justice," whom he employed as his advocate to restore equity at home. During the session, he imagined how "Mr. Justice" would convince the family members to eventually recompense him for his long-lasting sense of grievance. Another character, who was the patient's deceased grandmother appeared in a session. She supported his parents and helped her grandson to realize that there are many languages of love and ways of showing it. This continued in the family consultation, when once more the patient's grandmother was recalled and she became recognized as a good spirit of the family, particularly attentive to the patient's needs. After this session, his self-inflicted aggression stopped.

To recapitulate, during the stage of verbalization, the unconscious and contradictory feelings, desires, thoughts, values, and motives are eventually named and are manifested through symptoms or dysfunctional behaviors. During the previous stages of therapy, the aim was to recognize the context in which they had been developed and their genesis, in addition to the initial analysis of their content. Currently, deepened differential analysis leads to their externalization. Under the conditions of the safe therapeutic environment, it becomes possible to experience an insight, reveal suppressed emotions, and undertake behavioral

experiments outside the sessions. The child, eventually strengthened by the therapist and their family, finds their way to positive resolution of their conflicts and acquires a healthy lifestyle.

Stage 5: Broadening of Goals

Broadening of the goals is the last phase of therapy. During this stage, the summing up of the individual changes that have occurred in the patient and their family environment up to now takes place. Once more those skills and resources are named that have proven helpful for the child and appear to be for him or her an object of identification in the future. Therapeutic effects are strengthened by techniques using imagination, e.g., "*John, if you travelled in the near future with your time machine, tell me which of your abilities would you take with you. To each of them you can assign one of the objects you find in the box next to you. Tell me exactly why you take this and not the other object and what it means to you. Tell me also under which circumstances do you think each of your skills may be particularly useful.*"

During that final stage, what also appears to be useful is to define together with the child potential difficulties and unwanted events, in addition to strategies that can be developed to maintain the sense of efficacy. The patient's family members should be included in that process to enhance their ability to consciously sustain previously achieved psychological changes in the system. A case example with diagnosis and therapeutic interventions is shown in Fig. 16.1.

Case Example with Diagnosis and Therapeutic Interventions

Circumstances Under Which the Therapy Started

A mother with her 12-year-old son came to a therapy session. The general practitioner that directed her noted in the referral that for several months the boy had been suffering from gastroesophageal reflux disease (GERD) and the standard treatment was applied, but there was no improvement in the boy's state of health.

Stressors (Actual Conflict)

In the interview, the mother confessed that the psychosomatic symptoms of her son are probably related to the incident that took place during the school dance a year before. At the time, the boy dedicated to his homeroom teacher a piece of

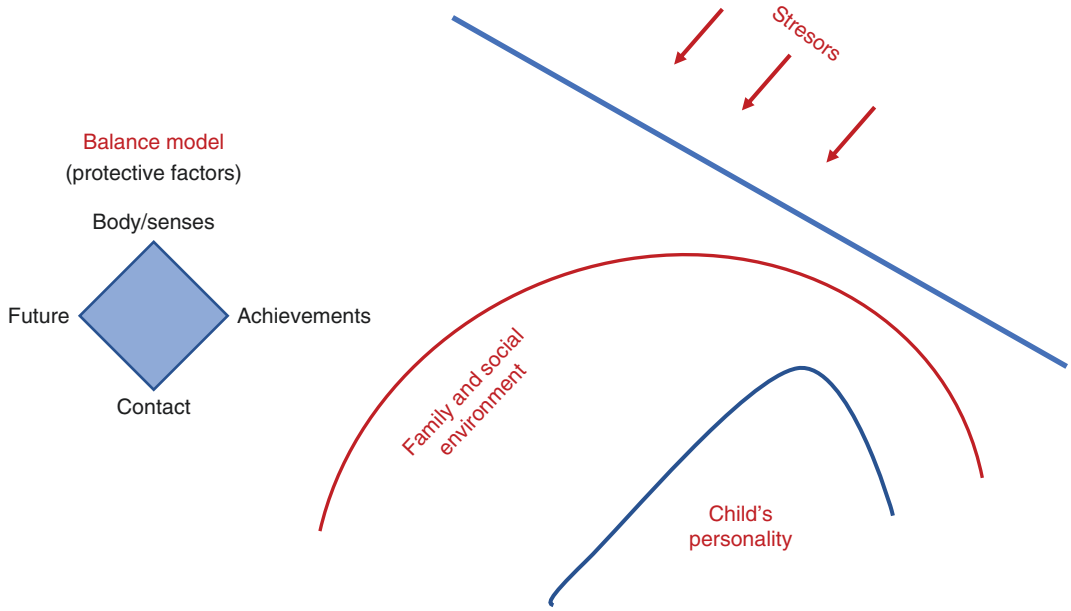

Fig. 16.1 Model of therapeutic diagnosis and intervention

music from the charts, in its original English version. It turned out that the song contained obscene words. The teacher took the behavior of her student as an act of hooliganism. She started to discipline him in front of the class and deprive him of previous privileges (class president, top of his class). The boy consistently refused to talk about the motives for his behavior at the school dance and subsequently avoided going to school. Interventions of the mother with the school partially improved the situation.

Family Context (Basic Conflict)

The young man had grown up in a single-parent family. The patient's father had left his mother for another woman when he was 6 years old. The father remarried a year after and had a new family. The boy met up with his father regularly, but wasn't keen to share with his mother what he was experiencing during those meetings.

In the situation of the breakdown of the family, the patient tried to maintain a good image of both the mother and the father, struggling with a conflict of loyalties. He was brought up with respect for the authorities and a sense of politeness, at the same time he suffered from the injustice that he had experienced in his early childhood. He gained his parents' recognition and appreciation with ambition, diligence in school, and being responsible.

Personality Traits of the Boy Enhancing Development of GERD

- Excessive tendency to suppress and control emotions for fear of rejection of his environment
- Tendency to experience strong emotions such as anger or irritation
- High level of anxiety

Child's Resources

- Ambitious, conscientious, independent, resourceful, responsible

Internal Conflict

The boy was accustomed to showing respect to adults whom he was attached to and he never questioned their decisions. During the memorable school dance, he dedicated his favorite piece of music to his homeroom teacher, not fully understanding the content of the original version of the song. The reaction of his teacher surprised him and evoked a sense of injustice. For fear or rejection and loss of relation that was important to him, he was unable to consciously experience or openly express his grudge. Confronted with his teacher's disapproval, he tried to earn her appreciation with even more diligence in studying and distinguishing oneself with politeness. This strategy was not helpful in the resolution of his internal conflict. He suppressed negative feelings, which resulted in the development of GERD.

Balance Model

- Body—physical symptoms indicate the existence of internal conflict, but the patient is incapable of interpreting them
- Achievements—the boy is trying to resolve the conflict by fulfilling his school obligations even more conscientiously, but that is not evoking the appreciation of his homeroom teacher
- Contact—on the one hand the boy is afraid of losing the relationship with his favorite teacher, but on the other hand, he does not use social support, struggling to resolve his conflict on his own
- Future—the boy's experiences are dominated by a sense of injustice and the lack of hope of regaining it

Interventions Applied and Therapeutic Change

Identifying stressors and discovering the boy's personality traits (his resources and limitations), in addition to the broader family context, enabled the therapist to define the nature of the patient's conflicts and plan therapeutic actions. Therapeutic interventions aimed at the development of those capabilities of the patient that would bring balance to his life (four dimensions of life model) and in this way initiate psychological change and strengthen his mental resilience.

During the first stage of therapy, the boy became aware of his suppressed emotions (grudge, anger, loneliness) and was provided with tools (role-play, change of roles, externalization of emotions) to express them more openly. During the next stage, he named the strategies that he applied in situations of growing psychological tension, which only exacerbated his problem (being diligent, hardworking, polite, and only apparently independent). After that, he was confronted with the choice of new and more useful strategies, in the context of the balance model. These assumed greater body awareness (dialogs with the stomach and reading the signals sent by the body), in addition to turning to adults for help (assertiveness training). During trials of adopting new behaviors, his internal conflicts concerning the loyalty and politeness to adults and the related disappointment became more intensive. The boy gradually became engaged in the role-play with his parents, his homeroom teacher, and his peers. Then his realized how much he feared rejection and loneliness. At this difficult moment, the therapeutic relationship became particularly important. At this stage, the boy revealed a strong need to tell imaginary stories about children who were forced to take care of adults. But the next sessions involving his mother helped him to confront his fears and once again to be found in the role of a child who can feel dependent on his parents. Planned interventions of the mother at school and discussions with the teacher and the boy's father helped him to restore the sense of justice. At that time, psychosomatic symptoms that initiated when starting a therapy gradually disappeared.

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Part IV

Special Settings and Populations

This part, *Special Settings and Populations*, includes eight chapters.

Chapter 17 joins the voices calling for the development of culturally relevant preventive mental health interventions, which are both practical and sustainable, in order to overcome disparities in mental health care services.

In a natural progression, Chapter 18 brings concepts of PPT, like the basic capacities or the model dimensions, as practical tools to work on the transcultural content behind the psychiatric and psychological symptoms.

Chapter 19 discusses Positive Interventions in Athletes/Sports.

In Chapter 20, Positive Psychotherapy for Families and Couples, the Balance Method, the 5-Stage Process, use of stories, and the Differentiation Analysis Inventory (DAI), all tools developed under Positive Psychotherapy (PPT) principles, are applied to work with couples and families.

Chapter 21, on Positive Pedagogy and Counselling, discusses the experience of bringing the skills and tools of Positive Psychotherapy to teachers in Bulgaria.

Chapter 22, Positive Group Therapy, applies the PPT's balance model and the five stages of treatment to groups with a case example of individuals with autism spectrum disorder.

Chapter 23, Positive Psychotherapy and Coaching in Organizations, brings the rich experience of combining PPT and coaching in corporate settings as the OPTIC approach: Organizational Positive Therapy and Integral Coaching.

Finally, Chapter 24 discusses the challenges and approaches to work with men in psychotherapy.

17 Culture and Minorities: Positive Psychology and Positive Psychiatry Perspectives

Gina Newsome Duncan and Rama Rao Gogineni

> My mission in life is not merely to survive, but to thrive; and to do so with some passion, some compassion, some humor and some style. –Maya Angelou

Introduction

Positive psychology is the study of positive emotion, positive character traits, and enabling institutions [12]. Over the past two decades, the field of positive psychology has grown substantially and shown great promise as a refreshing approach to the field of mental health care as well as fields such as education and business [1]. Positive psychiatry is closely allied with positive psychology and shares many overlapping constructs and aims [2]. New approaches to mental health care are greatly needed, as our society is increasingly faced with mental health crises that a pathology-focused approach has not been able to sufficiently address [3, 4].

As mental health clinicians, we should aspire to provide every individual we serve with skills, tools, and corrective emotional experiences that enable them to achieve optimal human functioning. Positive psychology, psychotherapy, and psychiatry add to our traditional mental health armamentarium by providing an understanding of the factors that enable people to flourish and providing tools to assess and build these individual strengths [2, 3, 12]. This chapter focuses on positive psychology and psychiatry. For positive psychotherapy approaches across different cultures, see Chap. 18.

Positive psychiatry as a science and practice aims to understand and promote well-being in individuals experiencing, or at risk of developing, mental or physical illness through assessments and interventions centered around positive psychosocial characteristics (PPCs) [2]. As outlined by Dilip Jeste and collaborators, positive psychosocial characteristics (PPCs) include traits such as resilience, optimism, social engagement, and spirituality, all of which have been associated with better health outcomes and subjective well-being [2]. As a branch of medicine, positive psychiatry also seeks to better understand the biological bases of such traits and to develop preventive psychosocial and biological mental health interventions [2].

In positive psychology theory, well-being, the experience of flow, and positive emotions such as happiness rest on foundational virtues and character strengths [4, 13]. Six virtues are considered

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to be universal to all cultures around the world: wisdom, courage, humanity, justice, temperance, and transcendence [4, 13]. Each virtue has several associated character strengths, making 24 character strengths in total [4, 13]. According to Peterson and Seligman (2006), each individual possesses all 24 character strengths but to varying degrees [13]. When individuals understand and operate from their character strengths, they experience subjective well-being [13].

Martin Seligman's PERMA theory describes five elements that contribute to well-being: positive emotion, engagement, relationships, meaning and purpose, and accomplishment [14]. Character strengths are the backbone of the PERMA theory [15]. When an individual knows and acts on their strengths, it leads to more positive emotion, more engagement, better relationships, a greater sense of meaning and purpose, and the opportunity to experience accomplishment [14, 15]. When all components of the PERMA model are being lived to the fullest, the result is *flourishing* [14, 15].

Therapeutic interventions based on positive psychology theory seek to increase positive emotion, engagement, and meaning and have shown benefit in the treatment of depression [16]. Positive psychotherapy (PPT) is a short-term humanistic form of psychodynamic psychotherapy developed by Dr. Nossrat Peseschkian that emphasizes activation of patients' innate therapeutic capacities. See Chap. 2 for a summary of Peseschkian's positive psychotherapy model [17, 18].

Cross-Cultural Applications of Positive Psychology and Psychiatry

Traditional models of care have been ineffective at fully reaching multicultural populations in the United States, and there are significant disparities in mental health care [5, 6]. Contributors to these disparities are barriers at the level of the individual, the community, and the health-care system and include pervasive issues of mistrust, stigma, systemic inequality, and a lack of clinicians of color [7, 19]. In their 2008 article, Sriwattanakomen et al. called for the development of culturally relevant preventive mental health interventions that are both practical and sustainable in order to overcome disparities in mental health-care services [7].

With its emphasis on strengths over deficits, and its core built on virtues shared by most cultures across the world [4], positive psychology can serve as an effective foundation for such interventions if applied in a culturally responsive manner. Unfortunately, to date there has been a relative paucity of studies exploring positive psychology constructs and interventions within populations of color [8]. But the mental health clinician seeking to provide positive psychology-oriented care in a culturally relevant manner need not lose heart. Studies done to date [20] and explorations of cross-cultural values and norms [8, 9, 21, 22] strongly suggest that positive psychology interventions (PPIs) have the potential to be applied in effective, culturally congruent ways. However, several issues affecting cross-cultural application of positive psychology and psychiatry should first be explored [9].

One issue is to recognize that in order to most effectively apply a positive psychology approach in multicultural contexts, it must be acknowledged that positive psychology itself arises from a specific cultural frame of reference (Western/European-American) [9]. As a result, it may not fully encompass the values and experiences of ethnic minority/non-Western cultures, most of which are fundamentally collectivistic rather than individualistic [9]. Collectivistic cultures are characterized by additional key positive values, strengths, and traits which complement those held by mainstream positive psychology [9, 8]. Collectivistic cultural values/strengths include social support, being other-focused rather than individually focused, and a central importance of spirituality and religion [8, 9, 23, 24]. An abundance of existing literature supports the significant role these key cultural elements play in supporting the mental health of people in collectivist cultures [8, 9, 23, 25, 26].

A second issue is to recognize that for many people of color in the United States, opportuni-

ties to truly flourish may be blocked by factors such as systemic discrimination, racial microaggressions, poverty, and limited educational opportunities [9, 27, 28]. Finally, a third issue is to understand that people of color in the United States often possess what Constantine and Sue (2006) describe as key *adaptive* strengths which are the direct result of their experiences as minorities living in and overcoming discrimination and adversity [9, 11].

Positive psychology and psychiatry interventions that (1) acknowledge the effects of historical and ongoing systemic inequality, (2) explore and emphasize collectivistic values, and (3) recognize key adaptive strengths have the potential to be powerful tools for cross-cultural mental health promotion [9, 11, 29]. Furthermore, helping people tap into and apply their individual and collective strengths with greater intentionality may empower individuals and their communities to further overcome the systemic barriers they have historically faced.

The Necessity of Self-Examination

Successfully implementing a culturally competent positive psychology or positive psychiatry approach in clinical care requires that the clinician not only has a solid understanding of core positive psychology and psychiatry concepts but also engages in self-examination around several key areas. The first area has to do with self-examination around the extent to which one, as a clinician, is truly coming from a strengths perspective and is committed to carrying it out in patient care [8].

Saleebey (1996) has written extensively on the strengths perspective and how it compels clinicians to look beyond the pall of adversity to truly see people in the full context of their abilities, ideals, and potential [30]. Positive psychology is inherently a strengths-based approach [4]. Much of the positive psychology literature to date has focused on understanding and developing personal character strengths in order to help individuals achieve well-being [8, 9, 12, 13, 31–33]. However, literature on the strengths perspective (which comes out of the field of social work) places additional emphasis on understanding, appreciating, and drawing upon the resources available in the broader community of which the individual is a part [30, 34]. This is of central importance in a discussion of positive psychology's applicability to the mental health care of people of color in the United States, particularly those who are from underserved or marginalized communities. For example, a patient from an underserved, marginalized minority community in the United States may not present with the measures of success many of us as clinicians are accustomed to associating with certain character strengths and which we can readily identify in our more affluent and better-educated patients, in our peers, and in ourselves. In some cases, this may be due to the individual not having had the opportunity to fully display character strengths such as *creativity, leadership, or love of learning* in ways that are easily identifiable, directly as a result of systemic barriers such as poverty, a poor quality of education, and discrimination [9, 8, 11].

The second area around which clinicians must examine themselves has to do with their commitment to cultural competence. The model of cultural competence in health-care delivery developed by Josepha Campinha-Bacote (2002) consists of five constructs:

1. Cultural awareness.
2. Cultural knowledge.
3. Cultural skill.
4. Cultural encounters.
5. Cultural desire [35].

While each of the five constructs is essential, we would like to highlight the construct of cultural desire in particular because it specifically speaks to the health-care clinician having an authentic passion to learn and grow from an understanding of cultural similarities, differences, and nuances [35]. In culturally competent care, the clinician makes a concerted effort early in the treatment relationship to learn about the patient's cultural orientation and religious/spiritual beliefs [35–38]. This means going beyond

knowing the "what" of the individual's culture or beliefs to understanding the "how." In other words, knowing that someone is Chinese American and that they are Buddhist is a "what" level of knowledge. A culturally competent clinician seeks to understand *how* those identities impact the person's perceptions of their strengths, their purpose in life, and what they see as the meaning behind their suffering or challenges. Clinicians cannot assume that they know the "how" even if they are familiar with the surface-level "what" [36, 37].

The third area around which clinicians must examine themselves is their ability to recognize the adaptive strengths possessed by minority groups in the United States and how these adaptive strengths contribute to individual and collective well-being [8, 9, 11]. Despite experiences of significant discrimination and oppression, people of color in the United States have demonstrated considerable ingenuity, drawing from their own unique cultural traditions—emphasizing family, community, and collectivist principles, using spiritual and religious perspectives to make meaning of adversity, and engaging in deliberate practices to instill ethnic identity and pride—to become resilient [19, 29, 39–41].

Resilience is the capacity to thrive in the face of significant adversity [42] and can be viewed as a particularly defining characteristic of the African American experience. While enduring the dehumanizing conditions of bondage over centuries, enslaved African Americans maintained a healthy sense of self-identity that enabled them to push for emancipation and never accept enslavement as a permanent reality. This same characteristic has been a central driving force behind the ongoing struggle for civil rights in the United States. Resilience for African Americans has been inseparable from their innate spirituality, rooted in African cultural tradition, and sustained and fostered by institutions such as the Black Church [43]. Constantine and Sue (2006) have discussed additional psychological adaptive strengths developed by people of color in the United States in order to navigate life in the face of discrimination and oppression [9, 11]. These include heightened perceptual wisdom, ability to rely on nonverbal and contextual meanings, and bicultural flexibility [9].

The fourth area of self-examination requires one to eschew notions of the superiority of one cultural frame of reference or belief system over another.

It is critical that clinicians are aware of the assumptions they bring into treatment with patients [34, 36, 38]. Clinicians must recognize that appraisals of strengths and optimal functioning based solely on one's own personal or cultural frame of reference can be deceptive [38]. As an example, for young adults in American society, moving out after graduating from college and building a career and family in a separate household from one's family of origin are generally expected and a sign of a successful "launch" [11]. If we were to consider young adults we know (whether in our personal or professional lives) who have successfully navigated this transition, it is likely that we could easily associate certain positive psychology character strengths with them (e.g., *zest, love of learning, self-regulation, judgment, and perseverance* to name a few). In my practice (Gina Duncan, MD), a generous subset of patients are young adults in their early to mid-20s who present with their parents with a chief concern that they have had a "failure to launch," because they are still living at home with their parents following unsuccessful attempts at going away to college or moving out on their own. This is a central concern for their parents and a source of depression, anxiety, and low self-esteem for them. By contrast, young adults from other cultural backgrounds, particularly immigrant communities in which interdependence is a central value, may experience the opposite expectation; they may be expected to remain at home and attend to family obligations while pursuing higher education and starting their career [11, 44]. When clinicians are unaware of the impact of their own cultural background, values, beliefs, and privilege, they can unknowingly pathologize the perspectives, behaviors, and beliefs of others [38]. The ADDRESSING model proposed by Dr. Pamela Hays (2008) provides an excellent

framework for examining the many dimensions of culture, including one's own cultural orientation, areas of bias, and privilege [38].

The final area of self-examination requires the clinician to acknowledge that in every clinical encounter, there are always two experts in the room [45]. The clinician possesses a level of expertise based on their training, but the patient is the expert when it comes to their own history, values, and preferences [45].

Stigma, Culture, and Mental Health

Though anti-stigma campaigns are showing effectiveness in raising awareness around mental health, stigma is an unfortunate but very real barrier to acknowledging mental illness and to seeking mental health treatment in many societies [2, 45]. In Western societies such as the United States, it is important to recognize that stigma can impact the mental health of minorities and persons of color in complex ways.

Constantine and Sue (2006) have discussed the circular and interconnected context in which many cultures view human behavior and its consequences [9]. Because many cultures are highly spiritual and view mental, physical, and spiritual health as interrelated, mental health problems may be perceived as having a spiritual origin [9, 8, 23, 26, 40, 43, 46, 47]. For example, symptoms of mania or psychosis may be interpreted as evidence that a malevolent spirit is at work, or the inner turmoil associated with anxiety and depression may be viewed as punishment for sins or as evidence of a lack of faith. As discussed by Pargament and Mahoney (2002), negative religious reframing can lead to negative experiences such as guilt, blame, and denigration [48]. Such experiences can further intensify emotional pain, increase stigma around mental illness, and decrease individuals' comfort with non-traditional forms of help-seeking [5, 7, 19]. The recovery literature has shown that mental health-care clinicians also contribute to stigmatizing experiences for persons receiving mental health services [45]. This has largely been related to clinicians' use of stigmatizing language and labels that convey a sense of the person being defined by their illness [45].

Positive Psychology Interventions (PPIs)

Positive psychology interventions (PPIs) are intentional activities designed to increase subjective well-being by inducing positive affect, thoughts, and behaviors and by minimizing negative affect [33] [49]. They may be used in the context of psychotherapy to supplement traditional interventions or as self-help strategies [10]. Frequently discussed PPIs include the *Gratitude visit, Three good things in life, You at your best, Using signature strengths in a new way,* and *Identifying signature strengths*.

Seligman et al.'s 2005 study of positive psychology interventions is a helpful study to highlight [10]. The authors conducted a 6-group, random assignment, placebo-controlled Internet study of 577 adults. They found that individuals who experience the greatest life satisfaction are those who orient their life pursuits toward engagement, meaning, and the experience of positive emotion, with the greatest weight being carried by engagement and meaning [10]. Participants were randomly assigned to one of five happiness exercises, the *Gratitude visit*, *Three good things in life*, *You at your best, Using signature strengths in a new way,* and *Identifying signature strengths*, or one placebo-controlled exercise: *Early memories* [10]. Participants were, on average, mildly depressed based on baseline CES-D (Center for Epidemiological Studies-Depression Scale) scores [10].

In the *Using signature strengths in a new way* exercise, participants were asked to take a strengths inventory at www.authentichappiness.org and to then use one of their "signature" strengths daily for 1 week in novel and unique ways [10]. In the *Three good things in life* exercise, participants were asked to make a nightly practice of writing down three things that went well that day and the reason [10]. In the *Gratitude*

visit, participants were asked to write and then hand-deliver a letter expressing thanks to someone who had been particularly kind to them [10].

While the *Gratitude visit* was shown to induce positive changes for 1 month, *Using signature strengths in a new way* and *Three good things in life* were found to increase happiness and decrease depressive symptoms for 6 months [10]. Participants who continued to practice the exercises demonstrated the most significant benefit in terms of improved happiness scores [10].

While the study itself provides very helpful information on how positive psychology interventions (PPIs) might be implemented, a primary limitation of the study is that the sample was predominantly White, well-educated, and financially well-off [10]. This makes direct generalizability to minority, lower-income, and less educated populations difficult [10].

Though not directly focused on cross-cultural applications of positive psychology, Sin and Lyubomirsky's 2009 meta-analysis is also a helpful study to highlight because their findings encourage broad use of PPIs in depressed and non-depressed patients and because they speak to the importance of designing culturally relevant PPIs [20]. In the meta-analysis, the authors examined 49 PPI studies across 4266 individuals [20]. They found that PPIs significantly enhance well-being and are effective for treating depressive symptoms [20]. Therefore, they recommend that PPIs be implemented broadly in the treatment of patients in general, including those who are currently depressed or experiencing residual depressive symptoms, those who have recovered from a depressive episode, and those who are euthymic, as both depressed and non-depressed patients are likely to benefit from these strategies [20].

Furthermore, they provide three helpful suggestions for clinical practice:

1. Patients should be encouraged to maintain regular practice of their PPIs and keep a record of them so as to turn them into habits [20].
2. Practicing multiple different PPIs may be more beneficial than engaging in only one activity [20].
3. It is imperative that clinicians take into account a patient's cultural background when implementing PPIs, as members of collectivist cultures may benefit more from PPIs that are focused on others (e.g., acts of service) rather than focused on self (e.g., reflecting on personal strengths) [20].

Specific Applications and Clinical Examples

In keeping with Seligman et al. (2005), we recommend that clinicians think in terms of enhancing patients' experiences on each dimension of the *PERMA* (*Positive emotion, Engagement, Relationships, Meaning and purpose, Accomplishment*) model [10], working to engage the patient in identifying activities that are of greatest relevance to their cultural and spiritual perspective [20]. As an example, for an African American Christian patient, increased church involvement may provide a prime opportunity to enhance the dimensions of PERMA. Participating in corporate worship, prayer, and Bible study groups can enhance connectivity with others and increase social support by strengthening established relationships and fostering the development of new ones [50]. Such activities can also enable individuals to share their struggles and celebrate their successes with others and to see that they are not alone. Engaging in church missions such as a clothing drive, soup kitchen, or homeless ministry may help promote further engagement with the community and a sense of accomplishment. Furthermore, providing acts of service to those who are less fortunate may help to foster feelings of gratitude, as such activities often cause us to reflect on the blessings and resources we have. Participating in corporate prayer, praise, and worship and listening to sermonic messages may also help to reinforce a sense of subjective well-being from a spiritual standpoint by allowing individuals to reflect on the struggles they have had in the past and the ways in which God has provided for them [C.G. Newsome, Ph.D., personal

communication]. Such experiences can enable individuals to derive a sense of meaning from their struggles.

Patients who are not religious may still benefit from exploring and connecting with their own innate sense of spirituality by taking inventory of the activities they engage in that promote a sense of purpose and oneness with nature, with others, and/or with a Higher Power [8]. For some patients in minority communities, civic engagement and working toward issues of social justice may be a central way to enhance connectedness, meaning, and purpose. Such activities may help to offset the challenges associated with being in a marginalized group by building a sense of empowerment.

Clinical Example #1

D.L. is an African American woman in her 50s who has been disabled for the past decade due to mental illness. Her personal struggles have included economic stressors, domestic violence, a chronically ill family member for whom she is a primary caretaker, and exacerbations of her own physical and mental illnesses. Despite this, she is a very active member of her community. She manages her own mental health struggles in part by being deeply involved in the community as a foster parent and neighborhood watch leader, attending city council meetings, and participating in voter registration efforts.

Engaging in community activities that help to celebrate and educate others on one's culture may also be beneficial. Such activities could include being involved in programs where younger members of the community are educated on their history and heritage. Doing so provides the patient the opportunity to build relationships with others, to "give back" in a meaningful and purposeful way by building the ethnic pride and identity of the next generation, and to reinforce their own sense of ethnic pride [8]. Such activities may help to promote subjective well-being and positive emotions individually as well as collectively.

Clinical Example #2

C.B. is a middle-aged woman and first-generation American who is the daughter of immigrants from Central America. Her family history is significant for severe mental illness, alcohol dependence, and domestic violence. Despite the patient's own mental illness, and despite financial limitations, she tirelessly serves in her local church helping other immigrant families and participating in local cultural festivals that allow her to showcase her heritage and the strengths of her community. She views her community and church engagement as part of her therapeutic process as well as her Christian duty.

As in Clinical Example #1, engaging in community activities, especially same-ethnic community activities, can promote subjective well-being and positive emotions, and this is sometimes hard for the children of immigrants who may live "in between worlds." Religious institutions can be instrumental in providing a space for this engagement and connection.

Clinical Implementation of Culturally Relevant Positive Psychology Interventions (PPIs)

Step 1 Detailed Psychosocial History Including Cultural History, Religious/Spiritual Beliefs, and Strengths Inventory

Effective treatment rests on the foundation of a solid rapport and trust between the patient and clinician. We recommend beginning treatment with a detailed psychosocial history. Doing so allows you to familiarize yourself with the patient's experience and the ways in which their cultural background, religious/spiritual perspectives, and other experiences have influenced their health beliefs [38]. We recommend taking your time in gathering this history and explaining to the patient why you are taking this approach. For example, you might state: "In order for me to best help you, it is important for me to have a good

understanding of who you are as a person and the different experiences and influences that have shaped who you are today."

We recommend that the initial assessment of strengths be approached in a less formal way and be incorporated as part of the initial process of building rapport and gathering history. In our experience, patients who are very depressed or demoralized are likely to have significant difficulty identifying positive traits in themselves. A critical role of the clinician in this scenario is to help the individual move into a healthier frame of mind by reflecting back to them the positive traits we see in them. We cannot do this in an authentic way if we have not gotten to know the patient as a whole person or established an effective rapport. Xie (2013) has outlined practical strategies for approaching an initial strengths assessment in a therapeutic encounter [34]. In particular, Xie notes that if the individual is having difficulty identifying their strengths, informal conversation with general questions about their hobbies, activities they enjoy, or how they have gotten through acute phases of their illness in the past can be illuminating [34].

In addition to gathering details of the patient's family history and significant experiences of childhood and early adulthood, we recommend devoting attention specifically to an exploration of their unique cultural background and heritage. This process enables the clinician to gain insight into the patient's cultural norms and the extent to which they identify with collectivistic vs. individualistic values [8, 34, 38]. Invite the patient to be curious with you as you engage in this exploratory process, paying particular attention to personal and collective cultural narratives of overcoming adversity. Doing so may have therapeutic benefit and enhance well-being by providing inspiration and meaning [30]. Lopez et al. (2009) have noted that leading a patient through an exploration of their cultural background has been shown to promote the development of self-esteem in Asian-American, African American, and Hispanic adolescents [8]. For many people of color, identifying with the struggles of ancestors who overcame adversity instills a sense of pride and can be another source of strength, encouraging them that they, too, can meet the obstacles they face.

Finally, it is important to explore with the patient their own sense of spirituality and their religious beliefs [8]. This entails going beyond screening-level questions which ask simply whether faith or spirituality are important to the individual or whether they use prayer as a coping strategy. Go further by engaging the patient in a discussion of what they believe the meaning of their struggle is. If approached in a sensitive manner, this can initiate a helpful dialog leading to deeper understanding for both the patient and the clinician. Questions such as "Why do you think you are going through this?", "What do you believe God is trying to show you through this experience?", and "Could you say more about the ways in which you feel your faith supports you?" are examples. The goal is to get the patient connecting more deeply to their beliefs and, if they have not previously been spiritually in tune, to open an opportunity for them to explore their intrinsic spirituality.

Key Questions to Explore a Patient's Faith on a Deeper Level

- Why do you think you are going through this experience?
- What do you believe God is trying to show you through this experience?
- Could you say more about the ways in which you feel your faith supports you?

Following the detailed psychosocial history or concurrent with it, the patient can be directed to a resource such as the VIA Survey of Character Strengths and other questionnaires at www.authentichappiness.org [51]. The results of the surveys as well as the information gathered from the psychosocial history can then serve as the foundation for the development of individualized PPIs.

Step 2 Design Culturally Relevant PPIs with the Patient

Once the psychosocial history and survey of strengths is completed, we recommend reviewing with the patient all strengths and observations that have emerged during the assessment. Then, in concert with other necessary therapeutic interventions (e.g., medication and additional psychotherapeutic techniques as appropriate), assist the patient in designing PPIs that are in sync with their unique cultural identity, spiritual frame of reference, and personal goals. Xie (2013) notes that this can require a shift for the clinician, who may be accustomed to designing treatment interventions based on what the clinician perceives to be most important [34]. However, this is very much in keeping with the concept of shared decision-making [45].

Cultural celebrations can provide helpful material for the development of unique, culturally relevant PPIs. For example, the African American celebration of Kwanzaa provides a look at a culturally specific practice that naturally incorporates a number of strategies used in positive psychology. Kwanzaa is an African American cultural holiday celebrating African cultural heritage by highlighting seven cultural principles or *Nguzo Saba* [52]:

1. *Umoja* (unity).
2. *Kujichagulia* (self-determination).
3. *Ujima* (collective work and responsibility).
4. *Ujamaa* (cooperative economics).
5. *Nia* (purpose).
6. *Kuumba* (creativity).
7. *Imani* (faith) [52].

During the Kwanzaa holiday (December 26–January 1), families and communities come together and spend time reflecting on the principle of the day, giving thanks to the ancestors for their examples of perseverance, expressing gratitude to one another for mutual support and enrichment, and identifying new ways in which one can exemplify each Kwanzaa principle in one's own life. African American patients may derive significant benefit from engaging in positive psychology activities using Kwanzaa as a frame of reference. Such an exploration need not be confined to the actual Kwanzaa holiday. While the specific practice of Kwanzaa may resonate most with people of African cultural heritage, patients of other cultural backgrounds may have similar celebrations around which they could build their own culturally relevant positive psychology practices.

Summary

In conclusion, as mental health clinicians, our goal should be to provide every individual we serve with skills, tools, and corrective emotional experiences that enable them to achieve optimal human functioning. This is achieved by not only addressing their areas of deficit but also building up their strengths [4, 12, 30]. Also of central importance is self-reflection on the part of the clinician and a commitment to cultural competence [35, 38]. A positive psychology and psychiatry approach emphasizing and supporting adaptive strengths [9] and collectivist values in addition to the core constructs outlined by Seligman et al. (2005) holds great promise as a way to help address the mental health needs of multicultural populations and enable the provision of high-quality, culturally competent care [9–11].

This is of particular importance given the barriers minorities in the United States experience in accessing mental health-care services [5–7, 19]. Sriwattanakomen (2008) has outlined the necessary strategies to circumvent disparities in mental health care [7]. Further exploration into ways that positive psychology, psychotherapy, and psychiatry strategies can be incorporated into clinical care, community-based participatory research (CBPR) interventions, outreach programs, and community psychoeducation is essential [20].

Key Points

- Positive psychology, psychiatry, and psychotherapy add to our traditional mental health armamentarium by providing an understanding of the factors that enable people to flourish and by providing tools to assess and build individual strengths [2, 3, 12].
- Positive psychology's applicability to multicultural populations has been understudied. Yet, because its core constructs center on virtues shared by most cultures across the world [4] and because it emphasizes strengths over deficits, positive psychology has the potential to serve as a powerful foundation for high quality, culturally relevant mental health interventions.
- Successfully implementing a culturally competent positive psychology approach in clinical care requires the provider to engage in self-examination around 5 key areas:
  1. Commitment to a strengths perspective in patient care [8, 30].
  2. Commitment to the five constructs of cultural competence [35].
  3. Ability to recognize, appreciate, and affirm the adaptive strengths [9] possessed by patients from marginalized communities.
  4. Commitment to eschew notions of the superiority of one cultural frame of reference or belief system over another.
  5. Commitment to shared decision-making [45].
- Positive psychology interventions that (1) acknowledge the effects of historical and ongoing systemic inequality, (2) explore and emphasize collectivistic values, and (3) recognize key adaptive strengths [9] have the potential to be powerful tools for cross-cultural mental health promotion [9, 11, 29].

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18 Positive Psychotherapy in Different Cultures

Enver Çesko and Ebru Çakıcı

Positive Psychotherapy and Transcultural Encounters

In the past, the majority of people lived in the same city in which they were born, but today, people can easily move from one city to another and even to different countries. Migration occurs for many different reasons around the world; some move to improve their lifestyles, whereas others seek better economic conditions, education or migrate for certain political reasons. A transcultural meeting between two individuals is more possible today than it ever has been in history. This is why a transcultural understanding of clients is vital in therapeutic practice. In psychotherapy, transcultural issues are important to understand the client's point of view and what he really suffers from. Without this understanding, the therapist may make the wrong assessment and apply an unsuitable approach. However, it is also essential for the client to understand the transcultural issues related to his/her own life events. The tools and concepts of PPT help the client to gain an insight into the transcultural issues of his life more easily.

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Whereas physical complaints are regarded as focal illness in many Western cultures, by trying to investigate physical symptoms, in Eastern cultures, the problem can be understood by explaining the real reason for the causes of particular physical complaints. One client explained how he had to seek medical assistance for stomach pains after dinner at a friend's house. During the dinner he was repeatedly invited by the host to take more food and, not to be rude, he felt obliged to accept each time. From the traditional perspective of the host, it is expected to serve more food than required to show his respect and readiness to entertain his guest. From the different cultural point of view of the client, the politeness of the guest requires him not to leave food on the plate to show his appreciation of the host. As a result of his loyalty to his friend and his politeness, he suffered from a stomachache and had to go to the emergency room. In PPT, this situation can be understood by explaining the meaning of loyalty and politeness. The matter is how both sides understand cultural habits in terms of time, environment, and between people to avoid misunderstandings.

In PPT, capacities represent expressive behaviors in terms of how people act in certain situations, with certain people and at certain times. Both primary and secondary capacities develop from early childhood as a result of internal and external influences of the family and subsequently become a social part of the community

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trying to adapt to the norms, regulations, and patterns in society. By accepting and reacting according to the social norms, an individual has to balance his/her developed primary capacities from the family environment in social encounters. Often, this process of transformation from the narrow family, usually from the traditional patterns passed through different generations, makes it difficult to invest in and be accepted in new social and community environments. These difficulties create problems and misunderstandings, meaning that these conflicts first need to be understood and then solved [5].

Transcultural understanding includes ethnological, cultural, anthropological, and sociopolitical aspects of social development. Research has shown how ethno-psychotherapy [2, 7, 9, 11, 12] has an important impact on the success of the treatment process, whereas anthropological [27] studies have shown how the focus is on the cultural elements to achieve a greater understanding of social and human development. PPT considers all of these aspects from a transcultural perspective; it is important to understand the whole process from the beginning, in terms of how it was, how it is, and how it should be.

Interaction in PPT starts from the stage of attachment, when the therapist and patient meet each other and begin to understand each other through the presentation of complaints and needs, to the differentiation where they can work differently by using their own capacities, skills, and opportunities to achieve results. In this move from the starting point (attachment) to the stage of differentiation, which challenges the patient's own capacities for better results, the patient is becoming aware of his/her suppressed or unused capacities that he/she may activate to achieve successes in life, to reach new goals (detachment), and to become independent, helping not only him/herself but also to be an adviser for others.

How Positive Psychotherapy Started in Different Cultures "from West to East"

We are living in a time in which many transitions in living conditions are taking place. Today, the problems surrounding refugees and migrants are influencing the basic needs of human beings, such as food, environment, relations, and contacts, in addition to global health policies. The movement from one place to another presents different challenges in terms of cross-cultural adaptations.

Positive psychotherapy, with its broad consideration of different methods, techniques, and principles, is very suitable for different cultural environments. For this reason, the founder of PPT, Nossrat Peseschkian [21], first started his "journey" in his own clinic in Wiesbaden, Germany, working with patients from different cultures, using the stories from his cultural background and very often also presenting them to the patients from Western cultures. He also noticed that the patients from Western cultures found his storytelling to be beneficial, in addition to the patients from Eastern cultures.

As a result of his interest in developing PPT in other countries, Peseschkian started his journey by giving seminars, workshops, and international training programs in more than 68 countries.

Subsequently, his colleagues and co-workers continued to spread and develop PPT in their own and other countries. Many positive psychotherapists not only started to apply PPT with their clients in their own countries, but organized different kinds of training programs that promoted PPT as a transcultural and psychodynamic approach.

The application of PPT in different cultures has been examined and described in various publications [4–6, 8, 10, 13–15, 16, 25].

Positive Psychotherapy and Its Application in Different Transcultural Communities

Peseschkian grew up in Iran and had his medical education and practice in Germany. The transcultural situation in his own life helped Peseschkian to realize how psychosocial norms and capacities are important in socialization and interpersonal conflicts. Actual capacities are the behavioral patterns. Actual capacities are contents of education and they are taught to the children according to the needs of society ([19], pp. 45). Peseschkian emphasizes society to be the chief transmitter of

the norms by which we appraise certain behaviors ([19], pp. 105). For example, in an industrialized culture, more emphasis may be placed on secondary (behavioral) capacities such as punctuality and orderliness, whereas primary (emotional) capacities may be neglected. In one culture, a child who obeys his parents without discussing the meaning of their rules may be perceived to have a good attitude, whereas in another culture a child who questions what he is told might be appreciated. A young man who gives up a relationship with his girlfriend as his family does not approve may be perceived to have dependent personality features in a more individualistic culture, but in more collectivist cultures it is very important to get approval for marriage from the family, and this might be what he should do.

Actual capacities develop in a *certain situation* and at a *point in time*. During the psychotherapy of a university student, it was revealed that being successful at school, obtaining a scholarship and not becoming a financial burden to the family were particularly important for her. Her family had been forced to migrate during the war in Cyprus in 1974, causing them to leave all their possessions and they experienced financial difficulties in the place in which they settled. However, about 40 years after the war, at the time she was attending university, her family had already succeeded in recovering from these financial problems, although she remained very careful about her expenses. Even though times had changed and they had a better financial situation, frugality was still very important, and this created significant amounts of stress for her. To understand the function of an actual capacity. It is important to understand the context and time in which it was developed and sometimes this might be related to previous generations.

Standards may also change over time, which causes intergenerational conflicts. Today, the parents of many adolescents complain about how much time their teens spend on computer games on the internet, which has similarities to the complaints made by parents 30 years ago about how much time their teenagers spent watching TV and talking on the phone. If the grandparents engage in the raising of their grandchildren, conflicts can frequently emerge between the parents who follow the current guidelines from pediatricians about how to feed and look after the baby and the grandparents who believe that the best method is the one they used many years ago to look after their own children. As Peseschkian says, the antidote to overcoming intergenerational conflicts may be to learn how to unite the past, present, and future ([19], pp. 112).

In his book "Positive Psychotherapy in Psychosomatics Medicine" [24], Peseschkian demonstrated how two essential aspects of human nature, the concept of body and mind, can be unified. The method of his paradigm is that these two concepts can work together and share common factors by influencing each other. In the field of psychosomatic medicine, body and mind (sometimes identified as the soul), are always working in tandem, because the words *"psych-o"* and *"soma-tic"* are related to the mind and body. Furthermore, this work demonstrates that human beings are good by nature, and that all individuals have the power and capacity to take care of their own wellbeing. For this reason, he believed that a person, with his or her cognitive and spiritual being, has an unlimited capacity to reach his or her goals. All difficulties, disorders, illnesses, and problems, even aspects of the mind, manifest through psychosomatic symptoms, usually starting in the body and explained through the mind (cognitive expression).

Many examples presented in the book [24], show how a variety of disorders may be treated from the transcultural aspects through the use of different tools that patients from both Western and Eastern cultures can easily understand and accept.

The personal experiences of trainers working in Eastern and Western Europe, the Middle East, the Balkan countries, African cultures, and in America show that PPT is very warmly and closely accepted because of its wide semi-structured methodology in creating the relationship between the client and therapist. For example, using stories all the time and without any exceptions had a special stimulus when attempting to find similar solutions, as this allowed the clients to solve actual problems, difficulties, and symptoms. The therapist presents a different concept via the story, which gives the patient an alternative way of understanding or solving his/her problem. Identification with this

new point of view enables the patient to get a better understanding about his/her situation and a different way of coping with the problem ([17], pp. 264).

Positive psychotherapy offers a transcultural perspective in the form of stories, proverbs, myths, and fables in which the client/patient may recognize him/herself in "allegorical terms," and is therefore able to establish a new relationship between the messages received from the story and his/her actual complaints. Stories are predominantly used during the psychotherapy sessions for two reasons: one is to stimulate the patient's creativity and self-awareness to find similarities between the patient's life story and the story being told; and the second is that the patient can use the ideas taken from the message story to solve his/her own problems. Also, the stories are very powerful for reflecting the reader's own situation in psychotherapy education settings as a method of self-exploration and self-discovery with the students [20].

The use of three principles known as

1. The Principle of Hope, with a positive interpretation of actual complaints
2. The Principle of the Balance Model, as meta theory in making the awareness of human capacities
3. The Principle of five stages in therapeutic treatment

enable PPT to be adapted to different cultures without difficulties.

The *model dimensions* of PPT help to clarify the concepts that are valid in the family of origin. The individual's attitude toward him/herself, expectations in romantic relationships, the way of making contact with others, and his world view are all shaped through his experiences with others who serve as models. During the sessions of a couple who applied for marital counseling, the wife complained about her husband's indifference. She claimed that he would never make a comment about her clothes, friends or activities. The man was surprised to hear this. When the model dimensions of each were discussed, the couple could see that they were both from conservative families in which the father was the dominant figure. As a child, the husband always believed his father interfered too much with his mother and disturbed her with his endless comments about what she should or should not do. As a small child, he promised himself that he would never act like his father when he became a husband. He never made a comment about his wife's clothes, friends or hobbies as he believed she had the right to choose them herself. The wife talked about her parents' relationship in an idealized way, as a loving relationship. The father had been very concerned about his wife, would buy her clothes himself, and they would spend much of their time together. Her father had died when she was 12. She had an idealized view about her father and her parents' relationship, although it sounded very oppressive.

Another tool of PPT is the concept of the *family tree*. The concepts of the family are not only formed by the family members' experiences but also from the experiences of the past generations and political and philosophical traditions of the family. These concepts shape the rules of our way of life, our interaction with others, and the way in which we attempt to resolve conflicts. Peseschkian suggests that to understand a family's situation, the therapist should learn about the situation of the parents' family of origin ([17], pp. 300).

Developing an understanding about the content of his/her conflict enables the patient to solve his problems or be less affected by them. The patient becomes a therapist for himself and for others around him.

Transcultural Concepts in Positive Psychotherapy in Comparison with Other Psychotherapy Modalities

As PPT belongs to the psychodynamic and humanistic approach, one of the goals of therapy is the remission of symptoms, where the success of treatment is not only based on relieving the symptoms but also on fostering the positive presence of psychological capacities and resources [26]. As stated above, the founder of positive psy-

chotherapy, Nossrat Peseschkian, was originally from Iran and moved to Germany to started work as a neurologist, psychiatrist, and psychotherapist. He used concepts derived from Eastern culture and applied them to his patients from Western cultures. He was inspired in the 1960s and 1970s by his personal contacts with eminent personalities in the fields of humanistic psychology, psychiatry, and psychotherapy, such as Victor Frankl, Jacob L. Moreno, Raymond Battegay, Gaetano Benedetti, Heinrich Meng, and others.

Compared with other psychotherapeutic methods, where the core focus is on analytical and behavioral drivers that can be interpreted as different stimulus responses of individual reactions (psychoanalytical and behavioral approaches), PPT focuses on understanding and increasing the awareness of personal capacities and how they are developed in relationships with family and the social environment [17].

"For its part, positive psychotherapy defends the view that environmental influences continually affect the individual, and that prior experiences, in the sense of micro traumas, form the frame of reference for subsequent experiences. Not only early childhood but each and every period of development has psychological effects" ([17], pp. 379).

As a meta-theory, PPT sometimes uses techniques and tools of other psychotherapeutic schools, such as behavior therapy, individual psychology, analytical psychology, logotherapy, gestalt therapy, primal therapy, transactional analysis, at the same time, PPT is a wider concept. As *logotherapy* emphasizes the meaning of life, PPT includes logotherapeutic elements at different stages of treatment and actual capacities. From *gestalt therapy*, in which the focus is on the solution of present problems, PPT uses "actual capacities and experiences that a person has had within his environment" ([17], pp. 396).

The fundamental concepts that *psychoanalysis* include, i.e., the role of the unconscious and the structure of Id, Ego, and Superego, are also common in the majority of other approaches. PPT combines these three concepts with four aspects of life using the balance model (body, achievement, contacts, future), the model dimension (I, You, We, and Primary We) and three levels of interaction in therapeutic relationship (attachment, differentiation, and detachment).

In *behavioral therapy*, symptoms are treated by changing behaviors. PPT underlines the role of actual capacities, where patients are using the tool DAI to have a broader clinical profile and identifying the conflicts between partners.

Transactional analysis uses three ego states (parental, adult, and child) as the interaction between two persons, whereas PPT considers these three ego states, especially in group family therapy and the context of situational encouragement.

As a psychodynamic and humanistic approach, many other schools and modalities can be integrated into the PPT treatment system. "Positive psychotherapy itself is not to be understood as an exclusive system, but rather attributes a particular value to each of the values of psychotherapeutic methods. Therefore, psychoanalytic, depth psychology, behavioral therapy, group therapy, hypnotherapy, psychopharmacology, and physiotherapy are considered. Positive psychotherapy thus represents an integral method in the sense of a multidimensional therapy" ([17], pp. 400).

Individual lifestyle and acting patterns in daily life in terms of various concepts, habits, behaviors and achievements, produce many conflicts—often as a result of extreme forms of different kinds of orientations that are associated with individual capacities.

Therefore, the transcultural approach is like "a red thread" in the psychotherapy process, "because the transcultural aspect also offers material to understand the individual conflicts" ([22], pp. 102) between the client and society, and all other significant aspects in life.

Positive and Transcultural Psychotherapy and Global Development

Today, we are living in very unpredictable, stressful, and insecure environments, which can make it a challenge to reach our life goals. The

time in which we are living is witnessing constant developments in terms of science and technology, associated with extreme materialistic aspirations. A large proportion of people in society consider themselves to be believers who are utilizing spirituality as important aspects of their lifestyles. Clients and therapists often have considerable differences in their views, concepts, habits, and behaviors, and how they approach problems, difficulties, disorders, and diseases. Usually, one side in this process is not enough in consideration of the cultural background of the other side.

Good psychotherapy requires proper understanding of the patient's culture. The cultural norms of the patient, his/her religious beliefs, concepts of disease, ways of expressing emotions, language, attitudes, and social norms should be considered to understand the patient [1].

Positive psychotherapy is based on a psychodynamic and humanistic approach that gives emphasis to transcultural issues. It is a resource-oriented and conflict-centered method where symptoms are unsolved conflicts derived from the past, usually from childhood. In PPT, the term "positive" comes from the Latin word "positum," which means factual and given; and allows the therapist to see the client as a whole personality, where he/she is able to manage the problems, challenges, disorders, and diseases [18]. The basic concepts of PPT can be phrased in everyday language and this makes it easy to be understood by different cultures, ethnic groups, and communities during the therapeutic process in the relationship between the therapist and patient. Transcultural psychotherapy with its basic concepts provides a framework of the psychotherapeutic process, where communication between therapist and client with different cultural entities can be promoted.

If a therapist originates from a traditional and religious background, when contacting, lecturing, presenting, and introducing the basic concepts either for students or for clients, he has to respect and accept all existing different cultural norms.

When a person from Eastern culture meets a friend from Western culture, and if his friend asks, "*How are you?"* he will not feel good, because he is not also asked about his family. This is because, from his perspective, family is more important than the person alone. But, if he meets a friend from Western culture, and asks, *"How are you?"* the question automatically elicits the reply; *"Fine, thanks. And you?"*

This shows how different cultural values and norms assess different reactions and behaviors from people who assign importance to different concepts and norms. For one person, how he or she is developing with regard to career and body, physical form might be important (usually for Western cultures); for somebody else, the relationship, contacts, and spiritual values might have more importance (usually in Eastern cultures).

Social changes are rapidly moving from one extreme to another. This rapid change is perceived consciously only to a limited degree [17], and the norms and goals of yesterday may suddenly become questionable and a burden today. One of the most stressful challenges during the last 20 years has been trying to maintain this balance.

The world is facing increased population growth, which is becoming one of the greatest challenges in society, creating problems in terms of food, socioeconomic forces, migrants and refugees, terrorism, etc. This creates the problem of urbanization as an indirect result of the population growth, as a result of migrant and refugee movements in the search for better socioeconomic conditions. The problem of urbanization brings new influences in the division of labor, where mankind is moving from differentiation to specialization in the sense that roles are constantly changing. This might be observed more easily in cultures that are still in political and sociological transition, and trying to find a real identity. Many families under the influence of global changes are attempting to find a new identity by losing their traditional family structures. And finally, Peseschkian points out that these changes make many national, ethnic, and cultural groups have more contact with outside groups today. This may

create new possibilities and new transcultural problems [17].

Peseschkian identifies different values and norms, not only between people from different cultures, but also between parents and children (intergenerational conflicts), between marriage partners, and among members of other groups. A transcultural way of thinking must consider not only the major cultures, but also the subcultures, which have their own standards. People tend to forget that there are norms and values other than their own and this causes misunderstandings ([23], pp. 49–51). When two people get married, even if they are from the same village, living on the same street, this is still the meeting of two different cultures. Each family has its own way of living. In one family, dinner should be eaten at the same time and with the whole family sitting at the dinner table, whereas in the family of origin of the other spouse, dinner might be eaten by the family members separately at different times. Actual capacities may be the source of misunderstandings. If "punctuality" is very important for one family, the spouse who comes home late for dinner may be perceived as disrespectful. Or, if "contact" is very important, it might be perceived as rude if the other family members do not wait for each other to eat dinner. Patience and contact become more important virtues than punctuality.

Case Example

A couple had applied for marital therapy. The main complaint of the woman was her husband's unceasing financial support for his family of origin. The husband was the eldest son of the family and he would provide financial support to his brothers and sisters. His wife had accepted her husband helping his siblings during their education and marriage, but even though they were now adults, they would still ask for help when buying a house or starting a new job. She believed that the siblings were manipulating her husband. The discomfort of the woman was obvious; she wanted the family budget to be used for themselves and for their children's needs. From the husband's perspective, he was not being deceived by his siblings, but his decision to support them was his choice. During the therapy, it was understood that his sacrifices were rewarded with respect and occupying the dominant position of the father of the extended family. The man wanted to remain a part of his extended family and the woman wanted to be a nuclear family. Both family types have their advantages and disadvantages. An extended family provides affection and protection, but also demands integration and contact ([23], pp. 56).

Psychotherapeutic treatment must be chosen on the basis of client's cultural background to be able to help the patient with the aspects of cultural adjustment. It is important for modern psychotherapists who are working in mixed ethnicities and with different cultural backgrounds to know the qualities necessary for culturally competent psychotherapy. The modern psychotherapist needs to develop special qualities such as *cultural sensitivity*, *cultural knowledge*, *cultural empathy*, and *cultural insight* [3].

Therefore, in general, positive and transcultural psychotherapy have to deal with two main questions, which are important for maintaining the harmonious connection between different cultures: the first is *What do all people have in common,* and the second is, *How do they differ*? This can be better understood if human beings are aware of and able to accept the similarities where they can meet, but not when they are far from each other. Different worlds of traditions clash because of their diverse content and goal projections and the question always arises: how well can these worlds harmonize under the new conditions? [22].

Conclusion

Positive psychotherapy is based on a psychodynamic and humanistic approach that places emphasis on transcultural issues. The cultural point of view of the individual affects how he/she appraises certain behaviors and events in his/her life. Sometimes, in interaction among themselves, people tend to forget that different norms and values other than their own exist and this causes misunderstandings and conflicts.

The meeting of the client and the therapist is also a transcultural encounter. The therapist should gain a good understanding of the client's cultural background to make an accurate assessment and an effective therapy plan.

It is also essential for the client to understand the transcultural content behind the symptoms and interpersonal conflicts. Concepts of PPT can be phrased in everyday language and provide practical tools in the therapy process. Investigating one's actual capacities, model dimensions, and family concepts helps the client to understand what is underpinning the conflicts.

Being aware of their own capacities, the patient and therapist, in PPT settings, explore common elements why conflicts, problems, and illnesses occur at certain times, in certain environments, and in the body. Case vignettes are given within the text to clarify how these are used in practice.

Different values may exist, not only between people from different cultures but also between parents and children (intergenerational conflicts) or between partners. A transcultural perspective helps understanding of not only interpersonal problems but also relations among people in different cultural communities. Positive and transcultural psychotherapy are dealing with the operationalization of two sides: the Eastern and the Western approach, which are both important for maintaining a harmonious connection between different cultures. This is especially relevant in the world today.

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Positive Sports Psychiatry

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Francis Aguilar and Garrett Rossi

Introduction

As physicians, our essential role is to identify health disparities and at most levels meet our patients at the point of tertiary treatment. The specialty of psychiatry embraces and executes medical decisions based on a model that evaluates a patient's biopsychosocial formulation in order to manage and treat psychopathologies. The implementation of positive psychiatry focuses on well-being through a variety of methods. Positive psychiatry seeks to understand well-being and how to identify and enhance overall health through biological, psychological, behavioral, and psychosocial interventions. Its applications extend past recognizing overall well-being and can be implemented to identify performance enhancement. An area where the principles of positive psychiatry may be of value is the emerging field of sports psychiatry. Sports psychiatry aims to deliver and optimize psychiatric care for athletes of all levels. This specialized field looks to identify psychological traits (resilience, optimism, personal mastery and coping self-efficacy, social engagement, spirituality and religiosity, and wisdom including compassion) and environmental factors (family dynamics, social support, and other environmental determinants of overall health) and understand the neurobiology/neurophysiology of stress related to sports. Sports psychiatry and positive psychiatry share the common goal of enhanced well-being leading to improved performance in many aspects of patient's lives. Both disciplines focus on thought process and psychological skills such as goal setting, visualization, and relaxation techniques with the goal of enhancing overall well-being.

Inside the Athlete's Mind

There is no specific trait that defines a person as an athlete. However, there are some general personality traits that are somewhat pervasive in the athletic community. People who compete in athletics tend to be more extraverted and exhibit high degrees of perfectionism and narcissism. These personality traits while not pathological in themselves do predispose athletes to certain psychopathologies. Athletes tend to develop a narrow range of focus early in their careers. This can be a benefit to them when developing a skill in a sport and achieving athletic success. The intense focus on performance and achievement in sport can interfere with maturation and development particularly in young athletes. Success in athletic endeavors does not always translate to success in other areas of life. The lack of maturity and psychological development outside the area of sport

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places athletes at risk for mental illness. Athletes are at high risk for "burnout" and overuse injuries which can further predispose them to psychiatric disorders. Given the high levels of confidence, combined with narcissistic and perfectionist traits, athletic mindsets pose a unique challenge to the sports psychiatrist. The risk of receiving suboptimal care exists for the athletic population. As athletes gain more notoriety, they receive higher status in comparison to peers. Furthermore, there are unique ethical issues faced when treating this population. For example, professional boundaries and confidentiality are at risk of being violated if the clinician is not mindful of professional standards.

The Link between Athletes and Mental Illness

People who achieve a high degree of success in athletics are viewed as the pinnacle of health and well-being. The general population perceives these people as healthy, physically fit, and mentally tough. Research indicates that athletes are not immune to mental health issues and prevalence rates for some mental illnesses are similar to the general population. The best studied disorders include eating disorders and substance use disorders. This population faces the unique risk of performance enhancing drug use which includes anabolic steroids. Mental illnesses with the highest prevalence in the general population are relatively common among athletes. Some of these illnesses include depression, bipolar disorder, anxiety disorders, and attention deficit hyperactivity disorder (ADHD).

One study looked at mental health of 224 elite Australian athletes (118 female, 106 male), which revealed 46.4% of athletes were experiencing symptoms of at least one mental health issue [1]. The study found percentages meeting criteria for mental disorders were similar to other studies of international athletes and community samples. Common psychiatric disorders included depression, eating disorders, and generalized anxiety disorder. Athletes who were injured had higher levels of both depression and generalized anxiety disorder symptoms. The authors concluded mental health problems reported by elite athletes appear similar to those observed in the community samples. In particular, injured athletes should be carefully monitored by a mental health professional given their increased vulnerability to depression and anxiety disorders.

Another study looked at a sample of high-level French athletes to determine variations in the prevalence of psychological problems based on sex and sport practiced. A representative sample of 13% of the French athlete population was obtained. Seventeen percent of athletes were identified as having at least one ongoing or recent disorder with generalized anxiety disorder being most prevalent. Overall 20% of women and 15% of men had at least one psychopathology [2]. The authors concluded that sex-based differences in psychopathology resemble those of the general population. Psychological stressors should be addressed early to help avoid further development of mental disorders.

Studies on the prevalence of psychiatric disorders among athletes are complicated. The samples are limited because of the lack of people who identify themselves as high-level athletes. There is often a lack of awareness or unwillingness to acknowledge the presence of mental health disorders on the part of the athlete and coaches. The athletic mindset of "toughing it out" can lead to a lack of openness and reluctance to seek help. There is still a stigma surrounding mental illness in athletes with high-level sports performance, even beyond what is seen in the general population. Early identification of at-risk athletes and connection with professional help can improve well-being, resilience, and performance in athletes.

Common Psychiatric Disorders in Athletes

Depression in Athletes

There is existing data in the literature indicating the benefits of physical activity on mood and depression. However, athletes can still be affected by depression. Athletes are fine

discussing physical injuries, but emotional injuries are much more difficult to talk about. The athlete does not want to appear to lack the necessary "mental toughness" to face the demands of the sport or be labeled as "a head case." As a result, many athletes go undiagnosed and do not receive the treatment necessary to improve their mood symptoms.

As detailed earlier in the chapter, there is difficulty in finding high-quality data regarding the prevalence of depression in athletes. Among college athletes the prevalence of depression is estimated to be between 15.6% and 21% [3]. Based on these rates, up to one in five college-level athletes is suffering with depression. Consistent with data from nonathletes, female athletes had higher rates of depression than male athletes. Other risk factors identified for the development of depression included being a freshman and having an injury or pain.

Athletes have unique risk factors for depression including the competitive nature of sport, high stress about performance, and burnout from overtraining [4]. As clinicians we cannot forget that athletes also have personal lives outside of sport and include similar stressors faced by the general population. There can be relationship issues with significant others, family issues, and financial issues adding to the demands of athletic performance.

Another unique risk factor for depression in athletes is injury. Injury is a part of playing sports, and sometimes severe injuries occur and have long recovery periods. These injuries can play a significant role in the athlete's mood, and the symptoms can be severe enough to cause post-traumatic stress disorder (PTSD) – like features such as reliving the injury through intrusive thoughts or nightmares. These athletes need to be closely monitored for the development of depression, and sometimes a psychiatrist will be called in to help facilitate the recovery process.

Depressive symptoms can present in unique ways and may be identified by coaches or trainers based on the athlete's performance. A depressed athlete may have a decreased interest in attending practice and look fatigued or out of it during games or overly self-critical of mistakes. These things can be mistaken as issues with the technical aspect of the sport or performance. Psychiatrists must recognize these signs and evaluate the athlete for depression.

Anxiety Disorders in Athletes

Anxiety disorders are poorly studied in this population, but one type of anxiety that is common among athletes is performance anxiety [5]. Athletes have a heightened level of anticipation prior to performing that does not interfere with other areas of their life. Performance anxiety is a common chief complaint among athletes seeing a sports psychiatrist. Determining ways to cope with the anxiety and reduce it to manageable levels that do not interfere with performance is a primary goal of treatment.

ADHD among Athletes

ADHD is a common diagnosis in the general population with a prevalence rate of 7–11% among school-aged children. As a result, there will be a fair number of athletes that have the disorder, and there is possibly an increased prevalence of ADHD among young athletes. Physical activity and athletics severe as a form of treatment helping the person to cope with the disorder. Athletes with ADHD may find certain aspects of learning a sport difficult such as learning the play book or certain rules related to the sport. Inability to focus or being easily distracted can affect performance. Stimulant medications are the first-line treatment in many cases for ADHD. This poses unique issues for athletes as these medications are considered performance-enhancing drugs. They often require a therapeutic exemption and can be a barrier to adequate treatment of the disorder in this population. The diagnosis can also add to self-esteem issues which also affects performance.

Eating Disorders

Many athletic endeavors require athletes to be in a certain weight class in order to compete. There is a concept in sports known as "weight cutting"

where an athlete will choose to compete at a lower weight class than their natural weight. In order to achieve this goal, they undergo strict dietary restriction and often various dehydration protocols to achieve this goal. This behavior, along with the desire to achieve an athletic advantage, can lead to eating disorders. The opposite can also be true where athletes are encouraged to add additional weight to their body in sports where large size is a competitive advantage. It's no surprise that the most studied psychiatric disorders among athletes are eating disorders.

One study looked at the prevalence of eating disorders in Norwegian elite athletes both male and female in comparison to the general population. The study found that there are higher rates of eating disorders in elite athletes (13.5%) compared to controls (4.6%) [6]. They also found that female athletes were more likely than male athletes to have eating disorders. Female athletes are at an increased risk of serious medical complications from severe caloric restriction including chronic fatigue, menstrual dysfunction including amenorrhea, and low bone mineral density that could lead to osteoporosis [7]. This is most common in sports that emphasize leanness and appearance, such as wrestling.

Most athletes do not meet full criteria for a specific eating disorder; rather they have unhealthy practices with regard to eating. The diagnosis that is commonly applied to these athletes is unspecified feeding or eating disorder. This can present in a variety of ways, and athletes should be screened for unhealthy eating habits. Although eating disorders mostly affect female athletes, it's important to screen both males and females for this. Risk factors in both groups include a family history of eating disorders, a personal history of eating disorders, female gender, and mood or anxiety disorders.

Substance Use Disorders

The National Collegiate Athletic Association (NCAA) conducted a study of substance use habits in college athletes using a self-reported retrospective survey. Alcohol was found to be the most widely used drug in the past 12 months (80.5%), followed by cannabis (38.4%) [8] and smokeless tobacco (22.5%). The study indicated that substance use was highest among Division III athletes and among Caucasians.

Athletes that use substances such as alcohol have decreased athletic performance as well as negative health consequences. Alcohol is the most commonly used substance by athletes and is often cited as a cause of reduced performance. Athletes are at increased risk of problematic alcohol consumption and have higher rates of binge drinking. Alcohol can affect performance by disrupting sleep patterns, reducing inhibition leading to more impulsive and dangerous behavior. Screening tools can be used to clarify the diagnosis and assess severity of substance use disorders.

Performance-enhancing drugs are a common problem in sports. Drugs such as anabolic steroids, amphetamines, human growth hormone, and erythropoietin provide a competitive advantage in sports. These substances are banned at all levels of athletic competition. Most athletes are subjected to random drug testing to help ensure a level playing field. In some cases, the use of performance-enhancing drugs can lead to psychiatric symptoms. Increased aggression is a well-established side effect of anabolic steroid use [9]. Anabolic steroids have also been known to cause mood symptoms. Amphetamines often used to increase focus and attention can increase irritability, lead to poor sleep, and decrease appetite. The added pressure of winning allows an athlete to want to have a perceived advantage by using these drugs.

Psychiatric Treatment of Athletes

There are two primary methods for treating athletes suffering from psychiatric illness: pharmacotherapy and psychotherapy. Psychotropic medications are known to have adverse side effects that may not be well tolerated by athletes. Most antidepressants have the risk of developing sedation, weight gain, and gastrointestinal distress that would be counterproduc-

tive for athletic performance. Athletes may be reluctant to take these medications if they believe it will interfere with their ability to perform. Stimulant medications used to treat ADHD will require a therapeutic exemption given the performance-enhancing abilities of these drugs. Patients being treated with benzodiazepines for anxiety or panic disorder will test positive on typical toxicology reports which can result in disciplinary action against the athlete. It's essential that the clinician discuss with the patient the risks and benefits of pharmacological intervention so the athlete can make an informed choice.

The other primary method of treating athletes is psychotherapy. The goal of this intervention is to alleviate psychiatric symptoms and improve athletic performance. The sports psychiatrist should be well versed in traditional "sports psychology" that focuses on goal setting, self-talk, relaxation techniques, and guided imagery. These techniques focus more on the performance aspects of athletic pursuits and less on the treatment of specific psychiatric disorders. The goal of talk therapy for treatment of psychiatric disorders is to alleviate symptoms with the goal of restoring optimal performance. Cognitive behavioral therapy (CBT) has a well-established record of reducing psychiatric symptoms in a wide variety of conditions. It is time limited and manual based, thus making it an ideal choice for the busy athlete. Most other forms of psychotherapy can be difficult to execute in the athletic population and have limited evidence to support their use.

The concepts of courage, optimism, honesty, and perseverance are important to develop for athletics. This is a focus of positive psychiatry, and enhancing these areas can lead to improved athletic performance. The sports psychiatrist should use a biopsychosocial formulation to identify key psychological traits (resilience, optimism, mastery, self-efficacy, and social engagement), and environmental factors (family dynamics, social support) as they relate to the neurobiology of stress in sport. Helping athletes to develop and utilize these traits leads to improvement in sport and life.

Applications

How can positive psychiatry be used in the treatment of athletes? Certain characteristics such as resilience and optimism not only play a role in overall well-being; they also have the potential to increase performance. Assessment of these characteristics and implementation of strategies to enhance these qualities should be a part of a sports psychiatrist's clinical practice. These practices would not replace current evidence-based treatments for psychiatric illness but can be used as an adjunct therapy to support or enhance current treatment. Practicing optimism, doing yoga, and daily mindfulness meditation practices can enhance well-being and performance. Patients should be encouraged to practice such lifestyle interventions to improve and strengthen these characteristics.

Positive psychiatry principles can be incorporated into any behavioral or psychosocial interventions. The goal is the same regardless of other interventions: to reduce symptoms and prevent relapse. To date, most psychiatric interventions focus on secondary and tertiary prevention. In contrast, positive psychiatry focuses on primary prevention. The goal of primary prevention is to prevent the onset of psychiatric illness and to strengthen key personality traits that foster resilience [10]. Resilience is associated with better health outcomes, lower risk of all-cause mortality, and overall increased life expectancy. In the high stress world of competitive athletics, there needs to be a strong focus on therapies that enhance this characteristic.

Positive psychiatry interventions can be implemented immediately to complement any existing medication or psychotherapy intervention. The goal of adding this adjunctive measure is to help patients who have had partial responses and to prevent relapse of symptoms. Trails of interventions such as meditation, writing gratitude letters, practicing optimistic thinking, acts of kindness, and forgiveness therapy have worked well with other psychiatric populations. The change in attitude along with enhanced optimism has reduced alcohol consumption in people struggling with substance use and alters attitudes about aging in

older adults. Optimism is a vital characteristic for athletes to develop and enhance. Having an attitude of positive expectation can result in enhanced performance on the field and overall better quality of life off the field [11].

The potentials for biological interventions based on positive psychiatry are still being developed. As we increase our understanding of neuroplasticity and the genetics associated with these positive traits, pharmacological interventions to enhance adaptative function may develop. Areas of interest in biological psychiatry include enhanced adaptive function of the hypothalamic-pituitary-adrenal axis as well as monoamine, neuropeptide, and other stress response mechanisms. Given the limitation and testing for performance-enhancing drugs in competitive sport, these agents if developed will require ethical and legal review prior to being used in the athletic population.

The concepts of healthy diet, mindfulness mediation practice, gratitude journals, and therapy to improve resilience and optimism can be added to existing treatment plans immediately. While the shift from management of chronic psychiatric illness to primary prevention of disease processes is a goal of positive psychiatry, the goal of all medical and psychological interventions should continue to be to treat and cure disease if possible. Interventions should also maximize performance and quality of life. In sport performance is key, and any intervention and prevention that can improve and sustain resilience, optimism, and performance is likely to help ward off the onset or exacerbation of mental illness.

Summary

Both sports psychiatry and positive psychiatry are relatively new branches of general psychiatry. Athletes, although generally seen as more confident and physically fit than the general population, are not immune to psychiatric illness. The demands of competition can increase stress levels leading to burnout and reduced performance. In general, psychotropic medications are not well tolerated in the athletic population, and the adverse side effects of these drugs limit their potential use in this population. Positive psychiatry and sports psychiatry are not mutually exclusive and can enhance each other. Many of the benefits of positive mental attitude, stress reduction, and visualization are already components of high performance in athletics. As we learn more about the neurobiology of stress and development of resilience, more clinical applications will emerge. As more research develops, the focus can shift from management of mental illness to primary prevention in this population.

Key Points

- Sports psychiatry is an emerging subspecialty of general psychiatry with unique challenges.
- Confident, hardworking, and resilient athletes are still susceptible to prevalent psychiatric disorders.
- Common psychiatric disorders among athletes include depression, eating disorders, and generalized anxiety disorder.
- Early identification of at-risk athletes, and connection with professional help, can improve well-being, resilience, and performance in athletes.
- There are two primary methods for treating athletes suffering from psychiatric illness: pharmacotherapy and psychotherapy.
- Psychotropic medications are known to have adverse side effects that may not be well tolerated by athletes.
- Although cognitive behavioral therapy (CBT) has a well-established record of reducing psychiatric symptoms in a wide variety of conditions, positive psychiatry can enhance an athlete's well-being.
- The sports psychiatrist should use a biopsychosocial formulation to identify key psychological traits (resilience, optimism, mastery, self-efficacy, and social engagement), and environmental factors (family dynamics, social support) as they relate to the neurobiology of stress in sport.

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Positive Family and Marital Therapy

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Positive psychotherapy (PPT) is an integrative approach derived from four main schools: psychodynamic, existentialist–humanistic, behaviorist, and transcultural therapy [1]. According to its founder, PPT, with its own specific intervention methods, in addition to features of other therapy theories, is a humanistic, resource-oriented, complementary, and transcultural approach [2]. At the same time, it is a psycho-dynamic approach based on a positive conceptualization of human beings and is focused on conflict resolution.

The word "positive," which is the most important concept of PPT, comes from the Latin word "positum" and means "thing that is posited and factual". So, it means that both the positive and the negative aspects of an event or situation should be considered together.

Positive psychotherapy has three important principles: the balance model, the principle of consultation, and the principle of hope. According to this concept, a balanced life is possible with a balance within the four dimensions of body, achievement, contact, and meaning/future [3]. Generally, persons refer to these four areas, when they face a problem, feel disappointed, exhausted, or find life insignificant. To be mentally healthy, happy, and peaceful, it is recommended to distribute time, labor, emotional relationships, and spiritual energy in a balanced manner in these four areas [4]. The "principle of consultation" means the client's cooperation with the people around him in resolving the problems. This cooperation is performed by addressing the five stages of each session and of the entire therapy process. The "principle of hope" means that clients are talented individuals in resolving their problems and have the belief that the problems can be resolved [5]. The most significant purpose of the therapist is to reveal and foster this belief and hope.

Positive family therapy (PFT) is the form of PPT used with families and couples. In the family approach, the individuals are handled separately as a part of the system and the relationship system between them is studied as a whole. Here, there are some different methods to shape the process. All of these are named family therapy and take the following forms: individual/one spouse, couple, nuclear family, extended family, and other systems [6].

To work with an individual/one spouse: at the beginning, although referring to this as family therapy is not meaningful, this approach is necessary for situations in which other people involved in the conflict cannot be included in the treatment sessions. In the context of the belief that a single change in system elements affects the whole system, the person is given the task of abandoning the patient role and acting as a therapist in his/her case. This situation allows behavioral change in the client and thus can have a curative effect on the whole family.

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To work with a couple: here, both members of the couple participate in therapy and the behavior that they demonstrate during sessions mirrors how they are affected by each other. In PFT, instead of talking about their conflicts immediately, what holds the couple together is discussed and how the conflict has a function in their relationship. Thus, a common base is formed to cope with the content of the conflict. This situation brings the couple to a new position in which they can look for different ways to resolve their problems.

To work with a nuclear family: here, parents and children are involved. Conflict experience and its resolution is continued within the family as far as possible. The five-step intervention method is used in PFT to define family rules and their conceptualization. The family uses the system for self-help. This approach helps the family to clarify and differentiate their positions and make them aware of misunderstandings.

To work with the extended family: in addition to the nuclear family, other people in close contact may also be involved in the treatment (grandmother, grandfather, aunt, uncle, family friends, etc.). The size of the group can only be limited by reasons due to arrangements. The "family tree" of concepts is often discovered through the patient's memory and experiences, and takes its actual form here. Later, these concepts can be discussed in therapy sessions without hurting some members of the family.

To work with other systems: here, therapy passes beyond the family limits. External contacts and social institutions participate in the therapy as affecting variables (Teachers, directors, physicians, clinic personnel, etc.). The system to be used in therapy can be modified to cover other subsystems, such as institutions at work, social, and governmental groups. This method complements family therapy and verifies the fact that the family is not an independent and single entity and is part of the ecological environment. In PFT, we try to adapt the principles of community psychology in the treatment of individuals, couples and families. As such, by paying attention to social institutions, PFT covers the spectrum ranging from individual therapy to community psychology. Wherever the person starts, the center is still the family, because the family is the original group where individuals experience socialization and it shapes current relationships and carries emotional significance [6].

Transcultural Positive Psychotherapy

The concepts, norms, values, behavioral patterns, interests, and perspectives that are valid in culture are dealt with in the transcultural context. This approach includes the characteristics of a community. It uses community norms and behavior patterns as a guide. One way of objectifying these values is to compare the laws and legal norms of the nation. Conflicts, possible solutions, and daily behavior patterns that are typically seen in a culture are perceived differently in another culture. At this point, the transcultural approach seeks to mediate between various views and to find a different form of communication that will help to break down prejudices in discussions about conflicts. These prejudices can be German, American, Iranian, Turkish, peasant, urban, etc. For these reasons, there are examples of transcultural definitions that always allow exceptions and are examples of individual situations, such as the "Prussian" Middle Eastern who took punctuality, regularity, and accuracy very seriously; and the "Middle Eastern" Prussian who is highly tolerant of punctuality lapses [6].

Solution-Focused Family Therapy

In solution-focused therapy, the focus is on the possible helpful solutions, paying less attention to problems. A basic postulate is "Change is continuous and inevitable." Only a small change is necessary. Changing a small part of the system also changes other parts. The term "domino" as a metaphor is illustrative. It means that small changes can and often do lead to bigger changes especially when they are noticed. The counselor helps the client to identify what he/she should do when he/she meets the problem in the future [7].

Psychodynamic/Experiential Family Therapy

This therapy is aimed at examining the unconscious functioning of the family, i.e., the forces that connect the family or interfere with their functioning. The method is through talk. The way in which the family members talk and begin to talk allows the therapist to work starting from the transference and countertransference. In addition, the therapist performs a special kind of listening that supports the exchange of relationships and bonding, without any instruction or advice. The therapist tries to establish a close bond with every member of the family. Although this method is useful in dealing with dysfunctional relationships or after traumatic events, it can also handle problems of parenthood, divorce, and remarriage. In fact, many couples formed of second marriages, think that love and goodwill will solve the disputes between the children. However, the internalization of the restructuring process always requires an adaptation process. Some supportive techniques that are defined as activation techniques allows the dynamics of family relationships to be revealed [8].

Family Tree Therapy

Family tree therapy, based on the idea of intergenerational psychological transmission, uses the family tree as a tool. Traumas, secrets, losses, deaths, and migrations from past generations are transferred to the next generation. It widens the family perspective by including invisible ties between generations to the concept of individual therapy based on the idea that a person's psychological structure is shaped by the family in which she/he was born. Some of the difficulties encountered in life do not belong to the individual; they are passed through the first, second, and even earlier generations. Family tree therapy examines the broad family dynamic, the individual's place in these networks of relationships, and how it is affected. When these knots are united by understanding each, the repetition is prevented by transferring them to the future generations. Therapists usually work around a "family tree" drawing that helps to talk. Meaningful childhood and family photos are also used to visualize the family system and help to analyze the family tree [9].

Systemic Family Therapy

The systemic therapies emerged in the 1950s in the USA and contain a number of schools. They address individuals, couples, and families. The complaints that force consultation at an individual level also have a meaning and function in the system in which they appear. To be aware of these, the approach is based on the therapeutic alliance. If the family is eager and trusts the therapist, the bond with the therapist makes everyone feel self-conscious. During this 1-year process, with an average of one session every 2 weeks, a therapy system is established including not only the client but also the therapist. The complaint of the therapist is questioned in its "cyclicality." The therapist has an approach, so that everyone can talk, and experience the situation that the family is blocked in a different way. The basic idea is to give the family a more flexible listening opportunity, which they can reuse among themselves. Another frequently used technique is "reframing," which is aimed at defining a situation so that family members can perceive it in different ways and consider new possibilities [10].

Parent Couple Therapy

This supportive therapy addresses couples who face difficulties with being a parent rather than with marital life. The method was developed as a result of clinical experience with children and is based on evidence. When a mental disorder occurs in a child, individual therapy is required. However, in the presence of relational difficulties, working with the child in parallel with the sessions dedicated to the parent provides more effective results. For example, in the case of different educational needs or when a child or young

person is stuck in a conflict of loyalty after divorce, this approach is aimed at placing the child's interests at the center of parental communication [10].

Gottman Method

This approach has been created to help couples to learn about the original skills needed to deepen the intimacy and friendship in the relationship. To ensure the efficient management of conflicts, it offers ways of addressing solvable problems and establishing dialogue on deadlocked issues. The Gottman Approach symbolizes the secret of happy couples utilizing the concept of the sound relationship house [11].

Holistic Family Therapy (Gestalt Therapy)

The aim of holistic family therapy is to investigate the individual's experiences, models or instances and to integrate and complete all the separate pieces. Gestalt is a process of creating or designing awareness. Or, rather, it is a process that facilitates the individual obtaining an idea of the processes, such as "what does s/he do, how s/he does it, and how it can be changed?" and it is a process that facilitates the process of grasping and at the same time learning to accept. It tries to change the family by changing individuals and focusing on the "here and now " [12].

Principles of Positive Family Therapy

- *Self-help:* PFT is a self-help method for helping to resolve family conflict. For instance, rather than focusing on a child's problem or parental conflict, it teaches the whole family to mobilize their healing capacity that is already present. The focal point of the therapist is the family. Although addressing the family, the therapy deals with the values, impressions, social norms, and cultural characteristics that already exist in it. The method applied to the family or couple is taught during the therapy. Thus, the aim is that the person will able to use this method for him/herself or the family after the therapy ends.
- *Transcultural dimension:* the family or couple should be handled together with their cultural environment because it is not independent of that cultural environment. In PFT, it is argued that it is possible to use appropriate methods and meet their needs fully only after understanding the cultural characteristics of the family.
- *Overview of the content:* It tries to answer questions such as "What are the points at which people are common and differ?" It uses the differentiation analysis inventory (DAI) and stories to do this (see below).
- *Meta-theoretical dimension:* PFT provides a holistic approach by incorporating insights from many theories. It provides for a framework in which different therapeutic techniques can be applied and integrated.
- *Relativity of family bonds:* PFT is a special form of therapeutic thought. Although the family is at the center, therapy is not limited to the family. Family members are regarded as individuals and social factors also play a part in the treatment.
- *Uniqueness of humans:* In PFT, we try to understand the psychological and psychosomatic reactions the person has to the conflicts. How and with what content do these responses emerge in terms of personal sensitivity are examined. At the same time, understanding the rules governing everyday life (including reactions, cultural, traditional values, and belief systems) is also considered a significant element of the therapy process [5].

Actual Capacities and Differentiation Analytic Inventory

The differentiation analytic inventory (DAI), one of the basic instruments of PFT, reflects the rules and components behind the conflicts that manifest in a series of repetitive behaviors or norms behind the symptoms of a person's disorder.

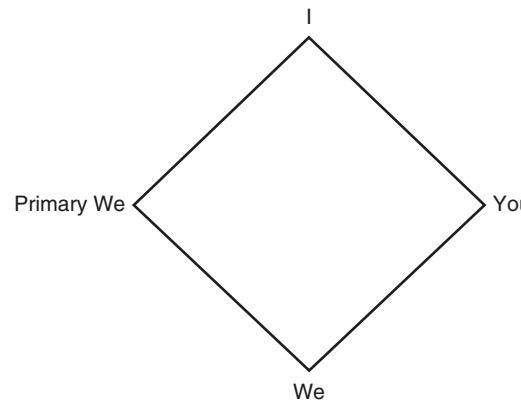
Within the scope of this inventory norms of behavior such as punctuality, openness, kindness, cleanliness, loyalty, and justice. are called actual capacities [6]. The DAI is an inventory in which concepts related to individual, cultural, and family conflicts are gathered and it is a guiding inventory in the determination of actual capacities.

Actual capacities are psycho-social norms that come from family, social values, and belief systems. They constitute the rules that define the relationships between family members. The obvious reflections of actual capacities are hidden in the behavior patterns, which seem very unimportant [13]. For example, for the boss looking at the clock continuously, punctuality is an actual capacity hidden in the background. At this point, the differentiation analysis begins with a detailed assessment of actual capacities, which include both development and conflict potential. Information such as when the person is angry, with what she/he is contacting, and the reasons for explaining the situation are gathered. With this analysis, we attempt to understand how sensitive the person is to the conflicts is defined and the real reasons, concepts, and special content behind the emotional conflicts.

By applying the DAI to each of family members, we can obtain information about the entire family. In the table illustrating this situation, a person's own data are shown in the "I" column, assessments of the person's wife or other family members are depicted in the "Spouse/Partner/Conflicted person" column, and comments about this capacity are indicated in the "Spontaneous Answers" column. The person can bring these assessments about her/himself and the other person with whom he/she is experiencing conflict together and can obtain a general overview. The assessments here are subjective assessments and not decisive judgments. The individual standards of family members are compared with those of the others. It can be easily understood which family member's capacity is more developed and which ones need to be improved. Thus, these conflict areas and their contents can easily be identified.

Model Dimension

According to PPT, actual capacities develop according to the relationships with parents or primary caregivers and childhood life. Peseschkian, with the concept of the model dimension, defined the development of actual capacities and how to understand them. The model dimension defines the basic relationships in which each person is involved in one way or another. These relationships are "I, You, We, and Primal We." PFT also demonstrates how the actual capacity in humans develops according to the person, time, and environmental conditions by using the model dimension.



The model dimension is about concepts that are valid within a family. These concepts can be impulses that produce behaviors, norms, and habits that lead these impulses. These concepts have special importance in the social life in PFT and these are cognitive and emotional structures that comment on relationships with the environment. In these concepts, there are some expectations, such as a critical and pessimistic approach to the person in the relationship or the exact opposite, the desire to establish close relations. The model dimension is defined to reveal the concepts of the family in which the person grows and the experiences of the person with regard to these concepts. To understand conflict, understanding its infrastructure and the concepts contained therein is required first of all. The model dimension is helpful in understanding why people prefer to reject some

relationships. It sheds light on the person's relationships and values in the family. A person can combine his/her relationships with other people and the models symbolized by these experiences [14].

The "I dimension" is developed by taking a person's relationships with his/her parents and siblings as the model; the "You dimension" is developed by experiencing the relationship between one's parents as a child; the "We dimension" is developed by the example of one's parents' relationships with other people; and the "Primal We Dimension" is developed by experiencing one's parents' meaning in life, attitude toward religion, and relationship with spirituality. The basis of the behaviors and the models used can help the client to be informed about their emotional relationships, to understand the source of their problem, and to provide him/her with data to evaluate the situation from a different point of view.

Stages of Interaction

Human beings follow certain stages of interaction in each relationship they have established and will establish. Each stage has specific characteristics and these characteristics help to understand the needs and expectations in relation to the dynamics of the relationship and help to understand and solve the conflict. Therefore, people go through three stages in marriage and in other couple relationships: connectedness (attachment), differentiation (discrimination), and detachment. In each close relationship and couple relationship, these transitions are seen continuously. In PPT, we speak about the "three stages of interaction" [3]:

- *Attachment stage*: every human being requires togetherness and intimacy with others throughout his/her life from birth. This need greatly explains the person's search for a marriage partner, his/her desire to be with other people, and his/her commitment to the family community. It can be understood from the sentence "I want to be with my spouse more often, I need her/him." that the person is at the attachment stage during a marital relationship.
- *Differentiation stage:* this is defined by the acquisition of the socially desired behavior. This situation occurs in the differentiation of the person's ability to recognize and learn and in the formation of the secondary capacities that enable him/her to control nature and express her/himself socially. Trying to attract someone, giving advice, and trying to control someone's attitudes and behaviors are the obvious behaviors of this stage. It can be understood from the sentence "Do I advise my partner/spouse? What is my response when my expectations are not met?" that the person is at the differentiation stage during a marital relationship.
- *Detachment stage:* this is a period when the person is separated from the one she/he is close to and when the person is looking for things and when the person starts to take on his/her own responsibilities. This stage provides an opportunity to start relationships with other people and it means expanding one's qualifications, trying new decisions, or reconsidering his/her old values. This is the characteristic of maturity and mature personality. It can be understood from the sentence "Do I expect my partner to be independent? Do I prefer to give him/her responsibility anymore? Do I think that she/he has the right to take care of him/herself?" that the person is at the detachment stage during a marital relationship [6].

Most people alternate between attachment and detachment. They want to be independent and they see that they cannot manage their independence. Or, they want love and the interest of their spouse and they avoid it because of their ambition of freedom. We call these kind of relationships 'two different attachments'. These kinds of people are under the influence of sudden powers

and new possibilities that they can not think. They are seen as a type of person who is not certain what to do with their environment and themselves. "I both want and do not want."

Clinical Examples

These three stages of interaction can be seen in every kind of interpersonal relationships. Each person has other needs and expectations, and might be in another of these stages.

(a) For instance, a 3–4-year-old girl wants to play with her father (Stage of attachment). But father retracts himself stating he has no time (Stage of differentiation)
(b) One partner wants commitment and the other thinks that he should give information and warning.
(c) A working woman waits to show compassion to her husband in the evening. But the husband questions by saying "Kitchen is untidy, toys are everywhere. Why did I marry?"
(d) One partner wants commitment. However, the other gives a different commitment than she expects. An 18-year-old young person is invited to a party organized by the family. She/he is not comfortable among the adult people. But as she/he tries to feel confidence through her/his closeness to mother, the mother smothers him/her with kisses. And child feels very ashamed.
(e) While one partner needs information, warning and verbal instructions; the other expects him/her to be independent, to make his own decisions and supports his/her spouse. For example; A young boy asks his mother for advice about his young girlfriend, whom he loves but cannot trust. The mother may reject him by saying "You have never asked me before, you managed by yourself. Why don't you ask your father?"
(f) One partner asks for information, but doesn't get it from the person she/he asked, or gets in a way that she/he doesn't desired. A housewife says, "The washing machine broke down last week. I wanted to hear from my husband what I should I do. However, he gave me a lecture about how to use the machine more carefully."

Here, one of the partners needs information, warning and help in decision making (stage of differentiation). But the other wants to reach a stage of commitment based on care and attention.

(g) A working person wants to get an idea about training on his/her profession. If her/his visitor is mother, she may say "It is obvious that you have much to do and you look bad. Come stay with me. I will let you rest."
(h) One of the partners wants to prove him/herself. The other one is not aware of this desired or obtained independence. On the contrary, she/he wants to control his/her couple by giving ideas and suggestions. A mother of a newly married woman comes to visit. The mother says "I am glad I came. Everywhere is dust. Now, your mother will show you how to clean."

Here one of the partners wants independence and separation while the other takes this as dependence need.

(i) A young girl is admitted to a college in another city. The father may reject this by saying "You cannot go so far away. Something bad can happen. No need to go university. Stay in your home." [15].

These types of interaction may provide orientation to analyze conflicts between his/her partner or inside of individual. Person with the help of these may have a good understanding on the tentative problems and can also consider his/her own attitude.

Five Stages of Positive Psychotherapy (Principle of Consultation)

The core of the PPT is a 5-stage process which serves as a guide to shaping the therapy. While

applying these five stages in therapy, PPT also benefits from the techniques of other therapy approaches.

1. *Observation/Distancing Stage:* The basic objective of this stage is to make analysis of the situation. First, the therapist listens in an objective manner without commenting and tries to understand what he/she needs with what the client brought as a problem. Thus, the therapist tries to examine all sources of information both situational and past about the symptoms and the accompanying behaviors. Family and couple have an opportunity to look at the current situation by going one step back. PFT uses several tools to be able to keep distance with the problem. With stories, proverbs and also how other cultures experienced these tools are used to reveal new points of views.
2. *Inventory Stage:* In this stage by using balance model the information about what they experienced in last 5 years are gathered in the four life dimensions. The therapist tries to to find out how they solve the problems they faced and which dimension of the balance model they use more. And also, at which level they use actual and capacities is examined. DAI is used at this stage.
3. *Situational Encouragement:* Situational encouragement has a central significance in PPT. Since the family focuses only on their problems, they cannot recognize their positive aspects and capacities. At this stage, the family and the couple are encouraged on the positive aspects of the situation by a realistic point of view. The therapist tries to help them in finding new alternative ideas.
4. *Verbalization:* After the creation of the necessary therapeutic environment in the previous stages, the basic conflict is started to be studied in this stage. The thoughts of the other party about the apparent problems and deeper problems are asked. The therapist tries to help the family solve their conflicts by using the balance model and the model dimensions. They learn about each other's ideas and expectations. The main objective in this stage is to emphasize what the family and the couple can do to achieve balance in the four dimensions of life.
5. *Broadening of goals:* In this stage, after reaching the application goals of family and couple, it is focused on how they want to live in the future (in short-medium-long term). In this stage the main goal of the psychotherapy relationship is to provide information to family as self-help. So, people will be equipped with a self-help method to accompany them during their life after stopping therapy. In this stage, the family learns to reconsider the goals pursued before the restart of neurotic restrictions. While doing so, the family takes the four dimensions of life in the balance model and plans how to maintain balance in their life and examines with which methods to deal with them when new conflicts occur [14].

In summary, Positive Family Therapy, due to its structured techniques, and as transcultural, psychodynamic, and system-oriented method has proven to be effective with some 8–12 sessions, and the goal to assist the patients to use their own resources.

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The secret of happiness

A certain shopkeeper sent his son to learn about the secret of happiness from the wisest man in the world.

The lad wandered through the desert for forty days, and finally came upon a beautiful castle, high atop a mountain. It was there that the wise man lived.

Rather than finding a saintly man though, our hero, on entering the main room of the castle, saw a hive of activity: tradesmen came and went, people were conversing in the corners, a small orchestra was playing soft music, and there was a table covered with platters of the most delicious food in that part of the world.

The wise man conversed with everyone, and the boy had to wait for two hours before it was his turn to be given the man's attention. The wise man listened attentively to the boy's explanation of why he had come, but told him that he didn't have time just then to explain the secret of happiness.

He suggested that the boy look around the palace and return in two hours. "Meanwhile I want to ask you to do something," said the wise man, handing the boy a teaspoon that held two drops of oil. "As you wander around, carry this spoon with you without allowing the oil to spill."

The boy began climbing and descending the many stairways of the palace, keeping his eyes fixed on the spoon. After two hours, he returned to the room where the wise man was. "Well," asked the wise man, "did you see the Persian tapestries that are hanging in my dining hall? Did you see the garden that it took the master gardener ten years to create? Did you notice the beautiful parchments in my library?"

The boy was embarrassed, and confessed that he had observed nothing. His only concern had been not to spill the oil that the wise man had entrusted to him.

"Then go back and observe the marvels of my world," said the wise man.

Relieved, the boy picked up the spoon and returned to his exploration of the palace, this time observing all of the works of art on the ceilings and the walls. He saw the gardens, the mountains all around him, the beauty of the flowers, and the taste with which everything had been selected. Upon returning to the wise man, he related in detail everything he had seen.

"But where are the drops of oil I entrusted to you?" asked the wise man. Looking down at the spoon he held, the boy saw that the oil was gone.

"Well, there is only one piece of advice I can give you," said the wisest of wise men. "The secret of happiness is to see all the marvels of the world and never to forget the drops of oil on the spoon" [14].

Pedagogy is a science of education and upbringing of those growing up. As practice, pedagogy is in the hands of the teachers in the different types of schools.

Nowadays, a teacher prioritizes mostly education, giving knowledge in a given field, including the science of ethics. That is why one defines as a "subject teacher" an instructor of a certain school subject.

Schooling, the actual "teaching" of moral rules of interaction, starts early during the course

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of education in the immediate child–teacher contact. The child hears the verbal requirements of how to act in the group; a moral assessment of the success of his behavior. It assimilates the science of ethics in the course of actual interaction with teacher and classmates. In this type of communication, the teacher's behavior fully covers the adopted, throughout the years, social role of *"mother"* and *"father,"* also based on one's own personal abilities.

During the course of their professional growth, the teachers, regardless of their personal traits, mainly develop and use their secondary qualities—order, discipline, time frames, achievements, and assessment. This matches the goals of the institution ("school") and the social task that has initially been given—to introduce, appropriate to the child/teenager's age, the minimal required knowledge in different scientific fields.

There are situations (mainly in recess, but not exclusively), in which the teacher faces the challenges of the age particularities, when it comes to communication between children/teenagers. They are expected to remedy specific situations that arise in the interaction between peers or when a child is in contact with a younger or older student. Normally, the teacher takes the social role of an "educator" based on his own personal traits. Usually, in such cases, the teacher takes the role of the "father," who establishes the norms and expects them to be followed. He becomes strict, demanding, and firm in observing the social norms, socially just.

During supervisions and Balint groups with school psychologists, competent in psychotherapy (trained by coaches in the school of PPT), teachers share the insufficient efficiency of their own professional behavior when it comes to solving everyday school situations without a conflict. On the one hand, the reason for that they see in their only theoretical knowledge in psychology, on the other—in the specifics of the teacher's behavior in class. There, they are the ones imparting the required knowledge in a specific subject, demanding and assessing.

With the help of the psychologist–positive psychotherapist, they learn to:

A. *Acknowledge the psychological needs of the child/teenager according to the particularity of their psychological development*

Because of the peculiarities of the respective age crises, the child/teenager reacts mainly with his primary capacities. They are impulsive, unrestrained, direct, with high emotional charge and a need to vindicate themselves. The forms of social interaction are in and of themselves immature, particular to that age. This often leads to conflicts between children/teenagers. They unfold at school but are also carried over to the family environment. Teachers share about the frequent out-of-place intervention of parents and even parents' attempts to personally deal with the child, causing the discomfort in their own child. In most cases, this parental involvement brings unpleasant consequences to all the participants. They further reflect on the child/teenager's relationship with teachers and classmates and create a new base for interactive conflicts.

B. *Reflect on the psychological content of the external conflict "student–classmate" and the role of the participant's initial inner conflict regarding the unfolding conflict situation.*

As a rule, each side takes part in the unfolded external conflict with the already established and stabilized by that moment individual capacities for coping with the inner conflict [5]. The "students–teachers" conflicts follow the same psychodynamics, when the teacher enters the conflict triangle "student – student – teacher" by necessity, with the desire to resolve the conflict.

Within the formal communication in the classroom, the teacher comes into contact with the student according to content of his/her personal actual conflict (AC). He expects the student's behavior to be a display of the secondary actual capacities—obedience, discipline, responsibility, consistency, achievement, order, and punctuality. The student, on the other hand, comes into contact with the teacher with the mindset to gratify his/her own needs—content of the basic conflict (BC). He expects to receive

from the teacher attitude that gratifies the basic actual capacities—compassion, assurance, time, patience, and hope.

Dreikurs [2] identifies the four main goals of misbehavior: *avoidance of failure, attention, revenge, and power*—needs that define the nature of the common conflict relationships between student and teacher. According to his theory, this comes from the child/teenager's need to belong to the social group of peers (primary capacities—unity/integrity). Our psychotherapeutic practice [12] shows that the growth and development of students only changes the hierarchy of personal needs. Children between the ages of 6 and 11 have the need to find their place among peers; at between 12 and 14 they search for their uniqueness in contact with others. Youths who are 15–16 years old begin to identify their social "Self," and teenagers between 17 and 19 aim to display their capability to cope with problem relationships independently. Examples of our practice with most common school conflicts according to the student's age [11–13] are given in Table 21.1.

In the given examples, all the participants are left with the feeling of being misunderstood, that their personal needs have not been taken into consideration, and have the morbid readiness to counteract. Everybody's experience is a result of a type of psychodynamics that is well summarized in a statement by Maya Angelou [1]: "I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."

C. *Unfolding the capabilities for a more successful role as an educator, which is acquired by using the tools of positive psychotherapy*

The efficient teacher looks like the good parent. Teachers who have passed psychological training with psychotherapists, already have deep psychological knowledge on how to use the strength of *"the balance model"* [6]. After systematical training and series of supervisions, they already possess skills for "recognition of the contents of one's own psychic balance and that of their students, as well as skills for conflict-free communication.

The Balance Model of PPT teaches teachers to recognize the psychological content, localization and about the areas of processing of the student's conflict behavior [10]. Having seen through that, teachers manage to find more accurate ways to react to the students' unacceptable behavior by introducing a different experience and/or a new variation of their old approach.

What the teachers have shared, shows tendencies for repetition of certain strategies.

In the *area Body* (Identity – "Who am I?"; "What am I?") the teachers manage to observe, reflect on and react to the student's individual style of functioning in a group – skills for connecting and differentiating, a necessity to insert oneself and one's own experience. For himself, the teacher adopts new manifestation of his role behavior, realizes personality traits, new interactive abilities (activity, reactivity, passivity) and coping strategies.

In the *area Achievement* (Motivation, achievements, acts – "What?", "How?", "How much?"). Gage and Berliner [3] illustrate motivation with a picture of a car – "the engine of the car – the motor" (intensity) and the "wheel" (direction), steering the car. Through a discussion on such a picture, the teacher recognizes the psychological problems, corrects and develops the significant actual capacities of the student for success in the group and multiplies the emotional engagement of the student to the school contents.

On the individual level, the teacher works on unfolding the student's capacities for choice of goals, effort (diligence), perseverance (consistency), and achievements.

In the *area Contacts* (Surroundings – "When?", "Where?", "With who?", "How?") on the class/group level. The teacher observes the school dynamics – formulation, struggle, norming, transformation [8] and the level of maturity of the group (class) in the sense of interacting capabilities: standing up for oneself; one's own share in group work (responsibility and ambition); reactions to requirements, norms, rules; skills for coping with conflict situations, attracting allies and opposing others; seeking and giving help; trust (capability to count on one another); differentiation – competence and independence

Table 21.1 Most common school conflicts according to the student's age

Problems	Student's behavior	Teacher's behavior
7- to 11-year-old students		
Related to drawing attention; help-seeking: *Making noise; disobeying the classroom rules*	Makes strange noises, cries, leaves the classroom spontaneously, causes noise by knocking down objects; talks during class	The teacher reacts with annoyance by sanctioning the child—writing a black mark/absence in the report card; puts the child in front of the class and expects him/her to explain his/her behavior; refuses to help the child by making tasks easier to perform; does not include the student in discussions during class, to avoid crying
Related to avoidance of failure: *Refusal to attend classes and/or school; "Escape into sickness"*	Refusal to write and read, to attend school, psychosomatic reactions—stomachaches, vomiting, vertigo, etc.; inability to separate from the parents and enter the school; insists on having a figure of authority by his/her side during school hours	The teacher reacts to the student's helpless condition and shows over-care by making tasks easier to execute; attending to the symptom; allowing a parent to be by the child during classes; excusing the student from classes; going through individual training, which affirms the feeling of failure in the child when it comes to the requirements of the school age
Related to revenge: *Aggressive and oppositional behavior*	Oppositional behavior against the teacher—refuses to carry out the given tasks; verbal and nonverbal aggression toward classmates—creates conflicts in recess, breaks and destroys objects in the classroom, scribbles on classmates' drawings or notebooks, takes others' belongings	The teacher reacts by imposing his/her authority—gives the student a black mark. Punishes him/her by making him/her sit alone at a desk or isolates him/her in the corner of the classroom, asks him/her to leave the classroom, takes him/her to the headmaster or school psychologist. Arranges meetings with the parents to complain about the student; reprimands him/her in front of the class; puts labels on the student: "You are a very disobedient/bad student"
Early adolescence, 12–14 years old		
Related to attracting attention: *Making noise; disobeying the classroom rules; disruption of class*	Produces all kinds of strange noises, causes a stir in any way possible during class. Tries to hide the source of the noise and denies it is his/her doing. Acts like a clown; uses every opportunity to create a commotion; makes innocent faces or gestures when the teacher looks at him/her or asks him/her to stop; enjoys his actions, acts deliberately, provokes the teacher on purpose	Reacts to the provocation, feels challenged, forced to counteract, often with hostile behavior. Expresses opinion about this type of student rashly and contradictory, usually in front of the class; removes the student from class or ignores his behavior
Related to avoidance of failure: *Polarized into over-ambitiousness or achieving recognition through failure*	Rarely carries out the given tasks; does not finish what he started, demonstrating his mediocrity; tends to blame others or external factors or refuses to work on the given assignments, does not study, does not prepare, sabotages him/herself during examinations and revision of knowledge	Loses control and turns this student into the topic of discussion in class; reacts with annoyance and anger; makes threats he cannot fulfill; removes the student from the classroom, sends him to the headmaster or summons the vice-headmaster/headmaster to his/her class
Related to revenge: *Scribbling on walls and desks; destruction of school property; fighting, threatening, and bullying others*	Agitates, swears, and hits classmates; demonstrates a lack of interest in both school and extracurricular activities	Undertakes over-the-top disciplinary actions or presses the student through consequences. Verbally humiliates /insults/the student in the presence of other students or adults. Categorizes this student as difficult or hopeless to change or ignores him and leaves him to manage on his own

Table 21.1 (continued)

Problems	Student's behavior	Teacher's behavior
Related to power: *Tendency toward belittling, degrading the teacher's authority; disregard*	Breaks rules; argues; causes commotion in the classroom over the most insignificant of things; does his best to provoke a reaction in the teacher and to upset him/her	Reacts emotionally, allows him/herself to be involved in the situation; tries to deal with the student through sarcasm; takes it personally
Middle adolescence, 15–16 years old		
Related to power: *Openly disparages the teacher's authority; behaves with disregard; blackmails/manipulates others to oppugn the authority and oppose the school rules.*	Tests, tries, and questions the teacher's authority; usually tries to create discord and raise disputable questions; oppugns and openly rebels against every demand made by the teacher; attacks, provokes, talks back; does not respect the rules, resists punishment	Reacts emotionally and gets involved in the situation; uses insults, sarcasm, revenge through grades, black marks, and/or punishment through unacceptable means. Tries to get the other students on his/her side; uses threats he/she is not prepared to carry out or cannot fulfill
Related to attracting attention: *Making noise; does not observe the rules in the classroom; refusal and/or opposition; lack of independence.*	*In active form*: the student demonstrates all kinds of behavior to disrupt the class's dynamics, distract other students; diverts the teacher; reacts impulsively, does not listen, bothers others, meddles, interrupts; displays inadequacy or lack of self-control *In passive form*: the student acts by the words: "slow and easy," does not perform the tasks or performs them ostentatiously slowly	Emotionally reacts to the provocation; acts provocatively, accuses; rashly expresses opinion about this type of student, usually in front of the class; either removes the student from class or ignores his behavior
Related to revenge: *aggression; bullying and violence; provoking teacher and students*	Constantly threatens; boasts/talks tall; negative mindset, acts aggressively at the slightest sign of a problem; problems with assimilating the educational content; publicly humiliates others	Constantly instills the notion that, because of his behavior, nobody likes or will like him/her; publicly reprimands him/her; tries to bribe him/her with promises; attacks the personality and not the behavior; disregards the positive/strong sides in his/her behavior, his/her potential; defends others but never him/her
Related to avoidance of failure: *Polarized into over-ambitiousness or getting recognition through failure; refusal to attend classes, drops out of school*	Demonstrates superiority, acts arrogantly and selfishly; confident—acts like a "star," exaggerates his/her capabilities; belittles those of others; fails/sabotages him/herself during examination and assessment of knowledge; does not prepare his/her lessons; stops attending certain or all classes	Argues with the student. Gets angry; dismisses this type of student with the conviction that they lack what it takes to develop their true potential. Uses provocations; ignores or consoles him/her; give him/her special treatment, different from the way he/her treats other students. Bribes him/her, tries to manipulate him/her or declares he/she is spoiled and throws the blame on his/her upbringing in the family
Late adolescence, 17–19 years old		
Related to avoidance of failure: *Over-ambitiousness or failure, does not attend classes or school*	*In active form:* Provocative, arrogant behavior; does not follow rules; does not see the need to be told what to do or how to do it; tries, tests, and questions the teacher's authority; dethrones the teacher; creates discord, argues openly; belligerent. *In passive form:* does not prepare, focuses on his/her own mistakes and weaknesses or those of others; demotivated; approaches assignments with failure in mind, does not make an effort	Argues with the student; competes with him/her—"Let's see who's right!" Takes challenges personally. Criticizes or derides him/her in front of the class. Sets unrealistic goals in an attempt to change the student's behavior; lowers his/her expectations of him/her; loses control and turns this student into the center of discussion in class. Sends him/her out of class or makes threats that cannot be fulfilled

(continued)

Table 21.1 (continued)

Problems	Student's behavior	Teacher's behavior
Related to power: *Confrontation, challenging of the teacher's authority; disregard; blackmails/ manipulates others to oppugn the authority and oppose school rules.*	Oppugns the teacher's competence and authority with facts and notions that contradict the teacher, or seeks a way to show that the teacher's work and views are insufficient/insignificant. Demonstrates superiority; does not let anybody tell him/her what to do or how to do it; verbally aggressive; confronts and breaks order; openly challenges the teacher; criticizes; demands; ostentatiously refuses to perform tasks, obey rules, and conditions	Loses control and self-control; gets angry, takes the challenge personally; displays disappointment, annoyance, and impatience; takes a defensive position and allows the student to see that he is afraid of him
Related to revenge: *Aggression; bullying, and violence; provoking the teacher and students*	Physical and psychological attacks: the student insults the teacher, the other students or both; does not acknowledge and opposes rules, responsibilities, and obligations; combative toward the teacher's justice; is "battle"-ready; insists that there is injustice, makes statements such as "I'm the only one who you pick on!"	Takes a defensive position; vexed, angry; acts negligently regarding the student, proving the success of his arrogant behavior. Tries to press him/her through consequences; verbal humiliation/ insulting/of the student in the presence of other students; categorizes him/her as difficult and hopeless; ignores him/her
Related to attracting attention: *Disobeys rules in class, asks questions or bothers others while they are working*	Noisy and loud. Tries through immature behavior or power to force him/herself and his/her style upon the class. Often late for class; gets off his/her seat and walks around the classroom; asks redundant questions; takes the position: "Against everyone and everything," to get attention; says the wrong things at the wrong time, speaks up unprepared; wears unusual, strange or attention- attracting clothes; sometimes uses obscene words or coarse language	Tries to calm him/her down; starts treating him/her as a person lacking the skills to cope on an academic and behavioral level; ignores the student's behavior; rashly forms a controversial opinion about that student; tries not to pay attention to him/ her; sends him/her out of class; demonstrates annoyance and impatience towards him/her and the whole class; criticizes or derides him

regarding the decisions made and achieving goals and tasks.

At the individual level in *area Contacts*, the focus is on the contents of the contact with oneself and with others. The teacher knows how to guide the student through important for him topics regarding the establishing of a firm and stable Self-image: self-evaluation, self-respect, self-confidence, and self-presentation. Through contact with others, the teacher stabilizes the interactive capabilities (closeness – distance), works by using the newly adapted role behavior for building in the student capabilities for evaluation of others and the hidden needs; for pleasure and gratification in contact with others – acceptance, attention, patience, faith, trust, time and other.

Area Fantasy/Future (Convictions, values, reason "Why?)" On conceptual level, the teacher manages to observe and develop the students' capabilities for adaptation (flexibility) and self-regulation (different role behavior), resistance and defense mechanisms. On level individual student, the teacher reaches a new level of realization of the contents of life philosophy, beliefs, attitude; works on developing the capabilities for acceptance, assertion and bearing hardships, stability, maturity, realizing and rethinking life settings.

Having adopted *the concept of Positum,* teachers become good role models for their students, guardians of their own and their students' psychological health. This happens most successfully when the teacher acknowledges the already existing psychological capabilities of each participant as a coping resource. Through the course of work with the psychologist –positive psychotherapist, the teacher acquires the skill to use *the*

transcultural approach, for *positive reinterpretation* – a skill for discovering the function of the student's behavior.

Clinical Examples or Vignettes

- Seven-year-old Vasil does not sit still. During classes, he suddenly gets up and leaves the classroom. His teacher interprets his behavior, saying that active and energetic people seek diversity, new activities. Having said that, she offers Vasil opportunity to solve not one but three or four problems from the unit instead of leaving class.
- Eight-year-old Ivan, a second grader, disrupts the discipline during class by eating crackers. The other students are disturbed by the noise he creates and are distracted. The teacher pays attention to Ivan's behavior by saying: "Ivan gives us a good example of how a person can enjoy himself when he's having difficulties." Following those words, the teacher urges Ivan to share whether there is something in the lesson that hinders him, by pointing out that probably he is not the only one having a predicament and that other students may have the same problem.
- Nine-year-old Ivo gets into a fight with Miro, because Miro gives him a pencil as a gift and right after that, he wants it back. Neither of them backs down. The conflict expands. Other children from the class get involved. The teacher smartly tells them both: "You know how to fight to the very last for that which is important to you. Ivo, I can see that for you justice is very important. Miro, you had the good intention to make your friend happy by giving him a present, but obviously, you figured out that this pencil is important to you. Now, let's see how to solve this situation in a better way for both of you."
- Nine-year-old Mia is a shy and insecure child. She is a third-grade student and has difficulties when asked about the lesson in front of the class. In written exams, Mia does brilliantly. Despite that, her parents and teachers are worried. Her teacher, after training in positive psychotherapy, tells the following story to the class: "Do you know to what we owe the pleasure of reading books?! To the ability of some people to express themselves better in writing than they do verbally. That's writers. They know how to arrange their thoughts successfully when in front of the blank sheet, but they feel insecure and unable to say anything when they have to talk in front of people..." The transcultural approach used by the teacher brings peace to everyone.
- Eleven-year-old Victor does not work in English classes. His notebooks are blank, and when questioned, he stays quiet or answers the teacher in a rude manner. She finds a good application for his behavior and says: "You possess the ability to openly and honestly tell what's on your mind, to stand up for your position, so let's do the same in English. That way you'll be successful in every new, unexpected situation, even when in other countries."
- Simeon, 16 years of age, avoids his classmates, prefers to be by himself, acts defensively, and refuses to participate in group activities on a regular basis. Often, his classmates tease and mock him. The teacher reacts to this by saying: "Simeon is one of those people who know how to give space and time to patience and civility. He is capable of consistently standing up for his own interests. It's only right to respect those skills of his."
- Hristo, 17 years old, is unfriendly, gloomy, grumpy, and sullen. He does not like anything or anyone. He is capable of hostile acts. He "gets square" with others through physical aggression. He reveals and proclaims his intentions and actions and how, somehow, he is proud of them. He often gets angry and is capable of holding grudges and anger for a long time. After another situation, some of his classmates complain to the teacher. The teacher presents the vengeful and malevolent behavior of Hristo as an ability—stubbornness, relentlessness are expressions of assertion; thus, he can be more transparent in front of his classmates.
- The behavior of 18-year-old Lyubomir indicates: "I'm a rebel!" He is open, straightfor-

ward, set against everyone and everything. He rarely cooperates, always knows what he is against, but does not always know what he wants. Strives to be different, rejects everything that is imposed from the outside, especially authority. He sees himself as misunderstood, unappreciated. Teachers want Lyubomir to be punished by transferring him to an individual form of education. Before the pedagogical council, the class teacher defends Lyubomir by interpreting his behavior as a call for help and search for a helping hand.

Positive psychotherapy teaches the teacher to recognize *the connection of one's own primary and secondary capacities*. For that purpose, the WIPPF (Wiesbaden Inventory of Positive Psychotherapy and Family Therapy) by Peseschkian and Deidenbach [7] can be used, adapted to its present version, WIPPF 2.0, by Peseschkian and Remmers [4]. Recognizing this interconnectivity in each student's behavior, especially in that of the problem student, helps the teacher to find an appropriate way of communication.

D. *Unfolding skills for coping with external conflicts*

To practice new skills, means to learn from one's own bitter experience and through understanding, to try to change it. The well-known model of Peseschkian [5] "*What I did vs What I should do"* (Ist-Wert vs Soll-Wert)" is of help to both teacher and older students.

Communication with psychologist–positive psychotherapists, participation in training seminars, and receiving help for self-help prompts and stimulates the teachers toward reflection and new practical approaches.

Examples of our practice, which teachers recognize and share as a change they've accomplished after being trained in the method of PPT [9], are given in Table 21.2.

At the beginning, not by chance, we introduced a saying by Paulo Coelho [14]. Through it, we wanted to exemplify the use of a significant tool of positive psychotherapy—*work with parables, tales, and language pictures.* This is an indirect way of entering the conflict situation and helping to resolve it. By using this set of tools, teachers rediscovered a pedagogical ability of theirs—to illustrate what they teach. What was new to them was that they could use this very same ability to cope with emotionally rich conflict situations here and now or in the classroom.

Table 21.2 Teachers' reflection and new practical approaches

What I did/used to do before the training	What I can do now, as a more successful educator
Through annoyance and sanctions—black marks for poor discipline, removal from class, writing absences on the report card	I point out the problem and give opportunities for coping
I demanded an explanation from the student for his bad behavior, reprimanded him openly in front of the class	I present a positive reinterpretention, hidden behind the student's bad behavior and imply my specific expectations for better behavior
In conflict situations I defended only myself—saw only the bad in the student	I learned to acknowledge the partial participation in everybody in the conflict; I view the conflict as a problem that needs to be solved cooperatively
I categorized the student as difficult and as having no hope of change	I see the positum; the student's recourses for change. I name them out loud, openly, and with good intentions
I pressured the student and sanctioned him by giving him low grades on a subject, because of his lack of discipline	I learned to differentiate between discipline and educational success. I learned to help the student cope separately with the problems in these two areas

Conclusion

The skills and tools of PPT (after Peseschkian) give the present-day teacher a new image. It revives the ancient requirement for the work of the pedagogue—to not only be the one imparting

knowledge, but also a person who educates and guides children and adolescents through their psychological and social growth.

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Positive Group Psychotherapy

22

Ewa Dobiała

Introduction

In positive psychotherapy (PPT), the group psychotherapy dynamics is reflected on by both the individuals forming the group and by the group as a whole. This multiple-level understanding has been developed and described for several decades by theorists and practitioners representing different approaches: Bion 1961; Berne 1966; Whitaker &Lieberman 1964; Yalom 1970 [6].

Historically, the roots of human perception as both a separate entity and as part of the group can be traced back as far as Aristotelianism. However, the first scientific study of the effect of a crowd on an individual, meeting the contemporary criteria of psychological research, dates back to 1985 and was published by Gustav LeBon, French physician and social psychologist, who first studied crowd psychology and coined the term "group mind." Social psychology pioneers focused mainly on large group (crowd, mob) mechanisms. Sigmund Freud carried out similar observations in groups such as armies or nations [12]. The precursor of current understanding and application of group therapy was Kurt Lewin [9], the American psychologist born in 1890 in Greater Poland (the area of Poland that was the Prussian Partition), and educated in Poznan and Berlin.

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Positive psychotherapy—at times referred to as positive transcultural psychotherapy—is a resource-oriented, transcultural, inherently and systematically integrative method, combining psychodynamic understanding with systemic reflection and humanist views. The founder of the approach [10] has developed a concept of basic and secondary capacities that enable understanding and describing of intra- and interpersonal conflict dynamics within the same conceptual framework [4]. Such a perception of the dynamics and origin of an individual's conflicts makes it possible to work both on interpersonal conflicts in individual therapy and intrapersonal conflicts in group therapy (see Fig. 22.4).

The role of a group therapist evolves with subsequent stages of a group process and with different processes taking place in each of the dimensions reflected upon. In the initial stages of the therapy, a therapist acts as a tutor of the phenomenon, helping the participants to set the limits and verbalize the goals. During the subsequent stages, a therapist becomes a source of tools and methods, in addition to a container for emotions, transference, and countertransference experienced in an interpersonal and group dimension. The therapist also moderates the setting and atmosphere in the group in addition to the therapeutic relationship. The therapist's role is determined not only by the stage of therapy but also by the level of the occurring phenomena. In group therapy, the intrapersonal dynamics overlaps with the interpersonal, group and systemic

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dynamics and with the group process to take place. All these dimensions affect one another, potentializing the processes occurring at a given level and are filled with content contributed by the group members.

The group develops conscious and unconscious dynamic interaction patterns that evolve with time and constitute the unique experience of togetherness. These blending processes constitute the social environment and determine how group members experience themselves and one another, affecting their behavior in this social environment. As part of psychotherapeutic intervention, the group is guided to reflect on a given dimension. Well-balanced interventions, tailored to the needs of the group, enable smooth transition to subsequent stages of group development. The achievable goals are somehow determined by the within-group diversity and by ensuring its optimal level.

Definition and Key Concepts

Aspects (Facets/Dimensions) of Group Psychotherapy According to Positive Psychotherapy

Intrapersonal Aspect

Positive psychotherapy has developed an extensive conceptual apparatus to characterize intrapersonal dynamics (conflict types: actual conflict, basic conflict, inner conflict, and key conflict (Fig. 22.1)—see Chap. 27). This dimension of the therapeutic process is aimed at creating the conditions for the participants to identify and verbalize their personal conflicts [5].

The content of these conflicts is expressed by means of capacities (basic, secondary, actual), which are based on and affected by an individual's lifeline and their culture of origin. Clinical reflection on the degree of the individual's integration within the group is aided by contemplating their self-perception ability (including degree of separation), impulse control ability (channeled outward or inward), and ability to connect (to themselves and others) and by acknowledging their internal object (Fig. 22.2) [13].

Interpersonal Aspect

The nature of group therapy provides an excellent means of accessing the interpersonal aspect (Fig. 22.3), which is present in each dyad of group members. The cognitive and emotional insights into the content of interpersonal conflicts enable an individual to associate them with intrapersonal dynamics. The PPT framework offers a narrative that combines both dimensions in a manner therapeutically significant for an individual [11].

The interpersonal conflict in group therapy offers a chance to face and acknowledge the unconscious thought patterns and active capacities of interacting individuals (Fig. 22.4). Owing to open verbalization, it is possible to ascertain the content of internal conflicts that are reflected in the content of the actual conflict.

Positive psychotherapy emphasizes the aspect of cultural differences, just as the communication style, the content, and experience of actual, basic, internal, and key conflict is affected by the social and cultural contexts (Fig. 22.5).

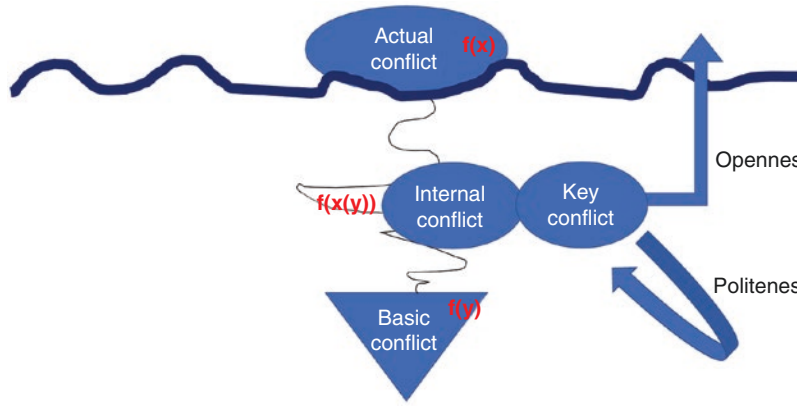


Fig. 22.1 Conflict operationalization

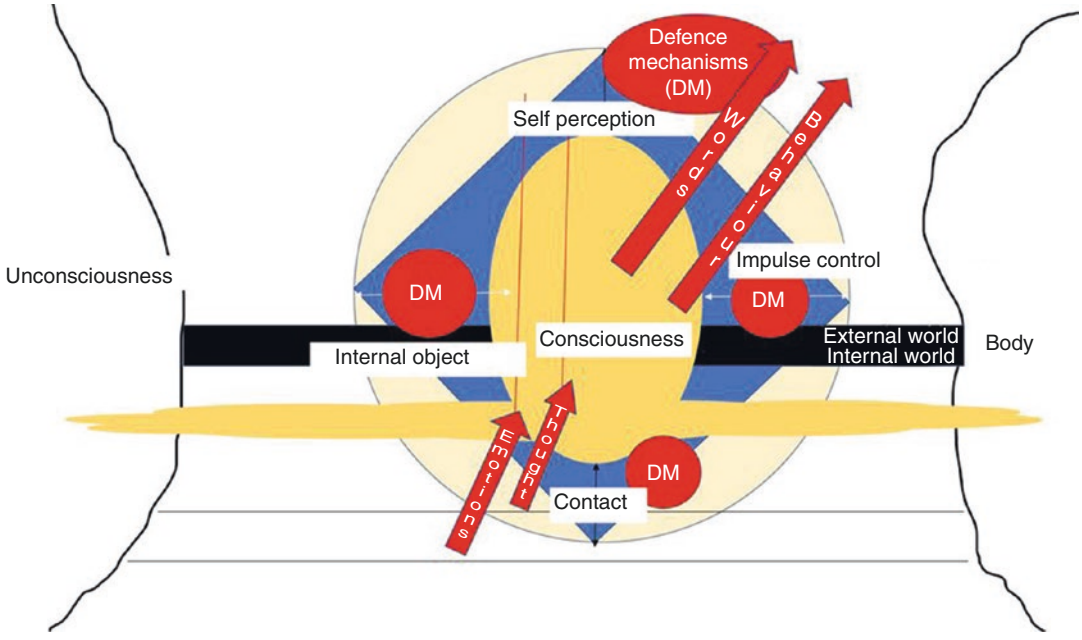


Fig. 22.2 Intrapersonal space

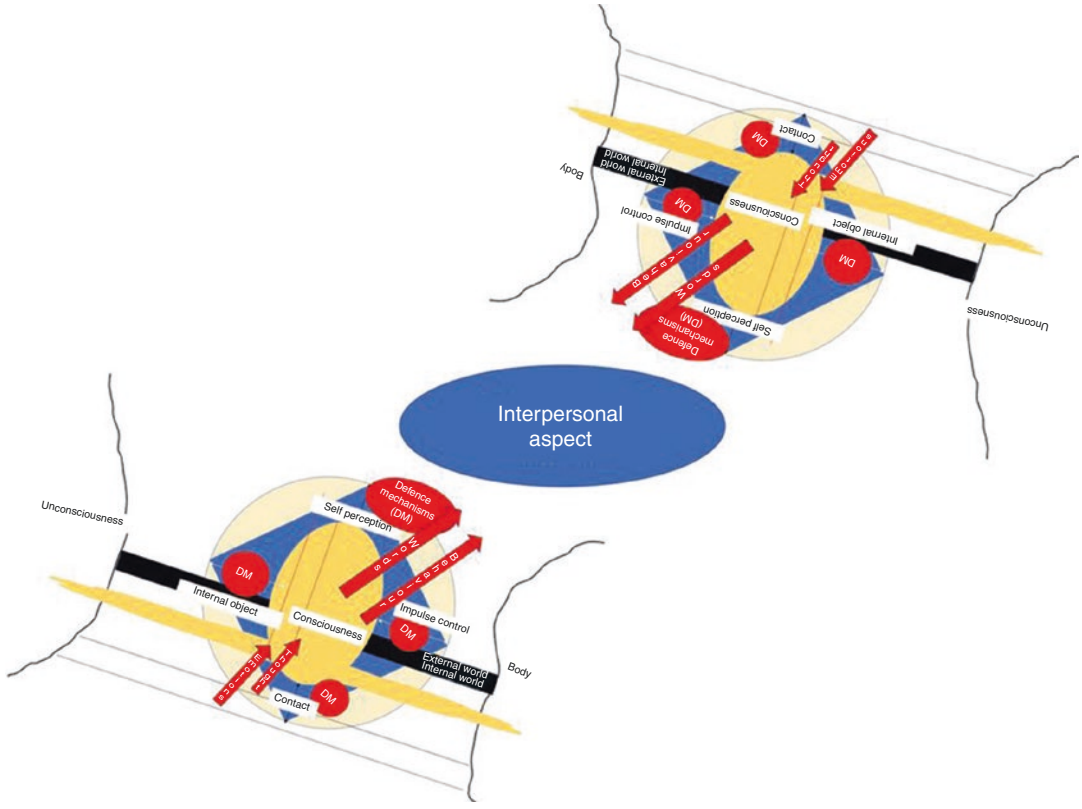


Fig. 22.3 *Interpersonal* space

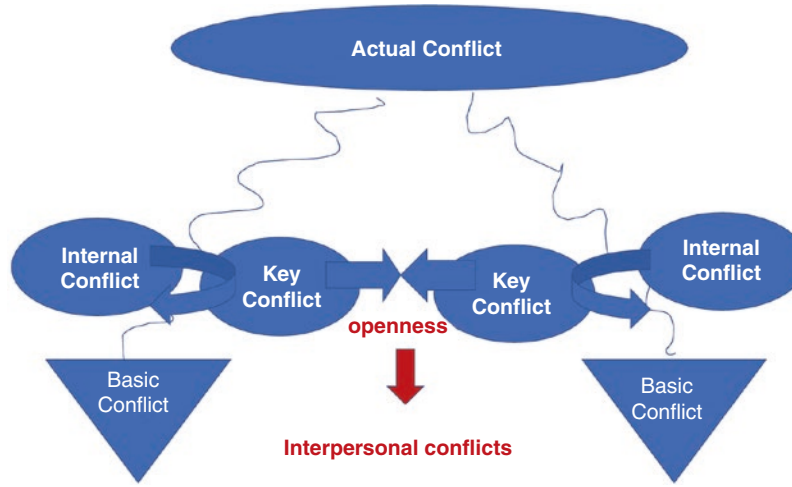


Fig. 22.4 Interpersonal conflict vs. inner conflict

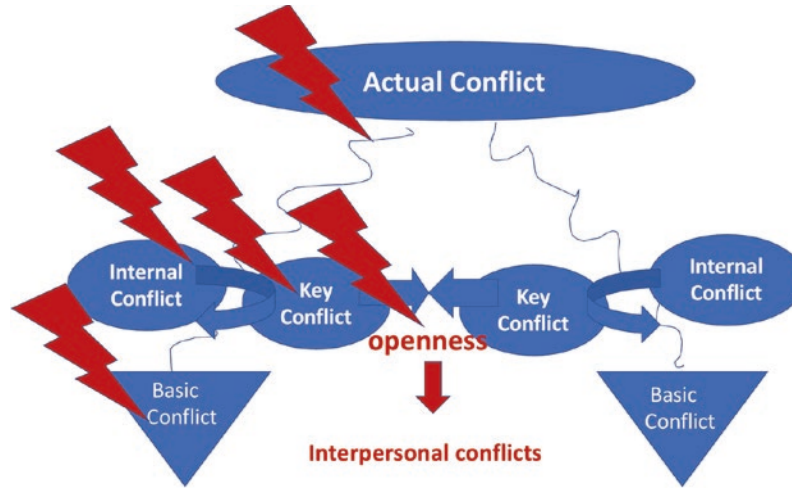


Fig. 22.5 The effect of cultural context on inner conflict dynamics

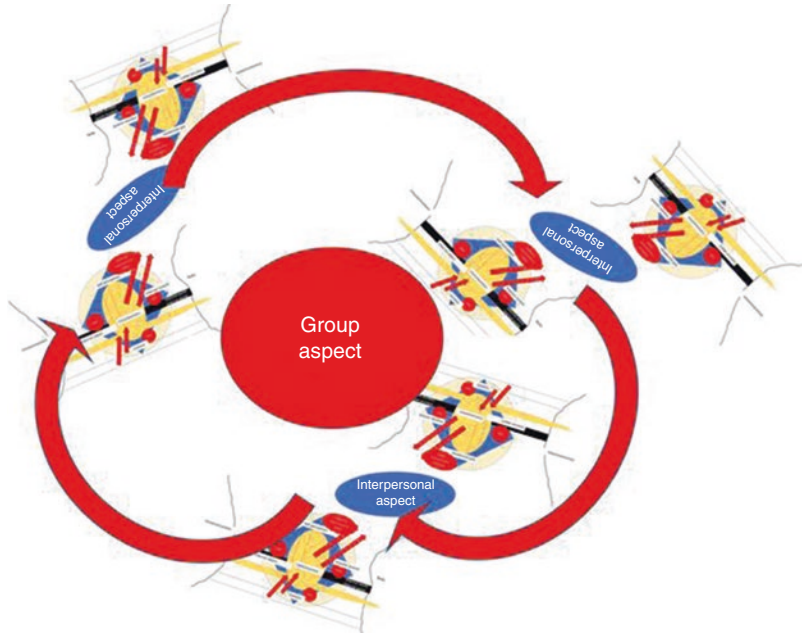
Group Aspect

Each group has its own conscious and unconscious beliefs and assumptions that apply to group task performance, decision-making, and roles, in addition to a set of formal and informal rules and norms (Fig. 22.6). The positive psychotherapist reflects on the phenomena occurring de novo in each group and on specific transcultural modifications brought in by participants belonging to minority communities (national, ethnic, sexual, autistic, etc.).

Systemic Aspect

Just like other social systems, a therapeutic system is complex and consists of multiple elements (people: participants and therapists; individual goals and expectations, reality, shared goals and the means of achieving them, place, time, space), being separated from the outside with an agreed, conventional boundary. Once the group is stable at the cohesion stage, the most balanced (multidimensional) therapeutic work takes place in the systemic area (Fig. 22.7).

Fig. 22.6 Group space



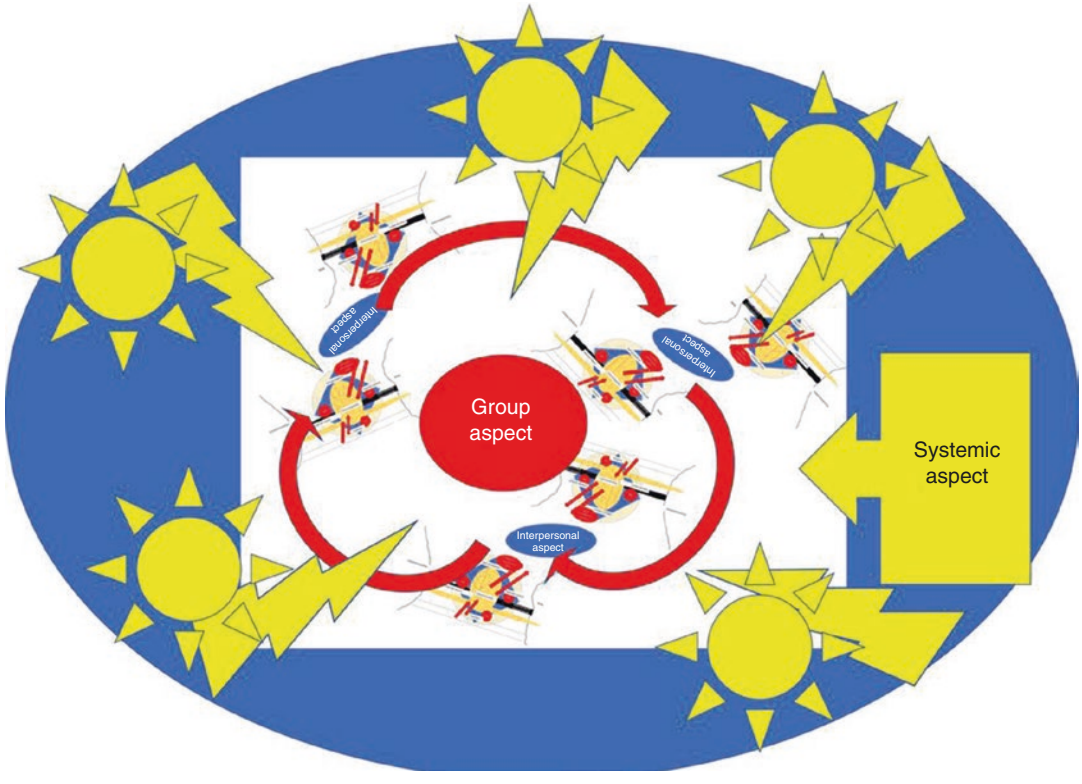


Fig. 22.7 Systemic dimension

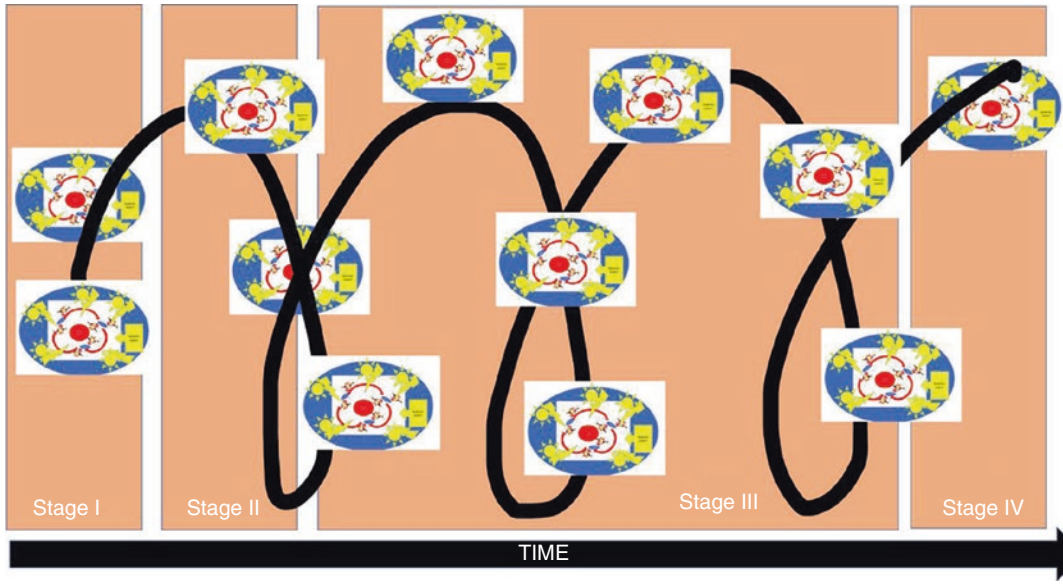


Fig. 22.8 Multidimensionality of a group therapy process

Group Therapy Process

The term "process" denotes a character of interaction taking place inside the group, between its members and between the members and the therapist(s) [14]. It combines all the above-mentioned dimensions: intrapersonal, interpersonal, group, and systemic (Fig. 22.8). During group therapy, the therapist needs to reflect on both the content and the stage of the process. Metaphorically speaking, the process can, therefore, be likened to an operating system that serves as a background on which the participants' intra- and interpersonal space content is presented. Observation, clinical experience, and research carried out by theorists and practitioners representing different psychotherapy approaches have confirmed a certain sequence and repeatability of a group process. The course of individual stages and participant needs at these stages are universal and do not depend on the language of modality that is used for expressing therapeutic content.

At the *forming stage*, orientation, tentative conversations, search for structure, and dependency on the leader predominate the contents [14]. The *second stage* of group development, that is, *storming*, involves conflict and resistance. It is the stage at which the fight for control takes place and ambivalent, often hostile, feelings toward the therapist may be evoked. The actual therapeutic work is possible at the *third stage, norming and performing*. It is the stage of mature group cohesion, in-depth work on participants' goals, and their search for ways to meet their own needs in a mature manner. Each therapy needs a conscious closure, goal expansion, and shifting the therapeutic experience from the participant's resources to their reality. Therefore, I always emphasize the *final stage of transforming*, which completes the therapy process.

The role of the therapist, therefore, involves consciously supporting the transition through the subsequent stages and using the natural dynamics of this process as a means of working with the content brought in by the participants.

Application

Group Process Contents in Positive Psychotherapy

Having a multidimensional space, overlapping phenomena that occur in that space and time, a therapist supports group members in filling the space with contents consistent with their goals and needs. The PPT model has conceptualized

the stages of a psychotherapy process (observation/distancing, inventory taking, situational encouragements, verbalization and goal expansion), and numerous therapy tools (described in detail in preceding chapters), which can have multiple uses in the hands of a therapist reflecting on the role of a relationship and a therapeutic alliance (Fig. 22.9) [3].

Considering multiple and various actions of a therapist during group therapy and different roles a therapist needs to play depending on the level of intervention, it seems reasonable to look at individual stages of group therapy in terms of their content in an attempt to conceptualize them using the nomenclature specific to PPT (Fig. 22.10).

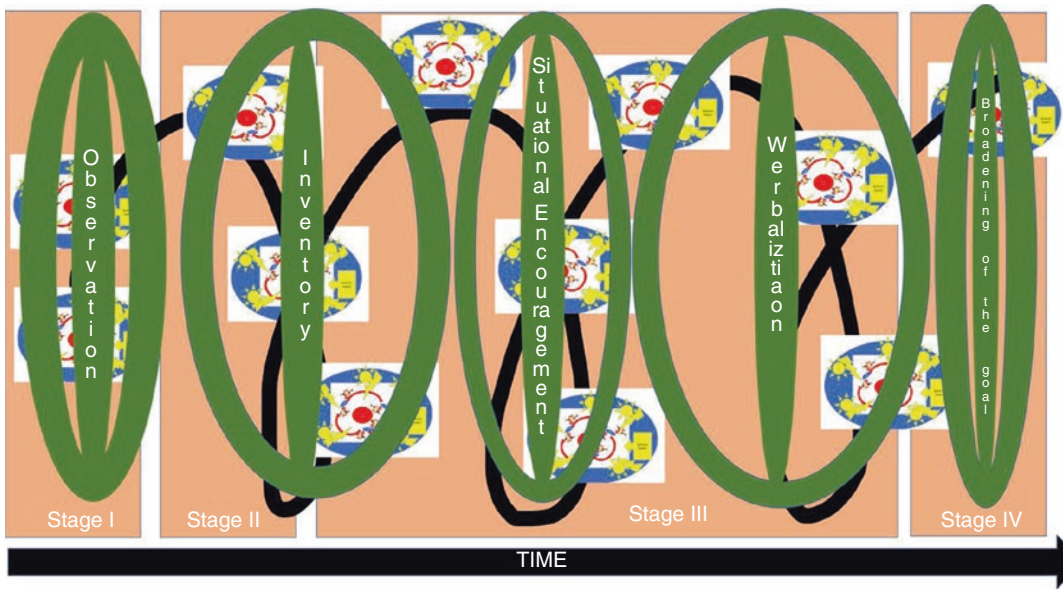


Fig. 22.9 Stages of a psychotherapy process and their respective contents

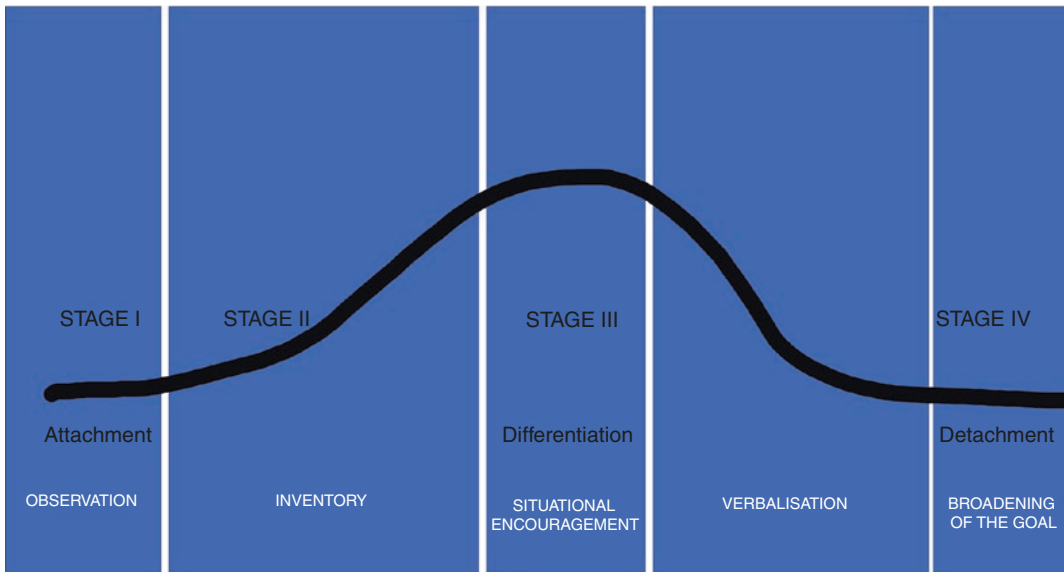


Fig. 22.10 Interaction stages in the group process vs. the psychotherapy process

Stage I

Group formation.

The earliest stage of group development is when the group structure is formed and working principles are defined.

- At the systemic level, the in-group social norms and the behavior and communication models are developed at this stage.
- At the interpersonal level, it is the stage of building group cohesiveness and trust.
- At the intrapersonal level, the participants feel the need to belong and determine their own role and place in the group.

The *key conflict* that becomes manifest in participants at this stage is the one between kindness and openness. The concerns at this stage of group formation can be verbalized to a variable extent. They address four different dimensions: (1) intrapersonal, (2) interpersonal, (3) group, and (4) systemic.

1. The first set of questions expresses participant concerns originating from their intrapersonal space:
   - "Why am I here?"
   - "How do I introduce myself?"
   - "Can I safely disclose personal information here?"
   - "Can I disclose who I am and still belong to the group?"
   - "Will the group see me as a unique person?"
   - "Will I not differ too much from others in the group?"
2. The second set of questions expresses participant concerns addressing the interpersonal dimension:
   - "Are there any other people like me in this group?"
   - "Will they understand me?"
   - "Will anyone want to listen to me?"
   - "How will they see me?"
   - "Will they accept me?"
   - "Will I be judged? rejected? ridiculed?"
3. The third set of questions pertains to the norms and principles of group therapy:
   - "What are we going to do during a group session?"
   - "What will it look like?"
   - "What are the rules and expectations?"
4. The fourth set of questions addresses systemic aspects of group therapy:
   - "Will anything I share be disclosed outside the group?"
   - "Will anybody else be able to access my records?"
   - "Will the participation in the group affect my future life, employment, etc.?"

At this stage, a therapist should facilitate relationship building and address the concerns arising in all the above areas. A therapist consciously models communication methods, supports the definition of group norms and principles by creating the space to agree the contract, educates the participants on the basic phenomena of the group process, and provides a structure for group work. The amount of structure provided needs to be adjusted to create a balance between the need for structure and discouraging dependency. The main task for a therapist, however, is to foster the atmosphere of trust, in which participants can dare to be open and which fuels the processing dynamics of each participant at each of the above-mentioned levels.

Stage II

Conflict and resistance.

The main challenges at this stage include the issues of power, authority, and control. The participants begin to reflect not only on what they have in common but also in what ways they are different. They feel the effect of a group process on their internal experience and have to confront their differing active capabilities. The first actual conflicts emerge. Group processes simultaneously take place at (1) intrapersonal, (2) interpersonal, and (3) systemic levels.

The challenges encountered at the intrapersonal level at this stage include:

- Recognition of one's own emotions
- Readiness to express difficult emotions
- Readiness to disclose and probe their own responses to what goes on in the group
- Readiness to work on rather than avoid interpersonal conflicts
- Promoting/reinforcing autonomy and independence

The challenges encountered at the interpersonal level at this stage include:

- Spotting differences in the significance of individual basic and secondary capabilities for group members
- Acceptance and openness to acknowledge and understand the systemic, cultural or biological origin of observed variability
- Teaching the participants to respond to behaviors of other participants without labeling them

The challenges encountered at the group level at this stage include:

- Modeling behaviors being a direct response to criticism
- Awareness of group role delegation
- Modeling respect for other group members' resistance and constructive response to different manifestations of resistance

The challenges encountered at the systemic level at this stage include:

- Preventing subgroup formation and expression of difficult emotions outside the group

The biggest challenge the therapist encounters at this stage is the need to intervene in a mindful and sensitive manner. Containing the group aggression directed at the therapist's role and undoing the potential setting up of a scapegoat can also be difficult.

The main task is to provide sufficient support for the differentiation process at its origin to become the first step of the inventory, which opens up a space for each participant to look into their own relational dimension and reflect on their individual anxiety-masking strategies. By fostering openness to expressing differences and dissatisfaction, the therapist consolidates participant awareness of group norms.

Stage III

The norming and performing stage can only be achieved after the two previous stages of group development have taken place and have been constructively closed. At this stage, the level of trust and cohesion among the group members is already high and the open communication enabling them to accurately express their feelings has been established. The feedback is spontaneous; it can now be received without being defended and accepted.

Using the nomenclature of the PPT, it is the stage for an in-depth inventory-taking, situational encouragements and verbalization. At the intrapersonal level, the main goal for the participants is to identify their own basic conflicts, understand the dynamics of inner conflicts, in addition to conscious and unconscious coping strategies. At the interpersonal level, the main goal is to acknowledge and resolve the conflict between politeness and openness, and to consciously manage actual conflicts, whilst reflecting on the diverse development of capabilities in each individual. The group and systemic levels of group functioning are usually the gauge of a therapist's skills. If a therapist often uses whole-group interventions at the preceding stages, the participants will be able to maintain their systemic function. At this stage, a therapist is perceived as an experienced leader rather than the highest authority. The group members are important to one another, and the system becomes a source of resources and offers the space for individual growth and personality integration.

Stage IV

In the reflection of a positive psychotherapist, this is the stage for the closure of the therapy process by the expansion of goals and ending of the therapeutic relationship. The main task of the participants at this stage is to consolidate the learned contents and reflect on responsibility. A positive psychotherapist for the last time uses the tools specific to the modality they identify with to give the participants the space to reflect on:

- The degree of assuming responsibility for themselves (intrapersonal dimension)
- The type, extent, and limits to the responsibility for their spouse/partner, children, parents, other family members (interpersonal dimension)
- The extent of responsibility for friends, acquaintances, neighbors, other group members (group dimension)
- The responsibility of an individual for the world in which our lifeline has been placed and the human race (systemic dimension)

Entering the closure stage, the participants are confronted with the need to contain the emotions evoked by parting, which may, in some cases, require closure of unprocessed issues and problems. Separation anxiety may appear at this stage of a group process. The role of a therapist is to ensure that participants may express all emotions likely to occur because of the imminent completion of therapy and name potential areas that require further therapeutic attention.

Clinical Application: Examples

Alongside scholarly knowledge and clinical experience, PPT also originated from Nossrat Peseschkian's personal life history. Leaving his homeland (Iran) for his new home (Germany), he encountered great cultural differences between collectivistic and individualistic societies. Considering these life circumstances, the basic dual question of "What do all people have in common, and in what ways are they different?" seems deeply emotionally understandable. This question became the research hypothesis and the foundation for further development of a psychotherapy concept and the concept of "positum" [2], from which the name of the modality originates.

The transcultural perspective and emphasizing a holistic view (positum) of both resources and functional challenges opens up the space for therapeutic work with those clients, who, being extremely distinctive, do not fit the standard settings of psychodynamic, systemic, or cognitive behavioral therapy. A good example can be multinational or ethnic minority groups, in addition to groups of immigrants or individuals with autism spectrum disorder.

Clinical Example: Positive Group Therapy for Individuals with Autism Spectrum Disorder: Specific Transcultural Aspects

Autism spectrum disorder (ASD), as a non-neurotypical developmental pattern, affects approximately 1.5% (1:67) of the general population. The Peseschkian question, paraphrased for the needs of group therapy in the ASD population, may therefore be "What do autistic individuals have in common with neurotypical ones and in what ways do they differ from them?" Differences in functioning, emotional codes, communication, and cognition form a basis of a unique culture described by autistic individuals. Knowledge, understanding, respect, and openness to neurodiversity are basic conditions that a therapist needs to meet if they are to become a leader of a therapeutic group of ASD individuals.

> The differences in communication style in autistic people are much subtler than in deaf people, and often very hard to detect for an outsider. Yet, such differences clearly exist, as autistic people often report that they have very few problems communicating with and understanding people 'of their own kind'. One could, thus, speak of a culture: communication problems arise when the cultural border is crossed. —(Martijn Dekker, Autscape, [1])

Stage I

Group formation is based on the atmosphere of trust and belongingness. Life experience, numerous relationship traumas, frequent iatrogenic traumas associated with "therapies" an individual may have been exposed to as a child and adolescent, make it difficult for a therapist to navigate a group transition to the subsequent stage. It takes special awareness of a therapist to ensure that connectedness occurs and a relationship be established at the interpersonal and group levels.

Below are needs expressed specifically by individuals with autism spectrum disorder:

> My main expectation from group therapy would be a closed group, preferably with people I have already met outside the group, whom I consider safe. Totally homogeneous—only individuals with ASD and/or ADHD, without significant comorbidities, such as personality disorder or bipolar affective disorder, with a formal diagnosis of ASD in all cases. The presence of individuals with personality disorder or bipolar affective disorder would make it impossible for me to be a part of the group. I think this is why I have never decided to join any open group sessions, e.g., at the day mental health units —Joanna, a 40-year-old female special educator, Asperger's syndrome
>
> In group therapy, I would expect to have my distinctness respected in a group space (not perceiving my feelings as a joke, being mean or challenging someone's authority) and tailored goal setting, where my needs differ from those of other group members. —Weronika, a 25-year-old female political sciences graduate, Asperger's syndrome
>
> I would like a therapist to consider ASD as neurodiversity, without stereotyping, applied behavioral analysis and attempts to suppress autistic traits in group members. I'd like a therapist to be able to identify the resources of individuals on the autistic spectrum and support them in developing self-awareness. At the same time, a therapist should support the group in developing the ability to see one another and to talk about their difficulties. Above all, a therapist needs to understand the difficulties that individuals on the (autistic) spectrum may experience when identifying their own needs. —Agnieszka, a 30-year-old-female psychologist, Asperger's syndrome.

At the forming stage, the ASD participants of group therapy can benefit from, and be put at ease by, learning a clear structure of a therapy process (observation/distancing, inventory, situational encouragement, verbalization, and broadening of goals). Distinctive emotional codes, sensory sensitivity or language processing can be reflected on as different aspects of being biologically transcultural. By introducing this narration, a therapist opens up a space for interest in diversity, a willingness to know it and understand its role in the lives of individual participants. As a result, relationships between group members can develop and a transition to the next stage is possible.

Useful transcultural aspects of the PPT process for individuals with ASD at the initial stage are:

- A clear, well-structured therapy process
- Language of imagery
- Transcultural reflection on sensory, motor, emotional, communicative or cognitive uniqueness of individual participants observed during the first stage

Stage II

The conflict and resistance stage is usually a major challenge for a therapist, and is even more difficult in a group of individuals with ASD. This greater difficulty stems from the relatively lower number of available and trained useful communication strategies, concomitant alexithymia, and relationship trauma fairly common in this population.

Below are needs expressed specifically by individuals with ASD:

> I'd like the therapist to be vigilant and prevent the group from scapegoating anyone, which I happened to have witnessed once and I suspect that the scapegoated person was on the autistic spectrum, just as I am. In group therapy, I'd like to learn how to be a part of the group without losing my specificity. I'd like to know how to work in a group whilst not giving myself up, and without resorting to behaviors that are completely unnatural for myself. I'd like to accept and to be accepted. First and foremost, though, I'd like to be understood. I'd like others not to assign negative interpretations to my behavior, which I have experienced in the past from the therapist in a group setting. I also expect that group therapy does not turn into autism re-assessment. I want to be strengthened rather than questioned. —Elżbieta, a 30-year-old female psychologist, Asperger's syndrome.
>
> Starting group therapy, I'd be afraid that the therapist may be unprepared, with no idea how

> people on the spectrum think or perceive, or (which is equally bad and dangerous) that the therapist may be an ABA practitioner. I would also be anxious about the unpredictability and "over-spontaneity" of the process. —Joanna, a 40-year-old woman.
>
> (I fear) that whatever I disclose to others may be used against me; that I will happen to be in a group, in which I will be jeered at… —Olga, a 22-year-old female university student, Asperger's syndrome.

Positive psychotherapy, with its transcultural emphasis, provides tools that enabled interpersonal conflict to be looked at from the value-based perspective (Fig. 22.4). Analyzing the situation to understand it is a strategy commonly utilized by individuals with ASD when in a group. For them, understanding is a basic prerequisite essential for feeling safe. This sense of safety, in turn, is a basic prerequisite essential for the first attempts at emotional recognition and emotional code identification (frequently masked by alexithymia) to take place.

Useful aspects of the positive transcultural psychotherapy process for individuals with autism spectrum disorder at the second stage:

- Tools available for use at the inventory stage (differential-analytic inventory, Wiesbaden Inventory for Psychotherapy and Family Therapy)
- Language of imagery
- Reflection on interpersonal conflicts expressed using basic and secondary capacities
- Awareness of interaction stages (connectedness, differentiation/discrimination, and detachment) and their resultant dynamics
- Transcultural reflection on observed sensory, motor, emotional, communication or cognitive uniqueness of individual participants
- Using transcultural examples

Stage III

The norming and performing stage of PPT involves inventory, situational encouragements, and verbalization. At the level of the inventory, each group member can face their own model dimensions, relational aspects, and lifeline, with particular emphasis on macro- and microtrauma, wisdoms, capabilities, and how they developed. Situational encouragements, often disregarded by other psychotherapy approaches, are of particular importance when working with ASD clients. The differences, for which they were ridiculed, suppressed or humiliated for years may in their positum constitute the largest resource of an individual. Verbalization is the culmination point of each psychotherapy process. It is the moment in which each group member has acquired sufficient insight into their intrapersonal dynamics and has developed the resources necessary to integrate their personality structure further.

The above general description of the norming and performing stage of psychotherapy is true for any group. Working with individuals with ASD at this stage requires understanding the specificity of their perception and making sense of their experiences. Only after these particularities have been catered for and embraced in the process will an individual be able to build on their therapeutic experience and develop a growth-promoting narrative.

Useful aspects of the PPT process for individuals with ASD at the third stage are:

- Inventory stage tools—model dimensions, relational aspects, lifeline, family tree, wisdoms, balance model
- Microtrauma and macrotrauma theory
- Basic capacities
- "Positum" and its consequence for self-narrative by an individual with ASD
- Verbalizing intrapersonal dynamics expressed as conflicts (actual, inner, key, and basic), which combines the active capabilities one develops throughout ones' life, in addition to interpersonal dynamics
- Transcultural reflection on observed sensory, motor, emotional, communication or cognitive uniqueness of individual participants
- Verbalization with inclusion and respect for transcultural aspects
- Using transcultural examples

Stage IV

The end of group therapy is associated with two main aspects: reflection on the responsibility model and the ability to end the relationship (detachment). Individuals with ASD tend to be

"all-or-nothing" in their responsibility models. Some of them may present with learned helplessness and submissiveness (often a by-product of behavioral therapies they have been exposed to), whereas others, usually those with high IQ scores, tend to be overly responsible. Both attitudes may render them particularly vulnerable and prone to abuse and suffering. Realizing this takes time and understanding how group and system dynamics work. Furthermore, the positive experience of group therapy may often be the first life experience of a safe relationship with another person for individuals with ASD. Ending the therapy may, therefore, be experienced as mourning and grief, which is another aspect that a therapist needs to reflect on and consider when conceptualizing a psychotherapy process.

Useful aspects of the PPT process for individuals with ASD at the completion stage are:

- Responsibility
- Awareness of the final stage of interaction (detachment)
- Verbalization with inclusion and respect for transcultural aspects
- Goal expansion stage: working out goals for the next weeks, months, and years following therapy completion

Conclusion

Owing to a holistic view of an individual, multidimensional conceptualization of psychotherapeutic processes and transcultural mindfulness, PPT can be used in clinical practice with very diverse groups. Despite the obvious advantages of group therapy, regardless of modality, two main conditions should always be prioritized. These are group selection, participant consent, readiness, and willingness. As much as they are objects of reflection for therapists, they also happen to be institutionally disregarded.

> (in hospital) I participated in therapeutic activities alongside individuals with autism spectrum disorder, mainly boys, who lacked independence, basic understanding of their own needs, sexuality or diagnosis; who were neither in education nor in employment, living on benefits. Compared to them, with my totally different problems, I seemed to be at the other end of the continuum. Needless to say, as a result of such activities, my functioning suffered significantly. The group started dragging me down. —Weronika, a 25-year-old female political science graduate, Asperger's syndrome.

Group mismatch, that is, disregarding differences in intellectual abilities, degree of independence, and concomitant mental health conditions, is the most common factor precluding an effective psychotherapy process from taking place.

Many individuals present with some degree of tension and uncertainty between the need to protect their own identity, intrapersonal separation, and the effect of participation in interpersonal, group or systemic processes. The causes and nature of this phenomenon are complex and multidimensional. It is particularly manifest in representatives of all minority groups: ethnic, religious or neurodevelopmental [8]. The in-depth reflection and understanding of these aspects pose a particular challenge for therapists and the worldwide community in the twenty-first century [7]. It is at least concerning that therapeutic abuse, just like the examples demonstrated in the ASD community, is still reported in many parts of the world. Many ASD individuals have been exposed since their early childhood, against their will and without their consent, to numerous "therapies" aimed at their behavioral adjustment to the needs and expectations of a neurotypical world. This stems from insufficient knowledge and understanding of their developmental specificity alongside unconscious projections of society and therapists.

> My dream would be that specialists have sufficient understanding of a human, their personality and preferences, regardless of the autism spectrum, to actually respect all individuals. Thus, in a nutshell, my dream would be that nobody (i.e., no specialist) offered me group therapy ever in my life. (…). I obviously agree with what others mentioned before (matching intellectual level, no pressure to speak/participate, no patronizing, IQ-matched group and therapist). However, even a remark of this sort evokes in me a very strong response to minor social trauma, to all those obsessive attempts to prove that "loneliness is abnormal" and ill. I am genuinely sad that despite my diagnosis and my fight for my identity, I still cannot be understood—even by those on the spectrum—and, like it or not, I still have to suffer due to the fact that (my) unwillingness to participate in group meetings is considered not ok. —Agnieszka, a 41-year-old female IT specialist, Asperger's syndrome

Group therapy is one of the sharpest tools in the psychotherapy armamentarium. Just like a surgical blade in the hands of a surgeon, it may introduce irreversible changes to the lives of its participants, the effect depending closely on the knowledge, experience, and personal preferences of the therapist. Thus, although these changes can "cure" and improve the quality and comfort of life, it may well take years of medical therapy and/or psychotherapy to remediate their consequences.

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Positive Psychotherapy in Organizational and Leadership Coaching

23

Yuriy Kravchenko

Introduction

In this chapter, we look at the concepts and practices of applying the method of positive psychotherapy (PPT) in working with leaders, teams, and organizations.

> The question arises: who is sick and who needs to be treated, a person who appears to be a patient, his family, his partner, his subordinates and colleagues, the society and its structure, politicians who want to represent his public interest, or someone else, called his therapist? –Nossrat Peseschkian (1987)

The approach described here is based on the developments of the Ukrainian School of Positive Psychotherapy over the past 20 years and on the experience of working with more than 40 large and medium-sized international and local companies (business, public, private, non-governmental), which number from 50 to 10,000 employees. Among many others are *Vodafone, NovoNordisk, BNP Paribas, VTB, Metro Cash&Carry, Luxoft,* and *SoftServe*. The author is grateful to all his individual, team, and organizational clients for being the best teachers.

To make it easier for the reader to navigate and absorb the content, the material of this part of the book is structured into five subsections—alluding to the classic five-step model of N. Peseschkian [55]:

1. *Observation. O*rganizational *p*ositive *t*herapy and *i*ntegral *c*oaching (OPTIC)
2. *Taking inventory. S*ystem of *p*ositive *o*rganizational *t*herapy (SPOT)
3. *Encouragement. "H"-o*riented *t*riangle (HOT)
4. *Verbalization. TRACK* system in organization
5. *Broadening of goals*. Model *"WORLD"*

Part 1. Observation

*O*rganizational *p*ositive *t*herapy and *i*ntegral *c*oaching (OPTIC)

Observation of the Organization Request Through OPTIC

When we first start working with a potential client, we suggest working with the OPTIC model, which is also:

A. An abbreviation of the name of the approach in which we will work: **o**rganizational **p**ositive **t**herapy and **i**ntegral **c**oaching (OPTIC) (see Fig. 23.2).
B. Strategic directions, which we will discuss during the observation: the organization itself, taking on the nature of its existence and its problems through the prism of the positive approach, possible prospects for the application of PPT models and/or integral coaching in this case.

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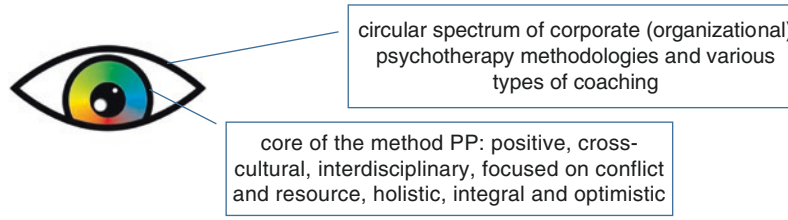


Fig. 23.1 The "OPTIC model" for observation in organization

Fig. 23.2 Organizational PPT and integral coaching

C. A symbol of an eye, which is easily remembered and reminds us that we are at the observation stage with a client. In addition, (1) the "pupil" itself symbolizes a special vision through the core of the method: positive, cross-cultural, interdisciplinary, focused on conflict and resource, holistic, integral and optimistic; (2) the "iris" of the eye, which, as is well known, can be of different colors and shades, and is a moving muscular diaphragm, symbolizes a circular spectrum of various working ("movable," "muscular") methodologies, models and tools; (3) the "eyeball" area—that is, the eye itself as an organ—symbolizes the organization itself or its part that "sees the problem or task" and calls for help (Fig. 23.1).

Before proceeding to the working and applied sections, we briefly pay attention to the view—the positive view of human nature and organization (Fig. 23.2).

A View of Human Nature and the Nature of Organization in PPT

Positive psychotherapy focuses on human nature. Is a person born tabula rasa, or is there a certain predetermination in human nature? What other alternatives are there? And how does this affect our vision of large human communities, systems, and societies? These questions are raised by many ancient and classical philosophers in addition to thinkers and practitioners of the twentieth century: Freud, Jung, Adler, Fromm, Maslow, Rogers, Peseschkian. Also, this issue is at the basis of the majority of the world's traditional teachings and religions; it is an important reference point. At the same time, for example, in many of them, the detection, cognition or discovery of one's true nature as a person is not only a reference point but the ultimate goal.

Positive psychotherapy offers a broad and at the same time both optimistic and realistic concept of human nature: we are born with two basic capacities: to love and to know. These capacities are an integral part of our nature, our essence, the innermost—which, through the development and discovery of potential, becomes explicit.

We come to the organization with the same capacities. Based on this, we view any individual person, or the entire human system (team, community, organization, society) through the prism of these two basic capacities.

Perhaps, at first glance, it seems simple or even simplified (the way many clients react at first). But then it turns out that this is a productive

approach and it opens up new perspectives for a cross-cultural, existential and integral understanding of organizations.

For example, for existential coaching in organizations, it is also important to understand the existential nature of people and organizations. In classical approaches, the human nature and its life are considered through "existential dichotomies" and "existential needs" (Fromm), "existential conditions/concerns" (Yalom), "existential motivations" (Frankl, Längle). This classic is good for existential psychotherapy, but for existential coaching it is too "cumbersome." A view through "love" and "know" (which means, through primary and secondary processes and capacities) makes it possible to describe dichotomies, needs, concerns, and motivations. For more information about existential coaching in organizations, see the section on existential coaching.

One of the tasks of a healthy organization is to help a person overcome the existential dichotomy of know/love and turn it into an existential dialectic. In other words, to create a dynamic integrity of know and love, in the "unity-in-diversity" of their differentiated manifestations through the self-realization of man.

Matrix of Work with Leaders, Teams, and Organizations

In this matrix, we use the scaling approach, which we have used since 2008 in the Organizational Coaching School and in the Corporate Training Program "Evolution of Leaders, Teams, and Organizational Systems" [38].

We work on three focused scales:

1. Individually with a leader and his life
2. With a team
3. With an organizational system as a whole (including leaders and teams)

At the same time, we can work at different levels of depth with each scale: therapeutic (deeper and longer) and/or coaching (more future-oriented and short-term in separate iterations; Table 23.1).

Part 2. Taking inventory: *S*ystem of *P*ositive *O*rganizational *T*herapy

This section is devoted to taking inventory—the deepest and most systematic part of the five-step process.

Here, we describe the characteristics and principles of the system of positive organizational therapy (SPOT) (sections. "Main Characteristics of SPOT" and "Main Principles of SPOT"), share the vision of working with the basic conflict in the organization (section "Psychotherapy of the Basic Conflict of a Person, Team, and Organization"), and summarize everything in one table, taking into account the modern developments of operationalized psychodynamic diagnostics (OPD-2).

We conclude this section with an example of the *first interview* that we use in working with organizations (Appendix: Organizational FIND: First Interview: From Needs to Development).

The classical method of PPT is described in the main characteristics and the three main principles. All of this is fully applicable to organizations. Further, we briefly clarify how the specific characteristics and principles of the method are refracted in working with organizations.

Main Characteristics of SPOT

Integrative psychotherapy method

- We consider everything that can or could be "mined" and developed using other methods and approaches in organization: psychoanalysis, transactional analysis, management analysis, cognitive-behavioral approaches, schema therapy, gestalt therapy, spiral dynamics, "U" theory, training, etc. We do not denigrate other methods, but we try to integrate all of them, "gathering into one pattern." The integral map [68] also helps us in this.

Humanistic Psychodynamic method

We simultaneously look "in two eyes" ("stereoscopic vision"—N. Peseschkian):

(a) We look positively at human nature, a person's basic and actual capacities and contribute

Table 23.1 Two-level matrix: coaching and psychotherapy in organization

	General review (can be realized by preliminary meetings or studies)	**Individual work with a leader and his life**	**Work with separate teams**	**Work with an organization as a whole**
Psycho-therapy	**At what levels does the *problem* exist?** *– Economic* *– Energy* *– Emotional* *– Existential* **.. How do we know that this problem exists?** **For whom is it a problem?** **.. And for whom is it – not a problem?** **– What are the cross-cultural views on this situation?** **– From what level and from whom does the REQUEST come?** **– At which E-levels are currently the largest resources?** **– What changes and results do we want to achieve and at what levels?**	**"Corporate therapy" as a psychotherapy in an organization** (conflict and resource-focused assistance from a specially trained specialist present in the organization)	**"Corporate therapy" as psychotherapeutic training on topics:** • Non-violent communication • Cross-cultural approach • Differential analysis • Five steps to solve problems in a team	**"Corporate psychotherapy" as a therapy of the organizational system at different levels:** • Perception and processing of current experience • Of the experience of present and past relationships • Conflict dynamics • Organization structures • Organization cultures
Coaching		– Managerial coaching – Life coaching and health coaching – Existential coaching – Vertical Development coaching – Perspective coaching	– Psychodynamic Coaching – coaching of existential motivations – Training coaching program "evolution of teams"	Systemic organizational coaching based on models: *4E model* *4R model* *Umansky model* *Bion's model* *Adizes model* *Cook-Greuter model* *SAPE model* *4M model* *five-step model* *DA-, TA-, EA- models (Kravchenk& Konischev, 2018).*

to the actualization and self-disclosure of the potential of his/her abilities in the organization and in the workplace (this is the humanistic pole, the so-called "positive process")

(b) We see psychodynamics inside the personality, in teams, and in the entire organizational system, and we perceive psychodynamics not only in its form ("symptoms" and "syndromes"), but also in its content—"what is behind this?" (this is a psychodynamic pole, the so-called "substantial process"). Such stereoscopic vision allows us to remain both optimistic and realistic. Here, we use the best practice of humanistic-oriented psychoanalysts: Fromm, Kohut, Winnicott.

An example of the practical implementation of these two poles of the method is the "psychodynamic coaching" developed by us (there is information about it later in the book). "Coaching" represents the humanistic, optimistic pole of the method, and the ability to see and work with psychodynamics—realistic.

Cohesive, integrated therapeutic system

- Positive psychotherapy is not only an integrative but also an integrating method that strives for the healthy integrity of any system. Based on two basic capacities, three principles, four areas, and five steps, we integrate, unite, and bring together the emotional, cognitive, behavioral, fantasy, physiological, relational, and spiritual aspects of the functioning of people, teams, and organizations. Integrative development results of other authors also help us in this [10].

Conflict-centered short-term method

- As already mentioned, we notice psychodynamic processes in an organization, not only in their forms but also in their content. Owing to the focus on the content and dynamics of the conflict (within the individual, within the team or between teams or departments of organizations), the method works at the same time deeply, precisely, and in the short term. *"Do not repair what is not broken."*

Cultural-sensitive method

There are four scales here:

1. In a strict sense, we see that people working in the same organization are carriers of different ethnic, national, subcultural values and we help leaders, managers, and human resource departments to take this into account
2. Organization has not only a "body" (organizational structure and material base) but also a "soul" (organizational structure)
3. Organizational culture is a "system of systems," "culture of cultures," "transculture," "transit culture"; cross-cultural processes take place within it, not only between cultures of different teams but, for example, between management culture and learning culture, between client culture and team culture
4. Culture of organization, external culture of society, and culture of participants of the organization are in complex interaction and superposition [24].

Use of stories, anecdotes, and wisdoms

- "Like golden apples set in silver is a word spoken at the right time" (Solomon). As modern organizations still remain very much "left brain systems" (aimed at secondary capacities, logic, schemes, and figures), the use of images, metaphors, and creativity opens the door to new opportunities and resources. But it is even more valuable not just to "switch the cerebral hemispheres" but to connect them; using stories, anecdotes, and wisdom is best for this when the verbal (right) and the imaginative (left) hemispheres connect. For example, in team coaching, during business meetings, at strategic sessions, we can use parables, stories, myths, and legends as mirrors and as intermediaries [60].

Innovative interventions and techniques

- Colleagues developed such methodologies as psychovampirism prevention [50], stress surfing [29, 50], health coaching [55], decision-making methods, principles of personnel management, and management strategies [22, 25, 26]. And we further develop psychody-

namic coaching and existential coaching to work with teams and leaders.

Application in psychotherapy, other medical disciplines, counselling, education, prevention, management, and training

- The use of the method in organizations is already an application. But we strive not to make it one-dimensional: for example, having developed health coaching in the field of health care initially, now we are making a second arrangement: health coaching itself, connecting it, for example, with stress surfing, is transferred to the sphere of organizations and business [36].

Main Principles of SPOT

The three main principles or pillars derived from PPT and applied in positive organizational therapy are:

- *The principle of hope*
  We have a humanistic hope that the human desire to realize the potential of its abilities and aptitudes is so great that even in one-sidedly developed organizations and human systems, people have many chances to show their positive nature. Organizational, labor, and business conflicts are sometimes particularly difficult and risky, but it is often they that give chances to learn partnership, openness, cooperation, and interdependence [53, 54 69] and/or better understand the way they form and develop.
- *The principle of balance*
  We consider the main balance to be the balance of development, renewal, and recovery of organizational structure and organizational culture, so that "hard" and "soft" processes in the organization are given management attention and time. We also work with an organization balance model and a differential-analytic model of capacities that it is important to harmonize at the situational and system levels, both in individual managerial or production relations and in the system as a whole. We have been developing this methodology since 2000 at the Ukrainian–German Center for Positive Psychotherapy and since 2005 at the Ukrainian Institute for Positive Cross-Cultural Psychotherapy and Management [22, 25, 26].
- *The principle of consultation*
  Organizations, as complex organisms, being systems of interconnections [38], are wise enough to regulate themselves in most cases. More often, people and teams in organizations do not need "repair" or "treatment" but accompaniment and support. One of the best forms, we believe, are events aimed at psychoprophylaxis and mental hygiene (measuring the mental health and emotional wellbeing of an organization), as well as coaching technologies (measuring horizontal and vertical development and new achievements). We build most of the technologies and processes on the basis of a five-step process, which is good for both consulting and coaching, and self-help.

Psychotherapy of the Basic Conflict of a Person, Team, and Organization

> You have to swim against the stream to get to the source.
> Go upstream to find the source.
> Nossrat Peseschkian

As basic conflict, in its broadest meaning, we understand the conflict between the past (which we carry in ourselves) and the present (which surrounds us). This basic conflict prevents us from moving forward to a better future that lies ahead of us.

We could organize this better future for us, if it were not for this basic conflict, "forcing" us to serve the past and turn the present in its direction.

This is a common pattern for individuals and for their families, communities, teams, organizations, and entire societies.

The basic conflict cannot be solved in a simple manner, for example, by changing behavioral habits, emotional acting out, negotiations, or balancing.

This is because the basic conflict includes the defense mechanisms and the coping strategies that proved their value earlier. These defenses

and coping strategies are justified by negative events and traumas of the past (hereinafter, this corresponds to the first axis in) and protect against them. At the same time, they do not allow to new potentials to be realized. There is a vicious circle: to protect ourselves from the worst, we avoid the best, and we repeat this psychodynamic cycle more than once.

In terms of in-depth approaches to coaching, the basic conflict refers to those situations where a person, leader, team or the entire system repeats protective psychodynamic patterns again and again instead of choosing to realize their economic, energetic, emotional, and existential potentials (realizing the potential in terms of the 4E system).

Positive transcultural psychotherapy is a psychodynamic conflict-centered method. Therefore, we pay much attention to the basic conflict.

At the same time, we do not consider the basic conflict separately but in combination with actual, internal, key conflicts and resources.

The method of positive cross-cultural psychotherapy at this stage of development offers a fairly developed technology of conflict operationalization [18, 20], which at the same time is consistent with the system of operationalized psychodynamic diagnostics [50].

This allows us to use this system in a flexible and focused way, both as tools for psychotherapeutic practice for working with individuals, teams, organizations, and communities as a whole, and through in-depth coaching (psychodynamic and existential).

Work System: OPD, Classical Method, Existential Expansion, In-depth Coaching Tools (Table 23.2)

Part 3. Encouragement: Two "HOT" Models

Situational encouragement in PPT is a very important, key, core stage. In the word "encouragement", the base is "courage," and the words "core" and "courage" have a common origin. This is the emotional and energetic core of working with the client, the "hot spot" in the best sense.

To keep this in mind, we use two HOT models.

In the section Substantive "HOT" Model: "H"-Oriented Triangle, we describe a substantive model showing which topics and contents it is important to build interaction with the client around at this stage.

In the section Process "HOT" Model: Holders Opinion Trialogue, we touch upon the process of such an interaction: with whom and how is it carried out?

Finally, in the section, we refer to our practices on health coaching based on PPT.

Substantive "HOT" Model: "H"-Oriented Triangle

There are three central resource substances in working with leaders, teams, and organizations (Fig. 23.3):

1. *Hope.* This is a humanistic dimension and it corresponds to the first principle of PPT. *What do you have hope for? Which hopes are justified and which are not in this organization? What strengthens or weakens hope?* (more details can be found in the second section on the primary interview for organizations).
2. *Health*. This is an important focus, especially for corporate (organizational) psychotherapy. Considering health in a narrow, broad, and comprehensive sense, we are talking about team health and systemic organizational health. We are talking not only about physical health but also mental health, emotional health (emotional well-being), existential health (for more details see health coaching publications, where we consider various types of health: [32–34, 37, 38, 40, 45, 46]). Questions that are helpful to consider: *What are we already healthy at? How do we experience this health at the existential, emotional, energy, and economic levels?*
3. *Habits*. Useful and constructive habits that already exist—an important available resource (positum) —on which one can and must rely.

Table 23.2 Work system, based on four axes of operationalized psychodynamic diagnostics (OPD)

Axis in OPD (first four axes)	Compliance in the classical PPT method	Expansion in positive existential psychotherapy method	Working practices with teams and organizations	In-depth (psychodynamic and existential) coaching tools
Axis *Illness, treatment, and health experience*	Positum-approach Cross-cultural approach to the interpretation of diseases and health, conflicts and difficulties Positive view of the nature of a human and its capacities The principle of hope. "Global identity" (Peseschkian)	Introduction of the concept system: 1. Positive existential interpretation (*positive existential meaning*) [36, 43, 54] 2. Existential *capacities* [36] 3. Existential *concerns/givennesses* [27, 69] 4. Existential *activities* [41] 5. Existential *identities* [23, 27] 6. Existential *motivations* [13, 43] 7. Existential *needs* (Ivanov, [36]) 8. Internal *existential objects* [36] 9. Existential *relationship* [36]	Work with criteria of "organizational" and "team" health. Positive existential interpretation of negative events (through an understanding of *existential motivations and meanings* [42, 61] What *existential capacities* allow you to develop these challenges and these givennesses/concerns	Psychodynamic health coaching of organizational system: work with the *disease-psychodynamics-coping-health* axis Work with four existential "R" in coaching: 1. What *result* will bring us the greatest *meaning*? 2. What are the existential *risks* of these *changes*? 3. What existential *resources* (activities, capacities, identities) do we have?) 4. What do we expect from new *resolutions*? What *existential needs* will they satisfy? What identities will expand? [36]
Axis *Relationships*	Differential relationship analysis Three stages of interaction in relationships Principles of hope, balance, and joint councils in relationship development	Relationship through identification with internal *existential objects* (heroes of stories bearing a positive existential charge), for example, Hodja Nassredin and Avicenna	Development of the *existential relationship* concept as an alternative to psychodynamic relationship *Existential analysis* of the relationship with the leader Defining *existential motivations* in teams	Establishing an *existential relationship* with a coach (including to counter psychodynamics in the client's systems) and their differential analysis using the systems of actual [55] and *existential* capacities
Axis *Conflict*	Operationalization of conflicts and their dynamics [18] Actual, inner, basic and key conflicts	Consideration in the dialectics of *basic conflict* (emotional nature) and *basic resource* (existential nature) Resolution of the *key conflict* at the spiritual level [27]	What is the level: *Economic?* *Energy?* *Emotional?* *Existential?* of conflict? At what level is conflict resolution required?	Work with psychodynamic conflict in a three-dimensional coordinate system: 1. Organization structure 2. Organization culture 3. Relationships
Axis *Structure*	Four channels of reality learning and traditions fixed in them Basic emotional attitudes, entrenched in protective configurations	Existential identities and "five pinnacles of destiny" [23] Integration with spiral dynamics Integral approach	Structural maturity of the team and organization based on the Umansky model Practices of vertical development and ego evolution [3]	Check for compliance of the organizational structure with the organization objectives How do the leader's personality structure and organization structure interact? Coaching of perspectives [38, 39, 56, 57]

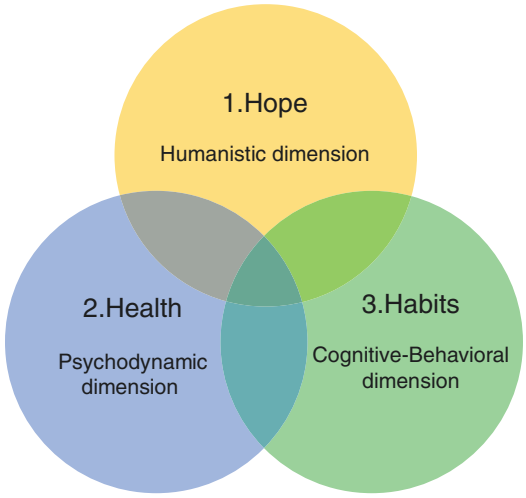


Fig. 23.3 Substantive "HOT" model: "H"-oriented triangle

What are we already good at? What we do not need to change? How can existing habits help us to develop new ones?

We talk about these three focuses with an individual client or with teams, including strategic boards and boards of directors. In our opinion, it is important in the triangle of these topics to observe the balance of attention so that it is equilateral and we can take into account the *positive (humanistic), psychodynamic, and behavioral resources* of the client.

Process "HOT" Model: Holders Opinion Trialogue

The second "HOT" spot for encouraging and finding resources is to involve the maximum number of participants (holders) of the change process in the dialogue. We consider at least three parties: (1) a customer of changes, (2) a client (he is not always a customer!), (3) a specialist who helps with changes (coach, consultant or psychotherapist). If you bring them together, often their trialogue immediately switches to problems and solutions. At the same time, what is already good is overlooked.

> One rotten egg is remembered better than a thousand fresh ones
> Eastern wisdom

To involve these three parties in the trialogue exactly at the resource stage is a special chance to establish a solid basis for cooperation. Because when we proceed to solving problems, the dialogues and trialogues will be under a special test.

Part 4. Verbalization and Implementation of Changes

System of TRACK Principles

The fourth stage corresponds to the implementation and justification of changes. So that the interventions are systemic, accurate, directional, and safe, we have developed a system of five TRACK principles.

- *T—Training.* Change at the level of behavior is a necessary and sometimes sufficient level of change. PPT is a method of training for small behavioral changes in everyday life. This also applies to working life, business, and organizations. "One can open large doors with a small key" (N. Peseschkian).
- *R—Relations.* It is the psychotherapeutic perspective in organizations that gives an additional understanding of how important for the introduction of changes are changes in relationships and/or support in relationships.
- *A—Attitude.* Change at the attitude level is an important component, and here, PPT fully takes into account the groundwork of cognitive science and practice.
- *C—Consultation/consulting/coaching.* Everything described above (the therapeutic content of the changes) exists, best of all, and is carried out in an organization in the form of partnership counseling and coaching in the format of the relationship between two adult personalities.
- *K—Keys.* Corporate psychotherapists and consultants work in such a way that they become less needed, so that the "keys of self-help" (Peseschkian) are increasingly transferred to the client.

Each of these principles is taken from Nossrat Peseschkian's method and reflects the essence of

how PPT approaches changes. This is primarily a focused cognitive behavioral approach ("T" and "A" principles). At the same time, we are deeply convinced that changes at the level of behavior ("T") are mediated by relations ("R") —solely an attitude change is not enough ("A").

> Positive Psychotherapy is a relationship-oriented method
> (Hamid Peseschkian)

All of this is worked out and consolidated by consulting and coaching ("C") and remains with the client in the form of "keys of self-help" ("K"). This correlates with the third basic principle of PPT: the principle of counseling and self-help.

It is also important to note that in modern organizations a shift from management consulting to management coaching can be observed: there is a "softening" of the paradigm and a transition to agile management. Owing to the fact that since the 1960s, the consulting business especially has penetrated into an increasing number of countries, cultures, and economies; it has become not only a "knowledge industry" but also a "cross-cultural communication industry" [26, 30], all while progressive methods of psychology and psychotherapy have also moved in the direction of cross-culturalism over the past 70 years, in particular, the last 50 years. Peseschkian's method is one of these methods, and in the 2000s it was mature enough to become a deep cross-cultural methodological platform for management consulting, coaching, and corporate psychotherapy.

Further, in the section What Is Subject to Change for a Better Positive Future? Structure, Culture, Conflicts, Relationships, Experience, we look at the levels at which we make changes with the help of corporate psychotherapy, and various types of coaching and training.

Then, in the sections The Relevance and Essence of Positive Psychodynamic Coaching and Specific Competences of a Psychodynamically Oriented Coach and Their Focus on the Elements of Psychodynamics in PPDC, we describe one of the most interesting and modern types of coaching, which is becoming increasingly popular in organizations: a positive approach to psychodynamic coaching.

Finally, in the section Psychodynamic Management in Work Groups: Models and Tools for Team Evolution and Vertical Development of Leaders, we relate the management of team psychodynamics to their development and the development of leaders.

What Is Subject to Change for a Better Positive Future? Structure, Culture, Conflicts, Relationships, Experience

> Do not fix what is not broken.
> A small key can open a large door.
> (Nossrat Peseschkian)
> High-Quality Future is more accessible in High-Quality Present.
> (Inna Didkovska)

When we work with a leader, a team, or an organization as a whole, determination of the subject of our changes in coaching or psychotherapy becomes especially important.

What happens in relationships (for example, between a leader and a team; or within a team; or between teams)—is this normal or does it require intervention? How deep? Selective or systematic?

What should be done with the conflict? How deep and "healthy" is it? Or is it already destroying culture and structure?

Can we change the culture? Of a personality, team, organization?

How can the structure be changed and to what extent? Leader personality structure and organization structure.

This system of interrelated issues is complicated but solvable.

It is important to remember: what do we want to make these changes for? What better positive future? However, not only "for what?" but also "for whom?" What resources are needed for this? What risks await us along the way and as a result? Sergey Konischev, the trainer of the Organizational Coaching School [38], likes to ask clients and students at the School: "What's the worst which can happen—if you achieve the best results?" This question is surprising, and sometimes shocking. But in most cases it turns out to be useful.

Whether we work with an individual or with a human system, we treat these issues in a *differential and analytic way* [25, 53] on the one hand, and in an *integral way* [3, 67, 68] on the other. What does this mean in practice?

First, we certainly consider it, how deep we will "get" with our interventions on the following levels (Fig. 23.4):

1. *The level of current actual experience (actual conflict and actual resource):* its perception and passing through. For example, how does a team and a leader go through if, let us say, they are on deadline and it seems that the project will not be completed? What do they feel? What are they trying to do with this? How do they cope (the level of actual coping)?
2. *The level of relationship experience.* We often find here accumulated (past) experience with the actual tasks of reality and actual experience in the current relationships. For example, the team on deadlines in previous relationships with previous managers experienced fear—when managers began to "oppress" during time of crisis and threaten dismissal if the project is not realized on time. But now, for example, the new manager is trying to build a new experience in partner-coaching relationships. To do this, he listens a lot to the positions of the team members. However, this leads to inner conflicts among some team members who cannot yet reconcile the accumulated experience of authoritarian relationships and the new partnership experience. These people seem to be torn inside between "obey and be afraid" (as it was before, and it somehow worked) or trust and begin to speak (taking risks, according to previous experience, to be punished for an opinion that does not match the boss's one). Then, we should help in accessible ways (coaching, facilitation, moderation) to realize and overcome this level of inner conflict.

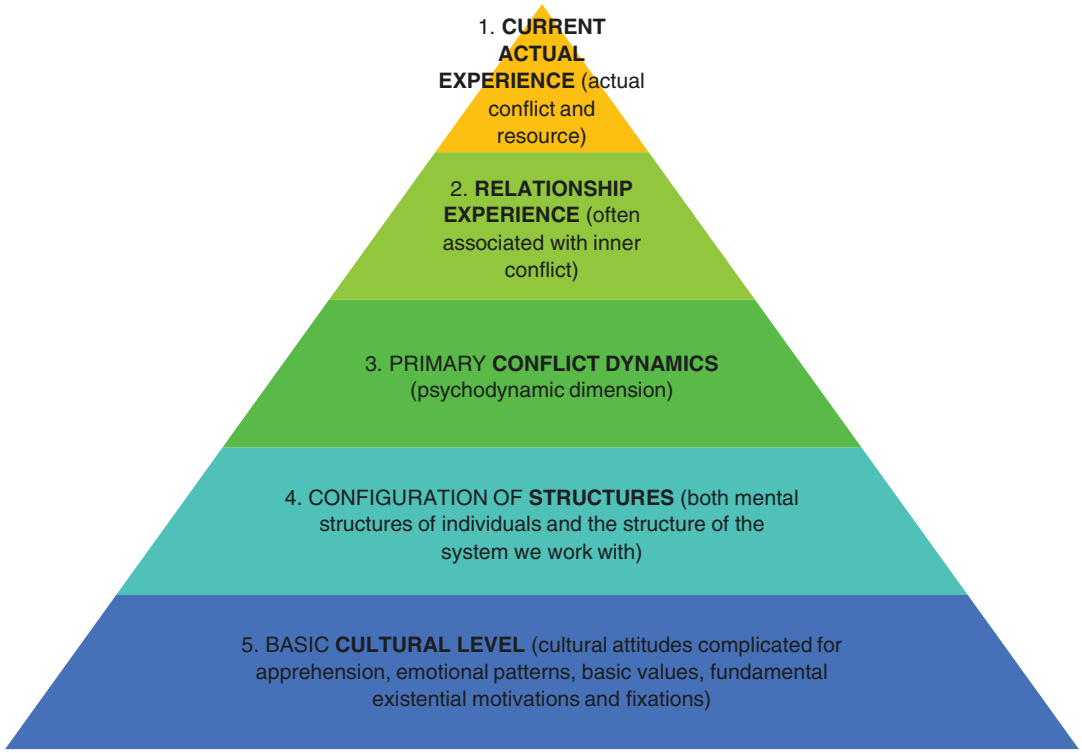


Fig. 23.4 The five levels in organization systems

3. *The level of conflict dynamics (psychodynamic level).* Here, laws come into force that can be constructively taken into account and understood, if one has psychodynamic thinking and a certain psychodynamic concept of the method. As PPT is a psychodynamic method, we have the opportunities to work at this level: through organizational (corporate) psychotherapy (if we want to work with the dynamics of inner and basic conflicts of the system and its participants) or through psychodynamic coaching (if we want to work with the dynamics of inner/actual conflicts, resources and behavioral changes).
4. *The level of structures.* Here, we are talking about the structures of individuals, teams, and organizations in general. This is a complicated level where interdisciplinary in-depth knowledge and careful practices are required [12, 25]. One of the main questions is how do the leader's personality structure and organization structure interact? What, why and how can we influence? It is also possible to work at the psychotherapeutic and deep-coaching level (psychodynamic coaching, existential coaching). Consulting is possible and managerial decisions are needed. But in any case, much depends on the productive orientation of the leader's personality structure [14, 16], his mental health and emotional well-being.
5. *The level of cultures.* In our opinion, this is the deepest level, because cultural content is present in the individual and the collective psyche at the level of artifacts, heroes, traditions, and practices [53–55, 64]. First of all, it is important to respect, consider, realize, and integrate this level, and only then try moderately to influence it. "Old habits, like old friends and guests, should be politely escorted through the front door, and not thrown out the window" (Nossrat Peseschkian). Such work at the cultural level is possible owing to the cross-cultural nature of the PPT method and the possibility of working with value structures using existential coaching [50].

The Relevance and Essence of Positive Psychodynamic Coaching

Positive psychodynamic coaching (PPDC) has been developing for only the last 10–15 years, starting during the second half of the first decade of the 21st century [31].

In our opinion, this is because the world is becoming increasingly dynamic, and the leaders, who constitute the bulk of coaching clients, are experiencing increasing stress in a complicated and sophisticated world.

Volatility uncertainty complexity ambiguity (VUCA) world is a cause of anxiety, stress, and inner conflicts, which can be accompanied by increased psychodynamics within an individual, within interpersonal relationships in private and in business life, in teams, and in organizational systems.

As psychodynamic coaching is as close as possible to psychodynamically oriented methods of psychotherapy (including the method of PPT, as a psychodynamic, conflict-centered method), it seems to us important to find common traits and differences between these two approaches. We do this in Table 23.3.

As can be seen, PPDC is an approach that, like many methods of psychotherapy, focuses on working *with the psychodynamic content of the conflict.*

Also, PPDC, in addition to other methods of psychotherapy (including PPT), also focuses on working with resources (of an individual, team or organizational system).

However, the peculiarity is that PPDC is focused on working in the present tense, with the existing *inner conflict* (the inner reality of a client, an individual or a system), as well as the *actual conflict* (mostly the external reality of a client), only sometimes describing [70] separate concepts and attitudes related to the basic conflict.

This allows PPDC to be oriented to the present and the future and to maintain a *balance of attention to the inner and external reality of a client.*

Table 23.3 Comparison of psychodynamic-oriented psychotherapy and positive psychodynamic coaching

	Psychodynamic-oriented psychotherapy	Positive psychodynamic coaching
Work with psychodynamics	*Yes*	*Yes*
Conflict-centeredness	*Yes*	*Yes*
Resource-centeredness	*Yes, but not all methods (PPT—yes)*	*Yes*
Focus on conflicts	*Basic conflict/inner conflict*	*Inner conflict/actual conflict*
Attention to three tenses	*Past (50–80%)* *Present (50–80%)* *Future (0–20%)*	*Past (0–-20%)* *Present (50–80%)* *Future (50–80%)*
External/inner reality of a client	*Inner reality >> external reality*	*Inner reality ≤ external reality*
Briefness	*30–100 sessions (on average)*	*10–30 sessions*
Special competences of a specialist	*Psychodynamic thinking* *Psychotherapeutic relationship*	*Psychodynamic thinking* *Positive coaching world view* *5C competences*
Ultimate orientation	*Toward conflict resolution* *Resource activation (in some methods)* *Expansion of goals (in positive and existential psychotherapy)*	*Towards all 4R of coaching* 1. *Activization of resources (of an individual and system)* 2. *Risk management* 3. *Development of resolutions* 4. *Achievement of results and formation of further vision*

This also allows PPDC to be as short as possible (compared with short-term psychotherapeutic methods). Although it may be one of the longest coaching types.

Finally, the use of the classical structure of coaching (*4R model*) allows us not to get lost in the "wilds" of psychodynamic processes, phenomena, and psychological defenses. On the contrary: purposefully and vigorously enough to move toward a larger *resource*, good renewing *resolutions*, and a new positive *result*, taking into account *risks* through it all [38, 56].

But how exactly is psychodynamic coaching carried out? How is it not confused with the psychotherapeutic process? What are the differences between psychodynamic and classic coaching?

To answer these questions, it is better to look at PPDC from the perspective of the coach himself: what competencies should a psychodynamically oriented coach possess?

In PPDC, we use the 5C model of specific competences of a coach or a leader who meets psychodynamic processes or phenomena.

Specific Competences of a Psychodynamically Oriented Coach and Their Focus on the Elements of Psychodynamics in PPDC

Thus, we encourage coaches who want to be able to meet and work effectively with personal, team or organizational psychodynamics, to develop their *5C competences*.

1. *Contacting.* In this competence, we mean not only "contact" as an event or a fact of life, but as a sensitive and not always sustainable process. And this contact may be interrupted and unstable. For example, psychodynamic phenomena and psychological defense mechanisms may interrupt contact. Therefore, we focus on the procedure of contact, as on contacting. In doing so, we prefer to rely on the *contact-in-relationship model* [10, 11].
2. *Containment*. Here, we use this term in a narrower sense than in the psychoanalytic tradition. This is the ability of a coach to withstand

psychodynamic emotions, fantasies, threats, and intentions of a client in addition to his own. What is very important: this should not only be negative! For example, idealization at narcissistic psychodynamics is formally pleasing. However, it also requires containment, not a response [25].

3. *Confirmation.* Of course, we use this term beyond the religious meaning, and we understand by it the ability to confirm, validate, support, and assert the client's experience. At the same time, this does not mean that we agree with this experience. This is a confirmation of existence (positum—given, actual) and the value of experience, and the recognition of its subjective importance [10].
4. *Confrontation.* Oftentimes, this is the classic competence of both a number of psychotherapy methods and classic coaching in general. However, in PPDC we use confrontation very purposefully and in a focused manner (hereinafter we describe that it should be directed, first of all, at "criticizing and expecting forces," and second, at coping mechanisms, but with a view to limiting them, not destroying them; for this, the confrontation must be empathetic; [70, 71]). We follow a very important principle in PPT: the balance of confrontation and support. The confrontation is singled out in a separate, fourth, competence (only the fourth!). At the same time, support is the system of the first three competences: contacting, containment, and confirmation. Thus, we come to important balances in our method: the balance of "love" and "know," the balance of acceptance and justice, the balance of politeness and candor, the balance of the existing present and the desired future.
5. *Contracting*. This is the final, integrating stage and competence at the same time. What is special about PPDC is that it takes its time to bring the client to the contract (an adult and mature contract is hardly possible with active psychodynamics). The contract—in this case—is not the initial condition of PPDC, but its main product. Paraphrasing Freud, we may say the following about this important goal of PPDC: where there was an unconscious psychodynamic scenario, a conscious mature contract should appear.

We get not what we deserve,
But what we managed to agree about.

Psychodynamic Management in Work Groups: Models and Tools for Team Evolution and Vertical Development of Leaders

One of the important tasks in helping leaders, managers, and executives—from the side of a coach and a corporate psychotherapist—is to train them in psychodynamic management in work groups.

By psychodynamics, we understand the direction of mental and psychophysiological energy, cognitive attention not to achieve results and the search for resources and solutions, but to the scenario-based acting-out of basic conflicts, unproductive resolution of interpersonal conflicts, inadequate resistance to changes, and passive behavior.

The initial position that we offer to leaders and managers is that they themselves are partially responsible for the psychodynamics existing in the team. One of the key questions that we teach leaders to ask themselves is the following: *"How do I "push" my team to such a group psychodynamic response ("answer") with my habits, thinking, behavior, characterology, and perhaps my personal psychodynamics?"*

In addition, one of the key moments regarding how the psychodynamics of a team is connected with the personal psychodynamics of a leader consists in correlating the current maturity level of a given work group (team) and the leader maturity level. Here, we consider several possible options, which are frequent in our practice:

- Option 1. *The leader is ahead of the team in its maturity*. Then we ask about what is happening with the team and how it feels that "the engine pulled away from the wagons"? Or, perhaps, they have a different situation? It also happens that the "engine" tears off "several wagons"

and drives ahead with them, and the team ("the remaining wagons") continue to move by inertia and slow stops. Or do not move at all. In this case, the psychodynamics of the team (psychodynamic phenomena, processes, and manifestations) is very often a kind of appeal to the leader to turn around and go back for the lagging team or its part. It is like a child's cry by means of which he draws the parent's attention and calls for help. Very often, this may have the pattern of a self-defeating ("masochistic"), depressive ("sacrificial"), histrionic ("hysteroid") psychodynamics. In Bion's model, this may correspond to the basic assumption of dependency [25].

- Option 2. *The team is ahead of the leader in its development.* In this case, we are particularly interested in what the leader understands, thinks, feels, and does. And also what he fantasizes about. If he is afraid that he will not be needed by the team. Indeed, it happens that the team, having reached the "autonomy" level of maturity, according to the "*Umansky model*" [38], expects the leader to be a "strategist," according to the Cook-Greuter model [39], because the team requires exactly this. But if the leader is at the lower evolutionary stages of his managerial logic development (for example, at the level of "diplomat" or "expert," which is good for "association" and "cooperation"), then the team can:
  A. Devalue such a leader (narcissistic psychodynamics)
  B. Blame such a leader (paranoid psychodynamics)
  C. Morally "crush" such a leader or declare war on him (sociopathic psychodynamics)
  D. Encapsulate so as not to interact with such a leader (schizoid psychodynamics)
  E. Regress to the leader's level
  F. Go to one of the unconscious scenarios that correspond to the basic assumptions of fight–flight or pairing, according to Bion [25]

If such phenomena occur, then the coach will have to deal with quite complicated work with both the leader and the team. At the same time, it is good if the corporate psychotherapist can help both the leader and the team to at least be aware of their characterological peculiarities and defense mechanisms that support psychodynamics.

The main minimal task is to help to understand the current levels of evolutionary development of the leader and the team and help to relate them.

At the same time, the two main working models that we use for awareness and correlation are the *Umansky model* of "team evolution" (the upper vector) and the *Cook-Greuter model* of "leader's ego evolution" (the lower vector). In coaching practice, we combine them visually in such a way as is shown in Fig. 23.5.

Part 5. Broadening of Goals in Working with Leaders and Organizations

Wisdom for Waves of Organizational Relationship, Leadership, and Development and Existential Coaching

In this fifth and final part of our chapter devoted to PPT in organizations, we will touch on the topics of new horizons, broadening of goals, and existential coaching.

At this step in working with the client, we again return to the mutual influence of "everything on everything" and what this means for the client's future.

In organizations, we sometimes offer the "circles on the water" metaphor: how does what I do (or not do) affect my environment? Systems that surround me? Society? The world? The future? Traditionally, these questions concern leaders, but:

1. First, we believe that everyone is a leader at least for himself. Therefore, it is good to ask everyone these questions.

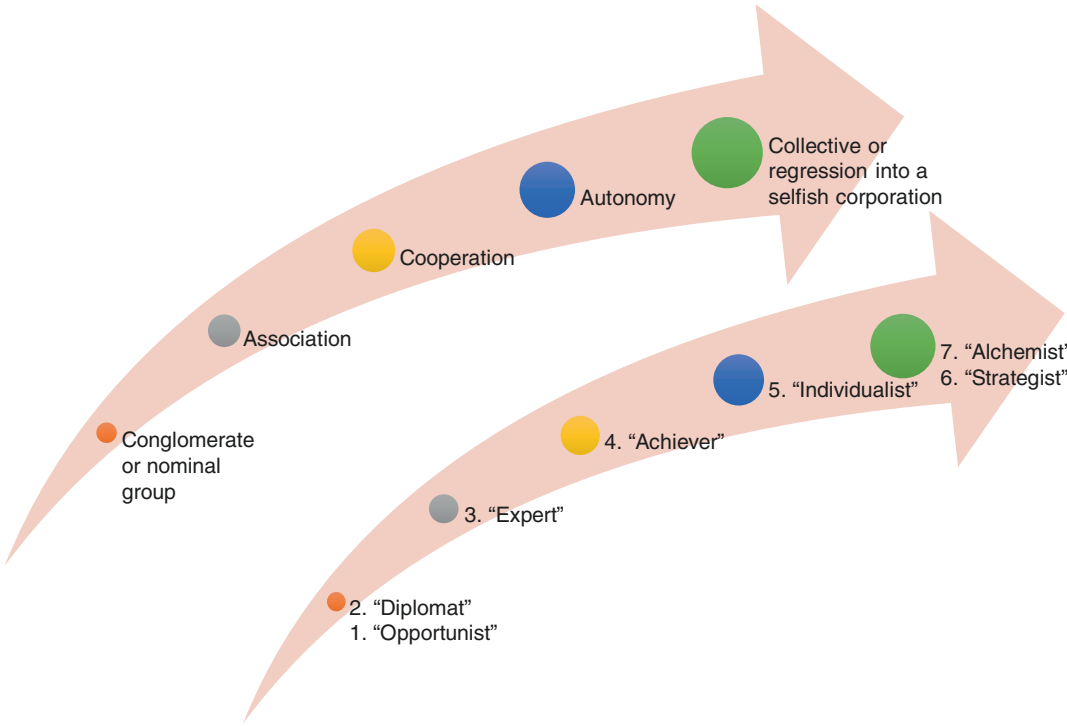


Fig. 23.5 Double evolution: team and leader

> How can I affect the environment and serve humanity with my actual and internal situation and even with my basic conflict?
> Nossrat Peseschkian

2. Second, we note that there is something deeper than leadership; namely, the relationship. After all, leadership is a special kind of relationship.

For practical use of these concepts, we use the Waves of Organizational Relationship, Leadership, and Development (WORLD) model (Fig. 23.6).

The “WORLD” model shows how, by changing attitudes and relationships in an organization, we can positively influence leadership. And thanks to leadership, “waves of water diverge” - waves of change, emotional and existential growth - into the dimensions of the development of people and teams.

Next, we look at how we can bring wisdom into the “WORLD” (the section Wisdom of Positive Psychotherapy in Leader Evolution) at the level of the concepts and content of PPT, and then we describe the basics of existential coaching—our development—as the main tool at this stage (the section Existential Coaching: Positive and Positum Approaches). Finally, we conclude the section and chapter with closing thoughts that require further discussion and consideration (Conclusion).

Fig. 23.6 Waves of Organizational Relational, Leadership and Development (WORLD) model

Wisdom of Positive Psychotherapy in Leader Evolution

When applying PPT in organizations, we attach particular importance to *vertical development*, the *evolution of leaders* [3, 11], *spiral dynamics* [1, 19, 21], and the *integral model* [67, 68].

The Cook-Greuter and Torbert models and the like are based on the understanding that people are developing, consistently rethinking the balance between differentiation and integration.

Therefore, this is in good agreement with PPT as an integrative method, and its differential analysis [55, 60]. At each level of evolution, the leader and the team have the task of integrating what was at the previous levels, and also learning to distinguish (differentiate) new content.

> Wisdom is the ability to notice
> Nossrat Peseschkian

The scope of this chapter does not allow us to describe all our experience and tools that we use. Therefore, we briefly described in Table 23.4 the correspondence between the level of the leader evolution and the PPT content: something that can be relied on to develop more and move on to the next stage, something that it is important to work with. At the same time, we metaphorically described each level as a special kind of wisdom (Table 23.4).

Existential Coaching: Positive and Positum Approaches

In relation to existential schools of the twentieth and twenty-first centuries [2, 4, 5, 13, 43, 44, 48, 61, 62, 65, 69], we apply an *integral, interdisciplinary, and cross-cultural principle*, and of course, the *positum approach* toward existential concerns and a positive approach toward the existential nature of a person, first of all in relation to its existential capacities [35, 36, 47].

We add to these modern Western schools the existential wisdom of deep Eastern traditions: primarily Sufi wisdom and Zen Buddhist wisdom, in addition to the wisdom of Christian mystics [54].

In the key moments of an existential search for meaning, we also use concepts and wisdom, published by Nossrat Peseschkian in his "In Search of Meaning" [59, 60]. In existential coaching, Peseschkian's views on the search for meaning are very organic for at least two reasons:

1. They are consistent with the model of Erik Erikson [6–9] and the further concepts of vertical development [3], the growing-up of adults and spiral dynamics. This is very important from a coaching perspective!
2. They contain kindred (spiritually close) values to logotherapy and existential analysis of Viktor Frankl. This allows at the modern stage of development of the existential analysis of the "Third Viennese School" (Langle) their concepts to be integrated perfectly into our practice of positive existential coaching [36].

We fundamentally distinguish among *existential psychotherapy, existential counseling,* and *existential coaching.*

Existential coaching is the youngest of these three practices and aimed at healthy clients (individuals, teams or organizations) ready and able to self-reflect and make existential decisions that change the course of life.

From our perspective, existential psychotherapy is more focused on the existential treatment of suffering and trauma, in addition to mature encounters with the ultimate concerns of existence. To be more precise, on existential maturation in the course of psychotherapy: *the development of existential capacities* [35, 36, 41, 42, 47] and *the expansion of existential identities* [23].

Existential counseling helps current life situations and events to be handled reflexively in one of four existential worlds [4, 5].

From the point of view of positive existential psychotherapy, existential counseling corresponds to the level of actual conflict, where simple cognitive-behavioral practices are insufficient because the actual conflict situation itself affects either deep areas (for example, the area

Table 23.4 Vertical development and identity expansion of leaders and systems

color codes of identity-levels:
Yellow: identities: **"I," "You," "We," "Prime-We"**
("Prime-We" is the greatest identity with the human race: our ancestors and descendants)
Green: identities: **"I," "You," "We"**
Blue: identities: **"I," "You"**
Gray: identy: **"I"**

Stages of ego development and logic of the leader's actions	A meaningful description of the development stage in the language of PPT and a special kind of wisdom
Uniting stage "Ironist"	"**Wisdom of ingenious simple souls**" (see Idries Shah) Actual capacity "integrity". The principle of "unity-in-diversity" We: **identification with humanity.** We, as a part of Prime-We Area: future/fantasy/spirituality. Me, You, We are parts of the world
Construct-conscious stage "Alchemist"	"**Wisdom of profound healers**" (Avicenna) Actual capacity "faith"/"meaning". Area: future/fantasy Identity: expansion from "We" to "Prime-We". Expanding global identity "The fifth pinnacle of fate" (V.Karikash) "I am a human"
Autonomous stage "Strategist"	"**Wisdom OF inventors for humanity**" (Da Vinci) Identity: "I," "You," "We": Identification with those who have similar principles, who are "like-minded". Positive thinking. Wisdom in conflict resolution. Development of global identity. A new understanding of the areas: work, contact and future
Individuality stage "Empathic individualist"	"**Wisdom of fair padishahs**" (see the Peseschkian's parables) Harmonious balance model as an exemplar Balance of primary and secondary capacities. Team is not as a mechanism, but as an organism. The development of cross-cultural sensitivity and respect for differences Identity- "I," "You" : the principle of "man for himself" (Erich Fromm) "I am "Ok," You are "Ok" Existential capacity to "be myself" and let others do the same
Conscientious stage "Rationalist" or "achiever", "successful leader"	"**Wisdom of honest scientists**" Differentiation of secondary capacities and development of primary ones Step: taking inventory/differential analysis Identity: "I," "You" (identification with like-minded people)
Self-conscious stage "Expert" or "technician"	"**Wisdom of expert technologists**" (example: IT engineers) Area: work/mind/logic. Secondary capacities "Me": self-esteem is based on the capacity to "know" Step: taking inventory/causal analysis Identity: "I," "Me," "Myself"
Conformist stage "Diplomat"	"**Wisdom of polite politicians**" Areas: contact/traditions and work/logic. Rational/pragmatic/adaptive use of contacts for profit. "Politeness" for the sake of safety and survival Step: observation Identity: :"I"/"Me"/"Myself"
Defensive stage "Opportunist" or "manipulator"	**"Wisdom of dexterous hunters**" Area: body/sensations/survival. Undifferentiated primary capacities. Deficiency of secondary ones Step: observation and distancing. The beginning of the tendency of separation from the merger (symbiosis of a newborn) Identity: "I," "Me" "Myself"

of the meaning of life in Peseschkian's balance model) and/or is tied to one of the existential identities [23, 28].

A feature of existential coaching is that it remains in the *4R coaching space*: resources-resolutions-risks-result. It means that we stay focused on the result together with the client.

In existential coaching, we are talking precisely about the existential result. Such an existential result can include finding or creating meaning,

making a vital decision, changing lifestyle, addressing the issue that will lead to greater inner freedom, discovering a new existential identity in oneself, transition to a new "pinnacle of destiny" [23, 28], resolving the key conflict [54, 55] at the integrative spiritual level [27]. Finally, the ultimate goal that existential coaching can focus on is to assist the client in the realization of his *fulfilled existence.*

Conclusion

The Concept of Conflict and the Concept of Development in Relation to the Person and Organization

Positive psychotherapy, on the one hand, is a psychodynamic method. This means that it is important to understand the dynamics of psychic conflict at different levels (basic conflict, inner conflict, actual conflict, key conflict).

On the other hand, PPT considers the development of a person throughout life as an important factor: first of all, through the differentiation of his/her actual capacities on the basis of basic ones, and also the inclusion of these capacities (I call this process integration) into four qualities of life.

At the same time, such a flexible and differentiated approach to development issues in PPT corresponds to the most advanced views in modern development sciences:

> … We also must keep in mind that maturation can be markedly uneven; that a person can have extraordinarily well-developed capabilities yet suffer from a crippling deficit in the area of, say, sexuality or the ability to be alone or the capacity to mourn, or comfort with competitiveness. "Fixation" is not a simple, unidimensional thing. [49]

These two dimensions of PPT—conflict psychodynamics and continuing development through the differentiation and integration of abilities—are very important, scientifically, methodologically, and practically. We work within these two dimensions.

Integrity as a General Task of Overcoming Alienation

From the point of view of the actual capacity "integrity," the final primary actual capacity in the differentiation-analytic inventory [55] is the task of all types of coaching, which are described here. This task consists in strengthening and improving the internal reliable relations within an individual or a system of people (family, community, team, organization, society). Many researchers and practitioners claim that disunity and alienation is an ever-increasing problem [17, 59]. Coaching also seeks to overcome this problem [58].

Working with the Internal Enemy and Other "Internal Objects" in Psychodynamic Coaching

- When in positive psychodynamic coaching we meet with the effect and opposition of internal objects (Timothy Gallwey initially called them internal opponents), we do not fight them and do not oppose them. Even when they appear as forces (most often we single out criticizing, depreciating, expecting, and punishing [humiliating] forces) or parts, we still treat them as "living objects" and try to establish a regular, respectful dialogue. In this way, we somehow "humanize" these forces or parts when we begin to treat them "humanely": with attention, respect, fair evaluation, recognition of their value [42]. The latter can be successfully done through a *positive existential and cross-cultural interpretation* [36, 50, 52, 54, 56, 60].
- The ultimate goal of supporting nonviolent but structured dialogue is to invite the "internal heroes" to cooperate.
  - *Coach: Michael, what prevents you from starting to live your life more fully and making decisions that satisfy you?*
  - *Steve: It is my internal critic, internal opponent.*

- *Coach: What is he saying?*
- *Steve: He says that since I still couldn't put my life in order, now I'll also fail and I'll have to keep a low profile.*
- *Coach: Steve, we may not investigate the origin of your internal opponent and won't fight him, we'll just get to know him better.*

Working with "Internal Objects" in Psychodynamic Coaching

In relations with the "internal opponent," we follow the recommendations of the schema therapy practice [71] and confront this internal object and its psychodynamics.

However, it is a short-term strategy that solves the here-and-now problem.

In the long term (systemic solution of the problem and the subsequent vertical development of the client), we suggest considering the confrontation of the "internal opponent" as the second of the four stages of emotional evolution [69]. According to the Weinhold model, we go through four stages in our development: codependence, counter-dependence, independence, interdependence. It is important to go through these four stages, in our opinion, when working with internal objects.

Two Levels of Work with Basic Conflict: the "Intimate" Core and the "Overt" Periphery

In the basic conflict, we consider two levels:

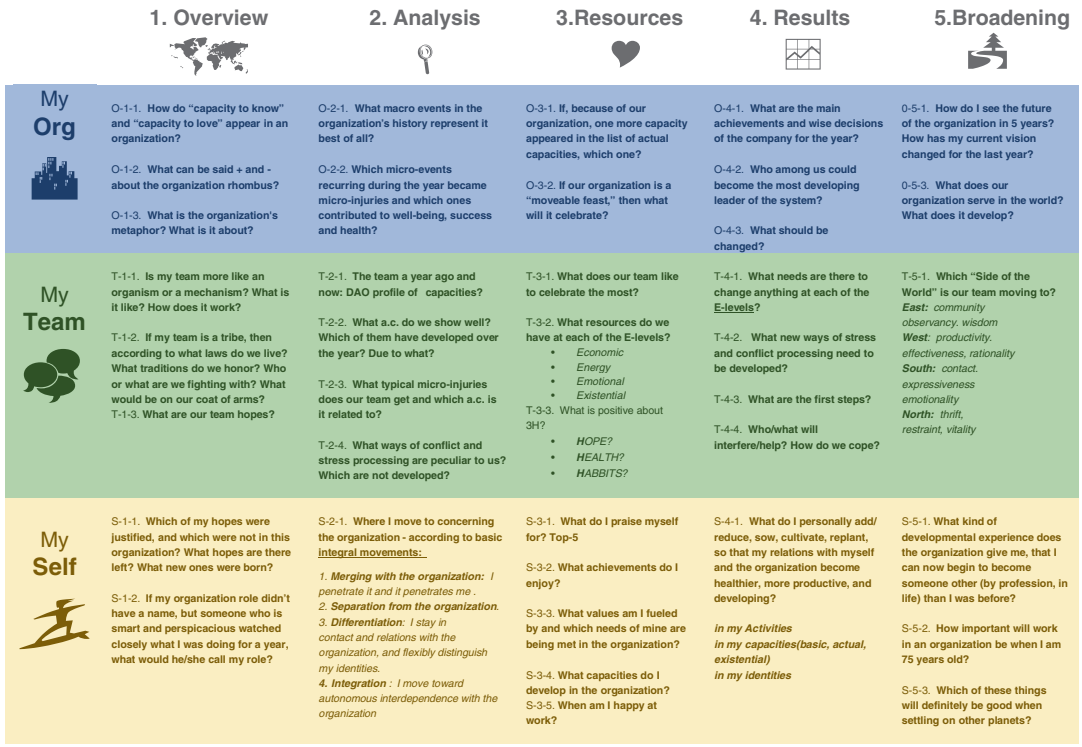
1. The phenomenology of basic conflict ("overt")
2. The essence of basic conflict ("intimate")

In PPT, it is important to respectfully accept psychological defenses and coping mechanisms as certainties. This means that we, believing in the positive nature of a person, trust what manifests and take it into account. We do not seek to immediately penetrate the "intimate." Working initially with the "overt," we gradually and carefully move from the phenomenology of the "overt" (what we observe) to the content. There is a chance here to gain access to the "intimate" in the basic conflict. When working with leaders, teams, and organizations, this is especially valuable.

Versatility of Positive Psychotherapy as a Method in Organizations

We also give some important theses on the diversity of views on PPT

1. Positive psychotherapy as a "positive psychoanalysis." This method can work deeply with the unconscious level of leaders, teams, and organizations. At the same time, work is focused, safe, oriented on resources and solutions. That is why PPT is sometimes called "positive psychoanalysis."
2. Positive psychotherapy as learning wisdom through the ability to distinguish. The methodical core of PPT is differential analysis. In fact, we learn to distinguish between important details and nuances, and this is one of the facets of wisdom. We help leaders, managers and teams to be not only smart but also wise.
3. Positive psychotherapy as a balance of differentiation and integration. PPT is an integrative method. At the same time, it is based on differential analysis. Thus, PPT has two balanced poles: differential and integrative. This coincides with the models of vertical development of leaders and allows us to use these models consistently.



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Psychotherapeutic Work with Men

24

Claudia Christ and Ferdinand Mitterlehner

Introduction

In recent years, more and more alarming newspaper articles have been published about the negative changes in the male self-image and the overall poorer psycho-physical state of male health [1–3]. The Cologne-based Zukunftsinstitut (Institute for Future) described men as "the psychosocial problem child of the 21st century" [4]. Other article headlines are "Reden oder saufen" (talking or drinking) or "women get sick, men die." On average, men's life expectancy in Germany is 7 years lower than women's. They have a significantly longer working life, sometimes work under very dangerous conditions (heat, cold, night shifts, manual labor), consume more alcohol and drugs, and are victims of physical, psychological, and institutional violence almost as often as women [5–8]. Mental illnesses such as stress-related depression [9, 10] or anxiety are rarely recognized in time and psychotherapy is still considered "uncool" for men. Why is everything surrounding the idea of "psycho" still so contentious? Or, to rephrase the question, what can positive psychotherapy (PPT) do to improve the biological, psychological, and social state of male health?

For many years we have been working both theoretically and in practice to find out which psychotherapeutic offers men require, how these can be utilized in a constructive way, and how accepting help can be better integrated into the self-image of men [11–14]. How can and should a psychotherapeutic setting be tailored to the needs of men? We do not wish to divide psychotherapy into "female" and "male" forms of therapy, but even considering only a few factors can make access to psychotherapy much easier for men [15]. The starting point for men motivated to seek therapy seems rather intricate: If a man shows his distress and vulnerability, his "manliness" may be questioned by his those around him. If a man does not immediately talk about his feelings, he could be considered unempathetic, cold, unable to trust or unmotivated. More than 80% of all therapists are female and even the setting of the therapist's office can be daunting for some "tough guys". Therefore, we wish to promote a gender-sensitive approach.

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Biological, Psychological, and Social Health of Men

We can only think of health as the interplay between physical-biological factors, psychological resilience, and social inclusion [16]. In 1986, all the world's nations met in Ottawa to define the goal of "Health for All" in a globally accepted charter [17]. The following points are to be emphasized for men in particular:

- "Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society."
- "Health promotion generates living and working conditions that are safe, stimulating, satisfying, and enjoyable."
- "Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love." (Ottawa Charter for Health Promotion, 1986)

The charter shows that in every country, conditions should be created that make health possible in all areas of life. For men, this applies in particular to work, if it is performed under extreme physical or psychological conditions.

> This report by a construction worker is truly heartbreaking: For 35 years he had been slaving away at his job. Today, he is in disbelief, depressed, has given up on himself and is psychologically and physically exhausted because his pension payments will not be enough to cover his everyday needs. "All my life I have been toiling away, now I am left with nothing."

Many companies have recognized that they too have to care for their employees and that the implementation of occupational safety measures, healthy canteen food, low-threshold counselling services, back training, etc., is extremely important in lowering periods of incapacity to work in addition to reducing illness and premature departure of employees.

In addition to healthy situational conditions, however, one's own behavior is also decisive for a constructive long-term framework for safeguarding one's own health. Fast food, convenience food, coffee to go or "to run" are all very bad sources of nourishment that cannot simply be offset by the occasional smoothie. Unfortunately, the food industry, as it is, is not conducive to getting rid of that excessive body weight. In fact, it promotes diseases of affluence, such as diabetes mellitus, high blood pressure, orthopedic disorders, etc. Drugs such as alcohol or nicotine only play into this pool of risk factors even more. With all that sugar, fat, alcohol, etc., our neuronal reward system is activated, and we cannot help but want more and more of it. In addition, media consumption turns us into couch potatoes, which is even more detrimental to our overall health [18].

The Balance Model in Positive Psychotherapy

The balance model according to PPT is an excellent tool for recording the interplay between the individual aspects of a particular biological, psychological, and social health status in a therapy session [19]. The model is easy to understand and visualize, does not put emphasis on educational level or native language, and quickly shows clear-cut areas of action for patient-related work. From this, therapeutic goals can be developed. The institutional, interpersonal or intra-psychological aspects of these goals can be clarified and, if necessary, the therapeutic process can also be visualized. The balance model is also suitable for regular "self-assessments" even after therapy has been concluded [20]. "Are my personal pillars of life still in balance? Have I neglected individual aspects too much? Have recent events had a strong influence on individual areas of my life? In what way? What can I change?

The first steps towards psychotherapy with the help of the balance model is low-threshold, structured, and comprehensive. Figure 24.1 shows an overview of the four areas of life "body/soul," "work/finance," "family/contact," and "vision/mission." This model can be quickly explained to both patients and clients and can also be used in the field of transformational coaching.

Once the balance model has been outlined, these four areas of life can now be expanded upon using specific questions. However, it is also possible to let the patient/client report freely and have them structure their own perspectives in accordance with the balance model. This gives the therapist a quick overview of the patient's life situation.

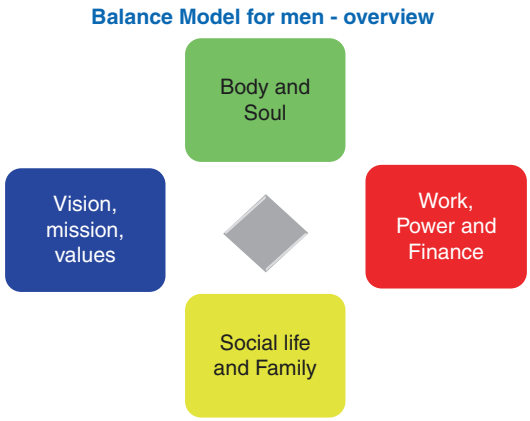

Fig. 24.1 Overview of the balance model according to positive psychotherapy

Expanding upon the four areas in a dialogue helps to create a biological, psychological, and social health model almost on its own and lets the client develop his own goals. For example, an "as-is state" for the question "What effect did your current situation have on the four areas of your life?" can be worked out. Next, a "to-be state" can be evaluated by asking the question "Where would you like to be in 6 months' time?" By reflecting on the therapeutic relationship, additional bonding patterns, maladaptive reaction patterns, and intra-psychological resistances can be reflected upon to bring depth-psychological and psychodynamic aspects to light.

The most important points of expansion that are tailored to psychotherapeutic medical work with men are summarized in Fig. 24.2.

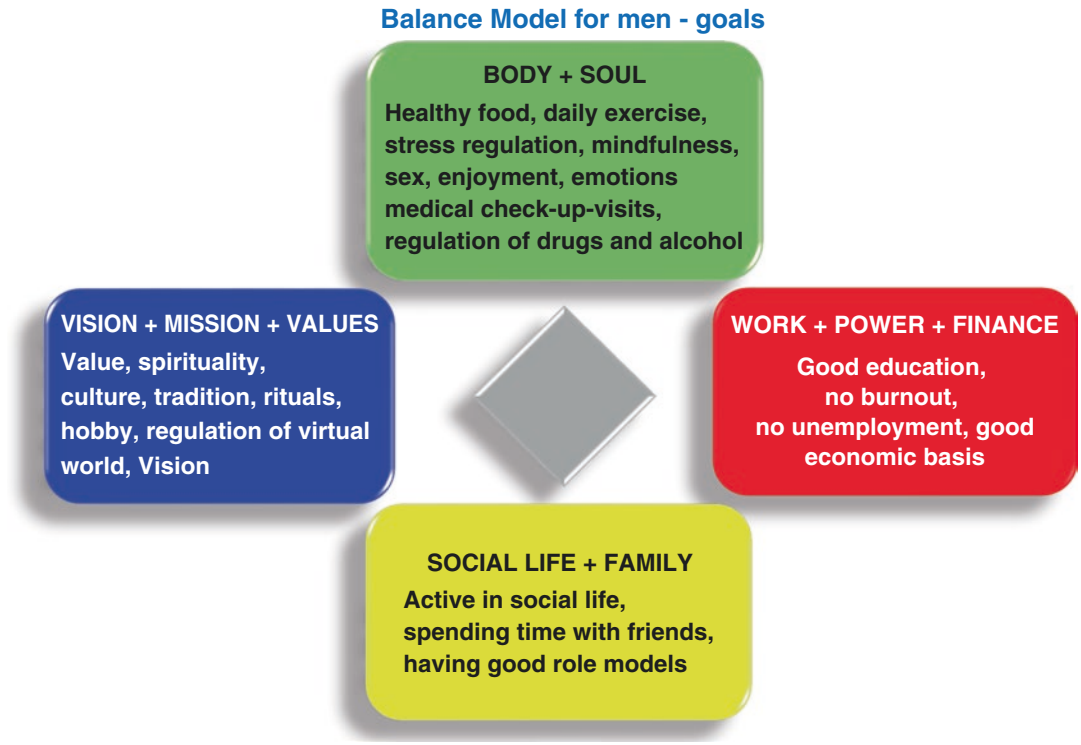

Fig. 24.2 Expanding upon the balance model for work with men

The Four Areas of the Balance Model: Key Considerations for Men

To enable specialized therapeutic work, this chapter presents the four areas specifically from a male point of view. Based on experience, men feel comfortable when the work to be done is outlined at the start of therapy [12], where even embarrassing issues can be discussed. At the same time, a classification of one's own topics as described by Aaron Antonovsky's concept of "Comprehensibility" [21] can be worked out. Therapy thus becomes apparently "easy" and low-threshold. Even after a few hours of therapy or coaching, the foundations for behavioral changes can be laid or the assessment standards can be redefined. For men, clarity on the choice of topic, the orientation toward everyday demands, the encounter with the therapist "at eye level," the desired help for questions about the working life, and the feeling that "there is someone sitting opposite me who may have experienced something similar" are particularly important.

"We suggest that good therapists for men, like good ship pilots, are informed and prepared." [22].

Balance Model: Body and Soul

Body + Soul
Healthy food, daily exercise, stress regulation, mindfulness, sex, enjoyment, emotional regulation, preventive medical check-ups, and regulation of drugs and alcohol.

"No Risk, More Fun": General Principles for Best Possible Physical Health

The commonly known basics for physical health such as healthy diet and exercise [23] have already been mentioned. Even if the therapist may not have been trained in orthodox medicine, it is important to consider the general medical and medication history to quickly recognize psychosomatic interrelations. Seeing a physician for cancer prevention, early detection of cardiovascular risk factors, sleep apnea, thyroid gland or blood sugar level check-ups, differential diagnoses of herniated discs, etc., happens more often for women than for men, as the business hours of the practices are often not compatible with the working hours of men. For this reason, the necessity of medical check-ups should be addressed during therapy.

> It is not uncommon for a generalized anxiety disorder to turn out to be the result of high blood pressure or hyperthyroidism, many times a depressive episode is caused by sleep apnea or low levels of certain hormones [24].

Fortunately, men often take on therapy as a result of a recommendation of a general physician or consulting physician. As Thure von Uexküll put it: "Nothing is purely somatic. There are only psychosomatic diseases" [25].

> Read what this 40-year-old university graduate who contacted the doctor's practice again and again after inflicting injuries onto himself said: *"It's happened yet again: I'm in too much stress and I've cut myself, sprained my ankle, injured myself during exercise, and so on. I wish to reflect upon my situation and change it."*

"Less is More": Stress Regulation and Mindfulness

Many mental and physical illnesses are now classified as stress disorders. Many people see their professional and their private everyday life as permanently stressful. Companies in Germany are required by law to conduct a "psychological risk assessment" of their employees. In many cultures, the concept of "burnout" is socially recognized. At the same time, this phenomenon creates confidence among men seeking therapy. When labeled a victim of burnout, a man is allowed to say that the stresses he is put under are overwhelming and that the "personal limit" has been reached or they "just can't go on like this." We meet more and more young adults who are unable to cope with the pressures of our modern age and who seek psychotherapy stating symptoms of depression and fatigue. In particular, men who live in a single-earner situation tend to push themselves too hard. Statements such as "everything is fine" or "everything will be fine

eventually" are nothing but trivializing excuses for long-standing symptoms of stress. The very first warning signs of burnout or stress-associated diseases are:

- Sleeping disorders
- Frequent infections
- Back pain
- Inability to focus
- Social withdrawal
- Erectile dysfunction
- Aggressive or risky behavior

Figures show that only half of all cases of depression (caused by exhaustion) are recognized and only a small percentage of them are treated adequately—a scary thought. Psychotherapy should therefore actively address the issues of stress regulation and body awareness [26]. In this way, individually meaningful measures for improving the regularization ability can be compiled. Even in a depth-psychological setting, men, in comparison, need more psychoeducational sensitizing and specific practical advice to translate the insight gained in therapy into everyday life. A positive attitude toward therapy and the intervention techniques of PPT are extremely helpful for this.

"Enjoy Your Sex": Sexuality

In his drive theory, Sigmund Freud outlined our drives or feelings of vitality and emphasized the importance of satisfying sexual needs and desires. As the discrepancy between the relevant theory [27] and the reality of sexual anamnesis created in psychotherapy sessions seems to be relatively large, therapy of men-related topics around sexuality should be addressed actively, without judgement and shaming. For instance, these sample questions could be asked:

- Are you happy with your sexual life?
- 20% of men (11% of women) look at pornography at work—do you?
- Would it be possible for you to live out your sexual fantasies?
- Do you suffer from erectile dysfunction?
- Are you happy with your gender role?
- What about homoerotic sexuality?
- Do you take any medications such as Viagra?

Case Examples

Filled with shame, a banker who developed a generalized anxiety disorder after a heart attack asked in a therapy session *"May I take Viagra again? I'm feeling inadequate toward my younger wife."*

Over the course of therapy, a facility manager at a hotel chain suffering from sleeping disorders, depression, and diabetes mellitus under insufficient glycemic control hinted at a subconscious trauma he experienced in his childhood. After he was given the chance to talk about it in therapy, the issue of regulating his blood sugar levels had resolved itself.

During therapy sessions with a young homosexual man it became apparent that he displayed self-destructive behavior by having frequent, unprotected sexual intercourse. Over the course of therapy, this behavior could be constrained successfully. "I was only looking for human closeness and comfort," he said after being subjected to confronting questions.

Since the idea of gender and sexuality is being increasingly accepted (or at least more frequently discussed), the "gender debate" is becoming more complex and thus the relevant issues for psychotherapy are becoming ever more relevant.

"Stop the Beginning": Addiction

> A 45-year-old journalist who is in treatment states: "I drink too much red wine and during stressful periods I smoke more than 40 cigarettes. I feel like I have damaged my own body to a degree that I am afraid I could get a heart attack at any time. I am also a notorious pessimist."

Addiction is a major problem, especially among men, and usually hints at more profound psychological conflicts, which can be accompanied by problems with self-esteem, childlike, regressive needs or attempts at "self-medicating." Addiction is usually a creeping and therefore unnoticed process, which is associated with the idea of "too little" (having received too little, being too little, experiencing too little approval).

- Addiction is a very slow process
- Addiction means mostly longing for…
- "I need more" instead of "being more"
- Who am I? What shall I do? Where should I go?
- Losing yourself
- Developing "tunnel vision"

There are countless substance-based and non-substance-based forms of addiction (Fig. 24.3). In addition to widespread addictions such as alcohol, gambling, and drugs, we are also seeing increases in addiction to physical fitness, healthy eating, and cosmetic surgery. The feeling of being inadequate, having to be perfect, needing to reach a certain professional goal can lead to tunnel vision, a weakening self-esteem, and can encourage addiction. In psychotherapeutic work with men, it is essential to address and reflect on possible addictive behaviors and implement health-promoting behaviors. The first warning signs of a possible addiction are as follows:

- Neglecting personal needs
- Emotional anesthesia
- Risky behavior (sports, reckless driving, sex)
- Conflicts with close friends or family
- Avoiding feelings of anxiety and negative effects such as guilt, shame, and anger

"Negativity and Hate Are Destroying Your Heart": Emotional Factors Contributing to Cardiovascular Disease Risks

In medical–physiological terms, we usually think of risk factors for physical illnesses as elevated sugar levels or changes in blood pressure. Research in the field of psycho-cardiology (i.e., questions about the possible influences of mental

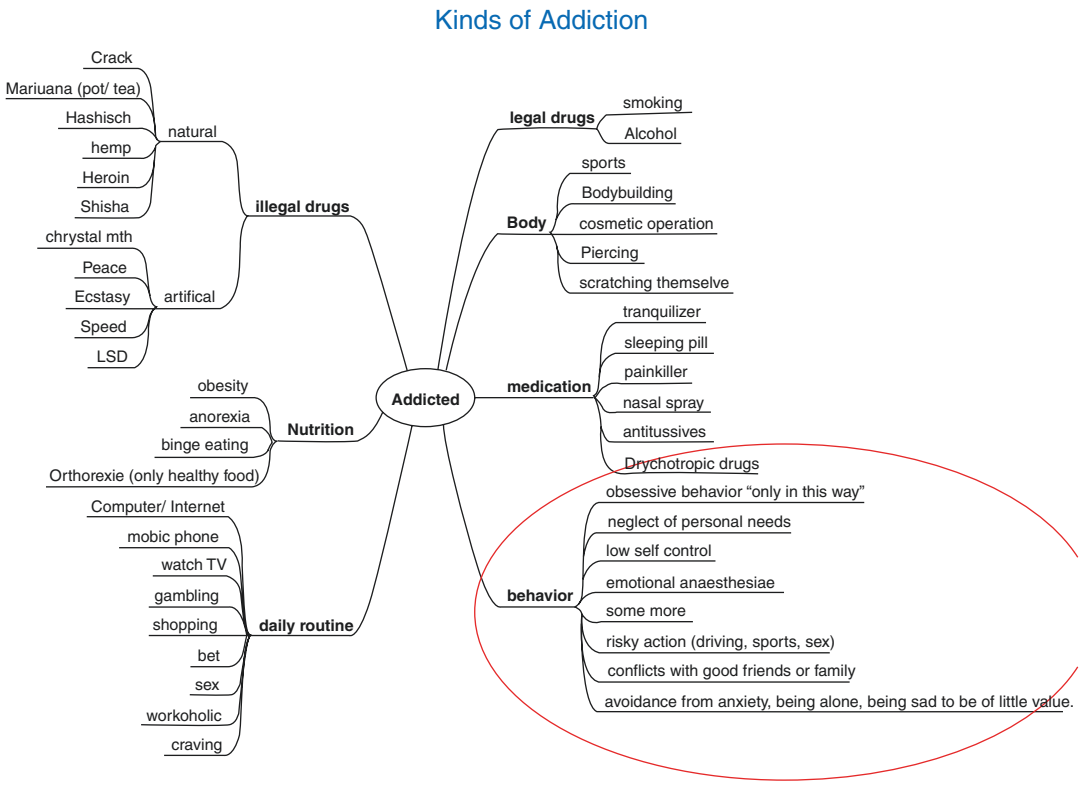

Fig. 24.3 Kinds of addiction: our attempt to gain an overview of the different forms of harmful dependence

factors on cardiovascular diseases) has shown that emotional experience—just like risk factors that are measurable in the laboratory—has an influence on the calcification of blood vessels and therefore the pumping capacity of the heart. Experts also talk about "broken heart syndrome" when a heart attack is triggered by severe emotional stress.

Men also have "gratification crises" [28, 29], in which the ego, the self-esteem, the feeling of self-worth, the autonomous self-control, the dignity, and one's own effectiveness are very seriously violated.

Case Example

A 48-year-old man had to be taken to a hospital for 3 days after he was laid off by his employer. He suffered a severe heart attack and had to go into early retirement after the events. After being fired by his employer, his life had been turned upside down. Everything he worked for was over after he had received the letter of dismissal from his employer. After a long time and with therapeutic support, he was able to work out a comprehensive adaptation to his new life situation and was able to "recover."

The following emotional traits are "poison" for our cardiovascular system:

- Worse readiness
- Perfectionism
- Hate
- Unfairness
- Negativity
- Rating
- Competitive behavior

During a recent therapy session, a 36-year-old patient sarcastically said: "In my case, you might as well tick all the items on your list!"

It is crucial to ask about early negative mentalization patterns in therapy and search for the origins of these thought patterns to develop new thought concepts with the patient. The patient mentioned above, who drank far too much red wine and had never reflected on his negative attitude before, was able to gain a more open view of his achievements in life and his own abilities.

Balance Model: Work and Finance

Work + Finance
Good school education
No burnout
No unemployment
Good economic basis

What boys enjoy is mostly forbidden.
What boys are especially good at is not required anywhere—
not at kindergarten or at school.
(Quote by Wolfgang Bergmann, German family therapist and educator)

"What Boys Really Need": Good School Education

In addition to family, school is an important environment for acquiring the basics needed for social and professional integration. No phase in life is as formative and so full of development in the areas of motor skills, mental capacity, social skills and hormonal developments as childhood and adolescence. These 18 years are a "rapid intoxication with all senses," which can both open new directions and close off many paths. At this stage of life, severe traumas usually have permanent consequences. Therefore, we would like to promote a healthy growth environment, both in family life and in school, which should cover the following aspects:

- Creating a safe, appreciative, calming, and stimulating environment that sets clear borders
- A creative space for one's own experiences, mistakes, boredom, and frustration
- Freedom for healthy psychomotoric development
- Freedom to test physical strength
- Learning through a general basic education
- Learning through healthy and preventive behavior
- Learning through craftsmanship
- Learning through respectful social interaction
- Learning values

- Learning and adhering to rules and limits
- Learning life skills and basic knowledge (i.e., legal, financial, ecological, etc.)
- Taking on responsibility early
- Enticing development in the areas of music, art, literature, acting, etc.

Boys use school more as a meeting place than as an educational institution. Sitting at a school desk for 8 h is as detrimental to learning as playing 8 h of videogames. This turns boys in particular into so-called "educational failures." Forty percent of boys receive their general qualification for university entrance; in girls, the number is 60%. Ninety percent of children with attention deficit hyperactivity disorder are male. In modern society, it seems like there are virtually no children who are not assigned a label such as being "gifted," "highly emotional," "dyslexic," "dyscalculic," "hyperactive," "socially incompetent," or "allergic." Why do we no longer use family and school space as an environment for educating young people on how to be responsible, socially integrated, and well-educated?

"Be Happy With Your Work": Working

"Those who enjoy their work will have many happy hours in life" (a quote from a friend who has been stationed in Afghanistan for 9 years with the German military). There is nothing to be added to this quote. As we spend about 40 years of our life at work to make a living and save up for retirement it is important to make the most of our time there. The better the education/vocational training, the better the chances on the job market. Occupational identity gives purpose and contributes to personal integrity [30]. It is therefore logical to see that the transition from active working life to retirement age presents an individual challenge for many men [31].

The "wheel of work" [32], as illustrated in Fig. 24.4, gives a comprehensive overview of the different aspects of work and can be used to create a structured reflection. From a methodical standpoint, the transition between coaching and psychotherapy is certainly fluent. As work is a very important dimension in itself, especially in the lives of (single-earner) men, this model can be used over and over again for purposes of self-reflection. Asking explicitly about difficulties with colleagues or superiors, about financial security/insecurity, missing or received support from others, and about one's own motivation in the job, provides a concrete entry point for working on the topic.

Fig. 24.4 Wheel of work (model varies according to full circle global)

> "My job has become completely meaningless to me" a 54-year-old marketing executive said a few months ago.
> A young trainee described his situation as follows: "My superior only criticizes me and I have no idea what I could do to improve.".

This model can be used in therapeutic work to uncover intrapsychic issues, subjective attributions of meaning, social strengths/conflicts, and institutional influences in the working environment. Statements such as "I always get into a fight with my boss" possibly hints at underlying bonding issues or maladaptive relationship patterns. It is also possible to use this model in a transformation process as a method to get from an as-is status to a to-be status.

"Be Aware of Your Limits": Burnout

Our modern working environment demands a lot from us, especially mentally. Be it high flexibility, high pressure to perform, high-speed requirements, more stressful situations, fewer opportuni-

ties for retreat, constant availability, understaffing, more personal responsibility, etc. These stress factors can lead to psycho-physical exhaustion that, in turn, leads to clinical depression or a generalized anxiety disorder.

Issues at the workplace often cause men to seek psychotherapy for the first time [33, 34]. Another reason is that they are often referred by a psychiatrist or a general physician. As a therapist, it is important to encourage men to work on topics immediately and not to wait too long. Depressions, especially in men, can be trivialized as "all is fine" or be disregarded as nothing but "acting out behavior." In principle, the following aspects of therapy for men are to be taken into consideration:

- Men are downplaying their symptoms "All is fine!"
- Depression in men is often undiscovered—the symptoms are reckless driving, drinking, violence, aggressive behavior
- Unemployment and a lack of recognition are risk factors for burnout
- Increase in absent working days as a result of burnout/depression
- Presentism (people not calling in sick when they should, the consequence being that they are only physically present)
- Absenteeism (people pretending to be ill to avoid working)

In our online contact form, people pick burnout as the reason why they seek treatment over any other illnesses.

Balance Model: Family and Contact

Family + Contact
Active family time
Active contact and social life
Spending time with friends
Being a good male role model

Family and Friends: Sense of Belonging

One of the possible basic conflicts of the psychodynamic diagnostic instrument OPD-II [35] is balancing between belonging and autonomy. Knowing that we "belong somewhere," have a certain place in society or, more broadly, are involved in society, gives us a sense of purpose and the feeling of being needed. The two questions "what do we want to be like" and "what are we supposed to be like" have to be answered by the individual themselves.

Global online social networks such as Facebook, Twitter, Instagram, etc., are more popular than ever before. Every way of life, every gender identity receives "likes" and is accepted. In a world where everything is possible, how can we know which way of life is the best for us?

The concept of "family" has recently become a heated battlefield, where legal, psychological, transcultural, and open aspects of family life are being discussed. One of the questions we ask our patients most frequently is "Who exactly do you mean when you talk about "WE"?" Who exactly is part of "WE"? Relationships are no longer self-explanatory (family = father, mother, child), but require a clear definition.

Belonging and social relationships must therefore always be re-established and resemble a perpetuum mobile rather than something fixed. Who accompanies us in life, who can we trust, who helps us in difficult situations? Oftentimes, the therapist is an important person of trust because this exclusive time of listening and him putting his own interests aside has become something special for the patient.

In the therapeutic setting, we ask not only about the biographical history of the original family but also about the "current family." In depth-psychology in particular, we want to get an idea of the early bonding patterns, the important persons of reference during childhood, the atmosphere in the parental home, and the satisfaction of basic needs to better understand the dynamics of the lives of our patients. Some fundamental questions of depth-psychology are how relationships can be shaped and how tensions around crucial issues over the entire course of life can be resolved.

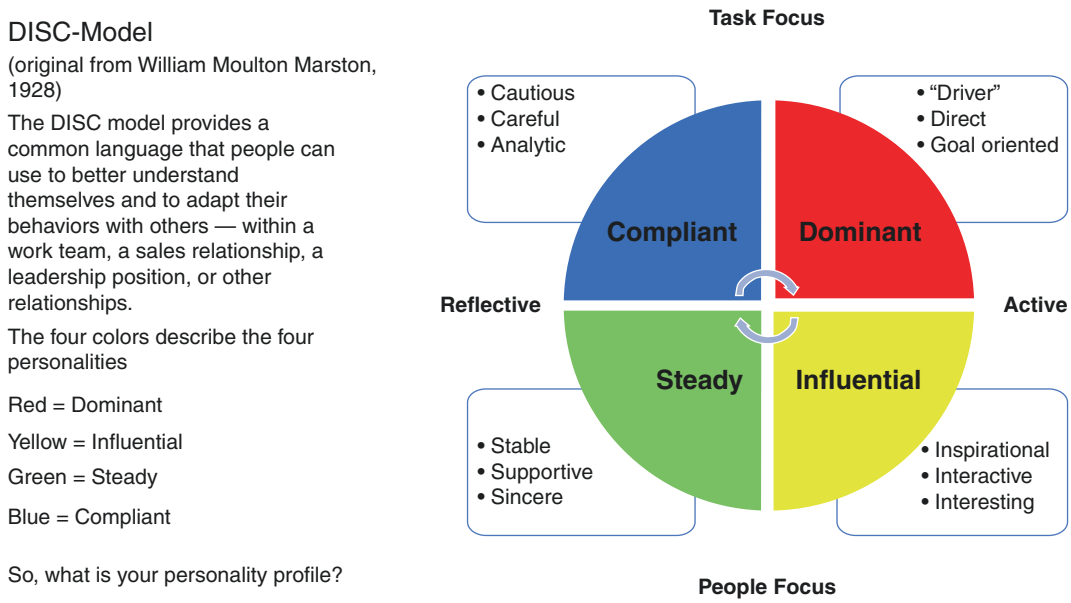

Fig. 24.5 Graphical representation of the DISC model, a personality profile

Who Am I?: DISC Model

The so-called DISC model (Fig. 24.5) is a simplified but quickly comprehensible model for patients/clients with different personalities and social relationships [36]. This determines, for one, whether we are people-focused or task-focused and also whether we are active or reflective as a person. In the DISC model there are four main behavioral styles: *d*ominant, *i*nfluential, *s*teady, and *c*ompliant. As a rule, every behavior has advantages and disadvantages and we assume different roles depending on the situation.

> "I wasn't even aware I was so demanding in my interaction with people," explained a marketing manager, who, during our therapy sessions, gave me the constant feeling of needing to perform fast.

In this case, the borders of coaching and psychotherapy become fluid once again. We consider models to be helpful in explaining the complexity of the psyche to the patients so that they can become "experts of their own person."

Recurring, mono-dimensional relationship patterns, which other people perceive as disturbing and stressful, can then be worked on in axis 2 of the psychodynamic diagnostic tool (OPD-II) [35] in a therapeutic setting.

Being a Good Father: Men as Fathers

"The most powerful role models for children sit across from them at the dinner table."

Men are different from women and fathers treat children differently than mothers do. And it is fine that way. Studies show that fathers who work more than 55 h a week and are not available to the children are not regarded as a person of reference by them. This creates above-average numbers of behavioral abnormalities in the sons [37]. Spending quality time with one's children in addition to the partner is an important factor in making role models effective. In a therapeutic setting, we ask men about their experiences and memories with their own father. Sometimes, working with a family tree is also helpful to discover certain patterns in family history. Which male role model of the patient becomes apparent? What kind of father do I want to be? What kind of role do I want to assume as a partner?

During periods of separation, it is important for the father to continue playing that particular role. In therapies, we see various kinds of fathers: from uninterested fathers who neither pay alimony nor look after their children, to extremely committed fathers who are kept from being a father to their children by all (legal) means imag-

inable. The way these separations are handled is also crucial for the mental health of the children.

"Blood Brothers": Friendships Among Men

Most social contacts in families originate from and are maintained by women. Many friendships between men, on the other hand, are based on joint activities such as playing sports, watching football, riding motorcycles, being involved in a club, doing handiwork or attending a cooking course. It is important for contacts to be cultivated continuously and not let them fall victim to family and work.

> "It's always been my dream to ride along Route 66 on a motorcycle. To be honest, I was just working and taking care of my mother and my partner," says a 37-year-old car rental business owner who seeks psychotherapy because of a depressive episode.

Perpetrator or Victim

It is not well known that men are victims of domestic, psychological or institutional violence (politics, institutions, work, cyberbullying, etc.) just as much as women. More than 90% of prison inmates are male. When it comes to sexualized violence, however, women are more often the victims [38, 39]. Violence is an absolute "no-go," a violation of boundaries, which in turn can lead to violence (brawls, sexual or other offences) or self-harming tendencies (physical illnesses, addictive behavior, a trend toward a conflictual lifestyle). As therapists, we need more courage to address violent experiences of our patients during psychotherapy to better deal with these "traumas."

> When somebody's talking smack, he's gonna get it...

Resist the Onset of Violent Behavior!

Psychotherapy needs to take a clear stance on the issue of violence and needs to better educate the population. Men who have experienced violence often do not talk about it because they are ashamed, and their gender identity does not allow them to do so. We need sensitivity to the topic.

Other reasons for men seeking psychotherapy because of problematic social relationships are:

- Difficult separations
- Childlessness
- External relations
- Detachment issues from parents
- Feelings of insecurity because of gender identity
- Unfulfilled sexual desires
- Financial distress
- Trouble with the law
- Diverging values from transcultural, interreligious networks of relationships

Balance Model: Vision and Mission

Vision + Mission
Hobbies
Inner values
Spirituality
Culture, tradition, rituals
Regulation of virtual world vision

> If you want to build a ship, don't drum up people to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea. (Antoine de Saint Exupéry)

Visions Are Powerful: Visions, Goals, Traditions

We need visions, inner images, goals, to embed ourselves within a larger frame of reference, such as culture, tradition, and a connection to something divine, to lead a fulfilled life [11]. Founders of religions, literary men, and spiritual-oriented scientists such as Carl Gustav Jung have dealt with the question of what holds all people together, deep on the inside. A well-known concept is Jung's description of a "collective unconscious" as the transpersonal layer of the unconscious, "but this personal layer rests upon a deeper layer, which does not derive from personal experience and is not a personal acquisition" [40]. Jung instead sees it as transcultural, originating from myth, fairy tales, and rituals.

The commonality of the human psyche and the accomplishments in a person's life become clear and tangible as soon as the prevalent archetypes are recognized.

As part of a vision quest or vision work, we ask men the following questions as a form of mental exercise:

- What do you *really want* in your life?
- What is your vision right now?
- Don't lose your *passion*
- Follow your *intuitive power*
- Remain *curious*
- Outdated? Discover yourself in a new way and *simplify your life*
- Do you have hobbies and resources?

In the natural and significant changes in life, there is always a need for a new adaptation of one's own vision and mission in life. A Jewish–American psychologist and psychotherapist of German origin, Erik Erikson, outlined what is most likely the best-known psychosocial phases of self-development in our field. Each change of phase is connected to new questions of meaning, changes of life, competences to act on, social changes, and new questions of identity. Changes need new vision!

Dücker, as shown in Table 24.1, has outlined these phases in a way that is easy to understand and emphasizes the social framework [41].

Leaving Your Comfort Zone: Change

"You never change your life until you step out of your comfort zone; change begins at the end of your comfort zone." (Roy T. Bennet)

Every change and the resulting adaptation of our habits and social companions, requires us to leave our "comfort zone" [42]. We grow with the challenge, bit by bit, like a snake that sheds its skin, only to produce a new one. This process is associated with diverse feelings such as fear, uncertainty, and doubt. Whatever "used to be" is no longer applicable, but "what is now" has not yet been found. It is necessary to embark on unknown terrain and to rely more and more on instincts, one's own attentiveness, and one's new vision. Spiritual anchors, rituals, and the feeling of being connected to something greater can help:

Table 24.1 Phases of change, according to Dücker [41]

Psychosocial "crises"	Relevant people of trust	Psychosocial relations	Elements of social order
Trust vs. mistrust	Mother	Receiving, giving	Nurturing and caring for a child Support
Autonomy vs. shame, doubt	Parents	Withholding, giving	Practicing obedience, self-worth
Initiative vs. guilt	Family	Act, "act as if" (pretending)	Parents and idols as role models
Sense of purpose vs. feelings of inferiority	Neighborhood, school Peer groups	Doing things, creating, questioning	Things and people in the environment
Finding identity vs. diffusion of identity	Peer groups Role models, idols	Who am I?	Opinions, sentiments, ideas, ideologies
Intimacy and solidarity vs. isolation	Friends, sexual partners, rivals	Self-discovery through things that are unfamiliar	Cooperation and competition
Ability to procreate vs. self-isolation	Workplace, household	Creating, caring	Upbringing and tradition
Integrity vs. desperation	All of mankind, divine entities	Accepting self-development and evanescence	Wisdom or inflexibility

- Your comfort zone makes you feel safe, but it can also be a place of stagnation
- Every process of change makes you uncomfortable
- The old situation is history, and the new one is not built in 1 day
- You need good and powerful vision to go through the process
- You feel uncertain, nervous, sometimes aggressive and depressed or full of hope—this is all normal
- The new one is not 100% perfect; it needs time to grow
- Spirituality could give you basic trust, solidarity, and meaning

A 46-year-old business economist said that whenever his boss accused him of poor work, he would end up in a state of complete helplessness. He has his department under control, works hard and is very popular among employees. The helplessness he experienced was so violent that he was hardly able to react in a sensible manner.

We were able to work out that these situations reminded him of his old mathematics teacher, who, over the course of 2 years, tormented him at school. Even the smell of his office reminds him of the old classroom. In addition, he had feelings of existential insecurity. Using these findings, the patient could change his life: he spoke openly with his boss, reduced his working hours, spent more time with his family and friends, and started viewing his financial means from a realistic standpoint. This process of change was visualized with the help of the balance model, and the important changes in all respective areas of life were highlighted.

Discover and Respect Your Resources

When treating men, it is essential to ask them about their skills, hobbies, and resources to activate positive associations. Fixation on mental issues and symptoms is not helpful in establishing meaningful visions.

At the beginning of resilience training for engineers at a big airline that lasted several months we asked the participants about their hobbies. It was unbelievable how many exciting things were brought to light: one of them built fireplaces, the other had just restored his third vintage car, another ran a cocktail bar parallel to his job, another had cycled through China, and another took care of his paraplegic friend.

The ice was broken and a space for constructive work had been created (even though, originally, we were sent to treat underlying physical stress factors and outplacement developments).

Clinical Applications of a Gender-Sensitive Approach

In addition to the tool of theory-based training in a coaching-oriented methodology, a therapist can use his own personality, including his sexuality and relationship skills, as a tool. Therefore, mindfulness is necessary to work out what the working and transferring relationships that develop based on the gender of the therapist and client are like [43]. We are advocating a gender-sensitive therapeutic approach. Additionally, there seem to be differences between female and male clients when it comes to determining what for, how, and why they are seeking psychotherapy [34]. These differences are displayed in Table 24.2:

Table 24.2 Psychological gender differences between men and women

Men	Women
• Active coping, "acting out behavior" • Aggressive coping mechanisms • Prone to addiction • More suicides • Action-oriented • Less relationship-oriented • Lower perception of symptoms of illness • More averse to seeking help • Do not discuss their feelings as often • Embarrassing topics are avoided • Tend to trivialize their situation • Need recognition	• More feelings such as: doubt, guilt, depression, fear, grief, worry, anxiety • More dependent on positive feedback, lower self-confidence • Less action-oriented • Stronger extraversion, empathy, relationship-orientation, worse differentiation? ("Cost of caring") • Talk about feelings more often • Embarrassed because of their own body, social skills or performance • Role shift after motherhood and menopause • Depressive powerlessness, possible acquired helplessness or feeling of dependency

What a Man Wants: Special Features of the Therapeutic Setting

So far, there are few studies on the required differences in a therapeutic setting with regard to the treatment of men and women. A Canadian website (www.mantherapy.org [15]) has pushed forward and implemented an innovative online platform as a way of offering low-threshold therapy for men. The aim was to establish a casual setting to encourage men to reflect on themselves to reduce addictions, suicide attempts, and depression. On the website, a fictitious therapist, Dr. Mahagony, sits in a room filled with typically "manly" ornaments (sports certificates, hunting trophies, a large wooden desk) and addresses the men openly and with wit. He treats them at eye level and more as a friend than a therapist. The self-tests are designed humorously and in simple language. Dr. Mahagony also shows how changes are possible using practical examples and opens himself up.

In a practical setting with men, it is necessary to consider the following points [44]:

- Nonverbal: shaking hands, greeting with a smile, eye contact
- Formal respect, for example, not being sent away despite appearing late
- Male attributes within the scope of therapy
- Clothing and hygiene of the therapist
- Beverages
- Administration outside the therapy session
- Emotional support through self-revelation of the therapist
- Clearly addressing the relevant topics
- The therapist does not act like an expert but a coach
- The therapist also asks about topics that go beyond the problem areas
- The therapist is mostly chosen by recommendation; often, the client has already gathered information about the therapist by listening to a lecture or looking them up online, "blind dates" are virtually non-existent
- The client needs to be required to cooperate
- The therapist teaches client skills
- The therapist recommends books, movies, and educational material
- Working with a questionnaire, "homework"
- The therapist recommends an attorney, credit counseling, social services
- Integrating additional people such as, partners, colleagues, superiors, etc.

A quick journey toward self-reflection for our colleagues [12]:

- How do I design my practice in a manner that makes men feel accepted?
- How can I detach myself from gender-specific thought patterns and integrate both male and female role ideals?
- As a therapist, how can I better understand a man and all his various facets?
- How can professionals win the trust of men during psychotherapy?
- How can I understand the man behind the symptoms?
- Which needs are repressed in men?
- What does a man replace his actual needs and desires with?
- How can I understand male courage, male anger, and feelings of revenge, but also feelings of guilt and shame?
- How do I break the chain of powerlessness, anger, aggression, and guilt?
- How can I understand intergenerational tasks that are required of men?
- Wanting female attention while rejecting it at the same time: how can a man escape this dilemma?
- How do I get a man to experiment?
- How do I awake the curious boy that is inside the strong man?
- How do I heal the relationship to their own father/grandfather?
- How can I help the man understand himself as the son of his mother and father while still going his own way?
- How can I involve the partner or other related persons in a productive way?
- What different techniques do I have at my disposal when I am treating men?
- How can I work with groups of men?

Clinical Vignette

A 53-year-old man sought therapy after a recommendation from a general physician and said: "I've been through a lot lately..." With the help of the balance model and extensive anamnesis, we quickly found out about the various obstacles [12] in the patient's life. Figure 24.6 displays the balance model of the respective patient.

By asking questions, the situation and relationship towards his parents became very clear: he had learned that, as a man, he had to "support women" and fulfil his father's athletic hopes that were projected onto him. When we made him create a family tree on his own, the father was above all the other people. The patient knew very little about his own family. One of the central guidelines in his upbringing was to be "hard on oneself," which manifested in a year-long pursuit of the sport of cycling. No one in the family talked to each other and "feelings" were a foreign concept. The patient fulfilled the wishes of the parents whom he idealized and unconsciously prohibited himself from "expanding" and founding a family of his own. The seventh stage according to Erik Erikson, "intimacy vs. isolation," was clearly shifted toward the latter aspect.

The inner desire for peace, security, and emotional attention could only be "earned" by many physical ailments. For him, the hospital was a place of peace and care. At the same time, the hospital was also a place where aggression took place, in the form of anger, which was directed toward the strict parents, the sport, or the medical system (which was manifested by him demanding many surgeries). The patient proceeded to shift the aggression toward the working world by displaying aggressive behavior toward his colleagues and superiors.

Only after a period of time was it possible for the patient to soften his "hard shell." He contacted his sisters, was able to enjoy the sport ("I can cycle with joy now"), and realized that he was very afraid of losing his parents. He sought a conversation with his father, who wanted to learn more about the "lost generation." His girlfriend broke up with him via text message, which made him fall back into a crisis for a short period. After a short time, however, he found a girlfriend on a dating platform. With her, he was able to experience new bonding patterns for the first time and was able to reciprocate!

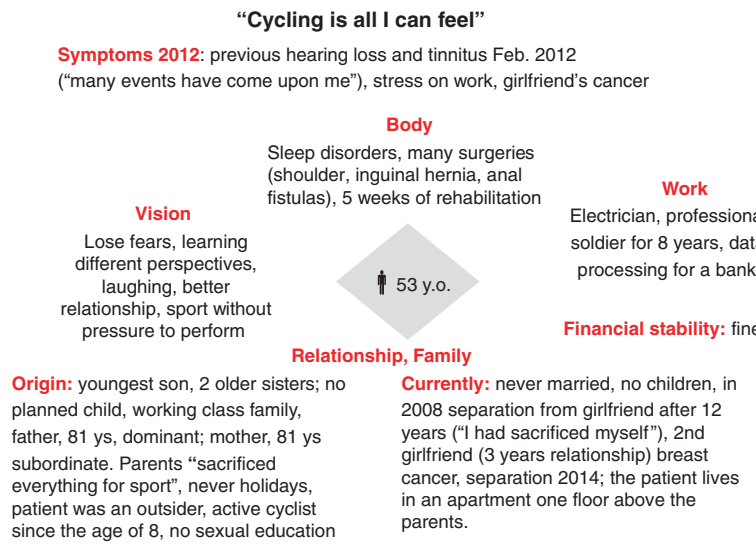

Fig. 24.6 Adapted balance model

Summary

With the help of the balance model of positive psychotherapy, the most important areas of life can be recorded in a structured way and specified in a gender-sensitive way. Men do not need a "different" form of therapy. Therapists only need to be aware of specific "male issues," male relationships, and the male point of view of the symptoms. It is important to meet the men in a low-threshold scenario and act more as a coach than as a superior. The setting should also meet the needs of men and each therapist should practice self-reflection on the individual topics! Men feel more secure when met with comprehensible ideas for action and can then, in the second phase, report more easily on embarrassing and critical topics. Visualization of the topics developed, clear tasks for the time between sessions, resource activation, book recommendations or suggestions for physical activity can set change processes in motion. It can also be helpful to include important persons of reference and to make free use of technical media [14].

Key Points

Poorer physical and mental health compared with women (globally), longer working life, working under dangerous conditions, rare medical check-ups, higher likelihood of addictive behavior, trivialization of symptoms, forced to be "a strong man" by the identity construct (and social obligation), gender-sensitive psychotherapy, balance model of PPT, individual biological, psychological, and social health model, concrete plan of action, health behavior, sexuality, stress regulation, working conditions, family, fatherhood, dealing with violence, developing visions and resources, therapy at eye level, issues relevant to men.

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Part V

Theoretical Foundations and Training

This part, *Theoretical Foundations and Training*, brings in the theoretical underpinnings of Positive Psychotherapy (PPT) after Peseschkian.

Chapter 25 revisits the theoretical and historical roots of PPT.

Chapter 26 includes a discussion of the First Interview Process in PPT and includes the Differentiation Analytic Inventory – for capabilities – and an addendum with the English version of the semi-structured first interview questionnaire.

Chapter 27, on the conflict model, explains the PPT's underlying theory of four conflicts: Actual, Key, Basic, and Inner.

Chapter 28 articulates the unique use of stories, anecdotes, and humor in PPT. The functions of stories are numerated and the experience of using such tools in psychotherapy, in the Ukraine, is summarized.

Chapter 29, on supervision in psychotherapy, provides the theoretical model for supervision and the relationship to the professional development of the supervisee as a therapist.

Chapter 30 discusses Spirituality and Positive Interventions from a Positive Psychology perspective.

In Chapter 31, Positive Psychotherapy as an Existentialism, the parallels between PPT and Existential Philosophy are highlighted, in particular their common focus on meaning, responsibility, and capabilities.

Chapter 32 discusses how other methods can be integrated into Positive Psychotherapy and how they can work together.

Chapter 33 brings the experience of practicing PPT in Brazil and its use in finding meaning in life.

Finally, Chapter 34 applies a PPT tool, Positive Interpretations, as a tool for clients in identifying and replacing inaccurate thoughts based on clinical experiences in Ethiopia.

Theoretical Foundations and Roots of Positive Psychotherapy

25

Arno Remmers

Humanistic Roots

> It is as if Freud supplied us the sick half of psychology and we must now fill it out with the healthy half.
> Abraham Maslow [1]

In the first chapter about a "positive view" in treatment, Peseschkian explained in his book "Positive Psychotherapy" (1987): "While many of the existing psychotherapeutic procedures take the disturbances and illnesses as their starting point, prophylactic and preventive medicine and psychotherapy require a different method of proceeding, starting from the person's developmental possibilities and capacities instead of the disturbances." Abraham Maslow, the proponent of the hierarchy of needs and one of the founders of humanistic psychology, saw "…the importance of focusing on the positive qualities in people, as opposed to treating them as a "bag of symptoms" [2]. Maslow was also the first psychologist to use the term "positive psychology" (1954). Humanistic psychologists "believe that every person has a strong desire to realize their full potential, to reach a level of self-actualization." The main point of humanistic psychology was "to emphasize the positive potential of human beings" [3] and as such "…the final level of psychological development that can be achieved when all basic and mental needs are essentially fulfilled and the "actualization" of the full personal potential takes place [4]."

The idea for positive psychotherapy (PPT) arose in the 1960s, concerning an oral message by Manije Peseschkian, the wife of Nossrat Peseschkian, on a flight to the USA in 1968. It was the period of the development of humanistic psychology and psychotherapy in the USA, pioneered by Abraham Maslow and Carl Rogers. The American Association for Humanistic Psychology (AHP) had been founded in 1962. Humanistic psychologists had been influenced by Kurt Goldstein, who saw *self-actualization* as "the tendency to actualize, as much as possible, [the organism's] individual capacities" … "At any moment the organism has the fundamental tendency to *actualize all its capacities*, its whole potential, *as it is present in exactly that moment, and in exactly that situation in contact with the world under the given circumstances*" [5]. "The curative force in psychotherapy–man's *tendency to actualize himself*, to become his potentialities… to express and activate all the *capacities* of the organism [6]."

The term "*actual capacities*," *used in PPT*, is in line with this humanistic tradition: "The roots of differentiation analysis reach back farther, to the schools of classical psychotherapy" [7]. Peseschkian describes "actual capacities, because

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in daily life they are, in the most diverse ways, being continually addressed at every moment." In September 1974, Peseschkian had a lecture about the "Actual Capacities as Aspects of Connotation and Social Organization of Conflict Handling" [8], and in the same month he delivered a speech about "The meaning of norm conflicts in the development of psychosomatic diseases" at the 12th International Congress on Internal Medicine in Tel Aviv. The actual capacities have been worked out by factor analysis of psychotherapeutic interviews with patients from different cultures ([9], 1988). Peseschkian compared these terms with those used by other authors (1977), including Maslow's description of "self-actualizing people, that share the following qualities: Truth: …pure, *clean* … *honesty*, … *perfection*, … *unity*, integration, tendency to oneness, …*order*, … *acceptance* … *uniqueness*… *justice*…" and Engler [10] comments, that "the usefulness of the concepts of self and self-actualization continue to attract discussion and debate." Peseschkian wanted to create a practicable, understandable, and systematic psychotherapy method using the terms of actual capacities for self-development.

Peseschkian's personal transcultural experiences drew his attention to the significance of psychosocial norms for socialization and the birth of interpersonal and internal psychological conflicts. He "found, … that in connection with the presenting symptoms there were conflicts stemming back to a number of recurring modes of behavior." In turn, "an inventory [was] drawn up, with the help of which the content components of the central conflict areas could be described. That which appeared as conflict potential and developmental dimensions in the spheres of child-rearing and psychotherapy was, in the domain of morality and religion, reflected in the normative sense as *virtues*. Out of the psychotherapeutically relevant behavioral and attitudinal norms was developed, the differentiation-analytic inventory (DAI), as a relatively comprehensive system of categories. I called the behavioral norms contained therein *actual capacities*, an expression I held to be necessary because these norms are inherent as capacities in human development; they are the developmental dimensions, the shaping of which is furthered or suppressed by favorable or inhibitory environmental influences" [7].

The *modelling dimensions* of Peseschkian described later are also close to the humanistic approach: "As a result of interaction with the environment, and particularly as a result of evolutional interaction with others, the structure of the self is formed—an organized, fluid but consistent conceptual pattern of perceptions of characteristics and relationships of the 'I' or the 'self,' together with values attached to these concepts."

This terminology and method of Peseschkian are in line with the early phase of humanistic psychology. The difference from this approach is reflected in a structured approach, in the application of a semi-structured first interview and a five-step process in therapy, family, and self-help, in the use of visualizations such as the balance model, modeling dimensions, stories [11], proverbs, and questionnaires for the actual capacities and conflict reactions (see also Chap. 2 on the DAI and the Wiesbaden Inventory for Positive Psychotherapy and Family Therapy [WIPPF] questionnaire). The therapeutic process was seen in a five-step development. In this aspect, PPT is also close to the organized way Alfred Adler conducted his individual psychology therapy process in five steps and a sixth step of self-help. Alfred Adler's method seems to play an important role for Peseschkian to combine the psychodynamic and humanistic background of PPT and its process with the application of family styles, self-help, encouragement or actual capacities as psychodynamic conflict content.

Psychodynamic Theory of Conflict, Personality, Relation, and Symptom

Meetings and training took place with psychoanalysts in Frankfurt, Germany, where Peseschkian worked in the University Mental Health Hospital. He learned from well-known Swiss psychoanalysts such as Heinrich Meng in Basel, conducting his psychoanalytic self-experience, from Raymond Battegay, who was like a mentor and

friend for him, and from Gaetano Benedetti. Their influences encouraged Peseschkian to develop a psychodynamic conflict theory, fitting the needs for a clear psychodynamic diagnosis in the Germany of the 1970s.

In connection with the psychosocial norms, [Peseschkian] asked [himself] the following questions: How do conflicts arise? How can these conflicts be adequately described? What lies behind the symptoms of psychological and psychosomatic disturbances and the curtailment of interpersonal relationships, and how can these disturbances be adequately treated? (1987). He described the resulting subconscious inner conflicts as following a partly conscious actual conflict situation, waking up former basic conflicts.

From 1968 on, Peseschkian developed the "differentiation analysis" or "differentiation-analytic theory" [7] and published it at conferences in 1974 as a complement to the psychoanalysis of that time, which was concerned primarily with the psychosexual phases of development (for example, oral, anal, and Oedipal), the development of autonomy and conflicts between the Id and the superego. In differentiation analysis, the client and the therapist work out which specific contents and values have been important at earlier stages, and which are still important today: the patience of the parents, the development of trust, the experience of love in unconditional acceptance is a developmental psychological prerequisite for successful development in the oral phase. These capacities, known as "primary," are imprinted on the child by the direct behavior of the parents and through their modeling. Primary capacities such as having patience (with oneself or others), having trust (in oneself, in others, or in fate), having and giving time, are basic necessities for the development of the newborn child. The child needs warmth, time, patience, and empathetic, unconditional acceptance to develop her/his own age-appropriate inner balance. In this way, the phases of psychoanalytic development psychology had been filled with specific terms for conflict content defined as capacities, understandable by everybody, linked to cultural values.

The experiences of the clients with their parents, and with other reference persons, and their values, capacities, and social norms are described within *four modelling dimensions*. These occur through the child's direct relationship with the parents, through experiencing the relationship of the reference persons with one another, with others, and with their philosophy of life. The actual symptom of a patient can therefore be understood on the one hand as the expression of an inner psychic conflict situation, and on the other hand as being culturally imprinted and as receiving its social function from within the patient's social system. This is also true for the capacity to bond and relate, the early development of trust, as opposed to mistrust, the basic attitude toward life, identity, and self-image as a man or woman. Above all, the primary actual capacities are developed in this area in mutual interactions that demonstrate the modeling functions of the primary reference person. This is equivalent to the experience of the self-object and the development of self- and object representation in psychoanalytical theory. The grandparents are also important here in their independent role as transgenerational transmitters of tradition and preferred primary capacities, and in the widening triangulation, they play a significant role in their grandchild's development of self-esteem because of their special form of acceptance of him or her ([12], p. 126). With the modelling dimensions and with the terms "sociogenesis and sociodynamic," Peseschkian widens the self-object theory of Kohut and Kernberg to apply this wider concept of psychodynamics and sociodynamics to collectivistic and family-oriented cultures as well. In this way, Peseschkian became an proponent of a bridge between individual psychotherapy theories and the collectivistic cultural needs in treatment and counseling.

This individual psychodynamic conflict model and the psychogenesis are complemented by a model of *sociodynamics* and *sociogenesis* [13]—and this is a remarkable addition to the individually oriented psychodynamic therapy. Jacob Levy Moreno was one of Peseschkian's teachers and the inventor of sociodrama and sociometria. Peseschkian coined the terms sociogenesis and

sociodynamics to describe the dynamic and genesis of the family and cultural value system and concepts within the terms of actual capacities. In this way, it became a bridge between the systemic and humanistic and the psychodynamic understanding. Along with the intrapsychic conditions of the formation of health or disturbances and of the individual psychodynamics, it is the family, social, cultural and transcendental relations that imprint the concepts of sociogenesis and the value models, forming a culturally imprinted sociodynamic.

Peseschkian's model also leaves the classical deficit, instinct and pathology orientation in psychoanalysis and comes back to the "potentials" in the clients, another humanistic term used by authors such as Maslow: "Suppressed and one-sidedly unfolded capacities are possible sources of conflicts and disturbances in the psychological and interpersonal areas. They may manifest themselves in anxiety, aggression, conspicuous behavior, depression, and that which is called psychosomatic disturbance. Since the conflicts arise in the course of a person's development in the confrontation with his environment, they … present themselves as problems and tasks which we seek to resolve. With this, an essential difference becomes clear: traditional psychiatry and psychotherapy take as their point of departure disturbances, conflicts, and illnesses. Accordingly, the goal of treatment is set: to heal illnesses and eliminate disturbances. What is overlooked is that it is not disturbances which are primary, but rather capacities, which are indirectly or directly affected by these disturbances" (1987).

As with other approaches based in "depth-psychology", "Tiefenpsychologie" as psychodynamic short-term therapies are called in Germany, PPT recognizes a psychodynamic conflict causative agent. This is, however, more sharply differentiated and complemented by the theory of *microtrauma*. It means a repeated subconscious conflict of values that will not be existential each time, but in its sum the balance and inner conflict resolution capacities of a person will be disturbed, so that symptoms can be the subconscious answer and language of body and soul on the repeated smaller conflicts touching old basic concepts and basic conflicts. "Conflict" (derived from Latin *confligere* meaning clash, fight) presents the apparent incompatibility of inner and outer values and concepts or an inner ambivalence. Emotions, affects, and physical reactions can be understood in this connection as signal lamps that indicate an inner conflict of values and the distribution of actual capacities. Therefore, in PPT the question is asked about the content: Exactly what triggers this emotion? The conflict reactions, defense mechanisms, and resistance are then seen as *capacities* and viewed according to their functions.

The *balance model* broadens Freud's concept of the "libido," as with Adler, to four areas of a general and pro-social life energy of body, activity, social drive, and existential or spiritual motivation. Areas of conflict reactions can be specified in the four areas in their influence on actual everyday life, in their function and spectrum of symptoms.

Interactions with others are described by the *three stages of interaction* on the basis of a specific developmental psychology. Natural stages of human interaction occur in the traditions of greeting, meeting, and separating. "Hello!" shows the attachment. The question that so often follows: "How are you?" introduces the differentiation as well as the exchange of news. The "Good-bye!" is the sign of detachment, combined with the wish to meet again. Thus, the three stages of interaction in PPT can be understood as three phases of a meeting in which the orientation of one toward the other and expectation for the future play a role. Affect and emotions are seen as outward expressions of content behind which are found values and value conflicts (*actual capacities*). Relationship models are described according to the three stages of interaction and explored for any one-sidedness that may lie behind them. In one's individual development as in a situation of partnership, one moves continuously through different stages, which are characterized by the following principles: the principle of development, the principle of differentiation, and the principle of unity. In human relationships these principles are equivalent to the three stages of interaction: fusion (attachment), differentia-

tion, and breakaway (detachment, separation), which are observable in every conflict and in every meeting [7]. They structure the life of all human society [11].

Within psychodynamic theories, the three stages of interaction represent a broadening of the duality of dependence and autonomy in relation to differentiation. They are at first glance similar to the three steps of meaning in medical treatment described by Victor von Gebsattel, the stage of being summoned in an emergency, the distancing of the diagnosis and the coming together as partners in the treatment [14]. As Viktor Frankl and von Gebsattel were in close contact, and Nossrat Peseschkian was a student of Viktor Frankl, it is probable that von Gebsattel's three phases of the medical encounter had some influence on the reflections that led to the stages of interaction. However, Nossrat Peseschkian based the stages of interaction on the history of a child's development, then carried them over into the therapeutic process, the general patterns of human interaction, and the analyses of interaction described above.

A longtime companion and friend of Nossrat Peseschkian's, the Swiss psychoanalyst Raymond Battegay describes PPT in this connection as: "…a method of depth psychology which enlists not only the individual unconscious but also the collective/typical in the clarification of the psychodynamic. The unconscious is understood by means of transcultural comparison even more than in the junction of analytical or complex psychology."

In this way, PPT is clearly defined as based on a *psychodynamic conflict theory*. The *basic conflict* of the early experience in childhood uses Freud's term, and the *inner conflict* is defined as being close to modern psychodynamic therapies. However, the inner and the basic conflict exist between the needs of primary capacities and the social norms represented in secondary capacities [15]. In this way, the clients can easily understand their formerly subconscious *conflict dynamic* and *conflict genesis* in terms of actual capacities such as trust, honesty, justice, orderliness, or hope.

Transcultural Psychotherapy: the Fourth Way

In 1955, a program in transcultural psychiatry was established at McGill University in Montreal by Eric Wittkower, from psychiatry, and Jacob Fried from the department of anthropology. The American Psychiatric Association established a Committee on Transcultural Psychiatry in 1964, followed by the Canadian Psychiatric Association in 1967.

Transcultural psychiatry had been working with the differences between mental health disorders in different countries, but a transcultural psychotherapeutic treatment had not yet been developed. It seems that Nossrat Peseschkian consecutively invented his "transcultural psychotherapy" in 1968, and from 1979 on, he used the term "transcultural psychotherapy" for his approach. As a practitioner, Peseschkian not only looked at the intercultural perspective but also at the transcultural way: "Transculturalism is defined 'seeing oneself in the other'. Transcultural … is in turn described as 'extending through all human cultures' or 'involving, encompassing, or combining elements of more than one culture.'" "In 1940, transculturalism was originally defined by Fernando Ortiz… as the synthesis of two phases occurring simultaneously, one being a deculturalization of the past with a métissage … with the present, which further means the 'reinventing of the new common culture.' According to Lamberto Tassinari transculturalism is a new form of humanism based on the idea of relinquishing the strong traditional identities and cultures which […] were [the] products of imperialistic empires […] interspersed with dogmatic religious values [16, 17]." Thus, we are back to the humanistic approach that made transcultural psychotherapy possible. In it, the transfer of the knowledge and the wisdom of different cultures in therapy and counseling as "seeing oneself in the other" is the new approach in therapy and seems to be one of the reasons why PPT is accepted in many different cultures and countries.

Culture and religion are consciously presented as themes in PPT. This is similar to the use of

these themes in the logotherapy of Viktor Frankl, one of Peseschkian's teachers, and the existential psychotherapy of Irvin Yalom. Both C.G. Jung and Nossrat Peseschkian take as their point of departure a person's particular experience of transcultural and religious conflicts, and an entirely personal motivation to find solutions. Consequently, in both models, transcultural observations and deeper experiences occur at the end of the therapy and the patients' personal development stands at the center of the process. As they were both empiricists and transcultural pragmatists, they have brought visualization into psychotherapy. Using stories, concepts or symbols, dreams or images that have been passed down, they create from the common treasure of humanity. Both methods have systems for personality typing, four areas of distribution of personal energy, two forms of expression of conflicts, and of working with them, in addition to the influence of the collective unconscious in relation to the cultural influence found in personal development. However, the consequences of their models of development, in addition to the theories derived from them, differ considerably.

According to Nossrat Peseschkian, the capacity to love is equivalent to the emotional content of an interaction, as with patience, time, love, sexuality, modeling, and trust. The capacity to know constitutes the social norms, such as punctuality, orderliness, obedience, diligence, faithfulness, or justice. These characteristics as such are found in all cultures. They differ from one individual or culture to another in their valuation. In addition, there is content from the inheritance of human history, which, according to Jung, finds its expression in symbolic images from the area of the collective unconscious. It is these symbol-laden images that Nossrat Peseschkian's therapy explores for their content and socio-cultural valuation.

Cognitive and Behavioral Therapy

Sometimes it is stated that Peseschkian helped to build bridges among behavioral therapy, psychodynamic therapy, and other therapies. Are there roots of PPT in behavioral therapy? Hans Deidenbach, a former monk, as a psychologist and as one of Peseschkian's most active co-workers from 1986 onward, had been trained as a behavioral therapist. His influence in the development of PPT was evident in that it was described systematically, resulting in that WIPPF questionnaire, and in the semi-structured first interview (1988). Concerning Dieter Schön, another early medical co-worker of Peseschkian and contributor to his articles, discussions with Lilo Süllwold, a professor from Frankfurt, behavioral therapist and author of the FBS and FBB questionnaires led to a common understanding and integrative ideas for both methods. Peseschkian himself described the relationship with behavioral therapy in the chapters of "Positive Psychotherapy and Other Theories" ([7], p. 375).

Cognitive behavioral therapy was published by Aaron Beck in 1976 [18]. The descriptions of "concept" (Peseschkian) and "cognition" [19] (Beck 1990) are quite similar. Peseschkian's "concepts,", based on "actual capacities," as "virtues" or "values," are comparable with "cognitions" in cognitive behavioral therapy [19, 20]. They are a bridge to making cognitive behavioral therapy understandable for clients and therapists. However, PPT developed these capacities and concepts, independent of cognitive behavioral therapy, on a humanistic and psychodynamic basis. PPT became an integrative tool for translating other psychotherapeutic methods into a language clients and therapists can understand.

Positive Psychology

Positive psychotherapy after Peseschkian [7] and positive psychology after Martin Seligman [20] differ with regard to the structure of the treatment process, and to their theoretical background. The orientation toward salutogenesis and psychodynamics in PPT has in mind the inner subconscious conflicts causing symptoms, whereas Seligman's approach is based on learned helplessness and learned happiness. In a study of depressive mood disorders with 40 students and 46 depressive persons, Seligman and his colleagues used "positive psychotherapy" as their own term [22], applying virtues training. The

strengthening of positive emotions figures significantly in this treatment (the opposite of Seligman's theory of learned helplessness), in addition to striving toward engagement and meaning in life by using techniques from positive psychology, rather than dealing with the depressive symptoms directly. Seligman proposes to lay out the meaning of happiness in three scientifically verifiable terms: positive emotion (the pleasant life), engagement (the engaged life), and meaning (the meaningful life). "Each exercise in [PPT] is designed to further one or more of these" ([22], p. 776). Exercises and methods from behavioral therapy are employed and 24 strengths of character and virtues are differentiated. The facilitation of orientation, engagement, joy, and the demonstration of positive resources are steps in this therapy.

Seligman's view seems to be similar to that of Peseschkian at first sight, and quite different when looking at the psychodynamic and humanistic therapeutic approach integrated by Peseschkian. Psychotherapy has been entirely taken up with trying to repair the negative for so long, now it is the time to move on to the positive. Unfortunately, Peseschkian, whose book "Positive Psychotherapy" had already been published in English in 1987 and available in the libraries of American universities, has never been cited in this context.

The concepts of positive psychotherapy used by Peseschkian as a treatment method in mental health, family therapy, and psychosomatics were first used in Europe, and were published worldwide in the 1970s [7, 12]. A co-worker of Martin Seligman's, C.R. Snyder, author of the "Handbook of Hope" (2001) was invited to the Second World Conference of Positive Psychotherapy in Wiesbaden in 2000. He was then exposed to the theory, practice, and international spread of PPT, which he took back to the USA. The German medical journal (*Deutsches Ärzteblatt*) published an article in which both methods were presented side by side, and Christian Henrichs commented on it later [23]. Theo Cope compared the development and background of PPT and Seligman's positive psychology [24]. Seligman and Rashid had used the term "Positive Psychotherapy" since 2006 without mentioning Peseschkian, and Rashid took part in a conference of the World Association of Positive Psychotherapy in Kemer/Turkey in 2014 and also in a round-table discussion about the two methods. Peseschkian's PPT had been developed since 1968, published in 1977, and applied as a transcultural, mental health, and psychosomatic treatment method against a humanistic and psychodynamic background with a structured therapy process to treat ill patients and families. Positive psychology uses its interventions for healthy humans against a psychological background of behavior theory and research about learned helplessness and learned happiness, today with the goal of flourishing and virtue development [25].

Family Therapy

Family therapy was developed mainly in the USA, Italy, and Germany at the same time as Peseschkian founded PPT and differentiation analysis. It was a developmental period for different kinds of systemic family therapy, such as Maria Selvini Palazzoli, also using positive connotations, the Palo Alto school, or Virginia Satyr. Peseschkian's idea was to combine individual therapy with partnership and family therapy, applicable both in collectivistic and individualistic cultures. He understood the symptom in its function within family and used family therapy tools not only for a single member with regard to how to self-help but also for the complete family to see the symptom as an expression of a conflict in the family system. Different from systemic therapy and unique in Peseschkian's therapy are the instruments for self-help in family therapy, such as differentiation analyses, WIPPF, balance model, model dimensions, first interview structure, or the five-step self-help concepts [26, 27].

Self-Help, Pedagogy, and Process Orientation in Five Steps

Several similarities link Alfred Adler and Nossrat Peseschkian: both of them went out of their office early to teach normal people psychotherapeutic

and pedagogic knowledge. Both focused on public health, medical and psychological prevention, and social welfare, both wanted each client to have an own individual type of therapy. Both founded a five-step process model for communication, therapy, and self-help. The basic structure of individual therapy in Adlerian psychotherapy consists of five phases and a follow-up. Each of these stages has different tasks for the client and therapist.

In the first stage, the therapist provides warmth, acceptance, and generates hope, while giving reassurance and encouragement to the client in Adler's approach as well as Peseschkian's. The second stage in the Adler method is to focus on gathering information on the client, like Peseschkian's inventory. Adler used clarification and encouragement similar to Peseschkian's situational encouragement in the next step, followed by Adler's insight interpretation and recognition, a stage like Peseschkian's verbalization, and finally the change and challenge steps are similar to Peseschkian's widening of the goals. It seems that both thought in a very similar way about therapy and education; thus, it is understandable that Adler's and Peseschkian's methods are useful today for parents, in self-help, and in education.

The five steps concept seems to be like a natural law for groups and communication, as Moreno described five phases of psychodrama, Battegay five phases of the group therapy process, and Adler five phases of therapy and one more for self-help. Peseschkian's ideas about these five steps formed a systematic and simple skill for the communication process.

The Construction of PPT in Comparison with Other Approaches

1. The *positive approach* of Peseschkian is very similar to Selvini Palazzoli's family therapy practice at the same time, and very similar to what the German transcultural psychiatrist Mentzos later saw as the "function of dysfunctionality" [28]. Similarly, Geoffrey Zeig explained that not only the "individual capacities of the client but also the problems of the clients can be utilized to construct solutions out of this." The positive approach was used in psychosomatic medicine by Peseschkian very early on.
2. The *transcultural approach* compares concepts with those from other cultures. Stories from other cultures are used, like oriental stories in Western culture, to surprise people with another cultural perspective. In this way, it is similar to hypnotherapy, where for instance Milton Erickson also used stories. Peseschkian clearly defined a transcultural approach to using stories and proverbs to change the point of view of the client, to see his/her own situation and the function of the symptoms in a new way.
3. The *first interview* after Nossrat Peseschkian, a semi-structured interview with the client, developed with his coworkers Hans Deidenbach and Hamid Peseschkian, is one of the first in psychodynamic therapy to gather the all the information for the client and the therapist so that can plan therapy. Hamid Peseschkian's dissertation, presented in 1988, was the first doctoral dissertation dealing with PPT. The first interview in PPT was first structured in this dissertation, a questionnaire for this first interview was presented and a psychodynamic study of it was undertaken. This first interview questionnaire was published shortly thereafter in 1988 (with minor modifications) together with the WIPPF questionnaire on PPT. This precursor of the later semi-structured psychodynamic first interview was one of the first in psychodynamic psychotherapy.
4. The *balance model*, useful for therapy, self-help, in family therapy, and in many other fields, is well-known. The balance model of the four areas of life energy is comparable with a broadening of Freud's libido construction, Adler's goals of life, or Jung's four functions (perception, ratio, sensitivity, intuition). This balance model presents a structural model of the personality and provides for a new balance of those areas that were in deficit; therefore, a new synthesis, can be arrived at within the framework of the therapy.

The operationalized psychodynamic diagnosis (OPD2) describes four observable basis capacities of the personality structure, which are similar to the four means of the capacity to know [7]:

(a) The "means of the senses" (Peseschkian) is comparable with the structural capacity to perceive oneself and others, as described in the OPD-2. In the foreground, there stands the body—the self—the feeling ([11], p. 94).
(b) The "means of reason"serves in Peseschkian's balance model as the reality check through which problems can be resolved systematically ([11], p. 96) and it directs our activities. It is related in OPD-2 to the structural capacities that direct our inner and outer impulses.
(c) The "means of tradition" serve as the capacity to take up relationships and to flee from them ([11], p. 97). In OPD-2, the analogy to this is the emotional communication with oneself (internal dialogue) and with others as the structural capacity for empathy, and the anticipation of relating to and thinking about others.
(d) The "means of intuition"is described by Nossrat Peseschkian as the fourth area, that of meaning, future, and fantasy. He defines it as the capacity to imagine something in one's thoughts. It can allow for the sudden appearance of the vision of a painful separation from a partner. Intuition and imagination can go beyond immediate reality and take in whatever we can depict as the meaning of an action, the meaning of life, desires, pictures of the future or utopia ([11], p. 99). In the OPD-2, the fourth capacity of the personality structure is the "capacity to form attachments" [21]. Included in this is the imagination of objects that provide support, the connection to an ideal and the external connections with persons. In Nossrat Peseschkian's scheme we understand this to be the capacity for imagination. With its help, the small child can imagine its parents or emotionally close persons, so that after a period of being alone, the imagination of these persons can quieten down, in contrast to those with structural disturbances, who often find such an image impossible to imagine. In this sense, the distribution of the four areas of the balance model represented a forerunner of the structural models in the OPD-2 [21] in 2006.

5. *Differentiation analyses* are based on the roots of humanistic psychology and on psychodynamic therapy. It is a real link between humanistic and psychodynamic therapy.
6. The *basic capacities*–to know and to love–are quite similar to the humanistic approach and are based on Peseschkian's personal experience of the Bahai faith.
7. The *three stages of interaction* represent a broadening of the duality of dependence and autonomy in relation to differentiation, a further development of a description of the medical doctor–patient encounter by Gebsattel at the stage of being summoned in an emergency, the distancing of the diagnosis, and the coming together as partners in the treatment [14]. Nossrat Peseschkian based the stages of interaction finally on the history of a child's development, then carried them over into the therapeutic process, the general patterns of human interaction, and the analyses of interaction described above. The result was the invention of an interaction analysis specific to PPT in addition to the application of the three stages of interaction in a therapeutic relationship, in partnership counseling, and in children and youth therapy.
8. The four *modelling dimensions* widen the analytic self and object theories of Kohut and Kernberg in such a way that there is not only the object and subject, the "I" dimension, in PPT but also the parents' partnership, the "You" dimension, a "We" dimension such as the experience of the parents with others, and the "Primary We," which is unique in PPT, describing the relations of the primary important persons such as the parents and grandparents with their life philosophy and religious backgrounds. With these four

different subject relations, the self-object theory is widened, and I believe that this unique approach could have a future influence on psychodynamic therapies.

9. Language, stories, and proverbs offer a *narrative and associative approach*. In psychodynamic therapy, this was unique, it had existed in hypnotherapy (Milton Erickson), but not in psychodynamic therapy. While Carl Gustav Jung used fairy tales, the Peseschkian method can use a much wider range of narrative therapy and association tools. "Using *stories and parables* from the Orient and other cultures, an effort is made to recognize and further a person's potential for self-help. With reference to the symbolic meaning of proverbs and old words of wisdom drawn from many cultures, the person to whom they are told is led in psychotherapy to a more positive view of himself" ([29], p. 92).
10. The *five-step concepts* of individual and family therapy—like five fingers of each hand—are quite similar to the natural process in groups as described by Raymond Battegay in group psychotherapy, as described by Moreno in psychodrama, and as described by Alfred Adler, using it for the "further education" of people. The unique contribution in Peseschkian's use is that this process model now exists in psychodynamic therapy. The five steps are a guideline for the client and the therapist to finally find the right way to self-help. Therapy research showed that the better we cope with difficult therapy situations and the better we both reflect the therapeutic relation, the better the outcome of therapy will be.

Conclusion: the Place of PPT in Psychotherapy Fields

The roots of PPT are to be found in humanistic psychology and in psychodynamic therapy, seen from the scientific point of view. There are other roots to find in the religious life philosophy of the founder, as Theo Cope described in 2009 ([30], pp. 79–89). The constructions of PPT have roots and are based in scientific theories that exist nowadays in other therapies as well. There was a unique development of Nossrat Peseschkian's method, widening psychodynamic and humanistic psychotherapy theories and practice, creating a transcultural psychotherapy and implementing an integrating approach, concerning the individual needs of the client, salutogenesis, and family therapy and self-help tools.

Positive psychotherapy was originally developed for mental health, psychosomatic medicine, prevention, and psychotherapy as a basic *positive psychosomatic* treatment, as used by several thousand medical doctors in Germany. It is applied in some hospitals, and in the state-licensed training program in psychodynamic therapy at the Wiesbaden Academy of Psychotherapy in Germany.

The PPT method has also been applied for counselling in Germany since 1992, and in some countries such as Bulgaria in pedagogy as well since 1992, or in China since 2014 to train social workers about mental health disorders, how to cope with the families, and how to prevent burnout. It is an example of how to apply psychotherapeutic competences outside the classical psychotherapy and counselling fields. A specialized children and youth therapy training program, based on PPT has been developed since 2006 in Bulgaria and later in Ukraine and Russia. Colleagues from Germany, Bulgaria, Cyprus, Turkey, Kosovo, China, Bolivia, and Ukraine are specializing in positive family therapy and counselling. The method became a bridge for sharing psychotherapeutic competences and experiences in other professional and cultural fields across different societies.

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The First Interview in Positive Psychotherapy

26

Arno Remmers and Hamid Peseschkian

Introduction

The semi-structured "First Interview of PPT" allows clients and therapists to recognize the particular psychodynamic and biographical characteristics and resources important to the origin and development of the patient's state of health or illness. It is a systematic starting point for brief therapy. Described first by Nossrat Peseschkian [4], it was structured by Hamid Peseschkian [5] in his dissertation [14]. Combined with the Wiesbaden Inventory for Positive Psychotherapy and Family Therapy (WIPPF) questionnaire, a patient's therapy calendar (timeline), and a therapist's calendar, it was published as First Interview Questionnaire [5] (see Appendix A for the complete form). It is comparable to the medical history and physical examination in somatic medicine. Previous work on the first encounter included "First Interview" by Argelander [10] and "The Psychodynamic First Interview" of A. Dührssen [9]. Further investigation found the first interview had a diagnostic, therapeutic, and prognostic value and a hypothesis-formulating function [11]. The First Interview in PPT includes all of these as well as several other elements. It cares about the psychosomatic medical history and about relationship factors [12] as well as aspects of the therapeutic alliance (Hubble et al. 2001). It includes the recognition of the effects of expectation [12], particularly the hope for an effective therapy [16, 17]. All this is useful in different settings; in therapy with individuals, children, youth, couples, and families; and in counseling and coaching and applied in different cultures.

Structure

The First Interview in PPT consists of obligatory main questions and optional subordinate questions, which are optional, depending on the answers given to the main questions in each situation. There are both open-ended and closed questions [14].

The First Interview is used in the first encounter or during the early sessions which form the preliminary phase for the purposes of orientation and then goes into greater depth in particular areas during the following sessions.

The First Interview is divided into four areas:

1. Socio-demographic data.
2. Current history and main complaints.
3. Psychosocial situation.

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3.1 Actual conflict.
  3.1.1 Macrotrauma: Stressful life events during the last few years.
  3.1.2 Microtrauma: Contents of the daily conflicts (actual capacities).
3.2 Balance model: The patient's present life situation.
3.3 Basic conflict: Childhood experiences and concepts development.
4. Diagnostic reflections and further procedures.

The structure given above is further embedded in the three stages of interaction of PPT: attachment, differentiation, and detachment [3]. In the context of the First Interview, *attachment* means the patient's developmental relationships and his ability to observe the scene around him. It goes on to include diverse questions, in the context of a therapeutic process, which help open up the atmosphere and form the basis for finding out about existing trust and hope within the patient. In the second stage, *differentiation*, information relating to the patient's psychosocial situation and values is collected. The third stage, *detachment*, deals with explaining the diagnosis to the patient and the discussion of further procedures (treatment plan). The patient's hope is strengthened through changing the point of view by the use of stories, proverbs, and figures of speech. The basis of the therapeutic relationship is established, and an informed consent is agreed with the patient about the tasks and ways of therapy.

The *socio-demographic data* which are produced are common objective data that can unlock the origins of current stressful life events and subjective experience. In practice this has another important function. During the first sessions, the therapist can take in the most important data in a short form (age, family situation, professional ability, parents, brothers, sisters, etc.) in order to place the patient's subjective experiences into their context. An ordinary patient file can be enhanced by the recording of additional objective data (education, partner relationships, etc.). Recent data are important for the building of a report for an expertly crafted case. However, most of this cannot be gotten within the time of the first session. Also, many patients experience being asked for objective data at the beginning as a great unburdening, and it is only after this that they can present their subjective suffering.

The *actual history* begins with the patient's current subjective complaints and problems, those which caused him to seek a therapist. Even at this early stage, the therapist, in an effort to discover the function of the symptoms, named "positive connotation" by Nossrat Peseschkian, tries to find an initial possible explanation for them, for example, the fear of loneliness as the need for contact with other people or that a psychosomatic complaint is the somatic manifestation of a psychic conflict, such as telling a patient with severe eczema that "something has gotten under your skin" or that a hearing loss means not to have to hear something or someone any longer. The development of psychodynamics can be compared to a puzzle whose pieces must be searched for in the deep psychological exploration of the subconscious [18]. The symbolic function of the disturbance is one of the first and most important pieces of the puzzle. To put it simply, one can say: Patients can hide something or lie, but not their symptoms. We gain understanding of the symptoms, the time when they began, and their function as catalysts for understanding significant inner conflicts. This section contains questions about previous illnesses, treatments, and risk factors.

After dealing with socio-demographic data and current complaints, we come to the questions about *stressful life events*, a natural transition for both patient and therapist. The opening question in this section of the First Interview in PPT reads:

> What has happened to you and your family during the last few years?

Most of these significant life events (separation, job loss, illness, death of important persons, etc. and also positively connotated events like giving birth, marriage, or new jobs) were already mentioned earlier in the section dealing with the biographical data, but now they are explored in more detail and in different areas of life. These events are noted down in the balance model by the therapist in order to explore them more specifically later. Then the events in all of the areas of life can

be asked about and dealt with. The authors like to ask in this context about the influence of the illness or problem on the patient and his environment in the four areas of life:

> What influence has your illness had on your physical well-being, on your work, on your family, and on your view of the future?

This is also where the impact which the present problem has had on the patient can be clearly seen. The preparations for exploring this can be made either now or in later sessions. However, what is essential in the first session are the sociodemographic data, the symptoms of the actual complaint, and the questions about stressful life events, and the ways of coping. Questions about the current life situation in the four areas of the balance model, the distribution of energy, and the significance of specific areas of life on the patient's self-esteem are connected followed by those relating to the influence his illness has had on the four areas of life. By means of this graphic presentation, the patient begins to recognize the one-sidedness of his way of life on the one hand and his possibilities for development within the framework of therapy on the other. Visualization is an important instrument in PPT for patients to create an own model of understanding of their situation and symptoms, to find a symbol or narrative for the own life.

One distinguishing feature of PPT is the description and understanding of imprinting situations in early childhood which found basic concepts and can lead to a basic conflict. In the First Interview, the patient is asked questions within the context of the four modelling dimensions about his relationship to his parents, their relationship with one another, their relationship to society, and their value system. Even though this sometimes causes some surprise in our psychoanalytic colleagues – why would one wish to identify the basic conflict so quickly – these questions grasp very well the early childhood situation and its influence on the present concepts and capacities, though they are presented briefly and graphically. Of course, these themes will be explored at greater depth during the psychotherapy itself. These questions which illuminate the basic situation form the basis on which a primary psychodynamics hypothesis can be formulated. Now PPT provides the explanation for the patient. He is asked to summarize what was most important for him in this meeting and what conclusions they suggest about his capacity for reflection. The therapist also offers some summarizing observations, his view of the assessment of the main symptoms, of possible basic conflicts, and of their actual manifestations. This is an important component of the questions asked by every patient: How to proceed from here, what is going on with me, and is there any hope that I will be able to get out of this situation? Depending on the patient, it may be possible to give him a task to do at home and bring next time, to write the details of these stressful life events, or to discuss the discovered subjects at home. If applicable, the patient can be given the story "On the Way" [19], as an associative tool for his or her own situation. These approaches prepare in an early stage self-help and self-exploration by the patient to become independent of therapy as early as possible.

Nossrat Peseschkian's First Interview responds to the perception of objective and subjective data just as Argelander [10] had put this data in the forefront. The "scenic description" of Argelander, as an impression of the encounter scene, will be described in PPT using additional terms like the actual capacities and describing the type of interaction pattern. The psychodynamic first interview [9] raises the particular significance of the social relationship structure and family which are systematically presented together here in the First Interview in PPT. Therapy can be planned with it in which the social resources can be purposefully collected and considered. The model presented here clarifies factors and themes which are functioning for a psychodynamic treatment plan. The *Operationalized Psychodynamic Diagnosis* [13] diagnoses psychodynamically define conflict contents, relationship models, and structural elements of the personality which are constantly coming up again in current relationships and predominate in relationship episodes. In the First Interview in PPT, these dimensions are more sharply differentiated

according to their contents. Their historical sense is defined, and the history of the relationships is traced back as well as connected with the background of family concepts. The use of this procedure in the guidelines for psychodynamic therapy was described in the book *The First Interview* [7].

Therapeutic Attitude and Competences Needed in First Interview and Therapy

A palette of different patterns of behavior in psychotherapy is necessary: i.e., the supporting aid in a deeply depressive patient, the structuring in affective disorders, the freedom of association after telling a story or metaphor, surprising, or postponing subjects. A whole variation of accepting, supporting, surprising, complementary, and contrary behavior seems most effective in client care, both rationally and emotionally.

Grawe [20] and others showed the effectiveness in psychotherapy of the following factors: aid in conflict solving, understanding and clearing, quality of the therapeutic relation, optimism to find and to give help on the outcome on psychotherapy, and personality and maturity of the therapist independent of the method he uses.

Competencies required for a comprehensive first interview [3]:

1. *Observation – Distancing*: The ability to listen patiently with empathy, to accept and understand, and to add other points of view. In PPT, therapists need their capacity to be sensitive to the client, looking first at the capacities, to see the functions of the symptom using a positive connotation, or to compare transculturally with other points of view, to visualize, and to find the language the client can accept while looking like from a distance on oneself, changing of point of view.
2. *Inventory*: The ability to ask exactly and to define contents, capacities, history, areas of conflicts, and conflict reactions of the client.
3. *Situational encouragement*: To encourage the self-aid of the patient (support, self-help, and the patient as therapist for his environment), resources are developed; the patient and his surroundings play an active part in the understanding of the process of illness and self-help in this step.
4. *Verbalization*: The ability to solve problems in frank consultation limited to the area of the problem; the conflict is subsequently worked through in its ambivalence having in mind different ways and consequences; and to see responsibilities for the four areas of relation. Included is the interactive experience of the key conflict courtesy and openness and actual capacities within the therapeutic relation as a field for training.
5. *Broadening of goals*: The ability to ask about the future after working out the conflict: to ask what the patient will be healed for. It is the step to see conflicts and the feedback about the treatment as an opportunity which includes looking back, summarizing, and testing the new concepts and strategies and new perspectives.

This therapeutic process as a whole is predominantly oriented toward the future and toward change, and it involves understanding the past through concepts which are effective for the current time. In the therapeutic alliance, the process is reflected and checked, which phase is just going on, and to initiate the next phase by questions. The goal is to start each session with the first step in attachment and to end up with a feedback and perspective as a last step. The pace of moving through steps can vary according to the flow of the conversation. The same process is applied in self-experience of therapists in their training and in supervision.

The Five Stages of the First Interview Process in Practice

The five stages of therapy provide a structure for the process of communication within a single session or during the whole therapeutic process, which would spontaneously come to an end without it. The therapist facilitates them by means of an appropriate attitude, open questions, stories,

association triggers, and re-visiting themes previously mentioned. The five-stage process in PPT provides both the therapist and the patient with a starting point as well as a sense of security and prepares the patient for the work with conflicts and for self-help, particularly for the time after the end of therapy.

Phase of Observation and Distancing

The actual history begins with the patient's current subjective complaints and problems, those which caused him to seek a therapist. The therapist, in an effort to discover the function of the symptoms, will gain an understanding of the symptoms, the time when they began, and their function as catalysts for understanding significant inner conflicts. This section contains questions about previous illnesses, treatments, and risk factors. Disturbances and illnesses are seen as capacities which react in conflict, the function of the illness, its meaning, and consequently its positive aspects [6].

Therapists can start with the inner attitude like "Be yourself here and now in the therapeutic relation with the client, be sensitive and open for changing the point of view on the client and her or his uniqueness." This is the potential orientated humanistic approach with acceptance, an honest and sensitive relation similar to the conditions Rogers described. To look at the clients' capacities in every description, therapy situation with each other or with others, the possibility of development and change, helps to change the view to a positive interpretation of the whole situation and the symptoms. The meaning of the term capacity is close to the ideas of development of the person described by Maslow as the importance of focusing on the positive qualities in people, as opposed to treating them as a "bag of symptoms" (see chapter 25).

The patient begins with an emotional supposition, symptom description, and impact on life. He is led from an abstract stage of suffering to a concrete, descriptive point of view. The patient is brought to an understanding of the functions and effects of his symptoms in the four areas of life, with the use of figures of speech and transcultural comparisons. As part of the therapy, the patient is asked to observe the situations he or she experiences and his or her own emotions, particularly with conflicts, and to write it down as spontaneously as possible without changing anything. Viewing his own conflicts from the position of an observer helps the patient attain a growing distance from his own conflict situation. He becomes an observer of himself and his environment. An important effect of this stage is the high level of unburdening in a conflict situation.

In the same way, the stage of observation is helpful from the beginning of treatment in interpersonal relationships such as between life partners or in the workplace because the patient becomes much less critical and all at once conflicts and hurts are obviated. The patient is informed that he will be able to talk about everything during the fourth state (verbalization) and that he will prepare for this during the next three stages, with his conflict partner, if this is appropriate. The broadening of what is at first a one-sided perception provides the preparation for the next stage in the process.

Questions in the first phase:

- "By whom are you referred?" to find out about motivation and others involved to treat the client.
- "What brings you to see me?" to understand the symptoms and other reasons for consultation.
- "Can you describe how this influences your life?" to see the impact of symptoms or conflicts.
- "When did this occur to you the first time; when was it worse?" later to compare with the timeline.
- "Can you tell me more about it?" to open a space for free conversation.
- "How could you cope with it?" to find out about own activities of the client for help and self-help.

The clients will have the freedom just to talk in an emotionally safe atmosphere and the

therapist will at the same time be actively interested reflecting the situation and feelings of the client. A balance between spontaneous expression and getting information has to be found. It shows already the possible flexibility of the personality, hope, anxiety, and therapy motivation.

At this time the therapist can write down expressions of the clients on the form or on a free paper with a balance model at the places where it fits before later using the questions of the form to ask the client more systematically in the second phase.

A Patient, Her Situation, and Her Suffering in the First Interview: Case Example [3]

After the sudden death of her father, a high-school teacher, a 24-year-old economics student began to suffer from increasing panic attacks with heart-oriented, vegetative symptoms. Her pre-existing anxiety concerning long travel became stronger until she was completely unable to leave her house alone or, if accompanied, to go any farther away from it than 400 meters. She had not pursued her studies for almost a year and had been required to give up her job as a clerk, which had financed her studies. All medical analyses had produced no evidence of illness. The diagnosis was described as an agoraphobia with panic disturbance (F 40.01 according to ICD 10). The patient came to the therapist at the instigation of her mother and her friend and arrived together with them. This treatment took place in a Southeast European country.

The patient had grown up with her father with whom she could ask about anything. He taught her to trust in exact, rational explanations, in love, and in hope. He was her model, an industrious, conscientious, almost pedantic man, who could pass his understanding of the world on to her through logical principles of order. Her mother's concept was protection and trust above particular friendly, obedient loyalty and to give motherly tenderness. Through the obedience and loyalty which she showed toward her husband, she remained in the bonding and depended on him for everything. The daughter experienced this harmonic partnership with mutual dependence as a shelter from the outside world and her father's explanations and exactness of dependability as the basis of safety and trust.

First step of the encounter and early use of PPT tools (transcript with thoughts of the therapist):

- *Female patient: "In the autumn it became very bad. I became afraid to go out of the house alone and increasingly also to stay in the house alone."*
- *Therapist (feels empathically, thinks about the balance model, specifically the area of the body): "How did you feel then? Would you describe this for me?"*
- *Patient: "I began to have attacks of pounding heart, very cold hands and feet, I had such trembling, and then my eyes, it was like seeing through fog. And then the pains in my heart. Sometimes they lasted for days."*
- *Therapist (interpreting): "Something terrible was happening with your heart. I understand this as a bodily sign of terrible fear?"*
- *Patient: "Yes, it was as if I was dying every day, but I survived somehow."*
- *Therapist (introducing distancing): "But you can talk about what happened and feel it even though it was so bad."*
- *Patient: "I don't wish such a thing on anybody."*
- *Therapist (wishing to discover the function of the fear, to prepare for a positive interpretation, if possible coming from the patient herself, he already knows the intellectual possibilities of the patient): "What is anxiety for, anyway? Everyone has known anxiety? Why do we have it?"*
- *Patient (considering): "It occurs to me that anxiety protects us from something even worse. If we had no anxiety, what would we actually do? We would have even more wars, I think." And she continues speaking about the historical situation of the Southeast European countries and of their newly gained peace.*

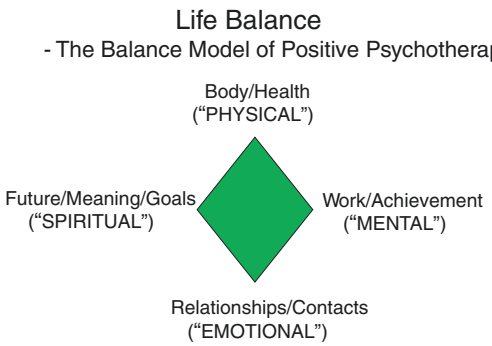
- *Therapist (thinking that this rationalization is like the patient's intellectual father, wishes to bring the focus back to the patient): "If anxiety is important for an entire people, what would their own anxiety say to them if it could speak?"*
- *Patient: "Until now I have always run from thinking about my father, about his death and what would happen after. With Daddy I felt a strong sense of security. When he was sick, I always avoided any thoughts about him dying (pausing)."*
- *Therapist: "They say, "Anxiety is like a magnifying glass." What comes to your mind about this?"*
- *Patient: "For me anxiety means that my mother can also die one day. Fortunately, she is healthy, but right after my father, my grandfather also died. I was not prepared for this, we had never spoken about anything like this. I can die any time, too. Now I am young and normally don't think about it."*
- *Therapist (thinks that after the patient's own insight into the function of anxiety, her mention of her family and her opening to the theme of the purpose of existence, that she is now more open for the verbalization of attachment and detachment. He thinks of the patient's great attachment to her mother and of the necessity of detachment from the parents and the therapist. He wishes to move to differentiation and thinks of the family resources): "How is your mother in this regard?"*
- *Patient: "I believe ... she doesn't show it but I think she is having a hard time with this. She tries to be strong for me."*
- *Therapist: "Could you talk about this with your mother sometime?"*
- *Patient: "Better here, just like the first time when she came. If you are there, maybe she will be able to talk about it. With me she won't."*
- *The therapist thinks that it is a good suggestion to draw her mother into this topic.*

Therapeutic Self-Help Tools

Changing the point of view by positive connotation, transcultural examples, proverbs, and verbal illustration or stories to visualize the experience of the client starts in the first interview to encourage self-help and autonomy as early as possible. Having the patients write down about symptoms like thoughts, body symptoms, and fears, they take a role of the observer for oneself. Giving the patients a story, like they are presented in the book *Oriental Stories in Positive Psychotherapy* [19], they can share with others promotes the patient's own activity and feeling of self-esteem. A supportively structured therapeutic process, the unconditional acceptance of the inner suffering, and an attentive understanding of the unconscious desires which lie behind it, all these are the prerequisites for a fruitful therapy. If patient and therapist can develop a sensitivity together through appropriate stories, transcultural examples, and the recognition of the function of anxiety, this is the starting point from which the themes which are hidden behind them can be found.

Stage: Taking Inventory

In this step the information about everyday life of the client, the socio-demographic data, important life events, and the subjective experience are summarized. This is also where the impact which the present problem has had on the patient can be clearly seen, in his hopelessness, etc. The preparations for exploring this can be made either now or in later sessions. Questions about the current life situation in the four areas of the balance model, the distribution of energy, and the significance of specific areas of life on the patient's self-esteem are connected followed by those relating to the influence his illness has had on the four areas of life, sorted in the balance model. Many of our colleagues in PPT like to ask in this context about the influence of the illness or problem on the patient and his environment in the four areas of life: What influence has your illness had on your physical well-being, on your work, on your family, and on your view of the future?



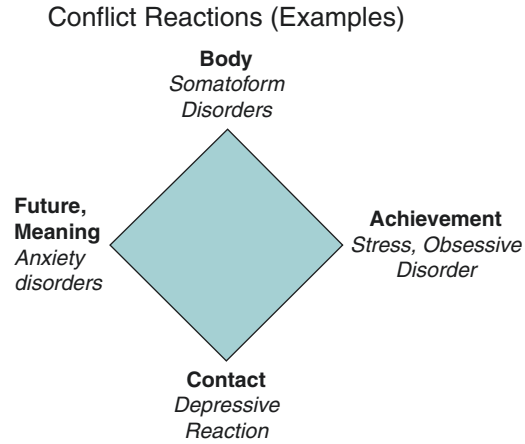
Balance model, Peseschkian [4, 22]

This is also where the impact which the present problem has had on the patient can be clearly seen, in his hopelessness, etc. The preparations for exploring this can be made either now or in later sessions. However, what is essential in the first session are the sociodemographic data, the symptoms of the actual complaint, and the questions about stressful life events. Questions about the current life situation in the four areas of the balance model, the distribution of energy, and the significance of specific areas of life on the patient's self-esteem are connected followed by those relating to the influence his illness has had on the four areas of life. By means of this graphic presentation, the patient begins to recognize the one-sidedness of his way of life on the one hand and his possibilities for development within the framework of therapy on the other. Visualization is besides structuring an important instrument in PPT for patients to create an own model of understanding of their situation and symptoms. In the first interview, we can ask about the four areas of life:

- Body: Physical activities and perceptions, such as eating, drinking, tenderness, sexuality, sleep, relaxation, sports, appearance, and clothing.
- Achievement: professional achievement and capabilities, such as a trade, household, garden, basic and advanced education, and money management.
- Contacts: relationships and contact styles in partnership and family and with friends, acquaintances, and strangers and social engagement and activities.
- Meaning: meaning and purpose, future and religious practices, meditation, reflection, beliefs, ideas, and development of vision or imagination-fantasy.

With it we can describe:

- The everyday life of the client, how the energy of this client is balanced, and in which areas the symptoms occur.
- 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 (the structure of personality, OPD-2).
- The goals and objectives for therapy.



Conflict reactions model, Peseschkian [6]

Patients with psychosomatic disturbances find the balance model which appears in the second stage to be of particular assistance, as the visualization helps to clarify issues and prepare for self-help. These patients are often astonished when they put the events that have happened in their lives in the past few years into the four areas of the balance model, see them as catalysts, and understand the influence they have had in changing their lives.

Questions to find out the functions of the symptoms:

- How do your complaints affect your physical Well-being?
- Can you sleep with your complaints and enjoy food and drink?
- How do your complaints affect your performance?
- Can you work with your pain?
- Can you concentrate on your work when you are restless?
- How does your partner (your family) react when you are in pain?
- How has your love life changed as a result of the pain?
- Who understands your suffering?
- Which people have you been increasingly dependent on since you became ill?
- Which contacts have suffered the most from your illness?
- How do you see your future with your clinical picture?
- Which of your plans have been thwarted by your illness?
- What has changed in your life as a result of the disease?
- What are you most afraid of?
- What do you think needs to change most urgently?[1]

We can put symptoms, conflict reactions, and resources into the balance model during the therapy session. Eventually the patient will distribute them into the four areas and will also thereby attain an understanding of his life situation and of the effects of his disturbance.

The balance model using the four domains of life also presents the basis for the conceptualization of typical conflict models. We flee into illness (somatization) or excessive body-building, into activity and achievement (rationalization in the sense of disturbances of overburdening and adaptation), into refusal to perform, into loneliness or gregariousness (accompanied by idealization or deprecation, which lead to affective disturbances and changes in social behavior), and into fantasy and the world of thought (denial in the sense of anxieties, phobias, panic attacks and disturbances of illusion, addictive behavior, e.g., into lack of imagination [21].

With the balance model, it is possible to understand the therapeutic relation as a mirror of the patients' 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.
- Relation patterns with the client.
- Intuition an fantasy.

This way, the balance model helps to classify and understand the therapist's own countertransference.

Differentiation Analytic Inventory (DAI) for Actual Capacities

During this stage, the main task is to recognize the connections, to clarify the pre-history of the individual actual capacities and the preparation for the conflict understanding and resolution, as well as to share the background of the concepts and misunderstandings into order so that she or he can develop a means of understanding them for herself or himself. The positions (attitudes) which as a rule the patient sees as being unchangeable characteristics of the personality will now be viewed as relative according to their meaning in her life history. The significances of the actual capacities are summed up through

[1] Boessmann U, Remmers A, Hübner G: Wirksam behandeln. Bonn 2005 p 75

association by means of an inventory of the actual capacities.

The analysis of the specific content of the conflicts as triggers for the emotions and focuses in counseling or therapy on the inner and outer conflicts or values lead to the capacities which are the contents of these conflicts. The emotions which lead to suffering or the physical symptoms can then be understood as values functioning in a conflict of opposite concepts. In this connection the conflict-centered process focuses less on the triggers than on identifying and then working through the conflict which caused them.

Application of the Differentiation Analytic Inventory DAI

"For whom of you this capacity is more or less important? You can mark it like described. In the last part you can write situations or emotions that come spontaneously in your mind."

Actual capacities	I	My partner	Situations, emotions
Punctuality			
Cleanliness			
Orderliness			
Obedience			
Courtesy/politeness			
Honesty/candor			
Faithfulness			
Justice			
Diligence/ achievement			
Thrift			
Reliability/ precision			
Time			
Patience			
Contact			
Love/acceptance			
Sexuality/ tenderness			
Trust			
Confidence			
Doubt			
Hope			
Faith			

Mark as +++/++/+/+/−

Differentiation Analytic Inventory (DAI) [4]

Actual Conflict

Capacities represent values, needs, social norms, or virtues that cause feelings and symptoms as a conflict reaction. With the DAI as a scale for social norms (secondary actual capacities, 1–11) and needs (primary actual capacities, 12–21) it is possible to find out about the subconscious associations concerning actual capacities and conscious experiences with microtraumatic events concerning these values [4]. The comparison of patient and partner/children/colleagues brings up more episodes containing these contents. With these the inner, subconscious conflict can be found out comparing actual and earlier episodes.

Basic Conflict and Modeling Dimensions

One distinguishing feature of PPT is the description and understanding of imprinting situations in early childhood which found basic concepts and can lead to a basic conflict – see Chap. 15 on the conflict model for details. In the First Interview, the patient is asked questions within the context of the four modeling dimensions about his relationship to his parents, their relationship with one another, their relationship to society, and their value system. These questions which illuminate the basic situation form the basis on which a primary hypothesis of the possible psychodynamics can be formulated.

Visualization of the early experiences in relation to the emotional important persons widens the classical object-subject perspective to a four-dimensional model:

- "I": The patient's relation with mother, father, or other close relational persons in childhood, specified by asking for the time or patience these persons took for the client and in which way these close persons had been modelling the client. It represents the object-subject experience of the child.
- "You": The relation of the parents or closest persons with each other offers another perspective on a close person's relation with each other (close object with close object): How

had been the influence of the closest partnership around the client? This later subconsciously moderates the own patterns of close relations concerning primary and secondary capacities.

- "We": The observed and experienced relation of parents or closest persons with others like wider family, neighbors, community, or groups (close object with far object).
- "Primary we": As the relation of the parents with the culture, world, spirituality, and life philosophy (close objects with the invisible objects). It was a new construction of Peseschkian; it may be influenced by Frankl, Jung (religion, culture, and meaningfulness of the parents), and Adler (style of the parents).

Personality Style Capacities (Four Areas) and Vulnerable Areas

The visualization of the actual life situation by means of the balance model shows personality traits and states, conflict reactions, or shortcoming areas of life.

The Operationalized Psychodynamic Diagnosis (OPD2) [13] speaks of four observable basis capacities of the personality structure which are similar to the four means of the capacity to know [4].

The questionnaire WIPPF [5] provides a complete summary of the areas of behavior in which the patient and, if appropriate, his partner or conflict partner possess a specific pattern of capacities as by the others positively or negatively evaluated characteristics, and where there are macro- or microtraumas or examples of conflict reaction. The WIPPF also facilitates access to the role models. The most important use of the WIPPF is in individual therapy in which, through the most commonly used evaluation, the patients are brought to an understanding of their resources, conflict contents, conflict reactions, and psychodynamic origins with reference to model dimensions by means of the process of differentiation of contents. The level within oneself, the expectation of the other, and the internalized ideal can be determined for each capacity. From this clarification moments ("Aha!" moments) and episodes in relationships can be associated with them. If the relationship partner, spouse, children, colleagues, or others have also filled out the WIPPF, the comparison clearly shows in which areas there is agreement, and the conflict mostly shows itself to be limited to a small area of actual capacities. A generalization of the conflict, which commonly occurs in partnership, can therefore be avoided. If the partners are actively involved, the WIPPF leads to the acceptance that self-help can be promoted and that therapy for a previous, unconscious conflict can go forward more quickly. The WIPPF can be applied in couple and family therapy as well as in coaching, psychological counseling, and support for children with or without reference persons.

Case Example: Stage 2

The therapist used the balance model in the beginning to present to the patient a complete picture of her life and to recognize her resources and conflict areas. Later her various anxieties are defined as well as the areas in which she felt secure (safe). In the session that is presented here, the patient, while unburdening herself, is able, for the first time, to see her many capacities as resources to be developed.

Later the therapist read her actual capacities from her DAI to her and asked her: "What comes to your mind spontaneously with each of them?"

To cleanliness she answered: "Water, bath"; to obedience, "Careful to a fault"; and to politeness, "to conceal one's own self in front of another person" (not to reveal oneself to another person). She associates faithfulness with "family," justice with "the worthiness of a person," and "trust" with "dumbness." Nothing came to her mind with hope, she replied to time with "immortal," and to both love and sexuality, she said "beauty."

In the following sessions, she illustrated these associations with experiences and lively descriptions of situations. The therapist took the position of one who asks questions, who would like to understand the patient's inner and outer world, while the patient was the one to provide the explanations. Politeness and achievement had been important to Mrs. N. in the present cases; carefulness, lack of trust, misplaced hope, one-sided contact, and sexuality are presumably the areas which will play a role in the therapeutic

relationship and in the family, especially in the fourth stage.

After the work of association with the DAI, Ms. N. was introduced to the questionnaire WIPPF. The result was that this patient placed a high value on many primary capacities (except for love and trust), in contrast to the secondary capacities. The model dimensions showed a very high value for the attachments she had experienced to her father and mother, for a symbiosis between the parents and the strong influence of their philosophy on the patient. During the discussions her protective upbringing and the narrow "togetherness" of the family were made clear. This was the basis for her almost naive-primary expectations and their intrusions into her mind after the death of her father, whose viewpoint toward life had had a strong hold on her through "rationality." The conflict reactions as shown in the WIPPF tended in the direction of "flight to contact and fantasy."

Stage 3: Situational Encouragement

Symptoms, Capacities, and Social Environment as Resources

This stage emphasizes the development of specific resources. The most important aspect of the therapeutic relationship is the reflection of the strengths. This keeps the focus on the available capacities of the patient and his or her reference person. In order to build a new relationship with the conflict partner, the patient and therapist must look at those capacities which speak to this and if possible have the patient name them himself. In any case the patient and therapist look together at those capacities which correspond to this relationship with the conflict partner and which are important to the patient. In this way the patient and therapist can work through the meaning of these capacities in the relationship with the conflict partner. Situational encouragement and appreciation are used based on what has been learned during the first and second stages rather than criticism of the partner. The patient and therapist put in order the resources previously established in the balance model as well as areas which have been only briefly touched upon and potentialities and desires which have not yet been fulfilled. The goal is to reach a balance of the energy of life, distributed among the four areas, body, achievement, contact, and meaning-fantasy, as favorable conditions for health and hardiness, and this balance or disbalance can become an instrument of the patient to strengthen areas as resources. The goal is to recover the balance in the four areas.

In this connection the relationship to the reference person is particularly valuable, whether it is discussed actively or only indirectly, especially in working toward the use of self-help. Information about his specific disturbance and about ways to deal with it, such as the use of medications, relaxation methods, and counseling services, are supportive tasks during this third stage of the process. N. Peseschkian emphasized that in the third stage, the conflict partner was being prepared to hold up under the criticism which would come his way during the following stage of verbalization. Instead of pointing out a deficit to the patient or those close to him and giving the advice not to aim so high, to begin with, the positive aspects of the one-sidedness are emphasized. The patient is encouraged, and his weakest feeling of self-worth is strengthened in order to create a basis for the analysis of the areas with the deficits. For example, a man who places a high value on achievement and so works long hours every day is not confronted at an early stage with the fact that he should spent more time with his family. At the outset his inclination for achievement and his motivation to work are seen and identified as a capacity. This is a constructive experience for the patient and is both important and fruitful for building the relationship between the therapist and the patient.

Case Example: Third Stage

Here the focus had been on positive reinterpretation connotation and resources.

Therapist: "I'm glad you're here, how was the trip?"

Patient: "Only my friend is with me today. He's waiting outside in the car. Everything worked out without my mother." (Note: She had been accompanied by her mother until now.)

Therapist: "How does that feel for you?"

Patient: "Somehow better than right after the end of the last session, when I had so much to think about after you told me the story about the

man with the grapes and the tiger. I said to myself, in this case of a threatening tiger, while I am in in a dangerous situation, the grapes would never have been sweet for me. I thought how terrible his situation is and wondered how he could be happy after this. But that's how it always is, April showers bring May flowers. I suddenly realized what a dear friend I had! What he has gone through others would not have put up with."

Therapist: (understanding these words as a step forward for the patient and her surprise at her friend's patience as the beginning of differentiation in the direction toward autonomy) "Today you came here entirely alone, without your mother accompanying you. You were not so comfortable with this story before, and I have the impression that you have overcome your reluctance to consider these unpleasant ideas. How does it feel to have done this all by yourself?"

Patient: "Today I really want to take up something from our last meeting again so that I can go through it myself."

Therapist (will set aside his own activities and give the patient an assignment which he has confidence she can do): "If you like, when you are home, you might note down all the things which make you anxious and in another column all the things which in the meantime make you feel secure and safe. When you have written them down, perhaps you can discuss them with your friend. What do you think about this?"

In this way a relationship of trust was constructed during the third stage, which makes open communication possible in the next step, in which also feelings and actual capacities are revisited and early experiences are remembered, organized according to themes and made conscious.

Story Used in Therapy:

The Tiger and the Sweet Grapes.

One unfortunate day a wanderer was fleeing from a tiger which was following him. He ran until he reached the edge of a stone wall which he had to climb down. He grabbed onto a thick vine and hung over the abyss. The tiger growled above him.

Suddenly a terrible growl was heard from below. "Oh, no!" A second terrible tiger was looking up from beneath. The man hung onto the vine – between the two tigers. Two mice, one white and one black, scurried over the calcified rock. They began to chew happily on the root of the vine.

The vine bent low under the burden of the wanderer. But in the sunlight in front of him he discovered a vine covered with small, juicy grapes. Holding on firmly with one hand, he reached out with the other and plucked a fruit and then another and another. He called out: "How tasty these grapes are!" From a Mongolian Tale, adapted by A. Remmers.

Phase 4: Verbalization

In order to move on past the speechlessness, or the outpouring of speech, so common with a conflict, the newly established communication must be carried over step by step into the social environment. In the fourth stage, we discuss both the positive and the negative characteristics of the experiences after which a relationship of trust was constructed during the third stage, which makes open communication possible. This is also the stage in which feelings and actual capacities are revisited and early experiences are remembered, organized according to themes and made conscious. The transference of wishes, expectations, and fears which were experienced with persons earlier in life or feelings which the therapist recognizes as signals indicating painful content are investigated together. This demands that the therapist be open and ready to be a confrontation partner and show a respectful attitude when the patient experiments with changes in behavior within the therapeutic relationship at this early stage. The therapist supports the patient in achieving a balance between politeness and openness and in taking the responsibility for change. The focusing on the themes of the central conflict, the work on the key conflict, politeness-honesty, and the active involvement in the therapy of the reference persons through the patient are the tasks which belong to the fourth stage. The therapist presents the concept of the family group and, if appropriate, brings the family into the therapy. The family concept and unconscious basic conflicts are worked through now. Verbalization means that the time has come for an open discussion after which each recognizes the strengths of the other through observation of the

situation, analysis of the contents of the conflict, and mutual encouragement. The conflict partner is now in a position to accept criticism or, at the least, to be able to speak about it. Experience shows that many people are inclined to speak about a problem right away and to hurt the other person by so doing, after which the other person must be strengthened through many hours of encouragement.

Case Example: Fourth Stage – Verbalization

In the *fourth stage*, the patient's unprepared-for bereavement for the father, the main actual conflict, came out. She unconsciously stood between two poles: On the one hand, her father's rational explanations as well as the capacities she had experienced such as dependability, loyalty, and obedience had instilled trust, certainty, and hope in her. On the other hand, she now was experiencing the loss of this clearly ordered, supportive model of her parents' partnership. During therapy this basic conflict presented itself: Emotional warmth and the child's early trust (primary capacities) had become conditional through rational explanations and dependability (secondary capacities) and had not been internalized as unconditional capacities. Her development of independence generated the concept: "I want to be intellectually independent, therefore, I will ask the one whom I know best, Daddy!" For this patient being independent meant trusting her father blindly. Independent thinking was the same for her as the loss of intellectual support. The patient's unconscious, inner ambivalence and an essential part of the basic conflict which rested upon it was because the fulfillment of primary needs within the family was dependent upon adaptation to secondary capacities.

Thus, an inner conflict was formed: Meaning, support, and trust were all lacking if something was not explained through the intellectual diligence of a dependable partner. The patient developed agoraphobia and panic attacks when alone and in leaving her home as symptoms of her existential anxiety because she had not yet experienced confidence in herself or hope and meaningfulness except in a triangular or couple relationship as being something viable. The compromise, the basic conflict, no longer worked: There is no one like my father to instruct me and no one so responsible to explain things. Because of her symptoms, she was still supported by her mother and her friend, with whom she felt free of symptoms at home. The therapist had been open in this phase and ready to be a confrontation partner and show a respectful attitude when the patient experiments the conflict contents within the therapeutic relationship at this early stage.

Stage 5: Widening of the Goals

The patient is asked to consider the following question:

> What will I do when I no longer have this problem?

This stage accompanies the patient from the first session. It has the function of preventing relapse, leads to a development which is more proactive than reactive, and prevents the patient from going back to using symptoms as means of relief after the completion of a successful therapy. The patient is therefore guided to detach himself from the therapist and to develop new capacities which he had neglected in the past. He will develop micro- and macro-goals together with the therapist. Goals for the foreseeable future can be determined using the balance model.

Case Example: Stage Five – Broadening the Goals

"What will I do when I no longer have this problem?" The seed for this question was planned in the patient's mind from the beginning of the first session on looking into a future, described in four areas of life as a motivation for own active participation in therapy by observing her own feelings and thoughts, writing about stories at home, and talking with relatives and friends about subjects coming up in therapy.

Appendix

First Interview in Positive Psychotherapy.

(by Prof N. Peseschkian, founder of Positive Psychotherapy in co-operation with Hans Deidenbach, Psychologist)

To be completed by the medical doctor/ therapist in collaboration with the patient (his partner, his family).

Last Name: Patient No.: Date of Examination:

Name:

Date of birth:

I. Introductory questions

1.Last name, name, etc.
(to be filled in above)

2. Referral from: .....

3. Attitude of partner (family) towards therapy: .....

4. Future prospects of the patient regarding his/her symptoms: .....

5. Details in short form: .....

Detailed information: questions 70-82

II. Current personal situation of patient (medical information, psychological triggers, reason for his visit)

6. Current symptoms: .....

7. Positive interpretation of symptoms: .....

8. Previous treatment: .....

9. Result of previous treatment: .....

10. Spontaneous comments on symptoms, supposed reasons for symptoms: .....

11. Initial momentum of symptoms:
Sudden occurrence of symptoms/trauma ○
Insidious beginning, due to illness ○
Others: .....

12. Time of first occurrence of symptoms: .....

13. Previous operations, illnesses, hospital stays: ...

14. Risk factors: .....

15. Family anamnesis, illnesses of family members:

(continued)

16. Physical examination for orientation:
Blood pressure: .....
Weight: .....
Height: .....
State of nutrition:
no abnormality ○ obese ○ very thin ○

General physical condition:
good ○ medium ○ bad ○

General impression:
Corresponds with age ○
Looks younger ○
Aged prematurely ○

III. Psycho-social situation of the patient

Actual conflict (AC)

17. What has happened during the last 5-10 years?
Please name 10 events (incidents).....
.....
.....
.....

18. Starting point of actual conflict (year):
AC before beginning of symptoms ○
AC before increase of symptoms ○
AC after symptoms ○

Influence of illness and difficulties on the patient and his surroundings

19. Which impact the illness has had on you general well-being?
strong ○ moderate ○ no impact ○
Spontaneous answer: .....
.....
.....
.....

20. Which impact the illness has had on your job?
Strong ○ moderate ○ little ○
no impact ○ not relevant ○
Spontaneous answer:.....
.....
.....

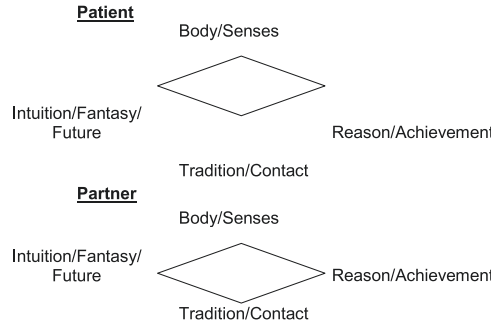
21. Which impact the illness has had on your partner and your family?
strong ○ moderate ○ little ○
no impact ○ not relevant ○
Spontaneous answer: .....
.....
.....
.....

22. Which impact the illness has had on your relationships and contacts?
strong ○ moderate ○ little ○
no impact ○ not relevant ○
Spontaneous answer: .....
.....
.....

23. Which impact the illness has had on your attitude towards your own future and future prospects?
strong ○ moderate ○ little ○
no impact ○ not relevant ○
Spontaneous answer:.....
.....
.....
.....

24. Did you recently have the sense of inner unrest or inner tension?
yes ○ no ○ I don't know ○
Spontaneous answer:.....
.....
.....
.....

The four areas of conflict management (capacity to know)



Area: Body/Senses

25. What is the importance of health and body issues for you? For your partner?

- very important (vi), important (i), moderate (m), not important (ni)

	+2 sw	+1 w	-1 m	-2 uw
Body care / Aesthetic:	○	○	○	○
Sports:	○	○	○	○
Relaxation:	○	○	○	○
Nourishment:	○	○	○	○
Sleep:	○	○	○	○
Sexuality:	○	○	○	○
Body contact / Tenderness:	○	○	○	○
Pain:	○	○	○	○

Area: Achievement

26. What is the role and meaning of your profession and job for you? For your partner?
very important ○ important ○ moderate ○
not important ○
Spontaneous answer:.....
.....

27. Are you happy with your present job situation? Your partner?
yes ○ fairly happy ○ no ○
Spontaneous answer: .....
.....
.....

Area: Contact

28. What is the role and meaning of social contacts for you (guests, friends, family, neighbours, colleagues and fellow men)? For your partner?
very important ○ important ○ fairly important ○ not important ○
Spontaneous answer:.....
.....
.....

29. Do you pay attention to social events? (Politics, clubs, environmental protection, citizens' initiatives) Your partner?
very important ○ important ○ fairly important ○ not important ○
Spontaneous answer:.....
.....
.....

30. Do you have contact with people from different cultures and backgrounds? Your partner?
often ○ sometimes ○ seldom ○ never ○
Spontaneous answer: .....
.....
.....

31. Which aspects attracted you by people from a different cultural background? Your partner?
Spontaneous answer: .....
.....
.....
.....

32. How do you see the international problems as well as possibilities in the encounter with people of diverse culture and background?
Spontaneous answer: .....
.....
.....
.....

33. Are you satisfied and happy with your partner relationship? Your partner?
a lot ○ averaged ○ insufficient ○ no ○
Spontaneous answer: .....
.....
.....

Area: fantasy/future

34. Do you think in general about your own future and the future of your family? Your partner?
a lot ○ sometimes ○ rarely ○ never ○
Spontaneous answer: .....
.....
.....

35. Are you worried about your future professional career? Your partner?
yes ○ no ○ not relevant ○

36. Do you also think in general about the distant future and about the global future of mankind? (World crisis, war, world peace) Your partner?
often ○ sometimes ○ rarely ○ never ○
Spontaneous answer: .....
.....
.....

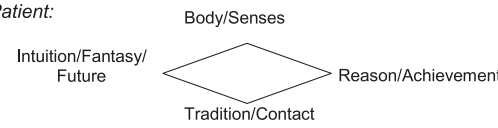
37. Are you hopeful towards future? Your partner?
yes ○ no ○ I don't know ○
Spontaneous answer: .....
.....
.....

38. Do you deal with questions concerning the meaning of life, of death or of life after death? Your partner?
often ○ sometimes ○ rarely ○ never ○
Spontaneous answer: .....
.....
.....

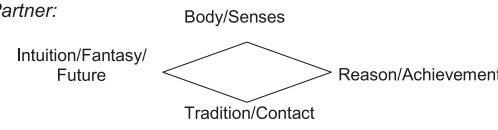
39. Do you believe in life after death? Your partner?
yes ○ no ○ I don't know ○
Reason: .....
.....
.....

40. Result of "4 areas of dealing with conflicts":

Patient:

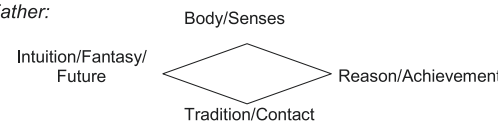


Partner:

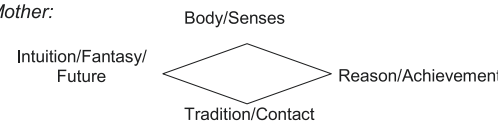


Parents:

Father:



Mother:



(continued)

Basic conflict:
(The 4 model-dimensions of capacity to love)

41. People who were responsible for the upbringing of the patient:
both parents ○ single parent ○
children's home ○ others ○
Spontaneous answer: .....
.....
.....

42. Were your parents married when you were born?
yes ○ no ○
Spontaneous answer: .....
.....
.....

43. To whom did you have a special or closer relation in your childhood?
mother ○ father ○ both parents ○
family members ○ others ○ nobody/none ○
Spontaneous answer:.....
.....
.....

44. Who spent more time with you in your childhood?
father ○ mother ○ others ○
Spontaneous answer: .....
.....
.....

45. Who was more patient with you?
father ○ mother ○ others ○
Spontaneous answer: .....
.....
.....

46. Who was your example?
father ○ mother ○ others ○ nobody ○
Spontaneous answer:.....
.....
.....

47. Relationship to siblings
good ○ ordinary ○ mixed ○ bad ○
no relationship ○ not relevant ○
Spontaneous answer:.....
.....
.....

48. How did you feel about your parent's marriage in your childhood?
very harmonious ○ harmonious ○ ordinary ○
bad ○ not relevant ○
Spontaneous answer: .....
.....
.....

49. Which importance did your parents attribute to the areas work and achievement?
very important ○ important ○
not very important ○ not important ○
Spontaneous answer: .....
.....
.....

50. Did your parents enjoy contact with other people?
yes (very much) ○ not very much ○
a little ○ not at all ○
Spontaneous answer:.....
.....
.....
.....
.....

51. Did you talk about issues such as "meaning of life", "death" or similar topics at home?
often ○ sometimes ○ rarely ○ never ○
Spontaneous answer: .....
.....
.....
.....

52. What was considered to be the meaning of life in your family? (Health, work, family / fellowmen, religion)
Spontaneous answer: .....
.....
.....
.....
.....

53. Which motto did you have at home?
Spontaneous answer: .....
.....
.....
.....
.....

54. Which proverbs, metaphors and concepts are most important to you?
Spontaneous answer: .....
.....
.....
.....
.....

55. Who is your favourite author?
Spontaneous answer: .....
.....
.....
.....

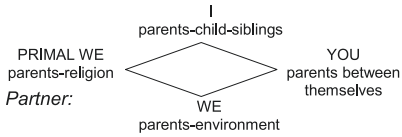
56. Who read or told you stories? (Father, mother, grandparents, nursery-school teacher, etc.)
Spontaneous answer:.....
.....
.....
.....

57. Can you remember situations in which you were told stories: How did you feel about that?
Spontaneous answer:.....
.....
.....
.....
.....

The findings of the 4 areas of model-dimensions / capacity to love (basic conflict)

58. Explaining the diagnosis to the patient and his family:

Patient:

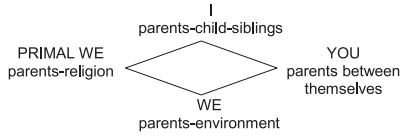


Partner:

Relationship of parents and siblings to patient

	Mother	Father
Time		
Patience		
Model		

Partner:



Relationship of parents and siblings to partner

	Mother	Father
Time		
Patience		
Model		

59. Differentiation Analytical Inventory (DAI) – Short Form

Actual Capabilities	**Patient** + -	**Partner** + -	**Spontaneous Answer**
Punctuality			
Cleanliness			
Orderliness			
Obedience			
Politeness			
Honesty Sincerity			
Fidelity			
Justice			
Diligence Achievement			
Thrift Economy			
Reliability Exactness			
Love			
Patience			
Time			
Trust Hope			
Contact			
Sexuality Sex			
Belief Faith			

(continued)

The findings of "Differential Analysis Inventory"

60. Description of DAI for the patient and the patient-family in regards of "inner conflict"…….
……
……
……
……
……
……

61. Which part of the first interview was important to you? Would you please explain that in your own words?……
……
……
……
……
……
……
……

62. Explanation of the further procedure. (Plan of therapy taking the 5 stages into consideration): ……
……
……
……
……
……
……

63. Are you a good listener?
Spontaneous answer:……
……

64. Are you able to ask precise questions?
Spontaneous answer:……
……

65. Are you able to encourage yourself and other people?
Spontaneous answer:……
……

66. Are you able to explain your problem to others in a suitable manner?
Spontaneous answer:……
……

67. Are you able to appear optimistic despite your problems?
Spontaneous answer:……
……

68. What are your desires and wishes for the next 5 years?
Spontaneous answer:……
……
……
……

69. Diagnoses, medication: ……
……
……
……
……
……

IV Socio-demographic data

70. Age: …… years
Partner: Age: ……. years

71. Sex: m. ○ f. ○

72. Marital status
married ○ since: ……
single without stable partner ○
single with stable partner ○
divorced ○
widowed ○
separated ○
remarried (after death of partner, divorce) ○
widowed or divorced but living together with stable partner ○

73. Number of children: ……
Age of children:……

74. Profession (education):……
……
……
……

75. School-leaving qualifications:
Special school for mentally / physically disabled ○
primary school ○ secondary school ○
a levels ○ graduate / university ○

76. Current job and achievement:……
……
……

77. The partner's job: ……
……

78. Parental family situation of the patient:
Both parents alive ○
When did they marry?: ……
Age of father:……
Age of mother:……
Only one parent alive ○
Who?:……
Year of death of late parent:……
Both parents have died ○
Year of death: Mother:…… Father: ……
Other family situation: (i.e. foster parents, adoptive parents, children's home) ○

79. Parents' professions:
Father:……
Mother: ……

80. Number of siblings: ……
Age of siblings: ……

81. Religion:
which? ……
No religious affiliation: O
Has left the Church ○

82. Nationality/Ethnicity: ……

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Conflict Model of Positive Psychotherapy

27

Maksim Goncharov

Introduction

The general meaning of conflict (from the Latin: *confligere*, to clash, to strike together) refers to the concurrence of different positions within one person (an inner struggle between motives, wishes, values, and ideas) or between several persons (Brockhaus German Encyclopedia, 1990) [29, 33]. Conflicts are universal phenomena. However, the conflict is not a quarrel or a scandal, as is often understood by people. Rather, it is the difference between the desired and what is actually happening. Conflicts happen all the time. In other words, conflicts happen constantly, they are always with us. However, not all of them have a significant impact on us. Therefore, conflicts need to be differentiated into useful categories. In PPT there are four kinds of conflict: actual conflict, basic conflict, internal conflict (inner conflict), and a key conflict. The conflict model of PPT has strong internal consistency and practical application, thus becoming a useful clinical tool to help clients to work through problems.

Key Definitions

Actual Conflict

In his books, psychiatrist Nossrat Peseschkian describes the actual conflict as acute or chronic situations happening at the present time; for example, professional changes or circumstances, family events such as divorce or marriage, financial difficulties, deaths of close people, etc. [34–38]. However, an actual conflict is not just an event, but also refers to situations that have been caused by this event (Fig. 27.1).

The problematic situation could have begun a long time ago, for example, some years or even decades, but retains its actuality until now. For instance, entering family life, divorce, changing work place, or moving somewhere can trigger the situation of chronic dissatisfaction and impact the quality of life. The event that starts an actual conflict initially is neutral and gets its personal color in accordance with its importance for the person. This importance is determined by the touched values (actual capacities) that were transmitted to us in the process of rearing, when we were children [34, 42, 48].

Fig. 27.1 Actual conflict

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Not every situation that does not satisfy our expectations creates noticeable conflict. For example, to be late for a bus and the loss of a close friend are not the same things. As any other conflict, an actual conflict is based on a contradiction of values. The conflictual stress takes place if the current life situation affects important values and needs that were developed in childhood [10, 14, 15].

The more significant and deeper the value connected with the person's perception of her/himself is, the more noticeable inner demands (expectations) it creates; as a result, its nonsatisfaction creates more salient disappointments [13, 34, 45]. For example, a person who lives with the principle "I am punctuality itself" experiences greater conflictual stress when meeting the unpunctuality of another person or his own. Thus, actual conflict is always an external, current situation. The importance of the actual conflict depends on the degree of discrepancy between the expected and what is actually happening, or better to say, observed. The greater the discrepancy, the more the conflict becomes actual, the greater conflictual stress it creates, and the more tangibly it is experienced by the person [2, 19, 21]. Graphically, it can be expressed in as shown in Fig. 27.2.

Thus, we arrive at the fact that the ***actual conflict is the current conflictual (problematic) life situation, which leads to emotional stress caused by the mismatch between the expected and the observed.*** An actual conflict is also an external situation that comes and checks on the intensity of our internal values [19].

The actual conflict can exist independently of the current problematic situation and may also become a trigger for the activation of the basic conflict with the formation of further conflict dynamics. Therefore, divorce, for example, can reactivate for women the early loss of her father, because she loses her lover again. Here, the actual conflict reopens old wounds and tests the existing family concept; thus, it gives extra energy to this conflict [36]. But we discuss this more later.

At the same time, there may be several actual conflicts, and they can be ranked in importance; for example, a problem at work, health situation, difficulties in the family or in relationships. Normally, we cope quite well with our actual conflicts.

An actual conflict is often a consciously understood conflict. This means it can be named and described in words. In this regard, it may be processed and resolved. However, the actual conflict may be unconscious, for instance, in psychosomatic disorders, anxiety and psychotic disorders, in addition to dependencies and some other situations. In these cases, the person is only aware of the symptoms; he/she is fixed on the sufferings and can describe them in detail, but does not understand what causes these symptoms. For the client, the connection of symptoms with the conflictual life situation may be missing.

In clinical practice, unawareness of the Actual conflict may also serve as a diagnostic criterion and indicate lower psychological mindedness, and either the impact of psychological defenses or reduced structural integrity [19, 31, 46].

The conflict always creates energy. If this energy for whatever reason does not have an output, it forms conflictual tension, which can lead to the formation of symptoms and disorders (Fig. 27.3)

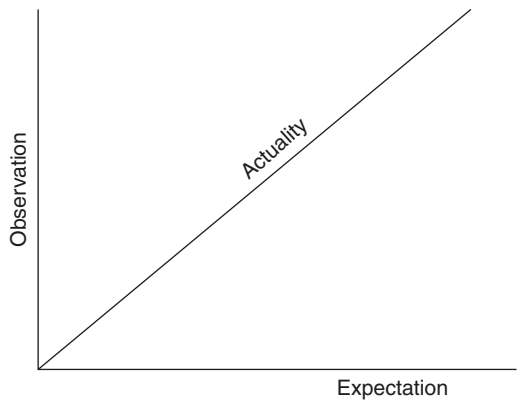

Fig. 27.2 Conflict actuality

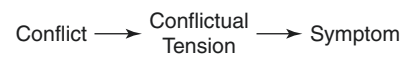

Fig. 27.3 Conflictual tension

In psychotherapy procedures, we try to go backwards and take a step back from symptoms of the conflict and thus get an opportunity to work through the cause of the symptoms.

Not every conflictual situation happening in person's life generates this conflictual tension. Whether it arises or not depends on the readiness of a person, which is determined by his/her basic conflicts. In other words, the energy of an actual conflict is not enough to generate the conflict dynamics and shape the symptoms of the disorder. It needs an additional energy, which is derived from the basic conflict.

The Causes of Actual Conflict

How did the actual conflict arise? Peseschkian describes two major categories of causes of actual conflict: macro-trauma and micro-trauma (Fig. 27.4). In the first case, the link between the causes and effects are relatively easy to trace; in the second, it may be very difficult.

Macro-traumas are life events, such as loss of job, bankruptcy, relocation, death of loved ones, etc. This are fairly large events, which for a while will derail almost any person. It is important to bear in mind that it is not just about the negative but also positive events as well [4, 40]. Typically, a person can relatively easily describe the impact of this event on his life situation and tell us the exact time of its occurrence. When psychiatrists question the patient about life before the disorder, they are in fact, trying to find these macro-traumas. If any are found, it is likely to be classified as a psychogenic or exogenous disorder. The magnitude of stress and the extent of the negative impact depend on the individual and cultural features of a concrete person [12, 21, 43, 50]. This should be considered in clinical application with clients.

The second category is micro-trauma. In contrast to the first category, this is an accumulation of insignificant events, for example, unpunctuality of a partner, unreliability and injustice of subordinates, disobedience of a child, etc. As you probably noticed, these micro-events can finely be described in terms of actual capacities. It is such a trivial event that life operates on the principle of "constant dropping wears away a stone." Opposite to macro-trauma, a person cannot accurately describe the time of this event's appearance, and argues rather broader temporal categories: "we had been fighting over the past few years", "our relationship changed about 5–6 years ago", etc. Recurring episodes of conflicts lead to re-traumatization, deplete resources, actualize the situation, and make it chronic. An actual conflict can arise as a combination of external stress, overload, and personally determined capacities [20, 35].

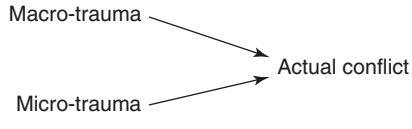

Fig. 27.4 The causes of actual conflict

Operationalization of Actual Conflict

As PPT is a psychodynamic method, we do not dwell just on the symptoms, such as fear or depression, but try to answer the question: "What is behind these symptoms that constitute the content of the conflict"? Like any psychodynamic construct, an actual conflict needs diagnosis and operationalization. The operationalization of the actual conflict is based on three aspects of the diagnosis:

1. Localization
2. Content
3. Reaction to conflict

Localization

Localization of the actual conflict is a domain where the conflict predominantly takes place. To describe the localization of the actual conflict, we use the balance model of PPT with the four areas/dimension/spheres of life (body/health, activity/achievements, contacts/relationships, and meaning/future).

Actual conflict in the sphere of body/health: trauma or disease, informing of the diagnosis, dysfunction of an organ or system, dissatisfaction of one's own appearance, etc.

The actual conflict in the sphere of activity/achievements: problems in the workplace (being

judged as not good enough, not being promoted, not being paid well), the problems regarding subordination or loyalty, etc.

The actual conflict in the sphere of contacts/relationship: tense relationship, misunderstanding with the partner or parents or other close ones; quarrels in the family, loneliness, inability to establish a dialog, etc.

The actual conflict in the sphere of meaning/future: loss of orientation, death, meaning or goals, anxiety, deadlock, collapse of ideals, etc.

Thus, the localization of the actual conflict helps us to identify and localize the area of life in which there is a discrepancy between the expected and the observed [19].

Content

The actual conflict always revolves around some values [23, 25, 26]. These values in PPT are described in terms of *actual capacities*. In its psychological content, these capacities are divided into two categories: the secondary and primary capacities.

Secondary capacities are associated with the transmission of knowledge and, thus represent a basic capacity to know. They reflect the values and norms of the social group of the individual.

Primary capacities represent the basic capacity to love, and they form from the first day of a person's life owing to contact with other people. See Table 27.1 for a list of primary and secondary capacities.

Table 27.1 Actual capacities

Primary capacities	Secondary capacities
Time	Punctuality
Patience	Cleanliness
Contact	Orderliness
Love/acceptance	Obedience
Sexuality	Courtesy
Trust	Honesty
Confidence	Accuracy
Doubt	Faithfulness
Hope	Justice
Faith	Diligence
Model	Thrift
Unity/integrity	Conscientiousness

Besides the above-mentioned functions, the actual capacities represent the core conflict theme as well. It means that a client can be traumatized by these social norms or values in their current life situation. When the expected behavior of someone does not correspond with behavior observed, it makes the client experience a conflictual tension [27, 28, 39].

Example: the actual conflict is located in the domain of achievements, in the content of actual conflict: reliability and obedience.

This means that the client, in the domain of achievements, for example, expects from someone greater reliability and loyalty.

As a rule, the content of the actual conflict may be described by the secondary actual capacities, as they are behavioral norms and may be relatively easily observed. Nevertheless, the primary actual capacities can be in the content of actual conflict as well. For example, patience, sexuality, trust [30, 34, 36, 37].

The content of the actual conflict is not always possible to determine immediately from the client description. For example: "You do not respect me." The claimed actual capacity: acceptance/love. But if the conflict partner does not openly express his/her disrespect, it means that the client interprets their partners' behavior as disrespect. In this case it requires clarification. For example: "You do not respect me, because you are late and make me wait" (punctuality). Or "You do not respect me because you do not obey me." In this case, "obedience" serves as a criterion of respect.

It is important to emphasize that actual conflict always has content that is the theme or value, which, in this life situation does not get the expected satisfaction and thus is frustrated. Further analysis clarifies the reasons for such vulnerability of those actual capacities involved in the conflict. The ability to see and name the actual conflicts can serve as good diagnostic criterion for good structural integration and psychological mindedness [19, 32, 33].

Reaction to Conflict

Despite all the cultural and social differences and peculiarities of each person, we can observe that all people apply the same forms of typical

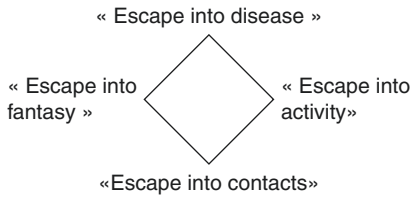

Fig. 27.5 Four ways of dealing with the conflicts within the balance model of PPT

conflict responses to overcome their problems [16, 49]. When we have problems (we get angry, become depressed and feel misunderstood, live in constant tension or lose the meaning of life), all these difficulties can be expressed in these four spheres of life. It gives a picture of how people perceive themselves and the world around and how is the recognition and the reality control happening. In other words, these four aspects of life, respectively, are used to process our conflicts [9, 38]. Thus, we come to four ways of dealing with the conflicts (Fig. 27.5):

1. *"Escape into disease" or "escape into body/symptoms*" implies that the client in response to the conflict begins to experience ailments, begins to care more about the body and health, tries hard to lose weight, exercise or trim oneself down. Physical reactions to conflicts can be the following: change of physical activity (sports—"to hold on, stop getting old"), sleep ("sleep over" the conflicts, sleep disorders), food (gluttony—"eat over the grief", refusal of food—"slimming mania"), sexuality (Don Juanism, nymphomania or abstaining from sex), functional disorders, and psychosomatic reactions. In addition, the episodes of secondary gain from illness could be classified as "escape into illness."
2. *"Escape into activity"* involves a situation in which, in response to the conflict, a person increases his/her activity and productivity, seeks to achieve greater results, loads work upon himself, tidies the apartment, takes on increased obligations at work, etc.
3. "*Escape into contacts*" is manifested in the search for companionship to resolve the conflict: meeting friends, chatting on the phone with parents, the use of social networks, etc.
4. "*Escape into fantasy*" means living in dreams or another less painful and more attractive reality. It can be reading books, watching movies, or playing computer games. In addition, this includes the use of alcohol or drugs, and suicidal behavior as well.

Normally, all the ways are available to us as a resource of conflict processing. For example, in response to a problematic situation we can become sad or annoyed (body/senses). Thus, we are able recognize and express our feelings. We can do something about it; we can do something useful (activities/achievements). We can also share our experiences with others, escape, seek for support and assistance (contact/communication). We can think about the consequences, invent a new plan or a new meaning (future/fantasy). That is, having at our disposal the ability to use all four domains of life as a resource, we can go through the difficulties much easier. Adequate processing of actual conflicts allows us to resolve problem situations on time and to maintain the balance and good quality of life. For example, if your health has deteriorated, it makes sense to give it some more attention, get the necessary examination and treatment. Even if the event is experienced as something joyless, targeted investment of energy to the conflict area allows us to get out of it with minimal harmful effects.

Despite the seeming naturalness of the above-mentioned approach to solving the difficulties, we do not always act so rationally [5, 19, 22]. For example, having a problematic situation in a partnership, we can load ourselves with work, trying to minimize communication with the partner. It means that the actual conflict unfolds in the domain of contacts, but is processed by "escaping into activity." Or, on the contrary, the client has serious problems at work, and instead of solving them at work, he complains about them to a friend or partner ("escape into contacts") or tries to be distracted by using alcohol ("escape into fantasy".) This type of conflict reaction is called "shifting". The reasons for such reactions should be sought in the family concepts.

Even if a conflict arises in the relationship with one partner, and processed in a relationship with another partner, this cannot be considered as an adequate investment in conflict resolution. Despite the fact that we can get some relief and support from such a way of conflict processing, sooner or later we will have to put our efforts into the domain and into the content that formed the actual conflict. This is a guarantee of effective conflict management. It means that the actual conflict should be resolved in the domain where it originated, with the object with which it originated, and on the subject around which it originated. Because in fact we cannot avoid all conflicts, we should strive to learn how to manage them.

An actual conflict encourages people to seek the way out, and they make it with the means available using the four domains of life. In clinical application, four ways of processing the conflict help us to identify how exactly our client is doing this [9, 34]. Here we estimate how the client responds to the unfolding actual conflict using four ways of processing the conflict, and what areas of life are mainly involved in the processing of the actual conflict. For example, in response to the conflict in the domain of achievements about reliability and obedience, the client tends "to escape" into chatting and discussing the conflict with loved ones.

To be able to accurately diagnose the actual conflict, it must be formulated in the shape of a short description. For example: "When I repeatedly explain to my subordinate what I expect from him, but he is unable to fulfil it, I get mad and cannot calm down until I talk to someone about it."

With regard to the formulation of an actual conflict, it is located in the domain of achievements (conflict with a subordinate). It is processed mainly by escaping into communication (contacts) and emotional reactions (body). The content of the actual conflict consists of conscientiousness and obedience (high expectations versus low performance).

Because the client is able to share his/her emotional experiences with others, it can reduce the conflictual tension and return to normality.

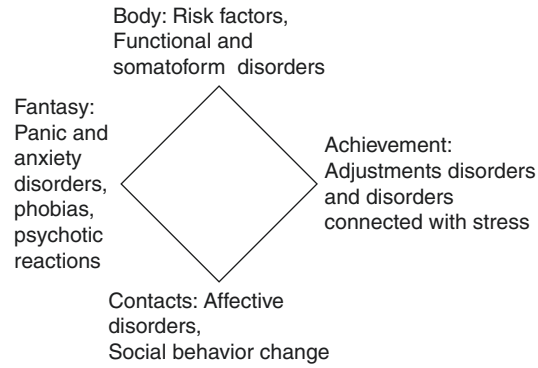

Fig. 27.6 Spreading the mental and psychosomatic disorders in the model of four spheres of life

The conflict and reaction to conflict should be clearly differentiated. The problem is that the conflict can be in one area, such as "contacts," and can be processed in a completely different area, such as "fantasy," for example. In this case, the conflict has very little chance of resolution, because it remains intact.

Headaches, gastrointestinal disorders, sleep disorders, rheumatic diseases, pain, asthma, cardiac pathology, sexual disorders, addiction, phobias, depression, obsessive–compulsive disorder, etc., are today considered in terms of experiencing and processing the mental and psychosocial conflicts. In this regard, all categories of mental and psychosomatic disorders can be distributed in this model (Fig. 27.6).

Key Conflict

In the work of Nossrat Peseschkian, the key conflict is described quite simply. However, it plays a significant role in the regulation of conflict reactions and even in symptom formation (Fig. 27.7).

Every conflict always creates energy. If for some reason this energy has no outlet, conflict tension is formed, which, under conditions of further blocking, can lead to symptoms and disorders.

When conflicting tension is already formed, it should be somehow utilized in the near future. Essentially, there are only two alternatives: to go out into the external world or to stay inside. Here

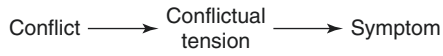

Fig. 27.7 Conflictual tension

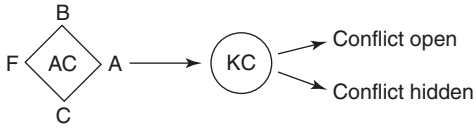

Fig. 27.8 Actual and the key conflicts

is the so-called "switch-on point," where the further direction of conflict processing needs to be determined [38] and a new field of conflict will be formed. After the actual conflict receives its individual meaning, the experiencing of this conflict and the response to it are facing another conflict, which has been named a key conflict. Thus, the key conflict exists, only when there is an actual conflict.

A key conflict is called key, because it is like a key that opens or closes our reaction to the conflict (Fig. 27.8). There is a choice between revealing the reaction to the conflict to others through "honesty" and hiding it away from them via "courtesy."

Substantively, the KC is a dichotomy of two capacities: honesty (openness, candor) and courtesy (politeness). In a sense, the key conflict is like a switch that directs our reaction to outside or inside. Getting into a conflict, we have a choice: to respond openly (outward) or react hiddenly (inside).

On this basis, "honesty" or "directness" is understood as an ability to openly express one's own needs, true thoughts and feelings, regardless of the consequences and reactions of others, an ability to say "No" and the ability to reject, stand up for oneself and to assert, allowing the risk of aggression. Example: "I always say what I think, regardless of whether they like it or not." (Fig. 27.9).

Besides all this, "honesty" is one of the conditions of verbalization. It makes an individual's experiences available for evaluation. However, if honesty/directness is too much, it can also prevent proper communication. In addition, honesty is an ability to stay in contact with yourself, to be

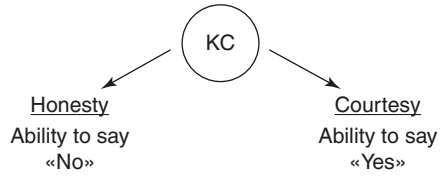

Fig. 27.9 The potential outcomes of the key conflict

honest regarding your own true manifestations (revelations). Hence, sincerity is an integral part of congruence and authenticity.

The second component, "politeness" or "courtesy", is understood to be an ability to suppress aggression toward the social environment, the ability to avoid confrontations, the ability to consider the attitude of the other, the ability to say "Yes" or the ability to accept with the cost of intuitive failure and potential emotional reactions of fear. Example: "I'm afraid to openly express my opinion, because I don't want to lose my good image in the eyes of others." "Politeness" can be understood as the need to stay in contact with others, the ability to maintain contact.

These two abilities, honesty and courtesy, are responsible for whether the conflict will be solved or whether it will be further developed and enhanced.

As the conflict is always a clash of interests between the two parties, for effective conflict management it needs participation of the second party: any individual, or other needs of the same person. For this, the conflict content should be comprehended and verbalized; this gives a chance for adequate perception of the conflict content of the other party.

From here we can distinguish three possible perspectives or patterns of conflict processing (Fig. 27.10).

Through the use of courtesy in the key conflict, a person consciously suppresses aggression and thereby creates an internal conflictual tension, which may also eventually lead to symptoms and disorders.

Most psychotherapy patients process their conflicts through the use of courtesy. In most cases, this is because politeness often lets one avoid escalation or minimize situational conflicts.

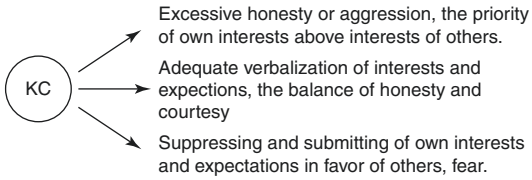

Fig. 27.10 Three possible perspectives of key conflict processing

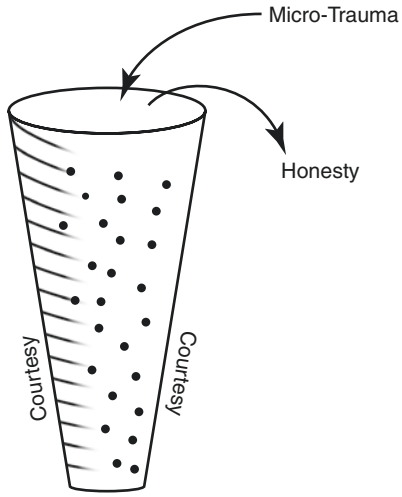

Fig. 27.11 High threshold of honesty

If "politeness" were to be compared to the walls of a vessel into which minor conflicts (micro-trauma) fall, and "honesty" to a threshold of a vessel or a hole through which the content can be expelled, it can be seen that the higher the threshold, the more intense the manifestation of honesty will look like. With a significant accumulation of honesty, it may look like a large wave or even a tsunami: intensive, aggressive, and sometimes destructive. In this case, the "honesty" will be forced and will be accompanied by a variety of complicated feelings (Fig. 27.11).

If the threshold of honesty is to be reduced, its intensity can be significantly lowered, and it will be easier to manage (Fig. 27.12).

From the examples that Nossrat Peseschkian offers in his books, it follows that the key conflict is conscious, because clients are able to verbalize the reason why they are either open (honest) or closed (polite).

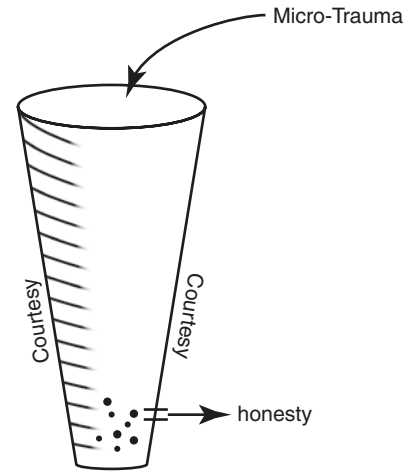

Fig. 27.12 Low threshold of honesty

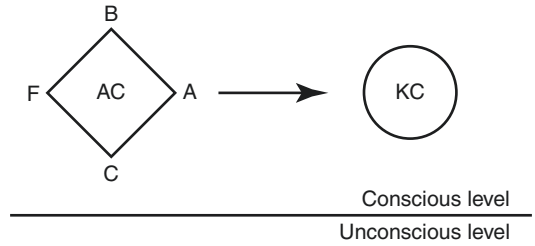

Fig. 27.13 Actual and the key conflicts and levels of awareness

The KC processes conscious content; however, it, in fact, is the inner conflict and can also lead to symptom formation because it can produce such strong emotions as fear or anger. However, not every IC is a KC. In contrast to the IC, as we have seen, the KC is its conscious analog. To open or to close something, you must be aware of what you are going to open or close (Fig. 27.13).

Thus, ***the key conflict is a conscious inner conflict between the need to express one's own interests (openness/honesty), and thus remain in contact with yourself (congruence) and the need not to compromise the attitude to yourself and thereby to stay in contact with the other (courtesy/politeness)*** [19].

In this regard, the key conflict can be called a conflict of conflicts, as it always occurs when there is a conscious choice creating tension: to

announce the significant conflict of interests or hide it. Equal accessibility of these two capacities to deal with conflict allows one to maintain the balance of contact with yourself and with others.

In the model of PPT, we consider the key point "courtesy (politeness)–honesty (sincerity)" the most vulnerable place for the following scheme of symptom occurrence: the reactions of courtesy correspond to the endocrine and mediator mechanisms of the central nervous system (CNS) and the reaction of fear; the reactions of honesty in the CNS correspond to aggression [37, 38]. Honesty taken to an extreme extent may look like aggression. At the same time, aggression is substantially connected with honesty. Physiologically, honesty activates the sympathetic nervous system (SNS) and requires from the person an active position and readiness for action. Accordingly, the potential problems of this person are most likely to occur in the area of contacts and achievements (Fig. 27.14).

Politeness to an extreme extent looks like fear. It activates the parasympathetic nervous system (PNS) and leads to a passive–defensive position. Accordingly, the potential problems are most likely to be located in areas of the body and fantasies, i.e., psychosomatic and phobic or anxiety disorders.

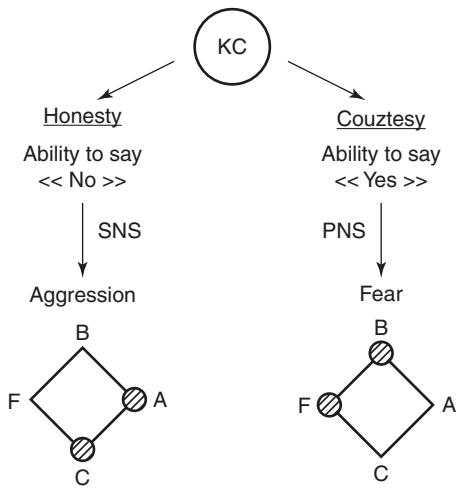

Fig. 27.14 The key conflict and symptom formation

Thus, if sincerity sharpens the conflict, politeness makes it chronic. However, even toughness and too straightforwardly telling the truth provide much more of a chance to understand the complaint and respond to it adequately than excessive politeness.

The key conflict processes the conscious content, i.e., the current conflictual life situation (actual conflict) or conscious family concept (basic conflict) may be verbalized (announced).

To assess the patient's conflict position and his/her communication capacities, we look for examples of their experience and attitude toward openness–courtesy described in specific situations [1, 7]. A key conflict, in the process of psychotherapy, is actively discussed at the stage of verbalization, when a greater understanding of conflicts and their contents has been achieved. In this regard, the emergence of a key conflict can be viewed as an opportunity to articulate one's own feelings; whereas keeping contact with others is a positive sign, verbalizing this conflict is a sign of increased awareness of the client. The awareness gives much greater choice and expands the repertoire of responses.

Basic Conflict

The causes of our failures are often our so-called "life concepts," which are indeed our inherited family concepts, and which in psychology or psychotherapy are termed *basic concepts* because they are planted into the foundation of our life, i.e., our childhood [6, 36]. These concepts are in other words ingrained and deep-seated views on life transmitted to us by our parents or parental figures, teachers or other significant people serving as a life manual from our role models.

What are life concepts? These concepts are the emotional and cognitive constructs that define the way we interpret our relationship with ourselves, with others, and with the environment. It is also a kind of belief about how the world operates and how to deal with it. In other words, they are psychological lenses through which we observe reality and understand our attitude to it.

That is why the concepts sometimes sound like a motto or a slogan.

These concepts often serve as motives that guide our behavior, as assimilated norms and habits, which we focus on. Thus, it is not a surprise now that they have such a big impact on our lives. These concepts for quite a long time may not have been made into our consciousness. We are simply not aware of them. This because as children we have no other alternatives and take them for granted. They become noticeable to us just through the clash with the reality that differs from the usual, and where they cease to perform their function, to fulfil the emotional needs and to serve as a reliable guide. When we are children, we do not have much choice in what is offered as facts of life; we simply accept them.

Hence, perhaps it becomes clearer now that not everything that we have experienced will be helpful for us at all times. Some things are a great help and facilitate our lives, whereas others turn it into a nightmare and create a strong potential for future conflicts and problems.

Fortunately, not each family concept will become a conflict in the future. Some concepts are potentially more conflictual than others. For example, the concept "a happy life is possible only if you have a high level of education" is much narrower and potentially more conflictual than the concept, "happiness is possible in any case." Not having the possibility, for different reasons, to obtain higher education, a person may assume that he or she is doomed to misfortune, and the fact of a lack of education will testify that one is unhappy. To make life happier, this person will have to overcome a lot of doubts related to prior beliefs, but it is better to call them superstitions.

Basic concepts are always built around values, and as is well known, values are not always universal, but rather culturally determined. In other words, what is valued in one culture may have absolutely no value in another. This is normal and natural. Now it becomes clearer how many problems we make up and invent by ourselves and thereby artificially create extra difficulties.

Here are some examples of other family concepts:

"You are worth something when you achieve something."
"Partnership is hard work."
"My children have to live better than I do."
"My child should live as well as I lived."
"God is punishing."
"All human beings are good by nature."
"Do not trust anyone."
"You can only trust relatives."
"Guests just bring expenses."
"Compassion would not be enough for everybody."
…etc.

Family concepts that served very well in our childhood can become a real burden in our adult life, because they stop fulfilling their functions to satisfy our emotional needs. Thus, we can see that family or basic concepts can transform into basic conflicts. Thus, ***the basic conflict is a family concept that becomes dysfunctional because of the current conflictual life situation*** (i.e., because of the actual conflict), and no longer serves to satisfy our emotional needs [19].

Energy that occurs in the actual conflict is multiplied by engaging the content of the basic conflict and leads to the formation of an unconscious inner conflict. Hence, the basic conflict is also imagined as an "awakened dog." For quite a long time this dog was sleeping and did not make any sound. But now, because of the actual conflict, the dog is awakened and lets us experience it by defending the usual values.

The model described below is related to the concepts that operate in the primary family group. In analysis here, we follow two conditions:

1. Concepts should be relevant for socialization.
2. They should concern the relationships with the outside world.

Carriers of these concepts are parents, siblings, grandparents, or people who take over these functions [38].

Operationalization of the Basic Conflict

As well as the actual conflict, the basic conflict needs diagnosis and operationalization. Unlike an actual conflict, the operationalization of a basic conflict is based on two diagnostic aspects:

1. Localization
2. Content

Localization of the Basic Conflict

The basic conflict is described by four concepts each of us carries:

1. Concept of "I"—the attitude of our parents and siblings to us when we were a child
2. Concept of "You"—the attitudes of our parents to each other when we were a child
3. Concept of "We"—the attitudes of our parents toward the world around and the social environment when we were a child
4. Concept of "Primary-We"—the attitudes of our parents toward a worldview, the questions of the meaning of life at the time, when we were a child

In Fig. 27.15 this is schematically represented.

Thus, these four categories of concepts describe the four dimensions of relationships: attitude toward ourselves, the attitude to the partnership, the attitude to society, and the attitude to the worldview. Accordingly, this attitude becomes the starting point for us in the future shaping of our own attitude to all these dimensions of relationships. Hence, if the actual conflict is always an external situation, it is about someone; the basic conflict is always about us.

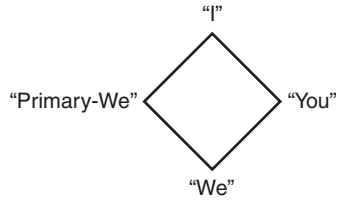

Fig. 27.15 Four dimensions of relationships

The concept "I" contains representations of ourselves, about ourselves, our own values, and their importance. It describes what we encourage ourselves for and what we punish ourselves for. Besides, this concept defines the ways in which we maintain and keep our personal value.

Here are some examples: "Nobody loves me and I don't love myself", "I am a happy person, everything that I undertake turns out. I trust myself", "I always need someone who would help me", "First me, then all the others", "I am a loser. I am an untalented person", "So what, anyway everything is meaningless".

The concept "You" describes our ideas of partnership. It is concerned with what the partnership has to keep it going on, how to function and to be supported. The model for this is the example that was given to us by our parents in their relation to each other.

Examples: "I want to establish the same harmonious family as my parents" or "I will never marry; I won't have children and continue all this rubbish in which my parents are engaged", "Marriage is a burden".

The concept "We" describes the developed relationship to one's surrounding environment and the society. Here, one is concerned with how to perceive it, what to expect, and how to interact with it.

Examples: "Guests are God's gift", "Relatives are like boots, the more one is close to them, the more they squeeze," "You are nothing, your people are everything," "We are on your own and others on their own," "We all are leaves of one branch and fruits of one tree," "It is better to have a rat in a cellar, than relatives in the house."

The concept of the "Primary-We" describes the family ideology, which contains views on the importance of clear life goals and values, religions, philosophies of life, and worldview, that is, the fundamental values that determine the character of life tasks.

Examples: "There is a higher power, merciful and fair," "The World was made comfortable," "Live in pleasure, not thinking about death and what will happen after it!"

Hence, all the family concepts, which we find in the client's description, can be distributed among these four categories of concepts. Graphically, it can be expressed as follows:

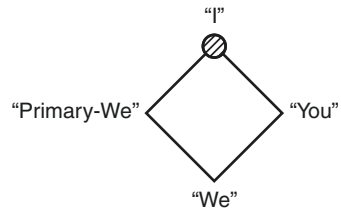

Fig. 27.16 The localization of the basic conflict in the conception of "I"

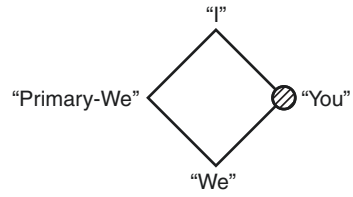

Fig. 27.17 The localization of the basic conflict in the conception of "You"

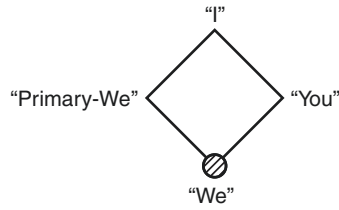

Fig. 27.18 The localization of the basic conflict in the conception of "We"

Concept "I am worth something when I achieve something" is localized in the conception of "I" (Fig. 27.16).

The conception of "Marriage is the work of raising children" describes the idea of partnership value and can be attributed to the conception of "You" (Fig. 27.17).

The concept of "You can only trust relatives" characterizes a friendly social group, in which you can feel safe with and is attributed to the conception of "We" (Fig. 27.18).

The conception "children are the main meaning of life" can be assigned to the conception of "Primary-We" and describes the meaningful orientation of life (Fig. 27.19).

Thus, any conception formulated by the client can be attributed to one of the four categories of concepts of the basic conflict.

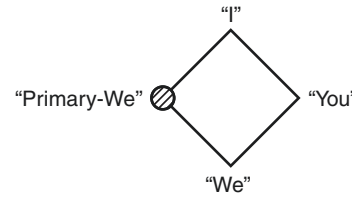

Fig. 27.19 The localization of the basic conflict in the conception of "Primary-We"

The Content of the Basic Conflict

The conceptions are always lined up around the values that in PPT are described by the actual capacities. Relationships are described by the primary actual capacities. We understand how we are treated and accepted through the time others spend with us, how others are patient with us, how others are tender with us, etc.

The need for love is a basic need for any human being. We want to be loved and accepted, appreciated, praised, and acknowledged, we want to be given time and some patience for our shortcomings, and many other things. These are our emotional needs. Sometimes, or rather quite often in the process of education, the secondary capacities replace the primary capacities. In such cases love ceases to be unconditional.

It means it exists only because of certain conditions. For example, "my father was patient and gentle to me only if I unquestioningly carried out what he asked me to do, with no arguments" (obedience). Obedience in this case becomes a reliable way of getting some time, tenderness, attention, and care from the father. Another one: "when my mother was angry, my help in cleaning the house could calm her down". Here, orderliness and cleanliness allowed one to get some love, patience, and perhaps contact.

For example, the conception with which we are already familiar "I am worth something when I achieve something" is localized in the concept of "I," contains an element of emotional need, expressed through relationship (primary capacity of love) and the social norms, through which this emotional need can be satisfied—the diligence.

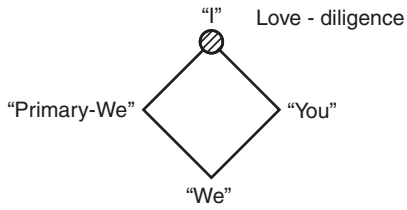

Fig. 27.20 Localization and the content of the basic conflict

It is expressed graphically in Fig. 27.20.

Thus, the content of the basic conflict needs to be described with two actual capacities. One describes an emotional need that is a primary actual capacity. The second is the social norm, through which this emotional need could be satisfied. For example: love—obedience, time—diligence, contact—faithfulness, confidence—reliability. Example: politeness, unity (integrity) —orderliness (order), sexuality—cleanliness, patience—thrift, etc. These are just a few examples of the content of the underlying conflict; actual capacities can be presented in different combinations. If a child is raised in an atmosphere of conditional love, to receive love, one has to fulfil certain conditions: to study well, to help in the home, to be obedient and diligent, etc.

Example: "If I helped my mother to get order in the house, my mother would become kind and soft and would allow me a little bit more" (love—cleanliness, orderliness). Thus, the basic conflict specifies a steady pattern of responses, which in childhood are more or less efficiently served to satisfy the emotional needs of that age. In this case, to gain more emotional warmth from her mother, a client had to fulfil the demands of orderliness and cleanliness.

The secondary capacities serve as social norms of family culture that must be satisfied to meet the emotional and age-specific needs. They are to be described by primary capacities. They allow one to find a creative compromise (including defense mechanisms) between the needs of this developmental period, on the one hand, and adaptation to the social norms on the other and, thus, to get an opportunity to enter the next stage of development.

Inner Conflict

The dominance of one or other motivation may be different at the conscious and unconscious levels [24, 44, 47]. For example, a person can consciously intend something but act in accordance with the inducements that are dominant at the unconscious level. In such cases, we are dealing with a disharmonious personality that is being constantly torn apart by inner conflicts. The inner conflict is the result of the addition of psychodynamic forces or conflict dynamics. The ongoing and persistent psychodynamic conflict, in turn, is characterized by an individual's predetermined patterns of experience, which, in the respective situations, lead to continued similar behavior patterns, without the person being aware of them, or being able to overcome them with his or her own free will ("neurotic fixation") [3, 17, 41]. Therefore, the inner conflict is also called *neurotic*, emphasizing its dysfunctionality.

A similar conflict arises only under certain conditions. These conditions are simultaneously external and internal. External conditions of the conflict are confined largely to the fact that satisfaction of some deep and active motives and personal relationships become impossible or are threatened. The internal conditions of a psychological conflict are reduced to a contradiction either between different motives and relationships of a person, such as debt and personal interests, or between the capacities and aspirations of the individual. Of course, the internal conditions of a psychological conflict do not arise spontaneously, but rather, in turn, are due to the external situation and history of the individual.

An inner conflict is an unconscious conflict of needs caused by the simultaneous existence of opposing or even mutually exclusive efforts, desires or ideals: for example, the desire to dissolve the marriage owing to unbearable relationships (actual situation) and a moral ban on divorce in virtue of education (basic concept) [19].

In connection with this the inner conflict is experienced as a temporary state of high emotional tension that feels unsolvable and a deadlocked situation. This dissatisfaction arises from the impossibility of overcoming the problem in a

way that was effective for the satisfaction of the emotional needs in childhood. In this conflict, the person repeats his behavioral pattern, no longer works. As a rule, it is a conflict between primary and secondary capacities and has the same content as the basic conflict.

Unlike the above mentioned actual and basic conflicts, the inner conflict does not look the same and must be described as the basic conflict pattern.

An inner conflict is an unconscious conflict of interest or expectations that are unfolding inside of one personality. It is manifested in repeated dysfunctional conflict patterns of the basic conflict. Recurrent conflict patterns of the basic conflict no longer resolve the conflict, but just create additional tension in the inner conflict.

Clinical Case Example Describing the Four Categories of Conflict

The actual situation: a woman, 35 years old, recently experienced a worsening of her relationship with her husband. They began quarrelling more frequently over trifles, mainly on the subject of justice, who and what kind of responsibilities are taken in their family. Over a period of time, they started to communicate less. The client began to experience a deficiency of attention and time from her husband. The husband began to spend more time at work, whereas the client was more involved in the housework. She felt lonely and that her husband loved her less.

The basic situation: in childhood, the client's mother was occupied by the household most of the time; she was quite cold and an emotionally greedy woman. She never had any free time, for example, to play with her daughter. To receive some warmth, some time, and acceptance from the mother, the client had to clean the house or help her mother with the housework. It made her mother happier, and she would become emotionally warmer and softer; thus, the daughter experienced the feeling of acceptance and love.

Inner conflict: now, at the present time, when the client feels a lack of love from her husband,

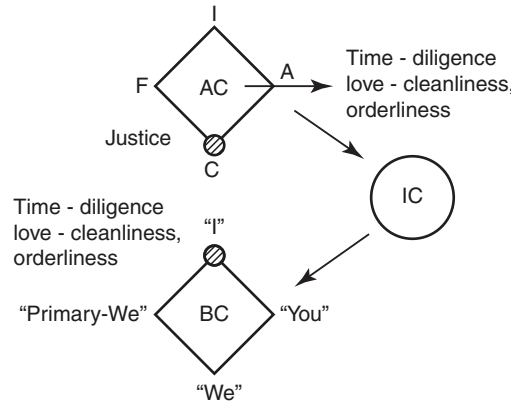

Fig. 27.21 The scheme of inner conflict occurring

she unconsciously reproduces the pattern of the basic conflict (love—cleanliness, orderliness). When her husband comes home, she begins to clean the house. Now, she has no time for her husband. The husband sees that his wife is occupied by the vigorous cleaning and goes to his room. The wife, in turn, seeing that her husband has again not encouraged her by paying her attention, feels rejected and escapes into work even more actively (Fig. 27.21). After an hour she experienced a hypertensive crisis [19].

What happened? The client's actual conflict is localized in the domain of contacts and occurs in her relationship with the husband. In content, the actual conflict is linked to the theme of justice. She expects greater justice, expressed in anticipation of her husband's help in taking care of the house. For example, the client believes that her husband must help her clean the house, and the husband thinks that this is not necessary: "it is already clean enough" or "I've been working so hard the whole day." However, the views and expectations of the client about justice are not met. Although her conflict is processed by "escaping into activities" at home, her husband deals with the same conflict by "escaping into activities" at work. The result is the same; the conflict in this relationship is not solved because the necessary energy is not invested into it.

One of the client's basic concepts is "time and love must be earned." In this sense, love is perceived rather as something that does not come

just like that, that must be earned, and looks more like justice. This explains the client's special sensitivity to the topic of justice. To earn love, time, and attention from the mother, she was able to succeed with the help of cleanliness, orderliness, and diligence. Only in response to these norms could the mother satisfy an emotional need for the affection of the daughter. Thus, she also manages to maintain her self-worth through these social values. Now, when the client feels devoid of love, her need for love has been actualized, which she is unconsciously trying to "earn," referring to the pattern of the basic concept. Here is the point where the basic concept is becoming a basic conflict as it does not execute the functions it had in childhood: to satisfy an emotional need for love. The client repeatedly refers to the usual pattern, which turns out to be inefficient in the current problematic situation. An inner conflict has been created with the growing tension. Here, the symptom of high blood pressure appears, which performs the function of a temporary compromise resolution. Now, the situation is changing. The husband leaves work and gives more time and attention to his wife. Temporarily, the client may not revert to the usual pattern, because this function is taken up by the symptom. The conflict temporarily loses its relevance owing to the emergence of a new actual situation (Fig. 27.22).

Psychodynamic conflicts are thus internal, unconscious conflicts and must be delineated from external or internal stressful conflictual demands. Internal, unconscious conflicts play a decisive role in the origin of mental and psychosomatic disorders. Unconscious intrapsychic conflicts are unconscious internal clashes of diametrically opposite motivation sets, such as the basic needs to receive care and to be self-sufficient [8, 11, 18].

The tension of an internal conflict is maintained until the actual conflict is solved or the basic concept is revised.

Interaction and Interrelation of the Conflicts in Positive Psychotherapy

The work with conflicts can absolutely and reasonably be defined as a goal of psychotherapy. For a better understanding of the formation of conflict dynamics, a good understanding of how the various conflicts interact with each other is required. After Sigmund Freud discovered unconsciousness and created his own model of the psychic apparatus, the "level" of awareness became firmly rooted in psychodynamic psychotherapy and later repeatedly compared to an iceberg. There even appeared a so-called "iceberg model," which illustrates the surface and underwater parts of psychological experience.

As is known, not all conflicts are available for awareness. The upper part is much smaller than

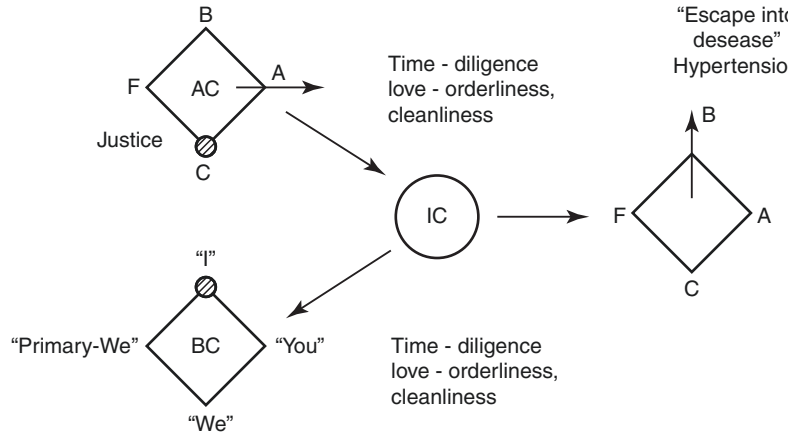

Fig. 27.22 The scheme of the appearance of the conflict dynamic with symptom formation

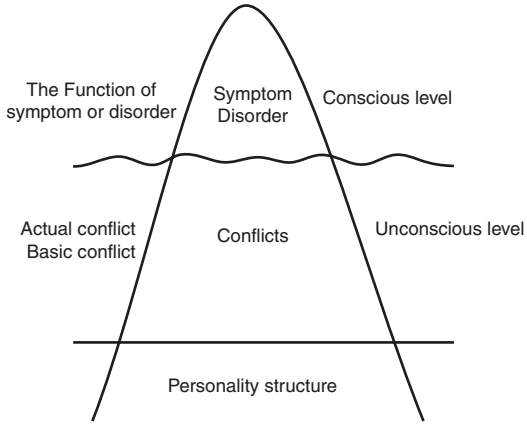

Fig. 27.23 Iceberg model

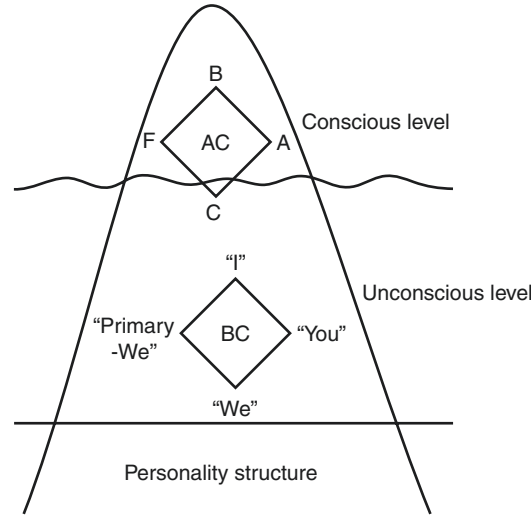

Fig. 27.24 Topographical model of conflicts in positive psychotherapy

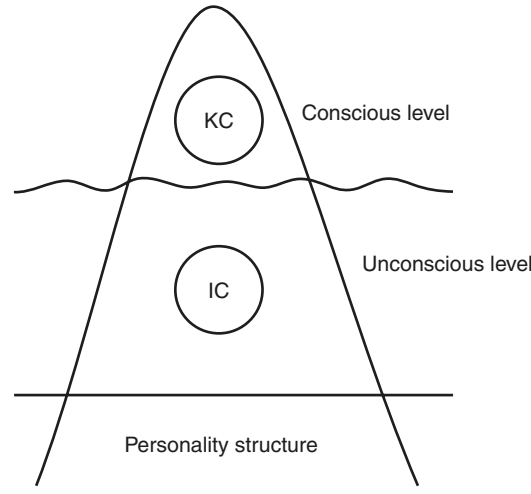

Fig. 27.25 Topographical model of the key and inner conflicts in positive psychotherapy

the lower part and illustrates the observed or conscious content; for example, symptoms and disorders. The actual conflicts, as is also known, are more often conscious, but sometimes they hide in a "shallow depth." However, it is not very difficult to detect. More deeply located are the unconscious conflicts and structural capacity. This is graphically depicted in Fig. 27.23.

The actual conflict is more often conscious, but not always so; therefore, it is mobile and is located on the border of consciousness. It can be reasonably compared with a fishing float bobbing in the water. When the actual conflict "clings" to the basic conflict, it goes under the water, becoming less accessible for awareness or even becomes unconscious. The topographical location of conflicts in relation to each other and levels of awareness are portrayed in Fig. 27.24.

The key conflict as a derivative of the actual conflict is conscious, but the inner conflict, as derived from the interactions of the actual and basic conflicts, is unconscious (Fig. 27.25).

The Actual Conflict and the Key Conflict

In fact, the key conflict is a derivative of the actual conflict because it does not exist away from it. The key conflict processes the actual conflict, directing the conflict energy outside or inside. Both conflicts are conscious and displayed in relationships with other people. During the psychotherapeutic process, we teach our client to understand his/her conflicts and the habitual ways of reacting to them. We help him/her to learn how to constructively share their experience, maintaining the balance of honesty and courtesy, and how to build a fair and open consultation and effective dialogue.

The Basic Conflict and Key Conflict

Here, we can talk about the level of self-discovery and increase in self-awareness, which can be achieved through understanding of the family concepts related to family traditions. Said simply, the unconscious experience cannot be verbalized. In the process of psychotherapy and with the help of a therapist, the client's awareness usually increases and, accordingly, this increases his/her ability to verbalize the findings. However, this is possible independently as well, when the client already has the skill to work through it by himself. Furthermore, family concepts can also be structured around the values of honesty and courtesy, and thereby affect their manifestation in conflict handling.

The Inner Conflict and Key Conflict

Both of these conflicts are similar in that they unfold within one person. However, unlike the inner conflict, the key conflict is conscious. The inner conflict is a derivative of the actual and basic conflicts. Verbalization of an inner conflict is possible only after awareness, or its possible resolution. This usually occurs during psychotherapy after analysis of all components of the conflict dynamics. Only then does the ability to verbalize it consciously appear.

Actual Capacities and the Key Conflict

Actual capacities as cultural values are contained in all of our conflicts. Being social values, they are very active psychodynamic units. Here, a person's ability to speak out about the actual capacities may differ substantially. For example, talking about thrift, faith or sexuality is more difficult than, for example, talking about punctuality or orderliness. This, of course, depends on the cultural values of these abilities.

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28

Using Stories, Anecdotes, and Humor in Positive Psychotherapy

Olga Lytvynenko, Liudmyla Zlatova, Volodymyr Karikash, and Tetiana Zhumatii

Introduction

Positive psychotherapy has a large variety of techniques for working with patients. Some of these techniques are new, whereas others are rooted in millennial layers of world culture. Since ancient times, people have used stories, parables, jokes, and humor to pass on traditions and experience to the next generation, and to support each other in a difficult situation. Even short anecdotes can convey the concentrated knowledge of several families, people, and generations. Those transmitted orally are honed from one narrator to next the narrator, retaining the most important aspects and letting the listener to extract the jewels for themselves.

In every epoch, modern mythological ideas about man and his place in the world arise. This is manifested in the fact that new political and religious myths, fairy tales, epos, social representations, national identity, and family tales are born and created in the cultural layer. These stories, as traditional phenomena of human culture, have a variety of forms and genres of folklore and authored texts. They include heroic epics, magic legends and myths, fairy tales of various kinds, but also everyday fables, tales, parables, and anecdotes. At present, narratives such as films and TV series are some of the new forms of processing meanings. All these phenomena belong to the metaphorical understanding of the world and can be used in psychotherapeutic practice.

Background

The method of positive psychotherapy (PPT) allows unlimited use of stories and humor in practical work. As in the old days, when people used stories, fairy tales, parables, and humor to support a friend, PPT uses them for psychological and psychotherapeutic care for patients.

Positive psychotherapy, which incorporated the conceptual ideas of other modalities (psychoanalysis, cognitive behavioral psychotherapy, the humanistic approach, systemic psychotherapy, etc.), in many respects uses the appropriate methods and techniques of working with metaphors. At the same time, there are some differences and peculiarities in the PPT approach. The peculiarity of the whole concept of PPT is the **transcultural approach** with the main question: *What do we*

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have in common and what is our difference? In this context, the metaphors of the patient's culture may play the role of forming a common emotional–semantic therapeutic field of contact, and the metaphors of other cultures may have the effect of novelty and carry counter concepts of new experience.

Nossrat Peseschkian was one of the first psychotherapists to use parables and humor in working with patients. He managed to see and appreciate the simple and understandable stories and successfully use them in therapy. His book "The Merchant and the Parrot—Oriental Stories as Tools in Positive Psychotherapy" became a classic work and is quoted by representatives of various areas of psychotherapy [1]. Speaking about the therapeutic properties of stories and parables, pointing out that they are used by the patient as metaphors, and also considering emerging experiences, emotions, and insights, Nossrat Peseschkian introduces the notion of "history function" into a scientific discussion [1]. These functions are: mirror, model, mediator, repository, transmitter of tradition, aid to regression, and serving as counter-points.

The Mirror Function

The content of the parable becomes the mirror that reflects the inner world of the person, thus facilitating identification with him. "By removing emotional stress, the stories help the client to see their problems from the side. So he can define his attitude to the usual possibilities of conflict resolution" [1]. "History becomes, as it were, the mirror that reflects and reflects which leads to reflection" [1].

The Model Function

The parables reflect various conflict situations and suggest possible ways of solving them, or indicate the consequences of individual attempts to resolve conflicts. Thus, they help to learn using the model. Stories display conflict situations in the form of algorithms and offer various options for resolving problems. "It enables a person to differently interpret the content of the story, the events outlined in it, to compare this content with its own situation. Stories offer different options for action, while in our thoughts and feelings we get acquainted with unusual answers to the usual conflict situations" [1].

The Mediator Function

The parable acts as a mediator between the patient and the therapist, thereby reducing the patient's resistance. "A person's fear of a new one, a fear of losing what he already has, can be weakened by transferring the severity of the situation into an imaginary world of stories. Habitual since childhood play of imagination in what is going on for fun, allows the client, speaking, as it were, not about himself, but about the character of the story, to solve significant conflicts. Discussing the hero of the story, the client teams up with the consultant. So, the situation "patient–therapist" changes to the situation "patient–story–therapist" [1].

The Repository Effect (Storage of Experience)

After the end of psychotherapeutic work, parables continue to operate in a person's daily life.

> Thanks to their imagery, stories are easily remembered and, after the end of a medical session, they continue to 'work' in the patient's daily life; a situation may arise in memory, similar to that depicted in history, or there may be a need to think through the individual issues raised in it. Under changing conditions, the patient may interpret the content of the same story differently. He enriches his initial understanding of history and assimilates new life positions that help to understand his own mythology. Thus, the story serves as a storage of experience, that is, after the end of psychotherapeutic work, it continues to exert its effect on the patient and makes him more independent from the therapist [1].

Stories as Transmitters of Tradition

Describing individual situations, the stories take them beyond the limits of individual experience and appeal to the cultural traditions and experiences of different generations.

> "As the bearers of tradition, stories reflect different cultures. They contain generally accepted rules of the game, concepts, norms of behavior, peculiar to a particular culture, familiar with the solution of problems that are accepted in this cultural environment. Stories belonging to other cultures convey information about the rules of the game and life principles that are considered important in these cultures and represent other thinking models. Familiarity with them helps to expand your own repertoire of concepts, principles, values and methods of conflict resolution" [1]. "Stories belonging to other cultures can help overcome the characteristic for our time and regrettable prejudices, hidden dislike" [1].

Stories as an Aid to Regression

The parable helps the patient to return to the former joyful immediacy. It causes surprise and bewilderment, opening access to the world of fantasy, figurative thinking, "the direct (straight) entrance without fear to be punished or judged. The parable contributes to the awakening of children's and creative forces in the consultant who works with the patient. It activates his work at the level of intuition. A return to the early stages of the individual development of a person is directed by a thematic selection of stories, which makes it possible to gradually implement it; and for patients with a weakly pronounced "I," that is, with a weakly expressed individuality, only a very careful therapeutic approach is possible in order not to regress in development [1].

Stories as Counter-Concepts

The parable does not sound to the patient in the generally accepted, predetermined sense, but suggests to him "... an alternative concept that the patient can either accept or reject. Stories are only a special case of human communication, involving the exchange of concepts" [1].

> Everyone temporarily identifies himself with alien views and checks what is acceptable for himself, what can help to better cope with real-life circumstances, and what fits and should be rejected. In other words, both interlocutors need time before they can draw one or another conclusion from the information received [1].

Change of Perspective

Proverbs unexpectedly cause a new experience for the patient, a change in attitude occurs in his consciousness [1] "The listener or reader gets a clear idea of how a change in attitude affects his life principles. Alternative concepts, the way they are given in stories, invite the reader to this change in attitude, to experiment with unusual concepts and possible solutions. The point is not to induce a person to abandon his point of view, proven in many of life's vicissitudes. Something else is connected with the change of position: it turns out that familiar situations can be viewed from a different angle, which gives them a different character, so sometimes a change of position is, in essence, the solution to the problem" [1].

In the second chapter of the book "The Merchant and the Parrot," Nossrat Peseschkian describes real cases from his practice using stories in various therapeutic situations. Comments on the parables proposed by the author can serve as a guide for the work of practicing psychologists and psychotherapists.

The "patient–story–therapist" method of interaction proposed by Nossrat Peseschkian has been successfully incorporated into PPT.

Case Example: Using Stories

A 43-year-old patient came to a psychotherapist, in a state of acute grief. Her only 21-year-old son had committed suicide. At that time, the woman had been divorced for a long time. As a result of the tragic death of her son, she was left all alone and constantly thought about her dead child. All meaning had been lost. She did not touch her son's things in his room and was in denial of her loss. After 3 months' work in therapy, when the intensity of the emotional tension had decreased slightly, the therapist resorted to the Persian parable of the Glass Sarcophagus.

Glass Sarcophagus

One eastern king had a wife of wondrous beauty, whom he loved more than anything else. Her beauty illuminated the radiance of his life. When he was free from affairs, he wanted only one

thing—to be near her. And suddenly the wife died and left the king in deep sorrow. "I will never," he exclaimed, "part with my beloved young wife, even if death has made her lovely features lifeless!" He ordered that a glass sarcophagus with her body be placed on a dais in the largest hall of the palace. He put his bed next to her so as not to part with his beloved for a minute. Standing next to the deceased wife, he found his only solace and peace. But the summer was hot, and, despite the coolness in the palace's chambers, the wife's body began to decompose gradually. Disgusting spots appeared on the beautiful forehead of the deceased. Her wondrous face began to change color and swell from day to day. A king full of love did not notice this. Soon the sweetish smell of decomposition filled the entire hall, and none of the servants ventured into it without closing their nose. The distressed king himself moved his bed to the next room. Despite the fact that all the windows were wide open, the smell of corruption followed him. Even the pink balm did not help. Finally, he tied his nose with a green scarf, a sign of his royal dignity. But nothing helped. All the servants and friends left him. Only huge shiny black flies buzzed around. The king fainted, and the doctor ordered him to be transferred to the large palace garden. When the king came to his senses, he felt a fresh breeze of wind, the scent of roses delighted him, and the sound of fountains pleased his ears. It seemed to him that his great love still lived. A few days later, life and health returned to the king. He looked at the cup of a rose for a long time and suddenly remembered how beautiful his wife was when she was alive and how disgusting her body became day after day. He tore the rose, laid it on the sarcophagus and ordered the servants to put the body into the earth. (Persian history) [1].

The patient was silent for a while and then said that the same sarcophagus was "standing" at her apartment. This parable acted as a "mirror" and led her out of the stage of denial. In further sessions, returning to the image of the "glass sarcophagus," both the therapist and the patient understood well what was going on. Thus, this parable also performed the "prolongation" function and became an intermediary for further work.

The traditional use of parables and stories is still popular and frequent among positive psychotherapists. The same parable causes unique living and insights for different patients. At the same time, PPT is a dynamically developing method in which the traditional techniques of working with a patient are closely intertwined with new ways and integrating capabilities from adjacent modalities. Psychotherapists can also use various versions of stories in their work—in situational encouragement to relieve the patient's tension and anxiety with humor. In advanced cases, the patient can independently write a story or a fairy tale that will help to uncover a subjective view of his life situation, limitations, abilities, and resources. Sometimes it will be useful to ask the patient to write the most dramatic and optimistic end of a story or a fairy tale. In any case, the use of metaphors allows the use of three vectors of the patient's subjective reality: mystical, cognitive, and reflexive. At the same time, it is possible to operate freely with three timeframes—past, present, and future—depending on the therapeutic tasks [5].

Use of Fairy Tales in Therapy

In psychology an interest has always been shown in the study of fairy tales and myths. The classics of psychology have repeatedly turned to the analysis of fairy tales. Freud himself believed that in myths and fairy tales, in folk sayings and songs, in common usage and poetic fantasy, the same symbols are used that allow the interpretation of dreams [8].

There are different ways of working with a fairy tale as a tool for help and development in PPT: using a fairy tale as a metaphor, drawing based on a fairy tale, discussing behavior, motives, plot, psychodrama playing of the whole fairy tale or individual episodes. It is also possible to use a fairy tale as a parable or creative work, which in turn includes analysis, narration, rewriting, and the creation of a personal fairy tale as a self-fulfilling prophecy with its plots and heroes.

The characters created by the patient in a metaphorical form reflect his own psychological

processes and can then be felt, lived, and analyzed in an environmentally friendly form of identification and self-reflection, and also gives a person the resources to adapt [7].

Fairy tales and parables are widely used as a narrative for both diagnosis and correction. By listening and perceiving fairy tales, a person identifies with the characters, embeds fairy tales into his life scenario and forms it, and, of course, as an opportunity to clarify internal conflicts, unconscious motives, to establish a connection between the conscious and the unconscious.

The main purpose of using fairy tales in PPT is learning the basic principles of PPT by personal experience and living, finding resources, finding new strategies, the possibility of successful socialization, adaptation, and the ability to respond to life challenges.

Writing a fairy tale as part of individual or family counseling fits in well with the five-step strategy of PPT. The stage of counseling and the stage of the fairytale narration relate and lead the client to a "fairytale" solution to the problem, which helps not only to structure the process, but also to achieve a therapeutic result [7].

Stage 1: Observation. We suggest starting a fairy tale with some traditional beginnings. The patient describes the main character, tells about his life situation at the time of the beginning of the fairy tale (actual situation).

Stage 2: Inventory. At this stage, the fairy tale metaphorically describes the challenge, symptom or actual conflict that occurred in the life of the patient. Formulation of the request.

Stage 3: Situational encouragement. What has changed in the life of the patient after the event, the challenge? How did he/she cope, what skills did he/she show?

Stage 4: Verbalization. At this fabulous stage, the client describes the development of events, suggests ways out, looks for magic helpers and magical objects, overcomes all difficulties and completes the Hero's Journey.

Stage 5: Broadening of goals. At this stage, the patient describes the outcome to which the hero came as a result of his or her tests, what conclusions he/she made, what he/she brings with him/her further into his/her life.

At the end of the tale, it is possible to offer patients a metaphorical delineation of the moral of the whole tale, to understand what symbolic function and task the symptom, conflict, performs in the life of the patient. After writing and reading—discussing the patient's feelings about his/her own fairy tale, analyzing the motives and behavior of the characters, of necessity—writing and rewriting the fairy tale [7].

The fairy tale analysis in PPT allows not only work with the **actual** and **key conflicts** but also to detect the **basic** and **internal conflicts** of the patient. In the logic of building a fairy-tale plot, family scenarios, concepts, and beliefs, including intense emotional experiences, are clearly visible. Writing one fairy tale during the course of therapy is not always sufficient to obtain a therapeutic result [7].

Case Example

Stage 1: ***Observation and distancing***. The patient, a woman aged 31 years, married with a child. She came with a request to get rid of a rash. The rash had first appeared as a symptom 6 months before. It periodically appeared and disappeared on the body. If the patient was nervous, she began to scratch the body and a red rash appeared on the skin. One of the most pronounced **actual capacities** of a woman is obedience, in addition to responsibility and punctuality. When in her life there was a question of choosing a new job, perhaps a change in her profession and, in connection with this, a new way of life in the family, the woman began to get nervous and noticed the irritation of her skin.

Stage 2: ***Inventory***. By asking clarifying questions, it was possible to find out that the patient very much doubted her abilities and opportunities to find work. One of her family concepts is "Nothing gets easy in this life. It takes a lot of work." Fear of failing a new business and disappointing loved ones paralyzed the woman and prevented her from moving forward.

Stage 3: ***Situational encouragement***. An important point in the work was to identify the strengths of the patient, such as patience, diligence, accuracy, and good faith. Attempts to be

perfect in any business caused the woman's anxiety; therefore, one of the tasks was to draw her attention to what she had already achieved in her life and learn to value herself and her achievements.

Stage 4: ***Verbalization***. At this stage, the patient was asked to write a fairy tale in which she could metaphorically identify her symptom and reflect on the "magic" resolution of the situation.

The tale of the psychosomatic symptom.

Once upon a time there lived a little, smart girl called Thumbelina, who was loved by her parents. She loved to wear purple things. So she was comfortable. She also loved to read different books and go into a world of fantasy, to experience events with the characters. Everything was beautiful in her world. For the time being ...

Then one day, walking along on a pleasant summer evening, she met Cerseya. A terrible, disgusting creature, worse than the most vile toad, all covered in abscesses, she appeared along the way to Thumbelina, still smiles, but this does not look more pleasant. The first thing Thumbelina felt was horror! This shameless pimply woman said hello to her, called her name, and hugged her. "Hello, my girl. Hello Thumbelina! I see you are sad, lonely ... Me too. You and I are so alike. Let's go for a walk together."

Thumbelina did not know what to answer. She didn't want such a friend, but she didn't have any others, and one cannot be judged by appearance. We must first talk, she thought, this acquaintance might be useful.

"Come on," she replied. - Let's go."

"I look sad to you."

"Depression ... Thumbelina said for some reason"

And Cerseya took advantage of this phrase, word for word, plunged into her confidence, got into the most secret corners of her soul, and took up all the space. Because of this, Thumbelina's life became even more isolated. Nobody approached her, did not talk to her, and did not look at her. She was not attracted to communicate with her rash. And Cerseya reassured her in her own way. "See, you don't need it! Absolutely! Only me. I am your true friend. I love and appreciate you." And Thumbelina had no choice but to believe it. *And inside her soul, she (Thumbelina) felt bad, inside her soul was getting harder.*

And then, somehow, it was a nice summer day, while two inseparable friends in misfortune were out for their regular walk, the Wizard appeared. Beautiful with intelligent, lively eyes, and most importantly, he had a genuine interest in Thumbelina. For the first time in many years! He came to meet her and suggested that she go on a great balloon flight. Of course, Thumbelina was interested and was "in favor" with both hands. But Cerseya did not sleep. She also wanted to fly with the Wizard, she had to be there!

Then the Wizard suggested to Cerseya that she go to the country of the same ugly creatures, "beauties." And moreover, gratuitously, in a beautiful paradise. Cerseya was delighted, immediately forgot about her friend and devoted friendship. She jumped into the baloon and was gone ... They never saw her again.

The wizard with Thumbelina remained on the ground to watch the baloon, aerostat quickly decrease in size.

Moral: We should learn to distinguish our desires from those of others.

The tale also helped to reveal the **key conflict (between honesty and courtesy**). The politeness of the patient did not allow her to limit communication with unpleasant people. Thus, she was constantly under stress and this restriction caused a rash. The skin, as the boundary between the outside world and the human body, began to respond with rashes. The tale also helped the patient to see for herself what was really happening in her life. The ending of the story had a happy outcome and at the stage of ***broadening of goals*** the therapist drew the patient's attention to her internal resources and knowledge how to solve the problem with the symptom.

In PPT, there are other original ways of working with a fairy tale. Richard Werringloer, in his book "The Little Kite Flyer," suggested using the author's fairy tale in **pedagogical psychology** as an educational and pedagogical material for children and their parents in the positum approach [3]. As a metaphorical image of the **balance model**, which is one of the basic concepts in PPT, the author created an image of a kite. This kite

has the shape of a rhombus, actually a balance model, and the father explains to the young aeronaut the meaning of each sphere in a fairy-tale statement that the child understands.

> Do you see this quadrangle in the form of a diamond? This form is the basis for a safe aircraft. It is designed for human proportions and is therefore extremely easy to control in the air. This diamond will also remind you of four directions: body, work, friendship and vision of the future. These four aspects are what life comes down to. If you want to lead a happy and fulfilling life as an aeronaut, then always remember this and try to keep the four aspects in balance. They will also help you succeed in competitions because they will provide you with strength, stability and peace of mind [3].

Thus, the PPT at the present stage of development continues to develop the ideas of Nossrat Peseschkian and proposes new forms of work with patients with the help of different types of stories.

Cinema Is like a Story: Working with Movies in a Group

All existing types of stories today can be seen and lived in films. Films can be short, comedic, with a psychological plot, romantic, contain mythology, etc. Very often, the patients independently during the session recall a plot from the cinema, compare themselves to someone from the famous movie characters, identify themselves with them. We can say that the modern stage of work with stories, parables, fairy tales, anecdotes and metaphors is also connected with film stories. Films are well remembered at the stage of situational encouragement and verbalization. Thus, it includes not only story, but also an image, a complete picture.

In our work, we apply the therapeutic method of cinema in practice. The work of a closed dynamic group, consisting of 8–10 people, usually takes place once a month for 6 h. After the greeting and sharing, the participants jointly watch a film selected by a therapist in advance, based on the group's objectives and psychodynamics. In each session, the group watches and discusses a new film story. The discussion of the film begins with the pronunciation of the phenomena—feelings, emotions, and bodily sensations that were discovered during the process of viewing, and then the therapist invites the group members to analyze the plot and think about how it responds to everyone's personal story [5].

Case "A Monster Calls"

At the **observation stage,** the movie "A Monster Calls" was watched (directed by Juan Antonio Bayona, 2016). The film is about a macrotraumatic story that occurred in the life of the main character, Connor. Connor is a boy of 12 years of age, his mother fell ill with a deadly disease, and his father has been living with his new family in another country for a long time. Connor has to grow up early, he feels a strong horror and fear of losing his mother. A magic tree comes to help the child—a huge monster yew. This monster tells Connor several stories and thus prepares the boy for the inevitable loss.

At the **inventory stage**, the group members exchanged their emotions, feelings, sensation, experiences about the plot itself, the characters, and special emotional inclusions in one or another episode of the film.

At the **stage of situational encouragement**, the group leader identified the protagonist's resources and mental abilities that helped him to deal with the situation. The use of fantasy and the processing of trauma through dreams and imagination helped the boy to live through a difficult situation of unbearable grief, prepared him for life without a mother. His creative abilities gave him the strength to endure.

At the **stage of verbalization,** the group members spontaneously began to recall and pronounce traumatic situations from their lives, how they lived with the grief, shared how they overcame the pain, accepted the loss, what their own experience was, thereby revealing their greater involvement and identification with the world of the protagonist.

The **broadening of the goal stage** was to integrate and assimilate the experience gained. The

group members gave each other many warm words of gratitude and support for the opportunity to process macro-traumatic experiences in a safe space.

Thus, thanks to the group work with cinema history, the participants were able to identify with the main character, his way of life, and his resources and abilities to cope with difficult life challenges.

The Use of Humor and Anecdotes in Positive Psychotherapy

Generally, humor implies a kindly mocking attitude to something, an expression of the emotional perception of reality. Humor is also one of the ways of discharging—the transformation of negative feelings into the very opposite—into a source of laughter. The role of humor in this case comes down to the protection of the human I, because it allows one to maintain self-control, dignity, and self-control under exceptional (extreme) conditions. Such an understanding of humor in psychology has its origin in S. Freud, for whom humor was "a means of receiving pleasure, despite the agonizing affects that precede it" [2]. Humor suppresses the development of this affect, taking its place. Moreover, the pleasure of humor arises in these cases owing to the unrealized development of the affect "it derives from the saving of affective expenses." Freud said humor can be understood as the highest of protective functions [2].

But when in the psychoanalytic tradition humor is usually defined as a protective function, in PPT, Nossrat Peseschkian suggested using parables and stories not only to relieve the patient's tension, but also as an intervention in a situation of limited time. This function was played by the parable "A good example" told by Dr. Peseschkian to his patient, a frustrated father in a briefcase from the book "The Merchant and the Parrot" [1]. Of course, intuition and professionalism are needed to subtly feel the possibility of therapeutic intervention in each particular session.

Anecdotes play a special role in PPT. An anecdote contains a brief story with an unexpected and ridiculous finale, thus facilitating further communication, having to contact. As a brief story, the anecdote carries an emotionally charged **metaphor**. First of all, this refers to well-known anecdotes, to phrases that have become sayings and can communicate information with the transfer of certain feelings and emotions, thereby finding common points for contact [4]. Short witty content also contributes to easy memorization, stress reduction, and is a demonstration of a person's **actual capacities**. Anecdotes help to unite goals and change familiar ideas, make it easier to perceive reality, and have a positive effect on the emotional state. At the **stage of situational encouragement** as an alternative point of view, the therapist can use anecdotes to work with the patient as one of the most accessible and understandable ways of demonstrating a new pattern of behavior.

Anecdotes, in addition to parables, have their own **morality**. It may be veiled at first glance. Through humor, a lesson learned from an anecdote is remembered better, takes the patient out of shame, awkwardness, anger, and other heavy emotions, and helps to overcome resistance. But the goal of humorous therapeutic stories is not so much moralizing as the opportunity to imagine an exemplary life situation and find yourself in it.

Therefore, in the anecdote there is a resource that can be used at the stage of **stimulation and encouragement** formatting during a consultation or psychotherapy, to discover **actual capacities** and their use; at the stage of **verbalization**, anecdotes help to recycle complex feelings, to accept and discuss resistance, to change a position, etc.

Anecdotes, because of their brevity, humor, and metaphor, can also be used for a **positive interpretation** of the situation.

Case Example: Humor

Moisha, I heard you divorced for the fourth time! Are all women so picky?

- No, only my mom.

The anecdote unambiguously hints at the strongest maternal influence and lack of separation. Here, the mother is the woman who destroys the life of her son, but there is no obvious criticism on her.

The anecdote becomes a **transcultural** phenomenon from the very beginning, because it has been told for a long time in a particular locality, it becomes part of the culture and, to some extent, is concentrated content of information about a people, a people of one region or one profession. Anecdotes, being easy to read and easy to remember, become a **model** and a **transcultural** way of communication. Because of common interests and problems, anecdotes from different nationalities in one locale are often identical, which can be a good incentive for the development of a common theme. Awareness of oneself and one's people connected with another culture is beneficial for intercultural communication [4]. Thus, the anecdote can also perform the **function of a social psychotherapist** [4].

In each culture and national community a series of popular anecdotes can be found, emphasizing one or another peculiarity of the mentality and their developed actual abilities. These anecdotes are so recognizable that in a single **phrase—a metaphor**, it is clear what kind of story is being told. With this particular narrative, the anecdote appears alongside another feature of the stories, peculiar to this particular genre—the **recognition function** (L. Zlatova) [4].

Through this **recognition function**, residents of one locality can use a set of well-known metaphors as an identifying mark and a sign of one community. The same function can be used in the contact between the patient and the therapist, which allows a safe contact and therapeutic alliance to quickly become established.

Case Example: Anecdote

A Frenchman, an American, and a Ukrainian were asked to find out how long they would ride a horse for, and that quantity of land would be given to him.

The Frenchman rode for a kilometer, stopped the horse, and said: "It is enough for me. Here I will build a house. There is a flower garden. And there I will have a rest on the sun loungers. And there is a vineyard."

The American traveled three kilometers and stopped the horse: "I have enough. My villa will be here. There's a lawn. There's a helicopter's playground. And even further, a golf court."

The Ukrainian jumped on his horse and rode ... Rode—road the horse, rode—rode... He rode the horse, the horse fell. The Ukrainian got up on his feet and ran! Ran, ran ... stumbled, fell. He already felt that he could no longer run. Crawling, crawling—everything hurt, he could no longer crawl. He took off the cap from his head, threw it with the last of his strength in front of himself and groaned: "And there I will also plant cucumbers!"

A similar anecdote is found in Bulgarians, Moldavians, and other nationals living in southern Ukraine. The humorous and metaphorical statement "also for cucumbers" can be changed to "even for tomatoes" or "... and this is for me and pepper." These are uniting and recognizable metaphors for people who are able to desire and achieve more, to be ready for hard work (till-age), and the ability to be hardy in achieving goals. Several **secondary actual capacities** come to the fore, such as: diligence, frugality, conscientiousness, and **primary actual capacities**: patience, hope, faith, confidence in ability, and determination.

Thus, the role of anecdotes in everyday life becomes significant in a positive and transcultural aspect and can be widely used in psychotherapeutic practice.

Case Example: Use of Humor

Dad-psychotherapist wakes up at night and goes to the fridge. He opens the door and sees his frozen son there.

"Dad, save me! Get me out of here!" The son asks.

"Stay with this," the father replies and closes the fridge door.

This anecdote is often enough told by fellow trainers in PPT in groups on personal experience, where candidates for psychotherapists, examining themselves, meet with their complex experiences, resistance, the need to be "here and now" in their "fridge" to give themselves time to live and rethink. The ironic and humorous form of the anecdote smooths the complexity of the

process and underlines its necessity. The phrases “Stay with this,” and “Have you already come out of the fridge?” denote a specific situation of professional growth, when space and time are needed before becoming a psychotherapist.

Nossrat Peseschkian in each of his works describes the use of stories in various life situations. He emphasizes: “If they are applied on time and in accordance with the recommendations, they can be the starting point for the therapeutic efforts of the doctor and contribute to changing the patient’s life position and behavior. However, incorrect dosage, insincerity and the underlined moralizing by the therapist can cause harm” [1].

Summary

Summing up the discussion about the role of parables and stories in the work of the positive psychotherapist, the words of Nossrat Peseschkian resonate “... along with extraordinary entertaining, poetic and vivid presentation, they contain something unexpected, unforeseen. The usual course of thoughts and desires suddenly appeared in a completely different light. A different way of thinking, which seemed previously unusual, became close and clear to me. This change of position I consider the most important function of the stories” [1].

Thus, stories and humor are an inexhaustible resource for a positive psychotherapist, a source of inspiration and support at all stages of working with patients.

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Supervision in Positive Psychotherapy

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Pavel Frolov

Introduction

Positive psychotherapy (PPT) was founded in 1968 as differential analysis. The first book on PPT was published in 1977. Since that time, PPT has developed not only as an academic, but more so as a clinical method, extracting knowledge primarily from medical practice, and only secondarily from the academic process. Therefore, supervision in PPT was oriented more toward the needs of professional psychotherapists in their work with the patients in hospitals rather than toward academic researchers. Even though formal training in PPT was established later, supervision has been used for decades, both by practitioners who have already completed their education, and by trainees in the process of education in psychotherapy.

There is no single definition of supervision, and probably one of the most comprehensive and detailed ones is Milne and Watkins' [9] definition based on the work of Bernard and Goodyear [2]:

> The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleagues. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods, that supervisors use, are corrective feedback on the supervisee's performance, teaching, and collaborative goal-setting. The objectives of supervision are "normative" (e.g., case management and quality control issues), "restorative" (e.g., encouraging emotional experiencing and processing, to aid coping and recovery), and "formative" (e.g., maintaining and facilitating the supervisees' competence, capability, and general effectiveness).

In their research, Simpson-Southward et al. [16] analyzed 52 different models of supervision, and despite the fact that all of them have used different approaches to forms and styles of supervision, all modern approaches are relatively united in their views of supervision as a professional activity.

Such a generalized view of supervision as a professional activity recognizes several of its inalienable functions, such as:

1. Becoming a competent therapist. According to Milne and Watkins [9]: "Perhaps the best-recognized function of supervision is to enable supervisees to become competent as psychotherapists."
2. Development of the therapist's abilities. This function addresses the practitioner's need for continued development in the course of daily work, and that of the supervisor to nurture the supervisee's ability to grow, emphasizing professional qualities, which should be prioritized.

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3. Creating a professional identity, engaging the supervisee in the development of ethical approaches that enable the supervisee to fulfill professional expectations.
4. Providing the supervisee with the opportunity to develop certain competencies (to achieve certain qualifications), when the supervisor indicates which specific competencies are lacking and which need to be nurtured for him/her to become a professional.

All the above-mentioned functions of supervision, in essence, ensure implementation of the primary function: the provision of safe and effective therapy, i.e., clinical benefits. Although most experts agree on the importance of supervision in the professional development of psychotherapists, what is often overlooked is the primary goal of supervision: to promote safe and effective clinical practice, that is, when effective supervision improves therapeutic outcomes in patients.

According to the map of supervisor's competences [13], some common competencies of the supervisor include the ability to:

1. Teach practicing within ethical standards
2. Adapt supervision to organizational and governance context
3. Develop skills in dealing with differences while taking into account cultural considerations)
4. Establish and maintain a supervisory alliance
5. Gauge the supervisee's level of competence
6. Recognize and act on limitations in his/her own knowledge and experience

Watkins [21] identifies six fundamental areas of professional competencies of a supervisor:

1. Knowledge and understanding of various models, methods, and interventions of supervision
2. Knowledge and ability to address ethical and legal aspects
3. Knowledge and skills in managing the relationship within the framework of the supervisory process
4. Knowledge and skills in delivering judgment and evaluation
5. Knowledge and skills in creating a therapy environment marked by openness to differences and diversity of approaches
6. Ability to self-reflect and conduct an adequate self-assessment in the process of supervision

Given the diversity and complementary nature of these competencies within the framework of supervision, there is never a question of prioritizing or choosing between them at any given moment. Generally, they are all important in each case, and all are present in each supervision session. Therefore, the task at hand is rather to apply all competencies in proportions appropriate to each individual session of supervision with each supervisee.

This proportion determines whether the supervisor is more supportive, succeeds in forming the supervisory alliance and developing supervisory relationships; or whether he/she focuses more on certain aspects of the therapeutic situation; or whether he/she confronts the supervisee regarding the ethical considerations of his action. Thus, the distribution of competencies may depend on many factors: the individual characteristics of a patient; the needs of the supervisee, his/her personal characteristics, and professional experience; the stage of the supervisory relationship; the stage of a particular supervision session, etc.

Positive supervision is based on the concept of a person as a creature consisting of capacities and inclined to develop, and at the same time possessing some advantages and limitations, based on the cultural context, which provides an understanding of the social norm. This is a cross-cultural analysis of the so-called "actual capacities' [19]. One of the important concepts lies in an immanent feature of actual capacities, which is their propensity to develop.

Thus, looking ahead, it can be said that supervision in PPT in a broad sense implies not only rational comprehension of the therapeutic situation by its participants but also the development of their own actual capabilities, based on the needs of the supervisee and his/her patient within the therapeutic situation.

During the formation of professional supervision, its model and tasks, and the profession of supervisor itself, has been subjected to repeated revisions and development. However, the part that dealt with the relationship between the supervised and the supervisor has always been understood to be crucial in this professional activity during the last few decades of research and development of supervision [1].

According to the theory of PPT, primary actual capabilities, such as trust, acceptance (love), patience, hope, confidence, inner unity, etc., cannot be developed simply by thinking about them or by rational comprehension. These abilities can be developed only by means of example (modeling) in terms of real relations with a significant other. In this sense, the supervisee's lack of these primary capabilities is often the main cause of complications or even the impossibility of successfully working as a therapist.

At the same time, secondary actual capabilities, such as justice, diligence (achievement), accuracy, reliability, loyalty, punctuality, thriftiness, obedience, etc., being demonstrated by a supervisor, on the one hand reflecting the values and customary patterns of the supervisor him/herself, on the other hand forming certain situations of clarity, stability, and controllability of supervisory relationships, allow anxiety to be reduced, creating a secure environment of interaction.

These secondary capabilities can be developed within the supervision rather than through direct training by the supervisor, encouraging their manifestation, both during supervision and in therapeutic work. Although, in fairness, the supervisor providing an example of politeness, openness, punctuality, thrift, justice, etc., can also be useful for the end result.

In this sense, supervisory relationships are the necessary environment, the space where these capabilities are manifested by the supervisor in an appropriate measure and manner, when he trusts the supervisee, his opinion, impressions, conclusions; supports him in difficulties and confusion; encourages in his despair and inspires in helplessness; patiently endures the limitations of the supervisee and his inability to do something; draws the supervisee to his values and ethics; enables him/her to discover the meaning of what is happening in the therapeutic situation.

As the supervisee experiences such deep, sincere, and congruent interaction with the supervisor enables him/her to focus on his/her own ways to use the actual capabilities, and use them in their relationship with the patient in the same way the supervisor used them in the supervisory alliance. Thus, it is a process of not only rational deepening of the patient's understanding of the current therapeutic situation but also the emotional development of the supervisee through supervision.

Previously, opinions were expressed that supervisees often simply imitate the behavior of their supervisor and just say what the supervisor wants to hear [3].

However, experience suggests that such a state of affairs might be possible only during the initial period of forming supervisory alliance and is a manifestation of the supervisee's need for support from the supervisor. In future, the skills and experience of relations are internalized and become the supervisee's own ones, available for future professional development.

Therefore, even if during the early stages of the supervisory relationship, it is just imitation through the use of the same words, expressions or intonations, then over time, the actual capabilities behind these manifestations will develop, the simulated behaviors and internal values (concepts) are internalized, forming what was called the "internal supervisor" [18]. At this stage, the different aspects of the supervisor's behavior, attitudes, values being internalized, become an internal support for the more autonomous and independent work of the supervisee, developing his/her own therapeutic style.

Five Stages of Positive Psychotherapy in Supervision

There is a specific five-step strategy of professional actions in PPT that is used in supervision [11]. PPT is considered a semi-structured method, but supervision, as an important tool for the professional development of a supervisee, is a well-structured process, with clearly defined stages

and tasks facing the supervisor and supervisee at each of these stages.

Although the content of each of the successive stages may differ considerably from case to case, from supervisor to supervisor, however, the sequence of stages itself remains unchanged for all supervisors and each particular supervision, and looks like this:

- Stage 1 "Observation and distancing"
- Stage 2 "Making an inventory"
- Stage 3 "Situational encouragement"
- Stage 4 "Verbalization"
- Stage 5 "Broadening of goals"

Stage 1: "Observation and Distancing"

At the first stage, the supervisor provides space and time for the supervisee's spontaneous statement of the relative case, its formal aspects (duration, frequency), the content of the patient's difficulties, his experiences and the goals of psychotherapy, the supervisee's own experiences, in addition to the difficulties prompting him/her to bring this case to supervision. The supervisor during this stage encourages narrative, emotionally supporting the supervisee, observes his expression, experiences, builds hypotheses and conclusions, collects emerging questions, but refrains from bringing them up at this stage. At this stage, and at the next stage, the supervisor has a specific task stemming from the concept of personality and its development.

This task of the supervisor is to detect and identify certain aspects of the supervisee's behavior that seem to be valuable and useful in the therapeutic situation; successful interventions, interesting interpretations, in addition to actual capabilities shown by the supervisee in the therapeutic situation.

The important skill for the supervisor is to see the supervisee's successes and capacities, and accurately verbalize them, which is critical in PPT and must be developed to a large extent. Its importance is separately explained in the description of stage 3.

At this stage, the supervisor establishes what is called a "supervisory alliance," the importance of which cannot be overestimated, given that one of the supervisory goals is to provide the experience of being unsuccessful, to acknowledge mistakes and limitations. Thus, it is important to empathize with the supervisee, to support him/her emotionally, and to encourage his/her efforts from the first stage of supervision.

As supervision, like psychotherapy, is not always a comfortable process, it is important that the supervisor and supervisee establish a good learning alliance [20]. A learning alliance implies that both supervisor and supervisee are allies with a common goal. Indeed, in various studies it has been suggested that the supervisory alliance might be "at the heart of effective supervision" [5].

Usually, the first stage is completed when the supervisee has exhausted information for spontaneous presentation, and the supervisor clarifies the difficulties of the supervisee in the case and expectations from supervision.

The most frequent requests in the framework of supervision are concerned with the diverse needs of the supervisee:

1. To understand the nature of the difficulties of the therapeutic case
2. To better understand the patient, qualify him/her clinically (nature and level of disorders)
3. To understand the appropriateness of the therapeutic actions (interventions)
4. To see mistakes or wrong decisions and assess their consequences
5. To understand the dynamics of relationships, causes, nature, and content of conflicts unfolding in a relationship with the patient
6. To understand his/her own countertransference experiences that are causing difficulties in the case
7. To discover unconscious aspects of attitudes and behavior toward the patient
8. To express the feelings, including complex or "unacceptable" ones for the therapist, such as anger, fear, anxiety or panic, a feeling of helplessness or disappointment

9. To get support in a difficult internal situation caused by the complexity of the therapeutic case
10. To discover professional limitations and internal conflicts affecting efficiency in this particular case
11. To see the professional strengths and skills in the current situation
12. To identify external and internal resources of the patient and the therapeutic situation itself that he/she could rely on
13. To understand the future prospects and possible tactics of strategy within the framework of the case
14. To determine professional behavior in ethically challenging situations and potential legal complications, etc.

After clarifying the request, a verbal agreement is established regarding the purpose of the current session of supervision, which can also be described as entering into a supervisory contract.

Stage 2: "Doing the Inventory"

At this stage, the initiative shifts toward the supervisor, who by this time has sufficient information and is able to formulate questions. It is time to ask the questions to clarify all the aspects of the therapeutic case, based on the request of the supervisee.

Depending on the expectations and needs expressed by the supervisee, all components of the therapeutic and supervisory process can be investigated. In this sense, any part of the so-called seven-eyed model of supervision [6] can be the subject of research during supervision:

1. The patient's situation and content of the therapy session
2. Technical tools and interventions used by the supervisee during the course of therapy
3. Content and dynamics of the therapeutic relationship between the supervisee and his patient
4. The therapist's processes (countertransference and other subjective experience)
5. Supervisory relationship between the supervisee and the supervisor.
6. The supervisor's processes (e.g., countertransference of the supervisor to the supervisee and the situation in therapy)
7. The environmental aspect (a wider transcultural context of the situation)

Whatever the request of the supervisee, factors directly related to the analysis of the patient and his situation are always dealt with, such as: the patient's balance model, identifying of actual conflict and its dynamics, its content in terms of actual capabilities, areas and ways preferred by the patient to handle the conflicts, basic conflict, its content and connection with the actual situation, family concepts and their origins, and the other concepts of the differential analytical part of PPT.

This stage requires from the supervisor sufficient openness and directness to ask all the necessary questions and clarify all aspects of the therapeutic situation, to define contents, history, dynamics and possibilities using the capacity to translate the emotional feelings of transference and countertransference into conflict contents, capacities, and relationship patterns [14].

The ability of the supervisor to adequately resolve his own "key conflict," that is, to maintain balance between directness and courtesy, the need to ask "tactless" questions while carefully considering the supervisee's capacity to endure confrontation, is crucial at this stage.

By the end of this stage, the supervisor should collect enough information and conceptualization to meet the request of the supervisee, whichever part of the complex supervision system it is concerned with.

Stage 3: "Situational Encouragement"

The stage of situational encouragement is unique because of its isolation in a separate part of supervision, as it relates to the important tasks facing the supervisor.

We have to admit that generally, the supervisee is not expected to feel comfortable during supervision. Rather, he is in a rather vulnerable position, as the supervision has traditionally been imposed on difficult therapeutic cases, causing the supervisee to have the most internal conflicts and difficulties that he/she may not be proud of. Having to ask for help from a supervisor does not make the supervisee feel successful and confident; on the contrary, he/she feels confused and second-guesses his or her actions, abilities or further work tactics. This contributes to additional self-criticism.

Such a state of affairs never helps either rationally to analyze a complex therapeutic situation, or to encourage professional curiosity and the creative process; thus, one of the main tasks at this stage is to inspire the supervisee. The supervisor should focus primarily on the supervisee's achievements and successes, and not on his/her mistakes and blunders.

At this stage, the supervisor devotes enough time to analyzing what in his/her opinion was done by the supervisee correctly and successfully. The supervisor honestly and sincerely shares what he noticed during two previous stages regarding the actual capabilities, manifestations of the supervisee both in his/her work in relation to the patient and the therapeutic situation, and during the presentation of the case within the supervision session. The supervisor must be able to point out aspects of the supervisee–patient relationship that were useful, any successful interventions, capabilities, and traits of the supervisee that have proved effective; skills and competencies that are sufficiently developed: anything that resulted in professional respect, approval or even admiration from the supervisor. At this stage, it is especially noticeable that an experienced supervisor offers horizontal relationships instead of vertical, hierarchical ones, as this is what makes the supervisee more confident, allowing him/her to learn a respectful attitude toward him/herself and the patient.

It is very important that the supervisor has the skill of situational encouragement, because everything that will be pronounced must be part of objective reality, and it is very important to avoid baseless praise. The balanced opinion expressed by the supervisor should be the result of focusing on positive aspects during the previous two stages, the ability to argue their impressions of the strengths and behavior of the supervisee. This should not turn into merely an "emotional bribe" or flattery of the supervisee. At this stage, the supervisee has a substantial amount of information confirming what has been done correctly and successfully. The supervisor draws on the strengths of the situation, on the external resources of the therapeutic situation on which the supervisee can rely in his/her work, in addition to his/her internal competencies.

The result of this stage is a more level attitude to what is happening in therapy, a sense of relief, reduction of anxiety, guilt, and hopelessness in the supervisee, a sense of hope and inspiration regarding the therapeutic reality, and their own capabilities and actions. Over time, by regularly participating in supervision, and observing such behavior in the supervisor, the supervisee learns to be more impartial toward him/herself, focus on his/her strengths, see his/her skills, build on them, readily acknowledge achievements and successes, thus developing a more conscious and holistic understanding and acceptance of himself as a psychotherapist.

Moreover, one has to admit that the difficulties of those who are supervised in a therapeutic situation are often associated with a deficit of primary actual abilities, such as hope, acceptance, trust, patience, etc. The part of the relationship exhibited by the supervisor toward the supervisee, especially at this stage, is absorbed and reproduced later on in the therapeutic situation in relation to patients. This is only possible if the supervisor does not simply suggest how the supervisee should behave in the therapeutic situation, but the supervisor manifests all these primary actual capabilities in the living field of human relations with the supervisee within the framework of supervision.

To be fair, we have to admit that quite a few cultures do not develop the skill of attentiveness to success and healthy aspects, and this competence is sometimes difficult not only for

supervisees but also for supervisors. Therefore, the development of this competence in supervisor training in PPT is given special attention.

Fundamental to this approach is the focus on the supervisor, demonstrating his actual capabilities as they relate to various emotions and behaviors in the process of supervision. In this sense, the supervisor always creates the conditions for the supervisee to develop his/her current capabilities and identifies the areas of development of the supervisee. To develop "actual capabilities," the supervisor has to identify those already developed and those in need of developing; he/she has to cease opportunities and create conditions under which such development can occur. Successful development in this area is primarily conditioned on the relationship of support and acceptance, respect and recognition of merits, which is the primary objective at the stage of situational encouragement.

The self-disclosure of a supervisee is a rather common and accepted part of the effective supervisory relationship, which enables the supervisee to gain new knowledge within clinical supervision [17]. However, self-disclosure of the supervisor at this stage, when he/she shares his/her experience of difficulties, failures or success, in addition to how he/she experiences a relationship with the supervisee, allows him/her to create warmer and more trusting relations within the supervisory alliance [7].

Different styles of relationships from their supervisees notwithstanding, all supervisors establish and develop a supervisory relationship.

One of the studies conducted by group of researchers [4] found that the work of therapists was evaluated differently by their supervisors and by independent judges. All supervisors in three modalities, chosen by the researchers, rated their supervisee higher than independent judges. This is interesting, as the explanations ranged from the supervisors' excessive loyalty to their supervisees to their greater professional immersion in the context of therapeutic situations and their understanding of the situation of supervisors. However, perhaps one of the probable reasons is that supervisors could see the dynamics that distinguished the current work of the supervisee from his previous work, and could see the prospects for its development, thus referring to the supervisee, as though he or she had already become more experienced. There is a possibility that this is an unconscious mechanism of inspiration for supervisees, when their supervisors assess them in terms of development, admitting advances for success, which they will only achieve in the future. Perhaps this is precisely what is really needed to inspire the supervisees, to revive their optimism, allowing them to mobilize their strength to work and develop consistently. In this sense, one of the important functions of the supervisor is to see potential. Supervisors should take pains to discern it as part of their routine supervisory duties.

When the participants in supervision understand what strengths and resources of both the patient and the supervisee are, in addition to assessing the therapeutic situation in its entirety, only then do they proceed to the next stage.

Stage 4: "Verbalization"

This is the stage where a more comprehensive discussion of what is happening during therapy takes place. The supervisor shares his/her observations, hypotheses, and conclusions based on the request of the supervisee and his own vision of the situation. The ability of the supervisee to confront with the experience of his own mistakes and limitations becomes emotionally accessible because of the well-conducted previous stage, when anxiety and a sense of insecurity are reduced.

At this stage, a significant role is assigned to the supervisor, who, during the previous stages had the opportunity to observe what was happening in the therapeutic situation, and now can express his observations. The supervisor must not only conceptualize but also clearly verbalize his conclusions and observations. The supervisor has to be open enough so that, avoiding any criticism, he/she can nevertheless tell the supervisee what was done in vain or was lost.

At the stage of verbalization, the supervisor has the opportunity to share his countertransference

experiences during supervision, which is very useful for illustrating and explaining what is happening in the therapeutic situation with the patient. In this sense, the generally accepted concept of parallel processes, when it is believed that dynamics in a supervisory alliance often mirror dynamics in a therapeutic relationship, is very useful.

The supervisor is expected not only to share his vision of the situation and difficulties of the supervisee but also to provide the supervisee with space to actively participate in creating new concepts and drawing conclusions from the supervisory work. Very often, if the work is done correctly, the supervisee manages to see what he/she had not seen before. Therefore, at this stage, there is usually joint work, when the supervisor and the supervisee together create a more holistic and comprehensive vision of the therapeutic situation that has become the subject of the supervisory research.

By the end of this stage, the interest of the supervisee regarding the causes and nature of the difficulties presented for supervision is generally addressed, but the question of strategy and tactical actions that are needed in the future remains. This task constitutes the final stage of supervision.

Stage 5: "Broadening of Goals"

This is the stage when it becomes clearer what is happening in the therapeutic situation, and the supervisor and the supervisee develop a plan for further therapeutic actions, or at least outline the vector of further development of the therapeutic situation.

In addition to meeting the needs of the supervisee, it is important for the supervisor in his/her feedback to expand on ideas about what is happening not only in the area of interest stated by the supervisee but also in those areas that could escape the supervisee's view. The ability to see areas of development in the presented therapeutic situation, and in the supervisee himself, as a professional, is one of the important skills of the supervisor in PPT [11].

As the goals and objectives of supervision differ from the goals of therapy, those findings that relate to personal material of the psychotherapist arising during supervision and affecting professional behavior are usually indicated, but not worked through. They are recommended for research outside of supervision within the framework of personal therapy.

Transcultural Approach in Supervision

One of the important competencies of the supervisor is the transcultural approach, the primary objectives of which are understanding and accepting similarities and differences between the cultures of all participants in supervision: the supervisor, the supervisee, and the patient.

Despite the idea that cultural sensitivity is a competence that requires a person to be willing to address issues of race and ethnicity [8], in PPT the transcultural approach can be considered in a wider context as the capability to see the unique individuality and resources of patients and, in the case of supervision, the supervisee, within their specific social and cultural environment in three dimensions:

1. Comprehensive dimension implies similarities and differences in the widest context at the level of different continents, countries, and states, and not just national cultures. Accordingly, at this level, differences will encompass the largest spectrum of human life, relationships, and traditions.
2. Transcultural approach in a broad sense implies similarities and differences at the level of one country, but different ethnic groups (for example, despite a single citizenship, currency, constitution, and laws, Russia is populated by representatives of 194 separate ethnic groups), and each of them may be a carrier of its own—sometimes very different and even opposing—habits and traditions.
3. In a narrower sense, the transcultural approach allows similarities and differences to be found, even if individuals belong to the same

culture, speak the same language, were brought up in the same city, or even grew up in the same apartment building. In this case, significant differences can be found in ideas about how to build relationships in the family, what values are fundamental to life, what is the value of an individual, etc., because these aspects vary considerably even in the same society from one family to another. Therefore, in this case, the carrier of similarities and differences is the parent family, as the narrator and carrier of family culture.

In this context, the transcultural approach implies the ability of the supervisor to proceed not based on their own cultural values and experience, but based on values and traditions of the culture of the supervisee and the culture in which he/she operates.

This should not be seen as a supervisor's denouncing of his/her own culture, which should be well understood and accepted, but it should be understood and experienced as his/her culture, rather than one that is superior just because he/she was brought up within this culture.

This does not mean giving up one's own culture, its values, and traditions. On the contrary, it has to be well understood, supported, and developed by the supervisor.

Here, the supervisor is required to understand his/her culture, precisely as being relatively valuable, with the recognition of the same value of the culture of the supervisee and his/her patient. The supervisor's ability to move away from the values of his/her own culture for the sake of understanding and supporting the supervisee or patient is one of the important competences, in addition to his ability to estimate the limit of difference that can be tolerated and accepted without deceiving himself and the supervisee. The transcultural approach implies the ability to get out of their usual cultural point of view to understand and share the cultural point of view of another, in this case, the supervisor or his/her patient.

Vignette

During supervision, the supervisor talks about the difficulties in family therapy of a married couple (Japanese and Russian), where, during the study of family conflict, it turned out that the trigger for a serious trial, including family therapy, was the discovery that the Japanese husband, with enviable regularity for many months, had been attending the so-called "*pinsaro*" (pink salon, blow-job bar), while engaging in sex with his wife quite infrequently. For the supervisee, the main difficulty in dealing with the family situation was the fact that neither spouse particularly focused on this circumstance, regarding it as an annoying misunderstanding. Their major difficulty in marriage was the lack of time spent together and attention given to one another. In countertransference, the supervisee had many experiences, including aggression, associated with the complete rejection of such behavior of her husband in marriage and an inability to imagine that this could really hurt partners so little. The supervisor rather regarded such lack of interest and reactions at this moment as the result of psychological defense mechanisms on the part of both partners. Anger and intense aggression made it difficult to focus on other aspects of the conflict and the family situation as a whole. There was a suspicion that patients either demonstrated resistance or intentionally misled the therapist, which seriously impeded the development of a therapeutic alliance.

In the course of supervision, the supervisee was given the task of studying the traditions of sexuality in Japanese family culture in general from a transcultural point of view, and further, the place reserved for the *pinsaro* in particular.

After conducting this research, the supervisee learned that this behavior is not only legal, but that it is only occasionally frowned upon under certain conditions, i.e., it is considered conditionally undesirable, and therefore, easily dismissed by all participants in a family conflict. Thus, the supervisee had to expand his/her ideas about the conditional norm in sexual and family behavior, which was fundamentally different from his/her own culture. In the end, he/she managed to separate the traditions of family culture (in full disclosure, it should be noted, after several sessions of personal therapy) so that he/she was able to focus on other aspects of family relationships presented by the family, and to help this couple.

To become more transculturally educated, the supervisor needs to study his/her own limitations, expand his/her transcultural experience, and resist the tendency to narrow down the type of preferred patients or the nature of their difficulties, limiting them only to Christians, women who have suffered violence, representatives of only one ethnic group, race or profession, etc. On the one hand, the higher the level of transcultural differences, the more difficult to understand, accept, and share the traditions of another person, the more emotional reactions they cause in a specialist. On the other hand, the more transcultural experience working with professionals from diverse cultural backgrounds the supervisor has, the easier it is for him/her to accept the relative value of his/her own cultural traditions and, therefore, to accept diversity in its many dimensions.

That is why, in the spirit of constant apprenticeship, curiosity, and openness, the supervisor should be able to interest and captivate the supervisee with other cultures and traditions, regardless of their transcultural differences. As a result, the more the supervisee studies the various traits leading him/her to love another culture, the more he/she learns to understand and respect its traditions and genuinely accept its differences from his/her own culture and traditions. Thus, a transculturally educated supervisor is one who has experience dealing with representatives of different cultures, who recognizes their equality and value, and knows how to deal with cultural similarities and differences.

The Use of Metaphors and Humor in Supervision

As the founder of positive psychotherapy Nossrat Peseschkian was Persian by origin and in the culture in which he was brought up, one of the therapeutic elements of the method is the use of metaphors, which were initially Persian parables. Having reached the age of 21, moving from Eastern to Western culture, finding the use of primarily rational thinking, and ignoring the power of imagination and fantasy, Peseschkian conceptually developed the idea of using metaphors in psychotherapy, which are now actively used in supervision. Over time, the list of therapeutic parables increased, the functions of metaphors were described in more detail [10–12], and the methods of metaphorical utterance became more diverse.

The main idea of using metaphors is to move away from habitual rational thinking to activate the supervisee's imagination, give him/her the opportunity to go beyond the usual view of what is happening, evoke more emotions, activate creative thinking, change and expand perspectives. All this can be very useful in the case of supervision, when the supervisee feels confused, frustrated, and helpless. The use of metaphors provides an expanded view of the therapeutic situation, the behavior of the patient or therapist, can help to see what is happening under a different, sometimes unexpected for the supervisee, angle, provides alternative ways of relating to a behavior in the therapeutic situation, reflects certain aspects of the supervisee's behavior that elude him, etc. The beauty of using metaphors in supervision also lies in the fact that, owing to their humor and paradox, they strip complex situations of perceived drama and hopelessness, the exaggeration of finality of the ending. It removes the supervisee's perception of his difficulties, helplessness, disappointment, etc., as being unique, and brings faith in his ability to resolve the issue.

The supervisor can use as metaphors not only parables, whether oriental, Buddhist or others but also experiences from his/her own life, his/her own experience as a therapist, cases of other supervisions, episodes from movies, TV shows, books, anecdotes, etc. It is even better if the supervisee can find his/her own metaphors applicable to the therapeutic situation or its various aspects. As one of the functions of metaphors, because of their emotional charge, is the storage of personal experience, it is then easier for the supervisee and the supervisor, in the event of continued collaboration, to access previous findings and conclusions, containing them in one or other metaphoric form.

In addition, the experience of supervision, gradually filled with its own metaphors, which have a very specific and personal meaning, known only to the two participants in the supervision, becomes the product of their interaction and helps to create that unique alliance that is necessary for effective supervision. As with all the tools of PPT, the supervisor should have not only the ability to design useful metaphors but also to use them in moderation, based on their adequacy for a particular therapeutic case, the nature of the experience of the supervisee, the relationship stage, etc. However, to paraphrase Peseschkian's words about the importance and usefulness of humor in a therapy session, I would say: a supervisory session where a supervisee has not laughed at least once is a session wasted.

Group Supervision

Since the supervisory process is well structured, it lends itself well to group supervision as it provides practical benefits and a didactic effect. Among the many formats of group supervision in PPT, the most common one focuses on one case during a session with one supervisee, and all the rest of the group being participants, including the supervisor, who help the supervisee to deal with difficulties of the case. In a sense, the supervisor makes the other participants his co-supervisors, enabling the supervisee's view on the case to be enriched with other perspectives and the additional views of all the participants of the group.

In group supervision, the tasks and sequence of actions of all participants are very similar. However, the supervisor must be mindful that in the context of group work, where the supervisee is the object of observation and discussion, the supervisee is more vulnerable to criticism and judgement, primarily from the most influential participant—the supervisor—in addition to the other members of the group. They do not simply observe the supervisor in action, but also actively participate, responding to the encouragement of the supervisor to emulate his actions. Each stage, strictly outlined, has its own clear objectives. The overall objective of the supervisor and the group is to create conditions for the supervisee to feel so comfortable that he/she can be open to both emotional and intellectual experiences, without the need to defend him/herself, which results in getting the most out of the supervisory process. In fact, the characteristic sign of group supervisions going well is when participants come again and again and try to get their case selected for group supervision. The group supervisor must be attentive to his/her countertransference reactions and derived behavior, because, based on many years of observations, it is the behavior of the supervisor, not his/her words and didactic introductions, that determine what other participants learn. The more supportive the supervisor, the more the group supports the supervisee, and vice versa: the more critical the supervisor, the more likely the other participants are to focus on the mistakes and oversights of the supervisee and express criticism.

Most modern research in the field of supervision end with the words that we do not yet have sufficient evidence of the effectiveness of supervision on the patient's outcome [20, 22]. In this regard, we have to use this format of professional activity so far, relying only on empirical experience and our own, albeit subjective, assessment of its value, just as we continue to participate in supervision and develop it after its effectiveness has been proven scientifically.

To concur with Arno Remmers [15] about the identity of the positive psychotherapist, I could repeat his words about being a positive supervisor:

> I see myself as a learning human being in interaction with my supervisee, and my duty as a positive supervisor today is to prepare myself and my supervisee for the world of tomorrow by using a positive resource-orientated approach to resolve the conflicts we face and will face tomorrow.

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Spirituality and Religion in Positive Psychiatry and Psychology

Mark Famador, Shridhar Sharma, and Rama Rao Gogineni

Introduction

The primary objective of this chapter is to clarify the concept that spirituality is the basis of positive psychology. The second objective is to show that religion and spirituality are not two mutually exclusive terms. Religion and spirituality have a positive correlation to psychological well-being. However, there has been a great deal of confusion over their operational definitions, concepts, and dimensions. Religion is about helping us to deal with sorrow that we see in life and helping us to see meaning in life and to live in relation to the transcendence. It helps to promote both inner and outer peace, harmony, and morality in both individuals and humankind. Spirituality operates at a higher level. It is concerned with the soul and is directed toward the pursuit of personal meanings and reflects positive emotions; while positive psychology is that part of psychology that takes on the task of deciphering the mechanisms and the opportunity of nourishing positivity in life. How this has evolved in human history is both an interesting and a fascinating journey [1].

There have been philosophers who contributed to the idea of an "ultimate reality" as a unique and *the* central idea in both religion and spirituality. The French intellectual, philosopher, and playwright Gabriel Marcel (1889–1973), a noted opponent of atheistic existential philosophy (the latter approach recognized for its view that life's experiences and interactions are meaningless), struggled with the concept of God. From the beginning of his career, Marcel's writings on religious belief are one of his most profound contributions to philosophy. His main interest has been the interpretation of religious experience, that is, of the "relation between man and ultimate reality" (Internet Encyclopedia of Philosophy). Another aspect of the concept of positive psychology and dimensions of religion and spirituality will be explored in the context of the life of a medieval saint, Ignatius of Loyola.

Until the early nineteenth century, psychiatry and religion were closely connected. Religious institutions were responsible for the care of the mentally ill. A major change occurred when Charcot and his pupil Freud associated religion with hysteria and neurosis. Albert Ellis in 1980 wrote that there was an irrefutable causal relationship between religion and emotional and mental illness. At its most extreme, all religious experience has been labeled as psychosis. All these created a divide between religion and mental health care, which has continued until

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recently. But (thank God), in 1994, "religious or spiritual problems" were introduced in *DSM-IV* as a new diagnostic category that invited professionals to respect the patient's beliefs and rituals.

Definitions and Concepts

Religion and spirituality have a positive correlation to psychological well-being. However, there has been a great deal of confusion over their operational definitions, concepts, and dimensions. Religion is about helping us to deal with sorrow that we see in life and helping us to see meaning in life and to live in relation to that transcendence. Religion helps to promote both inner and outer peace, harmony and morality in both individuals and humankind.

Spirituality operates at a higher level. It is concerned with soul and is directed toward the pursuit of personal meanings and reflects positive emotions, while positive psychology is that part of psychology that takes on the task of deciphering the mechanisms and the opportunity of nourishing positivity in life. How this has evolved in human history is both an interesting and a fascinating journey [1]. Spirituality usually refers to a dimension of human experience related to the transcendent, to the sacred, or to the ultimate reality. It is closely related to values, meaning, and purpose in life. Spirituality may develop individually or in communities and traditions.

Religion is often seen as the institutional aspect of spirituality, usually defined more in terms of systems of beliefs and practices related to the sacred or divine, as held by a community or social group (Koenig H, King D, and Carson VB). The act of believing in an "ultimate reality" appears to be a unique and central idea in both religion and spirituality. The French intellectual, philosopher, and playwright Gabriel Marcel (1889–1973) is a noted opponent of atheistic existential philosophy (the latter approach recognized for its view that life's experiences and interactions are meaningless). Marcel's philosophical writings on religious belief are one of his most profound contributions to philosophy. Marcel's main interest has been the interpretation of religious experience, that is, of the "relation between man and ultimate reality" (Internet Encyclopedia of Philosophy). Regardless of precise definitions, spirituality and religion are concerned with core beliefs, values, and experiences of human beings. It is my hope that in the discussion of the concept of positive psychology in the context of the life of a medieval saint, Ignatius of Loyola, these concepts and dimensions of religion and spirituality will become more clearly understood.

Positive psychology is based on a particular model of the individual that was developed in the popular culture of the United States from the end of the eighteenth century. This model, which we have called "positive" individualism, started with Emerson's transcendentalism by defending, against puritanism, that the individual, as a part of divinity, is an essence capable of self-command, self-exploration, and endless self-development. Current positive psychology moves away from the most striking metaphysical aspects of "positive" individualism, but maintains its historical, asocial, and subjectivist conception of the individual. Religion and spirituality have a positive correlation to psychological well-being [1]. For our purposes, well-being is defined here as an optimal experience of life.

Positive psychology embraces the whole person, one's strengths and weaknesses, as the cliché goes: "Warts and all." In a sense, it is living life to the fullest to the measure that one can. In the words of Christopher Peterson (2009), positive psychology is the scientific psychology of what makes life most worth living [3]. Viktor Frankl, founder of logotherapy, a form of existential analysis, tried to grapple with the meaning of life amidst the uncertainty of surviving through the concentration camps during the holocaust. He tried to share his own struggle to find meaning, fulfillment, and happiness in the face of suffering in his best-selling book, *Man's Search for Meaning* [8]. Philosophers from ancient Greek to modern ones have grappled with the basic question: "Who am I?" Socrates espoused: "The unexamined life is not worth living." Aristotle, philosopher and pupil of Plato, emphasized the

importance of developing excellence or virtue of character to achieve. The highest aims are that of living well and *eudaimonia* (a Greek word often translated as well-being), happiness or "human flourishing," or doing well in this life. Eudaimonia here is defined as "an activity of the soul in accordance with *arete*." *Arete* ("excellence" in Greek) here is defined as a distinct wisdom or knowledge achieved through repetition, doing, or practice. Virtue here is moral virtue, or excellence of character, the disposition (Greek *hexis*) to act excellently, which a person develops partly as a result of upbringing and partly as a result of a habit of action [8].

In short, positive psychology seeks to make people happy by making life meaningful. Adopting the thought process of the ancient Greek philosophers, a meaningful life is characterized as living a virtuous life. More so, this virtuous life is partly a result of one's developmental experiences starting from family onward and partly (I would argue) a result of constant repetition and practice. Positive psychology is an "inner discipline," in search of realizing the truth about the self and the full potential of the human being. The goal is to find one's true, authentic self through a special kind of consciousness, meditative, or prayerful state. It is an activity not only of the brain but more of the mind, where there is an intuitive kind of knowledge born out of successive trials and errors where one discovers *one's disordered attachments* in order to freely pursue the path in life that will lead to fullness and happiness [2].

Furthermore, positive psychology is a dynamic process that must lead to further self-realization and service to others. It is a knowing that leads to being (K. Ramakrishna Rao) [9]. It is not monolithic but universal in that it has the potential to inspire whole cultures to achieve their better selves. The idea of "the better self" is not relative but can be generalized for all human beings. In order to nurture individual talent and make life more fulfilling, positive psychology focuses on three areas of human experience (as described by Seligman 2000). These three areas will help define the scope and orientation of a positive psychology perspective.

At the subjective level, positive psychology looks at positive subjective states or positive emotions such as happiness, joy, satisfaction with life, relaxation, love, intimacy, and contentment.

At the individual level, positive psychology focuses on a study of individual traits or the more enduring and persistent behavior patterns seen in people over time. This study might include individual traits such as courage, persistence, honesty, or wisdom. That is, positive psychology includes the study of positive behaviors and traits that historically have been used to define "character strengths" or virtues.

Last, at the group or societal level, positive psychology focuses on the development, creation, and maintenance of positive institutions. In this area, positive psychology addresses issues such as the development of civic virtues, the creation of healthy families and communities, and the study of healthy work environments and positive communities. Martin Seligman and Mihaly Csikszentmihalyi (2000) described positive psychology as "psychology of positive human functions, which helps to build thriving individuals and communities" [9]. Another concept extensively researched in positive psychology is "flow." Csikszentmhilayi (1990) has written extensively on "flow." Flow is the "state in which people are so involved in an activity that nothing else seems to matter; the experience is so enjoyable that people do it even at great cost, for the sheer sake of doing it"[9]. Csikszentmihalyi derived the concept of flow and its characteristics by studying a "few hundred 'experts,' – artists, athletes, musicians, chess masters, and surgeons." Later, his team of researchers and "colleagues around the world" interviewed thousands from different walks of life belonging to different cultures and age groups. They also tried to measure the quality of subjective human experience, the so-called subjective well-being.

The paper describes the surveys of religion and spirituality in our society, definitions of spirituality and religion, positive psychology and positive psychiatry. The paper then describes the connections of these surveys and definitions from various philosophical, religious, and theological perspectives. Finally, the write-up describes *Ignatian*

spirituality to highlight the subject of the paper in detail before making the concluding remarks.

Some Positive Statistics and Philosophical Explanations

Plato said that man is not only conscious, but he is "conscious of his consciousness." Scientists believe consciousness and thought are entirely physical products of our brain and are created by the electrical and chemical changes in the neurons in our brains. While philosophers who believe in spirituality claim that spirituality is concerned with soul and it is directed for the pursuit of "personal meaning." It has been suggested that there is a difference between spirituality and religion. There exists however, an intimate relationship between spirituality, religion, and mental health. Science gets us physical comforts; spirituality brings us mental peace and raises our consciousness. Positive values, attitudes, beliefs, and strengths acquired through spiritual practices contribute to the sense of bliss. But spirituality is not just about following our bliss alone. Spirituality has a deep psychobiological basis and a reality that needs to be understood. The pleasure we derive is through our senses and is basically physical. While happiness, which is a positive emotion, is psychological. "Bliss" which is higher than "Pleasure" and "Happiness," is spiritual. This hierarchy of positive emotions will help us to clarify the concept of spirituality and its proximity with mental health [1].

Various spiritual traditions indicate that the nature of mind, consciousness, and reality as well as the meaning of life can be apprehended through an intuitive, unifying, and experiential form of knowing [1, 8]. A scientific frame of reference must address the evidence for that. Such a framework would greatly stimulate the scientific investigation of the neural, physiological, psychological, and social conditions favoring the occurrence of mystic experiences as well as the effects of such spiritual practices on health, psychological wellbeing and social functioning. There is a newer trend in human evolution toward spiritualization of consciousness. The proposed new scientific frame of reference may accelerate our understanding of this process of spiritualization and significantly contribute to the emergence of a planetary type of consciousness. The development of this type of consciousness is absolutely essential if humanity is to successfully solve the global crises that confront it and wisely create a future that benefits all humans and all forms of life on planet Earth.

At the beginning of May 2005, Gallup asked Americans to rate how important religion is in their lives. Of those surveyed, 55% rated religion as very important, and 28% rated religion as important. Only 16% stated that religion was not important at all. (These statistics are from Gallup.com.) Peterson and Seligman (2004) observed that spirituality is universal: "Although the specific content of spiritual beliefs varies, all cultures have a concept of an ultimate, transcendent, sacred, and divine force" (p. 601). If a belief in the transcendent is so much a part of the human experience, isn't it curious that research on spirituality and religion is so under-represented in the field? One explanation may be that the concept of spirituality doesn't fit neatly into our current research molds. ("Can you please rate on this 7-point scale how much the Spirit moved you today?") Even mapping the conceptual distinctions between what we refer to as "religion" and what we refer to as "spirituality" can be difficult. In their chapter on spirituality in the *Handbook of Positive Psychology*, Pargament and Mahoney (2002) make the distinction as follows:

> We prefer to use the term religion in its classic sense as a broad individual and institutional domain that serves a variety of purposes, secular as well as sacred. Spirituality represents the key and unique function of religion. In this chapter, spirituality is defined as a search for the sacred.....People can take a virtually limitless number of pathways in their attempts to discover and conserve the sacred.....Pathways involve systems of belief that include those of traditional organized religions (e.g. Protestant, Roman Catholic, Jewish, Hindu, Buddhist, Muslim), newer spirituality movements (e.g. feminist, goddess, ecological, spiritualities) and more individualized worldviews.

The Pew Research Forum on Religion and Public Life (2008) [24] found the following:

1. More than nine in ten Americans (92%) believe in the existence of God or a universal spirit.

2. Sixty-three percent of American women and 44% of American men say that religion is very important to their lives.
3. Americans are nearly unanimous in saying they believe in God (92%), and large majorities believe in life after death (74%) and believe that scripture is the word of God (63%).
4. Most Americans (54%) say they attend religious services fairly regularly (at least once or twice per month), with about four in ten (39%) saying they attend worship services every week.
5. Americans also engage in a wide variety of private devotional activities. Nearly six in ten (58%), for instance, say they pray every day.
6. People who are not affiliated with a particular religious tradition do not necessarily lack religious beliefs or practices. In fact, a large portion (41%) of the unaffiliated population says religion is at least somewhat important in their lives, seven in ten say they believe in God, and more than a quarter (27%) say they attend religious services at least a few times a year (Pew Research).

Religious Orientation or Style of Coping

Gordon Allport, the famous personality theorist, made the distinction between intrinsic and extrinsic religious orientation. In other words, an extrinsically oriented person seeks out religion because it provides comfort and security; however, he or she would also be motivated by guilt or external sources of pressure (family, social pressure, etc.). In contrast, an intrinsically oriented person is motivated more by faith and a search for meaning and purpose in life. Some evidence suggests that individuals with an intrinsic orientation are better able to cope with stressful life events since this orientation leads them to find meaning in what has happened. Other researchers highlight how differences in one's religious/spiritual problem-solving style can affect our ability to cope with adversity. Four styles have been identified [25]:

1. A collaborative style – Individuals with this style see themselves as working with God to deal with the problem at hand.
2. A deferring style – Individuals with this style are more passive. They wait for God to handle the situation.
3. A self-directing style – Individuals with this style are calling the shots. Though they may believe in a higher power, they rely on themselves to solve/handle any problems.
4. A surrendering style – Individuals make a conscious decision to relinquish those aspects of the situation that are truly beyond their control.

The collaborative style seems to be adaptive in a wide range of situations in that individuals tend to feel empowered (with God on their side) and motivated to do what they can to improve the situation. The self-directing style is also generally effective, largely because people tend to fare better when they perceive a situation as controllable. The noteworthy exception to this is when the situation is extreme and (by objective standards) largely uncontrollable. In extreme, uncontrollable situations like the death of a family member, the surrendering and deferring styles are often the most adaptive. When nothing can be done to prevent or undo the event, surrendering control provides an overwhelmed person with relief.

Spiritual Explanations of Positive Psychology

Deepak Chopra, M.D., is a best-selling author, teacher, and founder of the Chopra Center for Wellbeing. In his book *Nine Keys to Lasting Happiness*, he writes *according to the ancient philosophy of the Vedanta, there are two types of happiness. The first comes from things turning out the way we'd like them to,* i.e.*, getting what we want. We say, "I'm happy because. .. because I have family and friends, because I got a promotion, because I have money and security." This kind of happiness is inherently fleeting because it depends on external reasons that can be taken away from us at any time. The second type of hap-*

piness, in contrast, is a state of being, not something we do or achieve. It isn't dependent upon our mood or outer circumstances. Real happiness comes from having an unassailable connection to the deep state of unbounded awareness at our core. This state of being is our own inner joy that expresses the exuberance and wonder of being alive at this moment; it is our own self-luminous essence made conscious of itself.

The nine keys to lasting happiness are:

1. Listen to your body's wisdom, which expresses itself through signals of comfort and discomfort.
2. Live in the present, for it is the only moment you have. Don't struggle against the infinite scheme of things; instead, be at one with it.
3. Relinquish your need for external approval. There is great freedom in this realization.
4. When you find yourself reacting with anger or opposition to any person or circumstance, realize that you are only struggling with yourself. When you relinquish this anger, you will be healing yourself and cooperating with the flow of the universe.
5. Know that the world "out there" reflects your reality "in here." The people you react to most strongly, whether with love or hate, are projections of your inner world.
6. Shed the burden of judgment – you will feel much lighter. Remember that every person you forgive adds to your self-love.
7. Support your body and mind by giving it the most nourishing food, experiences, and environment. Your body is more than a life-support system. It is the vehicle that will carry you on the journey of your evolution. Don't contaminate your body with toxins, either through food, drink, or toxic emotions.
8. Replace fear-motivated behavior with love-motivated behavior. Fear is the product of memory, which dwells in the past.
9. Understand that the physical world is just a mirror of a deeper intelligence. Intelligence is the invisible organizer of all matter and energy, and since a portion of this intelligence resides in you, you share in the organizing power of the cosmos. Living in balance and purity is the highest good for you and the Earth.

Neural Basis

Happiness, pursuing that which we enjoy, appears to be neuroscience based as written by Drs. Higgins and George in their book, *The Neuroscience of Clinical Psychiatry: The Pathophysiology of Behavior and Mental Illness.* [15]. Happiness is hardwired and closely fluctuates around a genetic "set point." In the context of positive psychology, a meaningful life goes beyond the simple pursuit of pleasure from a biological perspective. We humans have what is called hedonistic hot spots (e.g., in the orbitofrontal cortex, the amygdala, and the ventral pallidum). "Meaningful" incorporates the whole function of the brain. Neuroimaging studies have shown that meditation results in an activation of the prefrontal cortex, an activation of the thalamus and the inhibitory thalamic reticular nucleus, and a resultant functional deafferentation of the parietal lobe. The neurochemical change as a result of meditative practices involves all the major neurotransmitter systems. The neurotransmitter changes contribute to the amelioration of anxiety and depressive symptomatology and in part explain the psychotogenic property of meditation. This overview highlights the involvement of multiple neural structures and the neurophysiological and neurochemical alterations observed in meditative practices (Mohandas). Compared to the study of negative emotions such as fear, the neurobiology of positive emotional processes and the associated positive affect (PA) states have only recently received scientific attention. Biological theories conceptualize PA as being related to (i) signals indicating that bodies are returning to equilibrium among those studying homeostasis, (ii) utility estimation among those favoring neuroeconomic views, and (iii) approach and other instinctual behaviors among those cultivating neuroethological perspectives. Indeed, there are probably several distinct forms of positive affect, but all are closely related to ancient sub-neocortical limbic brain regions we share with other mammals. There is now a convergence of evidence to suggest that various regions of the limbic system, including especially ventral striatal dopamine systems, are implemented in an anticipatory (appetitive) positive affective state.

Dopamine-independent mechanisms utilizing opiate and GABA receptors in the ventral striatum, amygdala, and orbital frontal cortex are important in elaborating consummatory PA (i.e., sensory pleasure) states, and various neuropeptides mediate homeostatic satisfactions.

Religious Perspectives

Buddhism

For Buddha, the path to happiness starts from an understanding of the root causes of suffering. Those who consider Buddha a pessimist because of his concern with suffering have missed the point. In fact, he is a skillful doctor – he may break the bad news of our suffering, but he also prescribes a proactive course of treatment. In this metaphor, the medicine is Buddha's teachings of wisdom and compassion known as *Dharma*, and the nurses that encourage us and show us how to take the medicine are the Buddhist community or *Sangha*. The illness, however, can only be cured if the patient follows the doctor's advice and follows the course of treatment – the Eightfold Path, the core of which involves control of the mind. In Buddhism, this treatment is not a simple medicine to be swallowed, but a daily practice of mindful thought and action that we ourselves can test scientifically through our own experience. Meditation is, of course, the most well-known tool of this practice, but contrary to popular belief, it is not about detaching from the world. Rather it is a tool to train the mind not to dwell in the past or the future, but to live in the here and now, the realm in which we can experience peace most readily. The word meditation is derived from the Latin verb meditari, meaning "to think, contemplate, devise, and ponder" [9]. The actual practice differs from belief to belief; but singularly it focuses to train the mind to a particular end. There are many mediation techniques.

Scientific research on mediation clearly indicates that brain circuits important for attention and emotion can be altered by the practice of mediation. We are able to get rid of all the rancor and rag from our system, thereby reclaiming peace and happiness.

Reading/hearing scriptures, positive literature, and associating with the wise will help us cultivate spiritual awareness and acquire a profound understanding of life and its purpose or function. This was the experience of Ignatius when he was recuperating in his home reading on books on the life of Jesus and the saints. Life is governed by specific and infallible natural laws like the cause-and-effect principle which need to be comprehended and adhered to. We reap what we sow, as the adage goes. When we embrace the awareness that each individual carries the onus of his or her on karmic account and also that we reap accordingly, then our emotions become less turbulent.

In this process of self-evolvement, the efficacy of meditation is paramount. The golden moments of supreme quietude illumine the path to the sublime inner voyage. As we proceed in meditation, we are able to connect with our inner core gradually; the unexplored and inaccessible territories become more familiar. Our unconscious repressions, grouses, and hurts buried in the darkest crevices of the unconscious mind start to reach the surface. Over time, the intense power and purity of regular mediation remove all toxins, resulting in a serene, happy, and wholesome life [16].

Hinduism

The first and second verses (above) of the *Dhammapada*, the earliest known collection of Buddha's sayings, talk about suffering and happiness. So it's not surprising to discover that Buddhism has a lot to offer on the topic of happiness. Buddha's contemporaries described him as "ever-smiling," and portrayals of Buddha almost always depict him with a smile on his face. But rather than the smile of a self-satisfied, materially rich, or celebrated man, Buddha's smile comes from a deep equanimity from within.

Indian psychology recognizes three levels of information processing, at the level of the brain, mind, and consciousness [17]. Classical Indian psychology considers the human person as "consciousness embodied." In Hindu, the "Mantra for Positive Thinking" is: *Life is the manifestation of our own thoughts*. Positive thoughts bring about positive developments in life and bring success to individuals. Hindu

mantras work with the sub-conscious mind and transform the potentials of people. Chanting a powerful mantra can encourage a lot of positive thoughts. Mantras are connected to the subtle forces in life. They help connect to the superhuman powers in the cosmos. Chanting a chosen mantra repeatedly as per the procedure advised can help reap the power of the mantras that will result in a positive change in the attitude, tendency, capabilities, confidence levels, and ability to endure in life.

Sikhism

Sikh means "disciple" and the prophets are called "gurus," which means teacher. The Guru, Nanak Dev, founded Sikhism in 1469 AD. The Universality of Sikhism espouses gender equality, belief in science, acceptance of other religions, meditation, belief in democracy, and spirituality of everyday life. All of these are positive psychological traits in Sikhism. Various studies have shown that those clients receiving religious psychotherapy showed significantly more rapid improvement in anxiety symptoms than those who received supportive psychotherapy and drugs alone [18, 19].

Islam

Islamic scholar Abu Amina Elias reported on June 4, 2016, "In the Name of Allah, the Gracious, the Merciful" [20] that thoughts have a powerful ability to determine our feelings and emotional states and ultimately affect how we behave, for better or worse. Islam teaches us to direct the act reflection (*tafakkur*), or deep thought, toward the signs of Allah, the names and attributes of Allah, to his blessings and wonders, to hope in the Hereafter, and to optimism. By controlling our thought processes in a positive manner, we can increase the effectiveness of our prayers and worship as well as relieve ourselves from the anger, depression, and anxieties that worldly thoughts induce. Contrary to popular belief, we have control over which thoughts we choose to follow. We may not have a choice over which particular thought occurs initially in our minds at a given time, but we do have a choice to either ignore it or pursue it. Our voluntary thoughts are nothing more than inward statements. Hence, the rule is that we should only engage good thoughts or keep our minds silent. Abu Hurairah reported: The Messenger of Allah, peace and blessings be upon him, said: وَمَنْ كَانَ يُؤْمِنُ بِاللّٰهِ وَالْيَوْمِ الْاٰخِرِ فَلْيَقُلْ خَيْرًا أَوْ لِيَسْكُتْ (Whoever believes in Allah and the Last Day, let him speak goodness or remain silent). Sunan al-Tirmidhī 1987, Grade: Sahih also reported "Positive thoughts are those that produce good feelings, good deeds, peace of mind, gratitude, tranquility, contentment, and other positive emotional states. These are truthful thoughts about Allah: hope in the hereafter, the prophets, our blessings, good deeds, and so on. They produce wisdom and enlightenment in the heart. Negative thoughts are those that produce bad feelings, anger, envy, jealousy, hatred, anxiety, depression, and other negative emotional states. These are thoughts about the world, our wealth, our status, people we do not like or who have wronged us, and so on. The cause of these thoughts is an attachment to the delusions of worldly and materialistic life that cloud the heart and prevent its purification."

Sufism

Sufism, based on the Koran and the teachings of Prophet Muhammad (610 CE), was influenced in its formation by Christian asceticism and Hinduism. Its origins are traced to the eighth and ninth centuries. Sufis have been known for a rich tradition of literature, poetry, storytelling, and using clever metaphors in stories, music, and dance. Sufism regards love, faith, experience, and knowledge as central concepts in resolving our existential dilemma to ultimately understand and experience the divinity in oneself or the union of self with the Supreme through a process of progressive *lifting of veils*, which hide true beauty and knowledge. Rumi regarded love as the "creative force in nature" (Arasteh 1965, p. 10); thus, love is the basis for all creation and creativity. In psychological parlance, seeking knowledge can

be described as progressive problem-solving to reveal the "hidden treasure" behind veils – true knowledge in the form of unity with essence. Sufis reject the dogma of a single path to salvation. They believe using such strategies as breathing, meditation, music, and dance [21].

Bahá'í Faith

The Bahá'í Faith offers an interesting and challenging ground for psychologists and psychiatrists: as the youngest monotheistic world religion (founded in 1844) [14], it is confronted with the challenge of individualism after millennia of collectivism in religious history; it has one of the most cultural diverse communities in the world (Bahá'ís live in more than 200 countries); its aim is the unity of humankind in diversity; harmony between science and religion is one of its main principles; and the existence of thousands of pages of original and authentic scripture and biographical literature offers the unique possibility of independent investigation – just to name a few aspects which make the encounter between psychologists and this religion interesting (from Peseschkian 2018) [14]

Based on a positive conception of human beings, "…regard man as a mine rich in gems of inestimable value. Education can, alone, cause it to reveal its treasures and allow mankind to benefit therefrom" (Bahá'u'lláh, 1994). The Bahá'í teachings offer a very positive and encouraging outlook toward life:

> As to spiritual happiness, this is the true basis of the life of man, for life is created for happiness, not for sorrow; for pleasure, not for grief. Happiness is life; sorrow is death. Spiritual happiness is life eternal. This is a light which is not followed by darkness. This is an honour which is not followed by shame. This is a life that is not followed by death. This is an existence that is not followed by annihilation. This great blessing and precious gift is obtained by man only through the guidance of God. (Abdu'l-Baha 1985) [11]

This important realization – that true happiness comes from turning your efforts toward serving other people – resonates throughout the Bahá'í teachings. This quote gives some indication of the Bahá'í view of the value of service as it relates to our inner joy and happiness: "Be not the slave of your moods, but their master. But if you are so angry, so depressed and so sore that your spirit cannot find deliverance and peace even in prayer, then quickly go and give some pleasure to someone lowly or sorrowful, or to a guilty or innocent sufferer! Sacrifice yourself, your talent, your time, your rest to another, to one who has to bear a heavier load than you – and your unhappy mood will dissolve into a blessed, contented submission to God" (quoted by Langness 2017) [13].

Judaism

Judaism is definitely an optimistic religion, and positive thinking plays an important role in a Jew's world view in general and service of God in particular. All the stories in the Torah are positive. Individuals or the Jewish nation may have experienced difficulties or suffered setbacks, but ultimately, they succeeded and good was achieved and prevailed. This is true regarding Adam's repentance and the continuation of humanity, the preservation of Noah and his descendants through the flood, Abraham's spreading the message of God to all mankind, the tribes' redemption from Egypt, and the Jewish people's receiving the Promised Land. The fact that all of these wonderful things happened not in the context of serenity, stability, and prosperity but rather on the backdrop of great personal and national obstacles and hardships illustrates that Judaism's optimism is not only of a "natural" sort, but even when against all odds.

There is no "tragedy" in Jewish literature, nor is there "fatalism" in Jewish philosophy. Even the suffering Job, tutored and elevated by his hardships, rose to true greatness in the end. The promising messages of the Prophets and the novel idea of the Messianic Era in Judaism also demonstrate its essential optimism. A religion which maintains such a glorious view of the future despite the often-dire reality of the present, particularly regarding the Jewish people itself, certainly encourages positive thinking. Prayer is another example of Jewish

optimism. One need not accept imperfections of the present. In fact, the word for prayer in Hebrew, *tefilla*, connotes wrestling. In prayer, one wrestles with oneself, with one's reality, and even with God in order to change things for the better. That being said, Jewish positive thinking also enables one to accept an imperfect present if need be. Or rather, Jewish optimism extends beyond hoping for a brighter future to include illuminating what seems to be a dismal present.

If after making responsible effort to improve our reality, things don't get "better," Judaism teaches not just that one must accept (at least temporarily) his lot but also that this reality, insofar as it's the Will of God (at least temporarily), is actually the best possible reality. This extending the idea of "making the best of a bad situation" to "seeing what seems to be bad as the best situation" is exemplified by a famous story regarding Rabbi Akiva. Rabbi Akiva was on the way and needed lodgings for the night. When he entered town asking for hospitality, he was summarily denied it. Exclaiming "Whatever God does is for the best," he set up camp in the nearby forest, lighting a candle and making provisions for his rooster and donkey, intending to get an early start in the morning. During the night, a wind came and blew out the candle leaving him in complete darkness. He exclaimed, "All is for the best." A cat came and ate the rooster preventing his early rise – "All is for the best." A lion came and devoured the donkey taking his source of transportation – "All is for the best." In the morning he saw that the town had been invaded and looted by robbers and all the inhabitants had been killed. When Rabbi Akiva considered that had he been admitted to the town or, after having camped in the woods, had the candle been lit, he would have been seen and had the cat meowed or the donkey brayed, he would have been heard, he once again justifiably exclaimed, "All that God does, He does for the best!"

An interesting idea to ponder is whether our thoughts actually have an effect on reality, such that pessimism breeds a negative actuality, while optimism actually creates a positive reality. The mystical and Chasidic teachings of Judaism are replete with the idea that not only what we do and say has an effect for good or for bad on the physical and spiritual worlds but even something as subtle and intangible as thoughts have such an effect. And in truth, since God thought existence into being (the statement in the book of Genesis, "Then God said, 'Let there be light.' "being understood as an expression of God's will, since God doesn't speak), and since mankind was created in the image of God (again, not to be understood literally but rather in our ability to will), then just as God thinks creation, our thoughts can also create reality and it's positively worth thinking positive!" (www.rabbiulman.com).

Rabbi Levi Brackman and Sam Jaffe [22] in an excerpt from their new book *Jewish Wisdom for Business Success: Lessons from the Torah and Other Ancient Texts* write "thoughtful optimism breeds success." People by their nature, optimistic and positive and cheerful and fun to be around, are chosen over negative people when it comes time to win the contracts or make the sale. Torah teachings stress optimism and positive thinking as keys to attracting success and positive outcomes. At the same time, the Torah also stresses that thought itself will not accomplish anything. It is only when thought is combined with action that positive thinking can result in the realization of dreams and the bringing of success.

Christianity

The idea that positive thinking results in positive outcomes can be traced back to the story of Noah and the Flood in Genesis. Peale's most widely read book *The Power of Positive Thinking* [23] was published in October 1952. It came at a time when national views of spirituality, individuality, and religion were shifting and the Cold War was a growing concern for many Americans. These factors, as well as Peale's growing popularity as a motivational public figure and the book's clear prose, propelled *The Power of Positive Thinking* into a self-help book. Peale begins by stating ten rules for "overcoming inadequacy attitudes and learning to practice faith." The rules include the following: picture yourself as succeeding, think a

positive thought to drown out a negative thought, minimize obstacles, do not attempt to copy others, repeat "If God be for us, who can be against us?" ten times every day, work with a counselor, repeat "I can do all things through Christ which strengthen me" ten times every day, develop a strong self-respect, affirm that you are in God's hands, and believe that you receive power from God. The next chapter describes the importance of creating a peaceful mind, which can be done through inspirational reading, clearing one's mind, or visualization. Peale continues with how to obtain consistent energy, saying that "God is the source of all energy." The mind controls how the body feels; thus, letting go of negative energy and emotions will give infinite energy through God. Next, Peale speaks of the healing power of prayer and how it will heal physical and emotional problems that arise from negative circumstances. In Chapters 5 and 6 of his book, Peale asserts that happiness is created by choice and that worrying only inhibits it and should be stopped. The next step in thinking positively is to always believe in success and not to believe in defeat because most obstacles are "mental in character." Habitual worrying is the next obstacle to overcome through emptying the mind and positive affirmations. Peale then states that asking God for help can solve one's personal problems and physically and emotionally heal them. In Chap. 12, he states that letting go of anger and embracing a sense of calm can help with physical illnesses, such as eczema. Next, he states that letting positive thoughts in can change one's outlook on life drastically and that practicing relaxation through God's help will lead to a content life. Chap. 15 gives concrete examples on how to get others to like you, including the following: remember names, praise others generously, become a people person, and resolve problems calmly as soon as they appear. Peale then continues with how to overcome heartache – through prayer, meditation, social interactions, and keeping a daily routine. The final chapter restates the importance of reaching out to a higher power for help in living a peaceful, positive life. Peale ends his book with an epilogue encouraging readers to follow his techniques and live more fulfilled lives. Peale writes, "I pray for you. God will help you — so believe and live successfully."

Ignatian Spirituality and Positive Psychology

St. Ignatius of Loyola was the founder of the religious order "Jesuits." He was also the author of the *Spiritual Exercises*, first published in 1548. For Ignatius of Loyola, the meaning of life can be captured in his life motto or mantra, *Ad Majorem Dei Gloriam,* translated as "For the Greater Glory of God." Iñigo de Loyola was born in 1491, the youngest of a family of 13, in the Basque region of northern Spain. Iñigo spent much of his young life aspiring to become the ideal man of that time and age, a courtier and a soldier. The young Iñigo was something of a ladies' man and a real hothead. He sustained battle wounds in the French army in 1521 and necessitated his convalescence at his family castle of Loyola, Guipúzcoa, in Basque, Spain. On his sickbed, he experienced a deep conversion. "Within him stirred a strange desire – to become like the saints and serve God." Gradually, he determined to turn away from court ambition, to embark on a pilgrimage that was to last years, and took him finally to studies for the priesthood at the University of Paris. There he gathered a group of friends who, in turn, presented themselves to the Pope as a new religious order. In 1540, the Society of Jesus was officially approved by Pope Paul III. For Ignatius, this kind of peace and happiness is what is being sought out in the "Examen." But it is more nuanced than that as I will explain further. But the goal is that if unburdened, we can move on in life.

The following are some takeaway points from Ignatius's life and preaching and writings.

1. Ignatius's take on the Christian journey is to insist that it is a movement, an active progress toward a radical decision to live one's life in harmony with Christ's vision and values.
2. Discovering one's true self and being truthful to this self is a dynamic that will lead to further oneness or intimacy with God. This kind

of communication, a unique form of spirituality, should lead to further action or service.
3. Ignatian concepts of consolation and desolation, i.e., movements of negative and positive affect, may be analogous to what Seligman describes as the subjective level of human experience of joy, satisfaction with life, relaxation, love, intimacy, and contentment. Subjective well-being "is a person's cognitive and affective evaluation" of oneself.
4. Discovering God's will, as described earlier (as one and the same with his own deepest desires or his will), would bring true lasting happiness, joy, satisfaction, peace, and contentment.
5. St. Ignatius: concept of "Examen" of consciousness, a form of meditative prayer where Ignatius learns how to distinguish between internal movements that are "of God" and those that are "not of God."
6. A central theme in Ignatian spirituality is the "battle within us to do the right thing and as a journey toward God. Early in his conversion, Ignatius was able to recognize the difference between that which moved him toward God (the consolation he felt when he thought of serving God), and that which moved him away from God (the dry feelings that attended his plans to seek fame). The discerning person, Ignatius believed, could distinguish between these two forces and make the right choices. In Ignatian spirituality this is called "discernment of spirits" [6].

Spirituality and Prayer

Prayer and Positive Psychology

The purpose and meaning of prayer in the context of the definition of positive psychology is to be able to discover one's own purpose and meaning in this life. It is a journey of relating with a "Thou," the mysterium tremendum. Marcel would describe this Thou as *disponibilité*. The book, *Spiritual Exercises of Ignatius of Loyola,* is the human being's guide to better understand what St. Ignatius calls the *foundational truths of Christian life*: creation as an act of love; human stewardship of creation, sin, and forgiveness; the life and work of Jesus as a paradigm of discipleship; Christ's suffering, death, and resurrection (what Catholics refer to as the Paschal mystery); and, finally, the surrender of human life into the hands of a loving God – first to love the Lord your God, with all your heart, and with all your soul, and with all your mind, and with all your strength and second to love your neighbor as yourself.

So, now, we can understand more clearly what kind of life is "worth living," for Ignatius of Loyola. He described his spirituality as a journey toward God (*The Formula of the Institute*). According to another Jesuit author, Fr. Howard Gray, Ignatius envisioned most everything in life as part of that journey – as created realities that facilitated or impeded its progress. For Ignatius, spirituality is about finding God in all things. His spirituality is based on the knowledge that "other things on the face of the earth are created for man to help him in attaining the end for which he was created." Shridhar Sharma in his paper, *Spirituality, Yoga, Religion and Mental Health*, describes spirituality as: "…concerned with soul and is directed towards the pursuit of personal meaning." Sharma adds: "Soon a spiritual person comes to realize that the self in him is the self in all, thus experiencing 'Godhood'." For Ignatius, that aspect of life which gives all human beings meaning and purpose in life is desiring and choosing that which is conducive to the end for which we all are created "…to praise, reverence, and serve God our Lord." [6]

Not being happy in this lifetime may be a universal fear or source of anxiety for any human being.

Positivity of Religion and Spirituality in Clinical Psychiatry

Though horrible atrocities have been committed in the name of religion throughout history, research suggests that religious and spiritual beliefs have tremendous positive benefits to individuals and societies. Research on religion and

coping suggests that the benefits of religion have to do more with how you are religious – your religious style or orientation –than whether you are religious. There are two ways to think about religious style. Pathways have been discussed in the literature through which religion/spirituality influenced positively is by increased social support, enhancing the importance of positive emotions, such as altruism, gratitude, and forgiveness in the lives of those who are religious. In addition, religion promotes a positive worldview, answers some of the why questions, promotes meaning, can discourage maladaptive coping, and promotes other-directedness [27].

Listed below are some of the benefits of religion reviewed in the Peterson and Seligman Handbook (2004) [26]:

- Several studies have shown fairly consistent relationships between levels of religiosity-enhanced outcomes of depressive disorders, traumatogenic conditions, substance abuse disorders, and others.
- Religion has been found to enhance remission in patients with medical and psychiatric disease who have established depression.
- Negative religious coping (being angry with God, feeling let down), endorsing negative support from the religious community, and loss of faith correlate with higher depression scores.
- Studies demonstrated lower levels of anxiety among more religious people. With regard to religious involvement in substance abusers, 90% found less substance abuse among the more religious. In some subjects preciosity caused more guilt and more anxiety. Among young people in particular, being religious is associated with reduced smoking, drug, and alcohol use.
- Patients reported that religion lessened psychotic symptoms and the risk of suicide attempts, substance use, non-adherence to treatment, and social isolation.
- Religion is associated with higher levels of obsessional personality traits but not with higher levels of obsessional symptoms.
- Young people who engage in religious practices (like going to church) are also more likely to have better grades and delay having sex.
- Being religious has positive benefits for relationships. People who actively participate in religious activities and who view religion as important are less likely to experience conflict in their marriage and more likely to perceive their spouses as supportive.
- Religious parents are also more likely to parent consistently and less likely to have highly conflictual relationships with their teenagers.
- Religious beliefs and practices are predictive of other virtues such as altruism, volunteerism, kindness, and forgiveness. Similarly, churches that actively promote displays of these values (especially volunteerism and philanthropy) are associated with community well-being.

Summary/Conclusion

The important correlation of happiness according to Park is social in nature [4]. In contrast to the modest demographic correlates of happiness and well-being, being religious is one robust correlate (in addition to number of friends, being grateful, being part community or marital union, being employed, etc.). But religion is defined here as a specific tradition or, in Ignatius' case, a certain way of proceeding. His way of proceeding is based on his own life story. His journey toward his true self led him to this life that he considered "the fullest." His method for achieving this realization of the true self was the *Spiritual Exercises*. The intention of the *Spiritual Exercises* is that of discovering and following this desire or choice that is conducive to our end: the end being following Christ's example. Ignatian meditation is not a form of rational (logical) analysis, nor does it seek scientific accuracy. It is rather a manner of experiencing and then discerning, that is, evaluating, the spiritual affects of (what Ignatius called) "consolation" and "desolation". We can only discover our true selves through living a spiritual life. This spiritual life is our bridge; it is our way of communi-

cating or relating with God (who is also actively trying to communicate with us in this world). This relationship is nourished and strengthened by prayer, specifically the "Examen of Consciousness." Through the Examen, we are able to distinguish between what is from God and what is from "the enemy of our human nature" [6]. Discovering what is from God is synonymous with finding our true selves. The evangelist John succinctly articulates this thesis of "finding our true selves as we find God," in his letter to the early Christians: "We belong to God, and anyone who knows God, listens to us, while anyone that does not belong to God, refuses to hear us. This is how we know the spirit of truth and the spirit of deceit" (1 John 4: 6–7) [10]. This ultimate consolation or subjective well-being as Seligman describes it is not something that is readily available in this material world; one has to seek it out patiently, fervently, and actively. A prayerful life requires a strong desire. Ignatius would later own realize that even this desire is a gift that only God can give. This desire could be what Csikszentmhilayi was trying to describe with the concept of *flow*. This desire to *find God in all things* is channeled through a spiritual life or a life of prayer. And living a spiritual life will ultimately result in finding our true selves. Living out our true selves will lead to a happy and joyful life. For Ignatius it is a life that should bring us to service: of being a contemplative in action. By the correct use of Ignatian discernment, one can be enabled autonomously to make decisions (to use the motto of the Jesuit order) "for the greater glory of God". It is a guide that in a way simplifies how we should live.

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Positive Psychotherapy as an Existentialism

31

Andre R. Marseille and Erick Messias

Introduction

Despite civilization's technological and medical advances, an observation of the present world reveals a landscape full of economic instability, shifting demographics, and threats of war. Such is the case that humanity has become more desensitized to the basic needs of displaced immigrants and refugees, the deaths of young children in unnecessary captivity, or the growing evidence that the Earth's climate is changing for the worst, posing a host of new and unforeseen challenges. Around the world, new racial and ethnic divisions are developing as some displaced groups assimilate successfully with the norms of mainstream cultures, while others are rejected, "racialized," and labeled as "minority" or disadvantaged brown and black minorities (Bonilla-Silva and [1, 2]). This stands in stark contrast to the fast-moving pace of technology and economic growth, creating thus a severely unbalanced – and unstable – world. In fact, the term VUCA world – standing for Volatility, Uncertainty, Complexity, and Ambiguity – has been proposed to describe the post-Cold War environment.

Existence in such a world requires that people have a capacity to change, adjust, and adapt to not only their own changing personal needs but also environmental demands and opportunities as well. The notion of having a "career for life" no longer exists in the face of globalization, increased life expectancy, and technological advances. As a result, a growing number of young people experience difficulties "finding themselves." Today, people live in a transcultural world, "shorn of moorings and in alarming disarray, doggedly exposing the extreme states of anxiety and confusion" ([3], p. 339). Many professionals who report the news and cover social media have described these exigencies as collateral by-products of globalization, while others view them as existential crisis.

Globalization poses a new set of challenges for the mental health profession. Globalization describes the accelerated integration of ideas, cultures, practices, and resources of sovereign nations into a more centralized existence [4]. As a result, globalization has rendered many existing conceptual therapies inadequate because they can no longer accommodate the rapidly shifting values, multicultural landscapes, and emerging identities of people around the world. Despite the darker impulses of human beings as chronicled through world history, positive psychotherapy (PPT) adopts a humanistic, positive, and

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optimistic view of humankind. In PPT, change is always possible. The German author Hermann Hesse [5] once said, "There is a magic in every beginning."

In existentialist philosophy, this concept is known as *becoming* [6]. According to German philosopher Heidegger [7], *becoming* describes "as far as we know, the human being is unfinished, always responsive to its world, and repeatedly carrying himself forward freshly, until death" (p. 65). According to many Eastern views about nature including Hindu and Buddhist, life is but a series of changes [8]. Existential philosopher Jean-Paul Sartre [9] argued that as long as people lived, they would forever reinvent themselves. Psychiatrist and psychotherapist Viktor Frankl [10] reasoned that it is from this view of existence that renders human beings capable of finding meaning in their lives. Meaning is perhaps the primary concern for existentialists.

This book chapter details how existentialist philosophy and positive psychotherapy can help people develop more insights and meaning into the core issues of life. We discuss the relationship among culture, consciousness, human capacities, and meaning. According to PPT founder Nossrat Peseschkian [11], humans have two innate capacities that underpin consciousness": the basic capacity to love and the basic capacity to know. These basic capacities make up the contents of the unconscious. PPT as an existentialism emphasizes humans' basic capacity to change and develop meaning in life and how one makes these capacities possible.

Culture and Acculturation

Peseschkian likened human capacities to seeds in the ground. Like undeveloped capacities in humans, seeds have an abundance of untapped potential. When properly nurtured (i.e., good soil, rain, and a caring gardener), they blossom. Such is the case with basic capacities. How one's conscious is shaped, how his/her capacities are developed, is deeply connected to the ecosystem or specifically the culture they grow up in. Man is thus a by-product of culture [12]. Culture is a bio-psychosocial trend that is as old as human history itself. Though there are several definitions of culture, in effect, culture takes the form of durable, long-standing beliefs, traditions, and practices that have defined and differentiated various groups of people for over millennia [7]. According to Vontress [6], culture is simultaneously visible and invisible, conscious and unconscious, and cognitive and affective.

In his work, *Social-Class Influences upon Learning*, Davis [13] explains culture this way:

> Culture, may be defined as all behavior learned by the individual in conformity with a group. Culture "teaches" the individual not only to recognize certain phenomena, but also certain symbols of phenomena, and the logical relationships among them. Culture also sets the goals of human problems and teaches the inferences (logic) which people in a particular culture regard as profitable (p. 59–60).

Learning implies a process. As many anthropologists have indicated, all human problem-solving includes cultural learning [13]. Acculturation is a process that psychiatrist Harry Stack Sullivan [14] describes as *consensual validation.* In his model, consensual validation is the process of testing one's cultural identity with the larger world through interpersonal interactions and self-appraisals. It is the process by which a person arrives at a healthy consensus with one or more persons about some aspect of his feelings, thoughts, and interpersonal relationships. This consensus is validated by repeated experiences that emphasize its soundness [14].

In positive psychotherapy, Peseschkian posits that every person, independent of their makeup (i.e., age, sex, race, type, illness, or social abnormalities) or culture, possesses two basic capacities: the capacity to love (emotionality) and the capacity to know (learning) [15] both of which cannot escape the influences of culture, acculturation, and the consensual validation process. Based on culture diversity, people's basic capacities differentiate and lead to a coalescing structure of essential traits (personality) over time. The expression of differentiated capacities defines each person's uniqueness. As a rule, basic capacities and the capacities that underpin them operate in all cultures. The difference lies only in

how some cultures versus others value each capacity and how people from different cultures express them.

Despite these cultural differences, PPT poses two fundamental questions about human existence: (1) What do all people have in common? (2) In what ways are people different? In many respects, both existentialism and PPT argue that culture is the answer to both. Culture connects people intimately and inextricably to experience. In this way, culture parallels experience. Among many things, culture provides people with a lens by which to interpret experience. Further, culture allows people to anchor their experiences in history and basis by which to freely investigate any origin and changing nature of their thoughts, values, beliefs, and decisions [16].

Anthropologist Edward Sapir argued "The true locus of culture is in the interactions of specific individuals" and "in the world of meanings which each one of these individuals may unconsciously abstract for himself from his participation in these interactions" ([17], p. 515). Embedded in the acculturation process is a perpetual self-appraising process that oscillates among factors like culture, experiences, and development.

Positive Psychotherapy

> The smart one wants to know everything, the wise does not need to know everything.
>
> *Nossrat Peseschkian*

Originally titled Differential Analysis, Positive Transcultural Psychotherapy (PPT) became the official title in 1977. Founded by Dr. Nossrat Peseschkian, an Iranian-born medical doctor who became a German citizen and member of the Baha'i´ Faith until his untimely passing in 2010, he was displeased with the limitations of medical science in the holistic healing of his patients. Undeterred, Dr. Peseschkian began an intensive study of over 20 Eastern and Western cultures. Through his endeavors, he discovered that despite people's cultural differences, people generally displayed the same innate capacities to navigate life. Further, he observed that people also tended to interpret and resolve challenges in roughly familiar ways as well.

Peseschkian describes PPT as a psychotherapeutic method to psychological healing which derives its scientific foundations from psychodynamic and behavioral psychologies and psychosomatic medicine, as well as philosophical inspiration from the writings of the Bahá'í-Faith. PPT is essentially humanistic at its core. In other words, PPT views man's nature in a positive light. The term "*Positive*" in positive psychotherapy derives from the original Latin expression "positum or positivus" which means the actual, the real, the concrete [18]. This chapter discusses three significant concepts in PPT: life balance, life energy, and capacities.

The Balance Model

Peseschkian [11] argued that all of existence may be interpreted through four domains of life. The effort (i.e., life energy) one applies to these interconnected and interdependent domains of life will dictate the extent by which he/she will experience life balance. In Fig. 31.1, Peseschkian [18] describes the balance model as the four domains that capture all of existence. Balance is about the

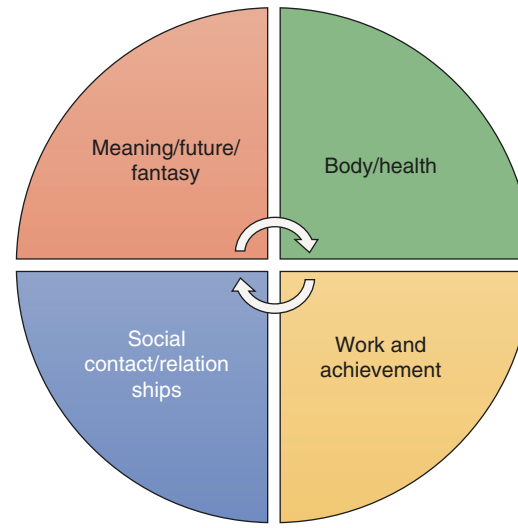

Fig. 31.1 Life balance model [19, 20]

equal application of life energy one applies across the four life domains: (1) body/health, (2) work/achievement, (3) social contacts/relationships, and (4) future/fantasy and meaning.

Body/Health

This domain refers to the physical body, the five senses, health, and appearance. At the outset, a child's development necessitates contact with its environment. In infancy, this contact initially occurs primarily through the senses. According to Peseschkian [20], the body domain includes the "biological factors which are basic to life: metabolic processes, reflexes, heredity, physical maturation, the functioning of the bodily organs, the functional capability of the senses and the vital needs" (p. 65). In this domain, one is concerned with physical health, appearance, and self-perception.

Work/Achievement

This domain is concerned with achievement and how it is incorporated into the self-concept. Thinking and understanding make it possible for one to solve problems and optimize achievement in a systematic way. Be it work, school, sports, or career, in the most practical sense, the work/achievement domain has everything to do with one's ability to take on tasks and resolve problems. It is a test of reality. This domain has strong implications for self-esteem and self-worth. In this domain, a person is concerned with competition, goals, and self-efficacy.

Contacts/Relationships

This domain represents one's capacity to establish and cultivate relationships including relationships to self and others, to one's partner and family, and with other people. A person's personality is especially influenced by those people closest to them and during the most intensive time of development. According to Sullivan, personality development begins in infancy and extends through early adolescence, growing in significant ways until late adolescence where "there was a tendency for the personality structure a person has developed to persist in its broad, general outlines" ([21], p. 76). The product of this process, Allport describes, is "a man working within a frame of choice, not destiny. The way a man defines his situation constitutes for him its reality" ([22], p. 84).

Future/Fantasy/Meaning

This domain refers to what some religious traditions call inspiration and what some psychological theories call intuition. Here is a place where fantasies go beyond the immediate reality and acquire meaning and future orientation. In this domain, notions of imagination, goals, values, and virtues are considered. One may think of this domain as their life compass that guides them spiritually, emotionally, and psychologically. This domain feeds into one's capacity to think creativity or "out of the box" to address life challenges.

Life Energy

Several cultures around the world have described, over hundreds years, life energy beliefs. In many ways, life energy has a universal quality. For example, life energy exists in many traditions, such as qi (chi) in China, prana in India, pneuma in Ancient Greece, spiritus in Latin, ruach in Hebrew, and vitalism in philosophy. Take for instance the G-field; it is an expression coined by the English physicist Oliver Joseph Lodge (1851–1940), used on his theory from the early twentieth century about a life force permeating the universe. In his view, matter was a concentrated form of this type of energy.

According to Peseschkian, everyone operates from 100% life energy. Though life energy is considerably more, one may think of life energy as effort. When a therapist asks a client to consider his life balance, he is asking him/her to consider how much life energy they apply to the four domains of existence. The concept of life balance implies a simple arithmetic. Ideal life balance is an equal distribution of life energy (25% × 4) among all four domains. This implies that one is applying a balanced effort to his health, his career, his family and friends, and his goals and values. Should his life balance model reflect an imbalance such as the example in Fig. 31.2

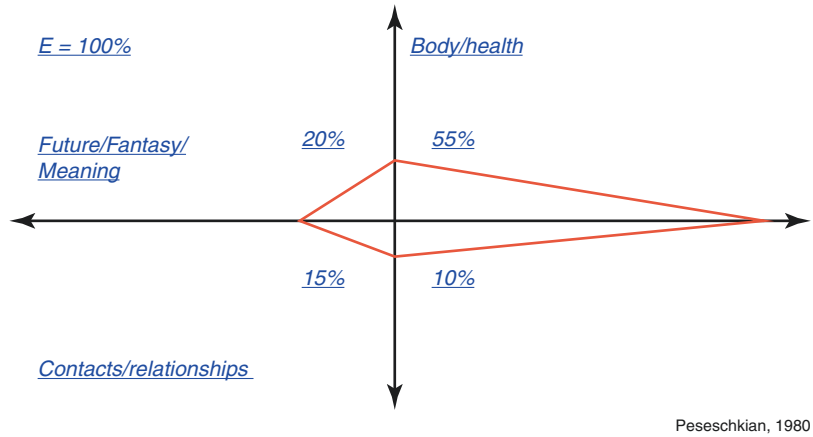

Fig. 31.2 Life energy distribution model [18]

[19, 20], what is causing the imbalance? The nature of this discussion creates the basis for some fertile therapeutic discussions.

In Sullivan's [14] *Interpersonal Theory of Psychiatry*, he describes the concept of energy as essential to interpersonal existence. Sullivan conceptualized personality as an energy system, with energy existing as either a tension or energy transformations. Tension is energy created from an unmet need (food) or desire (touch). Energy displacements literally involve the transformation of potential energy (tensions) into actual energy displacements (behavior) for the purpose of satisfying a need or reducing anxiety. Whereas tensions are helpful or conjunctive when satisfied, they can produce harmful anxiety when not satisfied. Sullivan used the words "integrate" and "integration" to describe the energy displacements that draw people together or push them apart. As Sullivan noted, "everything that happens to us that gets any sort of notice from us—conscious or unconscious, witting or unwitting—fits into the theory of the development and refinement of integrating tendencies or the interpersonal processes that characterize us" ([14], pps.69–70).

Capacities

From the perspective of PPT, in any interpersonal relationship, what is factual are not just conflicts but possibilities that can be developed. However, these physical, mental, and spiritual capacities need to be differentiated to be developed. Here culture and consensual validation play critical roles. Per Peseschkian [15], "the two basic capacities, to know and to love, are the foundation upon which the capacity for meaning develops" (p. 43). He further explains that human's basic capacities manifest themselves in the world as social norms, family norms, and patterns of behavior, value systems, and sources of internal and external conflict. PPT makes a distinction between basic capacities and actual (primary/secondary) capacities. The basic capacities are underpinned by primary and secondary capacities that are considered concrete contents of both the unconscious and psychosocial interactions.

Capacity to Love

The basic capacity to love is the domain of emotionality, feelings, and drives [15]. The capacity to love is initially expressed instinctually. In other words, people express their emotive needs and desire them to be met by a nurturing caretaker or partner or friend. This is a simple reciprocal process of emotionality [14]. One's capacity to love is the central form of expression in interpersonal relationships. It is the ability to love and be loved [14]. When one loves and is loved in return, he/she accepts something from another and is accepted in return. When this capacity is developed, other (primary) capacities within this

Table 31.1 Primary capacities of emotionality

Capacity to love	Definition	Possibilities
Love	Strong affection for another arising out of kinship or personal ties; unselfish loyal and benevolent concern for the good of another	Worship, adore, appreciate, fondness, devotion, ardor, tenderness, passion
Modeling	To produce a representation or simulation; to construct or fashion in imitation of a particular model; being a usually miniature representation of something	Demonstrating, sculpting, fashioning, patterning, teaching, learning
Servitude	A condition in which one lacks liberty specially to determine one's course of action or way of life	Bondage, serfdom, vassalage, dependency, subordination, subservience
Doubt	To call into question the truth of, to be uncertain or in *doubt* about; to consider unlikely; uncertainty of belief or opinion that often interferes with decision-making	Hesitation, uncertainty, reservation, distrust, suspicion, skepticism
Trust	*Assured* reliance on the character, ability, strength, or truth of someone or something; to hope or expect confidently	Reliance, expectation, hope, belief, conviction, presume, (despair)
Sexuality	The quality or state of being *sexual*; expression of sexual receptivity or interest especially when excessive	Self-esteem, worth, trust, fidelity, love
Confidence	A feeling or consciousness of one's powers or of reliance on one's circumstances; faith or belief that one will act in a right, proper, or effective way	Self-reliance, poise, sureness, buoyancy, faith, assertion, (uncertainty)
Unity	A condition of harmony, the quality or state of being made one	Harmony, agreeable, according, unison (disarray)
Time	A nonspecial continuum that is measured in terms of events which succeed one another from past through present to future	Rhythm, moments, phase, era, tempo, while
Contact	The apparent touching or mutual tangency of the limbs of two celestial bodies or of the disk of one body with the shadow of another during an eclipse, transit, or occultation	Connection, interaction, communication
Patience	The capacity, habit, or fact of being enduring, persisting, persevering	Endurance, tolerance, persistence, fortitude, perseverance, (impatient, temperamental)
Faith	Allegiance to duty or a person, strong belief or trust in someone or something, belief in the existence of god; strong religious feelings or beliefs	Reliance, conviction, belief, fidelity, constancy, allegiance, (doubt)
Hope	To cherish a desire with anticipation: To want something to happen or be true, to desire with expectation of obtainment or fulfillment	Expectation, aspiration, wish, yearn, optimistic, faith (despair)
Source	Merriam-Webster online dictionary	Source: Peseschkian [19]. In Merriam-Webster.com Retrieved May 8, 2019, from https://www.merriam-webster.com/dictionary/hacker

spectrum are developed. Table 31.1 lists the primary capacities thusly.

Primary and secondary capacities are the actual capacities. In other words, they are actual because they are actualized in daily life and take many forms within daily interpersonal living. They are not mere hypotheticals or abstractions like the id, ego, or superego concepts but rather dynamic interacting realities. These dynamic capacities, which have been referred to as virtues in philosophical and religious literature, are inherent and essential to the human condition. Within our innate basic capacity to love, one learns to trust and how to mitigate basic existential and interpersonal anxieties like love, death, loneliness, trust, security, etc.

Capacity to Know

According to Peseschkian, man's nature is to ask questions and seek answers to them. The capacity to know is mans' ability to learn and to teach others what he has learned [20]. This capacity has deep implications for one's sense of self-worth, esteem, efficacy, and overall purpose. Peseschkian [19] reasons, "one's capacity to know is not only conditioned by social experiences but by his/her unconscious mind" (p. 99). The capacity to know initially begins by differentiating self from non-self as the cognitive structures mature. Each person develops uniquely, dependent upon the individual's own inherent characteristics, family, environment, society, culture, and worldview of others we learn from and react to. We begin by testing what we learn about our world and the assumptions we make about how this world works – which capacities are enforced in the family, which are left undeveloped, or which are repressed. See Table 31.2 for a complete list of secondary capacities.

Our primary capacities to love and know form the basis by which one negotiates life. Our primary and secondary capacities are reflections of concrete observable representations of interpersonal living. This is what Peseschkian means when he explains that our capacities and how we express them make up the contents of the unconscious. As humans, the basic capacity to love and know and the methods by which people come to

Table 31.2 Secondary capacities to know

Capacity to know	Definition	Possibilities
Punctuality	Being on time, prompt	Reliability, regularity, time management (lateness, tardiness)
Orderliness	The quality or state of being clean, sequential, appropriate, organized	Neatness, tidiness, uniformity, symmetry, (disorderliness, messy)
Cleanliness	The quality or state of being clean: The practice of keeping oneself or one's surroundings clean	Sanitary, hygiene, purity (dirtiness)
Justice	The establishment or determination of rights according to the rules of law or equity: The quality of being just, impartial, or fair	Fairness, impartiality, reasonableness, integrity, lawful (unfairness, injustice)
Diligence	Steady, earnest, and energetic effort: Persevering application; earnest and persistent application of effort especially as required by law	Assiduousness, industrial, meticulous, attentive, careful (carelessness)
Truth/ honesty	The body of real things, events, and facts, the property (as of a statement) of being in accord with fact or reality, fidelity to an original or to a standard	Uprightness, morality, goodness, rectitude, honorable, sincerity, integrity (immorality, insincere)
Reliability	The quality or state of being reliable, dependable, ability to produce the same results	Dependability, consistency, steadfastness, trustworthiness (untrustworthiness)
Thrift	The quality of being frugal, parsimonious, careful management especially of money	Frugal, careful, prudent, cautious (extravagance)
Conscious	Having mental faculties not dulled by sleep, faintness, or stupor, perceiving, apprehending, or noticing with a degree of controlled thought or observation; capable of or marked by thought, will, design, or perception	Aware, mindful, cognizant, sentient, sensible (unaware, unintentional)
Courtesy	Behavior marked by polished manners or respect for others: Courteous behavior, consideration, cooperation, and generosity in providing something (such as a gift or privilege)	Politeness, considerate, civil, gallant, gentile (rudeness)
Obedience	An act or instance of obeying	Compliant, agreeable, deferential, docile (disobedient)
Fidelity/ faithfulness	Steadfast in affection or allegiance, firm in adherence to promises or in observance of duty	Authentic, believable, truthful, devoted, trustworthy (unrealistic, faithless)

Source: Peseschkian [19]. In Merriam-Webster.com
Retrieved May 8, 2019, from https://www.merriam-webster.com/dictionary/hacker

know themselves, through constant self-appraisals against others close to them, are also informed by the broader culture and world around us.

A human's basic capacities to love and know underscore an infinite number of complex capacities within his/her conscious that help negotiate existence. For example, the capacity to be self-aware or be self-appraising or the capacity to introspect and be self-reflective allows a person to develop insight into themselves. It is a complex capacity because it requires a combination of primary and secondary capacities. For example, introspection requires other capacities including time, patience, love, doubt, confidence, and honesty. Further, since many cultures incorporate past and future orientations to help them determine what value they place of different capacities, the complex capacities of *becoming and meaning making* are not static but are organic, fluid processes.

Existentialism

By 1945, existentialism was all the rage in Europe. After the fall of the Third Reich, many people living in post-World War II Europe felt that religion had failed them and looked for other ways to bring meaning into their lives. Existentialism quickly filled that void in the face of difficult social and economic times. The popular Parisian newspaper, *Le Monde*, attempted to understand existentialism but, after some consideration, could conclude a singular observation: existentialism was like faith really; it could not be studied; only lived. Davis and Miller [23] summarize existentialism from the views of Heidegger, Kierkegaard, and Nietzsche in this way:

> …there is much that is wrong with human nature. Man is an existential being whose life is more than logic and who must discover the meaning of existence. There are no answers to the human predicament to be found in the back of a book; Philosophy is to be lived, something to be proven in action… (p. 206) [23].

In much the same way, Peseschkian regarded human nature as full of possibilities. He often quoted, "regard man as a mine rich in gems of inestimable value" [24]. Positive psychotherapy demands that one "becomes yourself" which is a theme echoed in existentialism and many psychodynamic and spiritual and religious traditions.

However, many have interpreted existentialism as a philosophy that depicts human existence that is mean, sordid, and chaotic. However, that would also be ignoring the main point of existentialism entirely. Existentialism is a doctrine that affirms that every truth and every action imply both an environment and a human subjectivity [9]. Though existentialism at its core is a supremely philosophical activity, it evidences that the pursuit of purpose or life meaning is a centuries-old journey. For instance, Athenian and Roman philosophers like Socrates, Plato, Aristotle, Epicurus, Epictetus, and Marcus Aurelius searched and contemplated on a more meaningful and a fulfilling life over two millennia ago [23]. It was not just life and death that focused the attention of existentialists but themes like honest, fidelity, accountability, and freedom evidence that the quality of life was important themes as well. See Table 31.3 for a list of common existential themes.

People do not experience life or existential themes in a vacuum. Ludwig Binswanger [25] reasoned that people live within overlapping domains of existence that are inextricably connected. Per Binswanger [26], these domains defined what he meant by "being-in-the-world." Specifically, this sentiment of overlapping domains of existence comprises the Umwelt (or physical dimension), the Mitwelt (or social dimension), and the Eigenwelt (or psychological or inner dimension). Not satisfied with Binswanger's three dimensions of existence, Emmy van Deurzen-Smith added a fourth dimension – the Uberwelt (or spiritual dimension) – to explain the spiritual explorations of many existential philosophers, including Jaspers, Heidegger, Tillich, Buber, and Marcel. Figure 31.3 is a representation of Binswanger and van Deurzen's conceptions of domains of life that constitute *being-in-the-world.*

The Umwelt is the limit of an organism's world. This is true not only spatially but also in this sphere of existence: what is real is what is

Table 31.3 Existential themes

Common existential themes	Definition	Possibilities
Life	A principle or force that is considered to underlie the distinctive quality of animate beings An organismic state characterized by capacity for metabolism, growth, reaction to stimuli, and reproduction The sequence of physical and mental experiences that make up the existence of an individual	Animation, energy, existence, being, time, living, verve
Death	A permanent cessation of all vital functions: the end of life; the state of being no longer alive	Demise, collapse, loss, bereavement, mortality, transition, end
Responsibility	Moral, legal, or mental accountability	Duty, accountability, bond, fault, task, reliability, trustworthiness
Accountability	An obligation or willingness to accept responsibility or to account for one's actions	Answerability, responsibility, liability, culpability
Freedom	The absence of necessity, coercion, or constraint in thought, choice, or action	Liberty, autonomy, independence, choice, sovereignty, candor, conformity, inhibition, self-determination
Loneliness	Being without company, not frequented by human beings, producing a feeling of bleakness or desolation	Solitude, isolation, seclusion, psychosis, apathy
Meaning	Implication of a hidden or special significance, something meant or intended	Sense, value, significance, importance, necessitating
Becoming	The consistent possibility and capability to change into something else	Attractive, charming, changing, growing, enhancing, maturing, blossoming
Courage	Mental or moral strength to venture, persevere, and withstand danger, fear, or difficulty	Bravery, nerve, perseverance, audacity, valor, cowardice
Anxiety	Apprehensive uneasiness or nervousness usually over an impending or anticipated ill, mentally distressing concern or interest	Concern, worry, nervousness, disquiet, angst, fear, reassurance, calmness
Fear	An unpleasant often strong emotion caused by anticipation or awareness of danger, profound reverence, and awe	Terror, distress, anxiety, worry, phobia, trepidation, dread

Source: Created by Marseille (2019, 2011). In Merriam-Webster.com Retrieved May 8, 2019, from https://www.merriam-webster.com/dictionary/hacker Merriam-Webster online dictionary

detectable by the senses. As Vontress points out (1979, 1996), genetic endowment and life experiences are shaped by the ecosystem in which they live. At the outset, a child's development necessitates contact with its environment. In this domain, harmony with nature in one's physical environment is not pre-established. Hence, the goal in the Umwelt is to find "one's place" or harmony with nature [28].

The *Mitwelt* is the interpersonal world. Man is a historical being, and his relationships and contacts with the world reflect history and traditions. Different groups hold different traditions valuable or sacred from others. In life, a person is molded by his collective experiences and achievements. Beyond this, he stands within the history of his own culture and family. Harmony with others is dynamic not always given. Hence,

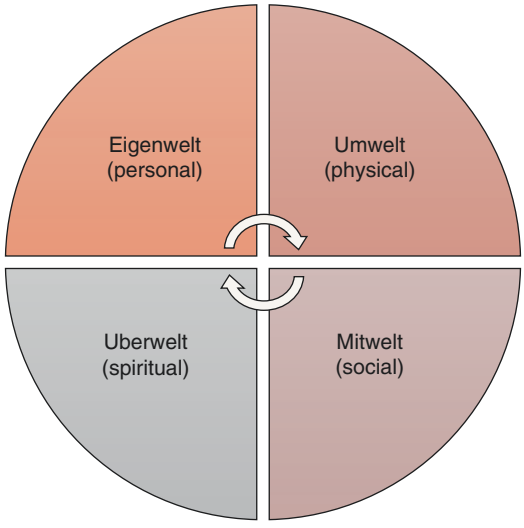

Fig. 31.3 Binswanger's "being-in-the-world" model [25, 27]. (Graphic created by Marseille 2019)

the goal in the Mitwelt is one's ability to connect with others. It is the ability to love and be loved.

Lao Tzu [29] once said, "He who knows others is wise, he who knows himself is enlightened" (p. 117). The Eigenwelt is one's personal world or private realm of which others cannot experience or fully understand no matter the intimacy shared between them. Here lies one's consciousness. The Eigenwelt connotes far more than one's personal world. It is a place where complex cognitive functions take place. It attends to existential anxieties. The Eigenwelt self-appraises and uses defense mechanisms to protect it. It reminds people that they are unique. Since no one can ever fully know this part of a person, we are ultimately alone in the world. The Eigenwelt is the most personal part of one's consciousness.

Finally, the Uberwelt is the spirit world. The spirit world connects us to those who have come and gone, to an area beyond the time-bound reality.

The search for existential insights is not novel. Philosophers around the world like Confucius, Lao Tzu, Buddha, and many others have pondered deeply about the meaning of life. Peseschkian would often quote a Chinese proverb, "When one drinks water, consider its source" [18]. He meant that every behavior has a meaning attached to it and that meaning has a cultural blueprint. Like PPT, existentialism considers deeply consequential themes about existence while recognizing one's unique attributes and capacities. Given individuals' basic capacities to love and know and the actual/secondary capacities that unpin them, one is always capable of "becoming." In other words, a person always has the capacity to change. However, the question that concerns most is: How can people change? The answer remains elusive, yet it is at the core of why people seek the help of counseling and psychotherapy professionals.

Capacity to Introspect

In *A Life Worth Living*, Mihaly Csikszentmihalyi [30] argues the human brain is unique in lieu of its ability to give rise to self-reflective consciousness. In existentialism, self-reflection, compassion, individual thought, and respect for others are central themes [31]. Existentialists view the capacity to introspect or self-reflect as an ability to think deeply about the "everydayness" of ones' existence in order to discover and reconcile their estrangement from the ordinary and mundane [12]. Schneider [32] writes, "Less and less is life animated through personal discovery, intimacy with others, or self-reflection. While life has become more manageable for many people, it has become commensurately less engaged" (p. 14). Existentialists and Buddhists share the belief that the path to a meaningful existence consists of one's capacity for compassion, self-awareness, and self-reflection and a detached analysis of one's own emotions.

In any culture time, is an important primary capacity underpinning the capacity to self-reflect because people are constantly trying to create a coherent identity that requires a successful integration of self that is based on the past, present, and future [33, 34]? A person's capacity to "become" is a significant complex capacity because it underpins all primary and secondary capacities. A person's awareness that he/she has the capacity for change and growth, meaning making often resonates from a self-reflective process. When a person stops and ask them-

selves "why does my room always look a mess?" or "Why can't I ever find anything?" these questions reflect upon her capacity of orderliness, perhaps punctuality. Either way, the self-reflective process allows her an opportunity to find new meaning in some aspect of her life. Sartre wrote, "Man is nothing else but that which he makes of himself. That is the first principle of existentialism" (Sartre as quoted by Riedlinger [35], p. 28).

Capacity for Courage (Act)

The word courage comes from the Latin word *cor*, which means "heart" [36]. Kierkegaard argued that truth could ultimately emerge only from being, not from thinking, and what people lacked most was the courage to live with passion and commitment. May [37] posited that courage is the capacity to confront life "as is." Existentialists believe the capacity for courage helps individuals recognize and accept their own mortality. Courage also gives people the volition necessary to face themselves and accept who they really are [6, 38]. The capacity for courage is complex because it is a capacity that not only requires a combination of other primary and secondary capacities but also requires an act or decision. Courage helps people shun their concerns about others' opinions. People who have courage care less about fitting into ill-suited or foreign identities for the sake of insincere validation and connections.

Courage means confronting what one fears instead of avoiding it. According to Kierkegaard, courage helps people deal with the anxiety of living. In existentialism, there is a consequence for not facing life with courage. In his book, *The Concept of Anxiety*, Kierkegaard [39] argues that people tend to lose themselves when they lack of courage. He explains that fear is tied to a tendency to avoid suffering and ignore their spiritual being. Because of such fear, people instead let themselves be consumed by "the world." Kierkegaard reasoned that a courageous person is prepared to suffer when he/she knows that this is required of him/her (IBID). In this view, the courage to act, to take risk to experience the "depth of existence" per Kierkegaard, may, in fact, be the only way people can develop a true sense of purpose and meaning in life. The capacity for courage to act is perhaps the most significant because it allows people to live, as existentialists would argue, "more authentic lives."

Positive Psychotherapy as an Existentialism

Positive psychotherapy as an existentialism comprises a view of existence that man is good-natured, conscious, and self-aware. Human consciousness comprises innate capacities that are influenced by experiences in the world and specifically by culture. PPT as an existentialism posits that the humans have a capacity to harness life energy, which affords them the ability to *become* or change. People rely upon their basic, primary, and secondary capacities to navigate the world and to understand the complexity of human consciousness. The basic capacities of loving and knowing underscore several primary and secondary capacities that, when combined, create an infinite number of possibilities for change and growth. Together, these capacities make up the contents of the unconscious.

Meaningful Decision-Making Model

When an individual must consider a significant life experience or decision, PPT as an existentialism encourages him/her to consider the experience at hand, the emotions tied to the experience, the facts of the experience, the context of the experience (i.e., grieving someone's death, considering a promotion, moving into one's own home, deciding what car to purchase or to get married, etc.), and, finally, what to do about it. As one deploys her life energy, this logical flow of cognitions involves the engagement of various capacities and the consideration of applicable existential themes. For example, a person engages many capacities when faced with the loss of a close relative.

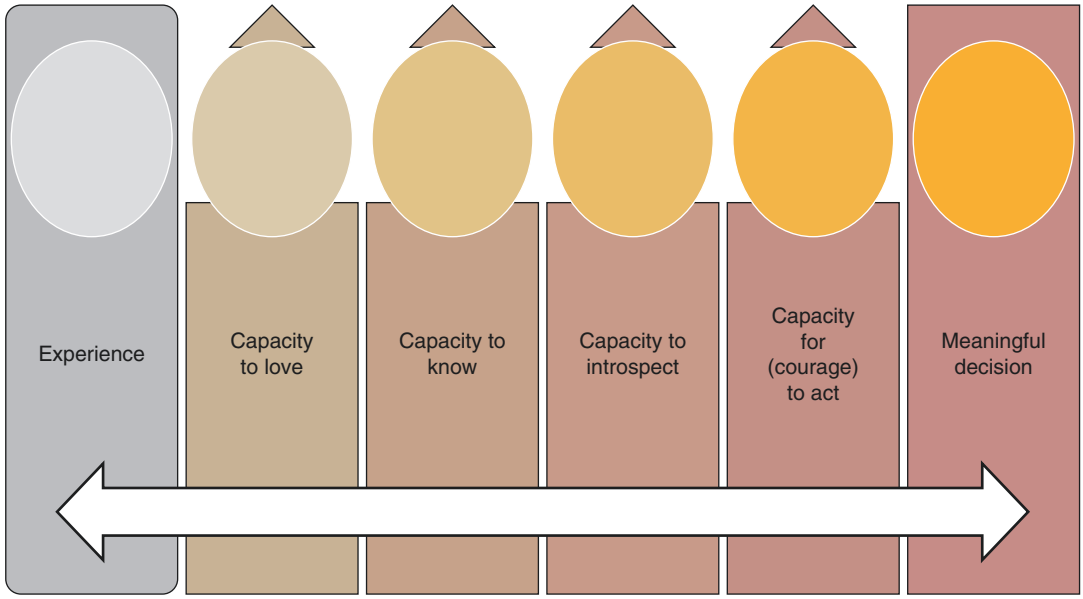

Fig. 31.4 Meaningful decision-making model. (Source: created by Marseille 2018)

The self emerges through experience [40, 41]. Binswanger argued that meaning came from a person fundamentally immersing into a world of human relating [42]. Experiences are a combination of significant and insignificant moments in time. Some experiences alter one's life, while others do not. Though experience is essential to existence, experience is unique to each person. Since people are free to choose [40, 43], they have the capacity to "surpass the given and look at things as if they could be otherwise" ([40], p. 3). Experience allows one this sensibility about freedom. It also allows people the freedom to "name alternatives, imagine a better state of things, [and] share with others a project of change" [40], p. 9). Getting a person to recognize that he/she is free to choose their purpose and that he/she must account for any decisions as a result of that freedom are central goals of existential counseling. Consider Fig. 31.4.

The meaningful decision-making model (MDM) is one method existentialists as well as positive psychotherapists can use to help individuals realize the weight of their own freedom and their responsibility for making meaning in their lives. The MDM model illustrates how the combination of PPT and existential concepts can work in tandem. Like the balance model, the goal of the MDM model is quite straightforward and simple. The goal of the life balance model is to help a person achieve life balance through introspection and better decision-making. Consider once more the concept of life energy. Suppose one has to make an important decision about a job. The MDM model simply argues that a person should equally distribute their life energy (25%) across the four capacities (love, know, introspect, courage) before making a significant decision (act) about any aspects of their life or, in this case, a job. Below is a basic example of how one would use the MDM model.

Jane Doe has been offered a new job but she would have to move to accept it.

- 25%: Capacity to love – How does she feel about the job. Is it a career job or just a job to help her get to a bigger career goal? Is it in her field? What primary capacities are evoked when she thinks about the job?
- 25%: Capacity to act – Does she know all she can know about the job? What about the city the job is in? Is there a different climate? Is it

more rural or urban? What is the diversity look like at the job? Will the benefits meet her needs? What secondary capacities are evoked when she thinks about the job?

- 25%: Capacity to introspect – Has she had similar jobs? How did she feel about those? How long does she think she will be in the job before she moves up? Is the job a fit for her long-term plans? Has she ever lived in the type of environment before? If so, what feelings does she recall having? Are there friends and family that have helpful information they could share?
- 25%: Capacity for courage – After all things are considered, can she actually make the move? How comfortable is Angela with change? What are the overall pros and cons of taking the job and moving? What are the overall pros and cons of not moving?

According to Peseschkian [44], "in good therapy, one should talk about the past 25% of the time, 25% about the present and 50% about the possibilities in the future" (p. 15). Though existential counseling emphasizes the present, using PPT as an existentialism, the therapist exploring a client's life must consider how all three dimensions of time impact his/her sense of self and worldview. Because freedom is theoretically boundless and time is inextricable from experience, the therapist must make clear that the client must understand his/her past to make any real sense of their present and plan for the future.

Conclusion

Existentialists who use psychotherapy attempt to "stay with," "stand beside," or attend to the client by exploring the client's immediate conscious experience of "being with another" or the therapist [6]. In PPT, to cultivate the client's sense of being, the therapist provides stories and words of wisdom to provide new perspectives and inspiration to the client. No matter how one disposes of the various therapeutic strategies, using existentialism within PPT helps the therapists to help clients explore deep fundamental questions of their existence, purpose, and possibilities in life through their own basic, actual, and complex capacities. Sartre wrote that the central theme of existentialism is that "existence precedes essence." He meant that a person's most important consideration is that they are "unique – independently acting and responsible, conscious beings ("essence")" – rather than what labels, roles, stereotypes, definitions, or other categories that tend to define them ("existence"). How one chooses to live their life is what constitutes "true essence" [45]. PPT as an existentialism is a means by which therapist can help clients deal with transcultural and existential issues in a world of globalization challenges and technological advances.

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Positive Psychotherapy and Other Psychotherapeutic Methods

32

Christian Henrichs and Gabriela Hum

Introduction

In his first book explicity refering to his approach as "Positive Psychotherapy" Nossrat Peseschkian explained in 1977: "While many of the existing psychotherapeutic procedures take the disturbances and illnesses as their starting point, prophylactic and preventive medicine and psychotherapy require a different method of proceeding, starting from the person's developmental possibilities and capacities instead of the disturbances" [14]. Abraham Maslow, well-known for the pyramid of needs and one of the founders of humanistic psychology, saw "the importance of focusing on the positive qualities in people, as opposed to treating them as a 'bag of symptoms'." Maslow was also the first psychologist using the term "positive psychology" in 1954 [8]. Humanistic psychologists promote that every person has a latent desire to realize her or his full potential, to reach a level of "self-actualization." Overall, humanistic psychology emphazises "the positive potential of human beings" [18]. Today, Positive Psychotherapy (PPT after Peseschkian) sees itself as a humanistic psychodynamic approach with a transcultural perspective. This pretty much summarizes its central relations and how it can be classified.

In terms of its founder's main training and its most prominent current discourses, Positive Psychotherapy is a psychodynamic modality of psychotherapy. Nossrat Peseschkian named among his personal influences his teaching analyst Heinrich Meng, a personal student of Freud, the psychoanalyst Carl Fervers with whom he did his time of clinical specialization, and Johannes Heinrich Schulz from Berlin, founder of autogenous training, with whom he took private lessons [21]. Today, Positive Psychotherapy's "mother institute," the Wiesbaden Academy for Psychotherapy (WIAP), has developed into one of the leading psychodynamic institutes in Germany.

However, in the spirit of his time, the late 1960s and the early 1970s, Peseschkian was also very much part of the humanistic discourse. Furthermore, Peseschkian was – as he often stated – very much influenced by his migration from Iran to West Germany, and this reflects in the transcultural perspective of Positive Psychotherapy [21].

Peseschkian used to say in his seminars, "the human soul is good by nature; unfortunately, it is prone to alienation." This saying points to what today is referred to as the "positive image of man"

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in Positive Psychotherapy. It might be best summarized by ideas of human nobility, of world citizenship, and of learning which are also prominent in the Bahá'í-Faith, Peseschkian's religious affiliation (i.e., "That one indeed is a man who, today, dedicates himself to the service of the entire human race... The earth is but one country, and mankind its citizens," [1]). Peseschkian was born into this religious community and lifelong an active member. In its positive image of humans and the empathies on culture, Positive Psychotherapy seems to breathe the spirit of the Bahá'í teachings that claim to address the condition of humanity in the time of globalization.

In a broader sense, however, the idea of the human potential, of purpose, and of transformation toward goodness is shared by many of the humanistic approaches (one example being how Jacob Moreno claims that every person has their creative potential that can be unlocked through play). This humanistic perspective might contrast with the classical psychoanalytic or behavioral approaches with their more mechanistic and deterministic paradigms (such as Skinner's idiom "Give me a child and I will shape him into anything").

Basic Assumptions

In Positive Psychotherapy, the positive image of humans is the starting point of a clear theoretical line of thought in which all concepts and models are capacity-based. This goes, as Peseschkian said in many lectures, free after Goethe who said that one should look at humans as they are and as they could be. At the core of the Positive Psychotherapy theory, there is the assumption that all of us share the basic capacities to know and to love. A similar assumption is made in the also Bahá'í-inspired, pedagogic "Anisa model" of Dan Jordan [5].

In Positive Psychotherapy, all the models and concepts are then derived and elaborated from these capacities to love and to know. One might relate the Positive Psychotherapy idea of capacity in the broadest sense with the psychoanalytic assumption of libido. Elaborating this comparison further, Positive Psychotherapy's basic capacity to love resembles the psychoanalytic lust principle, whereas the capacity to know resembles the reality principle. This shows both: the deep relation of Positive Psychotherapy to psychoanalysis and its radical change in the image of human beings.

This radical change is not only of theoretical but also of practical importance as the therapist becomes a co-agent in a two-person psychology or even a multi-person one (in comparison to a one-person psychology that is represented by classical psychoanalytical and behavioral therapies). In the process of capacity development, the human aspirations of loving and knowing are acknowledged and mutually active in both patient and therapist.

Peseschkian spoke of psychotherapy in a narrow, a wider, and a comprehensive sense referring to the treatment of the current disorder, the development of the patient's capacity to act in her or his life, and the changing of social and cultural conditions themselves. Of course, this claim goes much beyond one-person psychology.

What we become in life is the result of three conditions as Peseschkian stated: the conditions body, environment, and time [22]. This means both experiential and relational influences and our biological dispositions. Here, it is not so much a question of the static weight of these factors, but of how they interact in time: in a process of unfolding and reciprocal exchange – with society, culture, zeitgeist, and religion (dimensions of giving meaning and finding meaning as Peseschkian put it). In the process, one's conscious self-reflection and a consultative process of social learning are important. Nossrat Peseschkian said that we are like a letter written with invisible ink. What we become in life depends on the spot where the heat is placed on the letter.

Striving for Integration

The understanding of the process of maturation of the human organism can again be linked to psychoanalysis, namely, its phases of psychosexual development. Here, so to speak, also the conditions of body, environment, and time interact with the human capacities from the oral to the anal and oedipal phase. However, the psychoanalytic concept including the term

fixation has still a quite mechanistic flavor. In Positive Psychotherapy, these classical developmental phases influence the person and are reflected in the understanding of the current interactional situation: in the model of interpersonal interaction [11]. Here, the stages of attachment, differentiation, and detachment help to describe and analyze conscious and unconscious levels of communication being shaped by transference and countertransference. Again, the psychoanalytic heritage is combined with a humanistic transformation of premises and a pragmatic approach to treatment empowering the patient as an agent of her or his positive development.

The transcultural perspective in Positive Psychotherapy does not only point to the significance of culture which is evident in Positive Psychotherapy's etiological concepts and in its interventions (e.g., model dimensions and actual capacities in theory, stories, and proverbs in intervention). For Peseschkian, "transcultural" also implied interdisciplinary and integrative aspects in psychotherapy. He described the situation of psychotherapy often with the traditional oriental story of the elephant and the blind men – see Box – who only see parts of the whole. He wanted to go beyond the partial, often even ideological perspectives and to integrate. He formed the idiom: "who works alone adds, who works together multiplies."

Namely, he had great vigor to bridge the walls between psychoanalysis and cognitive-behavioral therapy. This again is reflected in his personal relationships: One of the most important coworkers in his own practice, Hans Deidenbach was a behavioral therapist. He co-authored the strategically important WIPPF questionare (Wiesbaden Inventory for Positive Psychotherapy and Family therapy, 1988, [16]). Also, interventions such as the confrontation hierarchies regarding the actual capacities, autosuggestion, or self-verbalization at certain stages of the intervention ("psychoserum" in Positive Psychotherapy), symptom protocols, and self-observation instructions (e.g., "situational control" similar to Ellis' ABC Technique) show the discourse with cognitive-behavioral therapy already in the early days of Positive Psychotherapy.

A final point should be mentioned in the historical perspective and Positive Psychotherapy's relations: its own learnings in its expansion to eastern countries. After the collapse of the Soviet Union, Positive Psychotherapy was very actively thought in Eastern European countries by the initiative of some dedicated trainers. One result of this is that today some of the strongest centers of Positive Psychotherapy can be found in Eastern European countries such as Ukraine, Bulgaria, and Romania. At that time, the situation of psychology completely changed in Eastern Europe. Big changes also bring opportunities, and therefore, in Bulgaria, the relationship between Positive Psychotherapy and psychodrama influenced the practice of Positive Psychotherapy itself. In Germany, there was a similar mutually inspiring cooperation between Positive Psychotherapy and systemic and hypnotherapeutic teachers from Heidelberg.

The Blind Men and an Elephant

A group of blind men heard that a strange animal, called an elephant, had been brought to the town, but none of them were aware of its shape and form. Out of curiosity, they said: "We must inspect and know it by touch, of which we are capable." So, they sought it out, and when they found it, they groped about it. The first person, whose hand landed on the trunk, said: "This being is like a thick snake." For another one, whose hand reached its ear, it seemed like a kind of fan. As for another person, whose hand was upon its leg, said, the elephant was a pillar like a tree-trunk. The blind man, who placed his hand upon its side, said, the elephant was a wall. Another one, who felt its tail, described it as a rope. The last felt its tusk, stating the elephant was that which is hard, smooth and like a spear.

(Indian traditional story, often quoted by Nossrat Peseschkian, e.g., in *Oriental Stories as Tools in Psychotherapy: The Merchant and the Parrot*, [12])

Differentiation Analysis

The publication of "Differentiation Analysis" historically preceded "Positive Psychotherapy" (1974, [10] vs. 1977, [14]). In fact, Positive Psychotherapy can be understood as an extended version of the earlier concept of Differentiation Analysis. Peseschkian explained why he chose the term "actual capacities, because in daily life they are, in the most diverse ways, being continually addressed at every moment." We operate in our daily life emphasizing certain (primary and secondary) actual capacities, such as politeness or orderliness – resources or even virtues – with which we got used to facing life with while having other capacities left behind underdeveloped or undifferentiated. The purpose of therapy is to make the patient become aware of these capacities and to accompany the patient during the process of discovering new capacities or differentiating capacities that are too rigidly set. This describes a process of personal growth, a humanistic perspective of Positive Psychotherapy.

While psychoanalysis taught us to unmask neurosis and behaviorism taught us to debunk neurosis, Positive Psychotherapy rehumanizes psychotherapy, just like the existentialist and the humanistic therapies do. While having psychodynamic roots, Positive Psychotherapy embraces the idea that it is not practical to start from a nomic principle and to only focus therapy on identifying disorders. The innate capacities and resources of the person are equally important in the psychotherapeutic endeavor. While Sigmund Freud believed that the purpose of psychoanalysis is to make the unconscious conscious and thereby to promote liberation [19], Alfred Adler believed that the aim of individual psychology is to increase the sense of responsibility [24], and Victor Frankl believed that the aim of existential psychotherapy is to increase both the level of awareness and the sense of responsibility [23]. In Positive Psychotherapy, the intervention aims to refine and amplify the individual capacities and to perform differentiations regarding one's actual capacities (primary and secondary) [15].

In Positive Psychotherapy, another element to be considered is the past experiences of difficult situations, trying to identify the resources the patient discovered and exercised during those experiences. As Peseschkian said, "a sane person is not someone who has no problems at all, but someone who is capable of dealing with the problems as they appear" [15].

The actual capacities are central to Positive Psychotherapy's conflict model, which is biographically rooted, exhibiting the psychodynamic perspective of Positive Psychotherapy. Here, it might be noted that the fact that the actual capacities can be easily observed in everyday life (with clear operationalization, e.g., in the WIPPF, described in this book's chapter on the first interview) was elaborated much before the mainstream of psychodynamic therapy started to operationalize their concepts (for instance, in the OPD group in Germany in the early 1990s [9]). Then it can be stated that actual capacities also operate on a cognitive-behavioral level: They involve attitudes and automatic cognition as well as behavioral skills and habits. This can be easily understood if one reflects, for instance, on the different levels of an actual capacity such as "politeness" for a moment (which might have cognitive, behavioral, psychodynamic, cultural, and humanistic aspects to it).

The symptom, as seen by Positive Psychotherapy, is a way through which the unconscious communicates. Finding the purpose of the symptom, giving it a positive interpretation leads to the actual conflict and improves the disturbed relationships of the patient to her- or himself as well as to others. It points to the capacities involved, clarifying needs, competence, but also lack and compromise. In Positive Psychotherapy, the symptom is seen as an access point to the bigger picture, not only as a technical objective as in cognitive-behavioral therapies.

Positive Psychotherapy then becomes a journey in the depths of the human being, for understanding what the person has become, as well as journey in the exterior world, to understand how the person adapted during their lifetime to the social environment and their culture of origin. This dual approach – internal and external – makes Positive Psychotherapy a unique undertaking that makes the person in front of you and her or his understanding a priority. By realizing that culture is an essential determinant in human

reality and by conceptualizing its core models such as the actual capacities or the balance model, Positive Psychotherapy – nowadays often referred to as Positive and Transcultural Psychotherapy – goes beyond traditional psychodynamic and humanistic approaches [7].

While Freud recognized the emotional significance of culture (*The Uneasiness in Civilization*, 1930, [6]), it is still modeled only indirectly: In psychoanalysis, the super-ego is shaped in the interaction with the parents who confront the child with their understanding of societies' demands. In Positive Psychotherapy, the actual capacities (which might be seen partly as contents of the super-ego) are entities also in the intersubjective personal space of a cultural context involving multiple agents and different points in time.

Therapeutic Understanding

The evidence-based trend in psychotherapy (embraced especially by cognitive-behavioral schools but, more recently, also by the psychodynamic schools) challenges the different psychotherapeutic traditions. Here, Positive Psychotherapy can provide a highly acclaimed effectiveness study [17]. For this study, Nossrat Peseschkian was awarded the Richard Mertens Medal for Quality Assurance, a well-known scientific recognition in Central Europe.

The Positive Psychotherapy intervention is focused on understanding the psychodynamics of the conflicts (with basic and actual conflict) that represent the foundation on which symptoms emerge. Just like in the psychodynamic schools, approaching conflicts is done by investigating the past as well as by analyzing transference-countertransference situations in both therapy and real life. In other words, Positive Psychotherapy is based on a psychodynamic conflict theory. Conflicts mainly exist between the needs of primary capacities and the social norms represented in secondary capacities [18]. Also, patients are helped to develop an understanding of their initially subconscious conflict contents in terms of actual capacities.

The description of what is referred to as an actual conflict was widened by Peseschkian's microtrauma theory, the little events that add up to inner conflicts, in addition to the formerly researched macrotrauma theory of Holmes and Rahe life event scales. Moreover, in Positive Psychotherapy, the therapist translates the actual conflict into actual capacities which the patient has exercised less often or which are undifferentiated. Discovering the capacities involved in the actual conflict is the tip of a thread that we then follow in order to discover the intrapsychic conflicts and their dynamics. This translation makes it easier for the patient to understand since the terms used are very similar to the everyday language used by the person in therapy. Through this translation, Positive Psychotherapy brings its own contribution to the therapeutic process, making it more human and easier for the patient to further transfer it into his/her daily life. All these "translation" methods link Positive Psychotherapy again also to the humanistic approaches.

Unlike traditional psychoanalysis where the behavior of the therapist should be abstinent and technically neutral, in Positive Psychotherapy the patient is implicitly learning from the therapeutic relationship as a model. Here, the stages of interaction are experienced, and, explicitly, the patient becomes aware of the stages that he had practiced and those that need more practice (we are talking here about the three stages of interaction, specific to Positive Psychotherapy: attachment, differentiation, and detachment).

Positive Psychotherapy was developed as an intervention method not only for the individual but also for the family. Family therapy was elaborated around the globe during the time when Peseschkian founded Positive Psychotherapy and Differentiation Analysis. Peseschkian's idea was to combine individual therapy with family therapy [13]. This is a reason why Positive Psychotherapy is accepted in both individualistic cultures and collectivistic cultures. Positive Psychotherapy understands the symptoms in its function within the families and gives us family therapy tools for an individual member for self-help and also for the complete family in order to see the symptoms not as of one person in the family but the symptom as an expression of a conflict in the family system [13]. In comparison to other family therapy approaches, the instruments for

self-help are particularly important, such as differentiation analyses, WIPPF, balance model, model dimensions, or five-stage procedure.

Interventions

Nossrat Peseschkian often used humor in his therapy sessions. He used to say his training groups that "a therapy session in which we have not laughed at least once has no result." Humor, as a mature defense mechanism, along with the use of metaphors and stimulation of creativity (sublimation) is one of the essential approaches in Positive Psychotherapy [3].

If we look at elements of effective therapy described by Frank [2], we notice how Positive Psychotherapy follows several healing principles which are universally valid:

1. *A therapeutic relationship* with emotional investment, full of trust, in which the patient is a priority. Its positive image of man holds the premise that the human being is essentially good. The therapeutic relationship is nurtured by using proverbs, stories, and accessible, respectful language. The positive interpretation strengthens the relation while challenging relational disturbances prevailing so far.
2. *An explanatory principle easy to understand* by the patient and still complex enough to allow the therapist to juggle with aspects of the unconscious life. Throughout, in Positive Psychotherapy, terms are used that are easily understood by the patient. For example, the reference to capacities such as justice, performance, tidiness, and patience helps the patient effortlessly understand the intrapsychic conflicts and how they work.
3. *An analysis of the situation of the patient which provides her/him with the possibility to take control of her/his illness* – in Positive Psychotherapy we start from the premise that the patient is equipped with everything she or he needs both for developing symptoms and for dealing with them. Illness is a situation in which the previous problem-solving methods reach their limits, the patient being on the verge of discovering new ways of dealing with life. Thus, the illness becomes an opportunity, the symptom becomes a partner, and the therapeutic process becomes a working model for dealing with life issues.
4. *Sending out hope* with the aim of putting an end to the patient's demoralization and suffering while accepting pain and to learn to live with pain and find a meaning for it.
5. *Analyzing and transmitting successful experiences* to provide the patient with more confidence and competence. Positive Psychotherapy focuses on the patient's previous experiences in which she or he successfully dealt with similar situations and emphasizes the resources and capacities involved in these experiences.
6. *Encouraging the act of experiencing emotions as a premise for changing attitudes and behaviors:* This is done, for instance, by providing stories and proverbs, activating past experiences, promoting inspiration and resonance by a comprehensible model, behavioral activation of resources, and changing interpersonal interactions.

The Five-Stage Procedure

The structured stages in Positive Psychotherapy treatment (five-stage procedure: observation/distancing, inventory, situational encouragement, verbalization, and expansion of goals) make the intervention – at least in a traditional understanding – less open than the psychoanalytic procedure where the "transferal neurosis" develops freely. However, newer psychodynamics approaches (e.g., Wöller's resource-based psychodynamic therapy for the borderline disorder [20]) also promote a more structured procedure, while Positive Psychotherapy does not come close to CBT-style manualization, but it is semi-structured. Also, the semi-structured way of organizing the patient's information in the first interview, as well as giving homework and self-reflection exercises at different stages, resembles more cognitive-behavioral approaches. The explicit focus on the objectives and future

visualization from the early beginning of the therapy promoted by questions such as "how your life will be when the symptoms are not present anymore?" link Positive Psychotherapy to short-term and solution-oriented therapy.

In the stage of *observation/distancing*, the therapist and patient take a step back and look at the situation of the patient from another perspective. This involves the therapist's observation of the unfolding scene and its transference-countertransference (psychodynamic aspect), but it also involves a more active, empathic, and present therapist (similar to client-centered therapy). The focus is not only on the symptom but also looking at the situation in a broader sense involving strengths, opportunities, and cultural aspects. Here, Positive Psychotherapy relates to humanistic approaches in terms of addressing aspiration, with solution-oriented therapy in terms of aim-setting and with cognitive-behavioral therapy in terms of promoting symptom observation in everyday life. Also, the patient's understanding of the problem is observed as well as whether her or his objectives are more symptom-related or toward relationship and self-understanding. This also influences whether later practical interventions are chosen more on a cognitive-behavioral or psychodynamic level.

The *inventory stage* promotes the patient's understanding employing different models for analysis and self-reflection (DAI, balance model, etc.). On the level of technical procedure, this resembles cognitive-behavioral approaches, while the reasoning itself is more a psychodynamic one. The concern of the therapist during this second stage is to find out the former experience similar with the one which the patient experiences now: the interplay of present and past (actual conflict, basic conflict), the understanding of early complexes and objects relations (model dimensions), current decompensation (microtrauma, life events, actual capacities, stages of interaction), and current compensation (balance model). However, other resources and the patient's learning style are emphasized, too (systemic perspective).

The stage of *situational encouragement* has resource-activating aspects comparable to hypnotherapy and solution-oriented therapy. Also, strengthening exercises are applied such as relaxation techniques (behavioral aspect). Biographical longings, compensations, and learnings are appreciated (humanistic and psychodynamic aspects). The positive re-assessment of symptoms and conflicts prepares the patient's "ego" for a more relaxed activation of conflict-related memories stored in the subconscious mind, thereby weakening resistance and promoting later reprocessing. As Peseschkian puts it, the stages 3 to 5 become then "anesthesia, surgery, and aftercare."

In the *verbalization stage*, working on the key conflict – between openness and politeness – is promoted. Connected with this, inner conflicts are worked through (psychodynamic aspect), neglected communicative skills are developed (behavioral aspect), and relationships are readjusted (family consultation, partner group – systemic aspect).

One of the core elements of the therapy used not only during verbalization but also in observation-distancing is the use of stories and metaphors. The role of stories, as Peseschkian states in *The Merchant and the Parrot*, is to settle existing norms or to render certain existing norms more flexible, without directly answering the patient's questions [12]. Through this way of experiential intervention, Positive Psychotherapy refers to humanistic therapies, to the Eriksonian hypnotherapy, and – through its collective view – to the symbolistic used in Jung's analytic therapy. In another way, the use of stories might be compared to the dream analysis in classical psychoanalysis, as the well-known Austrian psychologist Peter Hofstätter stated (cited in [14]).

The *broadening of goals*, the last stage of intervention, connects the patient with potentialities of the present life situation and a creative anticipation of the future. This element links Positive Psychotherapy to existential therapy. However, more than it is done in existential therapies, in Positive Psychotherapy at the end of therapy, the three aspects of time – past, present, and future – are considered connecting the patient with her or his life in full and the process of development.

Summary

Gaetano Benedetti stated in 1977 that Peseschkian's Positive Psychotherapy is a remarkable synthesis of psychodynamic and behavioral elements and thus represents an essential contribution to the unified relationships within psychotherapy (cited after [14]). From today's perspective, Positive Psychotherapy can also be seen as an early and consistent implementation of general ideas such as resource-oriented and short-term therapy. At the time of its first publication, these ideas were controversially discussed, but today they have become more and more state of the art (e.g., [4], [19], [20]). Positive Psychotherapy serves the demand "become yourself" that can be found in many humanistic and spiritual traditions. Today, the realities of life are understood to be globally influenced by more and more people. That is also a reason why Positive Psychotherapy integrates the cultural dimension into the therapeutic work and in doing so goes beyond pre-existing approaches.

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Positive Psychotherapy and Meaning of Life

33

Sam Hadji Cyrous

Introduction

We, humans, are animals moved by stories. When we feel well, we sit and tell our friends our best stories; when feeling down, we tell stories of pain and sorrow. At funerals, we recall our best stories with the departed ones. On birthdays, we mark the beginning of a new cycle, with the leading protagonists of the cycle that closes behind. When physically sick, our bodies react as if they were a story to tell (the story of a mistreated liver or a poorly cared stomach…); when mentally ill, we often imagine unreal situations (typical of *deliria* presented in many mental disorder conditions). And when we rest, our brains also tell us incredible stories, many times inspired by past episodes, other times recapping exactly what we have lived, and, yet many more times, stories with no appearance of sense or clear meaning. The challenge born by human beings is not accepting those stories but, rather, seeking, at every single moment, to understand their meaning. Here is an example of a simple, short, and meaningful story:

> I once dreamt I had an interview with God.
>
> "Come in," God said. "So, you would like to interview Me?"
>
> "If you have the time," I said.
>
> God smiled and said: "My time is eternity and is enough to do everything; what questions do you have in mind to ask me?"
>
> The first question came to mind: "What surprises you most about mankind?"
>
> God answered:
>
> "That they get bored of being children, are in a rush to grow up, and then long to be children again. That they lose their health to make money and then lose their money to restore their health. That by thinking anxiously about the future, they forget the present, such that they live neither for the present nor the future. That they live as if they will never die, and they die as if they had never lived…"

Many were the questions that could be set forth by the interviewer in this dream – as told us by an anonymous Internet writer (and oftentimes attributed to the Dalai Lama). But the first and utmost one was to ask the Creator what surprised Him the most in His creation! And, better yet, the way in which the answer was built: the fact that we live in fruitless vicious cycles. We sacrifice our physical body's health to take care of professional achievements so that later we may sacrifice our victories and producing and working hours to recover physical health. The same way, we sacrifice our family relations, our friendships, and the love we have toward our children to offer them what we never had, forgetting to be really there for them. And, finally, we have no glimmer of what our finitude really is, not ceasing the instants life offers us because we fear life to close itself too fast before reach-

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ing what we most desired. The absurd of all this is, nonetheless, to see the great amount of people that never find out what was that they really desired!

And as the words of Sigmund Freud [1] echoed with a higher intensity: "We can only say '*The goal of all life is death*'" (p. 118). After all, how would it be if, like José Saramago's novel *Death with Interruptions*, death would stop working? Aging, diseases, accidents, and no finitude to close the doors of time, and make us think and be concerned, today, with the other, the You in a relationship, visit the other today, tell the other what we feel. We would lose the opportunity to cease the moment but also solidarity and the link that binds us together. To reflect on the meaning of our lives is to comprehend who we are and how we live a life balanced with its finitude.

Meaning, Stories, and Psychotherapy

Peseschkian [2] comes even to declare "strictly connected to those questions [of meaning] is the question of future" (p. 12). For the founder of Positive and CrossCultural Psychotherapy (PPT after Peseschkian, since 1977), "time is not a formal scheme of order, but the dimension in which conflicts appear and are resolved" (p. 35). Thus, the role of the psychotherapist is to become a facilitator of a learning process, in which the patient deals "with their situation and, within the possibilities, [and hence becomes capable of] finding a fit attitude towards the future" (p. 37).

It is up to us, then, to understand the interlink between present, past, and future. In therapy sessions, I invite my patients to choose one of the sentences below and comment on it. After what ends up as a dialogue, I invite them to choose another sentence, this time the one they think they would have chosen, on the first session, having they had access to the sentences. Their reactions are generally of astonishment and enthusiasm.

- By reading the reality, I feel my work has meaning.
- By reading the reality, I see well what motivates me.
- By reading the reality, I understand that sacrifices are worth it.
- When I dream of the future, I understand many pathways.
- When I dream of the future, I feel I shall be rewarded.
- When I dream of the future, I see the result with clarity.
- When I look at life's rearview mirror, I see who I was and how I have progressed.
- When I look at life's rearview mirror, I understand I did it all correctly.
- When I look at life's rearview mirror, I feel how much I have accomplished.

The sentences are an invitation to metaphorically read about the present (readding the reality), the past (rearview mirror), and the future (dream), at the same time as it approaches the matter of freedom and its consequent responsibility in our actions. With each choice, patients understand where they stand, now, and have stood, in the past. In this exercise, people don't only choose their temporal focus on the present but also revisit its past being and perceive that, from the very beginning, they had within themselves a capacity to find the cure and/or overcome the challenges, confirming Peseschkian's claim [2], "Healthy is not the one who has no problems, but the one who has learned to deal with them" – a sentence that also confirms the Principle of Hope – a backbone for Positive Psychotherapy: patients are endowed with "capabilities and potentials (…), that enable them to find new, different, and perhaps even better solutions (…), bringing with them not just the illness, but also the ability to overcome it" [3]. As Sartre [4] would say, in its *Being and Nothingness*, the way we live makes us unavoidably responsible by the passing of time in our lives, and hence we bring our inner challenges but also the capabilities to beat them; we bring our personal wars but also the mechanisms toward peace:

> the situation is mine because it is the image of my free choice of myself, and everything that presents to me is mine in that this represents me and symbolizes me. It is not I who decide the coefficient of adversity in things and even their unpredictability by deciding myself.

> Thus, there are no accidents in life; a community event which suddenly bursts forth and involves me in it does not come from the outside. If I am mobilized in a war, this war is my war; it is in my image and I deserve it. (p. 677)

In many ways similar to the story of Job who, as it is described in the Bahá'í version, learns an important lesson:

> God conferred upon Job the mantle of prophethood. He was wealthy, owned a vast area of land, and lived with his wife and family in great luxury and comfort. Having been entrusted by God to guide the people to righteousness and truth, he dedicated his life to fulfilling this mission among his community. He summoned them all to the Cause of God, but they became jealous and accused him of insincerity, saying that his devotion to God was due solely to his wealth and material possessions.
>
> In order to manifest his truthfulness to the eyes of men, God surrounded him with tribulations. Every day a fresh calamity descended upon him. First, his sons were taken from him, all his possessions were removed and his crops burnt. Then he was taken ill and his body was afflicted with disease and covered with boils. In spite of all these calamities, he remained thankful to his Lord and patiently endured hardships with a spirit of resignation and detachment. Yet his afflictions did not end there, for he was forced out of his village with no one to help him except his wife, who believed in him and did all she could to alleviate his pain. In the end he became destitute and was without food for many days
>
> Job was so patient and resigned to the will of God that his thankfulness and devotion to his Lord increased with his trials. At last, having proved his detachment from earthly possessions, God again bestowed upon Job all that was taken from him. His teachings spread and his words penetrated into the hearts of the sincere, enabling them to recognize and acknowledge his station. (cf. told by Taherzadeh, 1988, p. 269-271) [5].

Once told, this story may cause mixed reflections. In some cases, people get even disturbed with the story; in one specific case, after hearing it, the person was in such a revolt that would simply refuse to, in his own words, accept such an aggressive God, who would punish those he claimed to love, which takes me to what is now my first question every time I tell this one story:

- *Does the story suit only to religious people?*

When asked that question, the patient is invited to bring the matter to a new level of clarity. People understand that by taking it off the religious field and putting it in their personal reality, adults of both gender and young people from the most diverse aging groups may question themselves on their actions and their own responsibility toward the processes in their lives and, even, if there would be a moment, a place, and a situation in which they would not be responsible for their choices and actions. They come to realize that it is not about being at the presence of a cruel or testing God but rather in front of the changes and chances in life that we cannot and shall not control but that may look as if they control us. And when we take our focus from off the problem, we may foresee the many elements that may help us to solve it. This is why I invite my patients to think in the functions of the story, as Peseschkian [3] has taught us, with the following questions:

- *What are the capacities you see in the main character?*
- *What other stories from the same genre do you know?*
- *Do you consider this to be a real or fictional story?*

The image of having a being in unjust suffering allows those who listen the story to more easily identify with the theme of the story, reflecting about their own lives (mirror function), being able to test new response models to be applied to the conflicts that brought them to the session (modeling function). The main point here is to provoke them to consider the following question:

- *What are the stories of suffering that we live and how to face them?*

Peseschkian [2] reminds us how "the subject is on a conflict between two possibilities that possess their light and shadow" (p. 42) or, in the poetic words of Oscar Wilde [6], set forth in the screams of Dorian Gray: "Each of us has Heaven and Hell in him" (p. 197). It is from this metaphoric revelation of constant trekking between heaven and hell that is made possible finding meaning to our own existence.

So, as it may happen, it is mandatory to those of us offering psychotherapeutic assistance to think:

- *What makes each of us unique?*
- *What binds us together?*

A personal reflection: My genetic origin is from my Persian parents, yet a Uruguayan baby, a Brazilian child, and a Portuguese youngster, and consequently, the following questions made me wonder: *Are we potentially one?, or Does our diversity make us stronger?* These questions troubled my thoughts for many years, up to the day I started noticing and appreciating the typical Portuguese pavement stones, each one externally limited, sometimes ugly, and with imperfect edges. Aren't we, humans, also like this, each of us imperfect in our own way? Beauty rises when we put these stones together and create pavements with the most beautiful images, only visible to those who see the whole picture and not only the single stones. In the same way, "If all men were perfect, then every individual would be replaceable by anyone else," like mosaics and stained glass perfectly cut and outlined seen in gothic German churches ([7], p. 122). Just as death, as a temporal limit, is a constituting element for meaning, our imperfections are limitations and thus assist us in finding meaning in our lives. So, by being unique and consequently different, or diverse, lastly, our diversity implies a unique and unrepeatable individuality.

Viktor Frankl, with whom Peseschkian spent a part of his psychotherapeutic education, and even worked together in Vienna and elsewhere says:

> ...The significance of such individuality, the meaning of human personality, is, however, always related to community. For just as he uniqueness of the tessera is a value only in relation to the whole of the mosaic, so the uniqueness of the human personality finds its meaning entirely in its role in an integral whole. Thus, the meaning of the human person as a personality points beyond its own limits, towards community; in being directed towards community the meaning of individual transcends itself. ([7], p. 123)

We are talking about a community that enables the development of the full potential of both the person and the collective, in a sort of double relationship with society and personal development, where one may find the meaning of their life. It is as if because of our limits that we are enabled to develop individually: our physical limits are the ones we try to surpass, the psychological conditionings that we try to overcome, and the social rules that we try to change. We are capable of evolving, individually and collectively, because of such limits.

Seeking Meaning Through Stories: Applying Peseschkian's Balance Model

Peseschkian asserts that we all possess two capacities. The primary ones are within the capacity to love, and the secondary ones are within the capacity to know. The first gives the emotional bond to give and receive love and the other the rational bond to learn and teach. Perhaps a third capacity is imperative for our scope – the capacity to seek, free and independently, the meaning of our existence – a prerational and preemotional, innate capacity unique to our species, a capacity some may ignore (because of fear, ignorance, unreadiness, lack of reflection…). The alienation of this process of seeking for existential meaning is what, many times, toss us toward depressive or anguished symptomatology and even suicidal thought or action.

Seeking to understand our own limits, so we may, afterward, love and know them, is transforming. If we think within the sphere of Balance Model, where we have four dimensions that ought to be balanced, we may realize how some patients arrive at the sessions and how should the therapeutic process be. This precept rooted in Positive Psychotherapy tells us that we have the physical dimension and the physical body ruled by natural laws; an achievement dimension that allows concrete and solid goals (often turned toward careers we now call professional); a relationship dimension where one finds traditions and family, friends, and other relations; and, lastly, a transcendental, intuitive dimension turned into the realm of dreams and the future.

This is the point that unites all human beings. The way in which we seek to live each one of these limits is what takes us to find a meaning in our lives or in the words of Peseschkian [2] – "Despite all cultural and social differences and the peculiarities of each person, we observe that all people resort to typical ways of dealing with conflicts so they may overcome their problems" (p. 133) – we are different in what points out to the essence but united in overcoming these problems and conflicts.

Peseschkian [2] teaches us that we need "first" to make "a global differentiation of what is me and not-me" (p. 88), being thus the role of the therapist to assist people in consultation to find their limits between me and not me in all the dimensions. When we are turned toward the **physical dimension**, our bodies react to the conflicts – headaches, pain in many organs and muscles, psychosomatization of many issues, and difficulties in sleeping, in sexuality, or in eating. We find out an alleged ugly image of ourselves (being it adulthood, weight, wrinkles, or aging as a whole), struggling with it or accepting it. We may be Dorian Gray whose picture mirror becomes uglier and older by the day while we protect, at every cost, our body; or we may be a Stephen Hawkins who accepts his physical limitations to overcome them, leaving his legacy as one of the highest genius of contemporaneity. I constantly invite patients to think of their bodies – *Is this the body you want? How did you come to discover it? What are the physical impairments? Do you like seeing yourself in the mirror? Do you appreciate food, eat too fast/slow?* Some of these questions, in our postmodern society where the body has become an empty temple, cause pain, since most are not aware or even know how to deal with the limits of their bodies or even respect other people's bodies (assuming they own the other, sometimes even through physical and sexual violence). It is thus mandatory to educate the generations of youth and pre-youth to know their bodies and accept the diversities they put forth, despite their similarities.

When focused on the **achievement dimension**, we confuse work with our own being, and any critics are held as personal; and to not hear them, we stick our heads in work or run away from the critics and work all together. We live expectations that are hard to achieve, with fear of failing, of assuming who we are, of coming out of the programmed, of the alternatives, and of ridicule. Questions are made on the *indecision before fear*, *other people's opinions on personal abilities*, *competitiveness*, and *consternation toward the ridicule* to better understand the way we live this dimension and its limits. Once, during therapy process, a patient, a Brazilian public high-school teacher, in his first session, told me he was tired of feeling like Sisyphus, always pushing the useless rock mountain up, to which I offered a contrast asking why didn't he try, rather, to be a Prometheus who also had a mission to accomplish and risked eternal damnation for infracting the norms and, eventually, becomes the true hero for humanity since he was the one who brought the flame of knowledge to people. In the many sessions to come, the patient claimed to increasingly be Prometheus, doing his best for his students: to transcend the limits of achievement dimension that offered him conflict, to achieve his meaning of sharing knowledge to others.

In **contact dimension**, our focus is on relationships. When conflict arises here, we become dependent of others or too independent, because we don't know how to connect. Feelings may be in constant boiling or totally withdrawn because of obvious fears. It is important to ask how they live their limits with and within their families, their couple life, and their friends. *To whom do you express your emotions? Do you have any difficulties expressing them? How do you feel before the disgust of not being who you would like to be? How do you feel before the disgust of not being who the other would like you to be? How do you feel before finding out the other is not who you thought him to be?* In the scope of this dimension, we find the dichotomy of Romeo and Juliet, on the one hand, and Majnún and Laylí, on the other: both cases show the absence of the other causing an apparent separation, but in the first one, separation took us to a meaningless suffering in which both die, and consequently, it

implies that they don't end up together and, in the second, both are graved side by side, implying that in the afterlife, there would be a reencounter. By reading both narratives, we learn that there is a feeling we all possess, but what differentiate us is if we are capable of living in this dimension's conflict, without seeing its meaning, or, instead, we find meaning in the limits of suffering that emotions may cause.

And lastly, the dimension of meaning and **future**, perhaps the dimension that makes us truly humans. In an allegoric sense, it would be the dimension of the alpinist who scales and tracks a mountain; he sees only the clouds ahead, not the summit, and may give up; another alpinist understands in the thin air and strong wind the proximity to the peak and doesn't abandon the journey. It is here we have the ability of interpreting reality; in the previous dimensions we may see, work, like her or not, but here we are capable of interpreting reality, and we may, of course, even be wrong! This is the dimension of the "in spite of": in spite of physical conditioning, in spite of critics and fears, and in spite of our feelings, we make the difference and change the ecosystem – it is the dimension of the unlimited, of possibilities, and, consequently, of responsibility for what I do and/or decide not to do. Deeper conflicts oscillate here between connecting or not to our essence, accepting who we are or fighting against it, and accepting a life of freedom without responsibility (indulgence? whim?) or of responsibility without freedom of choice (and consequently guilt). It is perhaps the dimension "in the core of our existence, in the disposition to serve all things, good and bad, beauty and ugly, living and dead," which Scheler ([8], p. 25) calls humbleness.

It is from the balance between the limits the four dimensions present to us that we are enabled to seek the meaning of our lives. It is like a fair garden. Our physical dimension allows us to plant the flowers, with achievements we organize the location of each one considering their needs of sun and nutrients, with contacts we enable those that need solitude or presence be comfortable in the whole, and, lastly, with future dimension, we visualize the garden months before, knowing our efforts shall be rewarded. The meaning of the garden isn't in any of the dimensions; it is in the four of them together. The meaning of the garden is not in the possibility of doing anything anyways but rather knowing the limits of what, when, and how to do. The meaning of the garden is not in the present nor in the past but in the capacity to deal today with the learnings of the past, to create a multicolored future.

And this is perhaps the ethics professed by Sartre [9] who said:

> And, when we say that man is responsible for himself, we do not mean that he is responsible only for his own individuality, but that he is responsible for all men. (…) When we say that man chooses himself, we do mean that every one of us must choose himself; but by that we also mean that in choosing for himself he chooses for all men. (…) To choose between this or that is at the same time to affirm the value of that which is chosen; for we are unable ever to choose the worse. What we choose is always the better; and nothing can be better for us unless it is better for all. (p. 20)

What may we understand here? That (1) our happiness is interlinked to the happiness of the whole and, furthermore, (2) ethics is to choose, free and responsibly, something we all, in equal circumstances, would choose. The sense of seeking a meaning for our lives is only possible if we respect this rule. Our responsibility is with humankind as a whole. In the words of Mandela, it is in the relationship with the other that we find a meaning: "What counts in life is not the mere fact that we have lived. It is what difference we have made to the lives of others that will determine the significance of the life we lead."

Doors as a Metaphor for Life

To end this matter, a final word on meaning of life in the framework of Positive Psychotherapy: we need to know good metaphors about limits of life. And what better metaphor on limits than a door?

Doors represent limits between (a) what we choose and (b) what we decide not to choose, between (a) a choice and (b) the proactivity to

open them. They are the limits of a life that has just been born since the door to this world has been opened and the limits before death which closes the door of life. They are the borders that separate feelings such as sorrow and happiness in the other side or the border that imbues us with fear for what is in the other side. In the middle ages, an X on a door would represent that within it there was a plague; in Andalusia there are moments and cities where the doors are opened so tourists may see the beauty of inner gardens. For the Hindus, it is important to decorate homes with *Bandanwar*, put over the doors, to attract and please Lakshmi, the goddess of wealth. These objects are the first thing seen by guests while welcoming them. In Islamic tradition, one may find the *Jannah*, the paradise temple with its eight doors, each describing the spiritual practices and virtues a true believer must have. John (10:9) recalls Jesus calling Himself "the door," through which one must enter in order to "be saved." In this same line, Bahá'ís call one of their two founders The Báb, which in Arabic means the door, the door through which comes a new era that unites and separates present, past, and future of humankind.

Doors limit our space. The eyes of someone turned to the physical dimension see them as structures (and ask about their material, their thickness and size, their color, and even about their beauty), understanding them all as equal in some aspects and diverse in others. The eyes of those turned toward the achievement dimension perceive that some serve better their security functions more than others, and assess the easiness to open them without the key, the easiness to copy the key, the fears of something going wrong, and the assurances to go right, and they perceive the strategic strengths and weaknesses of the doors. Those who look at the doors focused on contact, think of uniting those who are inside the door's premises and separate those who are out of it; delineate those who are together in a group from those who are not from the group. It is always from this limit between *what is* and *what is not* that we come to grasp *what may be*! And when we unite these dimensions to the future dimension, we learn that the door needs to be opened but in the correct way; if we hold a heavy weight, opening it to the inside may be hard; if many people want to come in, opening it to the inside may bring in new people, ideas, and information, without prior outing of who/what should leave; if stuck, pulling it will only increase the difficulty of opening it, since we need to push it to open. This is why, future dimension is so relevant. It is this last dimension that makes it possible to comprehend that the door must be opened from within out, allowing our openness to the diverse, the different, the external, and the new, so that *I* with *what is not a part of I* find happiness.

In the words Frankl has attributed to Kierkegaard: the door of happiness opens only from inside out. Or in Positive Psychotherapy, the door of happiness opens if we know its mechanisms, love what we may find out there, and, eventually, we seek to open it.

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Positive Interpretation as a Tool in Psychotherapy

34

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Introduction

A human being is governed by his thoughts, and what we are today comes from our thoughts of yesterday, which will build our life of tomorrow: our life is the creation of our mind. Buddha makes this point clear by saying "If a man speaks or acts with an impure mind, suffering will follow him as the wheel of the cart follows the beast that draws the cart. If a man speaks or acts with a pure mind, joy follows him as his own shadow" [4]. This clearly implies that an individual's thoughts and emotions can affect one's mental health. On the contrary, negative emotions can have a negative repercussion on mental energy; negatively affect the body, achievement, social contact, and spirituality; and lead to serious health problems. In connection with this, Gandhi said, "A man is but the product of his thoughts; what he thinks, he becomes" [6]. Thought has an immense power to bring into being the visible from the invisible, so it is of paramount importance to realize what we think, do, or say comes back to us. If individuals work on the capacity to change their thoughts, they can have a capacity to change their world [11]. Most often our irrational thoughts or cognitive errors dominate in our life, and these thoughts could be annoying, disheartening, and in some cases downright dangerous.

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An ethnographic study conducted among 140 clients, in Ethiopia, showed the following common irrational thoughts or thinking errors: all-or-nothing thinking, overgeneralizing, filtering out the positive, mind reading, catastrophizing, emotional reasoning, labeling, fortune-telling, and personalization [1]. After positive interpretation, most clients explained that positive interpretation will create real value in their life and help them to identify and build skills that last much longer than a smile. Most of the respondents affirmed that positive interpretation supported them to develop other life skills and gave them an increased sense of possibilities. Respondents mentioned that positive interpretation supported them to diminish routine stress and boosted their confidence. A significant number of respondents mentioned that positive interpretation ignited their mind to develop new skills and resources. Several respondents explained that positive interpretation enabled them to create a peaceful and balanced life principle across their body, achievement, social contact, and spirituality.

Because of our experience in childhood and cultural influences, individuals might lack the capacity to interpret problems positively. Lack of positive interpretation might be the triggering factor for deteriorating mental health, suffering from different psychosocial problems – a process where our conscious and subconscious minds play a great role.

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The responsibility of the conscious mind is filtering and scrutinizing thoughts coming from the outside and filtering messages to subconscious mind. What the conscious mind assumes and believes to be true, the subconscious mind will accept and bring to pass [10]. On the other hand, subconscious mind will have a responsibility to implement thoughts directly received from our conscious mind. It doesn't weigh the pros and cons of the thoughts. If it receives success, it will facilitate to implement success, and if it receives failure, it facilitates to implement failure. What you sow in the fertile lands of your subconscious mind, you will harvest in your body and environment too.

Generally, the human mind plays a seeding technique. Therefore, if we plant potato, potato comes out, and if we plant tomato, tomato comes out. However, it is impossible to expect potato after planting tomato. By the same analogy, if we plant positive thought, positive thought will come out, and if we plant negative thought, negative thoughts will come out. Every one's life is in his hands, to make of it what he chooses [7], and positive interpretation can serve as movers and shakers on one's life to create a stable mental strength: managing thoughts, regulating emotions, and behaving productively despite any circumstances. When people change their irrational beliefs to undogmatic flexible preferences, they become less disturbed [1, 2].

Definition of Key Terms

Thoughts

Thoughts are an idea or opinion produced by thinking or occurring suddenly in the mind. These thoughts can have a positive or a negative emotional valence. The happiness of individuals' life depends upon the quality of their thoughts [8] as negative thoughts produce negative actions and feelings, so positive thoughts produce positive actions and feelings [9].

Positive Interpretation

Positive interpretation is a technique used in Positive Psychotherapy after Peseschkian. It works by reinterpreting problems and avoiding passive attitudes, thus reflecting the ability of clients. With this interpretation, the therapist does not solely address the illness alone but also the subjective ideas about the illness as transmitted through the traditions of the family. In line with this, depression may be understood beyond the feeling of being sad or irritable, with predominantly passive attitude, and instead reflect the ability to react with deep emotionalism [12]. Another way to reinterpret depression is by looking at it as a result of depletion of the available energy during the period prior to the onset of the episode, and that the depressed state represents a kind of hibernation, during which the patient gradually builds up a new story of energy [3].

Irrational Thoughts or Cognitive Distortions

Irrational thoughts are unrealistic and generally negative thinking patterns that individuals might fall into and obsess over. These thoughts can be infuriating, discouraging, and in some cases downright hazardous. Thinking errors contribute to a lion's share for irrational thoughts. The most common thinking errors or cognitive distortions are all-or-nothing thinking, overgeneralizing, filtering out the positive, mind reading, catastrophizing, emotional reasoning, labeling, and fortune-telling [5].

Applications

Positive interpretation is a core concept of the Positive Psychotherapy (PPT after Peseschkian – see Chap. 2) akin to reframing in cognitive behavioral therapy (CBT after Beck). Positive interpretation should be considered across all five stages of PPT consultation: distancing/observation, taking inventory, situational encouragement, verbalization, and broadening of goals. To bring

effective positive interpretation, the therapist should be curious on the following points:

1. Understand the place of positive interpretation in the client's cultural context.
2. Support the client to define positive interpretation.
3. Identify individual and social factors influencing positive interpretation.
4. Identify barriers to positive interpretation.

The therapist should serve as a facilitator in the process of positive understanding and should avoid advising, directing, and judging the client. Then, the therapist should support the clients to interpret their problem positively and should follow the process critically in each session and stages of consultation. To maintain the positive interpretation and eliminate potential relapse, clients should be checked regularly to reinterpret their problems during Positive Psychotherapy. Positive reinterpretations are thus basically a stimulus for rethinking old concepts and for seeing if there are not alternative interpretations and forms of treatment available for the patient [12].

Furthermore, the therapist should focus on major barriers to adopt positive interpretation: personal barriers, social barriers, and environmental barriers. Personal barriers to positive interpretation may include lack of information, low-risk perception, poor perception of benefits, and lack of skills and confidence. Social barriers are comprised of peer influence, social norms, and perceptions about what is normal. Environmental barriers involve poverty, laws, mental health policy, and lack of access to psychosocial services. The main task of positive interpretation is enabling clients to develop alternative attitudes toward their illness and in appealing to therapists to be flexible as possible in their treatments. The table below illustrates change perspectives in the process of positive interpretation [12] (Table 34.1).

Some positive interpretations are capable of being enlarged up on primary capacities, secondary capacities, body achievements, social contact, futurity, and model dimensions (I, you, we, primal we).

Table 34.1 Change perspectives in the process of positive interpretation

Traditional interpretation	Positive interpretation
Depression	
The feeling of being despondent, with a prevailing passive attitude. Spiritual dejection, exhaustion	The ability to react to conflicts with deep emotions
Phobia	
Fear of certain objects, such as mice, dogs, spiders, or of specific situations	The ability to avoid situations and objects which are experienced as threatening
Bedwetting	
Bedwetting is a special form of uncontrolled emptying of the bladder. It occurs at night, when one is lying in bed asleep	The ability to recover earlier, not forgotten ways of reacting when faced with difficult situation. The ability to cry downward
Paranoia	
Madness, insanity, mental illness with primary crazy notions (delusions of persecution, grandeur, reference, among others)	The ability to see oneself as the midpoint of the world and its secret power

Clinical Vignette

The Ability to React to Conflicts with Deep Emotion

The client is a 48-year-old engineer. He is the father of a son and a daughter. He was in the process of divorce when one of his construction sites burned; in addition, he lost a significant amount of money and changed his religion two times. He was diagnosed primarily with depression in Addis Ababa, Ethiopia. After 2 weeks of intensive medication in the hospital, the client was referred to Positive Psychotherapy service.

During the first interview, the following irrational thoughts or thinking errors were observed in the client: persistent sadness; anxious or empty mood; feelings of hopelessness; pessimism; feelings of guilt, worthlessness, and helplessness; loss of interest or pleasure in hobbies and activities, including sex; decreased energy; fatigue; and feeling slowed down. He was even reluctant to receive Positive Psychotherapy. However, he was expecting appropriate service

to eliminate his irrational thought and thinking errors and confusion and return to his normal life and reconcile with his wife, restart his previous business, and get rid of his superstitious thoughts. Initially the therapist requested the client to positively interpret his personal problem. He replied that depression is depression, and it is lack of interest in everything what else could be. Then, the therapist supported the client in interpreting his problem as the ability to react to conflicts with deep emotion and critically observed and checked clients' change across the five-stage consultation. The process also enlarged up on his model dimension, including dimensions of time, trust, and hope. During consultation, he realized that his life components are unbalanced and decided to give due attention on his body, futurity, and social contact (see Chap. 5 on "The Balance Model"). During the termination phase, the client explained that positive interpretation created a real value in his life and helped him identify and build skills that "last much longer than a smile." In addition, the positive interpretation supported the client being able to see other life skills and gain an opportunity to increase his sense of possibilities. Moreover, he mentioned that positive interpretation supported him to diminish routine stress and boosted his confidence and ignited his mind to develop new skills and resources. Because of this positive interpretation, he was able to create a peaceful and balanced life principle across body, achievement, social contact, and spirituality – the balance model.

Summary

Positive interpretation can serve as a guide to shape clients' irrational thought distortions or thinking errors. In Positive Psychotherapy (PPT after Peseschkian), the patient is coming to the psychotherapy room not only with problems but also with solutions. Thus, the relationship between the two parties should be therapist with therapist, and the client is not considered as a patient. This relationship will open a door for supporting clients to interpret their problems positively. Positive interpretation can be influenced by a combination of personal, social, and environmental factors, and it may take some time to effectively bring impactful positive interpretations. Positive interpretation serves as a tool for clients in identifying and replacing irrational thoughts including all-or-nothing thinking, overgeneralizing, filtering out the positive, mind reading, catastrophizing, emotional reasoning, labeling, and fortune-telling. Relapse or setbacks are common across the five-stage consultation phase, and changing the destructive things what an individual says to himself when he experiences the setbacks that life deals all of us is the central skill of optimism [13]. Therefore, the therapist should follow critically and check the status of positive interpretation in each session.

Key Points

We should give priorities to the following points during positive interpretation in Positive Psychotherapy (PPT after Peseschkian):

- Be informed that the patient is entering the therapy room not only with his problem but also with potential solutions.
- Understand the client's experiences and cultural values toward positive interpretation.
- Differentiate client's personal barriers, social barriers, and environmental barriers of positive interpretation.
- Support the client to interpret his problems positively and gear his interpretation with ability or capacity. Then, positive interpretation will create a fertile land for clients to eliminate his irrational thoughts or thinking errors.
- Relapse or setback is very common among clients. Therefore, the therapist should remind and support his clients to reinterpret his problem across the five stages of consultation

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