PSYCHOTHERAPY SCIENCE TODAY

peer-reviewed multilingual journal

PSYCHOTHERAPY SCIENCE TODAY



Vol. 1, No. 1 / 2025

Print ISSN 3104-1868 | Online ISSN 3104-1728

PSYCHOTHERAPY SCIENCE TODAY

Peer-reviewed, multilingual journal available in English, Serbian and Russian.
Print ISSN 3104-1868. Online ISSN 3104-1728. Published biannually.

PST is a clinically oriented journal focused on research in psychotherapy and mental health.
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Published: August, 2025, Volume 1, Issue 1
Printed by Eurodream, Nova Pazova; print run: 100 copies.
Issue DOI: https://doi.org/10.64435/lhrl1288

https://psychotherapyscience.today

Dear Colleagues and Specialists,



We are delighted to present the inaugural issue of *Psychotherapy Science Today (PST)*, an international peer-reviewed journal serving as a new platform for cutting-edge research in psychotherapy and mental health. Our mission is to advance evidence-based psychotherapy by uniting clinicians, researchers, and educators to share expertise, methodologies, and innovative ideas.

PST publishes applied research, case studies, and interdisciplinary investigations spanning psychiatry, clinical psychology, neuropsychology, psychopharmacology, and public mental health. We focus on materials that not only deepen theoretical understanding but also serve as practical tools for clinicians. Particular emphasis is placed on validated methods that address key psychotherapy challenges and enhance patients' psychological well-being.

This first issue is the result of the collaborative efforts of an international team of authors, reviewers, and editors, united by a commitment to scientific rigor and clinical relevance. We express our gratitude to all who contributed to its creation and invite the professional community to join *PST*'s mission: publish your research, share clinical cases, and contribute ideas.

Registered in Serbia, *Psychotherapy Science Today* aims to bridge European and global science, inspiring specialists to make new discoveries. We hope it will become your trusted partner in practice, research, and education, as well as a source of inspiration for further scientific exploration.

Sincerely,
Yuri Tor
Editor-in-Chief

Dear colleagues, researchers, and readers,



It is with great enthusiasm and a deep sense of responsibility that I present to you the first issue of *Psychotherapy Science Today (PST),* where I have the honor of serving as co-editor. This journal is envisioned as a platform that integrates knowledge from medicine and psychology to establish a solid foundation for the development of psychotherapy as a scientifically grounded and clinically significant discipline.

Today, it is increasingly clear that mental processes — emotions, attitudes, behavioral patterns, and subjective experiences — directly impact neurotransmitter systems, autonomic functions, and overall somatic health. Research in the field of psychotherapy not only enriches clinical practice but also contributes significantly to the advancement of medical science by revealing the deep connections between the mind and the body. The ability to modulate somatic states through psychotherapeutic techniques opens new avenues for a truly interdisciplinary approach in which psychotherapy becomes not just supportive, but an active and scientifically validated instrument of healing.

It is a particular honor and joy for me to witness Serbia, with its rich scientific traditions, emerging as a hub for international collaboration in the field of psychotherapy.

I extend my heartfelt gratitude to all authors, reviewers, researchers, and readers of our journal. I wish you success, inspiration, and productive collaboration.

Let us move forward together to shape the future of psychotherapy and mental health!

Sincerely,
Dragan Obradović, MD, PhD
Co-Editor

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CIP — Каталогизација у публикацији
Библиотеке Матице српске, Нови Сад

615.851

Psychotherapy Science Today: peer-reviewed multitlingual journal / editor-in-chief Yuri Tor. — Vol.1, no.1 (2025) — Novi Slankamen: Institute Isida, 2025 (Nova Pazova: Eurodream) — 28 cm.

Polugodišnje. Drugo izdanje na drugom medijumu: Psychotherapy Science Today (Online) = ISSN 3104-1728. Ima izdanje na drugom jeziku: Psychotherapy Science Today (Srpsko izd.) = ISSN 3104-1876. Ima izdanje na drugom jeziku: Psychotherapy Science Today (Русский вып.) = ISSN 3104-1884.

ISSN 3104-1868
COBISS.SR-ID 173907721

Women in search of perfection and achieving a non-existent standard of beauty through plastic surgery

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Received: Feb 4, 2025
Accepted: Mar 14, 2025
Published: August 1, 2025

For citation:
Gurieva SD, Yumkina EA, Zinina AY, Maltseva AV, Shilkina NE. Women in search of perfection and achieving a non-existent standard of beauty through plastic surgery. *Psychotherapy Science Today*. 1(1):3-11. https://doi.org/10.64435/nttw7732

OPEN ACCESS

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Abstract

Objective: The study explores the characteristics of women who, in their pursuit of a "non-existent standard of feminine beauty", manage their appearance and body through plastic surgery. The research reveals the internal conflict of beauty perceptions, the gap between the real and ideal self-image, which is manifested in the opposition between imposed external beauty standards and internal dissatisfaction with one's own appearance.

Method: The study involved 106 women aged 18–42, divided into two groups: experimental (who decided to undergo plastic surgery) and control (who had no desire to alter their appearance through surgery). The Freiburg Personality Inventory (FPI), Hospital Anxiety and Depression Scale (HADS), Body Image Quality of Life Inventory (BIQLI), Life Satisfaction Index (LSI) test, Multidimensional Self-Esteem Inventory (MSI), and Dembo-Rubinstein "Self-Esteem" method were used.

Results: Women who choose plastic surgery exhibit a defensive reaction, a rigid ego image, unconscious emotional reactions, and a tendency to control emotions from the outside, characterised by vindictiveness and an alienated attitude towards their appearance. The lack of feeling that their inner world is of interest to others leads these women to concentrate on improving their outer appearance, depressive manifestations mediated by compensatory attachments to feelings of unacknowledged and incomprehension, and the desire to be the "mistress of one's own life".

Conclusions: Women's desire to achieve a non-existent standard of feminine beauty serves as an illusory solution to problems of inner dissatisfaction, reflecting the deep contradiction between the real and ideal self-image, which requires special attention in psychological practice.

Keywords: non-existent standard; plastic surgery; attitudes about beauty; women's body; self-concept; fear of rejection.

Introduction

What makes a woman decide to take a step that will change her appearance forever? Plastic surgery, one of the most dynamically developing areas of medicine, is no longer just a tool for correcting defects. Many plastic surgeons and psychologists are increasingly asking the question: What motivates women who are willing to go under the scalpel in search of change?

Women's motivation to undergo surgical changes to their appearance often has deep psychological roots, linked to internal conflicts and the desire to restore or change the situation in the best possible way for themselves, with the help of a non-existent standard of feminine beauty. It has been noted that almost every potential and actual female plastic surgeon patient has a history of unrequited love, suffering, and agonising answers to the question of why she was rejected and/or preferred over another [1]. The surgical route becomes a way for them to not only change their appearance but also to replay the script, take control of their story, and create a new, more confident version of themselves. For

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many women, plastic surgery becomes an instrument of 'revenge' or 'restorative justice' to regain their lost sense of self-worth and attractiveness after suffering emotional trauma. According to surveys conducted in surgical clinics, a significant proportion of plastic surgeons' patients are divorced women [2], for whom plastic surgery becomes a symbol of a new life.

Aesthetic medicine is a developing field that amalgamates expertise from diverse medical specialties to enhance physical appearance, elevate self-esteem, and improve quality of life. The integration of innovative technologies and techniques has led to a paradigm shift in procedures for facial and body contouring, offering patients safer, more effective, and minimally invasive options [3]. *Emerging technologies in face and body contouring*, written by world-renowned experts, details new state-of-the-art technologies in body contouring. This resource fills a gap in the literature by providing plastic, aesthetic and dermatological surgeons with clinical information on the latest proven techniques and technologies [4].

Modern technologies for three-dimensional visualisation of the body and face (real and desired) are also becoming available to a certain category of women, which are spreading to plastic surgery and the field of body contouring. These systems create pre-, intra- and post-operative benefits, facilitating a more objective conversation between surgeon and patient about pre-operative expectations, possible complications, personalized limitations, and allowing plastic surgeons to more accurately assess their results during surgery and over time [5].

Over the past decade, there has been a significant rise in interest in corrective and aesthetic plastic surgery, transcending age-related boundaries. The motivations for pursuing such procedures are multifaceted, encompassing both aesthetic aspirations and practical considerations. Key drivers behind the growing popularity of cosmetic surgery include rapid advancements in medical technologies, enhanced procedural safety, and reduced recovery periods, all of which have contributed to its increased accessibility and appeal among diverse patient demographics [6]. It should be emphasised that in recent years, the modern plastic surgery industry has become massive and accessible. According to the study of the International Society for Aesthetic Plastic Surgery (ISAPS), the total number of surgical interventions in the world increased by 7.4% in 2019, compared to 4% in 2017. The most recent survey of the ISAPS global aesthetic statistics has reported a global increase of 3.4%, including 34.9 million surgical and non-surgical aesthetic procedures performed by plastic surgeons [7]. The Russian plastic surgery market ranks among the top ten in terms of the volume of surgeries performed [8]. Plastic surgery is particularly popular among women, who account for approximately 87% of all cases [9].

What is the main trigger that triggers the mechanism of a woman's striving for a non-existent standard of feminine beauty the preservation of 'eternal youth' and 'eternal beauty'? Is there an alternative tool (way, path, mechanism) to plastic surgery for providing psychological help? This study aims to find answers to these questions.

An important aspect is the participation of a large staff of "assistants" for this category of women-attractive stories from glossy magazines, cosmetologists, stylists, image makers, coaches, consultants, and psychologists who recommend women change their image (hairstyle, hair color, style of clothing, etc.) to overcome depression and increase self-esteem. The main motto of such approaches is "Change yourself!". However, for many women, such changes are not enough to satisfy the inner need for transformation, and women go for more radical measures-plastic surgeries.

It is challenging to disagree with the assertion that by modifying one's attitude towards oneself, elevating self-esteem and confidence, and exuding positive energy and emotions, any woman can attract the interest and attention of men. The main reason is not only how you look but also how you feel about yourself: psychological attitude, self-relationship, positive emotions-all the things that are broadcast outwardly and read from the outside. However, only a small fraction of 'lucky' women who have undergone plastic surgery can boast of such a state. Many become regular clients of plastic clinics, continuously undergoing surgeries in search of achieving the pursuit of an elusive non-existent standard of feminine beauty and striving to become happy, successful, and the most beautiful in one day.

The average psychological portrait of a plastic surgeon's patient is as follows: she is an affiuent, independent, active woman who spends a lot of time on her appearance. These women can be very socially successful and adaptable. At the same time, they are characterised by high levels of anxiety, depressive symptoms, neurotic and dysmorphophobic disorders. It is noteworthy that plastic surgery can be used as a means to combat anxiety. It has been found that repeated use of aesthetic medical services correlates with a decrease in anxiety levels [2]. In the structure of these women's self-concept, the physical component of appearance is most pronounced, and they often have a discrepancy between the real and ideal images in the 'physical self' and the 'social self' [10]. According to their own

estimates, sexual dissatisfaction and a hard-to-bear feeling of loneliness occupy a leading place among the motivational factors that encourage women to seek surgery [2]. The evidence that the predominant accentuations of these women are hysteroid or sensitized types suggests that the deeper motives are the need for attention (in the hysteroid type) and social recognition (in the sensitized type). For both of these types, it is extremely unbearable to feel rejection. But while in the hysterical type this is associated with a pronounced egoism and narcissism, in the sensitive type it is associated with deep insecurity and feelings of inferiority and abandonment.

Given these features, the question remains open: to what extent does plastic surgery contribute to the improvement of the mental state of the individual and increase professional and social success? These questions are studied by such domestic and foreign researchers as V. V. Anikina [11], L. T. Baranskaya [12], A. G. Leonov [13], V. E. Medvedev [9], K. F. Mirakyan [14], A. A. Osminina [15], N. N. Petrova [16], N. A. Polskaya [17], G. Cafri [18], D. B. Sarwer [1], C. Shilling [19], J. K. Thompson [20], and others.

Numerous attempts to determine the main focus in understanding the essence of this problem are based on the following: lack of self-satisfaction and active aspiration for a happy and prosperous life. For this reason, we decided to approach the issue of ways to improve the psychological health of women who decide to undergo plastic surgery from the perspective of the construct of subjective well-being.

In scientific social-psychological literature, there are different approaches to conceptualisation of this concept. It is considered a complex, multilevel, socio-psychological phenomenon, which includes the assessment and attitude of a person to life and self (E. Diener, A. Yang, R. M. Shamionov, E. F. Yashchenko [21–24]); as an integral indicator that combines life satisfaction and the feeling of happiness (G. A. Monusova [25]); as an active position of the individual (A. A. Lebedeva [26]); as a developing network of positive social ties of the individual (S. A. Druzhilov [27]).

Based on the model proposed by E. Diner, we decided to conduct a comprehensive socio-psychological survey of women who decided to go to a plastic surgeon and compare their performance with women who do not feel the need to change anything in their appearance in such a radical way. Such a research design, in our opinion, will help to present more clearly the 'targets' of psychological care and support for aesthetic surgery patients.

Method

The initial hypothesis of this study was the assumption that women who have made a decision about the need for plastic surgery have a set of traits that mask their fear of being rejected (whether by a real person or by life). At the same time, a maladaptive, compensatory character will be observed in the structure of qualities mediating a decrease or increase in anxiety and depressive manifestations of these women.

Sample

Ethical issues were carefully considered: participants were informed about the nature of the study as well as its anonymity and confidentiality; informed consent to participate in the study was obtained from each respondent; every questionnaire was coded; and personal information was deleted.

The total sample of respondents was 106 women aged between 18 and 42 years. The whole sample was divided into two groups:

- Group 1, experimental—women who made a decision about plastic surgery (n=54);
- Group 2, control group—women who had no desire to change anything in their appearance through surgery (n=52).

The sociodemographic characteristics of the sample are presented in Table 1. The main age of respondents in Group 1 is over 35 years old; most of the women have higher education, are married, and are employed. The main age of women in Group 2 is from 26 to 35 years old; most of the women have higher

	Age, years			Education			Marital status			Employment	
Group	18-25	26-35	> 35	higher	specialised secondary	secondary	married	single	divorced	works	doesn't work
Group 1	20.4	33.3	46.3	70.4	24.1	1.9	63.0	18.5	18.5	72.2	27.8
Group 2	19.2	50.0	30.8	67.3	19.2	5.8	57.7	26.9	15.4	65.4	34.6

Table 1. Sociodemographic characteristics of the sample (%)

education, are married, and are employed. Thus, the sample is sufficiently balanced by sociodemographic characteristics. Despite the broadly balanced sociodemographic characteristics of the sample, there are differences in the age distribution between the groups, underscoring the necessity for additional research employing a more age-balanced sample.

Measures

1. The Freiburg Personality Inventory (FPI), adapted by A. A. Krylov and T. I. Roginsky, was used to study women's personality profiles [28];

2. The Hospital Anxiety and Depression Scale (HADS) by A. S. Zigmond and R. P. Snaith was used to assess women's levels of anxiety and depression [29];

3. The T. F. Cash Body Image Quality of Life Inventory (BIQLI) was used to quantify the impact of body image on women's quality of life [30];

4. The "Life Satisfaction Index" (LSI) test by B.L. Neugarten was used was used to assess women's overall psychological state [28];

5. S.R. Pantileev's multidimensional self-attitude research questionnaire was used to assess women's overall self-esteem levels [31];

6. "Self-assessment" modified Dembo-Rubinstein technique for measuring the level of self-esteem and subjective perception of one's own qualities.

Statistical data processing was performed using the Mann-Whitney U test for comparison of independent samples and correlation analysis using the Spearman's Rank Correlation Coefficient. Software IBM SPSS Statistics 22.0.

Results and discussion

Table 2 presents the results of a comparative analysis of personality profile indicators of the respondents of the first and second groups (Freiburg Personality Inventory (FPI)) using the Mann-Whitney U test.

Table 2 shows that there are statistically significant differences in the personality profile of the respondents of the first and second groups, which indicate the following: Women who decided to undergo plastic surgery are more prone to spontaneous manifestations of aggression (i.e., unaccountable manifestations of hostility, vindictiveness, and cruelty); they have a higher level of depression (lowered mood, motivation, and feeling of their own failure); they are more irritable (more susceptible to affective reactions). At the same time, in comparison with the control group, they are less shy, more withdrawn, inclined to introversion, and emotionally stable (i.e., they do not have strong mood swings). These features are consistent with the data of other authors [32].

The results of the comparative analysis of the emotional-value components of the self-concept of two groups of women (Table 2) show the presence of statistically significant differences in the closedness and reflected self-concept. This suggests that women from the experimental group are less inclined to realise and reflect on their own self-concept. At the same time, they are more predisposed to believe that they are respected and liked by others.

At first glance, the differences in the scales 'internal conflict' and 'self-accusation' may seem unexpected. However, given the previous findings, we can conclude that the greater internal freedom from conflict of women who chose to have plastic surgery, as reported by themselves, is consistent with a more pronounced tendency to reject information about themselves that could undermine their positive self-image. Consequently, self-blame, as a form of self-criticism, is also lower for them. In other words, internal contradictions are more strongly displaced by aesthetic surgery patients.

Let us present the results of a comparative analysis of anxiety and depression levels in women who decided to undergo plastic surgery (Table 3).

Thus, the levels of anxiety and depression are significantly higher in the experimental group. In addition, the level of anxiety has subclinical expression. In other words, women who have decided to undergo plastic surgery are characterised by a high level of anxiety with a predominance of negative emotions and moods, which is not inconsistent with the data in the scientific literature [33–35].

A comparative analysis of the quantitative assessment of the impact of body image on quality of life (Table 3) showed that women who had decided to undergo plastic surgery had a more negative perception of the impact of body image on quality of life compared to women who did not feel the desire to change something about their appearance.

The results of the comparative analysis of the indicators of the general psychological state of women (LSI) did not reveal significant differences, but it is worth noting that it is low in both groups (Table 3).

In the general level of self-esteem and life claims, we did not find any significant differences, while in such a parameter as 'appearance,' it was revealed at the level of statistical tendency ($p < 0.07$) that the assessment of the desired appearance of women who decided to undergo plastic surgery is higher than that of women from the control group. In other words, they are less satisfied with their current state of appearance.

In view of the evidence indicating that a significant proportion of the women seeking plastic surgeons are experiencing some critical events in

Characteristic	Mean value		Mann-Whitney U	p
	Group 1 (n = 54)	Group 2 (n = 52)		
Personality Profile Indicators				
Neuroticism	4.41	3.58	1282.0	0.411
Spontaneous aggression	5.46	4.21	871.0	0.001
Depressiveness	5.52	4.75	1035.0	0.018
Irritability	5.78	4.31	882.0	0.001
Sociability	5.98	5.46	1237.0	0.285
Poise	6.37	5.81	1210.0	0.216
Reactive aggression	5.93	5.48	1218.0	0.233
Shyness	3.76	5.90	616.5	0.000
Openness	4.50	6.21	671.5	0.000
Extraversion-Introversion	5.02	6.00	1028.5	0.017
Emotional lability	4.44	5.33	916.5	0.002
Masculinism-feminism	5.39	6.12	1105.0	0.056
Emotional-Value Components of Self-awareness				
Closed-mindedness	7.15	5.08	381.0	0.000
Self-confidence	8.67	8.69	1318.5	0.570
Self-management	7.59	7.60	1355.0	0.754
Reflective self-attitude	5.96	4.96	1028.0	0.016
Self-value	9.20	8.63	1116.0	0.051
Self-acceptance	8.26	7.79	1107.0	0.054
Self-attachment	5.13	4.83	1255.5	0.344
Internal conflict	4.80	6.04	1078.0	0.038
Self-accusation	3.61	5.10	956.5	0.004

Table 2. Results of the comparative analysis of the personality profile indicators (FPI) and emotional-value component of self-awareness of the respondents from the first and second groups

Characteristic	Mean value		Mann-Whitney U	p
	Group 1 (n = 54)	Group 2 (n = 52)		
Anxiety	9.07	4.15	221.0	0.000
Depression	7.20	3.52	347.5	0.000
BIQLI[a]	0.61	1.85	576.0	0.000
LSI[b]	17.52	19.46	1244.0	0.311

[a] *BIQLI — Body Image Quality of Life Inventory.*
[b] *LSI — Life Satisfaction Index.*

Table 3. Results of the comparative analysis of anxiety and depression level indicators, the Body Image Quality of Life Inventory (BIQLI), and the Life Satisfaction Index (LSI) of the respondents from the first and second groups

their personal lives, a decision was taken to separate and compare subsamples of married and unmarried women within the experimental and control groups (Fig. 1).

Using the Mann-Whitney U criterion, statistically significant differences in the indices of emotional lability and depression were found. Thus, the highest level of depression is in the group of married women who are willing to undergo plastic surgery. It is the lowest among married women from the control group. At the same time, the highest level of emotional lability (i.e., tendency to emotional state fluctuations) was among unmarried women from the control group, and the lowest was among unmarried women in the experimental group. These results can be interpreted in such a way that plastic surgery for married women is seen as a means of resolving an emerging crisis in interpersonal relationships or an opportunity to avoid it. Whereas for unmarried women, it is more an attempt to compensate for repressed internal contradictions and to assert themselves by changing their appearance. Women from the control group generally allow themselves to be more emotionally free.

Correlation analysis showed the following interesting data. As expected, the structure of correlations in the experimental group of women (women who made a decision about plastic surgery) differs from that in the control group (women who had no desire to change anything in their appearance through surgery) (Table 4).

Higher levels of personality depressiveness (FPI) in the experimental group of women are mediated by higher levels of self-management and spontaneous aggression and lower levels of positive evaluation of their own qualities. In other words, these women's depression grows along with the realisation that they are not perfect and that they themselves must be the source of their own activity and effectiveness. This state is also accompanied by manifestations of aggression that are irrational in nature. The presence of situational depression in these women is associated with a sense of self-worth that reflects attention and care for their inner world (love, spirituality). The more a woman values herself and her inner world, the stronger the manifestations of situational depression will be. It is possible that feeling unrecognized and unappreciated reinforces this state. As far as anxiety is concerned, we see that the increase in situational anxiety among women in the experimental group is curiously accompanied by an increase in mood and a desire to cooperate.

The same parameters in women from the control group have a different relationship (Table 4). Thus, personal depression is inversely related to neuroticism and sociability and directly related to reactive aggression and openness. It turns out that the lower the mood background and depression in these women, the higher the lower their desire for contacts with a simultaneously growing need for trusting relationships. At the same time,

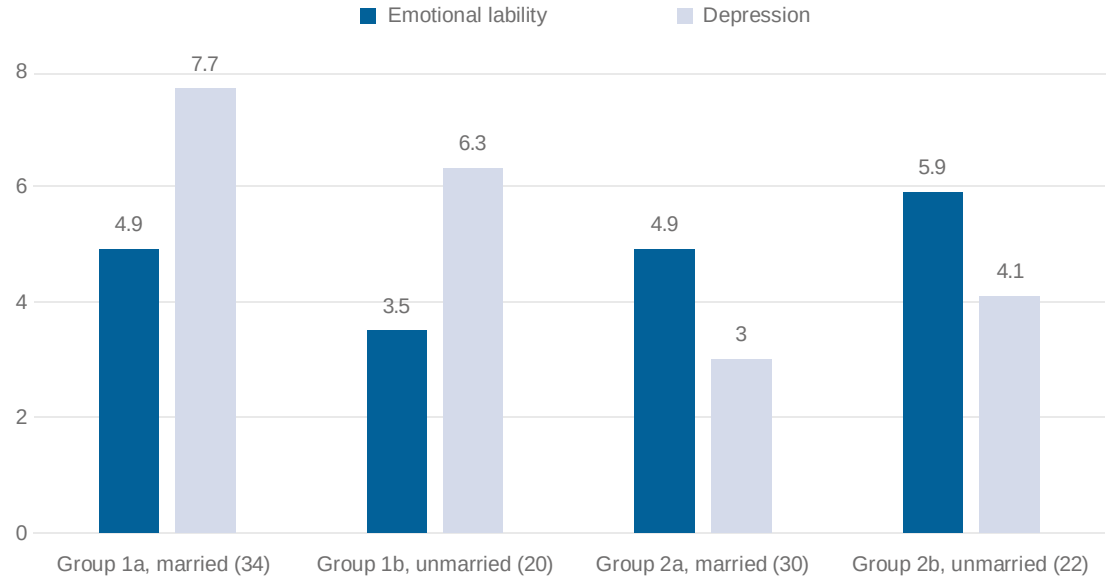


Figure 1. **Comparison of the level of depression and emotional stability in the experimental and control groups of women depending on marital status**

aggression in response to any irritating factors increases. That is, aggression in these women has a rational character.

Situational depression is also related to self-value, but with the opposite sign, i.e., the growth of depression is accompanied by a woman's dissatisfaction with the degree of richness and diversity of her inner world. This is consistent with an increase in internal conflict and mistrust with a decrease in the level of anxiety.

An increase in anxiety in the control group of women is accompanied by the experience of life failures and demonstrative behavior (a negative relationship with shyness).

Thus, the structure of relationships in the group of women who decided to have plastic surgery is largely compensatory in nature. The feeling of being unrecognized and misunderstood 'freezes' their inner pain. The need to be the 'mistress of their lives' contributes to the growth of depression. At the same time, in a situation when they feel the fullness of life and communication, irrational anxiety about the transience of this state grows. We can assume that these tendencies conceal a deep need for care, recognition, and emotional closeness.

Conclusions

The findings of the present study allow the following conclusions to be formulated.

Women who opt for plastic surgery are characterised by a complex of traits that mask a fear of social rejection and the fear of coming 'face to face' with themselves. The second fear is so strong that women choose to undergo plastic surgery as a quick, albeit illusory, solution to the problem, rather than consulting a psychologist and working towards building better interpersonal relationships and self-reflection. These women prefer to preserve their unchanged 'I' by any means, regardless of all the side effects and negative health consequences of plastic surgeries.

We have found data that give reason to speak to women's characteristics who desire to achieve a non-existent standard of feminine beauty through plastic surgery to demonstrate that they want and can be successful, beautiful, and loved.

This phenomenon is characterised by a complex of features, namely: powerful protective reactions (isolation); greater rigidity of the self-image; displacement of emotional, irrational reactions into an unconscious layer of the psyche; and external

Group	Characteristic	Correlative parameters	Spearman's ρ	p-value
Experi	Depressiveness (personality)	Self-guidance	0.312	p < 0.05
		Positive evaluation	-0.367	p < 0.01
		Spontaneous aggression	0.292	p < 0,05
	Depression (situational)	Self-value	0.282	p < 0.05
	Anxiety	General mood background	0.425	p < 0.01
		Cooperation	0.281	p < 0.05
Control	Depressiveness (personality)	Neuroticism	-0.515	p < 0.01
		Sociability	-0.446	p < 0.01
		Reactive aggression	0.328	p < 0.05
		Openness	0.302	p < 0.05
	Depression (situational)	Self-value	-0.373	p < 0.01
		Untrustworthiness	0.345	p < 0.05
		Anxiety	-0.340	p < 0.05
		Internal conflict	0.297	p < 0.05
	Anxiety	Consistency	-0.373	p < 0.01
		Goal achievement	-0.340	p < 0.05
		Depression	-0.300	p < 0.05

Table 4. C

control of emotions. In addition, there is a desire to achieve the desired result quickly and now. Life in such a state requires great mental and psychological tension.

Furthermore, the non-acceptance of one's natural appearance, coupled with the pursuit of transformation and modification through plastic surgery can lead to feelings of alienation and detachment, whereby the body is perceived as a mere instrument in achieving one's desired outcomes. The process of self-improvement is often intricate, protracted, and can be more distressing and paradoxical than undergoing surgery. Furthermore, if an individual perceives their natural appearance to be of minimal interest or value in the eyes of others, a well-known and expeditious method is available: altering one's physical appearance. This thesis is consistent with data from other studies [36].

It is also hypothesised that the decision to undergo plastic surgery may be driven by at least two motivational factors. Firstly, the desire for achievement, particularly among women whose professions are associated with beauty standards, such as dancers, aesthetic medicine practitioners, and models. Secondly, the fear of rejection, which can be considered the inverse of the affiliation motive. This tendency is particularly evident among women who have previously experienced rejection or who harbor a fear of facing such situations. These assumptions are planned to be developed in subsequent studies.

The implications of these findings suggest the need for a more holistic approach to addressing the motivations behind plastic surgery, emphasising psychological support and self-acceptance over physical alterations. Incorporating a more diverse sample and exploring additional variables has the potential to significantly advance our understanding of the psychological, social and cultural factors driving the decision to undergo plastic surgery. Future research should explore these dynamics further to develop more targeted interventions that foster healthier relationships with oneself and one's body. Interventions should be developed to promote healthier relationships with oneself and one's body, with the ultimate aim of reducing reliance on physical alterations as a solution to deeper psychological and emotional challenges.

Funding

This study is part of Project 124032600013-2 funded by Saint-Petersburg State University.

Declaration of interests

The authors declare that there is no conflict of interest.

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Etiotropic psychotherapy for depression through addressing unprocessed aggression: an approach within Integrative Causal Psychotherapy

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Received: Mar 26, 2025.
Accepted: Apr 30, 2025.
Published: August 1, 2025.

For citation: Tor YN, Rusina NA, Makoveeva PS, Shvetsova SV. Etiotropic psychotherapy for depression through addressing unprocessed aggression: an approach within Integrative Causal Psychotherapy. *Psychotherapy Science Today*. 1(1):12-19. https://doi.org/10.64435/spes8434

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Abstract

Objective: This pilot study aimed to evaluate the effectiveness of a short-term psychotherapeutic technique for treating depression by addressing unprocessed aggression, developed within the framework of Integrative Causal Psychotherapy**.

Method: The study involved 18 adult patients diagnosed with major depressive disorder with moderate and severe recurrent episodes (ICD-10 codes F33.1 and F33.2, corresponding to DSM-5*** codes 296.32 and 296.33, respectively) and persistent depressive disorder (ICD-10 code F34.1, corresponding to DSM-5 code 300.4). The patients were assessed by a psychiatrist before and after psychotherapeutic treatment. Treatment outcomes were assessed using psychiatric evaluations. In addition to the psychiatric examination before and after treatment, standardized psychological measures (e.g., Ryff Scales of Psychological Well-Being) and Tor's 'Satisfaction with Dynamics in Key Areas of Life' questionnaire were used to measure the patients' psychological well-being pre- and post-treatment.

Results: As a result of psychotherapy, 83% (N=15) of the participants achieved full remission, 17% (N=3) of the participants were diagnosed with a decrease in the severity of the disorder. At the same time, patients with neurotic personality organization****, who made up half of the sample (N=9), achieved remission in 100% of cases, and among patients with borderline personality organization, who made up the other half of the sample (N=9), 67% of the participants achieved remission, and 33% showed a reduction in symptom severity. In the follow-up, which at the time of writing is about a year for most participants, there was not a single case of recurrence of depressive episodes in patients who achieved remission and not a single case of worsening of symptoms in patients who had a decrease in the severity of depressive episodes during treatment.

Conclusions: The method of treating depression developed in Integrative Causal Psychotherapy, in which the therapeutic target is prohibitions on the awareness and expression of aggressive impulses, can be recommended as an etiotropic short-term method of treating primary (non-comorbid) depressive disorders for adult patients with neurotic and borderline personality organization. The method offers a drug-free, structured approach with no relapses observed in a one-year follow-up. This pilot study's small sample size (N=18) limits generalizability, necessitating larger-scale research.

Keywords: major depressive disorder; unprocessed aggression; Integrative Causal Psychotherapy; ICP; short-term psychotherapy; psychodynamic psychotherapy.

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** Integrative Causal Psychotherapy (ICP; Serbian: Integralna kauzalna psihoterapija, IKP; Russian: Integral'naya kauzal'naya psikhoterapiya, IKP) is a psychodynamically oriented psychotherapeutic approach developed by Y. Tor within a Serbian-Russian psychotherapy school [1].

*** According to the DSM-5 classifier [2].

**** Based on the classification by Otto Kernberg [3].

Introduction

Major depressive disorder (MDD), the hallmark of depressive disorders, is characterized by discrete episodes lasting at least two weeks, involving significant changes in affect, cognition, and neurovegetative functions, with inter-episode remissions. Persistent depressive disorder (dysthymia), a more chronic form of depression, is diagnosed when the mood disturbance persists for at least two years in adults or one year in children [2].

Globally, according to the 2020 Wellcome Global Monitor, nearly one in five adults reported experiencing anxiety or depression severe enough to disrupt their daily activities for two weeks or longer [4]. The World Health Organization (WHO) reported in 2023 that approximately 5% of adults worldwide suffer from depression, with over 700,000 annual deaths attributed to suicide [5]. Depression significantly impacts quality of life and is a leading determinant of suicide deaths [6]. It ranks among the top causes of disability globally and is a priority condition under WHO's Mental Health Gap Action Programme.

Despite its prevalence, most individuals with depression do not receive adequate treatment. Systematic reviews highlight the limited efficacy of antidepressant medications, which often fail to outperform placebo in clinical trials. Approximately 50% of trials show no significant difference between active treatments and controls, with minimal differences on the Hamilton Rating Scale for Depression. Existing psychotherapeutic approaches have also been criticized for failing to demonstrate clear superiority over waitlist controls [7–10].

Relapse following treatment cessation remains a significant challenge in both psychiatric and psychotherapeutic practice. A 2021 study from University College London found that 56% of patients who discontinued antidepressant medication experienced relapse within one year, compared to 39% of those who continued treatment. Long-term antidepressant use also increases relapse risk [11]. Similarly, non-pharmacological treatments face high relapse rates. Cognitive Behavioral Therapy (CBT), often cited as a highly effective psychotherapeutic approach for depression [12], shows relapse rates of 30–50% within the first year post-therapy, rising to 60–70% within 2–5 years [13]. Transcranial magnetic stimulation (TMS) results in relapse rates of 30–40% within six months [14], while electroconvulsive therapy (ECT) is associated with relapse rates of 50% within six months and 70–80% within one year [15]. In contrast, the current study reports no relapses within one year, suggesting a potential advantage of the proposed method in preventing recurrence.

Depressive disorders are thus a prevalent mental health condition and a leading cause of global disability, yet effective, relapse-preventive treatments remain elusive. This pilot study aims to evaluate the outcomes of a short-term etiotropic treatment for non-comorbid depression using Integrative Causal Psychotherapy (ICP), focusing on unprocessed aggression as a therapeutic target. Emerging evidence suggests that repressed and suppressed aggression may play a central role in the etiology of non-comorbid depressive disorders, making it a promising therapeutic target [16–18]. ICP is a psychodynamic approach that targets the root causes of mental disorders by addressing repressed affects and uncritically learned maladaptive cognitive-behavioral patterns.

Method

Hypothesis and theoretical framework

Our hypothesis posits that the primary cause of depression lies in the repression and suppression of aggressive feelings and emotions, leading to the accumulation of their derivatives. When these derivatives reach an individual threshold, they result in mental decompensation, manifesting as depressive disorder. This perspective draws on psychoanalytic theories of depression by Z. Freud, K. Abraham, M. Klein, and O. Kernberg [16–19], as well as neurobiological data on the effect of emotion suppression on the development of depression [20]. Additionally, irritable mood (rather than sadness) during depressive episodes in children and adolescents, as specified in the diagnostic criteria for depressive disorder [2], support the role of aggressive impulses in depression, as these impulses are more observable in younger individuals due to less developed repression mechanisms.

Integrative Causal Psychotherapy approach to treating depression

Considering unprocessed (repressed and suppressed) aggression as the primary cause of depressive disorders, we targeted the neutralization of mental factors that lead to such repression and suppression of aggression, specifically, attitudes prohibiting the awareness and expression of aggression. The primary therapeutic goal is the normalization of patients' aggressive feelings and emotions, fostering a constructive attitude toward them. A secondary goal involves processing accumulated aggressive affects and establishing functional patterns of thinking and behavior regarding aggressive impulses. To address these therapeutic goals, we developed a comprehensive methodology that comprises:

1. **Techniques of psychological neuromodulation** aimed at neutralizing attitudes that prohibit

To see more about the Integrative Causal Psychotherapy approach, follow the link https://icpmodality.org

aggressive feelings and emotions; processing accumulated aggressive affects, and enhancing the Ego's ability to manage aggressive impulses constructively:

a. *De-imprinting of prohibitions* to eliminate prohibitions on having aggressive impulses by modifying mental representations of experiences in which the prohibitive suggestion was received;
b. *Catharsis of memories* to process negative affects related to unresolved aggression and establish adaptive behavioral patterns;
c. *Bilateral neuromodulation* to correct the psycho-emotional state and dysfunctional beliefs;
d. *Resourcing of the life line* to process accumulated negative affects, replenish mental resource deficits associated with unfavorable periods in life, and strengthen the Ego's ability to withstand stress without developing auto-aggressive states;
e. *Merging with the Ideal Self* to model a more acceptable to the patient self-image;
f. *Archetypal gift* to model desired for the patient modeling personal qualities or behaviors, enhancing his psychological well-being;

2. **Motifs of Katathym-Imaginative Psychotherapy** by H. Leuner [21], both classical and author-modified:

a. *Flower* for diagnosing and treating of autoaggression*;
b. *Predatory beast* for learning to make contact and to channel one's own aggressive impulses;
c. *Stream* for normalizing the speed and quality of mental processes;
d. *House* for strengthening the Ego;
e. *Mountain* for directing aggressive energy toward goal achievement and social aspirations;

3. **Psychoeducation** on the nature of aggressive feelings, emotions, and the consequences of prohibiting their awareness and expression;

4. **Fostering a healthy attitude** of patients towards their own aggressive feelings and emotions.

The method follows a 20-session protocol, with a flexible sequence of sessions to adapt to the individual needs and narrative of the patient. It should be noted that the protocol techniques serve primarily as tools. The primary aspect of implementing the protocol is the focus on removing prohibitions on the awareness and expression of aggression and working within a psychodynamic framework.

The ICP protocol for the treatment of depression through addressing unprocessed aggression

Session 1. Processing affects, establishing a therapeutic alliance. The technique *Catharsis of memories* to address experiences of unprocessed aggression or the patient's sense of their "badness" (rejection, humiliation, devaluation, and similar experiences).

Session 2. Psychoeducation about interacting with one's aggression (using the client's narrative as an example, showing moments of suppression of aggression), suggestion a healthy attitude towards dealing with one's aggression. The technique *De-imprinting the prohibition on expressing aggression*.

Session 3. The motif *Flower*.

Session 4. Discussion of the drawing based on the motif *Flower*. The technique *Catharsis of memories* to address experiences of suppressed aggression or the patient's sense of their "badness".

Session 5. Identification and correction of negative and limiting beliefs about the self, using subjective scaling and the techniques *Bilateral neuromodulation* and *Catharsis of memories*.

Session 6. The motif *Predatory beast*.

Session 7. Discussion of the drawing based on the motif *Predatory beast*. The technique *Merging with the Ideal Self*.

Session 8. The technique *Catharsis of memories* to address experiences of suppressed aggression or the patient's sense of their "badness".

Session 9. The motif *Stream*.

Session 10. Discussion of the drawing based on the motif *Stream*. Identification and correction of negative and limiting beliefs about the self.

Session 11. The technique *Life line resourcing* for the most problematic periods of life.

Session 12. The technique *Archetypal gift* for the patient's desired quality or behavior pattern.

Session 13. The motif *House*.

Session 14. Discussion of the drawing based on the motif *House*. The technique *Life line resourcing* for the most problematic periods of life.

Session 15. The technique *Catharsis of memories* to address experiences of suppressed aggression or the patient's sense of their "badness".

Session 16. The motif *Mountain*.

Session 17. Discussion of the drawing based on the motif *Mountain*. Identification and correction of negative and limiting beliefs about the self, using subjective scaling and the techniques *Bilateral neuromodulation* and *Catharsis of memories*.

Session 18. The technique *Catharsis of Memories* to address experiences of suppressed aggression or the patient's sense of their "badness".

* Here we highlight the most significant therapeutic effects of the given motifs of Katathym-Imaginative Psychotherapy within our methodology; the therapeutic potential of these motifs are not limited to this range of effects.

Session 19. Identification and correction of negative and limiting beliefs about the self, using subjective scaling and the techniques *Bilateral neuromodulation* and *Catharsis of memories*.

Session 20. Techniques from the above, depending on the patient's material.

The methodology and protocol were developed by Yuri Tor, the founder of Integrative Causal Psychotherapy. They have been in use since 2018 and formed the basis of this study in 2023.

To replicate the results presented in this study, psychotherapists must:

- be proficient in psychodynamic approaches, particularly in recognizing unconscious material;
- have mastered all the techniques and methods of the protocol;
- have no personal prohibitions or negative attitudes toward their own aggression.

Sample and measures

The study was conducted from September 2023 to December 2024 at the Academy of Integral Psychodynamic Psychotherapy (Moscow, Russia), in collaboration with the Department of Clinical Psychology, Yaroslavl State Medical University (Yaroslavl, Russia). All participants provided informed consent, and the study protocol was approved by the Ethics Committee of the Academy of Integral Psychodynamic Psychotherapy.

The study included 18 patients aged 24–76 years, diagnosed with major depressive disorder (MDD) with moderate and severe recurrent episodes (ICD-10 codes F33.1 and F33.2; DSM-5 codes 296.32 and 296.33) or persistent depressive disorder (ICD-10 code F34.1; DSM-5 code 300.4). Participants were recruited through announcements by the Academy of Integral Psychodynamic Psychotherapy. Diagnoses were confirmed by a board-certified psychiatrist using structured clinical interviews based on ICD-10 criteria with corresponding DSM-5 codes provided for reference.

Psychotherapy was delivered by the method's author and five trained psychotherapists. Treatment consisted of 20 weekly 50-minute sessions conducted online via video, following the protocol described above. Each patient's treatment lasted 20 weeks. All psychotherapists participated in biweekly group supervisions led by the methodology's author. The supervisions ensured treatment fidelity and consistency across therapists, addressing challenges in applying the protocol.

Treatment effectiveness was evaluated through psychiatric examinations before and after psychotherapy. Psychological well-being was assessed using the Ryff Scales of Psychological Well-Being [22] and Tor's "Satisfaction with Dynamics in Key Areas of Life" questionnaire [26]. The Ryff Scales of Psychological Well-Being have demonstrated high reliability and validity in diverse populations [22]. Tor's 'Satisfaction with Dynamics in Key Areas of Life' questionnaire was developed based on clinical observations. The questionnaire assessed changes over the past 2.5 months to capture recent shifts in patients' subjective well-being, aligning with the treatment duration and post-treatment evaluation timeline.

Patients' psychological well-being was compared to a control group of 30 Russian individuals aged 18–51 years, recruited via snowball sampling, with no history of psychiatric registration or mental health monitoring. The control group was used to compare post-treatment psychological well-being scores (Ryff Scales) with normative data from a non-clinical population. Data were analyzed using the Mann-Whitney U test for independent samples and Spearman's rank correlation coefficient, with IBM SPSS Statistics 22.0.

Results and discussion

Following psychotherapy, 83% (N=15) of participants achieved full remission, while 17% (N=3) experienced a reduction in symptom severity: one participant improved from severe to mild, one from severe to moderate, and one from moderate to mild. Patients with neurotic personality organization (N=9, 50% of the sample) achieved full remission in 100% of cases. Among patients with borderline personality organization (N=9, 50% of the sample), 67% (N=6) achieved remission, and 33% (N=3) showed reduced symptom severity. During a one-year follow-up, no relapses occurred in patients who achieved remission, nor was there symptom worsening in those with reduced severity. The lower remission rate in patients with borderline personality organization may be attributed to greater ego fragility and difficulty processing aggressive impulses.

Figure 1 illustrates the dynamics of overall scores on the Ryff Scales of Psychological Well-Being before and after psychotherapy. Patients with neurotic personality organization had a pre-treatment score of 318 (low well-being range), which increased to 350 post-treatment (upper medium range), approaching high well-being levels — a 10% improvement. Patients with borderline personality organization showed a 5.4% improvement, remaining in the low well-being range but nearing the medium range*. While the 10% improvement in the neurotic group

* In the Ryff Scales of Psychological Well-Being, the general indicator of psychological well-being has the following levels of expression: 0–323 points — low level; 324–353 points — average level; 354 points and above — high level.

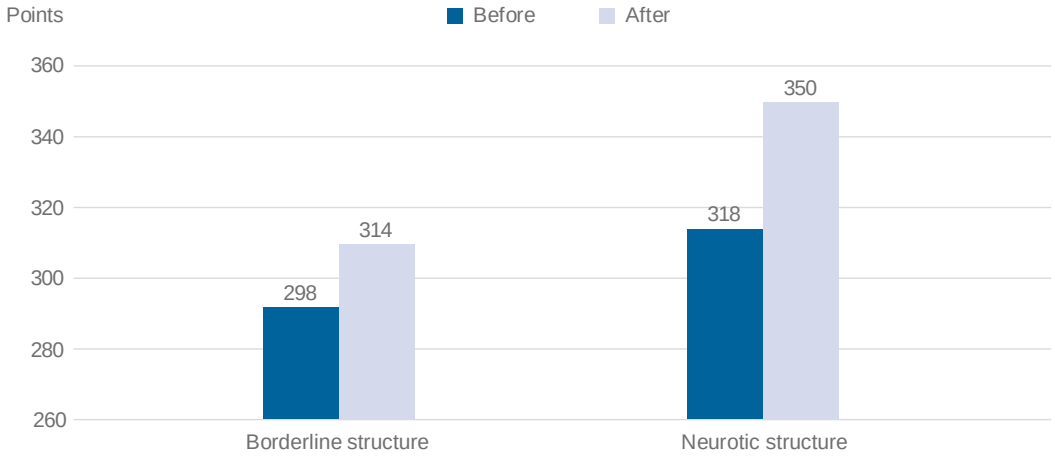


Figure 1. **Psychological well-being scores (Ryff Scales) among patients before and after psychotherapy**

approaches the threshold for clinical significance, the 5.4% improvement in the borderline group may be less clinically meaningful and warrants further investigation. Improvement of psychological well-being of patients in both groups after psychotherapy were statistically significant (Wilcoxon signed-rank test, $p < 0.05$).

Figure 2 presents subscale scores from the Ryff Scales, showing positive dynamics across all subscales, with the most significant improvements in "Self-acceptance" and "Environmental mastery." Post-treatment, "Autonomy" and "Environmental mastery" scores in recovered patients slightly exceeded those of the control group (by 0.84 and 1.00 points, respectively). Although these differences were statistically significant for the Environmental mastery and Self-acceptance subscales, as well as the Overall psychological well-being score ($p < 0.05$), their clinical significance requires further investigation in larger samples.

Figure 3, based on Tor's questionnaire, reflects patients' subjective assessments of changes in key life domains over the past 2.5 months. Patients assessed changes that had occurred over the past 2.5 months in key areas of their lives by selecting one of the following response options: "became much worse," "be-

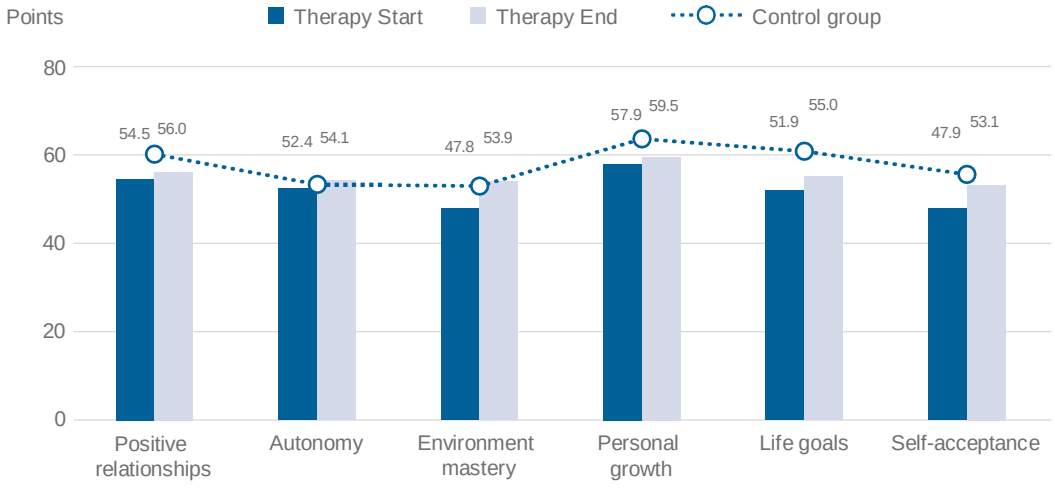


Figure 2. **Subscale scores from the Ryff Scales of psychological well-being in patients before and after psychotherapy compared to the control group**

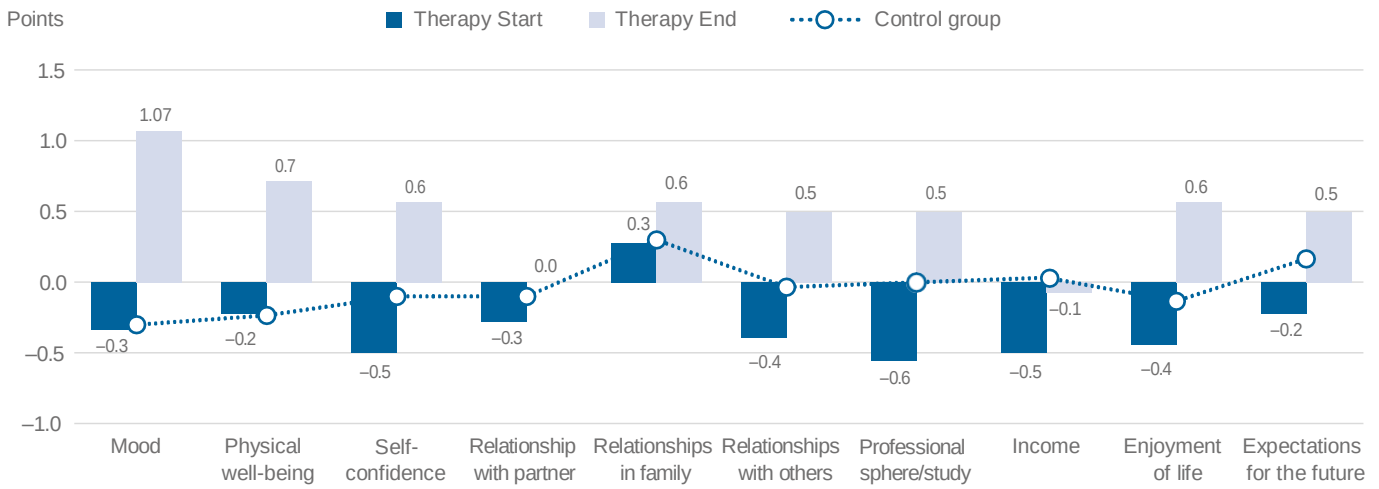


Figure 3. **Satisfaction with dynamics in key life domains before and after psychotherapy**

came worse," "no change," "became better," "became much better." Responses were rated on a 5-point Likert scale (1 = 'became much worse,' 5 = 'became much better').

Before psychotherapy, only family relationships showed positive dynamics. Post-treatment, patients reported improvements ("became better" or "became much better") across nearly all domains, with the most pronounced changes in mood, self-confidence, professional sphere/study, and enjoyment of life. These improvements correlate with the alleviation of depressive symptoms, particularly impacting emotional well-being, self-esteem, and hedonic aspects of life.

The findings support our hypothesis that unprocessed aggression is a primary cause of non-comorbid depressive disorders, and Integrative Causal Psychotherapy offers an effective, short-term, etiotropic approach to address this cause, achieve remission, and prevent relapses. Compared to relapse rates reported for CBT (30–50%), TMS (30–40%), and ECT (50–80%) [13–15], the absence of relapses in this study highlights the potential of ICP to address the root causes of depression and prevent recurrence.

Limitations and future directions

The small sample size (N=18) limits the generalizability of findings, necessitating larger-scale studies to confirm the method's efficacy. The lack of a treatment control group (e.g., patients receiving other therapy or waitlist control) limits the ability to directly compare ICP with existing interventions.

The method requires patients to have intelligence within normal limits and intention and ability to form the therapeutic alliance. Its effectiveness may be limited in patients with significant intellectual impairments and conditions such as neurodevelopmental disorders, schizophrenia spectrum disorders, substance-related disorders, neurocognitive disorders, or severe personality disorders.

Advantages of the method:

- Etiotropic approach;
- Short-term (20 sessions);
- Clear therapeutic target and mechanism;
- Structured protocol;
- Drug-free;
- Effective in both face-to-face and online formats;
- Trainable to qualified psychodynamic psychotherapists within two months.

A key advantage is the method's ability to address the root cause of depressive disorders and prevent relapses, supported by one-year follow-up data from this study. Unpublished clinical practice data presented at conferences indicate sustained remission in patients treated with ICP monitoring over six years [23–25]. This can be attributed to the elimination of a key cause of depression: prohibitions on aggression; when removed in adulthood, these prohibitions are unlikely to re-emerge.

This study's novelty lies in its focus on removing prohibitions on aggression to treat depression, a concept rooted in psychoanalytic theory since Freud's 1917 work [16], yet underexplored in contemporary psychotherapy research. Unlike traditional psychodynamic approaches that focus on grief or loss [16], this method directly targets prohibitions on aggression, offering a novel etiotropic framework for depression treatment.

Future research should evaluate this method in larger, diverse samples (considering age, gender, and social status), conduct cross-cultural studies, and perform longitudinal studies to assess long-term outcomes. The method's efficacy for comorbid depression, depression in children and adolescents, and patients with psychotic personality organization also warrants investigation. In comorbid cases, we hypothesize that the method may reduce depressive symptom severity, though full remission may depend on the treatment of the primary disorder.

Conclusions

This study suggests that non-comorbid depression may be driven by an inability to process aggressive impulses due to prohibitions on their awareness and expression. The 20-session protocol developed within Integrative Causal Psychotherapy effectively addresses these prohibitions, achieving remission in patients with neurotic personality organization and yielding variable outcomes (remission or symptom reduction) in those with borderline personality organization. For patients with borderline personality organization [3] therapists may decide to extend the protocol beyond the initial 20 sessions to strengthen the patient's ego to a level that allows them to process their suppressed aggressive impulses.

This method can be integrated into psychotherapy practice, offering a structured, etiotropic, time-limited intervention for clinicians working with non-comorbid depression in adults with neurotic and borderline personality organization.

Funding

The cost of psychotherapy for socially vulnerable patients unable to pay was covered by the Academy of Integral Psychodynamic Psychotherapy, with no additional external funding.

Declaration of interests

The authors declare that this study was conducted within the Academy of Integral Psychodynamic Psychotherapy, which developed the method under investigation. While the institution has an interest in its dissemination, the study was designed and conducted independently to ensure objectivity.

Acknowledgments

The authors express gratitude to the research psychotherapists Ekaterina Volkhonskaya, Nadezhda Rudenko, Alfiya Rakhmanova, Svetlana Kling, and Anna Poltorak for their dedication in delivering the treatment, and to psychiatrist Elena Saykina for her expertise in diagnostic assessments.

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Alexithymia and coping profiles in autoimmune disorders: a comparative study of AIT, RA, and type 1 diabetes

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Received: Apr 2, 2025;
Accepted: May 12, 2025;
Published: August 1, 2025

For citation:
Rusina NA, Zubova AV. Alexithymia and coping profiles in autoimmune disorders: a comparative study of AIT, RA, and type 1 diabetes. *Psychotherapy Science Today*. 1(1):20-24. https://doi.org/10.64435/sron4114

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Abstract

Objective: This study aimed to explore the association between alexithymia levels and the frequency of constructive coping strategies in patients with autoimmune diseases, specifically autoimmune thyroiditis (AIT), rheumatoid arthritis (RA), and type 1 diabetes mellitus (T1DM).

Method: A total of 120 participants were enrolled: 30 with AIT (14 men, 16 women, mean age 39 years), 28 with RA (8 men, 20 women, mean age 58 years), 32 with T1DM (6 men, 26 women, mean age 40 years), and 30 healthy controls (9 men, 21 women, mean age 31 years). Patients with AIT and T1DM were examined at Yaroslavl City Endocrinological Center (Russia), and patients with RA at the rheumatology department of Yaroslavl Regional Clinical Hospital (Russia). The control group was recruited from the patients' social circles without these diseases. Patients were assessed using the Method for the Determination of Individual Coping Strategies (E. Heim), the Toronto Alexithymia Scale (TAS), K. Izard's Differential Emotions Scale (adapted by A. V. Leonova), and the Dembo-Rubinstein Self-Esteem Assessment (modified by A. M. Prikhozhan). Statistical analyses were performed using Statistica 13, employing Spearman's rank correlation coefficient and the Mann-Whitney U test.

Results: Higher alexithymia levels were associated with reduced use of constructive coping strategies across all patient groups ($p<0.01$). The RA group exhibited the highest mean alexithymia score (74.46), followed by AIT (69.80) and T1DM (59.30). T1DM patients favored adaptive cognitive coping strategies ($p=0.015$), while AIT patients leaned toward adaptive behavioral coping ($p=0.068$). RA patients showed the least frequent use of behavioral coping strategies ($p=0.048$). In T1DM patients, a strong positive correlation was found between negative emotions and anxious-depressive states ($r=0.74$, $p<0.001$), while anxious-depressive emotions negatively correlated with behavioral coping ($r=-0.45$, $p<0.05$). Additionally, higher alexithymia levels were associated with reduced positive emotions ($r=-0.54$, $p<0.01$) and increased self-dissatisfaction ($r=0.45$, $p<0.05$), with self-dissatisfaction inversely related to emotional coping ($r=-0.51$, $p<0.01$).

Conclusions: Patients with chronic autoimmune diseases demonstrate elevated alexithymia levels compared to healthy controls, which negatively impacts their ability to employ adaptive coping strategies. Tailored psychotherapeutic interventions are recommended to address emotional expression issues in these populations.

Keywords: alexithymia, autoimmune diseases, coping strategies, emotional regulation, rheumatoid arthritis, type 1 diabetes mellitus, autoimmune thyroiditis.

Introduction

Autoimmune diseases, including autoimmune thyroiditis (AIT), rheumatoid arthritis (RA), and type 1 diabetes mellitus (T1DM), are chronic conditions characterized by the immune system attacking the body's own tissues, leading to persistent inflammation and complex treatment challenges [1]. These diseases often follow a relapsing-remitting course, with remission being difficult to achieve, and some may result in severe disability [2]. Beyond physical symptoms, the psychological impact of these conditions is profound, influencing patients' self-esteem, emotional regulation, and coping mechanisms [3].

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Changes in self-esteem and self-identity resulting from an incurable, poorly controlled, disfiguring, or fatal condition are integral components of the process of adapting to such a condition. Chronic illness alters a person's self-attitude, as the previously formed identity during health is replaced by a pathological identification reflecting physical impairments, emotional reactions to physical symptoms, and cognitive representations of the disease, introducing uncertainty into their lives [4].

Psychological factors such as stress, anxiety, depression, alexithymia, and suppressed aggression can modulate immune functions and influence the clinical activity of many chronic autoimmune diseases [5]. Alexithymia, defined as difficulty identifying and expressing emotions, is increasingly recognized as a predictor of psychosomatic disorders and a marker of emotional dysregulation [6]. Alexithymia is associated with hyperactivation of the sympathoadrenal and hypothalamic-pituitary-adrenal systems, exacerbating disease progression, and has been linked to various autoimmune conditions, including AIT, RA, and T1DM, particularly during phases of preserved organ function [7]. In patients with AIT, alexithymia is highly prevalent, especially during the euthyroid stage, and is closely related to emotional-personal characteristics, contributing to non-psychotic mental disorders [7]. Similarly, patients with RA often exhibit restricted emotional reactions, suppressed aggression, and coping mechanisms like denial and isolation of affect, indicative of alexithymia [8].

The adaptation of patients with chronic autoimmune diseases involves not only managing physical symptoms but also navigating emotional and cognitive responses to their condition [9]. A prospective three-year study showed that a pain-coping strategy characterized by restrictive behavior (e.g., reduced activity, limited exertion, and catastrophizing responses) predicts decreased quality of life and increased psychological maladjustment, regardless of disease severity [8]. Additionally, chronic illness can lead to nosogenic psychological changes, including fear, anger, grief, anxiety, social isolation, reduced self-confidence, and the development of an inferiority complex, particularly in T1DM patients [8, 10]. From a psychoanalytic perspective, somatic illness may provide a "secondary gain", allowing patients to avoid intrapersonal conflicts while seeking care and attention, which can contribute to the development of labile diabetes in patients [11]. In modern times, the emphasis on medicine and pharmacology, where every patient has the right to be heard, may drive individuals to express emotions somatically rather than psychologically, contributing to the prevalence of physical illnesses [8]. Patient behavior in response to diagnosis is marked by significant emotional distress, including withdrawal, alienation, and increased anxiety, potentially leading to obsessive fears about complications and an inferiority complex [10]. The pathogenic influence of chronic disease — marked by prolonged intoxication, impaired metabolic processes, and exhaustion — further alters mental processes, exacerbating psychological distress [8].

While much prior research has focused on type 2 diabetes, this study investigates the autoimmune forms of disease — specifically T1DM and AIT — as they represent prevalent conditions where the body begins to perceive its own tissues as adversaries [8]. To yield more intriguing outcomes, we chose to explore the connection between T1DM and AIT, given AIT's status as a common representative of autoimmune diseases [8]. The theoretical analysis of coping behavior suggests that patients with autoimmune diseases face greater difficulties in selecting strategies probably due to their reliance on illness perception and distinct emotional traits, which shape their attitudes and behaviors [12]. Developing programs to enhance coping strategies could prevent disorganized behavior in overcoming disease-related challenges.

In our initial study [13], we investigated emotional expression and coping strategies in patients with AIT and T1DM, finding that AIT patients struggle to express emotions constructively, leading to accumulated self-dissatisfaction over time, while T1DM patients lean toward anxious-depressive experiences, affecting their adaptive coping. This current research expands the sample and includes a group of patients with RA.

This study expands on prior research by examining the interplay between alexithymia and coping behaviors in patients with AIT, RA, and T1DM, compared to a healthy control group. We hypothesized that higher alexithymia levels would correlate with less frequent use of constructive coping strategies under stress.

Method

Participants

The study included 120 participants:

- **Autoimmune Thyroiditis (AIT):** 30 patients (14 men, 16 women; mean age: 39 years), recruited from a city endocrinology center.
- **Rheumatoid Arthritis (RA):** 28 patients (8 men, 20 women; mean age: 58 years), recruited from the rheumatology department of a regional clinical hospital.
- **Type 1 Diabetes Mellitus (T1DM):** 32 patients (6 men, 26 women; mean age: 40 years), recruited from the same endocrinology center as the AIT group.

- **Control Group:** 30 healthy individuals (9 men, 21 women; mean age: 31 years), recruited from the patients' social circles, with no history of autoimmune diseases.

Measures

The following validated instruments were used:

- Method for the Determination of Individual Coping Strategies (E. Heim): Assesses cognitive, emotional, and behavioral coping strategies.
- Toronto Alexithymia Scale (TAS): Measures alexithymia levels, with higher scores indicating greater difficulty in emotional identification and expression.
- K. Izard's Differential Emotions Scale (adapted by A. V. Leonova): Evaluates the intensity of positive and negative emotions.
- Dembo-Rubinstein Self-Esteem Assessment (modified by A. M. Prikhozhan): Assesses self-esteem and self-dissatisfaction.

Statistical analysis

Data were analyzed using Statistica 13 software. Spearman's rank correlation coefficient was used to explore relationships between variables, and the Mann-Whitney U test was applied for group comparisons. Statistical significance was set at $p<0.05$, with trends noted at $p<0.10$.

Results

Alexithymia levels across groups

Significant differences in alexithymia levels were observed between groups (Tables 1 and 2). The RA group exhibited the highest mean alexithymia score (mean: 74.46), approaching threshold levels for pronounced alexithymia (p=0.001). The AIT group also showed elevated alexithymia (mean: 69.80, p=0.002), exceeding normative values, while the T1DM group had a lower mean score (59.30), within the normative range. Healthy controls had significantly lower alexithymia levels compared to all patient groups ($p<0.01$).

Coping strategies

Patients with T1DM were more likely to employ adaptive cognitive coping strategies (mean: 1.67, p=0.015), whereas those with AIT favored adaptive behavioral coping (mean: 1.03, p=0.068, trend) (Table 3). RA patients used behavioral coping strategies least frequently (mean: 0.68, p=0.048) compared to T1DM patients (mean: 1.03) (Table 4).

Scale	Mean Score (AIT)	Mean Score (T1DM)	Standard Value	Mann-Whitney U	p-Value
Alexithymia Index	69.80	59.30	62	244.5	0.002

Notes: T1DM = type 1 diabetes mellitus; AIT = autoimmune thyroiditis. Higher scores indicate greater alexithymia levels.

Table 1. Comparative analysis of alexithymia index across T1DM and AIT groups ($p<0.01$)

Scale	Mean Score (RA)	Mean Score (T1DM)	Standard Value	Mann-Whitney U	p-Value
Alexithymia Index	74.46	59.30	62	102	0.001

Notes: RA = rheumatoid arthritis; T1DM = type 1 diabetes mellitus. Higher scores indicate greater alexithymia levels.

Table 2. Comparative analysis of alexithymia index between RA and T1DM groups ($p<0.05$)

Scale	Mean Score (T1DM)	Mean Score (AIT)	Mann-Whitney U	p-Value
Cognitive coping	1.67	1.17	307.5	0.015
Behavioral coping	0.70	1.03	334.5	0.068*

** Trend ($p < 0.10$). Scores reflect frequency of coping strategy use (arbitrary units).*

Table 3. Comparative analysis of coping strategies in T1DM and AIT groups ($p<0.05$)

Scale	Mean Score (RA)	Mean Score (T1DM)	Mann-Whitney U	p-Value
Behavioral coping	0.68	1.03	304	0.048

Notes: Scores reflect frequency of behavioral coping strategy use (arbitrary units).

Table 4. Comparative analysis of behavioral coping between RA and T1DM groups ($p<0.05$)

Emotional dynamics in T1DM patients

In the T1DM group, a strong positive correlation was found between negative emotions and anxious-depressive states (r=0.74, p<0.001), indicating that increased negative emotional expression is associated with heightened anxious-depressive tendencies. Additionally, anxious-depressive emotions negatively correlated with the use of adaptive behavioral coping strategies (r=–0.45, p<0.05), suggesting that higher anxiety levels reduce the frequency of effective problem-solving behaviors. Furthermore, alexithymia was negatively associated with positive emotions (r=–0.54, p<0.01) and positively correlated with self-dissatisfaction (r=0.45, p<0.05), while self-dissatisfaction was inversely related to the use of emotional coping strategies (r=–0.51, p<0.01) (Table 5). These findings highlight the complex interplay between emotional regulation, self-perception, and coping in T1DM patients.

RA group findings

In the RA group, alexithymia negatively correlated with both cognitive (r=–0.50, p<0.01) and emotional coping strategies (r=–0.39, p<0.05), and positively correlated with self-dissatisfaction (r=0.40, p<0.05) (Table 6). This suggests that difficulty in emotional recognition impairs adaptive coping and exacerbates self-dissatisfaction.

Discussion

This study confirms that patients with autoimmune diseases exhibit higher alexithymia levels compared to healthy controls, consistent with prior research [4, 5]. The AIT group demonstrated the most pronounced alexithymia, likely due to difficulties in emotional expression, which accumulate over time and exacerbate self-dissatisfaction, particularly with age [14]. T1DM patients, while displaying lower alexithymia levels, showed a propensity for anxious-depressive emotions, which negatively impacted their behavioral coping strategies [10]. RA patients exhibited the highest alexithymia levels, leading to reduced use of adaptive coping strategies and increased reliance on rational problem-solving [11].

The interplay between alexithymia, emotional regulation, and coping strategies underscores the need for targeted psychotherapeutic interventions. Suppressing emotions, as observed in T1DM patients, not only limits positive emotional experiences but also fuels self-dissatisfaction, hindering adaptive coping [12]. Similarly, RA patients' restricted emotional expression and avoidance of psychological engagement suggest a maladaptive coping style characterized by denial and isolation of affect.

Conclusions

This study highlights distinct patterns in patients with AIT, RA, and T1DM:

- **RA Patients:** High alexithymia levels correlate with reduced use of cognitive and emotional coping strategies, increasing self-dissatisfaction. Older patients tend to rely on rational problem-solving, which may complicate emotional work.
- **T1DM Patients:** Negative emotions are strongly associated with anxious-depressive states, reducing the use of adaptive behavioral coping. Alexithymia exacerbates self-dissatisfaction and limits positive emotions.
- **AIT Patients:** High alexithymia levels impair emotional expression, leading to increased self-dissatisfaction and reduced use of adaptive cognitive coping strategies.

Variable	Alexithymia Index	Positive emotions		Dissatisfaction rate
Alexithymia Index	–	-0.54**	-0.54**	0.45*
Positive emotions	-0.54**	–	–	-0.61**
Dissatisfaction rate	0.45*	0.45*	-0.61**	–

*Notes: T1DM = type 1 diabetes mellitus. *p < 0.05; **p < 0.01. Correlation coeficients (r) indicate strength and direction of relationships.*

Table 5. **Correlations among alexithymia, positive emotions, and dissatisfaction in T1DM patients (p<0.05*, p<0.01**)**

Variable	Cognitive coping	Emotional coping	Dissatisfaction rate
Alexithymia Index	-0.50**	-0.39*	0.40*

*Notes: RA = rheumatoid arthritis. *p < 0.05; **p < 0.01. Correlation coeficients (r) indicate strength and direction of relationships.*

Table 6. **Correlations among alexithymia, coping strategies, and dissatisfaction in RA patients (p<0.01**, p<0.05*)**

- Elevated alexithymia across all groups negatively affects the adoption of constructive coping strategies, ultimately impacting quality of life and psychological adjustment.

Recommendations for psychotherapeutic interventions

Based on these findings, we propose the following psychotherapeutic strategies:

- **T1DM patients:** Focus on enhancing emotional awareness and expression to reduce anxiety and improve adaptability. Teach cognitive and emotional coping strategies to mitigate anxious-depressive tendencies.
- **AIT patients:** Support patients in constructively expressing both positive and negative emotions to prevent the accumulation of self-dissatisfaction over time.
- **RA patients:** Address alexithymia to improve adaptability and self-esteem, considering the age-related shift toward rational coping, which may hinder emotional processing.

A comprehensive approach should integrate emotional, cognitive, and behavioral interventions:

- **Emotional expression training:** Expand emotional vocabulary, encourage appropriate emotional responses, and introduce relaxation techniques.
- **Self-esteem development:** Use psychotherapy techniques to foster a positive self-image.
- **Coping strategy enhancement:** Train patients in adaptive coping through practical exercises and support group participation.
- **Stress and anxiety management:** Employ relaxation, breathing exercises, and creative outlets to reduce anxiety.

This holistic approach aims to improve self-regulation, self-perception, and coping abilities, enhancing patients' quality of life.

Declaration of interests

The authors declare no conflicts of interest.

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Bridging dentistry and psychotherapy: dream analysis in sleep bruxism treatment

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Received: Apr 15, 2025;
Accepted: May 10, 2025;
Published: August 1, 2025

For citation: Mišović A. Bridging Dentistry and Psychotherapy: Dream Analysis in Sleep Bruxism Treatment. *Psychotherapy Science Today*. 1(1):25-28. https://doi.org/10.64435/ytzg5858

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Abstract

Objective: This case study evaluates interdisciplinary collaboration between dentists and psychotherapists, using dream analysis to treat sleep bruxism, a prevalent psychosomatic disorder driven by anxiety.

Method: Nastović's three-dimensional dream analysis, integrating personal, collective, and familial unconscious contents, was applied in a case study to explore sleep bruxism's psychosomatic etiology.

Results: In a 40-year-old female patient, dream analysis uncovered unconscious conflicts contributing to anxiety and bruxism, achieving symptom relief without dental interventions.

Conclusions: Integrative therapy, particularly dream analysis, is vital for addressing sleep bruxism's psychosomatic roots, requiring enhanced dentist-psychotherapist collaboration and psychotherapeutic training for dentists.

Keywords: sleep bruxism, dream analysis, integrative therapy, psychosomatics.

Introduction

Sleep bruxism, characterized by involuntary teeth grinding or clenching during sleep, is a prevalent psychosomatic condition linked to anxiety and unconscious psychological conflicts [1, 2]. Unlike awake bruxism, often associated with severe psychiatric disorders, sleep bruxism affects both psychologically stable and unstable individuals, posing a significant public health challenge [3]. Standard dental treatments, such as occlusal splints, mitigate symptoms but often fail to address the psychosomatic etiology, risking symptom persistence or migration to other organ systems [4].

In dentistry, psychosomatic symptoms like burning mouth syndrome, atypical odontalgia, and bruxism reflect psychological stressors disrupting physiological balance, necessitating holistic treatment approaches [5, 6]. This study advocates an integrative model combining dental and psychotherapeutic interventions, with in-depth dream analysis as a novel tool to uncover unconscious contributors to sleep bruxism. Through a case study and literature review, we demonstrate its potential to resolve symptoms and emphasize the need for interdisciplinary collaboration.

Background

Psychosomatic nature of bruxism

Bruxism manifests as a parafunctional activity of the masticatory system, causing tooth attrition, temporomandibular joint dysfunction, and related symptoms [4, 6]. Sleep bruxism, more prevalent than awake bruxism, is strongly associated with anxiety, with increased incidence amid societal stressors like the COVID-19 pandemic and geopolitical instability [7, 8]. Sleep bruxism is associated with REM sleep disturbances, where nightmares may induce defensive movements and intense jaw clenching, damaging teeth and masticatory structures [4, 5, 8]. These psychosomatic manifestations underscore the need for integrative treatment addressing psychological and physiological factors.

Role of the unconscious

The unconscious psyche drives psychosomatic disorders, with repressed emotions and conflicts manifesting somatically when defense mechanisms fail [10]. Dreams, described by Freud as the "royal road to the unconscious," offer direct access to these contents, making dream analysis a valuable therapeutic tool [11]. Nastović's three-dimensional method, integrating Freud's personal, Jung's collective,

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and Szondi's familial unconscious, provides a robust framework for uncovering the etiology of psychosomatic conditions [12].

Current challenges in treatment

Despite sleep bruxism's psychosomatic nature, treatment remains fragmented. Dentists primarily use occlusal splints or prosthetic reconstructions, which address symptoms but not etiology, risking symptom recurrence or migration to other organ systems [4, 13]. Psychotherapeutic interventions are underutilized due to limited interdisciplinary collaboration and insufficient psychotherapeutic training for dentists [13]. This gap highlights the need for integrative approaches targeting both symptoms and underlying causes.

Method

To see more about Nastović's three-dimensional method, follow the link https://ivannastovic.com

The study employed Nastović's three-dimensional dream analysis, examining dreams through personal, collective, and familial unconscious lenses [12]. This method analyzes dream symbolism, patient associations, and emotional responses to uncover repressed contents driving psychosomatic symptoms. A case study evaluated its efficacy in treating sleep bruxism, with therapy delivered via twice-weekly online sessions over two months, focusing on dream interpretation and life stressor discussions. Informed consent was obtained, ensuring ethical conduct [12].

Results

Case study

A 40-year-old single woman presented with early tooth attrition, intermittent temporomandibular joint pain, and morning generalized tooth pain due to nocturnal teeth clenching. Clinical examination and vitality tests excluded inflammatory dental causes, while anamnesis revealed chronic stress and anxiety. As attrition was not advanced, occlusal splints were not urgently required, and the patient declined their preventive use. She consented to a psychotherapeutic approach focusing on dream analysis to address conscious and unconscious anxiety and underlying conflicts.

Over two months, the patient engaged in twice-weekly online sessions, recording and analyzing dreams using Nastović's three-dimensional method. This approach decodes symbolic dream content through patient associations, requiring robust theoretical knowledge and clinical psychotherapeutic experience to identify actionable insights [12].

Dream analysis revealed narcissistic traits originating from a dysfunctional childhood family environment, including a need for maternal validation and a persistent sense of inadequacy despite notable talents and professional competence. This pattern persisted through her education and career, compounded by employment instability, which eroded her self-confidence. Living alone without familial support, she faced existential and societal pressures, exacerbated by the COVID-19 pandemic. Transitioning to remote work after securing stable employment led to social isolation and heightened anxiety, including hypochondriacal fears, which persisted upon returning to in-person work. She experienced ongoing concerns about project failure, despite dream analysis revealing her untapped potential, undermined by familial patterns of inadequacy [5, 7]. A pivotal moment occurred during the analysis of a nightmare titled Mephisto.

Mephisto dream (abridged)

The patient described:

I'm walking through a courtyard surrounded by small houses; my apartment is in the courtyard, which has grass and bushes, resembling old-fashioned courtyards. I step onto the street. It's cool and gloomy after the rain. I turn right and realize I can't find what I'm looking for because roadwork is underway — workers are removing old, large cobblestones. It's still gloomy and damp, but the grass is green. There's a wooden garden table on the lawn. I know my brother is sitting across the table, telling me not to fear the neighbor's dog he's watching. I look down at my feet and see a huge black dog, oversized, like a lion, lying with its paws crossed in front of me. I think I'm safe because I'm not alone and can slightly move my legs away from the dog, which scares me a little. Suddenly, the black dog traps my legs with its paws, and I dare not move to avoid injury. I don't want to move because I'm afraid, though I feel restlessness in my legs and an unbearable tingling sensation.

Analysis of the Mephisto nightmare marked a therapeutic breakthrough. Through symbolic interpretation, the patient identified an unconscious saboteur, symbolized by the dog "Mephisto", inhibiting professional expression despite workplace excellence. Green grass, a recurring motif, signified growth and readiness to realize potential. Restless leg sensations reflected eagerness to progress, while ceased rain indicated past challenges had subsided, despite gloomy weather mirroring her mood. Her brother's reassurance symbolized external support, mitigating unconscious destructive impulses and familial undervaluation, from which she recognized potential comfort. Her philosophical

and mythological knowledge accelerated insights. Confronting these barriers enabled workplace recognition, significantly reducing anxiety and jaw clenching, halting tooth attrition without dental interventions. Continued psychotherapy was recommended to prevent symptom recurrence or psychosomatic migration [5, 12].

Outcomes

Post-therapy, the patient reported significant anxiety reduction and no further jaw clenching, preventing progression to clinical bruxofacets. She was recommended psychotherapy to prevent symptom recurrence or psychosomatic migration. The case demonstrates the efficacy of dream analysis in addressing the psychosomatic etiology of sleep bruxism when patients are cooperative and possess resources for self-awareness.

Discussion

Efficacy of dream analysis

Dream analysis, particularly Nastović's three-dimensional method, efficiently accesses unconscious conflicts driving psychosomatic symptoms, aligning with contextual models of psychotherapy that emphasize tailored interventions for anxiety-related disorders [9, 12]. In this case, nightmares revealed repressed emotions and inadequacy patterns, enabling behavioral changes and symptom resolution. Jung's assertion that interpretation transforms a dream into an experience underscores this approach's therapeutic value [11].

Integrative therapy needs

This case highlights the limitations of symptom-focused dental treatments like occlusal splints, which fail to address psychosomatic etiology, risking symptom recurrence or migration to other organ systems [4, 13]. The global rise in sleep bruxism post-COVID-19, driven by heightened societal stressors, underscores the urgency of integrative therapy combining dental and psychotherapeutic expertise [7, 8]. However, dentist-psychotherapist collaboration remains rare, despite its potential to advance treatment models, improve outcomes through targeted psychosomatic interventions, and foster interdisciplinary research into bruxism mechanisms [13, 14]. Dentists, with training in head and neck anatomy and psychiatry, are well-positioned to contribute but require enhanced psychotherapeutic education [15].

Limitations

Reliance on a single case study limits generalizability, and dream analysis's success depends on patient cooperation and cognitive resources. The absence of a control group precludes comparative efficacy assessment. The lack of standardized protocols for integrating dream analysis into dental practice poses implementation challenges. Future research should involve larger cohorts, control groups, and longitudinal studies to validate these findings.

Conclusion

Sleep bruxism, a complex psychosomatic condition, requires integrative therapy combining dental and psychotherapeutic interventions. Dream analysis, as shown in this case study, effectively uncovers unconscious conflicts, alleviating symptoms in engaged patients. To advance care, dental and psychotherapeutic communities must foster collaboration, and dentists need access to psychotherapeutic training. Further studies evaluating psychotherapy's efficacy in bruxism treatment are essential to develop evidence-based guidelines, addressing both symptoms and causes for improved public health outcomes.

Declaration of interests

The author declares that there is no conflict of interest.

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Katathym-Imaginative Psychotherapy for complex post-traumatic stress disorder: a trauma therapist's perspective

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Received: Jan 5, 2025.
Accepted: Feb 9, 2025.
Published: August 1, 2025.

For citation:
Kuznetsova OV. Katathym-Imaginative Psychotherapy for complex post-traumatic stress disorder: a trauma therapist's perspective. *Psychotherapy Science Today*. 1(1):29-33. https://doi.org/10.64435/tizt2097

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Abstract

This article explores the application of Katathym-Imaginative Psychotherapy (KIP), also known as Symboldrama, as an effective therapeutic approach for patients with complex post-traumatic stress disorder (CPTSD), a condition often resulting from prolonged or cumulative trauma, such as childhood abuse or neglect. Drawing on the trauma therapist's perspective and clinical experience, the study provides a detailed analysis of KIP's symbolic motifs and their implementation across the three key stages of trauma therapy: stabilization, processing of traumatic experiences, and integration. Motifs are examined through patient case studies, highlighting their role in preventing retraumatization, fostering self-compassion, and restoring psychological continuity. The findings underscore KIP's diagnostic and therapeutic potential, particularly in addressing repressed affects, enhancing mentalization, and strengthening personality structure in patients with CPTSD. KIP offers a gentle, resource-oriented approach that mitigates the risk of retraumatization while promoting emotional regulation and identity reconstruction. The results advocate for the broader adoption of KIP in clinical practice and suggest directions for future research, including the development of new trauma-focused motifs and the exploration of KIP's long-term impact on CPTSD symptom management.

Keywords: PTSD, post-traumatic stress disorder, CPTSD, complex post-traumatic stress disorder, trauma psychotherapy, Symboldrama, Katathym-Imaginative Psychotherapy.

Introduction

Complex post-traumatic stress disorder (CPTSD) is a diagnosis encompassing various symptom clusters that arise in individuals who have experienced prolonged traumatization. Typically, these are extended traumatic events associated with violence, disasters, participation in combat, or often childhood psychological traumas. Serial traumatization, a series of traumatic events, or so-called cumulative (prolonged) trauma, is one of the significant criteria for CPTSD. Complex post-traumatic stress disorder corresponds to the diagnosis of enduring personality change after catastrophic experience (F62.0 in ICD-10). In the International Classification of Diseases (ICD-11), it was included alongside post-traumatic stress disorder (PTSD) [1, 2].

The introduction of the CPTSD category in the ICD was primarily driven by the fact that PTSD criteria are associated with event-based trauma, which is clearly defined in time. Psychopathological disorders in cases of prolonged traumatization — such as repeated physical and/or emotional abuse — were, to some extent, beyond the scope of the PTSD category. The traumatization of individuals who have experienced an accident or natural disaster differs significantly from that of those who have endured violence or rejection by significant others [1, p. 71; 2]. CPTSD may develop as a result of persistent or frequently recurring experiences of rejection, neglect, or disregard; exposure to domestic violence (physical, sexual, or verbal); betrayal trauma that undermines the foundation of trust; encounters with bullying or harassment; or experiencing traumatic events in a community without support from primary caregivers (parents or guardians). As significant stressors contributing to the formation of CPTSD, factors such as dependence on psychoactive substances and the presence of mental disorders in the family where the child is raised have been identified [1–4].

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Working with the symptoms of Complex PTSD requires a gentle approach. One of the most effective modern methods that meets the requirement of gentleness is Katathym-Imaginative Psychotherapy, developed by Hanscarl Leuner [5–7].

Katathym-Imaginative Psychotherapy for treating patients with CPTSD

To see more about the Katathym-Imaginative Psychotherapy approach, follow the link https://igkip.org

The application of Katathym-Imaginative Psychotherapy techniques is indicated for acute and chronic stress reactions, as well as for post-traumatic stress disorder and complex post-traumatic stress disorder. In cases of psychosomatic and somatoform conditions associated with CPTSD, the following therapeutic strategies are employed in Katathym-Imaginative Psychotherapy:

- Healing narcissistic regression;
- Satisfaction of archaic needs;
- Progression ("action and development in imagination");
- Working with aggressive impulses;
- Imagination in translating body language to verbal expression.

The symbol creatively connects the bodily symptom with the psychosocial conflict [5]. Working with imaginations allows the psychotherapist to gently address issues from the early, preverbal period of the patient's life (early childhood traumas increase the risk of developing CPTSD). Patients with PTSD are particularly attuned to the language of images and symbols, which facilitates a connection with the unconscious, thereby aiding in restoring the continuity of time and events.

Beata Steiner, in her work on psychotraumatic stress disorders, notes that since the 1990s, the KIP method has been widely applied in the treatment of patients with psychological traumas. Since 2002, Katathym-Imaginative Psychotherapy of Trauma (KIP-T) has emerged as a distinct method from KIP. It is used in the treatment of acute and complex psychotraumatic disorders, with particular attention to working with childhood trauma. The development of this method aimed to integrate findings from scientific research on attachment, infant psychotrauma, self-psychology, and social neuroscience [5].

Therapeutic targets and tools for treating post-traumatic states

Katathym-Imaginative Psychotherapy offers a wide range of diagnostic and therapeutic opportunities, particularly beneficial for patients with post-traumatic states. Introjective externalization in KIP protects therapeutic relationships from disruption caused by intense negative transference and serves as an intermediate step in treating patients with self-destructive tendencie [5].

When working with trauma, the psychotherapist's attention should primarily focus on the patient's resources and coping strategies. Motifs for imagination must be selected in a way that avoids reactivating intense trauma-related experiences and prevents potential retraumatization [5]. KIP motifs are also chosen with careful consideration of the patient's personal history. For instance, an initially resource-oriented motif like *Picnic in the countryside* would be inappropriate for a female patient with a history of violence-related trauma that occurred during a countryside picnic with friends.

When determining therapeutic strategies, the following functions of imagination should be considered:

- expression and clarification;
- stabilization;
- structure formation [6].

Differential diagnosis using the diagnostic triad can help identify both therapeutic targets and strategies, as well as the tools of therapy, including specific imaginations. Harald Ullmann notes: "Mental disorders for which psychotherapy is indicated are typically classified using a tripartite model: we must distinguish between conflict-dynamic disorders, developmental deficits, and disorders resulting from psychotrauma. This diagnostic triad sets the direction for exploration during the initial sessions and in the first imagination exercise, known as the 'initiating dream'" [5].

If the symptom is rooted in trauma, the therapist's tasks at the initial stage will focus on preventing retraumatization and creating a safe and stable internal space. This involves working with resources and developing coping strategies. In cases where the patient exhibits a low structural level of psychic organization and early developmental deficits — common in cumulative trauma — the therapist must cultivate ego functions, strengthening the personality structure. After working with resources, at a later stage of therapy, the focus may shift to the affective domain, aiming to develop skills for perceiving and verbalizing affects, as well as enhancing the ability to regulate them. In the long term, the goal of therapy may include improving the level of mentalization.

At all stages of trauma therapy (stabilization, trauma processing, and integration), KIP-T incorporates various imaginative techniques that provide a resource-based "safety cushion" and ensure a gentle approach to the patient's painful traumatic material.

Stages of trauma therapy and recommended KIP Motifs

Let us examine the stages of working with psychotrauma in greater detail.

1. Stabilization phase

At this stage, motifs that activate ego stabilization, narcissistic restoration, and help the patient feel safe are crucial. Narcissistic restoration is necessary because trauma disrupts the sense of self-worth, often leading to a fragmented ego. The following imaginations (motifs) may be offered to the patient: *A flower that has everything it needs to grow and thrive (Beautiful flower, Flower in a safe and protected place), Safe place (A place where I feel good, Place of strength), Meadow where I feel good* or *My meadow*, as well as the *Fortress* motif to restore and strengthen boundaries.

Additional stabilizing motifs may include *Temple of silence, Healing rays of the sun, Being a prince (princess).* A special role is played by "water motifs" which involve contemplation and interaction with water. Their inclusion in psychotherapeutic practice is referred to as "katathym hydrotherapy".

Motif "Spring of crystal-clear water" (patient case)

K., a 27-year-old female patient with cumulative trauma, experienced sexual abuse by her stepfather at the age of 14.

At the beginning of the motif presentation, K. struggles to concentrate, noting that various images flash before her eyes. Eventually, she manages to visualize a spring struggling to break through a pile of branches, last year's leaves, and debris. The weather resembles autumn — overcast with a light drizzle. Near the spring, there are large boot prints and trampled grass. The patient sees herself near the spring at the age of 14 (the age of the trauma). After some time, she feels a desire to clear the spring. She begins removing debris left by tourists and fishermen (her stepfather was an avid fisherman). Over time, she notes that it has become warmer (she also feels warmth in her hands, feet, and chest area). The sun comes out, reflecting in the spring and creating playful sunbeams. K. washes her hands and face with water from the spring. The patient starts cleaning the polluted spring (i.e., she takes active steps, which facilitates a shift away from the victim position).

In this case, the motif *Spring of crystal-clear water* became a turning point for the patient, transforming her relationship with herself and the world. This motif is recommended for work with psychosomatic patients, as well as those with post-traumatic consequences of violence, particularly sexual abuse (victims of sexual abuse often feel "dirty").

Before proceeding to the next stage, which focuses on working with psychotraumatic experiences, the therapist must introduce motifs that help the patient encounter inner protectors and helpers (companions, allies, support groups, etc.). These characters may possess various qualities, the activation of which provides the patient with a sense of strength and the ability to protect themselves (counteracting the helplessness often experienced by patients with PTSD and CPTSD), as well as wisdom, resourcefulness, and the ability to navigate new circumstances. Beata Steiner mentions that in trauma cases, a modified form of the imagination "Inner safe" is used for controlled engagement with traumatic material [5]. All these motifs help the patient cope with fear and feel more stable. A detailed list of recommended motifs of KIP for the treatment of CPTSD is presented in the Appendix.

Another critical aspect of therapeutic interventions at the stabilization stage is working with the "inner child". Beata Steiner describes the following concept of interacting with the "inner child" image:

- Motif *Healthy, non-traumatized child* is a stabilizing and stimulating motif that allows the patient to experience an ideal representation of themselves, feeling a sense of completeness, wholeness, and vitality;
- Motif *The child you once were* is focused on a representation of the self that encapsulates the entire experience of childhood at a specific age;
- Motif *Traumatized child* shifts the focus to the representation of the traumatized self, gently turning toward the traumatic experience — a cautious first glance into a painful past.

Thus, to prepare the patient for working with traumatic experiences without rushing the process and to prevent retraumatization, they may be invited to imagine meeting their helpers (protectors) and the "non-traumatized child" as well as "the child they once were" in a safe place as an adult. The primary therapeutic task at this transitional stage is to gently establish an indirect connection with the traumatized child. The latter is not explicitly named; instead, attention, protection, care, and comfort are directed toward "some child" [5].

2. Phase of processing traumatic experiences

At this stage, the patient encounters the "traumatized child," confronting difficult memories. There is a gentle and gradual approach to trauma-related introjects. Sometimes, a significant amount of time passes between the first session and the initial encounter with the wounded child, during which the patient may experience resistance that hinders establishing contact with the traumatized child. Feelings of tenderness, joy, or the desire to care for and protect this child may not arise immediately.

Motif *Traumatized child* (patient case)

N., a 32-year-old female patient with a request to build partner relationships.

N. imagines a baby toward whom she feels hostility, irritation, fear, and alienation. She looks at the baby and almost immediately says she does not want to see this girl, then opens her eyes.

It takes four more sessions before the patient finds the strength to look into the baby's eyes and hold her. The patient's life story begins with her parents' rejection of her birth. Her parents, both 18-year-old first-year university students, were unprepared for a child. The patient's hostility, rejection, and disregard for her child self likely stem from her parents' feelings toward her.

Throughout therapy, the patient repeatedly returned to the theme of relationships, complaining about her partner's inattentiveness and his accusations of her being "clingy" and intrusive. During one session, she realized she was seeking a parental figure in her partner — not only a father figure but also a mother figure.

After the initial confrontation with the trauma, the patient requires a prolonged stabilization phase. Subsequently, a controlled re-approach to painful and traumatic scenes can be undertaken using imagination techniques. Experiencing traumatic scenes in the"as if" mode allows for controlling the imagined scenes, adding new details, and modifying them as desired [5].

An effective technique for working with the aftermath of trauma is to invite the patient to become the screenwriter and director of their own film, "rewriting" the plot.

Following another stabilization episode, work aimed at engaging with trauma-related introjects can continue. Trauma-related introjects are expressed through metaphors such as "inner devaluer," "sadist," "offender," "critic," or "accuser," which are then processed imaginatively [5]. In cases of prolonged traumatic experiences or cumulative trauma, this approach is meaningful only within the context of long-term, extended therapy.

3. Phase of integration of traumatic experiences

Trauma, particularly early childhood trauma, becomes part of the psychic structure, requiring lengthy processing in psychotherapy. The most challenging aspect to overcome is the so-called loyalty conflict, where patients, on the one hand, suffer from aggressors, tormentors, or sadists, but on the other hand, are strongly attached to them — especially if these are parents or other family members. At this stage, working with affects and "unfreezing feelings," as well as rehabilitating the emotional sphere, is essential. Beata Steiner recommends the "House of feelings" motif, which allows the patient to connect with a wide range of emotions, such as guilt, resentment, rage, and shame. In this journey through the landscapes of the soul, the patient can also visit rooms of joy, dreams, and happiness.

Conclusions

Katathym-Imaginative Psychotherapy simultaneously serves in diagnosis and direct trauma therapy from initial stabilization to integration. Differential diagnosis, including the use of imaginations, helps not only to identify therapeutic targets and strategies but also to incorporate KIP motifs that can address various symptoms of psychotrauma, including manifestations of depression, self-harming behavior, and psychosomatic conditions.

When supporting patients with CPTSD symptoms, KIP focuses on preventing retraumatization, creating a safe and reliable internal environment, utilizing personal and external resources, and fostering healthy coping mechanisms. Additionally, it addresses early developmental deficits and strengthens the personality structure. Katathym-Imaginative Psychotherapy promotes a gentle attitude toward oneself, self-compassion, and the ability to be a good parent to oneself.

Psychotherapy for patients with CPTSD using Katathym-Imaginative Psychotherapy helps reduce psychoemotional tension; gradually recognize the origins of problems, establishing a causal link between life events, personality traits, and symptoms; and more clearly understand the meaning of symptoms and their secondary benefits. The method enables work with repressed affects, facilitating the restoration of identity and the psychological timeline of life.

All this together support the use of Katathym-Imaginative Psychotherapy as a highly effective modern therapy for patients with complex post-traumatic stress disorder. Further research into the impact of imaginations on various symptoms of CPTSD, as well as the development of new trauma therapy strategies leveraging the vast potential of KIP, holds promising prospects.

Declaration of interests

The author declares that there is no conflict of interest.

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Appendix

Recommended Katathym-Imaginative Psychotherapy motifs for treating CPTSD symptoms

Resource-oriented motifs:
- *Water where it felt pleasant*
- *Spring of crystal-clear water*
- *Oasis*
- *Source of strength*
- *Paradise fruit*
- *Lying in a hammock*
- *On a warm beach*
- *In a warm room*
- *Land of abundance*
- *Picnic in the countryside*
- *Resort vacation*
- *Planting a garden*
- *In the garden*
- *Tending to plants in the garden*

Working with the "Inner child":
- *Healthy, non-traumatized child*
- *The child you once were*
- *Traumatized child*
- *Box of toys*
- *My favorite plush toy*

Boundaries:
- *Building a house*
- *Managing your own plot of land*
- *Ruling your kingdom*

Aggression:
- *Storm*
- *Watching a thunderstorm*
- *Thundercloud*
- *Letting off steam*
- *Throwing mud and rolling in mud*
- *Volcano*
- *Secret weapon*

Depressive states:
- *New clothes*
- *Golden ball*

Body Self, psychosomatics:
- *Journey inside your own body*
- *Cloud*
- *Massage*
- *Two gardens*

Life scenarios:
- *In a fairytale land*
- *My fairytale*

Timeline:
- *Imagining yourself 10–20 years older*
- *I am 80 years old*
- *Time machine*
- *Journey through time*

Comprehensive support for blind and visually impaired students: integrating psychotherapy to overcome academic stress — experience of Vladimir State University

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Received: Feb 4, 2025.
Accepted: Mar 14, 2025.
Published: August 1, 2025.

For citation:
Cherkasova IP. Comprehensive support for blind and visually impaired students: integrating psychotherapy to overcome academic stress — experience of Vladimir State University. *Psychotherapy Science Today*. 1(1):34-38. https://doi.org/10.64435/asst9817

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Abstract

This article examines the potential of a comprehensive support framework to address academic stress and promote successful adaptation among students with visual impairments during their higher education journey. Drawing on a decade-long experience (2015–2025) of inclusive education for students with sensory impairments at Vladimir State University, the study analyzes the multifaceted dimensions of psychological, pedagogical, social, and psychotherapeutic support implemented across all educational stages. A mixed-methods approach, involving surveys, psychological testing (e.g., the Academic Stress Test and Strategic Approach to Coping Scale questionnaire), and observational data from 20 students, was employed to assess stress levels and coping mechanisms. The findings indicate that while psychological consultations and pedagogical interventions effectively mitigate stress for many students, approximately one-fifth of senior students exhibit persistent high stress levels, highlighting the limitations of standard support. This underscores the necessity of integrating targeted psychotherapeutic interventions, including existential-humanistic, psychodynamic, cognitive-behavioral approaches, and innovative art therapy methods (e.g., beading and scrapbooking), which have demonstrated significant potential in reducing stress, enhancing self-actualization, and fostering social integration. These results contribute to the growing body of knowledge on inclusive education and offer practical insights for designing tailored support systems to address the complex socio-psychological needs of visually impaired students.

Keywords: blind and visually impaired students; academic stress; psychotherapy; comprehensive support.

Introduction

Inclusive education has emerged as a transformative framework, offering blind and visually impaired students unprecedented opportunities to pursue modern, promising professions that were historically inaccessible due to societal and educational barriers. However, this shift toward inclusivity places significant demands on these students, requiring not only robust academic preparation but also substantial self-effort to navigate the complexities of higher education. Beyond cognitive and technical skills, these students face unique psychological challenges, necessitating readiness for self-organization, self-actualization, and the development of effective communication skills to engage with diverse academic and social environments [1]. Recent research highlights that one of the primary obstacles to self-actualization among students with disabilities is a chronic lack of internal psychological resources, which they often mitigate through external social support from peers, educators, and institutional frameworks. This reliance on external support is compounded by an insufficient alignment of their current activities with long-term career aspirations and life prospects, further exacerbating their vulnerability to stress [2].

Students with visual impairments frequently report heightened fatigue and emotional exhaustion, with the majority experiencing stress directly linked to the learning process, including challenges such as inaccessible materials, high academic workloads, and difficulties in social integration. This stress can impede their psychological well-being and academic success, underscoring the need for comprehensive support systems that address both practical and emotional needs. In this framework, psychotherapeutic interventions provide effective strategies to strengthen resilience and promote

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Challenge	1st Year (%)	4th Year (%)
High academic workload	100	50
Fear of the future	80	55
Living away from parents	75	20
Problems in personal life	70	50
Strict instructors	60	30
Shyness, timidity	55	40
Inability to properly organize daily routines	50	20
Irregular meals	50	30
Inability to manage limited finances	50	20
Unclear or unengaging electronic textbooks	20	20
Lack of textbooks in Braille	25	13.3
Lack of motivation to study or disappointment in chosen profession	20	13.3
Challenges of cohabitation with other students	10	6.7
Overly serious attitude toward studies	5	–
Conflicts within the group	–	6.7

Table 1. **Socio-pedagogical and psychological challenges of blind students**

adaptation, overcoming visual impairment-related barriers while cultivating a sense of personal agency. The experience of Vladimir State University, which began integrating blind students into its programs in 2015, provides a valuable case study to explore how tailored psychological, pedagogical, social, and psychotherapeutic support can mitigate these challenges, setting the stage for a deeper investigation into effective strategies for overcoming academic stress in this population.

Academic stress among blind and visually impaired students

Vladimir State University named after Alexander Grigoryevich and Nikolai Grigoryevich Stoletov (VlSU) began admitting blind students in 2015. From 2015 to 2025, the Humanitarian Institute of VSU enrolled 20 students aged 18 to 25 with varying degrees of visual impairment. Of these, 2 dropped out in their first year, 1 in their third year, 14 graduated with bachelor's degrees, and 4 are currently pursuing bachelor's and master's degrees. In total, 17 students were successfully adapted during their studies. These students face numerous challenges during their studies. We investigated academic stress among blind and visually impaired first-year students and their primary coping strategies.

Most blind students experience academic stress, which intensifies during tests and exams, particularly among first-year students. Stress levels among fourth-year students are somewhat lower. High stress levels, observed in 35% of blind and visually impaired first-year students, decrease to 20% by the fourth year. Conversely, 10% of students with low stress levels become more anxious over time (low stress decreases from 30% to 20%). The proportion of students with moderate stress levels increases fourfold over the course of their studies, from 15% to 60%. Let us examine the factors contributing to academic stress among students with visual impairments*.

Many barriers faced by blind and visually impaired students stem from a lack of independent living skills, underdeveloped abilities to manage finances, allocate time, and care for themselves. Over half of first-year students perceive instructors' expectations — aligned with those for sighted students — as excessive, viewing instructors as overly strict. Limited computer literacy among students impedes their ability to access and use electronic educational materials effectively. Fully blind students would prefer textbooks in Braille. Both at the beginning and end of their studies, most students

* The survey included 20 students. Data were collected using the "Academic Stress Test" by Yu. V. Shcherbatykh [3] and the "Strategic Approach to Coping Scale (SACS)" questionnaire, adapted by N. Vodopyanova and E. Starchenkova.

fear their future. For first-year students, this fear is tied to studying, independent living, and navigating new environments, while graduates fear unemployment or failing to meet professional demands.

A distinct group of challenges includes personal issues, which slightly decrease by the fourth year for some students but intensify for others, such as anxiety related to studies and job searches, as well as inadequate self-esteem. The most persistent challenges throughout their education are low interactive communication skills and heightened fatigue among all students.

Surveys of instructors, observations, and testing of students with visual impairments reveal that they tend to communicate primarily with each other or select peers, avoid initiating conversations, express requests through intermediaries, and prefer chatting online over face-to-face interaction. These students typically attend group psychological consultations by invitation; 20% sought individual psychological support, while 80% believed they could manage their challenges independently. These findings align with studies on sighted students [4].

Comprehensive support for blind and visually impaired students

Psychological and pedagogical support helps reduce academic stress, including group and individual psychological consultations, advanced computer literacy training, methodological assistance from instructors, peer support, and improved time management skills. At our university, blind and visually impaired students receive comprehensive psychological, pedagogical, and social support through the Research and Educational Center for Inclusive Education, established at the Department of Personality Psychology and Special Pedagogy. Developmental activities are conducted in various formats, such as:

- Communication training sessions;
- Viewing films and plays with audio descriptions;
- Visiting museums with tactile exhibits;
- Participating in accessible excursions designed for visually impaired individuals, featuring audio guides, audio descriptions, and tactile models of monuments and historical buildings;
- Rehearsals and staging of plays;
- Participating in beading and scrapbooking workshops, and university cultural events.

Our observations indicate that social support for blind and visually impaired first-year students significantly reduces academic stress and improves adaptation. The university provides an accessible architectural environment, enabling blind students to navigate academic buildings and reside in specially equipped dormitory blocks. Regular training is conducted for university staff — security personnel, librarians, and cafeteria workers — on assisting blind students. The inclusive university environment and joint education with sighted students foster interaction and effective social adaptation [5]. Volunteers assist blind students by escorting them to classes, medical facilities, and key city institutions. They are also prepared to support them throughout their academic journey by assisting with the formatting of written assignments and jointly attending engaging events.

However, we observed that one-fifth of blind and visually impaired senior students continue to experience high levels of academic stress. Therefore, alongside psychological and pedagogical support, we have provided these students with access to psychotherapeutic assistance based on existential-humanistic, psychodynamic, and cognitive-behavioral approaches, as well as art therapy, which has proven with us highly effective and shown significant potential in working with blind students.

We incorporated art therapy methods into the psychological support activities conducted by psychologists, group supervisors, and instructors from the Department of Personality Psychology and Special Pedagogy. For instance, beading is one of the diverse applications of art therapy in our work with blind students. Students choose the object to bead based on their preferences, such as recalling flowers they saw before losing their sight. They verbally describe the flower's image, size, color, and associated emotions while receiving assistance in selecting beads and techniques. Another example of art-therapeutic support is scrapbooking, in which two of our blind students participated. They used pre-made shapes to attach to cards, choosing themes such as figurines of people and animals, flowers, bows, beads, and buttons, and they learned basic composition techniques, assisted by sighted students.

Engaging in collaborative activities, such as beading and scrapbooking workshops, not only fostered closer relationships with peers through meaningful exchanges like sharing tactile cards with classmates but also provided a therapeutic outlet for emotional expression and social integration. By incorporating psychotherapeutic assistance into the comprehensive support system for students with visual impairments, we observed a multifaceted positive impact on their psychological well-being and academic journey. Specifically, psychotherapeutic interventions significantly reduced academic stress levels, as evidenced by

a decrease in reported anxiety during high-pressure periods like exams.

These interventions facilitated adaptation by helping students navigate the unique challenges of higher education, such as inaccessible learning environments and social isolation, thereby fostering a stronger sense of belonging and resilience. Moreover, psychotherapeutic support enhanced self-actualization, empowering students to explore their potential, set personal goals, and develop a clearer sense of identity despite their visual impairments. Interactive communication skills were markedly improved, with students demonstrating greater confidence in initiating conversations, expressing their needs directly, and engaging with diverse peer groups, moving away from their initial tendencies to rely on intermediaries or online communication. Self-organization skills also saw substantial growth, as students learned to better manage their time, finances, and daily routines, reducing the burden of independent living challenges.

The integration of art therapy, such as creating tactile cards, proved particularly effective in addressing underlying emotional barriers, allowing students to process past traumas and build emotional resilience in a safe, creative space. Over the long term, these interventions not only supported immediate academic success but also laid the foundation for sustained psychological growth, equipping students with the tools to face future professional and personal challenges with greater confidence and autonomy.

Conclusions

This study underscores the critical need for a multifaceted support system for blind and visually impaired students during their higher education, encompassing psychological, pedagogical, social, and psychotherapeutic interventions. Our findings demonstrate that academic stress, particularly pronounced among first-year students, significantly impacts their adaptation and overall well-being. While psychological and pedagogical support, such as group consultations and communication training, effectively mitigates stress for many students, a notable proportion continues to experience high levels of academic stress, necessitating more targeted interventions.

The integration of psychotherapeutic assistance into the comprehensive support framework proved to be a pivotal factor in addressing the socio-psychological challenges faced by these students. Specifically, psychotherapeutic approaches, including existential-humanistic, psychodynamic, and cognitive-behavioral methods, alongside art therapy, have shown considerable promise in reducing academic stress, enhancing self-organization, and fostering interactive communication skills. Art therapy, in particular, emerged as a powerful tool, which not only alleviated stress but also facilitated social integration by encouraging collaboration with sighted peers and volunteers. These activities enabled students to express emotions, recall sensory experiences, and build meaningful connections, thereby supporting their psychological adaptation and self-actualization.

Social support, including volunteer assistance and an inclusive university environment, played a complementary role in reducing stress and improving adaptation, especially during the initial stages of education. Volunteers provided practical help, such as escorting students and formatting educational materials, which alleviated some of the logistical challenges associated with visual impairments. Additionally, the university's accessible architectural environment and staff training further contributed to creating a supportive ecosystem for these students.

However, the persistence of personal challenges, such as fear of the future, low interactive communication, and heightened fatigue, indicates that for students with more complex socio-psychological issues, such as anxiety related to employment prospects or inadequate self-esteem, psychotherapeutic support becomes critical. To further enhance support systems, we recommend the following practical steps:

- incorporating regular psychotherapeutic sessions into the academic support framework, particularly for students exhibiting high stress levels;
- expanding art therapy programs to include a broader range of sensory-based activities tailored to individual needs;
- providing specialized training for educators and volunteers on the psychological needs of blind and visually impaired students; and
- fostering peer mentorship programs to strengthen social bonds and communication skills.

Additionally, future research should explore the long-term effects of psychotherapeutic interventions on academic and professional outcomes for these students, as well as investigate the efficacy of specific methods in addressing stress in this population. By adopting a more integrative and personalized approach, higher education institutions can better support the psychological well-being and academic success of blind and visually impaired students, ultimately empowering them to navigate their educational and professional journeys with greater confidence and resilience.

Declaration of interests

The author declares that there is no conflict of interest.

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Psychological interventions for labor migrants' sociocultural adaptation: a resource-oriented approach illustrated by Uzbek migrants in Russia

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Abstract

Objective: This article examines the adaptation characteristics of labor migrants from Uzbekistan in the Russian Federation, focusing on their sociocultural integration challenges, and proposes evidence-based recommendations for psychological support and targeted psychocorrection to enhance their adjustment to a new environment.

Method: The study was conducted at the Migration Center of Vladimir Oblast, Russia, involving a sample of 150 male labor migrants aged 21 to 51 years. A mixed-methods approach was employed, utilizing the Personality Adaptation to a New Sociocultural Environment Scale by L. V. Yankovsky, the Multilevel Personality Questionnaire "Adaptability" by A. G. Maklakov and S. V. Chermyanin, and the Personality Adjustment Inventory by K. Rogers and R. Dymond to assess psychological traits and adaptation levels. Statistical analysis included Pearson's correlation coefficient (r) to explore relationships between variables such as interactivity, emotional comfort, and internal control.

Results: The findings revealed that 82% of respondents exhibited low adaptation levels, reflecting significant sociocultural integration difficulties. However, notable strengths were identified: 24.7% scored high on the "Interactivity" scale, 25.33% scored low on "Depressiveness", 40% demonstrated high "Emotional Comfort", and 70% showed high "Internal Control". Correlation analysis indicated a significant positive relationship between interactivity and both emotional comfort ($r = 0.217$; $p \leq 0.01$) and internal control ($r = 0.229$; $p \leq 0.01$), suggesting a foundation for resilience.

Conclusions: The findings underscore the potential of leveraging internal resources, such as interactivity, internal control, emotional comfort, and low depressiveness, to enhance the psychological resilience of Uzbek labor migrants in Russia. By informing tailored psychocorrectional and psychotherapeutic strategies, this study supports the development of adaptive interventions that mitigate sociocultural challenges and facilitate sustainable integration into the host environment.

Keywords: labor migrants; sociocultural adaptation; migration psychology; psychological support; psychocorrection; psychotherapy; internal resources.

Received: Mar 11, 2025.
Accepted: Mar 31, 2025.
Published: August 1, 2025.

For citation:
Tagunova AD. Psychological interventions for labor migrants' sociocultural adaptation: a resource-oriented approach illustrated by Uzbek migrants in Russia. *Psychotherapy Science Today*. 1(1):39-41. https://doi.org/10.64435/qpll4556

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Introduction

In the first and second quarters of 2024, a total of 1,282,244 citizens of the Republic of Uzbekistan entered the Russian Federation for employment purposes [1]. Obtaining a work visa in Russia entails a change of residence and relocation for foreign citizens, which inevitably involves their integration not only into a work environment but also into the sociocultural space of the local population. While support from Uzbek diasporas can help labor migrants avoid feelings of isolation by providing a shared culture, traditions, and language, these individuals face interactions with the local population from the moment they cross the border.

Broadly, adaptation refers to the process of adjusting to changing external and internal conditions [2]. In a narrower sense, adaptation involves the interaction between an individual and society, encompassing integration into social groups and the adoption of socially approved norms [3]. J. W. Berry developed a model of acculturation that describes various ad-

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aptation strategies for migrants, laying the groundwork for understanding how migrants interact with a new culture [4]. In this study, using three psychodiagnostic methods, we explore the resources and challenges faced by labor migrants upon arriving in a new sociocultural environment, and formulate recommendations for their psychological support.

Method

This cross-sectional study was conducted at the Migration Center of Vladimir Oblast, Russia, a key local hub for labor migrant registration and support. The sample comprised 150 male labor migrants from Uzbekistan, aged 21 to 51 years (M = 34.2, SD = 8.6), selected to explore gender-specific adaptation patterns. Psychodiagnostic tools included the Personality Adaptation to a New Sociocultural Environment Scale by L. V. Yankovsky [5] to assess cultural adjustment, the Multilevel Personality Questionnaire "Adaptability" by A. G. Maklakov and S. V. Chermyanin [6] to evaluate personal adaptive potential, and the Socio-Psychological Adaptation Diagnosis Method by K. Rogers and R. Diamond [7] to measure social and emotional adjustment. Pearson's correlation coefficient was applied for mathematical-statistical analysis to examine relationships between interactivity, emotional comfort, internal control, and adaptation outcomes [8].

Results

The psychodiagnostic assessment of 150 Uzbek labor migrants revealed significant insights into their adaptation to the Russian sociocultural environment, utilizing three distinct methods: the Personality Adaptation to a New Sociocultural Environment Scale by L. V. Yankovsky, the Socio-Psychological Adaptation Diagnosis Method by K. Rogers and R. Diamond, and the Multilevel Personality Questionnaire "Adaptability" (MLPQ-AM) by A. G. Maklakov and S. V. Chermyanin.

Adaptation levels (Yankovsky Scale)

Analysis of the Personality Adaptation to a New Sociocultural Environment Scale indicated that 82% of respondents exhibited low adaptation levels, reflecting substantial challenges in sociocultural integration. High scores were observed in 17.3% on the "Adaptability" scale, 24.7% on "Interactivity", 22% on "Nostalgia", and 12.7% on "Conformism", while low scores were noted in less than 1% for "Adaptability" and "Interactivity", 25.33% for "Depressiveness", 2% for "Conformism", 1.3% for "Nostalgia", and 27.3% for "Alienation", with the majority showing average scores. Migrants with high scores on "Adaptability", "Interactivity", and "Conformism" demonstrated an active life stance, engagement in activities, a drive for self-realization, and a focus on forming new social connections, coupled with confidence and self-critical abilities. However, they also expressed a need for social approval and emotionally warm relationships, suggesting a potential openness to adopting the host culture's value system. Conversely, low scores on "Depressiveness", "Nostalgia", and "Alienation" indicate a favorable psychological foundation for adaptation, reflecting minimal negative perceptions of the new environment.

Psychological traits (Rogers and Dymond Method)

The Personality Adjustment Inventory revealed diverse psychological profiles. High scores were recorded for 40% on "Emotional Comfort", 70% on "Internal Control", and 15.3% on "Maladaptation", while low scores were observed in 7.3% for "Emotional Comfort", 22.7% for "Maladaptation", and 26% for "Emotional Discomfort" (with 20.67% high). Additionally, 33.33% scored high on "Escapism", 16.67% showed submissiveness, and 18% indicated external control, contrasted by 13.33% low on external control. The predominance of high "Internal Control" (70%) and "Emotional Comfort" (40%) suggests a strong sense of autonomy and emotional stability, enabling migrants to influence their circumstances and maintain a positive outlook, which are critical for psychotherapeutic interventions.

Adaptive potential (MLPQ-AM)

The Multilevel Personality Questionnaire "Adaptability" provided a contrasting perspective, with only 4.7% of respondents in high/normal adaptation groups, characterized by ease in adapting, quick social integration, and emotional stability. A further 13.3% fell into the satisfactory adaptation category, showing dependence on external conditions and occasional aggression, while the majority (82%) were classified in the low adaptation group, exhibiting difficulties in reality perception, social contact establishment, and role assessment. This distribution underscores the need for targeted psychological support.

Correlational insights

Correlation analysis further elucidated these findings, revealing significant positive relationships between "Interactivity" and "Emotional Comfort" ($r = 0.217$; $p \leq 0.01$) and "Internal Control" ($r = 0.229$; $p \leq 0.01$). Higher interactivity correlated with greater readiness to engage with the new environment, expand social networks, and exhibit self-regulation, enhancing emotional comfort and autonomy — key factors for psychotherapeutic resilience-building.

Summary

Overall, despite 82% of migrants showing low adaptation, strengths such as high "Interactivity" (24.7%), low "Depressiveness" (25.3%), high "Emotional Comfort" (40%), and high "Internal Control" (70%) suggest a foundation for successful adaptation. These traits, including a positive outlook and self-control, indicate potential for psychotherapeutic interventions to address sociocultural barriers.

Discussion

The study reveals a striking paradox: despite 82% of Uzbek labor migrants exhibiting low adaptation levels, high scores on "Interactivity" (24.7%), "Emotional Comfort" (40%), and "Internal Control" (70%), alongside low "Depressiveness" (25.3%), indicate significant internal resources. These traits — reflecting resilience, autonomy, and positive outlook — suggest a foundation for enhancing adaptation, aligning with psychotherapeutic frameworks.

Proposed psychocorrectional interventions

Based on these strengths, targeted psychocorrectional strategies are recommended:

- **Social skills and self-regulation:** Leveraging interactivity and internal control to develop social competencies and self-regulatory skills.
- **Anxiety reduction and motivation enhancement:** Utilizing emotional comfort and low depressiveness to mitigate anxiety and boost motivation.
- **Cognitive restructuring:** Addressing maladaptive beliefs about the new environment through psychotherapeutic techniques, such as cognitive restructuring [9].
- **Positive reinforcement:** Employing visualization to reinforce purposefulness and optimism.
- **Reflective practices:** Encouraging self-reflection via diaries, capitalizing on high internal control and emotional stability for therapeutic engagement — high scores on the relevant scales suggest that migrants may actively collaborate with a therapist and will be receptive to self-reflection.
- **Reducing isolation via group dynamics**: Considering high interactivity and engagement with the environment, group psychotherapy, support groups for sharing adaptation experiences, social skills training with role-playing, intercultural communication training, and dialogue practice are suggested to decrease isolation and enhance social support [10].
- **Art and narrative therapies:** Leveraging low depressiveness for art therapy and narrative techniques to process adaptation experiences without exacerbating emotional distress [11].

Broader implications and future directions

While focused on Uzbek migrants, these findings may extend to other cultural groups, highlighting universal adaptation mechanisms alongside culture-specific needs. Future research could incorporate age-stratified samples to assess age-related adaptation variations, enabling tailored psychotherapeutic programs that address diverse migrant profiles.

Conclusion

Psychological support, psychocorrection, and psychotherapy play a crucial role in reducing stress and activating the internal resources of migrants, serving as invaluable tools for their adaptation to a new sociocultural environment. Preliminary psychological diagnostics of labor migrants can significantly enhance the effectiveness of psychocorrectional interventions by enabling the design of tailored support programs based on identified strengths and weaknesses. To ensure successful integration into a new sociocultural environment, we recommend incorporating psychological and psychotherapeutic support programs, developed through psychological diagnostics, into comprehensive adaptation frameworks alongside sociocultural initiatives.

Declaration of interests

The author declares that there is no conflict of interest.

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