



■ peer-reviewed multilingual journal

PSYCHOTHERAPY SCIENCE TODAY



Vol. 2, No. 2 / 2026

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 twice a year.

PST is a clinically oriented journal focused on research in psychotherapy and mental health.

It is an open-access journal. Registered with the National ISSN Center of Serbia.

The views expressed in the authors' materials do not necessarily reflect those of the Editorial Board.

EDITOR-IN-CHIEF

Yuri Tor

*Head of The Isida Institute for Psychotherapy and Mental Health, Serbia
and Academy of Integral Psychodynamic Psychotherapy, Russia*

CO-EDITOR

Dragan Obradović, MD, PhD

*Professor at the Faculty of Medicine, University of Belgrade,
Chairman of the Academic Council, Institute Isida, Serbia*

EDITORIAL AND ADVISORY BOARD

Julia Afanasyeva, PhD

North Ossetia State University, Russia

Jasna Bajraktarević, PhD

University of Sarajevo, Bosnia and Herzegovina

Irina Barilyak, PhD

Tver State University, Russia

Jelena Đukić, PhD

Academy for Human Development, Serbia

Anna Faustova, PhD

Ryazan State Medical University named after I.P. Pavlov, Russia

Olga Filatova, PhD

Vladimir State University, Russia

Svetlana Gurieva, DSc

Saint Petersburg State University, Russia

Dmitry Kasatkin, MD, DSc

Yaroslavl State Medical University, Russia

Takeyasu Kawabata, PhD

Shokei Gakuin University, Japan

İsmail Koçak, MD, PhD

Istanbul Mimar Sinan Fine Arts University, Turkey

Oksana Kuznetsova, PhD

Institute Isida, Serbia

Snežana Milenković, MD, PhD

University of Novi Sad, Serbia

Ekaterina Mordas, PhD

Moscow Institute of Psychoanalysis, Russia

Jelica Petrović, PhD

University of Novi Sad, Serbia

Natalia Rusina, PhD

Academy of Integral Psychodynamic Psychotherapy, Russia

Rosa Šapić, MD, PhD

Academy for Human Development, Serbia

Svetlana Shvetsova, PhD

P.G. Demidov Yaroslavl State University, Russia

Lelica Todorović, MD, PhD

Milutin Milanković College of Medical Sciences, Belgrade, Serbia

PRODUCTION TEAM

Alexey Chaly, *Managing Editor*

Milica Radojev, *Translator and Managing Editor*

Sergey Petrov, *Design and Layout*

PUBLISHER

Institute Isida, Novi Slankamen, Serbia

CO-PUBLISHERS

Academy of Integral Psychodynamic Psychotherapy, Moscow, Russia

St Petersburg State University, St Petersburg, Russia

Tver State University, Tver, Russia

Published: March 2026, Volume 2, Issue 2

Printed by Eurodream, Nova Pazova; print run: 100 copies.

Issue DOI: <https://doi.org/10.64435/idu5702>

<https://psychotherapyscience.today>

Dear colleagues, researchers, and professionals,

The articles in this issue share a common focus on mechanisms of psychological adaptation, the role of personal resources, and the possibilities of a personalized approach in clinical practice and rehabilitation.

The issue opens with a theoretical paper proposing an original causal typology of psychological trauma linked to mechanisms of Ego disintegration and their neurobiological correlates. The proposed model establishes a cause-oriented framework for clinical thinking, enabling a shift from nosological description toward an etiopathogenetic logic of psychotherapeutic intervention.

The empirical section includes studies addressing the role of aggression as a pathogenetic factor in depressive symptomatology, as well as the use of visual narrative as a psychocorrective tool in child practice. The findings clarify the contribution of aggressive impulses to the development of depressive states and confirm the therapeutic potential of visual narrative in the regulation of emotional processes in children.

The section devoted to clinical techniques presents a process-oriented model for selecting forms of therapeutic joining in work with pre-oedipal patients. This contribution combines the theoretical depth of the psychoanalytic tradition with practical orientation and close attention to the dynamics of therapeutic interaction.

A theoretical and clinical review examines numinosity and symbol as therapeutic factors facilitating the transition from symptomatic responding to the integration of experience. The analysis of symbolic experience extends the scope of analytic practice and highlights its role in processes of deep psychological transformation.

The concluding empirical section of the issue includes studies in clinical and health psychology. One paper analyzes age-related differences in resilience and quality of life following upper limb injuries within a biopsychosocial framework, while another identifies disturbances in self-concept among young adults with a history of psychological trauma, delineating key targets for psychotherapeutic intervention.

Overall, the materials of the issue reflect the diversity of contemporary psychotherapeutic approaches while maintaining a focus on clinical applicability, theoretical coherence, and methodological responsibility. The Editorial Board hopes that the presented works will be of interest to researchers and practitioners seeking a deeper understanding of the mechanisms of psychological suffering and the development of targeted psychotherapeutic interventions, and that they will stimulate further interdisciplinary research in this field.

Yuri Tor
Editor-in-Chief

Dragan Obradović, MD, PhD
Co-Editor

CONCEPTUAL FRAMEWORKS

- Types of psychological trauma by Ego disintegration mechanism
and their neurobiological profiles: a causal model 3
Yuri N. Tor, Dragan I. Obradović, Dmitry S. Kasatkin

EMPIRICAL CLINICAL RESEARCH

- Aggression as a key pathogenetic factor of depression: an empirical study 22
Natalya A. Rusina, Polina S. Makoveeva, Svetlana V. Shvetsova
- Visual narrative as a tool for psychological correction: an empirical study
of its impact on the mental states of children aged 5–7 years 29
Svetlana V. Veliyeva

CLINICAL TECHNIQUE

- Joining technique in psychotherapy with pre-oedipal patients:
a model of clinical navigation between intervention forms 36
Irina A. Zedgenizova, Alexey S. Chaly, Zhanna V. Sergeeva, Elena K. Sudenkova

THEORETICAL AND CLINICAL PERSPECTIVES

- Numinosity as a therapeutic factor: from symptom to symbol 44
Oksana V. Kuznetsova
- Resilience and quality of life after upper limb injuries:
the role of age within the ICF biopsychosocial model 49
Sofia Paulina Salvador Espín, Anna Isabel Costales Zavgorodniaya

CLINICAL AND MEDICAL PSYCHOLOGY

- Disturbances of self-concept in young adults exposed
to psychological traumatization as targets for psychotherapeutic intervention 55
Anna G. Faustova, Margarita O. Safronova

CIP – Каталогизacija у публикацији
Библиотеке Матице српске, Нови Сад
615.851

Psychotherapy Science Today: peer-reviewed multilingual journal / editor-in-chief Yuri Tor. – Vol.2, no.2 (2026) – Novi
Slankamen: Institute Isida, 2026 (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

Types of psychological trauma by Ego disintegration mechanism and their neurobiological profiles: a causal model

Yuri N. Tor^{1,2,*}, Dragan I. Obradović³, Dmitry S. Kasatkin⁴

¹ Academy of Integral Psychodynamic Psychotherapy, Moscow, Russia.

² Institute "Isida", Novi Slankamen, Serbia.

³ Department of Pharmacology, Faculty of Medicine, University of Belgrade, Belgrade, Serbia.

⁴ Department of Nervous Diseases with Medical Genetics and Neurosurgery, Faculty of Medicine, Yaroslavl State Medical University, Yaroslavl, Russia.

Abstract

This article presents a typology of psychological trauma developed within the framework of Integrative Causal Psychotherapy** and based on the primary mechanism of Ego disintegration. Four etiopathogenetic trauma types are distinguished: vital, invasive, egotomic, and constitutive trauma***. For each type, the following are consistently described: (a) definition and essence of the trauma, (b) mechanism of Ego damage, (c) clinical phenotype and its neurobiological correlates, (d) clinical implications, and (e) illustrative clinical case. The proposed typology forms a causal algorithm for choosing a therapeutic strategy according to the leading mechanism of traumatization. The compatibility and integrability of the presented typology with ICD-11 and DSM-5 are shown, allowing the translation of a nosological diagnosis into an etiotropic and personalized treatment plan. The article presents a theoretical and clinical model offering a causally oriented framework for conceptualizing psychological trauma. The presented material is intended for mental health professionals and aims to initiate discussion and empirical validation of the proposed typology.

Keywords: psychological trauma, Ego disintegration, causal typology of psychological traumas, vital trauma, invasive trauma, egotomic trauma, constitutive trauma, PTSD, Integrative Causal Psychotherapy.

Received: Nov 21, 2025

Accepted: Jan 21, 2026

Published: Mar 1, 2026

For citation:

Tor YN, Obradović D, Kasatkin DS. Types of psychological trauma by Ego disintegration mechanism and their neurobiological profiles: a causal model. *Psychotherapy Science Today*. 2(2):3–21. <https://doi.org/10.64435/zrge5096>.



© Author(s), CC BY-NC 4.0

Introduction

The problem of effective therapy for psychological trauma remains one of the central challenges in modern clinical psychology and psychotherapy. Despite a large number of methods, their effectiveness varies significantly, especially when working with chronic, complex, and hidden forms of traumatization: approximately two-thirds of patients may continue to experience clinically significant symptoms even after the application of first-choice protocols [1, 2]. This underscores the need for causally oriented models that allow not only the reduction of symptoms but also the diagnosis and impact on the very mechanism of their occurrence.

Existing approaches mainly rely on phenomenological or syndromal classifications

(PTSD, CPTSD, acute stress disorder, grief reaction, dissociative disorders) or on reductive dichotomies (PTSD and CPTSD, single and recurring trauma, etc.) [3]. However, ICD/DSM classifications remain syndromal and do not reflect neurobiological and structural-dynamic differences between forms of traumatization [4, 5]. Even the distinction between “simple” and “complex” PTSD, clinically useful, does not explain the mechanism of the problem’s emergence and does not allow the selection of an etiotropic therapeutic target. Similarly, classifications based on the type of traumatic event (sexual, military, childhood trauma, etc.) ignore what constitutes the decisive mediator in the etiology of post-

* Corresponding author, e-mail: yuri.tor@aipp.education.

** Integrative Causal Psychotherapy (ICP; Serbian: *Integralna kauzalna psihoterapija*, IKP; Russian: *Integral'naya kauzal'naya psikhoterapiya*, IKP) is a psychodynamically oriented psychotherapeutic approach developed by Yu. N. Tor within a Serbian-Russian psychotherapy school. ICP's therapeutic protocols focus on identifying and eliminating the causes of mental disorders and integrate neuromodeling methods, elements of Katathymic-Imaginative Psychotherapy, and psychoanalytic techniques.

*** Hereinafter, the word “trauma” is used to mean “psychological trauma”.

traumatic disorders: the individual mode of mental functioning and the specific mechanism of Ego impairment.

Despite advances in the study of amygdala functions, self-referential networks (default mode network (DMN), salience network (SN), central executive network (CEN)), dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, neuroinflammation, and epigenetics, their integration into clinical models remains fragmented. Neurobiological research describes final phenotypes but does not link them to disturbances in Ego structures [6, 7]. Consequently, a gap remains between neuroscience, describing dysfunctions of individual systems, and clinical practice, operating with concepts such as symptom and syndrome.

Traditional approaches explained trauma through threat to life, stress response, memory processing disorders, or attachment. However, no existing classification answers the key question of etiologic trauma therapy: which specific basic mechanism of Ego integrity and self-regulation was disrupted? Without understanding this mechanism, the therapist is forced to select interventions empirically, and the strategy either becomes universal (“one protocol for all”) or excessively individualized, not taking systemic guidelines into account.

Clinical experience indicates that psychological trauma is not homogeneous: it disrupts different Ego functions and forms various clinical phenotypes. Therefore, without a typology of psychological traumas based on the mechanism of Ego damage, it is impossible to accurately determine therapeutic targets, predict therapeutic response, and build a causally oriented treatment strategy. The proposed causal model attempts to fill this gap by revealing, for each trauma type, a specific mechanism of Ego damage and its unique neurobiological picture. The integration of neurobiological data provides not only the possibility of a more accurate understanding of the clinical phenotype but also a rationale for the use of pharmacotherapy in cases of its pathogenetic necessity.

Thus, the purpose of this article is to present and substantiate a new clinical hypothesis — the causal typology of psychological traumas based on the mechanism of Ego disintegration. This article does not aim to provide exhaustive empirical proof of the model, but propose it as a systematizing framework and practical tool for clinical reasoning, which requires further operationalization and rigorous empirical validation. The subsequent presentation should be regarded as a detailed substantiation of this hypothesis, supported by clinical illustrations.

Methods

This study employs theoretical modeling supported by clinical observations. The development of the typology proceeded in three stages:

1. Theoretical synthesis of key concepts from psychoanalysis (structural theory and attachment theory), contemporary psychotraumatology, and the neurobiology of affect regulation.
2. Inductive generalization of patterns observed by the authors in many years of clinical practice working with cases of psychological trauma.
3. For the purpose of demonstrating the internal logic of each type, four key cases were deliberately selected for the article, as they most clearly and representatively illustrate the proposed typology. These cases are drawn from the authors' extensive clinical experience but do not constitute a systematic sample. They are presented for illustrative purposes to demonstrate the internal coherence and practical applicability of the model.

In the presented clinical cases, outcome evaluation is based on the criterion of stable clinical remission, defined as the absence of the core maladaptive symptoms that prompted treatment and the restoration of premorbid levels of functioning in key life domains (social, occupational, and personal). Given the retrospective nature of the analysis and its focus on demonstrating pathogenetic logic, standardized psychodiagnostic scales were not used in these cases, which constitutes a limitation for the generalizability of the findings but does not diminish their value for illustrating the proposed model.

Causal model of psychological trauma by Ego disintegration mechanism

The typology of psychological traumas by the mechanism of Ego disintegration, developed in Integrative Causal Psychotherapy, includes four types: vital, invasive, egotomic, and constitutive traumas. The model relies on the structural theory of the Ego [8], the personality theory of Integrative Causal Psychotherapy [9], modern data on trauma neurobiology [10–12], polyvagal theory [13], as well as the theory of allostatic load and epigenetic changes [14, 15].

The novelty of the proposed typology lies in its systemic integration: it consistently links the primary mechanism of Ego damage, the clinical phenotype, and the specific neurobiological profile for each type of trauma. Unlike classifications based on the external event or syndrome, this model makes it possible to:

- determine hypothetically the leading mechanism of damage (“point of failure”) at the stage of diagnostic conceptualization;

To learn more about Integrative Causal Psychotherapy, follow the link: <https://icpmodality.org>

- build therapy based on the causes of the disorder, not just its symptoms;
- predict therapeutic dynamics and avoid errors arising from incorrect understanding of the trauma type;
- integrate methods from various psychotherapeutic schools around restoring a specific damaged Ego function;
- propose hypothetically justified indications for pharmacotherapy in accordance with the presumed pathogenesis of a specific trauma type.

The proposed typology provides the clinician with a map that allows them to identify the damaged part of the personality architecture behind the symptoms and determine how it can be restored.

Type 1. Vital trauma

Vital trauma (from Latin *vita* — “life”) arises from a collision with a force that, perceived as life-threatening and overwhelming, destroys the basic sense of safety and predictability of the world. This is a type of psychological trauma in which the core mechanism involves a severe overload of the psychological safety system as a result of direct confrontation with a real or perceived threat to physical existence or bodily integrity. The emotional core of this trauma is intense fear. The mechanism leads to a global collapse of the psychological safety system, resulting in a pervasive reorganization of the personality around the traumatic experience. This represents a general failure of the basic Ego structures responsible for regulation, integration, and maintenance of personality integrity. It disrupts the hierarchical organization of the psyche and forms a new, pathological architecture where the dominant organizing principle becomes constant readiness for threat [16].

Vital trauma typically arises in the case of repeated life-threatening situations or a single high-intensity life-threatening event (torture, participation in combat, terrorist attack, armed assault, etc.). It leads to complex and persistent changes in the functioning of the central nervous system. Its neurobiological profile represents not merely a set of isolated dysfunctions, but rather a self-sustaining pathological system. In this system, chronic hyperactivation of threat detection nodes, exacerbated by insufficient descending control and supported by fundamental pathophysiological processes, forms a stable state of maladaptation underlying the following clinical symptomatology [17]:

- *affective sphere*: background fear, generalized anxiety, hyperarousal, self-aggression, suppression of feelings up to alexithymia;
- *cognitive sphere*: intrusive memories and flashbacks, rumination, hypervigilance to potential threats;

- *somatic level*: high startle response, chronic muscle tension, increased fatigue, high sympathetic tone, possible sleep disturbances (nightmares, insomnia);
- *behavioral manifestations*: avoidance of triggers and situations reminiscent of the trauma, aggressive or impulsive reactions during activation.

The neurobiological picture of vital trauma is characterized by the following features.

1. *Chronic hyperactivation of threat detection and response systems* leads to a state of constant hypervigilance and readiness for a stress response. Excessive activation of the amygdala is associated with reactions to neutral or conditionally safe stimuli, interpreting them as potentially dangerous. High HPA axis activity, manifested in persistently elevated basal cortisol levels or its atypical diurnal rhythm, maintains a state of metabolic and immune readiness for stress. Hyperactivity of the anterior insula is manifested in somatosensory symptoms, such as increased pain sensitivity, nausea, and general physical discomfort in response to psychological stress [18].
2. *Dysfunction of regulatory and modulating systems* causes insufficient descending inhibitory control from higher cortical structures. Reduced activity of the prefrontal cortex, particularly in dorsolateral and ventromedial areas, leads to deficits in executive functions (planning, decision-making, working memory), impaired conscious cognitive control over emotional reactions, and weakened ability to reflect on them. Hippocampal hypofunction under the influence of excess glucocorticoids impairs the ability to differentiate past threatening situations from current safe reality and contributes to declarative memory deficits.
3. *Dysregulation of neurochemical systems* regulating mood, motivation, and general psychophysiological state is described by the following changes. Reduced dopaminergic activity in the mesolimbic pathway leads to anhedonia, apathy, and reduced motivation for goal-directed behavior. Increased activation of raphe nuclei and locus coeruleus leads to the development of depression, anxiety, and sleep/appetite regulation disorders. A shift in autonomic balance towards sympathetic dominance with simultaneous reduction in vagal control efficiency causes difficulties with relaxation and impaired restorative functions.

4. *Chronic pathophysiological processes* maintain the above functional changes and include the following mechanisms:

- General pro-inflammatory status of the body: elevated levels of pro-inflammatory cytokines (e.g., IL-1 β , IL-6, TNF- α) negatively impact neuroplasticity, exacerbate HPA axis dysfunction, and contribute to “brain fog” and asthenia;
- Oxidative stress and mitochondrial dysfunction: chronic hyperactivation of stress axes and inflammation leads to excessive generation of reactive oxygen species (ROS), damage to neuronal lipids, proteins, and DNA, reduced cellular energy supply, and accelerated apoptotic death of neurons and glia;
- Reduced neuroplasticity: decreased expression of brain-derived neurotrophic factor (BDNF) leads to impaired learning and adaptation ability, as well as hinders recovery processes and the formation of new, more adaptive neural networks;
- Epigenetic modifications: persistent changes in gene expression through DNA methylation and histone modifications can affect genes encoding glucocorticoid receptors, neurotrophins, and components of neurotransmitter systems, cementing stress

vulnerability and potentially transmitting it intergenerationally.

This diagram illustrates that the core pathological circuit is formed by the threat system and the dysfunction of regulatory structures. A hyperactive amygdala and HPA axis suppress the activity of the hippocampus and prefrontal cortex. In turn, the weakened prefrontal cortex and hippocampus cannot provide top-down inhibitory control over the amygdala and HPA axis. This vicious cycle serves as the primary driver of the pathological state [19, 20]. Chronic processes act as a reinforcing mechanism triggered by constant stress. They sustain and exacerbate the dysfunction of both the threat system and the regulatory systems [21]. Sympathetic dominance and autonomic nervous system rigidity are presented as both a consequence and an amplifier of the imbalance between the core systems. The clinical manifestations represent the final outcome of the interplay among all these disrupted neurobiological systems [22, 23]. The model presented in Figure 1 helps to understand why vital trauma is such a persistent state: the system closes in on itself, and the mentioned chronic processes prevent escape from this dysfunctional cycle. Therefore, it requires comprehensive psychotherapy at different levels of the personality, which includes the following targets aimed at the stepwise reorganization of the

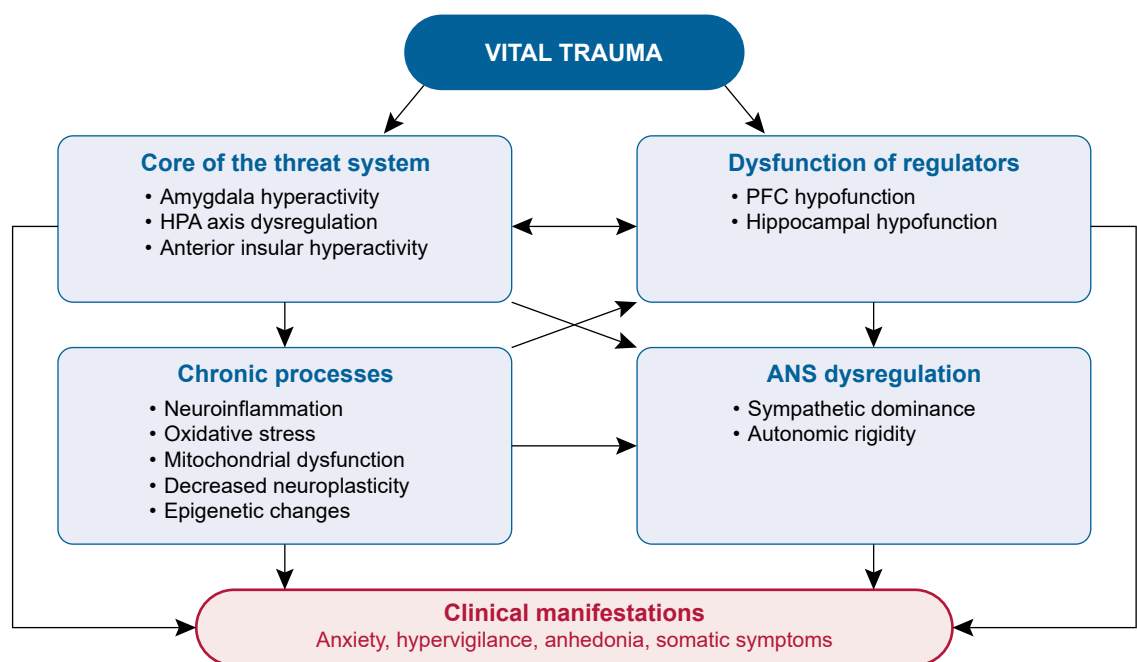


Figure 1. Pathogenetic model of vital trauma

maladaptive system of “traumatic survival” and the creation of a new, safe psychic architecture:

- restoration of basic trust through the therapeutic relationship;
- reprocessing and integration of traumatic experience — deactivation of pathological engrams*;
- formation of a new identity;
- creation of adaptive coping strategies.

In working with vital trauma, Katathym-Imaginative Psychotherapy (Symbol drama)** has shown clinical utility. We recommend it as the main method for treating this type of trauma in combination with neuromodeling techniques*** of Integrative Causal Psychotherapy. Clinical experience with this approach indicates that vital

trauma, in the absence of comorbid disorders, demonstrates stable positive dynamics, which, within our model, creates the prerequisites for achieving remission within medium-term therapy.

For the synergistic enhancement of psychotherapy for vital psychotrauma, pharmacotherapy may be recommended, specifically the use of selective serotonin reuptake inhibitors (SSRIs). Their application aims to create neurochemical stability, which contributes to reducing the overall reactivity of the amygdala and may indirectly influence the normalization of hypothalamic-pituitary-adrenal (HPA) axis dysregulation. This somatotrophic effect can help establish a more stable neurobiological foundation, thereby increasing the effectiveness of psychotherapeutic work.

Clinical case of vital trauma in childhood

Anamnesis

The patient, a 40-year-old female, experienced severe mistreatment over several years during her preschool age by her governess: she was locked in a dark room, subjected to painful pinches, episodically choked, regularly punished for imaginary transgressions, and kept in a state of constant fear and tension.

Diagnostic conceptualization

The clinical picture was identified as vital trauma. The key diagnostic markers were:

- introjected sadistic Superego: systematic self-restriction and self-punishment, active blocking of access to positive experiences, joy, and satisfaction;
- high degree of self-aggression and deep distortions in self-esteem and self-image;
- high-intensity trigger-conditioned panic states upon encountering potentially pleasant opportunities (rest, travel);
- activation of pronounced psychosomatic reactions upon attempts to overcome fear, serving the function of secondary defense against realizing desired goals.

Therapeutic process

Treatment using the Integrative Causal Psychotherapy approach with elements of Symbol drama lasted two years, consisting of once-weekly 50-minute sessions. It was aimed at restoring the basic system of psychological safety, processing affects related to traumatic situations, forming a stable positive self-relationship, and developing adaptive coping strategies.

Outcome and Follow-up

Sustained remission of trauma-related symptoms was observed. The patient formed a more stable and positive self-relationship and regained the ability to experience pleasure and positive emotions. Her life became more productive, and her emotional state became consistently favorable.

Conclusion

This clinical case suggests that an etiotropic strategy targeted at the identified mechanism of Ego disintegration may allow for achieving not only symptomatic improvement but also structural restoration of the impaired function, which clinically manifests as stable remission.

* An engram is a sensorimotor-affective trace of a lived experience, consolidated within the nervous system and psyche, which can be automatically reactivated and influence perception, emotions, and behavior.

** Katathym-imaginative psychotherapy is a depth-oriented psychotherapeutic approach developed by the German psychotherapist Hanscarl Leuner in the 1950s, based on the ideas of psychoanalysis and Jungian psychology. In this method, unconscious material emerges and is processed through guided work with images and symbols in a state of katathymic imagination.

*** Neuromodeling is a set of targeted therapeutic techniques developed within Integrative Causal Psychotherapy. These techniques enable the correction of pathological neural circuits associated with traumatic experiences, negative affects, repressed emotions, and dysfunctional behavioral patterns, thereby facilitating the restoration of a healthy Ego and authentic Self.

Local vital trauma

There is a subtype of vital trauma, represented by local (focal) trauma. In this subtype, the mechanism of Ego damage involves the formation of a stable but isolated pathological engram without generalization of the impairment to the entire personality structure and without a radical restructuring of the overall psychic architecture. Its distinguishing feature is the formation of a highly specific focus of hyperactivity in the threat system while overall Ego functioning remains intact.

In local vital trauma, a clearly delineated system of neurons is formed, including sensory triggers, an emotional component, and corresponding autonomic patterns. Outside the activation of this specific network, the brain and psyche function within normal limits. This trauma represents an example of a unique adaptation of the psyche to an overwhelming impact. The threat is processed and “packaged” into an isolated focus [24]. Examples of typical situations that can lead to local vital trauma include car accidents with physical injuries or severe

fright, industrial accidents, street muggings, animal attacks, witnessing a violent scene, etc.

As a result of local vital trauma, sensory-autonomic flashbacks are formed — involuntary, instantaneous, and intense reproductions of the sensory and autonomic components of the traumatic experience in response to a trigger, sometimes without full-scale conscious memory of the event. The formation of selective phobias with clearly delineated trigger reactions is also possible.

Integrative Causal Psychotherapy offers a model for working with trauma, focused on a profound process of transformation. We assume that traumatic experience is consolidated in the form of dysfunctional engrams — persistent memory traces that retain pain and fear. Our key technique, “Memory Catharsis,” is designed to initiate the process of complete affective and cognitive reprocessing of these engrams. Clinical observations and our theoretical model suggest that such reprocessing leads to their integration into personal history and the elimination of their pathogenic influence on the present.

Clinical case of hydrophobia due to local vital trauma

Anamnesis

The patient, a 45-year-old female, complained of a persistent fear of bodies of water, present throughout her subjective life experience. Symptomatology manifested during annual family trips to the sea: the possibility of entering the water was limited to ankle depth, accompanied by pronounced autonomic reactions (tachycardia, tremor, hyperventilation) and a subjective experience of uncontrollable fear. The patient had no access to an autobiographical memory explaining the genesis of the phobia.

Diagnostic conceptualization

The key diagnostic markers of local vital trauma were:

- clear trigger specificity (sight and feel of a body of water);
- intense autonomic reaction to the trigger;
- preservation of general functioning and absence of generalized anxiety outside the trigger context.

Therapeutic process

During therapy, the patient regained access to a dissociated childhood episode of a dangerous drowning incident. Subsequently, a cathartic technique aimed at processing its affective components was applied. After targeted intervention aimed at resolving the isolated traumatic memory, sustained clinical remission of phobic symptomatology was achieved, which, within our model, is interpreted as deactivation of the corresponding pathological engram.

Outcome and Follow-up

Sustained clinical remission of symptoms was noted upon completion of therapy. A behavioral marker of success was the patient’s independent purchase of a pool membership and starting swimming lessons without any trace of the former fear. Information from an external observer (the coach), who expressed disbelief regarding the 40-year history of the phobia, confirmed the clinically significant and stable changes.

Conclusion

The presented case demonstrates the high efficacy of targeted processing methods for isolated traumatic engrams. The localization of the damage, absence of structural personality changes, and preservation of general Ego regulatory functions made rapid and sustained clinical remission possible through the restoration of integration between sensory-affective and narrative memory components.

Type 2. Invasive Trauma

Invasive trauma (from Latin *invadere* — “to invade,” “to penetrate”) is a type of psychological trauma where the mechanism of damage to the Ego consists of overwhelming and uncontrolled penetration of external stimulation. This stimulation severely violates personal boundaries, exceeds the Ego’s metabolic capacities, and leads to “affective flooding.”

The essence of the trauma lies in a catastrophic failure of the function of psychological boundaries — the Ego’s fundamental ability to filter, dose, and assimilate incoming stimulation. The psychic container is flooded with contents that, being incapable of being processed and integrated, persist in the psyche as foreign and harmful. This leads to a collapse of subjective autonomy and the development of a clinical phenotype characterized by a dominance of ontological shame and disgust toward one’s own body and Self, chronic dissociation, gaps in memory related to traumatic episodes, a sense of permeable boundaries and contamination of the personality [25, 26]. Patients with this type of trauma exhibit profound disturbances in self-relationship, including self-aggression and destructive beliefs about themselves. They have difficulties distinguishing their own mental contents (thoughts, feelings, impulses) from those of others, simultaneous rigidity and permeability of psychological boundaries, fear of intimacy, and a tendency to recreate traumatic patterns in relationships. Somatoform disorders are often present in the form of conversion symptoms, psychosomatic illnesses, and hypochondriacal symptoms [27, 28].

A secondary formation in this type of trauma is suppressed aggression. Normally, aggression is energy for protecting boundaries, asserting oneself, and separation. In invasive trauma, the very function of boundary protection is broken. Aggression, having no avenue for healthy external expression, turns against the Ego itself and becomes the pathodynamic core of the trauma, causing chronic self-destruction, dissociation, and somatization.

Examples of situations leading to invasive trauma: repeated sexual, physical, or psychological abuse and other forms of massive, uncontrolled invasion of a person’s bodily and mental boundaries.

The clinical phenotype of invasive trauma may include the following disturbances:

- *Affective:* Anxiety, chronic feelings of shame as an ontological quality (“there is something wrong with me at the level of my essence”), disgust toward one’s own body, emotional instability with sharp fluctuations between numbness and affective outbursts, intolerance

of arousal (bodily and emotional) leading to automatic “shut-down” (dissociation).

- *Identity:* A sense that thoughts, feelings, or impulses are “not mine,” difficulty separating one’s own Self from the internalized image of the boundary violator, chronic vulnerability to external evaluation and control.
- *Cognitive:* Memory fragmentation — gaps in memories of traumatic episodes, distorted perception of one’s own bodily sensations, intrusive thoughts of contamination, depravity, or defectiveness, difficulties with mentalization;
- *Interpersonal disturbances:* Fear of intimacy and trust due to anticipation of invasion, control, or violence, inability to adequately regulate the degree of emotional or physical distance, tendency to recreate traumatic relationships, tendency to lose autonomy.
- *Behavioral:* Avoidance of situations requiring bodily closeness or trust; counter-phobic behavior; actions aimed at reducing the feeling of contamination; in severe cases, self-harming behavior as an attempt to restore the boundaries of one’s own body or reduce dissociative tension.

Neurobiological picture of invasive trauma

Invasive trauma overloads sensory, affective, and cognitive systems with excessive stimulation and leads to a state of neurobiological openness, where the brain loses its ability to modulate incoming information and protect the mental core.

1. *Increased overall activation of the thalamus* disrupts the function of input sensory control and leads to “sensory flooding” — significantly increasing the load on neural networks processing pain, tactile, and interoceptive signals. Additionally, excessive activation of the amygdala significantly heightens the response to any signals of penetration or threat of invasion, leading to a constant feeling of being flooded from inside and outside, an experience of boundary rupture.
2. *Significant reduction in dorsolateral prefrontal cortex activity* leads to a cessation of protective inhibition of the amygdala, causing a loss of the ability to maintain a cognitive frame and tolerate stimuli. Disintegration of executive control networks hinders making sense of, evaluating, or restraining what is happening. The volume and intensity of incoming stimulation significantly exceed the bandwidth of the Ego’s regulatory and integrative mechanisms, manifesting as a feeling of flooding, loss of control, and breach of personal boundaries.

3. *Dysfunction of the anterior cingulate cortex* reduces the ability for cognitive distancing from emotionally significant stimuli and voluntary switching of attention to other activities. Significant impairments in the Salience Network (SN) disrupt the function of the insular cortex and distort the perception of one's own bodily boundaries, while additional high activity of the amygdala within this network causes and sustains an "emotional storm" with the subjective experience of exhausting the psyche's regulatory resources and its "surrender."
4. *Activation of the periaqueductal gray*, occurring at the peak of stimulation, is accompanied by compensatory activation of endogenous opioid and cannabinoid systems, causing marked emotional numbness, a state of affective "power loss," and immobilization. The effectiveness of communication between the hippocampus and prefrontal cortex decreases, leading to context collapse and memory fragmentation. As a result, when the Ego's assimilative capacity is exceeded, a dissociative shut-down occurs, preserving the trauma as an internal invasion.
5. *Persistent changes in neural circuits* are characterized by the following processes. Hypersensitivity of the amygdala to signals of penetration and chronic hyperactivation of the insular cortex lead to painful interoception. Reduced control from the prefrontal cortex results in poor boundary restoration. Sensory hyperreactivity leads to persistent hypersensitivity to any forms of approach, resulting in a "syndrome of lost boundaries."

The pathogenetic model (Figure 2) shows how invasive trauma triggers persistent brain maladaptation through the formation of a pathological dominance of the Salience Network, which is chronically hyperactivated along with the amygdala complex and the HPA axis. Simultaneously, regulatory systems are suppressed — prefrontal cortex activity and hippocampal functionality are reduced, creating a pronounced imbalance between key neural circuits of regulation. Clinically, this manifests as a complex of hypervigilance, intrusions, emotional numbness, and somatization, reflecting a profound disturbance in self-regulation and experience integration processes. These changes are consolidated at a fundamental level through neuroinflammation, oxidative stress, and epigenetic mechanisms, forming a stable pathological state with a loss of mental boundaries [29].

Differential diagnosis from vital trauma

- Shame, guilt, and self-aggression dominate vs. fear for life, hypervigilance.
- Triggers are interpersonal relationships vs. external reminders of the traumatic event.
- Basic trust is globally impaired: fear of intimacy as a repetition of invasion vs. preserved capacity for selective trust.
- Dissociative symptoms are chronic or become personality traits vs. episodic dissociations only in response to triggers.

The described dynamics of invasive trauma explain the stability of symptoms and the necessity for long-term therapy aimed at restoring boundaries and processing accumulated suppressed aggression. Key therapeutic targets are:

- deactivation of pathological engrams — central experiences of traumatic boundary violation;
- destigmatizing prohibitions on awareness and expression of aggression and processing suppressed aggression;
- forming positive self-relationship based on unconditional love and self-acceptance;
- developing new adaptive coping strategies in situations of personal boundary violation.

For healing invasive trauma, a method for working with suppressed aggression developed in Integrative Causal Psychotherapy has proven effective [30]. According to our therapeutic model, focusing on the deactivation of boundary violation engrams and the processing of suppressed aggression create conditions for achieving stable remission within the framework of medium-term psychotherapy. Pharmacotherapy for invasive trauma has limited application and is not the first-line treatment. In cases of acute states, its prescription for symptom relief requires particular caution and is recommended only as part of a comprehensive approach, where it serves as an adjunctive means for stabilization alongside psychotherapy. This is necessary to prevent decompensation and secondary traumatization (re-victimization), the risk of which is associated with a number of psychological mechanisms. These include:

- an unconscious perception of the medication as a repetition of the invasion, which can reactivate the traumatic experience and increase anxiety;
- pathological shame, in which symptom relief may evoke feelings of guilt ("I do not deserve relief") and paradoxically intensify suffering;
- the psychological function of numbness. Emotional blunting often serves as a defense against unbearable affect. Its abrupt pharmacological removal without psychotherapeutic support can lead to an affective breakthrough and re-traumatization.

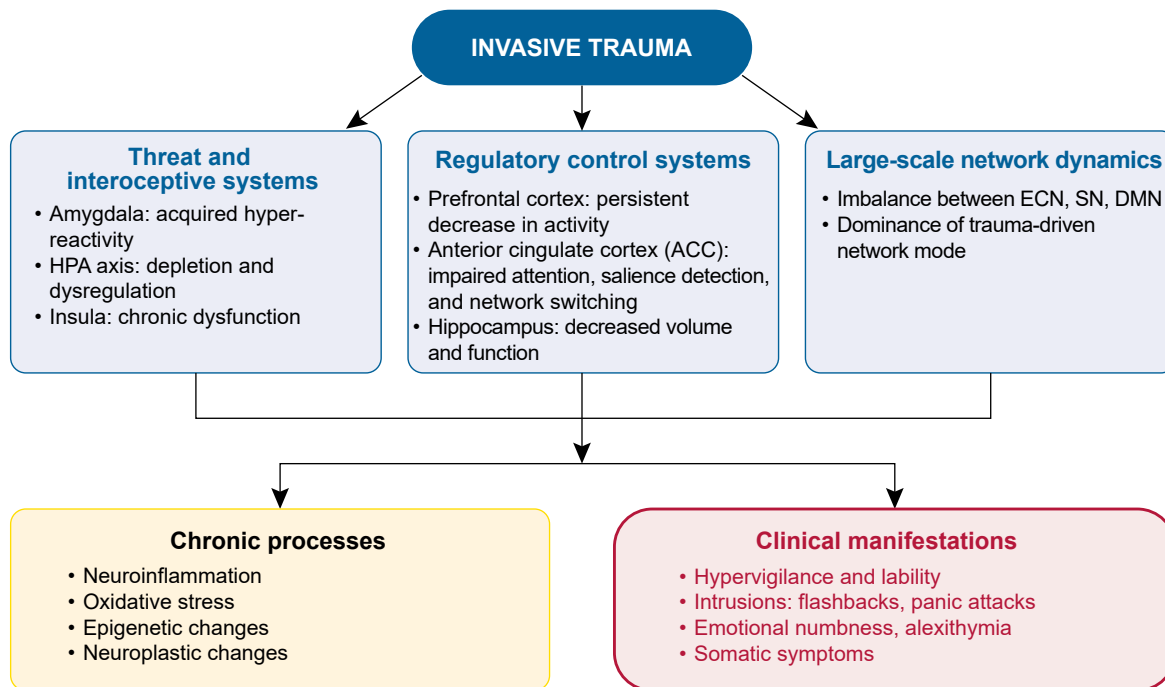


Figure 2. Pathogenetic model of invasive trauma

Clinical case of invasive trauma resulting from emotional incest

Anamnesis

The patient, a 24-year-old male, was an only child in the family and grew up in conditions of parentification*, fulfilling the role of a mother for his own mother: containing her affects, giving advice, mediating her conflicts with her spouse (his father), and being responsible for her emotional state. The situation was exacerbated by the fact that the patient's mother was aggressively biased against men, devalued them, and under the guise of "pacifist upbringing" gave her son messages "don't you dare become a man." Thus, the mother intruded into her son's psyche as an object of total dependence while simultaneously blocking the development of his gender and sexual subjectivity.

Diagnostic conceptualization

To survive in conditions of pathological symbiosis, the patient formed a conformist-martyred personality, fully compliant with maternal expectations. At the same time, male gender identity and sexual initiative became unconsciously equated with destructive aggression, inevitably followed by condemnation and punishment. The following markers indicated invasive trauma:

- prohibition on one's own subjectivity and corporeality;
- fear of criticism, especially from women;
- chronic shame and guilt in situations related to gender roles;
- repression of erotic fantasies and avoidance of penetrative forms of sexuality;
- pathological pattern of relationships with women, where intimacy was equated with servitude to an idealized maternal figure;
- psychological defenses guarding against gender-colored content and situations: using the gender-neutral "person" instead of "girl"; feminized intonation and speech in a higher pitch than his natural timbre; controlling his facial expressions and gestures to eliminate the slightest hint of "crude masculinity" and sexual interest.

* Parentification is the inversion of roles in the family, where a child is forced to perform adult functions: emotionally or practically caring for a parent, taking responsibility for the family's well-being.

Therapeutic process

Duration — 1.5 years in a setting of once-weekly, 50-minute sessions. Approach — Integrative Causal Psychotherapy, using motifs from Symbiodrama. Psychoanalytic interventions for interpreting parentification played a significant role in working with this case. The main directions of work were lifting prohibitions on aggression and separation, processing traumatic affects and suppressed aggression, appropriating and integrating male gender identity, and forming adaptive coping strategies in communication and intimate relationships with women.

Outcome and Follow-up

Sustained clinical remission of symptoms was achieved. The patient began forming love relationships with women, entered into harmonious sexual relationships, which later led to a successful marriage. Boundaries and healthy distance appeared in the relationship with his mother. Masculinity and healthy aggression became integrated parts of his personality.

Conclusion

The presented case illustrates that in invasive traumas, for restoring boundaries and the Ego's metabolic function, awakening healthy aggression plays a paramount role. This is achieved by lifting prohibitions on its awareness and expression, processing suppressed aggression, and forming effective coping strategies for protecting personal boundaries.

Type 3. Egotomic Trauma

Egotomic trauma (from Latin *ego* — “I” and Greek *tomē* — “cutting, sectioning”) is a type of psychological trauma associated with the irreversible loss of a highly significant element of the mental structure that served as a support for the Ego through attachment or identification. Such a loss disrupts the inner integrity of the personality, leading to a persistent Ego-dissociative disintegration, and evokes profound mental pain whose emotional core is existential emptiness and anguish, accompanied by a sensation of a “torn-out part of oneself.”

The essence of this trauma lies in the loss of an internal object that performed a stabilizing and structuring function for the Ego. This loss leaves behind a structural deficit in the internal representational system, leading to a collapse of internal support, disturbance of narcissistic balance, and continuity of existence. A future devoid of the object feels impossible. Affective dissociation arises — a split between intellectual understanding of the loss and its emotional rejection, forming “frozen grief” and splitting off parts of the Ego associated with the lost object.

Examples of possible situations of such loss: loss of a close person (death, breakup of a relationship), loss of health and functionality (a disabling illness, age-related loss of function), loss of a role, status, identity, symbolic losses (systems of values, habitual way of life, idealized beliefs).

The clinical phenotype is characterized by the following disturbances:

- *Affective*: Chronic yearning and mental pain, anhedonia and emotional numbness, attacks of acute grief with somatic manifestations, feelings of emptiness and meaninglessness of life.

- *Related to identity*: Sensation of losing a part of oneself, blurring of the boundaries of one's own Self, difficulties with self-identification outside the context of the loss, feeling of “being stuck” in the past.
- *Cognitive*: Intrusive thoughts about the lost object, idealization of the past and devaluation of the present, difficulties with concentration and decision-making, fragmentation of autobiographical memory.
- *Existential*: Loss of life direction and prospects, crisis of meaning and values, feeling of a broken connection with the world, a depressive position with a sense of hopelessness.
- *Somatic*: Sensation of physical emptiness/coldness in the chest or abdomen, psychogenic pain in the heart area, sleep disturbances, loss of energy tone.
- *Interpersonal*: Inability for emotional investment in new relationships, idealization of the lost object, tendency to recreate situations of loss.
- *Behavioral*: Dysfunctional preservation of habits and rituals associated with the lost object, social isolation and refusal of new activities, neurotic search for a real or symbolic substitute for the lost object.

Egotomic trauma forms a specific neuropsychological profile related to the loss of the Ego's structural support and the subsequent collapse of the brain's integrative systems [31–34]. This profile includes several interrelated levels.

1. Primary impairment of the brain's integrative mechanisms

Egotomic trauma strikes at the fundamental systems that ensure a holistic experience of self and the

world. Structures performing integrative functions are the most vulnerable:

- the hippocampus loses its ability to bind context, time, and affect into a unified episodic field, leading to fragmentation of autobiographical memory;
- the anterior cingulate cortex (ACC) loses the ability to flexibly switch between conflicting signals and ensure coherent decision-making;
- the insular cortex stops synchronizing interoception, affect, and the sense of bodily Self, leading to feelings of internal emptiness and alienation from the body;
- the corpus callosum demonstrates reduced efficiency in interhemispheric interaction, weakening the integration of sensory and cognitive streams.

As a result, implicit memory (bodily, sensorimotor, emotional traces) becomes hyperdominant, while explicit/narrative memory becomes fragmented or inaccessible. The person experiences not a story, but a set of disjointed sensory-affective fragments not integrated into a coherent autobiography [35].

2. Dissociative disintegration of brain macrosystems

The inability to maintain integration shifts the brain into an “emergency mode” of functioning. Characteristic changes occur in the operation of large functional networks:

- the Default Mode Network (DMN) becomes either hyperactive (rumination, fixation on the loss) or hypoactive (emptiness, anhedonia, breaks in the continuity of Self-perception);
- systems for automatic threat processing begin to dominate, leading to a crude dichotomization of stimuli: “threat / not a threat”;
- subcortical survival systems (amygdala, periaqueductal gray, bed nucleus of the stria terminalis) are activated by the slightest signal, forming automatic reactions bypassing conscious control;
- the Central Executive Network (CEN) is weakened: the dorsolateral prefrontal cortex loses its capacity for top-down regulation, planning, and cognitive flexibility.

This forms a dissociative mode in which the brain loses the ability to maintain the coherence of experience [36].

3. Neurochemical and pathophysiological circuit sustaining pathology

The neurobiological architecture of egotomic trauma is consolidated by a stable complex of changes:

- neuroendocrine dysregulation: dysregulation of the HPA axis with a shift to an exhaustion phase (reduced baseline cortisol contributes to the predominance of freeze and dissociation

responses) and dysfunction of the oxytocin system (loss of attachment, trust, ability to experience support);

- chronic neuroinflammation exacerbates damage to integrative structures (especially the hippocampus), reduces neuroplasticity, and hinders the restoration of experiential coherence;
- epigenetic changes consolidate increased stress sensitivity, alter the expression of genes related to GABA, glutamate, and glucocorticoid receptors, creating persistent vulnerability and potentially transmitting it to subsequent generations.

4. Formation of autonomous pathological Ego-states (hierarchical collapse)

In egotomic trauma, the brain shifts to a fragmentary organization: rigidly segregated emotional and defensive configurations, anchored in separate activation patterns of the amygdala, insula, ACC, and medial prefrontal areas, begin to activate rigidly, autonomously, and beyond voluntary control. Within our model, we assume that this is not a dissociative splitting of the personality, but rather rigidly segregated, insufficiently integrated Ego-states that can activate alternately, creating the phenomenology of internal fragmentation while preserving an overall unified sense of Self.

The Figure 3 shows how egotomic trauma causes dissociative disintegration of large-scale networks and hyperactivation of subcortical survival systems. This destroys integrative mechanisms, while dysregulation of the HPA axis, oxytocin, neuroinflammation, and epigenetic changes consolidate the process. As a result, a hierarchical collapse of self-regulation occurs, with the formation of autonomous pathological Ego-states and a clinical picture of fragmented identity, dissociation, and loss of a continuous self.

Differential diagnosis of egotomic trauma

From vital trauma:

- longing, psychic pain, passionate desire to regain the lost vs. fear of possible threat repetition, panic before potential annihilation;
- emptiness as a direct consequence of losing a part of the Ego vs. exhaustion from constant hypervigilance;
- sensitivity to triggers related to reminders of the lost object vs. hypervigilance to external triggers associated with threat;
- stress response: withdrawal, collapse, immobility vs. mobilization, hyperarousal;
- attachment impairment: Unavailability vs. Wariness;
- future is meaningless vs. future is dangerous;
- avoidance of the present moment: immersion in the past vs. scanning the future.

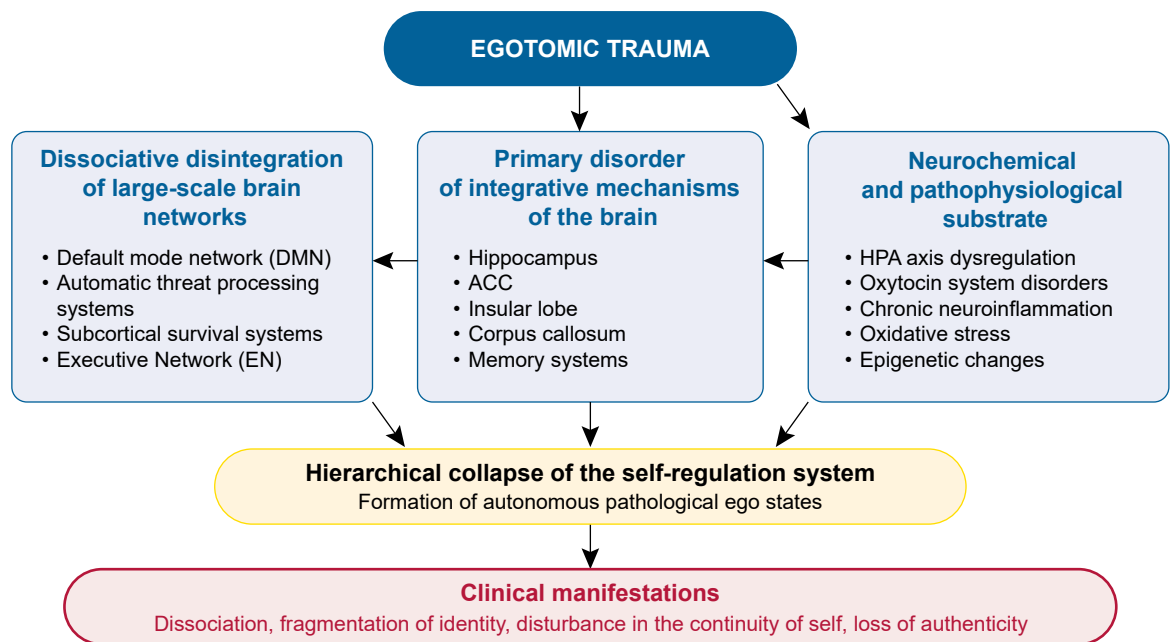


Figure 3. Pathogenetic model of egotomic trauma

From invasive trauma:

- emptiness vs. affective flooding due to boundary violation;
- feeling of internal deficiency vs. feeling of “internal contamination”;
- longing, despair vs. shame, self-disgust;
- body as a lifeless shell vs. body as a betrayer and source of shame;
- triggers: Anything reminding of the loss vs. anything symbolizing boundary violation;
- ego boundaries are preserved, but support is lost vs. boundaries are permeable;
- internal object: Idealized vs. devouring/contaminating;
- inability for closeness vs. fear of closeness.

Therapy should be aimed at restoring the integration of brain structures and include the following key targets:

- processing the emotions of grief;
- legitimizing and channeling suppressed aggression;
- reintegrating the split-off part of the Ego;
- restoring identity;
- repairing the future after collapse;
- psychic investment in new projects and plans.

Egotomic trauma, in the absence of comorbid disorders, may show positive progress within a relatively short period, provided that work focuses on key targets, such as suppressed aggression.

In cases of egotomic trauma, pharmacotherapy, according to our theoretical model, appears to be a method with limited applicability. Its primary mechanism of action — neurochemical modulation — fundamentally differs from the goal of in-depth psychotherapy, which in this context is aimed at restoring psychic integrity through the experiencing and integration of the loss. We hypothesize that this divergence in approaches not only limits the etiotropic potential of pharmacotherapy but also creates a risk of pathogenetic contradiction. Clinical observations within our model point to a number of specific risks. Serotonergic antidepressants, targeting the affective sphere, may alleviate symptomatic anguish but, according to our conceptualization, do not address the presumed primary deficit in integrative functions (of the hippocampus, cingulate, and insular cortices). Anxiolytics (benzodiazepines), in turn, may intensify dissociation and subjective alienation, pharmacologically reinforcing a state of mental distancing.

A key potential iatrogenic effect in this context is the risk of substituting and interrupting the natural process of psychic grief work, which theoretically could contribute to the preservation of a “frozen” state — the central phenomenon of this trauma. Finally, the pharmacological suppression of affect, particularly aggression — which in our model is considered a key resource for separation — may

deprive psychotherapy of an important catalyst for change, complicating the transformation of the pathological bond with the lost object. This criticism does not constitute an absolute contraindication. In cases of severe comorbid symptomatology (e.g., depression with suicidal risk), short-term pharmacotherapy may be considered as an adjunctive measure to stabilize the patient's condition with the aim of making them accessible for subsequent psychotherapeutic work.

Type 4. Constitutive trauma

Constitutive trauma (from Latin *constitutio* — “to establish,” “to form a structure”) is a type of psychological trauma in which the primary formation

of basic psychic structures is systemically impaired due to a chronic deficiency of the environmental conditions necessary for healthy development during the critical period of ontogenesis (up to around 6 years of age). The core affect of this trauma is existential fear and a deep experience of inherent defectiveness.

Constitutive trauma is caused not by a single event but by the overall quality of the developmental environment, which is unable to provide conditions sufficient for the sequential maturation of personality structures in early childhood: unpredictability and unreliability of attachment figures, chronic emotional deprivation, a chaotic environment.

Clinical case: prolonged grief disorder

Anamnesis

The patient, an 18-year-old female, with prolonged grief disorder that developed after the suicide of a close friend. For over 6 months, there was persistent pathological fixation on the loss: intrusive thoughts about the deceased, regular visits to the place of death, social self-isolation with broken family contacts. Academic maladaptation was noted with declining performance due to concentration difficulties, as well as irritability and emotional lability. She sought help after unsuccessful prior psychotherapy at a European clinic, where she was ultimately recommended to switch to pharmacotherapy.

Diagnostic conceptualization

The clinical picture was identified as egotomic trauma leading to prolonged grief disorder. Key diagnostic markers were:

- pathological fixation on the image of the lost object with compulsive reproduction of the circumstances of death;
- social autistic withdrawal and emotional alienation from the supportive environment;
- cognitive deficit in the form of concentration impairments and academic maladaptation;
- affective lability with predominance of irritability and psychomotor agitation.

This symptomatology reflects a structural impairment of the grieving process with the formation of a pathological symbiosis with the lost object, characteristic of egotomic trauma resulting from the death of a significant other.

Therapeutic process

Psychotherapy lasting 15 sessions focused on transforming the intrapsychic dynamics of grief. The key therapeutic mechanism was work with suppressed aggression, which with this patient was primarily conducted using the “Turning Aggression Towards the Therapist” technique. This allowed for legitimizing and channeling repressed aggressive affects and ensured positive dynamics already after the fourth session, with fairly rapid subsequent restoration of affective balance and social functioning.

Outcome and Follow-up

Sustained clinical remission of symptoms with restoration of the premorbid level of functioning was noted. No relapses were observed during a 4-year follow-up period. The patient fully readapted in academic and social spheres.

Conclusion

Successful therapy became possible due to the placement of aggressive affects within the therapeutic space, which allowed for interrupting the pathological symbiosis with the lost object and restoring the process of adaptive grieving. This clinical case demonstrates the importance and efficacy of aggression processing in egotomic traumas.

Mechanism of Ego formation impairment and clinical manifestation

In constitutive trauma, the Ego is not damaged; rather, it never forms adequately in the first place due to a systematic deficit of adequate mirroring, containment, and support during critical developmental periods. This leads to a cascade of impairments manifesting as follows:

- *Lack of stable mirroring* makes it impossible to establish a boundary between Self and Not-Self and to form a coherent self-image. The result is diffuse identity: the person doesn't know "who they really are," constantly "re-assembles" themselves from reflections in others, suffers from unstable self-esteem, and experiences identity crises with the slightest change.
- *The maternal figure's inability to perform the containment function* leaves affects unnamed and unbearable. Severe affective dysregulation forms: periodic "flooding" with affects or, conversely, emotional numbness and alexithymia; derealization and depersonalization become a baseline state of existence; body schema disturbances appear; chronic muscle tension or a feeling of "dissolving" in space; and self-regulation is only possible through external objects or primitive means (self-harm, overeating/starvation, etc.).
- *Breakdown in separation-individuation processes* reinforces symbiotic patterns and leads to the formation of a False Self* as a primary survival strategy and often forms disorganized attachment, leading to intense, unstable relationships and the recreation of traumatic scenarios.
- *Deficit in basic trust and primary narcissistic support* destroys basic self-worth and the sense of one's own right to exist, leading to chronic feelings of emptiness, worthlessness or, conversely, compensatory grandiosity.
- *Impairment in the formation of internal objects* leaves representations of Self and Other fragmented, dichotomous, and unstable. The patient struggles to tolerate ambivalence, has poor mentalization, fragmented autobiographical memory, and dysfunctional core beliefs.

All of this together creates a systemic disintegration of the personality dominated by the False Self, deficits in volitional regulation, maladaptive coping strategies, and self-regulation methods.

Neurobiological picture of constitutive trauma

Constitutive trauma disrupts the sequential maturation of the brain, creating a deficient foundation upon which higher functions cannot adequately form [37–39].

- *Primary deficit: disruption of basic neurosomatic homeostasis.* Early chronic stress and caregiving deficits lead to: 1) hyperactivation of the insular cortex — resulting in impaired interoception and emotional awareness; 2) cerebellar system dysfunction — disrupting the coordination of emotion, attention, and reaction time; 3) persistent activation of the hypothalamic-pituitary-adrenal (HPA) axis (chronic stress mode) — characterized by elevated corticotropin-releasing hormone (CRH), dysregulation of the diurnal cortisol rhythm, and downregulation of glucocorticoid (GR) and mineralocorticoid (MR) receptors; 4) autonomic rigidity — manifesting as low heart rate variability (HRV), impaired ventral vagal complex function (compromising self-regulation via social engagement), and hyperactive dorsal vagal complex (predisposing to freeze and dissociation responses).
- *Secondary deficit: breakdown of attachment and motivation systems.* Decreased density of dopamine D2 receptors in the nucleus accumbens (NAc) leads to anhedonia, apathy, or conversely, a drive for extreme stimulation. Decreased oxytocin receptors in the amygdala and NAc hinders the formation of secure attachment.
- *Tertiary deficit: underdevelopment of higher integrative functions.* As a result of the preceding breakdowns, there is a reduction in volume of the hippocampus and prefrontal cortex, anomalies of the corpus callosum, and fragmentation of large-scale neural networks: Default Mode Network (DMN) — no stable sense of self over time; Central Executive Network (CEN) — deficits in planning, impulse control, working memory; Salience Network (SN) — neutral stimuli are perceived as threatening.

At the molecular level, the described pathology is reinforced by: 1) hypermethylation of NR3C1, OXTR, and GABA-system genes, causing a persistent reorganization of the system into a stress mode; 2) chronically low levels of Brain-Derived Neurotrophic Factor (BDNF), reducing neuroplasticity and the brain's ability to learn and recover; 3) dominance of "survival" neural circuits over social and integrative ones.

The [Figure 4](#) shows how constitutive trauma disrupts the sequential maturation of the brain. Beginning with a breakdown in basic neuro-corporeal homeostasis, it makes normal formation of attachment and motivation systems impossible, which in turn catastrophically impacts the development of higher integrative functions.

* False Self — conformist, hyper-adaptive personality organization.

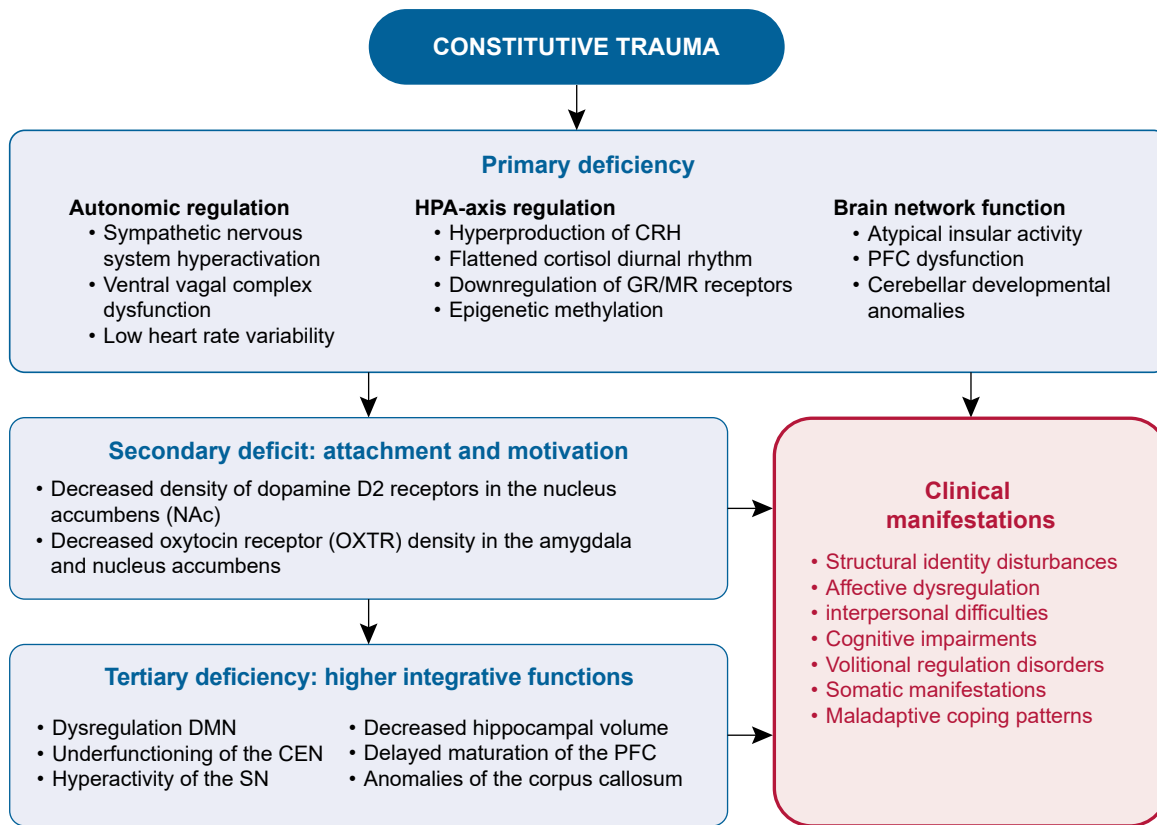


Figure 4. Pathogenetic model of constitutive trauma

Epigenetics and impaired neuroplasticity act as a transversal mechanism, “cementing” impairments at all previous stages and making the brain’s pathological organization stable. The final result of these processes is not just a set of symptoms, but a systemically disintegrated personality, manifested as severe impairments in self-regulation, identity, and interpersonal functioning.

Differential diagnosis from other trauma types

Unlike other trauma types, in constitutive trauma the personality structure itself is traumatic. Symptoms are not a consequence of damage but a manifestation of an inherently deficient personality organization. This is not a “healthy person who experienced trauma,” but a “personality formed by trauma.” Constitutive trauma is distinguished by:

- an inherently deficient, not damaged, Ego structure;
- absence of premorbid normal functioning;
- structural dissociation of personality as the basic architecture;
- absence of continuous autobiographical memory from early childhood.

Thus, constitutive trauma is a complex disorder of neuro-ontogenesis, requiring a multi-level therapeutic approach aimed at sequentially compensating for structural deficits through long-term “reconstruction” of the brain from the bottom up. The psychotherapy plan includes the following targets:

- stabilization and formation of states of basic safety;
- formation of reliable and stable internal objects;
- development of mentalization and reflective function;
- development of the capacity for affective self-regulation and autonomous maintenance of internal stability;
- formation of object constancy and emotional predictability in relationships;
- formation of a coherent self-image.

Constitutive trauma is the primary risk factor for the development of Borderline Personality Structure and represents the greatest challenge in trauma therapy. Unlike other types, constitutive trauma cannot be fully cured because specific structures did not mature during critical periods, and the brain can no longer return to that “window of plasticity.”

Clinical case: constitutive trauma

Anamnesis

Patient: 35-year-old female, married. Presenting issues: generalized anxiety, apathy, volitional deficit, difficulties with separation from parental figures and professional self-actualization.

Diagnostic conceptualization

Clinical picture identified as constitutive trauma. Key diagnostic markers:

- diffuse identity;
- developed False Self;
- narcissistic issues;
- chronic anxiety;
- deficits in volitional regulation;
- unstable self-esteem.

Therapeutic Process

Treatment lasting 90 sessions (once weekly, 50 min.) included the following target:

- formation of an experience of non-judgmental acceptance within the therapeutic relationship;
- weakening of manic defenses and establishing contact with suppressed negative emotions;
- legitimizing the right to boundaries and self-expression;
- restoring contact with aggression as a marker of the Self's existence and a resource for completing separation;
- separation from parental figures;
- work on narcissistic issues;
- development of the True Self;
- formation of professional identity.

Results

- The patient stopped presenting a false "ideal" Self and denying psychological problems;
- Manic defenses weakened, providing access to previously repressed negative emotions;
- Anxiety significantly decreased;
- Self-esteem stabilized.

At the time of writing, psychotherapy continues, focusing on therapeutic goals 4–8.

Conclusion

This case demonstrates that in constitutive trauma, therapy focused on gradually weakening the False Self and restoring contact with the True Self leads to sustained reduction in anxiety, stabilization of self-esteem, and emergence of volitional regulation, even while moderate narcissistic issues persist. The key therapeutic factor was the sequential creation of a new experience of non-judgmental acceptance, along with interpretations of psychological defenses and False Self scripts. This allowed the patient to begin the process of real separation and formation of an autonomous identity. Thus, the case demonstrates the possibility of satisfactory compensation for constitutive trauma and underscores the necessity of long-term therapy (two years or more) to achieve structural personality changes.

However, this trauma can be significantly compensated through long-term psychotherapy, making the patient relatively functional, stable, and emotionally mature. For work with this trauma type, we recommend psychoanalytic psychotherapy combined with Katathymic-Imaginative Psychotherapy.

In working with constitutive traumas, where the pathology is entrenched at the level of reorganized basic neurosomatic networks, pharmacotherapy proves to be of limited efficacy because it cannot

address the root cause—dysfunctional patterns of memory and affective regulation. Its role is confined to the palliative reduction of symptoms, without affecting the etiological core of the disorder.

Discussion

The proposed causal model of psychological traumas deepens and differentiates existing diagnostic models, allowing a shift from a syndromal diagnosis to a pathogenetically substantiated classification.

Integration with ICD-11

PTSD

The picture of Post-Traumatic Stress Disorder corresponds to the phenotype of vital trauma: re-experiencing, avoidance, and hyperarousal reflect a failure of the safety system and fixation on threat. Neurobiological data (amygdala hyperactivation, HPA axis dysregulation) confirm this mechanism. The typology allows differentiation between local and generalized forms of PTSD, which is crucial for prognosis and therapy selection.

Complex PTSD (CPTSD)

CPTSD encompasses the consequences of constitutive and invasive traumas, often in combination. The central CPTSD criterion of “Disturbances in Self-Organization” is the clinical manifestation of the deficit in basic Ego structures characteristic of constitutive trauma. Its components— affective dysregulation, negative self-concept, and relational difficulties—directly derive from the damage mechanisms of this trauma type. Simultaneously, dissociative symptomatology often accompanying CPTSD reflects the mechanism of invasive trauma— boundary violation and subsequent fragmentation.

Attachment disorders

In childhood, attachment disorders represent a direct consequence of constitutive trauma, as their etiological core is a deficit or distortion of early relationships with the caregiving figure.

Integration with DSM-5

PTSD: DSM-5 interprets PTSD more broadly than ICD-11, encompassing situations typical of invasive trauma (e.g., sexual assault). However, the basic clinical structure of PTSD remains closest to vital trauma.

Borderline Personality Disorder (BPD): BPD can be conceptualized as a severe outcome of constitutive trauma, often complicated by features of invasive trauma. Affective instability, identity disturbances, chaotic relationships, and dissociation are clinical manifestations of Ego structure deficits and boundary violations described in our typology.

Clinical Value of Integration

Integrating the causal typology with ICD-11 and DSM-5 creates a bridge between a standard diagnosis and pathogenetically grounded therapy. A standard diagnosis (e.g., 6B41 “Complex PTSD”) answers the question “what?“, while typological analysis (e.g., “constitutive trauma with elements of invasive“) answers the questions “why?“ and “how?“. This enables a shift from symptom-centric to etiotropic and personalized treatment.

Clinical Advantages of Integration

- Focus on mechanisms — from symptoms to understanding their formative mechanisms.
- Individualization of therapy — method selection according to trauma type and severity.
- Predictive value — prognosis determined by trauma type, not nosological category.
- Understanding comorbidity — comorbidity viewed as a logical combination of trauma types.
- Theoretical continuity — different models unified into a single pathogenetic system.
- The proposed typology retains the advantages of standardized diagnostic systems while supplementing them with a deep explanation of psychological trauma mechanisms, creating a foundation for genuinely personalized psychotherapy.

Limitations

The presented model and conclusions have several limitations. First, they are based on a retrospective analysis of clinical cases and theoretical synthesis, which does not allow for drawing conclusions about causal relationships to the same extent as in randomized controlled trials. Second, the assessment of effectiveness in the described cases was conducted clinically but without the use of a double-blind method. Third, the model requires further operationalization and validation on larger and more diverse clinical samples.

Despite these limitations, the proposed typology represents a heuristic system for clinical reasoning and requires further empirical verification. The aforementioned limitations do not negate the main advantage of the model — its ability to shift clinical thinking from a syndromal to a causal plane. The proposed framework opens new perspectives for personalized trauma therapy and serves as a foundation for the development of targeted therapeutic protocols.

Future Research Directions and Hypothesis Testing

The proposed causal typology represents a heuristic clinical hypothesis. Its validity and practical utility must be established through further research. We propose the following stepwise validation strategy:

1. Operationalization and development of a diagnostic instrument: the creation of a structured clinical interview or a screening questionnaire to identify the dominant trauma type according to the mechanism of Ego disintegration. This will allow for the assessment of inter-rater reliability of the diagnosis.

2. Empirical validation on representative samples: the conduct of cross-sectional studies to test hypotheses regarding specific neurobiological profiles (using EEG, fMRI, and hormonal assays) and psychometric patterns (using test batteries assessing affect regulation, dissociation, and personality pathology) for each type.
3. Testing prognostic and therapeutic validity: the implementation of randomized controlled trials comparing the effectiveness of trauma-type-targeted therapy (according to our model) with that of standard unified treatment protocols for PTSD and complex PTSD.

Conclusion

This article presents and substantiates a new clinical hypothesis — a causal typology of psychological trauma based on the mechanism of Ego disintegration. We propose that it may serve as an effective framework for case conceptualization, shifting the clinician's perspective from a syndrome-focused to a pathogenetic approach, while providing a coherent scheme for selecting therapeutic targets. If the hypothesis is confirmed in future research, it could pave the way for a fundamentally new level of personalization in trauma therapy. The empirical validation plan proposed in the "Discussion" section provides concrete guidelines for realizing this potential.

References

1. Bradley R, Greene J, Russ E, Dutra L, Westen D. A multidimensional meta-analysis of psychotherapy for PTSD. *Am J Psychiatry*. 2005;162(2):214–227. <https://doi.org/10.1176/appi.ajp.162.2.214>.
2. Steenkamp MM, Litz BT, Hoge CW, Marmar CR. Psychotherapy for military-related PTSD: a review of randomized clinical trials. *JAMA*. 2015;314(5):489–500. <https://doi.org/10.1001/jama.2015.8370>.
3. Resick PA, et al. A critical evaluation of the complex PTSD literature: implications for DSM-5. *J Trauma Stress*. 2012;25(3):241–251. <https://doi.org/10.1002/jts.21699>.
4. Brewin CR. Complex post-traumatic stress disorder: a new diagnosis in ICD-11. *BJPsych Adv*. 2019;26(3):145–152. <https://doi.org/10.1192/bja.2019.48>.
5. Friedman MJ, Resick PA, Bryant RA, Strain J, Horowitz M, Spiegel D. Classification of trauma and stressor-related disorders in DSM-5. *Depress Anxiety*. 2011;28(9):737–749. <https://doi.org/10.1002/da.20845>.
6. Ressler KJ, et al. Post-traumatic stress disorder: clinical and translational neuroscience from cells to circuits. *Nat Rev Neurosci*. 2022;23:185–201. <https://doi.org/10.1038/s41582-022-00635-8>.
7. Weber DA, Reynolds CR. Clinical perspectives on neurobiological effects of psychological trauma. *Neuropsychiatr Dis Treat*. 2024;20:1–14. <https://doi.org/10.1023/B:NERV.0000028082.13778.14>.
8. Фрейд З. Я и Оно. М.: Просвещение; 1990. С. 425–439.
9. Тор ЮН. Интегральная каузальная психотерапия. Грани психотерапии. 2023;2(4):1–19. <https://aipp.education/wp-content/uploads/2023/07/GP-24-2023.pdf>.
10. Teicher MH, Samson JA, Anderson CM, Ohashi K. The effects of childhood maltreatment on brain structure, function and connectivity. *Nat Rev Neurosci*. 2016;17(10):652–666. <https://doi.org/10.1038/nrn.2016.111>.
11. Letheby C, Gerrans P. Self unbound: ego dissolution in psychedelic experience. *Neurosci Conscious*. 2017;3(1):nix016. <https://doi.org/10.1093/nc/nix016>.
12. Yehuda R, LeDoux J. Response variation following trauma: a translational neuroscience approach to understanding PTSD. *Neuron*. 2007;56(1):19–32. <https://doi.org/10.1016/j.neuron.2007.09.006>.
13. Porges SW. Polyvagal theory: a science of safety. *Front Integr Neurosci*. 2022;16:871227. <https://doi.org/10.3389/fnint.2022.871227>.
14. McEwen BS, Akil H. Revisiting the stress concept: implications for affective disorders. *J Neurosci*. 2020;40(1):12–21. <https://doi.org/10.1523/JNEUROSCI.0733-19.2019>.
15. Yehuda R, et al. Holocaust exposure induced intergenerational effects on FKBP5 methylation. *Biol Psychiatry*. 2016;80(5):372–380. <https://doi.org/10.1016/j.biopsych.2015.08.005>.
16. Fragakaki I, et al. Post-traumatic stress disorder under ongoing threat: a review of neurobiological and neuroendocrine findings. *Eur J Psychotraumatol*. 2016;7:30915. <https://doi.org/10.3402/ejpt.v7.30915>.
17. Theodoratou M, et al. Neuropsychological consequences of massive trauma: implications and clinical interventions. *Medicina (Kaunas)*. 2023;59(12):2128. <https://doi.org/10.3390/medicina59122128>.
18. Shin LM, Liberzon I. The neurocircuitry of fear, stress, and anxiety disorders. *Neuropsychopharmacology*. 2010;35(1):169–191. <https://doi.org/10.1038/npp.2009.83>.
19. Sherin JE, Nemeroff CB. Post-traumatic stress disorder: the neurobiological impact of psychological trauma. *Dialogues Clin Neurosci*. 2011;13(2):263–278. <https://doi.org/10.31887/DCNS.2011.13.2/jshein>.
20. Daskalakis NP, McGill MA, Lehrner A, Yehuda R. Endocrine aspects of PTSD: hypothalamic-pituitary-adrenal (HPA) axis and beyond. In: *Handbook of Clinical Neurology*. Vol 182. Elsevier; 2023. p. 129–148.
21. Pitman RK, Rasmusson AM, Koenen KC, Shin LM, Orr SP, Gilbertson MW, et al. Biological studies of post-traumatic stress disorder. *Nat Rev Neurosci*. 2012;13(11):769–787. <https://doi.org/10.1038/nrn3339>.
22. Garfinkel S, Liberzon I. Neurobiology of PTSD: a review of neuroimaging findings. *J Clin Psychiatry*. 2009;70(8):112–120. <https://doi.org/10.3928/00485713-20090527-01>.
23. Lanius RA, et al. Emotion modulation in PTSD: clinical and neurobiological evidence for a dissociative subtype. *Am J Psychiatry*. 2009;167(6):640–650. <https://doi.org/10.1176/appi.ajp.2009.09081168>.
24. Delahanty D, Glover D, Golier J. Neurobiology of memory and dissociation in trauma survivors. *Ann N Y Acad Sci*. 2004;1032:183–185. <https://doi.org/10.1196/annals.1314.016>.
25. Lebois LAM, et al. A review of the neurobiological basis of trauma-related dissociation. *Curr Psychiatry Rep*. 2018;20(12):98.
26. Sleight F, et al. A novel ego dissolution scale: a construct validation study. *Conscious Cogn*. 2023;108:103474. <https://doi.org/10.1016/j.concog.2023.103474>.
27. Lanius RA, Vermetten E, Pain C, editors. *The impact of early life trauma on health and disease: the hidden epidemic*. Cambridge: Cambridge University Press; 2011. <https://doi.org/10.1017/CBO9780511777042>.
28. Basso JC, et al. Dissociation and other trauma symptomatology are linked to imbalance in the competing neurobehavioral decision systems. *Front Psychol*. 2023;14:1317088. <https://doi.org/10.3389/fpsyg.2023.1317088>.
29. Frewen P, Lanius R. *Healing the traumatized self: consciousness, neuroscience, treatment*. New York: W.W. Norton; 2015.

30. Тор ЮН, Русина НА, Маковеева ПС, Швецова СВ. Этиотропная психотерапия депрессии через переработку неинтегрированной агрессии: подход в рамках интегральной каузальной психотерапии. *Psychotherapy Science Today*. 2025;1(1):13–21. <https://doi.org/10.64435/spes8434>.
31. O'Connor MF, et al. Craving love? Enduring grief activates brain's reward center. *NeuroImage*. 2008;42(2):969–977. <https://doi.org/10.1016/j.neuroimage.2008.04.256>.
32. O'Connor MF. Grief: a brief history of research on how body, mind, and brain adapt. *Psychosom Med*. 2019;81(8):731–738. <https://doi.org/10.1097/PSY.0000000000000717>.
33. Shear MK. Complicated grief. *N Engl J Med*. 2015;372(2):153–160. <https://doi.org/10.1056/NEJMcp1315618>.
34. Northoff G, et al. Self-referential processing in our brain: a meta-analysis of imaging studies on the self. *NeuroImage*. 2005;31(1):440–457. <https://doi.org/10.1016/j.neuroimage.2005.12.002>.
35. Gündel H, O'Connor MF, Littrell L, Fort C, Lane RD. Functional neuroanatomy of grief: an fMRI study. *Am J Psychiatry*. 2003;160(11):1946–1953. <https://doi.org/10.1176/appi.ajp.160.11.1946>.
36. Chamberlain SR. Traumatic dissociation: neurobiology and treatment. *Am J Psychiatry*. 2007;164(12):1789–1795. <https://doi.org/10.1176/appi.ajp.2007.07081290>.
37. Schore AN. Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Ment Health J*. 2003;22(1–2):7–66. [https://doi.org/10.1002/1097-0355\(200101/04\)22:1<7::AID-IMHJ2>3.0.CO;2-N](https://doi.org/10.1002/1097-0355(200101/04)22:1<7::AID-IMHJ2>3.0.CO;2-N).
38. Danese A, McEwen BS. Adverse childhood experiences, allostasis, allostatic load, and age-related disease. *Physiol Behav*. 2012;106(1):29–39. <https://doi.org/10.1016/j.physbeh.2011.08.019>.
39. van Harmelen AL, van Tol MJ, Dalgleish T, van der Wee NJ, Veltman DJ, Aleman A, et al. Hypoactive medial prefrontal cortex functioning in adults reporting childhood emotional maltreatment. *Soc Cogn Affect Neurosci*. 2014;9(12):2026–2033. <https://doi.org/10.1093/scan/nsu008>.

Aggression as a key pathogenetic factor of depression: an empirical study

Natalya A. Rusina^{1,*}, Polina S. Makoveeva², Svetlana V. Shvetsova³

¹ Academy of Integral Psychodynamic Psychotherapy, Moscow, Russia.

² E. E. Volosevich First City Clinical Hospital, Arkhangelsk, Russia.

³ Department of Medical Cybernetics, Yaroslavl State Medical University, Yaroslavl, Russia.

Received: Dec 20, 2025

Accepted: Jan 22, 2026

Published: Mar 1, 2026

For citation:

Rusina NA, Makoveeva PS, Shvetsova SV. Aggression as a key pathogenetic factor of depression: an empirical study. *Psychotherapy Science Today*. 2(2):22–28. <https://doi.org/10.64435/ruob9440>.



© Author(s), CC BY-NC 4.0

Abstract

Objective: This pilot study aims to empirically investigate aggression as a psychological mechanism involved in the development and persistence of depressive disorders and assess its association with the severity of depressive symptomatology.

Methods: The study involved three groups: patients with depressive disorders (ICD-10 codes F32.00, F33.00, F33.11) receiving only pharmacological treatment (Group 1, N = 30) and receiving only non-pharmacological psychotherapy (Group 2, N = 18); and a control group of conditionally healthy respondents (N = 30). Assessments used the *Beck Depression Inventory–II*, the *L. G. Pochebut Aggressiveness Questionnaire*, and the *C. Ryff Psychological Well-Being Scales*. Statistical analysis included the Mann-Whitney U test, Wilcoxon signed-rank test, Spearman's rank correlation coefficient, and regression analysis.

Results: Patients with depressive disorders demonstrated statistically significantly higher levels of self-directed aggression (auto-aggression) and overall aggressiveness compared to the control group, as well as decreased psychological well-being. Regression analysis showed that the overall level of aggression is statistically significantly associated with the severity of depressive symptomatology and may be considered a potential predictor of depressive symptom intensity. Emotional aggression, in contrast, was negatively associated with depression severity, reflecting affect suppression as the disorder worsens. In the psychotherapy group, a significant reduction in depressive symptoms and improvement in emotional state indicators were observed, with differential effects depending on the level of personality organization (neurotic vs. borderline).

Conclusions: Aggression may be considered one of the key psychological mechanisms involved in the formation and maintenance of depressive disorders and is associated with the severity of cognitive-affective and somatic symptoms. Targeted psychotherapeutic work with suppressed aggression was associated with statistically significant reductions in depressive symptomatology and with improvements in self-regulation and self-attitude indicators. The findings underscore the need to include the diagnosis and processing of self-aggression in depression treatment protocols.

Keywords: depression, self-aggression, Integrative Causal Psychotherapy, suppressed aggression, psychological well-being, psychotherapy for depression.

Introduction

The relationship between depressive symptomatology and various forms of self-aggression is considered within theoretical models in psychodynamic psychotherapy and supported by numerous clinical observations. Even in classic psychoanalytic works, depression was viewed as a result of introjecting a lost or frustrating object and redirecting aggression from the external object onto the self [1–3]. Within

this logic, the depressive state is understood as a form of unconscious self-punishment, where aggressive impulses, finding no outlet in external behavior, turn inward, forming auto-aggressive tendencies.

Self-aggression in depression encompasses a wide spectrum of forms — from cognitive self-deprecation and chronic self-criticism to passive forms of self-destructive behavior (intentional

* Corresponding author, e-mail: narusina@mail.ru.

neglect of one's own needs, refusal of self-care, chronic self-devaluation) — and is a significant and specific component of depression. The level of passive self-aggression is statistically significantly higher in patients with depressive disorders compared to control groups and partially mediates the link between impaired self-control and the severity of depressive symptomatology. These data allow self-aggression to be considered not merely as a secondary consequence of depression, but as one of its significant psychological mechanisms [4–8].

Several studies indicate that active forms of self-aggression, including non-suicidal self-injury and suicide attempts, are also closely linked to depressive symptomatology. Patients with pronounced auto-aggressive and suicidal tendencies exhibit impairments in serotonergic regulation similar to those observed in severe depressive states. This supports the hypothesis of shared neurobiological mechanisms underlying depression and self-aggression [9–11].

Special attention is paid to the role of early traumatic experiences and emotional regulation disturbances in the formation of self-aggression in depression. Research shows that childhood trauma, chronic stress, and deficits in secure attachment increase the likelihood of developing auto-aggressive strategies as a means of affect regulation, which subsequently contributes to the chronicity of depressive states [12]. In these cases, self-aggression performs a paradoxical regulatory function, reducing the intensity of unbearable emotional states by transferring affect into the bodily or behavioral sphere.

Genetic and behavioral studies also confirm shared mechanisms of depression and self-aggression. Twin studies have shown that inwardly directed aggression and depressive symptoms are partly due to common genetic factors, yet a significant portion of the variability is explained by individual experience and environmental influences [13]. This underscores the importance of psychotherapeutic intervention aimed at reworking auto-aggressive patterns.

Thus, contemporary literature allows viewing self-aggression as a multi-level phenomenon encompassing cognitive, emotional, behavioral, and neurobiological components closely linked to depressive states. Self-aggression in depression manifests both in active forms (self-harm, suicidal behavior) and passive forms (self-devaluation, refusal of self-care, chronic self-punishment), with both forms contributing to the maintenance and worsening of depressive symptomatology. When externally directed aggression is suppressed, it accumulates and may be directed at the self, which typically leads to painful guilt, groundless fear,

neuroses, and in severe cases — to suicidal impulses.

Within the context of the presented data, the following research hypothesis was formulated: increased auto-aggressiveness is statistically significantly associated with the severity of depressive symptomatology and may be considered a potential predictor of both cognitive-affective and somatic symptoms and overall depression severity.

Sample and Assessment Methods

The study was conducted from September 2023 to December 2024 and included 3 respondent groups:

- group 1 — patients with diagnosed depression receiving pharmacological treatment;
- group 2 — patients with diagnosed depression receiving non-pharmacological psychotherapeutic treatment, and a control group — respondents not registered with psychiatric services or under psychiatric observation.

Group 1 consisted of 30 patients aged 18 to 63 years receiving inpatient and outpatient pharmacological treatment. The patients were examined at the State Budgetary Clinical Institution of the Yaroslavl Region “Yaroslavl Regional Psychiatric Hospital” (GBKUZ YAO “YORPB”).

Group 2 consisted of 18 patients aged 24 to 76 years. Participants were recruited via an announcement from the Academy of Integral Psychodynamic Psychotherapy (Moscow, Russia). Diagnoses were confirmed by a certified psychiatrist using structured clinical interviews based on ICD-10 criteria. These patients received psychotherapeutic non-pharmacological treatment for depression focused on working with unprocessed aggression, using a method developed within the framework of Integrative Causal Psychotherapy (ICP) at the Academy of Integral Psychodynamic Psychotherapy (AIPP).

The control group consisted of a sample of healthy individuals aged 18 to 51 years, recruited via snowball sampling.

All participants provided informed consent, and the study protocol was approved by the AIPP Ethics Committee.

The main focus of the study was: a) identifying and comparing the level of self-aggression in Group 1 and the control group; b) analyzing the dynamics of self-aggression before and after treatment in Group 2.

Testing utilized standardized psychological scales and questionnaires: the C. Ryff Psychological Well-Being Scales [14], the L. G. Pochebut Aggressiveness Questionnaire [15], the Beck Depression Inventory-II

(BDI-II) [16], and Yu. N. Tor's questionnaire "Satisfaction with the Dynamics of Changes in Key Life Spheres." For statistical processing of results, the Mann-Whitney U test, Wilcoxon signed-rank test, Spearman's rank correlation coefficient, and regression analysis were used.

Results and Discussion

A comparative analysis of data from Group 1 and the control group revealed that indicators of physical aggression*, self-aggression, total aggression score, and depression (cognitive, somatic, and total scores) were higher in Group 1. They were characterized by:

- stable negative beliefs about their own personality, accompanied by a tendency to direct aggression inward — towards the self, as well as destructive attitudes towards the environment;
- marked disturbances in affective state and distorted self-attitude, substantially differing from the indicators of the control group;
- low level of self-acceptance, expectation of punishment, indecisiveness, and subjective experience of social alienation;
- somatic components of depressive symptomatology, including sleep disturbances, increased fatigue, hyper-focus on health status and appearance.

Collectively, these manifestations indicate that individuals with depressive disorders experience existential emptiness and a sense of their own inadequacy, accompanied by a tendency towards auto-aggressive attitudes and behavior.

Comparison of Group 1 and the Control Group

Indicators of psychological well-being and satisfaction in key life spheres were statistically significantly higher in the control group (Table 1). Patients with depressive disorders were characterized by greater social isolation and frustration in interpersonal relationships, fewer trusting connections, difficulties in organizing daily activities, and a subjective sense of inability to influence the circumstances of their own lives. Compared to healthy respondents, they felt less self-actualized and developing. They were characterized by boredom, loss of interest in life, an experience of inability to establish new relationships or change behavioral patterns, reduced purposefulness, and a deficit of life goals and intentions. Furthermore, patients found no meaningful orientation in their

past experience and lacked stable ideas about prospects and values defining the meaning of life; they experienced greater dissatisfaction with themselves and pronounced anxiety regarding their personal qualities.

Regression Analysis: The Relationship Between Aggression and Depression

The results of regression analysis, which assessed the contribution of aggression and psychological well-being indicators to the overall level of depression as well as its cognitive and somatic components, were of substantial importance for understanding the relationship between aggression and depression. Table 2 presents data reflecting the contribution of aggression to depressive symptomatology, as the most significant for psychotherapeutic interpretation. The analysis also used the scales from C. Ryff's methodology.

The results of the regression analysis reveal how different indicators of aggression (per the Pochebut questionnaire) influence the severity of depression (per the Beck Scale). The data presented in Table 2 demonstrate that not all types of aggression are equally related to depression, and the role of emotional (often suppressed) aggression is particularly interesting. Key conclusions here can be:

1. The total aggression score is statistically significantly associated with the severity of depressive symptomatology. This applies to both cognitive-affective symptoms (guilt, hopelessness, low self-esteem) and somatic symptoms (fatigue, sleep disturbances, appetite changes). The total aggression score is a cumulative indicator that includes both external and internal manifestations. Its strong association with depression indicates that unexpressed, suppressed aggression may function as a psychological risk factor contributing to the worsening of depressive manifestations. The organism expends enormous resources on restraining aggressive impulses, leading to exhaustion, guilt, and somatization — direct symptoms of depression.
2. The "Emotional Aggression" indicator has a negative association with the total depression score and with depression severity. This indicator in the Pochebut questionnaire reflects emotional alienation in communication with others, accompanied by suspicion, hostility, antipathy, or ill will towards them. The obtained

* The "Physical Aggression" indicator in L. G. Pochebut's questionnaire is a marker of non-integrated aggression, measuring not behavior as such, but affective-motor predisposition and the level of activation of the aggressive-motor system.

Indicator	Mean patients (Group 1)	Mean healthy (Control)	Significance level
Physical aggression	2.53	1.40	p<0.01
Self-aggression	6.63	4.77	p<0.01
Total aggression score	18.87	15.80	p<0.05
Cognitive-affective scale	22.73	9.00	p<0.001
Somatic symptoms scale	10.97	5.90	p<0.001
Total depression score	33.70	14.90	p<0.001
Positive relations	53.63	60.13	p<0.05
Environmental mastery	46.17	52.93	p<0.01
Personal growth	53.77	63.60	p<0.001
Purpose in life	46.60	60.80	p<0.001
Self-acceptance	39.27	55.57	p<0.001
Psychological well-being	290.97	346.33	p<0.001
Mood	-1.03	-0.30	p<0.05
Physical well-being	-0.73	-0.23	p<0.01
Self-confidence	-1.40	-0.10	p<0.001
Relations with partner	-0.63	-0.10	p<0.01
Family relations	-0.57	0.30	p<0.01
Relations with others	-0.47	-0.03	p<0.01
Professional sphere/studies	-0.97	0.00	p<0.001
Income	-1.20	0.03	p<0.001
Life enjoyment	-1.17	-0.13	p<0.001
Future expectations	-1.03	0.17	p<0.001

Table 1. Comparison of scale indicators in patients with depressive disorders and the control group using the Mann-Whitney U Test

Aggressiveness	Depression level	p-value
<i>Total depression score</i>		
Total aggression score	0.615163	0.000086
Emotional aggression	-0.295086	0.033679
p-value of the regression model	0.000000005	
<i>Cognitive-affective scale</i>		
Total aggression score	0.410217	0.044901
p-value of the regression model	0.0000000014	
<i>Depression somatization</i>		
Total aggression score	0.520390	0.000317
p-value of the regression model	0.0000000110	

Table 2. Relationship between aggressiveness indicators (Pochebut Test) and depression level (Beck Scale)

data indicate that a higher level of conscious aggressive emotions (anger, irritation) is associated with less severe depression, and conversely — the more severe the depression, the weaker this type of aggression manifests. This suggests the triggering of an aggression suppression mechanism in severe depression. As depression deepens, apathy, anhedonia, and emotional numbness increase. Aggressive impulses do not disappear but cease to be conscious as anger. They are suppressed — repressed from consciousness and find outlet in other, more destructive forms: auto-aggression and somatization. Thus, in this case, a decrease in conscious aggressive feelings may reflect mechanisms of affective suppression often observed with the worsening of depressive states.

3. Suppressed aggression differentially influences mental and somatic symptoms of depression. The overall level of aggression is statistically significantly associated with depressive symptom severity and may contribute to its cognitive-affective and somatic components. However, the probable different pathogenetic mechanisms of these associations are of interest. Regarding cognitive-affective symptoms (guilt, low self-esteem, pessimism), high aggressiveness presumably acts through the mechanism of internalization and turning aggression against the self. Not being expressed outwardly, aggression transforms into stable negative cognitive schemas and affective experiences characteristic of depressive affect.

Group 2: Psychotherapy Results

The comparison of psychological indicators in Group 2 before and after psychotherapy focused on integrating suppressed aggression is of no less interest. As a result of psychotherapy, clinical remission was observed in 83% of participants (N=15), with the remaining 17% (N=3) showing a statistically significant reduction in symptom severity. Furthermore, among patients with neurotic personality organization (N=9), complete remission of depressive symptomatology was observed in all cases within this subgroup (100% of patients with neurotic personality organization). Among patients with borderline personality organization, constituting half of the sample (N=9), 67% achieved remission, and 33% showed a reduction in symptom severity [17].

Data in [Tables 3](#) and [4](#) demonstrate a statistically significant positive effect of the conducted psychotherapy in both subgroups: patients with neurotic and borderline personality organization*. In particular, the obtained indicators allow for the following conclusions.

1. *General positive effect observed in both subgroups:* therapy led to a significant reduction in both the cognitive-affective component of depression (guilt, pessimism) and an improvement in the general emotional background, reflected in the positive dynamics of the mood indicator.
2. *Differential effect depending on personality structure:* analysis reveals qualitative differences in therapeutic response, underscoring the importance of considering the level of personality organization. In patients with neurotic personality organization, therapy led to significant positive changes in the sphere of self-attitude and basic affect: the self-confidence indicator increased from a negative value (-0.29) to a positive one (1.00), indicating overcoming the feeling of uncertainty characteristic of depression and the formation of more stable self-esteem. Patients with a more preserved (neurotic) personality structure apparently managed to integrate suppressed aggressive feelings to a greater extent. This directly reflected in the improvement of their self-perception and emotional background. In patients with borderline personality organization, the “Environmental Mastery” indicator increased (from 43.86 to 50.57), indicating that patients began to feel more competent and capable of influencing their lives; the “Self-Acceptance” indicator increased significantly (from 43.29 to 50.14), suggesting a reduction in the intensity of splitting and the formation of a more integrated and less judgmental self-image.
3. The presented data provide empirical support for the clinical effectiveness of psychotherapy focused on processing unprocessed aggression in the treatment of depression. Moreover, in neurotic patients, therapy to a greater extent stabilized self-esteem, while in borderline patients, it additionally strengthened basic Ego functions — the ability to manage one’s life and accept oneself wholly. Thus, the therapy was associated with clinically meaningful improvements in both subgroups but led to somewhat differing, clinically relevant patterns of improvement corresponding to the patients’ initial level of personality functioning.

* Based on the classification of Otto Kernberg [18].

Group with psychotherapy (neurotic)	Mean before	Mean after
Cognitive-affective depression scale	11.00	6.43
Mood	0.00	1.29
Self-confidence	-0.29	1.00

Note: statistical significance was set at $p < 0.05$.

Table 3. Comparison of scale indicators in patients with neurotic personality organization before and after psychotherapy using the Wilcoxon signed-rank test

Group with Psychotherapy (Borderline)	Mean before	Mean after
Environmental mastery	43.86	50.57
Self-acceptance	43.29	50.14
Cognitive-affective depression scale	15.71	9.43
Total depression score	24.86	15.14
Mood	-0.71	0.86

Note: statistical significance was set at $p < 0.05$.

Table 4. Comparison of scale indicators in patients with borderline personality organization before and after psychotherapy using the Wilcoxon signed-rank test

Conclusion

The conducted study demonstrates an association between increased aggressiveness and greater severity of depressive symptomatology. Patients with depressive disorders demonstrate significantly higher levels of auto-aggression, physical aggression, and overall aggression compared to a control group of healthy respondents.

Regression analysis further indicated that the overall level of aggression is significantly associated with depressive symptom severity and may contribute to its intensity. At the same time, emotional aggression showed a negative association with depression severity, reflecting mechanisms of affect suppression in more severe forms of the disorder. Taken together, these findings suggest that depression is accompanied not only by internalized self-blame but also by complex processes of aggressive affect processing and suppression, which may transform into auto-aggression and somatization.

The results of psychotherapeutic intervention showed that psychotherapy aimed at integrating aggression leads to remission in patients with neurotic personality organization and a statistically significant reduction in depressive symptomatology and improvement in emotional state in patients with borderline personality structure. These data suggest that auto-aggression can be considered an important

pathogenetically significant link in depressive disorders. Thus, targeted psychotherapeutic work with aggressive patterns opens the way to mechanism-oriented psychotherapeutic interventions aimed at reducing depressive symptomatology and restoring psychological well-being. Further research may be directed at developing standardized protocols for assessing auto-aggression and evaluating the efficacy of auto-aggression-focused psychotherapy on larger samples of patients with diagnosed depression.

Conflict of Interest Statement

The authors declare no conflict of interest.

References

1. Фрейд З. По ту сторону принципа удовольствия. Я и Оно. Печаль и меланхолия. СПб.: Азбука-классика; 2006. С. 233–252.
2. Абрахам К. Фрейдовский психоанализ и смежные направления. СПб.: Б.С.К.; 2000.
3. Кляйн М. Скорбь и её отношение к маниакально-депрессивным состояниям. СПб.: Речь; 2000.
4. Schanz CG, Equit M, Schäfer SK, et al. Self-directed passive-aggressive behaviour as an essential component of depression: findings from two cross-sectional observational studies. BMC Psychiatry. 2022;22:200. <https://doi.org/10.1186/s12888-022-03850-1>.
5. Schanz CG, Equit M, Schäfer SK, Käfer M, Mattheus HK, Michael T. Development and psychometric properties of the

- Test of Passive Aggression. *Front Psychol.* 2021;12:579183. <https://doi.org/10.3389/fpsyg.2021.579183>.
6. Fonagy P, Gergely G, Jurist EL, Target M. Affect regulation, mentalization, and the development of the self. New York: Other Press; 2002. <https://doi.org/10.4324/9780429471643>.
 7. O'Connor RC, Noyce R. Personality and cognitive processes: self-criticism and different types of rumination as predictors of suicidal ideation. *Behav Res Ther.* 2008;46(3):392–401. <https://doi.org/10.1016/j.brat.2008.01.007>.
 8. Dixon-Gordon KL, Weiss NH, Tull MT, DiLillo D, Messman-Moore T, Gratz KL. Characterizing emotional dysfunction in borderline personality, major depression, and their co-occurrence. *Compr Psychiatry.* 2015;62:187–203. <https://doi.org/10.1016/j.comppsy.2015.07.014>.
 9. Hawton K, Saunders KEA, O'Connor RC. Self-harm and suicide in adolescents. *Lancet.* 2012;379(9834):2373–82. [https://doi.org/10.1016/S0140-6736\(12\)60322-5](https://doi.org/10.1016/S0140-6736(12)60322-5).
 10. Nock MK, Favazza AR. Nonsuicidal self-injury: definition and classification. In: Nock MK, editor. *Understanding nonsuicidal self-injury: origins, assessment, and treatment*. Washington, DC: American Psychological Association; 2009. С. 9–18. <https://doi.org/10.1037/11875-001>.
 11. Wolff JC, Ollendick TH. The comorbidity of conduct problems and depression in childhood and adolescence. *Clin Child Fam Psychol Rev.* 2006;9(3–4):201–20. <https://doi.org/10.1007/s10567-006-0011-3>.
 12. Teicher MH, Samson JA. Annual Research Review: enduring neurobiological effects of childhood abuse and neglect. *J Child Psychol Psychiatry.* 2016;57(3):241–66. <https://doi.org/10.1111/jcpp.12507>.
 13. Kendler KS, Aggen SH, Czajkowski N, et al. The structure of genetic and environmental risk factors for DSM-IV personality disorders: a multivariate twin study. *Arch Gen Psychiatry.* 2008;65(12):1438–46. <https://doi.org/10.1001/archpsyc.65.12.1438>.
 14. Ryff CD. Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *J Pers Soc Psychol.* 1989;57(6):1069–81.
 15. Почебут ЛГ. Методика диагностики агрессивного поведения. В: Практикум по социальной психологии. СПб.: Речь; 2001. С. 112–118.
 16. Бек АТ, Стир РА, Браун ГК. Опросник депрессии Бека (BDI-II): руководство. Пер. и адапт. Тарабриной НВ. М.: ГНЦ ССП им. В.П. Сербского; 2001.
 17. Тор ЮН, Русина НА, Макоева ПС, Швецова СВ. Этиотропная психотерапия депрессии через переработку неинтегрированной агрессии: подход в рамках интегральной каузальной психотерапии. *Psychotherapy Science Today.* 1(1):13–21. <https://doi.org/10.64435/spes8434>.
 18. Кернберг ОФ. Тяжёлые личностные расстройства: стратегии психотерапии. М.: Класс; 2000.

Visual narrative as a tool for psychological correction: an empirical study of its impact on the mental states of children aged 5–7 years

Svetlana V. Veliyeva*

Department of Preschool Pedagogy and Psychology of Education,
Chuvash State Pedagogical University named after I. Y. Yakovlev, Cheboksary, Russia.

Received: May 15, 2025
Accepted: Aug 5, 2025
Published: Mar 1, 2026

For citation:

Veliyeva SV: Visual narrative as a tool for psychological correction: an empirical study of its impact on the mental states of children aged 5–7 years. *Psychotherapy Science Today*. 2(2):29–35. <https://doi.org/10.64435/hush6011>.



© Author(s), CC BY-NC 4.0

Abstract

Objective: To investigate the impact of a visual narrative art therapy program on the mental states of older preschool children.

Methods: The study involved 56 children aged 5–7 years; a formative (intervention-based) experiment was conducted with baseline, intervention, and control stages. Methods included theoretical analysis, psychological assessment, qualitative and statistical data analysis. Pearson's χ^2 was applied to a subgroup ($n = 24$), and descriptive analysis was used for a subgroup ($n = 6$). The psychological correction program was based on the creation of a visual narrative using Ebru techniques, drama therapy, collage, sand therapy, work with mandalas and metaphorical cards, aimed at optimizing children's emotional and behavioral reactions.

Results: Within a quasi-experimental pre-post design, positive dynamics in the mental states of preschoolers were revealed (Tables 1–3). The most pronounced changes were observed in the physiological component, the least in the behavioral component.

Conclusions: The narrative art therapy program had a positive impact on the mental states of older preschool children; visual narrative is identified as a clinically significant tool for psychological correction and assessment.

Keywords: narrative art therapy, visual narrative, emotional self-regulation, childhood fears, psychological intervention, older preschoolers.

Introduction

The problem of anxiety states in preschool age has gained particular clinical and social significance in recent decades. According to modern epidemiological studies, the prevalence of anxiety disorders in preschool children shows a steady upward trend, associated both with changing socialization conditions and with increased sensory, informational, and emotional load in early development [1, 2]. Furthermore, childhood anxiety has not only a symptomatic but also a structure-forming character, reflecting the development of the attachment system, affective regulation, and the formation of self-representations [3, 4].

Within modern clinical psychology, anxiety is considered not as an isolated symptom but as a multidimensional mental state, including

cognitive, affective, somatic, and narrative-symbolic components [5]. From the perspective of polyvagal theory, chronic anxiety in children is linked to the dominance of defensive patterns of the autonomic nervous system, manifested in hyperactivation of the sympathetic circuit or dorsal vagal shutdown [6, 7]. This necessitates therapeutic interventions aimed not only at cognitive processing of experiences but also at bodily-sensory processing of affect [6, 8, 9].

Narrative and projective approaches to child psychotherapy are based on the premise that preschool children primarily operate not with abstract concepts, but with images, characters, and metaphorical structures [10, 11]. Externalization of internal experiences through imagery and

* E-mail: stlena70@mail.ru.

story allows the child to distance themselves from the symptom, reduce its subjective threatening significance, and adopt an observer position towards their own mental states [10, 12]. In this context, anxiety ceases to be a diffuse inner tension and takes the form of a symbolic object with which dialogue, change, and integration become possible.

Art therapy methods, particularly sculpting and visual techniques, possess additional regulatory potential through the involvement of sensorimotor and proprioceptive channels of affect processing [13, 14]. Tactile-kinesthetic activity contributes to reducing physiological arousal, enhances the sense of control, and promotes the integration of emotional experience at a pre-reflective (implicit) level. This is especially important when working with preschoolers, whose verbalization of emotions is not yet fully developed and whose dominant forms of representing experiences remain bodily and imaginal [15].

Recent clinical literature increasingly emphasizes the effectiveness of integrative models combining narrative, art therapy, cognitive-behavioral, and sensory-based techniques in working with childhood anxiety [16]. Such approaches allow simultaneous impact on cognitive interpretations, affective intensity, and bodily response patterns, increasing the stability of therapeutic effects [17, 18].

In this context, visual narrative acts as a key tool for symbolizing anxiety, facilitating the transition from unformed bodily affect to a meaningful and manageable image [19, 20]. Through creating, modifying, and discussing visual images of anxiety, the child gains the ability to integrate emotional experience into the self-structure, aligning with both narrative therapy models and psychophysiological self-regulation mechanisms.

In this regard, the development and empirical testing of programs based on visual narrative art therapy integrated with sensory and cognitive techniques for working with anxiety states in preschool children is of particular interest. This study aims to analyze the clinical and psychological effects of such a program in the context of group correctional work.

Methodology

Hypothesis: It is hypothesized that a) the mental states of children aged 5–7 years are characterized by the presence of negative emotional reactions (anxiety, fears) and an imbalance in autonomic regulation, associated with insufficiently developed mechanisms of emotional self-regulation; b) the use of visual narrative as a tool of narrative art therapy will optimize these states.

To identify the features of mental states and conditions for their optimization in older preschoolers ($n = 56$; 6 ± 1.2 years), a formative art therapy experiment was conducted in preschool educational institutions in Cheboksary, Chuvash Republic (Russia). The sample was formed from children of senior groups in two kindergartens. In this study, mental states are conceptualized as a multi-level system including physiological, affective-personal, cognitive, and behavioral components.

The experimental part consisted of three stages. The baseline stage aimed to identify features of the structural components of mental states in children. The control stage established the dynamics of mental states and the effectiveness of the tested program.

Research methods included theoretical analysis of literature on correcting mental states in preschool children, a formative experiment, quantitative, qualitative, and statistical data analysis (Pearson's χ^2). For the subgroup ($n = 6$), descriptive analysis of mental state dynamics was used.

Psychological assessment employed the following methods: A.I. Zakharov's *Child Fear Susceptibility Questionnaire*, *The Person in the Rain* drawing technique by E.S. Romanova and T.I. Sytko, the projective method *The Little Engine* by S.V. Veliyeva (calculating K. Shiposh's integral coefficient), and *The Anxiety Test* by R. Temple, V. Amen, and M. Dorkey.

To assess mental states, their structural components were analyzed: physiological, affective-personal, cognitive, behavioral. Additionally, socio-communicative situations provoking negative states were recorded: communication with peers and adults, domestic, play, and communicative situations in different conditions. The diagnostic procedure was conducted in the first half of the day, individually with each child, with prior written parental consent.

Correction program

The formative stage involved developing and testing a system of art therapy activities to optimize the mental states of older preschool children. The program consisted of 17 sessions, conducted twice a week for 30–35 minutes in groups of 14 children in a psychologist's office. The office space was organized as a therapeutic environment: immersive elements were used (mobiles, light and projection effects, thematic decorations), creating an atmosphere of safety and engagement.

Each session included three parts:

1. Beginning — reducing autonomic tension, tuning in to work, neuropsychogymnastics, and sensory stimulation.

Examples of questions for working with anxious feelings in children:

- If your anxiety were a character, what would it say?
- What do you feel when you encounter your anxiety?
- How can you take care of yourself so that your anxiety becomes calmer?

2. Main part — individual and collective work with visual narrative and art therapy imagery.
3. Completion — feedback, discussion of results, sharing emotions using stickers.

To enhance the therapeutic effect, the following were used:

- targeted audio stimulation — musical compositions for relaxation, attention activation, and emotional self-regulation;
- structured facilitation — clear instructions, motivational support, flexible adjustment of work;
- personalization of tasks — selection of form, theme, and materials according to age characteristics, interests, and specifics of the child's mental state;
- emotional interaction — stimulating the exchange of emotions, discussions, and evaluations of created images.

During preparatory and concluding stages, children performed individual and collective creative tasks: making and coloring mandalas, simple decorations for further work with visual narrative, preparing joint projects. The main stage (9 sessions) used Ebru, drama therapy, collage, sand therapy, work with photographs, metaphorical cards, textiles, and clay. Instructions were gradually complicated: from working according to the facilitator's model to independent and collective creation of a visual narrative. For example, children create a visual image of anxiety, then transform it into a more positive or safe image. The psychologist does not interpret the child's experiences but supports independent reflection and verbalization. A new visual and verbal self-image is formed in various situations, contributing to the development of emotional regulation and experience processing.

Results

Within a quasi-experimental pre-post design, statistically significant positive dynamics in the mental states of preschoolers across all studied parameters were revealed.

General dynamics of mental states

Based on data from the Little Engine and Person in the Rain methods (n = 56) at the control stage compared to the baseline stage, the following changes in the dynamics of mental states were identified (Table 1):

- The number of children with positive states increased from 26 (46.4%) to 35 (62.5%), indicating a significant improvement in emotional background and optimization of adaptive resources after the program.
- The number of children with low-intensity negative states decreased from 24 (42.8%) to 20 (35.7%), indicating partial optimization of the emotional sphere.
- The number of children with moderate-intensity negative states decreased from 6 (10.8%) to 1 (1.8%), indicating pronounced positive dynamics in reducing the severity of negative reactions.

High-degree negative states were not found at any stage (0%), reflecting the absence of profound emotional disturbances in the sample.

Psychophysiological indicators

Autonomic tone coefficient

At the baseline stage, the autonomic tone coefficient was (Table 2):

- High in 33 children (58.9%).
- Medium in 3 children (5.4%).
- Low in 20 children (35.7%).

Mental States	Baseline Stage		Control Stage	
	Absolute number	%	Absolute number	%
Positive (optimism, joy, activity, cheerfulness, vigor, freshness, calm, attention, concentration)	26	46.4	35	62.5
Negative, low intensity (anxiety, fatigue, inhibition)	24	42.8	20	35.7
Negative, moderate intensity (excitement, tension, fear)	6	10.8	1	1.8
Negative, high intensity	0	0	0	0

Table 1. Distribution of preschoolers by levels of expression of mental state components (The Little Engine, The Person in the Rain methods)

Mental States	Baseline Stage						Control Stage					
	Low		Medium		High		Low		Medium		High	
	Abs.*	%	Abs.	%	Abs.	%	Abs.	%	Abs.	%	Abs.	%
Autonomic Tone Coefficient	20	35.7	3	5.4	33	58.9	1	1.8	34	60.7	21	37.5
Tension Coefficient	11	19.6	2	3.6	43	76.8	1	1.8	37	66.1	18	32.1

* Abs. — absolute number.

Table 2. Distribution of preschoolers by level of autonomic tone coefficient and tension level

At the control stage, the distribution changed:

- High level — 21 children (37.5%).
- Medium level — 34 children (60.7%).
- Low level — 1 child (1.8%).

The marked reduction in the proportion of low level (from 35.7% to 1.8%) and the growth of medium level (from 5.4% to 60.7%) indicate normalization of autonomic tone regulation in most children.

Tension (stress) coefficient

The tension coefficient at the baseline stage (Table 2):

- High — 43 children (76.8%).
- Medium — 2 children (3.6%).
- Low — 11 children (19.6%).

At the control stage:

- High — 18 children (32.1%).
- Medium — 37 children (66.1%).
- Low — 1 child (1.8%).

The marked reduction in high tension level (from 76.8% to 32.1%) and growth of medium level (from 3.6% to 66.1%) indicate a decrease in stress load and improvement of adaptation mechanisms.

Dynamics of fears and anxiety

Analysis of data for the entire sample (n = 56) showed positive dynamics on A.I. Zakharov's questionnaire: the proportion of children with a high level of fears decreased from 40.0% to 16.7%, while the low level increased from 16.7% to 43.3%.

For a more detailed understanding of the program's effectiveness, changes were analyzed separately in two subgroups identified at the baseline stage.

- In the subgroup with low-intensity negative states (n = 24), a substantial reduction in high anxiety (according to the R. Temple, V. Amen, and M. Dorkey test) was observed — from 66.7% to 16.7% of children, with a simultaneous increase in the proportion of children with medium anxiety from 8.3% to 75.0%.
- In the subgroup with moderate-intensity states (n = 6), pronounced positive dynamics across all parameters was also recorded.

Statistical verification confirmed the high significance of these changes ($p \leq 0.01$) for both the level of fears and the level of anxiety in both subgroups (Table 3). The most significant shifts occurred in anxiety indicators.

Statistical significance of observed changes

Results of the comparative analysis of mental state indicators before and after correctional measures are presented in Table 3.

1. Integrative indicator of mental states.

- Children with a predominance of low-intensity negative states (n = 24) showed highly reliable dynamics in the structure of mental states ($\chi^2 = 423.88$; $p \leq 0.01$), indicating significant improvement in integrative parameters (emotional background, adaptation, cognitive activity).
- Children with moderate-intensity negative states (n = 6) showed positive dynamics across all mental state components; statistical verification with χ^2 was impossible due to the small sample, results are presented descriptively.

2. Degree of actualization of mental states (positive/negative).

- For subgroup n = 24, a shift in balance towards positive states was noted ($\chi^2 = 9.45$; $p \leq 0.01$).
- For subgroup n = 6, dynamics are descriptive: a decrease in the dominance of negative reactions and activation of emotional regulation resources is observed.

3. Psychophysiological parameters.

- In subgroup n = 24, statistically significant improvement in the autonomic tone coefficient ($\chi^2 = 81.66$; $p \leq 0.01$) and reduction in the tension coefficient ($\chi^2 = 89.20$; $p \leq 0.01$) were found.
- In subgroup n = 6, changes are descriptive: reduction in high levels of tone and tension, growth in medium level.

4. Emotional-affective sphere.

- In children with low-intensity negative states, the severity of fears ($\chi^2 = 21.6$; $p \leq 0.01$) and

Assessment Parameters	Preschoolers with Predominance of Negative Mental	
	Low-Intensity (n = 24), p ≤ 0,01	Moderate-Intensity (n = 6)
	Pearson's χ^2	Descriptive dynamics
Integrative Mental State Indicator	423.9	Positive dynamics across all mental state components
Degree of Actualization (Positive/Negative)	9.5	Shift towards positive states
Autonomic Tone Coefficient	81.7	Decrease in high and increase in medium level
Tension Coefficient	89.2	Decrease in high and increase in medium level
Fear	21.6	Decrease in severity of fears
Anxiety	91.8	Decrease in anxiety and improvement in emotional regulation

Table 3. Comparison of mental state indicators before and after the program

anxiety ($\chi^2 = 91.8$; $p \leq 0.01$) was statistically significantly reduced.

- In the subgroup with moderate-intensity negative states, dynamics are assessed descriptively: reduction in the severity of fears and anxiety, improvement in emotional self-regulation.

Conclusion: The effectiveness of the program is statistically confirmed for children with low-intensity negative states. Children with more pronounced disturbances (moderate intensity) show positive dynamics, confirmed by descriptive analysis.

Discussion

Analysis of the obtained diagnostic data allowed identifying three groups of preschoolers with different levels of actualization of mental states (Tables 1–3). High-degree negative mental states were not identified.

Most children (46.4%) were characterized by positive mental states and moderate levels of tension and autonomic tone coefficients, displaying natural adequate reactions in various life situations. Preschoolers in this group possess balanced states in accordance with age characteristics, ensuring optimal communication, concentration, friendliness, and adaptation in the studied socio-communicative situations. Color choices included yellow, green, and blue hues; even shading and medium pencil pressure were used. Drawings were placed in the middle of the sheet, fairly clear, moderately large, including necessary details. Post-assessment interviews did not cause difficulties; verbalization was free, children easily engaged in dialogue.

In 42.8% of older preschoolers, low-intensity negative mental states were detected. In this group, social, spatial, and fears of natural phenomena, physical discomfort, tension in autonomic tone, and anxiety were recorded. For children in this group, positive and negative non-equilibrium states periodically hinder communication, adaptation, and play activity in different life situations. Color choices contained predominantly red, brown, and blue hues. Shading and pencil pressure were enhanced. Drawings were placed in the middle or top of the sheet. In post-assessment interviewing, children in this group answered monosyllabically, were often distracted, and justified their choice by referencing significant adults.

Moderate-intensity negative mental states were identified in 10.8% of children. This is the most vulnerable group; their mental state palette is represented predominantly by high and low levels of negative non-equilibrium states, tension in autonomic tone, fears, and anxiety. Situations of communication with peers and surrounding adults caused the greatest tension in these children. Children in this group exhibited neurotic manifestations: low mood, increased aggressiveness and fatigue, increased or decreased speed and intensity of emotional and motor reactions, impaired self-esteem and voluntary regulation, autonomic and psychosomatic disorders, obsessive movements, sleep and speech disturbances.

Interpretation, changes in exposition, additional drawing details indicated a predominance of withdrawal reactions, avoidance, activation of defensive psychological mechanisms, dependence on the parental figure, and a need for safety and support from others. Color choices included predominantly

black, gray, red, brown, and purple cards. Shading and pencil pressure were so strong they left an imprint on another sheet; there were many erasures and additional lines. Small or, conversely, oversized drawings were placed at the bottom or top of the sheet. During post-assessment interviewing, children in this group either did not answer or spoke monosyllabically, struggling to define and name experiences, emotions, and feelings.

Conclusion

The narrative art therapy program showed a positive impact on the mental states of older preschool children within a quasi-experimental pre-post design.

- For children with low-intensity negative states, the dynamics are statistically significant (χ^2 ; $p \leq 0.01$).
- For children with moderate-intensity negative states, positive dynamics are observed, reflected in descriptive analysis.

Visual narrative demonstrated high effectiveness as a tool for psychological assessment and intervention. Future research prospects may include in-depth development of a block for correcting behavioral manifestations, studying the program for children with more pronounced negative states and adaptation for inclusive groups, and creating a standardized diagnostic protocol based on the analysis of visual narratives as a supplement to traditional psychodiagnostic methods.

References

1. Muris P, Field AP. Distorted cognition and pathological anxiety in children and adolescents. *Clin Child Fam Psychol Rev*. 2008;11(3):199–210. <https://doi.org/10.1007/s10567-008-0034-8>.
2. Martinez JM, Marangell LB, Hollrah L. Vagus nerve stimulation: current use and potential applications in child and adolescent psychiatry. 2005;14(1):177–191. <https://doi.org/10.1016/j.chc.2004.07.003>.
3. Bowlby J. Attachment and Loss. Vol. 1. New York: Basic Books; 1969.
4. Mikulincer M, Shaver PR. Attachment in Adulthood. New York: Guilford Press; 2007.
5. Gross JJ. The emerging field of emotion regulation: an integrative review. *Rev Gen Psychol*. 1998;2(3):271–299. <https://doi.org/10.1037/1089-2680.2.3.271>.
6. Porges SW. Polyvagal Theory: a Science of Safety. *Front Integr Neurosci*. 2022;16:871227. <https://doi.org/10.3389/fnint.2022.871227>.
7. Haeyen S. A theoretical exploration of polyvagal theory in creative arts and psychomotor therapies for emotion regulation in stress and trauma. *Front Psychol*. 2024;15:1382007. <https://doi.org/10.3389/fpsyg.2024.1382007>.
8. Schore AN. Affect Regulation and the Repair of the Self. New York: W.W. Norton & Company; 2003.
9. van der Kolk B. The Body Keeps the Score. New York: Viking; 2014.
10. White M. Maps of Narrative Practice. New York: W.W. Norton & Company; 2007.
11. Пиаже Ж. Представления ребёнка о мире. Москва: Издательство «Педагогика»; 2005.
12. Payne M. Narrative Therapy. 2nd ed. London: SAGE Publications; 2006.
13. Kramer E. Art as Therapy with Children. New York: Schocken Books; 1971.
14. Malchiodi CA. The Art Therapy Sourcebook. New York: McGraw-Hill; 2006.
15. Выготский ЛС. Игра и её роль в психическом развитии ребёнка. *Вопросы психологии*. 1966;(6):62–76.
16. Kendall PC. Child and Adolescent Therapy: Cognitive-Behavioral Procedures. 4th ed. New York: Guilford Press; 2012.
17. Slayton SC, D'Archer J, Kaplan F. Outcome studies on the efficacy of art therapy: a review of findings. *Art Ther*. 2010;27(3):108–118. <https://doi.org/10.1080/07421656.2010.10129660>.
18. Haeyen S. Effects of art therapy on emotion regulation. *Front Psychol*. 2018;9:194.
19. Angus L, McLeod J, editors. The Handbook of Narrative and Psychotherapy: Practice, Theory, and Research. Thousand Oaks: SAGE Publications; 2004.
20. Neimeyer RA, editor. Meaning Reconstruction & the Experience of Loss. Washington, DC: American Psychological Association; 2001.

Appendix

Abridged session protocol “Journey to the planet of anxiety”

Target group: Children aged 5.6–6.5 years.

Goal: To develop adaptive coping strategies for regulating anxiety states through narrative art therapy, sensory stimulation, and cognitive-behavioral techniques.

Session structure

1. Introductory stage: motivation, tuning in, greeting ritual, activating knowledge about emotions.
2. Main stage:
 - Bilateral motor activity to reduce tension.
 - Sensory immersion (music, visual effects).
 - Art therapy task: sculpting the image of anxiety and its transformation.
3. Concluding stage: consolidating results, visual reflection (Ebru technique), discussing the new image of anxiety and its functions.

Example of working with anxiety (abridged)

- The facilitator asks questions for self-expression: “If your anxiety were a character, what would it say?”
- Children sculpt an image of anxiety from plasticine, discuss its properties, and transform it into a safe or positive object.
- New feelings, physiological and emotional reactions are discussed.

Methodological basis

- Narrative therapy — externalization and renaming of emotions.
- Art therapy — visualization and control of emotions through creativity.
- Polyvagal regulation theory — reducing anxiety through sensorimotor techniques.
- Cognitive-behavioral approaches — reframing and identifying triggers.

Key results

- Children successfully personify and transform anxiety.
- They master self-regulation skills and positive group interaction.
- Reduction of physiological and emotional tension occurs.

Joining technique in psychotherapy with pre-oedipal patients: a model of clinical navigation between intervention forms

Irina A. Zedgenizova, Alexey S. Chaly*, Zhanna V. Sergeeva, Elena K. Sudenkova

Academy of Integral Psychodynamic Psychotherapy, Moscow, Russia.

Abstract

The joining technique is widely used in psychoanalytic practice when working with patients at a pre-oedipal level of personality organization. However, in clinical work, therapists regularly face the necessity of choosing between different forms of joining, primarily ego-syntonic and ego-dystonic, depending on the current psychodynamic situation. This article proposes a process-oriented model of clinical navigation between forms of joining, focusing on ego-syntonic and ego-dystonic joining based on the analysis of the patient's affective presentation, the therapist's countertransference reactions, and the phase of the psychotherapeutic process. Drawing on the theoretical foundations of modern psychoanalysis in the tradition of H. Spotnitz and the authors' clinical experience, the article analyzes the mechanisms of the technique, including ego-syntonic and ego-dystonic joining, as well as their role in reducing resistance, facilitating narcissistic transference, and safely processing intense affects. Particular attention is paid to the differences between these forms and the logic of clinical decision-making in their application. Using clinical vignettes and examples from individual and group psychotherapy, the conditions for the effective application of the technique are demonstrated.

Keywords: joining, ego-syntonic and ego-dystonic joining, clinical decision-making, modern psychoanalysis, pre-oedipal patients.

Received: Dec 4, 2025
Accepted: Jan 16, 2026
Published: Mar 1, 2026

For citation:

Zedgenizova IA, Chaly AS, Sergeeva ZV, Sudenkova EK. Joining technique in psychotherapy with pre-oedipal patients: a model of clinical navigation between intervention forms. *Psychotherapy Science Today*. 2(2):36–43. <https://doi.org/10.64435/vtfl8883>.



© Author(s), CC BY-NC 4.0

Introduction

The joining technique is a psychodynamic intervention in which the therapist tunes into the patient's dominant current affect, verbalizing and containing ego-syntonic experiences or cautiously engaging with ego-dystonic impulses, with the aim of reducing defensive resistance and enabling the safe processing of affect. The essence of the technique is that the analyst joins the patient's resistance, their subjective perception of reality, affective state, belief, or defensive position, instead of immediately subjecting them to interpretation or confrontation. This joining conveys to the patient the message: "I share, understand, and accept your position," which may facilitate the establishment of narcissistic transference and contribute to the weakening of primitive defense mechanisms. This technique is particularly effective when working with narcissistic and borderline personality structures and is one of the core psychotherapeutic tools for establishing trusting contact with the patient and reducing resistance to the work.

The history of the application of joining in psychotherapeutic practice has been examined in

detail by Y. Feldman [1] and H.S. Strean [2]. This technique is sometimes described as "joining the resistance" [3] and has been discussed in relation to various psychotherapeutic traditions, including M. Erickson's hypnosis [4] and modern psychoanalysis. H. Spotnitz characterized joining as a "generalized set of clinical interventions aimed at working with preverbal forms of resistance and functioning," typically including suppressed aggressive impulses [5].

Despite the clinical significance of the joining technique, existing works leave insufficiently clarified the issue of the differential choice between its ego-syntonic and ego-dystonic forms. The use of this technique still relies largely on intuitive clinical judgment and is transmitted through practice and supervision.

The aim of this article is to explicate the logic of clinical choice between forms of joining and to propose a process-oriented model of clinical navigation that allows intuitive use of the technique to be translated into reflective professional decision-making. The model is based on the analysis of the patient's affective presentation, the therapist's

* Corresponding author, e-mail: alexey.chaly@aipp.education.

countertransference reactions, and the phase of the psychotherapeutic process and is presented as a visual scheme supplemented by clinical decision-making criteria.

This article is theoretical-clinical in nature and is based on an analysis of the literature in the tradition of modern psychoanalysis, primarily the modern psychoanalytic tradition associated with H. Spitz, as well as on a synthesis of the authors' long-term clinical experience in working with patients at a pre-oedipal level of personality organization. The article employs a conceptual approach aimed at explicating the clinical logic of therapeutic decision-making and proposes a conceptual model illustrated by typical clinical vignettes. The presented model is not an algorithm or protocol but serves as a tool for reflective clinical thinking.

Theoretical premises for the effectiveness of the joining technique

The joining technique is aimed at interacting with preverbal modes of functioning from the period when the infant's psyche functioned in close emotional unity with the maternal figure. In modern psychoanalysis, such patients are considered to function at a pre-oedipal level of personality organization, characterized by fixation on early, preverbal ways of experiencing and interacting.

In this context, it is important to be sincere, to avoid monotony, and to resort to special warm, supportive intonations. With correct use of joining, the therapist's psyche temporarily functions as an external regulating system for affect, analogous to the maternal psyche in the symbiotic phase [6].

Attachment, established in early childhood, influences a child's future behavior. Attentive, sensitive, caring parents foster in the child a sense of basic trust in the world [7]. If the mother or a substitute maternal object is emotionally unavailable during the critical period of the infant's development (up to three years), the inability to contain and process the infant's raw affects leads to their encapsulation, which may later become a source of symptoms. Such a frustrated infant suppresses its rage and directs it inward to avoid destroying the maternal object.

The inability to integrate "good" and "bad" aspects of self and others is associated with powerful early aggression activated in such patients. According to M. Klein's theory, the primitive defense of splitting separates "good" and "bad" objects to protect the fragile ego from the destructive force of its own aggression [8]. The less the infant's instinctual drives are satisfied, the greater the suppressed

aggression will be towards significant objects, and the higher the degree of negative influence on the forming ego. A significant portion of psychic energy, instead of being directed towards ego maturation, is expended on maintaining primitive defenses against affect. Using special techniques of modern psychoanalysis, it is possible to establish a strong emotional connection, reminiscent of the infant's attachment to the mother in the symbiotic phase. Such transferences revive in the therapeutic situation the emotional relationships of the first few years of life and thereby promote the restoration of the capacity for maturation [9].

Pre-oedipal patients, similar to infants with unsatisfied basic needs, may at the beginning of therapy demonstrate a habitual behavior pattern conducive to psychological and physical survival — exhibiting silence, idealizing the therapist. A common denominator when working with patients demonstrating primitive mental functioning is the difficulty for the therapist in containing strong countertransference feelings and impulses — the therapist may experience intense countertransference reactions, such as irritation, anger, boredom, anxiety, or helplessness [10].

The patient's narcissistic rage can be considered a phenomenon functionally similar to the infant's rage discussed above, and the therapist's ability to cope with it facilitates the patient's progress, the formation of a stable self-image, and an increase in the level of psychic functioning. The task of psychotherapy is to bring suppressed and repressed anger and rage into the therapeutic space, relieving the ego of the tension of the affect [11]. To accomplish this, it is important to be able to join, to form stable relationships, and then, based on a sufficient level of affective stability, to begin working ego-dystonically, to actualize repressed aggressive impulses.

Features of applying the technique

Joining is particularly suited for initial meetings with a patient and can be used in moments of strong affect, for example, when working with pronounced aggression, to reduce its escalation and move to exploration. This technique is especially relevant when working with borderline patients, for whom it is especially important to feel that the therapist is on their side. When working with hysterical and narcissistic patients, it is important to avoid both being captured by intense countertransference and becoming involved in the patient's acting out.

With a narcissistic patient, one can empathetically meet their grandiosity but

The joining technique may be compared to surfing, in which the psychotherapist "catches" the patient's dominant affect and, by balancing on it, moves beyond resistance.

monitor the degree of expressed admiration — if it is too strong, some patients may perceive it as manipulation. Hysterical patients may draw the therapist into their experiences. In response, for example, to the phrase from a gesticulating patient: “Can you imagine, he didn’t answer my message! What an idiot, right? Tell me, tell me he’s an idiot!” one can avoid dampening the drama and instead attune the intonation, try to name the feeling: “Of course, it’s infuriating when messages go unanswered!” — in order to accept the patient’s feelings but not become “infected” by them. It is not necessary to comply with the patient’s request — in this case, it could launch a new dramatic turn and prevent reaching exploration.

Illustrative vignette

Patient S. (26 years old) comes to sessions in a strong affect, devalues therapy, wants “immediate solutions.” It is important to maintain contact and avoid increasing the patient’s frustration.

Patient: *Well, what’s the point of all this? I come every time, I talk, and nothing changes! Why come if life is going to hell anyway?*

Therapist: *It’s very tiring when you’re waiting for something. You have remarkable endurance; many people would have given up long ago.*

Patient: *Yes! Exactly!*

Therapist: *You speak in such a way that I can directly feel that boiling point. Let’s try to decide together what to do next.*

In this case, the therapist reflects the intensity of the patient’s affective charge without lowering the temperature of their experience but also without escalating it. Here, a rapid response and explicit validation of the patient’s emotional experiences are important — a clinical position in which the therapist actively and consistently confirms the subjective reality of the patient’s experiences, without questioning them or offering immediate processing, interpretation, or frustration. The patient’s affect gradually subsides, and contact is restored. The patient later said: “For the first time, I felt that I wasn’t being calmed down or corrected, which usually infuriates me even more.”

The joining technique is not limited to the expression of empathy but presupposes the therapist’s ability to recognize and actively engage with the patient’s dominant affective experience. This technique constitutes the foundation of the therapeutic relationship, allowing resistance to be reduced, bridges to be built between different levels of experience, and the patient to be gently guided toward inner transformation.

Ego-dystonic and ego-syntonic joining

According to the theory of the psychoanalytic school of Hyman Spotnitz, the joining technique is capable of provoking a breakthrough of aggressive impulses, which is very important when working through narcissistic defenses to form narcissistic transference. The therapist can, depending on the patient, join either *ego-syntonically* (adopting the patient’s perspective and values, joining their feelings, temporarily aligning with the ego) or *ego-dystonically* — when the therapist also agrees, but in a paradoxical way (for example, hyperbolizing the introjected figure of the attacking superego or the grandiose ego). This initially leads to a strengthening of defenses, which may subsequently result in a breakthrough of restrained aggressive impulses and a resolution of resistance.

The unconscious signal from the therapist “I am just like you!” facilitates the formation of narcissistic transference, without which effective work with pre-oedipal issues is impossible. This intervention promotes a subjective experience of a reparative connection [12].

Examples of ego-syntonic joining

Patient: *I’m sure you’ve had at least a hundred patients like me. And for you, I’m just a simple nut. I wonder, in how many sessions will you be able to crack me?*

Therapist: *You have a unique taste in therapists and amazing intuition. I am a specialist in dealing with difficult cases and cracking hard nuts. Shall we estimate the number of sessions or let it be a pleasant surprise?*

P: *Frankly, I either don’t remember or don’t understand half of what you ask.*

T: *You know, sometimes I also feel like I don’t understand myself. Our work will definitely be productive, because we are so similar.*

P: *I’ve completely lost heart, and I don’t want to do anything at all.*

T: *I’m also completely drained today. Let’s not do anything and just sit here until the end of the session.*

For example, when a patient says: “I’m acting like an idiot, everything in my life is terrible, I’m always doing the wrong thing, I’m a complete idiot”—the therapist joins ego-dystonically: “Yes, it seems so. But don’t worry, I happen to be a specialist in human foolishness.” Joining the attacking superego position creates, for some part of the patient’s psyche, a sense of being understood (acknowledging that they might seem like an “idiot” to themselves), while on the other hand, it provokes anger and rage (“I didn’t expect to hear that from you, my therapist, you are cruel and unempathetic”). Thus, the therapist steps into the transference position of the bad object, which was cruel and attacking. Ego-syntonic joining in this clinical context may be less effective.

To a patient convinced that they are “*the most disgusting person in the world*,” the therapist can amplify this statement by saying they are “*the worst person who has ever existed*.” Typically, the patient acknowledges: yes, they really are as bad as they imagine, but at the same time, they feel uncomfortable hearing such words from a professional. Thus, this form of exaggerated ego-dystonic alignment (in ego-dystonic joining) has the effect of ultimately shifting the target of the attack from the ego toward the therapist [5].

Ego-syntonic joining is especially clinically justified when working with patients at a pre-oedipal level of personality organization, as well as in situations of pronounced anxiety, affective disorganization, and threat of rupture of therapeutic contact, as emphasized in a number of works on early forms of psychoanalytic therapy [13].

Examples of ego-dystonic joining

Patient: *I've completely despaired.*

Therapist: *Yes, it looks like you have nothing to hope for.*

P: *Your whole therapy is a complete farce! No benefit at all, just ripping off honest people!*

T: *I knew you were insightful, but to this extent... I really do love money.*

P: *I'm good for nothing, but at least on me you can write your dissertation!*

T: *You may be right, at least one of us will benefit in some way.*

Both formats of joining may be effective in situations of pronounced resistance to therapeutic progress in pre-oedipal patients, contributing to alliance strengthening and reinforcing narcissistic defenses, which paradoxically supports their gradual transformation over time.

Therapeutic change becomes possible when the therapist, consistently using both types of joining, functions as both a mirror and container for the patient's unbearable affects. By joining the patient's ambivalent messages and feelings, the psychotherapist introduces their own personality to the patient at a safe distance, until the ego develops.

Of course, the psychotherapist's work cannot be limited to this technique alone and represents a mixture of working interventions, among which joining is the basis and foundation for forming stable relationships and safety for the patient, therapist, and working space.

Figure 1 illustrates a process-oriented heuristic model of clinical decision-making when using the joining technique in psychotherapy. The model shows how the therapist, assessing the patient's affective and defensive presentation, chooses between ego-syntonic and ego-dystonic

forms of joining depending on the patient's subjective relationship to the presented content. The cyclical nature of clinical assessment, the significance of affective dynamics and resistance, as well as the necessity for constant monitoring of countertransference, therapy phase, and containment capabilities are emphasized. The presented scheme is conceptual in nature and is intended to support clinical thinking, rather than to provide an algorithmic procedure.

It should be emphasized that ego-syntonic and ego-dystonic joining are not mutually exclusive or mechanically alternating techniques. The choice of the form of joining is made by the therapist in the process of clinical work and is based on a set of factors, including the nature of the patient's affective presentation, features of resistance, the therapist's countertransference reactions, and the phase of the psychotherapeutic process. Thus, joining implies not a fixed technical device but dynamic clinical navigation between different forms of intervention depending on the current psychodynamic situation. The model presented in Figure 1 reflects the process of navigation between ego-syntonic and ego-dystonic forms of joining in the course of real psychotherapeutic work.

Within the proposed model, the distinction between ego-syntonic and ego-dystonic joining can be clarified from the perspective of the clinical function performed. In some cases, joining is aimed primarily at containing affect and reducing internal tension, supporting the integrity of the patient's ego. In other cases, joining is used as a means to provoke previously blocked affect, primarily aggressive, for its subsequent working through in the transference. Such a functional difference does not introduce a new typology but clarifies the mechanism of action of different forms of joining in the clinical process.

Using joining with silent patients

Working with silent patients represents a particular, yet clinically illustrative, case where the necessity for a differentiated choice of the form of joining is especially evident. Silence can perform various psychodynamic functions and requires different clinical tactics depending on the patient's affective state, the nature of resistance, and the phase of therapy.

Silence as a phenomenon in classical psychoanalytic practice has long been theoretically conceptualized, but its management in the past was limited to interpretive techniques, which rarely led to its resolution. Silence serves many purposes. From a defensive or conflictual perspective, silence may

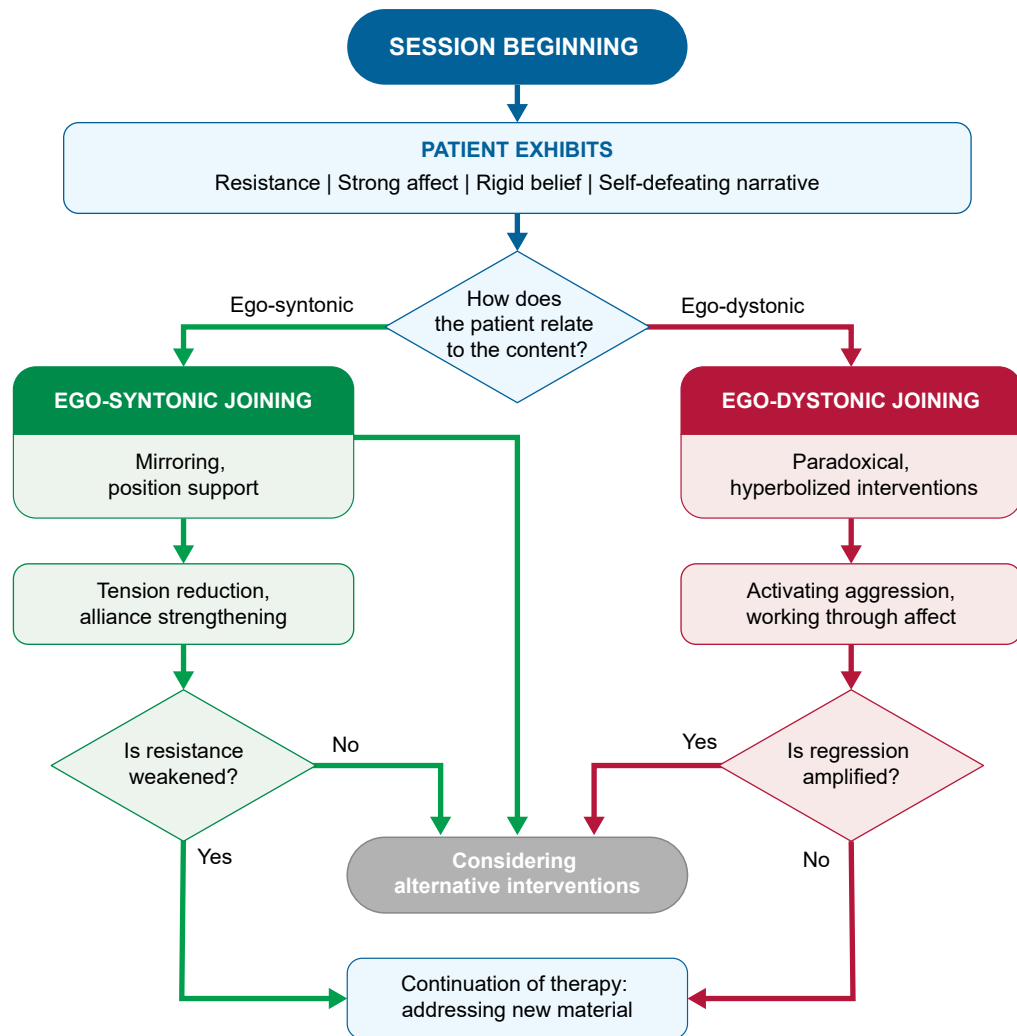


Figure 1. A process-oriented clinical decision-making model for ego-syntonic and ego-dystonic joining

signify anger, fear, despair, depression, contempt, and aggression [14]. The joining technique can be effective with such silent patients.

In individual work, one encounters silent patients whose silence is provocative or controlling, creating tension in the dyad. For example: “I don’t know what to say.” In this case, the therapist can join ego-syntonic and gently say: “You’ve already said enough, we can just be silent today.” Or, when the patient expresses themselves more aggressively, for example: “I don’t want to talk with you today,” the therapist can join ego-dystonic and say: “We are, after all, a harmonious pair, because I have no mood to listen to you today either.”

For group therapists, it will be useful to use joining with silent groups: “It seems this is a very caring group

that has decided to be silent today so I could rest. I’m completely fine with that, I also like this group’s choice.”

It is important here that the joining should be to the group as a whole, not to an individual member. This can promote group cohesion, for example, when participants do not communicate very well with each other or do not build connections well with one another.

Joining in relation to other psychoanalytic techniques

In practical work, joining is often identified with empathic mirroring, which can lead to methodological inaccuracies when choosing interventions, especially when working with patients at early levels of

personality organization. Comparison with the mirroring technique reveals differences in the logic of therapeutic action and the specificity of joining as an intervention oriented toward the active inclusion of resistance and affective dynamics into the therapeutic process. Comparing these approaches allows for a clearer delineation of the specificity of the joining technique, as well as avoiding its reduction to the general concept of empathic reflection. In this context, it is important to emphasize that this is not a comparison of psychoanalytic theories as a whole, but rather differences in clinical emphases and the logic of applying specific techniques when working with patients at early and primitive levels of personality organization.

Despite the external similarity of some clinical methods, the joining technique as understood by the modern psychoanalytic school of Spitz significantly differs from other psychoanalytic interventions aimed at working with early developmental disturbances. In particular, in clinical practice, the joining technique is often compared with the mirroring technique described by H. Kohut within self psychology. Both interventions rely on the therapist's empathic presence and sensitivity to the patient's subjective experience, yet they stem from different theoretical premises and are oriented toward different clinical tasks.

Table 1 presents a comparative description of the key clinical characteristics of the mirroring technique in H. Kohut's self psychology [15] and the joining technique in the modern psychoanalytic tradition of Spitz. The comparison is conducted along a number of parameters, including the clinical

focus of the intervention, attitude toward resistance, features of working with affect, the nature of transference, the role of countertransference, as well as typical clinical risks and target patient groups. Such a comparison demonstrates that, despite a common orientation toward early levels of mental functioning, these techniques differ in the direction of therapeutic impact: mirroring is primarily oriented toward stabilizing and maintaining the ego, whereas joining focuses on actively including resistance and aggressive affect in the therapeutic process. The presented table serves as a tool for the theoretical positioning of the joining technique and allows for a more precise determination of its place among other psychoanalytic interventions.

The presented comparison emphasizes that the differences between the mirroring technique and the joining technique lie not only in theoretical premises but also in the logic of clinical choice of interventions. Unlike mirroring, where the intervention is primarily oriented toward stabilizing the ego, joining presupposes constant clinical assessment of the form of resistance and the patient's affective dynamics, making flexible switching between ego-syntonic and ego-dystonic forms of work necessary. It is precisely this necessity for clinical navigation that underlies the decision-making model proposed in this article.

Clinical limitations and risks of applying the joining technique

Despite the clinical effectiveness of the joining technique when working with patients at a pre-oedipal level of personality organization, its

Aspect	Mirroring (Kohut, self psychology)	Joining (Spitz, modern psychoanalysis)
Clinical focus	Support and strengthening of the ego	Work with resistance and aggression
Attitude toward resistance	Minimization of frustration in early stages	Active inclusion of resistance in the process
Type of intervention	Empathic reflection of subjective experience	Ego-syntonic and ego-dystonic joining
Work with affect	Validation and gradual differentiation of affect	Containment and activation of aggressive affect
Transference	Narcissistic – mirroring, idealizing	Narcissistic – positive (including idealizing) or negative
Role of countertransference	Used to a limited extent	Is a key diagnostic indicator
Clinical risks	Maintaining dependency	Intense countertransference reactions
Typical patients	Ego disturbances, narcissistic structures	Pre-oedipal borderline, psychotic
Direction of therapeutic change	Gradual maturation of the ego	Transformation of self-aggression and resistance; resistance resolution; ego strengthening

Table 1. Comparative features of mirroring and joining techniques in psychoanalytic practice

application requires careful clinical differentiation. The use of joining outside appropriate clinical conditions or in an unsuitable phase of therapy can undermine the therapeutic process and lead to the intensification of pathological forms of functioning.

In a number of clinical situations, joining is capable of supporting symbiotic fixation, especially with insufficient differentiation between the ego and the object. In such cases, constant empathic joining can hinder the formation of boundaries and increase the patient's dependence on the therapist, slowing the process of psychic separation.

Another risk is the support of narcissistic grandiosity, when ego-syntonic joining is used without subsequent working through of aggressive and frustrating affects. In such situations, the technique can contribute to the reinforcement of defensive narcissistic structures instead of their transformation.

Furthermore, excessive or untimely use of joining can block the development of symbolization, especially if interventions replace analytic work with transference and interpretation. In this case, joining loses its auxiliary function and becomes a form of avoidance of more complex therapeutic interventions.

Particular attention is required regarding the application of the technique in different phases of the psychotherapeutic process. In the early stages of therapy, premature use of ego-dystonic joining can lead to patient disorganization and the destruction of the therapeutic alliance. In later phases of therapy, maintaining exclusively supportive ego-syntonic joining can hinder the transition to working through and integrating conflictual material. Thus, the clinical effectiveness of joining is determined not only by the choice of its form but also by the accuracy of assessing the therapeutic context and the patient's readiness for the corresponding level of intervention.

Considering the nature of transference when choosing the form of joining

The choice between ego-syntonic and ego-dystonic forms of joining is also determined by the nature of the forming transference and the degree of its affective stability. In situations where symbiotic expectations, idealization of the therapist, or pronounced dependence on the object predominate in the transference, ego-syntonic joining may be clinically justified only in the early stages of therapy and under the condition of its limited and conscious application. Otherwise, it can reinforce symbiotic fixation and hinder the development of the patient's autonomy.

In cases where the transference is fragile or disorganized and accompanied by pronounced anxiety, fear of destroying the object, or loss of

a basic sense of security, the use of ego-dystonic joining may be contraindicated. Premature provocation of aggressive affect in such transference patterns increases the risk of patient disorganization and disruption of the therapeutic alliance.

The use of the joining technique requires special caution when working with patients in states of pronounced disorganization, as well as with an insufficiently formed therapeutic alliance. In such cases, premature or uncritical application of joining can increase dependence on the therapist or serve as a form of avoidance of deeper analytic work, as emphasized in classic works on early developmental disturbances and the technique of psychoanalytic therapy [14].

Thus, the clinical appropriateness of one or another form of joining is determined not only by the nature of the patient's affective presentation but also by the current transference pattern, as well as the degree of its stability and the tolerability of aggressive impulses in the therapeutic field.

Conclusion

Clinical observations and accumulated practice indicate the significant therapeutic value of the joining technique, especially in work with patients at pre-oedipal borderline, and psychotic levels of functioning. Its application helps reduce self-destructive tendencies and contributes to a decrease in affective disorganization and the formation of stable narcissistic transference. The effectiveness of the technique is determined by the accuracy of psychopathological diagnosis, the flexibility of interventions, the authenticity of the therapist, and sensitivity to the patient's affective dynamics.

In group work, joining can both reduce the risks of acting out in individual pre-oedipal participants and in the group as a whole, as well as cause a directed increase in affective charge in "quiet" passive-aggressive groups. The joining technique makes it possible to translate aggression from acting out into symbolically mediated verbalization, which positively affects therapeutic relationships, enhances trust in the therapist, and promotes stabilization of the patient's mental state.

The model of clinical navigation between forms presented in the article does not claim to algorithmize the psychotherapeutic process but allows for the explication of the clinical logic of navigating between interventions when working with pre-oedipal patients.

The proposed model can be used in training novice psychotherapists as a tool for developing reflective clinical thinking. Explicating the criteria for choosing between forms of joining makes the

processes of therapeutic decision-making more transparent, processes that in clinical practice often remain implicit and are transmitted primarily through experience and supervision. In this sense, the model can serve as an auxiliary tool in an educational context, without replacing clinical experience.

A promising direction for further work is the empirical testing of the proposed model, as well as its further development and adaptation for use in the clinical training of psychotherapists. In a broader context, the model may be of interest for interdisciplinary research aimed at studying the mechanisms of affect regulation in therapeutic interaction.

References

1. Feldman Y. The early history of modern psychoanalysis. *Mod Psychoanal.* 1978;3:15–28.
2. Strean HS, editor. *New approaches in child guidance.* Metuchen (NJ): Scarecrow Press; 1970.
3. Sherman MH. Siding with the resistance versus interpretation: role implications. *Mod Psychoanal.* 2007;32(2):194–230.
4. Haley J. *Uncommon therapy: the psychiatric techniques of Milton H. Erickson, M.D.* New York (NY): W.W. Norton & Company; 1993.
5. Spontnitz H. *Modern psychoanalysis of the schizophrenic patient: theory of the technique.* 2nd ed. New York (NY): YBK Publishers; 2004.
6. Wang TS. A qualitative study into modern psychoanalytic joining and mirroring through psychotherapeutic exchanges [dissertation]. Pittsburgh (PA): Duquesne University; 2022. <https://dsc.duq.edu/etd/2215>.
7. Авдеева НН. Особенности материнского отношения и привязанность ребёнка к матери. *Психологическая наука и образование.* 2006;11(2):82–92.
8. Кернберг ОФ. Тяжёлые личностные расстройства: стратегии психотерапии. М: Независимая фирма «Класс»; 2000.
9. Федоров ЯО, Белов ЕН, Белова ЕБ, Клокова МВ, Шиканова ЕА. *Тотем без табу: психоанализ доэдипальных состояний.* Санкт-Петербург: ООО «ИПК «КОСТА»; 2017.
10. Verhülsdonk L, Petzold MB. Eine Untersuchung der Gegenübertragung in der psychosozialen Arbeit mit Geflüchteten. [German] *Forum Psychoanal.* 2024;40(3): 357–374. <https://doi.org/10.1007/s00451-024-00552-0>.
11. Bird J, Caligor E. A case report of the treatment of narcissistic personality disorder with transference focused psychotherapy. *Authorea.* 2023. <https://doi.org/10.22541/au.169228820.03736190/v1>.
12. Shechter A. The join and distinction-union: a resonant and complex oneness. *Eur J Psychoanal.* 2021;8(2). <https://www.journal-psychoanalysis.eu/articles/the-join-and-distinction-union-a-resonant-and-complex-oneness>.
13. McWilliams N. *Psychoanalytic diagnosis: understanding personality structure in the clinical process.* 2nd ed. New York (NY)/London (UK): The Guilford Press; 2011.
14. Лигнер Э. Ненависть, которая лечит: психологическая обратимость шизофрении. Ижевск: ERGO; 2014.
15. Кохут Х. *Анализ самости.* Москва: Когито-Центр; 2003.

Numinosity as a therapeutic factor: from symptom to symbol

Oksana V. Kuznetsova*

Academy of Integral Psychodynamic Psychotherapy, Moscow, Russia

Received: Dec 30, 2025

Accepted: Jan 22, 2026

Published: Mar 1, 2026

For citation:

Kuznetsova OV. Numinosity as a therapeutic factor: from symptom to symbol. *Psychotherapy Science Today*. 2(2):44–48. <https://doi.org/10.64435/ftcs7951>.



© Author(s), CC BY-NC 4.0

Abstract

The article explores the symbol as a key mediator between the symptom and unconscious processes in analytic psychotherapy. The symptom is considered not only as a manifestation of psychopathology but also as a symbolic expression of intrapersonal conflict and traumatic experience. The multi-layered nature of the symbol, its connection with archetypal and cultural images, and its role in the redistribution of psychic energy accumulated in symptoms and complexes are analyzed. The processes of symbolization and the method of amplification are considered as tools for revealing unconscious meanings and integrating the personality. Using an illustrative clinical vignette with mythological amplification, it is demonstrated how the experience of a symbol activates processes of transformation and individuation, contributing to psychic development and the restoration of personality integrity.

Keywords: symbol, symptom, mythological amplification, individuation.

The symbol itself is a bridge or connection between us and the mystery of existence; moreover, it expresses this connection through the images in which it is presented.

D. Kalsched

From the perspective of depth psychology, a symptom represents a symbolically organized form of psychic adaptation through which unconscious conflicts, traumatic experiences, and developmental deficits find expression and temporary stabilization within the personality structure. It acts as a compromise solution between consciousness and the unconscious, between the individual's instinctual needs and the psychological and existential needs of the personality [1, 2].

Typically, symptoms are produced by emotionally charged groups of ideas (or complexes), the source of which lies in the deep layers of the unconscious. Some complexes acquire an autonomous character and are expressed through bodily functional disturbances, which clinically manifest as psychosomatic disorders or neuroses.

In the late 19th century, Sigmund Freud and Josef Breuer suggested that neurotic symptoms (hysteria, certain types of pain, etc.) carry symbolic meaning. Like dreams, such symptoms are a form of expression of unconscious psychic processes and contain a certain symbolic load [3]. Thus, a patient encountering a psychologically unbearable situation (something that cannot

be “digested”) may develop a gastrointestinal symptom; a patient burdened by responsibility may develop back pain, etc. Therefore, a symptom can have symbolic significance, representing a particular case of the manifestation of a symbol. In this case, analytical work with the symbolic meaning of the symptom allows for the healing of the internal conflict, traumatic experiences, or other psychic contradictions that gave rise to the symptom. In many ethnic groups and cultures, ancient healing practices existed that included the analysis of symptom symbolism. An example of such a tradition is the ancient Greek Asclepieia — temples dedicated to Asclepius. To better understand the healing mechanism of working with symbols in psychotherapeutic practice, let us consider the nature of symbols.

Symbols are unique multi-level structures that connect the visible and the invisible. This concept is key to expressing ideas and realities not always amenable to verbal description. The etymology of this term reveals its unifying nature (symbol — “joined together” and “that which joins”).

A symbol is “the best possible expression or formulation of something as yet unknown” [4].

* E-mail: kzeniko@mail.ru.

Numerous attempts have been made in art, philosophy, and psychotherapy to comprehend the very concept of the symbol. As an independent aesthetic category, the symbol began to be considered at the end of the 18th century. Thus, J.W. Goethe and K.F. Moritz noted that the symbol must be distinguished from the image, the sign, and allegory. And G.W.F. Hegel returned to the concept of the symbol as a sign or image possessing meaning. Various ideas explaining the nature of the symbol were developed in the works of Schelling, Cassirer, Freud, Jung, Gadamer, Langer, and many other authors [5, 6].

C. G. Jung distinguishes between “natural” symbols and symbols introduced by culture. Regarding the origin of the former, he writes that they are infinite variations of basic archetypal images (their development can be traced by referring to the heritage of ancient cultures) [3, 7]. We can encounter these archetypal images when examining the cave paintings of ancient people, Egyptian hieroglyphic writing, or Sumerian cuneiform. Symbols introduced by culture (“cultural symbols”) have undergone numerous metamorphoses and have become collective images, part of universal human culture. Contemplating these images, a person often encounters the numinous, experiencing a powerful emotional resonance. Cultural symbols can still carry within them an archaic beginning, the “divine,” the “sacred.”

Jung notes that modern man has become captive to his rationalism, which has disrupted his ability to perceive divine symbols and ideas, *“delivering him to the mercy of the psychic underworld”; “...the moral and spiritual tradition has disintegrated..., leading to disorientation and disunity.”* [3]. The contact of modern man with nature has been interrupted, leading to the disappearance of the deep emotional (psychic) energy provided by this connection.

The process of symbolization is associated with the search for meaning and can become a valuable tool for a deep understanding of both intrapersonal and interpersonal processes, a kind of key to a deeper comprehension of reality. When we want to understand a symbol, we move from its external manifestation to its internal meaning. Each symbolic expression can provide access to new levels of understanding, making symbols inexhaustible in their meanings. Symbols represent a bridge between the material and the spiritual, the individual and the collective, allowing us to comprehend and interpret our experiences and ideas.

In analytical work, this movement from the external aspects of a symbol toward the search for

an inner meaning that is not immediately apparent becomes especially valuable. Analysis develops the ability to find this “invisible” and, at first glance, non-obvious reality behind the visible shell. The nature of symbols is polysemantic and inexhaustible. Any symbol can be interpreted in different contexts, revealing new facets of meaning.

The primary task of analytic work is to understand and “decipher” the symbolic message contained in the symptom. In cases of recognizing and accepting the symbolic meaning of a symptom, the conflict material it expresses is brought to the level of consciousness. This process is associated with the redistribution of psychic energy, which was previously accumulated in complexes manifesting through symptoms. Then, symbols can play the role of a kind of “energy transformer” through which psychic energy, previously bound in symptoms, can be integrated into life. The movement from symptom to symbol represents an important part of psychotherapeutic (analytical) dynamics [8–10].

Analytical work is not only the process of interpreting and elucidating symbolic material, but also an exploration of meanings associated with feelings and emotions, traumas and experiences, individual history, and collective memory. In the therapeutic context, symbols enrich the perception of reality. To symbolize means to seek the meaning that lies behind a particular situation. This exploratory, symbolizing function of the psyche manifests not only in symptoms and dreams, but also within the therapeutic process itself. Therefore, it is crucial for the analyst to attend to symbolic messages. What does the patient’s account of what he saw on the way to the session reveal about intrapsychic conflict? What do lateness, or conversely, the desire to begin the session a few minutes early, symbolize? What processes unfold in the patient’s inner life when the therapist announces an upcoming vacation? What is symbolized, repeated, or reenacted, perhaps decades later?

Work with symbolic material is effective when symbols not only become meaningful but are also emotionally experienced [9]. Marie-Louise von Franz considered archetypal experiences as the central healing factor in psychotherapy. Following Jung, she noted that if an analyst does not strive to recognize archetypal content in dreams, they, on the one hand, fail to notice the depth, and on the other hand — miss a stunning opportunity, since according to Jung, “archetypal experiences are sent to us by the unconscious, and then they are manifestations of grace”; archetypal experiences “... cannot be artificially induced.” [10].

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

Illustrative clinical vignette based on a real therapy case of a patient with a fear of public speaking

Anamnesis and symptoms

Patient S., 35 years old, manager, sought therapy with a request to overcome a disabling fear of public speaking that was blocking his professional advancement. The symptom, manifested somatically (tremor, hyperhidrosis, muscle tension) and cognitively (ideas of self-deprecation), first crystallized in adolescence in a situation of systematic public criticism from a teacher. Despite academic success, the patient developed a stable association between the act of self-presentation before an audience and the existential risk of annihilation.

Symbol dynamics and the therapeutic process

Through the application of Katathymic-Imaginative Psychotherapy (Symbol drama),* the patient was asked to imagine fear in the form of any image his imagination would draw. The symptom was personified in a spontaneous image of a grotesque “Giantess,”** dominating the space and causing the patient to experience a state of regressive childhood terror. In the imaginal process, the patient envisioned himself as a small boy aged five to six. The figure of the “giantess” was constellated by the image of an authoritarian grandmother and was associated with a repressed childhood episode of humiliating coercion to perform publicly. Initial interpretation allowed linking the current fear with personal history, deconstructing projections onto authority figures.

A turning point in therapy occurred at the stage of archetypal amplification of this image. Rather than further analysis of personal trauma, the therapeutic focus was shifted to investigating the “Giantess” as a carrier of a universal mythological motif. Through reference to the cross-cultural mythologem of the Devouring Mother (Kali, Baba Yaga), the patient was invited to consider his image in the context of an archetypal encounter with the numinous.

During guided imagery, the patient entered into a dialogue with the image. He found the strength to look at the “Giantess,” overcoming his fear. Gradually, the image of the small boy began to change, and within the imagery the patient started to experience himself at his actual present age.

Suddenly, in the course of this interaction, the visual representation of the “Giantess” underwent a spontaneous transformation: her frightening features softened, and instead of a threatening gesture, a bundle of keys appeared in her hands. The keys were forged from metal, and some of them bore ancient inscriptions.

The patient reported a powerful ambivalent experience: overwhelming fear was replaced by a profound, almost sacred awe. He described it as an encounter not with a personal persecutor, but with an ancient, impersonal force that “does not so much want to destroy as to guard some ancient secret and is now capable of granting access to that secret.”

The appearance of the keys points to the ambivalent nature of the Mother archetype: simultaneously destructive and generative, devouring and life-giving. This moment was described by the patient as the most significant and energetically charged experience of the entire therapy — a classic manifestation of numinous experience.

Integration and transformation

Subsequent analytical work was devoted to the integration of this experience. The keys were interpreted as a gift from the “Giantess,” who no longer appeared as threatening or frightening to the patient. These keys symbolized new possibilities for the patient, indicating that the psychic energy previously bound in the traumatic symptom and the negative maternal complex was being released and made available for the process of individuation.

* Katathym-Imaginative Psychotherapy (Symbol drama) is a depth-oriented psychotherapeutic approach developed by the German psychotherapist Hanscarl Leuner in the 1950s based on ideas from psychoanalysis and Jungian psychology, in which unconscious material is revealed and processed through directed work with images and symbols in a state of katathymic imagination.

** The American psychoanalyst Bruno Bettelheim, in his work *The Uses of Enchantment: The Meaning and Importance of Fairy Tales*, suggests that this is precisely how young children perceive their parents — in the form of giants. In many fairy-tale plots, children defeat giants, become capable of outwitting them, and take possession of their resources (that is, they grow up, become big, become adults).

The patient began to spontaneously employ the metaphor of keys opening new doors to describe the presentation of new projects and the permission he gave himself to speak clearly, confidently, and with expressive freedom. The metaphor of keys recurred several times throughout the therapy: the key that can close something (renunciation of negative patterns and behavioral programs), the key that opens new possibilities, and the key as a resource — a key understood as a spring emerging from the ground.

Follow-up

Upon completion of the therapy course, the patient not only successfully handled work presentations but also voluntarily engaged in activities requiring public speaking. He reported that speeches ceased to be a battlefield where he was a victim and became a “meeting place” for exchange. The therapeutic process resulted not merely in symptom reduction, but in a shift in the patient’s life position from a defensive to a proactive stance.

Analytical commentary: working with the symbol, interventions and key emphases

The presented case demonstrates the evolution of therapeutic work from the level of the personal unconscious (trauma) to the level of the collective unconscious (archetype), where genuine symbolic experience becomes possible. Key interventions that shifted the process into this plane can be identified:

Transition from image analysis to symbol amplification. As C.G. Jung emphasized, a symbol is not a sign denoting something known (such as the image of a trauma), but rather “the best possible expression of something yet unknown” (an archetype). Amplification extends personal material into the collective, providing fertile ground for a numinous experience.

- The symbol of the keys as a gift indicates the activation of the individuation process, wherein psychic energy is redirected from serving a complex (fear) toward serving the wholeness of the personality. The ambivalence of the numinous experience highlights the transcendent function of the symbol as a mediator between opposites.
- The numinous experience (“awe mingled with the sacred”) represents the cornerstone of transformative experience. It possesses a healing potency in itself, as it directly connects the ego with archetypal energy.
- Integration through a “living” metaphor: the bundle of keys that opens doors to new possibilities. This corresponds to the Jungian understanding of the symbol as an energy transformer. A symbol does not merely signify; it acts within the psyche — redistributing energy. The patient began to utilize energy previously blocked in fear for creative self-expression, which exemplifies the aim of the analytic process: not adaptation through suppression, but transformation through integration.

Thus, the therapeutic effectiveness in this case was achieved not through working through the trauma (although this constituted a necessary foundation), but through a conscious focus on the symbol. The therapist created conditions in which a personal image, having undergone amplification, revealed itself as a window into the collective unconscious, allowing the patient to experience a numinous encounter. It was precisely this experience, rather than cognitive understanding, that became the catalyst for a profound reorientation of the psyche — from the patterns of the past (trauma) toward the potential of the future (individuation).

The living energy, healing power, and archaic potency of a symbol are released only through its holistic sensory-emotional experience. Symbols are categories of “condensation”: a symbol “binds” within itself a whole series of associations, but in connection with the need for certainty, this irritates

us, and in connection with the need for mystery and meaningfulness, it is experienced as a treasure [9].

The method of amplification* — is one of the key tools in Jungian psychology, allowing for a deeper understanding of personal symptoms by linking them to archetypal figures and mythological

* Mythological amplification is the clarification and clarification of individual images in dreams and products of visual creativity (drawings, painting, sculpture, sandplay, etc.) with the help of direct association and in accordance with the data of the humanities (symbolism, mythology, mysticism, folklore, history of religion, ethnology, etc.) [4].

narratives. Engaging with this material provides an opportunity to uncover deep psychological patterns and recognize their universal significance. The identification of the relevant myth constitutes the first step on this path. The next stage involves recognizing and interpreting the archetypal core of the symbolic meaning underlying both the symptom and the myth. It unites individual experiences and archetypal motifs and also becomes the basis for understanding the symptom and its roots. The final stage of this work is the return and application of the found, realized meaning in the individual's life, which promotes the integration of various aspects of the personality and is a necessary condition for achieving wholeness.

Through analytical work with symbolic material, not only current difficulties and internal obstacles arising on the path are revealed, but prospects and possibilities for development also become visible. The symbol unfolds the psyche in the direction of the future, both in the therapeutic process and in real life. Through the symbolic, the process of individuation is revealed. "The symbol remains an eternal challenge to our thoughts and feelings. Perhaps this explains the stimulating nature of symbolic work, why it captivates us so intensely" [7].

Thus, the transition from symptom to symbol in analytical work opens the way to genuine healing, allowing not simply to eliminate the manifestation of conflict but to integrate its energy into the integral structure of the personality. The

symbol, being alive and multifaceted, contributes to the restoration of the subject's connection with the archetypal and deep layers of the psyche, overcoming the rupture caused by excessive rationalism. Through the emotional experience and amplification of symbolic material, the patient gains not only an understanding of their internal processes but also an orientation toward the future, revealing the potential for individuation. In this regard, the symbol remains an enduring source of meaning and transformation, reminding us that behind every symptom lies an impulse toward wholeness and the integration of the personality.

References

1. Roesler C. Theoretical foundations of analytical psychology: recent developments and controversies. *J Anal Psychol.* 2019;64(5):669–81. <https://doi.org/10.1111/1468-5922.12540>.
2. Калшед Д. Внутренний мир травмы: архетипические защиты личностного духа. М.: Когито-Центр; 2015.
3. Юнг КГ. Человек и его символы. М.: АСТ; 2020.
4. Araujo S. The symbol theory in S. Freud, C.G. Jung and C.S. Peirce. *Int J Jungian Stud.* 2017;9(2):92–105.
5. Зеленский ВВ. Толковый словарь по аналитической психологии. М.: Когито-Центр; 2008.
6. Jones R. Dialectics of sign and symbol and the utterance of archetype theory. *J Anal Psychol.* 2023;68(4):1–19. <https://doi.org/10.1111/1468-5922.12942>.
7. Юнг КГ. Архетип и символ. М.: Ренессанс; 1991.
8. Regovec M. *Cogito Alchymicum*. Zurich: Spring Journal Books; 2025.
9. Каст В. Динамика символов: основы юнгианской психотерапии. М.: Центр гуманитарных инициатив; 2020.
10. фон Франц МЛ. Кошка: сказка об освобождении феминности. М.: Класс; 2007.

Resilience and quality of life after upper limb injuries: the role of age within the ICF biopsychosocial model

Sofia Paulina Salvador Espín¹, Anna Isabel Costales Zavgorodniaya^{2,*}

¹ Sofi Physiotherapy Center, Quito, Ecuador.

² University of the Hemispheres, Quito, Ecuador.

Abstract

Objective: To identify age-related differences in resilience and subjective quality of life among patients after upper limb injuries, in the context of personal factors within the International Classification of Functioning, Disability and Health (ICF).

Method: A cross-sectional study involved 22 patients from a specialized hand therapy center. The WHO Quality of Life-BREF (WHOQOL-BREF) questionnaire and the Wagnild and Young Resilience Scale (RS) were used. For comparison across three age groups (" < 24 years", " $25-40$ years", " > 40 years"), the non-parametric Kruskal–Wallis test was applied. Additionally, an analysis of individual items of the RS scale was conducted.

Results: Statistically significant differences were found between age groups in the Psychological Health domain ($p = 0.05$). The highest subjective well-being in this area was recorded among patients aged 25–40 years. Trends toward age-related differences were observed in the Physical Health domain (increasing with age) and the Social Relationships domain (peaking in the middle-aged group). Analysis of RS scale items revealed that the most pronounced age differences concerned aspects related to self-reliance.

Conclusions: The results indicate a non-linear relationship between age and various aspects of adaptation. Young patients (< 24 years) demonstrate lower levels of psychological well-being and self-reliance. At the same time, the subjective assessment of physical health is higher among older patients. These findings underscore the importance of considering age-related and psychological factors for personalizing rehabilitation programs within the ICF model.

Keywords: resilience, quality of life, specialized hand therapy, upper limb injury rehabilitation, ICF.

Received: Apr 16, 2025

Accepted: Aug 19, 2025

Published: Mar 1, 2026

For citation:

Salvador Espín SP,
Costales Zavgorodniaya AI.
Resilience and quality of life
after upper limb injuries:
the role of age within the
ICF biopsychosocial model.
Psychotherapy Science Today.
2(2):49–54. <https://doi.org/10.64435/zddr6062>.



© Author(s), CC BY-NC 4.0

Introduction

The International Classification of Functioning, Disability and Health (ICF), developed by the World Health Organization (WHO), is a conceptual framework for understanding functioning, disability, and health in modern healthcare. This classification offers a biopsychosocial approach, considering the interaction of biological, psychological, social, and environmental factors [1] and serves as a universal standard for collecting, analyzing, and developing health-related policies [2]. However, despite the central role of personal factors in the ICF model, they remain the least formalized and clinically utilized component, particularly in orthopedic rehabilitation.

Injuries to the upper limbs, especially the hand, often lead not only to physical limitations but

also to significant psychological distress, reducing patients' quality of life. An integrative review by Maddison et al. identified a high prevalence of mental disorders among individuals with such injuries: depression is observed in 7–71% of patients, anxiety in 23–71%, and post-traumatic stress disorder in 3–95% [3]. Key risk factors for adverse psychological outcomes are injury severity, chronic pain, limb dysfunction, negative perception of the injured hand, ineffective coping mechanisms, and limited social support. These mental symptoms can persist long-term, although they typically diminish three months post-injury. A systematic review by Ghițan et al. emphasizes the significant psychological impact of complex

* Corresponding author, e-mail: annacostales@gmail.com.

Resilience acts as a factor that modifies the impact of injury severity on functional and subjective outcomes.

hand injuries on patients and strongly recommends an interdisciplinary approach combining physical rehabilitation with psychological support to achieve optimal functional and emotional outcomes [4].

In recent decades, an important paradigmatic shift has occurred in psychology: from a model emphasizing risks, trauma, and psychopathology to a preventive model focused on resources, potential, and personal strengths. The central construct of this model became resilience — the ability of an individual to withstand life's adversities, overcome them, and to be positively transformed by them. Resilience is viewed as a dynamic process dependent on the interaction of internal resources (personality traits, cognitive strategies) and external factors (social support, cultural context). It serves a protective function, mitigating the consequences of stress and transforming threats into opportunities for growth [5]. Empirical data confirm that higher levels of resilience are associated with better mental health outcomes post-injury [6], more successful outcomes of orthopedic hand surgeries [7], reduced psychological burden from severe injuries [8], and improved long-term quality of life in elderly patients after trauma [9]. These studies indicate that resilience not only correlates with well-being but also modifies the impact of injury severity on functional and subjective rehabilitation outcomes. It is a key factor influencing the trajectory of recovery.

Quality of life, as defined by the WHO, represents an individual's perception of their position in life in the context of culture, value systems, personal goals, expectations, and interests [10]. This multidimensional concept includes both objective (physical functioning, economic resources) and subjective aspects (emotional well-being, relationship satisfaction) [11]. In the context of upper limb injury rehabilitation, quality of life is an integral indicator, and specialized hand therapy contributes to its improvement by reducing pain, restoring functionality, and facilitating social reintegration [12, 13]. However, the effectiveness of such interventions varies depending on the patient's individual psychological resources, highlighting the need for a personalized approach that considers resilience and age-related characteristics.

The objective of this pilot study is to assess and compare levels of resilience and quality of life among patients who have suffered upper limb injuries and undergone a course of specialized hand therapy, while accounting for age differences within the framework of the ICF biopsychosocial model.

Methods

Design and Ethics

The study was conducted as a quantitative, comparative, cross-sectional investigation from October 2023 to April 2024. The procedure adhered to the Helsinki Declaration, the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association [14], and the Ministry of Health of Ecuador's Code of Ethics. All participants provided informed consent.

Participants

The sample consisted of 22 patients from a specialized hand therapy center in Quito, Ecuador. Inclusion criteria were: an upper limb injury, completion of a hand therapy course, age over 18 years, and voluntary consent.

Instruments

1. Wagnild and Young Resilience Scale (RS) — assesses overall resilience and two factors: "Personal Competence" and "Acceptance of Self and Life" [15].
2. World Health Organization Quality of Life-BREF (WHOQOL-BREF) questionnaire — contains 26 questions assessing quality of life across four domains: physical health, psychological health, social relationships, and environment.
3. Clinical Classification Scale for Injury Severity: To stratify injury severity, a clinical classification scale developed by the authors based on commonly accepted criteria for assessing upper limb function was used. It considers characteristics such as neuropathic or dissociative pain, deep sensory loss or severe impairments, complete dysfunction in functional tasks, and the need for an interdisciplinary approach (medical, physical, and occupational therapy, psychology). This scale is based on commonly accepted clinical criteria for upper limb evaluation [16–18] and proposes the following levels:
 - Level 0 — No functional impairment: Full and symmetrical range of motion; absence of pain or sensory disturbances; normal strength and coordination; complete independence in daily functional activities.
 - Level 1 — Mild injury: Mild or intermittent pain; minor limitations in mobility or strength; minimal impairments in fine or repetitive movements; ability to perform daily activities, albeit with compensatory techniques.
 - Level 2 — Moderate injury: Persistent or localized pain, partially interfering; reduced

strength and/or joint range of motion by 25 to 50%; moderate sensory impairments; difficulties performing daily activities without assistance or adaptation; active therapy is required to restore function.

- Level 3 — Severe injury: Pronounced or limiting pain; limitation of movement or strength exceeding 50%; significant sensory impairments; inability to perform basic daily activities without assistance; presence of edema, atrophy, or significant stiffness; possible use of splints, orthoses, or assistive devices.
- Level 4 — Critical or complex injury: Absence of voluntary movement in key segments or the entire limb.

Data Processing and Analysis

Data were coded and processed in Statgraphics Centurion. Descriptive statistics methods were used. For comparing the three independent age groups (“< 24 years”, “25–40 years”, “> 40 years”) across resilience and quality of life indicators, and, due to non-normal distribution, the non-parametric Kruskal–Wallis H test was applied. The level of statistical significance was set at $p < 0.05$.

Results

Sociodemographic Characteristics

The sample was divided into three age groups: under 24 years ($n = 6$), 25–40 years ($n = 7$), and over 40 years ($n = 9$). The groups were comparable in terms of gender. The majority of participants had secondary specialized or higher education. Socioeconomic status and marital status varied with age, reflecting expected demographic differences.

Age-Related Differences in Quality of Life

As shown in Table 2, the only indicator for which statistically significant differences were found between age groups was the Psychological Health domain ($H = 5.99$; $p = 0.05$). The highest median score was recorded in the 25–40 years group (24 points), while it was minimal in the youngest group (18 points).

For the Physical Health ($p = 0.11$) and Social Relationships ($p = 0.16$) domains, differences did not reach the level of statistical significance, although a trend toward higher scores with age was observed. No significant differences or trends were identified for other quality of life indicators.

Analysis of Resilience Aspects

Within the study, a comparative analysis of responses to items of the Wagnild and Young

Resilience Scale (RS) was conducted. The analysis revealed that the most pronounced age differences concerned items thematically related to self-reliance and confidence in one’s own abilities. Non-parametric analysis of these items showed a statistically significant difference between groups ($H = 5.82$; $p = 0.05$): median values were lower in the under 24 years group (10 points) compared to the 25–40 years and over 40 years groups (12 points each), indicating a lower level of self-reliance among young patients. For other thematic aspects of resilience, such as perseverance or meaningfulness, such distinct differences were not found.

Summary Effect of Age

Collectively, the obtained data indicate that age-related differences in patients after hand injuries are most pronounced in subjective psychological well-being (quality of life) and in the psychological resource of self-reliance as a psychological component of resilience.

Discussion and Conclusions

This pilot study revealed several age-related patterns in the subjective quality of life and psychological resources of patients who have suffered upper limb injuries. A key result was the discovery of statistically significant differences in the Psychological Health domain (WHOQOL-BREF), with the highest scores characteristic of the 25–40 years group. This age period, often marked by peak professional and social activity, likely provides greater access to coping resources, goal-setting, and social support, which mitigates the psychological impact of injury [3, 6]. These findings are consistent with studies indicating that psychological well-being depends non-linearly on age and is mediated by current life circumstances and resources [9].

Of particular interest is the differentiated age-related dynamics of other aspects of quality of life. Although indicators for the Physical Health and Social Relationships domains did not reach statistical significance, they show divergent trends. The subjective assessment of physical health increased in older groups, reaching a maximum in patients over 40 years. This result may be explained by the phenomenon of shifting internal evaluation standards: having greater life experience and possibly other concomitant age-related changes, older patients may assess the consequences of injury less critically in comparison to their overall physical condition [11]. At the same time, social relationship scores were highest in the middle-aged group (25–40 years), which likely reflects the peak of social activity and engagement at this age. A slight

Diagnosis	ICD-10	Injury Severity Level	Time from Injury to Start of Physiotherapy	Surgical Intervention	Conservative Therapy	Duration of Rehabilitation (Sessions)	Dominant Hand	Non-Dominant Hand
Injury of multiple flexor muscles and tendons at wrist and hand level	S66.6	4	5 days	■	□	1	■	□
Carpal tunnel syndrome	G56.0	1	3 weeks	□	■	15	■	□
Fracture of lower end of radius	S52.5	2	3 days	■	□	20	■	□
Dislocation, sprain and strain of joints and ligaments at wrist and hand level	S63	2	5 days	□	■	10	■	□
Contusion of finger(s) without damage to nail	S60.0	0	1 day	□	■	5	■	□
Carpal tunnel syndrome of left hand	G56.0	2	7 days	□	■	10	■	□
Spontaneous rupture of extensor tendons	M66.2	3	1 day	■	□	30	■	□
Traumatic rupture of ligament of wrist and carpus	S63.3	2	15 days	□	■	10	■	□
Traumatic rupture of ligament of wrist and carpus	S63.3	2	4 weeks	■	□	15	□	■
Fracture of lower end of radius	S52.5	2	6 weeks	□	■	5	■	□
Fracture of shaft of radius	S52.3	0	1 day	□	■	10	■	□
Other instability of joint	M25.3	0	1 day	□	■	10	■	□
Carpal tunnel syndrome	G56.0	2	5 days	□	■	10	■	□
Nonunion of fracture (pseudarthrosis)	M84.1	3	5 days	■	□	20	■	□
Fracture of other metacarpal bone	S62.3	3	5 days	■	□	20	■	□
Traumatic amputation of finger(s) (partial)	S68.2	4	1 day	■	□	40	■	□
Sequelae of fracture at wrist and hand level	T92.2	4	1 day	■	□	40	■	□
Carpal tunnel syndrome	G56.0	1	10 days	■	□	20	■	□
Fracture of first metacarpal bone, left hand	S62.2	2	3 days	■	□	20	■	□
Other instability of joint	M25.3	3	7 days	■	□	20	■	□
Fracture of shaft of ulna	S52.2	2	7 days	■	□	20	■	□
Malunion of fracture	M84.0	2	1 day	■	□	20	■	□
Fracture of other finger	S62.6	2	1 day	■	□	20	■	□
Ganglion of right wrist	M67.431	1	15 days	■	□	10	□	■
Ganglion of left wrist	M67.432	1	15 days	■	□	15	■	□
Injury of multiple flexor muscles and tendons at wrist and hand level	S66.6	2	1 day	■	□	15	■	□
Stiffness of joint, not elsewhere classified, 4th finger, right hand	M25.6	3	6 weeks	□	■	10	■	□
Fracture of other finger	S62.6	0	5 days	□	■	1	■	□

Note: Data are presented in accordance with ICD-10 criteria.

Table 1. Participating patients' data according to ICD-10 criteria

Variables	Medians			Kruskal-Wallis Test Statistic	P-value
	< 24	25–40	> 40		
Overall perception of QoL	4	4	5	0.86	0.65
Overall perception of health	3	3	4	3.40	0.18
Physical Health	24	27	28	4.44	0.11
Psychological Health	18	24	22	5.99	0.05*
Social Relationships	31	41	39.5	3.70	0.16
Environment	4	4	4	0.02	0.99

* $p < 0.05$. Domain scores (domains 1–4) are presented as points according to the standard WHOQOL-BREF scoring procedure.

Table 2. Quality of Life Indicators (WHOQOL-BREF) Across Different Age Groups

decrease in this indicator in the >40 years group may indicate a natural age-related trend towards greater selectivity in social contacts.

Additional analysis of items from the Wagnild and Young Resilience Scale, focused on aspects of self-reliance, also revealed age-related differences. Lower scores on this group of items among patients under 24 years may reflect an age-related feature of developing personal autonomy and confidence in one's own abilities during a crisis caused by injury. Consistently high scores in groups over 25 years are consistent with a model of psychological development suggesting growth in self-reliance and the ability to rely on internal resources with age and experience [5]. It is important to emphasize that other aspects of resilience (e.g., perseverance, meaningfulness) did not show pronounced differences, which may indicate the relative stability of the basic capacity for adaptation in this sample.

A limitation of the study is the small size and clinical heterogeneity of the sample, which precludes generalizing the findings to the broader population and requires caution in interpretation, especially regarding findings that did not reach statistical significance. Nevertheless, the obtained results have important practical significance. They point to the need for a differentiated approach in rehabilitation: for young patients (<24 years), the program can be supplemented with elements aimed at strengthening feelings of self-reliance and psychological support. For middle-aged patients, work on maintaining high social engagement as a recovery resource may be relevant. In the older age group, formed adaptation skills and a realistic assessment of capabilities can be used to personalize rehabilitation.

Conclusions drawn from this pilot study underscore the value of integrating quality of life assessment and specific psychological resources (resilience) into the clinical practice of

rehabilitation. This allows for not only evaluating functional treatment outcomes but also identifying targets for psychosocial intervention within the holistic ICF biopsychosocial model, contributing to the development of more personalized and effective rehabilitation strategies.

Conclusion

The present study demonstrates the informativeness of assessing resilience and quality of life in patients after upper limb injuries. The results highlight the presence of age-related differences in psychological adaptation and subjective well-being: young patients (<24 years) are characterized by lower levels of self-reliance and psychological health, whereas patients in middle and older age groups exhibit higher values for these indicators. The obtained data justify the need to integrate psychological assessment tools, such as the resilience scale and WHOQOL-BREF, into interdisciplinary rehabilitation practice. This approach allows for identifying key psychological resources and forming personalized recovery strategies, thereby enhancing therapy effectiveness and patients' quality of life.

Conflict of Interest Statement

The authors declare no conflict of interest. The study did not receive external funding.

References

1. World Health Organization. International classification of functioning, disability and health (ICF). Geneva: WHO; 2002. <https://cdn.who.int/media/docs/default-source/classification/icf/icfbeginnersguide.pdf>.
2. Fernández-López JA, Fernández-Fidalgo M, Reed G, Gerold S, Cieza A. Funcionamiento y discapacidad: la clasificación internacional del funcionamiento (CIF). [Spanish]. Rev Esp Salud Publica. 2009;83(6):775–783. http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1135-5727200900060002&lng=es&tlng=es.

3. Maddison K, Perry L, Debono D. Psychological sequelae of hand injuries: an integrative review. *J Hand Surg Eur Vol.* 2023;48(1):33–40. <https://doi.org/10.1177/17531934221117429>.
4. Ghișan AF, Gheorman V, Pîrvu D, Gheorman V, Udriștoiu I, Ciurea ME. A review of psychological outcomes in patients with complex hand trauma: a multidisciplinary approach. *Curr Health Sci J.* 2023;49(2):143–150. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10541061>.
5. Quiñones Rodríguez MA. Creatividad y resiliencia: análisis de 13 casos colombianos [dissertation in Spanish]. Madrid: Universidad Autónoma de Madrid; 2006. <http://hdl.handle.net/10486/2631>.
6. Zarzaur BL, Bell TM, Zanskas SA. Resiliency and quality of life trajectories after injury. *J Trauma Acute Care Surg.* 2017;82(5):939–945. <https://doi.org/10.1097/TA.0000000000001415>.
7. Anderson JC, Milam RJ, Drayer NJ, Zalneraitis BH, Hood DK, Shin EH, Kang DG. Resilience and patient-reported outcomes in patients undergoing orthopedic hand surgery. *HAND.* 2025;20(2):305–311. <https://doi.org/10.1177/15589447231201872>.
8. Werner D, Alawi SA. Hand Bionic Score: a clinical follow-up study of severe hand injuries and development of a recommendation score to supply bionic prosthesis. *Eur J Plast Surg.* 2021;44(1):81–96. <https://doi.org/10.1007/s00238-020-01679-z>.
9. Reitan I, Dahlin LB, Rosberg HE. Patient-reported quality of life and hand disability in elderly patients after a traumatic hand injury – a retrospective study. *Health Qual Life Outcomes.* 2019;17:148. <https://doi.org/10.1186/s12955-019-1215-9>.
10. World Health Organization. WHOQOL: measuring quality of life. Geneva: WHO; 1997. <https://iris.who.int/handle/10665/63482>.
11. Urzúa A, Caqueo-Úrizar A. Calidad de vida: una revisión teórica del concepto. [Spanish] *Terapia Psicológica.* 2012;30(1):61–71. <https://doi.org/10.4067/S0718-48082012000100006>.
12. Yeo S, Soro NM, Mobiot-Aka C, Ta Bi DW, Traoré A. Qualité de vie après un traumatisme grave de la main: à propos de 36 cas. [French] *Ann Chir Plast Esthet.* 2023;68(3):218–221. <https://doi.org/10.1016/j.anplas.2022.10.005>.
13. John R, Verma CV. Changes in the health status and functional outcomes in acute traumatic hand injury patients, during physical therapy treatment. *Indian J Plast Surg.* 2011;44(2):362–367. <https://doi.org/10.4103/0970-0358.85358>.
14. American Psychological Association. Ethical Principles of Psychologists and Code of Conduct. Washington (DC): APA; 2018. <https://www.apa.org/ethics/code>.
15. Wagnild GM, Young HM. Development and psychometric evaluation of the Resilience Scale. *J Nurs Meas.* 1993;1(2):165–178.
16. Hudak PL, Amadio PC, Bombardier C, et al. Development of an upper extremity outcome measure: the DASH (Disabilities of the Arm, Shoulder and Hand). *Am J Ind Med.* 1996;29(6):602–608. [https://doi.org/10.1002/\(SICI\)1097-0274\(199606\)29:6<602::AID-AJIM4>3.0.CO;2-L](https://doi.org/10.1002/(SICI)1097-0274(199606)29:6<602::AID-AJIM4>3.0.CO;2-L).
17. Parker SL, Jebson PJL. Evaluation of hand function. In: Skirven TM, Osterman AL, Fedorczyk JM, Amadio PC, editors. *Rehabilitation of the hand and upper extremity.* 6th ed. Philadelphia: Elsevier; 2011.
18. Michlovitz SL, Bellew JW. Modalities for therapeutic intervention. Philadelphia: F.A. Davis; 2012.

Disturbances of self-concept in young adults exposed to psychological traumatization as targets for psychotherapeutic intervention

Anna G. Faustova*, Margarita O. Safronova

Department of Clinical Psychology, Faculty of Clinical Psychology,
Ryazan State Medical University named after Academician I. P. Pavlov, Ryazan, Russia

Abstract

Objective: This pilot study aims to identify disturbances of self-concept in young adults exposed to psychological traumatization to determine potential targets for psychotherapeutic interventions focused on correcting personality functioning.

Methods: The sample consisted of 51 individuals aged 18–23 years, with a mean age of 19.255 ± 1.214 , including 28 females and 23 males. The differentiation criterion was the results of the Life Experiences Questionnaire (LEQ): the experimental group included 22 participants who had experienced psychological traumatization of various origins (natural disasters, domestic violence, road traffic accidents, robberies), and the control group included 29 participants with no history of psychological traumatization. The following instruments were used: *Self-Concept Clarity Scale (SCCS)*; *the Self-Image Variability Assessment*; the classical version of *the Dembo-Rubinstein Self-Esteem Test*; *the Self-Attitude Questionnaire*; and *the Behavioral Self-Regulation Style Questionnaire (BSSQ)*. For statistical analysis, the Mann-Whitney U test and Spearman's rank correlation coefficient (r) were applied.

Results: The level of self-concept clarity in young adults exposed to psychological traumatization is significantly lower than in those who have not encountered traumatic experiences; they also demonstrate an undifferentiated variability of self-image. The experimental sample is characterized by moderately formed self-representation, relative consistency of its components, and stability over time. They also show medium and low values of the general level of self-regulation, which may indicate the negative impact of psychological traumatization on self-regulation mechanisms. Half of the respondents from the experimental sample exhibit a pronounced feeling “for oneself”, indicating their ability to withstand negative influences and maintain a positive attitude towards themselves. The other half experiences the opposite feeling — “against oneself”. This may be related to exposure to more serious psychological traumas that evoke negative emotions and doubts about their own worth.

Conclusions: The formation and strengthening of positive self-attitude, increasing the clarity of self-concept, and training self-regulation skills are important components in psychotherapeutic work with the consequences of psychologically traumatic events.

Keywords: Self-concept, young adulthood, targets for psychotherapeutic intervention, psychological traumatization.

Received: Dec 3, 2025
Accepted: Jan 22, 2026
Published: Mar 1, 2026

For citation:

Faustova AG, Safronova MO. Disturbances of self-concept in young adults exposed to psychological traumatization as targets for psychotherapeutic intervention. *Psychotherapy Science Today*. 2(2):55–62. <https://doi.org/10.64435/koxw9115>.



© Author(s), CC BY-NC 4.0

Introduction

In modern society, representatives of various age groups often face a significant number of factors provoking psychological traumatization. According to the World Health Organization (WHO), more than 70% of people are exposed to psychologically traumatic factors at least once in their lives, such

as physical or psychological abuse, loss of loved ones, natural disasters, accidents, terrorist acts [1, 2]. Encounters with psychologically traumatic events are accompanied by serious consequences for mental health, especially for young adults at the stage of active personality formation [3–5]. Young adulthood

* Corresponding author, e-mail: anne.faustova@gmail.com.

is a critical period when a person forms a system of basic life priorities and values, adjusts and refines cognitive schemas regarding their own personality, others, and the world as a whole, which determines vulnerability to the negative consequences of psychologically traumatic events [6, 7].

According to WHO, up to 70% of people aged 18–23 have experienced a psychologically traumatic event at least once in their lives, related to violence, loss of loved ones, natural disasters, or social conflicts [1, 8]. Among youth aged 18 to 23, post-traumatic stress disorder (PTSD) is diagnosed in 7–8% of those affected [2, 9, 10]. In this age group, women are 2 times more likely to experience PTSD than men, which is primarily associated with a higher probability of sexual violence and social discrimination [11].

The consequences of psychological traumatization can vary: depressive states develop in 18% of young adults with traumatic experience [11–14]. Up to 15% of youth with severe post-traumatic experiences report suicidal intentions [8, 12, 15].

Studying the features of self-concept in young adults exposed to psychological traumatization has important theoretical and practical significance. On one hand, it allows for a deeper understanding of the mechanisms of formation and transformation of self-concept under the influence of traumatic experience. On the other hand, its results can be used to develop clinical-psychological intervention programs aimed at restoring a positive “self” image, increasing self-esteem, and the level of subjective well-being [16–19]. Timely psychotherapeutic work with young adults who have experienced psychological traumatization can prevent the development of chronic mental disorders in them and promote successful social adaptation.

Studying the influence of traumatic events on self-concept will enable the development of psychological and preventive measures aimed at proactively increasing psychological resilience among the younger generation. The formation of emotional and behavioral self-regulation skills, development of stress resistance, and orientation towards social support are important components of such programs [7, 19, 20].

Thus, the study of self-concept features in young adults exposed to psychological traumatization is relevant. It helps not only to understand the nature of changes occurring in the personality under the influence of traumatic experience but also to develop effective methods of psychological assistance and support. In the context of the growing number of crisis situations and psychologically traumatic events in the modern world, this research direction is gaining increasing significance, influencing the

improvement of the quality of life and mental health of young people.

Method

An empirical study of disturbances in the self-concept of young adults exposed to psychological traumatization was conducted to determine optimal targets for psychotherapeutic intervention aimed at correcting personality functioning.

The object of the study was the self-concept. The subject of the study is deviations in the functioning of the self-concept in young adults who have experienced psychological traumatization.

The aim of the study is to identify disturbances in the self-concept of young adults exposed to psychological traumatization, to determine potential targets for psychotherapeutic intervention focused on correcting personality functioning.

Research hypotheses:

1. The self-representations of young adults exposed to psychological traumatization lack internal consistency and stability, characterized by dysthymic, dysphoric, and inadequate variability of self-image.
2. Self-regulation in young adults with experience of psychological traumatization is developed at a low level.
3. Self-attitude in young adults exposed to psychological traumatization is distinguished by low levels of self-respect and self-understanding, insufficient self-affection and self-acceptance, combined with a pronounced tendency towards self-blame.

The following standardized psychodiagnostic methods were used in the study:

- *Life Experiences Questionnaire (LEQ)*, authors: J. Norbeck, I. Sarason, adapted by N. V. Tarabrina.
- *Self-Concept Clarity Scale (SCCS)* adapted by V. V. Vdovenko, S. A. Shchebetenko.
- *Self-Image Variability Assessment*, author: V. Boyko.
- The classical version of the *Dembo-Rubinstein Self-Esteem Test*.
- *Self-Attitude Test-Questionnaire*, authors: V. V. Stolin, S. I. Pantileev.
- *Behavioral Self-Regulation Style Questionnaire (BSSQ)*, author: V. I. Morosanova.

For statistical analysis of empirical data, the Mann-Whitney U test and Spearman's rank correlation coefficient were applied.

The total sample size was 51 people, 28 female, 23 male. Average age: 19.255 ± 1.214 years. The differentiating criterion was the score on the *Life Experiences Questionnaire (LEQ)*:

- experimental group — 22 individuals exposed to psychological traumatization of various

origins (natural disasters and catastrophic events, domestic violence, road traffic accidents, robberies/assaults);

- control group — 29 individuals without experience of psychological traumatization.

The main and control samples were comparable in socio-demographic characteristics.

Exclusion criteria:

- traumatic brain injuries;
- chronic cerebrovascular disorders;
- history of neuroinfections;
- brain tumors of various etiologies;
- type 2 diabetes mellitus;
- thyroid diseases;
- chronic avitaminosis;
- alcohol, psychoactive substance abuse;
- diagnosed mental disorders.

The program of empirical research was approved at a meeting of the Local Ethics Committee of Ryazan State Medical University, Ministry of Health of Russia (protocol dated August 28, 2024). At all stages of the research, ethical principles of organizing and

conducting psychological research were observed, consisting of voluntary participation, no harm, impartiality, full confidentiality, and anonymity.

Results

According to the results of applying the *Self-Concept Clarity Scale*, the following data were obtained (Fig. 1). Young adults who have experienced psychological traumatization predominantly demonstrate medium (68.2%, 15 people) and low levels of self-concept clarity (18.2%, 4 people). High self-concept clarity is more characteristic of respondents without traumatic experience (37.9%, 11 people) than those exposed to psychological traumatization (13.6%, 3 people). These differences are statistically significant (Table 1).

The results of applying the *Self-Image Variability Assessment* show that respondents with experience of psychological traumatization largely demonstrate undifferentiated variability of self-image* (63.6%, 14 people) (Fig. 2). Analysis of the results from the

Traumatized young adults demonstrate lower self-concept clarity compared to young adults without a history of psychological trauma.

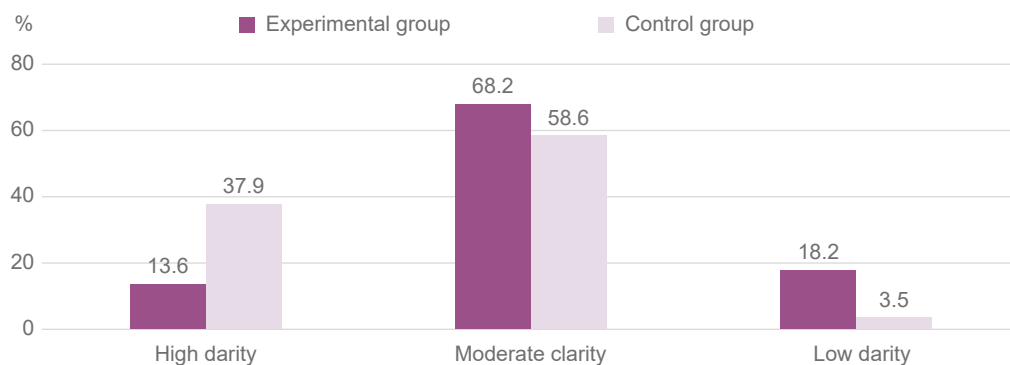


Figure 1. Distribution of respondents by level of self-concept clarity

	Mean (M) in experimental group (N = 22)	Mean (M) in control group (N = 29)	Uemp value
Self-concept clarity	3.00	3.49	194, $p \leq 0.01$
Self-assessed current happiness	53.40	70.86	185, $p \leq 0.01$
Self-understanding	54.19	75.54	185.5, $p \leq 0.01$

Table 1. Results of intergroup comparison using the Mann-Whitney U test

* In the *Self-Image Variability Assessment* (Boyko, 1996), "undifferentiated variability" is a specific diagnostic category. It describes a state of self-perception characterized by unstable, contradictory, and fragmented self-descriptions that lack an internal logical pattern or connection to situational factors. This is contrasted with other types of variability, such as "adequate/progressive" (linked to personal growth) or "dysthymic/dysphoric" (linked to low mood or irritability). The presence of "undifferentiated variability" indicates a lack of integration in self-concept, where an individual struggles to form a coherent and stable sense of self.

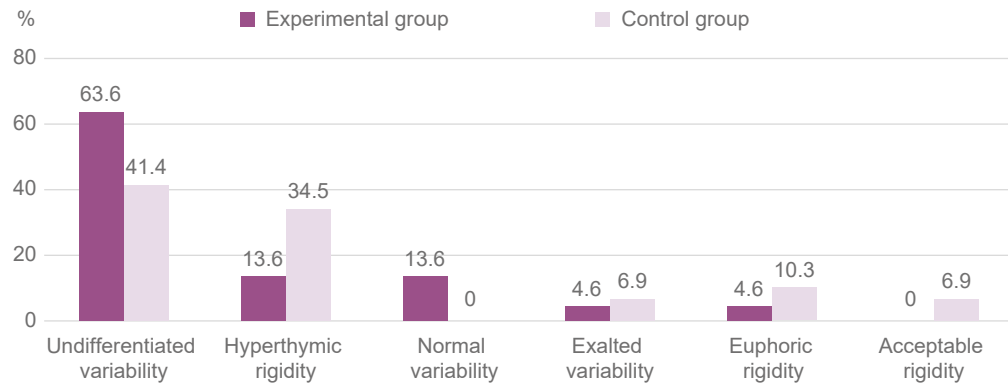


Figure 2. Distribution of respondents by type of self-image variability

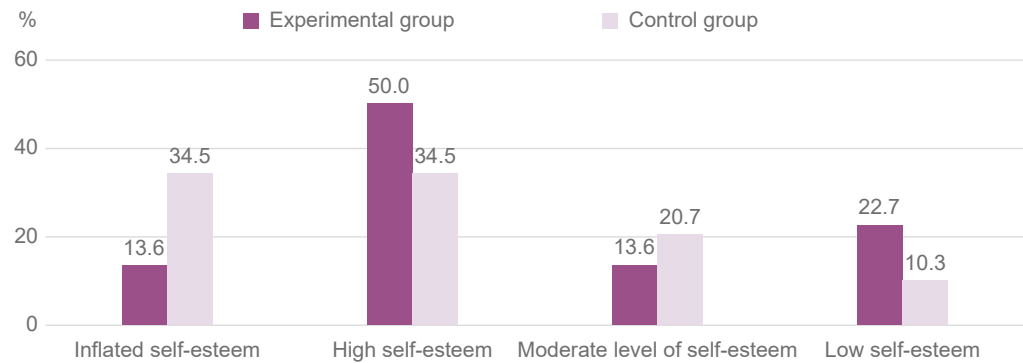


Figure 3. Distribution of respondents by level of self-esteem

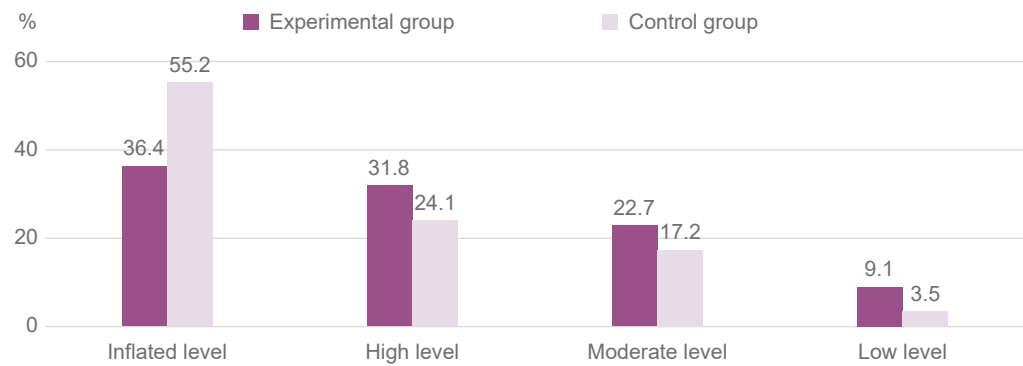


Figure 4. Distribution of respondents by level of aspiration

Dembo-Rubinstein Self-Esteem Test shows that half of the respondents in the experimental group demonstrate high self-esteem (50%, 11 people), and only one-fifth have low self-esteem (22.7%, 5 people) (Fig. 3).

The *Dembo-Rubinstein Self-Esteem Test* also allows establishing levels of aspiration in each group of respondents (Fig. 4). Among young adults exposed to psychological traumatization, inflated (36.4%, 8 people) and high (31.8%, 7 people) levels of aspiration are observed.

Based on the results of the *Self-Attitude Questionnaire* (SAQ), the following data were obtained (Fig. 5). More than half of the respondents in the experimental group exhibited a strongly positive attitude toward themselves ("for oneself") (59.1%, 13 participants). Fewer than one-quarter of respondents reported the opposite feeling — a negative attitude toward themselves ("against oneself") (22.7%, 5

participants).

The results from the *Behavioral Self-Regulation Style Questionnaire* demonstrate that young adults with traumatic experience have medium (31.8%, 7 people) and low values of the general level of self-regulation (68.2%, 15 people) (Fig. 6).

Statistically significant differences were found between the experimental sample and the control group in the degree of self-concept clarity, the level of self-assessed current happiness, and self-understanding (Table 1).

Correlational analysis of variables measured in the experimental group showed the presence of statistically significant relationships (Table 2).

Discussion of Results

This empirical study aimed to identify deviations in

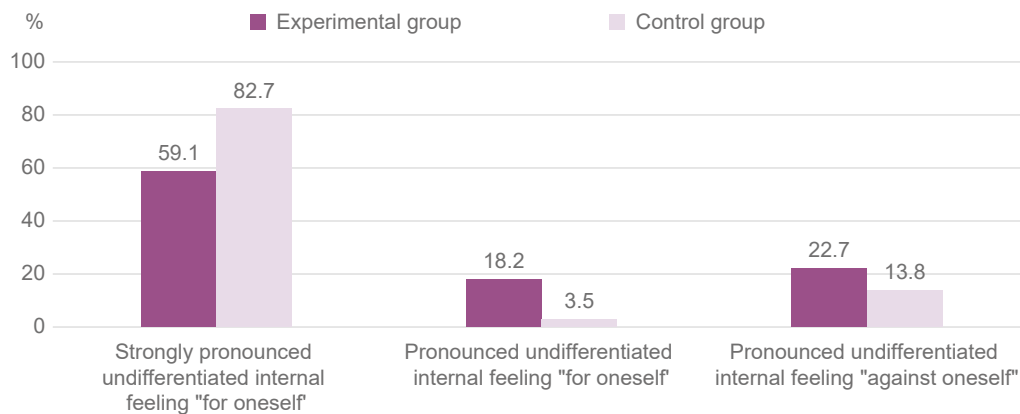


Figure 5. Distribution of respondents by severity of global self-attitude

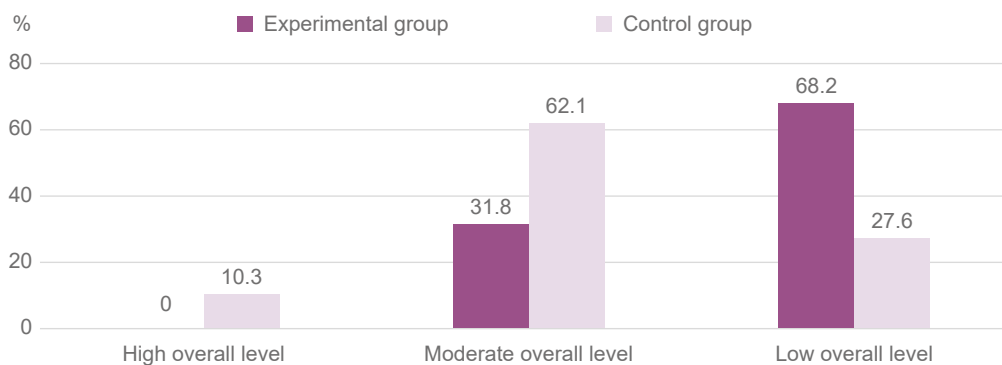


Figure 6. Distribution of the sample by value of general level of self-regulation

Scales of Methods	Coefficient Value	Significance Level
Number of experienced traumatic experiences (LEQ) x Reliability (BSSQ)	-0.457	$p \leq 0.05$
Number of experienced traumatic experiences (LEQ) x General level of self-regulation (BSSQ)	-0.426	$p \leq 0.05$
Degree of influence of traumatic experiences on respondent's life over the past year (LEQ) x Reliability (BSSQ)	-0.494	$p \leq 0.05$
Self-concept clarity (SCCS) x Mean self-assessment (Dembo-Rubinstein)	0.479	$p \leq 0.05$
Self-concept clarity (SCCS) x Evaluation of results (BSSQ)	-0.603	$p \leq 0.01$
Self-concept clarity (SCCS) x Reliability (BSSQ)	0.535	$p \leq 0.05$
Mean self-assessment (Dembo-Rubinstein) x Integral self-attitude (SAQ)	0.507	$p \leq 0.05$
Mean self-assessment (Dembo-Rubinstein) x Self-respect (SAQ)	0.442	$p \leq 0.05$
Mean self-assessment (Dembo-Rubinstein) x Self-affection (SAQ)	0.503	$p \leq 0.05$
Mean self-assessment (Dembo-Rubinstein) x Persistence (BSSQ)	0.427	$p \leq 0.05$
Discrepancy between aspiration level and self-assessment (Dembo-Rubinstein) x Flexibility (BSSQ)	-0.437	$p \leq 0.05$
Self-respect (SAQ) x Programming of actions (BSSQ)	0.575	$p \leq 0.01$
Self-respect (SAQ) x Persistence (BSSQ)	0.477	$p \leq 0.05$
Self-respect (SAQ) x General level of self-regulation (BSSQ)	0.616	$p \leq 0.01$
Self-affection (SAQ) x Programming of actions (BSSQ)	0.458	$p \leq 0.05$
Self-affection (SAQ) x General level of self-regulation (BSSQ)	0.446	$p \leq 0.05$
Self-guidance (SAQ) x Modeling significant conditions for achieving goals (BSSQ)	0.439	$p \leq 0.05$
Self-guidance (SAQ) x Programming of actions (BSSQ)	0.605	$p \leq 0.01$
Self-guidance (SAQ) x Persistence (BSSQ)	0.48	$p \leq 0.05$
Self-guidance (SAQ) x General level of self-regulation (BSSQ)	0.678	$p \leq 0.01$
Self-blame (SAQ) x Programming of actions (BSSQ)	-0.443	$p \leq 0.05$
Self-blame (SAQ) x General level of self-regulation (BSSQ)	-0.46	$p \leq 0.05$
Self-interest (SAQ) x General level of self-regulation (BSSQ)	0.556	$p \leq 0.01$
Self-understanding (SAQ) x Persistence (BSSQ)	0.44	$p \leq 0.05$

Table 2. Significant correlational links according to Spearman's rank correlation coefficient in the experimental group (N = 22)

self-concept potentially associated with experienced psychological traumatization and to determine corresponding targets for psychotherapeutic intervention.

It was found that experienced traumatic events have a multidirectional impact on various aspects of personality functioning. On one hand, psychological traumatization reduces the stability of mental regulation and the clarity of self-concept, thereby complicating the adaptation of the affected individual. At the same time, high indicators of self-esteem, self-respect, self-affection, and self-guidance indicate sufficient awareness and confidence in one's own abilities, forming the foundation for coping with the consequences of traumatic events. Additionally, young adults who have experienced psychological traumatization exhibit an insufficient level of self-understanding, which limits them in understanding and becoming aware of their emotional experiences.

The results of the conducted correlational analysis can be interpreted as follows.

The more traumatic events an individual has experienced, and the more significant their impact, the lower the identified abilities for conscious regulation of mental activity, behavior, and activity in complex life situations.

Self-concept clarity positively correlates with self-esteem. People with a clear and stable self-representation have higher self-esteem, accompanied by confidence in their abilities, capacity for self-regulation, and more adequate assessment of their actions.

High self-esteem, in turn, promotes the development of a more positive attitude towards oneself, confidence in one's own abilities, perseverance in achieving goals, as well as a benevolent attitude toward oneself. People with stable high self-esteem demonstrate greater

persistence, internal consistency, and ability to control their lives. Conversely, low self-esteem is accompanied by a tendency towards self-blame, distrust of oneself, and fixation on one's shortcomings.

A benevolent attitude towards oneself (self-affection), a high level of self-respect and self-understanding contribute to conscious planning of actions, perseverance in achieving goals, and development of the system of conscious behavior regulation.

The tendency towards self-blame negatively correlates with conscious construction of actions and building a system of behavior regulation. People with a low level of self-blame plan their actions more effectively and achieve better results.

The obtained results allow identifying the following targets for psychotherapeutic intervention aimed at achieving subjective well-being in young adults with traumatic experience:

- low level of self-concept clarity;
- undifferentiated variability of self-image;
- low self-esteem;
- inflated level of aspiration;
- negative self-attitude;
- low level of self-regulation.

Consequently, the tasks of providing psychological assistance to young adults who have experienced psychological traumatization are formulated as follows:

- increasing the level of self-concept clarity, overcoming intrapersonal conflict;
- developing adequate and stable self-esteem, ensuring harmonious personality development;
- optimizing the level of aspiration;
- forming a consistent positive self-attitude;
- developing skills of self-understanding and self-acceptance;
- forming skills of self-regulation and stress resistance.

When providing psychological assistance to young adults who have experienced traumatic impact, the following principles should be followed:

- *consistency and systematicity* — psychotherapeutic intervention begins with creating a safe environment, followed by psychotherapeutic work with emotions, then with cognitive attitudes;
- *individual approach* — consideration of personal experience and personality traits, degree of psychological traumatization, and the scale of its impact on subjective well-being;
- *active participation* — the client should be actively involved in the psychotherapeutic process as much as possible, which contributes to increasing their subjective control over the

ongoing changes;

- *resource orientation* — when selecting and implementing psychotherapeutic interventions, the emphasis shifts to the client's personal strengths to restore balance and strengthen the self-concept.

Conclusions

1. The level of self-concept clarity in young adults exposed to psychological traumatization is significantly lower than in those who have not encountered traumatic experience. This category is characterized by: moderately formed self-representation, relative consistency of its components, and stability over time. In psychologically traumatized individuals, representations of themselves, the level of beliefs and motives directed towards oneself are distorted. This group of respondents is characterized by a lower degree of internal consistency of self-concept and self-confidence, which also affects the structure of self-concept as a whole.
2. Young adults who have experienced psychological traumatization demonstrate undifferentiated variability of self-image. They exhibit disturbances in the integrity of self-perception, difficulties in forming a stable self-representation, fluctuations in self-esteem, and complexities in self-identification. It can be reasonably assumed that psychological traumatization significantly influences the formation of self-image, leading to its instability and heterogeneity of manifestations.
3. The majority of respondents from the experimental group who have experienced traumatic situations demonstrate high self-esteem, and only one-fifth of this sample have low self-esteem. Such results allow us to assume that high self-esteem may act as a narcissistic defense, helping to successfully cope with difficulties and adapt to complex life situations.
4. Young adults with experience of psychological traumatization more often exhibit inflated or high levels of aspiration. They strive for extremely high goals and may unrealistically assess their capabilities.
5. About half of the respondents from the experimental sample demonstrate a pronounced feeling "for oneself", indicating their ability to withstand negative influences and maintain a positive attitude towards themselves. On the other hand, some respondents experience the opposite feeling —

“against oneself”. This may be related to exposure to more severe psychological traumas that evoke negative emotions and doubts about their own worth.

6. Young adults who have experienced traumatic situations demonstrate medium and low values of the general level of self-regulation, which may indicate the negative impact of psychological traumatization on self-regulation mechanisms, insufficient formation of conscious self-regulation.
7. The formation and strengthening of positive self-attitude, increasing the clarity of self-concept, and training self-regulation skills are important components in psychotherapeutic work with the consequences of psychologically traumatic events.

Considering the pilot nature of the conducted study and the specificity of the obtained results, we consider the following prospects for continuing scientific work appropriate:

- conducting a longitudinal study of the dynamics of self-concept with periodic regular measurements of self-image indicators, self-esteem, and self-attitude over 1–3 years in a sample of adolescents or young adults, which will allow for a more detailed characterization of cause-and-effect relationships between traumatic experience and changes in self-awareness, as well as identifying protective factors determining the resilience and clarity of self-concept.
- conducting comparative studies considering age parameters (age at the time of psychological traumatization; age at the time of participation in the study), which will allow for a more detailed understanding of the role of narcissistic defenses in various age contexts.
- developing and testing a system of psychotherapeutic interventions aimed at stabilizing and increasing the clarity of self-concept, developing skills of emotional and behavioral self-regulation.

References

1. Kessler RC, Aguilar-Gaxiola S, Alonso J, et al. Trauma and PTSD in the WHO World Mental Health Surveys. *Eur J Psychotraumatol*. 2017;8(sup5):1353383. <https://doi.org/10.1080/20008198.2017.1353383>.
2. Koenen KC, Ratanatharathorn A, Ng L, et al. Posttraumatic stress disorder in the World Mental Health Surveys. *Psychol Med*. 2017;47(13):2260–2274. <https://doi.org/10.1017/S0033291717000708>.
3. Берчун АВ, Падун МА. Особенности структурной организации Я-концепции у лиц с посттравматическим стрессовым расстройством. *Консультативная психология и психотерапия*. 2020;28(3):8–30.
4. Губарева НА. Психотравма и жизненная перспектива личности: теоретический анализ и адаптационные механизмы. *Актуальные проблемы психологических исследований*. 2025;1(2):45–62.
5. Кочетова ЮА, Климакова МВ, Емельянова ЕА. Психологическая травма в разные периоды детства: влияние на Я-концепцию. *Социальная психология и общество*. 2025;16(2):112–128.
6. Galea S, Nandi A, Vlahov D. The epidemiology of post-traumatic stress disorder after disasters. *Epidemiol Rev*. 2005;27(1): 78–91. <https://doi.org/10.1093/epirev/mxi003>.
7. Truskauskaitė-Kunevičienė I, Brailovskaia J, Kamite Y, Petrauskaitė G, Margraf J, Kazlauskas E. Does Trauma Shape Identity? Exploring the Links Between Lifetime Trauma Exposure and Identity Status in Emerging Adulthood. *Front Psychol*. 2020;11:570644. <https://doi.org/10.3389/fpsyg.2020.570644>.
8. Всемирная организация здравоохранения. Насилие и психическое здоровье. Женева: ВОЗ; 2021. <https://www.who.int>.
9. Labouvie-Vief G. Postformal thought and adult development. In: Sternberg RJ, editor. *Adult development*. New York: Praeger; 1990.
10. Pynoos RS, Steinberg AM, Goenjian A. Traumatic Stress in Childhood and Adolescence: Recent Developments and Current Controversies. *Trauma Violence Abuse*. 2005;6(4):345–368.
11. Marcia JE. Development and validation of ego-identity status. *J Pers Soc Psychol*. 1966;3(5):551–558. <https://doi.org/10.1037/h0023281>.
12. Всемирная организация здравоохранения. Международная классификация болезней (МКБ-11). Женева: ВОЗ; 2018–2021. <https://icd.who.int>.
13. Rytwinski NK, Scur MD, Feeny NC, Youngstrom EA. The co-occurrence of major depressive disorder among individuals with posttraumatic stress disorder: a meta-analysis. *J Trauma Stress*. 2013;26(3):299–309. <https://doi.org/10.1002/jts.21814>.
14. Yehuda R, Hoge CW, McFarlane AC, et al. Post-traumatic stress disorder. *Nat Rev Dis Primers*. 2015;1:15057. <https://doi.org/10.1038/nrdp.2015.57>.
15. Panagioti M, Gooding PA, Tarrier N. A meta-analysis of the association between posttraumatic stress disorder and suicidality: the role of comorbid depression. *Compr Psychiatry*. 2012;53(7):915–930. <https://doi.org/10.1016/j.comppsych.2012.02.009>.
16. Cloitre M. The “one size fits all” approach to trauma treatment: Should we be satisfied? *Eur J Psychotraumatol*. 2015;6:27344. <https://doi.org/10.3402/ejpt.v6.27344>.
17. Katoch N. Trauma Exposure During Adolescence and Its Impact on Self-Concept Among Adults. *Int J Indian Psychol*. 2025;13(2):208. <https://ijip.in/articles/trauma-exposure>.
18. Melamed DM, Botting J, Lofthouse K, Pass L, Meiser-Stedman R. The Relationship Between Negative Self-Concept, Trauma, and Maltreatment in Children and Adolescents: A Meta-Analysis. *Clin Child Fam Psychol Rev*. 2024;27(1): 220–234. <https://doi.org/10.1007/s10567-024-00472-9>.
19. van der Kolk BA. *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. New York: Viking Press; 2014. p. 147–172.
20. Galatzer-Levy IR, Bryant RA. 636,120 Ways to Have Posttraumatic Stress Disorder. *Perspect Psychol Sci*. 2013;8(6):651–662. <https://doi.org/10.1177/1745691613504115>.

VI International Congress
CASE STUDIES IN PSYCHOTHERAPY
April 25-26, 2026 in Belgrade and online

**PSYCHOPHYSIOLOGICAL INTEGRATION:
A NEW PARADIGM IN PSYCHOTHERAPY**



Registration: en.aipp.education



Become our author

PST journal invites specialists in the field of psychotherapy who are actively interested in the development of science to collaborate. Publication in PST provides an opportunity for psychotherapists, postgraduate students, research associates of organizations, as well as all authors interested in creating a scientific dialogue, to share their scientific discoveries.

3 steps to publish your manuscript

Step 1. Choose the type of a manuscript that matches the idea of your article from *the Types of Manuscripts of Author Guidelines*.

Step 2. Prepare your article according structure and volume recommendations of *Author Guidelines*.

Step 3. Send us your manuscript, indicating which type of article from our classification it belongs to, with accompanying files given in *Accompanying Files* section of *Author Guidelines* at mail@psychotherapyscience.today.

Types of manuscripts and recommendations about its structure

Article type & description	Word limit	Abstract	References	Other
Research (Regular) Article: Substantial articles making a significant theoretical or empirical contribution	5,500	250*	≤50	Up to 5 displays
Brief Communications: Original but shorter manuscripts, with preliminary results or results of immediate relevance.	1,800	150*	≤15	Up to 3 small tables or figures
Reviews: Systematic literature reviews and meta-analyses.	7,000	250*	≤100	Up to 8 displays
Psychotherapy Tools: Descriptions, reviews, or illustrations of the technical aspects of psychotherapy practice that can be used to improve or evaluate psychotherapeutic treatments	3,000	150 words, unstructured	≤20	Conclude with at least 5 bulleted recommendations
Clinical Case Discussion: Disguised accounts of psychotherapeutic treatments of actual patients which go beyond simple case reports by using the case material to illustrate an important theoretical, clinical, or conceptual issue	2,000	No abstract	≤20	
Viewpoint: Brief opinion pieces that focus on topics relevant to the practice of psychotherapy	1,400	No abstract	≤5–10	Maximum of 3 authors, no figures or tables
Psychotherapy Musings: Brief reflective articles focused on topics related to psychotherapy. Could include first-person experiences with the conduct or receipt of psychotherapy, discussions about historical trends in psychotherapy practice, or broader reflections on the evolution or practice of psychotherapy	1,500	150 words	≤10	Maximum of 3 authors, no figures or tables

* Words limits exclude the abstract, captions, references, tables and figures.

Accompanying files

Along with the Manuscript, we ask the contact author to send us the following 4 files:

1. Clinical impact statement — a short statement, written in conversational English, that summarizes the article's findings and why they are important to clinical practice. Please structure it as short 1–2 sentence answers on the following questions:

- What is the applied clinical practice question this paper is hoping to address?

- How would clinicians meaningfully use the primary findings of this paper in their applied practice?
- What are the key conclusions and implications for future clinical practice and research?

2. Short biographies of the authors.

3. Disclosure Form (download or see at www.psychotherapyscience.today).

4. Copyright Assignment Form (download or see at www.psychotherapyscience.today).

If you have any questions feel free to contact us at

mail@psychotherapyscience.today



PSYCHOTHERAPY SCIENCE TODAY (PST) is a clinically oriented scientific peer-reviewed journal about research in the field of psychotherapy and mental health.

PST specializes in the analysis of psychotherapeutic approaches and methods, case-studies, as well as applied research in the fields of medicine and psychology that are related to mental health and psychological well-being: psychiatry, clinical psychology, health psychology, rehabilitation psychology, neuropsychology, clinical psychopharmacology and other scientific areas.

The goal of the journal is to cover research that is significant for the development of psychotherapy and related areas of medicine and psychology and to create a growing base of clinically proven psychotherapeutic methods, clinical cases and scientific knowledge on topical issues of psychotherapy. PST is aimed at psychotherapists, psychiatrists and psychologists.

The materials of the journal can serve as:

- ☒ a guide for psychotherapists on individual cases;
- ☒ a resource for training for specialists in the field of psychotherapy, psychiatry, clinical and counseling psychology;
- ☒ the basis for scientific research in the field of psychotherapy, psychiatry and clinical psychology.

Feel free to contact us at mail@psychotherapyscience.today.



SUBSCRIBE



■ free access

www.psychotherapyscience.today