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Dear colleagues, researchers, and professionals,

The contributions to the third issue of *Psychotherapy Science Today* span different levels of psychic reality—from specific emotional and cognitive processes to personality structures, group dynamics, and the social unconscious. Psychotherapy is approached not only as a set of therapeutic methods but also as a field of inquiry into the complex connections among individual experience, interpersonal relationships, culture, and society.

The issue opens with an empirical section comprising three studies. The first examines factors associated with the development of subclinical psychopathological symptoms. The study identified a core constellation of symptoms characterizing the subclinical state, while network analysis revealed activators and inhibitors of psychopathological symptom progression, thereby helping to delineate targets for early clinical interventions. The second study provides grounds for reconsidering the widespread view of cognitive reappraisal as an unequivocally adaptive emotion regulation strategy. The findings suggest that, in some cases, it may reflect a reconstruction of meaning rather than constructive emotional processing, thereby supporting self-justification and the maintenance of aggressive attitudes. The third study explores the plasticity of personality structures: following a brief psychotherapy program, statistically significant changes in participants' self-esteem and psychological well-being were observed, suggesting that personality structures may be less fixed than traditionally assumed.

The next section presents a phase-by-phase analysis of the psychotherapeutic treatment of a patient with complex posttraumatic stress disorder and risky sexual behavior, both stemming from childhood sexual abuse. The author demonstrates how detailed clinical case formulation makes it possible to move beyond a surface description of maladaptive behavior toward an understanding of the trauma-related mechanisms that maintain it.

The theoretical and clinical section features an article on group psychic retreat. Drawing on theoretical analysis and two clinical illustrations, the author conceptualizes it not only as a pathological defensive organization but also as a temporary, potentially adaptive response of the group to psychic overload.

The conceptual section presents a psychobiological model of the pathogenesis of primary psychogenic depression, linking its development to the chronic suppression of the impulse to act when existentially significant needs cannot be fulfilled. Based on the proposed model, the authors identify key psychotherapeutic targets and provide a rationale for an approach designed to address the underlying pathogenic mechanism and restore agency.

The issue concludes with an article that shifts the analysis from individual and group clinical processes to cultural and societal transformations. The author examines the weakening of patriarchal metastructures in the digital age, the persistence of some of their elements in the social unconscious, and the effects of this transformation on authority, identity, group dynamics, and therapeutic relationships.

The articles presented in this issue share a focus on the mechanisms underlying observed symptoms and patterns of behavior, as well as on the conditions under which psychotherapy can facilitate lasting change. The Editorial Board hopes that these contributions will help inform clinical practice and future research.

Editorial Board
Psychotherapy Science Today

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Activators and inhibitors of the progression of psychopathological symptoms associated with psychological abuse

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Abstract

Objective The aim of this paper was to identify psychological factors that intensify (activators) or attenuate (inhibitors) the progression of subclinical psychopathological symptoms in young adults exposed to psychological abuse during childhood and adolescence.

Method The study included 416 respondents (mean age, 18.73 ± 0.81 years) with a history of psychological abuse by parents or guardians during childhood and adolescence. Empirical data were collected using standardized self-report measures. Correlation analysis and undirected network analysis were performed.

Results Exposure to psychological abuse was correlated with the severity of subclinical psychopathological symptoms. The "core" of the subclinical condition among survivors of psychological abuse comprised obsessive-compulsive symptoms, interpersonal sensitivity, anxiety, and depression. Network analysis identified two functional groups: inhibitors (autobiographical memory specificity, flexibility and modeling, availability of social support, and trait detachment) and activators (early maladaptive schemas, hostility, obsessive-compulsive symptoms, and psychotic symptoms).

Conclusions The findings indicate the transdiagnostic nature of subclinical distress in young adults with a history of psychological abuse and provide a basis for developing a system of early clinical psychological interventions. Intervention targets and possible strategies are proposed, including strengthening inhibitors and modifying activators.

Keywords: psychological abuse; consequences; mental disorders; subclinical stage; progression; exacerbation; early adulthood.

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Introduction

Child and adolescent maltreatment remains a major socio-legal and medical-psychological problem. According to the World Health Organization (WHO), up to 400 million minors are regularly exposed to various forms of maltreatment by parents and guardians [1]. Psychological abuse accounts for up to 35% of all maltreatment cases, making it the most prevalent form of child and adolescent maltreatment [2]. In this study, psychological abuse is defined as a persistent, long-term pattern of adult behavior centered on disregarding the psychological needs and agency of a child who is inherently unable to resist the adult; this pattern is manifested through active and passive, verbal and nonverbal acts.

Contemporary clinical psychological research increasingly focuses on the long-term consequences of adverse childhood experiences. Psychological abuse is a transdiagnostic risk factor for the onset and progression of schizophrenia and schizotypal disorder [3], depressive disorders [4], anxiety disorders [5], and personality disorders [6]. Most studies in this field have used a cross-sectional design, which allows researchers to identify the presence and/or severity of psychopathological symptoms within a particular spectrum but does not explain the mechanisms through which psychological abuse leads to deterioration in psychological functioning or highlight the factors that may interrupt this association.

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Mental disorders are known to pass through several stages in their development, ranging from an asymptomatic state to a clinically manifest syndrome and a chronic form [7]. The subclinical stage is characterized by psychopathological symptoms that do not meet the diagnostic threshold under DSM-5 or ICD-11 criteria, yet significantly impair subjective well-being and everyday functioning. Subclinical psychopathological symptoms are highly prevalent, affecting 57% of the general population [8]. They are considerably more common among individuals aged 18–30 years and occur more frequently in this age group than clinically manifest mental disorders [9, 10]. Childhood psychological abuse is considered one of the most robust predictors of subclinical psychopathological symptoms in early adulthood [11, 12].

Mediators of the association between psychological abuse experienced during childhood and adolescence and the onset of mental disorders of varying severity, including subthreshold presentations, have been relatively well studied. The formation of early maladaptive schemas is among the most extensively examined mechanisms mediating the effects of psychological trauma [13]. Emotion dysregulation is another consistently identified mechanism. Important cognitive mediators include hopelessness, self-criticism, and impaired mentalizing [13].

Beyond mediators, considerable scientific interest concerns psychological factors that may intensify or attenuate existing subclinical symptoms of mental disorders in individuals exposed to psychological abuse during childhood and adolescence. Cognitive flexibility and self-compassion have been considered potential inhibitors of psychopathology progression [14, 15]. However, evidence regarding their role specifically in the context of psychological abuse remains fragmented. The practical value of such research lies in identifying targets for early clinical psychological interventions aimed at preventing the progression and broader manifestation of mental disorders.

Unlike previous studies, which have predominantly focused on mediating mechanisms, the present empirical study examines psychological factors that create specific conditions for the progression or reduction of subclinical psychopathological symptoms associated with a history of psychological abuse.

The aim of this study was to identify and analyze activators and inhibitors of the progression of psychopathological symptoms associated with psychological abuse experienced during childhood and adolescence.

In this study, activators are defined as psychological factors that contribute to an increase in existing subclinical psychopathological symptoms among survivors of psychological abuse. Inhibitors, in turn, are psychological factors with the potential to reduce the severity of subclinical psychopathological symptoms.

The study hypothesis was that certain psychological factors can either intensify or attenuate subclinical psychopathological symptoms in young adults who experienced psychological abuse during childhood and adolescence.

Method

The present study was approved by the Local Ethics Committee of Ryazan State Medical University of the Ministry of Health of the Russian Federation (Protocol No. 7 dated January 11, 2023).

The study included 416 young adults (318 women and 98 men; students enrolled in secondary and higher education institutions). The respondents' mean age was 18.73 ± 0.81 years.

Inclusion criteria were a history of psychological abuse experienced and terminated during childhood and adolescence and the absence of current traumatic exposure of any origin.

Exclusion criteria were a history of traumatic experiences of another origin, including other forms of maltreatment; diagnosed mental disorders; and somatic diseases that may affect mental and behavioral functioning.

Empirical data were collected using the following psychodiagnostic measures:

1. An author-developed self-report measure for the retrospective assessment of psychological abuse experienced during childhood and adolescence. The measure recorded contextual variables (the number of different psychologically abusive acts directed at the respondent and the subjective intensity of negative emotions caused by psychological abuse) as well as age-related and chronological indicators (mean duration in years and mean ages at onset and cessation). The self-report measure listed 48 psychologically abusive acts; respondents rated their emotional reaction on a scale from 0 (no negative emotions) to 10 (extremely intense negative emotions).

2. The Life Events Questionnaire (LEQ), adapted by N. V. Tarabrina et al. (2007), was used to screen respondents' histories for traumatic experiences of an origin other than psychological abuse.

3. The Personality Inventory for DSM-5—Brief Form (PID-5-BF), adapted by G. V. Kustov et al. (2022), was used to identify pathological personality traits associated with personality disorders.

4. The Young Schema Questionnaire (YSQ-S3R), adapted by P. M. Kasyanik and E. V. Romanova (2013), was used to assess the development of early maladaptive schemas in the respondents.

5. The Symptom Checklist-90-Revised (SCL-90-R), adapted by N. V. Tarabrina et al. (2007), was used to assess the severity of psychopathological symptoms.

6. The Style of Behavioral Self-Regulation questionnaire (SSPM), developed by V. I. Morosanova (1998), was used to measure variables of behavioral self-regulation.

7. The Autobiographical Memory Test (AMT), developed by J.M. G. Williams and D. Broadbent (1986), was used to assess the specificity of autobiographical memories.

8. The Multidimensional Scale of Perceived Social Support (MSPSS), adapted by N. A. Sirota and V. M. Yaltonsky (1994), was used to examine respondents' perceptions of the social support available to them.

Mathematical and statistical analyses were conducted in JASP and included descriptive analysis, correlation analysis, and undirected network analysis.

Results

Retrospective analysis of the respondents' traumatic experiences showed that the mean age at onset of psychological abuse was 10.87 ± 3.33 years and the mean age at cessation was 14.18 ± 2.69 years. Psychological abuse lasted for an average of 4.27 ± 2.98 years. Respondents reported that the pattern of psychological abuse by parents or guardians included an average of 10 different psychologically abusive acts. The most frequently reported acts were yelling and profanity, excessive control, devaluation and ignoring, excessive demands, criticism, inducing guilt, and fostering feelings of worthlessness. According to the respondents, these actions by significant adults were accompanied by pronounced psychological suffering involving fear and helplessness (mean intensity, 5.65 ± 2.45).

Descriptive analysis was then performed on the results obtained in the study sample using the SCL-90-R (Table 1). Among young adults exposed to psychological abuse during childhood and adolescence, mean psychopathological symptom scores exceeded the normative values established during adaptation of the measure (Somatization, 0.55; Obsessive-compulsive symptoms, 0.78; Phobic anxiety, 0.32; Interpersonal sensitivity, 0.95; Depression, 0.72; Psychoticism, 0.44) [16]. The scores more closely corresponded to the range characteristic of clinical groups with adjustment disorders and posttraumatic stress disorder (Somatization, 1.08; Obsessive-compulsive symptoms, 1.15; Phobic anxiety, 0.76; Interpersonal sensitivity, 1.25; Depression, 1.15; Psychoticism, 0.72) [16]. Because the respondents had not previously been diagnosed with mental disorders, the identified psychopathological symptoms were interpreted as subclinical spectrum manifestations. The "core" of the subclinical condition among young adults exposed to psychological abuse comprised obsessive-compulsive symptoms, interpersonal sensitivity, anxiety, and depression (Table 1).

Correlation analysis was conducted to examine associations between the variables of psychological abuse and the severity of psychopathological symptoms in the study sample (Table 2).

Correlation analysis revealed moderate positive associations between the contextual variables of psychological abuse (the number of psychologically abusive acts and emotional response) and all SCL-90-R scales at a high level of statistical significance. These findings suggest a dose-dependent traumatic effect: the more diverse the psychologically abusive acts and the more intense the negative emotional response, the greater the severity of psychopathological symptoms in adulthood. The greatest vulnerability was observed for depression, phobic anxiety, and psychotic symptoms. Mean duration of psychological abuse was also significantly correlated with all scales assessing psychopathological symptoms. Thus, chronic psychological traumatization during childhood and adolescence may contribute to the formation of persistent patterns of psychopathology. Age-related variables of psychological abuse were

Variable	M ± SD	Variable	M ± SD
Somatization	0.91 ± 0.67	Hostility	0.86 ± 0.74
Obsessive-compulsive symptoms	1.23 ± 0.73	Phobic anxiety	0.56 ± 0.60
Interpersonal sensitivity	1.17 ± 0.83	Paranoid ideation	0.98 ± 0.76
Depression	1.16 ± 0.76	Psychoticism	0.54 ± 0.53
Anxiety	1.02 ± 0.84	Global Severity Index	0.97 ± 0.60

Table 1. **Severity of psychopathological symptoms assessed using the SCL-90-R (N = 416)**

either virtually unrelated to psychopathological symptom severity in the study sample or showed weak negative correlations.

Undirected network analysis was used to identify psychological factors that may intensify or attenuate distress associated with subclinical psychopathological symptoms. Variables with high expected influence (EI) values were selected (Table 3). Unlike conventional strength centrality, which sums the absolute values of edge weights, expected influence retains the signs of associations, allowing activating (intensifying) and suppressing (inhibiting) nodes to be identified within the set of variables.

	Number of different psychologically abusive acts	Emotional intensity	Mean age at onset	Mean age at cessation	Mean duration
Somatization	0.320 p < 0.001	0.265 p < 0.001	−0.087 p = 0.076	0.083 p = 0.091	0.196 p < 0.001
Obsessive-compulsive symptoms	0.315 p < 0.001	0.294 p < 0.001	−0.094 p = 0.056	0.175 p < 0.001	0.263 p < 0.001
Interpersonal sensitivity	0.320 p < 0.001	0.376 p < 0.001	−0.144 p = 0.003	0.169 p < 0.001	0.301 p < 0.001
Depression	0.375 p < 0.001	0.397 p < 0.001	−0.136 p = 0.005	0.198 p < 0.001	0.342 p < 0.001
Anxiety	0.397 p < 0.001	0.373 p < 0.001	−0.120 p = 0.015	0.123 p = 0.012	0.264 p < 0.001
Hostility	0.320 p < 0.001	0.283 p < 0.001	−0.081 p = 0.098	0.130 p = 0.008	0.193 p < 0.001
Phobic anxiety	0.395 p < 0.001	0.373 p < 0.001	−0.186 p < 0.001	0.147 p = 0.003	0.314 p < 0.001
Paranoid ideation	0.295 p < 0.001	0.329 p < 0.001	−0.087 p = 0.076	0.180 p < 0.001	0.251 p < 0.001
Psychoticism	0.367 p < 0.001	0.382 p < 0.001	−0.153 p = 0.002	0.117 p = 0.017	0.266 p < 0.001

Table 2. Correlations between variables of psychological abuse and psychopathological symptom scores (N = 416, Pearson's r)

Variable	Expected influence	Functional role
Autobiographical memory specificity (AMT)	−2.260	Progression inhibitors
Modeling (SSPM)	−2.176	
Flexibility (SSPM)	−1.518	
Perceived social support—Friends (MSPSS)	−1.432	
Detachment (PID-5-BF)	−1.297	
Perceived social support—Significant Other (MSPSS)	−0.821	
Obsessive-compulsive symptoms (SCL-90-R)	0.916	Progression activators
Early maladaptive schema: Negativity/Pessimism (YSQ-S3R)	0.983	
Early maladaptive schema: Punitiveness (YSQ-S3R)	0.938	
Hostility (SCL-90-R)	0.860	
Psychoticism (SCL-90-R)	0.750	
Early maladaptive schema: Approval-Seeking (YSQ-S3R)	0.733	

Table 3. Selection of variables based on expected influence (N = 416, undirected network analysis)

Two functional groups of variables associated with the dynamics of subclinical psychopathological symptom progression in young adults with a history of psychological abuse were identified (Figure 2). Progression inhibitors included cognitive resources (autobiographical memory specificity as well as modeling and flexibility as self-regulation strategies), social support from friends and a significant other, and detachment as a stable personality trait. Progression activators included early maladaptive schemas (pessimism, punitiveness, and approval-seeking) and other psychopathological symptoms (hostility, obsessive-compulsive symptoms, and psychotic symptoms).

Discussion

This study sought to identify and analyze psychological factors that may intensify or attenuate subclinical psychopathological symptoms in respondents with a history of psychological abuse.

Young adults with a history of psychological abuse during childhood and adolescence exhibited pronounced subclinical distress despite having no previously diagnosed mental disorders. The polymorphic profile of psychopathological symptoms identified in the study sample is particularly noteworthy: the "core" of the subclinical condition included obsessive-compulsive and anxiety-depressive symptoms as well as interpersonal sensitivity. This finding indicates the transdiagnostic nature of the subclinical stage of mental disorders associated with psychological abuse and is consistent with previous research [17, 18].

The positive correlations between the contextual characteristics of psychological abuse experienced during childhood and adolescence and the severity of psychopathological symptoms support the dose-response model (Figure 1).

Previous studies have demonstrated a dose-response effect for physical and sexual abuse [19]. Our findings indicate that, alongside objective aspects of traumatic exposure, the subjective intensity of psychological suffering is also important. No consistent correlations were found between age-related variables and psychopathological symptoms. Duration, rather than the age at onset or cessation of psychological abuse, may play the key role, which is consistent with theoretical accounts [20].

Network analysis allowed us to move beyond identifying correlations and construct a model of the dynamic interaction among variables (Figure 2).

The key inhibitor was autobiographical memory specificity. This finding is consistent with studies by J.M.G. Williams et al., which showed that reduced specificity of autobiographical memories

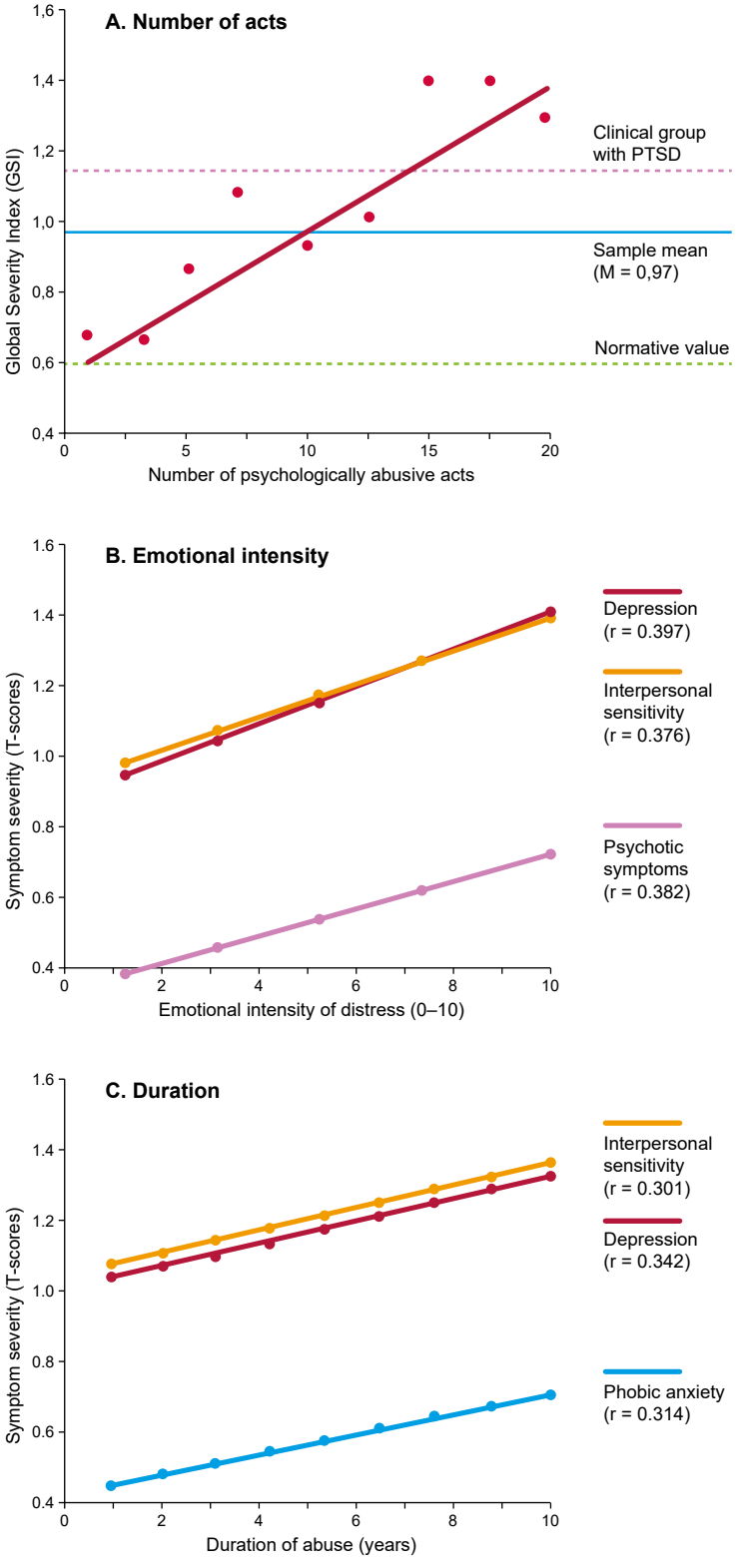


Figure 1. Dose-dependent traumatic impact of psychological abuse

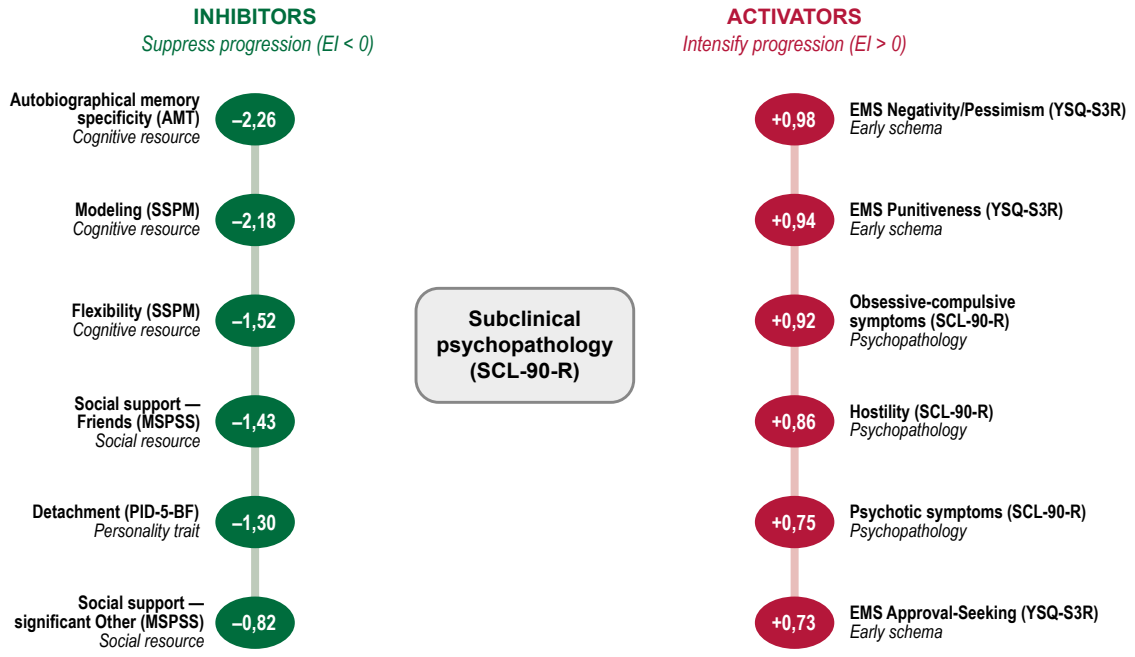


Figure 2. Structure of activators and inhibitors of subclinical psychopathology progression

in survivors of childhood maltreatment contributes to rumination and depressive symptoms [21–23]. Thus, preserving a high degree of autobiographical memory specificity may serve a protective function.

Preserved capacities to model possible courses of action and flexibly modify behavior in response to circumstances enable effective adaptation to various social situations and help prevent escalation of distress associated with subclinical symptoms. L. Yang et al. reported comparable findings: cognitive flexibility mediated the adverse effect of childhood psychological traumatization on the severity of anxiety-depressive symptoms [24].

The availability of social support is an important protective factor against the onset and progression of mental disorders, as confirmed by numerous studies [25]. Notably, perceived social support from friends and a significant other, but not from family, emerged as inhibitors. This may reflect the characteristics of the sample: young adults exposed to psychological abuse perpetrated by parents or guardians.

The most controversial finding was the classification of the PID-5-BF Detachment domain as an inhibitor, although this personality pattern is generally regarded as a risk factor in the scientific and clinical literature. This result may have arisen from the network analysis procedure itself, in which the Detachment variable statistically suppressed other nodes, or it may represent an artifact of the study sample: despite tendencies toward intimacy avoidance and anhedonia, the respondents remained sufficiently adapted to the demands of their social environment. Further research is needed to test the hypothesis that detachment may initially have functioned as a protective mechanism in survivors of psychological abuse but subsequently became consolidated as a dysfunctional personality trait that nevertheless facilitates coping with the consequences of psychological traumatization.

The activators of subclinical psychopathological symptom progression in young adults with a history of psychological abuse included early maladaptive schemas and indicators of impaired mental functioning.

Activation of the early maladaptive schemas of Negativity/Pessimism, Punitiveness, and Approval-Seeking may intensify psychopathological symptoms, particularly those forming the “core” of the subclinical condition among survivors of psychological abuse during childhood and adolescence. This finding is directly consistent with J. Young’s theory that early dysfunctional schemas formed in the context of maltreatment become a kind of “driving force” behind deterioration in mental health [26, 27].

The presence of hostility, obsessive-compulsive symptoms, and psychotic symptoms among the progression activators suggests a self-reinforcing cascade in which symptoms generate and intensify one another. This finding is consistent with the

network theory of psychopathology [28]. Thus, psychopathological symptoms arising from psychological abuse do not merely accumulate; rather, they become systemically organized through network interactions.

The findings have practical value and may be used to develop dynamic interventions aimed at strengthening and stabilizing inhibitors (autobiographical memory, behavioral self-regulation, and perceived social support) and "deactivating" activators (early maladaptive schemas and psychopathological symptoms).

We propose an approximate algorithm and a set of techniques for providing clinical psychological and psychotherapeutic care to young adults exposed to psychological abuse during childhood and adolescence. The following measures may be used to screen for subclinical distress: the SCL-90-R, the SCL-K-9, and the Depression Anxiety Stress Scales-21 (DASS-21). Because the perpetrators of psychological abuse were parents or guardians, family psychotherapy should be avoided during the early stages of care. At the same time, the inclusion of interpersonal sensitivity in the "core" of the subclinical condition warrants caution when introducing survivors to group-based psychological interventions and psychotherapy at the initial stage. Friends, significant others, and helping professionals may serve as sources of psychological resilience and support. Table 4 summarizes the clinical psychological intervention targets and recommended interventions.

Inhibitors	Intervention target	Recommended clinical psychological interventions
Autobiographical memory specificity (AMT)	Restoring the ability to retrieve specific, detailed autobiographical memories	Cognitive training (exercises in generating specific memories from cue words). Expressive writing practices (journaling, therapeutic writing)
Modeling (SSPM)	Developing the ability to mentally construct and test hypotheses about the future	Cognitive behavioral techniques. Metacognitive therapy
Flexibility (SSPM)	Restoring the ability to switch adaptively between behavioral strategies depending on context	Acceptance and Commitment Therapy. Dialectical behavior therapy techniques
Perceived social support—Friends (MSPSS)	Restoring the ability to perceive and use peer support	Social skills training. Group psychotherapy
Perceived social support—Significant Other (MSPSS)	Developing a secure attachment with one significant adult (partner, mentor, or therapist)	Attachment-oriented psychotherapeutic practices. Mentoring
Detachment (PID-5-BF)	Developing effective interpersonal skills in safe contexts	Interpersonal effectiveness skills from dialectical behavior therapy. Group psychotherapy
Activators	**Intervention target**	**Recommended clinical psychological interventions**
Early maladaptive schema: Negativity/Pessimism (YSQ-S3R)	Modifying persistent beliefs that negative outcomes are inevitable and change is impossible	Schema therapy techniques. Cognitive restructuring
Early maladaptive schema: Punitiveness (YSQ-S3R)	Reducing self-criticism and self-punitive tendencies	Schema therapy techniques. Compassion-focused therapy techniques
Early maladaptive schema: Approval-Seeking (YSQ-S3R)	Modifying the maladaptive need for external validation of self-worth	Schema therapy techniques. Group psychotherapy
Obsessive-compulsive symptoms (SCL-90-R)	Reducing patterns of cognitive and behavioral control	Cognitive behavioral therapy techniques for OCD. Metacognitive therapy
Hostility (SCL-90-R)	Modifying patterns of hypervigilance and aggressive defense	Dialectical behavior therapy techniques. Anger management training
Psychoticism (SCL-90-R)	Reducing perceptual anomalies and ideational disorganization	Cognitive therapy (modification of cognitive distortions). Reality-testing skills training

Table 4. Targets and techniques for early clinical psychological interventions

Conclusion

The study demonstrates that psychological abuse experienced during childhood and adolescence is associated with persistent subclinical distress in young adults, with severity comparable to that observed in clinical samples. The principal theoretical contribution is the use of a network approach to identify activators and inhibitors of subclinical psychopathological symptoms, thereby enabling a transition to a dynamic model of the factors that determine the trajectory of the subclinical condition.

The identified dose-response pattern — duration, diversity, and emotional intensity of psychological abuse — confirms the complex nature of psychological traumatization resulting from psychologically abusive treatment and indicates that subjective experiences, alongside objective aspects, should be considered when assessing the risk of psychopathology.

The subclinical condition associated with a history of psychological abuse was dominated by interpersonal sensitivity, obsessive-compulsive symptoms, and anxiety-depressive symptoms. Network analysis identified two functional groups of psychological variables with the potential to intensify or attenuate existing subclinical psychopathological symptoms among survivors of psychological abuse. This result is consistent with the network theory of mental disorders and indicates that clinical psychological interventions should target not isolated symptoms but the pathological connections among them.

Future research should include longitudinal studies to assess the stability of the identified configuration of activators and inhibitors, as well as empirical studies incorporating experimental manipulations designed to deliberately strengthen inhibitors and "deactivate" activators.

The study has several limitations. First, a well-known methodological risk is associated with the use of self-report measures and the retrospective nature of respondents' reports of psychological abuse. Second, the cross-sectional design and network analysis establish an associative structure; additional studies are planned to determine the directionality and causal nature of the associations. Third, women predominated in the study sample. Although this reflects the typical gender distribution in psychological research, it limits the generalizability of the identified patterns to the male population.

Conflict of interest statement

The authors declare no conflicts of interest. The study received no financial support.

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Reappraisal: adaptive emotion regulation or meaning reconstruction?

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Abstract

Objective The present study reexamined the function of cognitive reappraisal, which has traditionally been regarded as an adaptive emotion regulation strategy.

Method Participants were 169 Japanese male prisoners, including violent/serious offenders (n = 52) and theft offenders (n = 117). Measures included the Buss–Perry Aggression Questionnaire (BPAQ), Emotion Regulation Questionnaire (ERQ), K6 (6-item Kessler Psychological Distress Scale), and Balanced Inventory of Desirable Responding (BIDR).

Results Compared with theft offenders, violent/serious offenders showed significantly higher anger and reappraisal scores together with lower subjective stress related to work, family, and community life. No significant group difference was found in suppression. The elevated reappraisal tendency observed among violent/serious offenders was not sufficiently explained by impression management and showed only a partial association with self-deception.

Conclusions These findings suggest that reappraisal may not function solely as an adaptive strategy for reducing negative emotions. The coexistence of elevated anger, higher reappraisal, and lower subjective stress suggests that high levels of cognitive reappraisal should not automatically be interpreted as indicators of adaptive psychological functioning. One hypothesis generated by the present findings is that some responses captured by the ERQ may reflect meaning reconstruction processes that reduce subjective discomfort while maintaining self-consistent interpretations of one's own behavior.

Keywords: cognitive reappraisal; emotion regulation; adaptive functioning; violent offenders; anger.

Introduction

Anger is one of the major factors promoting aggressive behavior, and both experimental studies and meta-analyses have repeatedly demonstrated that the elicitation of anger or negative affect is associated with increased aggressive responses [1, 2]. For this reason, the recognition and management of anger have been regarded as important components of recidivism prevention programs for offenders and juvenile delinquents. In cognitive behavioral therapy (CBT)-based interventions, which currently constitute the mainstream approach in many countries, recognition of anger, identification of triggers, reappraisal, and problem-solving skills training are considered central intervention components [3, 4].

One of the emotion regulation strategies that has traditionally been emphasized in anger management is reappraisal. In emotion regulation research, reappraisal has generally been regarded as one of the most adaptive strategies [5, 6]. Reappraisal is understood as a process that modifies emotional responses by changing the meaning assigned to situations, thereby promoting psychological adaptation. In CBT-based offender rehabilitation programs as well, the acquisition of cognitive reinterpretation and emotion regulation skills constitutes an important component of interventions, particularly for individuals with violent tendencies.

However, in clinical practice within correctional settings, interventions for highly aggressive offenders do not always proceed in accordance with these theoretical assumptions. Among violent and serious offenders, some individuals are immature and impulsive but nevertheless relatively responsive to intervention and likely to benefit from treatment. In contrast, there are also offenders who appear superficially calm, yet strongly justify their own

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behavior, remain fixated on victim consciousness and externalization of blame, and even deny that they themselves have any psychological problems at all. In such individuals, although anger is often easily elicited by trivial events, they also appear to have difficulty maintaining awareness of the conflict and ambivalence associated with their anger and aggressive behavior. Negative emotions and interpersonal conflicts are rapidly resolved through interpretations that justify their own actions, with the result that such individuals often experience little subjective awareness of their own problems. Furthermore, even when they are encouraged to cognitively reinterpret aggression-related situations from alternative perspectives, such "reappraisal-like" cognitive operations do not necessarily reduce anger or internal conflict, but may instead function to preserve or reinforce cognitive consistency and self-justification.

These clinical observations suggest the need to reconsider the conventional assumption that reappraisal, defined as reducing negative emotions through reinterpretation of situations, is always an adaptive emotion regulation strategy. In other words, reappraisal may not always function to reduce anger or aggression itself; in some cases, it may instead function in ways that maintain or justify anger and aggressive tendencies. Nevertheless, the question remains whether such cognitive operations should truly be regarded as reappraisal within the framework of emotion regulation theory. Changes in meaning-making directed toward preserving cognitive consistency and self-justification have traditionally been discussed in relation to techniques of neutralization and may also be understood through the cognitive mechanisms proposed in motivated reasoning theory.

Gross, who proposed the process model of emotion regulation, defined reappraisal as "changing the way one thinks about a situation in order to decrease its emotional impact" [5]. Importantly, this definition does not explicitly limit the reduced emotion specifically to anger or aggression themselves. Given both this definition and the conventional tendency to regard reappraisal as adaptive, reinterpretation of situations has generally been assumed to function in ways that reduce anger and aggression. However, the clinical observations described above suggest that reinterpretation may also function to reduce subjective discomfort arising from threats to self-esteem or cognitive consistency, through processes involving externalization of blame and self-justification.

From this perspective, it may be possible that what has traditionally been treated as adaptive reappraisal may also include forms of cognitive functioning that differ from the adaptive emotion-reduction processes conventionally assumed. Recent empirical studies have likewise failed to provide entirely consistent support for traditional understandings of reappraisal. For example, Troy et al. [7] demonstrated that the adaptiveness of reappraisal varies according to the controllability of situations, suggesting that reappraisal may be less effective or even maladaptive in situations where direct action or problem solving is possible. McRae et al. [8] suggested that reappraisal is not a unitary strategy, but rather consists of multiple tactics. Furthermore, Ford et al. [9] demonstrated that the adaptiveness of emotion regulation varies flexibly depending on situational and contextual factors, suggesting that strategies traditionally regarded as adaptive may not necessarily function adaptively in all circumstances. More recent reviews have further suggested that the effectiveness of cognitive reappraisal depends substantially on contextual demands and individual differences, and that positive cognitive reappraisal may contribute to resilience under some conditions while functioning less adaptively in others [10].

Based on these considerations, the present study aimed to reexamine the function of reappraisal by comparing a violent/serious offender group, who had engaged in actual aggressive criminal behavior, with a theft offender group, who had not engaged in direct interpersonal aggression. Of course, offense category does not directly reflect an individual's inherent aggression tendency. Nevertheless, comparing offenders with histories of interpersonal aggressive crimes and offenders without direct interpersonal aggression may provide meaningful insight into the relationship between aggression and reappraisal, because the former group has engaged in actual aggressive behavior toward others in real-life contexts rather than merely reporting aggressive tendencies on self-report measures.

The hypotheses of the present study were as follows: compared with theft offenders, violent/serious offenders would (1) demonstrate both higher reappraisal tendencies and higher anger, and (2) exhibit relatively lower subjective stress despite elevated anger.

Method

Participants

Participants were male inmates incarcerated in correctional institutions in Japan. The sample consisted of two offender groups: a violent/serious offender group and a theft offender group. The violent/serious offender group included offenders convicted of violent crimes involving direct

interpersonal aggression, whereas the theft offender group consisted of offenders convicted of theft-related offenses without direct interpersonal violence.

The final sample consisted of 169 participants. Of these, 52 were classified into the violent/serious offender group and 117 into the theft offender group. Participants with histories of both violent and theft-related offenses were classified into the violent/serious offender group because they had engaged in direct interpersonal aggression.

The mean age of the violent/serious offender group was 45.31 years (SD = 12.23), whereas the mean age of the theft offender group was 50.56 years (SD = 13.29).

Measures

Buss–Perry Aggression Questionnaire (BPAQ)

Aggression tendencies were assessed using the Japanese version of the Buss–Perry Aggression Questionnaire (BPAQ) [11]. The BPAQ consists of four subscales: Physical Aggression, Verbal Aggression, Anger, and Hostility. In the present study, the Anger subscale was treated as the primary indicator of anger-related tendencies.

The internal consistency coefficients for the Physical Aggression and Verbal Aggression subscales were relatively low in the present sample (Physical Aggression: $\alpha = 0.439$; Verbal Aggression: $\alpha = 0.142$). Given the correctional setting, responses to items directly assessing aggressive behavior may have been influenced by socially desirable responding, defensive responding, or institutional self-presentation. Therefore, these subscales were not included in the primary analyses and were treated only as supplementary indicators.

Emotion Regulation Questionnaire (ERQ)

Reappraisal and suppression tendencies were assessed using the Japanese version of the Emotion Regulation Questionnaire (ERQ) [12]. The ERQ consists of two subscales measuring cognitive reappraisal and expressive suppression.

In the present study, the Reappraisal subscale was used as the primary indicator of reappraisal tendency.

Psychological Distress

Psychological distress was assessed using the K6 scale [13].

Balanced Inventory of Desirable Responding (BIDR)

Socially desirable responding was assessed using the Balanced Inventory of Desirable Responding (BIDR) [14]. The BIDR includes subscales measuring self-deceptive enhancement and impression management.

Subjective Stress

Participants were also asked to rate subjective stress in several life domains, including work, family, and community relationships.

Procedure

Questionnaire surveys were administered collectively within correctional institutions. Participation was voluntary, and participants were informed that their responses would not influence institutional treatment or parole decisions.

The study was conducted in accordance with ethical standards for psychological research involving human participants.

Statistical analysis

Group differences between violent/serious offenders and theft offenders were examined primarily using independent samples t-tests.

In addition, analyses controlling for socially desirable responding were conducted using covariance analyses with BIDR self-deception and impression management scores as covariates.

Effect sizes were calculated using Cohen's d. Statistical analyses were conducted using IBM SPSS Statistics (Version 20.0).

Results

Group differences between violent/serious offenders and theft offenders

Table 1 presents the descriptive statistics and group comparisons for the principal study variables.

Compared with the theft offender group, the violent/serious offender group demonstrated significantly higher scores on the Anger subscale of the BPAQ. In addition, the violent/serious offender group showed significantly higher reappraisal tendencies as measured by the ERQ.

Regarding subjective stress, the violent/serious offender group reported significantly lower levels of stress in several life domains despite exhibiting higher anger tendencies. In contrast, no significant group difference was found for psychological distress as measured by the K6.

With respect to socially desirable responding, the violent/serious offender group demonstrated significantly higher self-deception scores on the BIDR.

Although the Physical Aggression subscale of the BPAQ showed relatively low internal consistency in the present sample ($\alpha = 0.439$), supplementary analyses indicated that the violent/serious offender group also tended to score higher on physical aggression than the theft offender group. However, because of the low reliability of this subscale, these findings should be interpreted cautiously.

Variable	Violent/serious offenders M (SD)	Theft offenders M (SD)	t (df)	p
Age	45.31 (12.23)	50.56 (13.29)	2.51 (105.72)	0.014
Self-deception	51.06 (16.02)	43.12 (9.19)	−3.34 (66.41)	0.001
Impression management	43.90 (14.28)	46.50 (9.77)	1.19 (73.05)	0.237
Verbal aggression	16.98 (3.18)	16.03 (9.30)	−0.99 (159.88)	0.324
Hostility	21.44 (4.50)	21.84 (4.16)	0.54 (91.43)	0.591
Physical aggression	23.56 (6.58)	18.48 (9.69)	−3.97 (139.71)	<0.001
Anger	17.21 (4.12)	14.97 (4.10)	−3.26 (97.35)	0.002
Reappraisal	27.21 (7.57)	24.65 (5.73)	−2.18 (78.10)	0.032
Suppression	15.58 (4.95)	16.01 (4.02)	0.55 (82.24)	0.582
K6 (psychological distress)	5.92 (5.65)	7.10 (5.47)	1.27 (95.12)	0.209
Job stress	7.31 (3.78)	8.53 (3.06)	2.05 (82.02)	0.043
Family stress	6.08 (3.84)	7.62 (3.48)	2.48 (89.76)	0.015
Community stress	5.92 (3.46)	7.69 (3.57)	3.04 (100.69)	0.003

Note. Values are based on independent samples t-tests. Welch's t-test was used when the assumption of equal variances was violated. In the present correctional sample, the physical aggression and verbal aggression subscales of the BPAQ demonstrated low internal consistency (Cronbach's α = 0.439 and 0.142, respectively). Therefore, these scores are reported for descriptive purposes only and were not emphasized in the primary analyses or interpretation.

Table 1. Group differences between violent/serious offenders and theft offenders

Because the violent/serious offender group was significantly younger than the theft offender group, supplementary ANCOVAs were conducted with age entered as a covariate. Age was not significantly associated with reappraisal, anger, self-deception, or any subjective stress measures (ps = 0.159–0.865). In contrast, offender group remained significantly associated with reappraisal ($F(1,166) = 5.20$, $p = 0.024$), anger ($F(1,166) = 10.47$, $p = 0.001$), self-deception ($F(1,166) = 15.22$, $p < 0.001$), and subjective stress measures (ps = 0.001–0.027). These findings suggest that the observed group differences cannot be explained solely by age differences.

Analyses controlling for socially desirable responding

To examine whether the observed group differences could be explained by socially desirable responding, additional analyses were conducted controlling for BIDR self-deception and impression management scores.

The group difference in reappraisal tendency remained significant after controlling for socially desirable responding variables. Similarly, the tendency for the violent/serious offender group to exhibit higher anger and lower subjective stress remained generally unchanged.

These findings suggest that the elevated reappraisal tendencies observed in the violent/serious offender group cannot be fully explained by socially desirable responding or defensive self-presentation alone.

Summary of findings

Overall, the present findings demonstrated that the violent/serious offender group exhibited a paradoxical pattern characterized by:

- higher anger tendencies,
- higher reappraisal tendencies, and
- lower subjective stress.

At the same time, no significant group difference was observed in generalized psychological distress as measured by the K6.

Taken together, these findings suggest that the reappraisal tendencies observed in violent/serious offenders may not necessarily reflect adaptive reduction of anger itself, but may instead involve forms of cognitive reinterpretation functioning to reduce subjective discomfort while maintaining psychological consistency regarding anger and aggression-related tendencies.

Discussion

Theoretical implications

The present findings may suggest the need to reconsider the concept of reappraisal from the perspective of the process model of emotion

regulation [5]. Gross conceptualized reappraisal as an "antecedent-focused" strategy that modifies the meaning of a situation before an emotional response is fully generated, whereas suppression was conceptualized as a "response-focused" strategy that regulates the expression of an already generated emotional response [5]. However, in the present study, the violent/serious offender group showed significantly higher reappraisal tendencies than the theft offender group, while also demonstrating higher anger tendencies and belonging to crime categories involving actual aggressive behavior. These findings are difficult to explain solely from the conventional understanding of reappraisal as an antecedent-focused strategy for reducing negative emotions.

In Gross's extended process model, reappraisal may occur within a recursive cycle of World → Perception → Valuation → Action → World... [6]. Theoretically, this framework allows anger that has once emerged and been suppressed to be subsequently processed through reappraisal within a later cycle. However, in such cases, reappraisal may function in a manner different from the emotion-reduction function that has traditionally been assumed.

Furthermore, in the present study, the violent/serious offender group demonstrated a coexistence of high anger and low subjective stress, whereas no significant group difference was found in psychological distress as measured by the K6. This finding suggests that the lower subjective stress observed in the violent/serious offender group may be related not to reductions in generalized anxiety or depressive distress itself, but rather to differences in subjective appraisal and meaning-making regarding concrete life situations such as work, family, and community relationships.

In general, the persistence of anger is associated with increased stress responses and psychological burden. However, in the present study, high anger coexisted with low subjective stress in the violent/serious offender group. Given that the catharsis hypothesis — that the enactment of aggressive behavior relieves stress and negative affect — has not received consistent empirical support [15], the coexistence of reappraisal and anger in the present findings is difficult to understand merely as a "failure" of reappraisal.

Conventionally, reappraisal has been understood as a strategy that modifies cognitive meaning-making to adapt to situations and reduce negative emotions [6, 7]. However, the present findings suggest the necessity of considering additional functions of reappraisal beyond those traditionally assumed. Recent theoretical developments have also suggested that cognitive reappraisal may require conceptual refinement beyond its traditional characterization as a uniformly adaptive strategy [16].

The ERQ assesses the tendency to engage in cognitive reappraisal, but provides no information regarding the content, target, or motivational direction of such reinterpretation. Thus, adaptive reinterpretation, self-justifying reinterpretation, rationalization, and other forms of meaning reconstruction cannot be differentiated within the present design.

One possible hypothesis that may coherently explain these apparently contradictory findings is that what was measured as reappraisal may function less to reduce anger itself than to reduce subjective conflict and discomfort by construing anger and aggression-related tendencies as psychologically self-consistent. The present study does not equate self-justifying reinterpretation itself with reappraisal. Rather, it suggests the possibility that cognitive meaning-making processes measured as "reappraisal" may include such directions of functioning.

Gross defined reappraisal as "changing the way one thinks about a situation in order to decrease its emotional impact" [5]. This definition does not limit the reduced emotion specifically to anger itself, and may theoretically include forms of reappraisal that function to reduce conflict or inconsistency arising from threats to self-worth or self-justification. Furthermore, the ERQ used in the present study measures the tendency to use reappraisal, but does not distinguish the direction in which such cognitive reconstruction functions. Therefore, the reappraisal tendencies observed in the present study may also include self-justifying forms of reinterpretation.

This interpretation is also broadly consistent with several previously proposed theoretical perspectives. First, techniques of neutralization, proposed in offender research, describe cognitive justification processes that reduce guilt and conflict associated with deviant behavior, and may partially overlap with the self-justifying meaning reconstruction tentatively suggested in the present study [17]. In addition, the present findings may also be viewed considering the perspective of motivated reasoning [18], according to which individuals do not necessarily construct meanings based on objective facts, but rather reconstruct meanings in accordance with motivations to maintain self-concept and emotional consistency.

From the perspective of psychodynamic theory, the reappraisal tendencies observed in the present offender sample may also be tentatively interpreted as processes that share certain features with rationalization, functioning not merely as adaptive emotional regulation strategies but also

as means of avoiding direct confrontation with one's own aggression and internal conflict [19, 20]. Rationalization has been conceptualized as a process that may temporarily reduce subjective distress while simultaneously weakening self-reflection regarding responsibility and internal conflict [19, 20]. However, because the present study did not directly assess rationalization, neutralization, motivated reasoning, or self-justifying cognitive processes, these interpretations should be regarded as theoretical hypotheses intended to account for the observed coexistence of high anger, elevated reappraisal, and low subjective stress, rather than as direct empirical conclusions derived from the present data.

Recent longitudinal evidence has suggested that the effectiveness of reappraisal may depend on individual characteristics and situational contexts, raising the question of for whom and under what conditions reappraisal contributes to psychological adaptation [21].

Taken together, the present findings suggest that elevated reappraisal scores should not automatically be regarded as evidence of adaptive emotion regulation. Rather, one possible hypothesis is that some forms of cognitive reconstruction measured as reappraisal may function to reduce subjective discomfort while maintaining psychologically self-consistent interpretations of anger and aggression-related tendencies.

Although recent meta-analytic evidence has generally supported associations between reappraisal and resilience [22], the present findings suggest that elevated reappraisal scores may not uniformly indicate adaptive functioning, particularly among offender populations.

Clinical implications

From a clinical perspective, the present findings suggest that elevated reappraisal scores should be interpreted with caution in correctional settings. More broadly, they also indicate that emotion regulation theory, neutralization theory, and motivated reasoning may be understood within a broader integrative framework of meaning reconstruction. For some offenders, increased cognitive reappraisal may reduce subjective discomfort while simultaneously reinforcing self-justifying interpretations and defensive patterns of thinking, rather than promoting genuine psychological change.

These findings further suggest that cognitive reappraisal should not be regarded as a sufficient treatment goal, but rather as one cognitive skill that may contribute to offender rehabilitation. Accordingly, interventions designed to enhance reappraisal should be positioned within a comprehensive treatment program rather than implemented as an isolated target of intervention.

Contemporary offender rehabilitation generally emphasizes treatment targets such as acknowledgment of responsibility for one's offense, empathy toward victims, and motivation to change. Improvements in cognitive reappraisal should therefore be evaluated not as an endpoint in themselves, but in terms of whether they facilitate progress toward these broader rehabilitative goals. Otherwise, increased reappraisal may simply strengthen self-justifying meaning reconstruction while creating the appearance of psychological improvement without promoting meaningful rehabilitation.

Quantitative assessment remains indispensable in evidence-based practice. At the same time, psychometric indicators should always be interpreted within the broader context of comprehensive clinical assessment and ongoing therapeutic observation. From this perspective, elevated reappraisal scores should not automatically be interpreted as indicators of adaptive functioning or therapeutic progress, but rather should be understood in relation to the offender's overall psychological functioning and their progress toward the broader goals of rehabilitation.

Limitations and future directions

The present study was cross-sectional in design and therefore cannot directly establish causal relationships within emotion regulation processes. In addition, the ERQ used in the present study measures the tendency to engage in cognitive reinterpretation, but does not directly distinguish whether such meaning reconstruction functions in adaptive directions or in self-justifying directions. Furthermore, the present study did not directly assess neutralization processes or motivated reasoning themselves. Accordingly, the interpretations proposed in the present study should be regarded as theoretical inferences derived from the observed patterns of association.

In addition, the present study relied exclusively on self-report measures administered within correctional institutions. Although socially desirable responding was partially addressed using the BIDR, including its impression management component, self-report data obtained in correctional settings may still be influenced by additional factors not fully captured by the BIDR, such as institutional norms, concerns regarding possible consequences of disclosure, distrust of research procedures, and response styles shaped by prolonged incarceration.

Relatedly, although the present study used offense category as an indicator of histories of interpersonal aggression among Japanese male prisoners, offense classification does not necessarily directly reflect an individual's underlying aggressive traits, and other unmeasured factors — such as criminal history (e.g., number of prior convictions or recidivism) and institutional environment (e.g., security level, length of incarceration, or participation in treatment programs) — may also have contributed to the observed group differences. Although supplementary analyses indicated that these differences remained significant after controlling for age, the present design cannot rule out the influence of such unmeasured variables.

Moreover, because the present sample was limited to Japanese male prisoners, the generalizability of the findings remains limited. Emotion regulation processes may also be shaped, at least in part, by cultural norms concerning the experience, expression, and management of emotions. Japanese culture has often been characterized as placing relatively strong emphasis on interpersonal harmony, emotional restraint, and sensitivity to social evaluation. Such cultural factors may influence the relationships among anger, subjective stress, and cognitive reappraisal observed in the present study. Therefore, caution is warranted in generalizing the present findings to offenders from different cultural backgrounds.

Future studies should examine the relationships among emotion, meaning-making, and behavior in greater detail through experimental and longitudinal designs. It will also be necessary to develop research designs capable of directly assessing the direction in which reappraisal modifies meaning-making processes.

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Plasticity of personality structures: a study of changes in self-esteem following short-term psychotherapy

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Abstract

Objective To examine the possibility of modifying self-esteem as a key personality structure through a targeted short-term psychotherapy program.

Method The study included 58 participants (53 women and 5 men) who sought psychological help due to subjective difficulties related to self-esteem and self-perception. A repeated-measures design was employed. All participants underwent 10 individual psychotherapy sessions aimed at addressing dysfunctional aspects of self-esteem and related patterns of self-perception and interpersonal functioning. The following instruments were used to assess changes: the Sorensen Self-Esteem Test, the Self-Esteem Matrix by J. Weinhold, and Ryff's Psychological Well-Being Scale. Statistical analysis included the Wilcoxon signed-rank test and Spearman correlation analysis.

Results Following the psychotherapeutic intervention, statistically significant changes were observed across all measured variables. Sorensen Self-Esteem Test scores decreased, indicating improved self-esteem from 23.46 to 14.21 points ($Z = 5.40$; $p < 0.001$), self-esteem scores on the Self-Esteem Matrix increased from 61.80 to 70.00 points ($Z = 4.38$; $p < 0.001$), and psychological well-being scores on Ryff's scale increased from 348.75 to 374.89 points ($Z = 5.06$; $p < 0.001$). Stronger correlations were observed between self-esteem and psychological well-being after treatment.

Conclusions The findings indicate that substantial changes in self-esteem are possible in short-term psychotherapy. The observed changes support the view of self-esteem as one of the key clinical targets of psychotherapy and suggest the possibility of meaningful changes in personality structures even within brief psychotherapeutic interventions, challenging the assumption that personality structures are relatively fixed. Further controlled studies are needed to confirm these findings.

Keywords: self-esteem; psychological well-being; plasticity of personality structures; short-term psychotherapy; integrative causal psychotherapy.

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Introduction

Traditional personality theories have long conceptualized personality as a relatively stable system of traits, formed early in development and characterized by a high degree of structural stability across the lifespan [1]. In the early psychoanalytic tradition, personality stability was linked to early object relations, ego structure, and the formation of the superego [2, 3]. Classical psychoanalytic theorists emphasized that the key configurations of personality are formed primarily during early childhood and are subsequently reproduced in the form of stable patterns of perception, affective responses, and interpersonal interaction [2]. Similar views on personality stability are also present in dispositional theories of personality, particularly in the Five-Factor Model ("Big Five"), where personality traits are regarded as relatively stable structures [4].

For a long time, empirical research also supported the notion of high personality stability. Costa and McCrae pointed to the substantial temporal stability of personality traits in adulthood [4], while Roberts and DelVecchio demonstrated that the stability of personality characteristics increases with age and reaches its peak during mature adulthood [5]. According to these approaches, psychotherapy is

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considered to have a greater impact on symptoms, coping strategies, and levels of adaptation than on deep personality structures.

At the same time, over recent decades an increasing body of evidence has begun to challenge the notion of personality as a predominantly fixed system. Contemporary research in the fields of neuroplasticity, affect regulation, and memory reconsolidation suggests the possibility of changes in personality structures traditionally regarded as stable, including self-esteem, affective regulation, and core self- and object representations [6, 7].

One possible explanation for relatively rapid personality change is provided by contemporary models of emotional learning and memory reconsolidation. According to these models, the reactivation of emotionally significant experiences combined with a novel corrective experience can lead to the modification of previously established schemas of self- and other-perception. As a result, change may affect not only current emotional responses but also more stable cognitive-affective structures underlying self-attitudes and interpersonal functioning.

An additional explanation is offered by contemporary models of the mind that conceptualize personality as a system of internal models continuously updated through new experience. From this perspective, psychotherapy may serve as a unique context in which enduring beliefs about oneself, other people, and one's own capacities are re-examined and refined. Such an approach helps explain how meaningful changes in specific components of personality organization can occur not only over many years but also within the framework of relatively brief psychotherapeutic interventions.

Personality is increasingly conceptualized as a dynamic system of interconnected psychological structures that can change in response to affective experience, interpersonal relationships, and psychotherapeutic intervention [8, 9]. Contemporary meta-analytic research further supports the possibility of personality change through psychotherapy. For example, Roberts et al. demonstrated that psychotherapeutic interventions can produce statistically significant changes in personality traits, with the largest effects typically observed during the first months of treatment [9]. These findings challenge the view of personality characteristics as entirely stable entities and support the concept of their relative plasticity.

The concept of personality structure plasticity has been developed particularly extensively within contemporary psychodynamic and humanistic approaches. Otto Kernberg associated personality change with the transformation of internal object relations and the integration of affective experience [3]. Heinz Kohut considered the possibility of structural personality change through the correction of self-disturbances within therapeutic relationships [10]. In cognitive-behavioral therapy and schema therapy, central importance is assigned to the modification of deep-seated beliefs and maladaptive schemas that shape stable patterns of perceiving the self and the world [11].

One of the approaches that advances the concept of high plasticity of personality structures is Integrative Causal Psychotherapy (ICP)*. From the perspective of this approach, personality is viewed as a dynamic system of mental structures and habitual patterns of responding, many of which are formed implicitly through the individual's interaction with the social environment [12]. Within ICP, personality structures are regarded as more plastic than they are conceptualized in traditional theories of personality stability. Psychotherapeutic intervention targeting personality-related structures may modify self-representations, affective responding, and interpersonal functioning [12]. Particular emphasis within this approach is placed on self-perception, self-image, internal objects, limiting self-beliefs, and internalized social norms affecting psychological well-being.

One of the most significant personality constructs in this context is self-esteem. Self-esteem is closely related to processes of self-regulation, stress resilience, the quality of interpersonal relationships, self-efficacy, and psychological well-being [13, 14].

In contemporary literature, self-esteem is conceptualized not only as an indicator of one's attitude toward oneself but also as one of the central components of the system of personal structures that organize self-perception, emotional regulation, and interpersonal functioning. From this perspective, changes in self-esteem may be viewed as an indicator of broader processes of personality transformation. At the same time, the question of the extent of its plasticity remains controversial. On the one hand, self-esteem is regarded as a relatively stable personality characteristic shaped by early experience and social interactions [15]. On the other hand, contemporary psychotherapy research increasingly points to the possibility of

* Integrative Causal Psychotherapy is a psychotherapeutic approach developed by Yu. Tor that focuses on identifying core pathogenic mechanisms underlying mental disorders and developing therapeutic protocols aimed at addressing them.

clinically significant changes in self-esteem through interventions targeting affective experience, internal self-representations, and maladaptive cognitive-affective patterns [16, 17].

Self-esteem is increasingly viewed not as an isolated personality trait but as a component of a broader system of self-representations that includes self-acceptance, self-efficacy, and self-concept clarity [18]. Research has shown that self-esteem is closely associated with psychological well-being, the quality of interpersonal relationships, mental health, and successful adaptation across various domains of life [19].

Despite growing interest in the problem of personality plasticity, empirical studies examining changes in personality structures in short-term psychotherapy remain limited. Most studies focus either on symptomatic changes or on long-term psychotherapeutic processes. The possibility of relatively rapid modification of self-related formations within a structured short-term intervention remains underexplored. Accordingly, investigating the possibility of changes in self-esteem in short-term psychotherapy represents an important research objective.

Research hypotheses

- Self-esteem as a personality-related structure may undergo statistically significant changes during short-term psychotherapy.
- Changes in self-esteem are accompanied by improvements in indicators of psychological well-being.

Methods

Participants

The study included 58 participants (53 women and 5 men) who sought psychological help. Participants ranged in age from 18 to 45 years. Inclusion criteria were subjective difficulties related to self-esteem and self-perception, as well as willingness to participate in psychotherapy according to the study protocol. Exclusion criteria included diagnosed psychiatric disorders and severe somatic illnesses. The sample was non-clinical.

Study design

The study employed a pre–post design. Prior to the psychotherapeutic intervention, participants completed a baseline psychodiagnostic assessment. Following completion of therapy, repeated assessment was conducted using the same instruments.

All participants provided informed consent prior to participation. The study was conducted in accordance with the principles of confidentiality and professional ethics.

Measures

The following instruments were used:

- The Sorensen Self-Esteem Test, assessing self-esteem and related patterns of negative self-evaluation.
- The Self-Esteem Matrix by J. Weinhold, assessing the capacity for interpersonal connection, self-acceptance, acceptance of others, and maintaining a positive sense of self in relationships.
- Ryff's Psychological Well-Being Scale, measuring key dimensions of psychological well-being, including self-acceptance, autonomy, personal growth, environmental mastery, purpose in life, and positive relations with others.

Psychotherapeutic intervention

All participants completed a course of targeted* short-term psychotherapy consisting of 10 individual sessions. The intervention was conducted within the framework of Integrative Causal Psychotherapy (ICP) and consisted of weekly 50-minute online psychotherapy sessions conducted via videoconferencing.

The psychotherapeutic protocol primarily focused on self-esteem and related personality structures, including self-perception, self-image, limiting self-beliefs, and interpersonal interaction.

The main therapeutic focus included:

- processing emotionally significant experiences linked to a negative self-image;
- modifying maladaptive self-beliefs;
- developing a more stable, internally grounded sense of self-worth and self-acceptance independent of external evaluations and achievements;
- reducing discrepancies between actual and idealized self-representations;
- developing more adaptive affective responses and interpersonal functioning.

The therapeutic work focused primarily on unconscious components of cognitive, affective, and behavioral patterns through the processing of underlying affective material using ICP techniques, as well as motifs of catathym-imaginative psychotherapy (symboldrama).

* Targeted psychotherapy is defined as a psychotherapeutic intervention aimed at specific mechanisms involved in the development and maintenance of psychopathological symptoms.

The study was conducted in 2024 at the Academy of Integral Psychodynamic Psychotherapy. Psychotherapy was delivered by 25 trainee psychotherapists who received prior training in the treatment protocol and worked under regular supervision, ensuring standardization of the intervention and adherence to a unified therapeutic framework. The total study duration was 20 weeks.

Statistical analysis

Data were analyzed using the Shapiro–Wilk test, Wilcoxon signed-rank test, and Spearman's rank correlation coefficients. Effect sizes were additionally calculated using the formula $r = Z/\sqrt{N}$. In accordance with conventional guidelines, $r = 0.1$ was interpreted as a small effect, $r = 0.3$ as a medium effect, and $r \geq 0.5$ as a large effect.

Results

Distribution of the Sorensen Self-Esteem Test scores before and after psychotherapy was examined using the Shapiro–Wilk test (Table 1).

Because one variable significantly deviated from a normal distribution ($p < 0.01$), subsequent analyses were conducted using nonparametric methods.

Treatment effects were assessed using the Wilcoxon signed-rank test (Table 2).

Sorensen Self-Esteem Test scores decreased significantly from 23.46 to 14.21 points ($T = 146.5$; $Z = 5.40$; $p < 0.001$), indicating improved self-esteem.

Scores on the Weinhold measure increased from 61.80 to 70.00 points ($T = 275$; $Z = 4.38$; $p < 0.001$), reflecting greater self-acceptance and acceptance of others.

Psychological well-being scores also increased significantly, from 348.75 to 374.89 points ($T = 189.5$; $Z = 5.06$; $p < 0.001$). Improvements were observed across multiple domains of psychological well-being, including self-acceptance, autonomy, environmental mastery, purpose in life, positive relationships, and personal growth [20].

To examine changes in the relationships between the study variables following psychotherapy, Spearman correlation analyses were conducted (Table 3).

Correlation analyses revealed significant associations between self-esteem, psychological well-being, and self-acceptance/acceptance of others both before and after psychotherapy ($p < 0.001$). Following treatment, these associations became stronger: the correlation between self-esteem and self-acceptance/acceptance of others increased from −0.58 to −0.75, the correlation between self-esteem and psychological well-being increased from −0.66 to −0.72, and the correlation between self-acceptance/

		W	p
Pre-treatment	Sorensen	0.984	0.634152
	Weinhold	0.988	0.815028
	Ryff	0.980	0.440009
Post-treatment	**Sorensen**	**0.941**	**0.007308**
	Weinhold	0.980	0.440795
	Ryff	0.983	0.576381

Table 1. **Shapiro–Wilk test for normality**

Measure	Mean		T	Z	p	r
	Pre-treatment	Post-treatment				
Self-esteem (Sorensen)*	23.46	14.21	146.50	5.40	< 0.001	0.71
Self-acceptance and acceptance of others (Weinhold)	61.80	70.00	275.00	4.38	< 0.001	0.58
Psychological well-being (Ryff)	348.75	374.89	189.50	5.06	< 0.001	0.66

** Lower scores on the Sorensen Self-Esteem Test indicate higher self-esteem.*

Table 2. **Pre-post differences according to the Wilcoxon signed-rank test**

	Pre-treatment			Post-treatment		
	Sorensen	Weinhold	Ryff	Sorensen	Weinhold	Ryff
Sorensen		−0.58	−0.66		−0.75	−0.72
Weinhold			0.67			0.73
Ryff						

Note. Critical values for correlation coefficients at n = 58 were 0.26 for p = 0.05, 0.37 for p = 0.01, and 0.42 for p = 0.001.

Table 3. Spearman correlations before and after psychotherapy

acceptance of others and psychological well-being increased from 0.67 to 0.73.

Overall, psychotherapy was associated not only with improvements in self-esteem and psychological well-being, but also with stronger relationships between the measured variables. This pattern may reflect greater coherence across self-related psychological processes. The strengthening of associations among the measured variables may indicate not only improvements in individual aspects of psychological functioning but also an increase in their internal integration. This finding suggests that the psychotherapeutic changes affected not isolated characteristics but rather an interconnected system of self-representations.

Discussion

The present findings support the view that self-esteem is a relatively malleable personality structure that remains responsive to short-term psychotherapeutic intervention. The observed effect sizes were large (r = 0.58–0.71), indicating that the observed changes were substantial. The observed changes have not only statistical but also potential clinical significance. In particular, self-esteem scores on the Sorensen Self-Esteem Test decreased from 23.46 to 14.21 points, reflecting a substantial reduction in negative self-attitudes and the development of a more adaptive relationship with oneself. Similarly, improvements on the Weinhold and Ryff scales indicate positive changes in self-acceptance, interpersonal functioning, and subjective psychological well-being.

The present findings are consistent with research from various psychotherapeutic approaches demonstrating the possibility of statistically significant improvements in self-esteem during psychotherapy. In particular, similar effects have been reported in studies of cognitive-behavioral therapy for low self-esteem [17], as well as in meta-analytic research showing that psychotherapeutic interventions can lead to changes in enduring personality characteristics and self-related representations [9]. Thus, the observed changes are in line with a broader trend identified in the contemporary psychotherapy literature.

The findings also accord with contemporary views of personality as a dynamic system of interconnected psychological structures capable of relatively rapid change under the influence of emotional experience and psychotherapeutic intervention. In contrast to classical models that viewed personality structures as largely stable and resistant to change, contemporary psychotherapeutic approaches increasingly recognize the possibility of meaningful modification in self-related structures over the course of psychotherapy.

The present findings may be interpreted within contemporary conceptualizations of psychotherapeutic change as a process involving the modification of enduring cognitive-affective models that shape self-perception and interactions with the external world. From the perspective of Integrative Causal Psychotherapy (ICP), such changes may result from the targeted processing of affective experience, modification of negative self-beliefs, and transformation of automatic cognitive-affective patterns. The therapeutic protocol primarily focused on self-perception, limiting self-beliefs, and emotionally significant experiences underlying the development of self-esteem.

The observed improvement in psychological well-being suggests that the intervention may have affected multiple domains of psychological functioning, even within a relatively brief course of psychotherapy. The findings therefore suggest that self-esteem can be meaningfully modified during short-term psychotherapy.

Of particular interest is the strengthening of the associations among self-esteem, self-acceptance, and psychological well-being. This finding may reflect not only improvements in individual indicators but also an increased integration of the system of self-representations. From this perspective, the observed changes may be interpreted as reflecting greater coherence among different components of the self-

concept and the development of a more integrated and cohesive self-attitude.

It should be noted that the observed effect sizes (r = 0.58–0.71) fall within, and in some cases exceed, the range of effects reported in studies of psychotherapeutic interventions aimed at improving self-esteem [9, 17]. Nevertheless, the absence of a control group precludes an unambiguous interpretation of the observed differences as being attributable solely to the psychotherapeutic intervention. At the same time, further studies incorporating control groups and follow-up assessments are needed to determine the stability of the observed changes and clarify the causal nature of the identified relationships. The present design does not allow nonspecific factors, expectancy effects, or natural fluctuations in participants' psychological state to be ruled out. Additional limitations include the relatively small sample size and pronounced gender imbalance, both of which restrict the generalizability of the findings.

An important direction for future research may involve comparing the plasticity of personality structures during psychotherapy in individuals with normative vs borderline personality organization. Borderline personality organization is characterized by deficits in structural integration, impaired integration of self-representations, and unstable self-concept. It may therefore be assumed that both the mechanisms and limits of personality change differ qualitatively in such patients compared to individuals with normative levels of personality functioning.

Conclusion

The findings demonstrate statistically significant improvements in self-esteem following short-term psychotherapy. These changes were accompanied by marked improvements in psychological well-being, self-acceptance, and acceptance of others, as well as by stronger associations among the examined variables.

The results support the conceptualization of self-esteem as a dynamic and malleable personality-related structure responsive to targeted psychotherapeutic intervention. The observed changes are consistent with contemporary perspectives suggesting that personality structures may be modified even during relatively brief psychotherapeutic interventions.

The findings further suggest that self-esteem may represent an important clinical target in short-term psychotherapy and support the value of further research into the plasticity of personality structures in the context of psychotherapeutic intervention.

Conflict of interest statement

The study was conducted within an organization involved in the development and training of the Integrative Causal Psychotherapy approach.

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Risky sexual behavior in a female patient with complex PTSD following childhood sexual abuse

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Abstract

Risky sexual behavior in women with a history of childhood sexual abuse is often associated with prior abuse and is frequently accompanied by complex post-traumatic stress disorder (CPTSD). Despite the clinical significance of this association, detailed reports of psychotherapy for such patients are scarce. This article presents the case of a 32-year-old woman with a history of childhood sexual abuse, symptoms meeting the ICD-11 diagnostic criteria for complex PTSD, and risky sexual behavior, who underwent psychotherapy. Therapy was conducted in stages using stabilization, trauma-focused, and body-oriented techniques over 96 sessions. Change was assessed using *the International Trauma Questionnaire* (ITQ) and self-report scales. The total ITQ score decreased by 42%, the severity of shame and self-blame decreased from 8–9 to 2–3 points, and the frequency of risky sexual encounters fell to zero; the outcome was maintained over a 6-month follow-up. The case suggests that, in the presence of dissociative symptoms, sustained improvement may be associated not only with processing traumatic experiences but also with the gradual development of self-regulation skills and the capacity to establish interpersonal boundaries.

Keywords: risky sexual behavior; childhood sexual abuse; complex post-traumatic stress disorder; trauma-focused psychotherapy; dissociation; clinical case.

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Introduction

Risky sexual behavior (RSB) in women with a history of childhood sexual abuse is considered one of the possible long-term consequences of psychological trauma.

Among women who experienced sexual abuse in childhood, the risk of developing RSB is 2–3 times higher than in the general population, while the severity and persistence of RSB patterns correlate with the severity and duration of the trauma as well as with a younger age at the onset of abuse [1, 2]. Current studies link risky sexual behavior to impairments in emotion regulation, self-blame, dissociation, disturbances in body perception and awareness of personal boundaries, and the use of sexual behavior as a means of coping with the consequences of psychological trauma [3]. At the same time, the literature continues to be dominated by epidemiological studies and research focused on individual mechanisms underlying RSB, whereas detailed descriptions of structured psychotherapeutic treatment, the sequence of therapeutic decisions, and factors associated with sustained change remain considerably less common.

Clinical guidelines provide detailed recommendations for the psychotherapeutic treatment of PTSD and CPTSD [4, 5]. By contrast, psychotherapeutic approaches targeting risky sexual behavior as a distinct treatment target are considerably less well developed: existing protocols do not always take into account the effects of psychological trauma on sexual functioning, particularly the mechanisms that maintain RSB and difficulties in forming intimate relationships. Few publications describe in detail the sequence of clinical decisions, criteria for transition between stages of therapy, and factors associated with sustained change.

The aim of this article is to describe the course of psychotherapy stage by stage using measurable outcome indicators for risky sexual behavior in complex PTSD following childhood sexual abuse; to identify therapeutic factors potentially associated with sustained symptom reduction; and to describe the key therapeutic targets and their sequence in similar cases.

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Clinical case

The data are presented with the patient's informed consent. All identifying information, including names and potentially identifying details, was altered or removed. An overview timeline of key events is presented in Table 1.

The patient was a 32-year-old woman who sought therapy because she wanted to establish stable intimate relationships. At presentation, she exhibited a pattern of numerous sexual encounters with partners she barely knew, accompanied by marked dissatisfaction and a subjective sense of loss of control over her behavior.

Patient history

She was the only child in the family and was raised by both parents. She spent summers in a village with her grandparents, where from the ages of seven to thirteen she was repeatedly subjected to sexual abuse by older adolescents, including non-penetrative genital contact and oral sexual contact. After the age of 13, trips to the village ceased; however, she continued to have sexual encounters with male and female friends in the city.

At the age of 18, the patient enrolled at university, after which her sexual behavior became riskier: the number of sexual partners increased markedly, and she began engaging in group sexual encounters, often while under the influence of alcohol or drugs. When describing her experience, the patient insisted that everything had occurred by 'mutual consent', referring to an internalized belief: 'I had been promiscuous since childhood.' After graduating from university, the patient began working in her field and reported career advancement and satisfaction with her professional development.

Conceptualization

The diagnostic assessment was conducted by the author of this publication and included a clinical interview structured according to the ICD-11 diagnostic criteria, as well as the ITQ for quantitative assessment of PTSD and complex PTSD symptoms.

Based on the ICD-11 criteria, the assessment yielded a clinical presentation consistent with complex post-traumatic stress disorder (6B41)[6], including a chronic sense of threat, marked difficulties in emotion regulation, negative self-concept ('I am to blame', 'I am unworthy'), disturbances in interpersonal relationships, avoidance of triggering topics, and dissociative phenomena (episodes of detachment during sexual encounters, a sense of 'watching from the outside', and fragmented memories of the traumatic period).

The assumption that dissociation played a significant role in maintaining risky sexual behavior in this case is consistent with findings from recent systematic reviews [7]. In these reviews, dissociation is considered one of the factors that lowers psychological barriers to impulsive and risky behavior and contributes to emotion dysregulation and disturbances in interpersonal boundaries.

In this patient, dissociative reactions manifested primarily as emotional detachment during sexual contact ('a feeling that this is not happening to me'), fragmented memories of the traumatic period, and episodic derealization in triggering situations. This pattern is consistent with findings on traumatic memory following sexual abuse: memories retain vivid sensory and emotional intensity, remain fragmented, and are difficult to verbalize, which impedes their processing and integration into autobiographical memory [8].

Time	Event
Ages 7–13	Sexual abuse by older adolescents
Age 18	Marked increase in sexual encounters; establishment of a persistent RSB pattern
Age 32	Initial presentation for psychotherapy
Session 3	Acute episode of shame after a spontaneous sexual encounter with a man she barely knew
Session 12	Completion of the safety and stabilization stage
Session 20	Key insight: recognition that the experience constituted abuse
Session 22	Dissociative episode while working with a traumatic memory
Session 45	First sustained refusal of a partner's advances
Session 96	Completion of therapy; frequency of RSB reduced to zero
+ 6 months	Follow-up: outcome maintained

Table 1. **Timeline of the clinical case**

An important factor contributing to the persistence of dissociative patterns was the social response to the trauma: the patient had no experience of safely disclosing the abuse and receiving a supportive response. Systematic reviews of the influence of the social environment on the course of PTSD indicate that such a lack of support increases the risk that dissociative symptoms will become chronic [9].

Thus, dissociation served a dual function in this patient: in the acute period it was adaptive (reducing intolerable affect), whereas subsequently it became maladaptive, maintaining risky sexual behavior as a coping strategy for managing internal tension and shame. This logic informed the choice of a staged therapeutic approach: stabilization and development of self-regulation skills were prioritized before work with traumatic memories began, and body-oriented techniques were integrated to restore connection with bodily experience and awareness of personal boundaries.

In the differential diagnosis, bipolar affective disorder and substance use disorders were excluded using the structured Mini International Neuropsychiatric Interview (MINI). Features of borderline personality disorder were assessed separately during the clinical interview on the basis of the ICD-11 criteria for personality functioning (see the section 'Personality Functioning') and did not reach the diagnostic threshold. Alcohol and cannabis use were episodic and did not meet criteria for dependence; impulsive sexual patterns were regarded as consequences of trauma rather than as an independent compulsive sexual behavior disorder.

Personality functioning

- *Emotion regulation:* avoidance of traumatic experiences and dissociative reactions predominated; high levels of shame and self-blame and a tendency toward self-punishment were present.
- *Interpersonal relationships:* alternation between seeking closeness and abrupt distancing; difficulties establishing and maintaining boundaries; a tendency to repeat traumatic relational patterns.
- *Professional life:* stable employment and high productivity as a means of compensating for internal instability.
- *Sexual functioning outside RSB:* inability to experience emotional intimacy; sex was experienced as a source of personal validation or as a means of relieving tension rather than as a source of pleasure or intimacy.

Mechanisms maintaining RSB

A set of interrelated mechanisms contributed to the maintenance of risky sexual behavior:

- Cognitive — internalized guilt and the belief 'I am to blame', which helped maintain the pattern of risky sexual encounters; persistent self-blame and shame following childhood sexual abuse have been described as key barriers to trauma processing [10].
- Affective — use of sex to regulate anxiety and shame.
- Behavioral — automatic responses to triggers, difficulty refusing unwanted sexual contact, and difficulty recognizing one's own desires.
- Dissociative — emotional detachment that reduced the subjective intensity of shame.

These mechanisms formed the basis for selecting therapeutic targets: ensuring safety and stabilization, processing traumatic experiences, reducing self-blame, developing skills for emotion regulation and setting personal boundaries, and developing safer patterns of intimate relationships.

Therapeutic process and dynamics of change

Psychotherapy was conducted over two years in weekly 50-minute sessions and was organized in stages according to changes in the patient's clinical condition. Treatment effectiveness was assessed using the ITQ and self-report scales measuring the frequency of risky sexual behavior, shame, and guilt. Assessments were conducted every eight weeks; follow-up assessment was performed six months after completion of therapy.

Stage 1. Safety and stabilization (sessions 1–12)

Main goals: stabilization, reduction of anxiety, and self-regulation training. ITQ scores decreased slowly; the most notable change was a reduction in the frequency of impulsive sexual encounters (from 3–4 times per month to 0–1) by Session 8. Shame remained high; however, the patient began to discuss more frequently in therapy the situations that preceded episodes of risky behavior.

Clinical illustration 1 (session 3). The patient came to the session in a state of acute shame after a spontaneous sexual encounter with a man she barely knew. The therapist used a stabilization strategy, normalizing her emotional responses and helping her identify the trigger (fatigue and alcohol use), pause before acting impulsively, and develop a plan for similar situations.

Stage 2. Trauma processing (sessions 13–30)

Work focused on modifying dysfunctional beliefs; as traumatic memories emerged, elements of EMDR were introduced. By Session 20, the patient stated

for the first time: 'What happened in the village was abuse, and it was not my fault.' This became a turning point in therapy: self-blame decreased, and her capacity to tolerate the memories increased.

Clinical illustration 2 (session 22). While attempting to process the memory of the first episode of abuse, the patient experienced intense dissociation. The therapist discontinued further exposure and returned to grounding in bodily sensations, resourcing techniques, and metaphor-based work. This helped avoid retraumatization and preserve the patient's engagement in psychotherapy.

Stage 3. Work with beliefs (sessions 31–50)

The focus was on modifying beliefs ('I am unworthy', 'my body is an instrument') using EMDR and cognitive behavioral techniques, both of which have demonstrated efficacy in treating the consequences of childhood sexual abuse [11], together with narrative methods. Self-esteem and the capacity for emotion regulation increased gradually; the patient began to recognize her own desires and say no when necessary.

Clinical illustration 3 (session 45). The patient described a situation in which she was able to say 'no' to an insistent partner. This was emotionally difficult for her, but she did not return to her habitual pattern.

Stage 4. Self-regulation of sexual behavior (sessions 51–96)

Training focused on recognizing impulses, communicating with partners, and developing a more positive relationship with her body. The frequency of RSB decreased to zero; the patient established a stable intimate relationship in which she was able to openly communicate personal boundaries and discuss her own needs.

By the end of therapy, the total ITQ score had decreased by 42%, the frequency of RSB episodes had fallen from 3–4 per month to zero, and the level of shame and guilt had decreased from 8–9 to 2–3 points on the self-report scale. At the 6-month follow-up, the patient maintained a stable relationship, continued to report no risky sexual behavior, and retained her self-regulation skills.

The choice of therapeutic interventions was determined by the patient's current condition, level of dissociation, and readiness to work with traumatic memories. During the stabilization stage, stabilizing and body-oriented techniques predominated; during trauma processing, EMDR and cognitive techniques for modifying beliefs were used; during the integration stage, interventions focused on developing skills for setting personal boundaries and building safe intimate relationships.

Discussion

The favorable outcome in this case was probably associated less with the sequential processing of traumatic experience than with the timely recognition of dissociation and the systematic development of behavioral self-regulation strategies (pausing before acting, saying no, and discussing difficult situations with the therapist), contrary to the expectation that sustained change would require, above all, integration of traumatic memories. This pattern is consistent with findings from systematic reviews identifying dissociation as a mediator between traumatic experience and maladaptive behavioral strategies [7] and suggests that, when dissociative symptoms are pronounced and premature exposure may increase the risk of retraumatization [12], behavioral stabilization may make a therapeutic contribution comparable to trauma processing rather than serving only as a preparatory stage for it.

Analysis of this case suggests that the risk of treatment failure might have increased if trauma processing had been pursued too rapidly without sufficient emotional stabilization, if dissociative reactions had been ignored, or if insufficient attention had been paid to developing skills for asserting personal boundaries.

The case suggests a sequence of key psychotherapeutic tasks. At the first stage, stabilization of the patient's condition was the priority. As emotional disorganization decreased, the work gradually shifted toward reducing self-blame, making sense of the traumatic experience, cautiously working with traumatic memories, developing the ability to establish personal boundaries, and building more stable and safe intimate relationships. This sequence appears to have helped avoid retraumatization and support the durability of treatment gains.

Conclusions and limitations

This case illustrates the potential of staged psychotherapy for risky sexual behavior in complex PTSD. Standardized assessment methods enabled clinical changes to be tracked over the course of therapy, while follow-up assessment allowed the durability of treatment gains to be evaluated.

Several limitations should be considered when interpreting these findings. A single case does not support generalizable conclusions. The absence of standardized assessment at each stage of therapy limits the detail with which clinical change can be characterized. Follow-up was limited to six months; therefore, the long-term durability

of treatment gains requires further study. The findings need to be confirmed in studies with larger samples.

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Group psychic retreat: adaptive defense or pathological fixation?

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Abstract

Introduction The concept of the psychic retreat is traditionally considered in psychoanalytic literature as a pathological defensive organization that hinders the development of personality and the analytic process. This paper proposes reconsidering this position in relation to group analysis. The paper hypothesizes that, following severe psychic trauma, a group psychic retreat may serve not only a defensive but also a temporary adaptive function, preserving the group's analytic potential until its capacity for the joint working through of traumatic experience is restored.

Method A theoretical analysis of John Steiner's concept of the psychic retreat and its development in group analysis is combined with an analysis of two clinical cases conducted within group-analytic psychotherapy. Using clinical material, the mechanisms of formation of the group psychic retreat, its clinical signs, the conditions for transition to chronic functioning, and the specific features of therapeutic interventions are examined.

Results Analysis of the clinical observations identified the psychodynamic mechanism of the formation of the group psychic retreat, to propose its clinical criteria, and to describe two different pathways of its emergence: as the group's reaction to an external traumatic situation and as a consequence of the spread of one participant's individual psychic retreat to the group's dynamic matrix. It is shown that, when the group's capacity to restore its analytic function is preserved, the group psychic retreat may have a transitional character and perform an adaptive role, whereas its chronicization leads to disruption of the analytic process and hinders the development of the group.

Conclusions The group psychic retreat is an independent phenomenon of group dynamics that cannot be fully reduced to the individual psychic retreats of the participants. Its clinical significance is determined not by the fact of its emergence itself, but by its function and duration. The proposed model makes it possible to consider the group psychic retreat as a dynamic process that arises under conditions of psychic overload and has different developmental variants. The practical contribution of this paper is to provide a rationale for a therapeutic strategy oriented not toward the immediate dismantling of the group's defensive organization, but toward the timely restoration of its analytic function.

Keywords: psychic retreat; group psychic retreat; group analysis; psychic trauma; dynamic matrix; analytic function of the group; symbolization; defense mechanisms.

Introduction

The concept of the psychic retreat, proposed by John Steiner, occupies an important place in contemporary psychoanalytic theory as a description of a particular defensive organization of the psyche that arises in response to unbearable affects and the threat of psychic disintegration. The psychic retreat is understood as a form of withdrawal from relationships in which a person temporarily avoids contact with external and internal reality; however, the cost of such withdrawal is a limitation of emotional development, the capacity for symbolization, and the construction of genuine relationships [1].

In group analysis, this concept has been further developed. Observations of the dynamics of analytic groups have shown that analogous processes can arise not only in individual participants, but also at the level of the group as a whole. At times, the group begins to function as a single defensive system:

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emotional involvement decreases, free associations disappear, discussion shifts to superficial topics, and painful experiences are excluded from the shared psychic space. This state has been described as a group psychic retreat.

Most authors regard the psychic retreat primarily as a pathological phenomenon that impedes the development of the analytic process. However, clinical observations suggest that this perspective is not always sufficient when working with psychic trauma. When emotional overload becomes overwhelming, direct confrontation with traumatic material may exceed the capacity of both an individual and a group to process it. In such situations, temporary withdrawal into a psychic retreat may serve not only a defensive but also an adaptive function, creating conditions that preserve the integrity of the group until it regains its capacity for further development.

This article examines the said function of the group psychic retreat. Drawing on clinical observations, it considers the hypothesis that the short-term existence of a group psychic retreat after traumatic events does not always indicate a pathological fixation of the group process. Under certain conditions, it may represent a transitional phase of group dynamics, allowing the group to preserve its capacity for the subsequent working through of traumatic experience. The paper pays particular attention to the conditions under which the defensive function of the retreat promotes the development of the group, as well as to the role of the therapist in recognizing this state, choosing the moment of intervention, and accompanying the group as it emerges from it.

Theoretical foundations of the concept of the group psychic retreat

The concept of the psychic retreat was developed by John Steiner to describe a particular form of pathological psychic organization that arises as a defense against unbearable anxiety and painful experiences. Unlike individual defense mechanisms, which help reduce psychic anxiety, the psychic retreat is a relatively stable pathological organization of the internal world that brings together a complex of defensive processes and ensures withdrawal from emotional reality and psychic development through the creation of a subjectively safe internal space.

Psychic retreat provides a sense of safety and control, but this is achieved at the cost of renouncing development, limiting the capacity for symbolization, and destroying genuine object relations. It is for this reason that Steiner regarded the psychic retreat above all as an obstacle to the analytic process: the therapeutic task consists in recognizing it and gradually overcoming it.

However, Steiner's concept was formulated in relation to individual psychoanalysis, where the main object of analysis is the relationship between patient and analyst. In group analysis, psychic life is understood differently. According to S. H. Foulkes, the group is not the sum of individual participants, but an integral system of interconnected relationships with its own dynamics [2]. Unconscious processes arise and develop not only within the personality, but also in the shared communicative space of the group — its dynamic matrix. As a result, defensive processes can also acquire a group character and become properties of the group itself rather than of its individual members [3].

This understanding allows the concept of psychic retreat to be extended to the level of group dynamics. If an individual psychic retreat is the withdrawal of the person from relations with the analyst and with reality, then a group psychic retreat may be regarded as a collective form of the group's withdrawal from relationships — with the therapist, among its participants, or with the broader social systems it belongs to. In such states, changes affect not only individual members of the group, but also the dynamic matrix itself: emotional involvement decreases, free associations disappear, communication becomes superficial, and the most painful experiences are excluded from the shared space of thinking.

M. Mojović develops Steiner's concept in this direction. While preserving the idea of the group psychic retreat as a collective defensive organization, she puts forward a fundamentally new hypothesis: under certain conditions, above all following psychic trauma, the temporary formation of such a retreat may serve an adaptive function. If the intensity of experiences exceeds the group's capacity to process them, temporary withdrawal into a psychic retreat may prevent a deeper disorganization of the group process, preserving the possibility of subsequent development [4].

This understanding changes the traditional view of the psychic retreat significantly. In this case, the key issue is not whether the psychic retreat emerges, but rather its function and duration. A short-term psychic retreat may create a temporary period necessary for restoring the group's capacity to process traumatic experience. Conversely, prolonged fixation of the group in this state leads to the loss of analytic function, chronic avoidance of emotional experience, and the transformation of the defensive mechanism into a factor that impedes development.

Thus, a fundamental theoretical question arises: should the group psychic retreat be considered exclusively a pathological phenomenon, or, under

certain conditions, it may represent a natural transitional phase in the group's recovery after trauma? This article focuses on the analysis of this question.

A model of the formation and development of the group psychic retreat

The proposed model assumes that the group psychic retreat is not an independent pathological formation, but one of the possible modes of functioning of the group's dynamic matrix when the psychic overload becomes excessive. Its emergence depends not so much on the traumatic event itself as on the relationship between the intensity of the traumatic impact and the group's capacity for the collective processing of the experiences that arise.

In the ordinary functioning of an analytic group, the participants' emotional experiences become available for shared thinking. The analytic group performs a containing function that allows holding intense affects, transforming them into mentally processed experience, and returning them to the participants in a form accessible to understanding. Free association, symbolization, and interpretation allow emotional experience to be processed collectively, ensuring the development of both individual participants and the group as a whole [5].

However, a traumatic event may temporarily exceed the group's capacity to process emotional experience. If the intensity of anxiety, fear, grief, guilt, or helplessness proves to be greater than the group's capacity to hold these experiences in the analytic space, the group's capacity for shared thinking temporarily collapses [6, 7]. In this state, the dynamic matrix ceases to perform its main analytic function [8].

In response, the group unconsciously reorganizes its defenses. Instead of jointly exploring emotional reality, the group unconsciously organizes a space that minimizes contact with the most painful experiences. Communication becomes more superficial, free associations gradually disappear, the emotional richness of discussion decreases, and the amount of intellectualization, idealization, everyday talk, or other ways of avoiding traumatic material increases. This state is what we describe as a group psychic retreat.

According to the proposed model, the further development of the process may proceed according to three different scenarios.

The first scenario occurs when the analytic capacity of the group proves sufficient for processing experiences even after a traumatic event. In this case, the temporary strengthening of defenses does not lead to the formation of a psychic retreat, and the group preserves a working dynamic matrix and gradually integrates the traumatic experience.

The second scenario involves the formation of a transitional group psychic retreat. A temporary restriction of contact with traumatic material allows the group to avoid deeper disorganization and to preserve its own integrity. As the capacity for shared thinking is restored, interpretations are made in a timely manner, and emotional communication resumes, the group gradually emerges from the retreat. In this case, the psychic retreat acts as a psychological moratorium, creating conditions for the subsequent working through of traumatic experience.

The third scenario arises when the retreat becomes a stable form of the group's existence. The defensive organization ceases to be temporary and begins to determine the functioning of the entire dynamic matrix. Avoidance of emotional reality becomes chronic, the capacity for symbolization and analytic thinking decreases, and the group itself gradually loses its therapeutic potential. Under these conditions, the psychic retreat is transformed from an adaptive defense into a pathological organization that impedes further development.

Thus, the group psychic retreat should be viewed not as a static formation, but as a dynamic process. Its clinical significance depends not only on the characteristics of the defensive organization, but above all on its function, duration, and the group's capacity to restore analytic thinking. Time, together with the effectiveness of therapeutic interventions, determines whether the psychic retreat will become a transitional stage of recovery or a chronic form of pathological functioning of the group.

The proposed model offers a new perspective on the therapist's role. The therapist's task is not to dismantle the group's defensive organization immediately, but to recognize the moment when a temporarily necessary defense begins to impede development. Consequently, therapeutic intervention is directed not so much against the existence of the psychic retreat as such, but against its chronicization.

Clinical signs of the group psychic retreat

If the group psychic retreat is regarded as an independent phenomenon of group dynamics, a practical question arises: how can the therapist recognize its formation? Our clinical observations suggest that the group's transition into a psychic retreat is accompanied not by a single symptom, but by a characteristic change in the functioning of the entire dynamic matrix. None of the signs described below is specific in itself. However, their simultaneous presence and gradual increase strongly

suggests the formation of a group psychic retreat.

The first and most noticeable sign is a decrease in the group's capacity for free association. Instead of the natural development of the associative process, discussion follows a predictable, linear pattern. Long monologues arise, already familiar themes are repeated, and the group loses its capacity to elaborate emerging material collectively.

At the same time, there is a noticeable impoverishment of the group's emotional life. Despite the presence of objectively significant or traumatic events, emotional reactions become weak, monotonous, or completely absent. The impression is that the most painful experiences cease to exist in the group's shared psychic space.

Another characteristic feature is the replacement of analytic work by the discussion of everyday, intellectual, or abstract topics. Communication continues, but its function changes. Conversation maintains contact among the participants, but ceases to fulfill the analytic task of investigating unconscious processes. This creates the illusion of productive group work, while emotionally significant material is in fact being avoided.

Another notable sign is the avoidance of traumatic material. The group may remain silent about the events that objectively determine its emotional state, or may mention them exclusively in descriptive form without exploring the feelings, fantasies, and transference reactions that arise. As a result, traumatic experience becomes isolated from the analytic process.

As the psychic retreat develops, the group's capacity for symbolization decreases. Dreams become less frequent or are discussed superficially, the number of metaphorical images and spontaneous associations decreases, and the capacity to connect external events with internal psychic reality weakens. Communication becomes predominantly concrete and descriptive.

In many cases, an increase in the idealization of the therapist, individual participants, or the group itself is observed. Such idealization is often accompanied by an experience of particular safety within the group, which excludes the need to investigate emerging tensions and conflicts. Paradoxically, an excessive sense of calm and the absence of conflicts may indicate not the maturity of the group, but the formation of a collective defensive organization.

Another feature is a change in the subjective experience of time. The group seems to stop moving forward. The same themes are repeated over many sessions without the emergence of new understanding, and the sense of development of the analytic process gradually disappears. The group enters a state of temporal stagnation, resembling the timelessness of the individual psychic retreat described by John Steiner.

Finally, a significant diagnostic sign is a change in the character of transference and countertransference. The therapist may feel a desire to abandon interpretations, maintain superficial communication, or unconsciously join in the collective avoidance of painful experiences. For this reason, awareness of one's own countertransference and regular supervision acquire particular importance when working with such groups.

These signs should be regarded not as formal diagnostic criteria, but as clinical markers. Their significance depends not on individual manifestations, but by the general organization of the group process. The more of these signs are present simultaneously in the dynamic matrix, and the more persistently they are maintained over time, the higher the likelihood that the group is functioning in the mode of a psychic retreat.

Clinical illustrations

To examine the proposed model, two clinical cases were analyzed in which the formation of a group psychic retreat was observed. Despite substantial differences in the conditions of work and the nature of the traumatic event, the analysis was conducted according to a single scheme. This approach allows the cases to be considered not as independent descriptions, but as material for comparison with the proposed theoretical model.

Each case was analyzed according to the following parameters:

- **Group context.** The features of the group that are significant for understanding the subsequent dynamics are considered: the composition of the participants, the stage of development of the group, the conditions of therapy, and the nature of relations with broader social systems.
- **Traumatic event.** The event or set of circumstances that led to a sharp increase in emotional load and to a disruption of the group's capacity for the collective processing of experiences is identified.
- **Formation of the group psychic retreat.** The sequence of changes in group dynamics that led to the emergence of a collective defensive organization is analyzed.
- **Clinical signs of the retreat.** The observed manifestations corresponding to the proposed diagnostic criteria are described: changes in the character of free associations, the emotional life of the group, symbolization,

communication, transference processes, and the relationship to traumatic material.

- **Therapeutic interventions.** The therapist's interventions aimed at recognizing the group psychic retreat, increasing awareness of the processes taking place, and restoring the analytic function of the group are considered.
- **Emergence from the group psychic retreat.** The dynamics of the restoration of the analytic process, changes in emotional communication, the return of the capacity for symbolization, and the shared understanding of traumatic experience are analyzed.
- **Outcome.** The impact of the experience on the group's subsequent development is assessed, and the observed process is evaluated to determine whether it represents a transitional or a chronic form of the group psychic retreat.

The use of a single scheme of analysis allows us to compare the two cases with each other and determine the extent to which they correspond to the proposed model of the formation and development of the group psychic retreat. Particular attention is paid not to the traumatic events themselves, but to the changes in the group's dynamic matrix that arise in response to them, as well as to the conditions that determine the transition of the defensive organization from a temporary adaptive function to a pathological fixation.

Case 1. Transitional group psychic retreat as a response to an external threat

Context

The therapy group was held in the addiction treatment ward of the Special psychiatric hospital in Kovin, Serbia. All participants were inpatients on the ward; therefore, the analytic group functioned in constant interaction with the hospital system and the life of the ward. Sessions took place twice a week, and the observation period lasted about one year, from June 2022 to September 2023.

Throughout the observation period, the group demonstrated stable analytic functioning. The participants associated freely, explored emerging feelings, and connected current events in their lives with personal history and unconscious conflicts. The group as a whole performed a containing function, allowing intense experiences to be processed.

Traumatic event

The situation changed following the admission of a new patient who actively involved other patients in destructive forms of behavior. He systematically devalued treatment, encouraged patients to discontinue therapy, and attempted to distribute drugs within the ward. Although his actions were subsequently identified by the hospital administration and he was excluded from the therapeutic community, the presence of such a threat significantly disrupted the group's sense of safety.

For the participants of the group, this situation was not merely an external event, but a factor that led to a marked increase in anxiety and destroyed the sense of protection necessary for analytic work.

Formation of the group psychic retreat

After the emergence of the threat, the group dynamics changed markedly. Whereas previously the participants had freely discussed their own experiences and connected current events with inner experience, the analytic process largely came to a halt.

Free associations gradually disappeared. Instead of exploring emotional experience, the group increasingly sank into prolonged silence or discussion of neutral everyday topics. The experiences connected with the events taking place in the ward were rarely addressed, despite their obvious significance for all participants.

Within the proposed model, these changes indicated the formation of a group psychic retreat. The group limited contact with the most painful experiences, temporarily suspending the analytic processing of traumatic experience.

Clinical signs

In the case under consideration, most of the previously described signs of the group psychic retreat were observed:

- the disappearance of free associations;
- pronounced emotional impoverishment;
- the replacement of analytic work by everyday conversations;
- avoidance of discussion of the traumatic situation;
- a temporary halt in the development of the group process.

Taken together, these changes indicated not a decrease in the activity of individual participants, but a change in the functioning of the entire dynamic matrix.

Therapeutic interventions

The turning point came when the first open statement about fear appeared. One of the participants suggested that some members of the group might be connected with the patient who was distributing drugs. This statement marked the beginning of restoration of the analytic process.

Subsequently, therapeutic interventions focused not at discussing the external circumstances as such, but at exploring the feelings that arose. Gradually,

experiences of fear, anger, helplessness, and disappointment appeared in the group. A significant part of the aggression was directed at the therapist, to whom the participants unconsciously attributed responsibility for the inability to protect the group. Through interpretations of transference processes, emotional experiences gradually became the subject of collective analytic work.

Emergence from the psychic retreat

As emotional communication was restored, the group gradually emerged from the state of psychic retreat. Free associations resumed, participants once again connected current events with their inner experience, and the group's capacity to collectively explore emerging feelings increased.

The event was no longer experienced merely as an external threat and became material for analytic work. For many participants, it enabled discovering a characteristic personal tendency to withdraw from relationships in situations of experiencing danger or mistrust.

Outcome

This case is consistent with the model of a transitional group psychic retreat. The defensive organization that emerged was temporary and did not lead to the destruction of the group's analytic function. Timely interpretation allowed the group to restore its capacity for collective processing of traumatic experience. After emerging from the psychic retreat, an increase in group cohesion, a higher level of trust, and an expanded capacity among participants to withstand intense emotional experiences without the need for collective withdrawal into a defensive formation were observed.

Case 2. Formation of a group psychic retreat under the influence of one participant's individual psychic retreat

Context

The second case concerns an analytic group which took place in private practice in Belgrade, Serbia. The observation period lasted about three years. The group was established shortly after two mass killings that occurred in Serbia in May 2023. These events had a profound impact on society as a whole and shaped the emotional context in which the group's dynamic matrix was formed.

One of the participants (hereafter — patient S.) lost a loved one during the tragedy. The other participants were not affected so directly, but they experienced the consequences of collective trauma. Thus, the group functioned within a shared context of collective trauma while its members differed in their degree of personal involvement.

Traumatic event

For patient S., the mass killing became a severe psychic trauma accompanied by the loss of a significant object. In the course of analytic work, it became evident that the experience of loss periodically gave way to a state of emotional unavailability in which there was almost no contact either with his own feelings or with the reality of what had happened.

It gradually became clear that this was not only the patient's individual psychic retreat, but also its influence on the functioning of the whole group.

Formation of the group psychic retreat

Initially, the changes were evident primarily in patient S. He avoided discussing the loss, constantly redirected the conversation to general topics, rejected any attempts to explore his own experiences, and maintained superficial communication. Over time, however, similar changes gradually emerged in the work of the whole group.

The participants returned to the traumatic material less and less often, preferring to discuss neutral topics. Instead of a shared exploration of experiences, an implicit collective agreement emerged not to approach the emotionally most painful aspects of patient S.'s experience. Gradually, the individual psychic retreat became an organizing factor of the entire dynamic matrix.

Clinical signs

During the formation of the group psychic retreat, the following signs were observed:

- avoidance of discussing traumatic experience;
- the predominance of superficial communication;
- emotional impoverishment of the group process;
- increased idealization of the therapist and the group;
- decreased capacity for symbolization;
- the gradual involvement of the other participants in the collective avoidance of painful experiences.

Particularly striking was the fact that the group itself perceived this state as calm and safe, although the analytic process had virtually stopped.

Therapeutic interventions

Awareness of the group psychic retreat developed gradually not only through the therapist's interpretations, but also through symbolic material that emerged within the group.

One of the most significant episodes was a dream that patient S. had at the beginning of therapy. In

the dream, he was swimming toward the sinking Titanic, carrying the deceased loved one on his back. Climbing aboard by ropes, he saw the therapist standing still and not helping him. Despite the warnings of those around him that the ship was sinking, the patient continued to climb, certain that he was right and the danger was exaggerated. Only once he was on deck did he realize that the ship was indeed going down.

During the subsequent discussion of the dream, the patient said that ever since he was a child he had admired the hero of the film Titanic, who died to save the woman he loved, and that he had repeatedly fantasized about a similar heroic death. This made the dual nature of his psychic retreat evident. On the one hand, it preserved an internal connection with the lost object and protected him from the unbearable pain of loss. On the other hand, it represented a self-destructive formation that sustained suicidal fantasies and impeded the experience of grief. This dream became the group's first symbolic representation of the nature of the space into which all participants were gradually being drawn.

An equally important episode occurred later. During a discussion of physical phenomena, the conversation turned to black holes. Using this topic as an opportunity to interpret what was happening in the group, the therapist asked: "I wonder whether there is a black hole in our group now?" After a short period of silence, patient S. said that he felt like a black hole in the group and that he was drawing the other group participants into his black hole.

This metaphor became a turning point in therapy. For the first time, the patient was able to realize that his individual psychic retreat had ceased to be an exclusively internal process and had become an organizing factor of group dynamics. At the same time, the group itself was able to recognize what was happening not as a set of individual difficulties, but as a collective process in which all participants unconsciously supported the existence of the group psychic retreat.

Emergence from the psychic retreat

As the group's capacity to withstand intense experiences was restored, free associations and emotional communication began to return. Instead of collective avoidance, the participants gradually began to explore experiences of loss, guilt, fear, helplessness, and grief. This allowed the group once again to perform the containing function necessary for the process of living through the loss.

Outcome

Unlike the first case, the group psychic retreat in this example proved considerably more stable. Its existence was maintained not by an external threat, but by the constant influence of one participant's individual psychic retreat on the group's dynamic matrix. At the same time, the gradual restoration of the analytic function showed that even under such conditions a group psychic retreat can be overcome, provided that the group's capacity for shared thinking is preserved and therapeutic interventions are timely.

This case demonstrates a different mechanism of formation of the group psychic retreat. While in the first observation the determining factor was an external threat, here the collective defensive organization arose as a result of the spread of an individual psychic retreat to group dynamics. These findings suggest the existence of different pathways in the formation of the same group phenomenon.

Mechanism of formation of the group psychic retreat

The clinical observations presented suggest that the formation of a group psychic retreat is a progressive psychodynamic process that arises in response to an overload of the group's analytic function.

The starting point is the emergence of a traumatic event whose intensity exceeds the group's capacity for collective processing of emotional experience. During normal group functioning, the analytic group performs a containing function: the affects that arise become the subject of free associations, symbolization, and shared understanding. This process allows the emotional experience to integrate gradually into the psychic life of the group.

After severe trauma, the intensity of experiences may prove so high that the dynamic matrix's capacity for processing them is temporarily exhausted. As a result, the group's capacity to hold emotional tension without resorting to massive collective defenses is impaired. This can be understood as a collapse of the group's analytic function.

One of the first manifestations of this process is a decrease in the capacity for symbolization, which is accompanied by disruption of the mentalization processes as well as of the transformation of affective experience into meaningful psychic representations [9]. Free associations disappear, the number of dreams, images, and metaphors decreases, and emotionally charged experiences cease to be available for collective reflection. Communication becomes predominantly concrete, descriptive, or intellectualized.

In parallel, group relationships gradually change. Instead of exploring emotional reality, the group begins to organize interactions so as to minimize contact with the most painful experiences. Collective

avoidance of traumatic material arises. The group's emotional life becomes poorer, discussion shifts to neutral topics, and various forms of psychological distance intensify.

As collective avoidance intensifies, the entire dynamic matrix is restructured. The defensive organization begins to determine the functioning of the group as a whole. One of the mechanisms stabilizing this condition is the idealization of the therapist, individual participants, or the group itself. The experience of safety is gradually sustained not by the group's capacity to process experiences, but by the absence of contact with them.

A group psychic retreat thereby emerges — a collective defensive formation that temporarily limits the group's contact with psychic reality. During this period, emotional tension decreases, but at the same time the group's capacity for development is reduced. The analytic function temporarily gives way to the defensive one.

The subsequent course of the process depends on the duration of this defensive formation and on the possibility of restoring the group's analytic function. If, as the intensity of traumatic experiences decreases and thanks to therapeutic interventions, the group regains its capacity to withstand emotional tension, free associations, symbolization, and shared thinking are restored. In this case, the group psychic retreat performs a transitional adaptive function.

If, however, the defensive organization becomes a stable mode of group functioning, avoidance gradually turns into a chronic principle of organization of the dynamic matrix. The analytic process loses its capacity for development, and the psychic retreat becomes a pathological form of the group's existence.

The proposed mechanism helps explain why the emergence of a group psychic retreat should not be considered exclusively a negative phenomenon. In itself, it is a natural defensive reaction of the group to the overload of its analytic function. The pathological feature is not the emergence of the retreat, but the impossibility of emerging from it after the group's capacity for collective processing of emotional experience has been restored.

Discussion

The clinical observations presented here offer a new perspective on the concept of the psychic retreat in relation to group analysis. Although John Steiner's concept provided the theoretical foundation of the present work, the results of the analysis suggest that, when group processes are considered, it requires further development [10].

Steiner regarded the psychic retreat as a pathological defensive organization that impedes the development of personality and the analytic process. In this model, the retreat is a space in which the patient avoids contact with psychic reality, and the main therapeutic task becomes the recognition and gradual overcoming of this defensive organization. The observations presented in this paper do not contradict this concept; however, they suggest that when applied to trauma, this interpretation is incomplete. When the psychic overload becomes extreme, a temporary restriction of contact with the most painful experiences may help preserve the group's capacity for further development.

This understanding is consistent with the basic principles of S. H. Foulkes's group analysis. If the group is considered an independent system of relationships with its own dynamic matrix, then defensive processes should be viewed not only as individual but also as group phenomena. In this case, the group psychic retreat is not a simple sum of the participants' individual defenses, but a particular state of the dynamic matrix itself, in which a collective defensive organization temporarily replaces the analytic function of the group.

The proposed interpretation also builds on M. Mojović's ideas about the possibility of the existence of a positive group psychic retreat [4, 11]. The clinical material helps clarify this concept. In our view, the crucial point is not in evaluating the retreat as positive or negative, but in analyzing its function and dynamics. For this reason, the distinction between transitional and chronic group psychic retreat appears more productive. In the first case, the defensive organization is temporary and ends with the restoration of the group's analytic function. In the second, it becomes a stable mode of functioning of the dynamic matrix, impeding further development.

The present observations are also largely consistent with contemporary understandings of psychic trauma. Recent studies of group psychotherapy for trauma also show that the initial restriction of contact with traumatic material may perform a temporary regulatory function, creating conditions for the gradual restoration of the group's capacity for collective processing of experiences [12, 13]. Most contemporary models regard initial avoidance of traumatic experience as a natural reaction of the psyche to excessive emotional overload. The therapeutic task is not to immediately dismantle the defenses, but to gradually restore the capacity of the person or group to withstand and symbolize traumatic experiences. From this point of view, the group psychic retreat

may be considered one form of collective affect regulation that arises when the analytic function of the group is temporarily lost.

The mechanism of formation of the group psychic retreat is particularly noteworthy. The cases presented suggest the existence of at least two different pathways of its emergence. In the first case, the collective defensive organization formed as a result of an external threat that exceeded the group's capacity to process emotional experience. In the second case, the determining factor was the spread of one participant's individual psychic retreat to the dynamic matrix of the whole group through the processes of transference, projective identification, and the equivalence phenomenon. Despite the difference in the initial mechanisms, both processes ended in the formation of a similar defensive organization with common clinical signs.

The practical value of the proposed model lies in the change in therapeutic strategy. If any group psychic retreat is considered exclusively a pathological phenomenon, there is a natural tendency to try to bring the group out of this state as quickly as possible. However, the observations presented suggest that premature confrontation with the collective defense may prove not only ineffective but also potentially destabilizing if the group has not yet restored its capacity to withstand intense affects. In such situations, the therapist's task is not to destroy the psychic retreat as such, but to constantly assess whether it retains an adaptive function or has already turned into a chronic form of avoidance of psychic reality.

Thus, the proposed concept does not reject the classical understanding of the psychic retreat, but extends it to group analysis and work with psychic trauma. The contemporary development of group analysis has shifted from viewing individual phenomena of group dynamics as static formations to considering them as continuous processes unfolding in the changing dynamic matrix of the group [14]. In this context, the group psychic retreat may be considered not as a fixed pathological formation, but as a process whose clinical significance depends on its function, duration, and influence on the restoration of the group's analytic function.

Conclusion

The clinical observations presented here and their theoretical analysis support the following conclusions.

First, the group psychic retreat should be considered an independent phenomenon of group dynamics that arises at the level of the group's dynamic matrix and is not reducible to a simple set of the individual defenses of its participants.

Second, the formation of a group psychic retreat is a natural reaction to a situation in which the intensity of traumatic experience temporarily exceeds the group's capacity for its collective processing. Underlying this process is a disruption of the group's analytic function, accompanied by a decrease in symbolization, collective avoidance of traumatic material, and the formation of a shared defensive organization.

Third, the group psychic retreat should not be regarded exclusively as a pathological phenomenon. In case of severe psychic trauma, it may perform a transitional adaptive function by temporarily protecting the group from deeper disorganization and preserving the possibility of subsequent restoration of the analytic process.

Fourth, the clinical significance of the group psychic retreat depends not on the fact of its emergence, but on its function, duration, and influence on the further development of the group. Accordingly, it seems appropriate to distinguish transitional and chronic group psychic retreat as two different forms of organization of group dynamics.

Fifth, the proposed model has practical significance for group psychotherapy. The therapist's task is not to immediately dismantle the collective defensive organization, but to recognize its function and choose the appropriate moment for intervention, when the group regains the capacity to withstand intense affects, symbolize experiences, and restore analytic thinking.

The proposed concept does not contradict John Steiner's classical model of the psychic retreat, but develops it in relation to group analysis and work with psychic trauma. It allows the group psychic retreat to be viewed as a dynamic process whose clinical significance depends not on the mere existence of the defensive organization, but on its role in preserving or losing the group's capacity for development.

The model presented is based on the analysis of two clinical observations and represents a theoretical generalization. Its further development requires additional clinical observations, clarification of the diagnostic criteria of the group psychic retreat, and study of the factors that determine the transition of the defensive organization from a temporary adaptive function to a chronic pathological form.

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Primary psychogenic depression: a pathogenetic model based on impaired translation of the mobilizing impulse into action

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Abstract

Objective The aim of this paper was to develop a theoretical, clinical, and psychobiological model of the pathogenesis of primary psychogenic depression and to substantiate an etiological approach to psychotherapy.

Method A theoretical analysis of psychodynamic, neurobiological, and clinical studies of depression was conducted, together with an analysis of clinical observations obtained in the course of applying Integrative Causal Psychotherapy to the treatment of depressive disorders.

Results The proposed model identifies the central pathogenetic mechanism of primary psychogenic depression is the chronic inability to translate into action the mobilizing impulse arising during attempts to satisfy fundamental psychological needs. In this context, chronic inhibition of action may contribute to fronto-limbic conflict and mesolimbic dopaminergic hypoactivity, potentially promoting learned helplessness, diminished agency, and the development of a persistent depressive symptom complex. Based on this model, key therapeutic targets are identified and a mechanism-based psychotherapeutic approach is proposed, aimed at restoring access to the mobilizing impulse and the capacity to act.

Conclusions The proposed model integrates psychodynamic and neurobiological perspectives on depression within a unified causal framework and may serve as a theoretical basis for the development of targeted psychotherapeutic interventions for primary psychogenic depression.

Keywords: depression; pathogenesis; psychotherapy; aggression; mobilizing impulse; dopamine.

Introduction

Depressive disorders are among the most prevalent mental illnesses and are among the leading causes of decreased quality of life, impaired social functioning, and occupational disability worldwide. According to the World Health Organization, approximately 280 million people suffer from depression, accounting for about 3.8% of the global population [1]. A substantial proportion of patients experience recurrent depressive episodes rather than a single depressive episode. The risk of recurrence increases with each subsequent episode, and a substantial proportion of the burden of depression is attributable to its chronic and recurrent course [2, 3].

Despite significant advances in psychopharmacology and psychotherapy, the prevention of depressive relapse remains a major challenge. Meta-analyses demonstrate that even after successful treatment the risk of recurrence remains high. Following cognitive behavioral therapy, relapse or recurrence of unipolar depression occurs in approximately 29% of patients within the first year and in more than 54% within two years after treatment completion [4]. After discontinuation of antidepressant therapy, relapse during the subsequent year develops in approximately 56% of patients [5]. Contemporary approaches to relapse prevention in depression demonstrate limited effectiveness and do not eliminate the risk of recurrent depressive episodes [6].

This situation points to a fundamental problem in contemporary depression treatment: despite the large number of therapeutic approaches and theoretical attempts to explain the etiology of depression, there is still no widely accepted causal

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model capable of explaining the core mechanism underlying depressive symptoms and providing a basis for mechanism-based treatment aimed at reducing relapse risk.

An additional challenge is the heterogeneity of depressive disorders themselves. Contemporary diagnostic classifications include a broad range of clinical entities within the depressive spectrum, including recurrent depressive disorder, depressive episode, dysthymia, bipolar affective disorder, mixed anxiety-depressive states, adjustment disorders with depressive symptoms, and a number of other conditions. This suggests that depressive disorders are etiologically heterogeneous and makes the development of a universal model equally applicable to all depressive conditions unlikely.

The aim of the present article is to propose a theoretical and clinical model of the pathogenesis of a specific type of depressive disorder — primary psychogenic depression — and to substantiate a mechanism-based approach to psychotherapy aimed at eliminating the presumed central pathological process underlying this type of depression. The proposed concept was developed within the Integrative Causal Psychotherapy approach* and integrates psychodynamic, neurobiological, and clinical perspectives on the pathogenesis of depressive disorders within a unified causal framework.

Key concepts and definitions

The model conceptualizes depressive disorders as etiologically heterogeneous conditions that can be divided into two groups and four types according to their causal mechanisms.

Group I. Somatogenic depressions — depressions caused by pathological processes in the body.

- **Primary somatogenic (endogenous) depressions** are associated with neurotransmitter dysfunctions.
- **Secondary somatogenic depressions** are associated with pathological conditions of organs and physiological systems that affect neurotransmitter functioning, including vascular, metabolic, chronic pain, substance-induced, and other pathological processes.

Group II. Psychogenic depressions — depressions arising as a maladaptive psychological response and not primarily driven by somatic pathology.

- **Primary psychogenic depressions** develop directly in response to life circumstances.
- **Secondary psychogenic depressions** develop as comorbid conditions associated with other mental disorders (personality disorders, posttraumatic disorders, and related conditions).

This article examines the pathogenesis of primary psychogenic depression (hereinafter referred to as PPD). In the proposed model, PPD is conceptualized as an independent disorder arising as a psychological response to life circumstances and not caused by somatic pathological processes or pre-existing mental disorders.

Thus, the proposed model does not claim to explain the pathogenesis of depression as a whole, but rather describes one specific causal type of depressive disorder. The identification of primary psychogenic depression as a distinct etiological category is considered necessary for the development of differentiated mechanism-based psychotherapeutic interventions.

Theoretical foundations

The proposed model of primary psychogenic depression draws on psychodynamic theories of depression, as well as contemporary research on the neurobiology of depressive disorders, motivation, and psychophysiological regulation under conditions of chronic stress.

One of the early theoretical foundations of the model derives from the works of Sigmund Freud and Karl Abraham, who conceptualized depression as a condition associated with difficulties in processing aggressive impulses and redirecting them inward [7, 8]. In *Mourning and Melancholia,* Freud described melancholia as a process in which aggressive impulses originally directed toward an external object become redirected against the self [7]. Abraham further developed this concept by associating depressive states with ambivalence, object loss, and self-directed aggression [8]. Unlike classical psychoanalytic models, however, the present article conceptualizes aggression not as a destructive drive but as a natural adaptive mechanism — the affective component of the mobilizing impulse that enables the transition from motivation to action, facilitates overcoming obstacles, and supports the protection of personal boundaries and the satisfaction of significant needs.

* Integrative Causal Psychotherapy is a psychotherapeutic approach developed by Yu. Tor that focuses on identifying the core pathogenic mechanisms underlying mental disorders and designing therapeutic protocols aimed at modifying these mechanisms.

An important theoretical foundation of the model is provided by contemporary concepts concerning the role of the mesolimbic dopaminergic system in motivation, agency, and anhedonia. Research demonstrates that the nucleus accumbens, ventral striatum, and associated frontal structures are involved not only in the experience of pleasure but primarily in mechanisms of action initiation, goal evaluation, and reward anticipation [9, 10]. Dysfunction of these systems is considered one of the key mechanisms underlying anhedonia, psychomotor retardation, and reduced motivation in depression [11].

Research on motivation and learned helplessness also informs the proposed model. The work of M. Seligman demonstrated that repeated experiences of inability to influence a situation lead to the formation of a stable state of helplessness accompanied by reduced initiative, diminished motivation, and impaired capacity for active behavior [12]. Subsequent studies demonstrated associations between learned helplessness and impairments in dopaminergic reinforcement, motivated behavior, and reward anticipation [13].

Another important theoretical foundation of the model is provided by contemporary research on the neurobiology of chronic stress and emotion regulation. Prolonged suppression of emotional responses has been shown to be associated with dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis, amygdala hyperactivation, fronto-limbic dysregulation, and reduced neuroplasticity [14, 15]. Chronic stress is also associated with reduced brain-derived neurotrophic factor (BDNF) expression and impaired dopaminergic transmission, which are considered pathogenetic mechanisms underlying motivational and emotional deficits in depression [16].

Psychological mechanism of the pathogenesis of PPD

Primary psychogenic depression is conceptualized as a dynamic pathological process arising from chronic suppression of the mobilizing impulse, particularly its affective component — aggression. The mobilizing impulse is understood as an internal drive toward action that emerges in response to frustration of core psychological needs, is accompanied by psychophysiological mobilization, and is directed toward overcoming obstacles and enabling effective action.

Unlike models that conceptualize depression primarily as a disorder of cognition or motivation, the proposed model assumes that the central pathogenetic mechanism underlying PPD is a disruption of the translation of an internal mobilizing impulse into action aimed at resolving the chronic frustration of core psychological needs.

1. Blocking the satisfaction of existentially significant needs and the execution of related actions

The initial stage of the pathogenesis is characterized by chronic frustration of basic needs under conditions in which individuals perceive themselves as unable to take the actions necessary to preserve autonomy, psychological integrity, and control over significant life circumstances.

Unlike frustration arising from unmet situational or secondary desires, the blocking of existentially significant needs is experienced as a threat to psychological survival and is accompanied by the activation of aggression as a mobilizing affect directed toward overcoming the obstacle.

The pathogenic factor is not the stressful or adverse life situation itself, but its subjective experience as a chronic inability to satisfy critically important needs, maintain autonomy, or alter significant life circumstances. Such situations may include prolonged controlling or dependent relationships, chronic psychological pressure, emotional suppression, restrictions on social autonomy, and other persistent forms of restriction of personal agency.

Markers of this stage include:

- chronic frustration of needs experienced as essential for identity, autonomy, and psychological integrity;
- a persistent sense of diminished autonomy and inability to influence one's life circumstances;
- subjective experience of threat to core aspects of psychological existence.

2. Activation of aggression as a mobilizing affect

The key condition for the transition to the next stage is the persistence of the need despite chronic inability to satisfy it. This state activates aggression as a mobilizing mechanism directed toward overcoming the obstacle.

At the clinical level, the mobilization stage may manifest as:

- the emergence of an urge to change a subjectively intolerable situation;
- a sense of internal mobilization;
- the emergence of psychophysiological tension.

3. Repression of aggression and inhibition of the mobilizing impulse

However, in the presence of stable inhibitions against experiencing and expressing aggression, the mobilizing impulse and its affective component become subject to systematic suppression or repression. The sources of such inhibitions may include early introjects, fear of object loss, prior experiences of punishment for expressions of

aggression, strong dependence on external approval, or internalized beliefs regarding the unacceptability of conflict.

Clinical markers of the stage of suppression of the mobilizing impulse include:

- avoidance of confrontation and open conflict;
- rationalized explanations for why the situation cannot be resolved;
- reduced energy and mood associated with cortical inhibition of sympathetic activation.

4. Development of learned helplessness

The transition to the next stage is mediated by repeated experiences of failure to translate the mobilizing impulse into action. The individual repeatedly encounters situations in which an internal impulse toward action arises, yet its translation into action remains blocked. Over time, this leads to the formation of a stable sense that one's own actions are ineffective and contributes to the development of learned helplessness [13, 16].

At this stage, the following manifestations are observed:

- the development of a belief that one's own actions are ineffective in changing a situation of persistent frustration;
- the abandonment of attempts to change the situation or their rapid cessation;
- a subjective sense of losing the ability to influence events.

5. Development of depressive syndrome

Chronic blocking of the transition from mobilization to action results in an inability to complete the adaptive behavioral cycle. As a consequence, unresolved arousal that is neither behaviorally expressed nor affectively processed becomes consolidated as persistent internal tension and progressive depletion of regulatory and motivational resources.

At the psychological level, a sustained state of unresolved internal activation develops, accompanied by reduced agency, loss of behavioral initiative, and consolidation of helplessness. The prolonged absence of successful action and of reinforcement of behavioral efficacy contributes to the generalized expectation that one's efforts are ineffective.

At the neurobiological level, dysfunction emerges within motivational, reward, and stress-regulatory systems, including mesolimbic dopaminergic hypoactivity, reduced reward sensitivity, and chronic dysregulation of the stress response associated with HPA axis hyperactivation. A functional imbalance in prefrontal-limbic regulation develops, characterized by chronic hyperactivation of cortical inhibitory mechanisms that suppress the mobilizing impulse and persistently prevent its translation into action.

Clinically, this stage is manifested by:

- chronic diffuse psychophysiological tension;
- persistent exhaustion accompanied by an impaired capacity for recovery;
- anhedonia, reduced motivational energy, and decreased self-worth.

A self-perpetuating pathological cycle develops in which the chronic inability to translate the mobilizing impulse into action reduces agency and reinforces helplessness, which in turn further restricts active coping and contributes to the consolidation of the depressive syndrome into a persistent psychopathological state.

Neurobiological mechanism of the pathogenesis of primary psychogenic depression

Within the proposed model, psychological and neurobiological processes are viewed as interconnected components of a unified causal mechanism operating as an integrated dynamic system. They are discussed separately here solely for analytical clarity. Chronic inability to meet core psychological needs and systematic suppression of the mobilizing impulse are accompanied by simultaneous alterations in motivational reinforcement systems, emotional regulation, and stress adaptation mechanisms.

Key neurobiological mechanism: fronto-limbic conflict and suppression of the mobilizing impulse

The central neurobiological mechanism of PPD is a chronic fronto-limbic conflict associated with systematic suppression of the emotional and behavioral components of the mobilizing impulse. It is assumed that stable inhibitions against experiencing and expressing aggression enhance cortical inhibition of emotional activation and neural systems involved in action initiation and behavioral control, leading to a chronic fronto-limbic conflict between persistent mobilization and the inability to translate it into action [15].

Under normal conditions, emotional and physiological mobilization culminates in action directed toward overcoming an obstacle or restoring disrupted equilibrium. However, in the presence of aggression-inhibiting attitudes, the mobilizing impulse arising in a conflict situation undergoes cortical inhibition and remains unresolved both emotionally and behaviorally. As a result, a state of unresolved motivational activation develops, in which emotional activation systems remain engaged while its translation into action remains blocked.

Over time, this inhibitory state may lead to consolidation of neural patterns of passive responding, in which activation associated with the need for action becomes automatically suppressed even prior to behavioral expression. As a result, the gap between the subjective experience of the need to change the situation and the capacity to initiate corresponding action progressively increases. Clinically, this may manifest as chronic internal tension, difficulty recognizing one's own needs, conflict avoidance, psychomotor inhibition, experiences of helplessness, and a perceived inability to influence ongoing events.

An additional role in maintaining this condition is presumably played by the basal ganglia and associated mechanisms of action inhibition. Chronic suppression of the mobilizing impulse may be accompanied by increased activity of the indirect inhibitory pathway of the basal ganglia, resulting in enhanced inhibition of thalamocortical transmission [18, 19]. As a consequence, the impulse toward action fails to result in overt motor behavior and remains confined to subcortical-striatal circuits, thereby sustaining chronic internal tension and psychomotor retardation.

Indirect support for the proposed model may be found in experimental studies of learned helplessness and chronic stress in animals. These studies demonstrate that repeated inability to engage in avoidance or defensive behavior is accompanied by the development of behavioral passivity, reduced motivational activity, and states resembling depressive behavior [12, 17]. These observations are consistent with the assumption that chronic suppression of the mobilizing impulse may gradually impair systems responsible for action initiation and motivational reinforcement.

Mesolimbic dopaminergic hypoactivity and disruption of the action–reward system

One of the presumed key consequences of chronic suppression of the mobilizing impulse is the development of mesolimbic dopaminergic hypoactivity. In contemporary neuroscience, dopamine is regarded not merely as a neurotransmitter of pleasure, but as a central component of the systems involved in reward prediction and action initiation. Dopaminergic neurons of the ventral tegmental area respond primarily to the discrepancy between expected and actual action outcomes — the so-called reward prediction error. Under normal conditions, the mobilizing impulse proceeds through a sequential cycle: emergence of a fundamental psychological need, motivational mobilization, action, and dopaminergic reinforcement of successful action outcomes.

During the premorbid stage of PPD, this cycle becomes systematically disrupted: an impulse toward action arises, yet it cannot be translated into action due to chronic suppression and inhibition of action. As a result, the action cycle remains incomplete, and dopaminergic reinforcement of action does not occur. Repeated inability to perform subjectively significant actions may gradually alter dopaminergic reward prediction dynamics. The brain begins to anticipate failure even before action is initiated. Consequently, basal dopaminergic activity decreases, goals lose motivational salience, and the capacity to initiate action becomes impaired even when awareness of its necessity is preserved [20].

From this perspective, anhedonia in PPD may be conceptualized not merely as loss of the capacity to experience pleasure, but as a disruption of the action–reward system in which the individual no longer experiences action as likely to be effective [21]. This leads to reduced initiative, psychomotor retardation, experiences of helplessness, and a perceived inability to initiate activity.

Mesolimbic dopaminergic hypoactivity is viewed not as a primary biochemical deficit but as a consequence of a chronically incomplete mobilization cycle, in which repeated failure to translate the mobilizing impulse associated with fundamental psychological needs into action gradually leads to a weakening of motivational reinforcement mechanisms and the development of a persistent depressive state.

Chronic activation of the stress-response system and HPA axis dysregulation

The third key component of the neurobiological mechanism of PPD is chronic activation of the stress-response system associated with prolonged maintenance of incomplete mobilization. Chronic inability to carry out meaningful action in the presence of persistent internal tension is accompanied by sustained activation of the sympathetic nervous system and the HPA axis [14].

Prolonged elevation of cortisol levels and persistent activation of stress-response systems gradually lead to a state of allostatic overload accompanied by impaired neuroplasticity, reduced BDNF signaling and depletion of adaptive resources [16]. Simultaneously, chronic activation of the stress-response system maintains underlying anxiety, internal tension, and a persistent sense of incomplete recovery.

It is proposed that fronto-limbic inhibition, together with mesolimbic dopaminergic hypoactivity and chronic activation of the stress-response system, forms a stable symptom complex characteristic of depression.

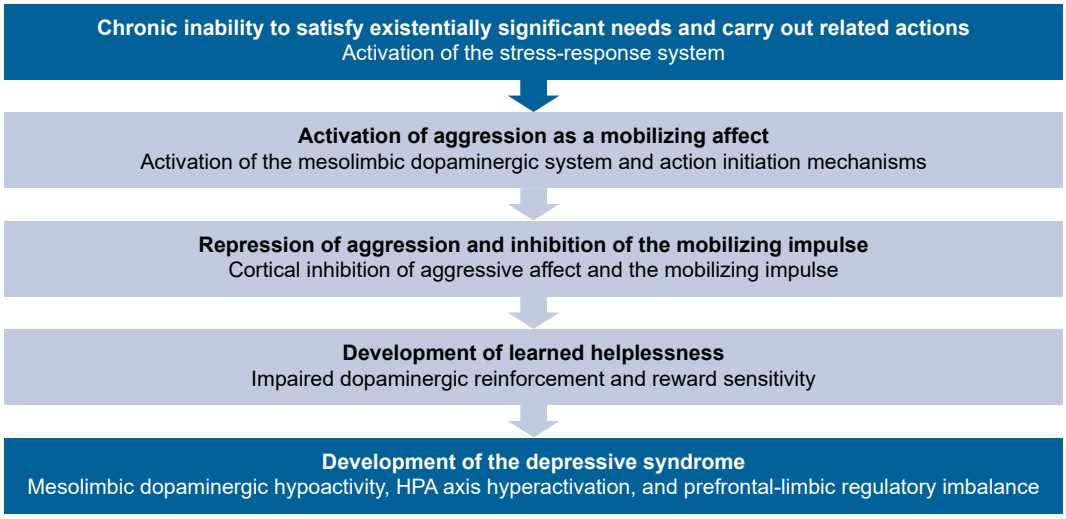


Figure 1. Model of the pathogenesis of primary psychogenic depression

Thus, from a neurobiological perspective, PPD may be conceptualized as a state of chronic suppression of the mobilizing impulse in which systems involved in emotional activation, action initiation, and the stress response remain chronically activated, while translation of the mobilizing impulse into action remains blocked. Persistence of such a state gradually leads to the formation of fronto-limbic conflict, mesolimbic dopaminergic hypoactivity, and chronic stress dysregulation underlying anhedonia, psychomotor retardation, reduced agency, and the sense of inability to initiate action. As the process becomes chronic, this pathological system acquires a self-sustaining character.

Causally targeted psychotherapy of PPD

The proposed pathogenetic model of primary psychogenic depression makes it possible to identify the core pathological mechanism of the disorder and define therapeutic targets whose modification may disrupt the core pathological cycle maintaining this type of depression. The core pathogenetic mechanism of PPD is conceptualized as chronic suppression of the mobilizing impulse arising in response to chronic inability to fulfill basic psychological needs and initiate meaningful action. Accordingly, targeted psychotherapeutic intervention should aim to eliminate the mechanisms that maintain chronic inhibition of action.

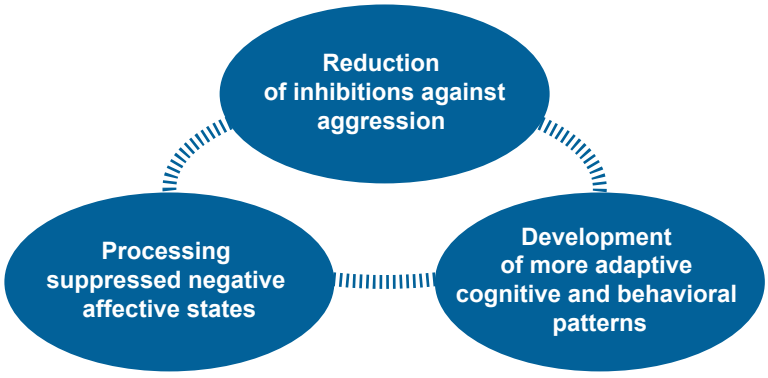


Figure 2. Key therapeutic targets of primary psychogenic depression according to the pathogenetic model

From the perspective of the proposed model, targeted interventions involve helping patients recognize aggressive feelings as adaptive and psychologically meaningful, as well as removing inhibitions against their experience and expression, thereby restoring agency. Reestablishing contact with the mobilizing impulse creates the conditions for successful action, an increased sense of self-efficacy, and a restored ability to shape one's life circumstances.

It is assumed that such an intervention simultaneously affects both the psychological and neurobiological mechanisms of PPD. At the psychological level, this is accompanied by a reduction in the internal conflict between the mobilizing impulse and the inability to translate it into action. At the neurobiological level, restoration of the ability to translate mobilizing impulses into action may potentially contribute to a reduction in chronic fronto-limbic inhibition, attenuation of stress-system hyperactivation, and normalization of dopaminergic reward processes associated with effective action.

A second important therapeutic target is the processing of chronically suppressed negative affective states associated with inhibition of aggressive impulses and the experience of learned helplessness.

Another therapeutic direction is the development of more adaptive cognitive and behavioral patterns that become accessible after disruption of the core pathological process — suppression of the mobilizing impulse.

Thus, therapeutic improvement is associated with patients regaining the capacity to engage in meaningful action and disengaging from the pathological cycle of chronically suppressed mobilization. Schematically, this process may be represented as follows:

ACCEPTANCE OF AGGRESSIVE IMPULSES AS LEGITIMATE → DEVELOPMENT OF THE ABILITY TO TRANSLATE THE MOBILIZING IMPULSE INTO ACTION → RESTORATION OF PERSONAL AGENCY → SUSTAINED REMISSION OF DEPRESSIVE SYMPTOMS

This sequence reflects disruption of the pathological cycle: recognizing aggression as adaptive restores access to the mobilizing impulse, thereby enabling effective action and promoting normalization of dopaminergic reward processing associated with motivation, subjective self-efficacy, and the capacity to experience satisfaction.

Clinical observations in the context of the model

Clinical observations obtained during the application of a 20-session protocol of Integrative Causal Psychotherapy in the treatment of depression generally correspond with the proposed model of PPD [22].

In patients, depressive symptoms were associated with pronounced inhibitions against experiencing and expressing aggression, fear of conflict, chronic suppression of anger and resistance, subjective inability to defend personal boundaries, and experiences of internal helplessness. The therapeutic dynamics observed during treatment corresponded to the proposed causal model of PPD: reduction of inhibitions against aggression was accompanied by a gradual restoration of the capacity for meaningful action and personal agency.

At the initial stages of therapy, patients predominantly demonstrated anhedonia, reduced initiative, psychomotor retardation, feelings of helplessness, and difficulties in recognizing their own aggressive emotions. A substantial part of the therapeutic work was aimed at helping patients recognize aggression as an adaptive mobilizing affect and revise beliefs that inhibited the experience and expression of aggression.

As inhibitions against aggression weakened during therapy, patients initially demonstrated increased emotional activation, emotional engagement, renewed motivation, and an increasing tendency to take an active role in shaping their life circumstances. During subsequent stages of therapy, a gradual restoration of agency was observed: patients reported increased self-confidence, improved ability to make decisions, defend personal boundaries, carry out meaningful actions, and take a more active role in shaping life circumstances. Simultaneously, the severity of anhedonia, helplessness, and depressive symptoms decreased. Such dynamics may reflect restoration of the previously suppressed mobilizing impulse.

In addition to remission of depression, psychotherapy outcomes included statistically significant improvements in self-confidence, professional functioning, enjoyment of life, and environmental mastery*, consistent with the hypothesis that the capacity for mobilized action had been restored [23].

* Environmental mastery refers to a dimension of psychological well-being in Ryff's model describing the perceived ability to effectively manage life circumstances.

Additional indirect support for the theoretical and clinical validity of the proposed model may be found in the absence of depressive relapses among patients who achieved remission during the one-year follow-up period [22]. From the perspective of the proposed concept, this may be explained by the fact that psychotherapeutic intervention aimed at reducing inhibitions against aggression directly targets the central pathogenetic mechanism of PPD — suppression of the mobilizing impulse. It is assumed that after patients become aware of and process these inhibitions, such inhibitions are unlikely to re-emerge because patients develop a stable understanding of aggression as an adaptive mechanism supporting self-protection, autonomy, and the satisfaction of core psychological needs. Such psychotherapy may not only reduce symptoms but also decrease the likelihood of reactivation of the core pathological mechanism underlying PPD.

Discussion

The proposed model conceptualizes primary psychogenic depression as a disorder associated with chronic suppression of the mobilizing impulse arising in response to the inability to fulfill core psychological needs and engage in meaningful action. Unlike approaches that conceptualize depression primarily as a state of motivational deficit, negative affect, or cognitive distortion, the present model proposes that the key pathogenetic mechanism of PPD is a chronic disruption of the transition from mobilization to action.

Anhedonia, psychomotor retardation, helplessness, and a reduced sense of agency are therefore viewed not as manifestations of a primary motivational deficit, but as consequences of a chronically impaired ability to act resulting from suppression of the mobilizing impulse. The proposed model also integrates psychodynamic concepts regarding the role of suppressed aggression in depression with contemporary findings on fronto-limbic conflict, dopaminergic dysregulation, and chronic activation of the stress-response system. The PPD model does not exclude the involvement of cognitive, personality-related, social, and biological factors in the formation of depressive states; however, it conceptualizes them primarily as variables influencing the degree of inhibition of the mobilizing impulse and the ability to act.

Clinical observations obtained during the application of Integrative Causal Psychotherapy are generally consistent with this model. Particularly significant is the absence of relapse among patients who achieved remission during the one-year follow-up period [22]. Within the framework of the proposed model, this may be explained by the fact that psychotherapeutic intervention is directed not only toward symptom reduction, but also toward modification of the central pathogenetic mechanism — chronic suppression of the mobilizing impulse.

At the same time, the proposed model remains hypothetical and requires further empirical validation. The small sample size, absence of a control group, and limited availability of neurobiological data do not allow firm conclusions regarding the validity of the proposed mechanism. In addition, the model is primarily applicable to primary psychogenic depression and does not claim to explain all forms of depressive disorders.

Future research should focus on validating the proposed model in larger samples and investigating the neurobiological correlates of restoration of personal agency.

Conclusion

The proposed model of primary psychogenic depression conceptualizes the depressive state as resulting from chronic suppression of the mobilizing impulse that arises in response to the inability to fulfill fundamental psychological needs and initiate meaningful action. Within this framework, the central pathogenetic mechanism of PPD is assumed to consist of chronic suppression of the mobilizing impulse and blocking of its translation into action, accompanied by impaired dopaminergic reinforcement processes, reduced agency, helplessness, and the development of a persistent depressive symptom complex. Depression in PPD may be understood not only as an affective disorder, but also as a state characterized by a chronically impaired capacity for action.

The model integrates psychodynamic concepts concerning the role of suppressed aggression in depression. It also incorporates contemporary findings on fronto-limbic conflict, dopaminergic dysregulation, and chronic activation of the stress-response system. From this perspective, aggression is conceptualized primarily as a mobilizing affect that facilitates overcoming obstacles and translating the mobilizing impulse into action.

Based on the proposed pathogenetic model, a causally targeted psychotherapeutic approach to PPD was developed to eliminate inhibitions against experiencing the mobilizing impulse and translating it into action. Clinical observations obtained during application of the Integrative Causal Psychotherapy protocol are generally consistent with the proposed model and suggest the potential value of a mechanism-based approach to the treatment of primary psychogenic depressive.

Thus, within the proposed model, depression is conceptualized as a state of unresolved mobilization and impaired translation of the mobilizing impulse into action in situations perceived by the individual as threatening fundamental psychological needs. Accordingly, the regained ability to shape one's life circumstances may be viewed not merely as a contributor to symptom reduction, but as a potential central therapeutic mechanism for primary psychogenic depression. Although the proposed model requires further empirical validation, it provides a preliminary pathogenetic framework for understanding the mechanisms underlying the development of PPD and for guiding its psychotherapeutic treatment.

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Metamorphosis of patriarchy in the electronic era: social unconscious manifestations and group-analytic perspectives

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Abstract

The gradual yet unmistakable subsidence of patriarchal metastructures has emerged as a defining characteristic of contemporary global society. This collapse is not confined to institutional or political arrangements but extends into the symbolic, psychological, and relational foundations of social life. The present article investigates the causes, consequences, and transformations associated with the decline of patriarchal authority, integrating theories of the social unconscious, symbolic mediation, mythological and psychoanalytic concepts, group-analytic processes, and the impact of the electronic era.

The erosion of patriarchy destabilizes traditional social bonds, generating fragmentation, aggregation and massification, polarized subgroup formations, and a crisis of symbolic authority. These processes are significantly intensified by digital technologies, which weaken vertical transmission, accelerate affective contagion, and reorganize authority into performative, algorithmically mediated forms. While overt patriarchal structures decline, their residues persist within the social unconscious through defensive processes, symbolic displacements, and transgenerational transmission.

In therapeutic groups, these transformations emerge as challenges to leadership, boundary confusion, intensified splitting, and the unconscious search for compensatory authority figures. Group-analytic psychotherapy is presented as a privileged space for observing, symbolizing, and working through the psychosocial consequences of patriarchal collapse and electronic mediation. The article argues that contemporary society stands at a crossroads: between regression toward authoritarian substitutes and the emergence of dialogical, ethically grounded, post-patriarchal forms of social bonding capable of containing complexity without domination.

Keywords: patriarchal transformation; social unconscious; group analytic processes; symbolic authority crisis; post-patriarchal subject.

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Introduction

Across many contemporary societies, long-standing patriarchal structures are undergoing profound transformation. For centuries, patriarchy functioned not only as a political and economic system but also as a symbolic framework organizing authority, gendered roles, kinship relations, and the formation of subjectivity. Its erosion therefore affects not only institutional arrangements but also the deeper symbolic coordinates through which social order, legitimacy, and identity have historically been structured.

Simone de Beauvoir's foundational insight — that gender hierarchy is socially constructed rather than naturally given — highlighted the historical contingency of patriarchal arrangements [1]. Anthropological analyses similarly demonstrated that patriarchal authority has been embedded within systems of kinship, alliance, and symbolic exchange that regulate social organization [2]. These structures, however, are increasingly destabilized in contemporary societies. From the perspective of Cornelius Castoriadis, patriarchy can be understood as part of the dominant social imaginary through which societies institute meaning and legitimacy [3]. As this imaginary loses coherence, the organizing principles that once structured authority, belonging, and generational continuity become less stable, exposing societies to new forms of uncertainty and institutional fluidity.

This transformation unfolds alongside another major historical shift: the expansion of the electronic era. Digital communication technologies

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reshape the conditions of social interaction by weakening hierarchical modes of transmission and replacing them with horizontal, instantaneous, and algorithmically mediated exchanges. Authority increasingly appears diffuse, performative, and unstable, while symbolic mediation and temporal delay — traditionally central to the regulation of desire and authority — are challenged by immediacy, visibility, and affective intensification [4, 5]. These technological conditions do not simply accompany broader cultural transformations; they also accelerate processes that destabilize inherited symbolic structures.

Within this context, contemporary societies display increasing signs of symbolic disorganization. These processes include forms of social aggregation and massification, the proliferation of antagonistic subgroups, and recurrent polarization between opposing identities. Mediating institutions often weaken, while leadership figures appear either fragile and self-referential or invested with exaggerated expectations of restoration and salvation. At the symbolic level, the mediating function historically associated with paternal authority — containing conflict, structuring boundaries, and introducing delay between impulse and action — appears increasingly unstable. Yet no broadly shared alternative framework of authority has fully consolidated in its place.

This article offers a narrative-theoretical exploration of these developments. Drawing on psychoanalytic anthropology, mythology, group analytic theory, and contemporary social thought, it examines how transformations in patriarchal symbolic structures — within the conditions of the electronic era — reshape authority, identity, and social bonds. In doing so, the article proposes that group analytic practice provides a particularly valuable observational and interpretive framework for understanding the psychic consequences of these historical shifts. By tracing how broader cultural transformations become enacted within group processes, it seeks to illuminate both the destabilizing effects of the current transition and the potential emergence of post-patriarchal forms of authority grounded in dialogue, shared responsibility, and ethical relationality.

Patriarchy as a symbolic metastructure

Understanding the consequences of patriarchy's contemporary transformation requires clarifying what patriarchy has historically represented within social life. In common usage, patriarchy refers to a form of social organization in which authority is concentrated in male leadership, particularly within family or societal structures dominated by men [6]. While descriptively accurate, such definitions capture only the institutional surface of a much deeper phenomenon.

More fundamentally, patriarchy can be understood as **a symbolic metastructure:** a supra-individual framework embedded in cultural meanings that organizes authority, gender roles, and relational expectations [3]. It operates through language, myth, law, and social practices, shaping not only the distribution of power but also the ways individuals imagine identity, morality, belonging, and the boundaries of social life [7, 2]. In this sense, patriarchy has historically functioned as both a political arrangement and a symbolic order structuring subjectivity itself [8].

Beyond its visible institutional form, patriarchy has served important symbolic functions within social organization. It provided hierarchical structures of authority that stabilized responsibility and decision-making across generations [9]. Through culturally codified divisions of labor and relational expectations, it structured roles within families and communities, producing relatively stable patterns of protection, provision, caregiving, and affiliation [1, 2].

Patriarchal systems also regulated social boundaries by defining permissible roles, behaviors, and spaces. These boundaries were reinforced through cultural narratives and mythological representations that linked authority, sacrifice, protection, and submission to broader systems of meaning [10, 11]. At the societal level, the distinction between public and private spheres further institutionalized these symbolic arrangements, assigning political authority and economic activity to the public domain while relegating emotional labor and caregiving largely to the domestic sphere [12].

From a psychoanalytic perspective, these social structures resonate with what Lacanian theory describes as the paternal metaphor. Lacan's concept of the *Name-of-the-Father* refers to the symbolic function that introduces law, prohibition, and mediation into the field of desire [13]. Although this concept cannot be equated directly with social patriarchy, historical patriarchal systems often embodied analogous mediating functions by organizing authority, boundary formation, and generational continuity. Consequently, transformations in patriarchal structures may also destabilize the symbolic frameworks through which societies regulate authority, identity, and relational cohesion.

The social unconscious: internalizing and transmitting patriarchy

To understand why patriarchy continues to influence social life even as its formal institutions weaken, it is necessary to examine the workings of the social unconscious — the shared, unspoken arrangements that shape perception, emotion, and behavior within a society. Hopper conceptualizes the social unconscious as the hidden matrix of norms, narratives, anxieties, and embodied practices through which societies reproduce themselves across generations [14]. Because patriarchy historically structured many of these arrangements, its assumptions remain deeply embedded within this matrix, persisting even when explicit ideological support diminishes.

Rather than operating solely as a set of explicit beliefs or institutional policies, patriarchy survives through implicit relational patterns, affective expectations, and habitual interpretations of social reality [15, 16]. These unconscious patterns shape how authority is experienced, how gendered identities are imagined, and how power relations are enacted in everyday life, often without conscious reflection.

Building on group-analytic understandings of the social unconscious, Carla Penna's work highlights how collective psychic life is shaped not only by visible social structures but also by unmentalized emotional climates circulating transpersonally within groups and institutions. From this perspective, the weakening of patriarchal authority can be understood as a disturbance in the group's containing functions, generating heightened anxiety, fragmentation, and defensive reorganization. As traditional symbolic coordinates of authority erode, unconscious group dynamics may oscillate between longing for omnipotent leadership and repudiating authority altogether. These tensions frequently manifest in polarized subgroup formations and primitive dependency dynamics. Penna emphasizes that such processes are not reducible to individual pathology but arise within the shared social field in which subjects are embedded. Group-analytic spaces therefore become important sites where these unconscious dynamics can be symbolized, allowing groups to metabolize the loss of familiar authority structures and tentatively explore new forms of relational responsibility grounded in mutual recognition rather than domination [17].

Patriarchy in the social unconscious

Patriarchy becomes embedded through long-standing cultural mechanisms that operate largely beneath conscious awareness. Child-rearing practices often emphasize obedience, gender differentiation, and submission to authority, creating early templates for how power and dependency are experienced [18]. Linguistic structures encode gender hierarchies through grammar, metaphors, and idioms that privilege masculine perspectives and universalize male experience [7].

Religious traditions frequently center paternal figures, framing authority, order, and creation through masculine symbolism [11]. Mythological narratives valorize masculine heroism and feminine passivity, embedding gendered symbolic roles into the collective imagination [10]. Educational canons historically elevate male achievements as foundational, reinforcing assumptions about who is central and who is peripheral in cultural memory [8]. Even everyday rituals — who speaks first, who occupies public space, who serves and who is served — quietly naturalize male leadership.

Through these processes, patriarchy operates not only as a political system but as a deep psychological environment. As psychoanalytic theory emphasizes, one does not escape such structures simply by rejecting them intellectually; unconscious residues continue to shape desire, anxiety, and expectation [14, 19–22].

Mechanisms of transgenerational transmission

Patriarchal norms persist across generations through subtle processes linking personal experience with collective continuity. Identification plays a central role, as children internalize patterns of authority, gender roles, and relational expectations modeled by caregivers [20–22]. At the same time, emotional residues — including unresolved conflicts, silences, and historical traumas — remain embedded within family systems, shaping attachment patterns and relational boundaries across generations [23].

Family narratives and cultural myths further reinforce these patterns by transmitting implicit lessons about authority, gender, and belonging [14]. Individuals may also experience unconscious loyalties to inherited roles, maintaining outdated relational arrangements in order to preserve continuity with family or cultural identity [24]. Through these intertwined processes, patriarchal assumptions often persist even when legal frameworks and explicit social norms begin to change.

Defensive mechanisms protecting patriarchy

The social unconscious also protects patriarchal arrangements through collective defensive processes. Denial may present patriarchal authority as natural or inevitable, while disavowal allows individuals to acknowledge inequality abstractly without recognizing its concrete implications [14]. Splitting reinforces binary gender categories, idealizing one pole while devaluing the other [25].

Idealization of protective leaders or paternal authority can further mask coercive structures beneath narratives of stability, care, or tradition [26]. At the same time, repression may silence conflict or trauma associated with patriarchal arrangements, limiting opportunities for critical reflection. These defenses help stabilize inherited structures even within contexts that consciously aspire toward greater equality.

Together, these dynamics illustrate how patriarchy persists as a psychic and cultural force even as its institutional forms weaken. The social unconscious transmits normative expectations, emotional residues, and defensive strategies that stabilize patriarchal patterns at deep levels of social life — making their transformation both psychologically unsettling and historically significant.

Mythic and psychoanalytic foundations of patriarchal order

Patriarchal authority has historically been sustained not only through institutions but also through symbolic narratives embedded in myth, religion, and the collective imagination. Long before modern political structures emerged, cultural stories and archetypal figures organized expectations concerning masculinity, authority, and social hierarchy [10, 11]. These symbolic forms continue to shape collective fantasies of leadership, morality, and relational order even in societies that explicitly challenge patriarchal norms [27]. As patriarchal structures weaken, these mythic frameworks do not simply vanish; rather, they destabilize and reconfigure, contributing to the emotional and symbolic turbulence accompanying contemporary social change [3, 18].

The Zeus archetype

Among the most enduring mythic figures is Zeus, whose image encapsulates the essence of patriarchal dominion. In Greek mythology, Zeus commands absolute power, governing through a combination of order, fear, and selective benevolence [28]. His unrestrained sexual entitlement — expressed through numerous conquests and transformations — embodies fantasies of masculine privilege exempt from accountability. Zeus protects favored offspring and allies while punishing challengers, reinforcing a hierarchical logic that rewards loyalty and crushes dissent. He tolerates no challenge to his supremacy, positioning himself simultaneously as sovereign and arbiter of justice [29].

This archetype saturates Western cultural and political imagination, shaping fantasies of strong leaders, charismatic authority, and masculine dominance [8, 30]. Even within secular and democratic contexts, attenuated versions of the Zeus figure persist in political rhetoric, corporate leadership ideals, and cultural representations of powerful men [9]. The persistence of this archetype demonstrates how mythic imagery continues to organize expectations of authority long after its mythological origins have receded from conscious awareness.

Freud's primal father

Freud's account of the primal father in Totem and Taboo offers a psychoanalytic model of the ambivalent foundations of patriarchal authority. In this mythic reconstruction, the primal father monopolizes power and provokes resentment among the sons, whose eventual rebellion results in his murder and subsequent symbolic idealization [19]. The internalization of the slain father establishes the moral prohibitions and symbolic law that regulate social life. Freud's narrative highlights a fundamental tension within patriarchal authority: it is simultaneously feared, resisted, and idealized. During periods when traditional authority structures weaken, these ambivalences may resurface at the collective level, producing oscillations between the rejection of authoritarian leadership and renewed longing for protective paternal figures [26, 31].

Taken together, these mythic and psychoanalytic perspectives suggest that the transformation of patriarchal authority represents not merely an institutional shift but a deeper disturbance within symbolic and unconscious structures that have long organized social life.

Systemic manifestations of patriarchy in social institutions

As patriarchal authority weakens in contemporary societies, its transformation unfolds unevenly across social systems. Institutional arrangements rarely disappear at the same pace as cultural ideals; instead, they reveal layers of inertia and symbolic residue that continue to shape everyday life [7, 8]. Consequently, the decline of patriarchy produces a transitional landscape marked not only by expanding egalitarian aspirations but also by persistent structural asymmetries and ambivalent forms of authority.

Gender roles and structural inequality

Despite significant social progress, gendered hierarchies remain embedded within many institutional environments. Economic and

organizational structures continue to reflect historical assumptions about the relative value of different forms of labor, contributing to persistent disparities in leadership representation and economic recognition [32, 33]. At the same time, the distribution of caregiving and domestic responsibilities still reflects longstanding gendered expectations, shaping professional trajectories and emotional burdens within families [34].

These patterns illustrate how patriarchal arrangements often persist not through explicit ideology but through institutional routines and cultural expectations that remain partially unchanged even as formal commitments to equality expand.

Institutional and cultural biases

Similar dynamics appear across education, politics, and healthcare systems. Educational traditions and cultural canons have historically privileged male perspectives and achievements, subtly reinforcing assumptions about authority and cultural centrality [8]. Political institutions in many societies continue to display uneven gender representation, while policy frameworks sometimes retain paternalistic assumptions regarding governance and social order [35].

Healthcare systems likewise reveal inherited biases, including research traditions that historically treated male bodies as normative and underrecognized gender-specific medical needs [36]. These institutional patterns illustrate how symbolic hierarchies may persist even where formal structures of authority have begun to shift.

Symbolic residues in social systems

Beyond institutional structures, patriarchal assumptions continue to circulate through legal frameworks, family organization, religious traditions, and linguistic practices. Concepts of lineage and inheritance, long associated with patrilineal models of social continuity, still shape cultural understandings of belonging and authority [2]. Religious narratives and ritual traditions frequently preserve symbolic representations of male leadership, while everyday linguistic expressions reproduce gendered hierarchies embedded within cultural memory [7, 11].

Such residues demonstrate that patriarchy persists not only as a political arrangement but also as a symbolic framework embedded within social institutions and cultural practices. Its transformation therefore generates a complex and uneven process in which inherited structures coexist with emerging forms of relational and institutional organization.

Failures of patriarchy: fragmentation and regression

The decline of patriarchy does not unfold as a linear transition from hierarchical domination to egalitarian freedom. Rather, the weakening of a long-standing symbolic metastructure generates instability and cultural turbulence. Patriarchy historically provided — however problematically — a framework of roles, boundaries, and legitimizing narratives that structured authority and relational expectations [3, 8]. As these organizing coordinates erode, societies often struggle to establish alternative symbolic frameworks capable of mediating desire, power, and collective responsibility.

Periods of such transformation frequently give rise to regression, polarization, and renewed appeals to paternal authority. Instead of producing immediate emancipation, patriarchal decline exposes unresolved cultural anxieties, generating a social landscape characterized by ambivalence: movements toward equality coexist with defensive reactions seeking stability, certainty, and restored hierarchy [4, 18, 26].

The crisis of symbolic authority

One manifestation of this transformation is the crisis of symbolic authority, evident in the emergence of what has been described as "weak, self-referential and visionless leaders" [37]. Such figures may hold formal power but often lack the symbolic legitimacy required to mediate between individual interests and collective order. Historically, patriarchal systems provided a paternal metaphor anchoring law, continuity, and accountability within the social order [9, 13]. As this symbolic anchor weakens, societies frequently oscillate between distrust of authority and renewed longing for its stabilizing return.

In the absence of a coherent symbolic framework, leaders are simultaneously distrusted as impostors and idealized as potential saviors. This ambivalence reflects deeper anxieties about boundary dissolution and uncertainty regarding how power should be exercised once traditional paternal norms lose legitimacy [3]. As symbolic authority erodes, political and cultural spheres become increasingly vulnerable to populism, charismatic manipulation, and the proliferation of "empty signifiers" that promise order without substance [38].

Backlash movements

Within the vacuum created by patriarchal decline, backlash movements emerge with particular force and urgency. Far-right populism, authoritarian nationalism, misogynistic digital subcultures, anti-gender ideologies, and hypermasculine revivalist

narratives all promise a return to stable hierarchies and clearly demarcated social roles [8, 30]. These movements present themselves as sources of protection, moral clarity, and identity in a world experienced as fragmented and unmoored.

Their appeal is not grounded solely in ideology or policy but in affective resonance: they mobilize fear of displacement, perceived loss of privilege, and anxiety over the erosion of familiar symbolic anchors [31, 34]. Misogynistic online communities, for example, function as affective refuges in which patriarchal fantasies of entitlement and dominance are reasserted. Digital anonymity amplifies aggression and grievance, allowing resentment to circulate without relational consequence or ethical containment [5, 39].

Similarly, anti-gender movements frame themselves as defenders of nature, tradition, and moral order, positioning equality, plurality, and fluidity as existential threats [40]. These formations are not historical anomalies but predictable defensive responses to the destabilization of patriarchal authority. They reveal how deeply patriarchy is embedded in the emotional and symbolic life of societies, and how its erosion often provokes consolidation and regression rather than immediate transformation [14].

Aggregation as a transitional defensive formation

Situated between collapse into massification and the possibility of genuinely relational group life is the phenomenon of aggregation. Aggregation refers to a form of social organization in which individuals cluster around shared affects, identities, or grievances without achieving symbolic integration or sustained relational cohesion. Unlike massification, which dissolves individuality into a fused collective identity, aggregation preserves the appearance of individuality while lacking the symbolic mediation necessary for mutual recognition and responsibility.

Aggregated groups are sustained less by shared meaning than by circulating affects — such as anger, fear, or nostalgia — that remain largely uncontained and untransformed. In the context of patriarchal destabilization, aggregation functions as a defensive response to symbolic uncertainty. Individuals gather in loose constellations that alleviate isolation without requiring engagement with difference or complexity [14].

Contemporary digital platforms intensify these dynamics by enabling rapid forms of affiliation organized around slogans, hashtags, or identitarian signals rather than sustained relational commitment [4]. Aggregation thus produces connection without responsibility and belonging without dialogue. While it may appear to gesture toward collective life, it frequently suspends the conditions necessary for genuine transformation. Without symbolic structures capable of metabolizing conflict, aggregated formations remain vulnerable to polarization and regression into massified or authoritarian dynamics [14].

Aggregation therefore represents a fragile transitional state: a holding formation that may either solidify into defensive collectivities or, under sufficiently reflective and containing conditions, evolve toward more relational forms of social organization.

Collapse into massification

When symbolic authority further weakens or fails altogether, aggregation may collapse into massification. In massified formations, individuality is increasingly relinquished as personal agency dissolves into large, impersonal collectives that promise certainty, coherence, and belonging. Lacking symbolic mediation, individuals become especially susceptible to reductive narratives, conspiracy theories, and propagandistic discourses that replace ambiguity with certainty and complexity with moral absolutism [41].

Mass movements — political, religious, or cultural — thus offer psychological refuge from the anxieties generated by the collapse of paternal and symbolic authority. Yet this refuge is purchased at a high cost. Identification with the mass often requires the suspension of critical thought, foreclosure of relational complexity, and rigidification of loyalty. The collective becomes an object of identification that substitutes for nuanced interpersonal bonds, producing polarized belief systems and heightened antagonism toward perceived outsiders [31].

Massification is therefore both a symptom of symbolic breakdown and a driver of further fragmentation, intensifying the instability it seeks to resolve.

Splitting of the social body

The erosion of mediating symbolic structures also gives rise to pervasive splitting of the social body into mutually hostile factions. Moral camps, political tribes, cultural echo chambers, and conspiracy-based communities proliferate, each sustained by simplified narratives dividing the social world into binaries of good and evil, pure and corrupt, self and other.

Such dynamics mirror primitive forms of group psychology in which difference is experienced not as plurality but as threat [19, 20]. In the absence of symbolic frameworks capable of containing conflict and integrating complexity, societies may regress into defensive formations — variously described as

social encapsulations [42], psychic retreats [43] or group bastions [44]—as solutions to their desperate needs for protection from experiences of failed dependency and relational insecurity.

Taken together, backlash movements, aggregation, massification, and social splitting illustrate how the transformation of patriarchal authority often produces fragmentation before new symbolic forms can emerge. The challenge is therefore not merely the dismantling of patriarchal structures, but the development of alternative frameworks capable of sustaining authority, complexity, and relational responsibility within a genuinely post-patriarchal social order.

The emergent post-patriarchal subject

The subject emerging in the aftermath of patriarchy is a hybrid figure, shaped simultaneously by residues of hierarchical tradition and by new relational and symbolic possibilities [8, 18]. No longer confined by rigid gender binaries, this subject encounters an expanded range of identity positions and emotional expressions. Yet the loosening of inherited structures also generates heightened anxiety, as historically stable roles and expectations no longer provide reliable orientation [45].

Freed from many traditional prescriptions, individuals gain greater autonomy in shaping their lives, but this autonomy is accompanied by uncertainty regarding belonging, continuity, and coherence [46]. Global connectivity expands cultural exchange while exposing individuals to multiple and often conflicting symbolic frameworks, intensifying experiences of fragmentation [47]. Consequently, the post-patriarchal subject approaches authority with skepticism, informed by historical abuses, yet continues to long for containment, guidance, and symbolic coherence.

These tensions reveal a transitional historical moment in which the psychological scaffolding once provided by patriarchal structures has weakened without being fully replaced. The post-patriarchal subject therefore requires new forms of symbolic support — frameworks capable of holding ambiguity, fostering mutual recognition, and sustaining belonging within the complexity of contemporary life [48].

The electronic era and the post-patriarchal subject

The electronic era accelerates the emergence of the post-patriarchal subject by transforming the conditions under which identity, authority, and relationality are constituted. Digitally mediated environments loosen traditional role constraints, enabling individuals to explore fluid and multiple self-positions across social and virtual platforms [49]. At the same time, this expansion of possibility introduces new vulnerabilities: subjects become increasingly exposed to surveillance, instantaneous judgment, and algorithmically intensified comparison [5].

Online environments amplify fragmentation as competing identities and symbolic demands collide with limited opportunities for mediation or reflective integration [4]. Authority within these spaces is often transient and performative, detached from responsibility or institutional grounding. Yet digital networks also facilitate new forms of solidarity, symbolic experimentation, and collective imagination that support emerging post-patriarchal modes of belonging [47]. The digital subject is thus both liberated and unsettled, navigating unprecedented freedom alongside intensified psychic and relational pressures.

The electronic era: digital mediation and the reconfiguration of the social bond

The electronic era represents a decisive structural condition shaping the contemporary aftermath of patriarchy. Digital technologies do not merely reflect social change; they reorganize the modalities through which authority, subjectivity, and social bonds are produced [5]. Whereas patriarchal systems relied on vertical transmission, temporal delay, and embodied authority, electronic mediation privileges horizontality, immediacy, and continuous circulation. This shift weakens traditional mechanisms of symbolic mediation and intensifies the crisis of authority accompanying patriarchal decline [4].

From a group-analytic perspective, digitally mediated environments can amplify primitive group dynamics. Bion's basic assumptions — dependency, fight–flight, and messianic pairing — appear with particular intensity in online collective formations where symbolic containment is limited [14, 50]. Algorithmic architectures reward emotional intensity, polarization, and rapid identification, often undermining reflective thought and sustained dialogue [4]. Authority becomes increasingly performative and unstable, producing visibility without durable responsibility.

Clinically, these dynamics intensify narcissistic vulnerability. As Turkle notes, digitally mediated interactions often provide the appearance of connection without the demands of reciprocity, ambivalence, or frustration tolerance [49]. Subjectivity becomes increasingly dependent on external validation — metrics of visibility, attention, and algorithmic affirmation — producing oscillations between grandiosity and emptiness [51]. In this environment, the paternal function of symbolic

delay and limit-setting is replaced by immediacy and saturation, contributing to heightened anxiety and difficulties in affecting regulation [13].

At the same time, the electronic era enables new forms of power that operate without overt hierarchy. Zuboff's concept of surveillance capitalism illustrates how authority shifts from visible paternal figures to opaque technological systems that shape behavior and desire through data extraction and predictive algorithms [5]. The resulting condition is paradoxical: apparent liberation from patriarchal authority coincides with increasingly subtle forms of control that remain largely invisible and difficult to contest.

Nevertheless, digital environments also contain post-patriarchal potential. Horizontal networks, plural identifications, and emergent forms of collective agency can challenge vertical domination and fixed identity structures [47]. The critical task is therefore not technological rejection but symbolic reintegration: developing cultural, institutional, and therapeutic frameworks capable of restoring mediation, responsibility, and ethical limits within electronically mediated social life.

Group-analytic processes in the aftermath of patriarchy

Group analysis is a field in which the individual, the interpersonal, and the social are understood as inseparably intertwined. This integrative perspective is articulated in Earl Hopper's elaboration of the tripartite matrix, distinguishing the foundation, dynamic, and personal matrices [52]. Together, these matrices provide a framework for understanding how historical, cultural, and institutional forces intersect with group processes and individual subjectivity. In the context of patriarchal decline, this model offers a particularly powerful lens for tracing how transformations in authority and symbolic order are registered simultaneously at societal, group, and personal levels.

Because the analytic group functions as a microcosm of its contextual society and its institutions, the erosion of patriarchal authority becomes visible across all three matrices. Within the foundation matrix, patriarchy persists as a historically sedimented symbolic structure organizing authority, gender roles, and relational expectations. Within the dynamic matrix, these inherited patterns are activated, contested, and transformed through ongoing group interactions. Within the personal matrix, individual members bring their own internalizations of patriarchal experience — shaped by family history, gender positioning, and cultural context — into the group [16].

The analytic group thus becomes a living laboratory in which the residues and reconfigurations of patriarchy can be observed with particular clarity. As the gravitational pull of patriarchal structures weakens within contemporary societies, groups struggle to establish new forms of symbolic organization. Authority no longer operates as a stable, taken-for-granted organizing principle, yet its absence generates anxiety and disorientation across all three matrices. The analytic group makes these tensions visible, rendering them available for reflection rather than leaving them diffused within the social unconscious.

Authority and leadership in the group

Ambivalence toward authority, characteristic of the post-patriarchal condition, often finds direct expression within the group's dynamic matrix. Members may challenge the conductor's legitimacy, questioning their authority, intentions, or competence. Although such challenges appear interpersonal, they frequently reflect deeper instability in the symbolic structures of authority embedded in the foundation matrix [16]. As the paternal metaphor weakens culturally, expectations that leaders should provide clarity, containment, and direction persist, while trust in the legitimacy of such authority simultaneously erodes [53].

Within the group, this tension often produces oscillations between idealization and attack. The conductor may be experienced alternately as a stabilizing paternal figure or as inadequate, intrusive, or illegitimate. Confusion about rules and boundaries may emerge, mirroring broader disruptions in social structures once anchored by patriarchal authority. At the level of the personal matrix, members respond according to their own histories of authority — some seeking strong containment, others reacting defensively against perceived domination. These layered responses enact a contemporary dilemma: the desire for leadership without domination, structure without hierarchy, and authority without authoritarianism. In this sense, the conductor becomes a nodal point where conflicts between foundation, dynamic, and personal matrices converge.

A brief vignette illustrates how these dynamics may unfold in practice. In one analytic group, members began to express frustration that the conductor did not intervene more decisively during emotionally charged exchanges. Some participants demanded clearer direction, insisting that the group needed stronger leadership. Others appreciated the conductor's reluctance to exercise covert authority, which resulted in withholding intervention. The discussion quickly polarized the group into opposing

camps — those seeking firm containment and those resisting perceived domination. Viewed through the lens of the tripartite matrix, this episode reflected not only intrapsychic conflicts or interpersonal tensions within the group, but broader anxieties concerning the legitimacy of authority in a post-patriarchal context.

Such tensions rarely remain confined to the conductor–member relationship. As uncertainty about authority circulates through the group, it often reorganizes the relational field itself, giving rise to subgroup formations and polarized alignments.

Subgroup formation and polarization

Fragmentation into subgroups can be understood as a dynamic-matrix response to instability within the foundation matrix. In the absence of shared symbolic anchors, the group seeks provisional forms of coherence through alignment and opposition. Outspoken members may align with one another, while quieter participants form coalitions of withdrawal. Gendered alliances may emerge, sometimes reproducing traditional patriarchal roles and at other times challenging or reversing them. Progressive and conservative positions may polarize, reflecting unresolved tensions circulating within the wider social matrix [14].

These subgroup formations are not merely defensive maneuvers but expressions of conflicts linking the foundation and personal matrices. Members gravitate toward positions that resonate with their personal histories of power, belonging, and marginalization, while simultaneously participating in collective enactments shaped by broader social constellations. Patriarchal logic may reassert itself through these dynamics, casting certain subgroups as dominant and others as subordinate — even within groups consciously committed to egalitarian values. In many cases the conductor becomes a contested symbolic figure, embodying unresolved struggles over authority embedded within the foundation matrix.

As subgroup tensions intensify, underlying gendered expectations regarding authority, care, and aggression frequently surface within the group matrix.

Gendered transferences

Gendered transferences emerge at the intersection of all three matrices. Within the foundation matrix, patriarchal cultures establish enduring symbolic associations between gender, authority, care, and aggression. Within the personal matrix, individuals internalize these associations in idiosyncratic ways shaped by family, culture, and lived experience. Within the dynamic matrix, these internalizations become enacted through patterns of speaking, silencing, caretaking, and confrontation.

Women may be implicitly positioned — or position themselves — as emotional containers or mediators responsible for stabilizing the group's affective climate. Men may be unconsciously cast as carriers of aggression, authority, or challenge. Members perceived as feminine, regardless of gender identity, often become containers for vulnerability or dependency, while those perceived as masculine may be positioned as bearers of strength or confrontation. These enactments persist even in groups explicitly committed to equality, revealing the depth at which patriarchal structures remain embedded within the foundation matrix and continue to shape relational expectations at unconscious levels [54].

These gendered dynamics frequently converge around another recurring phenomenon: the unconscious search for a stabilizing paternal figure.

The search for a new father

The recurrent search for a "new father" within analytic groups can be understood as a response to the destabilization of patriarchal authority in the foundation matrix. As traditional paternal structures lose legitimacy, groups may unconsciously seek alternative figures capable of providing symbolic containment and moral orientation [55]. This longing may crystallize around the conductor or be displaced onto a charismatic group member tacitly assigned a leadership role.

At the level of the personal matrix, individuals bring their own unresolved paternal histories into this search, intensifying processes of competition, idealization, and resentment. The group's ambivalence — simultaneously desiring, resisting, and fearing paternal authority — reflects the difficulty of relinquishing patriarchal containment without yet possessing stable alternative symbolic forms. These enactments should not be understood simply as regressions but as expressions of a transitional psychic and social state in which inherited structures are loosening while new relational frameworks have not yet consolidated [54].

Group analysis as a site of transformation

Despite these tensions, group analysis offers exceptional potential for transformation precisely because it operates across the foundation, dynamic, and personal matrices simultaneously. Within the dynamic matrix, the group provides a structured environment in which conflicts can be symbolized rather than enacted destructively. Within the personal matrix, members may recognize and work through authority-related traumas rooted in experiences of domination, neglect, or abandonment. Within the

foundation matrix, new symbolic configurations can gradually emerge through shared reflection and relational experimentation [52].

Earl Hopper's ongoing development of the tripartite matrix, in collaboration with international colleagues, has been central to articulating this transformative potential. By emphasizing that all groups are microcosms of their contextual society and its institutions, Hopper situates analytic work firmly within broader social constellations. His framework allows analysts to trace how anxieties originating in the social matrix, particularly those related to legitimacy, authority, and belonging, become metabolized within group processes rather than remaining unmentalized or enacted destructively.

In this sense, the analytic group may function as a prototype for post-patriarchal relationality. Leadership can become distributed rather than centralized, authority negotiated rather than imposed, and differences held rather than split. Symbolic meaning emerges through dialogue within the group matrix rather than being dictated by inherited hierarchies.

Through this work, group analysis contributes not only to individual and group transformation but also to the gradual elaboration of new social constellations capable of sustaining psychic life beyond patriarchy. Within the interplay between Eros and Thanatos, the group resists both manic denial and despair-driven paralysis, maintaining contact with the world as it is. In this way, the analytic group supports an ongoing personal and collective evolutionary process in which growth emerges through shared reflection and relational engagement.

Conclusion

The transformation of patriarchy represents one of the most significant symbolic shifts shaping contemporary social life. For centuries, patriarchal systems functioned not only as institutional arrangements but as organizing metastructures through which societies structured authority, gender relations, belonging, and moral order. As these structures weaken, their influence continues to reverberate across multiple levels of the social field — within symbolic frameworks of meaning, within the social unconscious that transmits relational patterns across generations, and within the institutions and cultural narratives that shape everyday life.

At the same time, the loosening of patriarchal authority creates new possibilities for relational and symbolic reorganization. Expanded understandings of gender, identity, and belonging open space for forms of social life that are less constrained by rigid hierarchies. Yet this transition also raises important questions concerning how authority, responsibility, and collective coherence can be sustained when traditional symbolic anchors lose their taken-for-granted legitimacy.

Within this evolving landscape, group analysis offers a particularly valuable perspective. By conceptualizing the group as a microcosm of the wider social matrix, group analytic theory enables clinicians to observe how broader cultural transformations become enacted within interpersonal dynamics. Earl Hopper's elaboration of the tripartite matrix — distinguishing the foundation, dynamic, and personal matrices — provides a framework through which these processes can be traced across societal, group, and individual levels simultaneously.

Within analytic groups, the transformation of patriarchal authority becomes visible in challenges to leadership, subgroup formations, gendered transferences, and the search for new forms of symbolic containment. Rather than viewing these dynamics simply as disruptions, group analysis understands them as expressions of a broader social transition. The analytic group provides a structured setting in which these tensions can be explored, symbolized, and gradually integrated.

In this sense, analytic groups function not only as therapeutic environments but also as spaces of social learning. Within the group matrix, authority can be explored as a relational process rather than a fixed hierarchy. Leadership may become distributed rather than centralized, and differences can be engaged without requiring rigid polarization. Through dialogue and shared reflection, members experiment with new ways of negotiating power, responsibility, and belonging.

This capacity to hold complexity is one of the distinctive contributions of group analysis. By working simultaneously across the foundation, dynamic, and personal matrices, analytic groups enable participants to recognize how inherited structures continue to shape expectations of authority and relationality. At the same time, they create opportunities for developing alternative forms of symbolic organization grounded in mutual recognition and shared responsibility.

The work of the group therefore extends beyond the resolution of individual conflicts. It contributes to the gradual emergence of relational frameworks capable of supporting psychic life in changing social conditions. Within the analytic group, members can reflect on experiences of authority, dependency, and responsibility in ways that foster both personal insight and collective understanding.

Through this process, group analysis helps cultivate what Earl Hopper describes as **mature hope** — a form of hope grounded not in the restoration of past structures but in the ongoing capacity of groups to think, relate, and create meaning together. In this way, the analytic group becomes a setting in which the possibilities of post-patriarchal authority can be explored: authority that is negotiated rather than imposed, relational rather than hierarchical, and sustained through dialogue, responsibility, and shared symbolic work.

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