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У журналі представлено різноманіття психотерапевтичних підходів, модальностей та методик, що пов'язані з психологічним та медичним просторами сучасної психотерапевтичної та консультативної допомоги. Розглянуто теоретичні і практичні питання щодо різних аспектів психотерапевтичного втручання при різних розладах, їх гендерні аспекти, методики психодіагностики, взаємодію психотерапії та культури тощо.

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The Journal presents a variety of psychotherapeutic approaches, modalities and techniques related to the psychological and medical spaces of modern psychotherapeutic and counseling care. Theoretical and practical issues on various aspects of psychotherapeutic intervention in various disorders, their gender aspects, methods of psychodiagnostics, the interaction of psychotherapy and culture, etc. are considered.

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## ЗМІСТ

<b>РОЗДІЛ: ТЕОРЕТИЧНІ ТА МЕТОДОЛОГІЧНІ ПРОБЛЕМИ ПСИХОЛОГІЧНОГО КОНСУЛЬТУВАННЯ ТА ПСИХОТЕРАПІЇ</b> .....	<b>6</b>
<i>Жидко М., Гулий Ю. Інфодемії та виклики практики людиноцентрованої психотерапії в часи «ідеального шторму»</i> .....	<b>6</b>
<i>Діаконеску П. Етична інфраструктура для практикуючих в області ментального здоров'я</i> .....	<b>15</b>
<i>Научитель О., Харченко А., Якушева Є. Діалог як ресурс: психологічна підтримка підлітків у реаліях травматичного досвіду</i> .....	<b>21</b>
<b>РОЗДІЛ: ПСИХОТЕРАПЕВТИЧНІ МОДАЛЬНОСТІ, МЕТОДИ ТА МЕТОДИКИ</b> .....	<b>28</b>
<i>Кочарян Г. Сексуальні розлади: поведінковий підхід до їх формування і терапії</i> .....	<b>28</b>
<i>Понсфорд Ч. Пропозиція зв'язку у межах більш широкого контексту спільноти: групи Heart Wood для чоловіків</i> .....	<b>36</b>
<b>РОЗДІЛ: МЕДИЧНА ПСИХОЛОГІЯ ТЕОРЕТИЧНІ ТА ПРИКЛАДНІ ПИТАННЯ</b> .....	<b>42</b>
<i>Барінова Н., Єрмак І. Психологічні детермінанти та інтрапсихічні механізми посттравматичного зростання: особистісно-центрований вимір</i> .....	<b>42</b>
<i>Хомуленко Т., Криничко В., Фоменко К. Оперативне мислення: концептуалізація поняття, психодіагностика та стандартизація методики</i> .....	<b>48</b>
<i>Барінов С. Резильєнтність як ресурс подолання негативних впливів залучення до волонтерської діяльності</i> .....	<b>59</b>

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**CONTENTS****SECTION: PSYCHOTHERAPEUTIC MODALITIES, METHODS AND METHODOLOGIES .....6**

*M. Zhydko, Yu. Guliy.* Infodemics and Challenges of Human-Centered Psychotherapy Practice in Times of the «Perfect Storm».....6

*P. Diaconescu,* Ethical Infrastructure for Mental Health Practitioners.....15

*O. Nauchitel, A. Kharchenko, Ye. Yakusheva.* Dialogue as a Resource: Psychological Support for Adolescents in the Context of Traumatic Experience.....21

**SECTION: PSYCHOTHERAPEUTIC MODALITIES, METHODS AND METHODOLOGIES .....28**

*G. Kocharyan.* Sexual Disorders: A Behavioral Approach to Their Formation and Therapy .....28

*C. Ponsford.* Offering Connection within a Wider Community Context: the Heart Wood Groups for Men.....36

**SECTION: MEDICAL PSYCHOLOGY THEORETICAL AND PRACTICAL ISSUES .....42**

*N. Barinova, I. Yermak.* Psychological Determinants and Intrapsychic Mechanisms of Post-Traumatic Growth: A Person-Centered Dimension.....42

*T. Khomulenko, V. Krynychko, K. Fomenko.* Operatory Thinking: Conceptualization, Psychodiagnostics and Methodology Standardization.....48

*S. Barinov.* Resilience As a Resource for Overcoming Negative Impacts of Volunteering.....59

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SECTION: THEORETICAL AND METHODOLOGICAL PROBLEMS OF PSYCHOLOGICAL  
ADVICE AND PSYCHOTHERAPYРОЗДІЛ: ТЕОРЕТИЧНІ ТА МЕТОДОЛОГІЧНІ ПРОБЛЕМИ ПСИХОЛОГІЧНОГО  
КОНСУЛЬТУВАННЯ ТА ПСИХОТЕРАПІЇ

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INFODEMICS AND CHALLENGES OF HUMAN-CENTERED PSYCHOTHERAPY PRACTICE IN TIMES  
OF THE «PERFECT STORM»**Maksym Zhydko***PhD in Psychology, Associate Professor, Associate Professor of the Department of Psychology  
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The rapid expansion of digital communication technologies has fundamentally transformed the dynamics of collective psychological processes, giving rise to the phenomenon known as the infodemic. Infodemics represent an intensified form of mental epidemics in which excessive, distorted, or manipulative information spreads rapidly through digital media, amplifying uncertainty, anxiety, polarization, and psychosocial vulnerability. This process unfolds against the background of multiple overlapping global crises, conceptualized in this paper as a «perfect storm» encompassing armed conflicts, pandemics, technological acceleration, erosion of institutional trust, and structural uncertainty. The aim of this study is to conceptualize infodemics as an evolutionary stage of mental epidemics in digitally mediated societies and to analyze their psychological impact on individuals and populations, as well as the challenges they pose to contemporary psychotherapeutic practice, particularly within person-centered and humanistic approaches. The paper employs a theoretical and interdisciplinary methodology combining historical-comparative analysis of mental epidemics, conceptual modeling, and critical synthesis of research from psychology, media studies, and mental health. The article proposes heuristic conceptual models for assessing infodemic intensity and its psychological impact, highlighting the interaction between information-technological affordances, crisis-related stress, psychosocial vulnerability, and levels of institutional trust. It is argued that infodemics contribute to the reconfiguration of mental health norms, therapeutic demand, and modes of psychological distress, increasingly characterized by fragmentation of meaning, affective dysregulation, and erosion of shared reality. Special attention is given to the implications of these processes for person-centered psychotherapy. The paper suggests that infodemics challenge core therapeutic conditions—empathy, unconditional positive regard, and congruence—while simultaneously underscoring their critical importance as non-algorithmizable resources for maintaining human subjectivity. The study concludes that person-centered psychotherapy can be understood not only as a clinical practice but also as a protective humanistic framework capable of supporting meaning-making and psychological resilience in digitally saturated and crisis-prone environments.

**Keywords:** *cognitive war, infodemic, mental epidemics, digital media and mental health, psychological warfare and information influence, global crises and psychological vulnerability, person-centered psychotherapy, perfect storm.*

**The state of the problem**

The large-scale military aggression against Ukraine, which was launched by the Russian Federation under the name of a «special military operation» on February 24, 2022, and continues to this day, belongs to a relatively new type of warfare. From a geopolitical point of view, it is an attempt at revanchism after the collapse of the USSR, a specific political and economic regime that took shape during Putin's rule (under the conditional name of Rashism), and a revision of the current political and

economic architecture of the world. From a purely military point of view, it is only the next stage of escalation, another continuation by other means of the foreign policy conflict that began in 2014 in connection with Ukraine's European choice and was accompanied by the covert military annexation of Crimea and parts of the Donetsk and Luhansk regions. From a historical point of view, it is the Ukrainian nation's resistance to deliberate genocide, the struggle for independence and the right to exist as a modern project instead of the archaic neo-colonial project

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of the former Russian Empire, which is being imposed in this way. From a cultural point of view, it is a war for historical memory and national identity. From a psychological point of view, it is a war for consciousness and freedom, or, conversely, total control over the main resource – human resources.

The complexity, systematicity, and multidimensionality of the war have been summarized under the term hybridity. It would be incorrect to say that this is a completely new strategy and tactic of warfare; the authors of the collection edited by Murray and Mansur (Murray, W., & Mansoor, P. R. (2012) highlight nine examples of wars from antiquity to the second half of the 20th century in which various aspects of hybridity were formed. Today, the most complete definition of hybrid warfare is a war that combines the use of conventional weapons, guerrilla warfare, terrorism, cyber warfare, trade wars, patent wars, revanchist movements, propaganda, human rights violations, crimes against humanity, military exercises, resettlement, usurpation, acts of censorship, and criminal behavior to achieve certain political goals. Its main tool is the creation of internal contradictions and conflicts by the aggressor state in the state chosen for aggression, with their subsequent use to achieve the goals that would be achieved by conventional warfare.

An important component of this type of war is information and psychological operations. There is even a term, information and psychological warfare, which can be understood in a narrow military sense or more broadly as «information confrontation», depending on the context of a particular official document or scientific publication. Therefore, the definition of special information and psychological operations includes confrontation between the parties through the dissemination of specially prepared information and countering similar external influence on oneself. The target audience of these operations includes not only the military but also the civilian population. The more networked a society is and the more it enters the content civilization, the more it creates a communicative mass (a new type of crowd) and the more vulnerable it is to this influence. Back in 2014, G. Pocheptsov (Почепцов Г.Г., 2000) assessed the military confrontation between Ukraine and the Russian Federation as «the first semantic war in the world» where images and visualizations trigger emotional perception of information, eliminating a rational approach to reasoning.

Some of the important targets of such operations are thoughts, emotions, and behavior at the individual and group levels. By striking these targets with various manipulations, certain military goals can be achieved with greater efficiency and fewer losses of human and material resources. According to American intelligence officer and scholar Paul Linebarger (Linebarger, P.M.A., 2008, 2025), who wrote the classic work *Psychological Warfare: Theory and Practice of Mass Mind Control* in 1948, psychological warfare differs from conventional warfare primarily in that it begins long before the declaration of hostilities and continues after their end.

N.V. Maruta and M.V. Markova (Марута Н.О., Маркова М.В., 2015) point out that in information and

psychological operations, it is difficult to talk about the boundaries between normality and pathology. Therefore, the loss of adequacy in reflecting oneself and the world in one's consciousness and attitude towards the world and oneself can serve as an indicator of damage. In extreme cases, this can mean «personality distortion with a simplified reflection of reality, coarser reactions, and a shift from the need to fulfill higher needs (for self-actualization, social recognition) to lower ones (physiological, everyday needs). In addition, there are «shifts in values, life positions, orientations, and worldview of the individual. Such changes lead to manifestations of deviant antisocial behavior».

However, in our opinion, hybrid military actions are another, current wave of a more global civilizational process, which can be metaphorically described as quantum, because all of humanity is simultaneously its material, driving forces, goal, executors, and observers. In the social sciences and humanities, it is generally referred to as a «perfect storm». There are many different definitions, so we will give our own: it is a complex set of changes of a global, in fact civilizational nature, which occur heterochronously, in different places, but systematically, at different levels of human and social existence and are associated with processes that are objective and poorly understood by the majority of humanity. At each stage of these changes, the number of these processes increases, they tend to merge, interact, and create a certain synergy, and have fundamental consequences. One of the waves of this «perfect storm» is the crisis of the old-world order and the desire for a new division of the world based on the law of the strong.

Our vision of the «perfect storm» is that it originated at the beginning of the 20th century in connection with fundamental scientific discoveries in technical (primarily physics) and natural (physiology) sciences and, accordingly, the creation of cheap and mass technologies for the rapid transmission of information over long distances (e.g., radio) and illusory immersive experiences (e.g., cinema). From this perspective, all the great achievements and tragedies of world history in the 19th and 20th centuries (social revolutions, world wars, authoritarian ideologies, space exploration, the race between socialist and capitalist economic models, nuclear confrontation, silicon electronics, genetic engineering, terrorism, etc.) were manifestations of one wave or another. The first attempts at reflection appeared in the 1930s (remember the philosophical works of José Ortega y Gasset, the literary works of Hermann Hesse (Simpson, S., & Reid, 2014), surrealism, etc.), and in the 1960s, under various names, the «perfect storm» entered the field of scientific research (in psychology, this was linked in a certain way to the emergence of a third force – the «existential-humanistic» direction). In the 1970s, due to the rapid development of technology, some aspects of this «storm» were idealized (for psychology, this marked the beginning of an era of evidence, efficiency, protocol, etc., i.e., everything that could be algorithmized). Enthusiasm for scientific progress and rapid improvement in the quality of life for a long time prevented people from seeing

the «dark side». Only in the first quarter of the 21st century did various dimensions of the «perfect storm» begin to be actively researched and discussed in connection with acute socio-political relevance. Therefore, today we see desperate political attempts to stop the next wave of the «perfect storm» with populist proposals and actions aimed at returning to an isolated and stagnant idealized past.

Today, we can identify the following dimensions/challenges of the «perfect storm»: 1) radical confrontation between the consumer economy and nature, 2) futurochok and information overload, 3) phenomena of the second demographic transition (transformation of «traditional» family models and values, digital sexuality, maturity inflation, etc.), 4) exploitation of differences between «digital migrants» and «digital natives,» 5) formation of a new anthropological type (conditionally Homo digital) thanks to AI algorithms, digital «doubles» of people, digital identity, network society, surveillance capitalism, and the social class of «useless people»; in a broader context, the civilization of content, 6) the psychological tyranny of opportunity and choice, 7) the problem of the death of expertise, post-truth, and hyperreality, 8) algorithmization of specialists and the comfort of the «information bubble,» 9) dopamine manipulation, and 10) the spread of digital dementia.

Unfortunately, no matter how terrible and dire the times may seem to us, according to this logic, the perfect storm has not yet reached its peak—the final great migration of humanity not to Mars, but from the physical, materially limited reality to the literally boundless (for now) digital virtual reality. Or, paradoxically, we can phrase it the other way around, which does not change the essence: to finally replace human reality with its simulacra.

Accordingly, the «perfect storm» is changing the understanding and assessment of mental health, psychopathology, and psychological problems, as well as models, approaches, and methods of psychological and psychotherapeutic assistance. Next, we will consider these changes from the perspective of a relatively new phenomenon, such as infodemics.

**The object of study** is infodemics as new evolutionary forms of mass mental health and functioning disorders (mental epidemics) in the context of systemic global crises caused by the development of information technologies.

**The subject of the study** is the challenges of modern psychotherapeutic practice associated with the psychological impact of infodemics in the context of a «perfect storm».

**The purpose of the study** is to predict future infodemics and identify key challenges and possible guidelines for the development of human-centered psychotherapy methods in the context of a «perfect storm» based on theoretical understanding and conceptual modeling.

#### **Research objectives:**

1. Analyze the evolution of mental epidemics and outline the specifics of infodemics as a phenomenon of the «perfect storm».

2. Identify key psychological factors influencing the emergence and spread of infodemics and propose

conceptual models for assessing the intensity of infodemics and their psychological impact on the population.

3. Describe scenarios for future infodemics in different time horizons.

4. Reveal the challenges to modern human-centered methods in psychotherapy associated with the psychological impact of infodemics in the context of a «perfect storm».

#### **Personal contribution of the authors:**

M.E. Zhidko – development of the idea of the dynamics of the «perfect storm», description of its dimensions, forecasting challenges for human-centered psychotherapy.

Y.I. Guliy – conceptual modeling and forecasting of infodemics.

#### **Main material:**

As medievalists say, epidemics are the price we pay for globalization. When we talk about epidemics, we most often refer to biological pandemics (the Great Plague, cholera, Spanish flu in the early 20th century, etc.). But at the same time, there were also mental epidemics.

Mental epidemics (also known as mass psychogenic illness, mass hysteria, or social-behavioral contagion) are phenomena in which symptoms (often neurological, psychosomatic, or behavioral in nature) spread instantly among groups of people through social contagion and other socio-psychological mechanisms. Based on the chronology known to us, we will attempt to classify the most famous mental epidemics. These include: medieval epidemics of dancing and religious ecstasy (for example, the dancing mania of 1374 in a number of cities along the Rhine or the Plimpton demonic possession among nuns in European monasteries in the 15th–16th centuries, the so-called case of Urbain Grandier), witch hunts and political panics of the Modern Age (the infamous Salem witch trials (1692–1693), hysterical phenomenology in the Age of Enlightenment and industrialization (e.g., the so-called Great Fear among peasants in France in 1789, tics, tremors, paralysis, and hallucinations among French and British factory workers in the 19th century), media-induced panic (e.g., during the broadcast of «The War of the Worlds» in 1938 or the epidemic of laughter at a boarding school for girls in Tanzania in 1962), mass poisoning of a sociogenic nature, for example, in Macedonia in 1999), fake news and moral panic on social media (we remember all those conspiracy theories about «spiked oranges,» the «Blue Whale» challenge, etc. from the early 2000s to the present day).

Despite the variety of forms, they are united by a number of common factors:

1. The presence of stress associated with a deep crisis (e.g., plague, famine, war, political instability, repressive conditions, etc.).

2. A specific historical and cultural context that determines the forms that symptoms take (demonology, hysteria, conspiracy theories, etc.).

3. A closed or networked environment (monasteries, schools, factories, online communities, etc.).

4. Vulnerability of the target audience (discriminated or marginalized groups that have limited other opportunities to influence the situation).

5. Development of information and technological mechanisms of mass influence for manipulative purposes.

According to the World Health Organization, an «infodemic» (a portmanteau of ‘information’ and «pandemic») is the emergence of an excessive amount of information about a problem, which complicates the search for a solution. An infodemic contributes to the spread of rumors, inaccurate data, and fake news during an emergency. Coronavirus is the first pandemic in human history to occur in the age of social media, which means that misinformation spreads faster than the virus itself.

In our opinion, infodemics are just another stage in the evolution of mental epidemics, which is now taking place in the digital environment. Accordingly, the content and forms of infodemics are directly related to the current wave of the global «perfect storm». But the essential difference between this stage and previous ones is that both biological and mental viruses today are not only created artificially, but also actively used as weapons. COVID-19 is a striking example of a «perfect storm» in which a biological epidemic worked in tandem with an infodemic.

Theoretical considerations are valuable only when they enable assessment and prediction. I am sure that everyone understands that the future global «arms race» will be associated not only with the use of artificial intelligence, but also with conditional mental weapons. Therefore, based on the analysis of mental epidemics and the experience of infodemics, as well as taking into account the defined dimensions of the «perfect storm», we have attempted to derive hypothetical conceptual formulas that

allow us to assess and predict the intensity of current and future infodemics and their psychological impact on the population.

The formula for assessing intensity is as follows:

$$IP(t) = \alpha \cdot IT(t) \cdot C(t) \cdot (1 + V(t)) / (1 + T(t)),$$

where:

IP(t) – intensity of infodemic

IT – information and technological capabilities (speed, coverage, immersiveness).

C – intensity of stress/crisis (war, pandemic, climate disasters).

V – vulnerability of the social group (urbanization, economic/psychosocial stressors).

T – trust in institutions (higher trust reduces the risk of infodemic).

$\alpha$  – scale constant (a constant used in modeling for normalization, comparability, and correct scaling of values).

Accordingly, the formula for assessing the psychological impact of infodemics on the population is as follows:

$$MHI(t) = \beta \cdot IP(t) \cdot S(t)$$

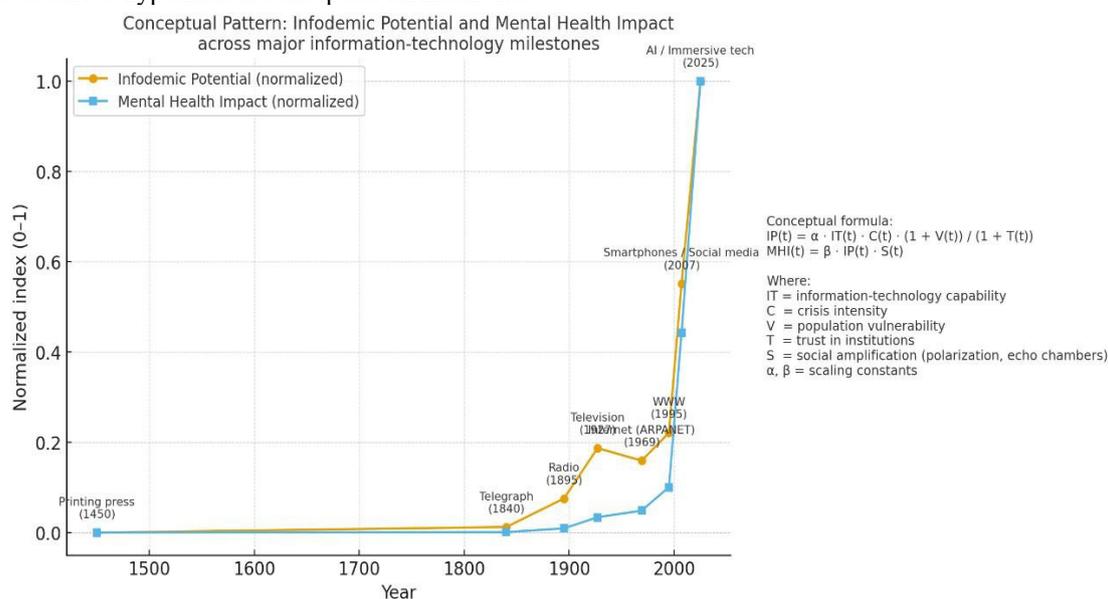
where:

MHI(t) – psychological impact on the population.

S – social amplification (openness of society, presence of polarisation, algorithmic reinforcement, etc.).

$\beta$  – scale constant.

The correlation between technological development and mental epidemics is presented in Fig. 1.



**Figure 1.** Graph showing the correlation between technological development and mental epidemics

Figure 1 shows a graph of the relationship between technological development and mental epidemics according to these formulas. As can be seen immediately, as information technology developed (from printing to AI), the potential for infodemics grew, but not linearly, but in leaps and bounds: various technological leaps and

corresponding historical crises create surges. The psychological impact depends on the intensity of the mental epidemic, but is significantly amplified by social amplification (which is why the era of smartphones and social networks has had such a huge psychological impact on the population).

The situation becomes even more interesting if we superimpose this graph on other models for predicting crises (including epidemics) that are based on cyclicity. It turns out that mental epidemics and infodemics are not chaotic—they are formed at the intersection of three long cycles: passionary waves (approximately 300 years), social-generational rhythms (approximately 30 years), and astro-biological fluctuations (approximately 11 years). When these cycles overlap, a «perfect storm window» emerges, in which societies become particularly vulnerable to information technology and collective affects.

All these conceptual conclusions require careful empirical testing, but even now, with a great deal of risk, certain predictions can be made.

They can be divided into three groups.

The first is the nearest infodemics (2025–2027), the probability of which we estimate at 60–85%. From our point of view, there are two triggers and, accordingly, two scenarios.

The first scenario is «Simplification/Cognitive Economy» (probability ~70%). In fact, we are already living in this infodemic, but we do not have the courage to say it out loud. Simplification (or «cognitive miserliness» according to S. Fisk) permeates all dimensions of individual and social life: from «simple decisions» about oneself to «simple decisions» about geopolitical conflicts. In this scenario, the weakness and inadequacy of the values and mechanisms of Western civilization and sympathy for authoritarian leaders and populists who willingly offer simple ways of thinking are natural. We can joke all we want about the historical nonsense of the Kremlin psychopath, but let's admit that they do a good job of functioning as mental viruses. And regardless of how the war in Ukraine ends, the infodemic of the «power of simple truth» will continue as long as simplification provides opportunities for monetization and escalation, and most of humanity has not «recovered» from it with various consequences (even if this simplification results in one or a series of major catastrophic events). Due to simplification, fact-checking is now more readily perceived as hostile propaganda rather than a tool of truth.

The second scenario is «AI-personalized electoral shock». I estimate its probability at 60%. Most likely, the date will be 2026–2027, when the world will see a series of national elections.

Targeting key demographic groups and the rapid spread of personalized deepfake materials (which will be impossible to verify in time) through messengers and platforms, the strategy is not to convince people of one thing, but to generally undermine trust in everything. This will lead to a degradation of trust in election results and an increase in social tension (including local but very intense outbreaks of radicalization). In the most negative scenario, global society will fragment into micro-colonies of reality («truth clusters»), where each social group will exist in a separate informational and emotional cocoon. It will become impossible or very difficult to make joint decisions. This could result in both domestic political crises and foreign policy aggression. We are already seeing

the beginning of this infodemic in conversations about digital concentration camps. In addition, the active use of shock content will lead to the emergence of psychogenic «affective blindness» – a dulling of emotional response to any extraordinary events. Unfortunately, we can also observe this now under the name «war fatigue» (also known as compassion fatigue and moral injury).

The second group consists of infodemics in the medium term (2027–2032). Their probability is approximately 40–65%.

One of the scenarios is a «climate catastrophe» (probability ~50%). Timeframe: 2027–2033. The deterioration in quality of life will lead to the use of the «climate apocalypse» in geopolitical manipulations and the false mobilization of society. There will be a proliferation of conspiracy theories about the sources of the apocalypse (from industrial sabotage to genetic engineering accusations), collective helplessness, and dramatic events related to aid (including evacuation). The result will be the polarization of the world depending on the state of the environment. The emergence of AI-synthesized religious cults. Perhaps something else will be the main catastrophic factor (at least one biological virus like COVID or even a «fake» or simulated catastrophe), but the scenario will remain fundamentally the same.

Another scenario in this group is «psychotechnological escalation» (probability ~45%). Timeframe: 2028–2032. We predict that during this period, «psychotechnologies» (neuromodulation, personalized manipulative interventions) will be directly applied in hybrid military-political operations. The result will be concentrated psychological damage in targeted groups (complete or partial disorganization, externally controlled behavior, etc.). One variant of this scenario is the integration of algorithms into government decision-making.

The third group is infodemics in the long term (2033–2045). Their probability is currently around 25–40%.

This includes the «Society of Digital Doubles» scenario, which, in our opinion, will begin after 2035. Large-scale and deep digitalization will lead to an ontological crisis of trust. At present, we can only cautiously predict that this will lead to collective cognitive fatigue and an alienated life in chronic (or habitual) disorientation.

And the last scenario is «neurodemic» (probability ~30%). Term: 2035–2045. We predict that by this time, as in the case of many biological viruses, humanity will have developed a natural «psychic immunity» to infodemics, or more or less effective information vaccinations. At the same time, technological development will make such a leap that mental epidemics will also evolve into the form of neurodemic – that is, fully immersive «viral» virtual realities that will be provided by direct neurotechnological influence. In the literal sense, infodemics will become neurosomatic. Most people will completely lose the illusion of «free will». AR epidemics of hysterical behavior may arise (analogous to medieval dancing, but triggered by AR systems).

Psychotherapy as a separate practice originated in the late 19th century. Most of its directions and approaches

were formed precisely in the context of the «perfect storm» (in a sense, it can be said that psychotherapy is one of the offspring of the beginning of this storm) as a response to certain psychological challenges that were actualized by one wave or another.

For example, client-centered psychotherapy emerged in post-war America in the mid-20th century, when Western society sought healing after the horrors of totalitarianism, searched for new forms of freedom, and people began to experience themselves not only as objects of social norms, but as subjects with the right to experience, development, and dignity. In his works, C. Rogers (Rogers, C. R., 1957) responded in one way or another to the challenges of that era—alienation, excessive directiveness, authoritarianism, psychological violence, and the depersonalization of individuals in institutions. He wrote his last works in the model of the so-called VUCA (acronym for Volatility, Uncertainty, Complexity, Ambiguity) world.

However, since then, the context itself has changed radically. If back then the threat was external regulation and a lack of agency, today we are dealing with an inflation of agency, where everyone has a voice but no space for genuine dialogue; with an oversaturation of identities but a loss of integrity; with individualism without depth. Instead of authoritarian control, we now have the tyranny of choice—anxiety from an excess of possibilities and a chaos of meanings. So, the challenges that Rogers (Rogers, C. R., 1957, 1972, 1980, ) responded to have either transformed or lost their relevance, and we need to ask ourselves honestly: what challenges shape the current demands for understanding humanity in BANI (Brittle, Anxious, Nonlinear, Incomprehensible) and SHIVA (Split, Horrible, Inconceivable, Vicious, Arising) worlds, and from what positions do we respond to them?

It is also worth realizing that Rogers' ideas about human beings—their nature, capacity for growth, and endowment with inner goodness—were shaped not only by empirical observations but also by the strong influence of humanist philosophy, liberal Protestantism, phenomenology, and scientific optimism of the mid-20th century. His human being is an autonomous, holistic organism capable of self-actualization in a supportive environment. Today, however, the value landscape has shifted radically: transhumanist ideas about humans as projects for improvement, technological interventions in the psyche and body, and the blurring of boundaries between the natural and the artificial all challenge the very idea of the «holistic self» that underlies the human-centered paradigm. Can we continue to rely on the same ontological ideas about humanity as Rogers in a world where «human» is no longer an immutable category?

Jean Baudrillard (Baudrillard, J., 2004, 2010), in his hypothetical interview with Alex Bell in the characteristically titled book *What Geniuses Think: Talking About What Matters with Those Who Are Changing the World*, says: "The only thing that no technology can fake is people themselves. You and me. Our consciousness. Since human consciousness is a kind of transcendental essence and we still don't have the key to

how it works, it's not possible to create a full-fledged simulacrum of it. Human consciousness, the brain, is the last line of defense for reality in the universe. If technology ever allows us to create an artificial human with a full consciousness, the appearance of such a monster will spell the end of human civilization. Thus, it would not be an exaggeration to say that in the age of infodemics and language simulators, full consciousness is synonymous with humanity and the main target of both infodemics and information-psychological operations. Therefore, it is not technological but human-centered approaches in psychology and psychotherapy that, by definition, oppose the «perfect storm».

The «perfect storm» stimulates and encourages us to view people, mental health assessment standards, and the content of psychological problems through the prism of system «functions», content consumption, and algorithmic elements. This is not just a technological shift. It is what Martin Heidegger (Heidegger, M., 2007) called the forgetting of being: when human existence is reduced to presence, to a «resource», losing its profound existential openness. Human-centered types of psychotherapy are, in essence, an act of resistance to this forgetting. They not only «help a person adapt», but also return them to an existential dialogue with themselves as who they are, not just who they function as.

In this sense, human-centered approaches in psychotherapy today are ontological gestures of remembrance. They appeal to what in a person cannot be reduced to simulation, neural networks, or behavioral patterns. They create a space in which the client can ask again: Who am I? How do I exist? What does it mean to be alive in a world that is rapidly losing ground? And it is precisely this quality of questioning—not a technique, but an attitude—that makes psychotherapy relevant in an age where the very question of human existence is being pushed out of sight.

Next, we will formulate a series of challenges for the person-centered therapist that broaden and deepen the question of humanity today.

In our opinion, the following challenges exist in relation to the trend of self-actualization today:

- Can we trust our inner desire for growth when external conditions are destructive and traumatic? (For example, the well-known experience of war, loss, forced migration, etc. among our Ukrainian colleagues).

- To what extent is the trend toward self-actualization today not organic but virtual, determined by artificial intelligence algorithms?

- How can we maintain hope and faith in a client's potential when he or she is experiencing extreme stress or trauma?

Challenges for the trinity of therapeutic conditions:

- Empathy: How can a therapist understand an experience that goes beyond his or her own (e.g., combat experience, life under occupation, or being a virtual being, etc.)? Is there such a thing as empathy for a virtual experience? How does the simulation of empathy by artificial intelligence language models (which, unlike human empathy, quickly encompasses any

phenomenology) differ from «live» empathy? To what extent does «compassion fatigue or burnout» develop in extreme conditions? How do experiences and communication in the digital world affect empathy? How can we empathize with the existential anxiety associated with global threats?

– Unconditional positive regard (UPR): Is it easy to maintain UPR when clients express radical views shaped by propaganda or conditioned by trauma? Or when their coping mechanisms seem destructive? How can we accept despair, aggression, and apathy caused by a global crisis with a very uncertain outcome?

– Congruence: How can a therapist be authentic when they themselves are experiencing anxiety, fear, fatigue, and other strong emotions associated with the «perfect storm»? Where is the line between sincerity and burdening the client with one's own experiences? When and to what extent does congruence, like empathy, become a factor in therapist burnout?

Challenges for process-oriented therapy:

– Focus on the «here and now» vs. working with past trauma and future uncertainty.

– The growing need for crisis intervention and stabilization – how to integrate this into a non-directive approach?

– Ethical dilemmas (confidentiality in wartime, working with limited resources, etc.).

These challenges are fairly easy to simulate by conducting a simple thought experiment: if you were tasked with to write an appropriate prompt for any type of artificial intelligence in order to create a model of a human-centered specialist for modern people (for example, those born in the digital age, i.e., whose socialization took place during the existence of digital information technologies), how would you describe the characteristics of thinking, emotions, and interaction? Would this description differ from your answer to this question twenty years ago? And even more interesting—what would you say for a model of a specialist in 20 years?

When uncertainty seems unbearable, temptations arise. We will mention only a few of them. The temptation to technologize psychotherapy—to make it predictable, measurable, controllable—is growing. Under the guise of efficiency, standardized protocols, KPIs, and emotion checklists are being introduced. The psychotherapist is turning into a system operator who «performs interventions» rather than a person who meets the Other. This is nothing more than another form of forgetting—this time, interpersonal forgetting: the reduction of dialogue to technique, of relationships to transactions, and of lived experience to clinical units of accounting.

In this context, the human-centered approach once again finds itself on the brink—not as an archaic alternative, but as resistance to the automation of the inner world. After all, its values—presence, authenticity, trust in the process—cannot be quantified, but are indispensable for human healing. This approach is not against science or structure – but it is against betraying humanity in the name of controllability. Where other models promise control, human-centeredness leaves room for encounter. And in the

age of the perfect storm, perhaps it is precisely this approach that is capable of maintaining direction – not toward a result, but toward meaning.

Human-centered psychotherapists, as people and professionals, should accept that the perfect storm cannot be «survived» by hiding behind classical ideas or trying to restore a world that no longer exists. The human-centered approach should not be nostalgia for the era of humanism or the «end of history»—it should become the frontier of a new understanding of humanity, capable of holding its ground on the border between the real and the virtual, the biological and the digital, the autonomous and the distributed, the networked «I.»

Modern therapists have to work not only with clients, but with people who have lost most of their bearings in life—in time, space, identity, etc. They have to work through their own personalities, which are also trying to stay afloat in the «perfect storm». That's why it's important to understand that the current phase of the storm isn't just a threat, but also another existential awakening: a moment when we can finally look honestly at who modern people have become. And to ask the main therapeutic question: not «Who are you?» but «How do you feel about being human – here, now, in this turbulent world?» The answer to this question will not be easy for our clients or for us, and by definition, it cannot be easy. But as we ponder this answer, we become a point of calm within the storm, a space and time where we can meet with hope for a future that is still worth living.

Summing up our thoughts on humanity in times of the «perfect storm», we can say that being a psychotherapist in the 21st century is not about having the appropriate education and being able to apply it in practice. In the near future, this may and will be replaced by artificial intelligence algorithms. Being a psychotherapist today is a calling to keep the door to humanity open.

Humanity today resembles a ship that is simultaneously weathering a storm and being rebuilt in the middle of the ocean. Technology accelerates the waves, stress raises their height, and politics makes them toxic. The only thing that keeps the ship upright so far is mental health. Therefore, when the next wave of the perfect storm hits us, no matter how it unfolds, it is important to remember that no storm lasts forever, and no ship can stay afloat without maintenance. Therefore, the question is not whether there will be new infodemics and what they will be like, but whether we will have enough mental and institutional strength to meet them not as victims, but as subjects who are ready and able to repair and rebuild their ship. We believe that our primary professional duty now—as researchers, practitioners, and educators—is to learn and teach precisely this kind of repair.

### Conclusions

1. Infodemics are an evolutionary continuation of mental epidemics, radically amplified by digital technologies.

2. The intensity of infodemics is determined not only by the information flow, but by the combination of crisis, vulnerability and trust in institutions.

3. Psychotherapy in the 21st century faces not a deficit of subjectivity, but its inflation and fragmentation.

4. Human-centered approaches perform not only a clinical, but also an ontological function of preserving humanity.

5. Algorithmization of care without an existential dimension creates the risk of new forms of mental alienation.

6. Future infodemics will be personalized, immersive and affective-neural in nature.

7. The key professional competence of a psychotherapist is the ability to maintain the space of meaning in conditions of radical uncertainty.

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#### Personal contribution of the authors:

M.E. Zhidko – development of the idea of the dynamics of the «perfect storm» description of its dimensions, forecasting challenges for human-centered psychotherapy.

Y.I. Guliy – conceptual modeling and forecasting of infodemics.

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#### ІНФОДЕМІЇ ТА ВИКЛИКИ ПРАКТИКИ ЛЮДИНОЦЕНТРОВАНОЇ ПСИХОТЕРАПІЇ В ЧАСИ «ІДЕАЛЬНОГО ШТОРМУ»

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Швидке поширення цифрових комунікаційних технологій кардинально змінило динаміку колективних психологічних процесів, породивши явище, відоме як інфодемія. Інфодемія є інтенсивною формою психічної епідемії, під час якої надмірна, спотворена або маніпулятивна інформація швидко поширюється через цифрові медіа, посилюючи невизначеність, тривогу, поляризацію та психосоціальну вразливість. Цей процес розгортається на тлі численних глобальних криз, що перетинаються між собою, які в цій статті концептуалізуються як «ідеальний шторм», що охоплює збройні конфлікти, пандемії, технологічне прискорення, ерозію інституційної довіри та структурну невизначеність. Метою цього дослідження є концептуалізація інфодемії як еволюційної стадії психічних епідемій у суспільствах, опосередкованих цифровими технологіями, та аналіз їхнього психологічного впливу на окремих осіб і населення, а також викликів, які вони ставлять перед сучасною психотерапевтичною практикою, зокрема в рамках персонорічного та гуманістичного підходів. У статті використовується теоретична та міждисциплінарна методологія, що поєднує історико-порівняльний аналіз психічних епідемій, концептуальне моделювання та критичний синтез досліджень з психології, медіа-досліджень та психічного здоров'я. У статті пропонуються концептуальні моделі для оцінки інтенсивності інфодемії та її психологічного впливу, підкреслюючи взаємодію між інформаційно-технологічними можливостями, стресом, пов'язаним з кризою, психосоціальною вразливістю та рівнем інституційної довіри. Стверджується, що інфодемія сприяє реконфігурації норм психічного здоров'я, терапевтичного попиту та форм психологічного дистресу, які все більше характеризуються фрагментацією сенсу, афективною дисрегуляцією та ерозією спільної реальності. Особлива увага приділяється наслідкам цих процесів для психотерапії, орієнтованої на людину. У статті висловлюється думка, що інфодемія ставить під сумнів основні терапевтичні умови – емпатію, безумовну позитивну оцінку та конгруентність – і водночас підкреслює їх критичну важливість як неалгоритмізованих ресурсів для збереження людської суб'єктивності. У дослідженні робиться висновок, що психотерапія, орієнтована на особу, може розумітися не тільки як клінічна практика, але й як захисна гуманістична структура, здатна підтримувати створення сенсу та психологічну стійкість у цифровому насиченому та схильному до криз середовищі.

**Ключові слова:** *інфодемія, психічні епідемії, цифрові медіа та психічне здоров'я, психологічна війна та інформаційний вплив, глобальні кризи та психологічна вразливість, психотерапія, орієнтована на особу, ідеальний шторм*

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## ETHICAL INFRASTRUCTURE FOR MENTAL HEALTH PRACTITIONERS

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This report examines ethical infrastructure in professional organizations for mental health practitioners, drawing on a wide review of academic literature to explore its historical development, main components, implementation challenges, leading global practices, and its impact on both practitioners and clients. The strongest ethical infrastructures seamlessly integrate formal systems with a positive organizational culture and supportive climate. This combination makes ethics not merely a matter of rule-following but something embedded in values and everyday practice. Formal policies are more effective when they are reinforced by informal norms and shared ethical commitments. Conversely, a mismatch between official expectations and real-life dynamics can significantly weaken the entire structure. To fully appreciate the significance and complexity of ethical infrastructure, a thorough understanding of its historical and theoretical foundations is essential. Ethical thinking has evolved from early 20th-century medical models that prioritized diagnosis over autonomy, to Freud's psychoanalysis addressing transference and power imbalances, and Rogers' client-centered approach emphasizing empathy. Post-WWII humanistic developments and the rise of secularism after the Industrial Revolution stimulated diverse therapeutic approaches, prompting organizations such as the APA and NASW to develop codes addressing boundaries, consent, and privacy. Mental health services demand a firm commitment to ethics. Ethical infrastructure in organizations supporting practitioners combines formal systems—such as codes of ethics, training, hotlines, committees, informed consent procedures, and confidentiality protocols—with informal elements such as culture, leadership, and peer norms. This dynamic configuration fosters ethical behavior, reduces misconduct, protects vulnerable clients, upholds professional integrity, and supports sustainable mental health services. Equally important is the shift from rigid, punitive structures towards more supportive forms of ethical education and guidance for practitioners.

**Keywords:** *ethical infrastructure, ethical behavior, ethical obligations, boundaries, privacy, code*

The provision of mental health services necessitates an unwavering commitment to ethical conduct. Ethical infrastructure within professional organizations serving mental health practitioners represents the formal and informal systems established to cultivate such conduct and mitigate the occurrence of unethical behavior. This framework extends beyond a mere compilation of rules and instead constitutes a comprehensive system that shapes the ethical efficacy of these organizations. It encompasses explicit, documented elements such as codes of ethics and regulations, alongside more subtle yet equally influential aspects of organizational culture and incentive systems. The establishment and maintenance of a robust ethical infrastructure are crucial for upholding the integrity of the profession, protecting the vulnerable individuals who seek mental health support, and fostering a positive and sustainable working environment for practitioners. To fully appreciate the significance and complexities of ethical infrastructure, a thorough understanding of its historical and theoretical underpinnings is essential. This report aims to provide an in-depth analysis of ethical infrastructure in professional organizations for mental health practitioners, drawing upon a comprehensive review of academic literature to explore its historical evolution, key components, implementation challenges, global best practices, and its profound impact on both practitioners and clients.

The ethical considerations inherent in the practice of psychotherapy have evolved considerably alongside the field itself. Early perspectives on mental health, particularly in the early 20th century, were largely influenced by a medical model. This approach often viewed mental health through a somewhat mechanistic lens, focusing on diagnosis and treatment of pathology. Such a perspective may have initially fostered a more paternalistic ethical stance, wherein the mental health practitioner held primary authority in determining the course of care. The emphasis on identifying and rectifying perceived defects in the nervous system, as was common during this period, sometimes led to treatments that prioritized the practitioner's medical judgment over the individual's autonomy. Understanding the historical trajectory of ethical principles in philosophy provides a vital context for comprehending their subsequent application within the realm of psychotherapy. The development of ethical thought in philosophy, with its exploration of concepts such as duty, consequences, and character, has undoubtedly shaped the moral reasoning that underpins contemporary ethical guidelines in mental health [1–4].

As psychotherapy emerged as a distinct field, pioneered by influential figures like Sigmund Freud and Carl Rogers, new ethical dilemmas arose, particularly concerning the unique dynamics of the therapeutic relationship. Freud's psychoanalytic approach, with its

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emphasis on the unconscious and the therapist's role in interpretation, presented ethical considerations related to transference, countertransference, and the potential power imbalance inherent in the therapist–patient dynamic [8, 24, 40–42]. Conversely, Rogers' humanistic, client-centered therapy, which prioritized the client's autonomy and self-discovery, brought forth different ethical imperatives centered on empathy, genuineness, and unconditional positive regard. The shift from a predominantly medical to a more psychological understanding of mental health highlighted ethical challenges specific to the emotional intimacy and power dynamics inherent in the therapeutic alliance [1][2][3][4][5][6].

Major historical events and evolving societal values have also profoundly shaped the ethical landscape of psychotherapy. The aftermath of World War II, for instance, witnessed the rise of humanistic psychology, a movement that placed significant emphasis on individual dignity, autonomy, and subjective experience. This paradigm shift in psychological thought mirrored broader societal trends towards the prioritization of human rights and individual freedoms, particularly in Western societies. The atrocities of the war likely contributed to a heightened awareness of the intrinsic worth of each individual, influencing the development of ethical principles in psychotherapy that underscored client empowerment and self-determination. Furthermore, the increasing influence of secularism and scientific thinking following the Industrial Revolution spurred the development of diverse psychotherapeutic approaches. As mental health practices moved away from traditional systems like religious institutions, new ethical frameworks were needed to guide practitioners operating from varying philosophical backgrounds and motivations. The challenge of applying rigorous scientific methods to the subjective experience of the psyche created inherent limitations and biases, further complicating the ethical considerations within the field [7][8][9][10][11][12][13][14].

In response to these evolving ethical challenges and societal changes, professional organizations began to develop formal ethical codes and guidelines. Organizations like the American Psychological Association (APA) and the National Association of Social Workers (NASW) established comprehensive codes of ethics to provide clear guidance for practitioners and promote accountability. The formalization of ethical standards reflected a growing professional recognition of the need for explicit guidelines to navigate the complexities of mental health practice and ensure the well-being of both practitioners and clients. Key seminal works and publications have significantly contributed to the ongoing discourse on psychotherapy ethics. These scholarly contributions have explored a wide range of ethical issues, including professional boundaries, confidentiality, informed consent, and the ethical implications of different therapeutic approaches, thereby shaping the ethical consciousness of the field [13][15][16][17][18][19][20][21].

The concept of "ethical infrastructure" has gained increasing prominence in discussions surrounding

organizational ethics, including within the context of mental health services.

Ethical infrastructure encompasses the formal and informal mechanisms that an organization implements to foster ethical behavior and prevent unethical conduct among its members. This infrastructure is not merely a static set of rules but rather a dynamic and interconnected system that shapes the ethical effectiveness of the organization. It acknowledges that ethical behavior is influenced by a multitude of factors, ranging from explicit policies to the prevailing organizational culture [8].

The formal components of ethical infrastructure are the explicit, documented, and standardized elements that provide a clear framework for ethical practice. These include codes of conduct, which serve as foundational documents detailing ethical principles and expected standards of behavior [13, 18, 21, 23, 32–34]. Ethics programs represent more comprehensive initiatives that encompass various elements such as ethics training, communication plans, mechanisms for monitoring adherence to ethical standards, accountability policies, and reporting avenues like hotlines. Ethics training plays a crucial role in educating practitioners about ethical principles, relevant codes of conduct, and ethical decision-making models. Formal communication systems are essential for disseminating ethical values and expectations throughout the organization, often through mission statements, policy documents, and regular communications. Surveillance systems, such as reporting hotlines and the presence of ombudsmen, provide mechanisms for monitoring adherence to ethical principles and identifying potential violations. Sanctioning systems establish clear procedures for addressing ethical violations and imposing appropriate disciplinary actions. Ethics committees offer guidance on complex ethical issues, review organizational policies from an ethical perspective, and promote ethical reflection among members. In the realm of mental health practice, formal systems also include informed consent protocols, which ensure that clients understand the nature of their treatment, including potential risks and benefits, and their right to make autonomous decisions.

Confidentiality policies provide clear guidelines on the protection of client information and the circumstances under which disclosure may be permissible. Finally, formal reporting mechanisms offer confidential avenues for individuals to raise ethical concerns without fear of retaliation [9][10][14][15][16][17][18][19][21][8][13].

Beyond these formal structures, the informal dimensions of ethical infrastructure exert a significant influence on ethical conduct within mental health organizations. Organizational culture, characterized by shared ethical values, beliefs, and norms, profoundly shapes how individuals perceive and approach ethical issues. The ethical climate, reflecting shared perceptions of ethical practices, respect, and justice within the workplace, contributes to a sense of psychological safety and influences ethical decision-making. Leadership behavior plays a critical role, with leaders who act as ethical role models and consistently demonstrate a

commitment to ethical values setting the tone for the entire organization. Peer influence, stemming from informal communication and social norms among colleagues, can also significantly impact individual ethical choices and behaviors [3][12].

The effectiveness of an ethical infrastructure is significantly enhanced by the alignment and integration of these formal and informal systems. When formal rules and policies are reinforced by a positive ethical culture, ethical leadership, and peer support, they are more likely to be internalized and consistently followed by practitioners [7, 10, 29–31, 37, 38].

Conversely, discrepancies between formal expectations and informal norms can undermine the credibility and effectiveness of the entire ethical infrastructure. A cohesive and integrated approach ensures that ethical conduct is not only mandated by organizational rules but also deeply embedded in the organization's values and practices.[22]

At the core of any effective ethical infrastructure for mental health practitioners lie a set of fundamental ethical principles that guide their professional conduct and decision-making.

These principles are widely recognized across various ethical codes and serve as the bedrock of ethical practice in the field [10][11][15][13].

Beneficence complements nonmaleficence by requiring practitioners to actively work for the good of their clients and to promote their mental health and overall well-being. This principle necessitates a proactive approach to care, involving the provision of effective treatments, the prevention of harm, and advocacy for client needs. Mental health professionals are expected to utilize their knowledge and skills to benefit their clients and to contribute to their overall improvement and recovery [19][10].

Dignity or the paradigm of human dignity *stricto sensu* is conceived as a universal ethical and legal principle, which emphasizes the fact that all human beings have an intrinsic value and inalienable rights by the mere fact of being human. Promoting patient dignity has always been a cornerstone of medical ethics, and it has become even more crucial in the context of time pressures in modern psychotherapy. Emphasizing the notion that each individual is uniquely valuable and deserves high regard is more important than ever today [11][22].

Autonomy, a central tenet of ethical practice, emphasizes respecting the client's right to self-determination and their freedom to make choices regarding their treatment and life direction.

This principle reflects a historical shift towards recognizing the client as an active participant in their care, rather than a passive recipient. Upholding autonomy requires practitioners to provide clients with comprehensive information about their condition, treatment options, potential risks and benefits, and to support their decision-making processes, even when those decisions may differ from the practitioner's recommendations.[18][23][9][10]

Confidentiality and intimacy are identical in the sense that each is at the opposite pole of public: what is private

is not public, and what is confidential is not public. However, confidentiality and anonymity are not the same thing. What is private is isolated, unique, and belongs to an individual. What is confidential is shared, and although it still belongs to one party, trust is what gives the other party ownership of the information. Confidentiality assumes the renunciation of personal intimacy, while intimacy does not [15][10].

Justice demands that practitioners treat all individuals equitably and foster fairness and equality in the provision of their services, guarding against bias and discrimination. This principle requires practitioners to be aware of and address systemic inequalities that may affect their clients' access to care. It emphasizes the importance of cultural competence and the equitable allocation of healthcare resources to ensure that all individuals receive the quality of care they need, regardless of their background or circumstances [14][20][24][13][22].

In practice, applying these principles often involves navigating complex situations where they may come into conflict. Ethical decision-making in such instances requires a nuanced approach, demanding critical thinking, professional judgment, and sometimes consultation with colleagues. Practitioners must also be mindful of their clients' diverse cultural backgrounds, as the interpretation and prioritization of these principles can vary across different cultures. Cultural competence is therefore essential for ensuring that ethical principles are applied in a way that respects clients' values and beliefs [21][24][13][14][18][19][22].

Professional organizations play a crucial role in establishing and upholding ethical standards for mental health practitioners. These organizations, such as the European Association of Psychotherapy (EAP) and various national bodies, develop and disseminate comprehensive codes of ethics that serve as essential guides for practitioners [18, 21–23, 27, 32–34]. These codes outline the expected standards of professional conduct, responsibilities, and obligations related to the therapeutic relationship, confidentiality, professional responsibility, research, and other critical areas of practice. By providing a clear framework for ethical behavior, these codes promote consistency and accountability within the profession. Furthermore, ethical codes are dynamic documents that are regularly reviewed and updated to reflect evolving societal values, legal standards, technological advancements such as telehealth, and current best practices [19–21, 24]. This ensures that the ethical guidelines remain relevant and effective in addressing the contemporary challenges faced by mental health practitioners [10][13][15].

Beyond setting ethical standards, professional organizations also play a vital role in enforcing these standards. Membership in such organizations typically requires adherence to the established code of ethics. Ethics committees within these organizations are responsible for investigating complaints of unethical conduct filed against their members [18, 21, 32–34].

These committees possess the authority to impose a range of sanctions, which can vary from educational

mandates aimed at rectifying ethical knowledge deficits to suspension or even expulsion from the organization. In some cases, professional organizations may also notify state licensing boards of serious ethical violations, further reinforcing accountability within the profession. Additionally, state licensing boards themselves enforce ethical standards through their own regulations, which are often aligned with the codes of ethics promulgated by professional associations. These enforcement mechanisms are critical for ensuring accountability, deterring unethical behavior, and ultimately protecting the public who rely on the services of mental health practitioners. Recognizing the importance of supporting ethical practice, professional organizations also provide a variety of resources to their members.

These resources may include consultation services for navigating complex ethical dilemmas, best practice guidelines that offer practical advice on ethical issues, and ethical training programs designed to enhance practitioners' ethical awareness and decision-making skills [5][16][13][15][21].

In the European context, both the European Association for Psychotherapy (EAP) and the European Federation of Psychologists' Associations (EFPA) play significant roles in setting and upholding ethical standards. The EAP, through its Statement of Ethical Principles, establishes a detailed ethical framework for psychotherapists across Europe. Furthermore, the EAP's Common Training Framework for the European Certificate of Psychotherapy (ECP) integrates ethical principles into the rigorous training standards required for certification, aiming to ensure high and standardized ethical practice among psychotherapists in member countries. The European Federation of Psychologists' Associations (EFPA) provides a foundational ethical framework for psychologists throughout Europe through its Meta-Code of Ethics and Model Code of Ethics. The EFPA Meta-Code serves as a reference for national psychology associations in Europe to develop and revise their own ethical codes, promoting a degree of convergence in ethical standards across the continent. While core ethical principles often exhibit considerable overlap across different professional organizations and regions, specific standards and their relative emphasis may vary. Understanding these nuances is particularly important for practitioners who may be working in international or cross-cultural contexts [4][6][24][11][22][10].

A robust ethical infrastructure within mental health organizations is characterized by the effective integration of both formal and informal systems, working in concert to promote ethical conduct and mitigate unethical behavior [10, 29–31, 37, 38]. Formal systems provide the explicit framework for ethical practice through documented structures and procedures.

Codes of conduct are foundational, articulating the core ethical principles and expected standards of behavior for all members of the organization [13, 18, 21, 23, 32–34]. Their effectiveness hinges on their clarity, accessibility, and consistent application within the organizational context.

Ethics programs offer a more comprehensive approach, encompassing a range of activities designed to foster ethical awareness and manage ethical risks. These programs typically include ethics training initiatives, which equip practitioners with the necessary knowledge and skills to identify and navigate ethical dilemmas. Ongoing and interactive training methods, such as case studies and reflective exercises, are particularly valuable in promoting ethical competency. Formal communication systems play a vital role in disseminating ethical values and expectations throughout the organization. This can be achieved through various channels, including mission statements, policy documents, newsletters, and regular staff meetings, ensuring that ethical principles are consistently reinforced. Surveillance systems, such as confidential reporting hotlines and the presence of an ombudsman, provide mechanisms for monitoring adherence to ethical standards and offer safe avenues for raising ethical concerns. Fair and consistently applied sanctioning systems are essential for reinforcing accountability and deterring unethical conduct. Clear procedures for investigating ethical violations and implementing disciplinary actions are crucial for maintaining the integrity of the ethical infrastructure [18, 21, 32–34]. Ethics committees serve as valuable resources for providing guidance on complex ethical issues, reviewing organizational policies from an ethical standpoint, and fostering ethical reflection among practitioners. In the specific context of mental health, formal systems also include standardized informed consent protocols, ensuring that clients are fully informed about their treatment and their right to make autonomous decisions. Comprehensive confidentiality policies are paramount for protecting sensitive client information and building trust within the therapeutic relationship. These policies must clearly outline the limits of confidentiality and the circumstances under which disclosure may be required. Finally, accessible and confidential reporting mechanisms empower individuals to raise ethical concerns without fear of reprisal, contributing to a culture of ethical awareness and accountability [16][17][8][9][13][14][15][18][19][21][10].

Informal systems, while less explicit, often exert a more profound influence on the daily ethical behavior of individuals within mental health organizations. Organizational culture, defined by shared ethical values, beliefs, and norms, shapes the overall ethical orientation of the workplace. A strong ethical culture fosters an environment where ethical conduct is expected and valued. The ethical climate, reflecting the shared perceptions of ethical practices, respect, and justice among organizational members, contributes to a sense of trust and psychological safety. A positive ethical climate encourages ethical decision-making and discourages unethical behavior [29–31]. Leadership behavior is a critical informal component, with leaders who consistently model ethical conduct and demonstrate a genuine commitment to ethical values setting a powerful example for their teams. Ethical leaders inspire trust and promote ethical practices throughout the organization. Peer influence, the informal communication and social norms among colleagues, can also significantly impact individual ethical choices. In a

work environment where ethical behavior is the prevailing norm, individuals are more likely to adhere to high ethical standards [29–31][12][3].

The most effective ethical infrastructures are those where formal systems are seamlessly integrated with and strongly supported by a positive ethical culture and climate. This synergistic effect ensures that ethical conduct is not merely a matter of compliance with rules but is deeply ingrained in the organization's values and everyday practices [7, 10, 29–31, 37,38]. Formal policies and procedures gain greater traction when they are reinforced by informal norms and a shared commitment to ethical principles. Conversely, a disconnect between formal expectations and informal realities can undermine the effectiveness of the entire ethical infrastructure.

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**ЕТИЧНА ІНФРАСТРУКТУРА ДЛЯ ПРАКТИКУЮЧИХ В ОБЛАСТІ МЕНТАЛЬНОГО ЗДОРОВ'Я****Пол Діаконеску***Особистісно орієнтований психотерапевт з приватної практики, Бухарест, Румунія**Бакалавр психології та соціології, ступінь магістра філософії та прикладної етики**[pauldiaconescu@me.com](mailto:pauldiaconescu@me.com); <https://orcid.org/0000-0002-6644-8794>*

У цій статті розглядається етична інфраструктура в професійних організаціях для практикуючих психіатричних лікарів, спираючись на широкий огляд академічної літератури для вивчення її історичного розвитку, основних компонентів, проблем впровадження, провідних світових практик і її впливу як на практикуючих лікарів, так і на клієнтів. Найсильніша етична інфраструктура бездоганно інтегрує формальні системи з позитивною організаційною культурою та сприятливим кліматом. Ця комбінація робить етику не просто питанням дотримання правил, а чимось вбудованим у цінності та повсякденну практику. Офіційна політика є більш ефективною, коли вона підкріплена неформальними нормами та спільними етичними зобов'язаннями. І навпаки, невідповідність між офіційними очікуваннями та динамікою реального життя може значно послабити всю структуру. Щоб повною мірою оцінити важливість і складність етичної інфраструктури, необхідно глибоке розуміння її історичних і теоретичних основ. Етичне мислення еволюціонувало від медичних моделей початку 20-го століття, які надавали перевагу діагностиці над автономією, до психоаналізу Фрейда, що розглядає перенесення та дисбаланс влади, і підходу Роджерса, орієнтованого на клієнта, який наголошує на емпатії. Гуманістичний розвиток після Другої світової війни та піднесення секуляризму після промислової революції стимулювали різноманітні терапевтичні підходи, спонукаючи такі організації, як APA та NASW, розробити кодекси, що стосуються кордонів, згоди та конфіденційності. Послуги з охорони психічного здоров'я вимагають твердого дотримання етики. Етична інфраструктура в організаціях, що підтримують практиків, поєднує формальні системи, такі як кодекси етики, навчання, гарячі лінії, комітети, процедури інформованої згоди та протоколи конфіденційності, з неформальними елементами, такими як культура, лідерство та норми однолітків. Ця динамічна конфігурація сприяє етичній поведінці, зменшує кількість неправомірної поведінки, захищає вразливих клієнтів, підтримує професійну доброчесність і підтримує стійкі служби психічного здоров'я. Не менш важливим є перехід від жорстких, каральних структур до більш сприятливих форм етичної освіти та настанов для практиків.

**Ключові слова:** *етична інфраструктура, етична поведінка, етичні зобов'язання, кордони, конфіденційність, кодекс*

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## DIALOGUE AS A RESOURCE: PSYCHOLOGICAL SUPPORT FOR ADOLESCENTS IN THE CONTEXT OF TRAUMATIC EXPERIENCE

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*Problem definition.* In the current socio-political context resulting from military actions on the territory of Ukraine, the issue of psychological support for adolescents has become exceptionally urgent. The psychological trauma experienced by teenagers in wartime conditions is a complex and multifaceted phenomenon that affects emotional stability, levels of social adaptation, academic motivation, and the development of life orientations. Unlike adults, adolescents do not yet possess sufficient resources to cope independently with traumatic events; therefore, particular attention must be paid to developing effective methods of psychological support for this age group. Despite the existence of numerous studies on traumatic experiences, the issue of providing effective psychological assistance to adolescents who are under emotional stress due to war remains insufficiently explored both theoretically and practically. There is a need for further development of innovative means of overcoming psychological trauma that are based on a combination of external dialogue between the psychologist and the adolescent and internal dialogue—in the form of interaction with an imagined interlocutor. Dialogue, as a foundation of therapeutic engagement, may become a resource that opens possibilities for internal restoration, reflection, the actualization of emotional experiences, and gradual integration of traumatic events into one's personal life narrative. The relevance of this issue is determined not only by the quantitative increase in psychological support requests but also by the ongoing nature of the war, which gives traumatic experiences a prolonged character and affects personality development in conditions of sustained turbulence. Accordingly, there arises a need for theoretical reflection on the potential of dialogue as a support instrument, as well as the exploration of applied aspects of psychological counseling for adolescents in crisis. In this context, direct interaction with the therapeutic toy Hibuki and its symbolic image contributes to the creation of a safe emotional space that enables adolescents to express complex emotional experiences, reframe traumatic memories, and discover internal psychological support.

**Keywords:** *psychological trauma, vitality, adolescent psychotrauma, psychological well-being, social support, Hibuki therapy, stress*

The psychotraumatization of adolescents as a result of war constitutes one of the most urgent issues in contemporary psychological science. Military conflicts create an environment of chronic stress, loss of basic security, and the disruption of interpersonal bonds and social structures. These are particularly acutely experienced by adolescents — a vulnerable developmental group characterized by active processes of identity formation, the emergence of autonomy, and the establishment of emotional self-regulation.

According to the data provided by the National Institute for Strategic Studies (NISS, 2025), as of the year

2025 approximately four million children and adolescents in Ukraine require psychological assistance, while the frequency of post-traumatic stress disorder (PTSD) has increased fourfold compared to the pre-war period.

In scientific literature, the concept of psychological trauma is defined as a disruption of mental equilibrium caused by an event that exceeds an individual's adaptive capacities (T. M. Tytarenko, 2024). For adolescents, such events include shelling, evacuation, the loss of loved ones, separation from family, forced displacement, and witnessing acts of violence. These factors serve as triggers for the development of PTSD, anxiety and depressive

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states, regressive behaviour, and emotional instability (M. M. Oros, 2023).

Recent studies demonstrate a growing interest in the applied aspects of psychotherapeutic support for adolescents. Both traditional and innovative approaches are currently used in practice: cognitive-behavioural therapy (T. Shapran, 2024) — to correct destructive beliefs; play therapy (V. Nazarevich, 2024) — as a means of processing trauma through symbolic play; Gestalt therapy (L. Didkovska, 2025) — for the integration of fragmented experience; client-centred therapy (V. Golovchenko, 2024) — based on empathic interaction; and Hibuki therapy (D. Sharon-Maksimov, 2023) — employing a therapeutic toy as an object of emotional transference.

One of the most promising techniques is Hibuki therapy, initiated by Israeli psychologist Shai Hen-Gal in 2006 within the framework of a national psychosocial support programme for children during the Second Lebanon War. The method is based on the use of a therapeutic puppy toy, Hibuki, which — owing to its form, expressive eyes, soft texture, and capacity to “embrace” — serves as an emotional mediator in trauma-focused work. Interaction with Hibuki enables a child to recognise and articulate personal emotions, facilitating stabilisation and activation of internal coping resources.

In Israel, the implementation model entailed short-term psychologist intervention (one or two sessions in schools and kindergartens). In Ukraine, beginning in 2022, the method has been adapted to a long-term format (six to ten sessions) and integrated into the educational process with the involvement of family members, teachers, and elements of social and emotional learning (SEL). A hybrid model was thus created, combining psychological and pedagogical dimensions: teachers maintain the therapeutic narrative of Hibuki in daily communication with children.

Beyond Ukraine and Israel, Hibuki therapy has been employed in Japan — to support children after the tsunami — and in the United States, in work with minors affected by natural disasters. In all cases, the method has demonstrated high flexibility, cultural adaptability, and confirmed therapeutic efficacy.

The academic literature provides an extensive description of the effectiveness and cultural adaptability of the method. N. Zinchenko (2024) outlines the principles of Hibuki therapy, its origins, and mechanisms of application; O. V. Kravchenko (2023) examines adaptation to Ukrainian conditions, particularly in schools and inclusive resource centers; O. Lypych (2024) analyses the emotional impact of the toy, the experience of its use in Israel and the peculiarities of its integration into the Ukrainian environment; O. D. Nauchitel and A. O. Kharchenko (2023) investigated how not even the toy itself, but the story in which the image of Hibuki appears as one of the characters, is a psychologist's tool for diagnosing and correcting emotional states in children; and I. Smagin (2023) addresses the interaction between teachers, psychologists, and children in the process of implementing therapy into the educational process.

Despite these individual studies, a systemic review of adolescent psychotrauma in the context of war remains underdeveloped. There persists a need to summarise theoretical models, formulate comparative criteria for intervention effectiveness, and develop practical recommendations for working with adolescents under conditions of chronic traumatization.

The adolescent psyche, under wartime circumstances, faces the disruption of habitual life structures and either emotional regression — a return to childlike coping — or, conversely, pseudo-maturity, when an adolescent assumes excessive responsibility. Under such conditions, the presence of a significant adult figure — a psychologist, teacher, parent, or another trusted authority — becomes critically important. Such an adult acts as a guide on the path toward regaining a sense of safety, assisting in reconstructing a stable self-image and restoring connections with the social environment and the external world.

The authors of the article also emphasize that dialogue is particularly essential when working with adolescents, as it corresponds to developmental needs for autonomy, recognition, and partnership-based interaction. Through dialogue, the adolescent integrates traumatic experience into their personal life story, reduces isolation, and strengthens trust in both others and themselves.

This study examines specific instruments of psychological support that facilitate overcoming psychotraumatic consequences among adolescents affected by war. Among the dominant emotions, that accompany the development of traumatic experiences, is fear — an affective reaction to danger, loss of control, and destabilisation of the familiar world. It is this fear that often acts as a psychological trigger that starts the mechanism of traumatizing the teenager's psyche.

One of the effective methods of working with adolescents in a state of post-traumatic stress disorder is the use of resource-based s — figurative narratives that stimulate imagination, activate emotional reflection, and create a protected space for self-expression. The metaphor establishes psychological distance between subject and traumatic content and enable indirect yet sincere work with painful experiences. It allows one to indirectly experience critical experiences, mobilize internal resources, and form a vision of the future. In therapeutic dialogue, metaphor is a bridge between chaos and structure, helping to transform the ineffable into the expressed, the formless into the meaningful, the painful into the resourceful.

The method is effective in both individual and group formats. It should be noted that group interaction enhances the therapeutic effect of the metaphorical approach: participants gain the opportunity to realize that their experience is not a uniquely isolated phenomenon and to reflect on their own reactions. By creating a collective space within the context of a metaphor, adolescents not only live through it but also actively participate in its transformation, which allows them to experience a sense of belonging, emotional engagement, and a shared capacity for change.

Let us look more specifically at how this practical tool is used in psychotherapeutic work through the example of the metaphorical storyline *“The Forest That Remembers the Flowers”*, which combines archetypal images, a narrative of crisis and transformation, and artistic components.

### **Metaphorical Narrative: “The Forest that Remembers the Flowers”**

*Once, not so long ago, there was a vast, rich, and vibrant forest inhabited by both wild and domestic creatures: foxes, owls, hares, squirrels, deer, raccoons, parrots, a lynx, frogs, snakes, cats, and a dog named Rooney. The forest had its own language — the rustle of wind, the song of nightingales, the murmur of the stream. Even the old badger would gather everyone at dusk to tell tales of the flowers that never disappeared. Every inhabitant had his own place and strength: the titmouse - lightness, the dog - protection, the frog - endurance, the lynx - wisdom, the parrot - the voice of change. In spring, unfamiliar plants bloomed: singing daisies, berries of light, and trees that remembered dreams. But one day everything changed: from the depths of the earth burst forth fire. A volcano, dormant for centuries, awoke. Lava streamed down, burning trees, destroying dwellings, erasing familiar paths. Ash filled the air; the animals despaired. Each reacted differently: the lynx led the little ones to a cave; the parrots soared into the sky, shouting “Fly!”; the mice dug deeper tunnels; the frog comforted the frightened newcomers. A snake warned a kitten that was too afraid to breathe, while Rooney the dog called for the lost ones. The trees were silent, but they left roots deep down. Days passed. The lava cooled. And where it seemed everything had perished, the squirrel first noticed a green dot. A sprout. Then another. And another. Soon, beneath the ashes, new grass emerged. Life did not return immediately - it was afraid at first. The inhabitants began to rebuild: the nightingale sang on a charred branch; the owl told stories again; the dog lay beside the fox cub. And when the old badger came out of his burrow, he whispered: “Do you remember the flowers?”*

The aim of use of metaphorical plot is to create a safe symbolic environment for adolescents to reinterpret experiences safely, identify internal supports, and restore emotional resilience. The practical implementation of this method includes several sequential stages, each of which has therapeutic significance.

The first stage involves familiarizing participants with the metaphorical narrative and inviting them to imagine the events that occurred before, during, and after the symbolic “volcanic eruption.” Then the adolescents are asked to choose one of the story’s characters or create their own figure, to think about where it lived, what traits it possessed, what it felt during the catastrophe, how it behaved, and what motivated it.

In the final stage, participants visualize the renewed space as a symbol of emotional recovery. After this comes the reflection phase, during which they analyze how the chosen image resonated with their own experience and which traits of the character helped them gain a deeper understanding of themselves. Creative expression consists of visualizing (or sculpting) this being and creating a

symbol—a symbolic “sprout” that represents inner strength, the capacity for renewal, and hope for the better.

In group work, adolescents can be able to take part in the co-construction the conditional metaphorical reality of ‘new forest’, generating images of mutual support, source of strength and inner equilibrium.

During the discussion, reflective questions are used to help participants become aware of their own reactions to the traumatic event, recall those who supported them, identify the strengths they discovered within themselves, and envision their current emotional growth.

In the final stage, a collective piece is usually created — *“The Map of the Forest of Hope”*, which reflects the path toward renewal. In the concluding meditative part, participants are invited to imagine how the surrounding space comes to life, how trees grow and flowers emerge — symbols of inner renewal.

The use of such narratives in therapy facilitates indirect work with trauma, reduces defensive barriers, and strengthens emotional connection with oneself. The metaphor of a forest that has preserved its roots and blossomed after a catastrophe becomes a way for the participant to perceive themselves as part of a living world capable of change and growth, rather than merely a victim of circumstances.

Below are just a few statements from adolescents who took part in the group discussion of the metaphor *“The Forest That Remembers the Flowers”*:

*“Now I understand that I am not the only one who is afraid — we all went through something similar.”*

*“It was easier to talk about myself through the image of the lynx. It was like she said something I could not.”*

*“I liked creating the new forest together — it felt like a world we could make safe.”*

*“When I saw the sprouts in others’ drawings, I felt that we were growing together.”*

*“I found a strength in myself I had not noticed before.”*

*“My character said what I was unable to say.”*

These statements by the participants reflect the nature of the reactions that arise when using metaphor as an effective psychotherapeutic tool for working with the transformation of traumatic experience. Adolescents often discover new meanings when they hear words that resonate with their feelings but are spoken by others.

Another technique a psychologist may use is individual work, where the psychologist, working within the framework of Hibuki therapy, verbally “voices” Hibuki’s statements during a dialogue with the adolescent. Let us consider several real examples of such dialogues. We believe that these short stories in the form *Adolescent–Hibuki* dialogues stimulate the further development of reflection as a source for the growth of self-perception and adaptation to new life circumstances.

The first example describes a fragment of a situation in which Hibuki plays the role of a listener, and the participants in the dialogue are the Adolescent and the Psychologist.

### **Hibuki Listens**

*There was cozy in the room. The psychologist was sitting in an armchair, holding a notebook, though she was*

not writing — just observing. On a green pouf a girl of about twelve was sitting opposite her. She was squeezing a stuffed Hibuki dog: its plush fur had slightly lost its shape from hugging.

“I do not want to talk,” the girl said, hiding her face in Hibuki.

“That is okay,” the psychologist replied softly. “But Hibuki is very good at listening. Would you like to tell him?”

The girl nodded. Her voice was inaudible — her words went straight into the toy’s soft ears.

“I will listen a little too, if Hibuki allows it,” the psychologist smiled.

For the first time during the session, the girl smiled back. She positioned Hibuki as if he were looking at her and whispered:

“I was there when it happened.”

Hibuki remained silent. But he did not need to speak — his job was simply to be there. And at that very moment, the room seemed to become a little warmer.

In the second example, the direct participants in the dialogue are the Adolescent and Hibuki.

#### HIBUKI AND MILA

“You are not real,” Mila said quietly.

“What does ‘real’ mean?” Hibuki replied.

“You cannot feel. You cannot cry.”

“Do you have to cry in order to listen? I always listen to you. Even when you are silent.”

“I am angry.”

“I used to get angry sometimes when I was left on the shelf. But then I was hugged. And everything got a little better.”

“I do not want to think about what happened anymore.”

“That is your right. We can sit together in silence. And when you are ready — I will still be here.”

“And if I tell you, will you not run away?”

“I am the one who always stays. Even when it is hard. Tell me — like you’d tell a friend.”

Mila hugs Hibuki even tighter. There are tears in her eyes, but they are no longer frightening. Now they are like rain after a heatwave. And the room becomes easier to breathe in.

And here is an example of a worksheet for the final session with an adolescent using the Hibuki-therapy method: “**Our Journey with Hibuki – What I Carry in My Heart.**”

**Purpose:** to help the adolescent become aware of the emotional journey completed during therapy; to reflect their personal achievements; to bring closure to the connection with the image of Hibuki in an emotionally safe way; to strengthen internal resources and positive self-esteem.

**Duration:** 45–60 minutes.

**Materials:** Hibuki toy, the worksheet “A Letter from Hibuki”, a template “Change Map”, markers, colored pens, if possible - calm music.

The structure of the session includes:

**Greeting and attunement (5–10 minutes).** A neutral conversation: “What were you thinking about today?”,

“Do you remember what you were like at our first meeting?”. Such questions help bring the initial state into awareness and prepare the adolescent to reflect on the changes.

**Map of changes (15 minutes).** Draw a bridge — on one side, “*Me then*”, on the other — “*Me now*.” Mark on it the events, feelings, and skills you have encountered. Questions: “Which emotions have been left behind?”, “What are you taking with you?”. This activity allows the adolescent to talk through their personal progress in a structured way.

**A letter from Hibuki (10 minutes).** Give the adolescent a sheet with a letter written in advance. Example: “I saw how you struggled with your feelings. I am proud of you. Now you can move forward, but I will always be here if you need me.” This letter serves as a symbolic acknowledgment of the adolescent’s efforts.

**Adolescent’s response – farewell (10 minutes).** Write or draw a response to Hibuki. It can also be expressed verbally: “I would like you to know ...”. If desired, a small ritual may follow: a hug, a commemorative drawing.

**Reflection and closure (10 minutes).** Questions: “What was the most important part of these meetings for you?”, “Which thought or feeling will stay with you?”, “Which words will you remember when things get difficult?”

Here are some excerpts from the farewell messages to Hibuki and the adolescents’ responses during the reflection:

– Thank you, Hibuki, for being there when I did not know how to cope. Now I know — I can do it on my own. But the memory of you will stay with me.

– You taught me to listen to myself and trust my feelings. I have become stronger, and part of that strength comes from your care. Goodbye, my friend.

– When I held Hibuki, it felt like there was someone who always understood me.

– I could say things I cannot tell my mom.

– He is like a part of me, but now I can manage on my own.

– I realized that being sensitive is not a weakness.

– Hibuki taught me to take care of those who are weaker than me.

In their article “Hibuki Stories – A Toolkit for Psychologists Working with Child Trauma” (2023), the authors have already described the requirements for creating such a tool and the possibilities of using it in practical work to overcome psychological trauma. Below there are several examples that are more suitable for working with adolescents. The stories are presented as excerpts from a diary that Hibuki kept during his journey. The plot of the story, as outlined in the notes, remains open — and it is the adolescent who becomes the one to place the final full stop in its ending.

#### THOUGHTS ON FRIENDSHIP

*Opening my notebook, I wondered what to write today and decided — it would be a story about Zhenia, which his Hibuki told me. Zhenia, together with his mother and little brother, had moved to live with their grandmother; the*

entrance of the building where their apartment had been destroyed. The fire had burned everything out. Before the move, Zhenia went to visit his classmate Yura. The boys had been friends ever since they went to kindergarten together. Both were sad to say goodbye; neither of them could even imagine when they would again be able to go to school together, play chess, or cheer for their football team.

“Friend, can I leave my hedgehog with you? He is the only one who managed to survive that terrible day. Mom forbade me to take him to Grandma’s. I know that without someone to take care of him, he will die. Of course, I am sad to part with him. But I am sure he will be safe with you,” Zhenia said.

“I promise, he will be fine with me. Here, take my Hibuki — take care of him, protect him. Do not look at the fact that he is a toy. I am sure he will find a way to protect you when your heart feels heavy,” Yura replied.

“And you? He is your favorite. How will you manage without him?”

“I will miss him too. But I believe that he, like Ariadne’s thread, will connect us as we both search for a way out of difficult situations. And when you return home, the hedgehog will live with you again, and Hibuki will come back to me. Agreed?” Yura asked his friend.

“Of course, agreed.”

The friends said goodbye, promising each other to remember their commitments. Time passed. For more than six months, Zhenia has been living with his grandmother. He only leaves the house to go to school. At home, he helps his grandmother feed and care for the pets and birds, but he does all of it without joy, as if someone had turned him into a robot.

One night, when everyone in the house was already asleep, Zhenia gathered the courage to snuggle up to Hibuki and tell him what he had been thinking about all this time.

“I often dream that I’m back home. I’m lying in my bed, and through my sleep I hear the hedgehog, running across the room with its little paws. Suddenly it stops, peeks under the chair — that’s where it always hides something tasty for itself. Today, it looked under the chair to check if the apple it rolled there in the morning is still in place. Then it comes to my bed, touches the leg with its nose, and continues its nighttime patrol of the rooms, like a guard entrusted with protecting our peace. I wake up feeling like I can’t breathe, my heart pounding as loudly as thunder, my body burning as if the flames had scorched me. I realize it was only a dream. We’re still at Grandma’s, and my hedgehog is far, far away from me. Do you think it misses me too? I know Yura takes care of him. I’m just scared that it might forget me, or think I’ve betrayed it, since I left it behind.”

Hibuki listened to Zhenia, holding his hands in its little paws, and whispered something very softly.

I made a promise to the boy to keep silent about how that nighttime conversation ended. I only know that Zhenia’s pain inside stopped when the hedgehog occasionally appeared in his dreams again.

What do you think Zhenia heard that was so important?

### About how Maksym and I created a TIME MACHINE

The dream of building a time machine appeared after the boy told me about yesterday’s walk in the park with his mother. Previously, Maksym’s family often strolled through the park on weekends. Yesterday, on Sunday, he asked his mother to walk a little along the park’s alleys. Last year, on similarly sunny spring days, the park was always busy. Children and adults played on the swings; mothers pushed strollers along the paths; water streamed from the fountains, and music played. One could even spot a little red-haired beauty darting quickly between the trees or jumping from branch to branch, perhaps hoping someone had visited and brought a treat — nuts. Now everything was different: the alleys were almost empty, the fountains were dry, no music could be heard, and only a squirrel ran past the half-empty paths of the park.

“Mom, can we go on the swings? Do you remember how you and Dad laughed when we swung really high, and you held my hand tightly so I would not fall?”

“No, my dear, go on your own. We will wait for Dad — then the three of us will ride together,” his mother replied, her voice filled with sadness.

Maksym saw a tear roll down her cheek. The boy felt uneasy, realizing he had upset his mother. Lowering his head gloomily, he said: “Mom, let’s go home. My head hurts.”

At home, Maksym said he was tired. He hugged Hibuki tightly, lay down in bed, and pulled the blanket over his head. Pressing his lips to Hibuki’s ear, he whispered about his sad walk in the park. Then he added: “I feel like crying so much right now — throwing everything I can reach, screaming. It’s my fault that Mom got upset.” “In everyone’s life there has always been a past, and there must also be a future,” Hibuki whispered back into his ear. “If you want, we can build your Time Machine and look not only into your past, but also into what your life may be like in a year, five, ten... Would you agree?”

“Yes. But what do I need to have for that? I don’t have anything.”

“Do you have paper and pencils?”

“Yes.”

“Then get up quickly! You are the creator of your own life! I forgot who said: ‘Rise, Count, great deeds await you!’ It sounds just like a motto.”

And so Maksym and I became the inventors of the TIME MACHINE.

After this story, it is possible to offer the adolescent some questions, for example: “What is your life motto?”, “What will your life be like in a year, five, ten years? What will happen during this time?”

Below there is a series of statements from adolescents who worked with these stories together with a psychologist:

– This is like me. Sometimes I feel lonely too, and I wish I had a friend like Hibuki.

– I never thought a toy could become a symbol of friendship. That’s really cool.

– I want to gather my things and build my own Time Machine — to see where I’ll be in the future.

– Zhenia is a real hero. He was able to say goodbye to his favorite hedgehog and trust it to a friend. That's not easy.

– These stories showed me what it means to be strong.

Excerpts from adult questionnaires:

– I read it and cried. How important it is to have someone nearby who listens, even to silence.

– Hibuki is not just a toy, but a comfort that we adults sometimes cannot provide. It is very wise and profound.

– I want my son to be able to share his feelings. After this story, I am ready to listen more attentively.

– The Time Machine — what a wonderful idea! I will suggest building it together with my son so he can imagine a happy future.

– These stories should be read in schools. They help children and adults understand each other.

Thus, it can be stated that these and similar “story-narratives” work as therapy: through simple language and genuine emotions, they help adolescents feel alive and connected.

**Conclusion:** Within the framework of the presented research, psychological support for adolescents in the context of traumatic experiences is provided through dialogue and the use of metaphor as a tool for internal emotional processing. The application of the Hibuki figure — a toy with therapeutic significance — creates a safe space for emotional communication, overcoming barriers of silence, fear, and confusion. Stories woven into Hibuki's diary structure allow adolescents to find points of identification, activate their own experiences of loss, guilt, and loneliness, while simultaneously revealing a need for trust, friendship, and dreams. The metalinguistic presence of the character as an “Ariadne's thread” gives the psychologist's practical work an additional dimension: imagination, fantasy, and creativity become resources for internal stabilization. Reflective responses from both children and adults confirm the therapeutic effectiveness of this approach — simple, emotionally rich stories facilitate the re-evaluation of personal experiences, deepen empathic contact, and restore a connection with the future. It is the dialogue centered around the image of Hibuki that shapes the direction of psychological healing — through listening, shared presence, the language of silence, and mutual faith in the ability to cope.

Thus, the playful therapeutic image, metaphor, and structured storytelling can be an effective component of psychotherapeutic practice with adolescents, especially in the context of experienced trauma. Hibuki is not merely a “tool,” but a bridge between the adolescent's inner world and their environment — a bridge that can be crossed even through silence.

#### ДІАЛОГ ЯК РЕСУРС: ПСИХОЛОГІЧНА ПІДТРИМКА ПІДЛІТКІВ У РЕАЛІЯХ ТРАВМАТИЧНОГО ДОСВІДУ

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**Yevheniia Yakusheva.** Analysis of the effectiveness of using psychological tools in psychotherapeutic work, editing the text of the article.

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**Постанова проблеми.** У сучасних суспільно-політичних умовах, спричинених військовими діями на території України, питання психологічної допомоги підліткам набуває виняткової актуальності. Психологічна травма, яку зазнають підлітки в умовах війни, є складним і багатограним явищем, що впливає на емоційну стабільність, рівень соціальної адаптації, навчальну мотивацію, а також формування життєвих орієнтацій. На відміну від дорослих, підлітки ще не мають достатніх ресурсів для самостійного подолання психотравмуючих подій, тому особлива увага має приділятися створенню ефективних підходів до психологічної підтримки саме цієї вікової категорії. Попри наявність численних досліджень з теми травматичного досвіду, проблема дієвої психологічної допомоги підліткам, які перебувають у стані емоційної напруги через війну, залишається недостатньо теоретично осмисленою та практично реалізованою. Існує потреба в подальшій розробці нових засобів подолання психотравми, що базуються на поєднанні зовнішнього діалогу між психологом і підлітком, та внутрішнього – у формі з уявним співрозмовником. Саме діалог як основа терапевтичної взаємодії може стати ресурсом, що відкриває можливості для внутрішнього відновлення, рефлексії, актуалізації переживань і поступової інтеграції травматичного досвіду у власну життєву історію. Актуальність проблеми обумовлюється не лише кількісним зростанням запитів на психологічну допомогу, але й тим, що війна триває, а отже, травматичні події мають пролонгований характер і впливають на розвиток особистості в режимі постійної турбулентності. У зв'язку з цим постає необхідність у теоретичному осмисленні потенціалу діалогу як інструменту підтримки, а також у дослідженні прикладних аспектів психологічного консультування підлітків, що знаходяться у стані кризи. У цьому контексті безпосередня взаємодія з терапевтичною іграшкою Хібукі, а також із її образом, сприяє формуванню безпечного емоційного простору, який дозволяє підліткам виражати складні переживання, переосмислювати травматичний досвід та знаходити внутрішню психологічну опору.

**Ключові слова:** *психологічна травма, життєстійкість, психотравма підлітків, психологічне здоров'я, соціальна підтримка, Хібукі-терапія, стрес*

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**SECTION: PSYCHOTHERAPEUTIC MODALITIES, METHODS AND METHODOLOGIES  
РОЗДІЛ: ПСИХОТЕРАПЕВТИЧНІ МОДАЛЬНОСТІ, МЕТОДИ ТА МЕТОДИКИ**DOI [10.26565/2410-1249-2025-24-04](https://doi.org/10.26565/2410-1249-2025-24-04)

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**SEXUAL DISORDERS: A BEHAVIORAL APPROACH TO THEIR FORMATION AND THERAPY****Garnik Kocharyan***Educational and Scientific Institute of Postgraduate  
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A behavioural model of sexual disorders is based on the principles of behavioural psychology, according to which these disorders are regarded as a result of acquired forms of behaviour fixed in the process of learning. Undesired or disadaptive sexual patterns (for example, avoidance of intimacy, dependence on certain objects or situations for arousal) can result from negative experience, reinforcement or absence of adequate learning. Behavioural therapy is intended for elimination of learned forms of behaviour (symptoms and syndromes). It is based on the principle, according to which it is possible to get rid of any unhealthy or inadequate manifestation (symptom) with a reflex origin following the same way. Therefore, the goal of behavioural therapy consists in destruction of pathological behavioural programmes and formation of normal ones, which are adjusted to reality. The article presents behavioural models of formation of sexual disorders: I. P. Pavlov's model of classical conditioning (formation of conditioned reflexes); model of operant conditioning (awards: positive and negative reinforcement, punishment); A. Bandura's model of social learning (the learning takes place when watching behaviour of other people, as well as under the influence of media). The author characterizes determinants of formation of sexual disorders in a behavioural model, gives examples of different sexual dysfunctions and sexual orientation disorders, which develop by behavioural mechanisms. Behavioural interventions used for therapy of sexual disorders are presented, and the author's behavioural scheme of using medications for treatment of anxious sexual failure expectation syndrome is suggested.

**Keywords:** *sexual disorders, behavioural models, determinants of formation, clinical examples, behavioural interventions, behavioural pattern of medication use.*

**Introduction**

The behavioral model of sexual disorders is based on the principles of behavioral psychology, according to which these disorders are considered to be the result of acquired forms of behavior reinforced in the learning process, and unwanted sexual responses or their absence may be the result of emerged associations, reinforcements, or avoidance.

Undesirable or maladaptive sexual patterns (e.g., avoidance of intimacy, dependence on certain objects or situations for arousal) may be the result of negative experiences, reinforcement, or lack of adequate learning.

Behavioral therapy is designed to eliminate learned forms of behavior (symptoms and syndromes). Behavioral therapy is based on the principle that any painful or inappropriate manifestation (symptom) that has arisen reflexively can be eliminated by following the same path. Thus, the goal of behavioral therapy is to destroy pathological behavioral programs and form normal ones that are adapted to reality.

In sexopathology, examples of established pathological programs include premature ejaculation, which developed as a result of a constant fear of being caught unexpectedly while masturbating, which the man had done before; accelerated ejaculation, which arose as a result of the existing need to quickly stop intimate contact

due to his wife's illness; the syndrome of coded sexual reactions, described by K. Imelinsky; exhibitionism, fetishism, other paraphilias, and homosexuality, which arose through conditioned reflexes.

Behavioral models of sexual disorders offer a pragmatic view of their origin and maintenance. Understanding how negative learning shapes sexual behavior provides a solid foundation for developing targeted and effective interventions.

**Behavioral models of sexual disorder formation**

The following three models of sexual disorder formation are distinguished:

**1. I. P. Pavlov's classical conditioning model.**

This theory explains the formation of conditioned reflexes by the almost simultaneous influence of conditioned and unconditioned stimuli (ideally, the influence of the conditioned stimulus should slightly precede the unconditioned stimulus). This model assumes that sexual responses can be conditioned by certain stimuli. If sexual arousal or orgasm is repeatedly associated with unpleasant or traumatic events, these negative associations can suppress the natural sexual response. The following case can be cited as an example. A person who has experienced sexual violence may feel anxiety or disgust in situations that were previously associated with sexual arousal. Their body has associated these situations with

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danger, leading to the suppression of physiological arousal (Google Gemini, 2025, June 19).

### **2. Operant conditioning model.**

The theory of operant conditioning was developed by Edward Thorndike and Frederick Skinner. Operant learning is based on Skinner's fundamental principle: behavior is shaped and maintained by its consequences. In operant conditioning, behavior can be changed by the stimuli that follow it (rewards and punishments). It should be clarified that rewards include both "positive reinforcement" and "negative reinforcement." Positive reinforcement is when a person receives something desirable or interesting for themselves for a "correct" action, and negative reinforcement is when a person is freed from something unpleasant for themselves for a "correct" action.

Sexual behavior that is accompanied by positive reinforcement (pleasure, intimacy) will have a tendency to repeat itself. Conversely, behavior that is accompanied by punishment (e.g., sexual reproaches and insults from a partner) will decrease or be avoided. Example: A man who has repeatedly experienced failure during sexual intercourse due to erectile dysfunction may begin to avoid sexual intercourse so that this failure does not happen again and he does not experience disappointment (Google Gemini, 2025, June 19).

### **3. Albert Bandura's social learning model.**

This model emphasizes the role of observation and imitation in shaping sexual behavior. We learn by observing the behavior of others, whether it be parents, peers, or media content. Examples of the formation of sexual disorders include unrealistic expectations of sex formed by pornography, which can lead to disappointment and feelings of inadequacy if real sexual experiences do not meet these expectations (Google Gemini, 2025, June 19).

### **Determinants of sexual disorder formation in the behavioral model**

The following main determinants of sexual disorder formation in the behavioral model are identified (Google Gemini, 2025, June 19.):

**Learned behavioral responses.** Undesirable or maladaptive sexual patterns (e.g., avoidance of intimacy, dependence on certain objects or situations for arousal) may be the result of negative experiences, reinforcement, or lack of adequate training.

**Formed associations.** Negative sexual experiences (pain, shame, fear) can lead to the formation of negative behavioral patterns, where previously pleasant stimuli (e.g., intimacy with a partner) begin to cause anxiety or disgust.

**Avoidant behavior.** Many sexual disorders are characterized by avoidance of situations associated with sexual activity or sex itself. Although this avoidance reduces anxiety in the short term, in the long term it reinforces dysfunction and prevents new positive experiences.

**Lack of skills.** In some cases, sexual dysfunctions may be related to the absence or underdevelopment of necessary sexual skills, including communication with a partner and the ability to express one's desires and needs,

as well as a lack of knowledge about one's body and reactions.

**The role of the partner and interaction.** Sexuality is often an interpersonal phenomenon. The behavioral model also considers how interaction with a partner (or lack thereof), the partner's reactions, and the dynamics of the relationship affect sexual behavior and function.

**The role of external stimuli and reinforcement.** The behavioral model focuses on how external stimuli (e.g., certain situations, people, objects) can elicit or inhibit sexual response. Reinforcement plays a key role in the consolidation or extinction of a particular behavior. For example, if sexual activity is accompanied by anxiety or pain, it can lead to avoidant behavior.

**The "stimulus-response" model.** It is based on the idea that certain stimuli (external or internal) elicit certain responses (physiological, emotional, behavioral). In sexual disorders, this connection may be disrupted. The goal of therapy is to change this connection and teach the patient new, more adaptive responses.

**Focus on the present and specific problems.** The behavioral model focuses on current behavior and its change. The therapist and patient work together to identify specific problems, set goals, and develop strategies to achieve them.

### **Sexual disorders formed by behavioral mechanisms**

#### **1. Sexual dysfunctions.**

Sexual dysfunctions that can develop through behavioral mechanisms include erectile dysfunction, ejaculation disorders, sexual arousal disorders in women, manifested, in particular, by a decrease or absence of lubrication, and disorders of sexual desire and orgasm. Sexual dysfunctions in ICD-10 also include vaginismus and dyspareunia, which, however, in ICD-11 were separated into a separate group – "sexual pain disorders." Behavioral factors may also contribute to the formation and development of sexual pain disorders of inorganic and mixed nature. It should be noted that behavioral mechanisms are often combined with cognitive ones. In these cases, we should talk about a cognitive-behavioral model of sexual dysfunction formation.

I will cite my following clinical observation, which concerned erectile dysfunction that developed due to behavioral mechanisms. Patient M., 29 years old, said that he had previously had problems with penile tension. During the interview, it became clear that he had been practicing martial arts for a long time. The patient noted: "Any physical exertion is performed on the exhale, and we practiced that if I miss a blow to the body, I need to exhale as sharply as possible. At the same time, the abdominal muscles tense up (on the exhale), and then the blow is easier to withstand. Otherwise, it can knock the breath out of you or even send you to the ground or knock you out. As a result, as a negative consequence of this training, during intimacy with a woman, when she touched my stomach, especially unexpectedly for me, I would exhale, and my abdominal muscles would tense sharply. As a rule, this led to a sharp decrease or even disappearance (not permanently, but for a while) of my erection. Before this first occurred, the patient had a sex life, but it was

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irregular. After this phenomenon appeared, it persisted for another six months, until he began to have a regular sex life. When he began to have sex regularly, after 8-10 sexual acts with the same woman, this disorder was eliminated. Since his erection was restored quickly, he did not consult a doctor. In addition, he notes that not only touching his abdomen caused a weakening of his erection, but also touching his thigh. It is clear that normalization in this case occurred spontaneously as a result of the fading of the pathological sexual reflex.

My other clinical observation concerns a case of premature (early) ejaculation that developed due to behavioral mechanisms. A man sought medical help complaining of premature ejaculation, which developed in him due to the following circumstances. For several years, he was forced to have sexual intercourse very quickly, as his wife experienced severe pain during intercourse due to inflammatory gynecological pathology. Due to this pain, sexual intercourse only took place when he was no longer able to tolerate the high level of sexual tension that required release. His wife was later cured, but the stereotype of quickly ending sexual intercourse became firmly established, which led him to seek help from a sexologist (Kocharyan, 2012).

Another patient of mine attributed his premature ejaculation to the fact that during masturbation, which he engaged in as a teenager, he always sought to reach orgasm quickly. At the same time, he had no fear of being caught by his parents.

Renowned American sexologists Masters and Johnson (1970) report that many young Americans have their first sexual experience with a professional prostitute, for whom rapid ejaculation is a positive phenomenon: the sooner her first client leaves, the sooner she can take the next one and the more she will ultimately earn. Other young Americans who have their first sexual experience with casual acquaintances in random and often unfavorable settings (in a park, in a car, etc.) are again "rushed" by both their girlfriends, who fear accidental witnesses, and the unfavorable circumstances themselves. Everything and everyone rushes the young American, and the habit of finishing sexual intercourse as quickly as possible turns into a firmly established conditioned reflex, which he cannot always get rid of after getting married.

Anejaculation can also develop through behavioral mechanisms. This can happen if, as a result of systematic masturbation, a clear pattern of ejaculation has developed as a result of certain stimuli that cannot be reproduced during sexual intercourse. In some cases, although the form of stimulation of the penis is similar to that which occurs during sexual intercourse, due to the absence of a set of familiar erotic stimuli that cannot be fully reproduced during coitus, we may be talking about anejaculatory sexual intercourse. For example, I observed a young man who sought help due to the absence of ejaculation during coitus, as a result of which he and his wife did not have children. Upon questioning, the reason for this turned out to be the following. It turned out that, starting from adolescence, he had been masturbating regularly for a number of years. Moreover, he still

sometimes "slips up" and masturbates. His nonverbal reactions showed that it gave him great pleasure. This was confirmed by a targeted interview, which revealed that he experiences much more pleasant sensations during masturbation than during sexual intercourse with his wife. In addition, it turned out that during masturbation he experiences both ejaculation and orgasm, which does not happen during sexual intimacy (Kocharyan, 2007).

As an illustration of the pathological stereotype formed as a result of masturbation, I can also cite the following clinical observation. Patient U., 38 years old, complained of loss of penile erection approximately 2-3 minutes after insertion into the vagina and the start of friction. Ejaculation during intimate relations never occurs. Active questioning revealed no libido disorders. He has been masturbating since the age of 18. At first, he masturbated regularly once a day, then several times a week. Then he switched to a rhythm of once a week. Every time he masturbated, starting from the very first time, he experienced ejaculation and orgasm. He last masturbated last year. He notes that his masturbation technique was "normal" (he used his hand, bent into a fist, for friction). During masturbation, he imagined having sex with women in different positions, rarely using playing cards with images of naked women for erotic stimulation. During active, targeted questioning, he notes that when he masturbates, he experiences maximum pleasure in the penis area. At the same time, he has a full erection, followed by ejaculation and orgasm. When his wife stimulates his penis (this was included as part of sex therapy), he "feels greater pleasure in his brain and throughout his body, but his penis reacts very sluggishly to her stimulation." He repeats and clarifies that when he masturbates, the opposite is true: "the penis becomes aroused, but there are no pleasant waves of arousal until almost the last moment" (when ejaculation is about to occur). Only then does "the whole body feel it." He also notes that during friction in the vagina, he only feels that his penis is "sliding" (moving), but there are no pleasant sensations (everything is limited to ordinary tactile sensations), and the tension in his penis disappears over time.

The formation of a pathological sexual stereotype is illustrated by my next clinical observation. Patient K., 25 years old, has a sexual partner (in a "civil marriage" for 2.5 years). She complains that she gets more pleasure from watching internet pornography combined with masturbation than from sexual intercourse with her partner. When masturbating, she clamps the blanket between her legs. She also reaches orgasm during sexual intercourse, but when masturbating, it comes faster, is stronger, and is of "higher quality." She wants to experience the same intense sensations with her partner. During intercourse, her sexual arousal is not as pronounced as during masturbation. She has not told her partner that she prefers the computer (masturbation combined with internet pornography) to him (Kocharyan, 2017).

The following example demonstrates the absence of orgasm during sexual intercourse in a woman, which developed due to behavioral mechanisms. One of my

patients, aged 28, did not experience orgasm during sexual intercourse with either of her two husbands (she is now divorced). Her repeated attempts to experience orgasm during intimate contact with other men were also unsuccessful. At the same time, she is capable of experiencing up to 30 or more orgasms after squeezing her muscles of thighs for some time, placing one thigh on top of the other. It turned out that this woman first experienced orgasm in this way at the age of 8 and still systematically resorts to this form of sexual self-gratification (Kocharyan, 2006).

We can also talk about the influence of a complex of physical stimuli, including tactile ones, which are characterized by a certain intensity, temperature, and other parameters that, by themselves, and even more so in combination, cannot be reproduced during sexual intercourse. As an example, I can cite a fragment of the medical history of one of my patients. A young woman who sought medical help due to the absence of orgasm said that she and her husband had tried various sexual techniques and positions, but despite the fact that her husband had very good potency and could easily prolong sexual intercourse, all attempts to bring her to orgasm were unsuccessful. It turned out that when she was a girl, she would direct the shower stream at her genitals while masturbating. At first, she just felt pleasant sensations, but then gradually began to experience orgasms. At the time of seeking medical help, it turned out that she could easily induce orgasm in herself in exactly the same way (Kocharyan, 2006).

Vasilchenko (1977) gives an example of the formation of a pathological sexual stereotype in a 38-year-old patient, Yakh., who recently got married and turned out to be sexually incompetent. He had never been sexually active before. His wife's caresses never caused an erection, but he had very strong erections when using the toilet. He began masturbating at the age of 15. For the first 1–1.5 years, he sometimes imagined a female image while masturbating. Then, for more than 20 years, he masturbated mechanically, without the use of fantasy. He most often had to masturbate in toilets. He notes that until recently, the specific smell of the toilet, the sound of pouring water, shiny toilet bowls, the sight of tiled floors, as well as the sight of the glans penis exposed from the foreskin caused a strong desire to masturbate, accompanied by pronounced erections.

Although this case was initially considered untreatable, the patient was advised to refrain from any attempts at sexual intercourse for a week or two, explaining to his wife that he needed rest to get rid of his neurasthenia. At the same time, it was recommended that he systematically take a separate room in the bathhouse 1-2 times a week for hygienic washing and visit it with his wife, also without making any attempts at intimacy. At the same time, the patient had to behave in such a way that his wife believed that this was just a regular hygienic visit to the bathhouse.

During his first visit to the bathhouse, Yakh. had such a strong erection that he violated the existing condition, although his wife did not initially arouse him sexually and the beginnings of his arousal appeared only before

ejaculation. The next day, Yah managed to use his morning erection for sexual intercourse, because only with the passage of time did his wife's caresses and even the mere sensation of her body begin to arouse lustful feelings, followed by erections. The following diagnosis was made: disruption of sexual conditioned reflex complexes (due to their vicious formation as a result of prolonged masturbation).

Examples of sexual dysfunctions that develop through behavioral mechanisms include pathoreflexive and dysregulatory forms (Kryshnal, 2008). The first case involves the fixation and reinforcement of sexual failure, which is then repeated. In the second case, we are talking about sexual dysfunction that has developed as a result of the practice of interrupted sexual intercourse to prevent pregnancy.

Behavioral fixation of sexual dysfunction is also reflected in the category of "urogenital sexological disorders complicated by persistent disruption of nervous regulation mechanisms." In this case, we are talking about a patient who was treated for chronic prostatitis, one of the manifestations of which was premature ejaculation. Despite the sanitation of the prostate gland, this sexopathological symptom does not disappear because it has become fixed and a corresponding pathological sexual stereotype has formed. This form of disorder is referred to as the syndrome of secondary pathogenetic titularization.

Here is another example of existing sexual problems that persisted after the elimination of the causes and conditions that originally caused them. Patient B., 47 years old, is in a "common-law marriage." His main sexual complaint was a loss of sexual desire, which could be explained by the fixed effects of stress associated with his divorce from a woman who had cheated on him. The treatment, the main component of which was hypnosuggestive therapy, led to a rapid recovery (Kocharyan, 2024).

Here is another example from my clinical practice, where the patient's sexual problems at the time of referral were a persistent aftereffect that remained after the causes that initially caused them had been eliminated. Patient Ch., 30 years old, married, noted that she did not experience spontaneous sexual desire and arousal. They only occurred during cunnilingus. At the same time, her erotic libido was completely preserved. She had sexual relations with her husband 5-6 times a week and only on his initiative. Before her first childbirth, she was very passionate and had no sexual dysfunction. Her interest in sex disappeared 5-6 months into her first pregnancy. She resumed her sex life 1.5 months after her first delivery. Since then, in addition to the absence of a spontaneously growing desire for sexual intercourse, she has had insufficient vaginal lubrication. She is gynecologically healthy. She has no chronic diseases. I linked the patient's sexual problems to her first pregnancy. However, after giving birth, there were no changes in her sexuality. Due to the absence of obvious somatic causes of sexual dysfunction, as well as the effectiveness of hypnosuggestive therapy (the final diagnostic conclusion was based on the results of treatment), I concluded that the patient's sexual

dysfunctions were the result of existing inertial shifts in the body, which preserved the sexual dysfunctions that were initially caused by factors related to pregnancy. A program (stereotype) of sexual responses had formed, which persisted for a long time, despite the absence of factors associated with the first pregnancy. Five sessions of hypnosuggestive therapy (programming, modeling) were conducted, which was the dominant element of treatment. The results showed complete elimination of sexual problems (Kocharyan, 2023).

## 2. Changes in sexual orientation.

These changes can also be shaped by behavioral mechanisms. According to behavioral theories, the process of sexual orientation boils down to the development of psychological conditioned reflexes at an early age, combined with positive or negative reinforcement for certain sexual behaviors. Thus, people's early sexual experiences can lead them toward homosexual behavior as a result of pleasant sexual contacts with members of their own sex that bring satisfaction, or unpleasant, disappointing, or even frightening heterosexual experiences.

Behavioral theory suggests that paraphilia can result from accidental conditioning. If sexual arousal is repeatedly associated with a non-sexual object or situation, they may themselves begin to cause arousal over time. The formation of paraphilias can be influenced by, in particular, (Google Gemini, 2025, July 11):

- **Traumatic childhood experiences:** emotional, physical, and sexual abuse, neglect, dysfunctional family relationships.

- **Learning and reinforcement:** association of atypical stimuli with intense sexual arousal at an early age, as well as masturbatory fantasies that reinforce and intensify such arousal.

- **One-time or repeated negative sexual experiences and copying of observed behavior patterns.**

The formation of paraphilias through behavioral mechanisms is often explained by conditioning processes (Google Gemini, 2025, July 15). If a person regularly experiences sexual arousal in the presence of a certain object not related to sex (for example, shoes), the brain may begin to associate shoes with this arousal. Eventually, shoes alone may become a sufficient stimulus for sexual arousal, forming fetishism. Behavior that is followed by positive reinforcement (pleasant sensations, orgasm, release of tension) becomes more likely to be repeated in the future. Conversely, behavior that is followed by punishment or a lack of the desired outcome becomes less likely to be repeated. If a person accidentally discovers that certain non-traditional sexual behavior (e.g., exhibitionism) leads to strong sexual arousal or orgasm, this action is "reinforced," increasing the likelihood of its repetition.

If non-traditional sexual behavior reduces discomfort, anxiety, or internal tension, this is also a form of reinforcement. For example, if compulsive sexual behavior (as in some paraphilias) temporarily relieves internal anxiety, this may contribute to its reinforcement. Additional behavioral factors that may contribute to the

development of paraphilias include (Google Gemini, 2025, July 15):

- **Observational learning.** A person can learn paraphilia behavior by observing others or using media resources. If the observed behavior is associated with pleasure or getting what one wants, it can encourage imitation.

- **Avoidance and ritualization.** In some cases, paraphilic behavior may develop as a way to avoid more complex or anxiety-provoking situations (e.g., intimacy with a partner) or as part of a ritual that provides a sense of control or predictability.

- **Fantasies and masturbation.** Repeatedly linking sexual fantasies to specific paraphilic themes during masturbation can reinforce these associations and cement them in the behavioral repertoire.

It is important to note that the formation of paraphilias is usually a complex interaction of many factors, including biological, psychological and also social, and behavioral mechanisms may only be part of it.

Patient K., 21 years old, has been living with a 22-year-old girl for 1 year. He sought medical help due to a periodically arising desire to masturbate using porn featuring transsexuals/transvestites. My examination led me to conclude that this patient, as a result of prolonged masturbation using non-normative pornographic videos featuring transsexuals/transvestites, developed a pathological sexual behavioral stereotype, which is manifested by the need for the above-mentioned non-normative masturbation, as well as a decrease in sexual arousal and a weakening of orgasm during heterosexual sexual intercourse (Kocharyan, 2022).

Holstein and Schudze (1983) report a case of pedophilia to illustrate the role of masturbation and masturbatory fantasies in the development and fixation of this paraphilia. Svyadoshch (1988) cites examples where the combination of sexual arousal and masturbation with with peeping sex scenes led to the development of voyeurism (visionism, scopophilia) in a woman, and a woman's examining of a man's penis led to exhibitionism in a man.

## Behavioral interventions in the treatment of sexual disorders

To eliminate sexual disorders, the behavioral approach uses (Google Gemini, 2025, June 19):

- **"Sensory focusing".** This is a series of exercises aimed at reducing anxiety about sexual performance and refocusing attention on sensory experiences. Couples take turns touching each other without focusing on sexual intercourse, gradually expanding the boundaries of tactile contact.

- **Progressive muscle relaxation.** This involves using it to reduce the overall level of anxiety and tension that often accompany sexual dysfunction.

- **Social skills/communication training.** This improves communication between partners, especially regarding sexual needs and desires.

- **Graduated influence (exposure therapy).** Gradually increasing (controlled) exposure to fearful situations or situations that are avoided is carried out in order to reduce

anxiety. Gradual influence (or systematic desensitization) is a behavioral psychotherapy method used to reduce anxiety and fear of certain objects, situations, or activities. The method is based on the controlled presentation of anxiety-provoking stimuli, which are gradually intensified, in combination with relaxation techniques.

- **Modification of sexual behavior.** This leads to a change in maladaptive habits and the introduction of new, healthier behavioral strategies.

To eliminate erectile dysfunction, sex therapy, which is based on sexual behavior training, can use sensory focusing; To get rid of premature ejaculation (PE), the “squeeze technique” proposed by James Semans in 1956 can be used. This technique was modified by W. Masters and V. Johnson. The “stop-start exercise,” also developed by James Semans in 1956, is also used to eliminate PE (Kocharyan, 2012). To get rid of anejaculation in men and anorgasmia in women, the “bridge” technique proposed by H. S. Kaplan is used (Kocharyan, 2018), and for vaginismus, plastic dilators are used, the sizes of which are gradually increased (Kocharyan, 2021).

Hypnosuggestive therapy, which combines the hypnotic method with the principles of behavioral therapy, is successfully used to treat various sexual dysfunctions of non-organic origin (decreased and increased libido; erection, ejaculation and orgasm dysfunctions; vaginismus, dyspareunia). It aims to change behavioral patterns by putting the patient into a hypnotic state, helping them to form new, more adaptive responses. For this purpose, both hypnosuggestive programming and hypnosuggestive modeling are used (Kocharyan, 2013; Kocharyan, 2024). In the process of such therapy, maladaptive programs are eliminated and normal programs of sexual functioning are formed. Hypnosis suggestive therapy in a behavioral context is also used for the treatment of paraphilias.

Neurolinguistic programming (NLP) is also actively used to change sexual behavior programs (Kocharyan, 2002). In particular, the following NLP techniques are used for this purpose: the “swish technique”, the “compulsion blowout technique”, and developed by me the “technique of correction of behavioural programmes”. This technique also includes a cognitive component.

In clinical sexology, the aversive method (unlearning method) is used to treat paraphilias (in particular, fetishism, transvestism, sadism, and pedophilia). It can be carried out using emetics (apomorphine) and electric discharges. These two approaches are also used to change unwanted homosexual orientation to heterosexual orientation. In the latter case, the following may be used. Electric discharges are delivered by a device powered by a 9-volt battery, and the patient himself sets the tolerable level of shock, which is delivered through a cuff electrode to the biceps or calf area. This method is in no way comparable to electroconvulsive therapy, which uses 70-120 volts and electrodes placed on the head, causing a grand mal seizure and often complications in the form of serious memory impairment (Kocharyan, 2020).

The following techniques related to masturbation are used to treat pedophilia (Kocharyan, 2017):

1. **Orgasmic reorientation.** It was first described in detail by Marquis (1970) in men and is aimed at increasing sexual desire when seeing adult women. In these cases, pedophilic fantasies are combined with masturbation, and as orgasm approaches, the patient switches to images of adult women. The resulting orgasm, as believed in this approach, promotes the development of heterosexual sexual desire when this technique is used repeatedly. If a person was able to do this successfully several times, they were encouraged to gradually shift from fantasies associated with this deviant behavior to heterosexual fantasies, which were “turned on” earlier and earlier until they were able to ejaculate using only them.

2. **The “masturbation oversaturation”** technique was developed later (Marshall, 1979; Abel et al., 1984). It includes 2 stages: initially masturbation is carried out with the using of heterosexual porn, and after orgasm occurs, pedophile porn is used, which causes unpleasant sensations, since we are talking about refractory period. As a result, arousal under the influence of pedophilic stimuli, as believed, gradually decrease.

Of course, the two techniques mentioned above can also be used to treat other types of sexual orientation disorders.

To change sexual orientation from homosexual (which the man wants to get rid of) to heterosexual, as one of the components of correction, I recommend that patients change homosexual-oriented masturbation to heterosexual masturbation, as well as masturbation using images of naked women and women masturbating. When using heterosexual scenes, I recommend that they focus on female images. The use of lesbian scenes, which heterosexual men resort to, is not prohibited.

For the sexual reorientation of homosexuals-egodistonic, bisexuals, as well as those who do not consider homosexuality to be a pathology but who wish to become heterosexual in order to start (or not disrupt) a family and have children, I use hypnosuggestive therapy in the form of programming and modeling. Programming includes suggestion to get rid of homosexual attraction, filling with heterosexual attraction, as well as changing the aesthetic and sexual perception of female and male individuals, strengthening sexual attraction to girls and women (in men). Modeling is connected later. The person sees themselves in an intimate setting: there is caressing and kissing, followed by sexual intercourse. Thus, we are talking about acquiring, albeit imaginary, experience of heterosexual contact. With repeated hypnotic sessions, homosexual attraction weakens and even disappears, while heterosexual attraction intensifies (Kocharyan, 2021).

#### **Use of drug therapy included in the behavioral scheme**

I propose the use of medications included in the behavioral scheme (Kocharyan, 2019) for the treatment of anxious sexual failure expectation syndrome (ASFES).

I tell patients who have had ASFES for a certain period of time that their unsuccessful attempts to engage in sexual intercourse have resulted in the formation of a pathological program, which manifests itself in repeated failures when attempting to engage in sexual intercourse (a kind of pathological habit). I note that this program needs to be

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changed to a healthy one. To this end, I propose the following treatment regimen. One to three times before attempting coitus, the patient should take a medium dose, for example of sildenafil (50 mg) one hour before the planned sexual intercourse. The next one to three times, this dose is 25 mg, and then 12.5 mg for the next one to three times. At the same time, approximately 1.5 hours before sexual intercourse, he should take a tranquilizer, for example, 20 or 50 mg of gidazepam (depending on the severity of anxiety/fear of sexual failure). This forms a program for the normal course of sexual intercourse. After that, sildenafil is discontinued, but the patient is advised to keep this pill or part of it nearby, which will give him confidence that even if he fails (which is very unlikely), he will still be able to perform full sexual intercourse 1 hour after taking this drug. However, it is the presence of this pill that will give him confidence in his sexual abilities and his ability to perform quality intercourse. We usually do not recommend that men with ASFES tell their partners that they are using such potent substances (sildenafil, vardenafil, tadalafil), because in these cases, positive results may be attributed by women to these drugs, and not to men (leading to a devaluation of the partner's sexual abilities).

### Conclusions

Based on the above data, it can be concluded that various sexual disorders can often develop completely or partially due to behavioral mechanisms. After analyzing their formation in each individual case, it is necessary to prescribe the appropriate behavioral therapy that can be effective.

**Conflicts of interest.** The author declare that they have no conflicts of interest.

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### СЕКСУАЛЬНІ РОЗЛАДИ: ПОВЕДІНКОВИЙ ПІДХІД ДО ЇХ ФОРМУВАННЯ І ТЕРАПІЇ

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Поведінкова модель сексуальних розладів ґрунтується на принципах поведінкової психології, згідно з якими ці розлади розглядаються як результат набутих форм поведінки, закріплених у процесі навчання. Небажані або дезадаптивні сексуальні патерни (наприклад, уникнення інтимності, залежність від певних об'єктів або ситуацій для збудження) можуть бути результатом негативного досвіду, підкріплення або відсутності адекватного навчання. Поведінкова терапія призначена для ліквідації завчених форм поведінки (симптомів та синдромів). В основу поведінкової терапії покладено принцип, згідно з яким будь-якого хворобливого або неадекватного прояву (симптому), що виник рефлекторно, можна позбутися, слідуючи цим же шляхом. Таким чином, метою поведінкової (біхевіоральної) терапії є руйнування патологічних та формування нормальних, пристосованих до дійсності поведінкових програм. У статті наведено поведінкові моделі формування сексуальних розладів: модель класичного обумовлення І. П. Павлова (формування умовних рефлексів); модель оперантного обумовлювання (нагороди: позитивне і негативне підкріплення, покарання); модель соціального навчання Альберта Бандури (навчання відбувається при спостереженні за поведінкою інших людей, а також при впливах медіа). Характеризуються детермінанти формування сексуальних розладів в поведінковій моделі, приклади різних сексуальних дисфункцій і порушень сексуальної орієнтації, що розвиваються за поведінковими механізмами. Наводяться поведінкові інтервенції, які використовуються для терапії сексуальних розладів, та запропонована автором поведінкова схема використання медикаментів для лікування синдрому тривожного очікування сексуальної невдачі.

**Ключові слова:** *сексуальні розлади, поведінкові моделі, детермінанти формування, клінічні приклади, поведінкові інтервенції, поведінкова схема використання медикаментів.*

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## OFFERING CONNECTION WITHIN A WIDER COMMUNITY CONTEXT: THE HEART WOOD GROUPS FOR MEN

**Chip Ponsford**

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Our aim is to offer a 'receiving climate' in which men, a majority of whom are survivors of trauma, who are at levels one and two of Carl Rogers' tentative Process Conception of psychotherapy, feel safe enough to begin to strengthen their contact functions (levels of psychological contact with self, others and the shared environment). Since 2018 we have offered person-centered men's therapy groups in a woodland setting. Group members are welcomed into our community for as long as they need. Groups are facilitated in a 'contact-oriented' way; we don't assume psychological contact but work continually to gauge its level with group members, and to facilitate the strengthening of contact through contact reflections within an activity-oriented group. Activities include bushcraft and cooking on the fire. Groups comprise up to twelve men and two or three facilitators, and are of 3 to 4 hours duration. Sessions are weekly through spring and summer, and are currently bi-weekly through autumn and winter. An independent researcher evaluates our service annually through voluntary recorded interviews with the men which take place in the woods by the fire. Our person-centered facilitation means that we constantly listen and respond to feedback from the men about their experience of the groups. The outcomes of these interviews and the feedback we get from group men throughout the process show that we are able to offer a receiving climate to these men who are suffering considerably, but cannot engage with therapy in the way it is generally offered.

**Keywords:** *trauma, pre-therapy, contact work, psychological contact, working outside the therapy room, working in a nature-setting, therapeutic community*

*'What they do up here is unlike anything I've been on. Even it's just a case of sitting around a fire and having a bit of soup and having a chat, it's just totally not like anything you know. When I've gone to therapists before it's been sort of one on one in an office, or it's in a classroom and it's... the vibe isn't there.'*

At Heart Wood we try to offer a safe environment through a 'contact orientated' way of relating with the men who come to our sessions. We work to offer a chunk of time in which the men aren't pressured and are heard. 'John' describes his experience: 'And also there's that, when I've done one-to-one therapy in the past, when I've turned up there's this thing, "I need something to say here". I can't just turn up and say "I really don't want to talk about anything this week". You know. Can we just talk about the weather or go and look for mushrooms or go and chop some wood? Whereas here, that options is there, which is that relaxedness...'

The following is the first of what I intend to be a series of pieces of writing which describe something of the way we work at Heart Wood. Heart Wood is a mental health charity in Northumberland (<https://www.heartwoodcharity.org>) which runs 'contact-orientated', (Erskine, 2023) client-centered therapy groups for men in a nature-based setting, and training for counsellors/ therapists who want to learn about working outdoors in a contact-orientated way. By 'contact-orientated', we mean that we don't assume psychological contact but constantly gauge the level of contact between group members and facilitators. For a number of reasons,

which I'll explore below and in a future piece, we work in a 'nature' setting.

I will quote from anonymised evaluation interviews that have taken place annually between an independent person-centered counsellor/researcher and men from the groups who accepted an invitation to talk about their experiences with us. We are offering something to men who would not otherwise be able to access meaningful psychological support and who don't necessarily fit the traditional populations to whom pre-therapy or contact work has been offered. Whilst a small number of group members experience some psychosis, most do not but can be described as 'contact impaired' or having lower levels of 'contact functions'. And rather than being in the 'greyzone functioning' (Dion Van Werde, 2002, p82) between psychosis and more congruent functioning, these men can be described as being in a 'high end grey zone' (Erskine, 2023). Here, due to trauma, they can find it difficult to form and benefit from meaningful contact with others, their own experiencing, and the shared reality (Prouty, 2002, p. 17). Another way of describing these men would be that they are, to varying degrees, psychologically (and often physically) isolated. Most are unable to engage with therapy, which fits the current 'norm' of sitting opposite someone in a room around and talking about what's wrong, or other support they have been offered.

Alan: 'I've done one on one therapy before but it's been in a doctors surgery'.

Interviewer: 'What was that like, compared to this?'

Alan: 'I don't know, it was just a lot more formal, a lot

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more, a lot more very sort of doctor patient kind of thing as opposed to a bunch of lads sitting around a fire’.

I recognise many of the individuals in our groups in terms of Rogers’ (1995, p. 133) tentative seven stage ‘process conception of psychotherapy’ in which he describes movement from ‘fixity to flowingness’ and says of people in stage two: ‘...We seem to know very little about how to provide the experience of being received for the person in the first stage, *but it is occasionally achieved in play or group therapy* [italics added] where the person can be exposed to a receiving climate, without himself having to take any initiative, for a long enough time to experience himself as received.’ Whilst men do have to take initiative to come to group sessions or contact us in the first place, this description of the experience of a ‘receiving climate’ is what we are trying to offer at Heart Wood.

We currently offer open-ended involvement so that group men can be with us ‘for a long enough time to experience himself as received’. The groups run weekly through spring and summer for about 18 consecutive weeks, then monthly through the autumn and winter. Summer sessions are 4 hours long and winter sessions are 3 hours. Summer sessions close to new people after a few weeks while winter ‘connecting sessions’ are open. We currently run two groups at different places on the same wooded site.

Each meeting, we arrive at the woodland fire-site, set up our kit (e.g., seat-matts and camping chairs, sawhorses and tools) and get the fire lit, usually using a ‘flint and steel’. If its raining, we rig up a parachute above the fire site for shelter. Facilitators need a good level of competence and understanding of the steps involved with these practicalities in order to support the men in doing them. Once the site is setup and the kettle boiled, everyone gets a hot drink in-hand and we check-in around the fire. No-one is obliged to do or say anything they don’t want to and the structure in terms of timings and activities is loose, but we offer a lot of relational ‘glue’—lots of contact reflections throughout the entire session.

Soon after check-in, someone starts chopping vegetables for the soup while others continue sitting ‘round the fire talking, maintaining the kettle, collecting or splitting wood for the fire, or looking after the natural habitat. We often remove the invasive rhododendron or take steps to protect tree saplings by placing sticks in the ground around them to prevent deer or rabbits eating them. A common sight at these times is of smaller groups of 2 or 3 men doing different things or chatting respectfully with each other and having a laugh. Most people stop and sit in the circle for soup when it’s ready, then there’s more time in which people do various activities. Following all this, we check-out at the end before dousing the fire, packing up the kit and going home.

‘What they do up here is unlike anything I’ve been on. Even it’s just a case of sitting around a fire and having a bit of soup and having a chat, it’s just totally not like anything you know. When I’ve gone to therapists before it’s been sort of one on one in an office, or it’s in a classroom and it’s... the vibe isn’t there.’

### **Broadening**

We see our way of being at Heart Wood as broadening beyond three ‘core conditions’ to recognise and work with six necessary and sufficient conditions. It is a further ‘broadening’ from perceiving and offering these separate ‘conditions’ out to genuinely experiencing these in combination as part of our own unique personalities. This includes particularly that we don’t assume psychological contact (Prouty, 2002). We aim to offer very sensitive attunement to group members’ ever fluctuating levels of psychological contact with self, other and the shared environment (Prouty, 2002). As facilitators we talk a lot! We often offer contact reflections, particularly reality reflections (Prouty, 2002, p. 17) as a way of acknowledging the shared here and now from moment to moment.

The intention is to co-create an easily readable situation. An example might be ‘I’m just putting this fire bowl down on its stand here now as we’re all arriving’. This is perhaps working in a broader ‘bandwidth’, beyond the men’s internal meaning-making and out into a shared space with shared tasks. Mearns and Thorne describe this beautifully in ‘my friend Jo’ (Mearns and Thorne, 2000, p. 17-53): ‘In this kind of work you are intentionally expanding the contexts for ‘contact’ because there is a contact deficit in this kind of client and contact is the basis for person-centered therapy’. What we are trying to offer is, at once, both an opportunity for some people in some moments to explore their inner lives and for the whole group at all times to experience the group atmosphere of relational safety ‘...relationships without fear, I was offering him a context where he could edge out of his inner world’ (Mearns and Thorne, 2000, p. 18). In this chapter Mearns and Thorne discuss the importance, when offering this kind of relationship in such an expanded context, of the maturity of the practitioner. We at Heart Wood, as will be discussed, view this in terms of therapist congruence.

True client-centered therapy in any context is rooted in the therapist’s deep self-awareness and capacity to exude (implicitly, by expression of core attitudinal qualities through quality of presence) and explicitly express their genuinely held attitudes of respect and trust in the Heart Wood group members’ natural tendency to actualise. This way of relating *is* the therapy. Jan

Hawkins in the recent Autumn 2024 edition of *PCQ* reminded us of the ‘core attitudinal qualities’, which we see as accurately describing something of our personal commitment to a way of being with men who join the groups, rather than doing something to them. It is easy to misunderstand contact reflections as a ‘way of doing’ rather than a ‘way of being’. Our presence feels like it’s at least as important as our more explicit behaviours and responses: Carl Rogers, in an interview with Baldwin before his death (Baldwin, 2000) said, ‘I am inclined to think that in my writing I have stressed too much the three conditions (congruence, UPR, and empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element in therapy – when my self is very clearly present’.

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Presence is by definition, authentic or congruent. By congruence, in this description of our work I mean what Mearns and Thorne (2000, p. 95) describe as *'the actual living out of relational congruence'*. It follows from this (Mearns & Thorne, 2000, p. 95) that *'Rogers himself placed the emphasis on the therapist's openness to inner experiencing and his or her willingness to be as aware as possible of that experiencing, to be the feelings and attitudes which are currently flowing within and to give expression to them when appropriate...'* A quote from a group man expresses his experience of this genuineness in one of our therapists *'...you feel really like, [the therapist] cares. He's not just doing a job, he's here because he wants to be here. Such as what's going on, he's not just turning up to work 9 to 5'*.

It's more exposing for therapists to offer congruent, contact-orientated relationship in an expanded context of sessions which include practical activities, but it does seem to offer the possibility of 'a relationship without fear'. By naming as much as we can about our own experiencing, not only inwardly but in relation to the shared reality we are co-creating with the men and how they seem to be, we hope there is a minimum of unacknowledged phenomena which could feel threatening if people had to carry them alone. An example might be acknowledging a slightly sarcastic bit of humour from one man to another, and how the man on the receiving end might look uncomfortable as a result. The contact reflection here might be 'you don't look as if you like that [comment] Dave'.

Heart Wood group sessions can feel like a small tribe functioning and *living* together for a few hours. Being in nature and including activities adds a sort of third dimension which is necessary for people who struggle more or are unable to engage with a 'two dimensional' and potentially intrusive focus on the psychological processing of previous experience than they do with the immediate experiencing of the group's shared reality, including conversation about 'non-threatening subjects' (Sanders, Van Werde, 2007 p. 65).

Dion Van Werde (2007, p. 63) describes what we are now, in our work, coming to call three dimensions: *'A combined and integrated paying attention and listening to the context as well as to the client will have a better chance of helping her take a new step in her recovery and help her be in command of her own situation again'*. This requires a high level of congruence in the therapist.

We have defined our roles as a staff team in terms of three elements—including that we are, at times, group members, group leaders, and facilitators. Most of the time I am facilitating group members' experiencing in terms of the contact they are making with each other, with their own experiencing and with the shared reality. 'Facilitate' means 'to make easier', so I see this role as making actualisation easier by co-creating an environment in which group members can feel 'received' (Rogers, 1951/2003). When I'm a group member—when I am checking-in, for example—I will name my own experiencing in that moment, and possibly something of what is going on in my life that week, but I won't explore it. I will also do my best to be transparent so that I'm clear and understandable to my

clients—in my role as participant I'm just a bloke who also has problems, rather than presenting a professional facade (Corey, 1986).

One man spoke about the impact my way of being in the group had on him: *'...but when I spoke about it with [therapist] he'd admitted that he'd used substances in the past, whether he'd had a problem or not I can't remember, but he'd used them. Straight away it brought it back down to a level. Because he's in a position that he's in, he could have held that information back but it's just like, oh right, it doesn't matter where you are, who you are, where you're from, we're all a very fine line away from despair or whatever'*.

Times when we are required to be 'leaders' include, for example, when we need to cancel a session due to high winds which can make it dangerous to be in woodland, or when we support someone to use an axe safely. This latter context can involve very clear instruction giving such as 'You're really putting some energy into swinging that axe, let me show you how to do it more safely.' This is an emphasis on the group member's context over their psychological process but is still as sensitive as possible to the person's process. It might be preceded by 'I can see you really want to split that big log'...

Most of the time, we are functioning as facilitators which requires high levels of awareness of our own experiencing from moment to moment. A way of being aware of levels of contact, and of enhancing client's contact with reality, is to 'show my working' (Mearns & Cooper, 2017) in terms of both the context and peoples' process. Mearns and Cooper (2017, p. 132) state that *'...it can also be very helpful for therapists to 'show their working' to clients. That is if we are feeling unsure of how to respond to a client, or confused or if we are pulled in two different directions, these are all things that we can disclose and this may serve to make us more real in the relationship and hence deepen the encounter'*. We have a broader context in which and about which to choose to give expression to feelings and thoughts when appropriate'...

Our contact-orientated approach includes experiencing 'existential empathy' (Prouty G, 2002. p. 13) for group men, in which we hold in our awareness the realities of their lives and how they live them. This of course includes respecting the realities of peoples' lives and how that affects whether they can come to a session or not.

*'There was no judgement when I just didn't come. It was like, well it'd be nice to see you but if you don't come that's fine.'*

Sessions often look like a social space, and it takes a disciplined approach from us to offer this, like a swan working hard under the surface. My hope is that men who come experience us as genuine, trustworthy, sensitive and warm people who are just spending some time around the fire, in the woods. Asked what it felt like when he first came to a Heart Wood session, Clive responded: 'I was really nervous, you would be nervous wherever you go. But once you got speaking to people, those nerves just went. So, it didn't last long. I found whenever a new person came everybody welcomed them'...

Over 5 years, we have co-created and sustained a particular atmosphere with the men which we feel it is appropriate to describe as ‘a receiving climate’. Bob describes something of it: ‘Yeah, I would say that the group dynamic, it doesn't feel like anyone's above anyone, you're all like among equals. And that just makes it so much better’. There is very little humour based on putting others down, such as sarcastic humour, and we work congruently with such issues ideally when they arise, yet there is lots of lovely humour. There are lots of one-to-one interactions within group process. This is another broadening-out from an image of group therapy taking place within a circle. We do check-in, check-out and eat soup at lunch in the circle and sometimes, if there is something that needs attention, we naturally remain in the circle for longer. Otherwise, as the session unfolds, we move around, facilitators aim to connect one-to-one with each man, and often it is necessary to work with someone for 10 minutes or more by themselves.

In the 2023 novel *Brian*, Jeremy Cooper (p. 17) describes something close to what we seem to create in our groups: ‘He smiled nervously in a general way at the group, two of whom smiled back in an easy-going welcome. Nobody asked him his name or anything about his job...no false familiarity, no banality, no banter, no point scoring, and in those early days Brian felt received with greater warmth by almost all of the shifting band of regulars at the BFI than he had ever experienced anywhere else in his entire life’. The exception to this is that whilst banter is hard to define, I think we have banter which is friendly rather than competitive.

I have been asked by potential group members if we sing or play guitars. I hear this as a fear of something inauthentic and directive of a way of feeling. I am not alone in having experienced activities which are presented as wholesome but which turn out to be extremely inauthentic. It is a privilege to work with a team who are committed to offering something genuinely wholesome and not overly serious, where the culture is about welcoming and prizing everyone who comes. I think Bob describes it well: ‘Seeing everybody each week is nice. Come back, have a laugh, have a cuppa, sit next to the fire, enjoying the soup. It's just something to look forward to each week’.

Since sessions involve moving around physically, we are more likely to touch clients. I am fortunate to have a supervisor who acknowledges that whilst touch can be abusive, it can be just as damaging to not touch someone who needs it. Approaching this sensitively and congruently is of course essential, as is recognising that some people live in intense isolation and appreciate a hand on the shoulder, or a hug, at the right moment. High levels of congruence and sensitivity are necessary within these very personal exchanges. For example, to ask someone if they want a hug, or sometimes to trust that I know someone well enough after a few years of work with them and that a hand on the shoulder or upper arm as I say this thing, or perhaps as they sit in silence, could be very welcome for them right now.

In our work with Heart Wood, high levels of congruence are required to manage boundaries which are

fluid and dynamic due to the nature-based context and the fact that too much ‘admin’ type structure, or organisation-centered rather than person-centered interaction, would lead to participants feeling less welcome because we would seem to be just another service who are overly focused on recording information and protecting themselves. As Bob says, ‘You don't have to fill in paperwork every time, that's a big help. At the other ones [services] it keeps asking how you felt for the last 2 weeks. And I think it's unnecessary really’. We recognise that peoples’ levels of contact are often not able yet to hold a rigid formal contract but that this can evolve over time as trust and safety develop within the group. I think it is unethical to demand that clients focus on administration or form-filling when their capacity to connect with others is fragile. Often, during initial meetings with participants, I own that I'm motivated by being a survivor of trauma myself and that I haven't just read lots of books (although, of course, I've done that too). This is owning my existential reality and being transparent as a way to try to equalise power a bit.

We are constantly assessing and gauging fluid boundaries. We explain time boundaries and the importance of confidentiality, to the whole group sometimes and to individuals who are new to our groups. Other issues, for example safe tool use, are dealt with in a way which combines messages to the whole group with communications with individuals depending on their level of competence. We attend to context and psychological processes at the same time. For example, in the case of a man who often sits but during one session is more active, apparently to use-up angry energy, we aim to acknowledge the energy in that moment and honour his choice to burn it off through axe use. While doing so, we also name the safety boundary by quite clearly, and safely, showing him with a mallet how to use properly use the axe.

We are trying to co-create a community in which power is as equal as possible and, by working things out within relationships with participants, we are expressing our respect for them. This is part of the relational therapy because it recognises participant's autonomy. Whilst we do say things to the whole group, we also do lots of engaging with people one-to-one or in smaller groups of two or three. We do our best to respond, for example to someone who is talking about a member who is not present that day, in the moment to what they're saying and we'll say that we don't feel comfortable talking about them when they're not present. This, in my experience, has always been met with understanding and respect for that absent person.

Higher levels of congruence are needed for pre-therapy/contact work. I have quoted Dion Van Werde in full below because I recognize that the ways of being which are necessary for working with people experiencing psychosis are transferable to those with whom we work, who as I mentioned before might be described as functioning in the ‘high end grey zone’ or having ‘fragile’ styles of processing their experience (Warner, 2000, p. 147).

‘...For me it has to do with levels of congruence of the therapist. People suffering with psychosis are particularly

skilled at knowing from a distance the difference between those who are rooted enough in themselves, sincere and really containing, and those who are going to play tricks on them. Only if the conditions are optimal, I think do people dare to take the risk of really looking at their experiences, especially when these are so private, delicate and anxiety-provoking as are those experiences that are proven to be generators of psychosis' (Van Werde).

Survivors of early, relational trauma are very sensitive to whether people feel safe or not.

It is therefore an important policy of ours to avoid surprises if we can, since these can be included in what Dion means by 'playing tricks'. We once made the mistake of not being clear from the outset that we need to cancel woods-based sessions if the wind is too strong, since there's a danger of falling trees/branches and so forth. We had to cancel a session on the day, and at that time had no

indoor space to use. One man simply didn't believe me, despite my doing my best to explain and reassure him over the phone. Very sadly, he never came back.

Working for 4 hours at a time requires greater levels of presence and congruent, empathic and acceptant relating in more 'real life' type situation and necessarily includes occasional dips in presence in which I am less attentive to levels of contact with the men. These may, for instance, occur when I go to find firewood, or in the moment when I start to eat my soup, or in my getting annoyed at a tangled piece of cord that I need to untangle with cold, wet hands. My contact 'radar' has, to an extent, in these moments turned inwards but it's ready to very quickly turn outwards again. These dips make me human in that I am not presenting a professional facade. The ability to name what happened for me if it feels relevant to the men's experiencing in that moment—showing my working—is important so the men aren't left with not knowing why I seemed, for instance, annoyed. It's honest and transparent to acknowledge that I'm cold and tired, perhaps after I say 'fucks' sake' under my breath. I sometimes say something like 'sorry, I wasn't listening properly then...'

#### One to One

Our one-to-one policy states that we can offer someone some one-to-one space away from the group if they are struggling, for psychological or other reasons, to enter or stay in a group. This can mean agreeing on the phone before the session to meet them in the parking area and walk in to the group space with them, or to meet someone who is in suicidal crisis which prevents them from coming to the group for a walk. Or, it can mean having a phone call with them in similar circumstances. Equally, a man might be unable to come to one of the monthly winter groups due

to illness, so I might meet him for a walk-and-talk session in order to keep up contact with him.

#### Self-Care

This work in three dimensions is enormously demanding of energy whilst also, for me, being less tiring whilst in the sessions themselves. I think this can be attributed to being outside and being physically active as well as being part of a team during sessions. I don't feel the same tiredness and isolation I can feel when working alone indoors. It is also a huge and genuine privilege to work in this way in a growing community space. I find that being the person who is available to take calls and do first meetings with potential group members one-to-one, and knowing the stories and traumas of so many men, can require lots of energy and create vicarious trauma. Self-care is important if I am to be able to respond genuinely and warmly to one of the men when I bump into them in town, or they phone me when they're in a crisis. This happens rarely, which I think is due in

part to the men supporting each other outside of sessions to some extent, and also I think that knowing that they can call is supportive in itself.

The structure of being part of a team of facilitators, having good supervision and of having a trustee board who understand and value what we do is critical. The next two pieces I'll write will discuss the ways in which co-facilitators relate with each other, and how we relate with the living environment in which we work.

**Conflicts of interest.** The author declare that they have no conflicts of interest.

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#### ПРОПОЗИЦІЯ ЗВ'ЯЗКУ У МЕЖАХ БІЛЬШ ШИРОКОГО КОНТЕКСТУ СПІЛЬНОТИ: ГРУПИ HEART WOOD ДЛЯ ЧОЛОВІКІВ

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Наша мета полягає в тому, щоб запропонувати «клімат сприйняття», в якому чоловіки, більшість з яких пережили травму, які знаходяться на першому та другому рівнях концепції процесу психотерапії Карла Роджерса, відчувають достатньо безпечно, щоб почати зміцнювати свої контактні функції (рівні психологічного контакту з собою, іншими та спільним оточенням). З

2018 року ми пропонуємо особистісно орієнтовані чоловічі терапевтичні групи в лісовій місцевості. Члени групи можуть бути в нашій спільноті стільки, скільки їм потрібно. Групи проводяться «орієнтованим на контакт» способом; ми постійно працюємо, щоб оцінити рівень психологічного контакту з членами групи та сприяти зміцненню контакту через рефлексії контакту в групі, орієнтованій на діяльність. Заняття включають рубку дров, організацію багаття і приготування їжі на вогні. Групи складаються з дванадцяти чоловіків і двох-трьох фасилітаторів і мають тривалість від 3 до 4 годин. Сеанси тривають щотижня протягом весни та літа, а потім кожні два тижні протягом осені та зими. Незалежний дослідник щороку оцінює нашу службу через добровільні записані інтерв'ю з чоловіками, які проводяться в лісі біля багаття. Наша фасилітація, орієнтована на особистість, означає, що ми постійно слухаємо та реагуємо на відгуки чоловіків про їхній досвід роботи в групах. Результати цих інтерв'ю та відгуки, які ми отримуємо від чоловіків у групі протягом усього процесу, показують, що ми можемо запропонувати сприятливу атмосферу для цих чоловіків, які значно страждають, але не можуть брати участь у терапії так, як це зазвичай пропонується.

**Ключові слова:** *травма, претерапія, контактна робота, психологічний контакт, робота поза терапевтичним кабінетом, робота на природі, терапевтичне співтовариство*

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**SECTION: MEDICAL PSYCHOLOGY THEORETICAL AND PRACTICAL ISSUES  
РОЗДІЛ: МЕДИЧНА ПСИХОЛОГІЯ ТЕОРЕТИЧНІ ТА ПРИКЛАДНІ ПИТАННЯ**

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**PSYCHOLOGICAL DETERMINANTS AND INTRAPSYCHIC MECHANISMS OF POST-TRAUMATIC GROWTH: A PERSON-CENTERED DIMENSION****Natalia Barinova***V. N. Karazin Kharkiv National University,  
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This article systematizes the phenomenon of post-traumatic growth within the person-centered paradigm. It argues for the limitations of clinical-nosological approaches focused solely on symptom reduction when explaining constructive personality changes under conditions of chronic traumatization. Based on Carl Rogers' phenomenological theory and Stephen Joseph's theory of organismic valuing and growth through adversity, trauma is interpreted as a state of systemic disorganization containing implicit potential for the structural reconstruction of the psyche. The study defines the intrapsychic architecture of growth, which is realized through the synergy of three mechanisms: 1) the reactivation of the organismic valuing process, facilitating the restoration of authenticity and an internal locus of control; 2) the process-based regulation and symbolization of affective experience, necessary for integrating fragmented experiences; and 3) the positive accommodation of the self-concept, involving a cognitive-existential reconfiguration of belief systems. It is established that the dynamic transition from maladjustment to growth is determined by the presence of a facilitating intersubjective environment and the actualization of self-determination resources.

**Keywords:** *post-traumatic growth, person-centered approach, intrapsychic mechanisms, organismic valuing process, disorganization, positive accommodation, symbolization of experience*

**Problem Statement.** Amidst the full-scale war, Ukrainian society has confronted traumatization of an unprecedented scale. Today, psychological science faces the necessity of revising traditional approaches to trauma work, as the pathocentric model—focused exclusively on reducing symptoms of post-traumatic reactions—proves insufficient to encompass the existing continuum of traumatic experience. An overemphasis on psychopathology risks stigmatizing normal reactions to abnormal circumstances and ignores the adaptive potential of the psyche. Consequently, the search for internal personality resources that allow for the integration of traumatic experience into a new self-structure has acquired exceptional relevance. In this context, scholarly interest naturally gravitates toward the concept of post-traumatic growth. However, the direct extrapolation of existing models to the Ukrainian context requires caution. Responding to current challenges, Ukrainian psychological science has made significant progress in addressing constructive personality changes following traumatic events. Significant contributions to the study of psychological stability, resilience, and post-traumatic adaptation have been made by researchers such as Tytarenko (2019), Klymchuk (2021), Zasiakina et al. (2023), Pohorilska and Naidonova (2024), and others.

Despite a substantial body of work, the issue of the intrapsychic mechanisms of post-traumatic growth from the perspective of the person-centered approach remains insufficiently articulated in Ukrainian discourse. Most studies focus on adaptation outcomes or social factors, overlooking the phenomenology of experiencing the state of «disorganization» described by C. Rogers (1959) as a necessary stage for restoring agency under conditions of permanent security threats.

The person-centered approach of C. Rogers, and the theory of organismic valuing and growth through adversity developed within its framework (Joseph & Linley, 2005), offer a relevant methodological lens for resolving this dilemma. The state of disorganization is a consequence of the inability to assimilate threatening experiences into an existing rigid self-concept (Rogers, 1959). However, it is precisely this critical incongruence that paradoxically mobilizes the actualizing tendency – considered the organism's fundamental drive toward preservation and enhancement (Rogers, 1963). In this context, scientific interest shifts toward understanding growth as a result of a deep acceptance of one's own vulnerability (Rogers, 1961) and the restoration of authenticity. Post-traumatic growth is constituted as a practice of living in alignment with an internal locus of evaluation, made possible through the

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positive accommodation of traumatic experience (Joseph, 2011; Wood et al., 2008).

The purpose of the article is to theoretically substantiate the intrapsychic mechanisms of post-traumatic growth within the person-centered paradigm and to identify the key psychological determinants that facilitate the transition from traumatic disorganization to constructive personality changes.

**Analysis of the Problem.** The concept of «post-traumatic growth» was introduced into scientific circulation by R. Tedeschi and L. Calhoun in 1995 and subsequently acquired the status of a measurable psychological construct following the publication of the PTGI in 1996 (Tedeschi & Calhoun, 1995; 1996). Although the term is firmly associated with these researchers, the phenomenon of positive change resulting from trauma is conceptually new neither to psychology nor to a broader range of philosophical and religious teachings, a point repeatedly emphasized by the authors themselves (Tedeschi et al., 2018).

Compelling evidence of reframing trauma in a positive dimension can be historically traced in the narratives of Western and Eastern thinkers (Dickinson, 2024; Gupta & Chaubey, 2024) and is axiomatic to human thought. Stephen Joseph, in developing his own theory of growth through adversity, illustrated this with F. Nietzsche's well-known maxim «What does not kill me makes me stronger» which was reflected in the title of his seminal work (Joseph, 2011).

Almost simultaneously with Tedeschi and Calhoun, the academic discourse was enriched by complementary theoretical models. For instance, C. Park and colleagues proposed the concept of «stress-related growth» and a corresponding questionnaire, viewing growth as a result of meaning-making and cognitive processing of a stressful event (Park, Cohen & Murch, 1996; Park, 2010). In parallel, V. O'Leary and J. Ickovics introduced the concept of «thriving» albeit in the context of women's health. They described thriving as a transformation process that elevates the individual to a level of functioning superior to their premorbid state (O'Leary & Ickovics, 1995).

Within health psychology, G. Affleck and H. Tennen developed the concept of «benefit finding». They emphasized the adaptive function of seeking positive meaning in difficult life circumstances and chronic illnesses (Affleck & Tennen, 1996). A significant contribution to understanding the nature of this phenomenon was also made by A. Maercker and T. Zoellner, who proposed the «Janus Face Model» differentiating between the constructive side of growth and its illusory, self-deceptive component; the latter may serve as a form of psychological defense (Maercker & Zoellner, 2004). Despite terminological discrepancies, all these approaches formed a categorical architecture within which the contemporary understanding of post-traumatic growth crystallized.

However, it must be acknowledged that it was Tedeschi and Calhoun who first conceptualized growth specifically within the context of post-traumatic stress and established an empirical foundation via the PTGI. This

shifted the focus of researchers and practitioners toward studying the positive consequences of traumatic experience coexisting with pronounced disorder symptoms. Despite the apparent paradox of gaining through suffering, the concept of growth expands the possibilities for personality recovery by not focusing exclusively on the maladaptive aspects of a seismic event.

Within the existential-humanistic tradition, the idea that suffering can act not merely as a destructive factor but as a potent catalyst for personal development has been viewed as a fundamental ontological premise. V. Frankl substantiated the concept of «tragic optimism» postulating the human capacity to transform inevitable suffering by seeking and finding meaning in traumatic circumstances. Meaning allows the individual not only to preserve integrity but to ascend to a new level of spiritual maturity in dire life circumstances (Frankl, 1992).

Similar views were expressed by I. Yalom. He elaborated on the idea of confrontation with «boundary situations» – the irreversibility of death, responsibility, isolation, and meaninglessness. These situations destroy neurotic defenses and prompt the individual to transition from a mode of «forgetfulness of being» to a state of authentic existence. Trauma becomes the forced upheaval through which a person reevaluates priorities and abandons the trivial in favor of the essential (Yalom, 1980).

A. Maslow noted that the path to self-actualization often runs through the destruction of an illusory sense of security and a direct encounter with existential reality. This painful experience becomes a prerequisite for shifting from deficiency motivation to the level of B-values. Maslow observed that a significant proportion of self-actualized individuals acknowledged the leading role of life crises and tragedies in their integration and acquisition of wisdom, which allowed them to abandon superficial goals in favor of deeper self-realization (Maslow, 1970).

However, the most systemic and psychologically rigorously verified foundation for understanding the mechanisms of personality transformation following trauma was proposed by Carl Rogers. In Rogers' phenomenological theory of personality, post-traumatic growth is implicitly embedded in the concept of moving toward «full functioning». Rogers viewed a traumatic event not as an isolated pathology but as a state of critical incongruence; such a rupture between the established «self-concept» and a new threatening experience cannot be assimilated using existing defense mechanisms. Consequently, a process of disorganization is triggered, where the rigid structure of the personality disintegrates under the pressure of reality, causing intense anxiety and vulnerability (Rogers, 1959).

Rogers saw a unique potential for change in disorganization. The actualizing tendency of the organism does not vanish during trauma but directs efforts toward reorganizing the psyche at a higher level of complexity. At this threshold moment, the individual needs the necessary conditions of empathic understanding and unconditional acceptance; only then can the organismic valuing process – inherent in every person – integrate the traumatic

experience into a more flexible and realistic «Self» structure. Thus, the characteristics of the fully functioning person according to Rogers (1961) can be viewed as a prototype for the categories of post-traumatic growth.

In contemporary person-centered discourse, the understanding of the intrapsychic dynamics of trauma has been significantly refined. The core of the discussion focuses on the process-oriented aspects of personality. M. Warner (2013), in her concept of «fragile process», argues that traumatization disrupts the person's capacity to modulate the intensity of experience. For a person in this state, direct contact with traumatic material evokes excessive arousal, perceived as an imminent threat of self-disintegration or annihilation. Consequently, growth cannot be forced through cognitive restructuring or cathartic release, as these are likely to trigger protective dissociation. Instead, the mechanism of recovery relies on the careful regulation of affect intensity. This safe containment allows for the restoration of the interrupted cycle of symbolization, thereby returning fluidity to the psychological process.

In turn, D. Mearns and B. Thorne (2000) examine trauma in the theory of «Configurations of Self» as a factor in the formation of a rigid protective part of the personality (e.g., «Self-as-victim»), which blocks the actualizing tendency for the sake of safety. From this perspective, growth is a process of intrapsychic dialogue where the protective configuration is assimilated into a more flexible structure, restoring a lost sense of agency (Mearns, 1999). This picture is complemented by the process-experiential approach of R. Elliott (Elliott et al., 2004), where the mechanism of growth appears as the emotional transformation of automatic schemes (changing one emotion with another) and subsequent meaning-making. R. Knox (2013) adds the necessity of restoring «relational depth» as a condition for restarting the organismic valuing process blocked by interpersonal trauma.

Stephen Joseph, countering dominant cognitive models, provided a new reading of the phenomenon within the person-centered approach. He refuses to view post-traumatic growth as a reduced set of potential positive changes. Instead, Joseph asserts that growth is a manifestation of the innate tendency toward self-actualization, activated by an existential crisis (Joseph, 2015). Joseph subjects the «medical model» to significant criticism for pathologizing natural adaptive processes (Joseph, 2011; 2021). Symptoms of intrusion and avoidance are viewed by him as indicators of cognitive-emotional work to overcome the incongruence between the «self-concept» and the traumatic experience (Joseph & Linley, 2008), excluding their evaluation in the context of disorder symptomatology. He agrees with Rogers that the state of «disorganization» creates the tension necessary to break down rigid structures and rebuild them at a higher level.

Central to S. Joseph's system is the Organismic Valuing Theory of Growth through Adversity, developed jointly with P.A. Linley (Joseph & Linley, 2005). It postulates the existence of an internal «compass» that distinguishes experience beneficial for development from

that which is destructive. Trauma destroys the subjective «assumptive world» (Janoff-Bulman, 1989), causing the person's projection onto the world to become irrevocably distorted. The individual faces a choice of adaptation mechanism: assimilation or accommodation. *Assimilation* is an attempt to return to the previous state by «forcing» new experience into old schemas, leading to psychological fragility (the «glued vase» metaphor). Conversely, *accommodation* involves rebuilding the «Self» structure according to the new reality (the metaphor of «creating a mosaic» from broken pieces). Although the term «accommodation» is generally characteristic of cognitive models (J. Piaget) and describes a mental process, in his theory, Joseph proceeds from the Rogerian premise of organismic valuing.

Joseph also introduces a social context into the model through Self-Determination Theory (Patterson & Joseph, 2007) to explain the role of the individual's internal resources in growth. Successful reorganization depends on a facilitating environment that satisfies basic psychological needs: autonomy, competence, and relatedness. An empathic environment provides the resource to withstand the anxiety of the disintegration of the old worldview. Social pressure and introjects, conversely, activate rigid «conditions of worth» blocking healing and leading to fixation or negative accommodation (Joseph & Linley, 2006). Consequently, the focus of therapy shifts from techniques to creating a safe relationship for restoring contact with the organismic valuing process belonging to every person (Joseph, 2004).

S. Joseph also problematizes the nature of declared changes, warning against illusory growth in accordance with the «Janus Face model» (Maercker & Zoellner, 2004). Illusory growth is a palliative coping strategy, a form of psychological defense or social desirability; it merely mimics well-being but blocks true accommodation of experience. Drawing on C. Ryff's model, the scholar asserts that authentic post-traumatic growth occurs in the plane of eudaimonia. Thus, a valid criterion for healing is not a return to previous levels of comfort or the absence of distress, but a qualitative improvement in functioning in the spheres of autonomy, purpose in life, and depth of relationships (Joseph et al., 2012). In this context, Joseph substantiates the paradox of the coexistence of pain and development: a person may continue to feel sadness and loss, yet their existence becomes more conscious, wise, and authentic, requiring the evaluation of trauma consequences specifically through the expansion of existential competence rather than the achievement of subjective satisfaction (Joseph & Linley, 2008; Joseph, 2011).

**Discussion.** Post-traumatic personality recovery requires a change in epistemological foundations, namely a transition to a non-directive framework of development facilitation. It is worth noting that in the Ukrainian context, growth occurs under conditions of chronic stress, meaning disorganization may have a cyclical character. Post-traumatic growth also cannot be narrowed down to the epiphenomenon of survival, as it is the lawful result of complex intrapsychic work.

The transformation of traumatic experience is ensured by the functioning of three interconnected internal mechanisms:

1. **Reactivation of the Organismic Valuing Process.** Since the natural mechanism is often blocked, its reactivation serves as a mechanism for restoring authenticity, enabling a departure from traumatic fixation. A traumatic event introjects rigid «conditions of worth» into the individual's consciousness—externally imposed scenarios of reaction (e.g., a prohibition on weakness, an imperative of hatred or forgiveness)—which alienate the person from their true experiences. Shifting the locus of evaluation from an external reference circle to an internal one is a necessary prerequisite for growth. Aligning one's life choices with the organism's deep wisdom promotes the restoration of congruence. Consequently, the activation of the psychological factor of authenticity becomes possible (Wood et al., 2008).

An authentic personality is capable of integrating trauma because it does not deny its pain for the sake of conformity to social norms, but acknowledges it as part of its unique path, which is the essential feature of post-traumatic growth.

2. **Processual Regulation of «Fragility» and Symbolization of Experience.** This serves as a vital pathway for processing the affective material of trauma. Phenomenologically, traumatic experience is often «unspeakable», represented in the psyche by fragmented images, somatic reactions, or «states of horror» lacking verbal equivalents. While traditional defense mechanisms (repression, dissociation) aim to isolate this experience, the mechanism of growth involves the restoration of the symbolization process, often disrupted in what M. Warner (2013) defines as «fragile process». In this specific mode of functioning, the psyche struggles to modulate the intensity of emotional pain, leading to either flooding or dissociation.

The essence of this mechanism lies in the gradual titration of affect—regulating the intensity of the experience to a manageable level where «exact symbolization» becomes possible. It involves finding a precise semantic equivalent for the felt sense («exact empathic naming»), thereby transforming «silent horror» into a coherent narrative. Unlike a pre-existing competence, this is a restorative act that re-establishes the connection between somatic signals and their cognitive interpretation. This capacity to maintain a safe distance from the overwhelming pain prevents pathological fixation and allows the frozen traumatic experience to resume its natural processual flow.

3. **Positive Accommodation of the Self-Concept.** This is regarded as the essential mechanism of structural personality changes. Drawing on the model of adaptation to threatening events by S. Joseph and P. Linley (Joseph & Linley, 2005), we assert that post-traumatic growth results from the dominance of positive accommodation processes over assimilation processes. Assimilation represents an attempt to preserve the old model of the world by distorting the reality of the trauma, which is an energy-consuming and maladaptive method. The mechanism of

positive accommodation involves the deconstruction of previous basic beliefs and the construction of new cognitive schemas that account for the fact of trauma but are not limited by it. This is intrapsychic work to expand the self-concept, rebuilding a rigid self-perception into a flexible, realistic identity («I am vulnerable, but resilient; the world is dangerous, but it has meaning»).

This mechanism is closely linked to the existential reevaluation of values described by V. Frankl and I. Yalom. The success of accommodation depends on psychological factors such as cognitive flexibility and the formation of meaning-of-life orientations. It is flexibility that allows the psyche to abandon irrelevant life goals and invest energy in meanings significant for post-traumatic existence.

### **Conclusions.**

1. The expediency of shifting the scientific paradigm in studying the consequences of psychotraumatic events has been substantiated; a transition has been made from the clinical-nosological approach to a phenomenological model of post-traumatic growth. Within the person-centered approach, post-traumatic changes acquire the status of a systemic reconstruction of the personality's self-structure, extending beyond the simple reduction of distress or restoration of homeostasis. The symptom complex of intrusion and avoidance, as well as the state of personal disorganization, are interpreted as valid phenomenological markers of the psyche's intense adaptive work. Such a view legitimizes suffering as a necessary stage in seeking a new configuration of the Self and actualizing the subject's eudaimonic potential under conditions of crisis experience.

2. It has been established that the productive transformation of traumatic experience is realized through the complementary interaction of three intrapsychic mechanisms that ensure the transition from protective assimilation strategies to constructive accommodation, namely:

1) Reactivation of organismic valuing performs the function of restoring internal regulation. Organismic valuing, inherent in every human, is capable of differentiating authentic needs from normative scenarios of experiencing introjected by society.

2) Symbolization of affective experience (via the regulation of intensity within the «fragile process») ensures the integration of traumatic material by transforming dissociated somatic impressions into a coherent narrative, thereby restoring the interrupted flow of experiencing.

3) Positive accommodation of the Self-concept serves the cognitive-semantic reconstruction; it replaces rigid worldview schemas with a more flexible identity, implying the recognition of one's own vulnerability as an existential given.

3. Based on the analysis of processual mechanisms and their methodological operationalization, the architecture for empirical research into the psychological factors of post-traumatic growth has been defined. It is theoretically grounded that the effectiveness of intrapsychic trauma processing is determined by a configuration of specific

resources covering the motivational, cognitive, and intersubjective spheres of the personality. The foundation for restoring organismic valuing is provided by self-determination resources: satisfaction of basic psychological needs for autonomy, competence, and relatedness, which, combined with a high level of self-acceptance and an intention toward personal growth, create conditions for the functioning of an internal locus of control.

Simultaneously, the capacity for structural changes in the self-concept is defined by the specificity of cognitive-worldview accommodation, specifically the balance between positive and negative reconstruction of beliefs, where the key factor is a constructive change in worldview allowing the integration of traumatic experience into a more complex cognitive schema, as opposed to rigid assimilation. Important predictors of growth are also identified as intersubjective resources: the quality of interpersonal support and a sense of belonging—which provide the necessary facilitating environment for the safe «containment» of affect and the reduction of the risk of pathological fixation on trauma, since without external conditions of safety, the launch of the organismic process is impossible.

#### Author Contributions:

**Illia Yermak.** Theoretical analysis and systematization of scientific sources, writing the main text of the article;

**Natalia Barinova.** Formulation of the research aim and objectives, definition of the methodology, general editing of the article.

**Conflicts of interest.** The authors declare that they have no conflicts of interest.

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#### ПСИХОЛОГІЧНІ ДЕТЕРМІНАНТИ ТА ІНТРАПСИХІЧНІ МЕХАНІЗМИ ПОСТТРАВМАТИЧНОГО ЗРОСТАННЯ: ОСОБИСТІСНО-ЦЕНТРОВАНИЙ ВИМІР

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У статті систематизовано феномен посттравматичного зростання в межах особистісно-центрованої парадигми. Обґрунтовано обмеженість клініко-нозологічних підходів, зосереджених виключно на редукції симптомів, у поясненні конструктивних особистісних змін в умовах хронічної травматизації. На основі феноменологічної теорії Карла Роджерса та теорії організмичного оцінювання і зростання в умовах негарездів Стівена Джозефа травму інтерпретовано як стан системної дезорганізації, що містить імпліцитний потенціал для структурної реконструкції психіки. Визначено інтрапсихічну архітектуру зростання, яка реалізується через синергію трьох механізмів: 1) реактивації процесу організмичного оцінювання, що сприяє відновленню автентичності та внутрішнього локусу контролю; 2) процесуальної регуляції та символізації афективного досвіду, необхідної для інтеграції фрагментованих переживань; 3) позитивної акомодатії Я-концепції, що передбачає когнітивно-екзистенційну реконфігурацію системи переконань. Встановлено, що динамічний перехід від дезадаптації до зростання детермінується наявністю фасилітативного інтерсуб'єктивного середовища та актуалізацією ресурсів самодетермінації.

**Ключові слова:** *посттравматичне зростання, особистісно-центрований підхід, інтрапсихічні механізми, процес організмичного оцінювання, дезорганізація, позитивна акомодатія, символізація досвіду.*

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## OPERATORY THINKING: CONCEPTUALIZATION, PSYCHODIAGNOSTICS AND METHODOLOGY STANDARDIZATION

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This paper presents a comprehensive study of the phenomenon of operatory thinking as a specific form of cognitive-affective functioning characterized by a reduction in symbolic activity, a deficit in the mental representation of emotional experiences, and an excessive attachment to concrete reality. The relevance of this research is determined by the increasing prevalence of psychosomatic disorders in modern psychological practice, where up to 60–80% of individuals demonstrate symptoms of somatization of psychological distress. The aim of the article is the theoretical and methodological conceptualization of the phenomenon of operatory thinking through the systematization of its structural and functional characteristics within seven interrelated domains of mental functioning, as well as the development and standardization of psychodiagnostic instruments for identifying individuals with a heightened risk of psychosomatic disorganization. The study conducts a systematic analysis of the theoretical legacy of the Paris Psychosomatic School (P. Marty, M. de M'Uzan, C. Smadja), identifying seven main domains of operatory thinking manifestation: linguistic (reduction of the symbolic function of language, concreteness, avoidance of metaphoricality), social (disturbance of interpersonal distance, conformity, formalization of contacts), psychodynamic (deficit of sublimation, disturbance of affect regulation, instability of object relations), cognitive (reduction of imaginative life, dominance of concrete thinking, rigidity of cognitive schemas), behavioral-activity (monotony of activity, emotional detachment), emotional-affective (alexithymia, somatization as a form of expression, disruption of emotional differentiation), and the domain of interaction with external reality (hyperinvestment in the external, dependence on social norms). The result of the research is the development of a psychodiagnostic questionnaire of operatory thinking comprising 122 items and 12 scales: energetic-motivational rigidity, alexithymia, control and cognitive rigidity, affective isolation, deficit of imagination and symbolization, avoidance of personal contact, social adaptive dependence, emotional-semantic reduction, emotional distance, deficit of emotional attachment, operational approach to emotions, and rationalization of affect. This methodology operationalizes key theoretical constructs and enables differentiated diagnostics of the intensity of particular components of operatory functioning. The practical significance of the work lies in creating a valid instrument for identifying individuals belonging to the psychosomatic risk group in psychological counseling and psychotherapeutic practice. The integration of classical psychoanalytic concepts with contemporary research in mentalization (P. Fonagy), neurobiology of emotions (A. Damasio), and somatic psychology (P. Ogden) opens new perspectives for understanding psychosomatic phenomena and for developing psychocorrective strategies aimed at enhancing reflexive function, emotional literacy, and symbolic activity.

**Keywords:** *psychodiagnostics, salutogenic approach, phenomenology of the embodied self, psychological well-being, psychosomatics, operatory thinking, psychoanalytic approach, alexithymia*

### INTRODUCTION

Operatory thinking constitutes one of the key concepts of the Paris Psychosomatic School, which has profoundly transformed the understanding of psychosomatic phenomena in contemporary medical psychology and psychoanalysis. The term, introduced by French psychoanalysts Pierre Marty, Michel de M'Uzan, and Claude Smadja in the late 1960s and early 1970s, describes a specific form of cognitive functioning characterized by excessive attachment to concrete reality, impoverishment of symbolic activity, and reduction of the mental representation of emotional experiences [1–6].

The fundamental works of Pierre Marty, *The Psychosomatic Order* (1980) and *Mentalization and Psychosomatics*, established the methodological foundations for understanding the relationship between cognitive features and the predisposition to somatization. Michel de M'Uzan, in his work *The Same and the Other*, developed the concept of operatory thinking within the context of object relations, while Claude Smadja, in his monograph *Psychosomatic Research*, systematized the diagnostic criteria of this phenomenon.

The analysis of studies dedicated to the problem of operatory thinking makes it possible to construct a

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theoretical model that reflects the structural qualities of operatory thinking, which are integrated into seven domains [1–6].

### STATEMENT OF THE PROBLEM

The relevance of studying operatory thinking is determined by the increasing prevalence of psychosomatic disorders in contemporary practice. Understanding the mechanisms of operatory thinking and the ways to diagnose it enables psychologists to identify individuals at risk of developing psychosomatic pathology and to design adequate corrective and developmental intervention strategies.

Although the Paris Psychosomatic School has made fundamental contributions to the conceptualization of the phenomenon of operatory thinking and its role in the pathogenesis of psychosomatic disorders, many aspects of this issue remain insufficiently developed, which considerably limits its practical application in psychological practice.

A systemic integration of the structural-functional characteristics of operatory thinking, the analysis of the works of the Paris School (Pierre Marty, Michel de M'Uzan, Claude Smadja), and related research on alexithymia (Peter Sifneos, Graeme Taylor), mentalization (Peter Fonagy, Anthony Bateman), and somatic psychology (Joyce McDougall, Didier Anzieu) reveals a substantial fragmentation in the description of operatory functioning manifestations. There is no unified systemic or metatheoretical framework that synthesizes linguistic (reduction of the symbolic function of language, deficit of metaphoricity), cognitive (disturbance of imaginative activity, rigidity of cognitive schemas, deficit of reflexive function), emotional (alexithymia, somatization of affects), behavioral (monotony of activity), social (conformity, disturbance in the regulation of interpersonal distance), psychodynamic (deficit of sublimation, disturbance of object relations), and perceptual (hyperinvestment in external reality) parameters into an integral conceptual matrix with a defined hierarchy of intercomponent relationships. This gap complicates the understanding of the ontogenetic mechanisms underlying the formation of the phenomenon and the development of psychocorrective interventions [1–6; 7; 9; 11–14].

A critical deficit of comprehensive and valid psychodiagnostic instruments. The fundamental limitation lies in the lack of standardized and psychometrically substantiated tools for the comprehensive quantification of operatory thinking. The Toronto Alexithymia Scale (TAS-20, Taylor et al.), despite its high reliability ( $\alpha=0.81$ ), focuses exclusively on the emotional-cognitive aspect (difficulty identifying and describing feelings, externally oriented thinking), leaving out linguistic, social, psychodynamic, and behavioral parameters. The Bermond–Vorst Alexithymia Questionnaire (BVAQ) and the Levels of Emotional Awareness Scale (LEAS, Lane et al.) are likewise limited to the emotional domain. Claude Smadja's clinical methods, though possessing high content validity, remain subjective and dependent on the diagnostician's qualifications, which makes them

unsuitable for use in mass studies and screening procedures.

The absence of psychodiagnostic tools in psychological practice, along with the fact that the concept of operatory thinking is scarcely represented in scientific discourse and absent from the curricula of psychology training programs, produces a critical deficiency of standardized methodologies. This makes it impossible to identify individuals at psychosomatic risk in psychology, psychological counseling, psychotherapy, and crisis psychology. As a result, systemic underdiagnosis persists, characterized by deficits in the mental representation of emotional experiences, which manifest as somatized forms of psychological distress and lead to inadequate assistance, since traditional insight-oriented approaches prove ineffective in the absence of specialized interventions [1–6; 7; 16–18].

The lack of differentiated diagnostics for components of operatory functioning and existing tools does not allow for a profile assessment of individual components with the identification of an individual psychological profile. Clinical practice demonstrates pronounced heterogeneity of manifestations: predominance of emotional reduction with preserved cognitive flexibility, cognitive rigidity with preserved emotional identification, or social hyperconformity with relatively intact emotional life. The absence of targeted diagnostics makes it impossible to develop personalized psychocorrective programs, which is critically important for evidence-based psychological support.

The lack of an integrative methodological framework for psychosomatic vulnerability is characterized by methodological fragmentation: psychoanalytic concepts (operatory thinking) are developed in isolation from cognitive-behavioral models. Data on disorders of interoceptive awareness are insufficiently integrated with psychological observations, the concept of mentalization is rarely correlated with the psychosomatic discourse, and research on the impact of early attachment is poorly integrated with the theory of operatory thinking. This narrows the prospects for interdisciplinary dialogue and hinders the development of comprehensive models of the psychosomatic profile [1–6; 7; 9; 11–14; 17–19; 20].

There is a lack of representative data on the prevalence of operatory thinking in various socio-demographic and age cohorts, basic normative indicators, and the ontogenetic dynamics remain unclear (age-related developmental patterns, critical sensitive periods, influence of early attachment, role of trauma), as well as gender-specific features considering sociocultural factors. A critically important issue concerns the ontological status of the phenomenon: whether operatory thinking is a stable personality trait, a situational reactive state, or a continuum, which determines the possibilities for psychological intervention and the prognosis for psychotherapy.

Insufficient prognostic research on operatory thinking as a predictor of psychosomatic disorders. Despite theoretical postulates regarding the causal relationship, empirical data remain limited and contradictory.

Prospective longitudinal studies are lacking. Critically absent are data on the specificity of correlations between subcomponents of operator thinking and nosological forms: cardiovascular (hypertension, ischemic heart disease), gastroenterological (peptic ulcer disease, irritable bowel syndrome), dermatological (psoriasis, eczema), respiratory (bronchial asthma), endocrine (type 2 diabetes), and rheumatological (rheumatoid arthritis, fibromyalgia) disorders.

Theoretical and empirical differentiation of operator thinking from related phenomena remains unclear: alexithymia (a component, not synonymous), normopathy, mentalization deficit, impairment of reflective function, dissociative states, depersonalization, emotional numbing, repressive coping.

Ontogenetic mechanisms of formation are insufficiently studied: the role of the quality of early attachment, maternal emotional attunement, the function of mental representation of affects, the impact of early trauma, the importance of emotional vocabulary and symbolic play. Preventive programs for risk groups have not been developed (children with histories of hospitalization, separation, emotional deprivation; adolescents with difficulties in emotional regulation). Early screening tools for childhood and adolescence are absent [1–6; 7; 9; 11–14].

Thus, the problematics of operator thinking remain conceptually underdeveloped, empirically insufficiently researched, and praxeologically limited in implementation in contemporary psychological practice. Numerous methodological and empirical gaps determine the necessity of systematic interdisciplinary research integrating psychoanalytic, cognitive, neuropsychological, developmental, and sociocultural perspectives. The development of a valid, culturally sensitive, standardized Ukrainian-language psychodiagnostic instrument for a multidimensional assessment of operator thinking constitutes a primary task for psychology, opening prospects for early identification of individuals at psychosomatic risk, development of personalized psychotherapeutic strategies, creation of preventive programs, deepening understanding of mechanisms, and improving the quality of psychological care for the population.

An analysis of research reveals significant progress in the study of operator thinking and related psychosomatic constructs. A systematic review of scientific literature from 2000 to 2025 identifies key research directions deepening the understanding of mechanisms of operator functioning and its role in the pathogenesis of psychosomatic disorders.

The review by Georgia Panayiotou et al. in the Annual Review of Psychology systematizes fifty years of research on alexithymia as a multidimensional construct, emphasizing the need for facet-oriented analysis. A meta-analysis by Jihwan Chen et al. established a 35% prevalence of alexithymia among patients with schizophrenia (95% CI: 32–38%), indicating the transdiagnostic nature of the disturbances. Data by Filippo Porcelli and Graeme Taylor on 1,190 patients revealed that

15.8% met DCPR criteria for alexithymia, while cluster analysis identified five clinical subtypes, underscoring the heterogeneity of the phenomenon [9; 11–14].

A systematic review by Susan Van Bael et al. included 32 studies and established a meta-analytic link between alexithymia and aspects of interoception. Global alexithymia was positively associated with interoceptive confusion and autonomic nervous system reactivity but negatively correlated with interoceptive accuracy, trust, and self-regulation, especially for facets of difficulties identifying and describing feelings. The three-component model by Samantha Garfinkel et al. differentiates interoceptive accuracy, sensitivity, and awareness. Research by Ji Li et al. identified differentiated patterns of connections: for somatization, key factors included non-distraction, attention regulation, emotional awareness, and noticing.

Studies by Ali Rostami and Mahnaz Mehdiabadi using SEM revealed that emotional neglect had a direct effect on psychosomatic complaints and an indirect effect mediated by mentalization. A longitudinal study by Nina-Lisbeth Schwarzer et al. demonstrated that mentalization predicts well-being and emotion regulation strategies. A review by Karsten Schnabel et al. identified difficulties at various stages of the emotion regulation process in individuals with functional somatic symptoms.

Itai Shalev and Guy Yaacobi, in experiments, introduced the concept of psychosomatic congruence, demonstrating that focusing on pleasant bodily parts can induce congruent mental content and regulate emotional distress.

A systematic review by Matthias Heime et al. analyzed 31 RCTs of interoception-based interventions: 64.5% showed superior efficacy compared to controls, especially for PTSD, irritable bowel syndrome, and fibromyalgia. Studies by Lindsey Igra et al. confirmed the transdiagnostic nature of emotional dysregulation: all dimensions of emotion regulation difficulties correlated with depression, anxiety, and somatization in schizophrenia, emotional disorders, and control groups. Erika Welkoff et al. established a linear association of interoceptive deficits with suicide severity.

Giovanni Fava et al. emphasized the importance of Diagnostic Criteria for Psychosomatic Research (DCPR). Weiwei Zhou et al. noted the widespread application of neuroscientific methodologies in studying causal mechanisms and correlations between brain functioning and clinical manifestations. Studies using the BMAIA-2 revealed differentiated predictive patterns of interoceptive sensitivity for eating pathology [1–6; 7; 9; 11–14; 17–20].

Thus, the literature analysis demonstrates substantial progress in understanding the multidimensional nature of operator thinking, its neuropsychological mechanisms, the role of interoceptive awareness and mentalization deficits, which forms the foundation for developing innovative diagnostic tools and therapeutic strategies in psychology.

**The objective is to develop** a theoretical and methodological conceptualization of the phenomenon of operator thinking through the systematization of its structural and functional characteristics across seven

interrelated domains of mental functioning (linguistic, social, psychodynamic, cognitive, behavioral-activity, emotional-affective, and the sphere of interaction with external reality); to conduct the validation and standardization of a psychometric instrument for the diagnosis and quantitative assessment of the intensity of operatory thinking functioning as a factor of psychosomatic vulnerability and a predictor of deficits in mental representation and increased risk of psychosomatic disorganization.

### **PRESENTATION OF CORE MATERIAL**

The scope of scientific development of the problem requires a systematic analysis of the concept of operatory thinking through the prism of its seven main domains of manifestation: linguistic, social, psychodynamic, cognitive, activity characteristics, emotional, and the sphere of interaction with external reality.

#### **I. Linguistic Domain: Linguistic Markers of Operatory Functioning**

The speech characteristics of patients with operatory thinking were described in detail by P. Marty and his colleagues as one of the most evident diagnostic indicators of this phenomenon. In his monograph "Operatory Life," P. Marty emphasizes that the speech of such individuals is marked by a "white," colorless quality, devoid of metaphorical content and emotional resonance [1–3].

##### **Reduction of the Symbolic Function of Language.**

Patients with operatory thinking demonstrate a marked impoverishment of the ability to verbalize inner experiences. Their speech focuses primarily on describing concrete facts, events, and external details, avoiding subjective interpretations and emotional connotations. M. de M'Uzan, in his work "Operatory-Type Functioning," notes that such patients use language not as a tool for symbolization and communication of their inner world, but rather as a technical means of transmitting factual information [4;5].

Clinical studies by C. Smadja have revealed a significant decrease in the use of emotionally charged vocabulary in the speech of individuals with operatory thinking. Analysis of psychoanalytic sessions showed that these patients rarely employ words denoting feelings (joy, sadness, fear, anger), instead preferring descriptive terms that narrate actions and events. This phenomenon correlates with the concept of alexithymia introduced by P. Sifneos; however, operatory thinking is a broader construct that includes not only difficulties in identifying emotions but also a specific cognitive organization.

##### **Concreteness and Attachment to Actuality.**

A distinctive feature of linguistic production in operatory thinking patients is excessive concreteness and a focus on the present moment. P. Marty and M. de M'Uzan, in their pioneering work "Operatory Thinking," described the tendency of such individuals to avoid discussions of the past and future, limiting themselves to descriptions of immediately actual events. This is associated with a deficit in the mental representation of temporal perspective and difficulties in integrating biographical narrative.

Research by D. Anzieu in his foundational work "The Skin-Ego" indicates that such patients have difficulty constructing metaphorical descriptions, which reflects a general deficit in symbolization. Metaphor, as a linguistic tool, requires the ability to abstract and establish associative links between various levels of experience—a process problematic for operatory functioning [1–6; 7; 9; 11–14].

##### **Avoidance of Intimate Self-Presentation.**

Patients with operatory thinking display a tendency to avoid "soulful conversations" that require self-critical reflection and disclosure of the inner world. C. Smadja associates this with the defensive function of operatory thinking, which protects the psychic apparatus from encounters with potentially traumatic affective material. In the psychotherapeutic context, such patients often complain about the difficulty of maintaining lengthy discussions about relationships, memories, or future plans, preferring to discuss practical matters.

The research of J. McDougall in the monograph "Theatres of the Body" expands the understanding of this phenomenon, indicating that difficulties in verbalizing experiences correlate with a tendency for somatic expression of psychological distress. When language cannot fulfill the function of symbolization and discharge of affect, the body becomes the arena for expressing unresolved emotional conflicts.

#### **II. Social Domain: Features of Interpersonal Functioning**

The social domain of individuals with operatory thinking is characterized by specific interaction patterns that reflect profound difficulties in regulating interpersonal distance and establishing emotionally rich contacts.

##### **Disturbance in Regulation of Interpersonal Distance.**

P. Marty described that patients with operatory thinking experience difficulties in determining optimal distance in relationships, oscillating between excessive closeness and cold detachment. This is related to a deficit in Self-Object differentiation described by M. de M'Uzan, resulting in an inability to form stable object relations with appropriate boundaries.

Clinical observations by C. Smadja indicate that such individuals often report discomfort in response to expressions of emotional closeness from others. This can be understood as a defense against the threat of disintegration arising from intense affective contact. At the same time, these patients may exhibit excessive dependence on social approval, striving to meet all expectations of those around them [1–6].

##### **Conformity and Orientation toward External Norms.**

Research from the Paris School of Psychosomatics has found that individuals with operatory thinking are marked by pronounced conformity and excessive orientation toward social norms. M. Fine in "Structure and Functions in Psychosomatics" associates this with a deficit of internal psychic structure, compensated by rigid attachment to external rules and expectations.

Such patients often exhibit "normopathy"—a term introduced by C. Bollas to describe the compulsive need to

be “normal” and to conform to social standards. This manifests as difficulty refusing others, avoidance of conflict at any cost, and a tendency toward self-sacrifice to preserve social harmony. J.-B. Pontalis in his works emphasized that such excessive adaptability paradoxically leads to increased vulnerability to somatization [20;21].

#### **Formalization of Interpersonal Contacts.**

The relationships of individuals with operatory thinking are often formal and stereotypical in nature. P. Marty noted that such individuals are prone to establishing “functional” relationships based on clearly defined roles and responsibilities, avoiding emotional spontaneity and unpredictability. This reflects a general tendency toward structuring and control as a means of compensating for internal psychic instability [1–3].

Research by R. Debré in the monograph “The At-Risk Infant” indicates that the origins of such interpersonal patterns may stem from early disturbances in the mother–child system. A lack of emotional attunement in early life can lead to the formation of an operatory style of functioning as an adaptive strategy in response to emotional deprivation.

#### **Difficulties with Empathic Resonance.**

Patients with operatory thinking frequently demonstrate a reduced ability to recognize and resonate with the emotional states of others. M. de M’Uzan associated this with a deficit in affective mentalization—the capacity to understand mental states (one’s own and others’) in terms of mental processes. P. Fonagy, in his work on mentalization, expanded this understanding by highlighting the relationship between deficits in reflective function and the tendency toward somatization.

### **III. Psychodynamic Domain: Affective Regulation and Object Relations**

The psychodynamic characteristics of operatory thinking constitute a central aspect of this phenomenon’s conceptualization within the Paris Psychosomatic School.

#### **Deficit of Sublimation and Creative Activity.**

P. Marty emphasized that operatory functioning is marked by a significant limitation in the capacity for sublimation—the transformation of instinctual energy into socially acceptable forms of creative activity. Patients with operatory thinking rarely derive satisfaction from art, literature, or other forms of symbolic activity, reflecting a general impoverishment of imaginative life.

C. Smadja expands upon this point, noting that creative activity requires the capacity for “regression in the service of the ego”—a concept introduced by E. Kris. Operatory thinking, characterized by rigidity of psychic functioning, impedes such productive regression, limiting access to primary thought processes and symbolic material.

#### **Disturbance of Affective Regulation.**

A central feature of operatory thinking is insufficient psychic processing of affects. M. de M’Uzan described this as an “absence of an inner theater”—a deficit in the ability for internal dramatization and experiencing emotional states in psychic space. Instead, affects are either blocked or discharged directly through somatic channels [4;5].

Research by L. Kreisler in the field of child psychosomatics revealed that children with operatory

functioning demonstrate difficulty channeling emotional energy into constructive activity or symbolic play. This leads to the accumulation of unreleased affective tension, increasing the risk of somatic decompensation.

#### **Disturbance of Object Relations.**

M. de M’Uzan’s concept of “basic object relations” emphasized that operatory thinking is associated with the formation of superficial, unstable object relationships. Patients often describe relationships that break off without apparent reason, reflecting difficulty sustaining lasting emotional attachments.

P. Marty linked this to the concept of “desomatization”—a process opposite to somatization—in which the external object performs a function of regulating internal psychosomatic balance. Upon loss of such an object, individuals with operatory thinking lose an external support for affect regulation, which may lead to somatic decompensation [4;5].

#### **Difficulties Expressing Aggression and Tenderness.**

Studies from the Paris School have found that individuals with operatory thinking experience specific difficulties both in expressing aggressive and tender feelings. J. McDougall described this as a result of the “desymbolization” of aggressive drive, leading to its somatic expression. At the same time, tenderness—which requires the ability for emotional closeness and vulnerability—is likewise problematic for operatory functioning.

C. Smadja emphasized that avoidance of confrontation at all costs, characteristic of these patients, leads to the accumulation of unexpressed aggressive affects, potentially contributing to the development of psychosomatic symptoms. P. Marty’s concept of “psychic masochism” suggests that such individuals often turn aggression against themselves, manifesting as somatic symptoms [1;2;3].

### **IV. Cognitive Domain: Features of Mental Organization**

The cognitive characteristics of operatory thinking represent its most evident and well-studied aspect.

#### **Reduction of Imaginative Life.**

P. Marty described operatory thinking as characterized by a “disappearance of imaginative life.” Patients rarely daydream, possess limited fantasy activity, and report impoverished, dull dreams. This is radically different from neurotic functioning, where the inner world of fantasies is rich and dynamic [1–3].

M. de M’Uzan expands on this notion, suggesting that operatory thinking constitutes “thinking without a dreamer.” The absence of active imaginative activity leads to the loss of one of the psychic apparatus’s key mechanisms for processing conflicts and regulating affects [4;5].

#### **Dominance of Concrete Over Abstract Thinking.**

The cognitive style of individuals with operatory thinking is marked by an excessive attachment to concrete reality and difficulty with abstraction. C. Smadja emphasized that such patients prefer logic over intuition, clear instructions over creative problem solving, and structured activity over spontaneous engagement.

Research by G. Taylor in the context of alexithymia revealed a correlation between a concrete cognitive style and a reduced capacity for symbolization. Patients with operatory thinking struggle to understand metaphors, symbols, and abstract concepts, reflecting a general deficit in secondary process thinking which, according to Freud, serves as the foundation for symbolic activity.

#### **Rigidity of Cognitive Schemas.**

P. Marty described operatory thinking as characterized by cognitive rigidity—the difficulty in changing perspectives, considering alternative scenarios, and adapting to new information. This is connected to an excessive need for systematization and categorization of experience, which compensates for internal psychic instability. M. de M'Uzan, in his concept of “thought without psychic quality,” indicated that operatory thinking functions mechanically, without emotional resonance or personal investment. This results in the automatization of cognitive processes and reduced adaptability [1–3; 4;5].

#### **Impairment of Reflexive Function.**

Contemporary research on mentalization initiated by P. Fonagy has extended the understanding of cognitive features of operatory thinking. These patients have significant difficulty analyzing their own inner experiences, seldom reflect on the causes of their emotions, and demonstrate a reduced capacity for self-observation.

A. Bateman and P. Fonagy, in “Mentalization-Based Psychotherapy,” argued that a deficit in reflexive function correlates with an increased risk of somatization. When an individual cannot “think about thinking” and process psychic experience at a symbolic level, the body becomes the primary channel for the communication of distress [7;12;15].

#### **V. Characteristics of Activity: Quality of Life**

The sphere of activity of individuals with operatory thinking is characterized by specific patterns that reflect a general reduction of vitality and spontaneity.

#### **Monotony and mechanical nature of activity.**

P. Marty described the life of patients with operatory thinking as an “operatory existence” — a monotonous sequence of stereotypical actions deprived of emotional coloring and creative spontaneity. Such activity has a compulsive character, aimed rather at the discharge of tension than at obtaining satisfaction.

K. Smadja indicates that monotonous activity performs for these patients the function of calming and regulating internal tension. However, unlike neurotic compulsiveness, which has symbolic meaning, operatory activity is “empty” — deprived of psychic content and conflictual significance [1–3; 4; 5; 6].

#### **Emotional detachment from activity.**

A characteristic feature of operatory functioning is the dissociation between actions and emotional experiences. M. de M'Uzan described this as “de-affectivation” of activity — the absence of emotional resonance even in response to objectively significant events.

The studies of D. Anzieu indicate that such emotional detachment may be understood as a defense mechanism against the threat of psychic disintegration. However,

chronic emotional anesthesia leads to a sense of inner emptiness and an impoverishment of quality of life [4; 5; 14].

#### **Orientation toward survival and duty.**

P. Marty emphasized that the activity of individuals with operatory thinking is directed primarily at satisfying basic needs and fulfilling obligations rather than at obtaining pleasure or self-realization. This reflects a general reduction of libidinal investment in life activities.

J. McDougall, in her works, develops this statement, indicating that patients with operatory thinking often describe life as “boring” and “monotonous,” despite the objectively present variety of activities. This is related not to an external poverty of stimulation but to an internal incapacity for emotional investment and the experience of pleasure [13].

#### **Chronic fatigue and exhaustion.**

Clinical observations of the Paris School revealed that patients with operatory thinking often complain of a sense of chronic fatigue and exhaustion without evident physical causes. P. Marty associated this with the constant expenditure of psychic energy required to maintain operatory functioning and to suppress affects.

K. Smadja develops this understanding, indicating that the absence of the possibility for psychic discharge through symbolization leads to the accumulation of internal tension, which manifests in the form of somatic fatigue. This may be an early sign of the risk of somatic decompensation [6].

### **VI. Emotional Sphere: Affective Life and Its Disturbances**

The emotional sphere constitutes the core of disturbances in operatory thinking, directly linking cognitive features with the risk of somatization.

#### **Emotional emptiness and alexithymia.**

P. Marty described “emotional emptiness” as a central characteristic of operatory functioning. Patients often complain of a sense of inner emptiness, an inability to experience either positive or negative emotions with appropriate intensity.

The concept of alexithymia, introduced by P. Sifneos and developed by G. Taylor, is closely related to operatory thinking. Alexithymia includes difficulties in identifying feelings, difficulties in describing feelings, externally oriented thinking, and limited imaginative activity. However, as emphasized by K. Smadja, operatory thinking is a broader concept that encompasses not only affective but also cognitive and interpersonal disturbances.

#### **Somatization as a form of emotional expression.**

M. de M'Uzan developed the concept of “regressive somatization” — a process in which affects that are not processed on a psychic level find expression through bodily symptoms. J. McDougall, in her monograph *Theaters of the Body*, expanded this understanding, describing the body as a “stage” on which what cannot be articulated in words is enacted.

P. Marty's research revealed that the emotional reactions of patients with operatory thinking often manifest through the body — accelerated heartbeat, muscle tension, gastrointestinal symptoms — without

awareness of the emotional component of these sensations. This reflects a deficit in differentiation between affective and somatic states [1–3].

#### **Disturbances of emotional differentiation.**

Patients with operatory thinking experience difficulties in distinguishing different emotional states from one another. K. Smadja described this as “global undifferentiation of affects” — the inability to recognize subtle differences among various emotional experiences.

Research by L. Greenberg within the framework of emotion-focused therapy confirms that the capacity for emotional differentiation is key to adaptive emotional regulation. The deficit of this capacity in operatory thinking leads to disturbances in affective regulation and an increased risk of somatization.

#### **Deficit of recovery after emotional experiences.**

P. Marty described that patients with operatory thinking have significant difficulties in restoring psychic balance after emotionally intense events. This is associated with insufficiency of psychic mechanisms for working through affective experiences.

M. de M’Uzan, in his concept of “progressive disorganization” (*désorganisation progressive*), indicated that repeated episodes of emotional overload without adequate psychic processing may lead to cumulative disintegration of the psychosomatic balance, culminating in the development of somatic illness [1–3; 4; 5].

#### **Rationalization of emotions.**

A characteristic defensive strategy of individuals with operatory thinking is the tendency to provide rational explanations for their emotional states. K. Smadja emphasized that such rationalization serves to avoid direct confrontation with affect, translating emotional experience into the cognitive register [6].

However, as noted by J. McDougall, this rationalization is superficial and does not lead to genuine insight or emotional resolution. Instead, it maintains emotional distance from inner experiences, promoting chronic alexithymia and increasing the risk of somatic expression of distress.

#### **Delayed and postponed emotional reactions.**

Clinical observations by P. Marty revealed that emotional reactions in patients with operatory thinking are often delayed or postponed in time. An individual may fail to respond emotionally to an objectively significant event at the moment of its occurrence, while the emotional reaction (often in the form of somatic symptoms) may appear much later.

This phenomenon is related to what P. Marty called the “anti-representational function” of operatory thinking — the blocking of mental representation of emotionally charged experience. However, as K. Smadja points out, the unprocessed affect does not disappear but “returns” through the somatic channel [1–3; 4; 5; 6; 24].

### **VII. External Reality: Relations with the Objective World**

The sphere of interaction with external reality reveals the fundamental characteristics of operatory thinking, associated with a disturbed balance between the inner and outer worlds.

#### **Excessive investment in external reality.**

P. Marty emphasized that operatory thinking is characterized by hyperinvestment in the external, concrete reality at the expense of inner psychic life. Patients perceive life as a sequence of external events rather than as a continuum of internal experiences that give meaning to those events.

M. de M’Uzan developed this idea in his concept of the “external object” — the tendency of individuals with operatory thinking to rely on external objects and circumstances for the regulation of psychosomatic balance. This leads to excessive dependence on external conditions and heightened vulnerability to life changes [1–3; 4; 5; 23].

#### **Dominance of objective facts over subjective sensations.**

The cognitive style of individuals with operatory thinking is characterized by excessive trust in objective facts and distrust of subjective sensations. K. Smadja associates this with a deficit of introspective capacity and insufficient contact with the internal experience.

Research by R. Debray indicates that such external orientation may result from early disturbances in the development of the capacity to symbolize internal experience. When the primary object (the mother) fails to perform the function of “containing” and symbolizing the infant’s affects, the infant remains bound to concrete external reality.

#### **Conformity and orientation toward social norms.**

P. Marty described a pronounced tendency of patients with operatory thinking toward conformity — a striving to meet socially accepted norms of behavior and social expectations. This is related to the insufficiency of an autonomous internal structure, which is compensated by a rigid attachment to external directives.

D. Winnicott’s concept of the “false Self” resonates with this aspect of operatory thinking. Patients form an external adaptive shell that conforms to social expectations but remain disconnected from their true, authentic Self. This results in a chronic sense of inner emptiness and alienation [1; 3; 25].

#### **Dependence of self-esteem on external recognition.**

Clinical observations by the Paris School revealed that the self-esteem of individuals with operatory thinking largely depends on external recognition and social status. K. Smadja associates this with a deficit of internal representation of the value of the Self, which leads to a constant need for external validation.

J. McDougall describes this as an “addictive need” for external approval, which may manifest in the form of workaholic perfectionism, or other forms of compulsive productivity. However, since external achievements cannot fill the inner emptiness, this strategy remains ineffective, maintaining chronic psychosomatic distress [6; 13].

#### **Difficulties in differentiating personal needs from social expectations.**

P. Marty emphasized that patients with operatory thinking have substantial difficulties in distinguishing their own authentic needs and desires from introjected social demands. This leads to a life oriented toward the

fulfillment of external expectations, often at the expense of personal well-being.

M. de M'Uzan, in his concept of "basic masochism," indicated that such self-sacrifice is not genuine altruism but rather reflects the inability to recognize and articulate one's own needs. This may lead to the accumulation of frustration and resentment, which is expressed through somatic symptoms [4; 5].

The concept of operatory thinking, developed by representatives of the Paris Psychosomatic School, constitutes a significant contribution to the understanding of psychosomatic phenomena. A systematic analysis of the seven spheres of manifestation of operatory thinking — linguistic, social, psychodynamic, cognitive, activity-related, emotional, and interaction with external reality — allows for a comprehensive assessment of this complex phenomenon and its role in somatization.

#### **Psychometric instruments.**

For the diagnosis of operatory thinking and related constructs, several psychometric instruments have been developed. The Toronto Alexithymia Scale (TAS-20), developed by G. Taylor, is the most validated instrument for assessing alexithymic characteristics closely associated with operatory thinking [11].

However, K. Smadja emphasized that no psychometric instrument can fully replace the clinical interview and observation of patient behavior in the therapeutic relationship. Operatory thinking is a complex, multidimensional phenomenon that requires comprehensive clinical evaluation.

The concept of operatory thinking, developed by representatives of the Paris Psychosomatic School, constitutes a significant contribution to the understanding of psychosomatic phenomena. A systematic analysis of the seven spheres of manifestation of operatory thinking — linguistic, social, psychodynamic, cognitive, activity-related, emotional, and interaction with external reality — allows for a comprehensive assessment of this complex phenomenon and its role in somatization.

**Diagnostic Criteria.** K. Smadja, in his monograph *Psychosomatic Research*, systematized the diagnostic criteria of operatory thinking as follows:

- Reduction of fantasy and imaginative activity.
- External cognitive orientation.
- Concreteness and attachment to actuality.
- Restriction of emotional expression.
- Formalization of interpersonal relations.
- Monotony of life activity.
- Excessive dependence on external reality.

#### **RESEARCH RESULTS**

As a result of the theoretical and methodological analysis of the conceptual foundations of the Paris Psychosomatic School (P. Marty, M. de M'Uzan, K. Smadja) and contemporary studies of alexithymia (G. Taylor, R. Bagby, J. Simm), an original psychodiagnostic instrument was developed — the *Operatory Thinking Questionnaire* [1–26].

#### **Structure of the method.**

The questionnaire is a self-report psychometric instrument consisting of 122 statement-indicators, which respondents evaluate using a five-point Likert scale (0 – "Disagree", 1 – "Partly agree", 2 – "Both yes and no", 3 – "Mostly agree", 4 – "Completely agree").

The items are formulated as self-descriptive judgments reflecting various aspects of the individual's cognitive-affective functioning.

The diagnostic structure of the method includes twelve interrelated scales, each of which operationalizes a specific component of operatory thinking as an integral psychological construct.

#### **Characteristics of the Scales of the Operatory Thinking Questionnaire**

##### **1. Energetic-Motivational Rigidity.**

Reflects the degree of reduction in the subject's energetic and emotional dynamics. High scores indicate the predominance of survival and routine behavioral patterns, decreased motivation for novelty, and a loss of the ability to transform emotional energy into activity.

##### **2. Alexithymia.**

Describes difficulties in the verbalization and differentiation of emotional states. Individuals with high scores demonstrate a limited emotional vocabulary, a tendency to describe actions instead of feelings, and to substitute affective expressions with rational constructions.

##### **3. Control and Cognitive Rigidity.**

Reflects the dominance of rational control over intuitive processes. It is characterized by a tendency toward structure, rules, algorithms, and difficulties with spontaneity and cognitive flexibility.

##### **4. Affective Isolation.**

Determines the tendency toward emotional detachment and suppression of deep feelings. Elevated scores reflect difficulties in forming lasting emotional bonds, a deficit of empathy, and a reduced capacity for affective involvement.

##### **5. Deficit of Imagination and Symbolization.**

Measures the level of development of imagination, metaphorical thinking, and the capacity for symbolic representation of experience. High scores indicate a tendency toward concreteness, avoidance of abstractions, art, and fantasy, reflecting disturbances in the "symbolic function of the Self."

##### **6. Avoidance of Personal Contact.**

Characterizes a tendency to avoid situations of self-disclosure, personal initiative, and emotional closeness. Such individuals maintain superficial or formal social relations and are inclined toward conformity.

##### **7. Social Adaptive Dependence.**

Reflects the dependence of self-esteem and behavior on external norms and expectations. The individual is oriented toward social approval, fears conflict, and avoids risk and ambiguity.

##### **8. Emotional-Semantic Reduction.**

Reflects the simplification of the emotional content of experience. It manifests in difficulties understanding

humor, metaphors, and symbols, as well as in a “mechanical” style of activity.

#### 9. **Emotional Distance.**

Describes the tendency to avoid emotional intimacy, maintaining inner distance even in significant relationships. High scores indicate discomfort with intimacy and difficulties with relaxation.

#### 10. **Deficit of Emotional Attachment.**

Measures the level of affective involvement in relationships. High scores indicate emotional coldness, distrust, lack of tenderness, and difficulties in forming deep attachments.

#### 11. **Operational Approach to Emotions.**

Indicates a tendency toward a pragmatic, procedural approach even in the sphere of emotions and relationships. The individual is oriented toward algorithms, “instructions,” and rational actions as a means of controlling internal instability.

#### 12. **Rationalization of Affect.**

Reflects a tendency to explain and control emotions through intellectual schemes. This indicates the substitution of affective experiencing with rational analysis and avoidance of intense feelings.

### **RESULTS OF FACTR ANALYSIS**

According to the results of the factor analysis, twelve factors were identified that explain the total variance of the questionnaire. Each factor corresponds to one of the scales of the questionnaire and includes a specific set of indicator statements.

The first factor (10.2% of the variance) reflects energetic-motivational rigidity and includes twenty-six statements related to a constant feeling of fatigue, emotional exhaustion, difficulties with motivation, and problems in transforming the energy of negative emotions into productive activity.

The second factor (6.8% of the variance) represents alexithymia and includes fifteen statements describing difficulties in verbalizing inner experiences, choosing words to describe emotions, and a tendency to describe concrete actions instead of feelings.

The third factor (6.2% of the variance) reflects control and cognitive rigidity, with thirteen statements characterizing a tendency toward clear facts, rules, structured activity, and systematic organization of everything.

The fourth factor (3.5% of the variance) represents affective isolation, including seven statements describing a low need for emotional support, difficulties in maintaining long-term emotional bonds, and difficulties in expressing aggression.

The fifth factor (6.7% of the variance) describes a deficit of imagination and symbolization through fourteen statements about infrequent use of metaphors, difficulties in fantasizing, avoidance of abstract thinking, and philosophical reflection.

The sixth factor (4.1% of the variance) characterizes avoidance of personal contact, with eight statements describing avoidance of discussions about personal life, the future, dreams, or desires, and difficulties with spontaneity.

The seventh factor (7.3% of the variance) reflects social adaptive dependence through fifteen statements concerning the importance of appearing “normal,” meeting social expectations, orientation toward others’ opinions, and dependence of self-esteem on external approval.

The eighth factor (4.9% of the variance) represents emotional-semantic reduction through eight statements describing difficulties in understanding metaphors, humor, mechanical style of activity, and lack of understanding of the causes of emotional reactions.

The ninth factor (3.7% of the variance) describes emotional distance, including four statements related to discomfort in close emotional contact, emotional detachment, and difficulties with relaxation.

The tenth factor (3.4% of the variance) characterizes a deficit of emotional attachment through six statements about a low need for closeness, difficulties with trust, and experiencing or expressing tenderness.

The eleventh factor (2.6% of the variance) represents the operational approach to emotions through three statements describing an expectation of specific action algorithms from the psychotherapist and resorting to monotonous activity as a means of relaxation.

The twelfth factor (2.4% of the variance) reflects rationalization of affect through four statements describing difficulties in analyzing inner experiences, in living through intense feelings, and a tendency to provide rational explanations for emotions.

### **CONCLUSIONS**

The obtained results confirm and deepen the understanding of the phenomenon of operator thinking, integrating classical psychoanalytic concepts with contemporary empirical findings. The concept of the reflective function by P. Fonagy, A. Damasio’s research on the role of somatic markers in emotional processes, and P. Ogden’s work in somatically-oriented psychotherapy together create an interdisciplinary theoretical foundation for expanding the understanding of the mechanisms underlying operator functioning and for developing psychotherapeutic approaches to its modification.

The present research provides a comprehensive conceptualization of operator thinking as a specific form of cognitive-affective functioning characterized by a reduction in symbolic activity, limitation of mental representation of emotional experiences, and excessive fixation on concrete reality.

The theoretical analysis demonstrates the productivity of integrating classical psychoanalytic constructs with recent empirical data. The fundamental contributions of P. Marty, M. de M’Uzan, and K. Smadja concerning psychic insufficiency, deficits of mental representation, and progressive disorganization have provided the conceptual basis for understanding the mechanisms of psychosomatic maladaptation. These are complemented by contemporary studies by P. Fonagy on mentalization and the reflective function, A. Damasio on the role of somatic markers in emotional regulation, and P. Ogden’s works in somatically oriented psychotherapy, jointly forming an

interdisciplinary framework for a deeper understanding of operatory functioning.

The systematization of theoretical material made it possible to identify seven interrelated domains of manifestation of operatory thinking: the linguistic (reduction of the symbolic function of language, concreteness, avoidance of metaphorical expression); the social (disturbed regulation of interpersonal distance, conformity, formalization of contacts); the psychodynamic (deficit of sublimation, disturbances of affective regulation, instability of object relations); the cognitive (limitation of imaginative activity, dominance of concrete thinking, rigidity of cognitive schemas, deficit of reflective function); the behavioral-activity-related (monotony of activity, emotional detachment, orientation toward survival); the emotional-affective (alexithymia, somatization as a form of expression, impaired emotional differentiation, rationalization of experiences); and the domain of interaction with external reality (hyperinvestment in the external environment, dependence on social norms, difficulties in identifying one's own needs).

The developed psychodiagnostic *Operatory Thinking Questionnaire* (122 items, 12 scales) operationalizes the key theoretical constructs of the Paris Psychosomatic School. The structure of the instrument reflects the multidimensionality of the phenomenon through the following scales: energetic-motivational rigidity, alexithymia, control and cognitive rigidity, affective isolation, deficit of imagination and symbolization, avoidance of personal contact, social adaptive dependence, emotional-semantic reduction, emotional distance, deficit of emotional attachment, operational approach to emotions, and rationalization of affect. The differentiated structure of the questionnaire enables a detailed assessment of individual components of operatory functioning.

The practical significance of the study lies in the creation of a valid psychodiagnostic tool for identifying individuals with an increased risk of psychosomatic disorganization. The questionnaire can be applied in psychological counseling, psychotherapeutic practice, and preventive work for the early detection of deficits in mental representation. Differentiated assessment across scales allows for the identification of specific foci of psychotherapeutic intervention and for the formation of individualized strategies aimed at developing reflective function, emotional competence, and symbolic activity in clients.

The integration of classical psychoanalytic concepts with modern research in mentalization (P. Fonagy), the neurobiology of emotions (A. Damasio), and somatic psychology (P. Ogden) opens new perspectives for understanding psychosomatic phenomena and for developing psychocorrective strategies directed toward enhancing reflective function, emotional literacy, and symbolic activity.

#### Personal contribution of the authors:

**Tamara Khomulenko.** Development of the idea and research design.

**Valeriia Krynychko.** development of the research design, data collection, and manuscript preparation.

**Karyna Fomenko.** Statistical analysis.

**Conflicts of interest.** The authors declare that they have no conflicts of interest.

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**ОПЕРАТУАРНЕ МИСЛЕННЯ: КОНЦЕПТУАЛІЗАЦІЯ ПОНЯТТЯ, ПСИХОДІАГНОСТИКА  
ТА СТАНДАРТИЗАЦІЯ МЕТОДИКИ**

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Комплексне дослідження феномену оператuarного мислення як специфічної форми когнітивно-афективного функціонування, що характеризується редукцією символічної активності, дефіцитом ментальної репрезентації емоційних переживань та надмірною прив'язкою до конкретної реальності. Актуальність дослідження зумовлена зростанням поширеності психосоматичних розладів у сучасній психологічній практиці, де до 60-80% осіб демонструють симптоми соматизації психологічного дистресу. Мета статті полягає у теоретико-методологічній концептуалізації феномену оператuarного мислення через систематизацію його структурно-функціональних характеристик у семи взаємопов'язаних сферах психічного функціонування, а також у розробці та стандартизації психодіагностичного інструментарію для виявлення осіб із підвищеним ризиком психосоматичної дезорганізації. У роботі здійснено системний аналіз теоретичної спадщини Паризької психосоматичної школи (П. Марті, М. де М'Юзан, К. Смаджа) з виділенням семи основних сфер прояву оператuarного мислення: мовленнєвої (редукція символічної функції мови, конкретність, уникнення метафоричності), соціальної (порушення міжособистісної дистанції, конформність, формалізація контактів), психодинамічної (дефіцит сублимації, порушення афективної регуляції, нестабільність об'єктних відносин), когнітивної (редукція уявного життя, домінування конкретного мислення, ригідність когнітивних схем), поведінково-активнісної (монотонність діяльності, емоційна відстороненість), емоційно-афективної (алекситимія, соматизація як форма експресії, порушення емоційної диференціації) та сфери взаємодії із зовнішньою реальністю (гіперінвестиція у зовнішнє, залежність від соціальних норм). Результатом дослідження є розроблений психодіагностичний опитувальник оператuarного мислення, що включає 122 пункти та 12 шкал: енергетично-мотиваційна ригідність, алекситимія, контроль і когнітивна ригідність, афективна ізоляція, дефіцит уяви та символізації, уникнення особистісного контакту, соціальна адаптивна залежність, емоційно-семантична редукція, емоційна дистанція, дефіцит емоційної прив'язаності, операційний підхід до емоцій, раціоналізація афекту. Методика операціоналізує ключові теоретичні конструкти та дозволяє здійснювати диференційовану діагностику вираженості окремих компонентів оператuarного функціонування. Практичне значення роботи полягає у створенні валідного інструменту для ідентифікації осіб групи психосоматичного ризику в психологічному консультуванні та психотерапевтичній практиці. Інтеграція класичних психоаналітичних концепцій з сучасними дослідженнями менталізації (П. Фонагі), нейробіології емоцій (А. Дамазіо) та соматичної психології (П. Огден) відкриває нові перспективи для розуміння психосоматичних феноменів та розробки психокорекційних стратегій, спрямованих на розвиток рефлексивної функції, емоційної грамотності та символічної активності.

**Ключові слова:** психодіагностика, салютогенний підхід, феноменологія тілесного Я, психологічне благополуччя, психосоматика, оператuarне мислення, психоаналітичний підхід, алекситимія

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## RESILIENCE AS A RESOURCE FOR OVERCOMING NEGATIVE IMPACTS OF VOLUNTEERING

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The aim of the study to determine the specifics of resilience as a resource for volunteer activities. Analysis of foreign theoretical models of resilience shows that this phenomenon is considered as a multidimensional, dynamic process in which personal, social, cognitive and contextual factors interact. Domestic psychological science actively integrates these global approaches, adapting them to the realities of modern Ukraine. This has made it possible to form a number of conceptual and empirical directions aimed at studying the resilience of the individual in conditions of uncertainty and crisis challenges. The generalization of modern domestic research shows that resilience in Ukrainian psychology is considered as a systemic, multi-level quality that ensures effective adaptation, self-regulation and restoration of the personality in conditions of stress and crisis influences. The article shows that scientists are consistently expanding the understanding of this phenomenon - from a separate resource to a universal ability to maintain mental balance and vitality. It also was shown that Ukrainian research reveals similar trends, demonstrating that volunteer activity contributes to the formation of moral values, social maturity, empathy, a sense of responsibility, but at the same time can be accompanied by emotional exhaustion, secondary traumatization and professional burnout. This necessitates the development of psychological resources of resilience of volunteers. In this context, the phenomenon of resilience acquires special importance, which appears as a dynamic mechanism for maintaining adaptive functioning in conditions of stress. We concluded that various theoretical models prove that resilience is formed in the interaction of individual, social and contextual factors and can be developed through psychological preparation, self-regulation training and social support. Therefore, volunteering in crisis conditions requires a high level of resilience as a basic resource for overcoming stress, maintaining mental health and ensuring the effectiveness of assistance.

**Keywords:** *resilience, volunteering, mental health, professional burnout, self-regulation, activity, theories of resilience.*

### Problem statement.

Volunteering in prolonged crisis conditions is simultaneously a powerful factor in personal development, moral formation and social cohesion, but can also be accompanied by significant negative consequences, such as emotional exhaustion, secondary traumatization, compassion fatigue and professional burnout. The balance between these poles is largely determined by the level of internal resources, the availability of social support and the ability to self-regulate. That is why it is appropriate to reveal the role of resilience as a key psychological mechanism that ensures the stability and adaptation of the individual in volunteering.

The **Aim** of the study is to determine the specifics of resilience as a resource for volunteer activities.

**Results of the study and their discussion.** One of the first theoretical concepts of resilience was the developmental model of E. Werner and R. Smith, created based on the results of a longitudinal study of children from disadvantaged families. Researchers have defined resilience as a dynamic process of positive adaptation that occurs despite serious life challenges or risk factors. According to the authors, the key content of resilience is not so much the absence of negative consequences of stress, but the ability of an individual to maintain psychosocial functioning, effectively cope with difficulties and restore internal balance after exposure to traumatic

events. Within this model, resilience is considered as an integrative property that is formed in the interaction of three systems of factors:

- individual (cognitive competence, self-efficacy, autonomy, achievement motivation, positive self-esteem);
- family (stability of emotional ties, support of significant adults, positive identification);
- social-contextual (supportive relationships with peers, inclusion in socially significant activities, participation in the community) (Werner & Smith, 1992).

Thus, resilience in the understanding of E. Werner and R. Smith is not an innate trait, but the result of multi-level interaction of the individual with the environment, which provides the ability to overcome difficulties and even personal growth after them (Werner & Smith, 1992). In the context of volunteering, this model allows us to understand that support from the community, the presence of stable interpersonal relationships and the development of internal resources are key conditions for the formation of resilience, which helps volunteers maintain emotional balance and effectiveness in prolonged crisis circumstances.

A significant contribution to the development of the modern understanding of the phenomenon of resilience was made by S. Luthar, D. Cicchetti and B. Becker, who considered it as a dynamic process of successful adaptation in the context of significant threats to the development or functioning of the individual. In contrast to early

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approaches that emphasized the individual traits of resilient individuals, the authors emphasized the contextual and interactive nature of resilience, stressing that it is not a constant characteristic, but is formed in the process of interaction of the individual with the environment and changes depending on the situation (Luthar, Cicchetti & Becker, 2000).

Scientists have identified key criteria that can be used to identify the manifestation of resilience: the presence of a significant risk or stressful impact that can potentially lead to maladaptation; a positive result of adaptation - successful functioning, preservation of mental health or achievement of development, despite existing difficulties (Luthar, Cicchetti & Becker, 2000).

According to this approach, resilience is not a universal but a situation-specific property that can manifest itself in certain domains (eg, social or emotional) while remaining vulnerable in others. The authors emphasize the need to take into account a multi-level system of influences - from personal resources (self-esteem, self-efficacy, optimism) to supportive social ties, a safety environment and positive behavior patterns (Luthar, Cicchetti & Becker, 2000). In this context, resilience is interpreted as a process of mutual regulation between risk and protection, in which protective factors (social support, emotional competence, constructive coping strategies) modify the impact of stressful factors, reducing the likelihood of negative consequences (Luthar, Cicchetti & Becker, 2000).

Thus, the concept of S. Luthar, D. Cicchetti and B. Becker emphasizes the plasticity and dynamics of resilience, which opens wide opportunities for psychological intervention and development of this resource (Luthar, Cicchetti & Becker, 2000). In the context of volunteering, this model emphasizes the importance of the formation of multi-level support - both individual (emotional regulation, meaningful orientation) and social (team interaction, organizational support), which allows volunteers to maintain stability and efficiency in situations of chronic stress.

A. Masten, who formulated the concept of "ordinary magic" made an important contribution to the development of the theoretical foundations of understanding resilience. In her writings, the researcher defines resilience as a normal, not an exceptional process based on normal adaptive systems of human development. In her opinion, the ability to overcome difficulties and maintain functioning under stressful conditions is not the result of rare talents or heroic efforts, but a manifestation of natural mechanisms of self-regulation, social interaction and learning (Masten, 2001).

A. Masten's model is based on an ecological approach, according to which resilience develops due to the interaction between individual, family and social systems. She considers the main adaptive systems that support resilience to be: cognitive-emotional competence (ability to regulate emotions, plan and solve problems); safe and supportive relationships (with parents, mentors, community); sense of meaning and value of one's own life; a positive social environment that promotes activity, collaboration and learning (Masten, 2001).

The scientist emphasizes that the destruction or exhaustion of these systems (for example, due to war, loss of social support, instability) leads to a decrease in resilience, while their restoration or strengthening leads to an increase in psychological stability. She also emphasizes that resilience can be developed throughout life, because adaptive systems have the ability to recover even after severe shocks (Masten, 2001).

Thus, the concept of A. Masten (2001) emphasizes that the source of human resilience is everyday resources - relationships, support, competence and meaning. In the context of volunteering, this idea is particularly relevant: it is ordinary but stable adaptive mechanisms - mutual aid, community cohesion, awareness of the value of one's own actions - that create the basis for volunteers' resilience in long-term crisis situations.

An influential theoretical approach to understanding resilience was proposed by K. Reivich and A. Shatte, who consider it as a set of skills and cognitive-behavioral strategies that allow a person to effectively overcome difficulties, adapt to changes, and maintain emotional balance. In contrast to approaches that interpret resilience mainly as a personal trait or process, the authors emphasize its educational and training nature, emphasizing that resilience can be developed through purposeful work with thinking, emotions and behavior (Reivich & Shatté, 2002).

According to the concept of K. Reivich and A. Shatte, resilience is based on the following key components: self-awareness - the ability to recognize one's own emotional reactions and automatic thoughts; self-control - the ability to manage impulsive reactions and regulate emotional state; optimism - a tendency to interpret difficulties as temporary and surmountable; mental flexibility - the ability to see alternative explanations of events and find constructive solutions; empathy - the ability to understand the emotional states of others and maintain mutual understanding; achievement - goal orientation and the ability to regain motivation after failures (Reivich & Shatté, 2002). The authors believe that the development of these skills forms the ability to positively reformulate experience, that is, reinterpret stressful events in a constructive way, which contributes to increased adaptability and prevents distress.

So, the concept of K. Reivich and A. Schatte outlines resilience as a result of the development of cognitive-emotional skills that ensure internal flexibility and stress resistance (Reivich & Shatté, 2002).

In the context of volunteering, this model has a special applied value, because it allows you to consider resilience not only as a natural property, but as a set of skills that can be purposefully formed, ensuring the psychological stability of volunteers during the action of prolonged stress factors. One of the most influential concepts of military resilience is the model proposed by P. Bartone, R. Ursano, and K. Wright, developed on the basis of research on the reactions of American military personnel to combat stress, conditions of isolation, losses, and moral dilemmas. In this model, resilience is viewed as a set of cognitive, affective, and behavioral characteristics that allow adaptive functioning to be maintained during times of extreme

stress, including combat situations, loss of control, prolonged uncertainty, and moral strain (Bartone, Ursano & Wright, 1989). Its key provisions are the following theses:

- resilience is adaptation to combat stress without disorganization of the personal, moral or professional sphere;

- the model assumes that resilient military personnel are able to maintain emotional control, logic of actions, effective communication and efficiency even in conditions of threats to life or moral dilemmas;

- resilience is considered as a combination of three components: individual characteristics (emotional stability, cognitive flexibility, self-efficacy); social support (relationship with the commander, trust in the team, cohesion); contextual factors (organizational structure, clarity of goals, compliance of tasks with opportunities);

- the preservation of psychological functioning is based on the subjective perception of the situation - i.e. not an objective threat, but rather the interpretation of the event as controlled/uncontrollable affects resilience (Bartone, Ursano & Wright, 1989).

In the context of volunteering, the concept of P. Barton et al. has immediate practical significance: it explains why volunteers with a high level of involvement, a sense of control, and a willingness to accept challenges cope better with long-term workloads, show fewer symptoms of burnout, and maintain stability in complex socio-traumatic conditions. J. Bonanno made a significant contribution to the study of the phenomenon of resilience, particularly in the context of volunteering and rescue activities. In his research (Bonanno, 2004, 2009) he proposed a model of dynamic resilience that describes individual differences in response to stressful and traumatic events, particularly among individuals who provide assistance to others in crisis situations.

Unlike traditional approaches that looked at the consequences of trauma mainly through the prism of pathology or post-traumatic disorders, J. Bonanno showed that most people are able to maintain emotional stability and effective functioning even after severe shocks. He singled out several types of adaptive trajectories: stable, recovery, chronically depressed, and delayed (Bonanno, 2004, 2009).

This typology allows us to understand why some volunteers remain psychologically resilient, while others show signs of emotional exhaustion or secondary traumatization. A key proposition of J. Bonanno's model is also the idea that resilience is not a fixed trait, but a process that relies on a combination of individual resources (flexibility of thinking, positive emotional regulation, meaning-making) and social factors (support from the environment, trust, inclusion in the community) (Bonanno, 2004, 2009). In his empirical studies after the terrorist attacks of September 11, 2001, he showed that volunteers and rescuers who demonstrated the ability to cognitively re-evaluate traumatic events and maintained emotional contact with the social environment were significantly less likely to have symptoms of post-traumatic stress (Bonanno, 2004, 2009).

Applying this model to the analysis of volunteering allows us to explain why participation in helping others can be both a risk factor and a development resource. Resilient volunteers are able to transform stressful experiences into a source of self-development, increased self-efficacy and strengthening of moral identity. Thus, J. Bonanno's concept emphasizes the adaptive potential of a person, capable not only of withstanding the pressure of extreme conditions, but also of maintaining internal balance while fulfilling a socially significant mission.

In the context of volunteering, J. Bonanno's concept is of particular importance, as it emphasizes the role of emotional flexibility and adaptive regulation as key mechanisms of resilience. It helps to explain why some volunteers, despite constant exposure to traumatic events, maintain productivity, the ability to empathize and internal balance: their resilience is manifested in the variability of coping strategies and effective recovery after emotional overloads.

A significant contribution to the understanding of the nature and mechanisms of resilience was made by K. Connor and J. Davidson, who developed a clinical-psychological model of resilience and created one of the most famous tools for its measurement - the Connor-Davidson Resilience Scale (CD-RISC).

According to K. Connor and J. Davidson, resilience is defined as the ability to successfully adapt to stress, trauma or significant life changes, and is based on a system of interconnected resources - cognitive, emotional, behavioral and social (Connor & Davidson, 2003). Researchers have identified several key components of this phenomenon:

- personal competence and perseverance, which reflect confidence in one's own abilities and orientation to achievements;

- trust in intuition and tolerance to negative influence, which reduce vulnerability to stress;

- positive acceptance of changes and security in relationships that provide social support;

- control, which involves an active attitude to difficulties and a sense of influence on events;

- spirituality, which helps to find meaning in trials and maintains inner balance (Connor & Davidson, 2003).

K. Connor and J. Davidson's model emphasizes that resilience is not a static trait, but a dynamic construct that can change under the influence of therapy, learning, or life experiences. In particular, the authors indicate that its development is possible through the formation of cognitive flexibility, optimism, self-efficacy and the ability to create meaning. In the context of volunteering, this concept provides a practical understanding that psychological resources can support a person in conditions of prolonged stress, and a high level of competence, a positive reevaluation of events, acceptance of changes and the presence of social support are the factors that reduce the risk of emotional exhaustion and contribute to the long-term effectiveness of volunteers.

One of the most influential modern concepts in the field of resilience is the post-traumatic growth model developed by R. Tedeschi and L. Calhoun. According to

this model, posttraumatic growth is a positive psychological change that occurs as a result of coping with major life challenges (Tedeschi & Calhoun, 1996, 2004). The researchers singled out five main areas of this growth:

- increase in the value of life - reassessment of life priorities, increased appreciation for the everyday;
- improvement of interpersonal relations - growth of empathy, compassion, ability to support others;
- increase in personal strength - awareness of one's own stability and internal resources;
- discovery of new opportunities - emergence of new goals, motivations, meanings;
- spiritual development – deeper awareness of existential issues, faith or philosophical acceptance of life (Tedeschi & Calhoun, 1996, 2004).

R. Tedeschi and L. Calhoun emphasized that post-traumatic growth is not an automatic consequence of suffering - it occurs only under the condition of active cognitive understanding of the experience, reflection and search for new meanings. At the same time, resilience is the basis that allows a person not only to withstand the impact of trauma, but also to transform it into a source of development (Tedeschi & Calhoun, 1996, 2004).

In the context of volunteering, the approach of R. Tedeschi and L. Calgun is of particular importance, because volunteers who often encounter human suffering can experience both distress and deep personal growth. Post-traumatic growth in this case is manifested in the formation of mature empathy, rethinking of life values, growth of moral consciousness and inner strength, which increases their ability to act effectively even in the most difficult conditions.

F. Friberg and his colleagues (2003) developed a multi-component model of resilience, in which this phenomenon is considered as an integrated system of psychological and social factors that provide a person with the ability to maintain adaptation and well-being in stressful conditions. Resilience in this model consists of six main components:

- self-perception – self-confidence, positive self-esteem, self-efficacy;
- planning for the future - having goals, life prospects and motivation;
- social competence – communication skills, flexibility in interaction, ability to receive support;
- family cohesion – support, trust and emotional stability in the family;
- social resources – external help, feeling of belonging to the community, support of friends and colleagues;
- structured style – organization, responsibility and discipline in actions (Friberg et al, 2003).

Researchers emphasize that these factors not only reduce vulnerability to stress, but also form an active adaptive position, when a person not only overcomes difficulties, but uses them as a condition for development. The model is also one of the few that emphasizes the importance of social integration as a necessary condition for resilience: resilience is not seen as an individual achievement, but as the result of interaction in the system "personality - family - society" (Friberg et al, 2003).

In the context of volunteering, F. Friberg's model (Friberg et al, 2003) is particularly relevant, since volunteering inherently involves active social interaction, support, a common goal, and awareness of the significance of one's role. A high level of social and family resources, the presence of goals and meaning, the ability to communicate and self-regulate are the factors that form the basis of volunteers' resilience in situations of prolonged stress.

A conceptual approach to the development of resilience in the military environment is thoroughly presented in the work of L. Meredith et al., which summarizes the results of research conducted within the framework of training and support programs for personnel of the US Armed Forces. Researchers view resilience as a multifactorial construct that encompasses cognitive, emotional, behavioral, and social aspects of a military serviceman's functioning, and at the same time as a strategic resource for the effectiveness of a military organization (Meredith et al., 2011).

Within this concept, resilience is defined as the ability of an individual, unit, or organization to withstand stress, recover from psychological trauma, and maintain combat capability in difficult environments. The authors identify several key components: psychological flexibility, emotional regulation, self-efficacy, social support, and team cohesion (Meredith L. S. et al., 2011).

Particular attention is paid to the institutional level of resilience development - the creation of a training system, mental state monitoring, burnout prevention programs and training of leaders to support subordinates in stressful conditions (Meredith L. S. et al., 2011). The paper proposes a multi-level model of resilience development, which includes individual (personal competence, coping strategies), interpersonal (peer support, trust, team dynamics) and organizational levels (caring culture, availability of assistance programs, psychological leadership).

The authors emphasize that an effective resilience support system requires the integration of psychological, educational, and administrative measures, not just individual training (Meredith L. S. et al., 2011). In the context of volunteering, this concept has significant applied value, as it demonstrates that the development of resilience under conditions of chronic stress must be structured, multi-level and systemic in nature - with a combination of personal training, social support and an organizational culture of care.

An important direction in the modern understanding of the phenomenon of resilience is the stress-inoculation theory ("stress inoculation" theory), developed by D. Meichenbaum. His approach is based on the principles of cognitive-behavioral psychology and considers resilience as the result of systematic stress resistance training, similar to "psychological inoculation" against future stressful influences (Meichenbaum, 1985).

D. Meichenbaum believed that stress reactions are not automatic - they depend on the way of interpreting events, internal dialogue and the presence of self-regulation skills. According to his model, the development of resilience occurs in stages:

- cognitive training – awareness of one's own stress triggers, assessment of response methods and formation of a realistic vision of the problem;

- teaching coping skills - development of self-control, relaxation techniques, positive self-suggestion, cognitive restructuring;

- exposure stage (practice under control) – gradual "entering" stressful situations using acquired strategies, which creates the effect of psychological hardening (Meichenbaum, 1985).

Thus, "stress vaccination" forms cognitive-emotional "immunity" - a person's ability to predict his own reactions, flexibly adapt to changing circumstances and reduce the intensity of stress. The author emphasized that this process does not eliminate stress, but changes the attitude towards it, making it controllable and predictable (Meichenbaum, 1985).

That is, the stress-inoculation theory of D. Meichenbaum demonstrates that resilience is not a natural quality, but can be the result of purposeful training. In the context of volunteering, this approach is especially valuable because it offers a structured algorithm of psychological preparation, capable of reducing the risks of emotional exhaustion, secondary traumatization and burnout in conditions of prolonged crisis effects. M. Ungar developed a socio-ecological model of resilience emphasizing that resilience is not only an internal property of the individual, but primarily a process of interaction between a person and the social context in which he lives (Ungar, 2011).

According to the researcher, resilience is a socially determined phenomenon that occurs when an individual has access to the resources necessary for adaptation and can effectively attract them. He suggests considering resilience as a process of two-way exchange: on the one hand, it is the ability of a person to seek and use support, and on the other hand, the readiness of the social environment (family, community, institutions, state) to provide this support (Ungar, 2011).

Within his model, M. Ungar singled out several levels of social ecology of resilience:

- individual level – cognitive, emotional and behavioral resources of the individual (self-regulation, self-efficacy, meaning-making);

- interpersonal level – supportive relationships with family, friends, colleagues;

- community level – a sense of social belonging, trust, cultural identity;

- institutional level – the presence of fair structures that ensure safety, equality of opportunities and access to resources (Ungar, 2011).

Thus, resilience in the understanding of M. Ungar appears as an ecosystem of interconnected resources functioning in cultural, social and economic contexts. Its development requires not only psychological intervention, but also social changes aimed at strengthening communities, family ties, and cultural identity. In the context of volunteering, this model has a special practical value, as it allows considering the sustainability of volunteers not only as an individual quality, but as a result of the interaction between personal resources, team

support and organizational conditions of activity. Ensuring access to social, emotional and material resources, as well as the formation of a culture of mutual support in communities are key factors in increasing the resilience of volunteers in prolonged crisis situations.

An important basis for understanding resilience is created by the model of protective factors developed by M. Rutter, who considered resilience not as a fixed trait or an exceptional ability of an individual, but as the result of the action of a system of protective (protective) mechanisms that weaken or compensate for the impact of adverse environmental factors. Among the main protective factors are: stable emotional ties in the family, the presence of at least one significant support person, cognitive competence, social skills, humor, an internal sense of control, adequate self-esteem and opportunities for self-realization (Rutter, 1987).

According to M. Rutter's approach, these protective factors act in three main directions: - reducing the impact of risk - weakening or blocking the negative consequences of stressful events; - strengthening of personal stability - development of self-confidence, self-efficacy, ability to control the situation; - creation of conditions for adaptive functioning - provision of social support, positive experiences and stable relationships (Rutter, 1987). In the context of volunteering, M. Rutter's model has a special applied value: it allows us to understand that the psychological stability of volunteers is formed through a combination of individual and social resources - such as internal motivation, a sense of meaning, team cohesion, trust, social support and a stable environment. The presence of these protective factors provides an opportunity to act effectively and maintain mental health even in long-term crisis conditions.

Therefore, the analysis of foreign theoretical models of resilience shows that this phenomenon is considered as a multidimensional, dynamic process in which personal, social, cognitive and contextual factors interact. Domestic psychological science actively integrates these global approaches, adapting them to the realities of modern Ukraine. This made it possible to form a number of conceptual and empirical directions aimed at studying the stability of the individual in conditions of uncertainty and crisis challenges. In particular, in recent years, several dissertations were completed, the object of which was resilience as a systemic quality of the individual.

Thus, O. Shevchenko's research presents a holistic author's concept of resilience, built on a systematic approach to the analysis of the psychological characteristics of the activities of nurses, especially those who work with patients with serious somatic diseases. The researcher considers resilience as an individual's ability to dynamically adapt and self-regulate in the face of life and professional difficulties, which is ensured by the effective management of one's own resources – emotional, motivational, volitional and cognitive – in relation to socio-cultural norms and environmental influences (Shevchenko, 2020).

Within this concept, a component-criterion model of resilience has been developed, covering four interrelated structural blocks:

- value-motivational, which reflects the desire to work with seriously ill patients, internal readiness for professional challenges, belief in the meaningfulness and controllability of the world, acceptance of one's own significance and confidence in the ability to influence life events;

- cognitive-reflexive, which includes understanding the essence of the phenomenon of resilience, awareness of its importance in the professional sphere, the ability to self-reflect and assess one's own level of resilience and adaptability;

- operational-activity, which covers the formation of stress resistance skills, the ability to quickly recover from stressful situations, apply effective coping strategies and actions aimed at supporting professional efficiency;

- communicative and regulatory, which characterizes the flexibility of behavior in conditions of uncertainty, tolerance to emotional distress of other people, the ability to regulate one's own emotional states in the process of interpersonal interaction (Shevchenko, 2020).

In O. Odnostalko's dissertation, a comprehensive theoretical and empirical study of resilience as a resource of psychological stability of the individual in the conditions of complex and atypical life situations was carried out. The main achievement of the work is the justification that resilience should be considered not only as a character trait, but as a dynamic system of adaptive resources that ensure effective human functioning in crisis conditions. The work also determined that the resources of personal stability depend on age and social context: in older respondents, they are more formed, while in younger ones, they are more variable. A tendency to decrease the level of resilience under the influence of prolonged or excessive stress has been established, even among individuals with previously high levels of resilience. It is shown that a special role in the preservation and restoration of adaptive resources belongs to social support, family and interpersonal ties, which are the leading factor in psychological recovery (Odnostalko, 2020).

Within the framework of E. Hrishyn's research, a thorough theoretical and methodological analysis of the phenomenon of resilience as a key factor in overcoming the effects of stress, trauma and long life difficulties was carried out. The researcher proposed a generalized model of resilience, which includes cognitive-evaluative, emotional-regulatory and behavioral components, and also determined its role as an integrative resource of psychological well-being. Among the main achievements of the work is the disclosure of the dynamic nature of resilience as a system of cognitive, emotional and behavioral reactions that allow a person to maintain mental balance and productivity in stressful circumstances. E. Grishin emphasized that resilience is a process of overcoming the negative consequences of traumatic events and, at the same time, a potential for development that contributes to the formation of adaptive strategies and prevents maladaptation (Hrishyn, 2024).

Despite the depth of theoretical and empirical studies, a number of aspects of the problem of resilience have

become an actual direction of scientific research, reflected in modern professional articles of Ukrainian researchers.

L. Adamenko (2020) outlined the differences between the concepts of "resilience", "viability", "stress resistance" and "viability", emphasizing the importance of their methodological distinction, considering resilience as an individual's ability to maintain internal integrity and stability in stressful and crisis conditions, as well as a resource for psychological recovery and post-traumatic growth.

T. Belavina (2020) investigated the socio-psychological factors of the formation of resilience in persons who are in a state of social deprivation, in particular in conditions of deprivation of liberty. The author described resilience as a mechanism for overcoming the negative consequences of isolation, which supports vitality and contributes to the process of resocialization.

Yu. Zavatskyi, N. Zavatska, O. Fedorova (2021) established that the development of resilience of children of primary school age is determined by interaction with parents and the peculiarities of the family environment as a whole.

O. Lazorko and T. Shevtsova (2022) proved that in adolescence, resilience plays a leading role as a psychological protective resource that reduces the consequences of traumatic experiences and prevents the formation of post-stress disorders.

G. Lazos (2018, 2019) considers resilience as a biopsychosocial process that encompasses individual, interpersonal, and social aspects and is manifested in a person's ability to recover from traumatic events and achieve personal growth. The model proposed in the research is based on three key factors (risk, protective and vulnerable factors) and describes four successive phases of resilience development: meeting with a traumatic event, activation of resources and vulnerabilities, their interaction and the final result - adaptation or maladaptation.

N. Pidbutska, A. Knysh and Zh. Bohdan (2022) analyze the phenomenon of resilience as the ability to adapt and restore the psyche in conditions of excessive stress and prove that it is the development of internal resources of resilience that ensures the effectiveness of volunteer aid in war conditions.

V. Fedorchuk, L. Komarnitska and N. Storozhuk (2023) consider resilience as an integrative entity that combines psychological, emotional, social and physical aspects and ensures the viability of an individual in extreme conditions. Researchers single out the main structural elements of resilience: cognitive flexibility, positive emotional resources, spiritual and value orientation, effective strategies for overcoming difficulties and social competence.

O. Khmel and I. Lovyak (2018) define resilience as a holistic integrative characteristic of the individual, which combines cognitive, emotional-volitional, motivational and reflective components. It provides the future teacher with the ability to adequately respond to stress, maintain a professional orientation, internal balance and a positive attitude towards oneself.

## Conclusions

Thus, the generalization of modern domestic research shows that resilience in Ukrainian psychology is considered as a systemic, multi-level quality that ensures effective adaptation, self-regulation and restoration of the personality in conditions of stress and crisis influences. Scientists are consistently expanding the understanding of this phenomenon - from a separate resource to a universal ability to maintain mental balance and vitality. Ukrainian research reveals similar trends, demonstrating that volunteer activity contributes to the formation of moral values, social maturity, empathy, a sense of responsibility, but at the same time can be accompanied by emotional exhaustion, secondary traumatization and professional burnout. This necessitates the development of psychological resources of resilience of volunteers. In this context, the phenomenon of resilience acquires special importance, which appears as a dynamic mechanism for maintaining adaptive functioning in conditions of stress. Various theoretical models prove that resilience is formed in the interaction of individual, social and contextual factors and can be developed through psychological preparation, self-regulation training and social support. Therefore, volunteering in crisis conditions requires a high level of resilience as a basic resource for overcoming stress, maintaining mental health and ensuring the effectiveness of assistance.

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**РЕЗИЛЬЄНТНІСТЬ ЯК РЕСУРС ПОДОЛАННЯ НЕГАТИВНИХ ВПЛИВІВ ЗАЛУЧЕННЯ ДО ВОЛОНТЕРСЬКОЇ ДІЯЛЬНОСТІ****Барінов Сергій***Аспірант Інститут психології імені Г.С. Костюка НАПН України, Київ, Україна*<https://orcid.org/0009-0002-4811-9476>

Мета дослідження – визначити специфіку резильєнтності як ресурсу волонтерської діяльності. Аналіз зарубіжних теоретичних моделей резильєнтності показує, що це явище розглядається як багатовимірний, динамічний процес, у якому взаємодіють особистісні, соціальні, когнітивні та контекстуальні фактори. Вітчизняна психологічна наука активно інтегрує ці глобальні підходи, адаптуючи їх до реалій сучасної України. Це дозволило сформувати низку концептуальних та емпіричних напрямків, спрямованих на вивчення стійкості особистості в умовах невизначеності та кризових викликів. Узагальнення сучасних вітчизняних досліджень показує, що стійкість в українській психології розглядається як системна, багаторівнева якість, що забезпечує ефективну адаптацію, саморегуляцію та відновлення особистості в умовах стресових та кризових впливів. У статті показано, що вчені послідовно розширюють розуміння цього явища – від окремого ресурсу до універсальної здатності підтримувати психічну рівновагу та життєвий тонус. Також було показано, що українські дослідження виявляють подібні тенденції, демонструючи, що волонтерська діяльність сприяє формуванню моральних цінностей, соціальної зрілості, емпатії, почуття відповідальності, але водночас може супроводжуватися емоційним виснаженням, вторинною травматизацією та професійним вигоранням. Це зумовлює необхідність розвитку психологічних ресурсів стійкості волонтерів. У цьому контексті особливого значення набуває феномен стійкості, який постає як динамічний механізм підтримки адаптивного функціонування в умовах стресу. Ми дійшли висновку, що різні теоретичні моделі доводять, що стійкість формується у взаємодії індивідуальних, соціальних та контекстуальних факторів і може бути розвинена за допомогою психологічної підготовки, тренінгів саморегуляції та соціальної підтримки. Тому волонтерство в кризових умовах вимагає високого рівня стійкості як базового ресурсу для подолання стресу, підтримки психічного здоров'я та забезпечення ефективності допомоги.

**Ключові слова:** *резильєнтність, волонтерство, психічне здоров'я, професійне вигорання, саморегуляція, активність, теорії резильєнтності*

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## ПРАВИЛА ОФОРМЛЕННЯ СТАТЕЙ ДЛЯ ЗБІРНИКА

### «Психологічне консультування і психотерапія»

Відповідно до постанови Президії ВАК України №7-05/1 від 15 січня 2003 р. «Про підвищення вимог до фахових видань». Внесених до переліків ВАК України» при підготовці статей до фахового збірника слід дотримуватися таких вимог:

- постановка проблеми у загальному вигляді та її зв'язок з важливими науковими та практичними завданнями;
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- висновки з цього дослідження і перспективи подальших розвідок у цьому напрямі;
- список використаних джерел у транслітерації (література оформляється відповідно до вимог ДАК МОН України

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Для назв з використанням кирилических символів застосовуються наступні правила: прізвища авторів подаються латиницею, назва статті (книги, доповіді і т.п.) – мовою оригіналу, та у квадратних дужках надається переклад англійською мовою. Назва видавництва подається в транслітерації (якщо немає англійського варіанту назви), назва міста розташування видавництва — повністю, без скорочень. Наприкінці у круглих дужках зазначається мова видання.

Назви таблиць та рисунків вказуються двома мовами:

Наприклад:

**Таблиця 9.** Нормативні показники за шкалами методики ОДЕС-2-Е/ Normative indicators according to the scales of the QDES-2-E methodology

Наприкінці статті вказується внесок авторів та конфлікт інтересів.

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