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Chapter

General Three-Component Structural-Dynamic Theory of Psychotherapy and Its Implementation in Method of Positive-Dialog Psychotherapy

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Abstract

On the base of analysis of psychotherapeutic practice, archaic therapeutic systems and basic methods of psychotherapy the author formulates the general three-component structural-dynamic theory of psychotherapy, describes its components, formulates the connecting script's concept for psychotherapy. The description of sociopsychological component of psychotherapy is based on “models of the disease and therapy” of the mass consciousness, its structure and dynamics. The psychological component includes the learning and intrapsychic subcomponents. The intrapsychic subcomponents contain the mechanisms of reactivation and the formation of the personal system of psychological adaptation. The biological component of psychotherapy is discussed from the perspective of mechanisms of learning, readaptation and neurogenesis. The method of positive-dialog psychotherapy (PDP) of anxiety disorders is based on the above theory of psychotherapy and describes the process of psychotherapy as a multidimensional staged dialog between the psychotherapist and the patient. PDP is realized as a serial resolution of the patient's systemic request for psychotherapy, which presents a set of consistently manifested, resolving stage requests of the patient (reflects in reverse order the history and biopsychosocial mechanisms of the formation of the disorder). PDP includes the method of universal hypnotherapy, which demonstrates mindfulness effect, and is effective in evidence-based research.

Keywords: three-component structural-dynamic theory of psychotherapy, social-psychologic, psychologic, biologic components, mass consciousness, the system of psychological adaptation of the personality, positive psychology, biologic readaptation mechanisms, positive-dialog psychotherapy, anxiety disorders, universal hypnotherapy
1. Introduction

Twenty years ago, the idea of superiority of cognitive behavioral therapy (CBT) was dominated in the evidence-based approach. The exponential growth in evidence-based research on psychotherapy had fundamentally changed the situation. Modern meta-analyses and systematic reviews indicate a lack of benefits in the effectiveness of various CBT techniques, psychodynamic therapy, and supportive psychotherapy for a wide range of posttraumatic, anxiety, and depressive disorders. Researchers note only the traditionally wide representation of the CBT methods, but do not indicate their therapeutic advantage, stating the reliable effectiveness of different psychotherapies [1–4]. The effect sizes for CBT, psychodynamic therapy, relaxation training, non-directive therapy, self-evaluating therapy, mindfulness meditation, psychodynamic and metacognitive therapies, anxiety management training for generalized anxiety disorder (GAD) ranged from moderate to high ($r = 0.76$).

The distinct and comparable effectiveness of a wide range of psychotherapy methods stimulates researchers to explore the general, universal mechanisms of psychotherapy. In recent years, evidence-based studies of psychotherapy have gone beyond the standard for assessing effectiveness, switching to the study of the psychologic and neuronal mechanisms of psychotherapy. The number of studies of psychotherapy psychologic and neuronal (f-MRI-, s-MRI-based) mechanisms over the past decade has increased five times—for psychometric, and more than 10 times—for neuronal methods. Based on f-MRI-, s-MRI-based studies of the neuronal mechanisms, different psychotherapy methods have shown the involvement of brain areas responsible for self-awareness, self-regulation, regulation of attention, self-perception, semantic processes [5, 6].

Widespread methods of psychotherapy have a limited (40–100 years) life cycle: formation, development, maturity, decline, and loss of relevance. The methods of psychotherapy are grouped into psychotherapeutic approaches that are more historically stable in comparison with separate methods. The methods of psychotherapy, which became the basis for the formation of psychotherapeutic approaches, as a rule, live longer than others. Orthodox psychoanalysis [7–13] and A. Beck’s cognitive therapy [14–16] can serve as canonical illustrations. The historicity of the psychotherapeutic methods presupposes their involvement in the historical process, conditioned by social changes, while within the psychotherapy the personified narrative of its methods development dominates (one of the examples is the relatively recent history of Ericksonian hypnosis [17–19]).

Any developed and demanded method of psychotherapy creates and maintains hermeneutic semantic structure, explaining a person, disorder, and therapy. The problem is that psychotherapeutic hermeneutics of the methods are not consistent (for example, for psychodynamic and behavioral therapy), which does not affect the comparable clinical effectiveness of the methods.

The data of evidence-based studies of psychotherapy, the aspect of its historicity, comparison of the interpretative constructs of separate methods potentiate the search for common, universal mechanisms of psychotherapy, and their direct use in psychotherapeutic practice. Based on the above logic, in the late 1990s and early 2000s, the author elaborated the three-component, structural-dynamic theory of psychotherapy, which in the 2010s turned into the basis for development of the positive-dialog psychotherapy (PDP) method that underwent an evidence-based assessment, highlighting predictors of its efficiency.
2. General three-component structural-dynamic theory of psychotherapy

Since human life is carried out on social, psychological, biological levels, then effective clinical psychotherapy will inevitably be systematically implemented at the same sociocultural, psychological, and biological levels. Therefore, the explanation of the general theoretical approach to psychotherapy will be based on a systemic analysis on the sociopsychological (cultural), psychological, and biological levels [20, 21].

2.1 Sociopsychological component of psychotherapy

The ethnocultural context, undoubtedly, is accepted by modern psychotherapy as traditional therapeutic practices, which partly are incorporated into modern therapies (an example of mindfulness meditation [22–25]). Nevertheless, the interaction of society, culture, and psychotherapy methods, in which psychotherapy in any society develops in response to current social dynamics and requests, does not become a significant area of the research in psychotherapy. However, if the conditionality of psychotherapy by society exists, then it should manifest since the first steps of social life development, being realized in archaic forms of therapy.

2.2 The analysis of archaic forms of therapy

2.2.1 Siberian shamanism and shamanic therapy

Shamanism is a traditional religiosity worldview of the indigenous ethnic groups of Siberia [5–9], which exists from the Neolithic era. It is founded on faith in spirits and the existence of special intermediaries between the world of people and the worlds of spirits—shamans, who are elected by spirits and endowing with special abilities.

The shaman’s universe consists of three worlds: the “upper”—skiey, the “middle”—earthly, and the “lower”—underground. People inhabit the “middle” world, the spirits—“upper” and “lower.” The shaman possesses the helper spirits, which supports him in guarding his relatives from the life troubles. The shamanic ability is inherited, the transformation into a shaman occurs as a result of the “shamanic disease” [26–29]. Shamans divided due to their supernatural capabilities into great and medium ones [26, 27]. Great shamans can visit all three worlds and possess the entire shamanistic practice arsenal. Medium shamans can visit only the middle and lower worlds. Siberian Yakuts divide the shamans into good and evil. Evil shamans—“eduns” are able to bring both benefit and harm, “eat” the “kut” (life force) of a person. The strength of the shaman is determined by the amount of helper spirits. The great shaman has helper spirits from all three worlds. Medium shamans have helper spirits from the middle and lower world.

The main reason of illness in Siberian shamanism is the abduction of the patient’s “kut” by spirits of the upper or lower world [26–29]. Less often, an evil spirit infuses a person. The treatment’s goal consists in returning of the stolen “kut” or in expelling an evil spirit. The basic component of shaman’s therapeutic practice is the ritual of “kamlanie” [26–30], which consists of (1) divination and (2) therapeutic “kamlanie” ritual. The divination’s aim presents “causal,” “pathogenetic” diagnostics that includes: identification of the disease typology (mental, somatic); determination of its cause (abduction of “kut” by the spirit, or the introduction of an evil spirit);
identification of “pathogenic” spirit’s “personality” and “domicile.” The “kamlanie” is night ritual, its duration is varied from several hours to several nights. The venue is the patient’s home. The patient, his relatives, and fellow villagers are becoming ritual member. During the “kamlanie,” shaman, striking a tambourine with a mal¬let, moves around the patient, dances, declares his own poetic improvisations on traditional themes. The script of “kamlanie” includes gathering the shaman’s helper spirits, diagnostics of disease, demonstration of the shaman’s supernatural abilities, communication with pathogenic spirits aimed at restoring the patient’s health, stating the results of ritual, and dismissal of the helper spirits. Conducting the “kamlanie” shaman keeps in touch with the patient and the audience for potentiation of the ritual effectiveness, demonstrates his supernatural abilities (flying, sinking into the ground, bloodlessly inflicting wounds on himself, etc.). It is considered that during “kamlanie” shaman develops controlled trance keeping full contact with the audience [27]. In case of abduction of the patient’s “kut” by spirits, the shaman travels to the upper or lower worlds during the “kamlanie” and, if successful, takes away, redeems the “kut” from the abductor, leaving them something in exchange, and returns the “kut” to the patient [26–29]. The details of the ritual journey are described by the shaman in his chant to all participants, who react vividly to what is happening, often becoming trance witnesses of the shaman’s journey and support him.

The results of “kamlanie” are distributed in the range from patient’s recovery, temporary improvement, to lack of effect, and worsening of the condition. The absence of a sufficient effect indicates the need for repeated “kamlanie” by the same shaman, or addressing to another, more experienced and powerful [27, 28].

2.2.2 Therapeutic ritual of primitive farmers

As an example of therapeutic ritual of primitive farmers, let us analyze the Ndembu (Africa) isoma ritual described by V. Turner, the goal of which is to cure women infertility [31]. Infertility is caused by too strong connection of a married woman with the “male side,” for which a deceased relative of a woman on the maternal side harms her fertility. He goes to the headwaters of the river flowing near the matrilineal village and utters a spell—“chisaku,” which awakens the “shadow” of isoma, who comes to a victim in a dream in the guise of the spirit of Mwenga, whose clothes bind and block female fertility.

Ritual divination precedes the treatment. The isoma treatment contains: finding by the healers the burrows of a rat near the river where the isoma spell was pronounced; instillation of “medicines,” with the utterance of a spell; digging of “hot” and “cold” sacred pits connected by a tunnel, clearing the ritual space around; giving a woman a white chicken—a symbol of fertility, wetting spouses with “medicines”; passage of spouses from the “hot” pit to the “cold” pit through the tunnel; drinking beer by participants, sprinkling of spouses with “medicines”; decapitation of the red rooster—the destruction of “chisaku”; re-sprinkling of spouses with “medicines”; singing ritual songs of life cycle by adherents.

2.2.3 Ritual therapy of Russian peasants in 17–19 centuries

The worldview of the Russian peasantry of that historical period has a religious and magical basis [32, 33]. The Orthodox Christian shell is saturated with the pagan, ritual-magical content. The World consists of Heaven with Paradise, Earth,
underground Hell. The world is ruled by the Lord God, the Lord of Hell is the Devil, Man lives on Earth. The world is full of supernatural forces of Good and Evil, good and evil spirits associated with the forces of Paradise and Hell. The Earth is inhabited by pagan spirits of nature, polarized between Good and Evil, or ambivalent. At the same time, earthly life presents the subject of the natural factors influences.

A person is able to directly appeal to God, angels, saints; however, without priests, part of the necessary rites is impossible. A person can directly appeal to the forces of Evil, but this interaction is improved due to intermediaries—witches and sorcerers. Influence on supernatural powers is carried out in the form of prayers, verbal ritual magic, subject-ritual magic. The diseases' reasons are divided into natural and supernatural [33]. Natural reasons of illness: colds, physical overstrain. A cold is caused by general feeling of cold, it includes: rheumatism, fever, typhoid, erysipelas, pulmonary diseases. Physical overstrain generates such diseases as “navel disruption” (diseases of the musculoskeletal system, gastrointestinal disorders). The pathological process develops from outside to inside, if it penetrates deeply, a person will die. Therefore, it is necessary to move the disease out. Dissemination to inside occurs with blood flow; therefore, “bad” and “stagnant” blood must be “released.”

Supernatural diseases can be sent by God, as a punishment for sins, sometimes as a teaching. Fighting such diseases is useless. More often, diseases are sent by pagan spirits (leshiy, kikimora) or by the Devil. The Devil is the father of all diseases, diseases sent by the Devil are the most difficult to treat. Diseases can be caused by people mediating the influence of evil spirits (spoilage, evil eye, fright) [32–35]. Evil eye can be sent by healers, sorcerers, witches [36]. Evil eye can be temporary, or permanent, until death. The incurable Evil eye can be removed by the sorcerer who sent it or by a stronger sorcerer.

A wide range of people are involved in magical, spell-ritual therapy: sorcerers, and witches, medicine men, holy elders, clergymen [32–35]. Sorcerers and witches are intermediaries between man and evil spirits, the Devil. The magical action of the sorcerer and witch on man and nature is based on rituals and spells. Sorcerers and witches are capable of sending evil eye, triggering disease on people and livestock, causing adverse weather events. At the same time, they can treat diseases, especially those sent by them; however, this treatment, being effective, uses devilish power. The medicine men mainly serve as intermediaries between man and God, although in some cases they cooperate with evil spirits. Through spells and prayers, they have the ability to heal people and animals and send diseases. The healing function of the clergyman is based on exorcism [33]. The holy elders, having a constant connection with the divine world, are able to realize direct and indirect (through prayers, rituals) harmonizing and healing effects on people. In the treatment by witchcraft and prayer, the therapeutic ritual uses spells—special formulaic texts.

Spells are generated by myths, being myth’s abbreviations, applications [37]. The general scheme of the spell and the myth: action—change (new state)—action, taking into account the achieved new state—the desired result. The spell formula has a complex semantic structure, is saturated with mythological and ritual symbolism, but is opaque, hidden from the healer and the patient [37]. For both the spell presents the mandatory formula that includes set of sacred magic symbols, listing them in the prescribed sequence provides the desired result.

If treatment is unsuccessful, its intensity should be increased. If the treatment with an appeal to God does not help, it is radicalized by an appeal to the Devil, an evil spirit (through an intermediary sorcerer).
2.2.4 The patterns of historical dynamics of therapeutic rituals

The effectiveness of all considered archaic therapeutic rituals is due to: the way of life in a certain historical era; correspondence of magical action to the way of life at the given stage of social development; the presence in the mass consciousness, culture of the community of the initial knowledge about rituals and their action. For each historical era, magical action presents an analogue of life-sustaining activity. For collector and hunter societies, the most universal way of activity was the territorial movement, because only it could lead to the goal of obtaining food and maintaining life. In a primitive agricultural society, life became handmade, manual labor—manual manipulations with objects provided life. With the advent of developed social institutions, the oral and written speech of the rulers, the carrier of verbal-symbolic action, began to play a decisive role in people’s life and therapeutic rituals.

The magical action in its historical development passed through analogic stages, manifesting in: the magic of movement in territorial space—flight of a shaman to the upper and lower worlds; manual-subject magic—rites of primitive farmers; verbal-symbolic magic spells. Such distinction is partly relative, since any magic is symbolic and already in the magical actions of the shaman all three types of magic are present as elements, but, nevertheless, their predominant representation in each case is different. The degree of participation of social group in the transition from shamanistic and agricultural therapeutic rituals to spells decreases, the magical effect from public becomes more and more individual.

The magical therapeutic ritual’s historical transformation, especially in the transition to spells, is accompanied by significant reduction, simplification of the ritual to a rather short verbal formula. The symbolism of therapeutic rituals during their historical transformation also changes significantly. The semantic content of the symbols of the ritual with the historical simplification of the form becomes more ambiguous, due to the absorption of the main symbolic constructs of previous rituals. Ritual symbolism develops from primary, concrete subject to secondary, universal, abstract-symbolic, replacing the multiple primary symbols of a given method of magical action with a basic symbol expressing the essence of such magical actions. In the process of historical development, ritual symbolism becomes increasingly incomprehensible to the performer and user of the ritual, which is most typical for spells.

The most important condition for the effectiveness of magical therapeutic rituals is the knowledge by all members of the community of the mythology of the world order, the nature of the disease and “therapist,” the scenario and, the possible outcomes of the ritual. It is obvious that ritual mythology is localized in the mass consciousness of the community, its culture.

2.3 Comparative analysis of some modern psychotherapeutic systems

Modern psychotherapy is represented by a great number of methods, grouped into three main approaches: psychodynamic, cognitive-behavioral, existential; the aggregate analysis of which in a single chapter is impossible. Therefore, in an extremely formal way, the iconic methods of Western psychotherapy (classical psychoanalysis, object relations therapy, cognitive therapy) and the Russian method of personality-oriented psychotherapy will be analyzed.
2.3.1 Psychoanalytic approach

2.3.1.1 Classical psychoanalysis of S. Freud

According to the mature Freud [7–13], the model of personality is represented by three components: Id (unconsciously biological, reduced to energy of libido), Ego (core of personality, constantly matching the requirements of Reality, Id, and Super-ego), Super-ego (social, formed in childhood on the basis of the Oedipus or Electra complexes and subsequently unchanged). The Id presents main motivational sphere, the Ego is its interpreter. Sexual libidinal and genital functions are separated. The libido in its development goes through the oral, anal-sadistic, genital stages, forming the Oedipus complex (the period of the son’s heightened attachment to the mother, with hostility to the father) or the Electra complex (the period of the daughter’s heightened attachment to the father, with the hostility to the mother). In addition to the libido, the Id includes the death instinct (Thanatos)—the desire for self-destruction, expressed in acts of hetero- and auto-aggression, the existence of the individual is a compromise between them. Personal anxiety is caused by pressure on the Ego of Reality, Id, Super-ego. The Ego is saved from the emerging stress through the mechanisms of psychological defenses.

Neurosis is the consequence of an unsuccessful defense process, the result of a weakening of the Ego's strength due to the pressure of the Id and the dissipation of energy to counter this pressure, or neurosis is a conflict between the Super-ego and the Ego. The roots of neurosis are in early childhood. The goal of psychoanalytic therapy is to resolve the neurotic conflict, i.e., strengthening the Ego, its independence from the Super-ego, changing its organization, and expanding the field of perception with the possibility of a more complete mastering of Id.

Classical psychoanalysis includes the steps of: material production, analysis, working alliance. The main methods of material production are: free associations, transfer, resistance. Analysis of the patient's material includes: confrontation, clarification, interpretation, study. The working alliance implies a rational relationship between the patient and the analyst, which makes the process of psychotherapy goal-oriented. Essential methods of psychoanalysis are also: the "rule of abstinence" and "the analyst as a mirror." The "rule of abstinence" is based on the patient's suffering in the process of analysis, and the suffering must reach such an extent that it becomes effective in work. The term "analyst as a mirror" implies a behavior in which the analyst remains "dark," impenetrable to the patient, but not cold-heartless.

2.3.1.2 Object relations therapy

The development of psychoanalytic theory led to the formation of the theory and therapy of object relations [38–40], the distinguishing feature of which is the shift in emphasis from instinct to relationship. In order to understand an individual, it is necessary to understand his self-representations, ideas about objects and object relations. This inevitably leads to an understanding of the individual's early relationships with the person who provided the main care for him. The individual, on the basis of early experiences, forms patterns, stereotypes that subsequently affect perception, thinking, feeling, and establishing relationships. Disturbance of the object relations of the developing Ego will determine the roots of all psychopathological conditions [41]. The main problem is the defect of the environment or the lack of sufficiently
good maternal care. Therapy of object relations is built as a replacement therapy. It involves replacing bad objects with good ones. Its objective is to give the patient relationships in which the “frozen parts” of his Self would have gained the opportunity to develop, in which the impaired development would be restored, making it possible for the patient to reborn. The intervention requires a good relationship between the psychoanalyst and the patient. Therapy uses “good” personal relationships to eliminate the harm from early “bad” relationships [38]. Regression and transference analysis presents important components of the intervention. The psychoanalyst, with some delay, corrects that which initially failed to make the “insufficiently good” mother [38].

2.3.2 Cognitive therapy

A. Beck’s cognitive therapy [14–16] explores the idea that the words and thoughts of people are of great importance. Along with conscious thoughts, unconscious, automatic thoughts are arising. Automatic thoughts consist of ideas that other people consider irrational (however, they seem quite reasonable to the person), as well as the rules and laws, according to which the person judges behavior actions and strategies. These rules can lead to non-adaptive actions. People react to events interpreting them depending on their influence on individual’s Self. The result of the interpretations generates various emotions. Interpretations containing a distortion of reality lead to emotional disorders, which are disorders of thinking. Disturbed thinking includes personalization of events, polarizing thoughts, applying rules in an unconditional manner.

Cognitive therapy aims to weaken emotional disorders by correcting false interpretations of reality and erroneous judgments. The therapist and patient establish a cooperative relationship with attention to solving problems, rather than correcting personal defects.

A. Beck with colleagues and followers has developed effective approaches to the treatment of depressive, anxiety, phobic, personality disorders.

2.3.3 Russian methods of personality-oriented psychotherapy

V. M. Myasishchev, the founder of personality-oriented psychotherapy, [20, 42], defined personality as a social formation, a system of relations with people, forming in ontogenesis, in the given sociohistorical and economic, everyday conditions. Relations present a conscious, empirical-selective psychological connection of a person with various aspects of life, expressed in his actions, reactions, experiences. Relationships are characterized by: level of activity, the interrelations of rational and irrational, conscious and unconscious, stability and instability. From the psychology of relations’ standpoint, neurosis is a psychogenic, caused by conflicts neuropsychic disorder based on the disturbance of personality-significant relationships. The goals and objectives of personality-oriented therapy [20, 42, 43] are: the study of personality, the specifics of the patient’s relationship system; the study of etiopathogenetic mechanisms of the onset and preservation of a neurotic state; the achievement of patient awareness of the cause-effect relationship of a relationship system and disease; help the patient in a reasonable resolution of a situation; change in the patient’s relationship with behavior correction. The applied methods of psychotherapy are individual and group, using the mechanisms of group dynamics.
2.3.4 Comparison of the described methods of psychotherapy

Preceding analysis of the methods of archaic magical therapy revealed several important points. Let us emphasize two: (1) the conditionality of the form and context of magical action and therapy by actual social life and ideology; (2) at the next step in the development magic ritual introjects and retains in a symbolic form, the previous magical action. The question arises, are these points of magical therapeutic rituals’ development persist in the field of modern psychotherapy? The answer is positive.

Thus, the early basic psychoanalytic construct of the irrationality of mental life, according to E. Fromm [44–47], is secondary and reflects the idea of irrationality that prevailed in the West on the eve of World War I. It also seems logical that therapy of object relations and cognitive therapy, which emerged in the era of the successful post-war reconstruction of Western Europe in the 1950s on the basis of the Marshall Plan, implement therapy as a positive, rational reconstruction of the psyche, distorted in the early period of development, based on corrective cooperation. Russian personality-oriented therapy in its interpretation of personality is based on the definition of K. Marx (a person is a set of social relations) [48], which became part of the ideology of the Soviet period.

All of the above methods of therapy should be accepted by the patient on the base of understanding, causing his confidence in their efficacy, when patient correlates the therapeutic information with own model of the world and disease.

It should be recognized that orthodox psychoanalysis had a profound impact not only on the development of all subsequent psychotherapy, introducing its own positive or negative introjects (including the examples given earlier), but also became a component of Western culture and mass consciousness. In general, psychotherapy, as well as magic therapy, appears to be a secondary phenomenon in relation to social life, worldview, mass consciousness, historically changing after the changes in the latter. The relative simplicity and integrity of social life, worldview, mass consciousness of the times of magic therapy generate its universalism, the limited set of concepts and means, fully incorporated into social life and culture. And, on the contrary, the complexity and differentiation of modern social life, worldview, and mass consciousness give rise to sufficient isolation, specificity of concepts and means of psychotherapy, creating the impression of its self-sufficiency.

Modern methods of psychotherapy are dualistic, have a well-defined theoretical basis and set of techniques, developing in response to an actual, but less conscious social, cultural requests.

2.4 Mass consciousness, “model of disease and therapy”

So, the analysis showed that psychotherapy in its historical development follows social life, changing in mass consciousness [21, 49, 50].

2.4.1 “Model of disease and therapy”

Seeking medical help for various diseases, the patient already has initial common ideas about the presence and characteristics of diseases, about how he will be provided with medical care on the base of his own experience of diseases and certain general cultural knowledge and norms. In the most general form, the provision of medical care is understood as step-by-step sequential: “examination,” “diagnostics,” “treatment.”
Certain knowledge about diseases, their severity, outcomes, sequence, types, and forms of medical care are acquired by a person both directly, through the experience of diseases and their treatment, and indirectly, through the experience of other people's illnesses, accumulated, transformed from the surrounding sociocultural environment, social networks.

The author considers that people's ideas about the causes of diseases and their treatment are not accidental and form a complex system that can be defined as a "Model of Illness and Therapy" (MDT), the repository of which is the mass, everyday consciousness [21, 49–51]. "Model of a disease" is people's set of the most generalized, averaged knowledge, ideas, opinions about diseases, their types, causes, treatment types, and outcomes. The "Model of the Disease" is inextricably linked with the "Model of Therapy"—a set of generalized, middling knowledge, judgments, opinions, and ideas about methods of treatment, their effectiveness, mechanisms.

The MDT—the medical component of mass consciousness is practically unexplored, while its study is of considerable interest not only for psychotherapy, or therapeutic disciplines in general, but, undoubtedly, for sociology, social psychology too. The MDT of mass consciousness is a component of the "Model of the World" (MW) of mass consciousness, which represents a systematic description of the world and man. From the standpoint of psychotherapy, one should single out in the MW of mass consciousness such a component as "Model of the problem and its solution."

In typical cases, in the process of treatment of diseases, medical measures do not go beyond the traditional, stage-by-stage "Examination," "Diagnostics," and "Therapy" of MDT; therefore, the patient's acceptance of the treatment is in line with his expectations. Modern methods of psychotherapy are probably the least traditional from the standpoint of the actual MDT and therefore must use the means to maintain social attractiveness and effectiveness. Traditional, generally accepted methods of psychotherapy (psychoanalysis, cognitive-behavioral therapy) have already been assimilated by the MDT of the Western mass consciousness. New psychotherapy methods that have developed their own techniques are not included in the MDT of mass consciousness and need to be explained to patients. Therefore, all relatively new methods of psychotherapy at the beginning of work with a patient include the presentation of a connecting script of subsequent therapy, with description of goals, objectives, normative roles, procedures, and expected results. Such a connecting script can be presented in a structured form at the beginning of therapy, or it will be clarified during therapy, at its beginning.

Thus, the development of modern psychotherapy, as well as the historical dynamics of archaic forms of therapy, is determined by uniform laws.

1. The conceptual foundations of the current psychotherapeutic system are in accordance with its contemporary MDT of mass consciousness. The relative discrepancies between the psychotherapeutic system and the model of illness and therapy are overcome with the help of a "Connecting Script" that allows to overcome the differences existing between them.

2. The development of psychotherapy and the dynamics of the MDT represent a single dialectical process with a system of direct and feedback connections, in which the historical, socially determined dynamics of mass consciousness and the MDT determine the development of psychotherapy, while the theoretical foundations of the psychotherapeutic system, which formulated and proposed
the solution of urgent existential problems, are included in the social ideology, penetrating into the mass consciousness.

3. The process of historical development of the mass consciousness MDT and psychotherapy has a qualitative integrity, continuity and is based on the accumulation, specific “conservation” of the previous traditional social models of decision. This is illustrated by the pseudo-spontaneous restoration of the semantic structure of the rites of passage [21] in modern group psychotherapy, using the ritual cliché, crystallized millennia earlier for solving similar problems.

2.5 Structure, variants of dynamics and historical development of the model of disease and therapy of mass consciousness

The author became interested in the nature of psychotherapy after the archaization of his patients’ attitudes toward his psychotherapy. For explanation, the hypothesis of archaization of mass consciousness was proposed as a result of a social deadlock developing in the life of the late USSR on the eve of the 1990s [21, 49–51]. In those years in Russia happened a boom in extrasensory healing, newspapers talked about magicians, A. Kashpirovsky, A. Chumak, D. Davitashvili consistently became TV stars, replacing each other. The author, observing breathtaking events, became interested in the possibility of an experimental study of the initial representations of people about diseases and their therapy (MDT) and the search for signs of archaization of these representations in: 1) an experimentally created deadlock situation; 2) persons involved in training in psychic therapy. Such a study was implemented, its results are described below.

2.5.1 The experimental method “Model of Disease and Therapy”

The method “Model of Disease and Therapy” was developed by the author for study of human representations about the effectiveness of various types of diseases treatment. The method is based on the principle of rank grid method of D. Bannister [52]. The rank grid presents a matrix filled in during the survey, which includes elements and constructs. Elements are groups of objects from a specific area that are reasonably related. Constructs are bipolar-scaled features that relate to the area characterized by the elements.

Our test uses the possible outcomes of different treatments as seven elements [21, 49]: (1) treatment is useless; (2) treatment brings minor temporary improvement; (3) treatment brings clear temporary relief; (4) treatment leads to gradual significant improvement in the condition; (5) treatment leads to gradual recovery; (6) treatment leads to rapid full recovery; (7) treatment leads to sudden full recovery.

The constructs were described by the language of the average patient. The 14 constructs describe various types of treatment, from traditional magical, attributed to “traditional medicine,” to conventional in medicine, and finally, high-tech: (1) treatment of a person with extraordinary abilities in recognizing and treating diseases, for example, a psychic who has the ability to sense the biofield and use it for therapeutic effects; (2) treatment by an experienced chiropractor; (3) treatment by an experienced healer, treating with special herbs, potions, spells; (4) treatment by a qualified psychotherapist (hypnosis, autogenous training, group psychotherapy, other types of psychotherapy); (5) treatment with medical massage; (6) treatment by a qualified acupuncturist; (7) treatment with medical tinctures, potions, drops,
prescribed by a doctor; (8) treatment with pills, prescribed by a doctor; (9) treatment with subcutaneous, intramuscular injections, prescribed by a doctor; (10) treatment with intravenous injections, droppers, prescribed by a doctor; (11) treatment with electrical procedures (such as electrophoresis); (12) treatment with balneological agents (baths, mud); (13) treatment by surgical means (operations); (14) treatment with modern technical means (laser, radioactive substances, ultrasound, and others).

The procedure of psychological research was as follows. All seven elements and the first construct are presented to the subject. The subject is asked to indicate the element (treatment result) that most fully characterizes the given construct (type of therapy). The indicated element is removed from, and the subject is again asked to indicate the element (treatment result), most completely, of the remaining, characterizing this construct (type of therapy). The procedure is repeated until the last element remains. When all seven elements are ranked by one construct, construct 2 is presented, its ranking procedure is carried out, similar to the ranking of construct 1. After the ranking is completed by seven elements of all 14 constructs, a $7 \times 14$ element ranking matrix is obtained.

Modern man has not only a general representation about medicine, but also distinguishes between its individual areas: diseases in general, therapy, surgery, oncology, infections, etc. Therefore, the method provides, on the base of goal setting of a concrete study, the assessment of representations about a specific field of medicine by highlighting the testing theme that is demonstrated to the subject in the testing cycle, when working with constructs and elements.

The ranking results are entered in the protocol form (with a $7 \times 14$ matrix). Constructs are columns, elements are rows. To assess the group results, the indicator of the sum of the scores of the relationships for each construct of the individual matrix, proposed by D. Bannister, was used; it characterizes the general variance explained by this construct. For each pair of rankings of individual matrix, using Spearman’s rank correlation coefficient, the scores of the relationship ($p^2 \times 100$) are calculated, which are then summed up for each construct without taking into account the sign. The sums of the scores of the relationships of the 14 constructs of the tested selected groups were subsequently subjected to the standard procedure of factor analysis by the method of principal components.

2.5.2 Experimental psychological study of the structure and dynamics of the model of disease and therapy

2.5.2.1 The objectives of the study

1. Revealing the archaization of representations about diseases and their therapy in adult subjects in a situation of an experimental impasse.

2. Comparison of the archaization of representations about diseases and their therapy in adult subjects in an experimental situation with the archaization of representations of diseases and their therapy in adult subjects who reacted to a social dead-end situation.

To achieve the first goal in 1989 (3 years after the Chernobyl disaster), 60 workers of the factory in the city of Mozyr (70 km from the Chernobyl nuclear power station),
during a preventive medical examination, on condition of voluntary informed consent, twice, with an interval of 5 minutes, were tested according to the MDT method; the theme of the first study is “Diseases in general,” the theme of the second study is “Diseases caused by radiation.” The author suggested that the second theme would actualize the experimental impasse and cause archaization of representations about diseases and their therapy. To achieve the second goal in 1990, during the period of active disintegration processes in the USSR, accompanied by a sharp increase in interest in psychic healing, 106 students at the “school of psychics” in the Ufa city, during a medical examination, on the basis of voluntary informed consent, a single test was carried out on the MDT method; research theme was “Diseases in general.” The author suggested that persons studying extrasensory healing during the collapse of the USSR had already, and most sharply, reacted to the social dead-end situation and would initially demonstrate archaization of representations about diseases and their therapy.

The study design for both groups included MDT testing method: for the Mozyr group—twice, with an interval of 5 minutes, using the first theme “Diseases in General” and the second—“Diseases caused by radiation”; for Ufa group once using the theme “Diseases in General.”

2.5.2.2 Materials and methods

The Mozyr group consisted of 60 subjects, 37 women (62%), 23 men (38%), aged from 27 to 52 years (average age 38.5 ± 5.2 years). The Ufa group included 106 subjects, 68 women (64%), 38 men (36%), aged from 22 to 55 years (average age 43.4 ± 6.7 years). In the study, according to the design, the MDT method was applied, the themes “Diseases in General” and “Diseases caused by radiation” were used.

Statistical processing was performed using the Statistica 6.0 software. The sums of the scores of the relationships of Mozyr and Ufa groups were applied in factor analysis by the method of principal components.

2.5.2.3 Results of research

The results of factor analysis of the MDT testing for the Mozyr group data are presented in Tables 1 and 2, and the analogous data for Ufa group in Table 3. The names of the factors were given on the basis of a generalized interpretation of the totality of the variables included in them. The definition “External” methods of therapy characterize the methods of therapy that act through the surface of the body, the skin. The definition “Internal” therapy refers to therapies that act primarily through the mouth or ears.

The factor matrix for evaluating the therapy of “disease in general” is presented in Table 1 and consists of six factors (the variables of which are given in decreasing order of significance). The first factor—“Conservative Therapeutic Methods of Treatment” includes: treatment with pills, injections, electrotherapy, treatment with droppers, tinctures, balneological treatment, treatment with modern technical means. The second factor—radical therapeutic methods of treatment includes: surgical treatment, treatment with modern technical means. The third factor is formed by traditional medical methods of manual treatment: acupuncture, medical massage. The fourth factor presents the methods of therapeutic mental influence:
psychotherapy, psychic treatment. Factors 5 and 6 include single variables: treatment of the chiropractor and the healer.

The factor matrix for evaluating the therapy of “radiation-related diseases” by the Mozyr group is shown in Table 2 and consists of six factors (the variables of which are given in decreasing order of significance).

The first factor of “External” methods of therapy includes: acupuncture, massage, electrotherapy, balneological treatment, treatment with modern technical means, chiropractor treatment. The second factor of “Internal” methods of therapy includes: treatment with droppers, psychotherapy, treatment with injections, pills. Factors from the third to the sixth include, single variables: treatment with tinctures, treatment of a medicine man, treatment of a psychic, surgical treatment.
The survey of students of the school of psychics was carried out during the boom of psychic healing in the spring of 1990. The factor matrix of scores for the relationship of evaluating the effectiveness of therapy of the “disease in general” by the students of the school of psychics is given in Table 3 and consists of six factors (the variables are arranged in decreasing order of significance).

The first factor of Traditional magical methods of treatment includes: Healer's treatment, Acupuncture, Psychotherapy, Chiropractor treatment. The second factor of medical methods of “internal” treatment includes: treatment with injections, droppers, tinctures, tablets. The third factor presents medical methods of “external” treatment, including: electrotherapy, balneotherapy, medical massage. Factors from three to six include single variables: Modern technical therapy, Surgery, Psychic treatment.

2.5.2.4 Modern and archaic models of disease and therapy on the base of test results: Discussion

The first Mozyr factor matrix, which includes the subject’s assessments of supposed effectiveness of the treatment of “disease in general,” characterizes the MDT, which classifies various methods of therapy according to their presence in real life and adequately evaluates their significance: the dominance of conservative therapeutic methods, the important role of surgery and other modern technical methods, sufficient relevance, the proximity of traditional medical methods of acupuncture and massage. Psychotherapy, extrasensory therapy, chiropractor treatment, and a healer are combined, which justifiably gives grounds to define them as “Methods of therapeutic mental influence.”

The second Mozyr factor matrix, obtained during the examination of the same subjects, at the same time, but representing an extremely significant, threatening for those living in the Chernobyl zone, an assessment of the effectiveness of treatment of “diseases caused by radiation” (requiring essentially the same structure of medical care), is qualitatively different. The subjects unexpectedly divided the therapy methods based on the bipolar trait “external” and “internal”. Moderately significant in the previous “model of disease and therapy” and the most ancient of all traditional medical

<table>
<thead>
<tr>
<th>Factor</th>
<th>Factor name</th>
<th>Variables and their meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>Magic therapy</td>
<td>Healer’s treatment (0.76), Acupuncture (0.72), Psychotherapy (0.68), Chiropractor treatment (0.63)</td>
</tr>
<tr>
<td>F2</td>
<td>“Internal” Methods of Therapy</td>
<td>Injections (0.78), Droppers (0.74), Tinctures (0.59), Tablets (0.57)</td>
</tr>
<tr>
<td>F3</td>
<td>“External” Methods of Therapy</td>
<td>Electrotherapy (0.82), Balneotherapy (0.75), Massage (0.62)</td>
</tr>
<tr>
<td>F4</td>
<td>—</td>
<td>Modern technical therapy (0.73)</td>
</tr>
<tr>
<td>F5</td>
<td>—</td>
<td>Surgery (0.78)</td>
</tr>
<tr>
<td>F6</td>
<td>—</td>
<td>Psychic Treatment (0.83)</td>
</tr>
<tr>
<td>Number of subjects</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td>Dispersion</td>
<td>81%</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Ufa factorial matrix of scores for the relationship of assessing the effectiveness of therapy for “disease in general” by students of the school of psychics.
methods of treatment—acupuncture and massage, are assessed in the second survey as the most significant, leading the first factor of this matrix, which also includes the treatment of the chiropractor, while the indicator of surgical treatment, which headed the second factor of the first matrix, becomes the least significant. The MDT, actualized by the conditions of an experimental deadlock, loses its connection with the modern therapeutic reality and demonstrates different, archaic structure and content.

The factorial matrix for evaluating the effectiveness of treatment of “diseases in general” by students of the school of psychics is close to the Mozyr matrix of “diseases caused by radiation” and is also distant from modern therapeutic reality, since it highlights “internal” and “external” methods of treatment, reduces the importance of surgery. But, in contrast to the compared one, in this model the most significant are traditional methods of treatment (acupuncture, psychotherapy, chiropractor treatment), which acquire a magical coloring due to the leadership of the healer therapy in this group. It is interesting that the indicator of psychic treatment is highlighted by the students in the last factor of the matrix and, having a high significance (0.83), is separated from all other methods of treatment. This is due to the fact that extrasensory perception was understood by teachers and students as a fundamentally new, scientific, developing, if not refuting modern medicine, method of diagnosis, and therapy. The last factorial matrix reflects the most archaized MDT, which is acquiring a frankly magical coloring.

The division of therapy methods into “external” and “internal,” revealed in two archaized factor matrices, is, in author’s opinion, related to archaic MDT. This circumstance prompts the search for similar classifications of therapeutic techniques in traditional systems of therapy with archaic roots, which inevitably preserved, systematized, developed the provisions of the MDT of mass consciousness that corresponded to the period of their formation. The most developed traditional systems of therapy are the Chinese, Tibetan and Arab ones. Indeed, these systems have developed fundamental concepts of the “external” and “internal” causes of diseases (in line with the ideas of the connection between the Universe and humans) about the clinic, diagnostics, “external” and “internal” treatment.

In classical Chinese medicine, the categories of “internal” and “external” are codified in the concept of yin-yang (yin corresponds to “internal” and yang to “external”) [53], they develop in the concept of the cycle of interconversions of Wu Xing, are included in dialectics “I Ching (“ Books of Changes ”) [54] and are most consistently implemented in the theory and practice of pulse diagnostics and zhen-chiu therapy [53]. In the Tibetan medical science Zhud-shi, the system of medicine is represented in the form of nine trees growing from three roots [55]. Four trees grow from the third root, the first symbolizes food and drink, the second—the way of life, the third—medicinal substances (“Man”) taken internally, the fourth symbolizes external methods of treatment, including surgery (“Shad”).

Avicenna, who reflected in the “Canon of Medicine” [56] the achievements of Arab-Persian medicine at the end of the first millennium, subdivided, referring to Galen, all diseases into external and internal, distinguishing three types of therapy: regimen and nutrition; drug administration (“internal” treatment); hand action (“external” treatment).

Thus, the similarity of two factorial matrices showing archaized MDT is a natural phenomenon based on the actualization of previous “models” accumulated, “conserved” in the mass consciousness in the course of the historical development of MDT. It should be noted that the first archaic factor matrix was obtained during a psychological examination and reflects the experimentally determined, individual
regressive dynamics of the previously relevant modern MBT when the subject is placed in a situation that is insoluble from the standpoint of this model. The factor matrix of the psychics school students revealed the “background,” actual at the time of the survey, the most archaic of the three MDTs, obtained for persons who have a short interest in psychic therapy (4–6 months) and, for the most part, who had not previously thought about it. It can be reasonably assumed that this archaized MDT is a consequence of the regressive dynamics of the modern model under the influence of not an individual, but a socially conditioned cause, which in its meaning is close to an insoluble disease situation.

If we assume that the first, background factorial matrix of the Mozyr series reflects the modern MBT, the second—reflects the previous MBT; and the factorial matrix of students of the school of psychics reveals the most archaic of the three MBTs of mass consciousness; then the data structure of the models can be represented as follows.

1. Modern multicomponent MDT consists of blocks: (1) conservative therapy; (2) radical therapy; (3) traditional therapy, introjecting “external” and “internal” methods of treatment of the previous model; (4) therapy by psychic means (psychotherapy).

2. The previous two-component MDT consists of blocks of: (1) “external” methods of traditional therapy; (2) “internal” methods of traditional therapy.

3. The earliest of the compared, three-component-magical MBT consists of blocks: (1) spell-ritual magic therapy; (2) “external” methods of traditional therapy; (3) “internal” methods of traditional therapy.

It is principle that the second and third archaic MDTs were obtained with individual and socially conditioned regressive dynamics of the modern MDT. Consequently, modern MDT in a latent, mediated form contains previous MDT, which is possible only if MDT is a hierarchical, multilevel formation with the property of individual and social progressive historical development and regressive dynamics. So, MDT (both individual and social) is a systemic, hierarchical, multilevel formation, which can be represented as a hierarchical, multilayer “spherical” structure, each layer-level of which corresponds to a certain historical stage in its development. The functioning of such a structure is determined by the activity of the highest, modern layer-level of the MDT. If the upper layer-level of the model of the effectiveness of medical care does not correspond to the individual, it is inactivated, with the transition of systemic functions to the MDT of the lower level. The correspondence of the subordinate levels of the MDT to certain historical epochs is probably not literal, only the most essential, key elements are preserved.

The assimilation by the individual of the MDT of mass consciousness is provided by two mechanisms: “vertical” and “horizontal.” The “vertical” mechanism plays a decisive role in the formation of the structure of MDT, starting from the deep levels—at the first stages of socialization of the individual and is functioning in the general context of mastering culture, starting with its most archaized elements: myths, legends, fairy tales, signs, prejudices; in direct and indirect forms. The “horizontal” mechanism determines the detailed development of each individual level of the MDT and is based on the active interaction of the individual with the surrounding reality.

Three variants for the individual dynamics of MDT are possible. The first variant is progressive dynamics of MDT, in which, due to the assimilation by individual from
mass consciousness of modern scientific paradigms of pathogenesis and therapy, with formation of higher level of model, which takes on system-forming functions, integrating and transforming the functions of the underlying layers levels. The second variant is regressive dynamics, with inactivation, due to the ineffectiveness of the treatment of the highest level of MDT and actualization of the underlying phylogenetically and ontogenetically preceding level of the model, which takes on system-forming functions. The third variant—reactivation dynamics, in which due to positive outcome of therapy there occurs a restoration of functioning of the initially “external” level of MBT, deactivated by the previous regressive dynamics.

2.5.2.5 Structure, historical development, and dynamics of mass consciousness model of disease and therapy

Analyzing the structure and dynamics of the MDT, it is necessary to recognize the systemic unity, identity of such models of individual and general mass consciousness. The MDT presents a systemic block in the structure of MW of mass consciousness; therefore, it must preserve the basic principles of its organization. Mass consciousness represents a hierarchical, historically forming multilevel system, whose functioning is determined by the activity of the system-forming “external” level. Mass consciousness, MW as a system, undoubtedly has the progressive, regressive, reactivation dynamics discussed above.

Social tension, crisis from the position of the hierarchical system of mass consciousness can be considered as a discrepancy between the conditions of social life and the standards of the “external” level of the system, which should, according to our model, lead to a regressive dynamic of such a system, with the actualization of the historically previous level of mass consciousness, which takes system-forming functions. The disintegration processes that took place in the former USSR served as a vivid illustration of this provision. The regressive dynamics of the system of mass consciousness during social tension encompasses its highest level as a whole, deactivating all systemic blocks of MW, including MDT. Mass interest in various forms of archaic, magical healing, extrasensory therapy, growing during the intensification of social disintegration, is natural. The first wave of telepsychotherapy by A. Kashpirovsky in 1989 [57, 58] and in the 1990s was swallowed up by a flurry of “non-traditional,” “folk healing.” [34, 35, 59–64]. The development of such “non-traditional folk healing” during the period of social disintegration of 1988–1991 obeyed a certain pattern and proceeded in the direction of successive actualization: the verbal-symbolic (example of telepsychotherapy by AM Kashpirovsky [57, 58]); manual (A. Chumak [49, 60], D. Davitashvili [61], and many others); extrasensory-trance therapy, with the experience of moving in space (flights to “space,” to “planets of the hierarchy,” etc., in a trance state) [21]. In 1992–1993, the return of verbal-symbolic, spell-ritual healing (the coming of Maria Stephanie and sorcerers of Russia [21, 49, 50], the resumption of A. Kashpirovsky activities) took place. The noted dynamics of “folk healing” corresponds to the initial regressive dynamics of the magic block of the MDT during the collapse of the USSR, in the reverse order to the historical development of magical action (proceeding from the magic of movement in space to manual-object magic and verbal-symbolic magic), followed by the initial reactivation dynamics of the “model” with a return to verbal-symbolic magic during the initial stabilization of statehood in Russia [21, 49–51].

Based on the analysis of the experimental psychological material, as well as the socially conditioned dynamics of the MDT during the collapse of the USSR, we...
propose the following structure [21, 49, 50]. Spherical, hierarchical MDT is represented by three main layers levels.

1. The original, the most ancient, “nuclear” layer level of the MDT is formed by magic therapy, which in turn includes three sublevels: the “deepest”, the most ancient sublevel of therapy by magical movement in space; next—manual (manual-manipulative-subject) magic therapy; historically the later, “external” sublevel of verbal-symbolic magical therapy.

2. The second, “intermediate” layer level of the MDT is formed by traditional therapy, which distinguishes the opposing “external” and “internal” methods of therapy.

3. The third, modern, “superficial” layer level of MDT includes conservative therapy, radical therapy, therapy with psychic means.

Moreover, the blocks of conservative and radical therapy of the outer layer-level are genetically related to the layer level of traditional “external” and “internal” therapy, while the block of therapy with psychic means—with the layer level of magic therapy, which is revealed during the regressive dynamics of MDT.

It should be noted that the actualization of archaic MBT happened before in the historical past, preceding and accompanying major social upheavals. So, on the eve of the Great French Revolution, the famous Anton Mesmer treated patients with “animal magnetism,” and on the eve of October, the gloomy figure of the “healer” of the court and aristocratic Petersburg Grigori Rasputin had “materialized.” ***

The MDT of mass consciousness, relevant in the process of therapy, plays the role of a specific communicative “language” of the patient and the therapist. The correspondence of the representations of the patient and the therapist about the disease and its treatment leads to the establishment of psychotherapeutic contact, with the inclusion of individual psychological and biological mechanisms of psychotherapy. The degree to which the MDT context matches the psychological and biological changes of the patient is fundamentally insignificant.

2.5.3 The mythological nature of mass consciousness and its model of disease and therapy; psychotherapeutic aspect

A comprehensive, experimental-psychological and historical analysis of the MBT of mass consciousness made it possible to: describe its historically formed multilevel structure and socially and personally determined dynamics; when studying the experimental and social regressive dynamics of MDT, to reveal the genetic affinity of superficial and deep structures. However, the momentary experimental regression of the formerly rational “model” transforming into “external–internal” and magical methods of therapy confirms the mythological essence of the modern MDT.

So, MDT is a mythological formation, and its hierarchical structure and dynamics are the structure and dynamics of mythology [21, 49, 50]. Since the MDT presents a systemic part of mass consciousness MW, the last is also a mythological formation. The lives of man and mankind are saturated with mythology.

The system of psychotherapy widespread in a certain society interacts satisfactorily with the actual MBT of mass consciousness. Such interaction is provided by adaptation
of psychotherapy to the current MBT, generation of a connecting script and its subsequent exploitation. Psychotherapy, which qualitatively corresponds to the current MDT, inevitably is functioning as a mythological system. Thus, in a social context, psychotherapeutic systems are essentially mythological systems. The socially conditioned dynamics of MW and MDT generates the development of psychotherapy methods.

2.6 Psychological component of psychotherapy

Clinical psychotherapy is based on therapeutic communication between individuals or a group of individuals. Effective therapeutic communication triggers and maintains in the patient intrapsychic, intrapersonal mechanisms of psychotherapy, which provide the patient with the final result [21, 49, 50].

The intrapsychic mechanisms of psychotherapy are obvious, since without them the therapeutic result is impossible. The obviousness of the latter is combined with the mirror-like pseudo-transparency of the psyche’s “black box,” in which the involved observer will see the desired content, which often presents a reflection of the applied communicative-interpersonal component of psychotherapy. The real intrapsychic mechanisms of the psychotherapeutic process are hidden “behind the mirror” of the individual’s psyche and may, probably, not coincide with the methodical prescriptions.

2.6.1 Psychological communication in psychotherapy

Psychological communication of psychotherapy is characterized by (a) a historically determined communicative style, (b) methodological goal-setting and instruments of therapy, (c) partial spontaneity of interpersonal interaction [21, 49–51, 65].

2.6.1.1 Communicative style of psychotherapy

The concept of communicative styles [65] was formulated by the author in relation to hypnotherapy, in a comparative analysis of directive hypnosis, Ericksonian hypnosis, and the author’s method of Universal Hypnotherapy [66].

Communicative styles (of hypnotherapy) are determined by: (a) the approach to the use of the initial representations about the method of psychotherapy (hypnosis) among participants in therapeutic communication, (b) the peculiarities of the implementation of therapeutic communication at the verbal and nonverbal levels, (c) the ratio of the activities of the sides of psychotherapy (hypnotherapy), and (d) application of feedback by the therapist. It has been demonstrated that communicative styles of hypnotherapy are characterized by a natural historical sequence of appearance and development, from the Directive to Ericksonian hypnosis and, further, to Universal Hypnotherapy, since hypnotherapy translates historically relevant communicative styles of active influence of the mass consciousness [65]. Each communicative style has a characteristic profile of opportunities and limitations that work at the sociopsychological and psychological levels.

The concept of communicative style is applicable to any psychotherapy method. So, communicative styles are transferred to psychotherapy from everyday life, the historical dynamics of mass consciousness determines natural changes in therapeutic communication.
2.6.1.2 Methodological goal setting and instruments of psychotherapy

Psychotherapy as a methodology includes the methodological goal setting and methodological instruments [21, 49, 65–67]. The methodological component is determined by: theories underlying the applied methodological approaches to psychotherapy; methodological approaches embodied in specific psychotherapeutic techniques and patterns. Each method of psychotherapy reduces the general understanding of psychotherapy to this component.

2.6.1.3 The spontaneity of interpersonal interaction in psychotherapy

Despite the requirement to adhere to the therapeutic protocol, both sides of the therapeutic process are represented by living people, who inevitably bring an element of unique spontaneity to the methodically regulated process. Therefore, the spontaneous-communicative component characterizes the influence of the individual-personal characteristics of the participants in the psychotherapeutic process (therapist and patient) in their real communicative interaction on the results of psychotherapy. The influence of the psychotherapist’s personality and his behavioral style on the results of psychotherapy has been widely studied earlier [21, 49, 68] and therefore is not the subject of our consideration.

2.6.2 The intrapsychic mechanisms of psychotherapy

In the process of clinical psychotherapy, the patient learns and assimilates a lot of new information about himself, disorder, the applied therapy, he manages to therapeutically modify and stabilize the modified state, behavior that provide the final therapeutic result. Psychotherapy undoubtedly uses a variety of learning mechanisms that are an important part of the intrapsychic component of psychotherapy [69–76]. However, the author will highlight other, previously detected intrapsychic mechanisms described as the system of psychological adaptation of the personality [21, 49, 51, 68, 77].

2.6.2.1 Study of the intrapsychic personal system of psychological adaptation

In the 1980s and 1990s, the author investigated the dynamics of the MMPI basic scales before and after identical group hypnotherapy for two samples of patients with various types of Anxiety Disorders [21, 49, 68] (Mixed Anxiety-Depressive disorder, ASD, PTSD along with Dissociative and Somatoform disorders, OCD) (N = 145). Another group represented Anxiety Disorders due to Cerebrovascular disorder (N = 51). The design of the research included: (1) clinical estimation of psychotherapy efficiency; (2) analyses of MMPI data (basic validity and clinical scales) at the beginning and at the end of psychotherapy; (3) statistical analysis (descriptive statistics; means; nonparametric statistics [Wilcoxon matched pairs test] along with factor analysis—principal components method (varimax rotation)). For each clinical group of psychotherapy efficiency, we analyzed within the factor analysis the initial data, final data, and data on dynamics of psychotherapy (received by subtraction of final data from initial data).

Our study revealed two levels of the psychotherapy efficiency: significant improvement of the condition (equivalent of full recovery) with a full and persistent
reduction of clinical disorders, and improvement of conditions with only partial or unstable reduction of clinical disorders [21, 49, 68]. This research has shown that patients, who displayed either significant improvement or improvement of conditions, differ from the very beginning and that there are two types of dynamics, which represent mechanisms of the therapeutic effect and final outcomes of psychotherapy.

2.6.2.2 The model of personal system of psychic adaptation

We attributed positive dynamics of affective symptoms to the restoration of the Personal System of Psychic Adaptation (PSPA), which is the primary mechanism of positive change in cases of efficient psychotherapy for anxiety disorders. With regard to cognitive-behavioral parameters, the therapeutic dynamics were associated with developmental mechanisms of mostly supplementing and rebuilding the Personal System of Psychic Adaptation, which is the primary therapeutic mechanism in cases of efficient psychotherapy for Anxiety Disorders Due to Cerebrovascular Disorder.

In the 1980s, based on our research on outcomes from psychotherapy of anxiety and organic disorders, the author elaborated the model of Personal System of Psychological Adaptation (PSPA) [21, 49, 54, 68, 77]. PSPA is a spontaneously active homeostatic dynamic structure, which forms during ontogenesis and includes a hierarchy of adaptive mechanisms ranging from the earliest, most primitive and typical (similar to Freudian ego-defenses such as Regression, Replacement [78], etc., which are normal for early childhood) to mature, complex, individualized, and personal ones, which can be used as coping mechanisms. Hierarchical PSPA can be visualized as a spherical multilayered model (see Figure 1) involving the following components.

1. Concentric structure of levels of the hierarchical organization of adaptation mechanisms that form an expanding sphere around a “center” or the “Self.” The highest mature level of hierarchy of multilayer level mechanisms of psychological adaptation has a capability of transforming the interactions between the underlying levels.

PSPA dynamics may express themselves in regressive, reactivating or of progressive, forming transformations.

1. In cases of regressive dynamics (where there is relative inactivation of the highest, mature level of mechanisms of psychological adaptation) the underlying levels, ontogenetically antecedent to it, become primarily active and assume the role of regulatory functions overriding more advanced functions; this results in reorganization of the system of radial and spherical connections, and restoration of emotional and behavioral patterns of the previous stages of PSPA ontogenesis. Regressive dynamics is potentially convertible.

2. Reactivation dynamics became possible after previous PSPA regressive dynamics; it involves restoration of function of initially top level of psychological adaptations and of PSPA “normal functioning,” which has been disturbed by its previous regressive dynamics.

3. The formation of PSPA dynamics is possible through development of a higher level, which would overcome insufficiency and defectiveness of previous psychological adaptations of underlying levels.
In cases of anxious maladaptation (but not much disintegration), weakening in higher levels of PSPA adaptive mechanisms causes lower levels of adaptive mechanisms to acquire greater behavioral significance. (An example may be the development of dissociative symptoms in persons without a history of dissociative disorders in combat situations).

According to model, psychotherapeutic interventions [21, 49, 54, 68, 77] are especially suitable for cases of anxiety disorders in which there is a potential weakening of the PSPA due to regressive activation of early ontogenic adaptation mechanisms (i.e., dissociative, obsessive disorders) but also to a PSPA deficit, which is due to personality disorders or to organically based brain disorders.

Evidently, mechanisms of effective psychotherapy in cases of reversible psychogenic blocking and organically based PSPA deficit must be different. In instances of regressive dynamics of PSPA, “higher,” “normal” levels of psychological adaptation are deactivated psychogenically (or underutilized), in the course of maladaptive functioning, and the goal of psychotherapy is to facilitate their proper functioning again. In the case of deficit, the higher layer level of PSPA, which controls other functions, needs to be developed for the first time and as a result of psychotherapy efficiency, an opportunity for a normal psychic adaptation be formed. So, in psychotherapy of personality and organic disorders, the therapeutic efforts are similar to spontaneous developmental processes leading to formation of the PSPA hierarchy, which means that the patients need to acquire resources allowing for better adaptation.

The results of our empirical research on hypnotherapy outcomes have revealed that dynamics of efficient hypnotherapy with complete improvement in anxiety disorders is consistent with the mechanism of reactivation, and for organic disorders—with a mechanism of PSPA formation; whereas in cases of partial improvement, the psychological dynamics for anxious disorders corresponds to partial PSPA reactivation, and for organic disorders—to incomplete PSPA formation [21, 49, 54, 68, 77].

Consistent with the general resourcefulness model [79–83], our empirically based conclusion is that psychogenic blocking causes underutilization of resources. It also describes two different ways of native personal reintegration, which lead to recovery in cases of anxiety disorder. The first way of recovery, determined as PSPA reactivation, is more effective, simple, and needs fewer resources. The second way, namely PSPA formation, may be less effective and needs expanding acquisition of resources.
as PSPA formation requires acquisition through learning of new adaptive skills. In both instances (PSPA reactivation and PSPA formation), in the end the dynamic processes enable individuals to utilize their resourcefulness.

Research reveals the multidimensional nature (both culturally and personally based) of a psychological ability to maintain health and to prevent pathological disorders [79–83]. The mechanism of PSPA Reactivation is close to the Resourcefulness activation of latent personal qualities, while the PSPA Formation mechanism is linked to Resourcefulness as an ability to acquire new skills.

2.7 Biological component of psychotherapy

The patient's participation in psychotherapy changes his consciousness, thinking, behavior on the basis of effective learning [69–76].

Earlier, we formulated the hypothesis that successful psychotherapy should stimulate the process of neurogenesis in patients [84], now this assumption is supported [85]. In our study, it was shown that monopsychotherapy is effective in overcoming the states of anxiety and depression in anxiety disorders [86], which needs positive neurobiological changes.

The author is engaged in research on hypnosis and hypnotherapy [66]; therefore, his analysis of the biological mechanisms of psychotherapy is limited by this method and is applicable in relation to its essential analogues.

2.7.1 Biological component of hypnotherapy

In the 1980s and 1990s, the author conducted research on the biological effect of a hypnotherapy course on the blood system, in relation to its clinical efficacy in anxiety disorders. The obtained clinical and experimental data revealed that hypnotherapy has a distinct, systemic, biological effect on the patient's organism [66]. The following was found.

1. Hypnotherapy activates the systemic (stress-) readaptation processes that are reflected in changes in neurohormonal and neurotransmitter secretions; activities of the immunological system; activation of protein, bilirubin, and cholesterol exchange; etc.

2. Hypnotherapy activates protein metabolism and activity of several enzyme systems of the organism. Hypnotherapy has a positive influence on the metabolism of bilirubin. The activation of cholesterol metabolism, characterized by a significant reduction of its concentration in the blood, has a significant clinical importance. The observed decrease of cholesterol concentration in blood, normalizing its metabolism in the process of hypnotherapy, means the restoration of activity of cell membranes, cells, organs, and tissues, slowing down their aging.

The stressful, readaptive nature of hypnosis limits its therapeutic application, in that excessive intensity of hypnogenic stress may result in the maladaptation. Prolonged hypnotherapy may actually decrease and exhaust adaptable resources of an organism. Of course, the data of hypnotherapy should not be mechanically transferred to all methods of psychotherapy. But there is no reason to exclude the presence of a spectrum of biological mechanisms of psychotherapy associated with learning, neurogenesis, readaptation.
2.8 Discussion. Three-component, structural-dynamic theory of psychotherapy

The performed analysis of sociopsychological, individual-psychological, biological components of psychotherapy allows to proceed to a systematic presentation of the three-component theory of psychotherapy, highlighting its main points [21, 49].

1. The existence of social, psychological, biological components of human nature predetermines the presence of sociopsychological, psychological, biological components of psychotherapy, which determine the patterns and mechanisms of the psychotherapeutic process.

The primary basis of the sociopsychological component of psychotherapy is the MDT, which represents the system block of MW of mass consciousness. The MDT of mass consciousness and an individual, being a historically developing hierarchical system, retains in a latent form previous information and is subject to socially conditioned and individual dynamics in progressive, regressive, reactivation variants.

The psychological component of the psychotherapeutic process is formed by communicative-interpersonal and intrapsychic components. We highlight intrapsychic component of psychotherapy that is described in the context of the PSPA—a spontaneous homeostatic ontogenetically formed hierarchical structure, which includes adaptive mechanisms that are consistently formed from early primitive, typological, to complex individualized, personal, which have regressive, reactivation, progressive dynamics.

The biological component of psychotherapy includes a complex of neurophysiological, organismic mechanisms that ensure the processes of readaptation, successful learning (including neurogenetic ones).

2. The psychotherapeutic process is based on complex psychological interaction and is carried out at two related levels of: sociopsychological, cultural interaction; interpersonal interaction founded on actual communicative style, methodological goal setting, and instruments of therapy, partially spontaneous interpersonal interaction.

Psychotherapeutic interaction at the sociopsychological level uses a connecting script that coordinates the theoretical and methodological tools of psychotherapy with the actual MDT of the patient. The actual MDT of mass consciousness plays the role of the communicational “language” between the patient and the therapist. The psychotherapeutic method may correspond to the actual MDT completely, partially, or differ from it. In the first case, the content of psychotherapy is understood and accepted by the patient initially and completely. In the second and third cases, when the content of psychotherapy does not correspond to the actual MDT, it becomes necessary to reconcile them. In such cases, the methods of psychotherapy, mainly at the beginning of work with the patient, use the connecting script that fills the existing semantic, logical gaps between the applied therapy and MDT. The initial or achieved correspondence between the patient’s MDT and the method of psychotherapy leads to the establishment of psychotherapeutic contact and includes individual psychological and biological mechanisms of psychotherapy, initiating the psychotherapeutic process.

3. The complex psychological interaction carried out in the course of the psychotherapeutic process generates and supports the systemic psychological and biological
reactions of the individual to the psychotherapeutic action, including intrapsychic sanogenic mechanisms and a complex of organismic mechanisms (biological, neurophysiological, neurohormonal, etc.). In addition to the obvious mechanisms of effective learning, our study of psychotherapy at the intrapsychic level reveals the mechanisms of reactivation and formation of PSPA of the individual or their combination. We believe that at the biological level, psychotherapy engages mechanisms of stress-readaptive optimization of disturbed biological (and neuro-biological) indicators.

2.9 Section conclusion

The three-component theory of psychotherapy focuses on natural phenomena of human life at social, psychological, biological levels. The most significant data are obtained on the phenomenon of mass consciousness, its WM and MDT mythological nature, regressive dynamics in dead-end situations. The author is inspired by the fact that the modern mass consciousness in a latent, indirect, and common form preserves the entire historical totality of cultural ideas about the world and man (from the Stone Age to the present day). And the deepening regressive dynamics of mass consciousness is capable of consistently updating the previous levels of perception of the world, up to the most ancient ones. For the first time, the possibility of regressive dynamics of an individual's ideas about illness and therapy in an experimentally created dead-end situation is shown. In the light of author's research, the phenomenon of mass consciousness contains Jungian "collective unconsciousness."

Psychotherapy presents a secondary phenomenon in relation to the current mass consciousness, everyday culture; therefore, the connecting scenario of psychotherapy becomes its most important means, the effectiveness of which increases in cases of cognizant application by therapist.

Modern psychotherapy is based on psychological communication, in which the therapist, as the architect of the project, together with the patient, builds a therapeutic result. The mechanisms of reactivation and the formation of a PSPA, which are triggered by the patient's psyche autonomously, based on the characteristics of the disorder and the resources of the psyche, which are empirically identified by the author and consistent with a positive psychotherapeutic approach, are fundamental and enrich the understanding of psychotherapy.

The biological mechanisms of psychotherapy are inevitable for its active forms, are universal and based on the mechanisms of fixing positive experience (learning) and readaptation.

3. Method of positive-dialogue psychotherapy

In the 2000s, a similarity between the PSPA model and the resilience/resourcefulness model (Selinski M., Pylowski J.) [79, 82, 83], developed from the position of positive psychology, was revealed. A positive psychotherapeutic approach [79–83] relies on the patient's resources and his positive values, but not on overcoming psychological problems and symptoms. In contrast to the PSPA concept, which implies the neurobiological basis of the system of psychological adaptation of a person, the resilience and resourcefulness model has a philosophical foundation. Psychotherapeutic work in the resilience and resourcefulness model is based on stimulating corresponding mechanisms as positive targets of psychotherapy.
3.1 PDP specifications

Positive-dialog psychotherapy (PDP) was developed by the author in the 2010s as a systemic, integrative, dialogically, procedurally, and causally oriented method of clinical psychotherapy intended for psychotherapy of anxiety, affective, personal, organic (with anxiety symptoms) disorders. PDP is based on the understanding of the psychotherapy process as the communicative staged dialog between therapist and patient using verbal and nonverbal means, carried out at the sociocultural, interpersonal, intrapersonal levels as a system of three dialogs: interpersonal dialog between patient and therapist, intrapersonal dialog of the patient, intrapersonal dialog of the therapist (when the therapist consciously builds such a systemic dialog). PDP includes three stages: diagnostic and psychoeducational with the conclusion of a psychotherapeutic contract (1 session), therapeutic (2–8–10–15 sessions), completion of therapy with an assessment of the results, recommendations (final session).

The psychotherapeutic process in PDP is realized as a sequential resolution of the patient’s systemic request for psychotherapy, which is a set of successively manifested, staged patient requests for psychotherapy that are resolved in the course of psychotherapy, which reflects (in reverse order) the history and biopsychosocial mechanisms of the formation of the disorder.

3.2 PDP protocol

PDP is based on the protocol developed by the author [86]. The therapeutic intervention consists of three main components: (1) causal cognitive-orientated; and (3) hypnotherapeutic.

The psychoeducation component includes a didactic material covering the following information about: (1) anxiety as a normal reaction of mobilization, needed to cope or avoid a dangerous situation; (2) anxiety disorder and the phases of its development for PD and GAD, because of the “swinging” of anxiety reaction by a combination of social, biological, and psychogenic factors; and (3) possibilities of psychotherapeutic treatment of AD based on (a) the resolution of current psychogenic issues, (b) the excluding intoxicating mechanisms (if there are any), (c) the coping with phobic component (if it’s present), (d) the general increase of adaptive resources of the organism (through lifestyle rationalization), and (e) the normalization of vegetative regulation by psychotherapy or combination of psychotherapy with pharmacotherapy. The psychoeducational component of PDP is realized during the first therapy session, in an individual or group format.

The causal cognitive-orientated component of PDP has the following objectives: (1) Individual assimilation of the psychoeducational component. (2) Normalization of patient’s traumatic experiences during a panic attack (if there are any). (3) Stimulation of patient’s coping of anxiety triggers, restrictive behaviors, and phobias. (4) Stimulation of a healthy lifestyle with normalization of vegetative regulation. (5) Development of patient’s autonomous understanding and coping with problem situations. (6) Development of skills of positive thinking and attitude. The causal cognitive-orientated component of PDP is used during 2–7 sessions for about 20 min.

The hypnotherapeutic component of PDP uses the method of Universal Hypnotherapy (UH) [66, 67, 87], which contains the following therapeutic interventions: (1) Increase of self-identity and self-integrity. (2) Transformation of patient’s projections of his/her psychogenic and somatic-sensorial content. (3) Use of sedative and detachment influences of reproduced colors. (4) Stimulation of detachment of stress experience and
completion of negative states and experiences based on modeling and realization of positive correct behavior. (5) Repeat of the interventions mentioned above (1–4). (6) Creation in hypnotherapy a positive vector semantic space for patient's active therapeutic changes. The UH, done in the second part of a 1-h session of PDP, lasts for 40 min. The frequency of PDP sessions is three times a week; the total number of sessions varies from 8 to 15 (till the stable improvement of patient's state). The UH method has previously been described in detail by the author in chapters of international monographs on positive psychology [67], hypnotherapy and hypnosis [66], psychotherapy [87], which allows, without repeating, to restrict ourselves to a reference to previously published available materials. The implementation of the PDP, in accordance with the three-component theory of psychotherapy, includes the obligatory use of the connecting script component of psychotherapy involved in the implementation of: a general plan of subsequent psychotherapy; psychoeducational and causal cognitive-orientated components that explain the nature of (anxiety, affective, personality) disorder and the process of subsequent psychotherapy, hypnotherapy. The UH uses hypnotization and hypno-therapy scripts. The hypnotization script is realized before the beginning of hypnotherapy and allows effectively, in the interests of therapy, to transform the initial cultural ideas of the patient about hypnosis, hypnotization, with the achievement of a holistic acceptance by the patient of subsequent hypnotization and hypnotherapy. The patient's assimilation of all psychoeducational material is based on scientific data in the fields of positive psychotherapy and hypnotherapy, but is built on understanding of the mythological nature of mass consciousness, the involvement of the patient's imaginative thinking, and the dialogical form of information presentation. The PDP's deliberate appeal to the mythological side of mass consciousness, shaped into a formal-logical, consistent, scientifically grounded psychoeducational shell, makes the PDP procedurally and clinically effective.

3.3 The results of the controlled study of the PDP effectiveness

In 2010–2015, the author with the coworker [86] conducted a controlled study of the effectiveness of PDP for anxiety disorders. After diagnostic evaluation and completion of all questionnaires, 63 patients were randomly assigned to a treatment group or a waiting-list group. In the treatment group, patients went in therapy immediately and completed the self-report questionnaires at the end of the therapeutic process. Patients on a control waiting-list group were informed about a certain order for the beginning of the therapy and that they had to complete the questionnaires two times (the second time was 3 weeks after the first). The evaluation of psychometric data of the treatment group was carried out 3 weeks before the treatment, just before the start of treatment and at the end of treatment. The control waiting-list group was a control group for itself and for the first group. The study used psychometric and statistical methods accepted in the assessment of the treatment of anxiety disorders. Assuming a similarity of UH to mindfulness-based CBT methods, the study used additional psychometric estimation of UH mindfulness effect. The psychometric assessment used the symptomatic questionnaire SCL-90-R in Russian adaptation of N. Tarabarina [55], its scales: DEP, depression; ANX, anxiety; and GSI, general severity index, a measure of the overall psychological distress. The Spielberger State–Trait Anxiety Inventory (STAI) is a Russian adaptation of Hanin [56]. The following tools were also used: Beck's depression inventory (BDI) [57]; Sheehan Clinical Anxiety Rating Scale (ShARS) [58]; and Five-Factor Mindfulness Questionnaire (FFMQ) [59], its short version. The FFMQ was adapted for Russian-speaking population by the authors.
The Mindful Attention Awareness Scale (MAAS) [60] was adapted to Russian-speaking population by the authors. MMPI (clinical scales) and Resourcefulness for recovery inventory (RRI) [83] were used in the study of predictors of psychotherapy efficacy. The differentiation of the groups of full recovery and partial recovery was carried out using the author’s scale of systemic qualitative-quantitative assessment of the psychotherapy effectiveness [49, 86, 88], highlighting four gradations of the improvement degree: (1) significant improvement (full recovery), (2) improvement (partial recovery), (3) slight improvement, (4) lack of improvement. Grades are determined according to the following criteria: (1) the degree of reduction of clinical symptoms, (2) the degree of the patient’s conscious control of the current state, (3) the degree of activity in overcoming the disorder, (4) the dynamics of the patient’s dependence on the psychotherapist, (5) the stability of psychotherapeutic contact, (6) the patient’s own assessment of the degree of improvement.

The results of our controlled study of the effectiveness of PDP were described in the book “Hypnotherapy and Hypnosis” [87]. Therefore, in this chapter, we presented

<table>
<thead>
<tr>
<th>Scale</th>
<th>Therapy group n = 52</th>
<th>Waiting list control group n = 25</th>
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<td>M</td>
<td>SD</td>
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<td></td>
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<tr>
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<td>at baseline</td>
<td>1.85</td>
<td>0.93</td>
</tr>
<tr>
<td>at the end of treatment</td>
<td>0.93</td>
<td>0.84</td>
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<tr>
<td>SCL-90 GSI</td>
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<tr>
<td>at baseline</td>
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</tr>
<tr>
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<td>7.41</td>
</tr>
<tr>
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<td>at baseline</td>
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<td>9.28</td>
</tr>
<tr>
<td>at the end of treatment</td>
<td>80.12</td>
<td>8.06</td>
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only the final data (Table 4) and the results of the comparison of the obtained results with the results of CBT methods based on mindfulness meditation (Table 5).

The obtained results allow us to make a number of significant conclusions: (1) PDP is clinically effective for the treatment of PD and GAD, comparing with the wait list control group; (2) According to our data, PDP efficiency is comparable to the efficiency of Mindfulness-based Cognitive Therapy, Mindfulness-based Stress Reduction; (3) Moreover, UH produces a distinct mindfulness effect comparable to that for mindfulness-based CBT techniques.

Data from a controlled study allowed us to search for predictors of PDP efficacy [88]. According to the results of therapy and the systemic criteria of psychotherapy effectiveness, the sample was divided into groups of significant improvement (full recovery) and improvement (partial recovery). Differences in baseline indicators were found in selected groups for the “Health promoting factors” scales of the RRI (the greatest differences in scales: Positive Relationship with HCP- p < 0.0001, d = 1.24; Self-Responsibility- p = 0.0002, d = 1.19; Acceptance–p = 0.001, d = 1.13; Integration–p < 0.0001, d = 1.51; Minimizes loss–p = 0.0002, d = 1.17) and scales of the MMPI method (the greatest differences for the masculinity /femininity scale—p = 0.0002, d = 1.1). Predictors of the effectiveness of psychotherapy have been identified with the help of the discriminant analysis, which appeared to be indicators of the Integration and Positive values of the RRI and the Masculinity/Femininity of the MMPI. Our findings verify actuality of a positive approach in psychotherapy and interrelation between resourcefulness concept and PSPA through the psychotherapy effectiveness systemic criteria.

3.4 Conclusion of the PDP section

The data obtained in a controlled trial indicate a high clinical efficacy of the PDP method, revealing its distinct mindfulness effect. Additionally, a pure final delineation of full recovery and partial recovery groups made it possible to establish their initial difference in a number of psychometric indicators of RRI and MMPI, not only substantiating the concepts of PSPA, resourcefulness, and a positive

<table>
<thead>
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<th>Scale</th>
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<th>Waiting list control group n = 25</th>
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<td>SD</td>
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<td></td>
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</tr>
<tr>
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<td>0.71</td>
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</table>

Table 4. Treatment effect.

SCL-90 DEP, ANX, GSI—depression, anxiety and global severity index of symptom checklist 90; STAI-S—Spielberger anxiety inventory, state anxiety; STAI-T—Spielberger anxiety inventory, trait anxiety; BDI—Beck depression inventory; ShARS—Sheehan Clinical Anxiety Rating Scale; FFMQ-SF—Five-factor mindfulness questionnaire, short version, total score; MAAS—Mindfulness attention awareness scale. MPT group—monopsychotherapy group. PT + PPT group—psychotherapy + psychopharmacotherapy group with later psychopharmacotherapy withdrawal.
<table>
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<td>4.35</td>
<td>0.71</td>
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</table>

Table 5.
The comparison of PDP (UH) MBCT, MBSR efficiency, and mindfulness effect in therapy of anxiety disorders.
4. Chapter conclusion

The chapter context consistently describes the general three-component structural-dynamic theory of psychotherapy, substantiating the historical complementarity of therapies to the current state of the society mass consciousness. The analysis of mass consciousness, its mythological nature, historically formed structure and dynamics is carried out. The study of the application of therapeutic practices allows to form the concept of psychotherapy’s connecting script and to describe its practical realization in PDP. On the basis of an empirical study of the psychological component of psychotherapy, the author elaborated the PSPA model, described three variants of its dynamics and psychotherapeutic actualization of mechanisms of PSPA reactivation and the formation. The conceptual affinity of the PSPA model to the concept of resilience/resourcefulness of positive psychology is demonstrated. The brief description of the biological component of psychotherapy is built using mechanisms of learning, readaptation, and probable mechanisms of neurogenesis.

The implementation of the PDP method is based on the methodology of the general three-component structural-dynamic theory of psychotherapy. PDP is realized as a sequential resolution of the patient’s systemic request for psychotherapy, it uses the therapeutic protocol, opening a way for evidence-based studies of the effectiveness of PDP for anxiety disorders, searching of predictors of the therapy effectiveness. The results confirm the effectiveness of the given method, comparable to the corresponding effectiveness of modern CBT methods.

In the process of long-term studies, it became clear that the PSPA model, the empirically developed criteria for the psychotherapy effectiveness, and the identified psychometric predictors of the psychotherapeutic effect undeniably address the mechanisms of effective psychotherapy to the psychological structures of the Self and its dynamics. It should be emphasized that comparable results have been obtained in modern neurophysiological studies [5, 6], which indicates the involvement of neuro-anatomical zones responsible for self-presentation and semantic processes at various psychotherapies for anxiety and depressive disorders.
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