

*Section: Theoretical reviews and research in Positive Psychotherapy (PPT)***Positive and Transcultural Psychotherapy as an Integrative Approach****Roman Ciesielski**

M.D, Ph.D.,

Psychiatrist, psychotherapist, supervisor, Master trainer of PPT,  
Head of Polish Center for Positive Psychotherapy (Wroclaw, Poland),  
President of the Polish Association for Psychotherapy Development**Email:** [romcie66@gmail.com](mailto:romcie66@gmail.com)**ORCID:** [0009-0001-5992-2646](https://orcid.org/0009-0001-5992-2646)

Received 23.10.2025

Accepted for publication 23.12.2025

Published 23.01.2026

**DOI:** [10.52982/lkj297](https://doi.org/10.52982/lkj297)**Abstract**

This article presents theoretical considerations on integrative psychotherapy and the integration of Positive and Transcultural Psychotherapy (PPT) within the integrative approach, and describes the specific features of the PPT approach. The general principles of the integrative approach are presented, such as a) positive expectation; b) therapeutic alliance; c) awareness deepening; d) corrective experiences; e) reality testing. It also depicts the main characteristics of integrative psychotherapy, which consist of common therapeutic factors and an individualised approach to the patient. In addition, the main models of integrative psychotherapy were presented, which include: a) eclecticism, b) an approach based on common therapeutic factors, c) theoretical integration, and d) assimilative integration. Finally, the relationships between PPT and the main integrative schools were analysed, and a list of theoretical constructs common to PPT and other schools of psychotherapy, as well as constructs characteristic of PPT alone, was compiled.

The author attempts to characterise PPT as a method with its own unique identity, which consists of: a) theory of actual capabilities and microtraumas, b) theory of psychodynamic conflicts, c) structural models of the therapeutic process and relationship and individual personality, d) strategic therapy planning, and e) cultural sensitivity. The author also emphasises that PPT demonstrates flexibility in assimilating selected theoretical concepts and practical tools within its own metamodel.

**Keywords:** Positive Psychotherapy, integration in psychotherapy, integrative psychotherapy, models of integration in psychotherapy, assimilative integration

**Introduction**

Positive and Transcultural Psychotherapy (PPT) is an integrative approach recognized as a humanistic-psychodynamic method with a transcultural perspective (Peseschkian & Remmers, 2025; Česko & Tansel, 2025). Elements of the cognitive-behavioral and strategic schools are also visible within it.

What characterizes the phenomenon of integration in the main schools of psychotherapy is the search for what is shared in terms of effectiveness, usefulness, and sensitivity to the

patient's needs. Integration should therefore be accompanied by respect for the achievements and knowledge of other approaches and modalities, as well as recognition of their contributions to the universal development of contemporary psychotherapy.

These initial assumptions are consistent with the humanistic postulates of Nossrat Peseschkian – the founder of PPT – which may be paraphrased as: *Let us seek what is common to us, respect differences, and try to understand them.* The universal language introduced into

psychotherapy by Peseschkian became actual capabilities, which describe:

- a. attachment and interpersonal relationships (basic capabilities: contact, acceptance, empathy, love, etc.)
- b. social norms and related values (secondary capabilities: punctuality, politeness, thriftiness, diligence, etc.)

A closer look at Peseschkian's legacy indicates that the following guiding principles shaped his theoretical and practical contributions:

- a. egalitarianism, instead of elitism;
- b. pluralism, instead of uniformity;
- c. democracy, instead of absolutism;
- d. pragmatism, instead of dogmatism;
- e. inclusion and assimilation, instead of exclusion and isolation.

Norcross and Newman (1992) argue that integrative psychotherapy is defined by dissatisfaction with the overly narrow perspective of the school with which one identifies and by a desire to move beyond its boundaries to broaden this perspective and draw on knowledge and experience from other recognized approaches. The positive effect of such action is an increase in one's own effectiveness, agency, and flexibility.

Explanations of integrative tendencies in psychotherapy may be very diverse. Among them are listed:

- a. the availability of many equivalent psychotherapeutic approaches;
- b. the comparable effectiveness of different treatment models;
- c. the lack of a single approach with universal application;
- d. socio-political and economic considerations.

Integration acknowledges that a single chosen model of psychotherapy is imperfect, while respecting the contributions that other approaches, through personal professional experience, can bring. Álvarez *et al.* (2016) argue that the integration of psychotherapy invites us into a creative dialogue, the discovery of new phenomena, and personal involvement in continuous development, thereby advancing the evolution of psychotherapy. According to the authors cited, integration entails the collaboration of representatives of different therapeutic approaches, thereby achieving coherence and complementarity at the conceptual, clinical, and empirical levels.

## Discussion

### 2.1. Effectiveness of integrative psychotherapy

The community of psychotherapists and researchers has reached consensus that no single psychotherapeutic approach is sufficiently effective or appropriate for all patients, clinical problems, or the socio-cultural contexts associated with them. Each existing model of treatment and psychotherapeutic approach has its imperfections and limitations.

Evidence-based research has shown that therapeutic systems of an integrative nature, such as interpersonal psychotherapy, schema therapy, or cognitive-analytic therapy, are effective in the case of numerous mental disorders, such as: depression, social phobia, generalized anxiety disorder, personality disorders, dissociative identity disorder, etc. (Reay *et al.*, 2003; Hamidpour *et al.*, 2011; Stangier *et al.*, 2011; Masley *et al.*, 2012; Roediger, Dieckmann, 2012); Clarke *et al.*, 2013; Grawe, 2004; Grawe, 1997).

Analogously, this is also the case for PPT, which has likewise been studied for effectiveness in relation to a heterogeneous group of patients (Tritt *et al.*, 1997).

The American Psychological Association (2006) defines evidence-based practice as: *the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences*. Evidence-based practice emphasizes the results of randomized controlled trials to document the effectiveness of treatments for patient groups compared with untreated control groups and with other treatment methods.

From these assumptions, it follows that patients have the right to:

- a. treatment with a method whose effectiveness has been previously demonstrated;
- b. consultation with a specialist in choosing the appropriate treatment method.

In practice, these assumptions mean that the contemporary psychotherapist is obliged to:

- a. integrate knowledge and experience developed in various approaches;
- b. apply methods with proven effectiveness;
- c. skillfully adapt these methods to the individual needs of the patient and his or her life context.

## 2.2. Characteristic features of integrative psychotherapy

Authors of various publications mention two main aspects that characterize integrative psychotherapy (Norcross et al., 1992; Norcross & Goldfried, 2005). These are common therapeutic factors and an individualized approach to the patient. They will now be discussed in turn.

### A. COMMON THERAPEUTIC FACTORS

At the basis of the integration of psychotherapy lie research findings indicating that, regardless of the theoretical concepts across different approaches and schools, treatment effectiveness is comparable (Castonguay et al., 2015; Barth et al., 2013). What justifies the integration of diverse models of psychotherapy is the data showing that factors common to various psychotherapeutic approaches (e.g., therapeutic alliance, therapist's personality, patient motivation, etc.) account far more for treatment outcomes than the specific actions attributed to a given approach, such as interpretations in dynamic therapies or cognitive restructuring in cognitive-behavioral therapies. Well-documented studies show that specific therapeutic techniques account for only 7% of psychotherapy outcomes, whereas common factors account for nearly 20% (Wampold & Imel, 2015).

Among the common factors that, according to researchers, define the development of contemporary integrative models, one may list the therapist's ability to:

- instill hope and positive expectations for change;
- create an alternative and realistic perspective on self and the world;
- provide corrective emotional experiences;
- build the therapeutic Alliance (Lambert & Bergin, 1992).

### B. INDIVIDUALIZED APPROACH TO THE PATIENT

Contemporary models of integrative psychotherapy aim to adapt diverse therapeutic interventions to the individual needs of the patient, with particular attention to their affective, behavioral, cognitive, and physiological functioning, as well as to spiritual beliefs. In this way, the integrative psychotherapist demonstrates sensitivity to

each patient's unique problems and characteristics, drawing on a repertoire of techniques derived from evidence-based approaches.

As is well known, all these postulates are reflected in PPT. Its founder emphasizes the importance of appropriately adjusting a therapist's interventions and activities to the four simultaneously occurring dynamic levels of a patient's functioning.

Which include:

- a. the body and physiological processes;
- b. the mind and cognitive functions;
- c. behavior and social relations;
- d. the spiritual and worldview sphere.

Beyond identifying the specific characteristics of a given patient, the positive therapist also attends to the patient's unique national, ethnic, religious, and cultural background. Moreover, Peseschkian reminds us that every patient has preferred ways of acquiring knowledge and processing information, and the therapist's task is to identify and utilize them. These include:

- a. the body and senses;
- b. the rational mind;
- c. tradition and cultural transmission;
- d. imagination and intuition.

Alliance in the psychotherapeutic relationship in PPT is expressed in both the educational-informative dimension and the co-creation of therapeutic goals with the patient, as well as in the joint monitoring of their implementation.

## 2.3. Principles of the integrative approach

German researcher Grawe (2004) made an immense contribution to an empirically grounded, integrative model of change mechanisms; however, Goldfried (2012) identified five principles common to all psychotherapeutic orientations that, in his view, determine the outcomes of psychological treatment. These include:

- a. arousing the patient's hope and positive expectations and motivation for change;
- b. building the therapeutic alliance;
- c. deepening the patient's awareness and insight;
- d. creating corrective experiences;
- e. continuous reality testing.

### A. HOPE, POSITIVE EXPECTATIONS, MOTIVATION FOR CHANGE

Research on patients' expectations regarding the potential benefits of therapy indicates a significant relationship with positive treatment outcomes (Constantino, 2018). On the other hand, it appears that unmet patient expectations are linked to premature termination of therapy.

Representatives of all psychotherapeutic approaches agree that an important prognostic factor in treatment is the patient's hope for improving the quality of their life and changing their fate.

The topic of motivation for change has become the main criterion for assessing progress in therapy in the transtheoretical integrative model of Prochaska and DiClemente (1992). Related research has shown that patients who are least motivated for therapeutic work in the earliest phase of treatment – the precontemplation stage – have the lowest chances of positive treatment outcomes (Krebs et al., 2018). Their awareness of their own problems is limited, and they show considerably less activity in initiating and maintaining change.

In PPT, the patient's hope and readiness to engage in the therapeutic process are among the key aspects of the first phase of treatment – observation and distancing. The context of referral or self-referral to consultation, as well as potential sources of resistance to change, are gradually assessed. Positive therapists often use nondirective communication methods. In this way, they seek to engage in a "creative dialogue" with resistance and introduce elements of unexpected positive change. Another method is to identify hidden sources of motivation for change within the patient and systemic resources in his or her closest family environment.

### B. BUILDING THE THERAPEUTIC ALLIANCE

The therapeutic alliance is one of the strongest prognostic factors for successful therapy (Flückiger et al., 2018). A strong alliance between therapist and patient includes three essential aspects:

- a. jointly establishing therapeutic goals;
- b. collaborating in their realization;
- c. a positive mutual emotional bond.

Researchers have identified clear correlations between disruptions in the therapeutic alliance and poorer therapy outcomes, and, conversely, between a strong alliance and better outcomes

(Samstag et al., 1998). Factors fostering a strong therapeutic bond include:

- a. showing empathy and respect;
- b. acceptance;
- c. reflecting the patient's experiences.

A good way to develop a strong alliance is to define realistic goals with the patient, identify hidden or conflicting motives on the patient's side, and jointly monitor progress toward their realization.

In integrative approaches, important issues appear to be the weakening of the psychotherapeutic alliance and the threat of its breakdown. This phenomenon is most often indicated by the patient's overly confrontational attitude (overt anger, dissatisfaction, provocative behaviour) or by withdrawal (lack of involvement, emotional distance, seemingly cooperative behaviour). Threats to the therapeutic alliance (alliance ruptures) are important clinical signals that require recognition. They typically indicate the emergence and recurrence of attachment patterns, strong transference phenomena, and unconscious relational expectations within the patient-therapist dyad. Alliance ruptures usually require re-evaluation of previously agreed-upon goals and tasks in therapy and may provide valuable corrective emotional experiences that ultimately reinforce the therapeutic alliance. Research findings indicate that therapist competencies such as empathy, secure attachment style, and the ability to work with countertransference are crucial for accurately recognising breakdowns in the therapeutic alliance and effectively repairing them (Talbot et al., 2019).

In PPT, in the interest of good communication in the therapist-patient relationship, basic principles of cooperation are established, which include, among others:

- a. setting realistic goals;
- b. assessing gains and losses resulting from therapy;
- c. defining the patient's psychological resources necessary to carry out changes;
- d. monitoring changes;
- e. evaluating the strength of the alliance.

Furthermore, PPT has developed two structural models that serve to strengthen and monitor the therapeutic alliance (the three stages of interaction and the five stages of the process) (Peseschkian, 1987).

The three stages of interaction (attachment, differentiation, detachment) provide a framework for assessing the dynamics and quality of the therapeutic relationship. Analyzing each of the three stages enables the therapist to precisely identify the patient's needs and evaluate the degree of therapeutic attunement. Any discrepancies in this regard require detailed analysis and active intervention by the therapist. The goal is to adapt one's relational style to the patient's needs.

The five stages of the process (observation/distancing, inventory, situational encouragement, verbalization, and goal expansion) constitute a framework that enables both the patient and the therapist to progress safely through treatment. Each of these stages serves as an indicator of the direction and scope of changes at a given moment in therapy. Regarding patient motivation, stage three warrants attention, in which the therapist provides positive feedback, particularly regarding the patient's resources and hidden abilities and skills.

### C. DEEPENING THE PATIENT'S AWARENESS AND INSIGHT

Regardless of the therapeutic approach, expanding and deepening the patient's awareness is a key process associated with effective treatment. Depending on the school and its theoretical assumptions, insight is strengthened earlier or later and achieved through various therapeutic techniques. Goals related to patient insight are realized in different ways depending on the approach.

#### EXAMPLES

1. In CBT, patients are tasked with carefully recording their thoughts and interpretations, and later, with increasing awareness, discovering the connections between their own thoughts, emotions, and behaviors.
2. In humanistic-experimental approaches, such as Gestalt therapy, the empty-chair technique is successfully applied. As a result, the patient may identify with a distinct ego state and become more aware of hidden feelings, unmet needs, and barriers to their full expression.
3. Analytic and psychodynamic therapies undoubtedly belong to insight-oriented currents. Techniques such as

clarification, confrontation, and interpretation are used to identify unconscious conflict patterns underlying patients' difficulties.

4. Systemic approaches associated with family therapy aim to raise awareness among family members of the strength and importance of transgenerational transmissions, as well as the impact of hidden relational patterns and family transactions on emerging dysfunctions and disorders.

In PPT, the process of expanding awareness concerns:

- a. psychodynamics;
- b. sociodynamics;
- c. socio-cultural context.

Psychodynamics and related insights concern unresolved inner conflicts and include the discovery of their genesis, content, and dynamics, as well as their connections with symptoms and disorders. In the therapist's presence, the patient explores the nature of the actual, basic, and key conflict to ultimately discover what the inner conflict means for them and what its message is. Another equally important aspect of awareness expansion in PPT is the identification of hidden resources and abilities. These constitute an inseparable element of the patient's active engagement in health-promoting change and regaining influence over their own life.

Sociodynamics refers to interpersonal interactions and associated unconscious transactions within the family and social environment. These determine the dynamics and hierarchies of power, alliances and coalitions, rules of loyalty, principles of communication, and related factors. Positive psychotherapists uphold the principle that it is in the interests of both individuals and the entire family system to deepen awareness of how earlier transgenerational traditions, invisible loyalties, and obligations shape one's choices regarding the present and the future.

The socio-cultural context concerns the influence of culture on individuals' personal values, beliefs, opinions, judgments, choices, and behavioral norms. Worldviews, traditions, and collective customs shape the way an individual perceives and experiences the world. They also affect their stereotypes, thought patterns, sympathies and antipathies, and overt and covert discriminatory attitudes. Such

internalized cultural values may constitute a source of conflict and psychological trauma.

In PPT, the discovery of dependencies at the level of intrapsychic, interpersonal, and social conflicts is achieved through differential analysis. It serves to recognize both the active and latent capabilities within the individual's unconscious field, as well as to identify their personal and relational meanings.

#### D. CREATING CORRECTIVE EXPERIENCES

The concept of the corrective experience was permanently introduced into the psychological vocabulary through the discoveries and publications of Alexander and French (1946). They identified specific transference phenomena within the therapeutic relationship that explained patients' ingrained habits, reactions, and modes of functioning. Their analysis revealed that patients unconsciously assumed that the therapeutic relationship would replicate their relational patterns from childhood, and that the therapist would reflect the typical attitudes of significant past figures.

A corrective experience may also be understood as the risk of trying something new by confronting one's ingrained assumptions and beliefs. Such situations usually occur in therapy sessions but may also arise spontaneously between sessions or while performing experiments suggested by the therapist.

Ecker, Hulley and Toomey (2008; 2012), the creators of coherence therapy, equate corrective experience with experiential transformation. These authors discuss the mechanisms of brain neuroplasticity and the phenomenon of memory reconsolidation.

PPT also appreciates the significance of corrective experiences in the process of lasting psychological change. The main assumptions of this approach are that internal conflicts arise because earlier adapted models of functioning (basic conflicts) ceased to fulfill their adaptive function (current conflicts) (Peseschkian, 1987; Goncharov, 2015). Thus, after identifying them, the therapist's task is to create therapeutic experiences that generate new, contradictory knowledge relative to previously dysfunctional generalized patterns of thinking, reacting, and behaving. The aforementioned experiential transformation most often results from constructive relational experiences, nondirective communication, appropriately specific techniques, and behavioral experiments.

#### E. CONTINUOUS REALITY TESTING

Among most therapists, there is consensus that reality is subjective and that the purpose of psychotherapy is not to objectify it but rather to identify its pragmatic aspects. This usually means that the patient's task is to relativize excessively rigid and generalized descriptions of reality, thereby making their behaviors and coping strategies more flexible. In therapy, the patient acquires conscious competencies, as evidenced by adaptive functioning, which is assumed to undergo constant reality testing.

Through repeated corrective experiences, the patient's new knowledge and skills consolidate and provide an alternative frame of reference in problem situations. Before this occurs, however, patients remain in a trial-and-error phase. It is precisely then that the negotiation of descriptions of various events and their interpretation with the therapist takes place, constituting an important source of information exchange and knowledge expansion. In this way, patients' expectations regarding selected life situations become more appropriate, and their reactions and experiences are better adjusted. Thus, their image of surrounding reality and their self-esteem become more stable and predictable (Norcross & Newman, 1992).

In PPT, reality testing is explored in varying scopes at successive stages of the therapeutic process. The second stage – inventory – serves to identify the patient's coping strategies, which are adaptive and fulfill specific functions. One of its goals is also to identify hidden resources and abilities that previously constituted unconscious competencies. The third stage – situational encouragement – involves identifying and defining the patient's strengths and linking them to the assumed therapeutic goals. The fourth stage – verbalization – activates unconscious resources to consolidate adaptive behaviors while simultaneously testing new skills and abilities. However, essentially in the final stage – expansion of goals – the therapist and patient maintain a future-oriented perspective. It is then that they imaginatively test possible scenarios of future events.

#### 2.4. Models of Integrative Psychotherapy

J. Norcross and C. Newman (1992) summarized the integrative movement by identifying eight variables that define its main tendencies. These include:

- a. dialogue and cooperation instead of division and competition;
  - b. lack of a universal model of therapy whose effectiveness surpasses others;
  - c. lack of a single theory fully explaining the complexity of psychopathology, personality, and behavioral change;
  - d. growth in availability and usefulness of short-term psychotherapies;
  - e. improved communication between researchers and clinicians and their increased willingness to cooperate;
  - f. limitations of socioeconomic resources allocated for financing long-term therapies;
  - g. evidence for the existence of common healing factors independent of the theoretical assumptions of a given school;
  - h. development of professional organizations and networks, conferences, and journals devoted to research on psychotherapy integration.
- J. Norcross lists four main models of integration in psychotherapy:
- a. technical eclecticism;
  - b. common factors;
  - c. theoretical integration;
  - d. assimilative integration.

Each of these models will now be briefly described to define the place of PPT among them.

#### A. ECLECTICISM

The difference between eclecticism and psychotherapy integration lies in the fact that, in the former, therapists do not seek theoretical grounds to explain or justify the purpose of applying a given technique. Instead, they are guided by pragmatism and select specific tools for their proven effectiveness. In contrast, integrative therapists attempt to investigate how and why the patient changes.

A second difference concerns the fact that eclectic therapists do not adhere to a common set of guiding theoretical and practical principles that would constitute a unified explanatory concept. To illustrate the difference between eclecticism and integration, Davis's (1983) culinary metaphor may be used: „The eclectic therapist chooses one preferred dish from among many, while the integrative therapist selects various ingredients to compose the one appropriate dish”.

#### B. APPROACH BASED ON COMMON THERAPEUTIC FACTORS

This line of inquiry stems from the assumption that finding similarities is more important in explaining psychotherapy outcomes than identifying specific differentiating factors. Two definitions are worth citing here:

**Definition. Technical eclecticism** may be described as a way of thinking that goes beyond the rigid framework of a single paradigm or narrow set of assumptions and seeks to draw on multiple theories to achieve the intended therapeutic effect.

**Definition. An approach based on common therapeutic factors aims to identify the main universal components of effective psychotherapy (nonspecific factors), irrespective of the diverse theoretical concepts across schools.**

Among the common factors determining effective treatment are:

- a. the therapeutic alliance;
- b. exposing the patient to earlier difficulties, whether in imagination or in reality;
- c. corrective emotional experiences;
- d. positive expectations about the final therapy outcomes;
- e. specific therapist qualities such as mindfulness, unconditional acceptance, empathy, and respect;
- f. constructive explanations from the therapist regarding the causes of the patient's difficulties.

#### C. THEORETICAL INTEGRATION

An example of such a model is the combination of psychodynamic therapy with behavioral therapy (Wachtel, 1977) or cognitive therapy with analytic therapy (Ryle, 2014). Theoretically integrative approaches open new perspectives for understanding psychopathology, personality functioning, and psychological change, both on the theoretical and practical levels.

#### D. ASSIMILATIVE INTEGRATION

Examples of such assimilative models include:

- a) the psychodynamic assimilative approach (Stricker & Gold, 2005);
- b) the cognitive-behavioral assimilative approach (Castonguay et al., 2004);

c) the interpersonal–cognitive assimilative approach (Safran, 1990).

In the approach described here, integration occurs primarily at the level of practice rather than theory.

Finally, it is worth mentioning another researcher, Petzold (2001), who described an integrative model of therapy that emphasises the importance of multimodality, embodiment, social-cultural context, and relationality.

#### **Belonging of PPT to the integrative approach**

If one attempts to define the belonging of Positive and Transcultural Psychotherapy (PPT) to one of the four presented models, the task does not seem easy. This difficulty arises from the fact that the descriptions of each model are not unambiguous, and the differences among them blur across multiple levels. For example, some authors place the cognitive-behavioral school among theoretical integrative approaches, whereas others place it among assimilative integrations.

Two further definitions may be useful here:

**Definition. Theoretical integration** is the process of combining independent theoretical concepts, typically derived from two distinct approaches, into a coherent system, and of synthesizing selected therapeutic techniques into a whole.

**Definition. Assimilative integration** consists of identifying with one chosen therapeutic system, while simultaneously being open to selectively incorporating (assimilating) concepts and good practices derived from other schools of psychotherapy.

Similarly, to CBT, this is also the case with PPT. It combines two main theories - the humanistic and the psychodynamic (Remmers, 2021; Erylmaz, 2025). The first assumes that humans are born with basic capacities such as the ability to love and the ability to know. How these basic capacities develop depends on three interactive factors: a) neurodevelopment; b) the socio-cultural environment; c) time. As a result of the interaction of these factors, an adult person represents an individualised set of capabilities (some of which are active, and

others remain latent). In turn, the psychodynamic theory of PPT posits that the causes of human suffering and illness lie in unconscious internal conflicts, and that their recognition and processing serve integration and personal development.

Following the line of thought discussed here, initially, one might say that PPT represents the system referred to as theoretical integration (Henrichs & Hum, 2025). However, upon closer examination, it becomes evident that the treatment method PPT also assimilates diverse and useful concepts and therapeutic tools, incorporating them into its mainstream. Considering this new information, one may therefore hypothesize that PPT is more representative of assimilative integration. But is that really the case? Even closer examination shows that, beyond synthesizing psychodynamic and humanistic–experimental theories, this approach has developed its own specific language for describing and understanding phenomena such as psychopathology, personality, and the mechanisms of psychological change. As far as psychopathology is concerned, the explanations closest to PPT involve specific interactions between neurodevelopmental predispositions and the psychodynamics of the individual and their socio-cultural environment. Personality, in turn, is described here in a more process-oriented, dynamic manner rather than in a structural one. Peseschkian (2016) developed his own typology of personality, based on how the individual's development unfolded with respect to active and latent capabilities. Mechanisms of psychological change in PPT can be explained by experiential transformation and memory reconsolidation.

In sum, Positive and Transcultural Psychotherapy integrates various theoretical constructs from multiple approaches while employing its own unifying descriptive language. It is therefore worthwhile to seek analogies to the main psychotherapy approaches and to highlight the elements specific to PPT (Table 1).

Table 1. Positive and Transcultural Psychotherapy as an Integrative Approach

<i>PPT</i>	<i>Shared constructs with PPT</i>	<i>Specific constructs for PPT</i>
<i>Psychodynamic approach</i>	<ul style="list-style-type: none"> <li>• Importance of early development in shaping personality and dysfunctions of mental disorders;</li> <li>• Role of psychological conflicts in symptom development;</li> <li>• Analysis of transference phenomena in psychotherapy;</li> <li>• Importance of insight and corrective experiences;</li> <li>• Attachment theory.</li> </ul>	<ul style="list-style-type: none"> <li>• Microtrauma theory by Peseschkian;</li> <li>• Dimensions of modeling;</li> <li>• Theory of psychodynamic conflicts (Peseschkian);</li> <li>• Differential analysis (discovering conflict content);</li> <li>• Structural model of countertransference;</li> <li>• Intuitive insights through nondirective communication;</li> <li>• Description of attachment relations through basic capabilities.</li> </ul>
<i>Humanistic-experimental approach</i>	<ul style="list-style-type: none"> <li>• Concept of developmental potential, self-actualization, and blockages on their path;</li> <li>• Hierarchy of values and their evolution;</li> <li>• Influence of social systems on the emergence of dysfunctions and disorders in the individual;</li> <li>• Role of the therapeutic relationship and alliance in promoting and moderating psychological change.</li> </ul>	<ul style="list-style-type: none"> <li>• Balance Model of Life;</li> <li>• Concept of immanent capacities and basic and secondary capabilities;</li> <li>• Differential analysis of active and latent capabilities;</li> <li>• Importance of secondary capabilities as standards of behaviour and social values;</li> <li>• Description of the therapeutic relationship through the three stages of interaction;</li> <li>• Transcultural concept of the human being.</li> </ul>
<i>Cognitive-behavioral approach</i>	<ul style="list-style-type: none"> <li>• Learning theory and modeling processes;</li> <li>• Theory of positive and negative reinforcement;</li> <li>• Cognitive schemas and their role in the emergence of dysfunctions and disorders;</li> <li>• Restructuring of beliefs and change of cognitive schemas;</li> <li>• Behavioral experiments.</li> </ul>	<ul style="list-style-type: none"> <li>• Four dimensions of modeling;</li> <li>• Basic capabilities and the modeling process;</li> <li>• Secondary capabilities and social learning;</li> <li>• Differential analysis of capabilities and emotional schemas;</li> <li>• Use of experiments for experiential transformation.</li> </ul>
<i>Structural approach</i>	<ul style="list-style-type: none"> <li>• Goal orientation;</li> <li>• Focus on the symptom;</li> <li>• Involvement of family members in the treatment process;</li> <li>• Promoting changes in the family system;</li> <li>• Recognition and elimination of interactions maintaining the symptom;</li> <li>• Short-term nature of treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• Significance and function of the symptom;</li> <li>• Structure of relationships (three stages of interaction);</li> <li>• Structure of the process (five stages of the process);</li> <li>• Inclusion of the family–social context;</li> <li>• Defining and monitoring therapy goals and ways of achieving them;</li> <li>• Development of self-help strategies.</li> </ul>

## Conclusion

The contemporary understanding of integration phenomena in psychotherapy is undoubtedly complex and multifaceted. It seems that tendencies toward integration have quite diverse sources. Among the most important at this moment are evidence-based clinical research findings, which underscore the role of nonspecific factors in achieving positive therapeutic outcomes, as well as social, economic, and political transformations that promote shorter yet more effective therapies.

Contemporary psychotherapists face the challenge of assimilating and synthesizing theoretical and practical knowledge from the major approaches to psychotherapy, and adapting it to the individual patient's needs and cultural and social context. It may be assumed that PPT is, to a large extent, a response to this important question, and the developmental directions it sets for psychotherapy may prove to be useful signposts for a wide range of professionals.

## References

1. Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy: Principles and application*. Ronald Press.
2. American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist*, *61*(4), 271–285. <https://doi.org/10.1037/0003-066X.61.4.271>
3. Barth, J., Munder, T., Gerger, H., Nüesch, E., Trelle, S., & Znoj, H. (2013). Comparative efficacy of seven psychotherapeutic interventions for patients with depression: A network meta-analysis. *PLOS Medicine*, *10*(5), e1001454. <https://doi.org/10.1371/journal.pmed.1001454>
4. Castonguay, L. G., Eubanks, C. F., Goldfried, M. R., Muran, J. C., & Lutz, W. (2015). Research on psychotherapy integration: Building on the past, looking to the future. *Psychotherapy Research*, *25*(3), 365–382. <https://doi.org/10.1080/10503307.2015.1014010>
5. Castonguay, L. G., Newman, M. G., Borkovec, T. D., Holtforth, M. G., & Maramba, G. G. (2005). *Cognitive-behavioral assimilative integration*. In: Norcross, J. C., & Goldfried, M. R. (Eds.), *Handbook of psychotherapy integration* (pp. 241–260). Oxford University Press. <https://doi.org/10.1093/med:psych/9780195165791.003.0011>
6. Česko, E., Tansel, E. (2025). Positive Psychotherapy in Different Cultures. In: Messias, E., Peseschkian, H. (eds) *Positive Psychiatry, Psychotherapy and Psychology*. Springer, Cham. [https://doi.org/10.1007/978-3-031-94645-5\\_21](https://doi.org/10.1007/978-3-031-94645-5_21)
7. Clarke, S., Thomas, P., & James, K. (2013). Cognitive analytic therapy for personality disorder: Randomised controlled trial. *British Journal of Psychiatry*, *202*(2), 129–134. <https://doi.org/10.1192/bjp.bp.112.108670>
8. Constantino, M. J., Višlă, A., Coyne, A. E., & Boswell, J. F. (2018). A meta-analysis of the association between patients' early treatment outcome expectation and their posttreatment outcomes. *Psychotherapy*, *55*(4), 473–485. <http://doi.org/10.1037/pst0000169>
9. Davis, J. D. (1983). Slaying the psychoanalytic dragon: An integrationist's commentary on Yates. *British Journal of Clinical Psychology*, *22*(2), 133–144.
10. Demyanenko, B., & Uninets, I. (2024). Methodological bases of integration of Positive Psychotherapy with modern directions of psychotherapeutic assistance. *The Global Psychotherapist*, *4*(2), 93–107. <http://doi.org/10.52982/lkj237>
11. Ecker, B., & Toomey, B. (2008). Depotentiation of symptom-producing implicit memory in coherence therapy. *Journal of Constructivist Psychology*, *21*(2), 87–150. <https://doi.org/10.1080/10720530701853685>
12. Ecker, B., Ticic, R., & Hulley, L. (2012). *Unlocking the emotional brain: Eliminating symptoms at their roots using memory reconsolidation*. Routledge.
13. Erylmaz, A. (2025). Positive Psychotherapy in action: The “DYNAMICS” method for formulating basic conflicts. *The Global Psychotherapist*, *5*(1), 101–114. <http://doi.org/10.52982/lkj263>
14. Erylmaz, A. (2025). The REFLECTS Method: A systematic and comprehensive way to resolve the basic conflict in Positive Psychotherapy. *The Global Psychotherapist*, *5*(2), 54–66. <http://doi.org/10.52982/lkj275>
15. Fernández-Álvarez, H., Consoli, A. J., & Gómez, B. (2016). Integration in psychotherapy: Reasons and challenges. *American Psychologist*, *71*(7), 820–830.
16. Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316–340. <http://doi.org/10.1037/pst0000172>

17. Goldfried, M. R. (2012). The corrective experience: A core principle for therapeutic change. In: Castonguay, L. G., & Hill, C. E. (Eds.), *Transformation in psychotherapy: Corrective experiences across cognitive behavioral, humanistic, and psychodynamic approaches* (pp. 13–29). American Psychological Association. <http://doi.org/10.1037/13747-002>
18. Goldfried, M. R., & Robins, C. (1982). On the facilitation of self-efficacy. *Cognitive Therapy and Research*, 6, 361–379. <https://doi.org/10.1007/BF01184004>
19. Goncharov, M. (2025). The Conflict Model of Positive Psychotherapy. In: Messias, E., Peseschkian, H. (eds) *Positive Psychiatry, Psychotherapy and Psychology*. Springer, Cham. [https://doi.org/10.1007/978-3-031-94645-5\\_35](https://doi.org/10.1007/978-3-031-94645-5_35)
20. Grawe, K. (1997). Research-informed psychotherapy. *Psychotherapy Research*, 7(1), 1–19. <https://doi.org/10.1080/10503309712331331843>
21. Grawe, K. (2004). *Psychological therapy*. Hogrefe & Huber Publishers.
22. Hamidpour, H., Dolatshai, B., Shahbaz, A. P., & Dadkhah, A. (2011). The efficacy of schema therapy in treating women's generalized anxiety disorder. *Iranian Journal of Psychiatry and Clinical Psychology*, 16(4), 420–431.
23. Henrichs, C., Hum, G. (2025). The Development of Positive Psychotherapy in Dialogue with Other Psychotherapeutic Methods. In: Messias, E., Peseschkian, H. (eds) *Positive Psychiatry, Psychotherapy and Psychology*. Springer, Cham. [https://doi.org/10.1007/978-3-031-94645-5\\_40](https://doi.org/10.1007/978-3-031-94645-5_40)
24. Krebs, P., Norcross, J. C., Nicholson, J. M., & Prochaska, J. O. (2018). Stages of change and psychotherapy outcomes: A review and meta-analysis. *Journal of Clinical Psychology*, 74(11), 1964–1979. <http://doi.org/10.1002/jclp.22683>
25. Lambert, M. J., & Bergin, A. E. (1992). Achievements and limitations of psychotherapy research. In: Freedheim, D. K. (Ed.), *History of psychotherapy: A century of change* (pp. 360–390). American Psychological Association.
26. Masley, S. A., Gillander, D. T., Simpson, S. G., & Taylor, M. A. (2012). A systematic review of the evidence base for Schema Therapy. *Cognitive Behaviour Therapy*, 41(3), 185–202. <https://www.tandfonline.com/doi/abs/10.1080/16506073.2011.614274>
27. Norcross, J. C., & Goldfried, M. R. (2005). The future of psychotherapy integration: A roundtable. *Journal of Psychotherapy Integration*, 15(4), 392–471. <https://doi.org/10.1037/1053-0479.15.4.392>
28. Norcross, J. C., & Newman, C. F. (1992). Psychotherapy integration: Setting the context. In: Norcross, J. C., & Goldfried, M. R. (Eds.), *Handbook of psychotherapy integration*, (pp. 3–45). Basic Books.
29. Peseschkian, H., Remmers, A. (2025). Positive Psychotherapy: An Introduction. In: Messias, E., Peseschkian, H. (eds) *Positive Psychiatry, Psychotherapy and Psychology*. Springer, Cham. [https://doi.org/10.1007/978-3-031-94645-5\\_2](https://doi.org/10.1007/978-3-031-94645-5_2)
30. Peseschkian, N. (1987). *Positive Psychotherapy. Theory and practice of a new method*. Springer-Verlag (Germany, USA).
31. Peseschkian, N. (2016). *Positive Psychotherapy of everyday life*. Bloomington, USA: AuthorHouse.
32. Petzold, H. G. (Hrsg.) (2001) *Integrative Therapie – Das „biopsychosoziale“ Modell kritischer Humantherapie und Kulturarbeit* [Integrative therapy – The “biopsychosocial” model of critical human therapy and cultural work.]. Junfermann Verlag· Paderborn [in German]
33. Prochaska, J. O., & Diclemente, C. C. (1992). Stages of change in the modification of problem behaviors. In Hersen, M., Eisler, R. M., Miller, P.M. (Eds.). *Progress on behavior modification*, (pp. 184–214). Sycamore Publishing.
34. Reay, R., Stuart, S., & Owen, C. (2003). Implementation and effectiveness of interpersonal psychotherapy in a community mental health service. *Australasian Psychiatry*, 11(3), 284–289. <https://doi.org/10.1046/j.1440-1665.2003.00574.x>
35. Remmers, A. (2021). To be or not to be – Hamlet and the psychotherapeutic technique: About therapeutic alliance, growth and effective therapy. *The Global Psychotherapist*, 1(1), 41–44. <https://doi.org/10.52982/lkj140>
36. Roediger, E., & Dieckmann, E. (2012). Schema therapy: An integrative approach for personality disorders. *Psychotherapie Psychosomatik Medizinische Psychologie Journal*, 62(4), 142–148. <https://doi.org/10.1055/s-0032-1304615>
37. Ryle, A. (2014). Cognitive-analytic therapy at 30. *Advances in Psychiatric Treatment*, 20(4), 258–268. <https://doi.org/10.1192/apt.bp.113.011817>
38. Safran, J. D. (1990). Towards a refinement of cognitive therapy in light of interpersonal theory: I. Theory. *Clinical Psychology Review*, 10(1), 87–105. [https://doi.org/10.1016/0272-7358\(90\)90108-M](https://doi.org/10.1016/0272-7358(90)90108-M)
39. Samstag, L. W., Batchelder, S. T., Muran, J. C., Safran, J. D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. *Journal of Psychotherapy Practice & Research*, 7(2), 126–143.

40. Stangier, U., Schramm, E., Heidenreich, T., Berger, M., & Clark, D. M. (2011). Cognitive therapy vs interpersonal psychotherapy in social anxiety disorder: A randomized controlled trial. *Archives of General Psychiatry, 68*(7), 692–700.
41. Stricker, G., & Gold, J. (2005). *Assimilative Psychodynamic Psychotherapy*. In: Norcross, J. C., & Goldfried, M. R. (Eds.) *Handbook of psychotherapy integration* (pp. 221–240). Oxford University Press. <https://doi.org/10.1093/med:psych/9780195165791.003.0010>
42. Talbot, C., Ostiguy-Pion, R., Painchaud, E., Lafrance, C., & Descôteaux, J. (2019). *Detecting alliance ruptures: The effects of the therapist's experience, attachment, empathy, and countertransference management skills*. *Research in Psychotherapy: Psychopathology, Process and Outcome, 22*(1), 19–28. <https://doi.org/10.4081/ripppo.2019.325>
43. Tritt, K., Loew, T. H., Meyer, M., Werner, B., & Peseschkian, N. (1999). Positive Psychotherapy: Effectiveness of an interdisciplinary approach. *The European Journal of Psychiatry, 13*(4), 231–241.
44. Wachtel, P. (1977). *Psychoanalysis and Behavior Therapy: Toward an Integration*. Basic Books.
45. Wampold, B. E., & Imel, Z. E. (2015). *The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work* (2nd ed.). Routledge.