Section: Modern Positive Psychotherapy (PPT) practice

Tools for Physicians in Inpatient Units for Severe Mental Illnesses: Construction of a Balance Model Based on the Three-Stage Theory of Positive Psychotherapy

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Received 01.11.2025
Accepted for publication 23.12.2025
Published 23.01.2026
DOI: 10.52982/lkj300

Abstract

Based on Peseschkian's Three-Stage Theory and the Positive Psychotherapy Balance Model, this study constructed a localized Balance Model for application in Chinese inpatient units for severe mental illnesses. Through clinical practice by four psychiatrists over one year, eight integrated sub-models were developed to characterize ward environments, physician resources, and patient symptoms/treatment goals across Connection, Differentiation, and Separation stages. This preliminary framework may assist psychiatrists in systematically assessing patient conditions and implementing structured psychological interventions within inpatient settings. Initial observations suggest potential improvements in treatment adherence and insight, though further clinical validation is required. The study provides a conceptual basis

for developing evidence-based Positive Psychotherapy protocols in severe mental illness inpatient settings.

Keywords: Balance Model, three-stage theory, inpatient units, severe mental Illnesses, Positive Psychotherapy

Introduction

The global prevalence of mental disorders is 13.0%, among which major depressive disorder, bipolar disorder, and schizophrenia account for 0.5%, 2.49%, and 0.3% respectively (Castaldelli-Maia & Bhugra, 2022). In China, severe mental illnesses generally refer to mental disorders characterized by hallucinations, delusions, severe thought and behavioral disturbances, and significant impairment of social functioning (Qin, 2012). These primarily include schizophrenia, paranoid psychosis, and bipolar disorder. Patients with such conditions often require hospitalization to control acute psychiatric symptoms; most are admitted involuntarily and generally lack disease insight.

Mostly， the duration of psychiatric hospitalization in China typically ranges from 1 to 3 months. With the implementation of pharmacotherapy and physical therapy (e.g., Modified Electroconvulsive Therapy, MECT), patients' conditions tend to remit; adjunctive psychotherapy may potentially enhance patients' insight and treatment adherence. However, Chinese psychiatrists are mainly trained in clinical knowledge and skills, and have less systematic learning in psychotherapy. As a result, psychiatrists often rely on collaboration with psychotherapists. Nevertheless, due to the speech and behavioral disturbances of patients with severe mental illnesses during the acute phase, psychiatrists remain the primary medical staff in early contact with patients. They may demand even higher requirements for psychotherapy skills. Thus, psychiatrists play an important role in psychological interventions.

Existing evidence suggests that therapeutic alliances may play a substantial role in treatment efficacy and may enhance the effectiveness of both psychotherapy and pharmacotherapy, with interpersonal factors accounting for approximately 85% of the therapeutic effect (Kallergis, 2019). Senior psychiatrists can often provide basic psychological support based on experience, such as empathy, emotional comfort, and unconditional acceptance; however, such interventions are mostly non-systematic. Particularly junior physicians, on the other hand, often struggle to cope with patient resistance or symptomatic challenges.

Therefore, it makes sense to have a set of structured treatment methods or tools to assist psychiatrists in establishing therapeutic relationships with patients with severe mental illnesses and delivering effective psychological interventions. Existing studies have indicated that positive psychology intervention models might hold promise for patients with schizophrenia (Wang, 2025).

After a year of psychiatric practice, we have found that Positive Psychotherapy holds unique potential for implementation in psychiatric intensive care units, both during daily ward[1] rounds and in the process of psychotherapy.

Positive Psychotherapy is a transcultural, humanistic, psychodynamic, and conflict-oriented psychotherapeutic approach (Peseschkian, 1986), as cited in Sarı (2015). The Balance Model of Positive Psychotherapy (Christ et al., 2021) refers to the balance that individuals strive to achieve across four dimensions when facing conflicts: Body (through senses), Achievement (through intelligence), Relationship (through tradition), and Fantasy (through intuition) (Peseschkian, 2002). Based on this Balance Model, numerous subsequent models have been developed, including the Relationship Model, Responsibility Model, Role Model, Marital and Family Model, and Sexual Dimension Model. This study explores the development of a new Balance Model based on Professor Peseschkian's Three-Stage Theory (Connection, Differentiation, Separation).

This study presents a conceptual model, derived from prior theories and informed by practice. The new model mainly includes eight sub-models: the ward model describing the characteristics of severe psychiatric wards; the doctor model describing the therapeutic resources owned by psychiatrists; the symptom

[1] **Editor's note:** In this article, the term *ward* refers to an inpatient psychiatric unit within a hospital setting.

model and treatment goal model during the patient's connection stage in the ward; the symptom model and treatment goal model during the patient's differentiation stage in the ward; and the symptom model and treatment goal model during the patient's separation stage in the ward. That is, a "ward-doctor-patient" ternary descriptive model and a "disease symptoms-treatment methods-treatment goals" therapeutic model have been constructed.

The conceptual framework tries to explore the application of Positive Psychotherapy in severe psychiatric cases, create therapeutic tools for psychiatrists based on Positive Psychotherapy, explore systematic Positive Psychotherapy plans, and potentially enhance psychiatrists' psychotherapy capabilities in severe wards, thereby enhancing patients' treatment compliance and insight, improving treatment efficacy, and optimizing prognosis. This study hypothesizes that the construction of the Positive Psychotherapy balance model tool is feasible and has practical significance, and that future clinical research can be conducted using this tool.

Methodology

The participants in this study were four junior Positive Psychotherapy consultants who completed the Chinese Positive Psychotherapy Training from January to December 2024. All participants also underwent standardized training for resident physicians and rotated through inpatient units for severe mental illnesses from August to October 2023 and from August 2024 to April 2025. During clinical practice, they conducted psychiatric and psychological interventions integrated with Positive Psychotherapy. Based on their respective practical experiences, each participant independently summarized and developed a preliminary draft of the Balance Model for inpatient units treating patients with severe mental illnesses. Subsequently, through case discussions and model comparisons, the participants reached consensus and jointly revised and finalized the Balance Model.

2.1. Patients in severe psychiatric wards and the definition of the three stages

In this study, patients in the acute psychiatric ward primarily consist of individuals with severe mental illnesses, which may also include some patients with severe depression at high risk of suicide. Patients with severe mental illnesses refer to the six categories of patients mandated for supervision under Chinese law, including schizophrenia, schizoaffective disorder, paranoid psychosis, bipolar disorder, epileptic mental disorders, and intellectual disability. These patients may be experiencing their first episode or a relapse, and they are primarily involuntary inpatients who are hospitalized due to high risks of suicide, self-harm, or causing harm to others, as required by Chinese law and often brought to the hospital by family members or public security authorities. They are generally in the acute phase of their illness, with severely impaired mental functioning, leading to an inability to fully recognize their own health condition or objective reality, or to control their own behavior, resulting in actions or risks of suicide or harm to others.

The hospitalization period of patients with acute mental illnesses can be roughly divided into three stages: Attachment, Differentiation, and Separation.

Attachment Stage: Patients are involuntarily admitted to the acute psychiatric ward due to their illness. At this point, many patients are in the differentiation or separation stage, believing they are not ill and demanding discharge. Due to their high-risk status, these patients receive Grade One nursing, including 24-hour supervision to ensure their safety and prevent impulsive behaviors. This stage is also critical for establishing a connection with the psychiatrist, who must help the patient accept treatment.

Differentiation Stage: The patient's acute symptoms are under control, and they have largely adapted to the ward environment. They receive Grade Two nursing in the ward, but their condition may still fluctuate. This stage is important for improving the patient's compliance and insight.

Separation Stage: The patient's condition is largely controlled, and their medication regimen is stable. Discharge may be considered, but the patient may not yet be prepared for it. This stage is primarily focused on helping the patient prepare for life after discharge.

2.2. Balance Model of Inpatient Unit Characteristics

By summarizing the characteristics of psychiatric inpatient units, a Balance Model was established across four dimensions: Patients,

Medical Staff, Environment, and Social Perceptions (see Figure 1). The purpose is to comprehensively and transculturally describe the characteristics of inpatient units for severe mental illnesses, enabling medical staff, patients, the environment, and society to fully understand the unit's treatment context through this model, and to facilitate transcultural communication and conflict resolution.

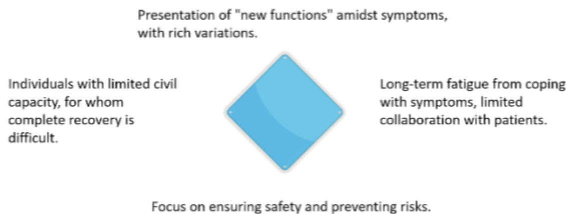

Figure 1. Balance Model: Ward Model

First, Patient Characteristics are placed in the "Body" sphere of the classic Balance Model, representing passive, emotional, and perceptual attributes. Affected by symptoms, patients experience changes in their social and daily functioning. In acute psychiatric units, their thinking, emotions, and behaviors become disorganized due to psychiatric symptoms, with poor insight and adherence. Conflicts between real-life problems and psychiatric symptoms are partially resolved or alleviated after treatment.

Second, Medical Staff Characteristics are placed in the "Achievement" sphere of the classic Balance Model, representing diligence, proactive adaptation, and rationality. From the perspective of the unit's medical staff, they accompany patients throughout hospitalization with patience. Faced with newly emerging, complex, and urgent symptoms of patients, they mainly provide treatment through an active-passive doctor-patient relationship (primarily using medications). Heavy and tedious workloads further limit the time available for psychiatrists to conduct systematic psychotherapy with patients based on a guidance-cooperation or mutual participation doctor-patient model.

Third, Environmental Characteristics are placed in the "Relationship" sphere of the classic Balance Model, representing communication and interaction. From the perspective of the objective environment, inpatient units for severe mental illnesses mostly adopt closed management. Different areas are designated to restrict patients' activity range according to risk level; surveillance is in place, and contact with the outside world is limited. Nursing assistants are assigned to patients at risk of suicide or harming others, and security personnel are deployed in the unit to prevent patients from self-harm or harming others. The management system and regulations prioritize safety assurance and risk prevention, thereby restricting the behaviors of both patients and medical staff.

Finally, Social Characteristics are placed in the "Meaning" sphere of the classic Balance Model, representing meaning, values, and the future. For patients hospitalized in inpatient units for severe mental illnesses, society generally lacks confidence in their treatment outcomes, perceives them as "abnormal", believes they are unlikely to recover, and assumes they will probably or certainly make wrong decisions. Consequently, they are subjectively regarded as persons with limited capacity for civil conduct and a lack of social trust.

2.3. Balance Model of Inpatient Unit Resources

By summarizing the Balance Model, the resources available to psychiatrists in inpatient units for severe mental illnesses were identified across four spheres (Body, Achievement, Relationship, Future/Values) in relation to patients(see Figure 2). After evaluating their own resource Balance Model, psychiatrists can help patients adapt more effectively to their current treatment stage and achieve stage-specific treatment goals, informed by an understanding of the Unit Characteristics Balance Model.

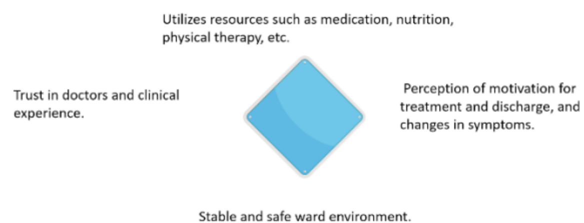

Figure 2. Balance Model: Resource Model

Body: Psychiatrists can promptly use resources such as medications, nutrition, and physical therapy to adjust patients' physical status or alleviate adverse drug reactions, enabling patients to maintain a healthier physical condition to cope with mental illness.

Achievement: Psychiatrists can help patients recognize their motivation for treatment or discharge, as well as changes in symptoms in themselves or others following systematic

treatment, thereby enhancing the efficacy of psychiatric treatment.

Relationship: Patients can alleviate insecurity through a safe, reliable, and simple inpatient environment, obtain support from the medical team's therapeutic alliance, and participate in recreational therapy.

Future: Patients naturally have a certain degree of trust and adherence to psychiatrists due to the "physician authority" effect. In addition, the extensive clinical experience of senior psychiatrists enhances their confidence in treatment, which in turn helps patients gain hope for treatment and discharge.

2.4. Balance Model of the Attachment Stage

In the Connection Stage, patients exhibit symptoms unique to this stage, which manifest across the four spheres as follows (see Figure 3):

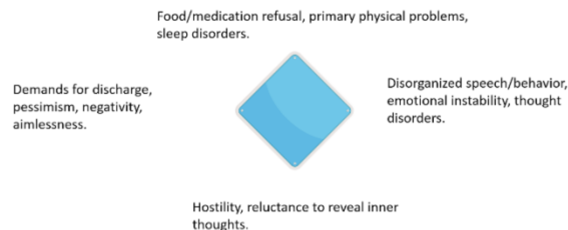

Figure 3. Balance Model: Symptoms in the Attachment Phase

Body: Patients may refuse food and medications, suffer from physical diseases (e.g., hypertension) or physical discomfort, and may experience sleep disorders due to psychiatric symptoms.

Achievement: Unable to adapt to the inpatient environment, patients may disobey unit management, display impulsive behaviors, shout, cry, or even engage in smashing behaviors; cognitively, they may believe they are "hospitalized against their will due to persecution".

Relationship: Patients may deny their own symptoms, be unwilling to share their inner experiences with doctors, and even develop hostile feelings toward doctors or other patients.

Future: Patients may insist on discharge at all costs, hold pessimistic, negative attitudes (believing they will never recover), or blindly comply with unit rules.

During the Attachment stage, patients have specific treatment goals across the four spheres of the Balance Model. Psychiatrists can assess the most prominent symptoms of patients and focus on achieving the corresponding treatment goals in that sphere (see Figure 4):

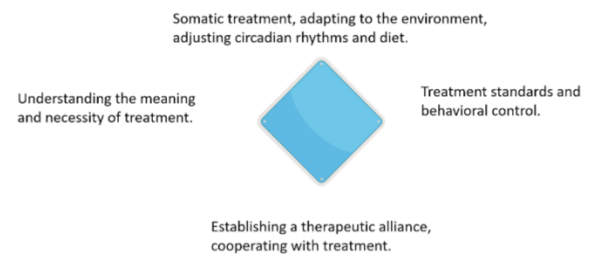

Figure 4. Balance Model: Treatment targets in the Attachment Phase

Body: Treat physical diseases, help patients adapt to the inpatient environment, and adjust their diet and sleep patterns.

Achievement: Jointly develop treatment standards with patients to enhance their ability and confidence in behavioral control.

Relationship: Establish a therapeutic alliance with patients to ensure their cooperation with medical work.

Future: Help patients understand the reasons and necessity of hospitalization and make them willing to accept treatment.

2.5. Balance Model of the Differentiation Stage

In the Differentiation Stage, patients' conditions are partially controlled, so their symptoms are related to the recovery of autonomy. They exhibit obviously differentiating behaviors and pay attention to the meaning of things, with symptoms manifesting as follows (see *Figure 5*):

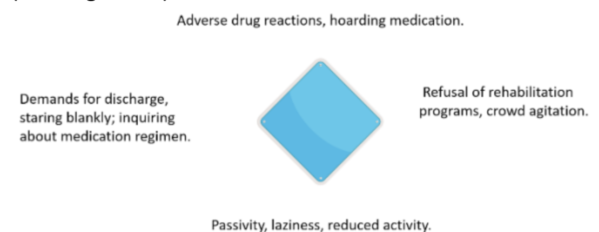

Figure 5. Balance Model: Symptoms in the Differentiation Stage

Body: Patients may experience adverse drug reactions (e.g., dizziness, nausea, weight gain, hand tremors, salivation). At this point, they begin to differentiate the advantages and disadvantages of medications; if they perceive more disadvantages than advantages, they may engage in drug-hiding behaviors.

Achievement: Patients may feel tired of or resist occupational and recreational therapy,

worry about economic expenses, and thus refuse rehabilitation programs or engage in collective protests; their demands for phone calls (to family members) may also increase.

Relationship: After adapting to the inpatient environment, patients may experience boredom, which can lead to passive inactivity, reduced participation in activities, or frequent requests to call family members.

Future: Patients may inquire about discharge criteria, remain dazed, or request to discuss medication treatment plans with physicians.

During the Differentiation Stage, psychiatrists should help patients achieve balance in treatment goals based on their symptoms (see *Figure 6*):

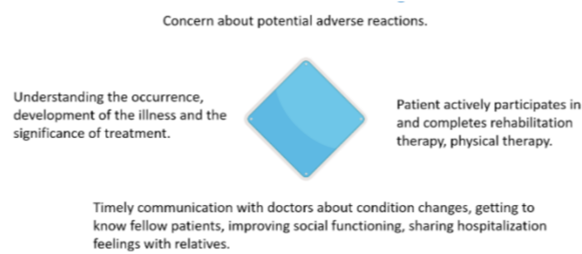

Figure Balance Model: Treatment targets in the Differentiation Stage

Body: Help patients understand and identify potential adverse drug reactions, and accept and cope with these reactions.

Achievement: Jointly develop rehabilitation and physical therapy plans with patients to alleviate their sense of burnout.

Relationship: Encourage patients to communicate with their doctors promptly about changes in their condition, to interact actively with other patients, and to restore social functioning.

Future: Help patients understand the occurrence, progression, and significance of their illness and its treatment.

2.6. Balance Model of the Separation Stage

In the Separation Stage, patients' conditions are basically stable, and they face the issue of discharge, thus developing new symptoms (see Figure 7):

Figure 7. Balance Model: Symptoms in the Separation Stage

Body: After re-examination, patients may have abnormalities in a few physical indicators, feel worried about this, and may experience insomnia.

Achievement: Patients may feel relatively excited (happy that their treatment is complete), but they may lack plans for the future.

Relationship: Patients may conflict with family members over post-discharge plans, make additional discharge-related requests, or request physicians' contact information.

Future: Patients may worry about their situation after discharge (e.g., fear of re-hospitalization) and feel anxious or ashamed about post-discharge life.

During the Separation Stage, psychiatrists should help patients evaluate the timing of discharge and develop post-discharge plans(see Figure 8):

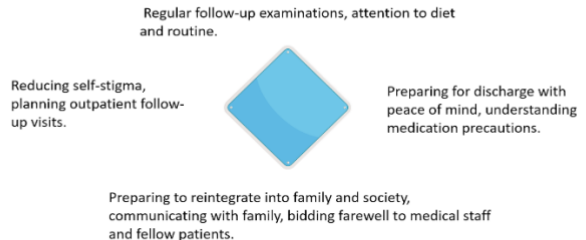

Figure 8. Balance Model: Treatment targets in the Separation Stage

Help patients develop plans to maintain physical health and affirm their current physical status.

Achievement: Help patients prepare for discharge with peace of mind and understand medication precautions to better manage medications after discharge.

Relationship: Facilitate communication between patients and their families, prepare patients for reintegration into family and society, and support them in saying goodbye to other patients and doctors.

Future: Help patients understand their illness to reduce mental illness stigma and develop follow-up treatment plans.

Discussion

In Positive Psychotherapy practice, the five-step model has been widely used, whereas the three-stage model examined in this study appears more applicable to acute psychiatric settings. This preference is partially attributed to the cognitive impairments commonly observed in patients with acute-phase severe mental illnesses, which may limit their capacity for complex psychotherapeutic engagement.

The proposed balance model could potentially extend beyond clinician-patient interactions. Through frameworks such as the "X3" model (presented by researcher Zhu Xinyuan at the First Chinese Positive Psychotherapy Conference), it may facilitate coordinated care among physicians, nurses, and families, with its three-stage structure potentially reducing communication barriers in multidisciplinary teamwork.

Furthermore, the dynamic clinical presentations in inpatient settings – where patients often experience fluctuating symptoms – suggest that the three-stage model may offer advantages for phase differentiation and positioning when compared to the five-step model.

The treatment of mental illnesses is divided into acute, consolidation, and stable phases. Integrating this model with psychiatric treatment phases, we note that Patients in severe psychiatric wards are in the acute phase according to the disease course. Post-discharge community management, often involving social workers, represents a critical continuation of treatment. The three-stage model is hypothesized to bridge hospital-to-community transitions, though its empirical utility for guiding post-discharge psychotherapy remains to be verified. Besides, the three-stage model can serve as a powerful tool for the observing stage of the five-step process.

The three-stage model is more straightforward, and positive psychotherapists may be able to assist physicians in mastering and applying the corresponding tools through basic training. The five-step model retains distinct advantages and may be used during hospitalization for mild cases.

However, this study is limited by its sample size. Currently, the model is based on the clinical practice experience of only four psychiatrists who are also Positive Psychotherapists. Future studies should expand the sample size and invite experts to evaluate the model. In practice, the model has not yet been promoted clinically among psychiatrists; further research is needed to evaluate its feasibility. Additionally, control groups can be included in future studies to conduct clinical trials of the model's application and treatment protocols derived from it, thereby assessing treatment effectiveness.

This study was conducted based on a Grade A tertiary psychiatric hospital in Shenzhen. In China, hospitals at different levels assume varying social responsibilities under the three-tiered healthcare model. Additionally, economic development levels and local cultures vary across regions, leading to diverse management models among these hospitals that may influence the application of the model. In different countries, due to legal and cultural factors, it is recommended that further localized research be conducted.

In the future, based on this model, treatment consensus and practice guidelines for inpatient units for severe mental illnesses can be further developed, and the model can be extended to inpatient units for mild mental illnesses, psychosomatic diseases, and general hospital wards.

Conclusion

Based on the clinical practice of four psychiatrists in inpatient units for severe mental illnesses, this exploratory study proposes a conceptual Balance Model system based on the Three-Stage Theory of Positive Psychotherapy. The model may assist psychiatrists in identifying patients' current stages and treatment goals through the three-stage Balance Model. Meanwhile, localized adaptations of the Three-Stage Theory of Positive Psychotherapy and the Balance Model were developed to suit the context of inpatient units for severe mental illnesses in China, providing a preliminary theoretical framework for the further development of systematic Positive Psychotherapy protocols. On this basis, clinicians could use this framework to design individualized interventions tailored to specific clinical cases, thereby enhancing the model's

practical value. By reviewing past Positive Psychotherapy practices in psychiatric inpatient units using this model, the researchers found that the model has theoretical value: it helps clinicians understand patients' symptoms and functioning more comprehensively and systematically, and serves as a tool for developing treatment plans.

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Acknowledgements

The authors thank international positive psychotherapist and trainer Jie Deng for her guidance on Positive Psychotherapy theory and its practical application.