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Typology of psychotherapeutic targets and changes in state of patients with neurotic disorders in the course of personality-oriented (reconstructive) psychotherapy

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Summary

We studied patients with three main forms of neurotic disorders and also psychotherapists trained in personality-oriented (reconstructive) psychotherapy with the aim of classifying specific psychotherapeutic targets significant for the dynamic of clinical and psychological patient features in the course of psychotherapeutic treatment. A two-stage study was conducted, in which on the first stage took. The results showed that specific characteristics of psychotherapeutic targets and their combinations used by the psychotherapist have a certain regularity; a reliable statistical relationship was found with symptomatic effects of ongoing psychotherapy.

medical (clinical) psychology, personality oriented (reconstructive) psychotherapy, psychotherapeutic target, neurotic disorders

One of the key concepts in the description of a psychotherapeutic process is the concept of psychotherapeutic target [1]. Choosing targets allows for an improvement of a psychotherapeutic effect and makes it available for description and scientific study [2,3].

On the one hand, in contemporary scientific literature, including in the field of clinical psychotherapy, the term 'psychotherapeutic target' is widely used, but on the other hand, it is difficult to find its clear-cut definition [4–7]. Psychotherapy as a method of treatment of mental disorders should be distinguished from counseling where some psychotherapeutic techniques may be successfully used [8]; this also includes the differentiation of the aims and targets of psychotherapy [9,10].

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Despite the fact that various aspects of psychotherapeutic targets have been described, there is no systematic approach or basic algorithm to be used. Therefore, there are limitations in the application of psychotherapeutic targets in such domains as scientific research, comparison of effectiveness of psychotherapeutic models, optimization of individual psychotherapeutic programs, and preparation of clinical guidelines [9,11,12]. For research purposes, optimization should be understood as a differentiated choice of psychotherapeutic interventions adjusted to personalized characteristics of the psychotherapeutic process, such as psychopathology, clinical, psychological and personal features of a patient, as well as content characteristics of different stages of psychotherapy [9,10,13,14].

The relevance of this study is determined by the necessity to systematize current approaches to the definition of psychotherapeutic targets. It will also form the basis for classification

that allows unifying targets and providing conditions for a uniform understanding of psychotherapeutic elements in general and those of personality-oriented (reconstructive) psychotherapy in particular [15–18].

AIMS

The objective of the present study is an optimization of individual personality-oriented (reconstructive) psychotherapy in the treatment of neurotic disorders on the basis of clinical and psychological characteristics of patients and involving the use of psychotherapeutic targets typology.

The study had the following aims.

Theoretical determination of a definition of 'psychotherapeutic targets' and their classification by means of theoretical-methodological analysis of the existing definition, in treatment of patients with neurotic disorders.

Study of individual medium-term personality-oriented (reconstructive) psychotherapy in patients with neurotic disorders by means of specially designed psychological analyses of psychotherapeutic cases.

Study of clinical and psychological characteristics in patients with various types of neurotic disorders during the course of personality-oriented (reconstructive) psychotherapy.

Identification of psychotherapeutic targets in individual medium-term personality-oriented (reconstructive) psychotherapy in patients with various types of neurotic disorders by means of a specially designed semi-structured interview with psychotherapists.

Study of the relationship between changes in clinical-psychological characteristics in patients with neurotic disorders during the course of psychotherapy and the choice of psychotherapeutic targets based on clinical and personal characteristics of patients.[end list]

METHOD

The sample consisted of 150 patients with neurotic disorders treated with individual personality-oriented (reconstructive) psychotherapy; they did not receive medication or any other type of treatment.

Participants

The mean age of the patients was 34.5 years (SD= 0.3). The share of women and men amounted to 80% (N=120) and 20% (N=30) respectively. The share of married and single people was 48.7% and 51.3% respectively; 50% of patients had a higher education degree, 47.3% had special secondary education and 2.7% had secondary education. The inclusion criteria were: age 18 to 55 years, signed informed consent to participate in the study and a diagnosis of a neurotic disorder verified by experts, including senior research associates. The exclusion criteria were the presence of apparent somatic, psychotic or neurological pathology and absence of informed consent.

Patients were recruited into the study on the basis of ICD-10 classification of mental and behavioral disorders from chapter F4 (neurotic, stress-related and somatoform disorders), namely the F40.01, F48.0, F42, F45.3, F40.8, F45.0, F41.2, F40.1, F44.4 diagnostic categories. According to the traditional Russian and Soviet classification of mental disorders, which is based on the concepts of Myasishchev and Karvasarsky and involves not only features of the clinical picture of the disease, but also etiopathogenetic mechanisms [9], patients were divided into groups by types of neurotic disorders: hysterical type – 76 patients (50.7%), obsessive-phobic type – 45 patients (30%) and neurasthenic type – 29 patients (19.3%). Additionally, 48 psychotherapists participated the study, each with at least 5 years of professional experience and trained in the method of personality-oriented (reconstructive) psychotherapy. Seventeen experts performed expert evaluations.

RESEARCH DESIGN

First, an analysis of literature was conducted alongside expert evaluations. This resulted in a formulation of a working definition of psychotherapeutic target, a preliminary list of the targets for neurotic disorders, and five groups of psychotherapeutic targets.

Second, an algorithm of psychological analysis of psychotherapeutic cases was developed and tested, various types of difficulties arising dur-

ing the psychotherapeutic treatment were studied and analyzed, and a list of psychotherapeutic targets for neurotic disorders was completed. At this stage, the following techniques were used: theoretical-methodological analysis, clinical-psychological method, expert evaluations and a statistical method.

Third, clinical-psychological characteristics of 150 patients with various types of neurotic disorders were studied in the course of personality-oriented (reconstructive) psychotherapy. The psychotherapy was conducted over 2.5–3 months, with sessions two times a week, each for 60 minutes; there were 24 sessions in total.

All patients were examined before and after treatment with the use of a battery of tests, which included: a questionnaire of psychopathological symptoms severity (Symptom Checklist-90, SCL-90), Ways of Coping Questionnaire (WCQ), Gießen personality test, and Personality Differential Semantic Test. Data were analyzed by means of statistical tests which included the following: descriptive statistics and normality tests using Kolmogorov–Smirnov criterion for normality; Mann–Whitney U-test for independent samples and Wilcoxon rank test for dependent samples in group comparisons; Spearman's rank correlation coefficient to determine the correlation; and Fisher's exact test to establish a relationship between variables. The 48 psychotherapists who treated patients in the main group were assessed using a semi-structured interview at the end of treatment. The interview was based on three stages of a psychotherapeutic process; it helped to get the description of it and employed psychotherapeutic targets.

To process data captured during the interviews, expert evaluations and a statistical method were used. This allowed us to analyze the choice of targets in personality-oriented (reconstructive) psychotherapy in patients with neurotic disorders, as well as a connection between the choice of targets and clinical-psychological characteristics of patients.

RESULTS

To begin with, the following working definition was drafted: psychotherapeutic target was defined as a clinical and psychological phenomenon shown (in the course of psychotherapy) by the patient or expected by the psychotherapist and aimed to be changed by means of psychotherapy at a particular stage of treatment. The suggested classification of psychotherapeutic targets is based on the assumption that the identified targets will belong to one of the following five groups which reflect some possible aspects of their definition:

- Group I – clinical implications of a neurotic disorder in patients treated with psychotherapy; group I targets include: symptoms of a disorder; current mental states and processes; negative affects; symptomatic behavior.
- Group II – personal and psychological characteristics of patients which significantly influence the emergence and dynamics of a disorder; group II targets include: personal characteristics subject to strengthening, weakening or normalizing; behavior that is subject to change or formation; self-regulation; patterns of emotional experiences (relationships).
- Group III – features of a psychotherapeutic interaction in the treatment process; group III targets include: patient's or therapist's communicative activity subject to strengthening, weakening or normalizing; role structuring; aspects of the relationship.
- Group IV – patient's conditions of life and micro-social functioning, including those that have psychogenic and pathoplastic impact on the disorder; group IV targets include: features of adaptation in the family; professional adaptation; features of other aspects of social adaptation.
- Group V – theoretical concepts worded in terms of psychotherapeutic methods; group V targets include: mechanisms of pathogenesis; phenomena to be treated by a particular psychotherapeutic method.
- The choice of psychotherapeutic targets was influenced by the stage of psychotherapy. Five most frequently chosen targets are represented on the slide.
- In the first stage of psychotherapy, the main efforts of the therapist were aimed

at building interpersonal contact, dealing with patient's actual emotional experiences, symptoms of a neurotic disorder and motivation for deeper psychotherapeutic work. An important object for the working-through at this stage was 'inadequate internal picture of the disease' (group II target). 'Mentally traumatic experiences' (group II target) are connected with the patient's emotional experiences of any urgent unpleasant aspects of his/her life and are likely to become a target at the beginning of treatment because of a high degree of concern about these experiences expressed by the patient.

- In the second (main) stage of psychotherapy, the most frequently chosen target was 'inability to realize the connection of symptoms with emotional tension, own individuality and major aspects of life', the so-called 'personality–situation–disease' causation. This target was used in 95.3% of cases and it proved the most popular. Evidently, this target is significant in personality-oriented (reconstructive) psychotherapy and all further interventions are built around it. The main efforts of the therapist were aimed at increasing the level of reflection (expanding the scope of realization of a patient's intrapersonal and interpersonal processes), working through intrapersonal conflict, as well as individual components of the etiopathogenesis of neurotic disorders – self-attitude, self-esteem, difficulties in close relationships, psychological defense mechanisms, lack of awareness of feelings, strong negative emotions, violation of self-regulation, behavior problems, and other personality phenomena involved in the maintenance of neurotic system relations.
- In the third and final stage, the focus of the psychiatrist's attention is shifted towards the behavioral domain and the most popular targets were 'insufficient integration of therapeutic experience', 'drawbacks of behavioral models', 'problems with goal-setting' and 'difficulties in addressing urgent life problems'. One of the critical goals becomes overcoming 'dependence on the therapist and psychotherapy'.
- Then, we compared various clinical and psychological indicators, their trends in the course of psychotherapy, and differences in the psychotherapeutic targets in patients from the three groups (hysterical, obsessive-phobic and neurasthenic neurotic disorders).

Table 1. The goals of relationship reconstruction in different structural domains of the relationship system.

Cognitive field	Awareness of the ones behavioral motives, specific features of the individual relationships, emotional and behavioral reactions Awareness of the destructive character of ones specific emotional and behavioral patterns Awareness of the connection between psychogenic factirs and neurosis onset Taking responsibility for one's own behavior in the conflict situations and in symptoms maintenance Awareness of the repetitive compulsion character of the interpersonal conflict situations and the conditions of its formation in early childhood in the relationship system with meaningful ones
Emotional field	Psychotherapist emotional support leading to weakens of defensive mechanisms Understanding and emotional verbalization skills training Experiencing of the more sincere feeling towards oneself Awareness of the emotional parts of the intrapsychic conflict Relationship emotional correction Changes in the emotional reactions patterns
Behavioral field	Providing skills of inadequate behavior patterns correction, Acquisition of the new behavioral skills and sincere communication experience Implementation of the new behavioral patterns in wide spectrum of life situations

Table 2. presents the dynamics of psychological characteristics in histrionic neurotic patients.

Table 2. Dynamic of the psychological characteristics in the histrionic neurosis patients in the process of treatment

Scales	Before treatment M ± m / Me	After treatment M ± m / Me	p (T)
SCL-90			
SOM	1.14 ± 0.08 / 1	0.95 ± 0.06 / 0.8	0.02
O-C	0.7 ± 0.09 / 0.43	0.47 ± 0.06 / 0.29	< 0.01
INT	1.41 ± 0.11 / 1.3	1.24 ± 0.08 / 1.22	< 0.01
DEP	1.86 ± 0.11 / 2.3	1.65 ± 0.08 / 1.4	0.09
ANX	1.26 ± 0.12 / 1.1	0.98 ± 0.09 / 0.9	< 0.01
HOS	0.87 ± 0.06 / 1	0.75 ± 0.07 / 0.5	0.13
PHOB	1.76 ± 0.1 / 1.5	1.37 ± 0.07 / 1.3	< 0.01
PAR	1.07 ± 0.08 / 1	1.01 ± 0.08 / 0.83	0.30
PSY	0.89 ± 0.07 / 0.9	0.76 ± 0.05 / 0.6	0.13
GSI	1.29 ± 0.07 / 1.27	1.08 ± 0.05 / 1.1	< 0.01
PSI	53.39 ± 2.41 / 57	50.7 ± 1.92 / 50	< 0.01
PDSI	2.11 ± 0.04 / 2.08	1.9 ± 0.05 / 1.9	< 0.01
Personality differential			
Assessment	9.68 ± 0.77 / 11	8.48 ± 0.63 / 8	< 0.01
Strength	2.71 ± 0.82 / 5	1.68 ± 0.71 / 0	0.16
Activity	4.97 ± 0.96 / 3	4.7 ± 0.99 / 5	0.71
Gießen personality test			
I	44.17 ± 1.69 / 46	45.3 ± 1.25 / 46	0.99
II	44.09 ± 1.48 / 45	46.81 ± 1.16 / 49	0.01
III	59.64 ± 1.19 / 58	56.04 ± 1.12 / 56	< 0.01
IV	57.56 ± 1.12 / 57	58.29 ± 0.99 / 59	0.49
V	55.88 ± 1.32 / 54	55.38 ± 1.43 / 44	0.44
VI	50.03 ± 1.35 / 48	50.45 ± 0.9 / 50	0.95
Lazarus coping test			
Confrontive coping	43.79 ± 1.69 / 39	46.18 ± 1.76 / 44	0.04
Distancing	48.69 ± 1.7 / 50	47.82 ± 2.05 / 50	0.46
Self-control	61.39 ± 1.5 / 67	63.26 ± 1.62 / 67	0.06
Seeking social support	64.18 ± 2.64 / 63	65.09 ± 2.46 / 61	0.60
Accepting responsibility	63.21 ± 2.71 / 67	76.77 ± 1.98 / 83	< 0.01
Escape-Avoidance	51.94 ± 1.81 / 54	55.84 ± 1.61 / 53	0.14
Planful problem-solving	61.68 ± 2.14 / 56	60.92 ± 1.6 / 61	0.68
Positive reappraisal	49.81 ± 2.4 / 48	52.71 ± 2.21 / 57	0.08

Hysterical type

According to SCL-90, complains intensity (GSI) and associated distress (PDSI) are more apparent in a hysterical type of neurotic disorders. In addition, higher values are observed on 'depression', 'somatization' and 'interpersonal sensitivity' scales (p (H) < 0.01), which reflect veg-

etative anxiety manifestations, low mood and emotional discomfort in interpersonal relations. In the course of psychotherapy, there is a significant reduction in the values of 'somatization', 'obsession-compulsivity', 'interpersonal sensitivity', 'anxiety' and 'phobic anxiety' (R (T) < 0.01). However, some symptomatic scales values remain above the normative values.

According to the Personality differential method, patients with hysterical type neurosis were characterized by high 'assessment' factor, scoring 9.68 (SD=0.77 / 11) and low 'strength' and 'activity' factor, scoring 2.71 (SD= 0.82 / 5) and 4.97 (SD =0.96 / 3) respectively. Patients had inflated self-esteem regarding their volition and communication ability. In the course of psychotherapy, the 'evaluation' factor scoring decreases, which may indicate that patients with hysterical type neurosis begin to more adequately estimate their abilities and personal qualities (p (T) < 0.01).

According to the Gießen personality test performed on the three groups of patients, communicative and social qualities are most apparent in patients with a hysteric type of neurotic disorder. In the course of psychotherapy, a decrease is observed in the level of impulsivity (p (T) = 0.01) as well as in excessive control of meeting the formal rules and regulations.

According to the Lazarus coping test, indicators of confrontational coping were relatively lower in patients with a hysterical type of neurotic disorder (p (H) < 0.01). Such patients are more active in overcoming difficulties and more passive in addressing problems. After treatment, these patients are more likely to use confrontational coping (p (T) = 0.04) as well as the strategy of commitment acceptance (p (T) < 0.01).

In this patient group, the following psychotherapeutic targets were frequently chosen by therapists: 'inadequate internal picture of the disease', 'excessive value of positive estimation from others', 'disorders of self-esteem', 'level of claims', 'problems of goal-setting', 'manipulative behavior', 'mechanisms of secondary gain from illness', 'relationships with psychotherapist'.

Obsessive-phobic neurosis

Table 3. Dynamic of the psychological characteristics in the obsessive-phobic neurosis patients in the process of treatment

Scales	Before Treatment M ± m / Me	After Treatment M ± m / Me	p (T)
SCL-90			
SOM	0.68 ± 0.06 / 0.6	0.39 ± 0.05 / 0.25	< 0.01
O-C	1.84 ± 0.14 / 2.2	0.71 ± 0.04 / 0.8	< 0.01
INT	0.8 ± 0.07 / 0.6	0.58 ± 0.06 / 0.56	0.01
DEP	1.03 ± 0.07 / 1.04	0.71 ± 0.07 / 0.62	< 0.01
ANX	1.19 ± 0.09 / 1	0.91 ± 0.09 / 0.5	< 0.01
HOS	0.82 ± 0.04 / 0.8	0.51 ± 0.06 / 0.30	< 0.01
PHOB	0.79 ± 0.11 / 0.43	0.63 ± 0.1 / 0.14	< 0.01
PAR	0.57 ± 0.06 / 0.5	0.33 ± 0.04 / 0.20	< 0.01
PSY	0.5 ± 0.04 / 0.5	0.29 ± 0.05 / 0.10	< 0.01
GSI	0.83 ± 0.04 / 0.79	0.57 ± 0.05 / 0.40	< 0.01
PSI	41.22 ± 1.53 / 47	32 ± 1.96 / 27	< 0.01
PDSI	1.74 ± 0.06 / 1.8	1.52 ± 0.04 / 1.59	< 0.01
Personality differential			
Assessment	8.09 ± 0.57 / 7	9.91 ± 0.5 / 11	< 0.01
Strength	-0.89 ± 0.71 / – 1	2.28 ± 0.88 / 3	< 0.01
Activity	5.89 ± 0.86 / 8	4.38 ± 0.95 / 7	0.06

Gießen personality test			
I	46.41 ± 1.18 / 51	49.34 ± 1.4 / 51	< 0.01
II	40.58 ± 1.28 / 43	44.41 ± 1.23 / 43	0.17
III	57.83 ± 1.81 / 54	58.5 ± 1.42 / 56	0.62
IV	58.05 ± 1.08 / 55	57.97 ± 1.68 / 57	0.30
V	56.89 ± 1.27 / 60	54.98 ± 1.43 / 54	0.06
VI	50.5 ± 1.16 / 53	51.89 ± 1.13 / 50	0.41
Lazarus coping test			
Confrontative coping	41.39 ± 2.11 / 50	43.19 ± 1.79 / 44	0.10
Distancing	39.94 ± 1.57 / 39	40.28 ± 1.96 / 39	0.96
Self-control	56.59 ± 1.7 / 57	57.38 ± 2.21 / 52	0.79
Seeking social support	57.33 ± 2.56 / 53	63.84 ± 2.31 / 61	< 0.01
Accepting responsibility	49.44 ± 1.77 / 42	47.75 ± 2.3 / 42	0.38
Escape-avoidance	49.69 ± 1.47 / 54	50.06 ± 1.6 / 46	0.83
Planful problem solving	51.72 ± 2.2 / 50	54.34 ± 2.41 / 56	0.36
Positive reappraisal	44.11 ± 1.73 / 43	44.69 ± 1.88 / 48	0.86

Patients with an obsessive-phobic type of neurotic disorder are characterized by relatively low indicators on all scales of SCL-90, in addition to an increased obsession-compulsivity indicator. After a course of therapy, there is a significant reduction on all indicators of symptom intensity and subjective illness severity, and all scales approach normative values. In patients with this type of disorder, the personality differential method indicated moderate 'assessment' and 'activity' factors scores (8.09 ± 0.57 / 7 and 5.89 ± 0.86 / 8 respectively), which, when combined with negative 'strength' factor scoring (–0.89 ± 0.71 / –1) indicated a decrease in volitional qualities, apparent uncertainty and anxiety, along with a sufficient estimation of personal qualities and activity. During the course of psychotherapy there were significant shifts in 'assessment' and 'strength' factors ($p(T) < 0.01$ – for both), and an increase in self-esteem and decisiveness.

According to the Gießen personality test, patients with this type of disorder scored higher on the scale of dominance and social weakness. This indicates more apparent conformity and dependence. After a course of psychotherapy, the social approval indicator value grew ($p(T) < 0.01$).

According to the Lazarus coping test, patients with obsessive-phobic (psychasthenic) neurotic disorder are characterized by less intensive use of the coping strategies of distancing ($p(H) < 0.01$), social support seeking ($p(H) = 0.02$), accepting responsibility ($p(H) < 0.01$), problem solving ($p(H) < 0.01$) and positive reappraisal ($p(H) < 0.01$) in overcoming stressful situations, and there was less usage of conscious methods of coping with stress. After a course of therapy, patients more frequently used the coping strategy of social support seeking ($p(T) < 0.01$).

In patients with obsessive-phobic type, the following psychotherapeutic targets were used relatively more frequently: 'violations of self-regulation', 'difficulties in relations with people of the opposite sex', 'lack of trust towards the therapist', 'lack of patient's self-disclosure', 'emotional tension during the sessions,' 'lack of social ties', 'hypernormativity'.

Neurotic neurosis (neurasthenia)

Table 4. Dynamic of the psychological characteristics in the neurasthenia neurosis patients in the process of treatment

Scales	Before treatment M ± m / Me	After treatment M ± m / Me	p (T)
SCL-90			
SOM	0.98 ± 0.09 / 1.2	0.11 ± 0.04 / 0.2	< 0.01
O-C	1.06 ± 0.08 / 1	0.78 ± 0.07 / 0.6	< 0.01
INT	1.32 ± 0.09 / 1.10	0.22 ± 0.03 / 0.3	< 0.01
DEP	1.73 ± 0.11 / 2	0.31 ± 0.07 / 0.5	< 0.01
ANX	1.51 ± 0.19 / 2	0.38 ± 0.09 / 0.6	< 0.01
HOS	0.76 ± 0.18 / 1.2	0.19 ± 0.01 / 0.2	< 0.01
PHOB	0.27 ± 0.05 / 0.4	0.17 ± 0.05 / 0.3	< 0.01
PAR	0.67 ± 0.21 / 1.2	0.28 ± 0.09 / 0.50	0.04
PSY	0.42 ± 0.07 / 0.6	0.06 ± 0.02 / 0.1	< 0.01
GSI	1.19 ± 0.12 / 1.5	0.28 ± 0.05 / 0.4	< 0.01
PSI	56.33 ± 2.64 / 63	21.56 ± 3.34 / 30	< 0.01
PDSI	1.83 ± 0.11 / 2.1	1.06 ± 0.02 / 1.10	< 0.01
Personality differential			
Assessment	5.44 ± 1.41 / 9	6.78 ± 0.88 / 9	0.07
Strength	1.67 ± 2.64 / – 5	7.22 ± 0.7 / 10	< 0.01
Activity	6.78 ± 0.88 / 9	6.11 ± 0.35 / 7	0.14
Gießen personality test			
I	46 ± 4.74 / 34	56.11 ± 0.35 / 57	0.14
II	52.11 ± 0.35 / 53	53.44 ± 1.76 / 49	0.37
III	56.67 ± 1.05 / 54	50.78 ± 2.28 / 45	< 0.01
IV	67.78 ± 2.28 / 62	59.33 ± 2.64 / 66	0.37
V	49.89 ± 2.81 / 57	64.33 ± 2.64 / 71	< 0.01
VI	58.89 ± 2.81 / 66	57.11 ± 3.51 / 66	0.07
Lazarus coping test			
Confrontative coping	56 ± 0.01 / 56	47.89 ± 1.93 / 43	< 0.01
Distancing	43.67 ± 6.85 / 61	53.44 ± 7.73 / 73	< 0.01
Self-control	68.11 ± 5.09 / 81	60.33 ± 4.22 / 71	< 0.01
Seeking social support	73.11 ± 1.93 / 78	45.44 ± 4.92 / 33	< 0.01
Accepting responsibility	77.78 ± 8.78 / 100	68.33 ± 5.8 / 83	0.04
Escape-avoidance	51.89 ± 4.39 / 63	42.44 ± 2.99 / 50	< 0.01
Planful problem solving	78.11 ± 1.93 / 83	79.22 ± 3.87 / 89	0.14
Positive reappraisal	71 ± 0.01 / 71	75.44 ± 1.76 / 71	0.07

In patients with neurasthenic neurotic disorder. depression and anxiety assessed by SCL-90 were most apparent. and the value on the 'Psychotism' scale was much lower than in the other groups. which indicates less intense interpersonal insulation (p (H) < 0.01). Post therapy. all values decreased and corresponded to the normative values range.

According to the Personality differential test. patients in this group were characterized by moderate 'assessment' and 'activity' factors scoring (5.44 ± 1.41 / 9 and 6.78 ± 0.88 / 9 respectively). and very low values on the scale of 'force' (1.67 ± 2.64 / –5). which indicates a significant overestimation of personal capabilities combined with anxiety and asthenia. After a course of therapy. there was an increase in the 'strength' factor. which may indicate increasing confidence in volitional qualities and independence.

According to the the Gießen personality test. patients with a neurotic type were more apparently disposed to low mood and self-accusation in comparison with other groups (p (H) = 0.02). They achieved higher values on the social abilities scale. which indicates greater social helplessness in comparison with the other groups (p (H) = 0.04) as well as higher propensity to dependence (p (H) < 0.01). After therapy. patients were less disposed to low mood. there was a reduction in excessive control. increased spontaneity in behavior (p (T) < 0.01). and a reduction in openness (p (T) < 0.01).

According to the Lazarus coping test. problem-oriented coping and strategies aimed at changing emotional state are more actively used. After a course of therapy. the intensity of avoidance in coping strategies decreased (p (T) < 0.01). there was a decrease of initially inflated values in self-control strategies. seeking social support and responsibility acceptance (p (T) = 0.01) and an increase in the strategy of emotional distancing (p (T) < 0.01).

In patients with a neurasthenic type disorder. the following targets were more frequently used: 'emotional lability'. 'low mood'. ' stressful experiences'. 'self-regulation disorders'. 'difficulties in close relationships'. ' disadvantages of behavioral models'. 'emotional tension during the sessions'. 'urgent traumatic situation'. 'lack of psychological competence'. 'perfectionism'.

Thus. changes in personality questionnaires mostly indicate an improvement in patients' interpersonal functioning. while they concern specific factors of different types of neurotic disorders: inadequate self-esteem – in the hysterical type. determination and volitional quality – in the obsessive-phobic type. hyper-control and hyper-responsibility – in the neurasthenic type. These specific psychological indicators' trends should be taken into account in psychotherapeutic treatment.

While there are universal targets which are determined by objectives of personality-oriented (reconstructive) psychotherapy common to all neurotic disorders. there are differences in the focus of psychotherapeutic interventions associated with different types of neurotic disorders.

CONCLUSIONS

The above typology of psychotherapeutic targets takes into account aspects of a variety of particular wordings and allows determining an algorithm of psychotherapeutic treatment and characteristics of the psychotherapeutic process. At the first stage of individual personality-oriented (reconstructive) psychotherapy. the main targets concerned the characteristics of psychotherapeutic relationships; at the second stage. the main targets concerned 'personality–situation–disease' causation and the domains of self-understanding and self-attitude; at the third stage. the problem-decisive and behavioral focus of interventions prevailed. These characteristics of the content of individual personality-oriented (reconstructive) psychotherapy were successful according to the positive trends of clinical. psychological and personal characteristics of patients.

A positive trend was observed in the course of individual personality-oriented (reconstructive) psychotherapy regarding symptomatic condition. personal characteristics and characteristics of protective and coping behavior in all patients with neurotic disorders – there was a significant decrease in subjective intensity of symptoms and their diversity. and of severity of distress; improvements in interactions with others and increase in behavioral adaptability; and finally. an improvement in self-esteem.

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