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The nature of resilience embedded in the 17 healing factors of Integrative Therapy *

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Personal Introduction - Preface

The writing of this final thesis has given me the chance to look back and make a summary for myself of the last six years of training in integrative therapy at the SEAG. The comprehensive understanding of the approach behind Integrative Therapy offers me an outstandingly suitable frame of reference, day after day. Its concepts and meta-concepts, models and meta-models, theories and meta-theories have a lasting influence on me.

The possibilities of using Integrative models and concepts, of disseminating Integrative impulses and suggestions are manifold for me: in my function as a psychotherapist, working with a client one-on-one but also on the interventive level in my function as an emergency psychologist, being on site and supporting clients when they are experiencing the worst moment in their lives. My latter occupation is why I chose to write this paper on the topic of resilience. Some clients adapt well in the face of adversity and overcome difficulties easier than others and this fact has always fascinated me. This paper summarizes key points on the topic of resilience.

Notes on terms and spellings

- I use the feminine form of terms in this paper; the masculine form is of course included.
- In this work, the persons we accompany are referred to as *clients*. With the differentiated term of client (vs. patient) I follow the conception of Integrative Therapy, in which clients are still able to regulate their life situation independently and to take responsibility for their actions.
- The intended meaning of the German word « *Wirkfaktor* », the way it is meant in the Integrative Therapy translates in this paper into « Healing factor ».

Notes on this thesis

Two concepts, the concept of Resilience and the concept of the Healing Factors are both being presented in this thesis.

Resilience: the art of bouncing back

Problem frame

A critical incident is a potentially traumatic single event that exceeds the « critical mark » of the extended frame of reference (Hausmann, 2010/2015). It strains or overwhelms the coping and adaptive capacity of the affected individual to a high degree. Natural disasters, accidents, acts of violence, or the sudden loss of close relatives are critical events in life.

Emergency psychology deals with the situation of people after stressful events that can no longer be coped with by the affected person alone. Emergency psychologists support affected persons and their relatives after the impacting event (Hausmann, 2006). They promote the processing of the experience, inform about the normal reactions to an abnormal event and - if necessary - initiate further measures. In doing so, they respect the autonomy and the will of the persons to be cared for (Lasogga et al., 2011/2013).

Some affected persons react stronger to a critical incident than others, some « bounce back » faster, some take more time. The ability to adapt to adverse situations with positive results is called *resilience*.

Where it began: the concept of resilience and early research

The studies that today are considered the beginning of resilience research were conducted in the 1950s and 1960s in the field of developmental psychology or developmental pathology in children and adolescents (Masten, 2007). The long-term consequences of perinatal complications and risky developmental conditions for the individual development and adaptability of children were investigated. For a long time, this branch of research dominated resilience research (Masten et al., 1995). Some of the early studies of healthy child and adolescent development are considered « classics » of resilience research. In the best-known and most comprehensive study, Werner and Smith examined the entire cohort of children born on a Hawaiian island in 1955 and followed them until 1987, over a period of 32 years. The researchers came to the then-surprising conclusion that 72 of a total of 200 children in the high-risk group grew up to be independent and successful young adults, characterized by a positive, optimistic, and responsible attitude toward life (Werner, 1982). Between 1964 and 1974, British psychiatrist Rutter (1998) compared children on the rural Isle of Wight with children growing up in central London in an

epidemiological study. Elder examined 1974 the impact of the Great Depression on child and adolescent development following the New York Stock Exchange crash of 1929, by comparing two cohorts from longitudinal studies already underway, the Oakland Growth Study and the Berkeley Guidance Study. Norman Garmezy and colleagues (Masten et al. 1995) studied the children of mentally ill parents in the Minnesota Risk Research Project from 1971 to 1982. The high proportion of children who would be described as resilient from today's perspective prompted him to conduct the first study in which the factors that could explain these positive developmental outcomes were specifically sought in the « Competence » project (Garmezy, Masten and Tellegen, 1984). In these early years of resilience research, healthy development in the face of severe risk factors was considered *exceptional*. However, as empirical research activity increased, it became clear that resilience was a common phenomenon and that the human psyche had great adaptive capacity (see chapter *« The Power of the Ordinary » or ... just basic human resources*). The first studies on resilience in adults also showed that coping abilities were underestimated from the perspective of pathogenetically oriented models; even after confronting serious and catastrophic events, at least more than half of those affected usually remain psychologically stable (Bonanno 2004).

Definition and Etymology

Resilience is generally understood as « positive adaptation » after a stressful or adverse situation. When a person is subject to daily stress, it disturbs their inner and outer balance (Lang, 2019). Although at the same time, it presents both challenges and opportunities: the routine stressors of daily life can also have positive effects that promote resilience (Croos-Müller, 2015). It is logically impossible to know what the « right » amount of stress is for each individual, as some people can handle greater amounts of stress than others and each individual's experience will vary as well throughout their life.

Resilience is the integrated adaptation of all aspects in a range of circumstances, whether they are good or bad. It is a coherent sense of self that is able to sustain normative developmental tasks that occur at different stages of life (Richardson, 2002). Resilience research focuses on studying those who engage in life with lightness and ease, with hope and humor despite devastating losses. It is important to note that resilience is not only about overcoming a deeply stressful situation, but also about *emerging from said situation with competent functioning* (Pedro-Carroll, 2005). In short: Resilience is the art of turning

a crisis into an opportunity, by getting out of the victim role and by accepting problems as challenges. Resilience refers to the psychological or psychophysiological resilience that enables people to withstand and cope with psychological and psychophysical stress undamaged (Fergus and Zimmerman, 2005). Resilience enables a person to emerge from adversity a stronger and more resourced person. Petzold et al. (1993a) defines resilience as the « resistance forces, which could be formed due to submaximal, manageable stress situations, which were possibly still buffered by protective factors, in the life span. They result in a kind of '*psychological immunity*' to renewed, similar stressful situations or critical life events, and thus increase the subject's coping competence in the face of risks and 'stressful life events'. »

The term resilience is derived from *resilire* (Latin for « to bounce back or to rebound »). In physics, it means the physical ability of a body to spring back to its original shape after elastic deformation. When it isn't used in physics, the term « resilience » is used in various areas of society, be it in engineering, the energy industry, or the resilience of ecosystems. In psychology, it is used as well, - as was just defined -, where it is defined as a person's resistance to pathogenic circumstances and the ability to master crises by drawing on personal and socially mediated resources and to use them as an opportunity for development, in short, « bouncing back ».

Interestingly, the concept of stress, which is closely related to resilience, also finds its roots in the field of physics. Stress in physics is defined as a change in a material caused by external force: distortion and bending follow. Stress in psychology is defined as the constant mismatch between internal and external demands on a person and her ability to cope. The increasing understanding of the relationship between stress and the organism's response to it led to the observation of the « General Adaptation Syndrome » by Hans Selye (1974), which states that the body's stress response is not based on the type of stressor, but on the *perceived need for an adaptive response*.

Resilience is not an exclusively innate ability, but it is also not exclusively the result of negative or positive (environmental) influences (Rutter, 2007; Masten et al, 1995). *Resilience develops over time*. Thus, resilience can be explained as a general human phenomenon that arises from the interaction of basal human adaptive systems with the environment to enable people to cope with difficult life situations (Southwick et al.,2014a). If these basal mechanisms are protected and nurtured, humans can develop robustly, even when exposed to negative factors (Stainton et al., 2018). More succinctly, resilience is

the healthy, adaptive, or integrative functioning over time following a traumatizing experience.

It is important to define resilience in terms of a stable capacity to respond to acute events (associated with a temporary dysbalance, stable resilience trajectory) or resilience processes (emergent resilience) that succeed in the face of chronic stresses (poverty, war). The term « minimal impact resilience » is used to refer to reactions to acute stress factors or potentially traumatizing events (Bonanno and Diminich, 2013).

The salutogenetic concept of Anton Antonovsky (1997) helps in the application of the resilience concept. The central theme of recovery is the sense of coherence, which consists of three parts: *comprehensibility* (the ability to understand the interrelationships of life), *manageability* (the conviction that one can shape one's own life) and *meaningfulness* (the belief that life has meaning). Various authors have used these approaches to make resilience and its promotion manageable. Seven factors influencing resilience development have been described (Deinert 2015): optimism, acceptance, solution orientation, leaving the victim role, taking responsibility, network orientation, and planning for the future. These seven factors appear to be amenable to treatment in therapy. According to Rönnau-Böse and Fröhlich-Gildhoff (2011), these factors coincide with the « life skills » defined by the WHO: Decision making, problem solving, creative thinking, critical thinking, effective communication, interpersonal relationship skills, self-awareness, empathy, coping with emotions and finally, coping with stress (World Health Organization, 1994).

The « Power of the Ordinary » or … just basic human resources

Ann Masten coined the term « *ordinary* magic » in 2001. In her paper *Resilience Processes in Development*, she shows that the most surprising result of resilience research is the *commonness* of resilience after adversity. Basic human adaptational systems work together in order to confront life's obstacles. Only if the systems are impaired, so Masten (2001), or if the difficulties are prolonged for too long, does the risk for difficulties (and in the case of children, the risk for developmental issues) increase. « The great threats to human development are those that compromise and endanger the systems underlying these adaptive processes, including brain development and cognition, caregiver-child relationships, regulation of emotion and behavior, and the motivation for learning and engaging in the environment » (Masten, 2001).

What Masten (2001) « The Power of the Ordinary » calls, is the fact that *resilience doesn’t need special or infrequent qualities to develop, but basic human resources*. Masten goes on explaining that programs should focus on strategies that protect or restore the efficacy of basic systems (Masten, 2001). This is a positive forecast, as for « normality » is easier to achieve than social programs that are complicated to implement. What is needed, is to understand how adaptive systems develop, how they operate under different conditions, how they work for a given child's success in environmental and developmental contexts, and how they protect, restore, promote, and facilitate these systems in a child's life.

Resilience research and childhood deprivation

As it has become dramatically apparent since the appearance of the pandemic in 2019, or the climate ecological crisis since the last decades, human life is interdependent on many other systems and their good functioning. We are continual on ecosystems, computer and communication systems, health care systems, emergency systems, and political systems (Masten, 2007). Psychological research constantly needs to examine and integrate multiple levels of analysis and multifactoriality. With this fact in mind, it is clear that research on resilience needs to analyze multilevel functions and their interactions (Masten, 2001). Masten notes in a later paper (2007) that research on the effects of early experiences on development is consistent with the idea that adversity can cause the most lasting and devastating developmental damage through its effects on developing adaptive systems. Research on childhood deprivation and its impact on cognitive development illustrates the profound potential impact of adversity on the development of basic human adaptive systems, as I will expand in the following paragraphs.

Effective parenting as a resource factor

Masten (2001) has focussed her research on resilience in children: in her paper, she compares different results. She states that *effective parenting** appears to have a protective effect on antisocial behavior (Dubow et al., 1997; Masten et al., 1999). (*Effective parenting is learning to parent the child you have, not the child you wish you had. It's not about being a perfect parent—it's about being a « good enough » parent.). The study from Dubow et al. (1997) conducted with children from ethnic minority groups shows that when they were confronted to stressful events and neighborhood disadvantage, higher levels of self-worth and family support were related to lower levels of antisocial behavior. Family support buffered the relation between stressful events and antisocial behavior, whereas the effect of their peer-group was working as an antagonist factor. Experimental intervention designs demonstrate clear changes in children's behavior as a function of changes in parental behavior. A study designed by Forgatch and DeGarmo (1999) evaluated the effectiveness of a parent-training program in a sample of single mothers. The intervention produced reductions in observed coercive parenting (i.e. threats, sarcasm, manipulation), prevented decay in positive parenting (i.e. listening, validating, working together), and generally improved effective parenting practices in comparisons of

mothers in experimental and control groups. These studies -among many others- support the hypothesis of the importance the family has as a buffer against the stressful events or the disadvantages that a child might encounter. Parenting appears to play a major role linking major life stressors to child behavior.

Intellectual factors

Another important effect on resilience is to be found in the intellectual capacity of a child. Several variable-focused resilience studies have shown that intellectual functioning has the power to moderate the effects of adversity on the development of rule-governed behavior (Masten, 2001), showing the difference between good conduct and antisocial behavior. Better intellectual skills are generally associated with competence (Masten, 2001), particularly in school-based domains.

Kolvin, Miller, Fleeting, and Kolvin (1988) were given the possibility to demonstrate how deprivation and criminality were arising across generations. The study suggested that children who grew up in « deprived » rather than « non-deprived » families were more at risk of offending during their life. Another study, conducted by White, Moffitt, and Silva (1989) attempted to show the protective effect of high IQ against criminality. Their hypothesis was proven right, delinquents showed significantly lower IQ scores than non-delinquents. Many other studies were conducted showing similar results (Masten, 2001). However, these capabilities appear to be particularly important protective factors against the development of conduct disorders for children growing with high exposure to difficult life events. It is not yet clear *what exactly* it is about mental suitability that accounts for this effect (Masten, 2001). Tests of intellectual functioning are intricated and results are multi-factorial.

Summarized in Masten’s paper, these findings suggest that cognitive abilities and parenting are moderators of risk for antisocial or disruptive-aggressive behavior, as long as the child has to endure difficult living conditions. Another factor that is implicated in both cases, is the aspect of effective self-regulation skills.

Person-focused resilience studies (Masten, 2001) underpin the same findings. Studies of romanian children being adopted from orphanages show the dramatic change in development, both physically and cognitively (Ames, 1997; Rutter and ERA Study Team, 1998, in: Masten, 2001). The aptitude to recuperate for loss time is amazing « when normative

(good psychological and physical care) conditions are restored » (Masten, 2001), although there needs to be added that not all children do recover.

Promoting resilience in children

In addition to the necessary individual staging, resilience promotion must always consider and plan for the social environment. In this sense, it must also initiate interventions in these areas (family, child and youth welfare, social assistance, etc.). It also requires the exploration of processes that are based on personal strength (resource and solution orientation). Kleinhanns (2008) stated in his work « Resilienzförderung im Kinderpsychodrama », that other personal systems whose integration facilitates resilience orientation include the use of the attachment system, the self-control system, and the coping motivational system. It is also helpful to note that the resilience process is not a linear process and that many factors influence this process at different times and with varying intensity and significance (Buchholz, 2012). This underpins the principle that many paths can lead to the goal and enables a multifaceted therapeutic approach.

A *lasting and reliable relationship with a caregiver* is one of the central resilience factors, and so the relationship with the therapist is also an essential resilience factor (Buchholz, 2012) and thus particularly valuable and significant. Ideally, this relationship enables growth processes, the willingness to act, the ability to reflect and supports the ability to reevaluate and positively reinterpret a situation. This requires a high degree of sensitivity, knowing recognition of the multi-layered connections at the moment of therapy. According to Buchholz (2012), the development of one's own resilience in dealing with the client in therapy is the basis in the professional role of the therapist. Only when these experiences are usable for the therapy, a deeper understanding of the counterpart emerges. It must also be taken into account that resilience is inconceivable without vulnerability. If one or the other pole is lost, pathological processes are at play. This means that in order to become resilient, vulnerability must be allowed and people must be able to face their weaknesses (Buchholz, 2012).

Adaptation is reacting and regulating

Gunnar (2006) states that successful adaptation to stress requires both reacting to stressful events adequately and being able to regulate the stress response. The collected data from a variety of mammals show that the regulation of stress in early development is linked to

the interaction between caregivers and infants. Moreover, the effectiveness of these interactions in regulating behavioral and physiological responses to stress has implications for the ontogenetic development of the nervous system, which processes threat information and activates defensive reactions. Although most of the data from Gunnar's research are derived from animal studies, it is becoming increasingly clear that early care also has some impact on the development of the human stress system.

Nelson and Jeste wrote (2008) an article in Child and Adolescent Psychiatry, stating that many different mechanisms of biological injury can result in psychopathology, ranging from profound intellectual disability to mild developmental delay or even behavioral problems. O'Connor writes (2006) in his article called « The persisting effects of early experiences on psychological development » in the chapter of the book « Developmental psychopathology: Risk, disorder, and adaptation », that one of the most striking observations from research about children who experienced severe early adversity is the *wide range of individual differences* in long-term adaptation. Children have shown remarkable resilience and appear to be functioning well within normal limits; other children are not thriving as much.

The importance of preventive interventions

In another article, this time in the book Handbook of Early Childhood Development, Zeanah et al. (2006) analyze the effect of growing up in an orphanage in the early-age development of the child. They summarized that institutional rearing leads to harmful effects on children's development, as children in institutions are more compromised than the ones that grow up in foster care and that many children adopted out of orphanages recover substantially from early abnormalities. Earlier intervention for deprivation is more likely to be beneficial than later intervention; this acts as an incentive to act the earliest possible.

On the other hand, new studies show that in some cases, when a positive caregiving or training environment is provided, a « reprogramming » of these systems to create an active care and learning environment is possible, two of these studies are listed below:

Cicchetti, Rogosch, and Toth conducted a study in 2006 about the malleability of insecure and disorganized attachment among infants from maltreating families. The study was able to show the importance of preventive interventions (infant–parent psychotherapy or psychoeducational parenting intervention) for altering attachment organization and

promoting an adaptive developmental course for infants that were subjects of maltreatment in their families.

Fisher, Gunnar, Dozier, Bruce, and Pears were able to show in their study in 2006 that because young children in foster care are exposed to high levels of stress, these experiences place them at risk for poor social, academic, and mental heath outcomes. The role of adverse events in stimulating neurobiological stress responses presumably plays a role in shaping neural systems that contribute to these problems. Early adversity is associated with altered hypothalamic-pituitary-adrenal (HPA) axis function. Systematic interventions might have the potential to change developmental trajectories and promote resilience. The interventions have produced evidence that it is possible to impact many areas that have been negatively affected by early stress, including HPA axis activity, behavior, and attachment to caregivers.

Genetics and the nature-nurture controversy

Bonanno (2019) states that although we know that there is almost certainly a genetic component in resilience, it hasn't been researched enough. Psychological factors, like optimism, plays a role in coping mechanisms, as does coping flexibility (Bonanno, 2019). Coping flexibility can be defined as the capacity to switch back and forth from negative to positive emotions, as well as *selecting* the way emotions are used.

With advances in genetics and genetic research, genetic influences on resilience have also been studied. It was shown that the presence of an allele (gene variants) for depression or antisocial behavior, for example, only has an impact if a risk factor is also present (Caspi et al. 2003). It was concluded that genetic influence takes effect through interaction with environmental factors. Epigenetic research in recent years has also been able to demonstrate interactions between behavior and changes in DNA, which can subsequently be transmitted across generations.

Is the capacity for resilience inherent in certain people, or is it a product of good nurturing in their socialization process - or both? It is important to take a complex view of the issue that considers multiple, internally and externally protective factors as sources of resilience (Welter-Enderlin, 2012).

Models of resilience

In view of the numerous factors that interact in an individual's lifetime, the question arises in how to weigh them in a resilience model. Some models show resilience factors in terms of a balance between protective and risk factors that can affect the individual. Both groups of factors act additively: The more risk factors there are, the more significantly resilience decreases and the same goes for protective factors, the more present, the greater the individual's resilience.

Resilience factors can be static or dynamic (Thun et al., 2020), i.e. they can be present continuously or only once. They can also change in their quality, expression and duration. Resilience is hence defined as a process that is *supported both by pre-existing resilience factors and by adaptation processes*.

Model concept

Masten (2001) explains further the need to differentiate between the two models that try to explain resilience: the variable-focused and the person-focused approach.

« *Variable-focused* approaches use multivariate statistics to test for linkages among measures of the degree of risk or adversity, outcome, and potential qualities of the individual or environment that may function to compensate for or protect the individual from the negative consequences of risk or adversity. *Person-focused approaches* compare people who have different profiles within or across time on sets of criteria to ascertain what differentiates resilient children from other groups of children. » As both approaches have their own method based strengths and weaknesses, to have a better overview, we rely on both approaches and we compare results.

The Protective Factor Resilience Cycle: The Integrative model

The circular protective factor resilience model, an Integrative model, focusses on the processes in which external and internal protective factors and resilience interact (Petzold, Müller 2004). Protective factors, by buffering stress and vulnerability create resilience. This newly created force is then available to the client as what is called « internal protective factors » (Petzold, 2004/2006). In the event of renewed stress, these learned coping strategies can be used and reaffirmed in further successful coping efforts, making more

effective use of external protective factors likely (Petzold, 2021, in press) and so being able to be a good (or better) friend to themselves.

Neurocognitive adaptation process

If resilience can be acquired by adaptation, the question arises what humans need to acquire resilience. The human being is constantly interacting on different levels (neurobiological, epigenetic, social) with its surrounding system. A study published by McCrory et al. (2017) modeled the results of epigenetic psychiatric-psychological research regarding post-traumatic stress disorder and response to trauma. This model includes the effects of early childhood negative events - Adverse Childhood Experiences. Children growing up in a negative environmental milieu, is to be understood as an interlocking, repetitive process of personality development (Strunk and Schiepeck 2008). McCrory's (2017) model assumes a child growing up in a negative environment absorbs and anchors these circumstances in herself through neurocognitive adaptation processes. This results in an altered emotional response to threat and to the creation of negative coping strategies, creating latent vulnerability. Through repeated experiences, whether they are positive or negative, the systems strengthen and become more and more differentiated, internalized and adapted. Bolsinger et al. (2018) was able to show that, at a biological level, this leads to changes in neuro-hormonal response, the development of vulnerable or resilient networks, and changes in brain organs. Reduced hippocampal, anterior cingulate and prefrontal cortex volumes are associated with higher vulnerability. Also associated with higher vulnerability is an increase in the volume of the amygdala. When confronted to external stimuli, an increased anterior cingulate cortex activity and decreased prefrontal cortex activity are associated with higher vulnerability, while increased prefrontal cortex activity was associated with lower vulnerability. Through these ongoing adaptive processes, the organism ensures adaptation to environmental conditions. In the negative milieu, this adaptation generates a non-optimal emotional regulation, an altered stress response, and thus leads to increased vulnerability. These repeated reactions subsequently lead to a substantially increased risk of illness. McCrory's study (2008) showed that childhood maltreatment leads to changes in brain regions with implications for emotion processing and self-control, to neurocognitive alterations that integrate a certain latent vulnerability to psychiatric disorder. It so presents a compelling case for identifying who is at most risk and act upon it, while keeping in mind that prevention is substantial. At each point of McCrory's model there is the possibility of change, of adapting the system by

changing external factors or improving coping strategies or raising resilience factors. Health and illness are always simultaneously present and so, mobilizing the subjective Healing powers is a vital route.

Neurobiological research confirms these models insofar as it is now clear thanks to the research being made on brain plasticity, that the repeated application of certain responses (resilient and non-resilient actions) leads to increasingly better networked structures, which allows for an increasing improvement of the response and, at the same time, a saving of resources (Bolsinger et al., 2018).

There are numerous examples for each of many major serious risk factors. Research on children who experienced early institutional deprivation are perhaps most telling about the importance of individual differences. Children that have experienced severe form of adversity for a prolonged period of time show, in the course of their deprivation experience, that they missed out on sensitive parenting and attachment experiences, *affect attunement* as in emotional connectedness, opportunities for emotion regulation, cognitive stimulation such as Vygotsky's scaffolding, and many other psychological processes that have been linked with healthy development in diverse samples of children (Masten, 2007). Research on resilience science focuses on helping young people and test resilience theories simultaneously (Masten, 2007). Preventive interventions are more and more designed to focus on behavioral and emotional self-regulation as well as cognitive performance. Petzold and Müller (2004) list further on that hyperstress not only hinders genes that promote neuronal growth (Sapolsky 1996; Bauer 2002 cited in Petzold and Müller, 2004), it can also lead to sensitization (kindling) of the limbic system and contribute to increased alertness of the amygdala.

Resilience factors

Our adaptive systems often require experience and learning to reach full potential, just as our immune system needs some exposure to pathogenes in order to become effective. Some experiences with challenges may be important for developing resilience. But the questions remain unanswered, when is stress « *good* » for development, and when is it « *harmful »*? Resilience criteria are criteria that have proven to be effective in the face of risk-increasing hazards. These criteria have a compensatory influence, and thus moderate the effects of challenges or negative influences accordingly (Holtmann and Schmidt, 2004; Laucht et al., 1997). Resilience research has found a wide variety of factors that are associated with better outcome on the one hand or higher risk on the other (protective factors versus risk factors). The central collection and description of these factors goes back to the work of Emmy Werner (Werner, 1989/2001/2002/2004). Among most studies on resilience, the so-called resilient criterion has often been defined as follows in the next chapter (Bengel and Lyssenko, 2012). Masten (Masten, 2001) has argued that there are basic human adaptive systems that keep behavioral development on track and facilitate recovery from adverse situations when more normative conditions are restored. These protective systems are thought to have evolved from biological and cultural evolutionary processes that have shaped human adaptive capacity. Some of these systems have been the subject of extensive theoretical and empirical study in psychology, while others have been left to other disciplines or neglected.

Both groups of factors have an additive effect (Müller and Petzold, 2003): For risk factors, the more there are, the more significantly the individual's resilience decreases. For protective factors, on the other hand, the more there are, the greater the individual's resilience.

Protective factors

Factors that lead to positive life adjustment or adaptation or that result in coping with the situation are called *protective factors*. Further, protective factors can be subdivided into external or internal: resources are defined as external protective factors, while characteristics are defined as internal protective factors (Fergus and Zimmerman, 2005).

Bronfenbrenner's socioecological model (Mash, 2018) distinguishes protective factors in the following areas: ***Cultural factors*** are value systems, customs, languages of a certain

region, a country. Based on these values, a ***society*** organizes itself in different forms. Societal factors of influence are the form of government in which individuals live or the immediate political effects of laws. ***Environmental*** factors of the immediate environment are positive school experiences and safe neighborhoods per example. Other factors include reliable, supportive caregivers into adulthood. ***Family*** factors are, on the one hand, a lasting good relationship with at least one primary caregiver and, on the other hand, the existence of an extended family in the sense of compensatory parental relationships and relief for the parents. In principle, a parenting climate with little conflict, open and oriented toward independence is an essential protective factor for children and adolescents. On a ***personal*** level, above-average intelligence and a robust, active and sociable temperament are strong protective factors, as is a secure attachment. ***Social*** support - whether from parents, friends, relatives or neighbors - is one of the key protective factors. Based on this understanding, it is clear that interaction with primary caregivers plays a central role in the development of resilience. Various authors today also equate the concept of resilience with the concept of secure attachment.

Risk factors

The stress factors that increase an individual's vulnerability and thus reduce resilience are logically the lack of the same aspects listed above.

War, natural catastrophes or pandemics such as Covid-19 are ***societal*** factors. The most prevalent social stressor remains poverty, low socioeconomic status as well as lack of social support (Wadsworth et al. 2018), which affects not only the society, but the ***culture*** as a whole. A large family***,*** living in poverty and with not enough space is at risk of suffering under ***environmental*** stress factors. Inside the ***family*** life, illnesses, life circumstances of the parents, frequently changing relationships or single parents and especially the absence of the fathers are significant stress factors (Masten, 2007). Fathers with authoritarian parenting styles and/or unemployment are a risk factor for the family (Masten, 2007). In addition to ***individual*** factors, specific protective or risk factors (Agasisti et al. 2018) have also been described for ***groups*** (Chamlee-Wright and Zhou 2009). This means that certain groups, ethnic groups or social classes have resilience factors that are common and specific to the group (for example religions or schools).

The contents of the 14+3 Healing Factors in the research on resilience

Petzold (1988) distinguishes a total of four *Paths of Healing (Vier Wege der Heilung)* in the concept of Integrative Therapy: 1. path: «Working on consciousness and finding meaning», 2nd path: «Post-socialization and development of basic trust», 3rd path: «Experience activation for personality development» and 4th path: «Experience of solidarity and promotion of social commitment».

More finely differentiated, these four paths contain the following 14 +3 *Healing Factors* (*Wirkfaktoren*) as process strategies, which can come into play in different weightings and combinations (Brumund and Märtens, 1998). In order to focus exclusively on the Healing Factors, this paper will not discuss the Four Pathways. The *fourteen* Healing Factors in Integrative Therapy (Petzold, 1993) were increased to *17* in 2014: (hence the name of Petzolds paper «14 + 3»). The addition of these three last further factors 15 to 17 have included nature as an ecological reality in which we are constantly embedded (Petzold et al., 2014).

As discussed throughout the present paper, resilience results from coping processes and adaptation (see chapter *Resilience: the art of bouncing back*), as has been the Protective Factor Resilience Cycle (see chapter *The Protective Factor Resilience Cycle: the Integrative model*). The interaction of protective and resilience factors is important, since protective factors influence the developmental process (see chapter *Genetics and the nature-nurture controversy*) and thereby buffer the experienced external influences and, at the same time, amplify the effects of external protective factors and resources (Petzold 2002/2000).

Healing Factor 1: Empathetic understanding and empathy

Compassion and empathy are indispensable qualities in therapeutical work. Petzold (2003a) says the client should feel understood in her life situation so that she feels « seen as she is », experiencing « coherent empathy » is an important and sadly also often a new experience for our clients. Empathic statements act as « adjusting emotional experiences ». This new « interpersonal interaction » has the effect of correcting attitudes and positions. In this way, it enables our clients to experience a new process of understanding.

In order to be able to empathize, it is often necessary to help the client reduce complexity, especially at the beginning of the session (Petzold, 2003). This means that when a client enters a counseling situation, she gets enabled to gain distance and eccentricity from her immediate situation. Already by asking the client how she is feeling, we help clarify her emotions by promoting emotional awareness as well as body awareness. Just by showing empathy, we can stimulate the perception and expression of the client's emotional states.

Social support, comfort, encouragement must be interiorized to be effective for resilience (Petzold and Mathias-Wiedemann, 2019a/2020).

Empathy and comfort

Empathy plays a significant role overcoming the feeling of loss and bearing with grief (see chapter *Healing Factor 2*). Empathic participation is necessary to support the subject's grief (Petzold, 2015h/2020e). Empathy is deeply rooted in the concepts of Integrative Therapy. Empathy and Empathetic understanding is the first (out of 17) and most important Healing Factor.

Comforting is about finding the way out of this difficult state that the grieving person is experiencing. Petzold differentiates *comfort* from *comfort-work* (Petzold, 2015h/2020e). Comfort-work is the continuously giving of comfort that might come from a professional. Comfort, or comfort-work is based on these different levels (Petzold, 2015h/2020e):

- on the **physiological** level: Calming down states of excitation with a hyperstress quality
- on the **psychological** level: Counteracting feelings of being overwhelmed, stress emotions as well as negative cognitions and to prevent the weakening of decision-making processes and a chronicizing fixation in bitterness and resignation
- on the **ecological** level: The aim is to provide reassurance and invigoration through experiences of nature
- on the **social** level: The aim is to promote the search for help; to prevent feelings of helplessness and the formation of dysfunctional social behavior and instead, to build and promote positive social patterns.

Healing Factor 2: Emotional acceptance and support

Emotional acceptance and support includes « acceptance, relief, comfort, encouragement, positive attention » (Petzold, 2003a) and especially the promotion of positive self-referential feelings such as self-esteem, self-assurance, self-acceptance, self-confidence to reduce negative self-referential feelings (inferiority, guilt, learned helplessness, shame, etc.).

Death, grief, comfort, bereavement and Oikeiôsis

Bonanno (2019) states in his book « the other side of sadness » that there is no magic behind grief work, instead he says that we come already well equipped: « We cope well with loss because we are equipped-wired, if you will, with a set of in-born psychological processes that help us do the job. » Although Bonanno (2019) states that although not everyone copes well with loss, bereavement research is important in order to help understand the reasons behind the differences in coping mechanisms. Bonanno's book summarizes his research on the topic and debunks Kübler-Ross' *five stages of grief.* The five-stage model of grief (also called the Kübler-Ross model) posits that people who experience grief go through a series of five emotions: denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969/1973). Kessler even added a new emotion to the model in 2019. Being one of the most famous and frequently referenced models, it hasn't none the less been empirically correctly demonstrated. The model is considered outdated and inaccurate (O'Connor, M. F., 2019). Kübler-Ross sourced her theory from the terminally ill, thus persons who were dying, not persons who experienced the death of a loved one. Bonanno's large body of peer-reviewed studies show that the vast majority of people who have experienced a loss are resilient and that there are multiple trajectories following loss (2019): « One of the most consistent findings is that bereavement is not a one-dimensional experience. It's not the same for everyone and there do not appear to be specific stages that everyone must go through. Rather, bereaved people show different patterns or trajectories of grief reactions across time. »

Mourning is a highly individualized, variable and dynamic process, which takes place in subjects partly unconsciously, partly consciously, and which is strongly influenced by contextual conditions (Petzold, 2015h/2020e). Grief is *not only a feeling, but a synergem of multilayered experience and behavior*. It is influenced by socio-cultural factors, life age, life experience, gender and social rules, the so called « collective mental

representations » (Petzold 2003b). Grief concerns the « whole grieving person », and therefore requires a differential and holistic approach (Petzold 1999p). Because biological/physiological, ecological, psychological (cognitive, emotional, volitional), sociocultural (ethnic, religious/spiritual) dimensions (Petzold, 2015h/2020e) come into play individually and collectively in mourning processes and their accompaniment and processing. All these dimensions can be touched and taken up in individual and collective mourning processes, which is why we also speak of « complex mourning work » in the Integrative Approach. The mourning and consolation practices all over the world reveal such complexity in their spontaneous and ritualized forms, complexity in the mourning process is thus to be regarded as normal (Petzold, 2015h/2020e).

The concept of Oikeiôsis is rooted in the Stoic ethics and in the work of the first Stoic philosopher, Zeno of Citium (Ramelli, 2009). Stephens (2009) and Richter (2011) translates the concept as « appropriation », « orientation », « familiarization », « affinity », « affiliation » and « endearment ». Oikeiôsis denotes the sense of perception of something as one's own, as belonging to oneself. At the same time, it stands for the sense of being « at home », of belonging to and by extension becoming « familiarized » with something (Richter, 2011). In this sense, Oikeiôsis - in our understanding of Integrative Therapy- is a path of knowledge that can expand and change personal self-view, worldview and life practice (Petzold, 2015h/2020e; 2019d/2020c). Ennenbach (2017) states that our ego produces our own suffering. Meaning that our ego does not create the *un*avoidable suffering, but the avoidable suffering. This suffering concerns our reactions to events. And the way we react is strongly dependent on our ego, which constantly whispers to us an almost endless stream of expectations, evaluations and ego impulses (Ennenbach, 2017).

Healing Factor 3: Help with reality-based practical life coping

Advice and active help in coping with everyday problems as a practical « life help » is one of the particularly effective therapy factors. Solution-orientated work is very much in demand from the clients.

To foster resilience, though, it is important to counter the feeling of impotence that arises from the experienced situation. In emergency situations, it is therefore important to offer help with practical life coping, in the sense of the 3rd Healing factor, while giving the

client the possibility to help herself out. Juggling these two different approaches in a sensitive way is what a good counseling is made of.

Through resilience research we know that the most significant risk factor for children is a « poor socioeconomic status » of the family (see chapter *Promoting resilience in children*). From this it becomes clear how important socioecological interventions at the parental level are for child therapy as well, but it also becomes clear where helpers reach their limits.

Here, cooperation with the available system of helpers, such as the social welfare office, solidarity communities, self-help groups or other external support options, seems to be of great importance.

Healing Factor 4: Promotion of emotional expression and volitive decisiveness

The fourth Healing factor supports and encourages the showing of feelings and especially the talking about feelings. The therapist's « accepting presence » is said to provide « cathartic relief » (Petzold, 2003a) and allow for the expression of forbidden, unwanted, or morally reprehensible feelings. Analogous to the emotional dimension, this impact factor also includes the volitive dimension, meaning the promotion and support of decisions. We can support our clients in the formation and execution of volitional decisions, while giving them enough space to not feel pressured.

Positive emotional interactions are a predictor of health. Successful emotional differentiation, the ability to empathically fine-tune emotional states through *co-correlated* emotional resonances, and emotional safety are important functions of socialization and *co-emotive*, developmental parenting. Negative emotional interactions and time-extended stress or extreme states, if they take effect without compensation, can be central moments in the possible development of diseases (Cohen et al., 2006).

The showing of feelings commonly *negatively* connoted such as pain, fear, and anger as well as *forbidden* feelings such as shame, guilt, hatred, and revenge is supported by the positive support and accepting presence of the therapist. Likewise, through her « partial engagement » and « selective openness » (Petzold, 1992), i.e., through the expression, tailored to the client, of her own feelings and the careful introduction of her own needs and volitions, she can assume a model function for the client. The atmosphere of openness

that this creates contributes to the development of a positive « emotional culture » and decision-making culture (Petzold, 2003).

Emotional differentiation and integration work are important aspects of therapeutic action for the treatment of « dysfunctional emotional styles » or the development of « adequate will styles » (Petzold, 2003), since they help the client to perceive and hierarchize her motives and intentions, taking into account her fears and uncertainties, in such a way that she does not become a plaything of her various impulses.

Healing Factor 5: Promotion of insight, sense of meaning and evidence experiences

This Healing factor is about promoting an insight into life and problem contexts or disease conditions (Petzold, 2003a). Understanding connections and backgrounds as comprehensively as possible, and being able to connect causes and effects at the same time helps the client structuring their life and their momentary situation.

It is by helping the clients to grasp their condition and to start accepting their new reality that the therapist -as well as the therapy process- is being truly helpful.

In order to create a personal draft of one's own life story and to be able to recognize and understand connections, the client needs this intersubjective *co-correspondence* with important reference persons, such as her therapist. These can promote her self-reflection and self-knowledge and thus accompany the processes of self-constitution and identity work. By ensuring that the environment promotes reflection on social references and opens up a space for the processes of personal and communal understanding of meaning, the client is enabled to link causes and effects, to see through connections, and to understand backgrounds in the most comprehensive way possible.

If this process of common meaning constitution and exchange is interrupted and the client is no longer able to reconcile her « own reality » with the « main reality » of her environment over a longer period of time, then a consensual communication is not possible and there is the danger of a chronic overtaxing of her comprehension capacity (Petzold, 2002).

Healing Factor 6: Promotion of communicative competence/performance and relationship skills

Petzold (2003a) states that when communication is successful, it makes people more communicative in general and so more communicatively competent. Successful communication and correspondence processes are model experiences. They are the prerequisite and basis for communication and relationship building on the other hand to be carried out into the relationships with the environment and to be applied there, in the integrative sense of a transfer experience.

Communicative competences and performances are needed to shape and regulate the relationship between the client and the therapist. The therapist has often an advantage (be it linguistic or semantic) in knowledge and experience compared to the client, which finds herself in a therapeutic situation seeking help. The fact of this advantage must be handled responsibly in order not to over-power the client. Therapists that show strong communication skills indicate a better resilience. Components of listening and interpersonal communication were found to be significant predictors of resilience in occupational therapy students (Brown et al, 2020).

The more the client is able to think simultaneously about both her own perspective and the perspective of others, the greater her ability to change perspectives, to change her inner position and to be flexible in her roles, and the better she succeeds in communicating with others. The development of her self-esteem, performance behavior, self-concept and her ability to cope with existential fears of life also depends on strong interpersonal skills.

Healing Factor 7: Promotion of bodily awareness, self-regulation and psychophysical relaxation

This Healing factor includes all interventions that serve to promote awareness and consciousness of our bodies, of our bodily movements and their sensations (Petzold, 2003a). The reality of us not feeling the body, what Petzold the « anesthesia of the perceptive body » calls, can cause illness, form functional or psychosomatic diseases.

Re-learning to feel one's body is essential to feel empowered again. This can be achieved via meditation, sport, mindfulness training or via other ways. Indirect therapeutical interventions can also promote body awareness and health in the client's mind.

The ability to self-regulate is a central developmental task of early childhood. From the ninth month of life, the child has the ability to communicate intentionally. By turning to her caregivers with negative feelings such as fear, frustration and anger, she demands closeness, security and regulatory aids. So, she is constantly developing strategies for regulation of negative effects. If she receives regulatory support when she demands it, the closeness to her caregivers becomes a secure basis, and she develops a sense of self-efficacy and gains self-confidence, so creating a sense of resilience for herself.

The development towards emotional *self*-regulation requires the support of *other*-regulation (Grimmer, 2004). Therefore, psychological and psychophysical self-regulation develops through exchanges with reference persons and -simultaneously- through dissociation from them.

Healing Factor 8: Promotion of learning opportunities, learning processes and interests

It is impossible for us not to learn. We are constantly learning new information, creating new connections in our brains, we were « born to learn » (Spitzer, 2013 in Petzold, 2019e/2021). Boyd (2015b) states that everything we are ever experiencing (if we are learning new facts *or* if we are recovering from brain damage) is being represented neurologically by plasticity in the brain. The brain is constantly reorganizing itself (Petzold, 2019/2021). In this sense, living is learning.

But exactly because *we cannot not learn*, is learning an on-going and a difficult process. This is why we profit from having a helping person (in form of a therapist) near. By acknowledging the necessity of a change in a specific situation, the first step has already been made. In a comprehensive perspective, learning and change occur « through complex experiences as a differential and holistic learning that is personally meaningful *and* combines bodily experience, emotional experience, and cognitive insight in relation to events of vital evidence» (Sieper and Petzold, 2002). Successful learning processes promote the individual's ability to cope with life, to strengthen her resilience traits and increase the quality of live at the same time.

Therapy also includes « unlearning » old coping strategies that are no longer adequate. This means that the clients need to take time to find out what has led to their difficulties and what happens when they get rid of their old reaction patterns and try a different way of dealing with life’s challenges. A major difficulty is the process itself of shedding old

beliefs. Thus, learning experiences are sometimes associated with the labilization of patterns that aren't useful anymore. In this way, schemata are reconsidered, and thus the opportunity for transitions arises, giving the possibility for new patterns to emerge (Sieper and Petzold, 2002), creating resilience in the process. The biological prerequisite for these changes is the neuronal plasticity of the human brain. Through it, the mental experience influences the cerebral functions and thus the structural design of the brain in the developmental process (see chapter *Neurocognitive adaptation process*).

Healing Factor 9: Promotion of creative experiences and creative forces

Petzold (2003a) describes the creative process from the perception of an experience to the last inner resonance: Perceive, Resonance, Experience, Resonance, Expression, Design and Resonance. Resonance (as the definition in physics) occurs when a system transfers energy. In the Integrative Therapy, Resonance means the response of feelings or thoughts in the other person (or in ourselves).

One example of how creativity can strengthen resilience is shown in Morenos model of Psychodrama:

Resilience in Psychodrama

Moreno introduced the concept of spontaneity in psychotherapy. His understanding of spontaneity is that a system (individual or society) can respond appropriately to a new situation. The creative circle (Bender and Stadler, 2012) describes development based on a challenge involving spontaneity and creativeness. This circle model can be seen as an early resilience model in which both the external factors find a place as well as challenges and demands for change, but also the inner state (spontaneity, creativity and willingness to change). At the same time, this model is also Morenos « disturbance model ».

Salutogenetic, but also pathogenetic factors can appear at any point of this cycle and promote, hinder or endanger the creative process. The original model of Moreno was extended and adapted by Schacht (2009) and by Krüger (2002). In Schacht's model, a given initial situation requires either a behavior that the person already has in his repertoire or has to generate anew (Schacht, 2009). The success of this adequate, adapted behavior depends on various conditions related to experiences during personality development. It is directly related to resources, coping strategies and the positive experiences or vulnerability factors and personal factors, such as the level of structure, motivation and

other factors. Krüger's model is about the disorder-oriented view of psychodrama techniques (Krüger, 2002). According to Krüger, specific blockages (risks) of the creative self-organization process would be present for each disorder. By providing adaptive and creative role models, the regulatory adjustment of feelings and thoughts, a further development, respectively the development of creative and adequate behavior is supported.

Psychodrama is therefore designed as a resilience-promoting method. Various authors have dealt with the resilience-promoting effect of psychodrama and have been able to demonstrate its positive effect on resilience development (Walters, 2017; Deinert, 2015; Aichinger, 2010; Aichinger and Holl, 1997; Bosselmann, 1996).

Healing Factor 10: Development of positive future perspectives and expectation horizons

We are all « designer of ourselves », so Petzold (2003a). « Make a project out of yourself! » is literally the first of the four guiding principles (*vier praxeologische Basisprinzipien*) of Integrative Therapy (Petzold, 2014).

Developing positive future perspectives is a matter of building up and affirming security and hopes, of reducing anticipated fears and expectations of catastrophe, of coming to terms with plans, designs for the future and goals in life. In the therapeutic work, there is a strong attachment to the clients' perception to the immediate, to the spatially and temporally close (McNally, 2003). Hopes and fears thus relate strongly to conditions in the here-and-now. But: the future builds on current circumstances. At the same time, a person's *identity* is not only based on the past; it also *encompasses her plans for the future* (Petzold, 2003). By inducing positive expectations in therapy (and communicating it, see Healing Factor 6), the therapist that envisions positive therapy goals is able to make the client see *future perspectives*.

The importance of including *future perspectives* in therapy is shown in Vissers paper (2020) that aims to set the theoretical foundations for a future resilience index. The author found 10 elements of future resilience, among them are: *emergency preparedness*; *creative adaptability; resource efficiency; purposeful motivation;* and *well-being orientation*. Showing a purposeful motivation *and* being prepared for emergency at the same time helps the client be equipped for its future. The future can hold positive or negative surprises. Yates and Masten (2004) investigated the reciprocal interaction between resilience

research and the practice of positive psychology in a chapter of the book « Positive Psychology in action ». They argue that resilience is necessary for future development in high-risk environments. Resilience gets defined as *normative functioning of basic developmental processes under nonnormative conditions* (Yates and Masten, 2004). Resilience-based practice with a future perspective recognizes that helping clients is not only looking for solutions to their problems. « It is about recognizing and nurturing their strongest qualities, what they possess and do best, and helping them find niches where they can best live out those strengths » (Seligman and Csikszentmihalyi (2000) p. 6, in: Yates and Masten, 2004).

Healing Factor 11: Promotion of a positive personal value system, consolidation of the existential dimension

Petzold (2003a) sees a « positive, consolidated value system » as a factor promoting development and health. Values and norms form one of the five Pillars of Identity of the Integrative Therapy. Value issues are thus of great importance and are closely related to the promotion of identity and personal sovereignty (see Healing factor 12). The palette of approaches and interventions ranges from reluctance to sharing values with the clients to the other extreme, the corresponding negotiation of values and boundaries.

The experience within the consequences of certain actions influences or controls later actions. From the repetition of the individual concrete evaluations of actions, the client develops and interiorizes its own value system, so creating and reinforcing her own resilience strategies.

Healing Factor 12: Promotion of a concise experience of self and identity and positive self-referential feelings and cognitions, « personal sovereignty »

Therapy must contribute to enable identity processes of the client in a positive way. Identity is constituted from the body-self through the activities of the ego (Petzold, 2003a). Positive identity processes promote personal sovereignty, which is needed to make progresses in therapy.

Further in this same thought, Petzold (2003a) goes on, defining the processes of the ego, which takes in the identity attributions coming from the environment and referring to different identity domains (Five Pillars of Identity) and synthesizes them with their evaluation through self-attributions as well as through the internalization of such attributions to identity. Personal sovereignty is necessary to resilience, as it is only by feeling confident that difficulties can be overcome. Thus, therapy is about supporting the development of a multifaceted and emancipated identity (Petzold, 2011, 2012q), in Petzold's sense: « *we are many* ».

The client, together with the therapist, encounters problems, works on resources and potentials given by the context and then, through the negotiation of boundaries, finds solutions by experiencing her self-identity. The therapist recognizes qualities and abilities in the client and communicates them to her through her reactions and behavior, in conversation, implicitly or explicitly. This is then perceived by the client consciously or unconsciously. Her cognitive appraisal and emotional evaluation of these attributions have a significant influence on the constitution of her identity (Petzold, 2011).

Psychotherapeutic interventions that take place in an attitude of respect toward the client, when interiorized, enable self-esteem and puts in motion resilience processes. If the client feels recognized by her therapist in her being as a human being and valued in her uniqueness and otherness, she will interiorize this and develop a positive attitude towards herself (Petzold, 2010/2011).

Healing Factor 13: Promotion of sustainable social networks

Supportive and resource-rich networks have great significance and influence on the client's health and well-being, as well as on their experience of identity. Integrative therapy attaches great importance to this factor. For Petzold (2003a), it is important to keep in mind that work in the dyad does not mean work with *individuals*, but always also work with *their social networks* - past, present and future Hass, Petzold 1999).

Unfortunately, the networks of our clients often show deficits. This fact has an impact on the relationship between the therapist and the client. Therapeutic relationships are therefore highly important, and they occupy an almost central position in deficit networks, so Petzold (2003a; Brühlmann-Jecklin, Petzold 2004). As described in the first chapters,

resilience research shows that, in addition to genetic factors, learning processes mostly take place in interaction with the environment. Therefore, it is important « to record and use the resources and potentials of the close network, especially those of the family, to address resource deficits, communicative difficulties, problems in the family atmosphere or climate, and to influence pathological interaction patterns ». (Petzold, 1995)

Healing Factor 14: Enabling experiences of solidarity and « sound partnership »

Clients benefit from experiencing how her therapist understands her, stands up for her interests and thus stands by her side in solidarity. This is especially true if the client has a history of not experiencing this solidarity in earlier (stressful) situations.

« Sound partnership », so Petzold (2003), happens whenever the supportive presence of the therapist is required and provided in the respective situation, when she takes on a problem in the concrete context of the client's life and offers practical help, when challenges and problems can be overcome together (*co-operatively*). Development takes place in the context of social relationships. Early relationships are most formative; however, later relationships also shape and influence the understanding of connectedness with others (Dornes, 2004; Petzold, 2011). By repeatedly experiencing such expressions of solidarity, clients internalize them and know how to actualize them later, when they are alone, in the form of « inner support » (see chapter *The Protective Factor Resilience Cycle: The Integrative model*).

Healing Factor 15: Promotion of a lively and regular contact with nature

In the process of a therapy, lifestyle changes are a major part of the therapeutical work. To be able to make it last beyond the actual treatment period, a transfer from the therapy room to the « new reality » of the client is necessary. The 15. Healing factor promotes a better contact with nature. Research evidence (Wells, 2014) suggests that views of *and* access to nearby nature serve as protective factors, bolstering resilience. (Günther 2019; Petzold, Ellerbrock, Hömberg 2019))

Healing Factor 16: Providing wholesome aesthetic experiences

An integrative therapist work in an *artistic,* often creative way and creates *experiences* during the therapeutic process. To be able to change one's restricted view and focusing on the beauty of everyday is one of the goals of a therapy. To change the focus will bring the client to see a problem from a different perspective. A resilient person will focus more on the positive changes than on the negative -lasting- repercussions of a tragedy.

This 16th factor opens a path to a fulfilled, a so called « good life » (Orth and Petzold, 2000): The goal is not only to heal, but also to contribute to a creative and aestheticization of life (Orth, Petzold 2000).

Healing Factor 17: Synergetic multimodality

Petzold wrote 1974 about the synergetic force of different interventions working together. « The totality of perceptions/impressions becoming effective is something other than the sum of partial impressions, and the totality of interventions/effects is something other than the sum of partial effects »

If different concepts are used together in a coordinated way, multimodal Healing effects combine and mutually reinforce each other through synergy effects. Specific interventions can *complementarily* enable additional, necessary side effects, the converging main effects are strengthened (Petzold 1971, 1974).

As seen in the studies cited in the chapter « *Resilience research and childhood deprivation* », several factors work together to form resilience in children (as well as in adults). Resilience and its occurence is mostly a combination of different influences that leverage the way a difficult situation is perceived by a client. The search of the different factors and their synergies necessary for the client to develop a healthy mindset and so also a resilient approach is part of the therapy process.

Synopsis: Importance of integrating the Healing Factors while working on therapeutic interventions, developing resilience

Incorporating the concepts described in the 14+3 Healing Factors during dyad therapy is highly beneficial. In the treatment of clients facing difficult situations, factors 1-3, 6, 13, and 14 are focused especially in the initial phase of treatment. Factors 5, 10, 11, 12 play

a larger role as treatment progresses (Petzold, Orth, and Sieper, 2016). As discussed throughout the paper, the way in which people respond to critical incidents varies and depends on numerous factors (genetic, developmental, cognitive, psychological, and neurobiological).

Southwick and Charney's work (2012) on resilience is summarizing general *protective factors* and their proposed respective *therapeutic intervention.* In this synopsis, the seventeen Healing Factors are being merged in with the chosen therapeutic interventions. Although already discussed in depth for every Healing Factor, this last chapter shall work as a summary, showing in this way the importance of the total integration of the Healing Fators in therapeutic interventions.

Southwick and Charney (2012) found the following protective factors in the areas of: 1. Cognitive/behavioral 2. Emotion regulation 3. Social 4. Physical health and 5. Neurobiology.

1.

In the **cognitive field**, the authors found the following protective factors to have an effect on resilience: having strong executive functions (strong cognitive processes that are necessary for the cognitive control of behavior), having high coping self-efficacy (as in the perceived capacity to successfully manage and recover from the demands of a stressful situation), as well as having a realistic optimism and positive emotions, showing cognitive flexibility and inner control beliefs.

The therapeutic intervention to strengthen these factors would be: cognitive reappraisal (cognitively reframe adverse and negative events in a more positive light), positive emotion exercises, coping skill development and training (Southwick and Charney, 2012).

In short, the implementation of Healing Factors 4, 5, 6, 9, 11, 12, (16), where the client learns the *cognitive* skills needed to successfully cope with a stressor. The client is then given the opportunity to practice those skills in therapy. The key is to develop confidence in one's capacity to deal with the implications of a critical incident, so to increase a sense of control and shift a perceived threat into a perceived challenge.

2.

In the field of **emotion regulation**, Southwick and Charney (2012) found the following protective factors to have an effect on resilience: Having a good self-regulation, as well as impulse control and showing rapid recovery after stress.

Therapeutic intervention encloses mindfulness training, which can be found in Healing Factor 7, 8, 10. Meditation and cognitive reframing may exert their adaptive effects on emotion regulation by enhancing prefrontal cortex regulation of limbic and brainstem systems (Southwick and Charney, 2012) so, strengthening the belief in the client's ability to cope with stressful situations.

3.

In the **social** field**,** the emphasis lies on the strengthening of social competences and the importance of a diverse social network, as well as the ability to accept help (and to ask for it).

Therapeutic interventions include the teaching of social emotional training and network support treatment.

The Healing Factors that apply to these interventions are the factors 1, 2, 3, 7, 13, 14. Teaching clients the skills needed to improve social competence and to construct and maintain supportive social networks are likely to enhance resilience (Southwick and Charney, 2012). Social-emotional training programs, which focus on enhancing executive function and prosocial behavior, increase the client's overall social competence.

4.

In the field of **physical health,** everything from good sleeping habits, having an overall physical fitness and showing a working capacity to relax demonstrates effects on resilience (Southwick and Charney, 2012).

Interventions from the therapist might include the teaching of a good sleep hygiene (quantity and quality of sleep); nudging the client to practice a sporting activity and improving the diet. Healing Factor 7 and 15 focusses on the implementation and the integration of healthy lifestyles.

5.

And last but not least, in the field of **neurobiology**, the effective regulation of the HPA axis and the sympathetic nervous system, the capacity to regulate limbic stress reactivity and robust prefrontal cortical executive function are being pointed out by Southwick and Charney (2012) as being protective factors for resilience growth in the client. (See also the chapter *The importance of preventive interventions*, as well as the chapter *Neurocognitive adaptation process*)

The whole 17 Healing Factors apply here, since (next to pharmacological interventions, that weren't discussed in this paper) most psychotherapeutic interventions help regulate neural pathways believed to be critical to resilience: emotion regulation, attention, positive versus negative outlook, reward and motivation, sensitivity to context, response to fear, learning and memory, adaptive social behaviors (Southwick and Charney, 2012).

Conclusion and own deductions

During the writing of this paper, it became clear to me that the capacity for resilience in humans is distributed across many simultaneously interacting systems. Many different factors inter-cooperate, influencing the effects on resilience on the individual. As we are a social species, we also influence each other. There are also *not only **inter**-individual interactions, but **intra**-individual interactions*. To differentiate all these interactions and to understand which ones implement the client's resilience, lies in the responsibility of the therapist and is buried in the client-therapist work/process.

Learning occurs throughout the lifespan, change and improving happens throughout the lifespan, neuroplasticity happens throughout the lifespan. Through exercise and training many of the stress protective factors described in this paper can be enhanced, allowing for better adaptation to pressure and faster recovery as well as reduced risk of stress-related diseases.

While risking to sound less scientific, one last thing needs to be said: a healthy optimism in life is key. Crises are not insurmountable, to maintain a hopeful attitude is crucial. Developing and maintaining a positive self-image while taking care of one self and for one's own environment and the relevant social and ecological without forgetting to be mindful, this are the ingredients in life's recipe, this is needed, day in day out. A large part is in fact self-responsibility, escaping from victimhood and accepting the new reality. In the same sense and to finish this paper on resilience in beauty, I'd like to cite Petzold (2014) on the second of the four guiding principles of Integrative Therapy (*praxeologische Basisprinzipien*): « **Use opportunities as chances!** ».

Summary

Summary: **The nature of resilience embedded in the 17 Healing Factors of Integrative Therapy**

This paper provides an overview over the concept of resilience and the concept of the fourteen plus three Healing Factors in Integrative Therapy. Criteria, factors and models of resilience are discussed, as well as latest research. Subsequent, the concept of resilience and the Healing Factors are joined to one approach.

Keywords

Resilience · Salutogenesis · Healing Factors · *Integrative Therapy*

Zusammenfassung: Das Wesen der Resilienz, eingebettet in die 17 Heilungsfaktoren der Integrativen Therapie

Die vorliegende Arbeit gibt einen Überblick über das Konzept der Resilienz und das der vierzehn plus drei Wirkfaktoren in der Integrativen Therapie. Es werden Kriterien, Faktoren und Modelle der Resilienz sowie die neuesten Forschungsergebnisse diskutiert und versucht, eine integrierte Sichtweise der Resilienz zu vermitteln. Das Konzept der Resilienz und die Heilungsfaktoren werden zu einem Ansatz verbunden.

Schlüsselwörter

Resilienz · Salutogenese · Heilfaktoren · *Integrative Therapie*

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