

Brief existential group intervention in complex trauma and personality disorders: feasibility, acceptability, and preliminary outcomes

Dorota Draczyńska, Agnieszka Nowakowska

“Everything can be taken from a man but one thing: the last of the human freedoms — to choose one’s attitude in any given set of circumstances, to choose one’s own way.”

— Viktor E. Frankl, *Man’s Search for Meaning* [1]

Abstract

Background: This study examined the feasibility and preliminary outcomes of a brief existential intervention, 4FM Acceptance Training, delivered in an inpatient psychiatric setting. Grounded in the Four Fundamental Motivations (4FM) model, the intervention aims to support recovery and inner reorientation by strengthening basic existential capacities. The study also examined traumatic experiences, attachment styles, ICD-11 PTSD/CPTSD symptom profiles, and their overlap with ICD-10 personality disorder diagnoses.

Methods: Thirty-two psychiatric inpatients were allocated to 4FM Acceptance Training plus treatment as usual (4FM-AT; $n = 13$) or treatment as usual alone (TAU; $n = 19$), according to routine clinical procedures. Self-report measures of worry, depressive symptoms, basic hope, and existential fulfillment were administered at baseline (T0) and after treatment (T1). Seventeen participants (nine in 4FM-AT and eight in TAU) provided complete pre-post data. Trauma history, attachment styles, and ICD-10/ICD-11 diagnostic classifications were also examined.

Results: Among participants with complete data, the 4FM-AT group showed a significantly greater increase in basic hope than the TAU group ($t(15) = -5.16$, $p < 0.001$). No statistically significant between-group differences were found in changes in worry, depressive symptoms, or existential fulfillment. All participants reported emotional abuse, and 96.9% reported emotional neglect. Post-treatment perceived improvement did not differ significantly between groups. Personality disorder diagnoses and trauma-related symptom classifications frequently co-occurred.

Conclusions: The findings suggest that 4FM Acceptance Training may complement standard inpatient psychiatric care, particularly by supporting basic hope in people with histories of relational trauma. The small sample, nonrandomized design, and incomplete follow-up require cautious interpretation. Larger studies should examine longer-term outcomes, feasibility, and acceptability.

existential psychotherapy, Four Fundamental Motivations (4FM), relational trauma, ICD-11 CPTSD, ICD-10 personality disorders, psychiatric care, basic hope

Dorota Draczyńska: Institute of Psychiatry and Neurology, First Psychiatric Clinic, Warsaw, Poland

Agnieszka Nowakowska: Nowowiejski Hospital, XX Day Ward, Warsaw, Poland

Correspondence address: Dorota Draczyńska, ddraczynska@ipin.edu.pl

INTRODUCTION

Relational trauma, defined as chronic or repeated exposure to interpersonal psychological threats, such as neglect and emotional abuse within attachment relationships, can have profound consequences for psychological development, identity formation, affect regulation, and autobiographical memory [2, 3, 4]. In the ICD-11 framework, trauma-related difficulties may include core posttraumatic stress disorder (PTSD) symptoms and disturbances in self-organization (DSO), comprising affect dysregulation, a negative self-concept, and interpersonal difficulties [5]. The co-occurrence of PTSD and DSO symptoms, together with the required functional impairment, defines complex PTSD (CPTSD).

People who have experienced relational trauma frequently report a loss of internal continuity, diminished self-worth, and difficulty engaging authentically in relationships and other areas of life. Trauma may also destabilize a person's fundamental orientation toward existence, contributing to confusion, loss of meaning, and dissociation [6, 7]. Posttraumatic re-experiencing has been linked theoretically to disruptions in prereflective self-awareness and episodic memory [4]. Experimental research in healthy participants has also shown that an induced out-of-body experience can impair episodic memory and alter hippocampal activity during retrieval [8]. In CPTSD, affect dysregulation may include hyperarousal, emotional numbing, and dissociative experiences involving depersonalization, reduced emotional responsiveness, and interpersonal detachment [4, 9]. Such symptoms may interfere with the integration of temporal, embodied, and relational experience and with the capacity to relate meaningfully to the world, others, and oneself [10, 11].

From an existential perspective, trauma can be understood as a rupture in a person's being-in-the-world [12]. Individuals may feel alienated from their existential foundations and confronted by questions of death, isolation, freedom, and meaninglessness. This fragmentation may involve an existential vacuum or a loss of inner consent [1, 13]. Existential literature and research highlight the relevance of meaning, existential well-being, and anxiety to psychological adjustment [14, 15]. The Four Fundamental Mo-

tivations (4FM) model provides a framework for understanding these difficulties [16, 17]. It describes four interdependent conditions of meaningful existence: being able to be (1FM: security and presence), experiencing the value of life and relationships (2FM), being oneself (3FM: self-worth and authenticity), and living meaningfully (4FM: values, direction, and purpose). Prolonged relational trauma may undermine these conditions and a person's sense of existential security [6]. Existential Analysis seeks to restore safety and trust in the world (1FM), emotional engagement and fulfilling relationships (2FM), an authentic and autonomous identity (3FM), and a sense of meaning and purpose (4FM) [6, 18].

Although the 4FM model is established in existential literature, its use in structured, empirically evaluated group interventions remains limited, particularly in inpatient psychiatry. The 4FM Acceptance Training was developed in response to this clinical need and is described in a facilitator's manual [19]. It is a brief, structured group intervention grounded in existential and phenomenological principles, intended for psychiatric inpatients with histories of relational trauma. The intervention offers experiential work within each existential domain, with the aim of supporting inner consent, relational presence, and a meaningful direction in life. It translates the 4FM model [16, 17] into a therapeutic protocol. To our knowledge, this pilot study is the first evaluation of a 4FM-based group intervention in a psychiatric inpatient setting.

Acceptance in this approach involves an active existential stance: a foundational "yes" to the realities of life, including limitations, responsibilities, and unavoidable pain [1, 16]. This article presents a pilot evaluation of the 4FM Acceptance Training in a specialized inpatient psychotherapy setting.

MATERIALS AND METHODS

Procedure

The study was approved by the Bioethics Committee of the Institute of Psychiatry and Neurology in Warsaw, Poland (Resolution No. 35/2022). Procedures involving human participants fol-

lowed the principles of the Declaration of Helsinki [20] and national regulations. Participants received written information about the study aims and procedures, the voluntary nature of participation, and their right to withdraw at any time without consequences. They were informed about data confidentiality and the possibility of temporary mood changes while completing the questionnaires. All participants provided written informed consent.

Participants were allocated to 4FM Acceptance Training plus treatment as usual (4FM-AT) or treatment as usual alone (TAU). At baseline (T0), all participants completed paper-and-pencil versions of the Traumatic Experience Checklist (TEC), the International Trauma Questionnaire (ITQ), and the Attachment Style Questionnaire (ASQ). These measures were administered only at baseline to assess trauma history, ICD-11 PTSD/CPTSD symptoms, and adult attachment patterns, respectively.

Measures of worry (PSWQ), depressive symptoms (CESD-R), basic hope (BHI-R), and existential fulfillment (Existence Scale, SE) were administered at baseline (T0) and after treatment (T1). At T1, both groups also completed the Patient Global Impression of Improvement measure, designated PGI-P in this study. This single-item measure assessed perceived improvement since the start of treatment on a seven-point scale, from 1 (no change or worse) to 7 (very much improved). Participants used anonymous identifiers to allow pre-post data matching. Data were collected within the project “4FM Acceptance Training as a New Form of CPTSD-Focused Treatment Based on Existential Analysis (A4FM/AE).”

Intervention: 4FM Acceptance Training

The 4FM Acceptance Training was developed by Draczyńska and Nowakowska [19] using Existential Analysis and the Four Fundamental Motivations framework [16, 17]. It integrates selected experiential techniques from the Professional Intervention Program for Adversity (PIPA), developed by Esly Carvalho and used with her permission [21]. The protocol also includes self-regulation exercises from EmotionAid® [22] and selected elements of the Flash technique

described by Manfield et al. [23] and incorporated into the group protocol by Carvalho and Guz [21]. The standard program comprises ten weekly 90-minute group sessions; an extended version comprises 12 sessions. The standard version was implemented in this pilot study. Appendix A presents the session themes and activities of the 12-session version.

MEASURES

Attachment Style Questionnaire (ASQ)

Attachment was assessed using the 40-item Attachment Style Questionnaire (ASQ) [24], with responses rated on a six-point scale from 1 (totally disagree) to 6 (totally agree). Reported Cronbach's alpha coefficients range from 0.65 to 0.76. The ASQ assesses five dimensions: Confidence, reflecting secure attachment; Discomfort with Closeness and Relationships as Secondary, reflecting avoidant attachment; and Need for Approval and Preoccupation with Relationships, associated with anxious attachment. Dominant attachment styles were classified using the highest total score across the subscales corresponding to each pattern, following procedures described in previous research [25].

Traumatic Experience Checklist (TEC)

Trauma exposure was assessed using the Traumatic Experience Checklist (TEC) [26], translated into Polish by Pietkiewicz and Tomalski. The reported Cronbach's alpha was 0.72. The TEC includes 29 items covering potentially traumatic experiences involving the family of origin, other relatives, and people outside the family. Respondents indicate whether an event occurred and report its perceived impact (1, none, to 5, extreme), duration, age at occurrence, and the support received (0, none, to 2, good). This study used individual items and the following categories: emotional neglect (items 14–16), emotional abuse (17–19), physical abuse (20–22), threat to life, pain, or bizarre punishment (9, 10, and 23), sexual harassment and abuse (24–29), and parentification (1 and 2).

International Trauma Questionnaire (ITQ)

ICD-11 PTSD and CPTSD symptoms were assessed using the International Trauma Questionnaire (ITQ) [27], in the Polish adaptation by Draczyńska et al. [28]. Reported Cronbach's alpha coefficients were 0.89 overall, 0.81 for PTSD, and 0.87 for DSO. The Polish version contains an initial open question about traumatic experiences and 18 items assessing symptoms and associated functional impairment. The scored items use a five-point scale from 0 (not at all) to 4 (extremely), with scores of at least 2 indicating endorsement. Classification requires symptoms across the relevant clusters and associated impairment. CPTSD requires the full PTSD profile plus DSO; when CPTSD criteria are met, a separate PTSD-only classification is excluded.

Existence Scale (SE)

Existential fulfillment was assessed using the Existence Scale [29], in the Polish translation used by Sym et al. [30]. The SE comprises 46 items rated on a six-point scale from 1 (strongly agree) to 6 (strongly disagree). It includes Self-Distance (eight items), Self-Transcendence (14 items), Freedom (11 items), and Responsibility (13 items). The first two subscales form the Personal Factor, and the latter two form the Existential Factor. Higher scores indicate greater existential fulfillment. Reported Cronbach's alpha coefficients were 0.93 for the total scale, 0.87 for the Personal Factor, and 0.90 for the Existential Factor.

Basic Hope Inventory-Revised (BHI-R)

The Basic Hope Inventory-Revised (BHI-R), based on the concept of basic hope [31], assesses the belief that the world is meaningful and benevolent, understood as rooted in early relational experiences. It includes 20 items rated on a five-point scale from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate greater basic hope, conceptualized as a relatively stable worldview relevant to coping and resilience. Reported Cronbach's alpha coefficients range from 0.75 to 0.88. The measure is grounded in theoretical and empirical work on meaning and personality development [31].

Penn State Worry Questionnaire (PSWQ)

Worry was assessed using the 16-item Penn State Worry Questionnaire (PSWQ), in the Polish adaptation by Janowski [32]. The reported Cronbach's alpha was 0.94. Respondents rate how characteristic each statement is of them on a five-point scale. Worry is understood as persistent, difficult-to-control thoughts and images that generate negative emotions and contribute to anxiety. Higher scores indicate more severe worry.

Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)

Depressive symptoms were assessed using the 20-item Center for Epidemiologic Studies Depression Scale-Revised (CESD-R), in the Polish adaptation by Koziara [33]. The reported Cronbach's alpha was 0.95. Respondents select one of five frequency categories for statements concerning mood and behavior. The measure covers dysphoria, anhedonia, appetite and sleep disturbances, concentration difficulties, guilt and worthlessness, fatigue, psychomotor changes, and suicidal ideation.

Study participants

The study included 32 adult inpatients aged 18–60 years who were admitted to a specialized psychotherapy unit. Participants had personality disorders and/or eating disorders, commonly with additional diagnoses. Allocation to 4FM-AT ($n = 13$) or TAU ($n = 19$) followed the unit's clinical procedures, therapeutic planning, and staffing arrangements. TAU comprised standard inpatient care, including group therapy, psychoeducation, relaxation training, and additional individual sessions. Allocation occurred before the study began and was reported to be independent of symptom severity or patient preference; it was not randomized.

Nine participants in 4FM-AT and eight in TAU completed all outcome measures at both assessments. Other participants discontinued treatment, were discharged before T1, or declined the follow-up assessment. Analyses of pre-post outcomes included only the 17 participants with

complete data. Baseline descriptive analyses included all 32 participants.

There were 25 women (78.1%), six men (18.8%), and one participant (3.1%) who identified as another gender. According to Table 1, this participant was in the TAU group. Mean age was 30.7 years (SD = 11.5) in TAU and 35.0 years (SD = 10.7) in 4FM-AT. Most participants were single and had secondary or higher education. Most lived in urban areas, and employment and family support were the most common sources of income.

The most frequent primary ICD-10 diagnoses were mixed personality disorder (F61) and emo-

tionally unstable personality disorder (F60.3). Secondary and third diagnoses were heterogeneous and included trauma-related conditions, eating disorders, neurodevelopmental conditions, and other psychiatric diagnoses. Detailed diagnostic frequencies are presented in Table 1.

According to the ITQ classification, 18 participants (56.3%) met CPTSD criteria: 12 of 19 (63.2%) in TAU and six of 13 (46.2%) in 4FM-AT. Three participants (9.4%) met PTSD criteria, six (18.8%) had DSO symptoms without a full PTSD/CPTSD classification, and five (15.6%) met neither classification. Table 1 summarizes baseline characteristics by group.

Table 1. Baseline sociodemographic and clinical characteristics by group

Characteristic	TAU (n = 19) n (%)	4FM-AT (n = 13) n (%)	p value
Gender			0.81
Male	3 (9.4)	3 (9.4)	
Female	15 (46.9)	10 (31.3)	
Other	1 (3.1)	0 (0.0)	
Relationship status			0.56
Single	12 (37.5)	7 (21.9)	
Married	1 (3.1)	3 (9.4)	
Cohabiting	2 (6.3)	1 (3.1)	
Divorced	3 (9.4)	1 (3.1)	
Separated	0 (0.0)	1 (3.1)	
Widowed	1 (3.1)	0 (0.0)	
Education			1.000
Primary	1 (3.1)	0 (0.0)	
Secondary	11 (34.4)	7 (21.9)	
Vocational	1 (3.1)	1 (3.1)	
Higher	6 (18.8)	5 (15.6)	
Residence			0.57
Rural area	3 (9.4)	2 (6.3)	
City with <50,000 inhabitants	2 (6.3)	3 (9.4)	
City with 50,000–150,000 inhabitants	2 (6.3)	1 (3.1)	
City with 150,000–500,000 inhabitants	3 (9.4)	4 (12.5)	
City with >500,000 inhabitants	9 (28.1)	3 (9.4)	
Living arrangements			0.17
Alone	5 (15.6)	2 (6.3)	
With parents	4 (12.5)	1 (3.1)	
With family	4 (12.5)	8 (25.0)	

Characteristic	TAU (n = 19) n (%)	4FM-AT (n = 13) n (%)	p value
With others	6 (18.8)	2 (6.3)	
Source of income			0.77
Employment (full-time or civil-law contract)	7 (21.9)	4 (12.5)	
Disability pension	3 (9.4)	3 (9.4)	
Social assistance	2 (6.3)	2 (6.3)	
Family	6 (18.8)	2 (6.3)	
Other	1 (3.1)	2 (6.3)	
Primary ICD-10 diagnosis			1.000
F50.0	1 (3.1)	0 (0.0)	
F60.2	1 (3.1)	0 (0.0)	
F60.3	6 (18.8)	4 (12.5)	
F60.9	2 (6.3)	2 (6.3)	
F61	9 (28.1)	7 (21.9)	
Secondary ICD-10 diagnosis			0.33
F19	0 (0.0)	1 (4.3)	
F31	0 (0.0)	1 (4.3)	
F41	1 (4.3)	1 (4.3)	
F43	2 (8.7)	3 (13.0)	
F50	5 (21.7)	1 (4.3)	
F84	1 (4.3)	3 (13.0)	
F90	3 (13.0)	1 (4.3)	
Third comorbid ICD-10 diagnosis			0.84
F12	0 (0.0)	1 (7.7)	
F19	1 (7.7)	0 (0.0)	
F31	1 (7.7)	0 (0.0)	
F33	1 (7.7)	0 (0.0)	
F41	1 (7.7)	1 (7.7)	
F42	1 (7.7)	1 (7.7)	
F50	0 (0.0)	2 (15.4)	
ITQ classification according to ICD-11			0.77
CPTSD	12 (37.5)	6 (18.8)	
PTSD	1 (3.1)	2 (6.3)	
DSO only	3 (9.4)	3 (9.4)	
Neither PTSD nor CPTSD	3 (9.4)	2 (6.3)	
Attachment style			1.000
Avoidant	3 (9.4)	2 (6.3)	
Anxious	16 (50.0)	11 (34.4)	
Secure	0 (0.0)	0 (0.0)	

TAU, treatment as usual; 4FM-AT, 4FM Acceptance Training plus TAU; DSO, disturbances in self-organization. Values are *n* (%). Percentages generally refer to *N* = 32; secondary-diagnosis percentages use a denominator of 23, and third-diagnosis percentages use a denominator of 13. *p* values are from Fisher's exact test and apply to each characteristic as a whole. ICD-10 codes: F10–F19, substance use disorders; F30–F39, mood disorders; F40–F49, neurotic, stress-related, and somatoform disorders; F50, eating disorders; F60–F61, personality disorders; F80–F89, disorders of psychological development; F90, hyperkinetic disorders.

Anxious attachment was the dominant style in 27 participants (84.4%): 16 in TAU and 11 in 4FM-AT. Avoidant attachment was dominant in five participants (15.6%): three in TAU and two in 4FM-AT. No participant was classified as having a predominantly secure attachment style.

No statistically significant baseline differences were found between groups in demographic or clinical characteristics, including gender, education, relationship status, residence, income source, or ICD-10 and ICD-11 classifications (all *p* > 0.05; Fisher's exact test).

Reported traumatic experiences

Figure 1 presents the numbers of participants reporting each category of potentially traumatic experiences assessed with the TEC.

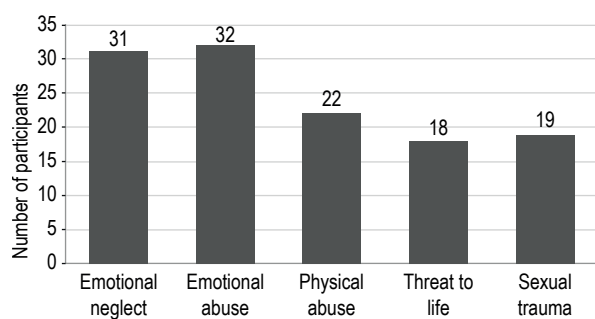


Figure 1. Numbers of participants reporting traumatic experiences by TEC category (*N* = 32). Participants could report more than one category.

Emotional abuse was reported by all 32 participants (100.0%), followed by emotional neglect (*n* = 31, 96.9%), physical abuse (*n* = 22, 68.8%), sexual trauma (*n* = 19, 59.4%), and life-threatening experiences (*n* = 18, 56.3%). These findings indicate a high prevalence of interpersonal trauma exposure in the sample.

Data analysis

Statistical analyses were conducted using jamovi, version 2.6.44 [34], and Microsoft Excel, version 16.89. Descriptive statistics included frequencies, percentages, means, medians, standard deviations, and ranges. The Shapiro–Wilk test assessed the normality of change scores ($\Delta = T1 - T0$). Change scores for basic hope, existential fulfillment, and worry met the normality criterion (*p* > 0.05), whereas depression change scores did not (*p* < 0.001). Independent-samples *t*-tests were therefore used for the first three outcomes, and the Mann–Whitney *U* test was used for depression. Both test results are reported for each outcome. Fisher's exact test was used for categorical variables with small expected cell counts. Within-group analyses used joint Friedman tests across the four measures at both time points, followed by Durbin–Conover comparisons. Tests were two-tailed, with $\alpha = 0.05$.

RESULTS

Between-group comparisons of change scores

Between-group comparisons used change scores ($\Delta = T1 - T0$) from participants with complete pre–post data. The 4FM-AT group showed a greater increase in basic hope than TAU (*t*(15) = –5.16, *p* < 0.001; Mann–Whitney *U* = 0.00, *p* < 0.001). Changes in existential fulfillment, worry, and depressive symptoms did not differ significantly between groups (Table 2). For depression, the Mann–Whitney comparison described in the Methods yielded *p* = 0.096; the *t*-test yielded *p* = 0.082.

Table 2. Between-group comparisons of change scores (T1 – T0)

Outcome	TAU ΔM (SD)	4FM-AT ΔM (SD)	t (df)	p (t)	U	p (U)
Basic hope (BHI-R)	-2.00 (3.30)	6.22 (3.27)	-5.16 (15)	< 0.001	0.00	< 0.001
Existential fulfillment (SE)	6.13 (33.36)	2.00 (28.09)	0.28 (15)	0.786	26.00	0.370
Worry (PSWQ)	-4.48 (5.81)	-3.00 (8.26)	-0.39 (15)	0.701	30.00	0.595
Depressive symptoms (CESD-R)	0.25 (0.46)	-0.11 (0.33)	1.86 (15)	0.082	24.00	0.096

Analyses include eight participants in TAU and nine in 4FM-AT. M, mean change; SD, standard deviation of change; t(df), t statistic and degrees of freedom; U, Mann–Whitney U statistic. p values are two-tailed. Negative changes indicate lower scores after treatment.

Within-group comparisons

In 4FM-AT, a joint Friedman analysis compared eight sets of scores: four psychological measures assessed at T0 and T1. The omnibus test was statistically significant ($\chi^2(7) = 60.51$, $p < 0.001$), reflecting differences across the combined set

of measures and time points. Durbin–Conover pairwise comparisons indicated an increase in basic hope from a mean of 32.11 to 38.33 ($p = 0.001$, Table 3). The corresponding pre–post comparisons were not statistically significant for existential fulfillment ($p = 0.179$), worry ($p = 0.075$), or depressive symptoms ($p = 0.652$).

Table 3. Descriptive statistics and within-group comparisons in 4FM-AT (n = 9)

Outcome	T0 M (SD)	T1 M (SD)	Friedman χ^2 (df)	Omnibus p	Pairwise p
Basic hope (BHI-R)	32.11 (6.0)	38.33 (6.5)	60.51 (7)	< 0.001	0.001
Existential fulfillment (SE)	136.11 (33.36)	138.11 (28.09)			0.179
Worry (PSWQ)	69.90 (5.5)	66.89 (5.2)			0.075
Depressive symptoms (CESD-R)	0.67 (0.46)	0.56 (0.33)			0.652

M, mean; SD, standard deviation; df, degrees of freedom. The Friedman statistic is the single omnibus result for all eight sets of scores (four measures at two time points). Pairwise p values refer to T0–T1 comparisons using the Durbin–Conover procedure.

In TAU, the joint Friedman analysis also compared the four measures at both time points. The omnibus result was statistically significant ($\chi^2(7) = 53.10$, $p < 0.001$). Most significant pairwise comparisons were between different psy-

chological measures. No statistically significant pre–post differences were found for basic hope ($p = 0.405$), existential fulfillment ($p = 0.676$), worry ($p = 0.214$), or depressive symptoms ($p = 0.405$; Table 4).

Table 4. Descriptive statistics and within-group comparisons in TAU (n = 8)

Outcome	T0 M (SD)	T1 M (SD)	Friedman χ^2 (df)	Omnibus p	Pairwise p
Basic hope (BHI-R)	37.00 (6.5)	35.00 (6.3)	53.1 (7)	< 0.001	0.405
Existential fulfillment (SE)	133.25 (33.36)	139.38 (28.09)			0.676
Worry (PSWQ)	70.88 (5.8)	66.50 (5.6)			0.214
Depressive symptoms (CESD-R)	0.13 (0.46)	0.38 (0.33)			0.405

M, mean; SD, standard deviation; df, degrees of freedom. The Friedman statistic is the single omnibus result for all eight sets of scores (four measures at two time points). Pairwise p values refer to T0–T1 comparisons using the Durbin–Conover procedure.

The statistically significant omnibus tests describe differences across a combined set of measures and time points. Because these measures use different scales, the combined tests and their post hoc comparisons should not be treated as outcome-specific evidence of change over time. Separate analyses within each outcome are needed for that purpose.

Patient-reported improvement after treatment

At T1, participants completed the PGI-P to rate their perceived improvement. Scores were numerically higher in 4FM-AT ($M = 5.22$, $SD = 1.64$; median = 6.00) than in TAU ($M = 4.50$, $SD = 1.51$; median = 5.00), but the difference was not statistically significant ($t(15) = -0.94$, $p = 0.362$; Mann–Whitney $U = 20.0$, $p = 0.119$). The reported effect sizes were Cohen’s $d = -0.46$ and rank-biserial $r = 0.44$. Figure 2 presents group means with 95% confidence intervals and medians.

Overlap between ICD-10 personality disorders and ICD-11 PTSD/CPTSD classifications

Table 5 compares primary ICD-10 personality disorder diagnoses (F60/F61) with ICD-11 PTSD/CPTSD classifications. Of the 20 partic-

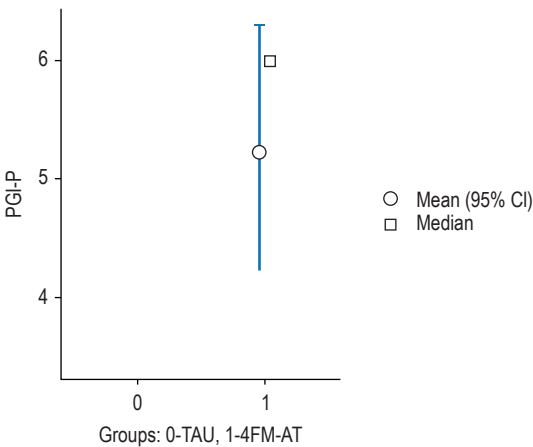


Figure 2. Patient-reported improvement (PGI-P) after treatment in TAU ($n = 8$) and 4FM-AT ($n = 9$). Circles indicate means, error bars indicate 95% confidence intervals, and squares indicate medians. Higher scores indicate greater perceived improvement.

ipants classified as having PTSD or CPTSD in this table, 19 (95.0%) also had a personality disorder diagnosis. Among the 31 participants with a personality disorder diagnosis, 19 (61.3%) were classified as having PTSD or CPTSD. The chi-square test did not indicate a statistically significant association ($\chi^2(1) = 0.619$, $p = 0.431$), and Fisher’s exact test yielded $p = 1.000$. Interpretation is limited by the presence of only one participant without a primary personality disorder diagnosis.

Table 5. Cross-classification of primary ICD-10 personality disorders (F60/F61) and ICD-11 PTSD/CPTSD

ICD-11 PTSD/CPTSD classification	ICD-10 F60/F61 present, n (%)	ICD-10 F60/F61 absent, n (%)	Total, n
Present	19 (59.4)	1 (3.1)	20
Absent	12 (37.5)	0 (0.0)	12
Total	31	1	32

Percentages refer to the full sample ($N = 32$).

As presented in Table 5, 19 participants (59.4% of the full sample) met both classifications, and 12 (37.5%) had a personality disorder diagnosis without a PTSD/CPTSD classification. One participant (3.1%) had a PTSD/CPTSD classification and a primary ICD-10 eating disorder diagnosis (F50).

DISCUSSION

This pilot study examined 4FM Acceptance Training in psychiatric inpatient care. Participants with complete pre–post data who received the intervention showed a greater increase in basic hope than those receiving TAU alone. No significant between-group differences were found in changes in worry, depressive symptoms, or existential fulfillment. The basic hope finding is relevant to existential therapy and the theory

of fundamental motivations. Basic hope is understood as a foundational attitude toward life, rather than a transient emotional state. It relates to Frankl's concept of the will to meaning [1], the BHI authors' account of belief in the world's order and benevolence [31], and Kepiński's emphasis on hope, trust, and ethical dialogue in the therapeutic encounter [35]. From this perspective, hope may be supported when another person recognizes the individual's existential struggle and affirms their right to exist.

The findings suggest that a brief intervention addressing existential motivations may support inner orientation in people receiving psychiatric care after traumatic experiences. Emotional abuse was reported by all participants, and emotional neglect by all but one. The increase in basic hope in this context warrants further investigation.

No significant between-group difference was found in existential fulfillment. One possible interpretation is that basic hope may respond within a relatively short period, whereas a more integrated experience of meaning may require longer engagement. In Frankl's account, meaning is discovered through engagement with one's experience and values [1]. The intervention may have supported the beginnings of this process, but this explanation remains tentative.

Both groups received intensive, multimodal inpatient treatment. This shared treatment context may have limited the ability to detect an additional contribution from the existential intervention for some outcomes. The difference in basic hope suggests a potential contribution that should be examined in a larger, controlled study.

Within the 4FM framework [16], increased basic hope may be interpreted as strengthening the first fundamental motivation: being able to be. The observed change is consistent with the possibility that trust in the world as meaningful and sufficiently safe can be supported after relational trauma. Whether this change facilitates progress in other existential domains requires further study.

Interventions based on the Four Fundamental Motivations may complement psychiatric treatment by supporting personal resources, agency, acceptance, and future orientation. This approach may be relevant for people with co-

curring personality disorders and trauma-related difficulties, as frequently observed in this sample.

Future research should use larger samples, randomized allocation where feasible, and longer follow-up to examine the durability and specificity of these findings.

Limitations

The small baseline sample ($N = 32$) and smaller sample with complete pre-post data ($n = 17$) limit statistical power and generalizability. Estimates may be sensitive to outliers and individual differences, and nonsignificant results do not establish an absence of treatment effects.

The study was not randomized. Allocation based on ward organization and clinical planning prevents firm causal conclusions. Selection bias is also possible because participants who completed both assessments may differ systematically from those who did not.

Both groups received several therapeutic interventions in the same clinical setting. The observed changes therefore cannot be attributed solely to the existential training, and the contribution of concurrent treatment remains uncertain.

Follow-up was limited to hospitalization. The persistence of changes, particularly in basic hope, is unknown. Future studies should include assessments after discharge.

Self-report measures may be influenced by social desirability, temporary emotional states, and participants' ability to recognize and describe their experiences. Trauma reports and subjective recovery outcomes should be interpreted in this context.

The co-occurrence of personality disorder diagnoses and trauma-related symptom classifications also complicates interpretation. Further research is needed to clarify their relationship and relevance to existential constructs such as basic hope.

The findings are preliminary and exploratory and do not support strong causal conclusions. Completion of the intervention and the Patient Global Impression of Progress provide limited information about implementation and perceived benefit; they do not constitute a formal assessment of feasibility or acceptability.

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Conflict of interest

The authors declare no conflicts of interest.

Data availability

The data supporting the findings are available from the corresponding author upon reasonable request.

Appendix A

Table A1. Structure of the extended 4FM Acceptance Training program (12 sessions, 90 minutes each)

Session	Theme	4FM focus	Goals and activities	Methods
1	What is acceptance — and what is it not?	Intro / 1FM	Introduction to training and group norms; recognizing inner consent (in body, thoughts, emotions); exploring the idea that behind every “no” there is a “yes.”	Group discussion, emotional awareness, body mapping, guided breathing
2	1FM — The possibility of being (space, protection, support)	1FM	Acceptance of what is given; recognizing what we can and cannot influence; identifying personal conditions that support one’s being-in-the-world.	Influence mapping, grounding, existential dialogue (chair method)
3	2FM — Enjoying life: Time and relationships	2FM	Understanding the relationship between time and relational investment (including with self); identifying values through time allocation.	Life wheel, sensory activation, self-care tasks
4	2FM — The Feeling Wheel: Emotions and choices	2FM	Recognizing emotions and the information they carry; practicing decision-making based on emotional awareness.	Emotion wheel, ABC model, mindfulness and grounding
5	2FM — Suffering as part of life	2FM	Acknowledging suffering as part of one’s biography; using the Flash technique to process trauma and refocus on sources of joy and relief.	Flash technique, Butterfly Hug, 5-4-3-2-1 exercise
6	3FM — Being oneself: respect, self-compassion	3FM	Recognizing and affirming one’s identity; reconstructing self-image; using anger to protect boundaries.	Identity narrative, self-acceptance exercises, expressive drawings
7	3FM — Being oneself: self-acceptance	3FM	Identifying and transforming internalized limitations; strengthening choices and adaptive beliefs in the here-and-now.	Self-respect journaling, symbolic imagery, therapeutic storytelling
8	3FM — The Pillars of life	3FM	Recognizing and strengthening personal resources rooted in one’s biography.	Positive memory recall (Carlos Raimundo’s method), Butterfly Hug

Session	Theme	4FM focus	Goals and activities	Methods
9	4FM — Meaning: Individual Meaning Map 4FM	4FM	Expanding freedom and agency; active search for personal meaning and responses to life's fundamental questions.	Reflection on life values, dialogue with meaning (Frankl), existential decision-making
10	4FM — Meaning: Making choices	All 4FM	Understanding the human being as an integration of body, psyche, and personhood; enhancing decision-making in alignment with values.	Life line mapping, dimensional integration, somatic awareness
11	4FM — Meaning: My life line	All 4FM	Meaning-making through narrative; integrating experiences and resources; fostering posttraumatic growth and creating a vision for the future.	Life-book chapter, reflective drawing and writing, Butterfly Hug
12	4FM — Meaning: Closure and farewell	All 4FM	Synthesizing experiences from the training; reinforcing an accepting and value-based attitude; ending with emotional self-connection and agency.	Pair feedback, individual reflection, farewell rituals

4FM, Four Fundamental Motivations. This table describes the extended 12-session program; the pilot study used a 10-session program.

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