# Perform-Therapeutic Explanation of Neurotic Disorders and Its Impact on the Acceptance of Pharmaco- and Psychotherapy

Anatolii A. Grebeniuk
Crimean Engineering and Pedagogical University, Simferopol, Russia

**Abstract**

The study describes and preliminarily evaluates a perform-therapeutic format of the first psychiatric consultation in patients with neurotic and anxiety–depressive disorders. The format is based on value framing of both symptoms and proposed treatment through four anchors — Truth, Beauty, Goodness, and Justice. The starting premise is that a substantial part of refusals and delays in treatment is determined not by clinical reasons but by value-related barriers, including the patient's perception of treatment as unfair or insufficiently benevolent [1–3]. In the perform-therapy model, the initial explanation is constructed as a performative act and combines the elements of Kleinman's explanatory model of illness [4] and shared decision making, which in psychiatry is considered a factor of better adherence [2,10–12]. In addition, neurotic symptomatology is presented to the patient as a "stuck" evolutionary protective mechanism, which reduces guilt and stigmatization and opens space for a "fair" offer of pharmacotherapy and/or psychotherapy [13–15]. A pilot scheme is proposed that compares standard clinical–informational explanation with perform-therapeutic explanation on the outcome "acceptance of treatment immediately after the first consultation."

**Keywords: perform-therapy; value framing; neurotic disorders; treatment adherence; shared decision making; justice in therapy.**

## 1. Introduction

Neurotic and anxiety–depressive disorders are frequently accompanied by partial or delayed adherence: patients start therapy and discontinue it shortly, or do not take the prescribed medication at all, referring to fears and doubts about the necessity of the intervention [1,2]. A standard clinical–informational explanation answers the questions "what is it?" and "how will we treat it?", but is weaker in answering the patient's questions "why do I have to take it?" and "is it fair to me?", which, according to shared decision-making studies, are crucial for accepting mental health treatment [2,10–12]. The mismatch between the physician's and the patient's explanatory models has long been described in medical anthropology: if the patient does not see the meaning and moral rightness of the proposed intervention, the probability of acceptance decreases even when clinical arguments are impeccable [4]. Perform-therapy proposes a different order of explanation. First, an outer value frame is created — Truth, Beauty, Goodness, and Justice — and only then are diagnosis and treatment placed inside this frame.

## 2. Theoretical Background

Perform-therapy draws on Raoul Eshelman's performatism, which overcomes postmodern irony through an orientation to trust, integrity and "second-order naivety" [5–7]. In clinical application this becomes double framing: first an outer value frame (truth, beauty, goodness, justice) is

constructed, and only then symptoms, diagnosis and treatment are placed inside it. This psychotherapeutic adaptation of performatism was described in Grebeniuk's works as "perform-therapy" — a method of restoring wholeness and identity in conditions of postmodern fragmentation [8,9]. After the value frame is set, mechanisms of shared decision making and value-based counselling, which are known to improve acceptance, can work more effectively [2,10–12]. Evolutionary interpretation of anxiety as a stuck defence provides the non-blaming clinical narrative [13–15].

**3. Perform-Therapeutic Explanation Model**

Step 1. Entry into the value frame: the physician states that the discussion will follow four anchors (truth, beauty, goodness, justice) to make treatment clear and non-punitive.

Step 2. Normalization through the evolutionary model: the disorder is presented as an overactivated ancient defence, adaptive in the short term but harmful when prolonged [13–15].

Step 3. Mapping symptoms and treatment onto the four values: truth — restoring clarity; beauty — restoring life-form; goodness — benevolent, feasible treatment; justice — fair distribution of load.

Step 4. Fair distribution of responsibility: patient, physician and illness each have their share; this restores subjectivity and reduces hidden resistance [11,12].

Step 5. Patient's fixing formula: the patient voices their reason for agreement (e.g. "I agree to be treated to live in truth, in a normal rhythm, kindly to myself and without extra burden").

**4. Methods**

Design. A quasi-experimental comparative study was conducted in an outpatient psychiatric setting. Consecutive adult patients with ICD-10 F3–F4 disorders were alternately allocated to the comparison or intervention group until 100 participants were enrolled.

Participants. Inclusion criteria: age 18–65 years; clinical diagnosis within ICD-10 F3 or F4; ability to give informed consent. Exclusion criteria: psychotic symptoms; bipolar affective disorder; organic cognitive impairment; active substance dependence; acute suicidality; severe somatic decompensation.

Procedure. Group 1 received a clinical–informational explanation of the diagnosis, stress-related factors and proposed pharmacotherapy/psychotherapy. Group 2 received the same clinical content, but preceded by value framing (truth, beauty, goodness, justice) and an evolutionary "stuck defence" explanation. Immediately after the visit patients filled in three 5-point scales (clarity, fairness, benevolence) and answered whether they accepted the proposed treatment.

Ethics. The study followed routine clinical practice; patients agreed to the anonymized use of their data. No procedures beyond standard care were applied.

**5. Results**

Primary outcome. In the comparison group, 33/50 (66.0%) accepted the proposed treatment; in the perform-therapy group, 44/50 (88.0%) accepted it. The difference was statistically significant ($\chi^2(1) = 6.83$, $p \approx 0.009$).

Secondary outcomes. Mean self-ratings were higher in the perform-therapy group: clarity 4.5 ± 0.5 vs. 3.6 ± 0.7; fairness 4.4 ± 0.6 vs. 3.2 ± 0.8; benevolence 4.6 ± 0.5 vs. 3.5 ± 0.6 (all $p < 0.001$).

**Table 1. Characteristics of the sample (n = 100)**

| Parameter | Group 1 (n = 50) | Group 2 (n = 50) |
|---|---|---|
| Mean age, years | 39.8 ± 11.2 | 40.3 ± 10.7 |
| Female, n (%) | 32 (64.0) | 33 (66.0) |
| ICD-10 F4, n (%) | 35 (70.0) | 34 (68.0) |
| Duration, months (median) | 7 | 6 |

**Table 2. Primary and secondary outcomes**

| Outcome | Group 1 | Group 2 | p value |
|---|---|---|---|
| Accepted treatment, n (%) | 33 (66.0) | 44 (88.0) | 0.009 |
| Clarity, mean ± SD | 3.6 ± 0.7 | 4.5 ± 0.5 | <0.001 |
| Fairness, mean ± SD | 3.2 ± 0.8 | 4.4 ± 0.6 | <0.001 |
| Benevolence, mean ± SD | 3.5 ± 0.6 | 4.6 ± 0.5 | <0.001 |

## 6. Discussion

The data show that value-framed perform-therapeutic explanation can increase immediate acceptance of indicated therapy. This supports the assumption that moral and justice-related barriers are clinically relevant for neurotic patients and can be modified during the very first visit. The model is consistent with Eshelman's performatism (outer frame first, meaning inside it) and with perform-therapy as a method of restoring agency in fragmented identities [5–9].

## 7. Conclusion

Perform-therapy can be integrated into routine outpatient consultations as a simple, reproducible step. A randomized study with longer follow-up is warranted to test effects on long-term adherence and clinical outcomes.

## References

[1] Bull S. A., Hu X. H., Hunkeler E. M., Lee J. Y., Ming E. E., Markson L. E., Fireman B. Discontinuation of use and switching of antidepressants: Influence of patient–physician communication. Journal of the American Medical Association (JAMA). September 18, 2002;288(11):1403–1409.

[2] Sleath B., Rubin R. H., Huston S. A. Provider–patient communication about antidepressants in primary care: A study of medication adherence. Patient Education and Counseling. January 2007;65(1):34–39.

[3] Joosten E. A. G., DeFuentes-Merillas L., de Weert G. H., Sensky T., van der Staak C. P. F., de Jong C. A. J. Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence and health status. Psychotherapy and Psychosomatics. April 2008;77(4):219–226.

[4] Kleinman A. Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine and Psychiatry. Berkeley: University of California Press; January 1980.

[5] Eshelman R. Performatism, or the End of Postmodernism. Aurora, CO: Davies Group Publishers; 2008.

[6] Eshelman R. Performatizm kak preodolenie postmoderna. Logos. 2021;31(6):1–34. DOI: 10.22394/0869-5377-2021-6-1-31.

[7] Eshelman R. Transcending Postmodernism: Performatism 2.0. New York: Routledge; 2024.

[8] Grebenyuk A. A. Perform-therapy as a method of restoring identity under postmodern fragmentation. Russian Journal of Education and Psychology. 2025;16(2):602–619.

[9] Grebenyuk A. A. Evolution of psychotherapy: From modernism through performatism to perform-therapy practice. Mir nauki. Pedagogika i psikhologiya. 2025;13(1):93PSMN125.

[10] Fiorillo A., Zabala A., Luciano M., Del Vecchio V. The role of shared decision-making in improving adherence to pharmacological treatments in patients with mental disorders. Chronic Stress. June 2020;4:1–8.

[11] Slade M. Implementing shared decision making in routine mental health care. World Psychiatry. February 2017;16(2):146–153.

[12] Thomas E. C., Salyers M. P., Tsai J., et al. Shared decision making in mental health care: A systematic review. Psychiatric Services. October 2021;72(10):1233–1245.

[13] Nesse R. M. Proximate and evolutionary studies of anxiety, stress and depression: Synergy at the interface. Neuroscience and Biobehavioral Reviews. January 1999;23(7):895–903.

[14] Nesse R. M. Anxiety disorders in evolutionary perspective. Current Opinion in Psychology. January 2022;46:101–106.

[15] Bergstrom C. T., Nesse R. M. Depression and anxiety: Maladaptive byproducts of adaptive mechanisms. Evolution, Medicine, and Public Health. January 2016;2016(1):214–226.