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Psychological Therapies

Science Book

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D/ Boualagua Fatima Zohra

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Introduction

In a world where the pace of life is accelerating and psychological and social challenges are on the rise, mental health has come to occupy a central place in human life. Concern for psychological well-being is no longer a luxury or an intellectual indulgence, but rather a pressing necessity for maintaining individual balance and continuity. In this context, psychological therapies have emerged as one of the most significant scientific and practical frameworks aimed at understanding the human psyche, alleviating psychological suffering, enhancing adaptive capacities, and guiding latent potentials toward growth and fulfillment.

From this standpoint, psychological therapies have witnessed remarkable development over recent decades, encompassing a wide spectrum of theoretical approaches and applied techniques that enable individuals to live with greater satisfaction and regain control over their lives. These therapies are no longer limited to classical models such as psychoanalysis or behavioral therapy, but now include modern therapeutic approaches characterized by flexibility, integration, and empirical validation of their effectiveness.

Accordingly, this book offers a comprehensive overview of these therapies by presenting their theoretical foundations, fields of application, and levels of effectiveness based on available scientific evidence. It also seeks to bridge the gap between academic specialization and clinical practice, providing content of relevance to professionals, researchers, and those interested in the fields of psychology and mental health alike.

The increasing reliance of psychological therapies on evidence-based treatment protocols is progressively shaping the field, particularly in

addressing disorders such as depression, anxiety, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), borderline personality disorder (BPD), eating disorders, sexual disorders, and others.

This book highlights contemporary psychodynamic approaches such as Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Dynamic Cognitive Therapy (DCT), in addition to therapies that expand the available options in psychological treatment. Therapeutic approaches may be classified by duration—such as long-term therapies like Psychodynamic Psychotherapy (PP), medium-term therapies like Psychodynamic Interpersonal Therapy (PIP), or short-term therapies such as Cognitive Behavioral Therapies (CBT). Other classifications, such as that proposed by Widlocher, rely on theoretical background, categorizing therapies into supportive therapy, psychoanalysis, analytic psychotherapy, brief dynamic psychotherapy, cognitive-behavioral therapy, as well as family, couple, and group therapies.

Through this book, we aim to increase awareness of contemporary psychological therapies in Arab societies, particularly within student communities, by offering an initial academic contribution that combines theoretical underpinnings with practical insights. For this reason, we have chosen to write in English, with the intention of supporting psychology students—especially those inclined toward therapeutic practice—in exploring these approaches through the dominant scientific language of English-language literature and studies.

Chapter 01 :

The Historical Development of Psychodynamically-Informed Therapy

Freud's Journey in Establishing Psychoanalysis (Classical Therapy Approach)

1-1 Key Years in the Formation of the Psychoanalytic Movement

Sigmund Freud (1856–1939) is recognized as the **founder of psychoanalysis**, which at the time was considered a **Freudian revolution**. He was born on **May 6, 1856**, in **Moravia** (present-day Czech Republic), and was of **Austrian-Hungarian Jewish descent**. His **humble origins** and **social challenges** significantly influenced his personal and professional journey.

Freud studied **medicine**, specializing in **psychiatry** (la psychiatrie). His **background and societal struggles** pushed him to **oppose bourgeois ideology and racial discrimination**, using **critical thinking and therapy** as his primary tools. During the period **1875–1885**, he made **groundbreaking discoveries** regarding the **psychic apparatus**.

In **1885**, Freud became a **private professor of neurophysiology** and continued his studies in **Paris** under **Jean-Martin Charcot**, where he also met **Hippolyte Bernheim in Nancy** and later **Josef Breuer**. Through these connections, Freud **explored hysteria**, **the body's language**, and methods for treating **hysterical disorders** through **"catharsis" and "induction"**—allowing patients to recount their **life experiences and traumatic memories**.

- **Charcot** utilized **hypnosis to remove physical symptoms**.
- **Bernheim** focused on **suggestion therapy**.
- **Breuer** developed the **talking cure**, which he used in treating **Anna O.**

This experience **shaped Freud's understanding** of hysteria, leading him to link **its origins to repressed sexual conflicts** and **unconscious mechanisms** (Clément, K., 2014, pp. 95-96).

After returning from **Paris**, Freud practiced **cathartic therapy** and co-authored the book "Studies on Hysteria" with **Breuer**. However, Freud later **abandoned hypnosis** and suggestion-based therapy. Instead, he developed **his own approach**, which he formally introduced as **psychoanalysis** (Abbas, F., 1996, p. 31).

Freud initially used the terms "analysis," "psychological analysis," "psychoanalysis," and "qualitative analysis" in his first article titled "The Cases of Defense Psychoneurosis" (Les cas de psychonévrose de défense) in 1894.

The term "psychoanalysis" was only introduced later, in his article on "The Causes of Neurosis," published in French. In German, the term "psychoanalysis" first appeared in 1896 in his article titled "New Observations on the Cases of Defense Neurosis." In 1900, he published his work The Interpretation of Dreams, which is considered the foundation of psychoanalysis, marking the beginning of his extensive works from 1897 to 1900, focusing on conceptual preparation for psychoanalytic practice. The following works played a crucial role in establishing this foundation: The Psychopathology of Everyday Life (1901), Jokes and Their Relation to the Unconscious (1905), and Three Essays on the Theory of Sexuality, along with the case study of Dora in Five Cases in Psychoanalysis (Clément K., 2014, p. 97).

1. The Wednesday Psychological Society

The Vienna Psychoanalytic Society was established in 1908, but the analytic institution had been gradually founded by Freud before that. Since 1902, the "Wednesday Psychological Society" had gathered around Freud, comprising students who would later become his school: among them were Rank, Stekel, and other physicians who would form the first psychoanalytic group.

In 1907, Jung founded the Freud Society in Zurich. This was a triumph for Freud, as Jung, a Swiss psychiatrist and an Aryan, contributed to the

expansion of psychoanalysis beyond Vienna and its Jewish roots. In 1910, the International Psychoanalytic Association was established (Clément K., 2014, p. 100).

2. The Epistemological Principles of Psychoanalysis

Psychoanalysis is built upon two fundamental principles:

- **The Monistic Principle**: Freud rejected the separation of psychoanalysis from the natural sciences. Instead, he explicitly placed it within a model inspired by physics and chemistry. This means that the paradigm should be the ability to treat unconscious psychological processes based on the explanatory models derived from physical and chemical sciences.
- **The Agnostic Principle**: Freud positioned himself within a movement aligned with Lange's notion of "psychology without a soul," implying that psychoanalysis does not seek to know "a thing in itself"—be it the soul or the unconscious. Instead, it examines a category of observable phenomena, shaping the objects of psychoanalytic knowledge towards unconscious processes (Assoun B.L., 2014, p. 103).

3. The Therapeutic Pillars of Classical Psychoanalysis

- **Avoidance of Hypnotic Suggestion**: Freud firmly established the use of the term "psychoanalysis" to distance it from hypnosis or suggestion, relying instead on free association as the sole method for obtaining analytical material. The best explanation for choosing the term "psychoanalysis" comes from Freud himself when he introduced the concept: "We called it psychoanalysis because through it, we bring repressed psychological content into the patient's consciousness. But why did we use the term 'analysis,' which means breaking down and investigating, and suggests an analogy with the work of a chemist analyzing substances in a laboratory? Because this analogy is genuinely

justified. The symptoms and manifestations of the patient are highly complex psychological structures, just like all psychological activities. In the end, these structures consist of instincts and drives, but the patient does not comprehend their origins. It is our task to teach him how to understand these complex formations, tracing symptoms back to the instinctual forces that drive them. Just as a chemist separates an essential element from a compound, we show the patient how unconscious drives contribute to his symptoms. Similarly, we analyzed human sexuality by breaking it down into its constituent parts. When interpreting dreams, we do not treat the dream as a whole but allow associations to arise from its isolated elements" (Laplanche J. &Pontalis J., p. 66).

- **Free Association**: In this method, Freud did not seek to influence his patients in any way. Instead, he asked them to lie down on a couch while he sat behind them. He did not ask them to close their eyes or touch them, as these methods could evoke hypnosis.

Freud considered this setup a kind of dialogue in which one party does not exert physical effort and is minimally exposed to sensory stimuli, focusing attention on internal psychological activity. He found that involuntary thoughts—those generally regarded as distractions and usually dismissed—served as a suitable substitute. These are what he termed "free associations" (les associations libres) (Faisal A., 1996, p. 51). This is what Freud referred to as the "fundamental rule": the patient must express everything without concealing anything from their associations (Clément K., 2014, p. 101).

- **Repression (Repression Mechanism)**: Through free association, Freud discovered gaps in patients' narratives. Some real events had been entirely forgotten, while others had been distorted—beloved memories altered as if something within the psyche had reshaped them over time. Chronological sequences were

confused, and causal relationships reversed. Based on this, Freud formulated the concept of repression as a psychological process.

In his book Five Lectures on Psychoanalysis, Freud writes: "The concept of 'resistance' led me to the theory of psychic mechanisms in hysteria. The process that I hypothesized and found proven through resistance, I named repression. In all cases, we observed the presence of a strongly felt aggressive desire that was in direct conflict with the individual's other desires and was incompatible with their moral and aesthetic beliefs. This unacceptable desire is subjected to repression, expelled from consciousness, and forgotten. Repression here serves as a mechanism of psychological protection, providing relief from discomfort" (Freud S., 1998, p. 26).

In 1918, he provided a definition of psychoanalysis: "We call psychoanalysis the work through which repressed psychic content is transferred from the depths of the patient's psyche to their conscious awareness." (Kleiman, K. 2014, p. 101).

Repression is one of Freud's key concepts in the field of hysteria, influencing his differential diagnosis of hysteria cases as well as his therapeutic objectives. The processes of repression that lead to hysteria leave clear imprints on memory, making it difficult for the patient to recount their life history in a coherent and logically structured manner. This highlights the connection between hysteria and memory disorders. Freud generalized the issue of childhood amnesia across all aspects of psychoanalytic treatment, including psychosomatic disorders—contrary to certain psychosomaticists who reject the possibility of a psychosomatic disorder merely because the patient's memory appears intact (Marty, P. & Others, 1990, pp. 15–16).

Resistance:

Resistance is a cornerstone of Freud's theory. He considers repressed thoughts or ideas to be derivatives of the unconscious structures that have been distorted due to resistance (Abbas, F., p. 52).

According to Fédlouchi, repression and resistance led Freud to what he called "defensive hysteria," distinguishing between "hypnoid hysteria" and "non-controlling hysteria." Additionally, he linked phobias, obsessions, and hysteria as psychological disorders rooted in an internal psychodynamic conflict (Si Moussi, A. R. & Ben Khalifa, M., 2012, p. 51).

Drosar, in the International Dictionary of Psychoanalysis, notes that analysts consider neuroses to be "psychological disorders with no identifiable anatomical substrate, where symptoms are linked to unconscious psychological conflicts related to the Oedipus complex and the defensive mechanisms it triggers" (Si Moussi, A. R. & Ben Khalifa, M., 2012, p. 57).

Resistance manifests in various ways:

- Changing the topic during therapy sessions or diverting discussions to non-essential subjects.
- Arriving late to appointments or forgetting them altogether.
- Experiencing speech inhibition, thought disturbances, or tension, which may lead to missing future sessions.

I distinctly remember how my psychoanalyst and professor, Si Moussi Abdel Rahman, used to describe resistance during training sessions on psychoanalytic-inspired psychotherapy at the Algerian Psychological Association (1997–2007). He observed that resistance can precede treatment itself, as some individuals delay seeking therapy for up to five years despite being referred much earlier. This pattern was not unique to a single patient but was a common response among many clients.

In my own clinical practice, I have encountered similar forms of resistance. Even clients who arrive early for their sessions sometimes display resistance through paradoxical defensive behaviors. While early arrival may indicate positive transference or engagement, in some cases, resistance manifests in various forms throughout the treatment process—particularly at the beginning, in the middle, and especially in the final sessions, when separation anxiety intensifies resistance.

Psychoanalysts assume that resistance in therapy is like "hitting a nerve" in neurosis. It may be a crucial factor in a patient's everyday life and could later become a valuable topic in therapy (Pomerantz, M., 2018, p. 359).

Slips of the Tongue and Behavioral Slips:

According to psychoanalysts, all behavior has an underlying cause—there is no such thing as a random mistake, accident, or slip. If a certain behavior cannot be explained by conscious motivations, unconscious drives must be responsible. While most slips occur in verbal speech, they can also manifest behaviorally (Pomerantz, M., 2018, p. 357).

-Dynamics of Transference:

Freud starts with two fundamental questions:

1. Why do strong emotional transfers emerge during psychoanalytic treatment that are not observed in other forms of therapy?
2. Why does transference in psychoanalytic therapy present as the most significant form of resistance, whereas in other types of therapy, it is considered a key factor in healing?

Regarding the first issue, Freud asserts that transference does not occur exclusively in psychoanalytic therapy but is also present in other therapeutic approaches. In extreme cases, it manifests as dependency and submission to the therapist's will. Thus, transference is not a unique

feature of psychoanalytic therapy but a fundamental characteristic of neurosis itself.

As for the second issue, Freud distinguishes between two types of transference:

- **Negative transference**, which acts as a hindrance to therapy due to hostile, resentful, or eroticized resistance.
- **Positive transference**, which involves friendly feelings that can be consciously acknowledged, along with deeper unconscious emotions.

The psychoanalyst utilizes positive transference as a tool for therapeutic influence, leveraging the emotional connection with the patient to establish the foundations of psychoanalytic technique (Abbas, F., pp. 52–53).

A Critical Note on Transference:

This binary classification of transference is now considered outdated. Modern psychoanalysis recognizes that transference manifests in diverse forms, reflecting the wide range of emotions and desires tied to early relationships.

J. Cournut, in his article "The Modalities of Transference and the Work of Mourning", defines transference as:
"A general psychological phenomenon. When we speak to someone, we do not only address them; unconsciously, we also project onto them figures and images from our personal history."

The analytic setting intensifies this repetition, bringing forth past emotions directed at parental figures and now redirected toward the analyst, who is expected to interpret them.

Transference can take multiple forms, including:
✔**Positive transference:** When the patient expresses trust toward the therapist, allowing the therapy to progress smoothly and even pleasantly.
✔**Hostile transference:** When the therapy is accompanied by feelings of hostility, resentment, or demands (e.g., "I hate you," mirroring past unresolved conflicts with parental figures).
✔**Erotic transference:** If left unanalyzed, therapy may veer into eroticized attachment. The analyst must clarify to the patient that such feelings are misdirected.
✔**Romantic transference:** A highly charged emotional state where the patient develops an intense, exclusive attachment to the therapist, sometimes making therapy difficult.
✔**Lateral transference:** The patient displaces transference onto another figure instead of the therapist (e.g., obsessively discussing a psychiatrist or pet rather than engaging with the analyst).
✔**Negative transference:** Previously mistaken for hostility, modern psychoanalysis sees it as an emotional withdrawal, where therapy becomes a routine ritual without genuine engagement.

Michel Le Doux highlights that therapeutic relationships establish a "new bond," which may not always be constructive. The eruption of repressed material under transference and countertransference effects means that the analyst is perceived not as they are but through the distorted lens of past relationships. The analyst must intervene to correct these projections through **interpretative listening**—without a transference relationship, no therapeutic change can occur.

Le Doux further emphasizes that repeated therapy sessions are crucial in gradually readjusting transference dynamics. The analyst must also analyze their own countertransference—their unconscious emotional responses to the patient—which influences the therapeutic process.

This aligns with the concept of **countertransference**, where the therapist's past experiences shape their reactions to the patient. This self-awareness is necessary for effective psychoanalytic treatment.

Countertransference:

As mentioned earlier, this term refers to the reactions that a client elicits in the therapist in the form of responses, thoughts, and emotions. This is especially relevant when the client's story closely resembles that of the therapist, which may influence the nature of the interpretations provided to the patient. This necessitates analytical work on the therapist's own psyche, particularly through review interviews (restitutions des entretiens), where the therapist, after the session, examines their reactions, interpretations, and how their interventions resonate internally (see Dr. Boualgha Fatma Zahra's lecture on interviews, published on the University of M'sila website, 2019).

A therapist must act as a "blank screen," revealing little about themselves to the client through verbal and non-verbal communication (in fact, this was a key reason Freud's clients lay on a couch while he sat behind them, out of their direct line of sight). Additionally, psychoanalytic trainees should undergo personal psychoanalysis to become more aware of their unconscious issues (Pomerantz, M., 2018, pp. 366-368).

Classical Psychoanalytic Therapy Techniques:

Classical psychoanalytic therapy is based on three main techniques: free association and interpretations of dreams, slips of the tongue, incomplete actions, resistance, and transference.

1. Free Association:

As highlighted in Lecture 2 on therapeutic foundations, psychoanalytic treatment relies on free associations, meaning that the client does not

follow a specific order when recounting events or experiences. This is because unconscious events do not adhere to logical principles; rather, they are illogical and distorted. The process promotes complete spontaneity, as noted by Armand Pomerantz (2018).

When a client feels sufficiently relaxed to engage in free association, their unconscious processes become clearer to the psychoanalyst and, eventually, to themselves. It is important to distinguish between Freud's free association and Carl Jung's word association technique, where the therapist presents a list of words, and the client responds with the first word that comes to mind. In Jung's method, therapists analyze the client's responses and reaction times, whereas free association in Freud's approach does not involve any external stimuli from the therapist (Pomerantz, 2018, p. 375).

2. Dream Interpretation:

Freud considered dreams to be "the royal road to the unconscious," stating that "a dream is not merely a fragmented mental activity... rather, the mental processes that contribute to its formation are highly sophisticated and complex" (Freud, S., 1967, p. 113).

In the introduction to The Interpretation of Dreams (Traumdeutung), Freud asserted that psychological research has shown dreams to be linked to pathological formations. These formations, ranging from hysterical fears to obsessions and delusions, should be of particular interest to physicians. The significance of dreams in understanding mental disorders is so great that if a doctor fails to comprehend them, their ability to treat phobias, compulsions, or psychotic delusions will be significantly impaired (Freud, S., 1996, p. 18).

According to Freud, dreams serve a therapeutic function. They contain fragments and residues of impressions from previous days or even early childhood, providing an outlet for unconscious material (Freud, S., 1967, p. 77).

A psychoanalyst does not necessarily interpret every dream recounted by the client during a session. Instead, the unconscious manifests itself through multiple dreams, and the client may even use dreams as a form of resistance (Abbas, F., p. 53).

For a deeper understanding of dream analysis, including types, functions, mechanisms, and sources, see Dr. Charade Nadia's book "Dreams: A Personal Psychological Experience," published by University Press.

Summary of Dream Analysis Components:

- **DreamContent :**Manifestcontent ; latent content
- **Functions :**Cathartic ;therapeutic ;compensatory
- **Mechanisms:** Transformation of latent thoughts into manifest content through defense mechanisms such as condensation, displacement, visual representation, and secondary revision.
- **Sources:** Memory traces from daily residues; childhood memories; physiological stimuli.

Neo-Freudianism and the Evolution of Classical Psychoanalysis

Neo-Freudianism emerged as an approach that distanced itself from Freud’s rigid classical psychoanalytic method. While still rooted in psychoanalysis, neo-Freudianism is more eclectic and less dogmatic. Unlike classical Freudian theory, which emphasizes neurotic conflict and unconscious exploration, neo-Freudian approaches allow for greater flexibility and adaptability in various therapeutic settings, including both individual and group therapy.

Neo-Freudianism has had a significant impact on psychotherapy, social work, and education, emphasizing **interpersonal factors** within a **psychosocial framework** (Asaad, M., 2010, pp. 115-117).

Psychoanalysis has also been applied in fields such as **anthropology**. Major developments in post-Freudian psychoanalysis include:

1. Alfred Adler's Individual Psychology

Adler's approach, known as **Individual Psychology**, emphasized the **social dimension** of human behavior. Considered a pioneer of **social psychological theories**, Adler wrote significant works such as "Study on Organic Inferiority and Psychological Compensation," "Individual Psychology in Theory and Practice," and "Neurotic Character."

Due to his focus on social issues, childhood experiences, and education, Adler founded **child guidance clinics** and an **experimental school** to implement his educational ideas—both of which were later shut down by the Nazis.

Adler believed that individuals possess a **self (soi le)** and are conscious of their aspirations and ambitions. Unlike Freud, he **did not** attribute behavior primarily to unconscious drives; instead, he argued that **feelings of inferiority** drive human actions. If these feelings are not managed, they can develop into an "inferiority complex" (Dabbagh, F., 1983, p. 30).

Adler's therapeutic method involves **reconstructing the client's past** to identify their **life style** and help them modify it. He distinguished between **neurotic personality types** and **criminal personality types**.

Neurotic symptoms, according to Adler, serve as a **defensive mechanism** against reality, allowing individuals to **evade responsibility** while still acknowledging it. This makes therapy an interactive process where the therapist engages **directly** with the client to **challenge their beliefs and behavior patterns** (Abbas, F., p. 58).

2. Carl Jung's Analytical Psychology

Jung's approach, known as **Analytical Psychology**, introduced key works such as "The Theory of Psychoanalysis," "Psychology of the Unconscious," "The Relationship Between the Ego and the Unconscious," and "Psychology and Religion."

While Freud emphasized childhood experiences, Jung proposed that the **past** includes not only **individual** childhood but also **collective human history**—a concept he called the **collective unconscious** (Abbas, F., p. 58).

Jung also classified personality types based on **introversion and extraversion**, recognizing that individuals often exhibit a **blend** of both tendencies (Farhati, A. B., 2016, p. 257).

Jungian therapy differs from Freudian analysis in that the therapist sits **face-to-face** with the client, rather than having them recline on a couch with the therapist out of sight. This **reduces resistance** and **minimizes the power dynamic** in therapy.

Unlike Freud's rigid approach, Jung's therapy is **more interactive and flexible**, focusing on confronting **neurotic behavior directly** (Abbas, F., p. 59).

3.2 Modern Freudians:

The contributions of the post-Freudian movement expanded the scope of psychoanalysis as a whole, keeping it both a theoretical and clinical discipline. A group of scholars delved deeper into neurosis and mental illnesses while maintaining Freudian foundations, but they leaned more towards local cultural factors, environment, and society. Some of the most notable figures include:

Otto Rank and Birth Trauma:

Rank's contribution to psychoanalysis is his theory of "birth trauma," first introduced in his book The Artist, followed by The Myth of the Birth of the Hero and Incest in Myth and Poetry. Rank was seen as a reformer of psychoanalytic ideas, arguing that all anxiety and predisposition to neurosis stem from the primal fear experienced at birth. He believed that this universal experience was fundamentally traumatic.

Rank proposed that healing neurosis was not about reconstructing the past or re-examining the origins of the illness but instead focusing on the client's birth trauma. He suggested that the patient should relive this trauma emotionally, projecting onto the analyst the role of the mother. The therapy process would culminate in a symbolic "psychological rebirth" when the patient left therapy, mirroring the original birth trauma but in a milder form.

Rank also saw children's games and adult play as therapeutic tools with "cathartic" value, allowing for unconscious emotions to be expressed. He considered these manifestations as healing attempts akin to the interventions of classical psychoanalysis.

Theodor Reik:

Reik offered alternative interpretations of personality, considering the unconscious as a receiver of rare, extrasensory stimuli, known as telepathy. He argued that neurosis results from a loss of self-confidence.

Erich Fromm:

Fromm focused on social psychology, emphasizing that humans are shaped by their social circumstances from birth. He believed that mental health could only be understood through philosophy and anthropology. He identified two types of human personalities:

✔**The productive personality**
✔**The unproductive personality**, which manifests in different forms:

- **Receptive personality**: seeks to receive everything passively from others.
- **Exploitative personality**: tries to obtain everything by any means.
- **Hoarding personality**: characterized by stinginess and anxiety over spending.
- **Marketing personality**: adapts itself to circumstances at the cost of authenticity.

Harry Stack Sullivan:

Sullivan emphasized the importance of human relationships between the patient and the therapist, even defining psychiatry as "the study of interpersonal relationships." He highlighted the role of empathy and identification with the client and believed personality is shaped through interactions with others. He identifiedtwo main humanneeds:

1. **Physical needs**
2. **Security and reassurance**Anxiety, according to Sullivan, arises from the failure to satisfy one or both of these needs.

Karen Horney:

Horney challenged many of Freud's ideas regarding female psychology, particularly the notions of internalized inferiority and "penis envy." She proposed alternative developmental theories for women, aiming to revise traditional psychoanalytic concepts. Her work influenced later feminist psychoanalysts, such as Nancy Chodorow (1978) and Carol Gilligan (1982).

Bronisław Malinowski:

Malinowski rejected Freud's theory that psychological structures are biologically inherited. Instead, he argued that social structures shape psychological experiences, emphasizing cultural differences in behavior. He found that some primitive societies did not experience sexual repression linked to the Oedipus complex, suggesting that culture plays a significant role in psychological development rather than biology.

Jacques Lacan:

Lacan expanded and deepened psychoanalysis by incorporating anthropology and linguistics. He distinguishedbetweenthreeregisters :

1. **The Real** – The unstructured and unspeakable reality before language.
2. **The Symbolic** – Social norms, language, and cultural structures.
3. **The Imaginary** – The phase of identity formation, particularly in the mirror stage, where the infant sees their reflection and recognizes themselves as an "other."

Lacan argued that neurosis and psychosis result from disruptions in the symbolic order, particularly failures in resolving the Oedipus complex. He emphasized the role of the "Other" (such as the therapist) in structuring a person's reality. His contributions provided new ways to understand psychological and interpersonal phenomena, merging linguistic and psychoanalytic perspectives.

The London School:

Key figures include **Ernest Jones** and **Melanie Klein**, who developed play therapy as a psychoanalytic approach for children. Klein believed that hostility and aggression were fundamental human instincts.

The Chicago School:

Notable members include **Franz Alexander, Karl Menninger, and Helene Deutsch**. They expanded psychoanalytic theory by proposing that conflicts were not solely rooted in childhood sexuality but also in issues of self-esteem, love, and validation.

4. Additional Notes: Key Works of Sigmund Freud

Title	**Year**
The Birth of Psychoanalysis: Letters to Wilhelm Fliess	1887
Studies on Hysteria (with Josef Breuer)	1895
The Interpretation of Dreams	1900
Psychopathology of Everyday Life	1901
Three Essays on the Theory of Sexuality	1905
Jokes and Their Relation to the Unconscious	1905
Five Lectures on Psychoanalysis	1910
Totem and Taboo	1913

Psychotherapy in Light of Classical and Modern Psychoanalysis:

1. The Therapeutic Framework: Its Nature and Conditions

1.1. Preliminary Interviews in Classical Psychoanalytic Therapy
1.2. Face-to-Face Interviews in Analytically Inspired Therapy

1.3. Conditions for Engaging in Classical Psychoanalytic Therapy
1.4. When Does Analytically Inspired Therapy Become Necessary?

2. Pitfalls in the Therapeutic Relationship

1. The Therapeutic Framework: Its Nature and Conditions

In psychoanalysis, the framework is defined as the set of agreements included in the therapeutic contract between the psychoanalytic therapist and the client when deciding to enter a therapeutic relationship. These agreements must be established from the very first interviews, clearly stating the implicit aspects of this contract. (…) The rules of this contract should align with the system of the institution to which the therapist belongs and should be discussed with the client in a flexible yet transparent manner.

The Therapeutic Framework in Psychoanalysis

In psychoanalysis, the framework is defined as the set of agreements that constitute the therapeutic contract between the psychoanalytic therapist and the client when they decide to enter a therapeutic relationship. This contract must be established from the very first sessions, with its implicit aspects clearly stated. (…) The rules of this contract should align with the system of the institution to which the therapist belongs and should be discussed with the client in a flexible yet transparent manner.

These therapeutic rules can be generalized to other therapies inspired by psychoanalysis. They can also be applied to non-analytic therapies, referred to as psychological care, to avoid risks related to the course of treatment. (Perron, R., 2001, p. 54)

Key Elements of the Psychoanalytic Therapeutic Framework According to Perron:

- **Agreement on Time and Cost:**
  The therapist must establish the session duration, cost, and payment schedule from the preliminary interviews. Freud's sessions lasted a full hour, whereas modern traditional "clinical" therapies, especially in France, typically last 45 minutes. Sessions for children, particularly those with disorders, have been reduced to 30 minutes. Both therapist and client must respect the agreed session duration.

  The cost should be mutually agreed upon—it should not exceed the client's financial means, nor be too low. For disadvantaged clients or therapy in public institutions, the institution should set a symbolic fee or provide financial aid. However, the therapist must inform the client that their therapy is funded by the government to prevent feelings of guilt. Additionally, if a client misses a session without prior notice, they are still required to pay for it, as the therapist reserves that time and does not schedule other clients in their place.

- **The Rule of "Say Everything, Do Nothing":**
  This refers to respecting the rule of free association, encouraging the client to express whatever comes to mind, no matter how trivial or unpleasant. At the same time, while promoting spontaneous expression, the therapist must maintain professional boundaries. For instance, minimal physical gestures such as handshakes or kisses should be avoided to prevent crossing professional boundaries and sexualizing the therapeutic relationship.
- **Confidentiality:**
  The therapist must inform the client that everything shared in the

session is strictly confidential and cannot be disclosed, even to close relatives, except in three specific cases:

1. **Team Discussions** – In difficult cases or institutional settings where two therapists treat different members of the same family (e.g., the mother with one therapist and the child with another).
2. **Supervision Sessions** – When the therapist discusses the case with an expert therapist for professional guidance.

Confidentiality and Professional Boundaries in Psychoanalysis

- **Scientific Publication for Knowledge Development:** Confidentiality must also be maintained when sharing case studies for scientific research aimed at enriching the professional field, improving clinical practice, and advancing theoretical understanding. In such cases, the therapist must ensure that the client's name, family name, or any identifiable details are omitted to protect anonymity.
- **Preserving the Therapist's Personal Data:** The therapist must refrain from sharing personal aspects of their life, political beliefs, or religious views with the client. (Perron, R., 2002, p. 55-61)

Psychoanalysis has established that the therapeutic framework plays a crucial role in building a strong therapeutic relationship. Modern researchers consider it one of the key predictors of therapy outcomes, referring to it by various terms such as:

- **Therapeutic Relationship**
- **Therapeutic Alliance**
- **Working Alliance**

Among these, the term **"Alliance"** best captures the essence of this relationship—depicting a coalition and partnership between two allies working within a framework of trust to achieve a common goal.

(Horvarth et al., 2012; Norcross &Wampold, 2011a, 2011b; Fluckiger, 2015)

1.1 Preliminary Interviews in Classical Psychoanalytic Therapy

The psychoanalytic interview follows the same principles as any other interview or even daily conversations. Sigmund Freud highlighted this in his 1913 paper "The Beginning of Treatment" (Le début du traitement), noting that what distinguishes psychoanalysis from casual conversation is the principle of **free association**. However, this principle is not immediately applied in the initial interviews. Instead, thesepreliminary meetings aimto :

- Clarify the nature of the client's request
- Discusspreviouspsychoanalytictreatments
- Establish communication that will later facilitate free association

This process is now referred to as **"the pragmatics of communication"**(Moeschler& Reboul, 1994).

Two Models of Communication in Preliminary Interviews

Widlöcher (1998) borrowed two linguistic models to explain communication in psychoanalytic interviews:

1. **Informative Communication** – Focused on conveying information
2. **Interactive Communication** – Centered on reciprocal interaction

Freud's Evolving Approach to Preliminary Interviews

Initially, Freud conducted **multiple, lengthy face-to-face interviews** to prepare clients for psychoanalysis. However, he later abandoned this approach due to its potential to **distort transference dynamics** and disrupt the psychoanalytic process. Instead, preliminary interviews

evolved into what is now called **"trial work" (travail d'essai)**—a phase where the client is evaluated for psychoanalysis under the same rules as analytic sessions.

Duringthese trial sessions :

- The therapist must refrain from **commenting on** the client's speech.
- The therapist must **not attempt to complete** the client's sentences.
- The format avoids **direct questioning**, unlike traditional psychiatric interviews.

(Fédida&Cyssau, 2013, p. 143-145)

2.1 Face-to-Face Sessions in Psychoanalytically Inspired Therapy

Psychoanalytically inspired therapy differs from traditional psychoanalysis in that it relies on **face-to-face interviews** as a fundamental part of therapeutic dynamics. Unlike classical psychoanalysis, where face-to-face sessions were merely preparatory or used for screening, in inspired therapy, they constitute the main therapeutic framework.

Below is a table outlining the **similarities and differences** between classical psychoanalysis and psychoanalytically inspired therapy:

Common Points	**Differences**
Both share the same **theoretical reference**.	The **analytic stance** differs: classical psychoanalysis follows the **"one-on-one setting" (dispositif seul à seul)** with the patient lying on a couch, while inspired therapy adopts a **face-to-face** approach.

Common Points	**Differences**
Both follow the **one-on-one method**.	The **physical positioning** differs: in classical analysis, the patient lies on a couch with the analyst behind them, whereas in face-to-face therapy, direct eye contact occurs.
Both maintain **confidentiality** and a **structured therapeutic framework**.	The number of sessions is **higher in classical analysis** and lower in inspired therapy.
Both use **free association** to explore thoughts, memories, and images.	Inspired therapy reduces **session frequency** while still maintaining a fixed schedule.

(Source: Cornut, J., 1996, p.15-66)

The Role of Physical Positioning in Therapy

René Roussillon (1999) analyzed how **bodily positioning** influences psychoanalytic work. In classical analysis, where the patient lies on a couch with the analyst positioned behind them, the communication is shaped by **free association without direct eye contact**. In contrast, face-to-face therapy creates a **different dynamic** due to the **perceptual presence of the therapist's gaze**.

- Roussillon describes **face-to-face analysis** as therapy **"under the gaze of the other,"** which modifies **preconscious processing** and **unconscious access**.

- The interaction in face-to-face therapy is **preconscious-to-preconscious**, serving as a **transformation system** that regulates unconscious material.
- Unlike classical analysis, which fosters a **state of solitude (Winnicott's "capacity to be alone")**, face-to-face therapy cultivates the ability to **"be alone in the presence of the other."**

(Roussillon, R., 1999, p. 71-72)

Session Frequency and Regression in Therapy

- In classical psychoanalysis, the **intensity of sessions (often multiple times per week)** fosters deep **regression**, leading to **transference neurosis**—where past experiences are projected onto the analyst.
- Inspired therapy, with its **lower session frequency (once or twice per week)**, **reduces regression levels**, leading to a **less intense transference**.
- Freud's approach sought to **analyze and work through transference**, while inspired therapy **allows transference to occur but does not seek to deepen it deliberately**.

This key difference means that classical psychoanalysis facilitates a **profound regressive experience**, while inspired therapy maintains **a more present-focused interaction**.

Symbolism of the Reclined Position in Classical Analysis

Lying on the couch in classical analysis can evoke **deep psychological and cultural symbolism**:

- It recalls **a solitary state** (e.g., early developmental stages, hallucinations of absent objects).
- It can resemble **death**—with the analyst positioned behind the patient, akin to someone awaiting final words.

- It evokes **sleep and dreams**, reinforcing the **unconscious nature of free association**.
- It may carry **sexual connotations**, particularly in cases where there is **gender difference** between the patient and the analyst. However, these connotations may persist even in same-gender therapeutic relationships.

These elements illustrate why the classical psychoanalytic setting **creates a unique symbolic space** distinct from face-to-face inspired therapy.

3.1 Conditions for Engaging in Classical Psychoanalysis

Abderrahmane Si Moussi, in his article "Psychotherapy Inspired by Psychoanalysis: A Clinical Necessity", argues that classical psychoanalysis requires two fundamental conditions for effective treatment of **neurotic disorders** in Algeria.

Would you like me to expand on these conditions and their implications?

3.1 Conditions for Engaging in Classical Psychoanalysis

Abderrahmane Si Moussi (2008) highlights two essential conditions for a patient to be a suitable candidate for **classical psychoanalysis**:

1. **A Stable Ego:** The patient's ego should not be fragile or weak.
2. **Moderate Levels of Conflict and Desire:** If the patient's inner conflict or desires are too intense, they may lead to heightened frustration and suffering, making it difficult for the patient to endure psychoanalytic work.

Many patients seeking help exhibit **ego fragility**, where their need for therapy resembles a demand for **maternal care**. This conclusion is supported by their responses to the **Thematic Apperception Test**

(T.A.T.), confirming their psychological vulnerability (Si Moussi A., 2008, p.140).

Psychoanalytically inspired therapy, in contrast, is more **adaptive** for such cases. Since it relies on **face-to-face interaction** and **active interventions** from the therapist (while still respecting the agreed therapeutic framework), it proves more **practical for the Algerian clinical setting**.

4.1 When Does Psychoanalytically Inspired Therapy Become Necessary?

Psychoanalytically inspired therapy emerged **in response to empirical critiques** from clinicians trained in **Freudian psychoanalysis**. Below are key cases where this approach is not just an **option** but a **necessity**:

1. **Cases of Emotional Deprivation and Abandonment:**
    - Germaine Guex (1904–1984) was one of the first to conceptualize **"Abandonment Syndrome"**, which later influenced theorists like **Jean Bergeret and Otto Kernberg** in their work on **borderline personality disorders**.
    - Guex proposed a **psychoanalytic approach centered on both past and present experiences**, as **classical psychoanalysis is often ineffective** for these cases due to the patient's intense **fear of abandonment and emotional insecurity**(Boualaka, F., 2018, p.44).
2. **Patients Who Have Not Transitioned to Symbolic Thought Through Language:**
    - These individuals, during early childhood, suffered from **severe personality deficits** or **attachment issues**, which prevented them from developing **symbolic processing skills**(Boualaka, F., 2018, p.25).
3. **Cases Dominated by Primitive Communication:**

- This includes patients who primarily express themselves through **actions rather than words**, such as:
  - **Adolescents engaging in riskybehaviors**
  - **Antisocial individuals**
  - **Suicidal patients**
  - **Psychosomaticdisorders**
  - **Psychotic conditions**(Roussillon, R., 2006 ;Magistretti, P. & Ansermet, F., 2006 ;Boualaka, F., 2018, p.23).

5.1 Challenges in the Therapeutic Relationship**(Translation of Perron, R., 2001)**

5.1.1 Goals of the Therapeutic Relationship

The **primary objectives** of the therapist-patient relationship include:

1. **Helping**(aider)
2. **Providing Care**(soigner)
3. **AlleviatingSuffering**(alléger la souffrance)

Regardless of whether we are **psychiatrists, clinical psychologists, or psychoanalysts**, our overarching professional mission is to **support the client** who seeks our help. The ultimate aim is to assist them in **resolving the issues they are struggling with** and to **alleviate their psychological distress**.

5.1.2 Challenges in the Therapeutic Relationship

Difficulties in the therapeutic relationship often stem from **relational patterns** formed during **early childhood** within **problematic family dynamics**. Other challenges arise from **marital conflicts, workplace tensions, or social adaptation issues**. For example, a young adult newly entering the workforce might experience:

- **Severe social anxiety**
- **Performance-related stress**
- **Aggressivebehaviors**

In more complex cases, individuals may suffer from **underlying personality disorders** leading to:

- **Phobias**
- **Obsessive-compulsive behaviors**
- **Generalized anxiety or "free-floating anxiety"**
- **Severe, prolongeddepression**
- **Post-traumatic stress disorders (PTSD)**, particularly in response to **Algeria's history of traumatic events**(Perron, R., 2001).

While all these cases **require psychological support**, the true challenge is **not necessarily achieving therapeutic success**, but rather **making a meaningful intervention** that helps alleviate suffering and improve social relationships.

5.2 Analyzing the Therapeutic Demand

A fundamental question in therapy is: **"Who is asking for what, and from whom?"**(Qui demande quoi à qui?)

This question is crucial because behind every **explicit request**, there often lies a **hidden or unconscious demand** that the client **may not even be aware of at first**.

Key aspects to consider :

1. **Who is speaking in the initial interview?**
    - Which **part of the client's personality** is expressing the request?

- **How does the client perceive the therapist?**

2. **Is the request direct or indirect?**
   - In some cases, a **third party** (e.g., parent, teacher, doctor) initiates the request, especially for **children**.
   - The child might be labeled as the **"symptom-bearer"** in a family conflict, serving as a **scapegoat** for unresolved parental issues.
3. **Hidden Contradictions in the Demand**
   - Sometimes families unconsciously **resist change** even while requesting therapy:
     - **"Fix the child, but don't change anything in our family dynamics!"**
   - If the therapist **overlooks these contradictions**, therapy may encounter **resistance and stagnation**.
4. **Understanding the Client'sTreatmentHistory**
   - Have they consulted other **psychologists or psychiatrists** before?
   - What kind of **help** have they received?
   - **Who referred them to therapy?**
5. **Exploring Motivations for Seeking Help**
   - **Whatprompted the request ?**
   - **Who in the family** is most invested in seeking therapy?
   - Are there **contradictions between different family members' perspectives?**

This **clinical listening process** enables the therapist to detect **unspoken conflicts**(ce qui n'est pas dit) and unresolved **relational or intrapsychic struggles**. By doing so, therapists can **better regulate their countertransference** and **adjust their therapeutic interventions accordingly**.

5.2.3 Possible Pitfalls in Psychodynamic Therapy

After analyzing the client's request, therapists may encounter **several therapeutic pitfalls**. These pitfalls are often linked to **the therapist's own psychological dynamics**, including **personal history and unconscious conflicts**. If left unchecked, these elements may **distort the therapeutic process** by projecting the therapist's personal struggles onto the client, rather than addressing the client's actual needs. This phenomenon is known as **countertransference pitfalls**(piègescontre-transférentiels).

1. The Illusion of Knowing What's "Best" for the Client

Therapists must be cautious when assuming **paternalistic** or **authoritarian** roles under the pretext of **acting in the client's best interest**:

- The therapist **is not a parent, sibling, teacher, or religious guide**.
- Therapy should **not involve giving advice, reprimanding, issuing orders, or expressing pity**—all of which the client has likely already experienced in life.
- Instead, the therapist's role is to **help the client understand their emotions**, **gain insight into their internal world**, and ultimately **take charge of their own destiny**.
- The goal is to **empower the client as an agent of their own life**, rather than **passively subjecting them to treatment**.

2. The Trap of Professional Arrogance

This pitfall is particularly common among **novice therapists**, who may develop an inflated sense of expertise.

- A therapist may feel **intellectually superior**, believing they "understand everything" about the client while the client "knows nothing" about them.
- This **hierarchical attitude** can lead to **manipulation of the therapeutic relationship** under the justification of "doing what's best" for the client.
- Arrogance, even if subtle, can **alienate** the client and create **resistance to therapy**.

3. The True Objective: Facilitating Psychological Freedom

The essence of psychodynamic therapy is **not to impose a predetermined path** but to guide the client toward:

- **New ways of thinking**
- **Deep emotional exploration**
- **Greaterpsychologicalflexibility**

A successful therapeutic process allows the client to **develop beyond their initial expectations**, even confronting thoughts they once feared.

Ultimately, therapy's **core objective** is to foster **personal freedom**—helping clients free themselves from **crippling internal conflicts** and develop **healthier interpersonal relationships**.

Common Pitfalls in Psychodynamic Therapy

In therapy, the primary goal is to **help the client achieve greater psychological freedom**. However, certain therapeutic pitfalls can create **dynamics of control and dependency** that contradict this goal. Below are four key pitfalls that therapists must **consciously avoid**:

1. The Pleasure of Control

- A **therapist-client relationship based on dominance** contradicts the **fundamental principle** of therapy: to foster independence.
- Therapists must **avoid positioning themselves as authoritarian figures**, as this reduces the client to a childlike state.
- The general rule in therapy is that the therapist should **not give advice, issue directives, or act as the ultimate authority on what is "right" or "wrong."**
- **Control is short-lived**, and the most dangerous dynamic is one of **influence and submission** (Relation d'emprise), where the client becomes **mentally dependent** on the therapist—seeing them as a role model to admire or even fear.
- This **dependency negates** the very psychological freedom therapy seeks to cultivate.

One of the major criticisms directed at **Jacques Lacan** was precisely this issue—**creating relationships of dependency with his patients** rather than fostering autonomy.

2. The Pedagogical Trap

- Some therapists fall into the **trap of acting like the "ideal teacher" or "perfect parent."**
- This happens even when, in their **own personal lives, they are neither great teachers nor great parents.**
- A therapist must ask themselves: "Am I truly so satisfied with myself that I should serve as a model for my client?"
- Many clients have already encountered "good teachers" or "good parents" who **harmed them under the guise of "acting in their best interest."**
- What the client **actually needs** is **not another authority figure** but rather someone who:

- **Refrains from prescribing what they should do.**
- **Does not judge or offer unnecessary praise.**
- **Above all, listens in silence rather than imposing their own views.**

3. The Trap of Ideological Preaching

- Some therapists attempt to **impose their own personal value systems** (ethical, political, religious, etc.) onto their clients.
- This creates a **dangerous imbalance of power**—where the therapist seeks to "convert" the client to their worldview rather than allowing the client to develop their own.
- It is crucial to **differentiate between universal values and personal beliefs**:
  - **Universal values** (e.g., respect for others, tolerance, and personal autonomy) are essential in any society and should be upheld in therapy.
  - **Personal values** (e.g., political affiliations, religious beliefs, and lifestyle choices) **should remain outside the therapist's influence**.
- The **role of the therapist is to support life and human flourishing**, not to shape the client in their own ideological image.

Historically, **dictatorial regimes have persecuted psychoanalysts, psychotherapists, and human sciences specialists** because they encourage **critical thinking and personal autonomy**—qualities that authoritarian systems seek to suppress.

Common Pitfalls in Psychodynamic Therapy (Continued)

In addition to control, ideological preaching, and the pedagogical trap, therapists must also avoid the following pitfalls:

5. Giving Advice

- **Therapists should refrain as much as possible from giving advice.**
- In daily life, advice often leads to two possible negative outcomes:
  - The client follows the advice, but it leads to a **bad result**, causing **resentment** toward the therapist.
  - The client **ignores the advice**, experiences **negative consequences**, and **blames the therapist for not insisting enough.**
- These situations often **disrupt therapy** and may cause premature termination.
- Instead of giving direct advice, therapists should **guide reflection**:
  - "Before making this decision, let's think together about what is driving you to do it."
  - "Let's analyze the situation and your motivations."
  - By doing so, **the therapist maintains their role**, helps clarify the client's motivations, and introduces **a delay before impulsive actions.**

6. Seduction and Charismatic Influence

- **Being admired can be seductive.**
- When therapy is progressing well, **clients may project their emotions onto the therapist** (transference).
- With proper training and clinical experience, **therapists can navigate these dynamics** without falling into counterproductive emotional entanglements.
- **Sexual attraction is a common dynamic in therapy, but it must be handled professionally.**
- **This does not mean therapists should be cold or distant.** Instead, they must **maintain professional boundaries while remaining warm and supportive.**

- **Client admiration should not be mistaken for a personal compliment.**
  - If a client says, "You are intelligent, kind, understanding," the therapist should recognize that these words may have been **repeated to other therapists** in similar situations.
- **In private practice, there is a risk of wanting to "seduce" clients to retain them.**
  - Therapists must resist this temptation and **remember that the person seeking help is not a "fish to be caught."**

7. The “Savior” Complex

- **This pitfall arises from a desire to "repair" the client’s suffering.**
- **It is tempting to position oneself as the “good person”** in contrast to those who have harmed the client.
- The underlying thought is: “Those people hurt you, but I will fix what they did because I am better than them.”
- This mindset is particularly common when working with:
  - **Children who have suffered abuse (physical, emotional, or sexual).**
  - **Clients who were mistreated by their parents or authority figures.**
- **Therapists must resist the urge to take sides.**
  - Unlike social workers, whose role is to intervene, **therapists must create a space for the client to express themselves freely** without aligning against others.
  - The therapist's role is to **listen seriously, acknowledge suffering, and support the client in their healing journey—without positioning themselves as a rescuer.**

Final Thoughts

Avoiding these pitfalls allows therapy to remain **a space of psychological freedom rather than control, dependency, or moral influence.**

Chapter 02: Therapeutic Steps in PIP (Psychodynamic Interpersonal Therapy)

1. The Therapeutic Framework of Psychoanalytically Inspired Therapy:

Psychoanalytically inspired therapies, as previously discussed, derive their foundations from classical psychoanalytic structuring but incorporate a degree of flexibility. These therapies adhere to the principle of free association within a face-to-face framework that allows the patient to confront their unconscious childhood conflicts, which continue to influence their present life—particularly their emotional relationships and adaptive difficulties. The therapeutic dialogue focuses on both past and present experiences, utilizing the therapeutic relationship as a supportive, containing, and even protective space.

2. Types of Psychoanalytically Inspired Therapies:

2.1 Short-Term Therapies:

The classical psychoanalytic therapy model requires a long duration, making it costly and less suitable for contemporary societies that favor faster results. Consequently, modern psychoanalytic therapies have shifted towards Brief Psychodynamic Therapy, which has become more widespread compared to traditional Freudian psychoanalysis (Steenbar, 2010; Levenson, 1997, 2008).

Below is a summary table of key differences between short-term and long-term psychoanalytic therapy:

Short-TermTherapy	Long-TermTherapy
The therapeutic alliance is formed quickly	The therapeutic alliance is formed gradually
Focuses on a specific, narrowly defined issue	Focuses on a broad range of issues
The therapist's activity level is relatively high	The therapist's activity level is relatively low
The patient's condition is less severe	The patient's condition is more severe

Emphasizes the "here and now"	Emphasizes both past and present
The patient's ability to separate is high	The patient's ability to handle separation varies
The patient has good object relations	The patient has poor to good object relations

(Source: Adapted from Dewan et al., 2009)

Short-term therapy typically consists of a minimum of **24 sessions** over approximately **six months**, with weekly sessions (Pomerantz, 2018, p. 373).

Andrew Pomerantz (2018) highlights that certain forms of **brief psychoanalytic therapy** have gained significant attention in recent years. Two key approachesinclude :

1. **InterpersonalTherapy (IPT) :**
    - Originally developed for treating depression, IPT operates on the premise that improving clients' relationships with others will alleviate depressive symptoms.
    - It typically lasts **14 to 20 sessions**, divided into three phases:
        - **Initial phase :** 2 sessions
        - **Middle phase :** 10 to 12 sessions
        - **Final phase :** 2 to 4 sessions
    - This model has also been adapted specifically for patients with **bipolar disorder**, under the name Interpersonal and Social Rhythm Therapy (IPSRT).
2. **Time-Limited Dynamic Psychotherapy (TLDP):**
    - A modern application of what was previously known as Corrective Emotional Experience.
    - Clients bring up **transference issues** in their relationships, and the therapist's role is to challenge these unconscious scenarios and ensure a different outcome in their interactions.

- The therapist increases the patient’s awareness of these patterns and designs "corrective scripts" for emotional experiences.
- A visual **"Maladaptive Pattern Schema"** is often used to categorize clients' core relational issues into four areas:
  - **Self-actions**
  - **Expectedresponsesfromothers**
  - **Actions of others toward the self**
  - **Self-actions toward the self**
- Therapy generally lasts between **20 to 25 sessions** (Pomerantz, 2018, pp. 374-376).

Chapter 03: Analytic Family Therapy

A. Group Analytic Therapy:

This therapeutic approach was initially introduced by **T. Burrow** in the United States after attending Freud's lecture on "Five Lectures on Psychoanalysis" (1909). By the 1920s, Burrow proposed the term **"Group Analysis"**, and later in 1934, **R.S. Slavson** developed group therapy for **children in the latency stage**, later expanding it to **adolescents and adults**.

During the same period, **P. Wender** and **K.L. Schilder** applied psychoanalytic therapy to groups of **borderline patients**. For these researchers, **psychoanalytic interpretation provided each individual with insights**, marking the **beginning of group psychoanalytic therapies**.

In **France**, significant contributions came from **D. Anzieu and J.-B. Pontalis**, who compared the group to a **"dream"** where **unconscious childhood wishes are realized**. Later, in **1976**, **R. Kaës** introduced the concept of **"the group psychic apparatus"**, highlighting the shared psychological structure that emerges within a group (**Privat, Quellin, &Rouchy, 2001, pp. 2-4**).

Principles of Group Analytic Therapy:

1. **The Principle of Internal Resonance:**
    - The presence of a group, its conversational style, listening patterns, and reactions create **internal echoes** in each member. This fosters **reflection and self-awareness**, allowing individuals to recognize and manage **their problems, which were previously perceived as external threats**.
2. **Overcoming the Feeling of Isolation:**
    - The sense of loneliness and helplessness in the face of suffering diminishes **when individuals witness and relate**

to the suffering of others. This marks the **beginning of therapeutic change in the group setting**.

3. **The Feeling of Existence :**
    - Listening to others' problems **does not reduce one's own sense of existence**, but rather **reinforces it**. Through this process, individuals develop the ability to stand up for themselves in situations they previously perceived as threatening.

Techniques Used in Group Analytic Therapy:

1. **Verbal Techniques**
2. **Non-Verbal ArtisticTechniques :**
    - **Drawing, writing, and therapeutic theater** are used to facilitate expression and self-exploration.

Rules of Group Analytic Therapy:

- The group consists of **5 to 8 members**, either **homogeneous** (with similar symptoms) or **heterogeneous** (with varying psychological or psychosomatic disorders).
    - **Heterogeneous groups** allow for **diverse experiences and perspectives**, fostering greater **self-awareness and openness**.
- **Duration of therapy :**
    - Sessions occur **once a week** for **one to two hours** over **one year**.
    - Groups can be **fixed (closed)** or **slowly evolving (open)**, where membership **changes gradually** based on participant departures and new admissions.
- **Free Association :**
    - Any topic can be discussed, promoting **spontaneous expression** and **emotional release**.
- **Confidentiality :**

  - Group members must **respect therapeutic confidentiality**.
- **Restrictions on ExternalRelationships :**
  - Members should **avoid forming relationships outside the therapeutic setting** to maintain the integrity of group dynamics.
- **EqualParticipation :**
  - Attendance and active engagement (**assiduity and fairness**) are essential.

Who Can Benefit from Group Analytic Therapy?

- Individualssufferingfrom :
  - **Psychologicaldisorders** (e.g., **depression, bipolardisorder, psychosomaticdisorders**).
  - **Cognitive inhibition** and difficulties in handling life situations.
  - **Behavioral disorders** (e.g., **aggressiveness, impulsivity**).
  - **Emotional disorders, phobias, and addictions**.

Who is Excluded?

- Individuals with **severe psychiatric disorders**—except when **group therapy is supplemented by parallel psychiatric treatments**.
- Group therapy **can be conducted alongside individual therapy** (**Souffir& Aude Caria, 2019, pp. 1-7**).
- This section introduces modern approaches to **family psychoanalytic therapy**, particularly the **Functional Psychoanalytic Family Therapy (PAF)**. This method aims to **help family members improve their relationships and become more authentic individuals**.

- Core Principles of PAF:
- ✔**Focus on the "Here and Now"** – Emphasizing present experiences rather than only analyzing past events.
  ✔**Utilization of the Therapeutic Relationship** – The **emotions and conflicts** experienced towards the **therapist** often mirror the **challenges within family relationships**. Expressing these emotions **in a safe therapeutic environment** allows family members to **develop new interaction patterns and healthier behaviors**.
  ✔**Principle of Courage, Awareness, and Love** – Encouraging **self-awareness and emotional courage**. The therapist acts as a **model**, demonstrating **open-hearted and mindful communication**, which inspires clients to do the same.
- (Source:https://www.blakepsychology.com/fr/approches/psychotherapie-analytique-fonctionnelle (2020).

Chapter 04: Child- and Adolescents Analytic Therapy

A. Psychoanalytic Consultation for Children: Play Therapy

The **psychoanalysis of children** has been significantly shaped by **several influential case studies**, including:

- **"Little Hans" (Followed by Freud)** – One of the earliest cases exploring **childhood phobias**.
- **"Dominique" (Studied by Jacques Allain)** – Contributed to **child psychoanalytic theory**.
- **"Dick" (Studied by Melanie Klein)** – Focused on **early childhood object relations and unconscious fantasy life**.

Two major figures in child psychoanalysis:

- **Anna Freud** – Specialized in **child psychoanalysis but worked primarily with older children**.
- **Melanie Klein** – Pioneered **play therapy** and worked extensively with **young children**.

During the same period, **Donald Winnicott (1971)** emphasized **the central role of play** in child psychoanalysis. Later, **René Roussillon (1999)** expanded upon these ideas, introducing a **psychoanalytic model for children and adults** based on **three fundamental elements**:

1. **The Object**
2. **Play**
3. **Dreams**

(Source : Rodriguez R., 2004, p.1849)

B. Psychoanalysis for Adolescents

Psychoanalysts believe that **adolescents can undergo psychoanalytic treatment**, though their therapy presents **distinct characteristics** compared to adults:

1. **Adherence to the Therapeutic Framework** – One major challenge is the adolescent's ability to **commit to the therapy process**, including **attending sessions regularly and paying for them** (as it symbolizes personal responsibility).
2. **Parental Images and Transference** – Adolescents often **project parental images onto the therapist**, leading to **intense emotional reactions** (both **positive and resistant**). The **therapeutic relationship challenges their perception of authority and reality**, which may result in **strong countertransference reactions** from the therapist.

C. The Psychoanalytic Therapeutic Process for Adolescents

Despite the importance of **self-analysis during adolescence**, it is often a **painful process**. Some psychoanalysts argue that when adolescence does not follow a **natural developmental trajectory**, therapy can serve as a **substitute for this missed process** (Dollé-Roche, B., 2013, p.116).

Psychoanalytic Consultation for Adolescents

- Consultation plays a **key role in adolescent psychotherapy**. According to **Dollé-Roche, B.**, some adolescents **only require one or two consultations**, particularly if they are already aware of the **role of psychoanalysis** or if their **parents are psychoanalysts**.
- The **therapeutic relationship** serves as a **mediator** between the adolescent and their **external reality**.
- **Short-term therapy is sometimes sufficient**, not because psychoanalysis should be brief, but because it can provide **support during the crisis of adolescence** (Dollé-Roche, B., 2013, pp.118-119).

Chapter 05: Analytic Therapy for Older Adults

The **longitudinal study of psychoanalytic therapy for the elderly** is challenging due to **difficulties in objectively measuring therapeutic outcomes**. However, this field remains essential, as it **respects the unique psychological needs of aging individuals**.

Aging is often associated with **various losses**, affecting both **physical and psychological unity**. While **elderly individuals rarely undergo full psychoanalysis**, psychoanalytically inspired approaches help assess:

✔**Psychological adaptation mechanisms** in later life.
✔**Identity construction**, which is often fragile due to **rigid defense mechanisms** developed over time.

Key Focus Areas in Psychoanalytic Therapy for the Elderly

1-**EmotionalBurdens of Aging**

- Therapy provides **support to ease the emotional weight** of adapting to **physical, cognitive, and social changes**.

2-**Fear of Bodily Decline and Fragmentation Anxiety**

- The aging process raises **concerns about physical deterioration**, loss of **bodily autonomy**, and feelings of **helplessness**.

3-**Fear of Abandonment and Death Anxiety**

- The **loss of peers and loved ones** intensifies **feelings of loneliness and existential dread**.
- Psychoanalytic therapy **symbolically reintroduces continuity**, allowing the elderly to **experience a sense of presence and emotional containment**.

4-**The Therapist's Role: A Stable, Supportive Presence**

- The therapist **acts as a reassuring figure**, helping to **absorb and contain existential anxiety**.
- This **symbolic continuity** prevents patients from **becoming trapped in symptoms**, offering them **a sense of extension and psychological survival** (Judith, E., 2015, pp. 747-754).

6.2 Psychoanalytic Relaxation Therapy

Relaxation therapy includes **various techniques** aimed at **achieving physical and psychological relaxation** through **muscular activity**, facilitating a state of **insight**. While **verbal therapy** dominated psychoanalysis for decades, **interest in the body as a therapeutic gateway** only emerged in the 1960s, following the work of Freud, Rank, Reich, and Groddek.

Relaxation techniques focus on the **sensory world of the body**, using **concentration, suggestion, fatigue, and relaxation**. Early influences include:

✔**Esalen Institute (USA)** – Pioneered **mind-body approaches** to treating psychological distress through bodily sensations.
✔**Johannes Heinrich Schultz (early 20th century)** – Developed **autogenic training**, a relaxation method based on **weight sensation, warmth perception, rhythmic breathing, and body awareness**.
✔**Other Contributors** – Alexander, Jacobson, Jarreau, Klotz, Vittoz, and Ajurriaguerra, who explored **muscular relaxation and self-awareness**.

Psychoanalytic Relaxation Therapy: Michel Sapir's Contribution

French psychoanalyst **Michel Sapir** introduced **psychoanalytic relaxation therapy** at Rothschild Hospital in Paris. This method, inspired by Schultz and further developed by **Félix Labhardt** in Switzerland (1954), integrates **verbal and tactile expression** to facilitate unconscious material.

- **Key Principles** :

- The patient is encouraged to **verbalize bodily sensations** and link them to **personal history**.
- The therapeutic relationship **bridges bodily expression and verbalization**.
- **Body and mind are treated as an integrated unit**, addressing **psychosomatic illnesses** and **pre-surgical anxiety management**.

✅ **Effectiveness**: The therapy's success depends on the patient's ability to **articulate their actual anxiety** and use the body in a therapeutic **relational** framework (Cohen Monique, 2015).

Chapter 06: Analytic Therapy Using Projective Technique

Projective techniques **go beyond diagnostic purposes** and serve as **essential tools for clinical communication**, particularly in child psychotherapy. According to **Palacio & Manzano (1989)**, projective mediationplays a crucial role in:
✔ Strengthening **child-therapist relationships**.
✔ Assessing the child's **capacity for solitude** in the presence of the therapist.

Projective methods create a **transitional space** in child therapy, particularly for **neurotic children**, allowing for **symbolization and expression of unconscious material**.

Projective Techniques in Therapy for Psychotic and Autistic Children

- **Labat Suarez Hélène (2015)** emphasizes that **classical psychoanalytic approaches** (e.g., free association, neutrality, waiting for the patient's request) are **ineffective for autistic children**.
- Children with **autism spectrum disorder (ASD)** require **active participation from the therapist** and a more **engaged approach**.

Monique Bucourt's Contributions

Psychoanalyst **Monique Bucourt** introduced **objective projective techniques** within a **play-based therapeutic framework**, allowing children to:
✔**Experience pleasure in play**.
✔**Freely engage in symbolic representation**.
✔**Develop relational skills in a structured therapeutic setting**.

For children with **severe relational difficulties**, Bucourt highlights the importance of **concrete, tangible play situations** to support **the development of therapeutic interactions** (Boualagua F.Z, pp. 145-146).

3. Relationship Between Psychoanalytic Psychotherapy and Other Therapeutic Approaches

This section examines the **position of psychoanalysis** in comparison with other **therapeutic orientations**, based on a **longitudinal study** conducted **seven times since 1960**. The study, carried out by researchers from **Division 12 (Clinical Psychology) of the American Psychological Association**, aimed to assess the **prevalence of different therapeutic approaches** among its members. The survey collected **responses from 549 clinicians** and included a comparative analysis of previous surveys (Karpiak & Norcross, 2012).

Trends in Clinical Psychology from 1960 to 2010

TheoreticalApproach	1960	1979	1981	1986	1995	2003	2010
Eclectic/Integrative	36%	55%	29%	29%	27%	29%	22%
Cognitive	-	2%	6%	13%	24%	28%	31%
Psychoanalytic	35%	16%	30%	21%	18%	15%	18%
Behavioral	8%	10%	14%	16%	13%	10%	15%
Humanistic/Existential/Gestalt	6%	7%	7%	12%	4%	2%	-

Interpretation & Psychoanalysis' Position Today

Despite **a decline in psychoanalytic therapy**, its principles **continue to influence modern psychodynamic approaches**, including **attachment-based therapy, mentalization-based treatment (MBT), and transference-focused therapy (TFT)**. The **rise of cognitive-behavioral therapy (CBT)** reflects **a shift toward evidence-based, structured interventions**.

Conclusion:

Sigmund Freud, the founder of psychoanalysis, described himself as more of a discoverer than a physician or scientist. He asserted that his long journey in establishing the key concepts of psychoanalysis

required extensive discussion. Despite their clinical appearances, these concepts do not rely on physiological or anatomical explanations when interpreting unconscious data that manifest as symptoms and neurotic disorders. Instead, Freud primarily based his interpretations on free association, resistance analysis, verbal and behavioral errors, dream analysis, and the dynamics of transference.

In our pursuit of objectivity in positioning psychoanalysis within the framework of psychotherapy, Freud rigorously and seriously contributed to establishing a structured approach that aligns with the therapeutic relationship, which is fraught with risks due to unconscious distortions and pathological transference projections.

During Freud's lifetime and after his passing, psychoanalytic thought sparked significant debate and criticism. Those who believed in Freudian theory or in the discoveries of psychoanalysis—despite their differences with Freud—leveraged these critiques as opportunities for further analytical exploration. Day by day, psychoanalytic theory continues to evolve, refining the conceptual framework that governs therapeutic practice. The therapies inspired by psychoanalysis have emerged as a more flexible adaptation of its classical origins, incorporating a variety of techniques to support individuals who require assistance in better adapting to themselves and their surroundings.

Chapter 07: Psychodrama: Morenian Psychodrama & Analytic Psychodrama

Psychodrama as a Diagnostic and Therapeutic Tool

Freud (1985) described **individual psychodrama** as a **form of "construction in analysis"**, used to **diagnose and work through unconscious conflicts**. Unlike **classical psychoanalysis**, psychodrama is not limited to **verbal interpretation**—it involves **real-life enactment of internal conflicts**.

The goal of **psychoanalytic psychodrama** is to **stimulate emotional and cognitive shifts** by allowing the individual to experience **unexpected reactions, projection errors, or spontaneous role shifts**. This helps uncover **hidden emotions and repressed conflicts**.

Key Characteristics of Psychoanalytic Psychodrama:

✔**Short Scenes with Interventions by the Director** – The **therapist (director)** facilitates the session by **guiding short scenes** and allowing space for **brief reflections** between each enactment. These pauses help the client **reinterpret their experiences**.
✔**Dynamic Emotional Processing** – The client oscillates between **accepting reality** ("Yes, that's exactly what happened!") and **denying its significance** ("I played that role, but it doesn't represent what I truly believe").
✔**Transition to Other Therapies** – After the **first psychodrama session**, the client may transition to **individual therapy or regular psychodrama sessions** (Dollé-Roche, B., 2013, pp.102-103).

The Role of Psychoanalytic Psychodrama in Therapy

Unlike other psychotherapeutic approaches, psychodrama **is not limited to specific psychological structures** (such as **neurotic, psychotic, or borderline personalities**). Instead, it **creates a symbolic space** where unconscious **defenses** (such as **repression, dissociation, or projection**) can be externalized and **worked through**.

By **expanding the therapeutic setting** through **role-playing and perspective shifts**, psychodrama allows for **deep emotional processing**. Didier Anzieu (p.153) explains that **resistance in therapy** often stems from **traumatic experiences** (either **external traumas** or **internal conflicts such as repressed desires**).

Psychoanalytic Psychodrama Is Particularly Effective For:

- **Hysterical neurosis**
- **Obsessive-compulsive neurosis**
- **Phobic neurosis**
- **Personality disorders and deviant behaviors**
- **Non-structural issues** such as adoption trauma, coercion, and sexual abuse

4.2 Psychoanalytic Psychodrama (Continued)

Psychoanalytic psychodrama **creates a theatrical space** where unconscious conflicts are **staged, enacted, and analyzed**. According to **Dollé-Roche (2013, pp. 104-106)**, the process functions as if the **preconscious** were a **stage for psychic life**. However, disruptions can occur:

✔**Intense repression may flood the stage**, overwhelming the patient with emotions.

✔**A lack of representation may emerge**, as seen in personality disorders where finding words for experiences is difficult.

✔**The script may be completely erased**, as occurs in psychosis, where repression gives way to total **dissociation or fragmentation**.

Key Elements of Psychoanalytic Psychodrama

1:**The Therapeutic Space**

- The therapist maintains **emotional distance and neutrality**.

- When the client arrives, they **choose the role they wish to play** and describe a **scene**.
- The therapist helps to **structure the scene** in time and space and assigns **roles to auxiliary egos** (3-4 supporting actors).
- Scenes are acted out while the therapist **observes, pauses the session to interpret unconscious dynamics, and clarifies key moments**.
- Typically, **3 to 4 scenes are played out in 30 minutes**, each one revealing deeper emotional layers.

2 :**Interpretation**

- Interpretation is **the core of psychoanalytic psychodrama**.
- The therapist **analyzes the client's choice of scenes** and **extracts meaning from repeated themes or symbolic representations**.

3 :**The Client'sRole**

- The client **interacts with supporting characters**, observing how they **interpret and enact the scene**.
- This externalization allows the client to **view their unconscious conflicts from a new perspective**.

4 :**The Role of Auxiliary Egos**

- Auxiliary egos (supporting actors) **help dramatize the unconscious content**.
- **Physical contact is strictly prohibited**, as it would break the analytic frame (Maillefert-Becerril, C., 2013, pp. 147-156).

Chapter 08: Art-Based Therapy: Music, Visual Arts, and Writing

. Art-Based therapy :

Art therapy is based on the idea that the creative process of art making is healing and life enhancing and is a form of nonverbal communication of thoughts and feelings. Art therapy based upon the theory that early trauma developmental conflict may not be accessible through typical verbal language but rather is stored in the unconscious in pre-verbal forms of sensory. kinesthetic or imaginal cognitions and associated emotional experiences represented in symbolic language. The process of accessing these pre- verbal ways of knowing and experiencing requires. the development of an intentional therapeutic relationship or holding environment in which the therapist attunes to, joins with and mirrors the pre-verbal consciousness of the client. Using emotional presence and attunement the art therapist selects relevant art processes to mirror the clients emotional and relational state and consequently nurture the emergence of metaphoric and symbolic language that re-constructs the personal narrative of the client. Outcome studies showed that long-term individual art therapy was effective in promoting cognitive and emotional development, enabling relationships and lessening destructive behaviors in adults and children.

Art therapy serves as a confirmation of human mental health by utilizing the creative process in its simplest form within art to develop and enhance the physical, cognitive, and emotional aspects of individuals of all ages. Studies have highlighted the significance of art therapy sessions in treating psychological disorders, such as severe depression, as well as in supporting children with special needs, individuals with schizophrenia, adolescents engaging in high-risk behaviors, pregnant women, individuals experiencing both pathological and non-pathological grief, and the elderly.

Eight key therapeutic factors have been evaluated: self-exploration, self-expression, the ability to connect with others, interpreting others' expressions, integration, symbolic thinking, creativity, and sensory stimulation. After ten therapy sessions, each lasting approximately one hour, therapists observed significant improvements in patients' conditions. Additionally, there was a major transformative impact on their daily lives, to the extent that some were able to reintegrate into the workforce.

HISTORY OF ART THERAPY

The roots of art therapy reach into prehistory, "to a time when people fist began to make images and objects intended to influence, make sense of, or express their experiences. Throughout time and across the globe, countless examples can be found of the use of visual arts in healing rituals". Archaeology is littered with examples of artistic objects used in rituals for healing, religious practices, the desire to be immortalised and many other such examples, from ancient Egypt, Greek and Roman Mythology to the Golden Calf mentioned in the Christian Bible. Indian mythologies and religion also reflect art and artistic objects in various ways, from traditions like making a Rangoli to creating handprints to folk arts like Madhubani. It is not difficult to grasp that the significance of art has never been merely aesthetic pleasure.

Even though art has for aeons been used in rituals, religions and many other practises, hints of its first uses in the area of psychiatry emerged in the first half of the nineteenth century. One of the most influential figures during this period was the German psychiatrist Johan Reil, who

outlined an elaborate programme for the treatment of mental illness, which included the use of art therapy.

Also, during the late nineteenth and early twentieth centuries, some psychiatrists became fascinated by the spontaneous art of the mentally ill. Around the turn of the century a few psychiatrists began collecting the spontaneous artwork of their patients, although"...most regarded them as mere curiosities". There were notable exceptions though, and from 1876 to 1888 Paul-Max Simon, a French psychiatrist, published the first serious studies of drawings of the mentally ill, with several other psychiatrists following suit.

"However, as psychiatry moved closer to medicine, the view that mental illness. was a result of brain abnormality gradually coming to assert itself. Henceforth, the structure and workings of the brain became the focus of psychiatric investigation and treatment. Among the many consequences of this were the increasing emphasis placed on physical, rather than psychological forms of treatment and the isolation of the mentally ill in vast asylums". During this period the therapeutic use of art therapy was largely reduced in importance to a supplementary role, often in the form of diversional, recreational or educational activities.

Nevertheless, it was against this backdrop and within these psychiatric institutions that art therapy began to emerge as a distinct paradigm from the 1940's.

Modern art therapy traces its origins to the founding father of psychoanalysis, Sigmund Freud, who himself analyzed pathological characteristics through art by interpreting the works of both past and contemporary artists. This focus led to an emphasis on the expressive and cathartic value of art, which has the potential to liberate the

unconscious from its repressed psychological conflicts. (Fayoumi, 2014, p. 340).

Freud (S.) concludes in his book My Life and Psychoanalysis that "for Freud, art is not mere imitation but rather the product of the ego's success in reconstructing itself and shaping its identity." (Boualagua, 2017, p. 53).

Freud and Carl Jung's early contributions ignited the field of art therapy. Unlike Freud, Jung was deeply fascinated by art, giving it a distinct place in his work. A skilled artist himself, Jung created numerous paintings that played a crucial role in his personal psychological equilibrium. Beyond personal expression, Jung actively encouraged his patients to engage in artistic creation for clinical benefit. His theories on psychotherapy and personality psychology became foundational to various domains related to art therapy, and subsequent art therapists widely adopted his concepts. (Fayoumi, 2014, p. 341).

According to Freud, both artists and scientists possess a unique capacity for regression, enabling them to capture messages from the unconscious. He regarded them as exceptional psychoanalysts. In his Attempt at an Interpretation of La Gradiva by W. Jensen, Freud was struck by the remarkable similarity between the novelist and the psychoanalyst's work, noting that the author provided a detailed account of neurosis, its symptoms, and even the steps toward recovery. Consequently, Freud (S.) suggested that the title Gradiva: A Point of Desire should be replaced with Gradiva: A Psychiatric Study.

Freud believed that an artist's profound understanding of psychological processes stems from their ability to listen to unconscious impulses and transform them into aesthetic creations rather

than repress them, a process made possible through sublimation. (Boualagua, 2017, p. 55).

Freud further explored this therapeutic approach in his dream theory, where he argued that dreams express repressed desires. In his psychoanalytic studies, he discussed drawing as a form of expression. The first practitioners of this therapeutic technique were his daughter, Anna Freud, and Melanie Klein. This method aims to enhance concentration, listening skills, self-control, and self-confidence. It serves as an expressive tool that unveils an individual's inner world, allowing therapists to identify psychological disturbances and facilitate personal transformation. (Ghoneim, M., p. 109).

Like any psychotherapy, art therapy aims to assist the patient to resolve internal conflicts and gain greater self-awareness through the development and exploration of the relationship between the individual and therapist, and the issues which arise in therapy. The inclusion of art making in therapy is the vital difference between psychotherapy and art therapy. Whilst this may appear obvious, it is easy to become lost in the similarities of the two therapies and confuse about the differences. Although some art therapists still choose to use varying degrees of verbal interaction with their patients, the role of the image and the process of art making are the key factors in art therapy.

To an onlooker there may appear little difference between art therapy and an art activity conducted by another health professional, teacher or artist. The distinguishing components are the purpose for which the art is being created and the thinking and understanding on the part of the therapist. To be considered art therapy, the primary goal of the art making must be therapeutic. If the goal of art making is for recreation or learning, then it is not art therapy. This is not to undervalue the

magnificent work of many artists and teachers working with children, as there is no doubt that this work are incredibly valuable. It is meant simply to help define the differing roles of each profession. Art therapists must have an understanding of both art and therapy. Of art they must know; the materials, the creative processes, the language and nature of art and symbols. Of therapy they must know psychodynamics, development, the nature and mechanisms of treatment and the therapeutic relationship.

What is art therapy?

Art therapy has a dual heritage from art and psychoanalysis which results in different definitions and ways of working. Some therapists put an emphasis on the healing properties of the art making process itself whereas others focus more on the context of making art as a form of communication within the developing relationship with the therapist. There are a number of definitions for the reader to think about. These can depend on the aetiology of the therapeutic setting, adaptation to work with a particular client group and also on the personality and theoretical orientation of the therapist. Art therapy in the United Kingdom has its own developmental history which is unique and differs from the development of the profession in other countries such as the U.S.A.

The current definition from the British Association of Art Therapists (BAAT) is as follows:

Art Therapy is a form of psychotherapy that uses art media as its primary mode of communication.

Clients who are referred to an art therapist need not have previous experience or skill in art, the art therapist is not primarily concerned with making an aesthetic or diagnostic assessment of the client's image.

The overall aim of its practitioners is to enable a client to effect change and growth on a personal level through the use of art materials in a safe and facilitating environment.

The relationship between the therapist and the client is of central importance, but art therapy differs from other psychological therapies in that it is a three-way process between the client, the therapist and the image or artefact. Thus, it offers the opportunity for expression and communication and can be particularly helpful to people who find it hard to express their thoughts and feelings verbally

Art therapy is psychoanalytically oriented, recognising the fundamental importance of the unconscious as expressed in the patients dreams, day dreams and fantasies Spontaneous graphic art becomes a form of symbolic speech which may serve as a substitute for words or as a stimulus which leads to an increase of verbalisation in the course of therapy.

The release of spontaneous pictures is not by itself enough to complete the process of art therapy. The patient's capacity to understand the meaning of his symbolic expression takes place in this process within the transference relationship.

Art therapists work with a wide range of clients across the age range from mothers and their babies to people in old age. Art therapists tend to specialise and adapt their practice accordingly. For example, the art therapist working with children has an understanding of child development and with emphasis on the importance of the internal world

of the child, attachment issues and early infantile experi- ence. Engaging in the process of art provides the possibility of a more spontaneous, non-verbal means of communication through which children can express many of the wide range of emotional and behavioural difficulties with which they are struggling. Also well documented in the literature is the work with children under five, children with ADHD, Looked After Children in the care system and those with attachment disorders and those struggling with family breakdown, bereavement and loss.

Using art, sand and water play can be particularly helpful in the assessment and treatment of children for whom words are very frightening - for example, disclosure work of past or present sexual abuse.

Children who have ritualistic or phobic responses to situations, or obsessive-compulsive disorders, can be helped to use art to explore their feelings in a safe, non-threatening environment. Trauma and sudden loss for a child can be particularly problematic when trying to make sense of con- fusion and chaos around them. This has been particularly noticeable during the COVID pandemic.

APPLICATION OF ART THERAPY

"Art therapy offers the opportunity to work with many different client groups"

This is one of its main advantages as a treatment process, as it can be made available to a wide variety of people with a multitude of different problems, needs and expectations. All people are at least able to make a mark and therefore can use art therapy in some way. The range of settings in which art therapists now work is extensive and constantly

developing. These include hospitals, schools, community-based centres, therapeutic communities and prisons. Art therapy is also often included as part of the services provided to particular client groups such as children, adolescents, families, older adults and individuals with learning difficulties. Within these broad areas art therapists may work with individuals on a one-to-one basis or with groups. Art therapists are also to be found practicing in a number of specialist fields including work with offenders, clients who have autism, eating disorders, addictions or who have experienced physical or sexual abuse, psychosis and physical illnesses.

Art in therapy has been used within many areas of therapy and in numerous settings, including:

- HIV/AIDS
- Trauma
- Sexual Abuse
- Separation and Loss
- Divorce
- Marital or Couple problems
- Bereavement
- Psychopathology
- NeurologicalDisorders
- Depression
- EatingDisorders
- Self Mutilation
- The Mentally Handicapped, Autism and other related problems
- Disabled
- Alzheimer'sDisease

- Physical Illness
- Prison Inmates
- Addiction
- Abuse

While not an overly extensive listing, it is clear that art therapy can and has been used in the treatment of a broad myriad of problems, as well as within a variety of settings and circumstances.

INDICATIONS AND CONTRAINDICATIONS

It might be assumed that those who are good at art or who have attended a fine art program would be the most suitable candidates for art therapy. However, this is not always the case as such a person might be too skilled at concealing to benefit from the process. It is partly the unexpected nature of what is produced that makes art therapy so effective and lack of skill or previous ability contribute to this. When there is a need for the unconscious material to press to the fore through visual expression previously unskilled people may find themselves surprisingly visually articulate. It is as if, when the unconscious needs to express itself, the ability is there.

It has sometimes been thought that art therapy should be restricted and not applied with patients in psychotic states. However, this has been widely challenged by research in art therapy where it has become clear that this client group, if appropriately understood and monitored, benefits from the experience of nonverbal expression in a contained setting more than the traditional psychotherapy.

ADVANTAGES OF ART THERAPY

The following are some of the advantages of art therapy that may be relevant in different circumstances:

Almost everyone has used art as a child and can still do so if encouraged to forget about images having to be 'artistically correct".

It can be used as a means of non-verbal communication. This can be important for those who do not have a good mastery of verbal communication for whatever reason. For those who cannot stop talking, it can sometimes be a good way of cutting through 'tangled verbosity'.

It can be used as a means of self-expression and self-exploration. A picture is often a more precise description of feelings than words and can be used to depict experiences which are 'hard to put into words'. Sometimes 'words are hard to find', as in dementia. The spatial character of pictures can describe many aspects of experience simultaneously.

Art Therapyprocesses:

The process of doing art can sometimes help people become more aware of feelings previously hidden from them, or of which they were only partly aware. It can help people become clearer about confused feelings.

Using art can sometimes help people release feelings, e.g. anger and aggression, and can provide a safe and acceptable way of dealing with unacceptable feelings.

It can help such people to look at their current situations and at ways of making changes. The 'framed experience' (an experience within a boundary, like a picture in a frame) can provide a context to try out or fantasise about possible futures without the commitment of reality.

It can be used to help adults play and 'let go'. Recapturing the ability to play can lead to creativity and health.

The concreteness of the products makes it easier to develop discussion from them. The pictures are there to return to at a later date and it is possible to look back over pictures from a series of sessions and note developments.

The existence of a picture as a separate entity means that therapist and client can relate to each other through looking at the picture together. This is sometimes a less threatening way of confronting issues or relating. This is also referred to as the 'triangular relationship of art therapy'.

Discussion of the products can lead to explorations of important issues.

'Interpretation' of a reductive kind is not widely used as pictures are often ambiguous and the most important thing is for the creator to find his or her own meanings.

Using art requires active participation, which can help to mobilise people who have become accustomed to doing very little. In a group setting, it is one way of equalising participation. Everyone can join in at the same time and at their own level.

It can be enjoyable and this may lead to shared pleasure and to individuals developing a sense of their own creativity. Many people who start art therapy in a very tentative way go on to develop a real interest in art.

Stages of Art Therapy

1. The First Stage: Building Trust

This stage focuses on introductory aspects, such as getting to know the client and helping them comprehend the therapeutic process while earning their trust. This is achieved through:

• Consistency in scheduling sessions and maintaining clarity regarding the duration and timeframe of therapy.

• Demonstrating care and reassurance, with the therapist conveying messages like, "I am here to help ease your burden."

• Emotional empathy, wherein the therapist shares in the client's feelings.

• Providing moral support to create a safe and accepting space.

At this point, the analytical phase of therapy begins.

2. The Second Stage: Analysis

In this phase, the therapist encourages the client to confront and acknowledge their negative aspects as part of their personality. The goal is to bring repressed unconscious factors into conscious awareness. It is crucial for the therapist to appreciate and understand the client's state without fully aligning with them emotionally.

3. The Third Stage: Separation

This phase consists of six sessions in which the client may experience emotional regression. The therapist's role is to help the client recognize their progress and reassure them that they are in a much better place. The separation process can evoke fears similar to those experienced in real-life losses or family detachment. Therefore, during these six sessions, the therapist facilitates a transition by encouraging the client

to articulate past and present fears, helping them face the new phase with confidence.

Procedures of Art Therapy:

The art therapy process can be summarized as follows:

• Preparation of Therapy Requirements:

This includes gathering necessary materials, collecting information about the client's personality and issues, and determining the appropriate setting. Therapy sessions should last at least two hours per week, balancing between artistic expression and discussion.

• Defining the Procedural Goals of Therapy:

The primary objectives include reducing aggressive behavior and alleviating fears in the client.

• Establishing the Therapeutic Relationship:

Creating a safe and supportive therapeutic environment that fosters trust and rapport.

• Encouraging Artistic Expression:

Helping the client use art as a means of self

Art Therapy: Two Complementary Aspects

1. Visual Art

This aspect refers to non-verbal artistic expression through mediums such as drawing, ceramics, and pottery.

2. Psychotherapy

This involves interpreting and understanding the experiences of the client, finding solutions to their problems, and bringing about positive changes in their personality and life in general.

Art therapy is typically carried out in therapeutic workshops, which may include:

- Drawing workshops
- Sculpture
- Photography
- Music
- Acting
- Reading
- And others

The Art Therapist

The relationship between the client and the art therapist, as well as between the members of the art therapy group, is of significant importance (Diehl, 2008, p. 5). The therapist and the art form serve as a bridge for communication between the therapist and the client (Rivera, 2008, p. 4).

Diehl (2008) argues that art therapy aims to help clients interpret and understand the meaning and significance of their artistic work ("drawings"). The therapist must provide an appropriate environment to encourage clients to express themselves and discover their creations, offering empathy, encouragement, and support. Insight into emotions

and defense mechanisms enables the client to progress in therapy. The art therapist looks for hidden messages in the clients' work and may provide interpretations during the sessions, grounded in an understanding of symbols, context, and verbal feedback. Interpretation gives meaning to the drawings, and the therapist works to help the client understand this meaning, which can be on an emotional, cognitive, or both levels (Diehl, 2008, pp. 3-10).

Art Therapy Program According to the Cognitive Model

1. First Session (Introductory): Establishing the therapeutic relationship and building trust.

2. Second Session: Introducing the tools and activities, and understanding their role in addressing problems.

3. Third Session: Beginning the practice of the chosen activity by the client.

4. Fourth Session: Focusing on positive emotions.

5. Fifth Session: Building self-confidence by participating with a group and engaging in art activities together.

6. Sixth Session: Highlighting the relationship with family members by involving them in the artistic process.

In the final sessions, the therapist focuses on three main points:

- Separation
- Reviewing the discussions from the initial therapy sessions
- Presenting and comparing the client's artistic work and discussing it (Jalal Kayed Dhumra, 2014, pp. 106-107).

Art Therapy Program According to the Analytical Model

Drawing is a more genuine form of expression than language; it is a process of catharsis where individuals express themselves unconsciously. Success in this therapeutic method lies in helping individuals gain self-awareness, including both conscious and unconscious aspects of their personality.

The analysis of the artistic work occurs in several stages:

1. Formative Analysis: Describing the work and its components, including shape and material.

2. Explanatory Analysis: Discussing the drawing through the therapist's questioning, turning it into a narrative.

3. Symbolic Analysis: Analyzing the symbols and shapes present in the drawing as components of the work.

Material plays a role in the therapeutic process; the choice of medium, such as clay, pencils, watercolor, etc., provides insights into an individual's characteristics, in addition to the colors used, which can have psychological and emotional significance (Aliem, 2001, pp. 110-111).

A Typical Art Therapy Session

A typical art therapy session lasts about an hour, with a group of 10-12 participants. The therapist briefly explains the task participants will undertake during the session. Then, the participants engage in drawing for about 25 minutes, followed by time for each individual to discuss

their feelings and emotions related to the drawing. The therapist treats the clients as equals in the therapeutic process.

In some sessions, the topic to be drawn is free, while at other times, participants may suggest a topic.

In the early sessions, the therapist may suggest a specific theme. There is a strong connection between the client's inner world and the artwork they create, and the therapist should discuss this connection. Some participants may express initial doubts, such as "I don't know how to draw" or "How will drawing help me?" It is the therapist's role to reassure them that drawing skills are not important, and they will do their best within their capabilities.

Materials used in art therapy sessions include paper, colored pencils, watercolor paints, clay, and glue (Rivera, 2008, p. 6).

At the end of the sessions, the therapist and the client will have a unique record of the stages of therapy represented in the client's artistic works (Sari, 1990, p. 262).

Conclusion:

Art therapy involves guiding individuals through psychological, physical, social, and existential struggles using artistic creations—such as visual artwork, music, theater, writing, expressive body art, and dance. Artistic expression allows for the projection of the inner world onto the art, creating a symbolic space where the individual addresses their own existence, contradictions, and relationships with others. This process fosters connections between the self and others, creating a form of expressive interaction that bridges personal and interpersonal realms.

Art-Based therapy : Music Therapy and Its Impact on Psychological Treatment

Music was used throughout the 20th century as a therapeutic medium that helped psychologists treat many patients and overcome various illnesses, especially during and after World War II. However, Arabs had already been using music since the Islamic Golden Age, as Arab scholars employed it to help alleviate certain diseases, particularly psychological disorders. All indicators point to the powerful influence of music in psychotherapy.

This lecture aims to shed light on the impact of music therapy by addressing its definition, its effects on physiological, emotional, cognitive, educational, and social aspects, as well as the steps involved in music therapy. It also covers the specific therapeutic effects of music, different forms of music therapy, and its applications. Lastly, it discusses the qualifications required for a music therapist.

Music Therapy

Music therapy is a therapeutic approach that uses music to solve problems, overcome disorders, treat psychological illnesses, and achieve psychological well-being and adjustment.

One of the main objectives of music therapy is to improve social and emotional behavior and contribute to overall personality development through carefully designed musical experiences. A professional music therapist, who combines expertise in psychology and music, administers this therapy.

Music therapy is based on the understanding that music is both a science and an art. It affects psychological and physical states and

serves as a universal language with vast expressive capabilities. Through its core elements—melody, harmony, and rhythm—music influences behavior in general and has physiological, emotional, cognitive, social, and educational effects.

Meyer (2001) introduced the concept of "embodied meaning", which refers to the process where one aspect of a musical experience acts as a cue that triggers expectations related to subsequent elements of the experience. According to Meyer, the true meaning of music lies in these deferred expectations. When music fulfills our expectations, it results in aesthetic pleasure, but when it does not, it may lead to feelings of discomfort or boredom.

The Cognitive Impact of Music

Music has a cognitive effect, as it stimulates the listener's imagination, especially when accompanied by lyrics that explain its meaning. The listener's musical background plays a crucial role in their response, as music involves a cognitive component. The more knowledge and experience an individual has in music, the greater their ability to respond to it.

Additionally, music enhances various cognitive functions, including:

- Sensory perception.
- Observation skills.
- Music reading and writing abilities.
- Logical organization skills.
- Auditory memory.
- Temporal awareness.

- Tactile and visual perception.
- Motor imagery.
- Creativity.
- Academic learning and information retention.

Steps in Music Therapy

For music therapy to be effective, it must incorporate a degree of creativity. The following framework serves as a reference rather than a rigid set of procedures for the therapy process:

1. Preparation Phase:

Before initiating therapy, a thorough assessment of the patient is conducted, including age, cultural background, hobbies, health, and physiological status.

2. Therapeutic Environment:

The therapy process begins by creating a suitable therapeutic atmosphere, which includes preparing an appropriate space. Music enhances the therapeutic setting by fostering social interaction between the therapist and the patient, as well as among patients in group therapy. Music also provides entertainment and stimulation, which facilitate the achievement of therapeutic goals.

3. Therapeutic Relationship:

A successful therapeutic relationship develops within an appropriate environment through therapy sessions. It must be built on mutual understanding, acceptance, and cooperation between the patient and the therapist.

When a musical connection, or musical rapport, is established between the therapist and the patient, it encourages engagement, reduces fear, and fosters trust in the therapeutic process. If the patient has a personal interest in music, this can be utilized to strengthen the therapeutic bond.

A well-trained music therapist who excels in improvisation can effectively communicate through music. They observe the patient's facial expressions, gestures, movements, and behaviors, adapting their musical performance accordingly using elements such as tempo, melody, harmony, and rhythm.

Musical Experience in Therapy:

A music therapy program must be tailored to each patient to achieve therapeutic goals. The core of the program is the musical experience, which should match the patient's personality and influence their behavior through auditory, visual, and tactile interactions with the music.

The therapist guides the patient through various forms of musical responses, including:

- Free rhythmic movement
- Unstable rhythmic patterns due to psychological or neurological conditions
- Limited rhythmic freedom.
- Forced or rigid rhythm.
- Disorganized or erratic rhythm.
- Emotional rhythmic responses.

- Confused rhythmic patterns.
- Instrumental performance.
- Accompanied singing.
- Humming along with music.
- Following melodic variations.

The Unique Therapeutic Effects of Music

Music plays a crucial role in treating psychological disorders. The therapy experience is carefully designed to achieve desired therapeutic outcomes.

Music brings joy and helps patients momentarily detach from their symptoms. It releases emotions, reduces fears, and enhances self-expression. Additionally, music cultivates an appreciation for beauty, especially when patients actively participate in musical activities such as rhythm exercises, singing, or playing an instrument.

Furthermore, music therapy helps socially withdrawn individuals re-engage with their surroundings, fostering interaction with the external world.

Forms of Music Therapy

There are two main forms of music therapy:

1. Individual Music Therapy:

This approach focuses on musical interaction between the therapist and the patient, utilizing the patient's musical interests and sensitivities. It aims to modify certain responses and maladaptive behaviors within the patient's personal context.

2. Group Music Therapy:

This involves collective musical activities such as group singing, ensemble playing, or choral performances. It encourages patients with similar psychological issues to engage together, boosting their enthusiasm and intellectual and emotional engagement. This form of therapy also promotes social interaction and emotional expression.

Additionally, music can be incorporated into psychodrama therapy, where patients act out roles within a structured musical and dramatic framework, fostering self-expression, cooperation, and responsibility.

Applications of Music Therapy

Music therapy is beneficial for individuals of all ages and conditions. It is used for various cases, including:

• Emotional and behavioral issues, such as emotional disturbances, sleep disorders, intellectual disabilities, and learning difficulties

• Neurotic disorders, including anxiety, phobias, depression, hysteria, hypochondria, and institutional neurosis

• Psychotic disorders, such as schizophrenia and mania

• Psychosomatic illnesses, including cardiovascular, respiratory, and endocrine system disorders

Mechanisms of Music Therapy

Music acts as an emotional outlet, allowing individuals to release built-up feelings and reduce psychological tension. Weber highlights the ability of music to lower stress levels, alter mood, and provide relief from daily monotony. Music also influences decision-making and behavior by affecting the brain's response to auditory stimuli.

Therefore, selecting the appropriate music for a patient's psychological condition is essential.

British psychiatrist Philip Heagos emphasizes that music serves as a non-verbal communication tool.

While verbal therapy is effective in some cases, music therapy provides an alternative when verbal communication is limited. Music stimulates the senses and interacts with personal experiences, facilitating unconscious emotional release, which aids the therapeutic process.

Qualifications of a Music Therapist

A music therapist must possess:

- Proficiency in playing at least one musical instrument
- Knowledge of different music genres
- The ability to use music flexibly and creatively in therapy
- Expertise in psychology and therapy
- A compassionate personality to provide proper care for patients

Art Therapy Through Writing and Its Psychological Benefits

Writing has always been a means of expressing emotions and thoughts, but in modern times, it has evolved into a recognized form of psychotherapy. Writing therapy is used to help individuals understand their emotions, process trauma, and develop deeper self-awareness.

This article explores the significance of writing therapy, its definition, psychological and cognitive impact, stages, types, mechanisms,

applications, and the essential skills required for therapists specializing in this field.

1. What is Writing Therapy?

Writing therapy is the practice of using writing as a tool to explore emotions, process trauma, and organize thoughts in a way that improves mental health. This approach does not rely on literary skills or writing expertise but rather on the free flow of thoughts and emotions.

Writing therapy focuses on the connection between personal experience and linguistic expression, helping individuals gain deeper self-understanding and emotional balance. It is often used with individuals suffering from anxiety disorders, depression, trauma, and even for self-development and creativity enhancement.

The core idea is that writing allows individuals to reframe events and experiences, helping to alleviate negative emotions and foster self-insight.

2. The Psychological Impact of Therapeutic Writing:

Writing plays a significant role in influencing cognitive and emotional processes by helping to:

• Regulate emotions: Expressing negative feelings reduces stress and suppressed emotions.

• Reinterpret experiences: Writing helps restructure distressing events more constructively.

• Develop self-reflection skills: Regular writing enhances self-awareness and behavioral understanding.

• Improve mood: Emotional release through writing can decrease anxiety and depression.

• Increase self-awareness: Writing allows individuals to recognize thought and emotional patterns, aiding in better decision-making.

From a biological perspective, studies show that therapeutic writing helps lower cortisol levels, the stress hormone, while activating brain areas linked to emotional regulation and decision-making.

3. Stages of Writing Therapy:

The therapeutic writing process involves several stages, varying based on the individual's psychological condition and treatment goals. However, most programs follow these basic steps:

1. Preparation and Readiness

• Introducing the concept and importance of writing therapy.

• Identifying emotions or issues the individual wants to express.

• Creating a stress-free environment for writing without restrictions.

2. Emotional Release and Free Writing

• Encouraging the person to write freely without concern for grammar or style.

• The focus is on spontaneous expression without edits or judgment.

• This stage may include writing about trauma, grief, anger, or daily reflections.

3. Reflection and Analysis.

• After writing, the individual reviews their text to identify emotional or cognitive patterns.

• A therapist may collaborate with them to discuss and analyze the writing for deeper emotional insight.

4. Rewriting and Adaptation

• In this stage, individuals reframe their experiences in a more balanced way.

• The focus is on reshaping the narrative to develop acceptance and understanding of past events.

4. Types of Writing Therapy:

Several writing techniques are used in therapy, and therapists choose the most suitable one based on each case:

1. Free Writing (Emotional Release)

• Writing spontaneously about anything without restrictions.

• Helps release suppressed emotions and clear the mind.

2. Journaling

• Encouraging individuals to keep a personal diary, helping them organize their thoughts and emotions regularly.

• Useful for people dealing with anxiety and stress.

3. Unsent Letters

• Writing letters to someone (alive or deceased) without the intention of sending them.

• Effective for addressing unresolved emotions like anger, regret, or grief.

4. Rewriting Traumatic Events

• Rewriting distressing experiences in a new perspective helps reframe associated emotions.

• Used for trauma survivors and individuals with PTSD.

5. Poetry and Creative Writing

• Some people prefer using poetry or storytelling as an indirect way to express emotions.

• This includes writing short stories, poetry, or reflective essays.

5. Mechanisms of Writing Therapy:

Writing therapy improves mental health through several mechanisms, including:

• Emotional expression: Allows safe emotional release.

• Cognitive restructuring: Helps change negative thought patterns.

• Enhancing psychological resilience: Promotes healthier coping mechanisms.

• Improving problem-solving skills: Encourages seeing situations from different perspectives.

6. Applications of Writing Therapy:

Writing therapy is used to address various psychological conditions, such as:

• Anxiety and stress disorders.

• Depression and mood disorders.

• Post-traumatic stress disorder (PTSD).

• Emotional trauma and grief.

• Enhancing self-confidence and self-esteem.

Additionally, writing therapy is widely used in self-improvement and creative fields, helping individuals enhance their cognitive and emotional expression.

7. Skills Required for a Writing Therapist:

A professional writing therapist must possess specific skills, including:

• A deep understanding of psychological principles and therapy methods.

• Knowledge of various writing therapy techniques.

• The ability to analyze texts and extract psychological insights.

• Providing emotional support and appropriate guidance.

• Respecting patient confidentiality and encouraging free expression without judgment.

Conclusion: Writing therapy is an effective tool for improving mental health, enhancing self-awareness, and providing a safe space for emotional expression. Through writing, individuals can explore their inner world and cope with life's challenges with greater understanding and acceptance.

Chapter 09: Humanistic Therapy

Rogers' theory in the field of humanistic psychology is one of the most famous and widespread theories in modern history, which focuses on the role of human relationships as a driving force for change and personal development. The theory focuses on the main concept of ongoing self-experience, where the individual is considered as an integrated entity and relies on his own experiences and suffering to achieve personal growth and self-development.

Clinical psychotherapy applications based on Rogers' theory are based on providing a supportive and intimate environment for the individual to express his feelings and personal experiences without any judgment or analysis from the therapist, which gives the individual the opportunity to free himself from negative foundations and psychological restrictions that may hinder his progress and personal development

- The concept of emotional participation (empathy):

Empathy is an important basic element in the process of counseling and psychotherapy. Through emotional empathy, the psychological counselor can understand the client's situation and help him realize his condition and feelings and deal with them in a positive and effective way.

Empathy means the ability to understand what others feel and see things from their perspective and not from a personal perspective, in addition to the ability to put oneself in their position and feel what they feel. In other words, empathy is the ability of a person to imagine himself in the place of another who is suffering and to feel empathy for what he is going through. It is worth noting that empathy is something that not everyone can do, because it requires entering into the depths of

others and feeling them. Empathy in psychology elevates a person and makes him beloved by people. It is one of the qualities that help a person form successful relationships with everyone, whether in the family, work, or otherwise. The lack of empathy indicates a personality disorder, so the unempathetic personality is hostile and narcissistic.

2- Components of emotional participation (empathy):

Empathy consists of three components:

2-1 The cognitive component: It means a complete understanding of the mental state of others.

2-2 The dynamic component: It means social connections and consists of emotional interest, which is the individual's tendency To feel emotional participation with others.

2-3 The affective component: It means an appropriate emotional response when facing the emotional state of the other person. There are levels of empathy:

A- The horizontal level: It means empathizing with all aspects of the individual's life, happy and sad (painful), not just the painful. That is, it cares about all the different feelings of the individual and their role in the current problem that the client is suffering from.

B The vertical level: It means empathizing with the superficial layers such as what the person understands, colors, clothing. That is, his initial perceptions about some of the things that revolve around him. (Burnan, 2020, p. 2)

3- Types of emotional participation (empathy):

There are three types of empathy and can be mentioned as follows:

3-1 Emotional empathy:

This type means the ability to understand the feelings of others and respond to them in an appropriate manner, and this type often leads to fear for the feelings of others and anxiety about their happiness and stability.

3-2 Physical empathy:

This type of empathy includes physical reactions that are a response to what others feel and suffer from, such as blushing cheeks and feeling an upset stomach when seeing someone embarrassed.

3-3 Cognitive empathy:

It is the ability to understand the mental state of others and what they might think in response to situations. In psychology, it is called the theory of mind or thinking about what others think. (Shawahin, 2018, p. 19)

4- Empathy and harmony according to Rogers:

Rogers says that I assume that personal growth occurs primarily when the therapist is who he really is: "... when he is able to accept the feelings and situations that control him at the present moment" We mean that he controls the feelings that control him and makes them conscious and is able to live them.

No one achieves this state completely, but the more the therapist is able to accept what he perceives when he listens and the more he is able to live his feelings in their entirety without anxiety, the greater the amount of harmony, harmony requires the therapist to be less neurotic.

Empathy is an essential element in the process of psychological therapy and counseling, through which the therapist is able to understand the client's position and help him realize his condition and feelings and deal with them in a positive and effective way.

To use empathy as a means of intervention in psychological and social aspects, two basic elements must be taken into account:

- The specialist must be able to choose the client's feelings and understand them as the client tells them.

- The specialist must be able to separate the client's feelings from his own feelings, and the client's feelings must not become part of his feelings.

When the examiner takes these two elements into account, empathy is useful.

Rogers believes that the state of empathy consists of an accurate perception of the internal frame of reference of others, including the emotional components and meanings associated with that, and the individual is the other in the sense of feeling the pain or joy of the other, as he feels it, and perceiving its causes as he perceives them without the matter turning into a state of identification.

Comparing this with Horney's similar theory, we find that the individual's inability to know his true needs makes it very difficult for others to help him satisfy them, which leads to the disruption of the individual's personal relationships. Rogers expresses this by saying: "Neurosis represents a significant obstacle to the individual's psychological adjustment because the communication between the patient and himself has been shattered, as well as his communication

with others, and parts of his self become unconscious, or are repressed or denied consciously, as the individual becomes closed in on himself and does not communicate with the feeling or the controlling part of himself." Rogers is similar to Erikson and Kelley in using formal diagnostic concepts, even if they are general, such as neurosis and psychosis. He sees that such names are innate and unscientific, which leads to the exaggeration of the psychotherapist's experience and the perception of the client as a person subordinate to him. Here, the client must match or match the nature of his internal conflicts with his organic value, meaning that if the client (the examinee) realizes the center of control and responsibility, he will become clearer with the therapist and will provide effective treatment (Riyadh Nayel Al-Asmi, 2016, p. 123).

Davis's Model of Empathy:

Davis (1983) refers in his model to two main paths to empathy:

5-1 Empathy as a process: It refers to the emotional feelings that occur when one person interacts with another (adopting the other's point of view, or unconsciously imitating the expressions and point of view of the other).

5-2 Emotional participation as a result or outcome: It results from emotional participation as a process, and is emotional or cognitive, and the first (i.e.) as a process is an important motivator for social behavior, while the second is related to awareness, understanding, and knowledge of the other person's condition. (Bornan, 2020, 5 p.)

6- Methods for applying emotional participation (empathy):

6-1 Get to know more people:

Ask everyone you meet about their condition. This kind gesture is applicable to everyone you encounter throughout your day, starting with the grocery store salesperson, your neighbors, or those you meet while walking in public parks. This does not mean that you intrude on their lives, but simply asking: "How are you?" - This simple amount of interest makes others feel comfortable and happy, and gives you the opportunity to direct your attention to what is happening in the lives of others, and then you become more capable of emotional participation.

• It is easier for all of us to just talk to those we already know, but closing yourself off to a specific circle of people puts you In a bubble with those you are similar to, and in the long run you lose your ability to sense what is going on in the minds of those who are different from you.

6-2 Understand the feelings of others:

Show those around you your understanding of the events and psychological pressures that are happening in their lives. You do not necessarily have to understand the feelings of others, as your ability to understand or not is not what acknowledges the truth of those feelings, but what is more important is that you appreciate what the other party is going through and convince yourself that as long as those feelings are formed inside him, they are real and honest. Agreement and disagreement are about opinions, but feelings should be respected and appreciated and you should ultimately understand that emotions and feelings are an integral part of human nature.

• You can say: "I want you to know that it is very normal and you have the right to feel angry. Each person has their own way of dealing with

sadness, and all you have to do is accept the feelings and emotions inside you now without blaming yourself."

• Or another example: “It’s completely understandable that you feel frustrated by what your boss said. I would have felt angry for the same reason.

6-3 Find out what you have in common with others:

Emotionally engage with those around you by finding common ground (which you have with anyone in the world). When you get to know someone new, try to discover two or three things that you share an interest in. Maybe you’re from the same city, the same age, or at the same stage of life with its challenges and experiences. The truth is that you have something in common with most—if not all—of the people around you. All you have to do is look for common ground, not differences.

• Show a positive and kind interest in the lives of others. This is one of the most important aspects of empathy.

6-4 Listen to the conversations of those around you:

Show that you are interested and interested in what others are saying. Be an active listener to others’ conversations by avoiding distractions and maintaining effective eye contact. You can also rephrase what is being said in your own words to make sure you clearly understand what is being said. It is said. Also focus on listening to what the other party is saying instead of being preoccupied with what you will say later in response.

• For example: When your friend talks about the difficulties of his life, you can say: "It is very clear that you are suffering from loss of

motivation and suffering due to pressures. I wish you the best of luck in dealing with these pressures from my heart."

• When a family member talks about his job, you can say: "It seems that you are very stressed at the moment. May God help you to bear this pressure, and I hope that you achieve your goals.

6-5 Consider the feelings of others:

Understand the feelings of others in order to be able to understand their actions. The moments when understanding is most needed are during disagreements, not the other way around; you must put yourself in the other party's shoes and see things from his point of view and understand his feelings that led him to a certain behavior. In turn, having this ability to understand benefits you because you create a common space between you and the other party and succeed in controlling your feelings, and then your actions, and you will not rush and do something that you will regret later.

• For example, let's say that your son cheated on a math test at school; You are supposed to sympathize with his behavior and understand that he did it out of fear of failing. From this point of understanding, you can work and build to correct your son's behavior. Do not accept the mistake, but understand it.

6-6 Put yourself - literally - in the circumstances around you:

Think about things as if you live in the body, mind and heart of the other party. Try to be present in places of worship of individuals of other religions to understand them more closely. Spend some time in poor homes and among the homeless to realize the reality of the daily lives of these individuals. One of the most important ways to show

emotional participation with others is to pay attention to the details of their lives instead of just passing by them indifferently.

• Try volunteering to provide meals to the needy or work in a development program in one of the poor villages in your country or in other parts of the world.

6-7 Maintain an open body language:

Realize that your body language says a lot about what is on your mind. You may say that you understand the position and what the other party is saying, while your body and posture reveal that this is just a dishonest claim. When talking to others, keep your arms uncrossed and your spine straight. Make eye contact with the other person and keep your facial features relaxed, so that you don't appear unintentionally angry or sad. Open your fist to show that you are open to conversation, to receiving and understanding new information, and to changing your perspective.

• Open body language helps you appear more approachable.

6-8 Connect with others through supportive touch:

Benefits of Empathy:

There are a number of benefits that accrue to a person who is characterized by empathy, including the following:

- Allowing the formation of social connections and relationships with others, which has a positive impact on mental and physical health.

Empathy with others helps learn how to regulate emotions.

- Empathy makes a person engage in some behaviors that are beneficial to him, and it also makes others sympathize with him when he faces problems.

8- Barriers to Emotional Participation (Empathy).

There are a number of things that make a person lack empathy, and here are some of them:

- Bias, as this person often sees that the failure of others is due to internal reasons within them, while his failure is due to external reasons.

- Blaming the victim and believing that you could have acted in a different way to avoid getting into trouble.

- Dehumanization. (Aron, 2000, pp. 34, 35) Benefits of Empathy:

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- Dehumanization. (Aron, 2000, pp. 34, 35)

Clinical applications of Rogers' theory

Concept of clinical applications:

Regular applications include a variety of programs, such as electronic medical file management applications, appointment and review management applications, monitoring, diagnosis and treatment applications. They also include clinical applications that are used to provide medical advice and health awareness.

Clinical applications have many advantages, including improving the quality of health care, saving time and cost, and facilitating communication between doctors and patients. They also help improve diagnosis and treatment and improve the quality of life for patients.

Clinical applications are used in various fields, such as mental health, psychiatry, addiction treatment, psychological rehabilitation, special education, psychological counseling, psychological training, and psychological research. Clinical applications help improve the quality of life of patients and improve their mental and physical health. (Al-Marzouqi, 2014, p. 45)

2- Psychological disorders according to Rogers:

Rogers' theory does not speak directly about psychological disorders, but rather focuses on the process of positive psychological change and self-growth that is represented in improving mental health and personal relationships.

However, Rogers' theory can be used as a framework for understanding psychological disorders and how they occur. In this context, a person's inability to adapt to the surrounding circumstances and the inability to deal with negative feelings can lead to psychological disorders.

In light of Rogers' theory, the process of positive psychological change requires a set of important factors such as self-respect, effective listening, and honest expression of feelings and needs. When an individual faces difficulty in meeting these needs and does not feel certain and secure, this can lead to the emergence of psychological disorders such as anxiety, depression, eating disorders, addiction, and many other psychological disorders.

Therefore, Rogers' theory can be used as a framework to improve mental health and treat psychological disorders by providing support, effective listening, honest expression, and self-respect, thus encouraging the individual to achieve positive psychological change and self-growth. (Al-Jamil, 2011, p. 35)

3-Professionalism of treatment according to Rogers:

Carl Rogers is considered one of the psychological theories that emphasizes the great importance of personal treatment based on complete trust in the patient, and this requires the therapist to be highly professional in applying the principles of this theory.

In Rogers' therapy, the focus is on establishing a comfortable and warm relationship between the therapist and the patient, where support, respect and attention are provided to the patient without judging him or interfering in his personal experience. The patient is encouraged to express his feelings, thoughts and needs freely, without any fear of judgment or rejection.

The professionalism of Rogers' therapy depends on the therapist's ability to provide a safe and supportive environment for the patient, the ability to listen effectively to the patient's personal experience and understand it accurately, and the ability to provide the necessary support to the patient and encourage him to express his feelings and needs honestly.

In order to ensure the professionalism of treatment, the therapist requires continuous training and learning, continuous development in clinical practice, and patience, dedication and respect in dealing with patients. The therapist must pay attention to ethical and legal aspects and learn about modern techniques and practices in the field of psychotherapy. (Shawky Shehata, 2004, p. 75)

4- Main factors of Rogers' theory

Rogers' theory is a theory in psychology that focuses on the process of psychological change and personal development. The theory is considered one of the most important theories in humanistic psychology.

The main factors of Rogers' theory include the following:

4-1 Openness and honesty: Rogers considers that frankness and openness in expressing feelings, thoughts and beliefs are a key factor in achieving positive psychological change.

4-2 Acceptance and appreciation: Rogers focuses in his theory on the fact that people need to feel appreciated, respected and accepted as an important person in their lives, and they look forward to experiencing this feeling through interacting with others.

4-3 Positive interaction: Positive relationships between individuals and constructive and supportive interaction represented by careful listening, mutual understanding, empathy and appreciation are a key factor in positive psychological change.

4-4 Growth and development: Rogers focuses in his theory on the fact that personal growth and development are achieved through new experiences and experiments represented by exploration, experimentation, learning and experimentation.

4-5 The understood self: In Rogers' theory, the understood self means the individual's personal perception of himself, which Rogers considers a major factor in achieving positive psychological change. Rogers focuses on the fact that people need to feel respected, accepted and appreciated by others, and that this feeling arises from within. (Al-Ghabti, 1992, p. 63)

5- Basic principles in clinical guidance and counseling:

The concept of clinical guidance and counseling:

Clinical guidance and counseling is the process of providing psychological and social support to individuals who suffer from psychological, social or health problems in preparation for solving those problems. This is done by providing them with the information, skills, psychological counseling and guidance necessary to overcome those problems and achieve improvement in their psychological and health condition.

The goal of clinical guidance and counseling:

- It works to improve the quality of life of individuals and increase their ability to adapt to various problems and achieve personal and professional success.

- It also helps in reducing various psychological and health symptoms and preventing psychological and physical diseases in the future. (Ali Saad, 2015, p. 15)

Guiding and counseling individuals in a clinical form according to Rogers revolves around the positive interaction between the therapist and the patient, and focusing on allowing the patient to recognize his own abilities and overcome psychological problems effectively. Therefore, Rogers adopts a set of basic principles in clinical guidance and counseling, including:

5-1 Attention to the patient's feelings and experiences: Rogers focuses on effective listening and true understanding of the patient's feelings and experiences, and full acceptance of them, which helps the patient talk about his problems and identify his psychological and emotional aspects.

5-2 Positive response: Rogers aims to provide a supportive environment full of love, appreciation and understanding for the patient, which helps him identify his own solutions and take them effectively.

5-3 Focus on the present: Rogers stresses the importance of focusing on the present, identifying current psychological problems and overcoming them instead of thinking about the past or the future.

5-4 Helping to identify oneself: Rogers aims to enable the patient to identify his strengths and weaknesses and work to improve them,

improve his interaction with others and achieve successful adaptation to life changes.

5-5 Encouraging self-reliance: Rogers encourages the patient to rely on himself and develop his self-skills, instead of relying on others or the therapist to solve psychological problems.

6- Rogers' methods of applying treatment:

Rogers' methods of applying therapy are based on the artificial self-mental theory on which the psychotherapy that bears his name is based. This theory is one of the basic theories in psychotherapy and emphasizes the close connection between the person and his experiences, feelings, thoughts and behavior.

Rogers' methods of applying therapy include:

6-1 Active listening: The therapist listens carefully to what the patient says, without evaluating or judging, and helps him understand his current feelings and experiences.

6-2 True understanding: This relates to the ability to understand the patient's feelings and experiences without judging or evaluating them.

6-3 Full acceptance: Rogers' method encourages the patient to fully accept what he feels and thinks, without restriction or modification.

6-4 Focus on the relationship between the patient and the therapist: The therapy focuses on building a positive relationship between the patient and the therapist and encouraging honest interaction between them.

6-5 Encouraging the patient to continue the healing process: This includes supporting the patient to explore different options and improve his mental and physical health.

6-6 Guiding the patient towards self-solutions: The therapist encourages the patient to think of his own solutions to his problems and to improve his ability to rely on himself. (Rogers, 1952, p. 79)

Chapter 10: Gestalt Therapy

Gestalt therapy emerged as a groundbreaking approach within the humanistic psychology movement. It focuses on self-awareness, the integration of thoughts, feelings, and behaviors, and an experiential mode of healing. This paper examines the core principles, techniques, and impact of Gestalt therapy on psychological well-being.

1. Historical Background

Gestalt therapy was developed in the 1940s and 1950s by Fritz Perls, Laura Perls, and Paul Goodman. Rooted in existentialism, phenomenology, and Gestalt psychology, it challenged the rigid structures of psychoanalysis and behaviorism by emphasizing direct experience and the holistic nature of human perception.

Key Contributors :

1. **Fritz Perls** (1969) - Developed core principles and techniques emphasizing awareness and personal responsibility.
2. **Laura Perls** (1970) - Expanded Gestalt therapy's application in group and body-oriented psychotherapy.
3. **Paul Goodman** (1951) - Provided philosophical and theoretical underpinnings in Gestalt therapy literature.

2. Theoretical Foundations

Gestalt therapy is based on several core principles:

- **Holism**: The individual is seen as a whole entity, integrating thoughts, emotions, and behaviors.
- **Awareness**: Central to therapy, awareness is the key to self-regulation and change.
- **The Here and Now**: Focuses on present experiences rather than past traumas.
- **Personal Responsibility**: Encourages individuals to take ownership of their actions and emotional responses.

- **Dialogue and Contact**: Interaction between therapist and client is direct, emphasizing authenticity and self-exploration.

3. Methodologies in Gestalt Therapy

Gestalt therapy employs unique techniques to enhance self-awareness and emotional processing.

3.1 The Empty Chair Technique

- Encourages dialogue between different aspects of the self.
- Helps clients explore unresolved conflicts and emotions.

3.2 Role-Playing

- Facilitates exploration of interpersonal relationships and unexpressed emotions.
- Engages clients in self-exploration through experiential enactments.

3.3 ExperientialAwarenessExercises

- Focus on bodily sensations and emotional experiences.
- Helps clients recognize patterns in their behavior and interactions.

4. Clinical Applications

Gestalt therapy is used to address various psychological and emotional conditions:

- **Anxiety and Stress Disorders**: Enhances mindfulness and emotional regulation.
- **Depression**: Helps clients process suppressed emotions and increase self-acceptance.
- **Trauma Recovery**: Facilitates emotional healing through direct experience and awareness.

- **Relationship Issues**: Improves communication and self-expression.
- **Personal Growth**: Encourages self-discovery and authentic living.

5. Empirical Evidence and Effectiveness

Studies have supported the effectiveness of Gestalt therapy:

- **Meta-Analyses**: Research suggests significant improvement in emotional well-being and interpersonal effectiveness.
- **Neuroscientific Findings**: Brain imaging studies indicate increased emotional awareness and cognitive integration post-therapy.
- **Clinical Trials**: Evidence highlights Gestalt therapy's effectiveness in treating anxiety, trauma, and depression.

6. Challenges and Criticisms

While Gestalt therapy has proven beneficial, it faces several criticisms:

- **Lack of Structure**: Some argue that its experiential nature makes it less predictable.
- **Empirical Validation**: Critics suggest the need for more controlled studies.
- **Cultural Considerations**: Gestalt therapy's emphasis on self-exploration may not align with collectivist cultures.

Chapter 11: Relaxation Therapy : For Adults -- Relaxation Therapy: For Children and Adolescents

Definition of Psychoanalytic Relaxation Sapir

Psychoanalytic Relaxation Sapir is closely related to Bergès Relaxation, as both stem from the same period and origins, with their foundation in Schultz's autogenic training.

In the 1950s, based on Schultz's autogenic training—a highly structured method concerning inductions, process evolution, and relaxation monitoring through touch—Michel Sapir recognized the necessity of allowing patients to discuss their sensations and emotional states. He also emphasized the impact of touch on emotional and affective states, the role of the unconscious, and transference and countertransference aspects.

Over time, he evolved this method into what he called "Relaxation with Variable Inductions." This relaxation technique is grounded in the psychoanalytic framework, focusing on bodily drives, interaction between touch and speech in therapy, and addressing transference and countertransference elements. The main objective was no longer just to relax the patient but rather to explore their experience during the relaxed state, in connection with the therapist's words and touch.

Differences Between Psychoanalytic Relaxation Sapir and Bergès Relaxation

Despite their common origins, the two methods differ significantly in their therapeutic framework and approach to patient treatment. This distinction led to extensive discussions between Jean Bergès and Michel Sapir regarding therapeutic processes, patient dependence on the therapist, countertransference, and regression. Bergès was influenced by Lacanian psychoanalytic theory, whereas Sapir was more influenced by the work of Ferenczi, Michael Balint, and Anglo-Saxon psychoanalysis.

Relaxation techniques have been widely used in psychotherapy to alleviate stress, anxiety, and psychosomatic disorders. Analytical Relaxation Therapy (ART) combines psychoanalytic principles with relaxation methods to facilitate emotional exploration and cognitive restructuring. This study delves into its conceptual basis, methodology, and effectiveness in treating various psychological conditions.

Historical Development

The roots of ART can be traced back to early psychoanalytic relaxation methods, such as Schultz's autogenic training and Jacobson's progressive muscle relaxation. The integration of these techniques into psychoanalysis began in the mid-20th century, with influential contributions from Michel Sapir and other psychoanalysts who emphasized the role of transference, countertransference, and unconscious processes in relaxation-based therapy.

3. Theoretical Foundations

ART is based on a synthesis of psychoanalytic and physiological principles:

- **Psychoanalytic Perspective**: ART views relaxation as a means of accessing unconscious conflicts and facilitating emotional processing.
- **Neuroscientific Basis**: Studies on autonomic nervous system regulation support the use of relaxation techniques to modulate stress responses and improve emotional regulation.
- **Cognitive-Behavioral Elements**: ART incorporates elements of mindfulness and cognitive restructuring to enhance self-awareness and adaptive coping.

4. Methodology of Analytical Relaxation Therapy

ART typically follows a structured format involving three core stages:

1. **Induction Phase**: Guided relaxation through breathing exercises, progressive muscle relaxation, or visualization.
2. **Exploration Phase**: Patients are encouraged to verbalize emerging thoughts, emotions, and memories within a psychoanalytic framework.
3. **Integration Phase**: The therapist helps the patient interpret and integrate insights gained during relaxation into their conscious awareness.

The role of the therapist is pivotal in facilitating transference, addressing resistance, and guiding the patient toward self-discovery.

5. Clinical Applications

ART has been applied to a range of psychological and psychosomatic conditions, including:

- **Anxiety and Stress Disorders**: ART has been found effective in reducing generalized anxiety and panic symptoms.
- **Trauma and PTSD**: By creating a safe space for unconscious material to emerge, ART assists in trauma processing.
- **Chronic Pain and Psychosomatic Disorders**: The relaxation component aids in alleviating somatic symptoms and fostering a mind-body connection.
- **Depression and Emotional Dysregulation**: ART helps individuals process repressed emotions and develop healthier emotional expression.

6. Empirical Evidence and Effectiveness

Several studies have examined the efficacy of ART:

- **Neurophysiological Research**: EEG and fMRI studies suggest that ART facilitates relaxation-induced neuroplasticity.

- **Clinical Trials**: Randomized controlled trials indicate significant reductions in anxiety, depression, and physiological stress markers among ART participants.
- **Case Studies**: Longitudinal case studies highlight ART's role in emotional resilience and improved psychological well-being.

Despite its promising results, more large-scale studies are needed to establish standardized protocols and efficacy across diverse populations.

7. Challenges and Criticisms

While ART offers a unique therapeutic approach, it is not without challenges:

- **Individual Variability**: Responses to ART may vary based on personality traits and trauma history.
- **Integration with Other Modalities**: ART works best when combined with traditional psychoanalytic or cognitive-behavioral therapies.
- **Need for Further Research**: More empirical data are required to validate ART's long-term effects and refine methodologies.

Therapeutic Framework in Psychoanalytic Relaxation Sapir

Patients may be referred to this therapeutic approach by other therapists, or it may be proposed during verbal therapy sessions. When suggested in such a context, it already challenges the patient's preconceived notions about psychotherapy, prompting them to reassess their therapeutic expectations.

Session Structure :

1. **First Phase:** Variable verbal inductions accompanied by therapeutic touch.

2. **Second Phase:** Silence and contemplation, where the patient focuses on their body without therapist intervention.
3. **Third Phase:** Verbal expression and psychological elaboration, encouraging free association as in classical psychoanalysis.

The Role of Verbal Inductions and Touch in Therapy

The type of verbal inductions used is determined based on the patient's response during the session. The therapist does not claim absolute awareness of the patient's internal reality but rather responds to their cues.

Inductions may take different forms:

- In the first person: "I feel my body relaxing..."
- In the third person: "My body is relaxed..."
- In the second person (used sparingly as it may be perceived as a directive): "Do you feel your body?"

Touch may vary in intensity, being firm and stable, light and superficial, or moving across the body. It can also be global, enveloping the body, symmetrical, or asymmetrical. These various types of touch can evoke emotions, memories, and introspective reflections in the patient.

The Role of Transference and Countertransference in Psychoanalytic Relaxation Sapir

Sapir highlighted that the patient's response to touch and verbal inductions always occurs within the framework of transference and countertransference, where their interactions with the therapist are shaped by past experiences. Thus, touch and verbal inductions become tools for exploring and analyzing these relational patterns.

In some cases, patients may refuse to express their feelings, and the therapist must navigate this silence analytically. This approach is reminiscent of the "squiggle" technique used by Winnicott with

children, which creates a transitional space between the body and speech, aiding in self-construction.

Analytical Relaxation Therapy

Various therapeutic relaxation techniques share the common goal of achieving a state of physical and psychological relaxation through muscular activity, allowing entry into a state of insight. The focus on the body as a therapeutic pathway gained recognition only in the 1960s, following the work of Freud and others, despite a long period dominated by vegetotherapy. Relaxation techniques are primarily based on the body's sensory experience and rely on concentration, suggestion, lethargy, and relaxation. The Esalen Institute, from an American perspective, contributed to the development of psycho-corporal approaches to alleviate psychological disorders through bodily expressions. Similarly, in the early 20th century, Johannes Heinrich Schultz developed relaxation therapy sessions based on:

- The sensation of heaviness

- The sensation of warmth

- Rhythmic exercises focusing on heartbeats

- Respiratory system exercises

- Awareness of the abdominal area and facial expressions

Schultz’s work laid the foundation for later studies conducted by J. Ajurriaguerra, G. Alexander, Jacobson, Jarreau, Klotz, and R. Vitt, who explored muscular relaxation as a sensory gateway to self-awareness.

The analytical relaxation technique was introduced by Michel Sapir at Rothschild Hospital in Paris as part of psychoanalytically inspired

treatments. Originally developed by Schultz, it was later brought from Switzerland in 1954 by Félix Labhardt.

According to Sapir, analytical relaxation therapy integrates verbal and tactile expression to help patients listen to their sensations and verbalize them in connection with their personal narrative—offering

Chapter 12: Cognitive Behavioral Therapy (CBT): Third Wave Approache

Cognitive behavioral therapy (CBT) has undergone significant evolution since its inception in the mid-20th century. The third wave of CBT expands traditional CBT techniques by incorporating mindfulness, acceptance, and metacognitive strategies. These approaches emphasize holistic well-being rather than solely reducing symptoms. This paper examines the core principles, methodologies, and impact of third-wave CBT on mental health treatment.

1. Historical Development

Third-wave CBT emerged in the late 20th and early 21st centuries as a response to the limitations of traditional CBT. Unlike first-wave (behavioral) and second-wave (cognitive) CBT, third-wave interventions focus on mindfulness, values-driven behavior, and emotional regulation.

Key Contributors :

1. **Steven C. Hayes (1999)** - Developed Acceptance and Commitment Therapy (ACT), emphasizing psychological flexibility.
2. **Marsha M. Linehan (1993)** - Created Dialectical Behavior Therapy (DBT) for emotional dysregulation and borderline personality disorder.
3. **Zindel V. Segal, Mark Williams, and John Teasdale (2002)** - Developed Mindfulness-Based Cognitive Therapy (MBCT) to prevent depressive relapse.
4. **Paul Gilbert (2009)** - Established Compassion-Focused Therapy (CFT) for self-criticism and shame-based disorders.

2. Theoretical Foundations

Third-wave CBT is based on several core principles:

- **Mindfulness and Acceptance**: Encouraging individuals to experience thoughts and emotions without avoidance or suppression.
- **Cognitive Defusion**: Reducing the literal meaning of thoughts to decrease their negative impact.
- **Emotional Regulation**: Enhancing coping mechanisms to manage distress.
- **Behavioral Activation**: Encouraging engagement in values-based activities to enhance psychological well-being.
- **Self-Compassion**: Cultivating kindness towards oneself to counteract self-criticism and shame.

3. Key Approaches in Third-Wave CBT

3.1 Acceptance and Commitment Therapy (ACT)

- Focuses on psychological flexibility through mindfulness and values-based action.
- Utilizes six core processes: cognitive defusion, acceptance, present-moment awareness, self-as-context, values, and committed action.

3.2 DialecticalBehaviorTherapy (DBT)

- Originally developed for borderline personality disorder, now applied to various emotional dysregulation disorders.
- Combines cognitive-behavioral techniques with mindfulness and dialectics.
- Includes four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

3.3 Mindfulness-Based Cognitive Therapy (MBCT)

- Designed for depression relapse prevention.
- Integrates traditional CBT with mindfulness practices.

- Helps individuals recognize and disengage from negative thought patterns.

3.4 Compassion-FocusedTherapy (CFT)

- Targets self-criticism and shame by fostering self-compassion.
- Uses mindfulness, imagery, and compassion-focused exercises to improve emotional resilience.

4. Clinical Applications

Third-wave CBT is widely applied to various psychological disorders:

- **Anxiety Disorders**: ACT and MBCT improve acceptance of distressing thoughts.
- **Depression**: MBCT prevents relapse, and CFT reduces self-critical thoughts.
- **Borderline Personality Disorder (BPD)**: DBT enhances emotional regulation and interpersonal skills.
- **Chronic Pain and Health Conditions**: ACT fosters pain acceptance and improves quality of life.
- **Obsessive-Compulsive Disorder (OCD)**: ACT and exposure therapy reduce cognitive rigidity and distress.

5. Empirical Evidence and Effectiveness

Numerous studies support the efficacy of third-wave CBT interventions:

- **Meta-Analyses**: Research confirms significant symptom reduction in anxiety, depression, and personality disorders.
- **Neuroscientific Findings**: Studies using fMRI demonstrate increased emotional regulation and cognitive flexibility following mindfulness-based interventions.

- **Clinical Trials**: Randomized controlled trials indicate that DBT, ACT, and MBCT are effective for emotion regulation and relapse prevention.

6. Challenges and Criticisms

Despite its success, third-wave CBT faces several challenges:

- **Variability in Treatment Protocols**: Different third-wave therapies lack a unified framework.
- **Training and Implementation**: Therapists require specialized training, which may limit accessibility.
- **Empirical Validation**: While evidence is growing, some critics argue that more large-scale studies are needed.

Chapter 13: Trauma-Focused Integrative Therapies : Concept, Principles, and Types

A person experiences several shocks throughout his life with varying degrees of impact. We have always known that the first shock that an individual experiences is the shock of birth, but not all shocks affect the individual's psyche, but rather they are part of his life's struggles. Perhaps the first struggle that a person experience is the struggle between the components of the sperm to obtain the egg, so that the struggles continue in order to remain physically and psychologically healthy in life.

Within these life's struggles, the individual needs a shock with a word, action, procedure, or new system to wake up and pay attention to his behaviors, actions, and deeds, and then recalculate, regain his balance, wake up from his negligence, and return to his senses and sanity.

Some of the methods of psychotherapy that are sometimes resorted to by some specialists for some individuals is the method of (shock therapy), as shock therapy has received great attention and greater development after the World War and its effects on humanity, and in our world today, shocks are not limited to wars only, but even with the spread of corruption, the loss of morals and principles, and the dissolution of standards, a person may be shocked by that situation, which may cause psychological crises, especially for those with fragile structures. Which requires the necessity of rapid intervention and (shock) therapy to save what can be saved from the individual's psyche, as well as his memory, which carries a lot of perceived and latent pain.

And despite the difference in psychological disorders between minor and major, and the acceleration of efforts in all fields of psychology, new therapeutic techniques have emerged accompanied by modern and advanced means.

In recent years, progress has been made to better understand diseases such as schizophrenia and depression, indicating that painful memory can sometimes be a motivating or aggravating factor. In this context, EMDR can be useful to complement other therapeutic and pharmacological approaches offered to some patients, further improving their mental health by working on the trauma(s) associated with their pathology. Some results in this direction have begun to emerge. To consolidate them, research must continue, with larger clinical studies being conducted. In this regard, we will try to shed light in our modest research on one of the therapeutic methods in treating trauma, which is the EMDR technique, where we will begin by identifying the concept of trauma and its types, then identifying the reasons for treating psychological trauma, followed by therapeutic techniques directed at psychological trauma, to reach the EMDR technique as one of the methods for treating psychological trauma to learn about its origins and the cases it deals with and those it refrains from treating, then we learn about its uses in Algeria, and to what extent the EMDR technique has developed, then we reach the presentation of the general protocol of the technique, embodied in presenting a case as a field application, and finally a conclusion on the subject followed by a list of sources and references

I. The concept of trauma and its types

1. Definition of psychological trauma

Definition of trauma according to Bergeret: Bergeret defines psychological trauma as the absence of help in the parts of the ego that must face the accumulation of unbearable effects, whether their source is internal or external.

Pierre Marty defines it as: the psychological and emotional echo whose effects appear on the individual and are the result of a situation (which may extend over time), or an external event that comes to disrupt the organization. It is in the stage of development and growth and affects the most developed organization when the shock occurs. Therefore, we conclude that psychological shock is a sudden external event that exceeds the individual's ability to bear and makes him helpless as he loses his self-esteem. She notes that the response of individuals to the shocking event varies according to his personal type. (Razzaq, 2018-2019)

2. Types of psychological trauma

Psychological trauma is divided into two basic types: primary trauma and life trauma.

A- Primary trauma: These are the clear experiences in the life of any individual that he encounters early and have serious psychological effects that cannot be caused by any other trauma. They are of the following types:

• **Birth trauma**: Birth trauma is one of the first traumas that a person experiences after being exposed to the first dangerous situations during birth. Perhaps the most famous person who spoke about birth trauma is Otto Rank in his book: le traumatisme de la naissance in 1923, where he considered that birth is "an event that shakes the child's soul and causes severe anxiety that is the origin of anxiety later on, and he considered that when the child leaves his mother's womb and experiences a different environment that is less safe than the one he lived in. He is thus exposed to the initial model or original pattern of

every anxiety and the nucleus of every neurosis. Psychological trauma directly activates primitive anxiety and causes traumatic neurosis."

The psychological trauma is reproduced in a typical way through disturbing dreams that appear in traumatic neurosis under the guise of the current traumatic event. In some details related to it, for example, the loss of a loved one, this means that this separation has a memory of the basic separation from his mother's womb. (Lamine, 2010, p. 49)

• **Weaning shock**: The mother makes the child consider the breast as a bad subject and hate it during weaning, while his relationship with his mother's breast was a good subject, and thus satisfaction and frustration may alternate in him since birth, the infant's positions on subjects vary as he draws imaginary images that make them bad or good, and this image may not actually be related to its reality, and from here lies anxiety and neurosis, as Melati Klein sees that the mother is the field of cultivation of the child, as she provides him with nutrition and a relationship with the outside world, and at the same time she is the source of all kinds of sea, as she contributes to the shock of birth and the shock of weaning. (Lamine, 2010)

• **Puberty shock**: Puberty is defined as the transition from childhood to adulthood, where a group of psychological and physiological changes occur to the individual related to his physical maturity, and it is an inevitable stage for every individual to go through during his growth, and therefore it is considered a shock and a psychological crisis, as it is known that the child in puberty witnesses changes in his body and feels feelings that he did not have before and performs actions through which he sees himself as completely different. He may have responses during his growth stage that have important effects on his psychological life and remain with him for the rest of his life. Therefore, some scholars

say that the shock of puberty is similar to the shock of birth in effect. (Lamine, 2010)

B- Life shocks: These are the experiences that an individual goes through or the events that he is exposed to, whether they are simple or violent, and if they are, they cause him psychological shock. They are of the following types:

• **Childhood shock**: Childhood is a sensitive stage in an individual's life, during which he may be exposed to painful, isolated events that take a short time to occur, such as undergoing surgical operations on a child without preparing him psychologically, or being exposed to sexual assaults, or the sudden death of one or both parents, or his kidnapping.

They may be long-term events that took some time, such as the separation of parents, abnormal family relationships, or the harsh treatment that the child receives from his environment. Freud believes that all diseases originate from psychological shocks that occurred in childhood. (Mawloud, (D.S.), p. 26)

• **Shock resulting from experiencing a traumatic event**: This is the result of violent natural events outside the scope of the individual, such as floods, earthquakes, and various natural disasters. It may also be caused by humans, such as wars, traffic accidents, and others.

• **Shock resulting from hearing painful news without experiencing the event**: Although the individual does not directly experience a painful event, when he hears about the death of someone close to him, this affects his psyche despite his absence during the death. In general, what the person experiences from an event goes beyond the usual framework of a human experience, even if this event is something that

any individual hopes for, such as: seeing a murder, sexual assault, or other serious threats to personal life, the body, or to a close family member. (Born, (Dr. S))

• **Future shock or cultural shock:** "It is a result of excessive excitement, as Toffler says, and this happens when the individual is forced to act in a way that is adaptive (and by its adaptive extent he means the individual's ability to adapt or acclimatize), and successful adaptation to the lived reality can only be achieved when the level of excitement is reasonable and without excessive increase or decrease. Therefore, "Toffler" warns against over-stimulating needs, which leads to the collapse of the body, as reducing excitement is the basis for achieving sound development. (Hanfin, 1996, p. 924)

Memorandum on divorce and psychological trauma in children. University of May 8, 1945, Guelma. Specialization in clinical psychology. Prepared by students Iman Zenati and Basma Zaghdoudi. 2018/2019

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II. Indications for treating psychological trauma:

Our purpose in researching this element is to know the consequences and repercussions of psychological trauma, and therefore why trauma needs to Treatment?

Trauma is a persistent emotional reaction that often follows a very difficult life event. Experiencing a traumatic event can undermine feelings of safety and identity as well as the ability to regulate emotions and manage relationships with others. Long after a traumatic event, a person often feels intense fear accompanied by feelings of shame or

helplessness... However, it is difficult to define what constitutes a traumatic event, because the same event can be more traumatic for some people than for others.

When the memory of the traumatic event and the thoughts that accompany it persist or become more intrusive, they can lead to post-traumatic stress disorder, which seriously impairs a person's ability to regulate their emotions and maintain harmonious relationships with others.

Traumatic events can be of several types:

A single, recent event (e.g., car accident, violent attack); A single event that occurred in the past (e.g., sexual assault, death of a spouse or child, accident, natural disaster, war).

A traumatic, recurring, and long-term experience (e.g., persistent childhood neglect, sexual or physical abuse). A person who has experienced a traumatic event may also develop post-traumatic stress disorder (PTSD) or complex trauma. (O. Guerrero, 2018)

In general, the experience of a single traumatic event leads to PTSD.

The consequences of traumatic memory and dissociation due to violence, whether current or past, are:

Very great psychological (traumatic memory) and physical suffering, a sense of constant danger, insecurity, loss of trust, hypervigilance and control over the entire environment, insomnia, and psychological and physical stress.

Feelings of alienation from the world, of being different, of being detached from reality, of depersonalization, of confusion, and of isolation. Generalized anxiety disorders, anxiety, panic attacks,

phobias, depressive disorders with suicidal ideation and suicide attempts, major cognitive disorders with problems with concentration and attention, decreased performance and absenteeism, risky behavior with exposure to danger, addictive behavior, eating disorders, paradoxical behavior consisting of dependence on the aggressor, reproduction of violence, tense, anxious or even panicky at certain times, tired, exhausted even, suffering from insomnia, sick all the time, smoking a lot, lost, doubting everything, confused, feeling alienated from the world and from themselves, complaining of forgetting everything. They also find it difficult to fulfill their obligations, their work, their administrative procedures, managing their expenses... All these symptoms serve the traumatic memory, making the victim more vulnerable and manipulable than others, they represent a vital danger, a danger to the physical, psychological, professional, social, emotional and personal integrity, the risk of reproducing violent behavior, the risk of re-victimization, the risk of deviant, antisocial and violent behavior. (salmona, 2020)

From what has been mentioned, the severity of the consequences of psychological trauma can be determined at the personal and relational levels, so it was necessary to search for positive and effective therapeutic methods.

The most common methods for treating trauma are cognitive behavioral therapy (CBT), psychodynamic therapy, sensorimotor therapy, emotional neurological integration through eye movements (EMDR), and drug therapy.

More generally, we can say that patients often benefit greatly from trauma-focused psychotherapies that take into account the experience that caused PTSD. These psychotherapies are based on the observation

that the symptoms of this disorder are coping strategies that have developed in response to a traumatic experience. Without making judgments, these psychotherapies recognize that the behavioral, emotional, or physical symptoms that people with PTSD display are adaptations to overwhelming stressors. (O. Guerrero, 2018)

Numerous clinical studies also show that EMDR is effective in treating PTSD, giving very good results compared to no treatment or other pharmacological or psychotherapeutic methods. In addition, these studies and evaluations have shown similar improvements in EMDR treatment to those obtained through cognitive and behavioral therapies, which are also indicated in the treatment of post-traumatic stress disorder. (Chaudieu, 2020) III. Trauma-oriented therapeutic techniques

Trauma-oriented therapeutic techniques differ between trauma therapy and PTSD therapy:

1. Trauma-oriented techniques:

- Active listening
- Verbalization
- Abdominal breathing

or "cardiac coriance"

- Help to link and organize events
- Social and psychological assistance and support

- **Emotional freedom technique (EFT**) :

Emotional freedom is a combination of Traditional Chinese Medicine (TCM) acupuncture based on stimulating certain acupuncture

meridians, through light tapping, and EMDR (Eye Movement Desensitization and Reprocessing) and is based on the close relationship between the physical and the mental, each emotion felt will also be expressed by the body. "It is a psychosomatic approach," because it works on the body by stimulating energy points, and on the psyche, through spoken words.

Three actions are combined when practicing the first EFT: a series of points that are stimulated by light tapping, located on the acupuncture meridian system. Then comes the pronunciation of a sentence describing the problem, in order to open the third action: self-acceptance.

Once the problem has been identified, its intensity must be measured. Does this problem affect my morale? Scale it between 0 and 10 (0: I feel no discomfort, 10: I feel the highest disturbance I have ever experienced). After completing the identification phase, you must find a sentence that summarizes your problem, and this will be repeated throughout the session. It is composed as follows: "Even if (I have this problem), I love and accept myself completely". Acceptance is an important point during this process, as it will allow you to find peace.

This is followed by a round of tapping. About ten strategic points located in the meridian area (head, chest, hands) will be "exploited". Tap each point 5 to 7 times, each time saying your reminder phrase "Even if (I have this problem), I love and accept myself completely". After a few rounds, the intensity level of your emotions is evaluated again. The purpose of the work is to continue until your problem reaches 0. The results of this practice are permanent, and for some permanent. (https://www.doctissimo.fr)

□ Psychodynamic treatments :

Some rigorous studies have found that psychodynamic treatments may be helpful in treating PTSD, while other studies have found them ineffective120, as there is no clear theory about the link between symptom maintenance and therapeutic suggestions, and there is no evidence of the effectiveness of analysis in reducing the risk of chronicity except for the trauma theory of HOROWITZ (1997).

A study showed that after 19 months of psychoanalytic treatment of traumatized Vietnam veterans, it was found that this treatment was not helpful, so imagery therapy was introduced, which is a brief psychodynamic treatment, in which the therapist presents a scene related to the trauma, and urges the patient to develop it spontaneously through associations, away from any planning. The use of the imagery technique is not planned in advance, but rather this technique is introduced at the appropriate time within the context of the session. Ten sessions of imagery therapy were effective in improving the patient's PTSD symptoms, based on what the therapist observed and the patient acknowledged. In general, in brief psychodynamic therapy, the focus is on the traumatic event itself, and by the patient talking about it to a calm, sympathetic, compassionate therapist without making judgments, that patient achieves greater meanings of self-harmony and develops more adaptive defenses and coping strategies, and is more successful in modifying his emotions. □ Cognitive Behavioral Therapy (CBT): This treatment includes various therapeutic programs, including cognitive restructuring processes, anxiety management programs, as well as a combination of these various methods. □ Cognitive Reprocessing :

This technique aims to identify the specific thoughts or self-talk associated with the anxiety caused by the trauma. Cognitive changes

are identified during exposure to a traumatic memory, and notes are taken on the patient's statements related to the ability to anticipate, the ability to control and the feeling of guilt. Then, new schemes are searched for directly, and the latter are the subject of inquiry and questioning using Socratic questions according to usual cognitive techniques, where the therapist draws the patient's attention to the process of thinking in the traumatic situation, and helps him identify the processes of "generalization", "conclusion" and "perception" in an all-or-nothing manner, or "personalization". Making changes in the patient's way of thinking has a great impact on his emotional state and behavior. This therapeutic technique helps the individual focus on the current environment, and evaluate the degree of threat he feels in specific situations and then in life in general in a more rational and adaptive way. (JEHEL L, p. 125)

- **Exposure Therapy :**

It is one of the forms of therapy Cognitive behavioral therapy used in the patient's case to confront the memories and situations that he fears. Exposure and avoidance have long been proven to lead to a decrease in anxiety in all cases, and permanently. Exposure therapy, as developed by FOA, ROTHBAUM and their colleagues, includes:

Imaginary exposure: The patient must re-evoke the traumatic memories during the treatment session. The therapist asks him to go in his mind to the time of the trauma, and to re-experience it in his imagination. He closes his eyes and describes his experience in the present tense and in a loud voice as if it happened now. This narration is often recorded on an audio recorder, and the patient takes this audio recording home. Imaginary exposure may be practiced daily between treatment sessions. Although re-experiencing is painful at the beginning of treatment, it

quickly becomes less painful the more exposure is repeated. The idea behind this type of treatment is that the trauma needs to be treated or digested emotionally in order to become less painful. Live exposure: This requires the individual to gradually confront and monitor anxiety-provoking situations. This technique allows, through the extinction/habituation process, to reduce the level of anxiety aroused by situations that were fearful, and as a result, avoidance behavior decreases. Most controlled studies on cognitive behavioral therapies have proven that the prolonged exposure technique (which is a form of exposure) and cognitive processing are all effective in reducing PTSD symptoms. (NUTT DJ, 2009, p. 110)

There are other therapeutic techniques related to cognitive behavioral therapy, including relaxation, self-assertion training, anxiety management techniques, and problem-solving, which are complementary techniques that help the patient improve his social skills and improve his self-image, which contributes to strengthening him to overcome PTSD.

Chapter 14:

- **EMDR Protocol (Eye Movement Desensitization and Reprocessing)**
- **CAT Protocol (Cognitive Analytic Therapy)**

1- EMDR Protocol (Eye Movement Desensitization and Reprocessing)

The idea of EMDR was born with scientist Francine Shapiro one sunny afternoon in 1987. She sat on the edge of a lake watching birds fly by. Then she felt light and formulated this hypothesis: what if moving the eyes back and forth could alleviate our negative thoughts and feelings? Then she embarked on a unique experiment: she asked 80 volunteers to follow her finger with their gaze while experimenting with eye movements. She tried it on a Vietnam veteran (Daug) and the first controlled study on 22 individuals was followed by her publication in 1989.

Several clinical studies were then conducted, and in 1990, EMDR was formalized. The model was primarily oriented towards the treatment of psychological trauma (in French: PTSD). It then became a complex and multifaceted intervention, described as a real revolution in the field of psychotherapy. In 1991, the word “Reprocessing” was added to the name of the technique to emphasize the cognitive and information processing elements, which are central elements in EMDR procedures. Shapiro had initially presented her method to the scientist J. Volpe, who wanted to confirm for himself the effectiveness of EMDR and conducted his experiment on a woman who had been raped and was suffering from PISD as a result. He reached impressive results by applying this technique, and thus scientists began to become interested in studying “Shapiro”, and more than 100 cases were published until 2007. Shapiro also published a 40-page book in 1995 describing the technique in detail. (Atiq Nabila, 2013, pp. 56-58)

It was first used in France in 1995 by F. Bonamel under the name: Oculairesrapides desensitization et restructuration par les movements (Al-Zarrad, 2005, p. 316)

Since then, EMDR, which registered its trademark, has seen significant development all over the world.

The method was then imported to France in 1994 with the book "Guerrier" by David Servan-Schreiber. EMDR therapy is practiced in the offices of psychologists, psychotherapists and psychiatrists. Its effectiveness was validated in 2007 by the High Authority for Health, by the World Health Organization in 2013, and then by Inserm in 2015.

In recent years, technology has begun to play an important role in improving the EMDR therapy process. These technological innovations offer new possibilities for personalization, efficiency and accessibility.

Technology-assisted EMDR tools provide consistent, standardized bilateral stimulation, eliminating the need for therapists to manually facilitate eye movements. Therapists can then focus on directing the session and monitoring the client’s responses.

One such technological tool is the light bar. This device consists of a horizontal bar with LED lights that move back and forth, mimicking the eye movements used in traditional EMDR therapy. The client can simply follow the lights with their eyes, while the therapist monitors and directs the session. Using a light bar ensures that bilateral stimulation is delivered consistently and accurately, enhancing the effectiveness of the therapy.

In addition to light bars, handheld devices have also become a popular option for technology-assisted EMDR. These devices typically feature

vibrating or tapping mechanisms that provide bilateral stimulation. The therapist can hold the device and move it from side to side, allowing the client to focus on sensations while processing their traumatic memories. This hands-on approach adds a tactile element to the therapy, enhancing client engagement and therapeutic outcomes. With technology-enabled EMDR, therapists can use a variety of tools, such as light bars, handheld devices, or software, to deliver bilateral stimulation. These tools are flexible and practical, making it easy to integrate EMDR into a variety of therapeutic contexts.

Computer programs designed specifically for EMDR have also become increasingly popular in recent years. These programs provide a virtual environment in which clients can participate in EMDR therapy sessions. The software displays visual stimuli, such as dots or moving images, that the client can focus on while processing their traumatic memories. The therapist can control the speed, direction, and intensity of the visual stimuli, tailoring the experience to each client's needs. This level of customization allows for a more personalized and effective therapy session.

In addition, technology has not only improved the delivery of bilateral stimulation, but has also expanded access to EMDR therapy. Telehealth platforms and mobile apps now allow clients to receive EMDR therapy remotely, removing geographical barriers and increasing convenience. Clients can participate in therapy sessions from their homes, ensuring that they receive the therapy they need no matter where they are.

Virtual reality devices are also emerging as a promising technology in EMDR, providing opportunities to improve the effectiveness and personalization of therapy.

While technology offers exciting possibilities for EMDR, it also presents unique challenges and ethical considerations that need to be considered.

Therapists using technology-assisted EMDR must follow ethical guidelines and ensure the confidentiality and security of client information. The application of technology in therapy requires careful attention to privacy and data protection.

Bilateral Eye Movement Disorder Emdr:

EMDR-FRANCE defined it as: Integrative therapy performed through bilateral stimulation (eye movements, etc.) and is a therapeutic technique discovered by American psychologist Francine Shapiro in May 1987, which allows for the activation of psychological potentials and the restoration of self-confidence, and the digestion of painful events.

VIII. General Protocol for Implementing EMDR:

The general EMDR protocol includes an EMDR practice sheet:

This sheet should be used by a therapist who has completed at least the first of three parts of training approved by the International or National EMDR Association.

The first battery is used in the first session with the patient and covers the first three stages of treatment; history, preparation for treatment, and assessment.

In this battery, the following aspects should be emphasized:

1. In addition to the history that therapists are accustomed to taking in practice in mental health services, the therapist should remember to focus the history taking on the target memory for EMDR treatment.

2. The environment in which the assessment and preparation takes place should be appropriate and safe, for both the therapist and the patient.

3. The patient needs to be able to tolerate the intense emotions associated with the trauma memory. Therefore, the patient needs to be trained from the beginning to have a dual focus by being able to maintain awareness of the disturbing past while remaining in the safety of the present and having the means and skills that help him to endure and control himself in a way that helps to control any discomfort and gives rise to positive feelings such as: a place of safety.

The sudden revelation of what may seem trivial, or previously unsuspected, may expose the patient to feelings that are difficult for the patient to bear.

4. New information during the session may open up new processing channels and processing may continue after the treatment session (between treatment sessions).

Stage 1: Taking History and Planning Treatment

1. Symptoms: Harmful or unproductive behavior: Emotions/feelings - Negative perceptions: Flashbacks: Intrusive thoughts: Panic attacks - Current triggers for symptoms: Frequency of symptoms, times of occurrence, location of occurrence - Any other symptoms.

2. Duration of illness: How long the problem has been ongoing. Any changes in factors that contributed to the problem.

3. Origin: Initial trauma, time of first symptoms, times of most distress for the patient, circumstances of those times.

4. Additional past events and traumas: Other events that influenced (or supported) the problem, who were involved in the event, vIllness reactions, negative perceptions, can the events be grouped into similar groups?

5. Other symptoms: Other difficulties, secondary dysfunction as an indirect result for the initial disorder.

6. Current complaints: current problems resulting, current emotional disturbances, current behavior, tasks the patient is unable to accomplish, functional problems that need to be addressed.

7. Desired state after treatment: The preferred state, what are the contraindications to this state? Expected outcomes of successful treatment, positive experiences in the patient's history (which he would like to refer to), any other clinically important information.

Stage 2: Preparation

1. Adopting a clear therapeutic position

• The therapist must emphasize that his role is to facilitate the self-healing process that the patient will carry out himself.

• The therapist's position: should focus on respecting and accepting the patient's need for security and reassurance. It should be directed precisely to the patient's needs and privacy.

2. Forming the therapeutic relationship with the patient:

• Ensuring an atmosphere of security and confidentiality:

• Establishing the therapeutic relationship on an atmosphere of honesty and trust.

• Agreement between the therapist and the patient on common therapeutic goals.

• Understanding the patient's need for trust, security and honesty from the therapist.

• Reassuring the patient that he cannot practice the treatment is wrong.

• The patient is in the cockpit and is the one who controls the treatment process.

3. Explain the theory: Use simple language including useful metaphors and analogies, especially: "The trauma seems to be locked inside the nervous system", "Eye movements in wakefulness, as in the similar sleep-REM stage, unlock the locked trauma" and "Your brain is the one doing the healing and you are in charge."

4. Experiment with eye movements:

• Experiment with eye movements to ensure the patient accepts distance, direction, etc.

• Experiment with rapid and slow eye movements.

• Try different eye tracking strategies: i.e. on both sides such as tapping on the hand or shoulder or audio stimuli or try other bilateral stimulation techniques (when optical technology is available).

• Agree with the patient on a sign to stop treatment by the patient such as: raising the palm (avoid using the word 'stop').

5. Create a safe/calm place: The reasons for this stage of preparation are to prepare the patient for a calming image of a temporary break during treatment when emotions are heightened. The safe (calm) place is also used Later to help close incomplete therapy sessions so that the patient does not leave the session disturbed.

Stages of creating a safe place (calm):

• Step 1: The patient searches for an image (actual or imaginary) that gives him a personal sense of safety and tranquility (a place he was in, passed through, saw or imagined

• Step 2: We ask the patient to focus on this image and deepen the feelings and sense the pleasant and soothing physical sensations associated with remembering the image of this place.

• Step 3: Focus and enhance the images, sounds, smells and physical sensations associated with the place.

• Step 4: Link the image and the pleasant sensations and fix them, using a group (between 4-6) of short and slow eye movements.

• Step 5: The patient determines the expression with one word (word cue-) describing the image and the pleasant sensations and fixes this with additional eye movements as in step 4.

• Step 6: The patient tries to remember the safe place by recalling the cue word without eye movements.

• Step 7: The patient brings a simple painful image and notes the negative feeling, and the therapist guides the patient to the safe place until the negative feelings dissipate.

• Step 8: The patient repeats Step 7 but without the therapist's help.

6. Description of the treatment idea:

• The memory that caused the PTSD is constantly being triggered, triggering the symptoms (it constantly comes to mind).

• This memory is stored in the brain as isolated memories; it remains as raw material that the mind cannot digest and learn from.

• Other memories in the brain are adaptive information that we need to solve the problem of the memory that caused the disturbance.

• The treatment occurs by connecting the adaptive information to the material that caused the disturbance.

• A network of associations is formed that brings new information to the mind that resolves the material that caused the disturbance.

7. Setting expectations:

• Emphasize the importance of safety, collaborative work, and the patient's control over the treatment process.

• Nothing will be imposed, and the therapist will respect the patient's request by 'stopping'.

• The treatment is a process that the patient does to heal himself.

• I use the metaphor of 'train travel' and the scene (disturbing images) passing before the patient. "

• Don't try to focus on the images and follow the eye movements" (I use 'neutral' images when needed).

• General description of the treatment: focus on the target memory, then make eye movements, then listen to the patient's responses.

• Sometimes things will change, sometimes they won't, but God willing they will change as the treatment continues.

8. Addressing the patient's fears:

• Confront all doubts and fears, and answer all questions honestly.

• Issues such as: 'fears that the patient will go crazy as a result of the treatment, 'not being able to get out of the target memory image, 'feelings of shame and guilt'...etc.

• It is acceptable for the patient not to disclose some information to the therapist; this is up to the patient.

• Show the patient pamphlets that he can read about EMDR.

• Arrange for the patient to talk face-to-face, if possible, with patients who have done the treatment before.

9. How ready is the patient for EMDR?

• Do you consider the patient ready for treatment? Disturbing memories Yes/No

• If no, does additional preparation need to be done?

• Any other clinically relevant information:

Stage 3: Assessment

1- Select the image

Therapist: “What happens when you think about the incident?” or “When you think about the incident, what happens to you?”

Specific memory ....

Therapist: “Which image best describes the incident?” If there are multiple options or the patient is confused, say: “Is there any image that represents the worst part of the incident?”

“If no image is available, say: “Think about the incident and tell me what you see?” Remember that the dominant memory may not be an image.

Selected image: ....

2- Identify negative perceptions:

Therapist: “Which words most closely match the selected image that expresses your negative perceptions about yourself now?”

Or we ask the patient to bring the image to mind and ask: “What are the disturbing thoughts you are having about yourself now?”

Now consider the following: The chosen cognition is an irrational cognition about oneself - in the present tense and generalizable and does not have to be a description of circumstances or feelings.

Note: EMDR therapy does not change environmental cognitions (i.e. what is actually happening now), functional responses (i.e. anxiety about getting the right answer), or descriptions of past events.

Examples (incomplete) of negative cognitions:

• Perceptions of low self-esteem:

I am not worthy of appreciation - I am a bad person - I cannot be trusted - I am shameful - I am worthless - My existence in life was a mistake - I am shameful - I do not deserve respect - I am not good enough - I only deserve bad things - I am ugly - I am permanently disfigured - I do not deserve anything - I am stupid - I am worthless - I am a disappointment.

• Perceptions of insecurity (vulnerability):

I can't trust myself - I can't trust anyone - I can't trust my judgment - I can't protect myself - I'm in danger - I shouldn't show my feelings - I can't control my feelings - I can't defend myself - I'm in danger - I don't belong anywhere - I deserve to die - I deserve to be miserable.

• Perceptions of lack of control/choice:

I'm not in control - I'm helpless/impotent - I'm weak - I can't get what I want - I'm a failure - I can't succeed - I have to be perfect - I can't get back up - I'm always falling short.

• Perceptions of lack of responsibility/doing something 'wrong':

I did something wrong - I must have done something wrong - I should have known.

Negativechosen cognition: .....

3- Forming a positive cognition:

Therapist:

"When you bring the image to mind, what do you prefer to believe positively about yourself now?"

Establish the following:

The chosen cognition: The chosen cognition is a cognition about yourself - in the present tense, generalizable, and the strongest expression that the patient is currently able to form in inverse relation to the negative cognition. Important: Avoid any cognition with a

negative expression (e.g.: I am not a bad person - negation of the negative).

Avoid illogical absolutes (e.g.: I will always succeed).

If the prevailing feelings are related to fear of past events, the use of a general positive expression (e.g.: It is all over, or I am safe now) should be studied.

Examples (incomplete) of positive perceptions

• Responsibility/Self-Confidence:

I deserve appreciation - I am a good person - I am good as I am - I deserve what I want - I am respected - I am loved - I am worthy - I am worthy of goodness - I am okay - I am right - I am capable of having - I am smart - I am important - I am fine as I am - I deserve to live - I deserve to be happy - I am doing the best I can - I have learned from what happened - I am capable of learning - I am doing the best I can.

• Choices/Leadership:

I am capable - I am now in control of my situation - I now have choices - I am strong - I can get what I want - I can succeed - I can handle the situation.

• Safety:

I can be trusted - I can learn to trust myself - I can trust my judgment - It's all over now - I can protect myself - I'm safe now - I can show my feelings without a problem - I can express my feelings - I can tell others what I want.

Selected Positive Cognition .....

4- Validity of Cognition-VoC Measurement

Therapist:

"When you think of that image or incident, how true are those words? (Repeat the selected positive cognition above). As they appear to you now on a scale of 1-7, where 1 is when they seem very false and 7 is when they seem very true?

1" 7-------- 6-------- 5-------- 4-------- 3-------- 2----------1)Very false) (Completely true)

Note: If the patient selects the validity of the positive cognition as 1, ask yourself if this is because the positive cognition is not really possible, false, not applicable, or inappropriate for the situation? In these cases, the positive cognition is most likely inappropriate and needs to be changed.

Value of Perception Validity…… (Voc)

5- Labeling Feelings:

Therapist: (Negative Perception) "When you bring the image and words to mind, what feelings are you feeling now?

Note: It is important not to confuse feelings with perceptions: there are no such feelings (e.g. 'I feel like I have failed'

Labeled Feelings…….

6- Associated Feelings and Subjective Disturbance Units (SUDs)

Therapist: “On a scale of 0-10, where 0 is neutral or no discomfort or distress, and 10 is the highest discomfort you can imagine, how much discomfort do you feel as a result of remembering the event now?

10--- 9--- 8--- 7 --- 6 ---- 5---- 4---- 3---- 2---- 1---- 0

(No Disturbance/Neutral) (Highest discomfort)

Subjective Discomfort Unit (SUDs) ……

7- Checking the bodily sensations

Therapist:

Where do you feel the discomfort in your body?

Important: It is not necessary to ask the patient to describe the sensation. The question is does the patient need training to assess the location of the discomfort? Alternatively, ask the patient where in the body they feel the subjective discomfort unit (SUDs).

Location of discomfort in the body of ..... (Walid Khaled Abdel Hamid, Matjal, 2013)

2- CAT Protocol (Cognitive Analytic Therapy)

1. Historical Overview (History and Development):

Cognitive Analytic Therapy (CAT) was developed as a form of individual therapy in the 1980s at Guy's and St. Thomas' Hospitals in London. The founder of this model, Dr. Anthony Ryle, proposed integrating cognitive theory—particularly ideas from information processing, personal construct theory, and the collaborative nature of

the therapeutic relationship—with psychodynamic techniques, primarily object relations theory. He introduced the concept of reciprocal roles. CAT was formally established as an independent form of psychotherapy in 1984.

The early days of CAT application trace back to the 1960s when the National Health Service (NHS) in the UK, which ensured free and equal access to healthcare for all, was still a newly established institution. Dr. Ryle, then a general practitioner in London, observed that many of his patients suffered from non-psychotic psychological difficulties, but no formal treatment framework was available to address their struggles. Despite having no formal training in psychology or psychiatry, Ryle, sharing the NHS's values of equality, began developing a suitable therapeutic approach for public healthcare.

Initially, CAT focused on helping individuals with neurotic symptoms. However, over time, its scope expanded to include patients with more complex psychological disorders, particularly personality-related difficulties. As a practical and collaborative model, CAT emerged to formulate patients' issues in dynamically relevant terms while making them accessible to patients and facilitating goal evaluation within therapy. Eventually, CAT was developed and adopted as a recognized therapeutic model.

Ryle (1982, 1990) developed CAT with the aim of integrating cognitive and psychoanalytic ideas. Since then, CAT has evolved into an integrated theory that reframes aspects of psychoanalytic theory from a cognitive perspective, providing a clear framework for clinical practice.

2. Founder of Cognitive Analytic Therapy:

Anthony Ryle (March 2, 1927 – January 2020) was an English physician who studied at Oxford Hospital and University College. He qualified in medicine in 1949 and worked successively as a founding member of a group practice in Kentish Town, London, director of health

services at the University of Sussex, and consultant psychotherapist at St. Thomas' Hospital in London. After retiring from the NHS, he worked part-time in teaching and research at Guy's Hospital.

During his time in general practice, Ryle conducted epidemiological studies on the patients under his care. His experience demonstrated the widespread prevalence of psychological disorders and their familial relationships, which later influenced his interest in developing psychotherapeutic approaches that could be practically delivered within the NHS. This led to studies on the process and outcomes of psychotherapy, culminating in an integrated psychotherapy theory and the development of time-limited therapy, which became CAT.

3. Concept of Cognitive Analytic Therapy (CAT):

CAT is a structured psychotherapy conducted in individual sessions, couples therapy, or group therapy for individuals with the same disorder.

Hussein Fayed (2005, p.344) adds that CAT focuses on describing various psychological states and helping patients identify reciprocal role procedures—relationship patterns learned in early childhood that are relatively resistant to change. Patients are taught to recognize and attempt to alter dysfunctional patterns of thinking and behavior associated with these states while becoming more self-aware. The therapist's role is to collect information about the patient’s experiences in relationships and different psychological states.

4. Stages of the CAT Therapeutic Process:

A compassionate relationship exists between the client and therapist within therapeutic boundaries, aimed at helping the client understand their condition and find ways to make positive changes.

Therapy sessions are agreed upon between therapist and patient, typically ranging between 16, 24, or 32 sessions.

Early sessions in CAT focus on collaboratively developing and reformulating a descriptive and schematic representation of the patient's overall distress, dysfunction, and developmental origins. These become essential for the subsequent therapeutic work.

CAT follows four key phases:

Phase One: Reformulation

Like most therapies, the therapist focuses on three primary tasks: establishing a therapeutic alliance where the patient feels that therapy will be beneficial and worthwhile, building trust in the therapist, and gathering the patient's life story.

The therapist encourages the patient to identify their strengths, areas of competence, and sources of satisfaction. The goal is to determine strengths and challenges. Reformulation is central to CAT and aims to provide an accurate description of the problem and how maladaptive patterns sustain these problems. A written reformulation narrative is provided to the client in the fourth session. Later sessions focus on developing a sequential diagrammatic reformulation (SDR), which provides a comprehensive representation of how maladaptive patterns are formed, connected, and maintained. Throughout therapy, the client learns to identify and revise these patterns, ultimately developing 'exits' from unhelpful cycles.

Phase Two: Recognition

In this phase, the focus shifts to recent experiences, exploring situations where the identified patterns occur. Many of these patterns involve relationships with others or oneself. This phase emphasizes observing occurrences with empathy rather than attempting to change them. The

CAT map serves as a guide to the client's difficulties, their development, and the patterns that keep them stuck.

Phase Three: Revision

As therapy progresses, the focus shifts to experimenting with new ways of relating, thinking, and acting. This stage involves trialing alternative behaviors and perspectives and assessing their effectiveness. Therapy aids clients in developing new coping strategies while recognizing and addressing relapses into old patterns.

Phase Four: Ending

Therapy termination can be challenging, so the last three or four sessions are dedicated to reflecting on the therapeutic journey and concluding the therapeutic relationship. The therapist writes a goodbye letter to the patient, inviting them to do the same and share it in the final session. The goodbye letter, along with the CAT map and reformulation letter, serves as written reflections for continued self-guided work post-therapy.

5. Therapeutic Process:

The therapist actively listens to the patient's story and identifies the meanings behind their experiences. Initially, this occurs verbally in sessions and later in the reformulation letter. The therapist and patient collaboratively identify patterns and themes in these experiences and agree on a concise reformulation to describe them.

6. Indications for CAT Use:

Initially, CAT was mainly used for patients with personality disorders, particularly borderline personality disorder. However, as CAT evolved, it proved effective for almost all psychological disorders. Therefore, CAT is highly recommended for any adult who does not meet the criteria for substance use disorders or psychotic spectrum disorders. Nonetheless, various CAT adaptations are being developed for use in these conditions.

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