# Humanistic Experiential Psychotherapy for Depression: a Case Study

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***Abstract***

***Introduction:*** *Past research has identified creativity as an essential psychotherapeutic factor in the treatment of depression. Nonetheless, using creative-expressive techniques to alleviate depressive symptoms within a humanistic experiential framework still remains a challenge for both scientists and practitioners.*

***Objectives:*** *This study is aimed at presenting a humanistic experiential psychotherapy (HEP) treatment protocol, based on visual creative-expressive techniques for depression.*

***Methods:*** *The single-subject design was used to illustrate the psychotherapeutic process and to provide preliminary evidence related to the HEP approach for depression. The humanistic experiential treatment consisted of 20 weekly sessions.*

***Results:*** *The results showed that the HEP treatment reduced depressive symptomatology.*

***Conclusions:*** *The current study provides preliminary evidence that may guide the development of an extensive trial, to test the efficacy of the HEP treatment protocol for depression, as well as to identify underlying mechanisms of change.*

***Keywords: art therapy, creative meditation, creative-expressive techniques, somato-genogram***

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## I. Introduction

In 2015, 322 million people worldwide suffered from depression, according to the Global Burden of Disease Study, which represented an increase of 18.4%, over the 2005 figures (Vos et al., 2017). Depression has biological, social, and psychological causes and effects, affecting the person's mind and body. As such, the treatment of depression requires an integrative and individually tailored approach, often combining pharmacological, psychosocial and psychological interventions (Zubala, Macintyre, Karkou, & Zubala, 2016).

Unfortunately, treatments for depression and anxiety are rarely provided adequately (Fernández et al., 2007). Nonetheless, results of a recent meta-analytic study regarding the effectiveness of seven psychotherapies in treating depression highlighted robust effects of cognitive behavioral therapy, interpersonal therapy, and problem-solving therapy, while effects were less robust for psychodynamic therapy, supportive counselling, and behavioral activation. However, effect differences between these psychotherapeutic interventions were rather small. Overall, the results showed that different psychotherapeutic interventions for depression have comparable, moderate-to-large effects (Barth et al., 2016). Furthermore, treatments with proven benefits still do not necessarily work for all patients, and which type might work best for a particular patient most likely depends on inter-individual differences (Barth et al., 2016).

Another line of research has found creativity to be a crucial psychotherapeutic factor in treating depression (Blomdahl et al., 2013). Creative-expressive techniques in general, and expressive arts therapies in particular, by recognizing the values of creativity and non-verbal communication, may offer a suitable treatment option for some patients with depression (Zubala, MacIntyre, & Karkou, 2014). More precisely, the psychotherapeutic process based on creative-expressive techniques facilitates a subtle or more obvious activation of the multiple roles residing in the patient's psychological dynamics. This is particularly beneficial in the case of depression, which is frequently characterized by a lack of energy, a feeling of emptiness or other negative emotions (Petre, 2018). During the course of art-based treatment, the patient plays multiple roles: of the spectator, performer, and director of specific stages. Therefore, the patient is able to observe, manipulate, control or change the psychotherapeutic environment at first, and then the existential context.

The patient's artistic products – drawings, collages, modelling, art genograms (Mitrofan & Petre, 2013a, 2013b), could be both the question and the answer to a specific problem, because the art therapeutic process facilitates immediate and objective answers, needed by the depressive person (Petre, 2018). Scientific literature demonstrates some potential effects of art-based techniques: acceptance of depression and its challenges, enhancing creativity and readiness to express emotions, sense of self and awareness of others, and readiness for meaningful communication and relationships (Zubala, MacIntyre, & Karkou, 2017). Additionally, art therapies may potentially bring a sense of achievement, of balance and new insights, and may facilitate growth and finding meaning for adults suffering from depression (op. cit., 2017). However, given that the psychological treatment of depression is demanding and brings challenges to both therapists and clients (ibidem, 2017), this study aims to present a protocol of humanistic experiential intervention based on creative-expressive techniques.

## II. Method

### Design

This study consists of a single-subject design. A humanistic experiential treatment approach was applied.

### Characteristics of the participant

For the purpose of this article, the participant was given a fictional name: Maria. Maria had been married for 20 years. She had a 14-year-old daughter and an 18-year-old son. While also being an active member of the community, she worked as a bank manager. She initiated therapy, accusing significant cognitive, emotional and social impairments. More specifically, the patient had noticed a significant deterioration of her social and professional competencies, accompanied by a wide range of psychosocial modifications: a "collapse" of her ability to sustain and complete work and family-related tasks, a diminished sense of autonomy, increased fatigue, emotional dysregulation, marked by fluctuations between crying and angry outbursts, anhedonia, and increased anxiety towards professional and social contexts. As for the cognitive domain, the patient exhibited difficulties of focused and sustained attention, as well as self-related obsessions that generated anxiety and instability. Psychosomatically, the patient reported multiple neurovegetative symptoms: headaches, dizziness, palpitations, and feelings of suffocation.

In order to establish the psychodiagnosis, the Millon Clinical Multiaxial Inventory-III (MCMI-III) was administered. Clinical data, obtained from the psychological assessment, indicated symptoms specific to a somatoform disorder in association with symptoms of major depression, on an avoidant and compulsive personality pattern.

The experiential psychodiagnosis revealed a depolarization of the sex-role identity, with deteriorations of the masculine and feminine sex-roles and a stagnant parentified child role. Taken together, these symptoms showed a maladaptive integration of parental roles, manifested as an excess of the paternal role and a deficit of the maternal one.

## III. Results

### The psychological treatment plan

The psychological treatment protocol consisted in 20 sessions with weekly frequency. This article will present the first 10 sessions of the protocol, by illustrating the psychotherapeutic assessment procedure and the intervention that aimed to alleviate the psychological symptoms. The last 10 sessions were dedicated to consolidating and implementing the psychological changes in the existential context.

The first 2 sessions were focused on the psychological assessment: the clinical and experiential psychodiagnosis was established, informing the psychotherapeutic objectives and the psychological treatment plan.

During the next 8 sessions, the profoundly restructuring psychological intervention took place. According to the patient, the psychotherapeutic objectives were: learning more about her mental health state, alleviating anxiety and depressive symptoms, resuming her work-related activities, regaining her sense of autonomy. Based on these objectives and the aforementioned psychodiagnosis, the psychological intervention aimed to:

1. facilitate the adherence to the psychiatric treatment, by educating the patient about the neuropsychological functioning, the interaction between psychological, social, and biological factors, the role of the social support network, and by engaging the patient in enhancing and sustaining these protective factors;

2. increase the awareness of the psychosocial meaning played by presenting psychosomatic complaints, and restructure the attitude towards anxiety and depressive symptoms by practicing adequate strategies of managing these symptoms;

3. restructure emotion regulation strategies and adaptively integrate aggressivity;

4. increase the awareness of, activate, and integrate the psychological resources that were blocked in the maladaptive patterns that favored the onset of anxiety and depressive symptoms;

5. develop and consolidate the masculine and feminine sex-roles;

6. unblock, develop and integrate individual and family psychological dynamics, and also adequately activate the inner child;

7. unblock and integrate parental roles.

### The course of psychological intervention

#### Session 3

*Objectives:*

*a. to facilitate the adherence to the psychiatric treatment, by educating the patient about the neuropsychological functioning, the interaction between psychological, social, and biological factors, the role of the social support network, and by engaging the patient in enhancing and sustaining these protective factors;*

*b. to develop working alliance.*

Given that the patient expressed negative obsessions regarding the psychiatric treatment, the adherence to the psychological and psychiatric treatment was strengthened by working on 3 dimensions:

- psychoeducation regarding the biochemistry of psychological functioning, and the impact of biological factors on developing, maintaining and worsening symptoms of somatoform, anxiety and depressive disorders;

- clarifying the working alliance, especially Maria's transference; her projections were identified by redefining the ambivalent relationship with authority figures and by making room for an authentic perspective towards the therapeutic relationship; the dynamics of the parentified (adapted) child role was explored, with fluctuations between the "obedient" and the "rebellious" parts, the "obedient" part needing help and psychotherapeutic guidance and the "rebellious" part opposing treatment and recommendations; the client explained the emotional symptoms, fatigue and exhaustion, as being caused by the fluctuations between these two parts; the specific needs of these two parts regarding the psychotherapeutic context were identified, influencing patient's ownership of psychological strategies that are tailored to her needs, such as consulting a psychiatrist and following their

recommendations; consequently, restructuring Maria's previous perspective towards the psychiatric treatment stimulated the next dimension of adherence, the relationship with the psychiatrist;

- recommending the initiation of psychiatric consultations and "laying the groundwork" for the relationship with the psychiatrist; taking into consideration the compulsive personality pattern and the anxiety and depressive symptoms of the patient, special attention and efforts were given to restructuring the obsessions by confronting reality and increasing the level of predictability regarding the psychiatric consultation, the psychiatrist's personality and attitude, the type of treatment, mode of administration, and possible effects.

*Psychological effects:* The patient made an appointment to see the psychiatrist. Anxiety levels decreased, as demonstrated by her facial expressions, gestures, and postures. The cognitive restructuring was made evident by changes in patient's speech.

**Session 4**

*Objective: The consolidation of working alliance and of adherence to the psychiatric treatment.*

The preliminary experience with the psychiatrist was discussed, which brought to surface ambivalent feelings reported by the patient: suspiciousness, anxiety, and negative expectations related to the treatment's effects. The psychotherapeutic focus was redirected towards exploring other relationships in which the patient had experienced such states. Thus, the patient became mindful of the psychological role she had positioned herself in professional relationships, alternating between the persecutor-victim-rescuer roles. This neurotic psychological dynamic was "unfolded", through metapositions. The technique of metapositions was tailored to Maria's low energetic level, but still keeping a mildly challenging aim. As such, from a dual observer and actor position, she experimented with the strategies that were specific to the neurotic triad of the persecutor-victim-rescuer roles. She became aware of the maladaptive psychological mechanisms that were incongruent with her present needs. More specifically, the needs that she identified were: support, guidance, and freedom (understood as an emotional and intellectual contact, not as a responsibility). Accordingly, the maladaptive psychological mechanisms "deprived" her inner adapted-rebellious child emotionally and overwhelmed her inner adapted-obedient child.

The Ego States were explored, with a focus on the adapted-rebellious child and on the adapted-obedient child, aiming to reposition these roles in an adequate life context and to develop new strategies of manifesting these roles in the psychotherapeutic space. To this end, mindfulness-informed strategies were used, as they were considered to be most effective in controlling the patient's regression and in preventing the psychological dissociation and neurotic deterioration. The overarching aim of these strategies was to integrate the psychological structure and to reinforce adaptive psychological mechanisms.

*Psychological effects:* The working alliance was strengthened, as manifested by the Maria's verbal and non-verbal communication – the body posture was more relaxed and open, the facial expressions and gestures were more dynamic, and the body temperature and blood flow increased mildly. Behavioral, cognitive, and emotional effects were also congruent with these changes, reflecting a growing receptivity towards the psychological and psychiatric treatments.

**Session 5**

*Objective: The exploration of the personal and transgenerational meaning embedded in the psychosomatic symptomatology, with a focus on mentally repositioning towards anxiety and depressive symptoms.*

A technique essential to the Experiential Unification Psychotherapy, the somato-genogram, was used (Mitrofan & Petre, 2013b; Mitrofan & Stoica, 2005). This technique unraveled the developmental patterns of the psychosomatic symptomatology, in a transgenerational analysis framework: the roles played by diseases in maintaining family myths and scenarios were explored, bringing light to transmission mechanisms, such as identification, counter-identification, projection, and repetition. This technique was particularly suitable to Maria's psychological traits and needs of learning about her mental state and of constructing meaning around the psychosomatic symptomatology. Working with the somato-genogram, the patient became increasingly mindful of the anxiety, depressive, and burnout symptoms manifested by the women in her extended family (her elder sister, mother, and maternal grandmother) and of the oncological diseases manifested by men (her father and grandfather). Moreover, Maria suffered from Hashimoto's disease, an autoimmune condition, defined by an exaggerated response of the immune system, which triggered an "attack" of the organism towards the thyroid gland that was perceived as an external and potentially threatening tissue.

The somato-genogram also worked as a projective test that was designed for the experiential psychodiagnostics. In this particular case, the identity confusion caught our attention, as it was represented by the sex-role inversion: the excess of masculinity and the deficit of femininity expressed by the women in the family, as well as the deficit of masculinity and the excess of femininity expressed by the men in the family. The resulting experiential psychodiagnostics is backed up by the projective representation of the psychosomatic symptomatology, by using natural elements. As such, the patient made a collage for each pathology of her family's members. Put simply, the anxiety and depressive symptoms of the women in her family were represented by green elements, with undifferentiated boundaries between them. The somatic pathology the men in her family suffered from was expressively represented with very small elements, such as white or pastel shells or rocks.

With regards to her personal representation, the patient used elements from both these configurations: the surface leaves hid a big shell, that was upside down. She spontaneously reflected "even though I hold everything together, it is as if I do not hold anything at all... not even myself" (with a sad face and a forced smile). The psychotherapist provoked this conflicting experience, mirroring what the patient constructed: "I understand that this is what your disease holds together... Let's see who you are, how you are like, what you can hold, and what you need to hold in the sense that it helps you evolve!".

Maria then understood that, paradoxically, her disease offered her a space, although maladaptive, to express her emotions. The disease made her emotions seem normal, to her and her family. The maladaptive patterns granted the women in her family "the right to cry", while at the same time, acting as a means to persuade men to conform. It was as if they did not allow themselves to be protected, cared for, loved, but at the sake of their physical and mental integrity. The psychosomatic disease gave women "an entrance ticket" to the world of the female victims and the men "access to their sickbed". The patient had an insight: "Since I have been sick, I spent more time in bed than ever with my husband... We caress, talk, and he is near me. I have never spent more than a month at home before, not even after I gave birth. My husband was on child care leave. My son, when I used to leave home in the morning, told me «Bye, bye! Come visit us again!». This disease brought us closer. It took away my job and gave him instead. I always thought that work came first, but I never thought that my couple relationship was important. It was just there, night and day. We always respected each other.". This fragment shows the rationalization of the disease and of the couple dynamics, characterized by heightened levels of commitment, emotional, cognitive, and social intimacy, but lowered passion.

Hashimoto's disease, anxiety, and depression all worked hand in hand in the patient's life scenario. Maria said: "They want to make me cry, to forget that I am strong. I shouldn't let myself be hypnotized by the leaves, and I should allow my shell to breathe.". This statement brought forth a deeply meaningful metaphor, of the psychological conflict between masculinity and femininity, control and openness, and of the patient's needs to take ownership of her impulses (aggressivity and sexuality).

The clarification of this therapeutic metaphor helped Maria to rearrange the projective elements, with a significant impact on the reconstruction of the sex-role identity. She symbolically "freed her shell", by offering it "a protective nest", but also a "foundation" made up of leaves. She explained that: "It is time for me to use my strength and ideas, in order to sustain my sensitivity. Up until now, I used to think that I was sensitive because I liked to take long walks in the park or to spend hours looking at leaves. I surely am sensitive. But from now on, I will look at leaves differently. Now I see why they fascinate me. Beyond their color and movement, the leaves know how to stand still, how to be carried by the wind, how to dance, how to cry. The leaves are not solely reliant on the tree. The tree only gives them support. I also want to be able to dance, not just shake my leaves here and there (...). It is true, I like what I do. At least now I understand why. Maybe it is not so much about what I am able to do, but what I want. Actually, although I find it hard to accept, maybe I do not want to be like a man anymore.".

*Psychological effects:* The patient reconnected with her affective states, improved her mood, and relaxed her body.

**Session 6**

*Objectives: To increase emotion regulation and adequately express aggressiveness.*

The creative-dynamic meditation was used, with a graphic projective support.

Maria reported alternating between fatigue and anger ("I feel like I am about to blow up..."). The psychotherapeutic scenario was focused on reconstructing the psychological conflict, as well as on

identifying alternative strategies of regulating this conflict. Through the creative-dynamic meditation, the patient was thereby guided to connect with her mind and body. After that, the patient was encouraged to maintain an adequate and authentic contact, as both an actor and an observer of the experience induced by meditation.

The overall aim was to identify the specific place where anger resided in her body. According to this aim, the meditative scenario was built in such a way as to allow the patient regain control over psychosomatic symptoms. Afterwards, the patient was challenged to bring this experience to surface, using drawing as an expressive support.

Maria identified the stomach area as the place where anger "lived". While drawing the anger, she became aware of the maladaptive psychological mechanisms used to regulate this emotion:

"T: I invite you to describe what you have drawn... *(The patient was initially challenged as an observer, in order to increase perceived psychological control and identification with the expressive product.)*

M: Something hideous...

T: Hideous and...

M: Frightening.

T: Something hideous and frightening. What exactly makes it frightening? Look at it! *(The experience is analyzed in the present, facilitating Maria's identification with experienced anger.)*

M: The color... It is dark.

T: The color. Is there anything other than the color?

M: The color is more than enough. *(A fragmentary answer, which could have indicated an emotional blockage and difficulties of regulating anger.)*

T: I take it that your anger is frightfully black... *(The identification with the aggressive part was facilitated, controlling the regression through constantly bringing the psychotherapeutic focus on the expressive product.)*

M: Yes, one cannot see anything else. *(The client did not use the first person in her speech, indicating a psychological dissociation from the negative emotion, as a way to control it and its embedded aggressiveness.)*

T: When you are angry, you cannot see anything else... *(The aim was to facilitate an intimate contact with anger.)*

M: Yes!

T: You feel hideous and you feel like...

M: It is horrible to be inflamed like that... No one makes me angry, but still, I feel like I am about to blow up.

T: No one makes you angry and still, you feel like blowing up! *(Reflecting Maria's emotions.)*

M: I have no right, no one is forced to put up with me... Sometimes I ask myself how much time others will be able to stand me... *(Avoidance and rationalization.)*

T: If I understood correctly, on one hand you feel anger, you feel like blowing up, but on the other hand, you think that it is not ok, that you have to be thankful that others put up with you. *(Clarification.)*

M: Well, isn't that normal?

T: For you, it is something ordinary. It is normal for you, that while you are blowing up (with anger), you also think you shouldn't feel like that, that no one is forced to put up with you. On one hand, something annoys you, on the other hand, you think that you are not allowed to feel anger. Is that right?

M: Exactly!

T: It is as if what you are thinking is in conflict with what you are feeling. On one hand, there is your reaction to norms or rules, that you withhold and interpret as being inadequate, on the other hand, there are your thoughts of what you consider to be right. If you allowed yourself to feel anger, if you listened to your emotions...

M: I cannot do that. I am scared.

T: You are scared... *(Reflecting the anger-fear polarity.)*

M: I am scared that I might lose control, that I might turn everything into ashes. I am scared of what might happen... I am scared of losing the ones I love.

T: I see. You are thinking that you might lose them if you expressed how you had been feeling. Meanwhile, your anger rises, blows up, turns you into ashes, as if your anger rises as fear increases... Like the anger is fed by fear? Or is it that the anger "burns" your fear?

M: Yeees, the more that I withhold, the blacker I look... *(Psychological insight.)*

T: The more frightened you feel, the angrier you are... It is as if in this drawing, behind, near the anger or somewhere else, also lies fear. Where is your fear in this drawing?

M: It isn't here."

At this stage of the psychotherapeutic process, there are several ways to further explore the psychological conflict between anger and fear, by facilitating contact with either the cognitive, emotional,

or behavioral dimensions. Considering that some of the most valuable functions of experiential psychotherapy based on expressive products are reducing defense mechanisms, anchoring the patient's experience within the expressive product, bringing the psychological conflict in the here and now, and restructuring the maladaptive coping strategies, the behavioral-pulsion dimension was chosen, as can be seen from the following sequence:

"T: I invite you to bring your fear as well, in this space in which you are safe. Bring it as you feel like now! Give it a shape, a color, and a content! Let it be exactly as you know and feel it! Let it be even as you remember it, as you live it, more or less connected to your anger! Let it be in this space as well, because sometimes, the more frightened you feel, the angrier you are."

Thereafter, the intervention was focused on identifying the psychological mechanisms that had been associated with fear, firstly through psychotherapeutic dialogue techniques and then, through role-play.

"T: Let's get to know them better! I suggest that we get even closer to them and for a few moments, you can even speak on behalf of each one of them. You could begin with the part that we know more of, this black one, be it darkened from demands, anger, rules, or with the other part, the one that is afraid to lose, to lose their attention or something else..."

The role-play was then initiated, in order to reconfigure the psychological conflict between anger and fear, and to reconnect the psychological resources through the dialogue of the parts, that were named by the client: "black, the anger of the rules" and "the naive pink" (fear).

During the dialogue of these parts, Maria became aware of the psychological contents engrained in these polarities. The patient identified the emotions that were experienced by the rebellious and the obedient parts of her Self. Anger was associated with coercion and imposed rules (the core psychological theme was the rejection felt from the parental figure), whereas fear was related to the loss of attention, safety, and affection. On the other hand, freedom was understood by Maria more as an absence of rules than as a differentiation of her own rules according to her psychological needs.

The patient mentioned the resistant character of her anger. She went on to describe this emotion as smoldering, while fear had more color, was more vibrating, making her feel alive. Hence, Maria brought back fear in the emotional dynamics, giving new meanings and functions to the emotions that she encountered. This reconfiguration was first facilitated in the psychotherapeutic context, laying the groundwork for changes in real life through psychotherapeutic anchors.

Maria emphasized the stubborn, rigid, and determined character of her anger – a sort of courage without purpose. In order to regulate her anger, she needed to practice spontaneity, flexibility in finding it a direction and a purpose, according to her psychological needs. Building from the role-play, Maria discovered an adaptive purpose of her anger: to foster and sustain the expression of fear. To anchor this psychological insight, she identified a key question to ask herself in moments when she felt anger: "What fears does my anger hide?".

After the role-play, Maria represented anger with a red heart and other colorful elements, and fear with a park (a personal space, designed for exploration and self-expression). Going even further, the patient chose to "wear" her courage (anger) through her clothes, taking the roles of a fashion designer and model, which indicated the dynamic activation of parental and child roles.

Therefore, the personal development theme was anchored through clothes, facilitating these changes in the psychological realm as well. Maria chose to wear a fashion accessory, that could express and sustain both her courage (anger) and her sensitivity (fear). The statement type of accessory reflected her courage, while the color symbolized her sensitivity.

As a result, the patient explored how to creatively turn maladaptive aggressiveness into an adaptive self-expressive behavior. Within the psychotherapeutic framework, Maria constructed a space that could later be used as an instrument that facilitated processing uncomfortable emotions: from the confrontation of opposing emotions, to their flexible cooperation. In other words, she repositioned towards these emotions, by learning new strategies of regulating them, according to her personality's needs.

*Psychological effects:* The psychological resources were activated, by integrating the anger (courage)-fear polarity, corresponding to the masculine-feminine axis, and to the rebellious child-obedient child roles. These themes will be explored during the following sessions.

**Session 7**

*Objectives: Continuing the process of consolidating the Self, integrating the anger-fear*

*polarity adequately and creatively, and activating the psychological resources through behaviors.*

Once again, expressive techniques, but with an Imago support were used. Considering that the last session was about balancing the anger-fear, masculine-feminine polarity, it was important to sustain the consolidation of these parts of the Self through a conscious growing process of the patient. That implied an activation of the inner nurturing parent towards the inner child (that was adapted and fluctuating between the rebellious and the obedient child). Thus, session 7 was focused on consciously activating the parental-filial relationship. Caution was taken in order to control any potential regressions, by simultaneously activating the emotional, cognitive, and behavioral dimensions, which allowed the patient to identify and develop coping strategies that were suitable for her psychological profile.

The psychotherapeutic scenario was focused on integrating body image, thereby guiding the patient to identify herself in images picturing both masculine and feminine silhouettes, made up of images with heads and bodies.

At first, Maria was challenged to find a face that best mirrored how her face looked like in the past. Then, the patient chose an accompanying body that was most suitable for her past Self. The scenario continued by choosing faces and bodies, that were emblematic for her present and future Selves. Like that, the patient constructed 3 silhouettes that corresponded to past, present, and future body images. Maria identified a common element among the 3 silhouettes: a discrepancy between rationality, affect, and pulsion. She believed that this discrepancy was most visible as the postures and facial expressions in the pictures were adjusted more to others' expectations, than to her own needs. The patient associated this insight with her roles of family leader, and of organizational leader, that made her paradoxically lose her "leading" ability, at least in relationship with her body.

Going further, the psychotherapeutic process sought to reconnect the head with the body. The patient was challenged to experience what it was like, living without a head, without control: she changed her body posture, from a tensed state to a more relaxed one. This stage of the process increased her anxiety levels, but the psychotherapeutic support facilitated the connection with the body. Maria became mindful of her body's needs of connection with the mind, of emotional containment, and of emotional expression. Asked about how she felt and thought, she replied:

"M: I feel like woman!

T: To whom are you saying this?

M: To everyone."

From this point, the psychotherapeutic process and dialogue were designed to facilitate the patient's experience of the feminine role, aiming to reconstruct this role in the following session.

Session 7 continued to lay the foundations for the development of adaptive emotion regulation strategies, by inviting the patient to find "her head" and to get to know it differently. Maria chose an image for her "newly found head", describing it "as hers".

"M: This head is mindful and knows how to say «I do not want»."

Wanting and not wanting were explored, based on an analysis starting from the body, its sensations and emotions, and evolving to speech and thoughts.

"M: I want to be a baby; I want to be a woman." *(Themes of maternal rejection and couple functioning.)*

As such, patient's needs of protection, support towards her inner child, and emotional contact came to light within the psychotherapeutic process. The strategies used for satisfying these needs were clarified, together with the patient.

*Psychological effects:* The emotional dimension was redefined, making space for the psychological resources of the feminine role to be expressed. The patient was navigating the process of owning her sex-role identity, in her mind and body. Maria's cognitive, emotional, and behavioral responses were congruent with the stage of integrating femininity.

**Session 8**

*Objectives: Integrating the sex-role identity, through the development and enhancement of couples functioning.*

During role-play and psychotherapeutic non-directive dialogue, the patient characterized her couple's dynamics as being blocked in a parental transaction with a strengthened commitment, effective communication related to interests, family values, life perspectives, and social status. On the other hand, sexuality was blocked, along with desire, and sexual drive. When discussing sexual behavior, the patient tended to use rationalization and reaction formation.

Thus, Maria was challenged to "clean" the image of the perfect couple, which she had struggled to maintain for the last 25 years. The aim was to differentiate real individual and partnership needs, from couple mythologies. Maria managed to identify and express her anger, associated with perceived

unsatisfactory stimulation and attention from her partner. Afterwards, Maria went on to assume responsibility for the "relationship's vibe" and she wanted to ask her partner for forgiveness because she had chosen to experience "desire and passion" mostly through her work.

"M: Although I had always said that family came first, I have betrayed it with my work (...) and now I pay for that. *(Talking from a rescuer's point of view, with a tendency to alternate between total responsibility and irresponsibility, between guilt and anger.)*"

After adjusting the couple's dynamics in the psychotherapeutic context, the patient intended to have an open discussion with her husband, expressing her needs, her recently discovered emotional, cognitive, and behavioral availability, in order to reconnect with him and to rediscover him as well. She was guided by the psychotherapist to inquire about his potentially different availability, as well as to activate the resources needed for redefining the sexual relationship with patience, seduction, openness, and transparency.

*Psychological effects:* The patient acknowledged that her aggressive instincts had been blocked in the professional context, thus affecting the couple functioning. The marital and feminine roles were restructured, facilitating sexual desire and intimacy. Maria's vitality and energetic level grew, as made evident by her relaxation response. She said that she felt as if "the woman in her was reborn".

**Sessions 9-10**

The psychotherapeutic process is currently ongoing, having the aims to sustain the psychological effects by implementing the somatic, cognitive, emotional, and behavioral reconfigurations in the existential context, through specific anchors and life plans.

## IV. Conclusions

Maria developed more effective and creative strategies of regulating the psychological, family, and social resources, as observed through her intrapersonal and interpersonal functioning. Beyond the remission of anxiety, depression, and somatoform disorder, the patient regained her cognitive, emotional, and behavioral control over life experiences, in general, and over her psychological vulnerability, in particular. In other words, the patient acquired creative and adaptive strategies of dealing with her specific pattern of psychological functioning.

She qualified as eligible for a low level of health disability and she chose to continue her professional activity in a flexible manner, collaborating on projects to which she could have contributed with her economist's experience. The collaborations were held in a more organized framework, with very well-determined working hours and responsibilities, indicating her increased levels of maturity and of integrating the adapted-parentified child into a responsible adult.

She also managed to establish a small business with mosaic decorations, which represented a creative integration of aggressiveness and an activation of the previously blocked masculine and paternal psychological resources. The integration of masculinity also emerged through physical activities that developed her gross motor skills. Whereas the creative work with the mosaic enhanced her fine motor skills and the balance of the Self, the cardiorespiratory endurance exercises consolidated her body's strength and endurance, with indirect effects on the Self's strength and endurance levels. It is no wonder, then, that the endurance training preceded the establishment of the creative professional space. The energetic levels have significantly increased, while the motivational domain was adapted to patient's psychological needs of intellectual and emotional contact, and of adequately expressing sex-role identity.

This case study provides evidence that HEP influences positive change in depressive symptomatology. Regarding the implications for psychotherapy practice, the results show that HEP is optimal for depth-oriented work, which is mandatory in depression.

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