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The trans-diagnostic current in pathological psychology alternative to nosography classifications and therapeutic prospects-Towards a contextual functional view of mental disorders.

Naima Ait Guenissaid[1], Hanane Guehiri[2]

[1, 2] University of Blida 2, El Affroun, Faculty of human and social sciences, Department of psychology**(**Algeria**)**.

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Abstract:

Parallel to the emergence of the third wave of cognitive behavioral therapies, a new trend emerged in the field of interpretation and diagnosis of mental disorders calling for the need to stop conceiving suffering and psychological difficulties as symptoms of the disease, and therefore must move away from categorical diagnoses of the type of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The stream of transitory diagnosis, or as it is called the psychological contexts model in psychopathology, takes into account the formulation of the individual psychological interpretation, so it is a matter of examining the different types of psychological contexts (cognitive, emotional, motivational, relational and identity) and trying to integrate them into a coherent interpretation, which also leads To determine as much as possible the biological role and social and situational factors. Such a person-centered approach makes it possible to approach the dynamics of rational psychological functioning in all its complexity and in its unique expression.

Keywords: the transdiagnostic, psychological processes, Category, Psychopathology.

The Author's Email: aitgueninaima7@gmail.com[1], hanane.guehiri@gmail.com[2].

Introduction

The issue of the regulation of mental disorders is as old as its study, whether it takes a theoretical form of mood in antiquity, beginning with the classification proposed by Philippe Pinel in the eighteenth century, or the current classification of the DSM and CIM. Hypotheses and testing them, in order to find a final solution to the problems they are trying to solve, organizing what we observe is necessary to understand it, so science often chooses to dismantle complex phenomena in order to better understand the mechanisms that govern them. It is the careful study of the different expressions of the phenomenon, as well as the circumstances of its occurrence, that allows us to understand the pathways that lead to complexity. Listing, categorizing, ordering, and identifying commonalities and differences are often the basic initial steps to understanding and solving a problem, and mental disorders are no exception.

We find that the latest classifications such as DSM and CIM have chosen the most accurate and comprehensive description of psychological disorders without relying on a strong theoretical hypothesis to organize this description.

They are differentiated into the geographical unit, and this is what makes separating these units problematic. It is as though, having satisfied our ambition to describe organisms, we find ourselves encountering a class of 'white-spotted cats' and 'red-spotted cats' and we often meet 'white-spotted and red-haired' cats.

For diagnosis in the early 2000s, the basic idea of this new approach is to focus on looking for commonalities among different disorders rather than differences. In this context, we can find two possible currents:

We can act simply by correcting the descriptive deviation by collecting the disorders that show common clinical signs in order to justify that they are different expressions of unique zoographic units, and in this way in the long run the number of classes decreases and this limits the problems. Unrecognized comorbid disorders. In the second stream, it is possible to search for similarities at the level of the processes responsible for the expression, the origin, and the retention of the clinical indicators observed in the various disorders. The introduction of this current - which is called the contextual - necessitates the need to rely on a strong theory, capable of generating predictions regarding the development of retention disorders and even proposals for their solution,

because it is no longer a matter of describing the observed symptoms but of developing hypotheses about the way they are organized and even their dynamics and this is the contextual current that It is highlighted from the point of view of transitivity in psychopathology.

The studied contexts do not necessarily have the same approach. It can aim to understand the phenomena present in at least two disorders, and at most, the phenomena that interfere with all the disorders described, and this leads to the formation of causal hypotheses for the group of psychopathological phenomena. Hypotheses often contain the reasons for the development and retention of clinical symptoms

As long as it aims to describe employment rather than structure, this is what leads us to criticize the existence of the categorical trend embodied in DSM and CIM, where we find the absence of interest in dimensional, reliance on neurobiological explanations, and neglect of social and relational variables. That is why the transdiagnostic current proposes that we go beyond the diagnostic categories and focus on the person and integrate the various psychological processes (cognitive, affective, motivational, relational, and identity related) in addition to the biological, social, and situational factors involved in psychological problems. That is why we will try, through this article, to provide clarifications and scientific data for the transient current of diagnosis by presenting the various personal contexts and the personality overlapping in the various disorders, their modifications, and the therapeutic interventions that result from them.

2. Freedom from the DSM or from the basic view of psychological problems

In January 2012, the American Psychiatric Association (APA) received an open letter from the Association for a More Human Psychology, containing reservations about the scientific weakness and the danger that DSM 5 would pose as a project in progress, and the letter was signed by 1,500 people From all over the world (mostly mental health professionals and more than 50 organizations) and despite this general mobilization, the APA decided to proceed with its publication of the fifth edition of the DSM without taking into account most of the problems raised by the letter. (Monestès, 2016, p. 23)

The DSM constitutes the most concrete emanation of the basic concept of psychological difficulties. According to this concept,

psychological difficulties are translated into diagnostic categories of mental disorders (a concept distinct from mental illness) that are considered structural characteristic that entails a core shared by all individuals who have these disorders and not by those who do not have them. Despite the dominance of the concept of basic and categorical, it was the subject of many criticisms, the first of which is that it is not adapted to the diversity observed in the heart of the diagnostic category with the presence of very important comorbid disorders. In addition, it ignores the fact that most psychological difficulties fall within a continuum, including So normal experiences. (Kendler, 2011, p. 1150)

In this regard, we mention a quantitative review of classification studies and research, based on 177 articles, from which Haslam, Holland et Kuppens (2012) concluded that most mental disorders (mood disorders, anxiety disorders, nutrition, and personality) are all of a dimensional nature and do not belong to the category (Latent category), pathological unit or mental illness. (Haslam, 2012, p. 903) In addition, we find that the concept of essentialism leads to a preference for neurobiological explanations, neglecting the relational context, social causes (poverty, unemployment, etc.), and psychological difficulties. It also focuses on disorders as underlying units rather than symptoms, neglecting that symptoms can be independent causal units (Borsboom, 2013, p. 92). interactions between these levels. Also, this concept leads to increased morbidity in the population (with the psychological suffering that results from it).

For example, we take the disorder of the basic concept of depression, which we find floundering in several problems. First, many classification and psychometric data are indicating that depression does not constitute a separate category, but it should be considered as a dimension (Haslam, 2012, p. 903) and in support of this observation. It has been shown that the presence of less than 5 depressive symptoms (criterion A of the DSM) is often of clinical significance with a level of functional problems and associated mental and physical disorders, in addition to a high risk of developing major depressive periods in the future similar to what occurs in the diagnosis of major depression. Secondly, we find the problem of the importance of disorders associated with depression such as generalized anxiety disorder and post-traumatic stress disorder. It is important here to refer to the DSM criteria for depression and generalized anxiety. They share symptoms (sleep problems, fatigue, problems concentrating, and sensorimotor agitation). As for symptoms (loss of

interest, problems focusing, feelings of misjudgment), we find them in depression as well as in post-traumatic stress disorder. (Monestes, 2016, p. 24)

Contrary to what the DSM postulates, different depressive symptoms are not equivalent and are subject to change. In this respect, Fried, Nesse, Zivin, Guille et Sen (2014) noted that among trainees who were assessed longitudinally once before and 4 times during the training period, a different effect The risk factors (family and personal case history, major depression, gender, stress during childhood, number of working hours) varied in terms of personal symptoms of major depression, as women, for example, were more concerned with sleep problems, appetite and fatigue during training, while men appeared to have more suicidal thoughts (Fried, 2O14, p. 466)

Given the limitations of the base current, Kendler et al. (2011) Adopting a current that does not define psychopathological problems as a core, but rather complex networks of causal mechanisms that are strengthened by the partnership. Because defined disorders have vague and unclear boundaries, they are not homogeneous and the mechanisms that interfere with them relate to different levels (biological, psychological, environmental, and socio-cultural), and even the symptoms themselves can interact with each other and reinforce one another.

According to this perspective, individuals who have a certain pattern of psychopathological problems are similar because causal mechanisms constantly stimulate the co-existence of some characteristics. Quite simply, it changes the risk and likelihood of a symptom or group of symptoms appearing. The same set of symptoms can also come from different causal mechanisms (Kinderman, 2014, p. 155).

In a more specific way, Borsboom and colleagues (2013) suggest that we look at mental disorders not as latent units that cause some symptoms, but as dynamic patterns of interaction between symptoms. It is not about having or not having the major depressive disorder, but looking at the major depressive period as a network of causally linked symptoms. When a person has these symptoms, they can activate or not activate at any moment. If symptom A activates, it will causally affect other symptoms, increasing the possibility of activating symptom B associated with it. For example, we can notice the following series: negative events (for example, emotional separation).

Negative mood → Feelings of guilt → Insomnia → Fatigue → Concentration problems. (Borsboom, 2013, p. 91)

These networks of symptoms are of a diagnosable transient nature, to the extent that disorders (assets of co-existing characteristics and characteristics) can share symptoms with other disorders and so on... In the example given by Borsboom, insomnia is a common symptom of major depression and generalized anxiety disorder, as well. It can be triggered by feelings of guilt (a depressive symptom) or by chronic anxiety (a generalized anxiety disorder symptom). Conversely, insomnia can also influence depressed mood (depressive symptom) or irritability (generalized anxiety symptom). Insomnia also forms a bridge between both disorders, and we find its roots in the individual himself, and it constitutes a transient factor for an internal diagnosis.

On the other hand, emotional detachment is a transient factor for external diagnosis. This network-based stream also allows consideration of the importance of individual differences in the expression of symptoms. Depending on the strength of the connection between the symptoms, both people's networks can respond differently to the same negative events, with a different probability of activating certain symptoms (anxiety rather than depressive symptoms with divergent trajectories).

At the same time, we can expect important comorbidities due to the diffusion of activation in the heart of the network - the bridge of symptoms - and the factors passing through the diagnosis. So it seems necessary to deeply reconsider how he deals with suffering and psychological difficulties, starting with the recognition that they lie at the heart of a continuum that includes normal experiences, and some experiences become problematic because of their extreme characteristic, recurrence, or permanence. It is also important to take into account that the factors causing these psychological difficulties often include social and circumstantial dimensions such as poverty, unemployment, or traumatic experiences.

Without forgetting other factors, especially genetic and developmental, can affect the way an individual responds to the challenges he faces. In general, we say that it is necessary to stop treating psychological difficulties as symptoms of a disorder, and therefore we

must free ourselves from the categorical diagnosis of the DSM type. For this reason
believes that a detailed and accurate description of the experiences, problems, symptoms, or complaints of individuals constitutes a more scientific alternative that allows taking into account the person in his individuality, and is considered sufficient to serve as a basis for planning interventions and communication with the examining individual and other professionals. (Kinderman, 2014, p. 145)

3. Network of Psychological Contexts in Psychopathology

3.1. Definition of Psychological Context:

The concept of the psychological context includes the transformation of the psychological element through a psychological element, and here we mean all the elements and data that enter into psychological phenomena, whether implicit or explicit, such as perception, feeling, memory, judgment, mental image or motor control.

Other elements cannot be considered purely psychological but are close to the psychological elements such as the changes that occur at the level of physiological or neurological activities. Elements that belong to these levels can enter into psychological contexts. (Monestès, 2016, p. 38)

So the psychological context is a mechanism that transforms a psychological element into another psychological element, for example, a mechanism that transforms a parent element into a psychological element Purely (the transformation of a physiological response into a physical sensation), that is, the context is essentially dynamic, as it includes inputs and the transformation of these inputs into outputs. We take the example of ruminations as a psychological context. Its inputs can be activated perceptions (images, autobiographical memories, terms) or stimuli perceived in the environment. Both are considered psychological elements.

When a (mental image) or idea (conceptual perception) is seen as related to a person's work, here the psychological context begins to take its place: the image or basic idea automatically activates other ideas, and the matter here is related to a simple context for the spread of activation in the structure of memory, if these ideas are related to elements Similar to a person's achievement anxiety schema, this schema will be activated which will, in turn, feed these thoughts of achievement anxiety and the

relationship between thoughts and the schema is bi-directional. (Philippot, 2011, p. 126)

This context then stimulates the activation of more general ideas that are incidental to a series of psycho-positivist moments involved. It results in an emotionally colored rumination thinking style. In the example given by achievement anxiety, this context is generated by the perceptions that maintain it, outputs in the form of depressed mood, loss of energy, and motivation (Watkins, 2008, p. 34).

Through this example, we have highlighted the psychological context that generates a ruminative rather than intrusive thinking style, and due to its dynamic and transformative nature, contexts can be modified. In other words, we can act on these contexts, and manipulate them to change the nature or intensity of their activation.

The characteristic of flexibility in this area has a major role in defining the concept of context. For example, we can work on recurring thoughts, either by allocating cognitive resources to a concurrent task or by changing their nature and having the person focus their attention on elements of the current situation rather than the schema. This last type of intervention generates a more realistic and experiential way of thinking that has positive effects on the mood and overall functioning of the individual.

2.3 Contexts in Case Perception in Psychopathology:

To form a procedural definition of the perception of the clinical situation, there are additional revisions to the aforementioned definition of psychological contexts that we mentioned must be observed here and now, as the clinician can act on them in the present moment and not historical factors or possible developments in the future. This definition indicates that the psychological context is distinguished from the presentation. The presentation can be the result of activating the context, but it is not the context in itself. For example, in the case of depressive rumination, we find that the depressed mood (presentation) can be the result (outputs) of an abstract repetitive thinking style (context) and the central concept is that the offer does not turn into a psychological element, it expresses a consequence of the context. Based on this definition, contexts can be determinants or causes of psychopathological phenomena and symptoms (Virues-Ortega, 2005, p. 567).

By the transient nature of a diagnosis, context constitutes a causal link necessary to consider the transformation of inputs into outputs or

symptoms, i.e. Context is the cause of the phenomenon or symptom that constitutes its output. In the same sense, predisposing or predisposing factors are considered combinations between input and context. It is always active here and now (and its effects are always observable) and during the perception of the situation it is also subject to modification during the psychological intervention by modifying or transforming the psychological elements or the original elements.

It should be noted that the psychological contexts are closely related to the perception of the situation, it is an attempt to explain the psychological employment, now and here for a person suffering from a psychological disorder. Where this modeling shows the dynamic and transformative relationships between the mental perceptions of the individual, his situation, his life experiences, and his memories, his perceptions. etc. Regardless of the modeling, the psychological contexts are also dependent on the view that Al-Ayadi adopts so that a psychological phenomenon can be considered a symptom (output), while in another view it is considered a specific context for other subsequent pathological psychological phenomena. In the previous example, consider the phenomenon of mental rumination as a context (especially called abstract and developed repetitive thoughts). Another view can realize differently in the case of an individual suffering from mental rumination: where the basic context is considered, for example: stopping my behavior, which is considered as a result of several results, which is the emergence of mental rumination. (Hopko, 2003, p. 705)

If we note from the foregoing that the psychological contexts are above all functional, aiming to provide the clinician with a conceptual framework that allows the modification of the situation and the construction of a functional analysis that integrates the various types of contexts and not only those derived from learning theories.

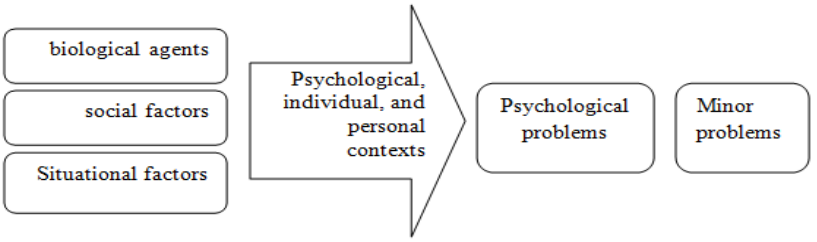
This functional choice implies a certain relativism, in which the specific nature of the observed phenomena depends in part on the perspective held by the clinician.

3.3 The location of psychological contexts in the general psychopathology model:

The centrality of psychological contexts in general psychopathology appeared in the Kinderman (2005, 2009) model embodied in Figure 1, where this researcher reintroduced the biological, psychological and

social model of psychopathology, which states that the latter is determined by the association of biological, psychological and social factors as represented by it. Figure 1. Kinderman suggests that mental disorders are determined directly and exclusively by psychological contexts These psychological contexts can themselves be determined by biological factors, social events, or life contexts. However, the impact of these latter factors on mental disorders is necessarily mediated by psychological contexts. Even in his definition of mental disorders, which he considers a mental defect, or rather psychological, and with the close determinants of this defect, it can only be psychological. Kinderman's model does not deny, therefore, that biological, social, and situational factors contribute to disorders, but gives them the status of 'distant causes' that act on psychological contexts that act themselves as 'proximal causes' (Monestès, 2016, p. 39)

Figure 1: The Determinants of Mental Disorders Model Model of Determinants of Mental Disorders by Kinderman et Tai (2007)



Monestès, 2016 : 40

adopted the Kinderman model with the introduction of interpersonal contexts that work in interaction with individual contexts. Both types of contexts have the same determinants (biological, social, and circumstantial) and they are mutually influencing and their interaction allows the identification of mental disorders. In this edition of the Kinderman model, we can also note the consequences of psychological problems that can affect in the short or long term the retention of psychological problems or the conditions that provoke them. For example, the continuous use of cocaine can lead, over time, to health problems, poverty, and crime. These secondary problems lead to an increased vulnerability in the individual, which facilitates falling into addiction.

So, through the foregoing, we deduce the idea of the centrality of psychological contexts in modeling cases in psychopathology, but the implications of psychological support go beyond the perception of the case, and in fact, this view includes the transient trend of diagnosis in psychotherapeutic interventions. That is, clinical interventions must target the context responsible for the onset and maintenance of the mental disorder.

The development in the literature has indicated the existence of many of these contexts in the various diagnostic processes, where we find that the qualification of 'transit diagnosis' defines this trend in which we find that the therapeutic psychological guarantee consists primarily in identifying the psychological contexts responsible for the emergence and maintenance of mental disorder, and in In the second place, we find that psychological intervention aims to act on these contexts in order to eliminate the disorder, for example: If abstract mental rumination and self-denial seem to be the context for maintaining the state of depression in the individual, then psychological intervention will specifically target this method of rumination (Watkins, 2015, p. 32) In this current, we find that the validity of psychological interventions is not based on the concept of diagnosis (i.e. what are the effective interventions in order to reduce the incidentalities associated with a particular diagnosis) but rather in the concept of contexts (i.e. what are the interventions that can modify the accusing contexts in order to change or even eliminate a cause maintain disturbance).

4.3. Towards naming psychological contexts:

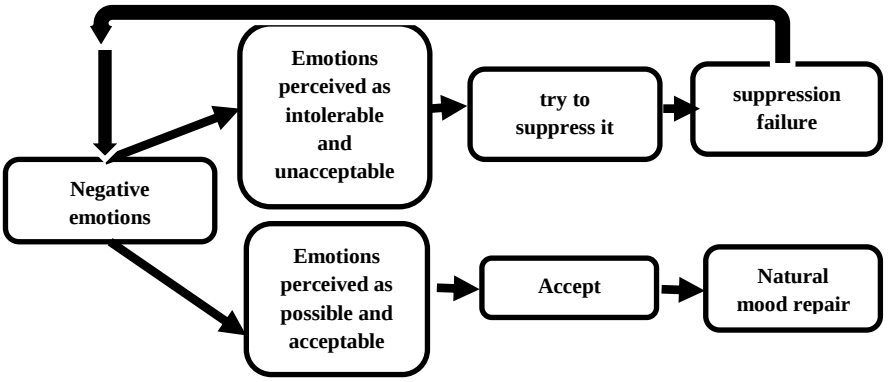
For our paper to be more procedural at the clinical research level, we must point out that the concept of context requires some form of classification or naming. So, what are the different types of contexts involved in psychopathology? The abundance of research in this field has shed light on a myriad of contexts, some of which are specific (such as the deficit in attentional disengagement in anxiety), while others are more general (such as the affective avoidance hypothesis as the cause of all mental disorders (Philippot, 2011, p. IN Press)

In front of this problem related to the number of possible contexts and the issue of the optimal level of specificity, we find two proposed answers in the literature in this field: the first with the concept of the only basic context and the second with the concept of cognitive functions.

Experimental avoidance: As a unique basic context, for many researchers, emotional avoidance plays a key role in psychotherapy. For this reason, Barlow believes that emotional avoidance is the central driver of many mental disorders, and on this basis, he developed a unified protocol for treating a group of anxiety disorders, mood disorders, and mental disorders. nutrition. (Barlow, 2007, p. 119)

This type of treatment mainly targets emotional avoidance, and the researcher's idea is summarized in Figure (2). Facing a preemptive emotion as difficult and threatening puts the individual before a choice: this emotion is perceived as too harsh and cannot be tolerated. To the point that it becomes unacceptable, or that perceived negative emotion is an unpleasant but tolerable experience. In the first case, the individual will try to cancel or avoid the emotion: he can avoid the situations in which the emotion is likely to appear and he does not focus or deny his feelings, he tries to cancel his anxiety by taking medication, etc.

Figure 2: Barlow's emotional distress retention model



Barlow, 2007: 220

For Barlow, psychological distress results primarily from a context of emotional avoidance, and the latter results from a failure to accept perceived emotion as so disturbing, so uncontrollable that it becomes intolerable. Rejecting emotion leads to a series of negative results: retaining or even amplifying the rejected emotion, failure to solve the problem underlying it, significant costs on the cognitive, and behavioral level, etc. If emotional avoidance remains the solution adopted by the individual, the cycle will be broken. A vicious circle that leads to feelings

of helplessness and emotional despair, and vice versa. Accepting the emotional experiences that we fear gives room for the natural repair of the state of mood. (Barlow, 2007, p. 220)

Barlow's proposal has received a lot of attention because it presents applied clinical perspectives in the treatment that has been tested in the treatment of anxiety disorders. Maintaining many disorders, for example in psychotic disorders, we find that information processing problem (hallucinations...) are central compared to emotional avoidance. On the other hand, we find that emotional avoidance is very broad, as it is in fact more of a function than a context if we resort to the definition that we suggested earlier.

Emotional avoidance can also be completed in several different contexts (attentive, cognitive) and therefore, theoretically and even clinically, it is better to focus on the specific level rather than the general concepts of emotional avoidance. Classification based on cognitive functions: Harvey (2004) proposed a classification system for the transient contexts of diagnosis, that is, the cognitive and behavioral contexts that appear in many psychiatric disorders. repetitive memories) and in the field of thinking (binary interpretation, emotional thinking) and in the field of behavior (behaviors of avoidance and security), there are those who allow the possibility of adding emotional responses such as feelings of shame or interpersonal relationships such as control _ and submission. (Mansell, 2008, p. 182)

The classification proposed by Harvey et al. (2004) and applied in pathological psychology on three dimensions: the first dimension is specific to the field of psychology, the second distinguishes between interpersonal and interpersonal contexts, and the third is specific to the level of specificity of dealing with each context.

The first dimension of the field of psychology is characterized by two levels: the first is based on the classifications resulting from the analysis of studies in psychopathology (the context of starting and maintaining disorders), and the second is characterized by five types: motivational, emotional, cognitive, metacognitive, and behavioral contexts. With regard to the motivational context, it appears especially in the difficulties faced by the individual in recognizing his psychological problem or starting and maintaining change in order to solve this problem. In this context, Prochaska et DiClemente (1984) proposed a transient model for theories to motivate change. One clinical procedure targeting the

motivational context has been developed and validated under the name of the motivational interview (Miller, 2013, p. 58).

Emotional contexts have received great attention at the heart of the so-called third wave of cognitive behavioral therapy, and these contexts concern: emotional evaluation, various emotional reactions and emotional regulation (Mirabel-Mirabel-Sarron, 2014, p. 134) With regard to cognitive contexts, they have been identified in the field of research in cognitive psychopathology, and they include simple cognitive contexts and non-thinking cognitive contexts, or as they are called metapsychology. In this context, Harvey et al. (2004) Several cognitive contexts: attentional control, parasitic memory, thought suppression, and cognitive suppression. As for meta-psychological contexts, they are two types: the first type pertains to our knowledge about our cognitive employment, that is, all beliefs about the expediency or danger of some ideas on our memory and our awareness,

For example, beliefs that feed anxiety that helps in the prevention or in solving problems, and may contribute to the individual's voluntary asylum To repeat if it encounters difficulties. This type of context is the target of a new type of intervention in psychotherapy called metacognitive therapy (Wells, 1995, p. 320).

The second type relates to self-perceptions, that is, self-esteem and self-efficacy. Finally, with regard to behavioral contexts, they pertain to all observed behaviors emanating from the individual, and in the field of psychopathology, there is a long tradition based on learning theory that shows the contribution of a series of behaviors to the emergence and maintenance of (Vervliet, 2013, p. 215)

The second dimension pertains to the nature of the internal and interpersonal contexts. With regard to personal contexts, it relates to the individual's management of himself. As for the interpersonal contexts, it pertains to the conduct of organizing his relationship with others. It is important to point out that they are psychological contexts related to the five domains defined in the first dimension. Thus, interpersonal contexts are not related to social contexts or group dynamics, but rather are related to the motivational, emotional, cognitive, metacognitive, and behavioral manifestations involved in his relationship with others (Monestès, 2016, p. 50).

The addition of this dimension highlighted Despite the importance of interpersonal aspects in psychopathology, in fact, with the exception of interpersonal, family, and marital psychotherapy, this dimension is often

very neglected in psychotherapy. The importance of the interpersonal aspects necessitates a reconsideration of the perception of the situation in which we find personal contexts (often preferred) and interpersonal contexts (often neglected), with the exception of family and marital therapy, as we have said. With regard to the third dimension, which relates to the level of specificity of the perception of each context, the level setting

Maximum privacy is a purely functional matter, and it is related to the goals that we pursue, whether they are clinical or research. For the clinical level, we must take 3 criteria into account in order to determine the maximum level of privacy for the context:

The first is that the context must be observable in the clinical context, whether directly by a party The examinee, or from another person in the environment, or from the therapist, in direct ways (observation, dialogue) or indirectly (measurements, tests). Secondly, the context must be tangible enough to be the subject of an intervention, or in other words, to be tangible procedurally in the clinical context or place of intervention.

The more procedurally tangible the contexts are, the more appropriate they are for the concrete intervention, and the more the changes resulting from the intervention on the target context can be assessed. For example, there are some very special contexts, such as early bilateral attention to threatening information in some anxiety disorders, that are very difficult to evaluate in the context of individual clinical care. Finally, the level of specificity must be adapted to the dynamics of the studied case. In fact, we can find for some that the disorder is maintained by a very special context, such as the classical conditioning of a very special subject, as in the case of a special phobia, while we find for some people generalized experimental avoidance on some types of generalized anxiety, (Monestès, 2016, p. 53)

So, we say that determining the level of privacy is according to the functional clinical judgment based on the clinical action and the characteristics of the clinical situation and its available resources with regard to the examinee or the therapist.

4. Psychological resilience:

A meta context responsible for psychological difficulties Psychological plasticity occupies an important place within the contexts that interfere with most mental disorders, and it has also been suggested

that it is the product of many other contexts. Therefore, it is recorded within the so-called meta-context. The meta-processus and its involvement in most mental disorders make it an important context in the transient approach to diagnosing mental disorders. Psychological flexibility includes many dynamic contexts: in a way that makes the individual adapt to the requirements of the environment that change and it also expresses the ability to reshape his psychological resources, and change his view about the situations and the arbitration that he made between the various needs and desires (Kashdan, 2010, p. 865).

If we conclude that psychological flexibility is the ability to change, and in the contextual behavioral stream that is the original source for proposing the concept of psychological flexibility, it has been dealt with as the ability to diversify behaviors according to the context and the results of these behaviors, in other words, flexibility is having a diverse behavioral repertoire, being sensitive to emergencies to these behaviors (discriminatory triggers and short- and long-term consequences), and to be able to mobilize these behaviors in specific contexts. If it comes to taking advantage of behavioral variance that is wide enough to benefit from good adaptability (Monestès, 2016, p. 90)

He proposed a procedural definition at the heart of ACT and clinical applications of contextual behavioral psychology, where the therapeutic goal lies in developing psychological flexibility, which is defined as the ability to be more and more in touch with the present moment as a conscious human being and to be able to change or insisting on behaviors that allow us to reach valuable goals.) (Hayes S.C., 2004, p. 123)
In the treatment of acceptance and commitment, psychological flexibility was conceived as a result of 6 underlying contexts: The ability to stay in touch with bad psychological experiences. Putting a distance with thoughts (disengagement). Sensitivity to what is happening in the present moment. - The ability to change his view of himself and the world. - A clear view of what he evaluates. The ability to act directly on what he evaluates. (Monestès, 2016, p. 93)

The loss of psychological flexibility in its extreme limits is characterized by stereotypical behaviors related to psychological events and the continuity of these behaviors regardless of their harmful results in the long term. 'AAQ-II' However, a large part of the studies conducted to date on psychological resilience are of the associative type and their large number has enabled meta-analyses that have highlighted part of the variance from 16 to 28% of psychological difficulties explained by

psychological inflexibility And the sum of the associations between the AAQ (whatever edition) and other measurement tools revealed the effect of psychological inflexibility on almost all signs of psychological distress, in particular the very strong association with symptoms of stress, depression, anxiety, severity of post-traumatic stress disorder, chronic pain, drug use, hair pulling, and abuse. Self and phobia. (Hayes, 2006, p. 25)

Finally, a negative correlation was found between psychological inflexibility and various indicators of quality of life (Boulanger, 2010, p. 107).

Delays in the various diagnostic classifications made it possible to confirm that psychological inflexibility is recorded as a necessary special context in the transient stream of diagnosis.

5. Conclusion

Through everything previously presented, we can say that the development known by the trans-contextual current of diagnosis presented a new suit for psychological treatments, where the concept of context took a central place, and its benefit appeared for the researcher and the practitioner alike, as it differs, as we have seen, from the concept of symptoms, functions and other terms that were It is used in an erroneous and variable way in the scientific literature, and the classification that we presented for these contexts is comprehensive because it allowed the inclusion of all psychological contexts that studies have shown to be involved in psychopathology. However, like any new theory, this current one shows a series of limits. On the one hand, it does not propose a model for contexts, but rather the framework in which these contexts are located. This absence was put forward for the theoretical foundation, due to the lack of a unified and comprehensive psychological theory that allows the conduct of the multiple aspects of this proposed classification. On the other hand, the collection of categories within the dimensions shows a kind of important recovery between the cognitive contexts and the emotional contexts in the dimension of the field of psychology, and the distinction between personal contexts and personality is not a matter of communication rather than being clearly distinct categories, and finally, we find that the prospects proposed for this The new approach is only a requirement for the practicing researcher or clinical researcher of psychology

The patients. And the combination of the three dimensions shows a great diversity in the psychological contexts that can be studied in psychopathological research, but it is impossible to control them entirely, so practice teaches us the most useful levels of perception so that we can simplify the acquired knowledge and use it in the contextual current. In this field, we mentioned psychological softness as a complex, rich, and appropriate context, because of its interference in a significant number of psychological difficulties, as it is considered a context that must be taken into account in clinical application and research. Even if this component suffers from relativity and approximation in its definition and even in its applications, its manifestations in Metaphysics make us consider it as a possible and common causal factor for many mental disorders. On the other hand, we find efforts exerted in this field in order to distinguish between psychological flexibility and psychological inflexibility and to create tools to measure this context in order to be able to identify possible areas: behavioral compared to psychological events, and this allows adaptation and access to psychological well-being, and in this field, we mention acceptance therapy and commitment, which raises psychological flexibility among its most important therapeutic goals.

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