

The largest PMT Institute
in the world is now
in the GCC!

COMPANY PROFILE





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About ISRP

Institut Supérieur de Rééducation Psychomotrice – Higher Institute for Psychomotor Rehabilitation (ISRP) is the largest Psychomotor Therapy (PMT) school in the world.

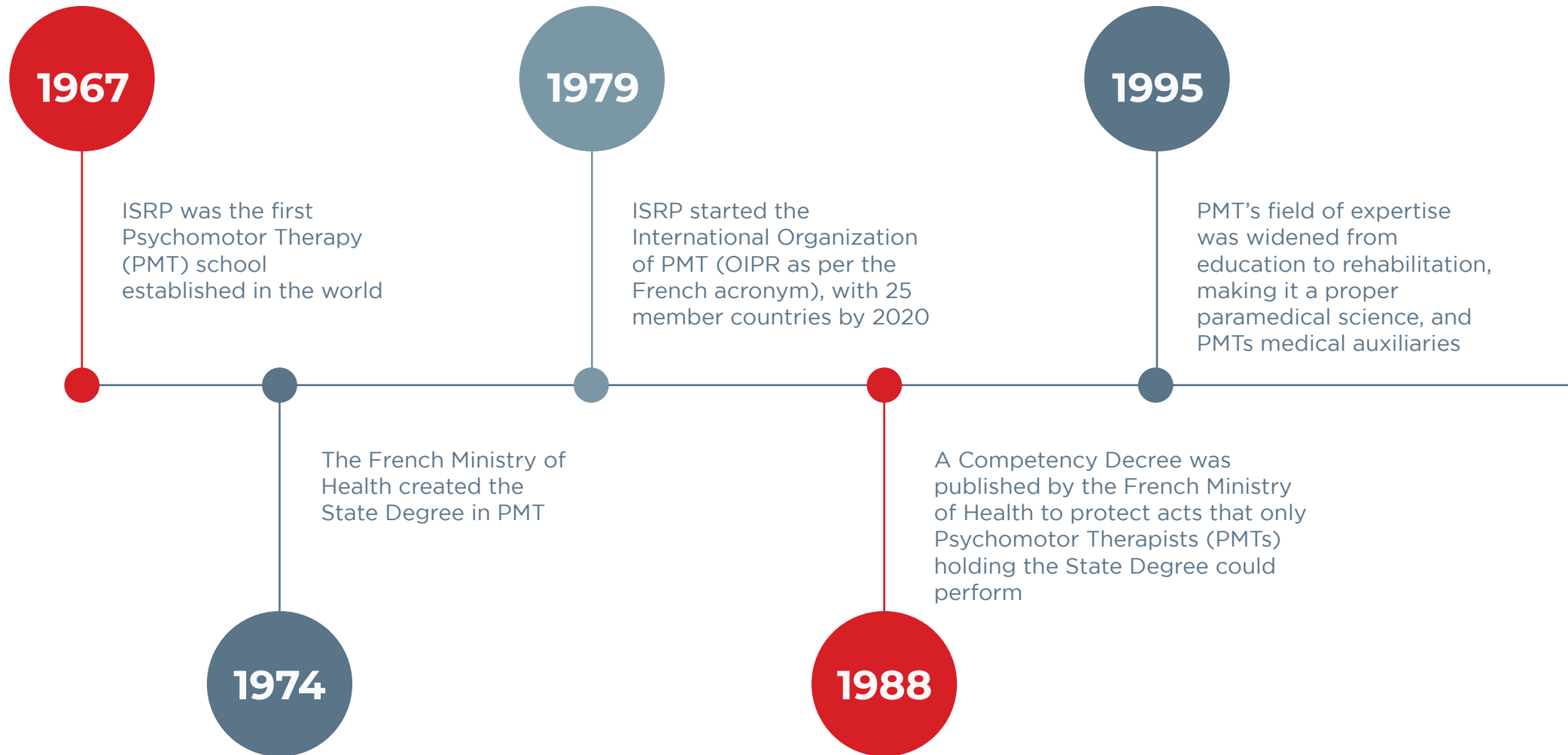
Currently, it has three campuses in France (Paris, Marseille, and Vichy), training about 1500 people per year at an initial education level (representing nearly half of Psychomotor Therapists (PMTs) trained in France, and about 20% trained worldwide), and on average 250 professionals through continuing education.

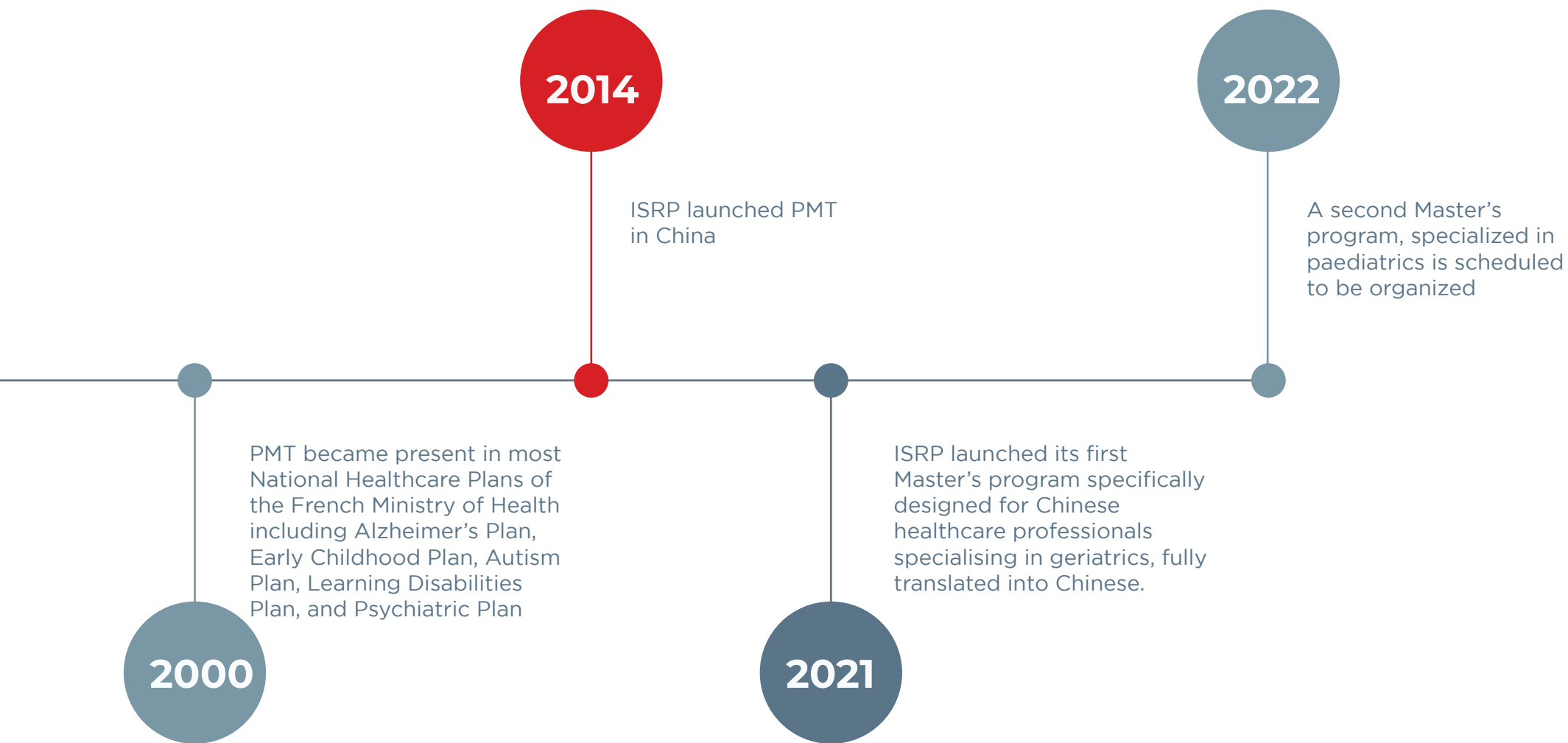
In addition to being fully approved by the French Ministry of Health, ISRP offers two degrees recognized by the French State: the State Diploma of PMT (Bachelor's level) and the Diploma of Expert in PMT (Master's level).

In 2014, ISRP launched PMT in China through a continuing education center in Shanghai which has trained more than 2000 Chinese healthcare professionals, showcasing very prestigious cooperation agreements and projects (China Disabled People's Federation, China Association of Rehabilitation Medicine, Peking University Sixth Hospital (Institute of Mental Health), Shanghai Mental Health Center, People's Liberation Army General Hospital, City of Guangzhou – Haizhu District, Guizhou Province, etc.).

In 2018, ISRP celebrated its 50th anniversary at the UNESCO in Paris, under the patronage of Mrs. Agnes Buzyn (Minister of Health) and Mrs. Sophie Cluzel (Minister of Handicapped People), and with the support of Mrs. Brigitte Macron, First Lady of France. In 2020, ISRP created a physical therapy school and won a call for tender to train doctor's assistants as part of the Ministry of Health's "My Health plan 2022".

A timeline





Our History

The word “psychomotor” or “psychomotricity” was already used from the second half of the 19th century, it was developed as a proper rehabilitation therapy in the 1950s thanks to the clinical work of Giselle Soubiran. She was a physical therapist by training and worked at the Henri Roussel Sainte-Anne Hospital in Paris, in the Child Psychiatry ward of Professor Julian de Ajuriaguerra, an innovative and open-minded child psychiatrist.

The main idea of their collaboration was simple, one came from the practice on the body, and one from the practice on the psyche, and they were both convinced that by binding both together, a new field of applied science could rise and prove useful to patients.

Mrs. Soubiran decided to focus on children that she would call “garbage cases”, not because she did not care about them, quite the contrary, but because they were a mystery to child psychiatrists who did not understand them and hence did not want to take care of them. These children were considered very particular at the time because they had a high IQ but suffered from many learning disabilities at school.

Mrs. Soubiran’s main approach was to never leave a patient behind and do everything she could to understand the specificities of the syndrome all her patients would suffer from. She hence spent many years developing a specific evaluation protocol and a therapeutic plan to help them.

In 1959, she published the first results of her research, in which she highlighted the main psychomotor functions that are affected for such patients. She was the first to understand that a certain number of neurological functions such as space and time orientation or muscle tone control could have a direct effect on writing. Indeed, to write correctly, one must be able to have a good consideration of the space on the sheet of paper, be able to coordinate properly a movement in space, adapt the rhythm of this movement in time, and apply the right pressure of the pen on the sheet of paper, directly resulting from proper muscle tone control.

Most of her patients had one or several of these neurological functions not working properly, explaining why, independently from their IQ, they would have difficulties writing. Her first applied therapy process aimed at working directly on these functions, but using the body as a mediator, using neurofeedback as the principle behind the rehabilitation process.

As Mrs. Soubiran perfected her techniques, her son, José Soubiran, believed that the most efficient way to enable as many people as possible to benefit from this innovative approach was to open a school. Giselle and José Soubiran hence established ISRP in 1967.

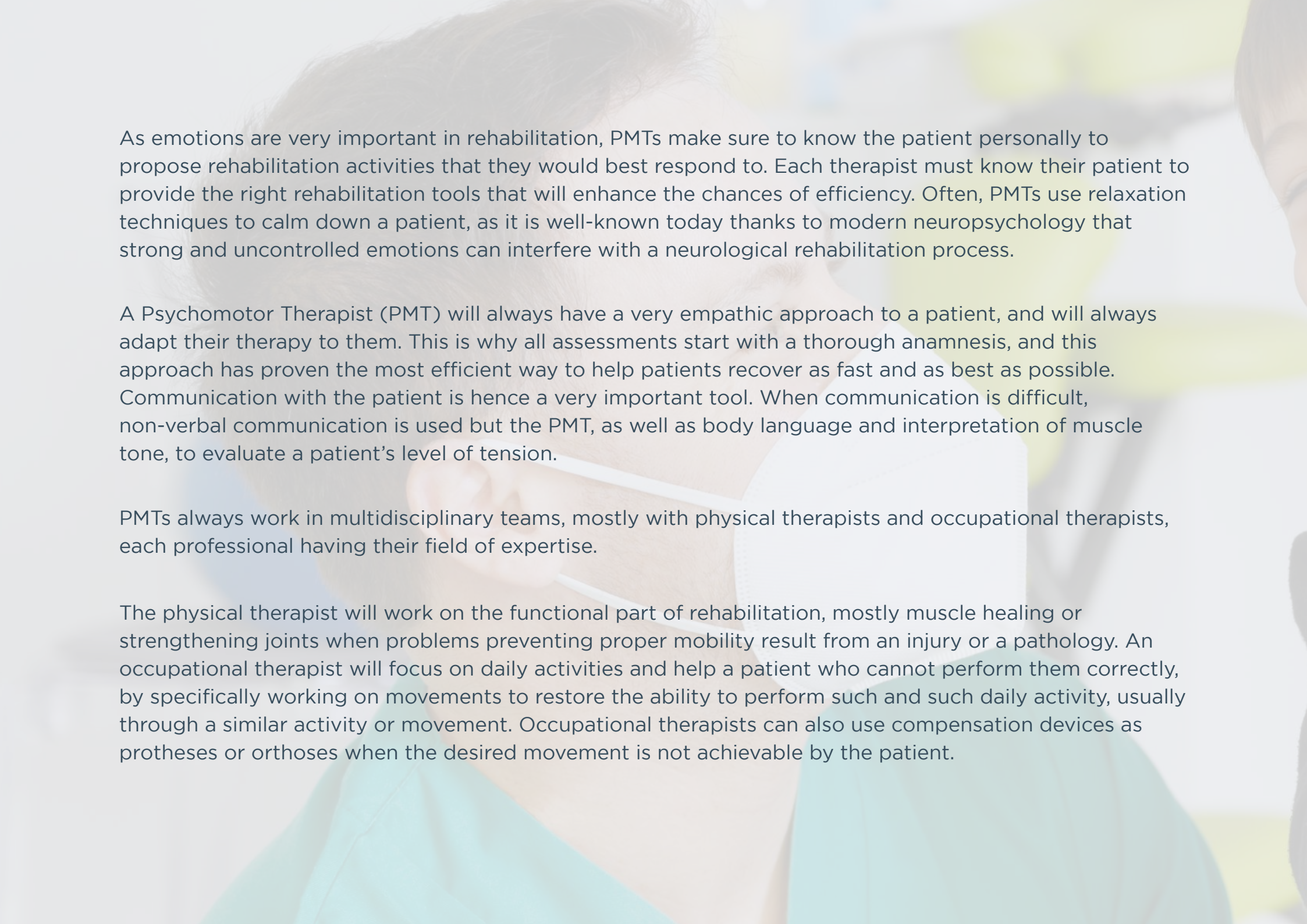
A young child with curly hair is looking down. In the background, there are hands, possibly belonging to an adult, one of which is pointing. A large, semi-transparent red circle is overlaid on the left side of the image, partially covering the child's face and the text.

What is Psychomotor Therapy (PMT)?

PMT is a holistic approach to the patient which considers that the body and the mind are linked and that dysfunction of neurological functions can have a repercussion on the body (including behavior). Indeed, every human being uses their psychomotor system to interact with and adapt to the outside world. This system is composed of body scheme, space and time orientation, general and fine motor skills, executive functions, memory, and muscle tone. If one of these items is altered, by pathology or an outside disturbance, a person will have difficulty adapting to its environment. One will start seeing the consequences of this lack of adjustment and adaptation, which are only the symptoms of psychomotor problems. Hence, some physical disabilities may be a symptom of a disturbance within the psychomotor system that requires specific assessment and specific techniques. Reversely, body injuries may also require an adaptation of the psychomotor system, and require a specific psychomotor approach. This is for example often the case when people suffer from phantom limb syndrome.

The principle of psychomotor therapy is that work can be done on, or rather through, the body to perform rehabilitation on the psychomotor system and the neurological functions that are disabled or dysfunctional. The rehabilitation process will either fix a neurological function or use brain plasticity to use a combination of other functions to compensate for a disorder. In parallel, it is also very important to strengthen the working functions, not only as a means of prevention but also as a means of potentially compensating in the future the alteration of other functions.

In PMT, the body is hence the main tool, which is why Psychomotor Therapists (PMTs) will use sensory-motor techniques such as relaxation (passive and active), sensory self-awareness, and sensory stimulation (water therapy, multisensory therapy, etc.) to better understand and control one's body and self. They will also use perceptive motor techniques such as dance, body expression (like theatre or painting) to work on interaction with the outside world. The main idea is to work on a combination of neurological and physical functions at the same time, to stimulate such functions and operate the neurological rehabilitation process.

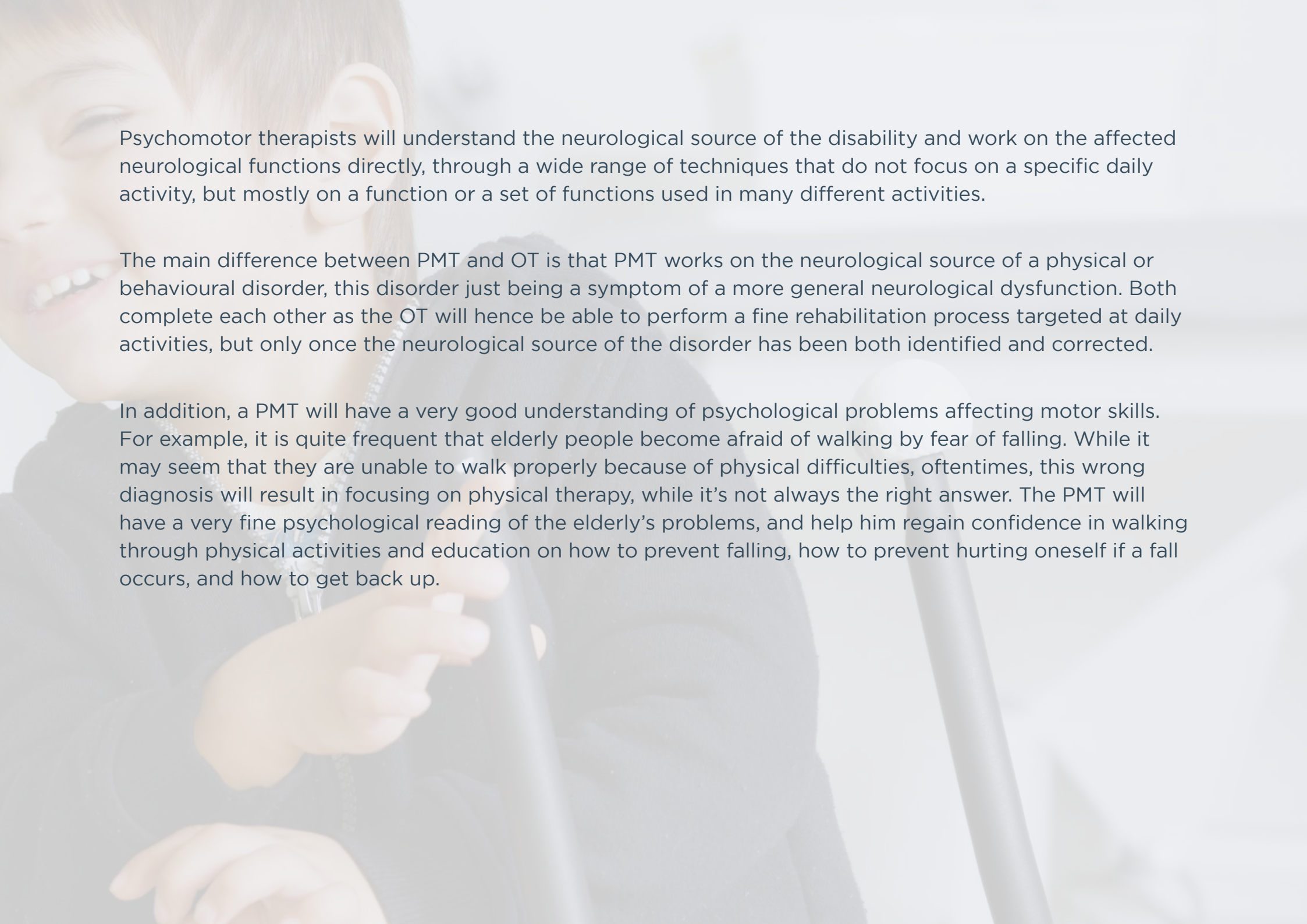


As emotions are very important in rehabilitation, PMTs make sure to know the patient personally to propose rehabilitation activities that they would best respond to. Each therapist must know their patient to provide the right rehabilitation tools that will enhance the chances of efficiency. Often, PMTs use relaxation techniques to calm down a patient, as it is well-known today thanks to modern neuropsychology that strong and uncontrolled emotions can interfere with a neurological rehabilitation process.

A Psychomotor Therapist (PMT) will always have a very empathic approach to a patient, and will always adapt their therapy to them. This is why all assessments start with a thorough anamnesis, and this approach has proven the most efficient way to help patients recover as fast and as best as possible. Communication with the patient is hence a very important tool. When communication is difficult, non-verbal communication is used but the PMT, as well as body language and interpretation of muscle tone, to evaluate a patient's level of tension.

PMTs always work in multidisciplinary teams, mostly with physical therapists and occupational therapists, each professional having their field of expertise.

The physical therapist will work on the functional part of rehabilitation, mostly muscle healing or strengthening joints when problems preventing proper mobility result from an injury or a pathology. An occupational therapist will focus on daily activities and help a patient who cannot perform them correctly, by specifically working on movements to restore the ability to perform such and such daily activity, usually through a similar activity or movement. Occupational therapists can also use compensation devices as prostheses or orthoses when the desired movement is not achievable by the patient.

A young child with light brown hair is smiling and looking towards the left. They are holding a dark vertical pole with their right hand. The background is a soft, out-of-focus indoor setting.

Psychomotor therapists will understand the neurological source of the disability and work on the affected neurological functions directly, through a wide range of techniques that do not focus on a specific daily activity, but mostly on a function or a set of functions used in many different activities.

The main difference between PMT and OT is that PMT works on the neurological source of a physical or behavioural disorder, this disorder just being a symptom of a more general neurological dysfunction. Both complete each other as the OT will hence be able to perform a fine rehabilitation process targeted at daily activities, but only once the neurological source of the disorder has been both identified and corrected.

In addition, a PMT will have a very good understanding of psychological problems affecting motor skills. For example, it is quite frequent that elderly people become afraid of walking by fear of falling. While it may seem that they are unable to walk properly because of physical difficulties, oftentimes, this wrong diagnosis will result in focusing on physical therapy, while it's not always the right answer. The PMT will have a very fine psychological reading of the elderly's problems, and help him regain confidence in walking through physical activities and education on how to prevent falling, how to prevent hurting oneself if a fall occurs, and how to get back up.

As previously mentioned, the field of competence of PMTs is very wide. The main pathologies it applies to are the following:



Paediatrics and adolescents

- Conditions affecting premature babies
- Developmental disorders in infants and children
- Neurodevelopmental disorders
 - Attention deficit hyperactivity disorder (ADHD)
- Learning disabilities
 - Autism
 - Trisomy
 - Polyhandicap
 - Cerebral palsy
- Teen depression and other conditions
 - Addiction
 - Eating disorders



Adults

- Mild mental illnesses
 - Stress
 - Anxiety
 - Depression
- Workplace disorders
 - Psychosocial risks
 - Burnout syndrome
- Severe mental illnesses
 - Paranoia
 - Schizophrenia
 - Bipolar syndrome
- Psychotrauma
- Other neurological conditions
 - Stroke
 - Cognitive disorders



Elderly

- Prevention and management of neurodegenerative disorders
 - Multiple sclerosis
 - Parkinson's disease
 - Alzheimer's disease

The proposed treatments are in line with the 1988 decree of competence of psychomotor therapists (presented at the end of this document): early education, stimulation and psychomotor awakening, re-education, and treatment of psychomotor disorders.

All care procedures begin with a precise and rigorous evaluation process. The psychomotor therapist, an auxiliary of medicine (book IV of the French health code), intervenes in medical prescription.

According to Soubiran & Coste, "The practical modalities of the psychomotor examination aim at the methodical evaluation of the sensory, praxis, kinesthetic, gnosis and relational possibilities of the child, the adolescent or the adult". (1975, p.54).

The psychomotor assessment has the originality and the richness of being based on a mixed methodology articulating quantitative and qualitative data. Thus, it is composed of non-standardized tests whose objective is to allow a fine observation of one or several components of the psychomotor development, and of standardized and calibrated tests whose objective is to measure a precise skill.

It's divided into several steps:

- STEP **1**

Carrying out preliminary anamnestic research, either through an interview and/or consultation of the patient's file.

- STEP **2**

To propose a set of tests allowing to approach the psychomotor development as a whole, except when the clinical situation does not allow it.

- STEP **3**

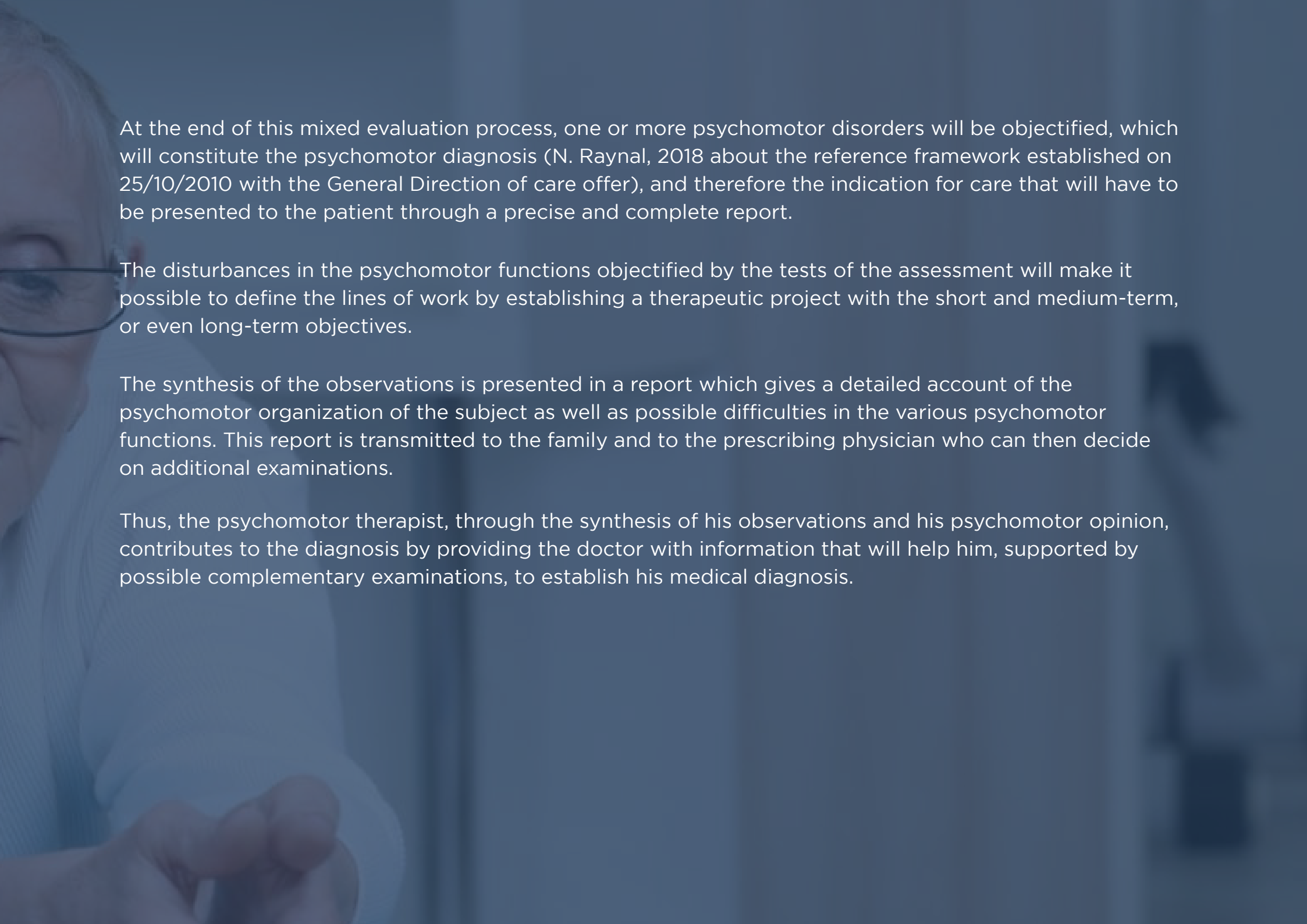
Passing one or several tests that will measure the skills related to the suspected disorders that motivated the assessment or were suspected by the evaluator during the assessment.

- STEP **4**

Adapting his or her proposals to the intrinsic characteristics of the patient (age, pathologies, fatigability, etc.).

- STEP **5**

Drawing up a report describing the observations made, the results of the measurements taken, an explanatory summary of the patient's psychomotor functioning and the possible disorders identified, as well as a care plan if necessary.




At the end of this mixed evaluation process, one or more psychomotor disorders will be objectified, which will constitute the psychomotor diagnosis (N. Raynal, 2018 about the reference framework established on 25/10/2010 with the General Direction of care offer), and therefore the indication for care that will have to be presented to the patient through a precise and complete report.

The disturbances in the psychomotor functions objectified by the tests of the assessment will make it possible to define the lines of work by establishing a therapeutic project with the short and medium-term, or even long-term objectives.

The synthesis of the observations is presented in a report which gives a detailed account of the psychomotor organization of the subject as well as possible difficulties in the various psychomotor functions. This report is transmitted to the family and to the prescribing physician who can then decide on additional examinations.

Thus, the psychomotor therapist, through the synthesis of his observations and his psychomotor opinion, contributes to the diagnosis by providing the doctor with information that will help him, supported by possible complementary examinations, to establish his medical diagnosis.

A soft-focus background image of a baby in a light blue shirt being held by an adult. The baby is looking towards the camera with a slight smile. The adult's hands are visible, supporting the baby. The overall tone is warm and professional.

The psychomotor assessment tools depend on the age and the psychomotor function being assessed. Thus, each test will have its specificity. Some tests for children will evaluate more specifically the tonic function, others the levels of motor evolution or the relational capacities. The aim is always to objectify deviance from the norm. There are many such tests. We will present here the most used and especially those recommended by the French High Authority of Health:

- Evaluation of the preterm infant : Évaluation neuro-psychomotrice du prématuré et du nouveau-né à terme de L. Vaivre-Douret (Neuro-psychomotor evaluation of premature and full-term babies)
- Assessment between 0 and 3 years : Brunet-Lézine Révisé de 2 à 30 mois ; Développement moteur fonctionnel du jeune enfant entre 0 et 48 mois (Functional motor development of the young child) ; Évaluation neuromotrice ENAT et ENTAT de Amiel-Tison entre 0 et 6 ans, DDST (Denver developmental screening test), BSID Bayley Scale IV (French version under calibration)
- Assessment of tonic function, global motor skills, and large coordination: Lincoln-Ozeretsky, Charlop-Atwell, NP-MOT
- Knowledge of the body map and body consciousness: Dessin du bonhomme de Goodenough (Drawing of a man), Daurat-Meljack, Chaviro, somatognosie de Bergès.
- Laterality: Bergès-Lézine, Piaget-Head, Harris, Auzias
- Sensory profiles : Dunn ; Échelle des particularités sensori-psychomotrices dans l'autisme (scale of sensory-psychomotor characteristics in autism), Bogdashina

- Assessment of fine coordination and praxia: Mabc-2, DCDQ-FE (Developmental Coordination Disorder Questionnaire French European), EMG (assessment of the gnoso-praxis motor skills), Rey's digital motricity, Digital gnosis of Galifrey-Granjon, Facial motricity of Kwint
- Spatial and visuo-spacial functions: Visual Motor Integration, Santucci, Bender, Figure de Rey, test des batonnets, trajets au sol d'Agostini, Frostig.
- Temporal functions : Mira Stamback, Adaptation au rythme frappé (Adaptation to the struck rhythm), Épreuves de Marthe Vyl
- Graphomotor : BHK, BHK for teenagers, Échelle E d'Ajuriaguerra, DTPV-2
- Attentional processes and Executive functions : Stroop, D2-R, Conners, Appariement d'images (Image matching), Tour de Londres, NEPSY II, Laby 5-12,.
- Assessment of the elderly: EGP (Geronto-psychomotor assessment), Up and Go, Test de l'horloge (clock test), MMSE (mini mental score examination)

There is also a global qualitative tool that synthesizes the different psychomotor functions to be evaluated for the same subject. It is only qualitative and is currently being calibrated to make it a quantitative and standardized tool: the Soubiran Evaluation, developed by Mrs. Soubiran, a reference in psychomotor therapy in France. This evaluation method is currently being updated through a thorough research project.

Each therapy plan is tailored to the patient and hence, it is not possible to describe a general protocol that applies to all. Here are a few examples to illustrate how a PMT works.

A child with learning disabilities

According to the WHO, learning disabilities are a permanent disorder of neurological origin that affects one or more neuropsychological functions and disturbs the acquisition, comprehension, use, and processing of verbal or non-verbal information.

These disorders may concern one or more cognitive functions: oral language, written language (reading, spelling), calculation, gestural and/or visual-spatial praxis functions, and transversal functions (attention, memory, executive functions). More specifically, developmental coordination disorder (DCD) is characterized by significant difficulties in planning, organizing, and automating motor gestures to act. There are 2 principal types of rehabilitation approaches:

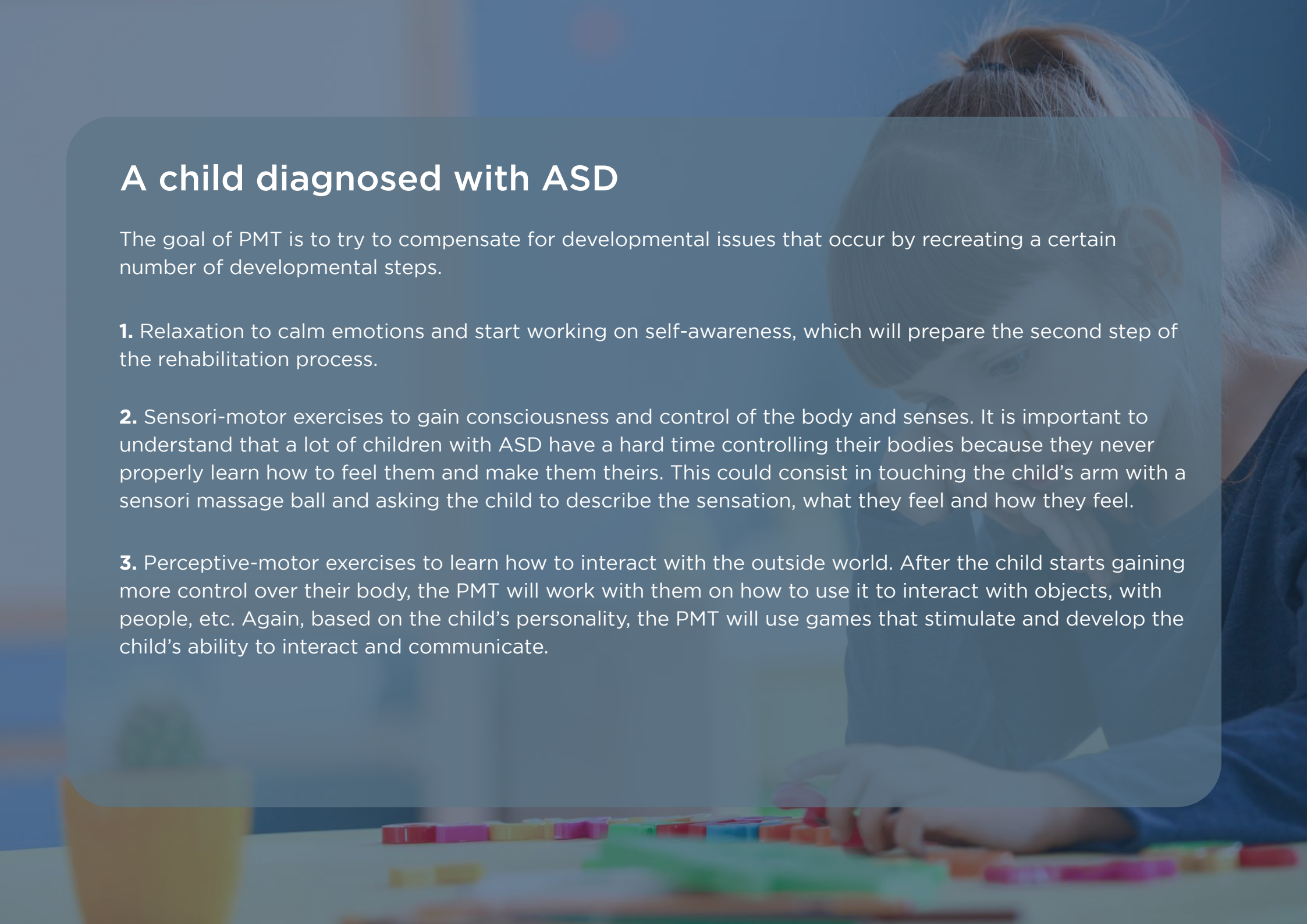
1. Bottom-up: to improve the foundations: work on the bases (muscle tone, balance). For example, by proposing motor and physical games such as courses that require tonus, support, balance.

2. Top-down (COOP method): which consists of working on the deficient activity and whose effectiveness has been demonstrated and validated scientifically. This method is based on the use of a strategy to solve a problem (goal, strategy, execute a plan, verify). The implementation of an efficient motor project is based on the co-analysis of the action by the patient and the therapist. The child is an actor in this method: he/she chooses the activity he/she wants to do. Thus, the child participates in the choice of his activities, organizes them, and evaluates himself. Various supports can be proposed such as graphics, modeling, construction, relaxation...

A child diagnosed with ASD

The goal of PMT is to try to compensate for developmental issues that occur by recreating a certain number of developmental steps.

- 1.** Relaxation to calm emotions and start working on self-awareness, which will prepare the second step of the rehabilitation process.
- 2.** Sensori-motor exercises to gain consciousness and control of the body and senses. It is important to understand that a lot of children with ASD have a hard time controlling their bodies because they never properly learn how to feel them and make them theirs. This could consist in touching the child's arm with a sensori massage ball and asking the child to describe the sensation, what they feel and how they feel.
- 3.** Perceptive-motor exercises to learn how to interact with the outside world. After the child starts gaining more control over their body, the PMT will work with them on how to use it to interact with objects, with people, etc. Again, based on the child's personality, the PMT will use games that stimulate and develop the child's ability to interact and communicate.



An adult suffering from depression

According to the National Institute of Science and Medical Research (INSERM), the characterized depressive disorder affects all ages of life. It affects approximately 15 to 20% of the general population, throughout their entire lives. It is presented as a succession of characterized depressive episodes, resulting in numerous symptoms - including pathological sadness, loss of pleasure, and cognitive symptoms - with major repercussions on the life of the patient and those around him. If they persist, the symptoms linked to depression will have major repercussions on the socio-professional level. The risk of suicide is particularly high and concerns 10 to 20% of these patients. Recent therapies include neurobiology and non-drug therapies as psychomotor therapy; because of its body-mediated therapy approach. Psychomotor symptomatology is associated with depression and psychomotor slowness is a diagnostic criterion for depressive states.

Thus, psychomotor therapy uses different ways to intervene:

For example, by increasing body awareness through various experiences. The fact of experimenting with new body experiences makes it possible to diversify and improve a range of sensations, in particular by proposing experiences that promote pleasure and well-being. This can be done through body expression sessions or dance therapy.

At the same time, we can also allow the patient to become aware of his tonic state to learn to better identify his tensions and to find ways to relieve them by adjusting his tonic state. The mediations used could be relaxation (Soubiran's method, Jacobson's method, or body harmonization method) or therapeutic contact and touch.

An elderly person suffering from Alzheimer's

As it is unfortunately impossible to retrieve functions lost because of neurodegeneration caused by Alzheimer's Disease, the PMT will focus on preventing further neurodegeneration, or at least slowing the development and spreading of the pathology.

PMTs usually follow the three following steps:

- 1.** Relaxation to calm emotions and favor the rehabilitation process. This is often used with patients who act aggressively or are particularly agitated. Psychomotor relaxation enables the patient to better feel their body, gain more awareness and consciousness of themselves, and hence regain control over their emotions.
- 2.** Focus on functions that have not been affected by the pathology to reinforce them. As every patient is unique, the PMT will adapt the rehabilitation process to the patient, creating for example a psychomotor course in which the patient will need to walk past a few obstacles, explain how they will do it to stimulate the execution functions, and always encouraging the patient staying close to them if need be, to show them they can be confident in walking and overcoming obstacles, and hence the fear of falling.
- 3.** Create a therapeutic plan to use the functions remaining to compensate for functions affected by the pathology. For example, if a patient suffers from short-term memory loss, they may get confused in time and not know what time of the day it is. A PMT will use a combination of unaltered functions to compensate for that deficiency to create a system to enable the patient to figure out the moment in the day, like situation cards describing each moment of the day, using episodic memory, executive functions, or semantic memory. If the patient likes to draw, they could draw the card directly to add an emotional value to the system.



International Presence & Development

The International Organisation of PMT and Relaxation

In 1979, Giselle Soubiran and her team from ISRP created Organisation Internationale de Psychomotricité et de Relaxation – International Organisation of PMT and Relaxation (OIPR). The main idea was to spread out the science of PMT to the world through national and international conferences. The goal was also to help the newly created schools throughout the world to get recognition from their State.

List of countries where PMT exists by the level of recognition

OIPR member countries

Argentina (R)	Denmark (R)
Bolivia (R)	Spain (CE)
Brazil (R)	Italy (R)
Burkina Faso (R)	Kazakhstan (CE)
Cameroun (R)	Lebanon (R)
Chili (CE)	Mexico (CE)
China (CE)	Paraguay (R)
Cuba (CE)	Peru (CE)
Equator (CE)	Portugal (R)
France (R)	Uruguay (R)

Non-OIPR member countries

Algeria (CE)	Luxembourg (CE)
Germany (R)	Morocco (R)
Austria (CE)	The Netherlands (R)
Canada (CE)	Czech Republic (CE)
South Korea (CE)	Switzerland (R)
Ivory Coast (CE)	Tunisia (R)
Finland (CE)	Vietnam (CE)
Greece (CE)	

Key:

(R): Countries where PMT is recognized as a profession

(CE): Countries where PMT is taught as a speciality in Continuing Education

Awards, Accreditations & Recognitions

2020: Thanks to the efforts of ISRP, the Chinese Association of Rehabilitation Medicine (CARM) created a PMT committee. This is the first step towards a nationwide recognition of the therapy in China as CARM is the main entrance point of new techniques and professions in rehabilitation in China.

2019: The Prime Minister of Burkina Faso signed a decree including Psychomotor Therapist (PMT) as part of the official professions recognized by the state.

2017: The French professional education system is controlled by the Ministry of Labor, through its agency called France Compétences. It establishes 8 levels of training, 1 being the lowest, 8 the highest (Doctorate). In 2017, ISRP was accredited for the diploma of Expert in PMT which has been registered at the French National Register of Professional Training (RNCP), level 7 (Master's level, registration number 28192). This accreditation is renewed every 5 years.

1975: The decree published on December 30th, 1975 by the Ministers of Health and Higher Education regarding operations of PMT institutes preparing to the State Degree in PMT gives authority to the Presidents of French Regions to decide upon accreditation of PMT institutes in their respective regions. This accreditation lasts for 5 years and has to be renewed. ISRP has been accredited ever since this decree was published.

ISRP is accredited by the French National Agency for CME (ANDPC)

ISRP is ISO 9001:2015 accredited for its pedagogical and administrative operations and quality management system

The French CME system is controlled by the ANDPC (National Agency for CME). ISRP is annually accredited under registration number 2069.

The French Healthcare system is governed by two main entities: the Ministry of Health, and the HAS (Haute Autorité de Santé – Higher Health Authority). The former designs and implements national healthcare plans based on the recommendations of the latter. The recommendations of the HAS are also applied in the French healthcare system independently from National Healthcare plans.

Our PMT Trainings

ISRP offers PMT training that equips healthcare professionals and healthcare organizations with the knowledge and skills to offer a unique approach that addresses neurological dysfunctionalities. Incorporating this innovative approach can certify healthcare institutions to provide comprehensive, holistic care to their patients by catering to the needs of the mind and body.

This training enables healthcare professionals to:

Understand the impact of pathologies on the psychomotor system and identify early signs of psychological disorders

Describe the link between the psychomotor system, learning abilities, and adaptation to daily activities

Build better therapeutic interventions, techniques, and rehabilitation methodologies

Training for doctors

Types of doctors concerned:

paediatricians, child psychiatrists, psychiatrists, and geriatricians

The goal of the training:

understanding the psychomotor system and psychomotor disorders, their impact on patients, being able to diagnose them, and steer patients to a psychomotor therapist (PMT).

Duration:

5 to 10 days (5-day modules)

3 specific specialities:

- Paediatrics
- Adult mental health
- Geriatrics

Training for therapists

Types of therapists concerned:

Occupational therapists, physical therapists, speech therapists, psychologists

The goal of the training:

understanding the psychomotor system and psychomotor disorders, their impact on patients, being able to perform a psychomotor evaluation, and create a therapy plan adapted to each patient

Duration:

15 to 25 days (5-day modules)

3 specific specialities:

- Paediatrics
- Adult mental health
- Geriatrics

Training for education professionals

Types of education professionals concerned:

teachers, resource teachers, child psychologists.

The goal of the training:

understanding the psychomotor system specific to the learning process, psychomotor disorders and their impact on children, being able to identify signs of psychomotor difficulties to steer children to the right professional

Duration:

10 to 15 days (5-day modules)

Training for assistant nurses, social workers, and other helpers to the elderly

The goal of the training:

understanding the basis of the psychomotor approach (empathy, soft skills, adaptation to patients, non-verbal communication, helping elderlies to walk, falling prevention, dealing with complicated patient behavior, managing daily life activities with the elderly)

Duration:

10 to 15 days (5-day modules)

Training for midwives and paediatric nurses

The goal of the training:

psychomotor stimulation for the newborn baby, favoring a good psychomotor development, identifying early signs of delayed psychomotor development to steer parents to the right professional. This training also focuses on specific care towards premature babies

Duration:

10 to 15 days (5-day modules)

ISRP's Bi-annual Summer School

Every other year, ISRP organizes an International Summer School to unite PMTs from all over the world. More than 20 nationalities are present each time, to share the latest research and developments in PMT in their respective countries. The format varies from year to year but always includes scientific seminars and practice sessions.

Specific On-demand Training in Paris

All the training mentioned previously can be organized in Paris, and will include visits to specialized institutions to see PMTs in their everyday practice and better understand the specific role of these professions in French multidisciplinary healthcare teams.

Master's Degree

By experience, it is easier to start with a Master's degree in a country where PMT does not yet exist. This program can be offered at a University offering medicine, rehabilitation, psychology, nursing, midwifery, etc.

Bachelor Degree

ISRP's goal is to eventually create a PMT Bachelor's program for the GCC region to get the profession of PMT fully recognized in the country.

Organizing Scientific Colloquiums in the GCC region

ISRP and its partners can organize colloquiums with French and Arab experts to promote PMT

Our Team in the GCC



José Soubiran

President - ISRP Group

President of the ISRP group, founder and former president of the INSEEC Group, José leads the group's management functions to ensure its local and global development.



Françoise Giromini

Psychomotor Therapist &
Pedagogical Director - ISRP International

Françoise completed her training in different physical, artistic and psychological disciplines in 1970. She obtained a Diplôme d'études approfondies (DEA) in Human Sciences from Paris Sorbonne-University and has been working with children and adults at the IFP Pitié Salpêtrière - Training Institute in Psychomotricity and ISRP since 1972. An author of reference books on Psychomotor Therapy (PT) including the Manuel d'Enseignement de la Psychomotricité, Françoise has been working towards and is committed to the development of PT.



Séverine Alonso-Bekier

Trainer & Pedagogical Manager - ISRP

Séverine holds a State Diploma in Psychomotor Therapy (PT) and a Máster Internacional en Psicomotricidad in PT from ISRP. Currently pursuing a Ph.D. in the field of specific and adapted education from the Catholic University of the West (UCO) and Université de Sherbrooke, Séverine has 15 years of experience working in the Neonatology and Neuropediatric departments at a hospital and has been actively involved in clinical and research activities within the Association for Psychomotor Research and Development (ARDP).



Mark Soubiran

General Manager, International Affairs - ISRP

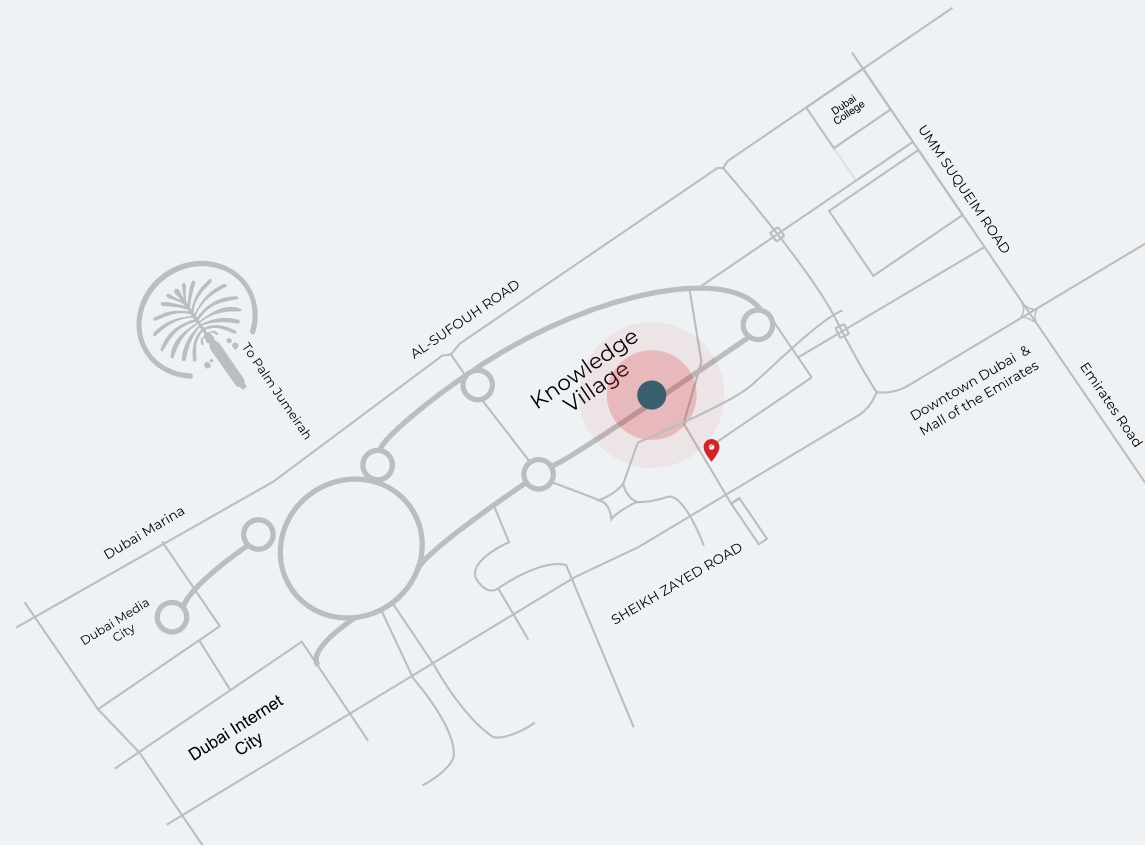
Mark graduated from HEC Paris in 2013 and worked in strategic consulting before joining ISRP in 2015 to continue the family venture. He developed PMT in China, achieving very promising results both in continuing education and initial education. Thousands of Chinese healthcare professionals have been trained in PMT as part of short-term trainings by ISRP, and Bachelor graduates are now studying PMT at a Master level. Since 2018, Mark has been taking over ISRP's leadership, and continues to develop PMT nationally and internationally.



Musa Al-Sadoon

Regional Director - ISRP

Musa Al-Sadoon is a Saudi national with over 40 years of professional business experience in leadership roles in various industries, including oil, fast-moving consumer goods (FMCG), investments, automobiles, and learning and development (L&D) across Europe and the Middle East. Musa is also active as a Board Member and supporter of the Senses Residential and Day Care for Special Needs (Senses Center) in Dubai.



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