Tiraspol State University
Moldova

Megiddo Institute of Advanced Studies
Established by the Hebrew University of Jerusalem
2014-2015

The Three-Year Program of Psychotherapy by the Dynamic Approach

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Bi-polar Disorder and Leadership: Uncovering the Links between Leadership and Mental Illness

Submitted by FarhanHabuz after attending the conference on "What Works for Borderline Personality Disorder" that took place in Tel-Aviv, Israel February 6-9,2014.

The Wikipedia describes Bi-Polar Disorder as a condition also known as **bipolar affective disorder**, **manic-depressive disorder**, or **manic depression**. This condition is defined as a mental illness characterized by episodes of an elevated mood known as mania, usually alternating with episodes of depression. The linkage between this condition and leadership has been a challenging research interest in spite of the theoretical, methodological and clinical problems this linkage might pose in scientific terms.

The contribution of the conference is mainly in understanding the professional literature that has discussed dominant leadership profiles described "non-conventional "personality". Moreover, understanding the history in which these leaders acted becomes possible through investigative personality type that actually falls into the Psychological and Psychiatric paradigms.

In terms of future contribution with relevant professional implications: this conference has left an impact on my personal capabilities to possibly identify universal traits of "abnormal" leadership in different cultures, environment etc.

Mechanism of Change through Dialectical Behavioral Therapy

The Dialectical Behavioral Therapy (DBT is a therapy method that suitable for Borderline Personality Disorder (BPD), this method was tested in seven randomized and controlled by four independent research teams clinical trials. On the base of the bio – social theory of the BPD, many mechanisms can be attached to this process: reducing of the tendencies to ineffective action that related to not regulated feelings. We refer especially to these interventions and relate them to mechanism of change of the: attention, validity, focusing, chain analysis and dialectic. The changing of the behavior of the patient with BPD has been perceived at first to assist to the patient to engage with improving the life functional behavior, even when he has intense emotions. Finally our goal is to provide guidance through theoretical and empirical research background about the mechanism of change in DBT.

The critical question is how and why the therapy works or by which processes which therapy change occurs? The mechanisms of change are mediator variables that are taken into account for the relation between intervention therapy and the result.

The main purpose is to describe the potential of mechanisms that are based on patient behavior changes that can be attributed to the effect of the DBT intervention. The final purpose is to provide a framework that encourages and guides the researchers to examine the mechanisms of change in the context of a clinical study about the DBT.

The DBT came from the dialectical philosophy. The dialectics not only shows the presence of a specific intervention, but also the style or the way in which the intervention occurs. The dialectical philosophy usually communicates with the socio – economic and Marxist principles, but the dialectical philosophy actually backs thousands of years backwards. According to Hegel, the phenomenon, the behavior or the claim goes through three stages in the dialectic: 1. the proposal or the initial claim occurs (Thesis), 2. The negation of the initial phenomenon occurs and it involved with contradiction (Antithesis) and 3. The negation of the contradiction or synthesis between the thesis and the antithesis occurs.

The dialectical philosophy also claims that the reality is consisted from interrelated parts and these parts cannot be defined without reference to the whole system. Also the system in whole is consisted from parts and cannot be defined without reference to its parts. The system and its parts always in a

state of change or flux and the change of the one change also the other. The theory leads to contextual systemic conceptualization of the behavior. The DBT relates to the patient as a one unit and not to his separate disease or disorder.

The bio – social theory of the BPD is dialectical and therefore offers a transcription between the biological tendencies to emotional vulnerability and as increases the moves of the environment as a lack of regulation of the emotional system of the patient. The emotional vulnerability refers to the ancient biological tendency to increased sensitivity and reactivity to stimuli. As a result, people with BPD usually experience significant disintegration of their cognitive, emotional and behavioral systems when they emotionally stimulant. In this way many of the behaviors that associated with BPD are perceived as inevitable complications of the lack of regulation of emotions or as an adaptive method of changing of emotional experiences.
The attention is at first for the quality of the awareness that the person contributes to present experience. The attention is also associated with skills and finding of an Interim Trail between extremism and polarity. The attention practice is also associated with radical perception of the contemporary situation, emotion or experience and preservation of the willingness to enter the life with alertness and efficiency. The final goals of the attention skills are to assist to the patients: to increase their conscious control to the processes that related to listening, to achieve a "smart" integration of their thoughts and the feelings and to experience a sense of unity with themselves, with others and with the world.

There are some mechanisms of change of the attention: behavioral exposure and learning of new responses, regulation of emotions, reducing of the literal belief in rules and control of the attention.

The validity involves a real interaction with the patient. In the DBT the validity is in order to balance the strategies that are based on a change and are rooted in behavioral therapy, strengthening or reinforcement of clinical progress, the self-validity model, to provide feedback and to enhance the therapeutic alliance. There are six levels of validity: 1. Active listening and awareness to the patient's issue, 2. accurate reflection of the feelings, the thoughts and the behaviors of the patient, 3. Non-verbal expression of feelings or thoughts or mind reading, 4. to express that the dysfunctional behavior of the patient is logical in the early history aspect or biological aspects, 5. To express that the behavior of the patient is normative, wise or expected, with providing of contemporary context and 6. action in a real way or in a way with radical honesty.

Mechanisms of change of the validity: increasing of the stability of the patient's sense of self, reducing of the emotional awareness and improving of the learning, increasing the motivation and valid behavioral processes: Management of the models and the drawer, dialectic and the behavior modification: focusing of the lack of emotional regulation through the DBT.

Mechanism of change of the focusing and chain analysis: evaluating of the dysfunction behavior of the patient through the DBT. In example, many patients with BPD deal with behaviors that don't oppose to disclosure and to discussion and it can be done a chain analysis on them. Therefore the chain analysis can function as a punisher of the behaviors. Over the time, the patient learns that is he hurts himself, in the following therapy session will be accompanied with a long discussion about behavior and its context.

The Chain mechanisms are: exposure and response prevention, improving of the episodic memory, vivo learning of behavior skills and inclusion of behavior of change: telephone consultation.

Reduction of the lack of emotional regulation and skills building: emotional regulation of skills opposite action – regulation of skills through the DBT intervention related to the bio-social theory according to is the BPD disorder is in its base emotional imbalance spread. The inclusion of didactic instruction is in the wide range of emotional regulation skills that is an aspect of the DBT. One of the most main skills of emotional regulation is an opposite action that involves: determination that the emotion isn't intimidated by the situation or isn't disrupted by the effective behavior, to be emotionally exposed to the stimulation, blocking the requested behavior through the active emotional impulse and replacement of the inconsistent behavior with the tendencies that the emotion mulches. The lack of emotional regulation occurs towards the multiple emotions (both positive and negative) in the BPD disorder, the opposite action of the DBT focuses on the wide range of emotions.

Mechanisms of change by opposite actions are: exposure and response prevention, expanding the repertoire of the patient, study of new responses and cognitive repair.

Dialectical strategies – in addition to the preservation of the balance and the integration of the reception of the change in the DBT, the dialectic has also created a number of specific therapy

strategies. In terms of style, these strategies involve a balancing of communication of the patient and his interoperability and reception of the change interventions. The dialectical strategies also involve the increasing of the tension towards the counsel of the devil or other strategies (i.e. paradox inserting), working on syntheses creation alternative options, feelings or thoughts, metaphors using fast and intense swinging of interactions with the patient and the use of fluid motion in the meetings in order to keep the patient awake and with little balance. The dialectical strategies necessarily involve balancing and dialectical syntheses that occur in the meeting.

The mechanisms of change that associated with dialectical strategies are: enhanced directed reactions and learning and vivo modelization.

Preservation of the dialectical therapy framework: mechanisms of change related to the therapist - patient system: In the DBT the dialectical philosophy contributes to the conceptualization of therapy networks as a holistic system that involves a dynamic interaction or transcription between the therapist, the patient and the other therapy providers. From the behavioral aspect the therapist is only who has influence on the behavioral principles of empowerment and punishment with the patient. With the challenging of the patients, the patient and the therapist can achieve a way in which the patient punishes, effectively treats and strengthens the medical diagnosed behavior or behaves in the way that directly stimulants defensiveness or hostility toward the therapist. This problem can be created if the therapist and the patient express opposite position toward the therapy. For the efficacy of this therapy they have to reduce the polarization and to maintain the effectiveness of the therapist.

Number of potential mechanisms of change can be related to the aspects of the DBT that are main and unique for the therapy and their theoretical infrastructures. These mechanisms are based on exposure, response, prevention, denial or screening of ineffective or unwarranted emotions and reactions, improvement of the learning of the skill of new response to emotional stimuli, attention domination improvement, , guidance and stimulation of the discrimination or the memory and balancing and nourishment of the effective therapy. The change of the behavior of the patient with BPD is at first engagement functioning, improving of the life and the behavior despite the existence of the emotions.

Mechanisms of change by the therapy that are based on mentalization of patients with BPD – psychotherapy. Borderline personality disorder (BPD) is a complex and serious mental disorder that

characterized by spreading pattern of difficulties in emotional regulation, impulses control and instability in both in the relationships and in the self-image with a morality rate that associated with suicide. The dysfunction on the self-regulation seems especially in the context of social relationships, the regulation of the feelings and the catastrophic reaction to the loss of social relationships in the context of communication. There was found that the psychotherapy is a most effective therapy method although the medication can enhance its effects, although the mechanism of change remained unknown. The unorganized attachment processes and the consistent instability in emotions and relationships in BPD. There are mechanisms of change by causing change through causal mechanisms.

The nature of the therapeutic intervention and the process of change – The key characteristics of the approaches of psychotherapy are: The therapist is asked to focus purely on the present mental state of the patient, the therapist is asked to avoid situations in which the patient talks about the mental states that he cannot associate to the subjective reality feeling. Here there are deviations from the traditional psycho – dynamic techniques. In this way of the therapy, the transition space of the reference where there are the thoughts and the feelings can function. The inevitable enactments during the therapy aren't interpreted or understood in the terms of subconscious meaning but in the terms of the situation and the engraved immediate effect.

The biological basis of therapy for change in MBT – the results of the change are due to an improvement in the regulation of the neuropsychological systems, therefore we must consider the biological basis of therapeutic change. On the basis of dysfunction resulting from your BPD has two areas of brain functioning that associated with psychological processes that associated with psychotherapy for BPD: reward circuits in communication and interpersonal relationship dysfunction and mentalization.

The role of networking in the communications systems neutralization - despite maternal and romantic love has different roles; there are also the number of objective and subjective features like engagement, deep interest and a high level of commitment. This infrastructure is a common set of brain mechanisms that act when the attachment emotions act strongly, but there is also a neutralizing of the set of feature of other neural functions. Waterless and Zaky offer to sort the mutual activity fields to two functional areas: the first includes middle front, lower vertex and the middle provisional cortex, particularly the right hemisphere as well as the back cortex. These areas are

intended for listening and long- term memory and involve both the positive emotions and the negative emotions. They have roles in both in the cognition and in the emotion, because these areas can specifically be responsible for integrating of emotion and cognition. The second set of areas neutralizes the activating of the attachment systems and it includes temporary poles, the temporary node, the tonsil and the prefrontal cortex. The activating of these areas consistently associated with adverse effects of social credibility judgment, moral judgment, opinion theory, tasks and attention to the self-feelings and they are especially for neural networks that are the basis of our ability to identify mental states of other people. The mentalization relevant not only in the opinion states of others but also the emotional state and the faith and consequently the activating of the neural systems. This judgment of the moral appropriateness for the assessing of the social reliability that based on face to face expression.

The implications of the mutual activation of mentalization and communication – The test shows that at first every neural association between attachment and mentalization confirms that we must distinguish between the two systems in the behavioral level, secondly we have to show the form of parental ability to do mentalization in the context of the attachment attitude that facilitates the development of the safe communication of the baby. Thirdly we have to see that the mentalization occurs prematurely in the children who feel safe as babies. Fourth we have to see that consistently the mentalization ability in the context of communication in some ways that doesn't t depend on the ability to do mentalization in the attachment, in the context of conceptual function, from the perspective of the behavioral results that are inconsistent with other measurements of mentalization.

Mentalization in the context of attachment and sorting of attachment types - even though from developmental aspect the mentalization less relevant in the context of communication than in other social contexts, the ability to do mentalization shows very desirable ability. Individuals who can do mentalization during the time thinking about romantic partners or infants who can manage these relationships better. The mentalization of individuals with BPD often represented challenge that is described in the psycho - analytic literature as the failure coding or reality of thought. Now the mentalization generally not considered as a problem for most individuals with BPD.
Implications of therapy and mechanism of change - The MBT is designed in order to improve the mentalization in the context of attachment relationships. In both in the individual therapy and in the group therapy the therapist works largely in the variety of unknown techniques in order to activate the attachment systems. This activation occurs through discussion about contemporary attachment

relationships, discussion about previous attachment relationships, encouraging of the patient to relative regulation of the patient's attachment relationships are surety for the creation of an environment that assists to influence the regulation of the patient the therapist's attempt to create attachment relationship of the group members in the context of group therapy. Paradoxically, the attempt of the therapist to improve the mentalization not only by therapy of instructions but also by therapist's interest in the emotional life of the patient, this issue creates a paradoxical situation in the terms of brain activity by psychological therapy simultaneously activates two delaying mutual sets of the systems. There are two other ways in which the paradoxical patterns of the activation are saved: activation of negative emotions when the therapist encourages confrontation with traumatic and negative experiences and encouraging of retrieving of laden temporary memories. In these ways the individual with BPD is encouraged to neutralize regular patterns of attachment that related to neutralization of mentalization of negative feelings and of social and moral judgment.

The implications of the general process of change through the therapy – there is estimated that the thought of the feelings, thoughts and beliefs in the context of attachment is beneficial because in the paradoxical brain situations because in these situations there can be more access to the change of conceptualization of the contents of the individual's or others' opinion in the issues of morality and social judgment. Activation of the attachment systems partially harnesses the biological processes of the brain to rethink about the dominance of the current and previous constraints (long term memory) and to create the possibility of rethinking and redefining of the inter-subjective relationship networks. The specific advantage of the MBT is that the process can focus on simultaneous activation of the attachment system and the encouraging of the development of psychological processes that delay as a result of it. The MBT represents the intersection between psychology and biology moves towards the infrastructure of processes of psychopathology that must update the renovation of the therapy.

Mechanisms of change through the therapy of borderline personality disorder by transition focused psychotherapy (TFP) - borderline personality disorder is a serious and widespread psychiatric problem that characterized by emotional instability, anger outbursts, frequent suicide and lack of ability to work and to maintain meaningful relationships. The BPD is particularly accompanied with other personality disorders as well as a number of axes of disorders, particularly depression, anxiety, eating disorders, post- traumatic stress disorder and substance abuse. There was found that the BPD can be described by the pattern that called accompanied morbidity that characterized by many

accompanied diagnoses including internalizing and externalizing disorders. There was also found that 86% of individuals who suffer from depression and substance abuse, it is accompanied with the BPD. There was also found that the BPD has detrimental effects that negatively affect both the efficacy of the psychotherapy care and the efficacy of psychosocial therapy of these disorders. Therefore this isn't surprising that patients with BPD are many times in emergency rooms, outpatient and partial hospitalization programs, outpatient clinics and inpatient units. Patients with BPD often have impairment in the generally functioning, for example they unemployed or underemployed for their capabilities, their training and their socio - economic status. In addition to these patients with BPD are known as people who it is hard to care. The disorder is characterized by high rates chaos and need medical or psychiatric service. One of the therapies that shows data that indicate the effectiveness and efficiency is transition focused psychotherapy (TFP) – it is clear that despite that the BPD is a chronic functional problem, it is also very given to therapy disorder. What remains uncertain is whether the mechanisms of development and maintenance of the BPD, processes of change in the patient during the therapy and the specific therapy techniques will lead to the desired changes. In order to conceptualize the mechanisms of change of the psychotherapy, we have to ask how the borderline personality disorder develops. In the literature the development is defined through the following steps: details of the emotional, cognitive and behavioral core of the mechanisms in the development and maintenance of the specific medical problem, to explore the heterogeneity of the disorder, to understand the relationships between the social environment and the biological tendencies and to understand the developmental processes, the pathways and the various moves that the disorder causes them. Understanding these questions leads to two further questions about the mechanism of change: what are the changes that occur in the person? And how and why the therapies work for a specific population of patients with a specific disorder? So the mechanisms of change can conceptualize two levels: what is approximated that changing in the patient? And what are the active ingredients in the therapy that stimulant the change in the patient?

How the TFP conceptualizes the cause the cause and maintenance of the BPD? - Patients with BPD have difficulty in the integration of different representations of themselves and others, partly because of negative emotions, especially aggression, disruption of the ability to integrate these representations. The high level of negative emotionality and aggression can be engraved or congenital as a result of experience or an integration of both. Regardless of its origins, the high levels of aggression interfere to normative developmental processes of integration of different representations, and instead of high levels of aggression that causes the separation between positive

and negative representations. There was also said that emotional instability can interfere to the ability to develop and to the perception of self and others' stability. There was also argued that emotional instability in BPD can be secondary to the lack of definition and integration of internal mages of self and others, which lead to instability in the sense of self at the end for emotional instability. So the relation between the lack of representations integration emotional instability can cause a negative cycle of intensity of the results from the previous effects of split experience of yourself and of others in order to protect the positive representations that can lead to emotional instability and by the failure to provide a basis for the self and others understanding. The relative effects of constitutional and environmental factors can vary from one to another. The common factors usually only conceptualize the elements of psychotherapy converges on the different therpy approaches.

What are the estimated changes in the patient who t treated with the TFP and how the therapist facilitates these changes? At the TFP it is estimated that the change mechanisms conceptualize the disorder in terms of effects and incomplete and undefined representations of the self and the others. The representations of self and others are paired and connected in part by the effects of the mental units that called object-relational pairs. These pairs are the elements of the psychological structure. At the borderline pathology, the lack of integration of internal objects of the pairs of relationships is parallel to the split psychological structure in which the negative representations distribute from the positive representations of self and others. The Mechanism of change in the patient who treated by the TFP by the integration of these polar effect situations and the representations of self and others for the more coherent complete. Exploration and integration of these divided cognitive-emotional units cause the awareness and the experience of the patient to be more enriching and regulated and the patient develops s the ability to think more flexibly, to be more realistic and more generous. Integration of the splits and the polar concepts of self and others leads to a more complex, more defined and more realistic emotion about self and others, and enables a better regulation of the effects and also the clearer thinking. Therefore the distribution of representations of representations becomes integrative. The patient tends to experience greater coherence of identification, the relationships are balanced and not at risk of a violent impact, a greater capacity for intimacy, reducing destructive behaviors and a general improvement in functioning. The level of intervention of the therapist begins the approach of structural therapy approach and the use of clarifying of the confrontation and beyond to the interpretations of the medical relationships. By using a trio of clarification, confrontation and interpretation, the TFP therapist is considered as who provide to the

patient an opportunity to integrate cognition and influences that are first of all divided and unorganized. In addition this very busy, interactive and emotionally strong position of the therapist is considered as expert and emotionally strong by the patient, because the therapist shows that he or she patient to the negative emotional states of the patient. Moreover, the therapist's expectation of the patient's ability to be with thoughtful and disciplined to the emotional states considered expert and with a cognitive hold. The therapist is t interpreted as topical, clear and polite he is also interpreted dominant, loaded and thematic and the enactments of the patient who tries to understand the reasons why the representations remain divided and gets the integration of the polar representations of self and others. The therapy framework of TFP facilitates the full activation of the distorted internal representations of the patient about self and others and in ongoing relationships between the patient and the therapist that are the transformation. There is expected that the non-integrated representations of self and others will be activated in the therapy environment as in any every aspect of the life of the patient. These partial representations always active in defining the patient's experience, interactions in his real life and motivates the behavior of the patient. On this process facilitates the determination of the therapist that the framework of the therapy is used as framework and maintenance for the patient and the agreed reality from which it is possible to examine the behavior outward, it reduces the potential of the therapist to action in the ways of medical diagnosis. The therapist doesn't respond on the one dimensional fragmented and partial representations f the patient, but assists to the patient to follow them. The TFP looks for cognitive clarification of the patient's inner experience but it is possible that the patient doesn't have a clear representation of his experience. . The technique of clarification turns to the explanation and reflection of inner states. At the practical level, the relationship with the therapist in TFP is structured under controlled conditions in order to enable to patient t to experience the effects without deciding the situation and destroying of the communication. The negotiations of the therapy framework provide a safe environment - commitment or holding environment – for the restart the internal relations paradigms. Safety and stability of the therapeutic environment allow starting to express what is happening now with the other person, in the light of these internal paradigms. With the guidance of the therapist, the patient becomes conscious to the extent in which his perceptions based more on internal representations than their basing on what is happening now. The therapist assists to cognitive understanding of what at first seems as chaos and also provides contain functions for the patient's effects. The TFP creates the listening of the patient to the internal mental representations behind the dysfunctional behaviors, in order to understand change and to integrate them. There is a faith that the focusing the activating of the inner world of the patient in the therapy

environment leads to lower chaos of the patient out of the therapy. The therapist is careful in the control of the patient's life conditions at the same time focuses on what assists in the therapy. Patients with BPD identify the lack of communication of thought as an attack on the linking thoughts, so the thought processes are affected. The thought processes can be much distorted and it is particularly affected by the negative processes that are expressed in action without cognitive conscious to its existence.

The TFP as other prominent theories of the BPD supposes there is an interaction between emotional vulnerability that is engraved in environmental experiences. The exact nature of the engraved vulnerability can vary but the general thought to put plenty of negative effects, particularly aggression, in relation to a positive effect. The study showed that the positive effects act as a buffer to negative experiences including from negative mental situations. Without the buffer of the positive impact, the negative impact paints the perceptions of the interactions and distorts the internal representations. Some researchers argue that lack or inhibition in the ability to do mentalization leads to instability in the sense of self. Hence the estimated change mechanism for patients with BPD is the increase in the capacity to do mentalization. This ability is considered to be something that increases the emotional stability of patients with BPD by this that it enables to them to change their attention when they experience negative emotional states and to find meaning in a cross- over behavior and the behaviors of other people. There is estimated that this ability is developed when there are achievements in the context of secure attachment to the therapist and it is associated with feelings of self-worth. We could show that during the TFP therapy the changes in integration and reflection of the evaluated occur the cohesion and the conceptual function respectively. These changes are specific to the TFP and the corresponding parallel significant changes in the results.