

Family MDT: vs. Treatment as Usual in a Community Setting

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Abstract

This article examines the effectiveness of Mode Deactivation Family Therapy, (MDT) in a community setting as compared to Treatment as Usual, (TAU). MDT is an evidenced based psychotherapy and has been shown to be effective treating adolescents with physical and sexual behaviors, as well as, problems with conduct and personality. In this study, MDT was shown to be superior to TAU in a community setting with assisting families of the previous described adolescents.

Keywords: Mode Deactivation Therapy, MDT, MDT Family Therapy, Conglomerate of beliefs and Behaviors, (COBB), fear-family assessment, family core belief assessment.

Introduction

Many Cognitive Behavioral Therapists have attempted to identify and address both distorted schemas and maladaptive behavior patterns in family interactions (Dattilio, Epstein, and Baucom. (1998). According to Dattilio, et. al., (1998) cognitive behavioral therapists interview the family to determine their perceptions of the family and how things operate in the home environment. In addition, the cognitive behavioral family therapist views the entire family as a case, avoiding the stigma of one individualized patient/client.

Epstein (1986) found that negative exchanges by individual family members increase the overall family distress. Dattilio et. al., (1998) suggested that the cognitive behavioral family therapist pays attention to the antagonistic exchanges between individual family members. Dattilio further suggested that the cognitive behavior family therapist pays attention to the following:

- 1) Frequencies and patterns of antagonistic/discordant behavior exchanges.
- 2) Expressive and listening skills for communicating thoughts and feelings.
- 3) Problem solving skills.

Dattilio, et. al., (1998) also stated that similar system to theorists, cognitive behavioral family therapists “carefully focus on the processes of family interactions.” He suggests that their systems are amiable to the CBT methodology. Dattilio, et. al., (1998) has published numerous studies to support his contention.

Baucom and Epstein (1990) developed a typology of cognitions that have been implicated in relationship conflict and distress: (1) “selective attention,” this is defined as each member of a relationship tends to notice some aspects of events occurring in their interactions but not others: (2) “attributions,” implies that inferences the individuals make about causes of event in their relationships: (3) “expectancies,” are predictions about the probabilities of particular events that occur the future: (4) “assumptions,” which actually involves belief about the characteristics of relationships and how relationships work: finally, (5) “standards,” these are the family members beliefs of how their relationships, “should be.”

Dattilio, et. al., (1998) states that cognitive behavioral therapists propose that these five types of cognitions have the potential to erode satisfaction in family relationships and they elicit dysfunctional family interactions.

It is important to note that Doherty (1981) found that family members who believe that there is a high probability of unity, will behave together as a group, as if they are helpless rather than making active attempts to resolve family conflicts.

Distressed families tend to view each other's negative behaviors as due to unchangeable patterns, and positive behaviors as atypical, Dattilio, et.al., (1998).

Dattilio, Epstein & Baucom (1998) suggest that a basic tenant of the cognitive-behavioral model of family is the basic dysfunction and distress in the family is the basic interaction of the cognitive behavioral and affective function. (Epstein (1998), Dattilio, et. al., (1998) detail considerable evidence that various negative exchanges among family members, adversely affects the relationships pf th family member.

Biglan, Lewin & Hops, (1990) address the problem of negative behavioral interactions directly affecting dysfunctional outcomes for children, in school, home and interpersonal interactions.

Dattilio, et. al., (1998) delineate how traditional behavioral family therapy methods of assessment and modification remain the control component to cognitive-behavioral approach.

MDT Family Therapy also examines the "process" of family interactions, Apsche & Ward, (2003), Apsche & Bass, (2006). MDT attempts to move the family to a new script, based on the collective case conceptualization process, Apsche, Ward, (2003), Apsche & Bass (2006).

Unlike multisystematic therapy, as delineated by Henggeler, et. al., (1998) which would focus on the youth as embedded 9in multiple systems that have basic direct and indirect influences on the his or her behavior, MDT focuses on the system of family beliefs and modes based on the collective and individual modes of family members. MDT tends to be a psychotherapeutic intervention rather than a system of treatments. *One* therapist is central to the individual, group and family process. This therapist is the team captain and coordinates individual, family, and group psychotherapy.

Most Cognitive behavioral treatments focus on an individual client (adolescent) Henggeler, et. al. (1998). MDT is a process that focuses first on the adolescent following the completion of the family core conceptualization, then the family. MDT includes a family workbook, Apsche & Apsche (2007), and exercises which help to reintegrate the troubled youth and his/her family and extended family.

To avoid the individual stigma, Apsche & Ward (2004), Apsche & Bass (2006), Apsche & Apsche (2007), the MDT Family Fear and Belief assessments were created to develop the collective family case conceptualization. This allows the MDT therapist to interpret his/her treatment approach using empirically derived methodology.

MDT Family therapy is designed as an extension of the MDT Methodology for Adolescents, Apsche & Ward (2004), Apsche & Bass (2006). MDT Family Therapy is not designed for implementation as a separate methodology, but is to be implemented as part of MDT treatment for adolescents.

Method

MDT Family Therapy was implemented with eight families in an out patient setting. MDT was compared to TAU in the community. (Families had pre treatment averages of 31 arguments per week, 7.5 acts of physical aggression and 25 threats per week).

The first author and staff met and conducted MDT Family Therapy with immediate family members in office for one-two hours per week or 20 weeks.

Application of MDT-Family

MDT family therapy as initiated by implementing the Family MDT assessments. The Family MDT assessments resemble the individual MDT assessments. The family MDT methodology includes a Family MDT Workbook. This workbook is revised to structure the Family Therapy, following an MDT methodology. The workbook is designed to provide a collaborative effect for all family members. The Family MDT Manual addresses the following topics:

- **Family Commitment to Treatment**
- **Responsibility for the Family**
- **Family Belief Analysis (Compound Core Beliefs)**
- **Mode for the Family**
- **MDT and Reactive Anger, Aggression, and Impulse Control**
- **Your Family's Beliefs and Problem Behaviors**
- **Problem Behaviors and NMDT**
- **Substance Abuse in Your family**
- **Empathy for the Family**
- **Becoming Survivors**

1). ***The Fear-Family Assessment:*** an assessment of sixty items that identifies basic difficulties, anxieties, or fears of the family. Each family member completed the assessment individually and the scores were totaled and a mean score was determined across each item.

2). ***The Family Core Beliefs Assessment:*** an inventory of ninety-six questions related to the familiar beliefs systems. The Family Core Belief Assessment was scored in the same manner as the Family Fear Assessment.

3). ***The Functionally Based Treatment Development Form:*** a form that addresses the collective family beliefs and supplies the family a specific methodology to develop and maintain more functional family beliefs.

The families re taught how to balance its beliefs with the **V-C-R** method. V-C-R is a methodology of *validation*, *clarifying* and *redirecting* the belief of the family. While there may be some identification of opposing beliefs, this method attempts to expose the unbalanced or irrational, illogical beliefs deeply held by families in crisis. The individual components of the V-C-R method included:

Validation. Each family member’s thoughts and beliefs were validated initially. Therapists searched or grains of truth in each family member’s responses. It was important to assure each member that his/her responses were accurate as far as his/her interpretation of his/her perceptions. Each member was given appropriate reinforcement that (s)he was certain that (s)he fully understood and believed.

Clarification. Therapist clarified the content of responses. Therapists also clarified the beliefs that were activated. It was important that clinicians understand and agreed with the content o the clarification. The Clarification step was crucial in understanding the long held thinking schemas. This was clarification of the member’s perspective or reality and beliefs.

Redirection. Therapists redirected responses, to view other possibilities or the continuum of held beliefs. The goal of this step was to help the family member find the exception in the beliefs system. The redirection involved in examining te opposite side of the dichotomous or dialectical thinking. It was crucial to partner with the member to see the “grain of truth” in each of the dichotomous situations presented.

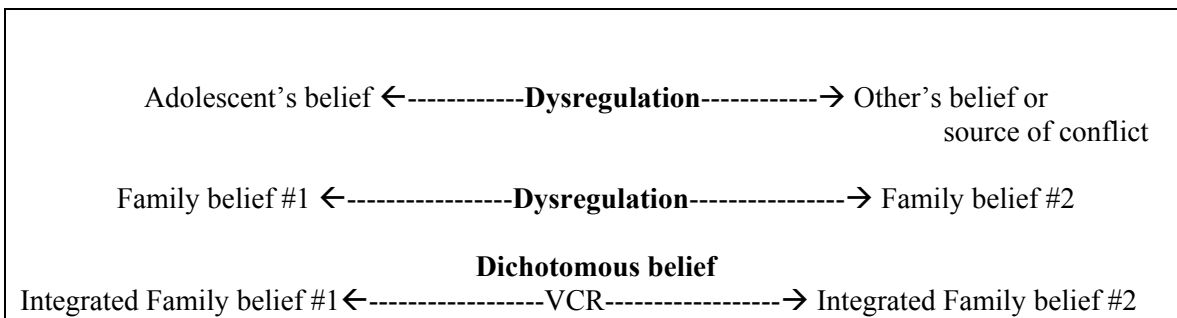


FIGURE 1: Diagram of the Dysregulation process

Figure 1 highlights the direction of the deregulated belief system. The redirection was an attempt to aid the youth and family member in seeing both sides of the dichotomous belief(s). Also, important was to look for the truth in each and compromise in understanding the truth in both beliefs. The use of a continuum of belief was implemented to examine the individual’s belief of truth in both of the dichotomous beliefs and situation.

Each individual in the family, as well as the family collectively completed the Conglomerate of Beliefs and Behaviors, (COBB). The COBB examined each individual’s belief as well as their corresponding behaviors. Once the families Beliefs and Behaviors were determined they were compared to each individual’s beliefs and behaviors.

These methodologies addressed the specific behavior of each family member and contrasted the family at larges’ score. The behavior was explained and understood as the individual integrated his/her belief(s) and behavior(s) within the family system at large.

CHART 1: Family Beliefs, Behavior and subsequent behavior

Beliefs held by adolescent	Direct Behavior	Sibling reaction	Mother	Conclusion
“When I get angry my emotions go from annoyed to furious.”	Punches Brother	Hurts, runs to mother	Screams at client	Mother apologizes and Criticizes again.
		Isolates	“You are a f--- mess!” Hits client	Continuation of Conglomerate Family

If we look at the example of the client's behavior, his anger belief is activated, he gets angry and his Mother screams and curse at him. She later apologizes and criticizes again. They wait for a change by repeating their behaviors, reacting to the identical belief. The activated belief prevents the family from progress and assures that only conflict is assured in the family.

The work of the MDT therapist was to implement V-C-R with the family while pointing out and balancing the individual and family beliefs.

TAU

The treatment as usual group included weight (8) families who were treated by therapists using a variety of methodologies and considered their treatment philosophies eclectic in nature.

Therapy was funded through a county office of Children and Youth; the adolescents were at high risk for placement in residential facilities. All clients' were assigned randomly by the referring agencies, in an even and odd system to both the MDT and TAU groups. The adolescents in both groups received individual therapy, as well as, family therapy.

Results

MDT Family Therapy was implemented with families in an outpatient setting. The results suggest that MDT reduced arguments and aggressions, both verbal and physical. The results also suggest that MDT might be an effective methodology for treating the families of the adolescent. Important in the data, is the reduction of all of the families' targeted behaviors. Arguments were anecdotes of more serious problems and the reduction of argument from week to week suggests that they served as triggers to aggression and violence in this limited study.

CHART 2: Baseline-per week

	MDT	TAU
Physical Aggression (hit, punch sibling or any family member)	8	7
Verbal Aggression	8	10
Arguments	30	32
Property Destruction	12	10

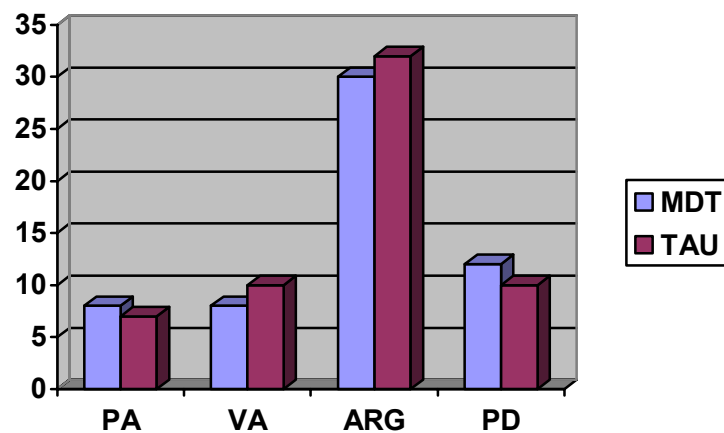


Figure 2: Baseline Pretreatment effects

CHART 3: 20 weeks post week (20)

	MDT	TAU
Physical Aggression	0	6
Verbal assault	2	9
Arguments	4	29
Property Destruction	0	10
Referrals for out of home placement	-	6

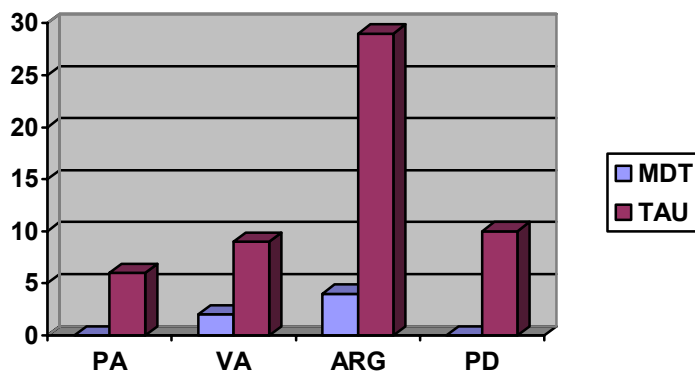


Figure 3: 20 weeks post week (20)

Threats were also interpreted as an antecedent to the more violent family behaviors, the reduction of threats suggest that hypothesis might have had some validity. The overall reduction of physical destruction and aggression were significant to encouraging more appropriate and desired means of family communication.

Discussion

First, as in all real world studies, this study was random by nature, but had to adhere to treatment guidelines, rather than research guidelines. All individuals and families in this study were informed that the results of the study would be submitted for publication and all agreed. Assignment of the families to groups was completed by the referral agent at the county office of The Department of Youth and Family Services.

The MDT group was treated by the first author and a Master's prepared therapist. The TAU group was treated by doctoral prepared licensed psychologists.

The results of this limited "real world" study suggest that MDT Family therapy might be a promising treatment for families that have children who are physically and verbally aggressive and have problems with conduct and personality. As of now, MDT Family therapy is designed for families that have children receiving MDT Therapy. This could change depending on results of further study. This study attempted to demonstrate the effects of MDT when applied to the family, as compared to treatment as usual in the community. MDT Family Therapy is a manualized treatment. The family is guided by the therapists in completing assignments during and outside of the therapy session.

Many treatment methodologies based on evidenced based psychotherapies are not often implemented in community or applied settings. They are used in university research clinics with a homogenous population. Evidenced based psychotherapies are often viewed as too cumbersome and "unrealistic" for "real world settings." MDT has been developed and tested in applied and "real world" settings, by Apsche and his colleagues with a heterogeneous client population. Treating all clients is a requirement in clinic or applied settings, clients cannot be disqualified because of narrow criteria often used in research clinic studies.

MDT Family Therapy followed the guidelines of applied settings, if the participants were referred, they received treatment in this study. The results suggest that MDT Family Therapy was more effective than TAU in a "real world" community setting. MDT Family Therapy with further study might offer an evidenced Based Psychotherapy for treating families of adolescents with problems with aggression, conduct and personality.

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