A Treatment Study of Mode Deactivation Therapy in an Out Patient Community Setting

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Abstract

This paper is an outpatient replication of Apsche, Bass, Jennings and Siv (2005) work which examined the effectiveness of Mode Deactivation Therapy (MDT) on adolescent conduct disordered males in an inpatient therapeutic setting. This research compared the effectiveness of MDT and Treatment as Usual (TAU) as treatments on adolescents with conduct and personality disorders in an outpatient setting. The results showed that MDT was superior in reducing overt aberrant behavior, including physical aggression and psychological distress as measured by the Achenbach Child Behavioral Checklist.

Keywords: Mode Deactivation Therapy (MDT), Treatment as Usual (TAU), Outpatient, Personality disordered, Conduct Disordered.

Introduction

The prevalence of youth earning the conduct disorder diagnosis is on the rise. Given the prevalence of conduct disorders and its major contribution to juvenile anti-social behavior, societal violence, sexual violence and delinquency, there is an urgent need for empirically based treatment methods for such youth.

There have been several interventions which have been implemented to reduce antisocial behavior in disruptive disorders. Because many clinicians conduct therapy in more eclectic fashion, the problem we encounter is identifying generalize-able efficient treatments which are effective across environments. Brestan & Eyberg (1998) conducted a review of treatments for children and adolescents. They identified 82 studies carried out between 1966 and 1995 involving 5,272 youth. Of the 82 studies, they discovered that many were not well- established with empirical validation and many more were not probably efficacious treatment. Another problem we face is identifying a comprehensive treatment approach which has suitable reliability and external validity. Unlike treatments from clinicians who worked primarily inpatient using structured empirically validated treatments, the finding of empirically validated studies which examined outpatient therapeutic practices with conduct disordered adolescents was scarce. While Kazdin and Weisz (2003) delineate some evidence-based treatment practices for children with Conduct Disorder, the same has been not achieved for adolescents over 14 years of age. Brestan and Eyberg found two psychosocial treatments. Both interventions were directed at training parents. Despite the misdirection of treatment both succeeded in reducing problem behaviors. The two treatments were a parent training program based on the manual *Living With Children* (Bernal et al., 1980) and a videotape modeling parent training (Spaccarelli et al., 1992). While both treatments were effective, they were more psycho-educational programs geared toward parents rather than stand alone treatments for the adolescent with conduct related disorder. Another promising approach for the treatment of conduct disorder is multi-systemic therapy, an intensive home- and family-focused treatment that has been empirically validated. MultisystemicTreatment has shown promise for antisocial youth (Henggeler, Schoenwald, Borduin, Rowland and Cunningham, 1998) and for adolescent sex offenders (Swenson, Henggeler, Schoenwald, Kaufman, and Randall, 1998), but it requires a resource-rich combination of services, one of which is psychotherapy, and it is not a realistic option for most

such youth. Cognitive behavioral therapy (CBT) is widely employed in the treatment programs for behaviorally disordered youth across many settings and is frequently used with aggressive youth. But there are clear limits to the effectiveness of CBT in the treatment of personality disordered clients, especially borderline and narcissistic types (e.g., Young, Klosko and Weishaar, 2003).

Apsche and his colleagues developed an advanced form of cognitive behavioral treatment called "Mode Deactivation Therapy" (Apsche and Ward Bailey, 2004a) in order to simultaneously address the multiple problem issues of conduct- and personality disordered youth, while also accommodating the particular defensive characteristics of the adolescent. Mode Deactivation Therapy (MDT) has been applied to adolescent sex offenders and mentally ill adolescents alike. MDT is an evidence-based treatment that blends key elements from Beck's theory of "modes" (Beck, 1996); traditional Cognitive Behavioral Therapy and Schema Therapy (Alford and Beck, 1997; Beck and Freeman, 1990); Dialectical Behavior Therapy (Linehan, 1993); and Functional Analytic Behavior Therapy (Kohlenberg and Tsai, 1993; Nezu, Nezu, Friedman and Haynes, 1998).

The present study was designed to assess the effectiveness of Mode Deactivation Therapy (MDT) as compared to Treatment As Usual (TAU) in the treatment of conduct disordered and personality-disorder youth with problems of aggression in an outpatient environment. The therapist of the TAU group in the community identified themselves as mostly eclectic as using "what works." Another goal is to add to the growing body of literature of empirically validated treatments which serve the adolescent diagnosed with conduct disorder.

METHOD

Sample Characteristics

A total of 13 male adolescents participated in the study. All subjects were referred to a private outpatient practice for the treatment of aggression. Referrals came from County Juvenile Justice and the Department of Youth and Family Services. In this study, subjects were randomly assigned to one of the two treatment conditions at the time of admission based on available openings in the caseload of the participating clinicians. The two treatment conditions showed similarity in terms of the frequency of Axis I and Axis II diagnoses, age, and racial background. To ensure consistency in the delivery of the two respective treatments, therapists were specifically trained in the one of the two treatment curriculums/methods. The average length of treatment across conditions was 6 months.

Condition one: Treatment As Usual (TAU) A total of six male adolescents were assigned to the condition. The group was comprised of 1 African American, 5 European Americans with an average age of TAU 16.1. The principal Axis I diagnoses for this group included Conduct Disorder (2), Oppositional Defiant Disorder (4), and Post Traumatic Stress Disorder (4). Axis II diagnoses for the group included Mixed Personality Disorder (4), Borderline Personality Disorder (1).

Condition two: Mode Deactivation Therapy (MDT): A total of seven male adolescents were assigned to the MDT condition. The group was comprised of 2 African Americans, 5 European Americans with an average age of 16.4. The principal Axis I diagnoses for this group included Conduct Disorder (1),Oppositional Defiant Disorder (3), Post Traumatic Stress Disorder

(4), and Major Depressive Disorder, primary or secondary (5). Axis II diagnoses for the group included Mixed Personality Disorder (4), Borderline Personality Traits (3). The MDT condition used the Mode Deactivation Therapy which is built on the mastery system for youngsters. They move through the workbook at the rate of learning that accommodates their individual learning style. The system is designed to allow the youngster to experience success, prior to undertaking more difficult materials. Initially, the individual needs to be aware of his negative verbalizations and negative thoughts, and record them in his workbook. Through the Case Conceptualization, workbook, and audiotapes, the system allows the youngster to systematically address the underlying conglomerate of personality disorders as well as, the specific didactics necessary, anger/aggression.

Measures

Three measures were included in this study: School disciplinary referrals, Parent Report and The Child Behavior Checklist (CBCL; Achenbach, 1991).

School records were used to assess disruptive and aggressive behavior in school. Behaviors which were assessed included school suspension, physical altercation, verbal aggression toward peers/others.

The Parent Report Record is a measure used to record aggressive behavior at home. Behaviors recorded included; Sibling altercations, Anger outbursts, and direct intentional disobedience.

The CBCL is a multi-axial assessment designed to obtain reports regarding the behaviors and competencies of 11- to 18-year-olds'. The means and standards are divided into three categories: internalizing (which measures withdrawn behaviors, somatic complaints, anxiety and depression), externalizing (which measures delinquent behavior and aggressive behavior), and total problems (which represent the conglomerate of total problems and symptoms, both internal and external).

RESULTS

Child Behavior Checklist

The CBCL means and standards are divided into three categories: internalizing, externalizing, and total problems. There was no significant difference in the pretest means between MDT (Internalization =73.5, Externalization= 75.5 and Total= 74.5) and TAU (Internalization= 73, Externalization= 75 and Total= 74).

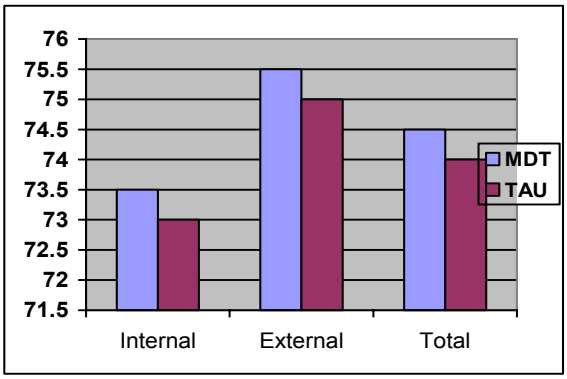


Figure 1. CBCL; Pre treatment mean scores for TAU and MDT groups

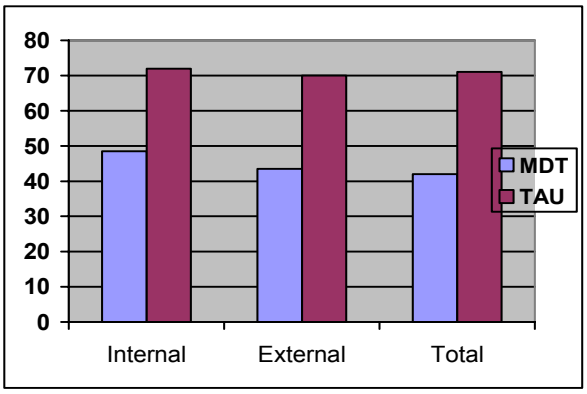


Figure 2. CBCL; Post treatment mean scores for TAU and MDT groups

The post test means showed a statistically significant difference in mean scores. In comparison to the TAU group, the MDT group was superior in reducing all three categories (MDT: Internalization= 48.5, Externalization= 43.5 and Total= 42; TAU: Internalization=72, Externalization= 70 and Total= 71)

The Parent Report Record

Results on the Parent Report Measure showed no significant difference in the pretreatment recordings of Sibling altercations (SA), Anger outbursts (AO), and direct intentional disobedience (DIB) (MDT: SA=5 per week, AO= 21 per week, DIB= 10; TAU: SA= 4 per week, AO= 22 per week and DIB= 11).

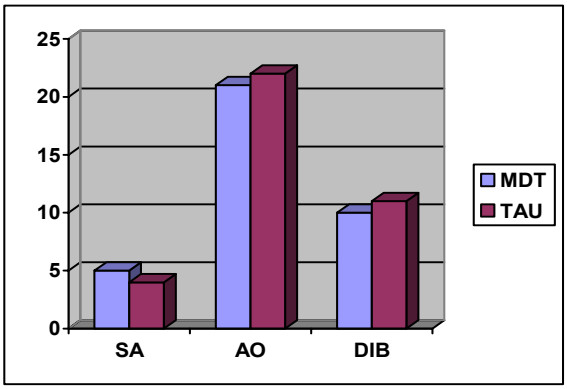


Figure 3. The Parent Report Record: Pre treatment mean scores for TAU and MDT groups

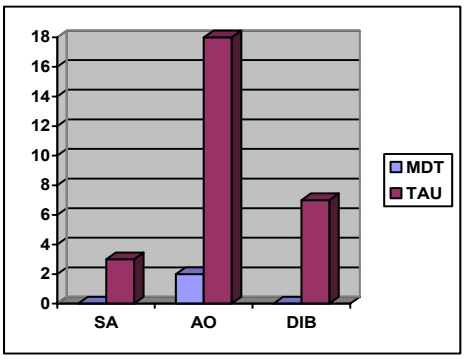
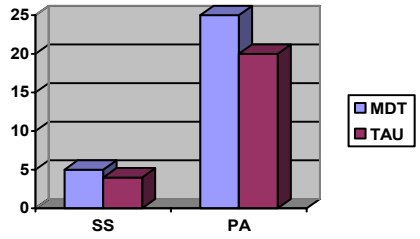


Figure 4. The Parent Report Record: Post treatment mean scores for TAU and MDT groups

Post treatment results on the Parent Report Measure showed a significant difference in the recordings of Sibling altercations (SA), Anger outbursts (AO), and Direct intentional disobedience (DIB) (MDT: SA=5 per week, AO= 21 per week, DIB= 10; TAU: SA= 4 per week, AO= 22 per week and DIB= 11).

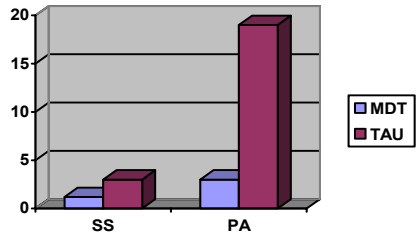
School Records

School records were kept by the school's Principal Discussion Office. The forms tracked aggression and school suspensions.



SS = School Suspension
(Pre treatment MDT= 5, TAU=4)

PA= Physical Aggression
(Pre Treatment, MDT= 25, TAU= 20



SS = School Suspension
(Post treatment MDT= 1.2, TAU=3)

PA= Physical Aggression
(Post Treatment, MDT=3, TAU= 19

Results demonstrate that MDT was superior to TAU in all categories in this study. Results initiate that MDT was statistically significant over TAU in reducing aggressive behavior, defiant behavior, school suspensions, as well as, reducing symptoms of psychological distress as measured by the CBCL. Symptoms such as anxiety and depression were reduced by MDT while some increased by TAU.

Reports by parents and School Administration reported that the behaviors of the adolescent in the MDT showed significant improvement. The TAU group received negative reports by parents and School Administration.

Discussion

The results suggest that MDT might be an effective treatment in community outpatient settings. They also suggest that in this limited study and setting that MDT was more effective than TAU or "eclectic" approach, the "using what works"

This treatment research was the first of its kind implementing MDT in a community outpatient setting. All previous studies were in residential inpatient settings. Apsche developed MDT for Conduct Disordered and Personality Disordered adolescents with physical and sexual aggression in Residential settings.

This study, although limited in scope and sample size suggests that with further study and modifications MDT might be a promising treatment in community outpatient settings. These community settings are often the first or last opportunities for troubled adolescents prior to being sent to residential settings, many as long as 18 months. Therefore MDT should be considered as a treatment of these adolescents prior to commitment to years in a residential treatment center.

It is also suggested that MDT is completely inter-gradable with other therapies such as, Multisystemic Treatment Therapy and Systems Family Therapy. The authors hope that MDT is tested in a larger, randomized study to further test with efficiency.

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