

A Summary of Published Mode Deactivation Therapy Articles

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Abstract

This article summarizes all of the Mode Deactivation Therapy, (*MDT*) articles published to date. MDT has shown to be more effective than Cognitive Behavior Therapy, (*CBT*), Social Skills Training, (*SST*), and Dialectical Behavior Therapy, (*DBT*), Apsche, Bass, Jennings, Murphy, Hunter, and Siv, (2005); Apsche & Bass, (2005); Apsche, Bass & Murphy, (2004). This article suggests that MDT is a viable clinical Evidenced Based Psychotherapy.

Keywords: Mode Deactivation Therapy (MDT), Cognitive Behavioral Therapy, (CBT), Dialectical Behavior Therapy, (DBT), Social Skills Training, (SST), Evidenced Based Psychotherapy, Adolescent Treatment, Child Behavior Checklist (CBCL), Devereux Scales of Mental Disorders (DSMD), Treatment as Usual (TAU)

Introduction

Mode Deactivation Therapy, (*MDT*) was developed by Apsche to address adolescents who were not successfully completing treatment. Prior to MDT, these adolescents were treated with Cognitive Behavioral Therapy, (*CBT*) and Social Skills Training, (*SST*) groups.

Many of these more difficult adolescents were unresponsive to CBT and SST. These adolescents engaged in aggressive, physical, sexual and verbal behaviors. MDT has evolved significantly since the initial article by Apsche, Ward & Evile, (2003). There now are a MDT Client Manual Apsche, (2006) and a new Clinician's Manual, Apsche, (2006), as well as a Family MDT manual, Apsche, (2006).

Apsche et. al., (2003) presented the initial article on MDT, as a theoretical article written as a case analysis of an adolescent who was non-responsive to CBT and any previous treatment(s). In the article Apsche et. al., (2003) reviewed the core foundation for MDT and introduced the aspects of MDT that were borrowed from DBT, Linhan, (1992) and CBT, A. Beck, (1994) & J. Beck, (1996).

Apsche & Ward, (2002) presented a descriptive treatment results between two groups of adolescents who were sexually and physically aggressive. The results of this study demonstrated that MDT was superior to CBT in redirecting both physical and sexual aggression. Apsche & Ward's results suggest that MDT was far superior by more than one standard deviation in reducing the internal and external distress in all categories as measured by the Child Behavior Checklist, (*CBCL*) and the Devereux Scale of Metal Disorders, (*DSMD*). MDT also reduced sexual offending in all behaviors as measured by the Juvenile Sex Offenders Adolescents Protocol (*J-SOAP*). MDT reduced the non-static portion of the J-SOAP almost two standard deviations more than CBT.

Apsche & Ward Bailey, (2003), (2004), published a three part article on the application of MDT in a Theoretical Case Analysis. These articles presented MDT in a linear step-by-step case analysis. These articles were the blue print for the clinical application of MDT.

The article attempted to outline a clinical application of MDT while presenting a case of an adolescent that had been removed from five previous treatment facilities for violent and aggressive behaviors. In this case, MDT helped reduce his aggression, physical and verbal, as well as it gave the youth a viable treatment to reduce his fears and anxieties.

Apsche, Bass & Murphy, (2004) presented a study that compared MDT to CBT on a total of forty adolescents with Conduct and Personality Disorders. Apsche, Bass and Murphy, (2004) expanded their previous study to include sexual aggression in their comparison of CBT and MDT. Apsche, et. al., (2004) demonstrated that MDT showed superior results in reducing internal and external distress, as measured by the CBCL, DSMD, and J-S0AP. MDT was superior to CBT in this study by more than one standard deviation in all categories, including internal psychological distress and sexual and physical aggression.

Apsche & Ward Bailey, (2004) presented a case study on MDT Family Therapy. This case study was a detailed theoretical case analysis. This therapy and practice in an actual case study on a 12 year old European American male adolescent and his family. Apsche, (2005) presented an article that articulated problems with Beck's, (1996) cognitive model. This article presented a theoretical framework from which MDT was developed as a clinical technology.

Apsche, Bass, Jennings & Siv, (2005) received specific results of 40 adolescent males treated with MDT and CBT. Once again MDT was far superior by nearly two standard deviations in reducing sexual and physical aggression, than CBT. MDT also reduced symptoms of Psychological distress as well.

Apsche, (2005) presented a study that examined the theoretical role of mode in relation to impulses. Apsche, (2005) concluded that hyper charged modes might often be mistaken for impulses. The article concluded that many behaviors thought to be impulses might actually be better accepted for under the "theory of modes". Apsche theorized that modes that are activated appear as impulses but is actually the youngster reacting to his perception of fear. These perceptions are "hyper-charged primal modes", Beck, (1996).

Apsche, Bass, Jennings, Murphy, Hunter & Siv, (2005) compared the efficiency of three treatment methodologies for adolescent males in residential treatment for problems with conduct, personality, sexual, and physical aggression.

Results suggest that MDT was far superior to CBT and SST in reducing both physical and sexual aggression in conduct disordered and personality disordered adolescents. This study had a clinical population of sixty male adolescents and was conducted following rigorous protocols to assure fidelity to each Treatment Methodology.

Apsche & Siv, (2005) presented MDT as a treatment methodology with a suicidal adolescent male. The adolescent had attempted suicide eight times. This case study examined the adolescent from the MDT assessment and case conceptualization process through treatment. The authors concluded that this specific case MDT showed promise in treating the adolescent's suicidal behaviors. Apsche & Siv, (2005) made no suggestions of MDT as a viable treatment methodology beyond this case study.

Apsche & Ward Bailey, (2005) presented a chapter on MDT as a Cognitive Behavior Therapy for young people who sexually abuse. The chapter was a review of the MDT methodology and a case study. The MDT methodology was detailed in both the case conceptualization process and treatment. Apsche & Ward Bailey, (2005) demonstrated the potential effectiveness of the MDT methodology as a clinical methodology.

Apsche, Siv & Matteson, (2005) presented a case study comparing the effect of Mode Deactivation Therapy, (MDT) with Dialectical Behavior Therapy, (DBT). It appears in this case study that MDT helped reduce Self Injurious Behavior, (SIB) 91.24%, physical aggression 87.56%, and physical holds 81.69%. MDT reduced all target behaviors 85-90% more than DBT. The authors' did not conclude

that BDT was a superior treatment to DBT. They did conclude that in this particular case MDT was far superior to DBT for this aggressive, self injures, 13 year old male adolescent.

Apsche, Bass, Siv & Matteson, (2005) examined the efficiency of Mode Deactivation Therapy, (MDT) as compared to Cognitive Behavioral Therapy, (CBT) on the sexual and physical aggression of adolescent males. This study included 40 adolescent males. The measures were the Child Behavioral Checklist, the DSMD, and behavioral data.

MDT was superior in reducing both physical and sexual behavior in this study. MDT also reduced both internal and external distress. In all areas of the CBCL and DSMD, MDT was nearly two standard deviations superior to CBT in this particular clinical study.

Apsche, Siv & Bass, (2005) implemented MDT in a case study with a 16 year-old male with problems with conduct and personality disorder and fire setting behaviors. MDT reduced his physical and sexual aggression 70-80% in three months. Previously this adolescent had been treated with DBT. It appears in this case that MDT was more effective with this adolescent than DBT. He had DBT in group and individual therapy for nearly one year with no change in his behavior, prior to the implementation of MDT.

Apsche, Bass & Siv, (2005) presented a study comparing MDT, CBT and SST on a group of 60 adolescents. The study examines the levels of internal distress and external distress, as measured by the CBCL and DSMD. In this study MDT was superior to CBT in all categories by at least two standard deviations and MDT was superior to SST by 4 standard deviations.

This study clearly demonstrated the superior affects of MDT to standard CBT and SST. Although, this study was again a "real world" descriptive study, it affected two control groups and as random assignments as possible in the real clinical world. All Clinicians in each condition were equally trained and supported by supervisors of a doctoral level Psychologist.

Apsche, Bass & Siv, (2005) presented a summary of results of MDT and included two year post-treatment results. Most significant in this study were the reported recidivism results.

The recidivism rates for the study are as follows:

- 1) MDT- 7%
No sexual offenses.
- 2) CBT- 20%
Includes sexual offenses and aggravated assault.
- 3) SST- 49.5%
Includes sexual offense, murder, aggravated assault, etc.

The significance of this study is that in an applied Clinical setting, MDT is superior to CBT and SST in reducing sexual aggression, physical aggression, internal and external Psychological distress, and MDT demonstrates the lowest recidivism results by 15% over CBT and 42.5% over SST two years post treatment.

The two year post treatment results for MDT strongly suggest that MDT has generalized effects to the community, post treatment. It was also significant that in the 7% recidivism, there are no felony arrests or seriously harmful behavior toward others as victims.

Apsche & Bass, (2006) presented a study of MDT vs. TAU, 7 adolescents per group, in community out patient setting for adolescent males. MDT was superior in reducing behaviors including physical and verbal aggression, school suspension and psychological distress, as measured by the CBCL. MDT was superior by more than two standard deviations in all categories. This study also included parent behavior reports that showed superior results on the MDT group.

Apsche & Bass, (2006) presented a study using MDT vs. TAU with 40 suicidal adolescent males. The suicidal ideations and thoughts were measured by the Beck Depression Inventory II, (*BDI-II*), and the Reynolds Suicidal Ideation Questionnaire High School Form (*SIQ-HS*).

The results demonstrated that MDT was superior to TAU by 6 standard deviations reducing suicidal ideations as measured by the BDI-II and the SIQ-HS.

The overall results in this study suggest that MDT might be an effective treatment methodology for this typology of adolescent males. These results are significant since there are few effective treatments for adolescent males with problems with conduct, personality traits and suicidal beliefs and behaviors.

Apsche & Bass, (2006) presented the follow-up recidivism data for MDT in a community treatment setting. A total of 13 males participated in this study and follow-up results. Results indicated that the MDT had significantly lower recidivism rates.

The MDT group had no referrals, 40 residential programs, while TAU had a 50% referral rate. MDT had a better than 4 standard deviation superior results in school suspensions and school explosions.

The MDT group had no sexually aggressive behaviors, as well as 75% better acting out, and 85% disobedience rate as reports by parents and school authorities.

This study suggest and supports the Apsche, Bass & Siv, (2005) results, indicating that MDT treatment effects are generalized to settings, including multiple group, residential, home, and community settings.

MDT appears to have demonstrated in applied clinical settings that it has great potential as an evidenced based psychotherapy.

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Demographics

Underwood, Von Dresner & Phillips, (2006) discuss and review evidenced based treatments for juveniles. Underwood, et. al., (2006) states that most evidenced based psychotherapists do not focus on African American youth. Underwood states, "more studies are needed to examine the effectiveness that they may have on youth with special needs. Including

youth of color, ethnic minorities, violent adolescents and those with mental health issues,” (p.295).

MDT research appears to address the concern that Underwood and his colleagues raised. The sample size of MDT suggests that 77.8% of the youth were African American, while 20.9% were European American and only 5% were Hispanic.

It appears that MDT might be an evidenced based psychotherapy that has some significant positive effects on African American youths with the typology described in the MDT literature.

MDT also has shown in numerous studies, Apsche, Bass, Jennings & Siv, (2005), Apsche, Bass, Siv, (2005), Apsche, Bass, (2006), to have reduced aggressive behaviors as well as mental health issues, Apsche, Bass, Jennings, Murphy, Hunter & Siv, (2005).

The demographic of the MDT appear to describe a typology of adolescents that MDT demonstrates a positive effect within treatment. This typology in adolescents from 14^{1/2} to 18 year olds including the following diagnosis:

- | | |
|--------|--------------------------------------|
| AXIS I | 1) Conduct Disorder |
| | 2) Oppositional Defiant Disorder |
| | 3) Post Traumatic Stress Disorder |
| | 4) Major Depression |
| AXISII | 1) Mixed Personality Disorder |
| | 2) Borderline Personality Disorder |
| | 3) Narcissistic Personality Disorder |
| | 4) Dependent Personality Traits |
| | 5) Avoidant Personality Traits |

A review of the MDT treatment research suggests that MDT might be a promising evidenced based psychotherapy for adolescents who fit the typology, regardless of their race or ethnicity.

Hopefully, further research will validate these current MDT findings.

METHOD

Sample Characteristics

A total of 143 male adolescents participated in MDT studies. All participants were clients in residential treatment centers, except for 7 who were treated in an outpatient center. All referrals were from County Juvenile Justice and the Department of Youth and Family Services. In this review, we examined the results of numerous publications of MDT and will compare them to the other treatment conditions. The case 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. For this review due to the range of clinical research the other condition in this case could composed of CBT, SST or DBT but will be referred to as the Treatment As Usual (TAU) group.

Mode Deactivation Therapy (MDT): A total of one hundred forty three adolescents were assigned to the MDT condition. The group was comprised of 97-77.8% African Americans, (20.9%) European Americans, 8 (5.6%) Hispanic/Latino Americans and 2 other races, with an average age of 16.2.

The principal Axis I diagnoses for this group included 39 (40.2%) Conduct Disorder, 10 (10.3%) Oppositional Defiant Disorder, 25 (25.8%) Post Traumatic Stress Disorder, and 17 (17.5%) Major Depressive Disorder, primary or secondary. Axis II diagnoses for the group included Mixed Personality Disorder (22), Borderline Personality Traits (3).

Table 1.

Axis I	MDT	Percentile
Conduct Disorder	39	40.2%
Oppositional Defiant Disorder	10	10.3%
Post Traumatic Stress Disorder	25	25.8%
Major Depression	17	17.5%
Other Axis I Disorder	6	6.2%
Axis II		
Mixed Personality Disorder	22	55%
Borderline Personality Traits	12	30%
Narcissistic Personality Traits	6	15%
Dependent Personality Traits	0	0
Avoidant Personality Traits	0	0
Race		
African American	97	77.8
European American	38	20.9
Hispanic/Latino American	6	.05
Other	2	
Total	142	
Average Age	16.2	

Measures

Two assessments were used to measure the behavior of the residents, which included the Child Behavior Checklist (CBCL; Achenbach, 1991) and the Devereux Scales of Mental Disorders (DSMD; The Devereux Foundation, 1994).

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).

To better elucidate between-group differences in magnitude of effect, independent factorial analyses on treatment model and variable were conducted.

Table 2
Post-Treatment Scores and Percent Reduction in Types of Aggression Across Treatments

	MDT		TAU	
	Post-Treatment Score	Percent reduction	Post-Treatment Score	Percent reduction
Physical Aggression	.30	80.7%	.425	70.7%
Sexual Aggression	.25	84.5%	.485	71.3%

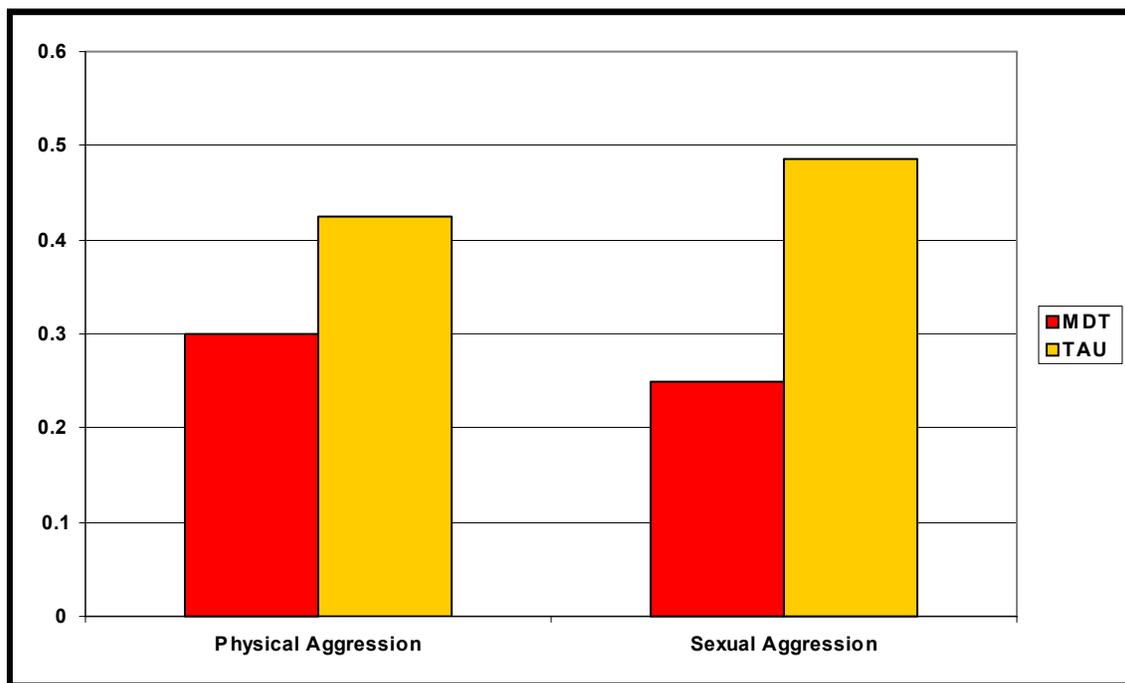


Figure 1: Physical Aggression and Sexual Aggression Percent reduction for both groups

Table 3
Means and Standard Deviations on Assessment Measures at Three Time Points By Treatment Groups

	MDT						TAU					
	Baseline		3 Months		6 Months		Baseline		3 Months		6 Months	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
BDI-II	34.2	14.65	14.6	9.54	9.9	6.18	26.8	20.62	17.5	14.37	12.7	12.91
SIQ-HS	57.2	29.29	10.9	14.43	7.2	7.37	55.4	49.34	18.6	18.90	12.9	13.66

Note: All baseline comparisons between groups were non-significant ($p > .05$)

BDI-II = Beck Depression Inventory 2nd Edition; SIQ-HS= Suicidal Ideation Questionnaire High School Form; MDT= Mode Deactivation Therapy; TAU= Treatment as usual

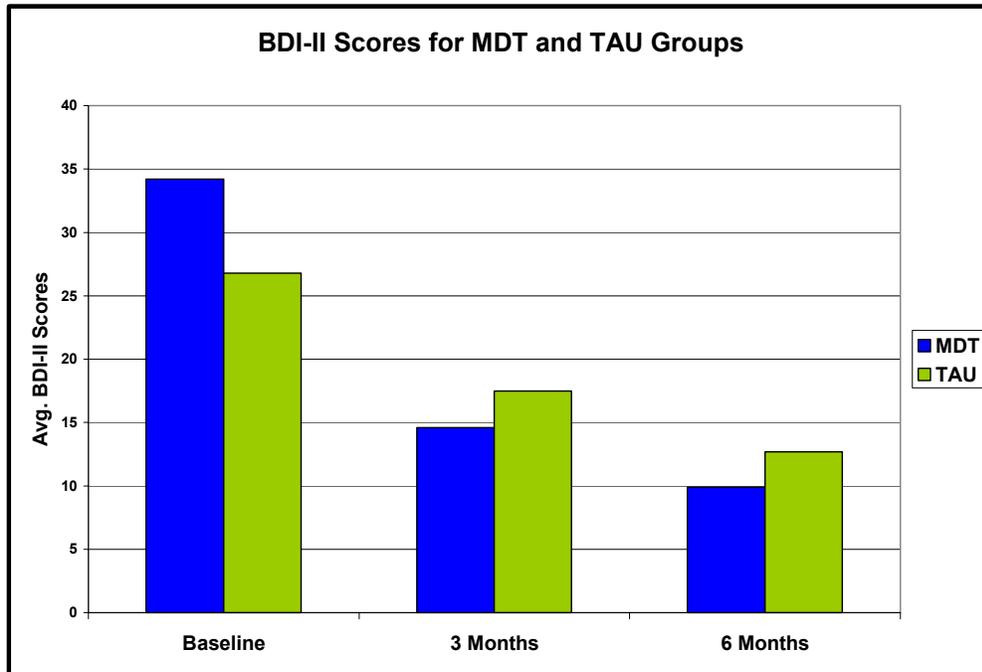


Figure 2: Means scores for BDI- II at three time points. Note: All baseline comparisons between groups were non-significant ($p > .05$) BDI-II = Beck Depression Inventory 2nd Edition; MDT= Mode Deactivation Therapy; TAU= Treatment as usual

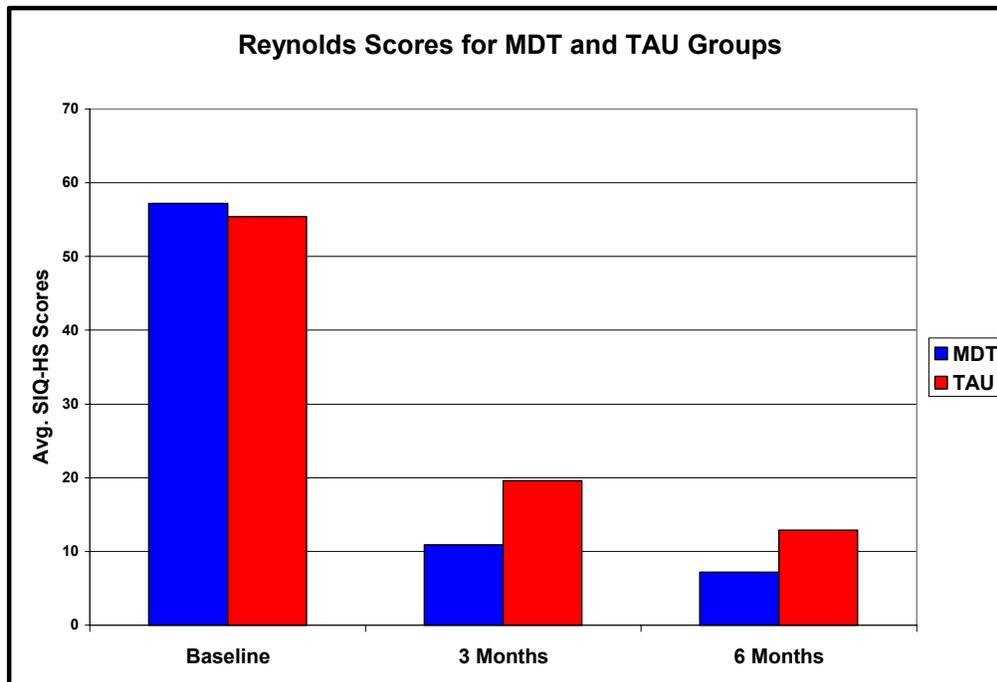


Figure 3: Mean Scores for SIQ-HS at three time points. Note: All baseline comparisons between groups were non-significant ($p > .05$) SIQ-HS= Suicidal Ideation Questionnaire High School Form; MDT= Mode Deactivation Therapy; TAU= Treatment as usual.

Follow-up Data

Table 3

18 Month Follow-up Parent Reports Received		
	MDT	TAU
Sexual Aggression (SA)	0	10
Acting Out (AO)	3	12
Direct intentional disobedience (DIB)	6	18
Table 2: 18 Month Follow-up School Data Received		
	MDT	TAU
Residential Placements (RP)	0	3
School Suspensions (SS)	3	20
School Expulsions (SE)	1	5

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 = 73.0, Externalization = 74.22 and Total = 73.62) and TAU (Internalization = 72.75, Externalization = 73.47 and Total = 73.13).

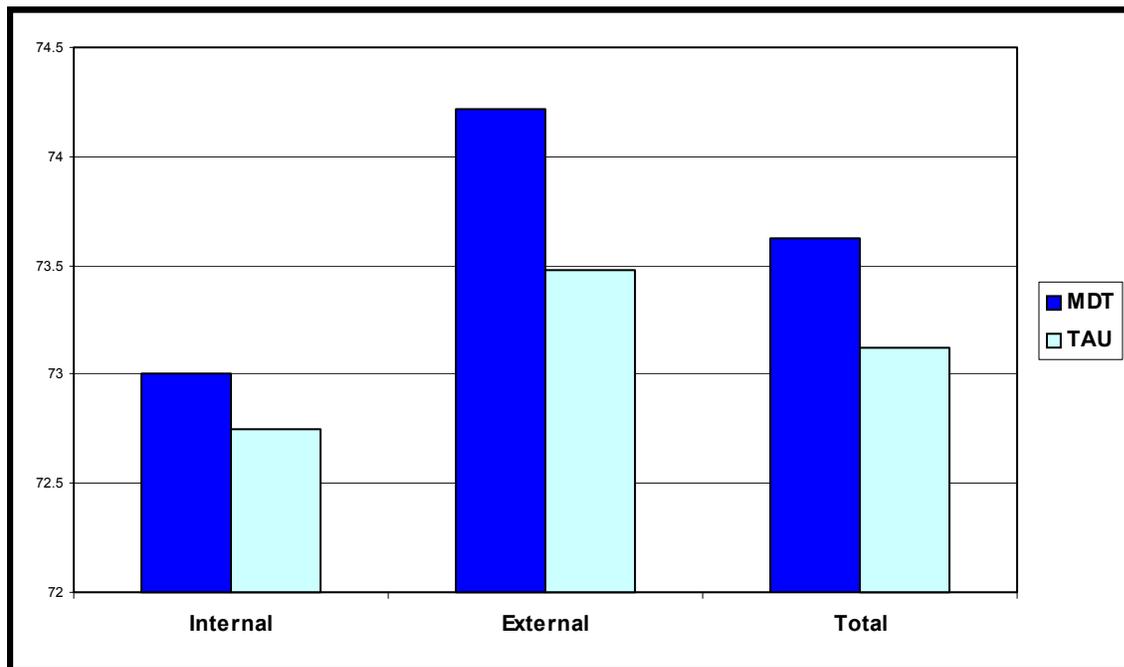


Figure 4: CBCL; Pre treatment mean scores for TAU and MDT groups

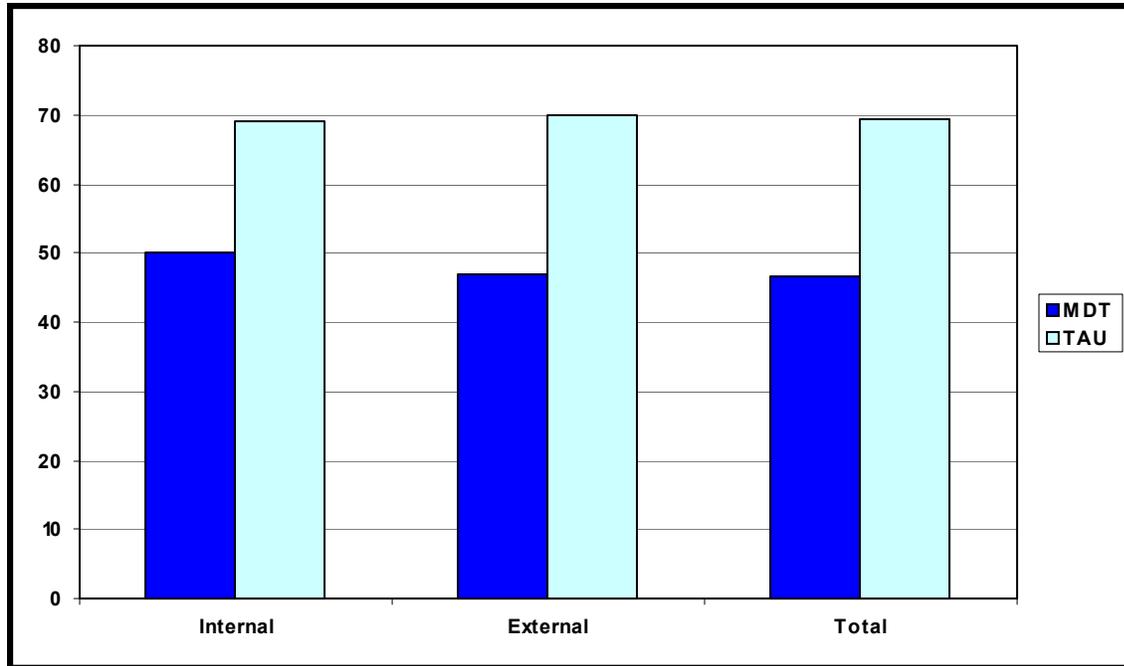


Figure 5: CBCL; Post treatment mean scores for TAU and MDT groups

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= 50.13, Externalization= 46.77 and Total= 46.50); TAU (Internalization= 69.17, Externalization= 69.82 and Total= 69.49)

The DSMD means and standards are divided into three categories: internalizing, externalizing, and total problems. There was no significant difference in the pretest means between MDT (Internal =71.3, External = 72.5, Critical Pathology = 70.5 and Total= 71.50) and TAU (Internal =70.5, External = 73.1, Critical Pathology = 68.7 and Total= 70.77).

FIGURE 6, NEXT PAGE!

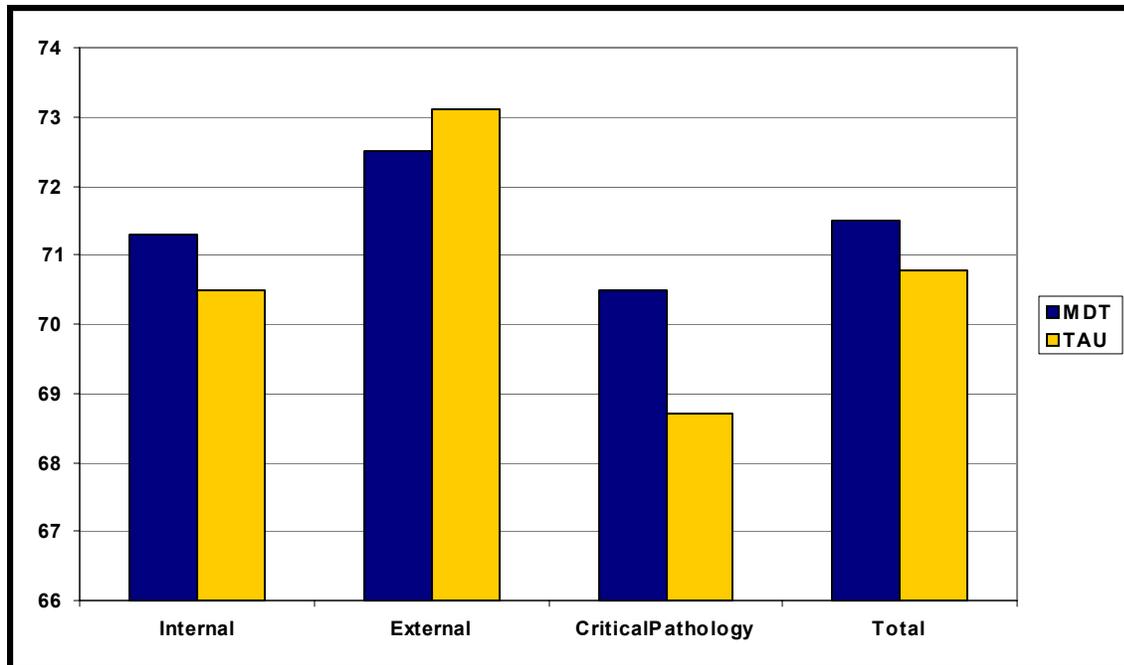


Figure 6: DSMD; Pre-treatment mean scores for TAU and MDT groups

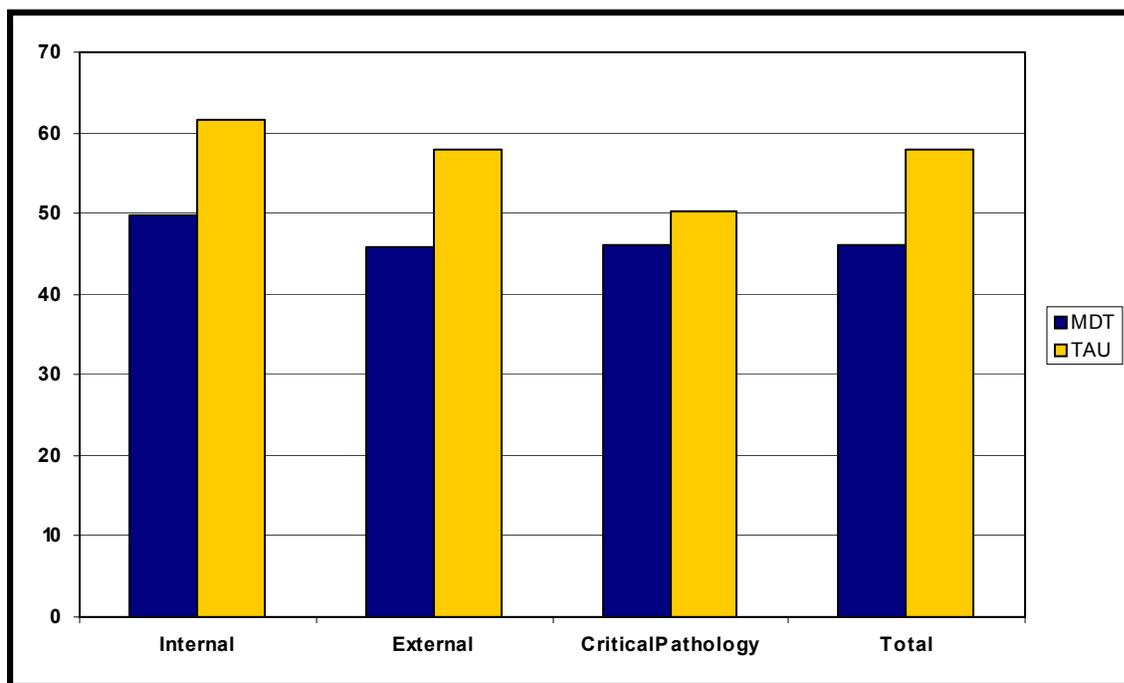


Figure 7: DSMD; Post-treatment mean scores for TAU and MDT groups

The Parent Report Record

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 (Internal =70.5, External = 73.1, Critical Pathology = 68.7 and Total= 70.77); TAU (Internal =70.5, External = 73.1, Critical Pathology = 68.7 and Total= 70.77)

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).

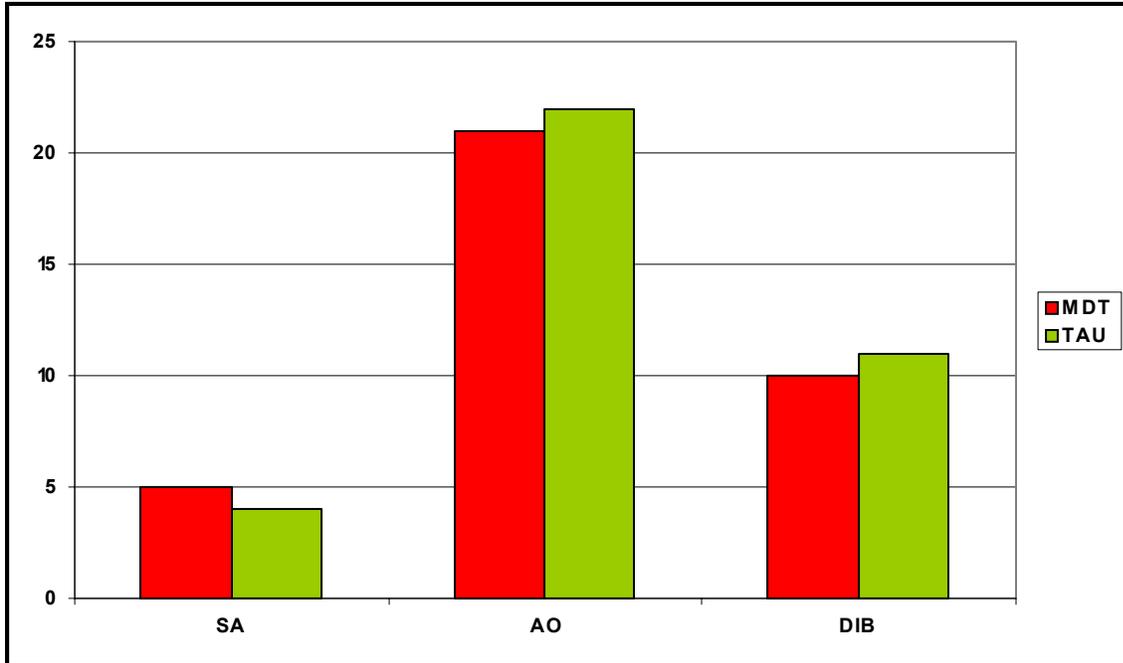


Figure 8: The Parent Report Record: Pre treatment mean scores for TAU and MDT groups

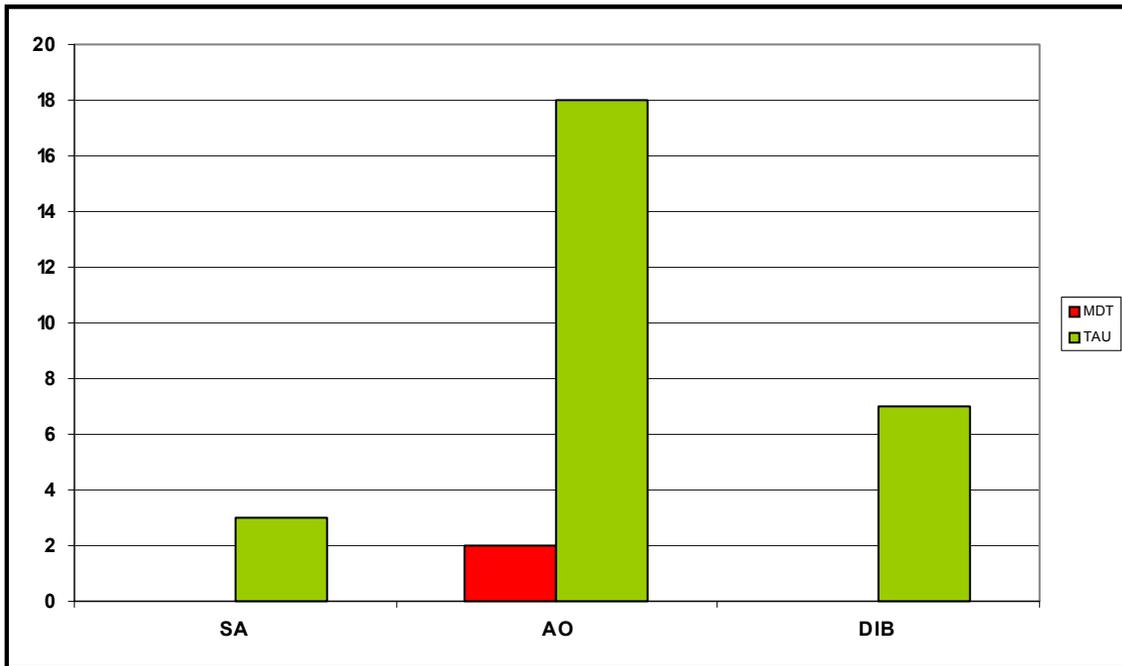


Figure 9: The Parent Report Record: Post treatment mean scores for TAU and MDT groups

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.

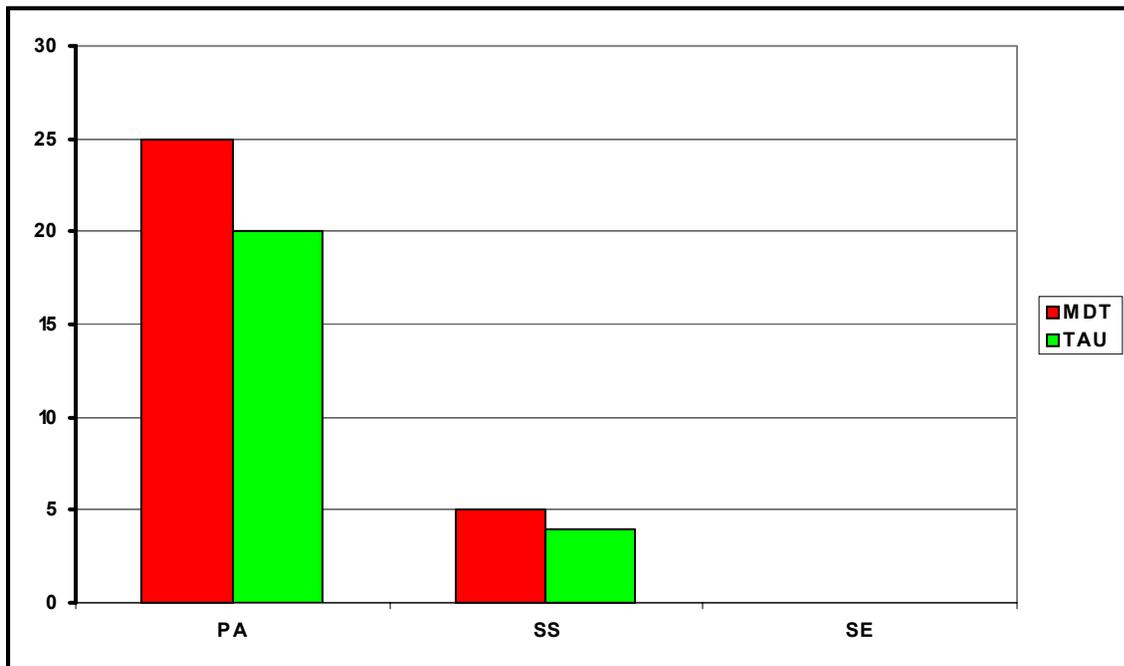


Figure 10: SS = School Suspension (Pre treatment MDT= 5, TAU=4); PA= Physical Aggression (Pre Treatment, MDT= 25, TAU= 20

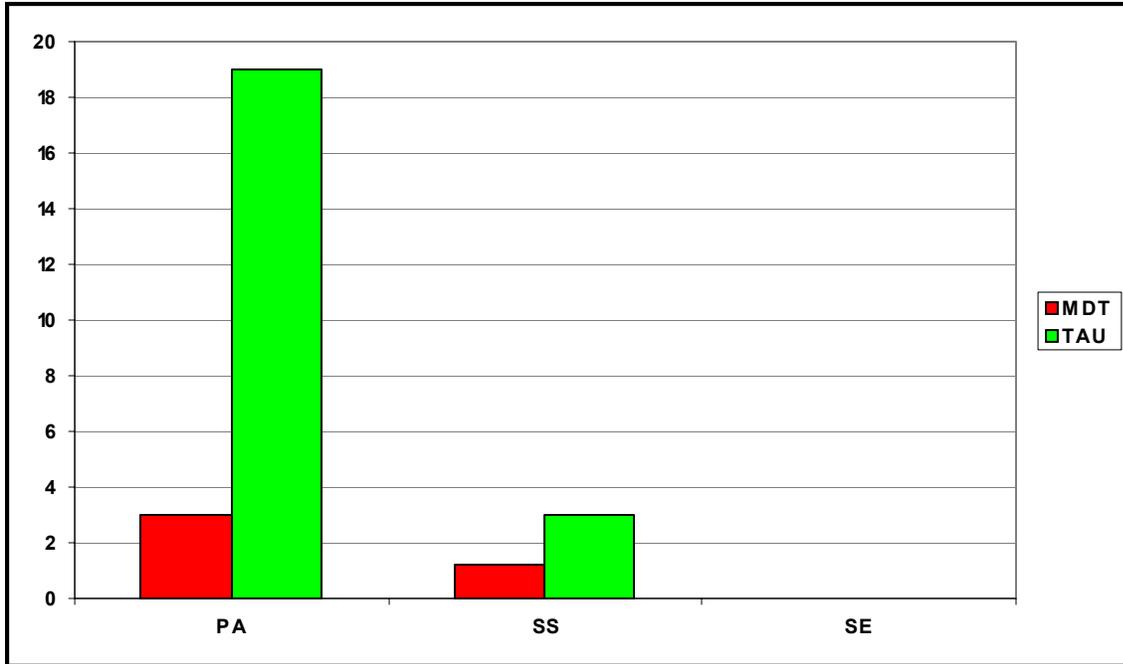


Figure 11: SS = School Suspension (Post treatment MDT= 1.2, TAU=3); PA= Physical Aggression (Post Treatment, MDT=3, TAU= 19)

18 Month Follow Results

Parent Reports Received

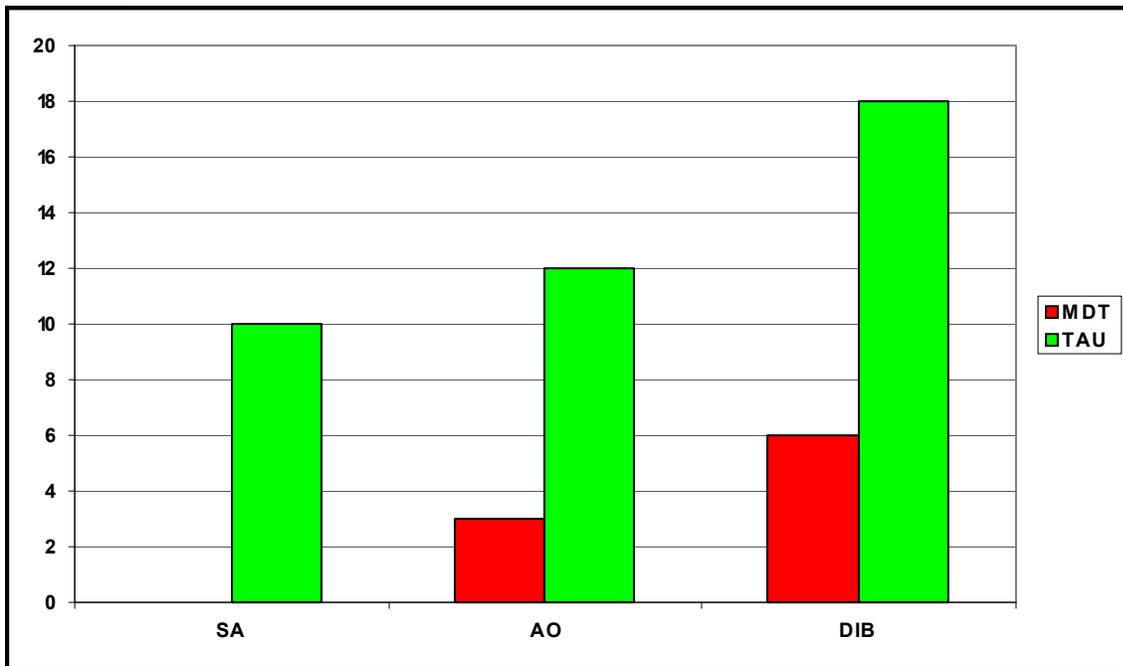
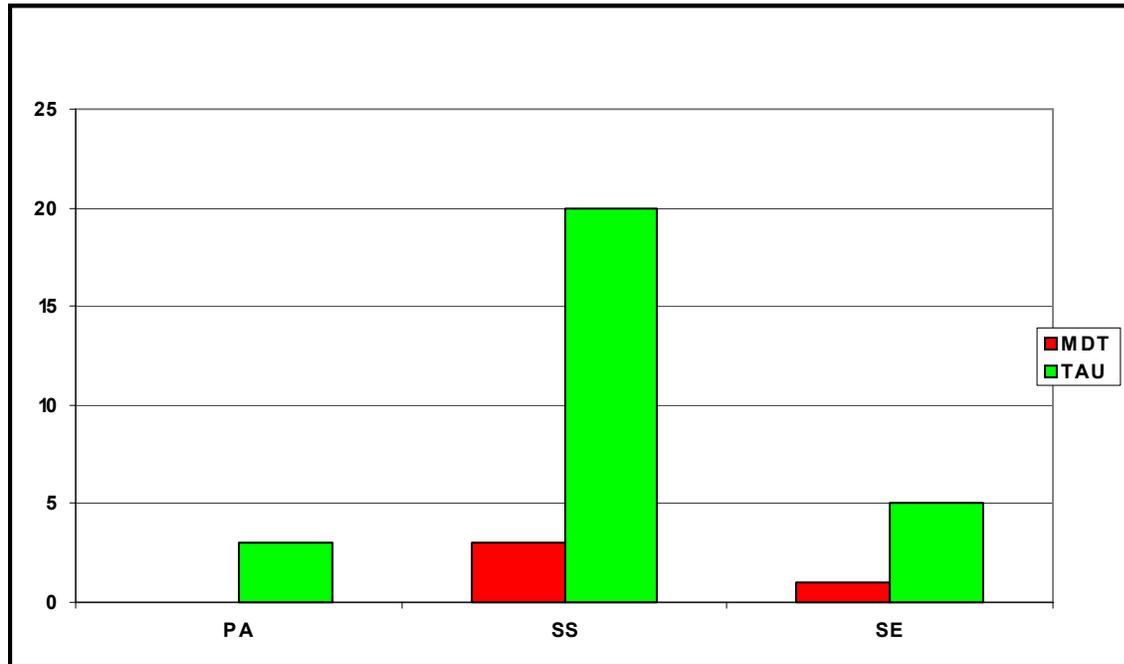


Figure 12: SA = Sexual aggression (18 Month Follow-up, MDT= 0, TAU=10); AO= Acting Out (18 Month Follow-up, MDT=3, TAU= 12); DIB= Direct intentional disobedience (18 Month Follow-up, MDT=6, TAU= 18)

School Records



RP =

Figure 13: Residential Placement (18 Month Follow-up, MDT= 0, TAU=3); SS= School Suspension (18 Month Follow-up, MDT=3, TAU= 20); SE= School Expulsion (18 Month Follow-up, MDT=1, TAU= 5)

Discussion

Over several years and multiple studies in applied clinical settings MDT has shown that MDT is more effective in these studies than CBT, SST and DBT, Apsche & Bass, (2006); Apsche, Bass, Murphy, Hunter & Siv, (2005).

MDT is effective as a well defined treatment of this particular typology of adolescents, between the ages of 14.5 to 18, who have problems with their conduct, personality, aggression, sexual and physical and anxieties and fears.

The summary data presented in this article provides support for MDT as an evidenced based psychotherapy. Underwood, Phillips, Van Dresner & Knight, (2006) reviewed evidenced based treatment for juvenile and included MDT as an effective treatment. Underwood, et. al., (2006) reviewed evidenced based treatments for juveniles and reported that MDT was the most promising for such underserved populations such as African Americans in correctional and secure treatment settings. Underwood et.al., (2006) also suggests that MDT might be an effective treatment for aggressive and violent adolescents with co-occurring mental health disorders.

Summary

Developing MDT has been both a difficult and dichotomous task and the most rewarding activity that one could be engaged. The actual clinical work with the adolescent clients has taught me how important and exiting this world can be. It has been a wondrous journey to be a small positive part of a troubled young man's life.

MDT has survived some academic criticism in some circles as the task of developing an evidenced based methodology outside of the federal grant mechanism is a monumental one.

Ethics dictate as a Psychologist that we must provide ethical clinical care. Ethical clinical care and random assignment of clinician's to needy clients often are not congruent.

In the MDT literature, both ethical issues and the demands of research protocol were both addressed to in that order.

MDT suggests that evidenced based psychotherapies might come from the applied clinical setting, as well as, "carefully controlled" grant founded university settings.

MDT needs to be tested in other settings with full fidelity to the research design. Most importantly, MDT is an effective clinical methodology if the clinician assures fidelity to the clinical application of MDT. There is a level of adolescent that Underwood, et.al., (2006) carefully delineated. African Americans, Hispanic, and European Americans who engage in violent behavior and have co-occurring mental health disorders, are in desperation need of evidenced based psychotherapies. It is suggested that MDT might be an effective intervention for this population.

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