Mode Deactivation Therapy (MDT): A Theoretical Case Analysis on a Suicidal Adolescent

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This case study presents a case study of the effectiveness of Mode deactivation therapy (MDT) (Apsche, Bass, Jennings, Murphy, Hunter, and Siv, 2005) with an adolescent male, with reactive conduct disorder, PTSD and 8 lethal suicide attempts. The youngster was hospitalized four times for suicide attempts, three previous placements in residential treatment centers. MDT is a form of cognitive behavioral therapy (CBT) that combines the balance of dialectical behavior therapy (DBT) (Linehan, 1993), the importance of perception from functional analytic psychotherapy (FAP) (Kohlenberg & Tsai, 1993), and A.T. Beck's (1996) mode theory with a methodology to address the adolescents' belief system. MDT has been shown to be effective in a descriptive study with CBT (Apsche & Ward, 2002). The analysis of this case will illustrate the potential effectiveness of MDT as applied an actively suicidal adolescent.
Keywords: Adolescent, MDT, Suicide, Conduct Disorder, Personality Disorder.

Introduction

Mode deactivation therapy (MDT) as an applied CBT methodology was developed for adolescents with reactive conduct disorder and/or personality disorders/ traits. MDT is targeted for adolescents with a complicated history of abuse, neglect, and multi-axial diagnoses.

Many of these adolescents are victims of sexual, physical, and/ or emotional abuse, as well as neglect. They have developed personality traits as survival coping strategies. These personality disorders and/or traits are not true to their cluster, or are cluster bound, meaning that they are translated into beliefs and schemas that are inclusive of beliefs from all three personality disorder clusters. Often it has been thought that individuals with personality disorders stay true to their cluster (Beck, Freeman, and Associates, 1991), which is not true with the adolescent typology as represented by Charles case in this case analysis.

Often CBT, as viewed by "arguing" or "challenging" the concepts of cognitive distortions, fails with these youngsters (Beck, Freeman, Davis and Associates, (1994). Freeman, A., Preter, J., Fleming, B.A, and Simion, K. M., (1990) Cognitive therapy as normally practiced will eventually trigger a negative reaction by the reactive youngsters. They perceive the therapist as another person attempting to change them from a system of defenses that has been developed to protect them. MDT was developed in response to the need for more effective treatment for this specific adolescent typology. MDT has been shown to be more effective than standardized normalized CBT in a descriptive study (Apsche and Ward, 2002). MDT has also been demonstrated as effective in a series of case studies (Apsche, Ward, Evile, 2002 a & b; Apsche and Ward Bailey, 2003) and a empirical study (Apsche, Bass, Siv, 2005).

Mode Deactivation Therapy (MDT)

Mode deactivation therapy (MDT) (Apsche and Ward Bailey, 2003) as an applied

CBT methodology aims to address reactive conduct disorders and personality disorders/ traits. MDT is based on A.T. Beck's (1996) mode model, with aspects of other therapies, including functional analytic psychotherapy (FAP) (Kohlenberg and Tsai, 1993) and dialectical behavior therapy (DBT) (Linehan, 1993). Additionally, there are areas of MDT which reflect concepts of schema therapy (Young, Klosko, and Weishaar, 2003).

The theoretical underpinnings of mode deactivation therapy are based on A.T. Beck's model of modes. In his article Beyond Belief: A Theory of Modes, Personality, and Psycho-pathology (1996), A.T. Beck defines modes as specific suborganizations of the basic systems of the mind. Specifically, suggesting that people learn from unconscious experiential components and cognitive structural processing components. Functional analytic psychotherapy (FAP) (Kohlenberg and Tsai, 1993) theory focuses on the deeper unconscious motivations that were formed as a result of past contingencies of reinforcement. Perception is based on past con-tingencies, therefore, reality and the concept of reality reflects what has been experienced in the past. Considering reinforcement history in the context of a person provides a more complete assessment of a person and specific behaviors (Kohlenberg and Tsai, 1993). Therefore, to change behavior of individuals there must be a restructuring of the experiential components, and a corresponding cognitive restructuring of the structural components. The dysfunctional experiential and structural learning (conscious and unconscious) develop dysfunctional schemas that generate high levels of anxiety, fear, and general irrational thoughts and feelings, as well as aberrant behaviors. This system is self-reinforcing and protected by the development of the conglomerate of the beliefs underlying the developing personality disorders. This conglomerate is comprised of multiple clustered compound core beliefs, which are the most pronounced impediment to treatment (A.T. Beck, 1996). The compound core beliefs are systematically treated and restructured throughout mode deactivation therapy, beginning with the MDT Case Conceptualization.

By restructuring beliefs, MDT addresses underlying perceptions that may be applicable to setting in motion the mode related charge of aberrant schemas, that enable the behavior integration of dialectical behavior therapy (DBT) principles, (Linehan, 1993) when treating adolescents with reactive conduct disorder and personality disorders/ traits. Many of Linehan's teachings describe radical acceptance and examining the "truth" in each client's perceptions. This methodology of finding the grain of truth in the perception of the adolescent is at the crux of MDT. We also "borrow" radical acceptance in the form of helping the youth accept who he is based on his beliefs. The other major similarity between DBT and MDT is the use of balancing the dichotomous or dialectical thinking of the client. Just as DBT emphasizes the importance of maintaining "balance," so does MDT.

The study of cognitive therapy emphasizes the characteristic patterns of a person's development, differentiation, and adaptation to social and biological environments (Alford & A.T. Beck, 1997). Cognitive theory considers personality to be grounded in the coordinated operations of complex systems that have been selected or adapted to insure biological survival. These consistent coordinated acts are controlled by genetically and environmentally determined processes or structures termed as "schema." Schema are essential both conscious and unconscious meaning structures. They serve as survival functions by protecting the individual from the trauma or experience. An alternative and more encompassing construct is that of modes and suggest that the cognitive schematic processing is one of many schemas that are sensitive to change or orienting event.

A.T. Beck, Freeman and Associates (1990) suggested that cognitive, affective and motivational processes are determined by the idiosyncratic structures or schema that constitute the basic elements of personality. This approach suggests that the schema is the determinant to thoughts, moods, and behaviors.

According to Young et al. (2003), CBT has helped many patients with Axis I disorders. However, many patients with Axis II disorders have gone largely untreated with their Axis II disorders. Using CBT alone, Axis II disordered patients continue to experience significant emotional distress and impaired functioning, especially patients with borderline personality disorder and narcissistic personality disorder. (Young, et al., 2003) In FAP theory, contingencies of reinforcement, such as families of origin, create the perception of reality and resulting beliefs, which drives behaviors. (Kohlenberg and Tsai, 1993)

Therefore, continuing to reinforce these perceptions/ beliefs thereby perpetuates the resulting aberrant behaviors. Modifying the beliefs and perceptions will in turn modify the behaviors. "In general, it is much better for patients with borderline personality disorder not to live with or have frequent contact with their family of origin, especially in the early stages of treatment. Their family is very likely to continue reinforcing the very schemas and modes the therapist is fighting to overcome." (Young et al., 2003)

Schema therapy (Young et al., 2003) states that internal schemas lie at the core of personality disorders and the behavior patterns. The behaviors are what is seen and therefore are usually the basis for Axis II diagnoses. Young et al. (2003) agrees that in order to address the underlying schemas beliefs) and take into account the modes, a concept which Young et al. acknowledges has been difficult to address in the past but is important. Mode oriented therapy is used when therapy seems stuck and patients are rigid, such as with personality disorders and those who display frequent fluctuations in affect (Young et al., 2003). Personality disordered patients present with varying symptoms, including: being highly self-punitive, self-critical, and experiencing emotional numbness. MDT is used because of the complexities of personality disorders.

Linehan (1993) views individuals with borderline personality disorder analogous with burn victims where the slightest movement is automatic and causes extreme pain. "Because the individuals cannot control the onset and offset of internal or external events that influence emotional response" she suggests that the experience is itself a "nightmare of intense emotional pain" and a struggle to regulate themselves.

The reactive adolescent has similar experiences of the world as Linehan's (1993) clients with borderline personality disorder. Their intense emotional pain has led them to "shut down" emotionally to control life's painful experiences. When they are in a situation that triggers fear, it is a reminder of pain and they cannot control the "internal or external events that influence emotional response" and they react with anger and/or aggression, they also often emotionally dysregulate.

According to Dodge, Lochman, Harnish, Bates, and Pettit (1997), there are two sub-groups of aggressive conduct type youngsters; proactive, the sub type that receives benefit and rewards from aggression and reactive, the sub type that is aggressive due to being emotionally reactive or dysregulates. Frequently, reactive adolescents have a conglomerate of personality problems according to Dodge, et al.(1997). It appears that reactive conduct disorder adolescents emotionally dysregulate and many of their aberrant responses are results of their emotional dysregulation. Reactive conduct disorder youth tend to have a history of early life trauma, such as parental rejection, exposure to family violence, and family instability. In addition, these youth show a pattern of emotional dysregulation that includes somatization, depressive symptoms, sleep disorder symptoms, and personality disorders (Dodge et al., 1997). Reactive conduct disorder youth demonstrate a greater tendency to interpret peers' intents as hostile, responding to their environment similarly to individuals with borderline personality disorder. They are reactive and engage in dialectical thinking that seems contradictory and often attention seeking. In reality, these youngsters often endorse dichotomous beliefs and engage in dichotomous behaviors. Often what appears to be impulsive behavior may be their acting upon these dialectical beliefs or being reactive (Dodge, et. al., 1997). Reactive conduct disorder youth have difficulty regulating their emotions with incoming stimuli. (Dodge et al., 1997) Koenigsberg, Harvey, Mitropoulou, Antonia, Goodman, Silverman, Serby, Schopick and Siever (2001) found that many types of aggression, as well as, suicidal threats and gestures were associated with emotional dysregulation.

Reactive conduct disorder youth have greater problems than proactive conduct disorder youth in encoding relevant social cues (Dodge et al., 1997), i.e., reactive youth have difficulty with modes and perception. As FAP theory states, perception is based on past experiences. MDT addresses reactive

conduct disorder by identifying beliefs that were developed from past experiences, borrowing validation of truth of the perception from DBT, and taking it a step further by balancing the beliefs and modifying them into healthier beliefs.

In CBT theory, it is believed that aberrant behavior is related to dysfunctional schema. CBT attempts to identify dysfunctional schemas and modify them. A.T. Beck (1996) suggested that the model of individual schemas (linear schematic processing) does not adequately address a number of psychological problems, therefore the model must be modified to address such problems. Working with adolescents who present with complex typologies of aberrant behaviors, such as anxiety→fear reactions and personality beliefs and/or disorders, it was necessary to address this typology of youngsters from a more "global" methodology.

The concept of modes provided the framework to develop such a methodology. MDT incorporates the model of individual schemas with A.T. Beck's notion of modes as integrated suborganizations of personality (1996). Modes assist individuals to adapt to solve problems, such as, the adaptation of adolescents to strategies of protection and mistrust when they have been abused. They consist of schemas (beliefs) that are activated by the fear↔avoids paradigm. To address the schema processing based on thoughts and beliefs without understanding the modes is insufficient and does not explain the specific adolescent typology referred to in mode deactivation therapy (MDT). MDT is a methodology that addresses dysfunctional schemas through systematically assessing and restructuring underlying dysfunctional compound core beliefs. MDT is applicable to adolescents with personality disorders/ traits, reactive conduct disorder, and/or who engage in aggressive and/or delinquent behaviors.

Specifically, A.T. Beck (1996) describes modes as a "network of cognitive, affective, motivational, and behavioral components" (pg. 2). He further described modes as "consisting of integrated sections or suborganizations of personality, that are designed to deal with specific demands" (pg.2). A.T. Beck continues to describe "primal modes" as including the derivatives of ancient organizations that evolved in prehistoric circumstances and are manifested in survival reactions and in psychiatric disorders. Young (2003) describes modes as "the set of schemas or schema operations – adaptive or maladaptive – that are currently active for an individual" (pg. 271). A "schema mode" is the "predominant state that we are in at a given point in time" (pg. 37). A.T. Beck also explains that the concept of charges (or cathexes) being related to the fluctuations in the intensity gradients of cognitive structures.

Alford and A.T. Beck (1997) explain that the schema typical of personality disorder is theorized to operate on a more continuous basis, the personality disorders are more sensitive to a variety of stimuli than other clinical syndromes. Since these youngsters are often personality activated, it seems that they are in continuous operation. This is one of the difficulties, they are always ready to defend and/or attack.

Modes are important to understanding reactive adolescents in that they are particularly sensitive to danger and fear, serving to charge the modes, that as multi victims of various abuse these youngsters are sensitive to danger and fear. These fears signal danger and are activated by conscious and unconscious learned experiential fears. The unconscious refers to the cognitive unconscious as defined by Alford and A.T. Beck (1997). Abused children develop systems to adapt to their hostile environment. These systems are often manifested by personality disorders/ traits (Johnson, Cohen, Brown, Smailes, & Bernstein, 1999). Longitudinal studies demonstrate that abused children frequently develop personality disorders in adolescence. From the perspective of modes, these disorders are adaptations to a dangerous environment. MDT suggests that the danger produces a fear reaction that is often reactive to danger and fear. This reactivity and sensitivity do not respond to traditional CBT. The adaptation of a theory, that was proposed by A.T. Beck (1996), on modes into the dialectical methodology of DBT, Linehan (1993),

created the blueprint for MDT. The understanding of conscious and unconscious fears being charged and activation the mode system explains the level of emotional dysregulation and impulse control of this typology of youngsters.

Modes provide the content of the mind, which is reflected in how the person conducts their perspectives. The modes consist of the schemas (beliefs) that contain the specific memories, the system on solving specific problems, and the experiences that produce memories, images and language that forms perspectives. As A.T. Beck (1996) states disorders of personality are conceptualized simply as "hypervalent" maladaptive system operations, coordinated as modes that are specific primitive strategies. Although the operation of dysfunctional modes in the present state is maladaptive, it is important to note that they were developed over time for survival and adaptation. These systems prove to become maladaptive as problematic behavior resulting in destructive behaviors.

Mode Activation

A.T. Beck (1996) introduced the concept of modes to expand his concept of schematic processing. He suggests that his model of individual schemas (linear schematic processing) does not adequately address a number of psychological problems, therefore he suggests the system of modes. A.T. Beck described the network of modes as consisting of integrated sectors of sub-organizations of personality that help individuals adopt to solve problems such as, the adaptation of adolescents to strategies of protection and mistrust when they have been abused.

A.T. Beck (1996) also suggests that these modes are charged, thereby explaining the fluctuations in the intensity gradients of cognitive structures. They are charged by triggers, fears and dangers that set off a system of modes to protect the fear. Modes are activated by charges that are related to the danger in the fear→avoids paradigm. The orienting schema signals danger, activates or charges all systems of the mode. The affective system signals the onset and increasing level(s) of anxiety. The beliefs are activated simultaneously reacting to the danger, fear→avoids and physiological system. The motivational system signals the impulse to the attack and avoids (flight, fight) system. They physiological system produces the heart rate or increases or lowers the blood pressure, the tightening of muscles, etc.

Additionally, mode deactivation therapy (MDT) includes imagery and relaxation to facilitate cognitive thinking and then balance training, which teaches the youngster to balance his perception and interpretation of information and internal stimuli. The imagery is implemented to reduce the external stimulation of the emotional dysregulation, which is the basis for the underlying typologies of these youngsters. Many of their underlying behaviors include aggression (physical and verbal) as well as addiction and self-harm.

Apsche & Ward (2002) found that MDT reduced personality disorder/trait beliefs significantly and fought the individual to self-monitor and balance their personality disorder beliefs. The study also found a reduction of internal distress, resulting from various psychological disorders, as well as a reduction of sex offending risk in the group that participated in MDT. Overall, the study indicates that treating this typology without addressing the underlying compound core beliefs, appears to be related to recidivism.

Often these classifications are not immediately recognizable when treating these youths. In addition, treatment protocols often are complicated by the presence of conglomerate of personality disorders, Johnson, Cohen, Smailes, and Bernstein (1999) found in their longitudinal study that childhood maltreatment results in the development of personality disorders in adolescents. The combination of

conduct disorders and personality traits or disorders presents a challenge to the clinicians and researchers alike when working with adolescents.

Conduct Disorder has been found to be a difficult disorder to understand and treat. Problems and symptoms associated with Conduct Disorder include chronic violence, various forms of physical aggression, sexual aggression and property destruction (Dodge, Lochman, Harnish, Bates and Pettit, 1997). While Kazdin, Weiz (2003) delineates evidence based treatments practices for children with Conduct Disorder, no evidence based procedures exist for adolescents over 14 years old with Conduct Disorder. Further, Kazdin and Weiz cite the prevalence rate for Conduct Disorder is 2% to 6% for children in the United States today (2003). In addition, clinical referral rates of 33% to 50% of cases referred to outpatient treatment: and 80% of these children and adolescents are likely to meet criteria for a psychiatric disorder in the future. This presents a major dilemma when attempting to treat this difficult disorder.

Kazdin, Weiz (2003) suggested that Conduct Disorder is comprised of a compendium of behaviors and symptoms. Dodge, et.al(1997), proposed a distinction in conduct disorders based on the differences in which the disorder is manifested by the youths. These categories differ in the youth's perception of threats and the function that the aggression serves. The reactively aggressive is aggressive to perceived threats and danger signals that the youth interprets from others verbal or physical behavior. These behaviors are interpreted by the youth completely separate and not including the other person's actual intent. The proactively aggressive youth is aggressive to receive something, or a "pay-off."

There are often numerous associated Axis I disorders within the Conduct Disorder diagnosis. Many of these youths have secondary diagnosis' of Major Depressive Disorder, Post Traumatic Stress Disorder as well as a variety of Axis II disorders (Apsche, Bass, Jennings, Murphy and Hunter, 2005). As part of their compendium of behaviors, many youngsters with the diagnosis of Conduct Disorder engage in suicidal and parasuicidal behaviors (Apsche, Bass, Murphy, 2004).

MDT and Suicide

In a comprehensive review of 12 years of published studies on adolescent suicide, Links, Gould, Ratnayake, (2003) found that the rate of personality disorders among adolescents who died by suicide were as high as 17%. They also found that the rates of serious suicide were 9 times higher with adolescents who were diagnoses with Anti-Social Personality Disorder, Bipolar Personality Disorder and Narcissistic Personality Disorder.

Links, et.al.2003, also reported that suicide rates for adolescents who had Borderline Personality Disorder was 44%. In addition, they indicated that adolescents with Narcissistic Personality Disorder were 9% more likely to die by suicide.

These data suggest that there is a significant risk of serious suicide attempts for category of reactively aggressive conduct disorder. This group represents a high risk of lethality, as well as, aggression and other destructive behaviors. Links, et al., 2003, clearly state that complications of conduct disorder as it is paired with Anti-Social Personality Disorder, Bipolar Personality Disorder and Narcissistic Personality Disorder as being the manifestation of the disorder by lethal behaviors, both internally and externally.

This research underscores the necessity for the clinician to be aware of the personality beliefs as delineated in the COBB. When implementing MDT, the clinician is required to be aware of these personality indicates of potential lethal suicide attempts.

Case Summary

This case analysis is a step-by-step case study, with a corresponding theoretical analysis based in mode deactivation therapy (MDT). The methodology known as MDT suggests potential for effective treatment of youngsters with similar backgrounds as Charles. Consider a case of this youngster -- Charles is a 17-year-old African American male who meet the criteria for MDT. He has been diagnosed with Post Traumatic Stress Disorder, Conduct Disorder, Major Depressive Disorder and Borderline Personality Disorder. He has a history positive for 7 serious and nearly lethal suicide attempts. Charles' last suicide attempt, an attempted hanging, prompted his entering treatment with the first author.

Client Family History

Charles' mother died from an overdose of cocaine. His father was a recovering addict and lived in a half-way house. Charles saw his father about once a year. He has two brothers. One brother was a drug dealer and had been extremely physically and emotionally abusive to Charles. His oldest brother lived out of state and wanted Charles to move in with him and attend a local college.

This was Charles's first admission to a sexual offender residential treatment program, although he was incarcerated in two separate juvenile detention facilities. He had a two year history of progressively increasing initial and midstate insomnia, mood variation, dysphoria, and difficulty concentrating.

From age 2, Charles was sexual abused by a family friend until he was 10 years old. He stated that they participate in 9 to 10 total incidents he fondled her vagina and she fondled his penis. He was forced to have sex. He also sexual abused an 8 year old neighborhood girl, when he was 4. Charles also forced his primary victim to perform oral sodomy on him, he started with sex play while they fondled each other through their clothing, and partly naked. He hasn't disclosed this information with any one other then his therapist.

Charles was physical abused by his grandmother, he was beaten with electrical extension cords, fishing pole and "any thing else they could get their hands on". He was told that this was discipline and that not abuse. He experienced emotional abuse as the result of from his mother and brother who were drug addicts. He started to "walk the streets" at the age of 14 for a year coming home "only to shower".

Charles preformed at the normal grade level at school, but he required increased structure and individualized attention. Charles has a history of repeated violations of school rules and disruption in class. He often was aggressive and often cut school.

Diagnosis

Axis I: Major Depression, Recurrent and Specified
Post Traumatic Stress Disorder
Sexual Abuse of a Child (victim and offender issues)
Conduct Disorder

Axis II: Personality Disorder, NOS - Mixed Features of borderline, antisocial, histrionic, avoidant, and narcissistic

Axis III:

Axis IV: Problems with primary support system, the social environment, educational problems.

Axis V: Highest GAF past year: 43
Current GAF: 61
Admission GAF: 43

Mode Deactivation Therapy (MDT) Case Conceptualization

Underlying the MDT methodology is the MDT Case Conceptualization. MDT Case Conceptualization is a combination of J.S. Beck's (1995) case conceptualization and Nezu, Nezu, Friedman, and Haynes's (1998) problem solving model, with several new assessments and methodologies recently developed to address the specifics of adolescents. Conceptualizing a case is a fluid and dynamic process (J.S. Beck, 1995). Many therapists "dismiss case conceptualization as an abstract exercise" (Friedberg & McClure, 2002). Although, as Friedberg & McClure (2002) have observed, conceptualizing a case is "one of the most practical tools" clinicians can use. The case conceptualization not only helps the clinician to have a clear idea of developing a treatment plan, but it can also aid in diagnosing a client (Friedberg & McClure, 2002). The goal is to provide a blueprint to treatment within the case conceptualization.

Case conceptualizations include the presenting problems, test data, cultural issues, history and development, cognitive issues, and behavioral issues (Friedberg & McClure, 2002). The MDT Case Conceptualization takes conceptualizing a case a step further. The MDT Case Conceptualization helps the clinician examine underlying fears of the youth. These fears serve the function of developing avoidance behaviors in the youngster. These behaviors usually appear as a variety of problem behaviors in the milieu. Developing personality disorders often surrounds underlying post traumatic stress disorder (PTSD) issues. The MDT Case Conceptualization method provides an assessment for the underlying compound core beliefs that are generated by the developing personality disorders; it is known as the Fear Assessment.

Thus far, preliminary results suggest that this typology of youngsters have a conglomerate of compound core beliefs associated with personality disorders. This conglomerate of beliefs may be a personality disorder reason why many youngsters fail in treatment. One cannot treat specific disorders, such as aggression, without gathering these conglomerate beliefs. It is also apparent that these beliefs are not cluster specific as suggested by Beck, Freedman, Davis and Associates, 2004. That is to say, that the conglomerate of beliefs and associated behaviors contains beliefs from each cluster that integrate with each other. Because of this complex integration of beliefs, it makes treatment for this typology of youngster more complicated. The conglomerate of compound core beliefs represents protection for the individual from their vulnerability issues, which may present behaviors that interfere with treatment. The conglomerate of beliefs and behaviors is consistent with schema therapy's categories of maladaptive modes (Young et al, 2003), although this acknowledges the complexities of these modes to allow for more individualized, specific identification through identifying the understanding beliefs and corresponding behaviors for the individual. The conglomerate of beliefs and corresponding behaviors serves to sort out the schemas of each individual. In contrast to Young, et al's (2003) schema therapy, MDT does not label the client's modes. Rather, MDT recognizes that modes are fluid and ever changing and therefore, they are not categorized.

The attempt to use the usual didactic approaches to treatment, without addressing these beliefs amounts to treatment interfering behavior on the part of the psychologist, or treating professional, is not empirically supported and counter-initiated. The MDT Case Conceptualization is a schematic representation of A.T. Beck's (1996) theory of modes combined with Apsche and Ward Bailey's (2003) interpretation of the applied methodology of Linehan's (1993) DBT, and

Kohlenburg and Tsai's (1993) FAP. It is intended to provide the blueprint for treatment for the youngster. The MDT Case Conceptualization provides a functional treatment methodology that integrates into the treatment plan.

The MDT Case Conceptualization also provides a methodology to identify and address the reactive adolescent's emotional dysregulation. The emotional dysregulation refers to the Linehan (1993) model of the Borderline Personality Disorder (BPD) emotional dysregulation, integrated with the Reactive Conduct Disorder (Dodge, et al, 1997).

MDT Case Conceptualization offers a step-by-step methodology to implement MDT. The MDT Case Conceptualization becomes the basis for implementing MDT methodology. Additionally, MDT offers specifically designed assessments, Fear Assessment, Compound Core Belief Questionnaire (CCBQ), and the Typology Survey, which are the basis of completing the MDT Case Conceptualization. All of these assessments have been tested for validity, reliability, and effectiveness. The results of statistical analysis of these assessments will be presented in future articles by the authors of this paper.

Charles' Fear Assessment Results

Results from the Fear Assessment suggest that Charles is an individual who has anxiety and fear that relates to external areas or things outside of himself, over which he has little or no control. Endorsed fears indicate that Charles' behavior is in response or reaction to external stimuli, which he perceived as threats. This appears to validate his history of sexual abuse and strong family enmeshment. He endorsed fears of being emotionally alone, trusting anyone, going to bed/being alone, someone coming up behind him, confronting his abuser, being physically hurt for no reason, his feelings and emotions, hurting someone and loosing control, not being masculine enough, being weak, that they will know his secret and failing. These fears are matched with corresponding beliefs to complete the Trigger, Fear, Avoids, Beliefs (TFAB) worksheet.

The Compound Core Beliefs Questionnaire (CCBQ) suggests that Charles has a personality disorder NOS – with mixed features of borderline, paranoid, antisocial, histrionic, and narcissistic. He endorsed numerous beliefs of the borderline personality. Many of these beliefs appear to have gone untreated by the previous therapists. Examining his beliefs indicates that Charles' sexual aggression and oppositional behavior are related to his dichotomous borderline beliefs and emotional dysregulation. He endorsed the following compound core beliefs as occurring always: "If I am not loved, I am unhappy," "If I don't do it, it won't be done right," "I can not trust others -- they will hurt me," "If I trust someone today, they will betray me later," "If I let others know information about me, they'll use it against me," "When I'm bored, I need to become the center of attention," "If I act silly and entertain people, they won't notice my weaknesses," "When I hurt emotionally, I do whatever it takes to feel better," "When I'm in pain, I'll do whatever I need to do to feel better," "I deserve admiration and respect, whether I work for them or not, others don't deserve recognition," "I try to control myself and not show my grieving, loss, and sadness, but eventually it comes out in a rush of emotions," "When I'm angry, my emotions are extreme and out of control," "If I'm afraid something will be unpleasant, I will avoid it," "If I'm not on guard, others will take advantage of me," "Weaker people are here for the strong to prey on, using any means I can," "Only I count, others are there to fill my needs," "If something makes me feel good, I do what I want," "If you annoy me, I'll go off and let you know it."

Case Conceptualization

The MDT Case Conceptualization is typology driven and individualizes the treatment based on empirically based assessment. The MDT Case Conceptualization also provides a methodology to address the reactive adolescent emotional dysregulation. The typology of these adolescents often demonstrates aggressive and destructive reactions through emotions to threats or perceived threats. The case provides the structure of the conglomerate of beliefs and behaviors to address the dysregulation by balancing the beliefs.

The conglomerate of beliefs and behaviors identifies behaviors that correlate with beliefs and is the structure needed to work with the youngster. This provides a method to relate the emotional dysregulation to the beliefs. The goal is to teach the youngster to balance beliefs by recognizing that they activate the emotional and behavioral dysregulation.

Once the information is gathered and the case is formulated, the client and the therapist collaboratively develop the Conglomerate of Beliefs and Behaviors (COBB). The collaborative nature of this process allowed Charles an opportunity to gain trust in his therapist as well as in himself. By empowering him to actively participate in the development of his MDT Case Conceptualization and the course of his treatment, he became significantly more motivated in participating in his treatment. Charles remarked as to the amount of his beliefs, which tended to correspond with most of his negative behaviors. He demonstrated insight, recognizing that resolving his compound core beliefs would enable him to address his negative behaviors. He was pleased with this realization and expressed optimism for true change and relief.

The Conglomerate of Beliefs and Behaviors (COBB) is the crux of treatment for the client. Once he collaboratively validates the Triggers→Fear→ Avoids→ Compound Core Beliefs (TFAB) and begins this form, he helps validate his behavior responses that are congruent with his compound core beliefs.

The COBB remains with him throughout treatment and is the basis for all of his work in the MDT Workbook. Charles recognized that these beliefs could be activated throughout his lifetime and he continually works to deactivate his fears, by balancing his beliefs. The MDT Case Conceptualization includes a situations worksheet, real life examples, to test the "hypotheses" developed with the COBB and TFAB.

After completing the COBB and TFAB, the MDT Case Conceptualization moves to address mode activation and the deactivation of modes. Following through the mode activation worksheet and inserting the already identified information into the appropriate boxes, Charles' experience became clearer. By providing a visual representation, the worksheet clearly demonstrates the overwhelming nature of Charles' cognitive system (preconscious processing, perceptions, beliefs, motivational schema), physiological system, affective schema, and behavioral schema all activating simultaneously. The deactivation of Charles's modes was evident. Addressing his unbalanced, dichotomous beliefs, would prevent the rest of the sequence from occurring. This meant that by balancing his beliefs, Charles could prevent his negative behavior from happening.
If Charles perceived that he could be in a situation where he may be confronted or reprimanded, his anxiety would increase and he would emotionally shut down. Anticipating the confrontation set in motion the cognitive, affective, behavioral, and physiological processes.

Although Charles may not be consciously thinking about confrontation (and may actually be focused on another activity), an attempt to elicit his thought at this point would generate the same information as if he were actively thinking about the anticipated event. He would express

anger about the upcoming perceived confrontation or attack on his vulnerability and he would be able to discuss that he has a dichotomous belief that had been activated. He would be able to identify the fear that was endorsed related to his anger and that he perceived physical danger from the perceived upcoming situation.

As the time of the perceived confrontation nears, he would have a conscious fear or threat of being a victim and was also fearful that he would become verbally and/or physically aggressive to protect himself. The situation appeared threatening (real or perceived) based on his life's experiences. He was fearful of his own actions in this situation and worried that he would later feel humiliated by the outcome of the situation.

At a later time, when Charles is no longer confronted with the dangers of the situation, he is not experiencing the fears of the perceived situation. The distance from the dangerous situation represents the Woody and Rachman, (1994) concept of a "safety signal." When the parameters of the same situation recur the pattern of fears ↔ avoids beliefs is repeated.

Reviewing the fear reaction pattern in Charles, using A.T. Beck's (1996) analysis of modes, the activating circumstances are directly related to the anticipated event and the perception of the re-victimization of the meeting. These circumstances are processed through the orienting component of the "primal mode relevant to danger" -- the imagined risk of being victimized, beaten and letting someone else control him. As this related fear is activated, the various systems of the mode are also activated and energized. During the physiological manifestation of the activation of the mode, Charles becomes tense, grinds his teeth, has involuntary muscle movements, increasingly intense headaches, tightened facial muscles, his hands and legs shake and move around, anxiety increases, and his fists may tighten.

The actual progression of the mode activates as Charles nears the time of the group or meeting, i.e., his orienting schemas signal danger ahead. This system is based on the perception of danger of victimization/ vulnerability and is sufficient to activate all the systems of the mode. The affective system generates rapidly increasing levels of anxiety; the motivational system signals the impulse and the flight/fight signal, increasing the attack or avoid and the physiological system, which produces the following: grinding of his teeth, involuntary muscle movements, tachycardia, etc.

Charles became aware of his distressing feelings at this point and he is often unable to activate his own cognitive controls, or "voluntary controls" to override this "primal" reaction to be able to mediate the conflict. Once he is able to mediate the fears and avoidance, he is able to participate in a supportive meeting and the anxiety begins to de-escalate.

Charles' interpretation of his physiological sensations magnifies his fears of the anticipated physical and psychological re-victimization. Throughout the process of the feedback that he received from his bodily sensations, the flush anxious feelings, the powerful fear of loss of control and the sequel of physiological responses develops the fear of yelling and screaming and potential aggression and a disastrous situation. This fear is compounded by the events that led to another fear, which is the fear of feeling humiliated by the perceived threat of victimization/ vulnerability and loss of control in the presence of other people.

The final step in the MDT Case Conceptualization is completing the Functionally Based Treatment Development Form. This form literally walks the client through how to balance dysfunctional beliefs and attempt to consider a more functional "healthy belief". The form is written from left to right demonstrating to the therapist each step in the process of developing

competing beliefs for the youngster. First, the therapist identifies the new healthy beliefs, then identifying the thoughts that will reinforce the new beliefs, developing compensatory strategies, reinforcement of behaviors, and most importantly, the V-C-R for each new healthy belief. The form is implemented right to left, beginning with the V-C-R to develop new thinking, new behaviors, and new beliefs. The therapist breaks the process into the smallest steps necessary, by actually completing a task analysis on the client's potentially healthy competing beliefs. The therapist and the client have a scripted methodology for the youngster and his parents or staff to follow in aiding him in developing new beliefs, one step at a time.

An integral part of MDT is the concept of validation, clarification, and redirection (VCR). Validation was defined by Linehan (1993), as "the therapist's ability to uncover the validity within the client's beliefs." The grain of truth reflects the client's perception of reality. The truth in this reality needs to be validated to clarify the content of his responses, and also to clarify the beliefs that are activated. It is important to understand and agree with the "grain of truth" in the clarification.

Redirect responses to others to other views or possibilities on his or her continuum of truths are important. There are numerous continuums implemented, as scales from 1 to 10 to evaluate areas such as truth, trust, fear, and beliefs. These continuums are essential to MDT in that they give both the client and the therapist an empirical measure of the client's measured perception of truth.

Teaching a youth who often engages in dichotomous thinking that their perception can fall within the range of a continuum, rather than only a 1 or a 10 scale (all or nothing), is extremely validating and it is the basis for a positive redirection to other possibilities for the client. This is a form of MDT mindfulness. The youngster is trained to be aware of how he feels at each movement. Being aware of his feelings is essential for the youngster to accept honesty his behavior in the moment.

In Charles' case, he was able to develop healthier beliefs due to his therapist and all staff members working with him using the V-C-R as described in his treatment plan, originating from his Functionally Based Treatment Development Form. For example, take Charles' belief about not being able to trust anyone outside the family. Validating his fears of trusting anyone outside of the family, clarifying that he could trust one person outside the family at a time, and redirecting him to use the trust scales to objectively to measure his level of trust for others allowed Charles to open his mind to possibilities, thereby balancing his beliefs about trust. The process also taught Charles how to balance his beliefs for himself. As a result, he developed a new belief, to trust some people some of the time.

Summary

This case study suggests that in at least this case, MDT was helpful in reducing lethal suicide attempts. The authors do not suggest MDT is effective in treating adolescent suicide without further rigorous study.

However, MDT might hold some promise in treating adolescent males with PTSD, CD and personality disorders, who engages in lethal suicide attempts. It is hoped that the results of this case study might prompt further study in a carefully monitored and controlled study.

Charles was discharged from treatment and moved with his brother in another state. Charles is currently attending a university, and reports that he has not attempted suicide since the

lethal attempt that landed him as a client of the first author. He also reports that he uses his "balance the beliefs" regulating exercise.

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