

A Comparison of MDT and DBT: A Case Study and Analysis

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Abstract

This case study examines a 13 year old adolescent male who engages in severe aggression, self-injurious and impulsive behaviors. He was treated with Dialectical Behavior Therapy (DBT) for thirteen months. DBT had limited success in reducing his problem behaviors. He was treated with Mode Deactivation Therapy (MDT) for four months and his problem behaviors were reduced significantly. It appears that in this case study MDT was more effective than DBT in reducing his severe behaviors.

Keywords: MDT, DBT, physical aggression, self injurious behaviors, adolescents, personality disorders.

Introduction

In this case study a thirteen-year-old adolescent male was treated successfully after MDT was implemented. He had previously been treated for thirteen months, unsuccessfully, with DBT. The DBT therapist was trained in the ten day intensive training offered by the developer of DBT. The MDT therapist was trained by the first author of this case study in an intensive MDT training.

DBT was developed by Linehan (1993) to treat people with Borderline Personality Disorder. Since the inception of DBT, it has been shown to be an effective methodology in treating a variety of disorders. Trupin, Stewart, Beach, and Boesky (2003) demonstrated the effectiveness of DBT with female juvenile offenders. Lynch, Morse, Mendlesen, and Robbins, (2003) demonstrated the effectiveness of DBT with older populations. In these studies DBT has demonstrated its effectiveness with populations other than Borderline Personality Disorder cases.

MDT was shown to be more effective than Cognitive Behavior Therapy and Social Skills Training with aggressive adolescent males with conduct and personality disorders. MDT has been demonstrated to be effective in reducing aggression, personality disorders, beliefs and symptoms of Post Traumatic Stress Disorder (Apsche, Bass, Murphy 2004; Apsche & Ward 2004).

This appears to be the first case study that examines the effects of MDT with a youngster who was not successful with DBT.

Case Summary

This case study 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 William. William is a thirteen-year-old Caucasian American male. He has been diagnosed with Post Traumatic Stress Disorder, Impulse Control Disorder, Reactive Attachment Disorder, Obsessive Compulsive Disorder and Personality Disorder Traits.

William had demonstrated a pattern of continuous disruptive behaviors, lying, social phobias, hoarding, aggressive and threatening behaviors, property destruction, academic performance problems and school behavior problems, difficulties with peer relationships, enuresis with purposeful urination on furniture and clothing, and sexually inappropriate behaviors, including attempting to have sex with his sister, excessive masturbation with stolen undergarments from his mother and sister, masturbating with animals and in front of other children, early sexual experiences and touching other children.

Client Family History

William had struggled behaviorally since he was a young boy, and some reports indicate he was as young as a year and a half. William had minimal care as a youngster and grew up in an invalidating environment where he and his sister were responsible for their own care. William's mother was diagnosed with Hodgkin's disease during her pregnancy with William and reportedly refused treatment. William was born prematurely and then incubated for one month after his birth to aid in his respiratory development. William's mother died in 1998. William and his sister visited with a family for approximately one and a half years prior to their adoption in 2001. Although William had behavioral problems prior to adoption, when the adoption was finalized, his behaviors deteriorated rapidly.

William's biological family was extremely unstable. His parents, never married, met in an orphanage where they grew up. Due to his mother's illness, he was neglected as an infant. His two younger sisters would eventually take responsibility for William. They did have an aunt who was involved. However, it is reported that due to William's challenging behaviors early on, she withdrew from their case to protect her children from William's behavior. It appears that William did not experience a nurturing bond with his mother and did not have anyone to fulfill that need to him to the extent necessary to develop appropriate and trusting attachments.

William and his sisters were left to fend for themselves in their developing years. Although their mother's illness played a role in their lack of care, it is evident that the neglect was only exacerbated by her illness, not the cause of it. Their father was in and out of their lives. However, when he was there he would become physically and sexually violent toward their mother. He was a substance abuser who never took responsibility for his children. One report indicated that when William was young his father threw him down the stairs. It was reported by an aunt that William and his sister were in bed with their mother while she watched pornographic videos.

Although William had behavior problems since early childhood, these problems severely escalated following his adoption. The Johnsons had other foster children, but due to the severity and potential harm of William's behaviors, they stopped taking in foster children. The family reported that William needed to be constantly monitored and supervised. Of particular note is William's apparent targeting of his adoptive mother with his aggressive behaviors. The foster parents locked their bedroom door to prevent William from ransacking their room and stealing. At times he would steal undergarments from his mother and sister and use them as objects for masturbation.

William was referred to a residential program to treat his disruptive behaviors. William presents as an extremely anxious child with obsessive compulsive features. Reports indicate that he has a history of inappropriate sexual behaviors, as well as aggressive behaviors.

Since arriving for residential services thirteen months ago, William has received DBT individual and group therapy. The target goals were to develop skills for managing his emotions and tolerating his distress, and to address his sexually reactive behaviors. This would also address his problematic sexual behaviors, and teach him about appropriate sexuality and relationships. William also participated in therapeutic recreation for further skill building and self-esteem enhancing activities.

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

Diagnosis

Axis I:	Impulse Control Disorder Post Traumatic Stress Disorder Attention Deficit Hyperactivity Disorder Type Obsessive Compulsive Disorder Reactive Attachment Disorder
Axis II:	Personality Disorder, NOS - Mixed Features of borderline, antisocial, histrionic, avoidant, and narcissistic.
Axis III:	Premature Birth by report
Axis IV:	Problems with primary support system, the social environment, educational problems. Sexual Abuse.
Axis V:	Highest GAF past year: 40 Current GAF: 50 Admission GAF: 40

Mode Deactivation Therapy (MDT) 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 the youth's underlying fears. These fears serve the function of developing and supporting avoidance behaviors in the youngster. These behaviors usually appear as a myriad of problem behaviors in the milieu. The MDT Case Conceptualization method provides an assessment of the underlying compound core beliefs that are generated by the developing personality disorders; it is known as the Fear Assessment.

Preliminary results suggest that this typology of youngsters has a conglomerate of compound core beliefs associated with personality disorders. These conglomerate of beliefs may be a 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, 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 then 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 MDT acknowledges the complexities of these modes to allow for more individualized, specific identification by 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. (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, and is not empirically supported and is 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 the 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.

William's Fear Assessment Results

Results from the Fear Assessment suggest that William is an individual who has anxiety and fear relating to external areas or things outside of himself, over which he has little or no control. Endorsed fears indicate that William's behavior is in response or reaction to external stimuli, which he perceives as threats. This appears to validate his history of sexual exposure and possible abuse, and strong family enmeshment. He endorsed fears of being emotionally alone, being home alone, of failing (life), of being emotionally intimate, fear of crowds, being alone, fear of being in a crowded room, fear of being dumb, someone coming up behind him, of being touched by someone that you I don't know well, confronting his abuser, being physically hurt for no reason, his feelings and emotions, hurting someone and losing control. These fears are matched with corresponding beliefs to complete the Trigger, Fear, Avoids, Beliefs (TFAB) worksheet.

The Compound Core Beliefs Questionnaire (CCBQ) suggests that William has a personality disorder NOS – with mixed features of antisocial, borderline, paranoid, antisocial, histrionic, and narcissistic, and obsessive-compulsive beliefs. He endorsed numerous beliefs of the borderline personality. Many of these beliefs appear to have gone untreated by the previous therapists. Examination of his beliefs indicates that William's 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: "Whenever I hope, I will be disappointed," "Other people have hidden motives and want something from me," "Unless you have a videotape of me, you cannot prove I did it," "If you criticize me, you are against me," "When I am angry, my emotions are extreme and out of control," "If I am afraid something will be unpleasant, I will avoid it," "When I hurt emotionally, I do whatever it takes to feel better," "Life at times feels like an endless series of disappointments followed by pain," "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," "If I act silly and entertain people, they won't notice my weaknesses," "When I'm in pain, I'll do whatever I need to do to feel better," "I would rather not try something new then fail at something," "I am happiest when people pay attention to

me “If I’m afraid something will be unpleasant, I will avoid it,” and “If I’m not on guard, others will take advantage of me.”

Case Conceptualization

The MDT Case Conceptualization is typology driven and individualizes the treatment based on an empirically based assessment. The MDT Case Conceptualization also provides a methodology to address the reactive adolescent and his emotional dysregulation. These adolescents often demonstrate aggressive and destructive reactions as responses to 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 William 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 to participate in his treatment program. William remarked as to the number 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 behavioral 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. William 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, with 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 the deactivation of the youngsters modes. Following through the mode activation worksheet and inserting the already identified information into the appropriate boxes, William’s experiences became clearer. By providing a visual representation, the worksheet clearly demonstrates the overwhelming nature of William’s cognitive system (preconscious processing, perceptions, beliefs, motivational schema), physiological system, affective schema, and behavioral schema all activating simultaneously. The deactivation of William’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, William could prevent his negative behavior from happening.

If William 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 William 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. 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 in order to protect himself. The situation appeared threatening (real or perceived) based on his life 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 William 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 William, 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/or 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, William becomes tense, grinds his teeth, has involuntary muscle movements, has increasingly intense headaches, tightened facial muscles, and his hands and legs shake and move around, his fists may tighten, and his anxiety increases.

The actual progression of the mode activates as William 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 response and the responses of his physiological system, including grinding of his teeth, involuntary muscle movements, tachycardia, etc.

William becomes 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 and thus 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.

William's 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, he responds to these sensations in a fear reaction. This fear is compounded by the events that lead 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 attempts 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 VCR is simply validation, clarification and redirection to a possible alternative belief. The Functional Treatment development 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 and their current belief. 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.

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 engages in dichotomous thinking that their perceptions can fall within the range of a continuum on a scale of 1 or a 10 scale is extremely validating and 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. All of these forms are sequential and found in the clinicians MDT manual.

In William's 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 William's belief about his inability to trust anyone outside the family. Validating his fears of not 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 measure his level of trust for others, allowed William to open his mind to possibilities, thereby balancing his beliefs about trust. The process also taught William how to balance his beliefs for himself. As a result, he developed a new belief, to trust some people some of the time.

Results

William's residential treatment milieu included DBT skills groups twice a week, individual therapy once a week, and psycho-educational model (PEM) Social Skills Training both during school and on the residential unit. He was in DBT for 13 months for which he averaged 10.92 holds per month, 9.38 incidents of physical aggression per month and 7.61 incidents of self-harming behavior per month. Due to his limited progress, he was then transferred from DBT to MDT individual therapy to address his aggressive behaviors. His transition from DBT to MDT individual therapy was smooth. After six months the inception of MDT, William's physical holds were reduced to an average 2 holds per month, 1.67 incidents of physical aggression per month and 0.67 incidents of self-harming behavior per month.

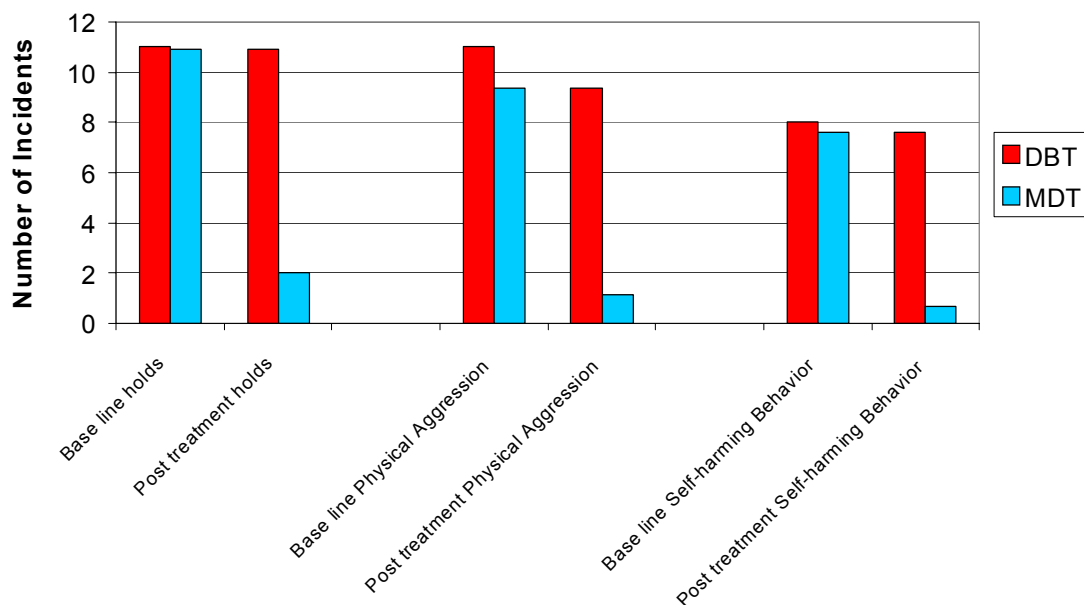
Table 1. Descriptive Statistics

	Holds	Physical Aggression	Self-Harming Behaviors
Mar-04	11	11	8
Apr-04	12	9	7
May-04	11	11	6
Jun-04	12	10	8
Jul-04	13	9	5
Aug-04	12	10	9
Sep-04	11	8	7
Oct-04	10	11	8
Nov-04	11	12	11
Dec-04	12	10	10
Jan-05	15	10	12
Feb-05	12	11	5
Mar-05	13	9	8
avg. DBT	10.92308	9.384615	7.615385
Apr-05	5	3	2
May-05	2	1	1
Jun-05	1	0	0
Jul-05	1	1	1
Aug-05	2	2	0
Sep-05	1	0	0
avg. MDT	2	1.166667	0.666667

Table 3: Post-Treatment Avg. Scores and Percent Reduction Across Treatments

	DBT		MDT	
	Post- T Avg.	Percent Reduced	Post- T Avg.	Percent Reduced
Holds	10.92	0.69%	2	81.69%
Physical Aggression	9.38	14.68%	1.17	87.56%
Self-harming Behavior	7.62	4.80%	0.67	91.24%

Table 4: Post-Treatment Reduction in Rates of Incidents Across Two Treatment Conditions



After a year with limited progress in reducing his number of holds and self-harming behavior, William was transferred into MDT. Shortly after starting MDT William's holds reduced by an average of 82.7 %, per month, along with his physical aggression and self-harming behavior which were reduced by 87.56 % and 91.24 % respectively.

Discussion

This case study suggests that in at least this case, MDT was more effective than DBT in reducing physical aggression and self injurious behaviors. This is not suggesting that MDT is superior to DBT other than in the results of this case study. However, MDT was developed for this typology of youngster and there is data suggesting that MDT is could be an effective psychotherapy for adolescents. The authors hope to continue to develop MDT and conduct randomized studies to test its effectiveness as compared to DBT and other interventions.

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