A Case Analysis of MDT With an Adolescent With Conduct Personality Disorder and Fire Setting Behaviors

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Abstract

This case study examines a 16.5 -year- old male adolescent who engages in fire setting, severe aggression and self injurious and impulsive behaviors. He was treated with Mode Deactivation Therapy (MDT) for four months and his problem behaviors have been reduced significantly. He was previously treated with Dialectical Behavior Therapy (DBT). It appears that in this case study MDT was effective in reducing his severe behaviors.
Keywords: MDT, fire setting, physical aggression, self injurious behaviors, adolescent males, personality disorders.

Introduction

In this case study a 16 year old adolescent male was treated successfully after MDT. The MDT therapist was trained by the first author of this case study in an intensive MDT training.

MDT was shown to be more effective with aggressive adolescent males with conduct and personality disorders then Cognitive Behavior Therapy and Social Skills Training. 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,Apsche, Bass, Jennings, Murphy, Hunt, Siv (2005).

After a thorough literature review this appears to be the first case study that examines the effects of MDT with an adolescent with fire setting behaviors.

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 Peter. Peter is a 16.5 -year-old Caucasian male. He has been diagnosed with Post Traumatic Stress Disorder, Conduct Disorder and Personality Disorder Traits. Peter demonstrated a pattern of continuous disruptive behaviors including; fire setting, lying, social phobia, aggressive and threatening posturing, property destruction, academic performance problems and school behavior problems, peer relationship problems and torturing animals. He also has tortured animals in front of other children and he had a history of early sexual experience, specifically sexual touching of other children.

Client Family History

Peter had demonstrated significant behavioral and impulsive problems since early childhood, which were manifested more prominently when he was four. During this time he was removed from his mothers care due to her continuous substance abuse. She reported using alcohol, cocaine, and crack cocaine during her pregnancy. He was the second youngest of six children all of whom have delinquent problems and are in Department of Social Services custody or involvement in some way. He was placed

with his grandmother who also failed to provide adequate supervision; as a result he was removed from her care. From 2000 to 2003 he was placed in nine inpatient settings, including residential placements and hospitals. He was removed from most of the nine placements due to disruptive, aggressive, suicidal behaviors.

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

He was placed briefly at a hospital then moved to a residential setting on an island. Within a couple of days, out of staff supervision he started a fire, which destroyed over 40 acres of protected woodlands. This led to his brief placement as an inpatient at a local Hospital prior to being admitted. Upon admission he has disclosed for the first time the he was sexually abused (repeated anal rape) by a 16 year old male cousin, in his grandmother's home, for several years starting at the age of seven. He reported that he told his grandmother, who did not believe him and punished him as a result of his disclosure. Later one of his older sisters eventually believed him and reported the crime. He was subsequently removed from her home, and the cousin was incarcerated. Peter also reported torturing animals and doing "sexual things" to them. He also reported that he set his grandmothers bed on fire while she was sleeping in it. Another disclosure involved playing in the back yard of his grandmother's home where he burned several toys.

Psychological testing was carried out in 2002 and his results indicated an average IQ using the Wechsler Intelligence Scale for Children-3rd edition. His scale scores included a verbal score of 93, performance score of 104 and a full scale score of 95. Further testing revealed his struggles with an extremely low self-esteem. He also provided somewhat odd answers on a sentence completion assessment, mentioning several times "that I wish I was never born".

Diagnosis

Axis I: Post Traumatic Stress Disorder
Attention Deficit Hyperactivity Disorder
Conduct Disorder, Childhood Onset Type

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

Axis III: Obesity Secondary to Psychotropic Medications

Axis IV: Problems with primary support system, the social environment, educational problems. Sexual Abuse of a Child (victim and offender issues)

Axis V: Highest GAF past year: 45
Current GAF: 50
Admission GAF: 45

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.

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 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 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).

Peter's Fear Assessment Results

The Fear Assessment is a sixty question measure designed to identify fears and anxieties that are interfering to the clients life and treatment. The Fear Assessment is a measure designed as one of the cornerstones of MDT treatment. These Results from the Proactive Fear Assessment suggest that Peter 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 Peter' behavior is in response or reaction to external stimuli, which he perceived as threat, which appears to validate his history of sexual exposure and abuse. He endorsed fears of trusting a relative, specifically his mother and grandmother. He had fears of being in a closed room with them, being emotionally alone, or them doing something sexual to him. His fears also included his cousin and his anxiety of failing in life. He had further anxiety about past incidents and believing that he did something wrong. Because of these fears and anxieties centering on his victimization, he developed fears of engaging in emotionally intimate relationships. PTSD symptoms included his fears of being dumb, of going to bed and of being weak. Other self defeating beliefs included his belief that he caused the problem, no one will believe him if he disclosed the abuse and of being alone in the world. He had significant fear of his feelings, someone coming up behind him, of being touched by someone that he doesn't know well, confronting his abuser and being physically hurt for no reason. Finally, further fears became manifest with the fear assessment including the fear of hurting someone and loosing control, of having sexual contact and of being locked or restricted in a room. These fears were matched with corresponding beliefs to complete the Trigger, Fear, Avoids, Beliefs (TFAB) worksheet.

The Compound Core Beliefs Questionnaire (CCBQ) suggests that Peter has a personality disorder NOS – with mixed features of antisocial, borderline, paranoid, antisocial, histrionic, narcissistic, and obsessive-compulsive. 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 Peter' 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," "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 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 would rather not try something new then fail at something," "I am happiest when people pay attention to me," "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,"

Case Conceptualization

The MDT Case Conceptualization is designed to individualize treatment based on empirically based assessments. The MDT Case Conceptualization also provides a methodology to address the reactive adolescent emotional dysregulation typical of adolescents with conduct and personality disorder. 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 Peter 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. Peter 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. Peter 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, Peter experience became clearer. The deactivation of Peter'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, Peter could prevent his negative behavior from happening.

If Peter 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 Peter 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 fears, 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 Peter 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 $\leftrightarrow$ avoids beliefs is repeated.

Reviewing the fear reaction pattern in Peter, 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, Dan 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 Peter 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.

Peter 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.

Peter'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 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.

Table 1. Descriptive Statistics

	Holds	Physical Aggression	Sexual Aggression
May-03	1	7	4
Jun-03	1	7	6
Jul-03	5	11	7
Aug-03	4	9	8
Sep-03	2	10	8
Oct-03	2	9	13
Nov-03	3	11	8
Dec-03	3	9	9
Jan-04	8	13	7
Feb-04	11	12	5
Mar-04	5	9	7
Apr-04	6	11	8
May-04	3	8	9
Jun-04	7	11	11
Jul-04	7	12	10
Aug-04	5	8	8
Sep-04	6	9	9
Oct-04	6	11	9
Avg. DBT	5	10.412	8.588
Nov-04			
Dec-04			
Jan-05			
Feb-05	3	4	10
Mar-05	2	4	9
Apr-05	5	6	5
May-05	4	4	3
Jun-05	3	3	0
Jul-05	1	3	2
Aug-05	2	3	3
Avg. MDT	2.857	3.857	4.571

In Peter' 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 Peter' 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 Peter to open his mind to possibilities, thereby balancing his beliefs about trust. The process also taught Peter how to balance his beliefs for himself. As a result, he developed a new belief, to trust some people some of the time.

Results

Peter's residential treatment milieu included and individual therapy once a week and Psycho-educational model (PEM) Social Skills training both during school and on the residential unit.

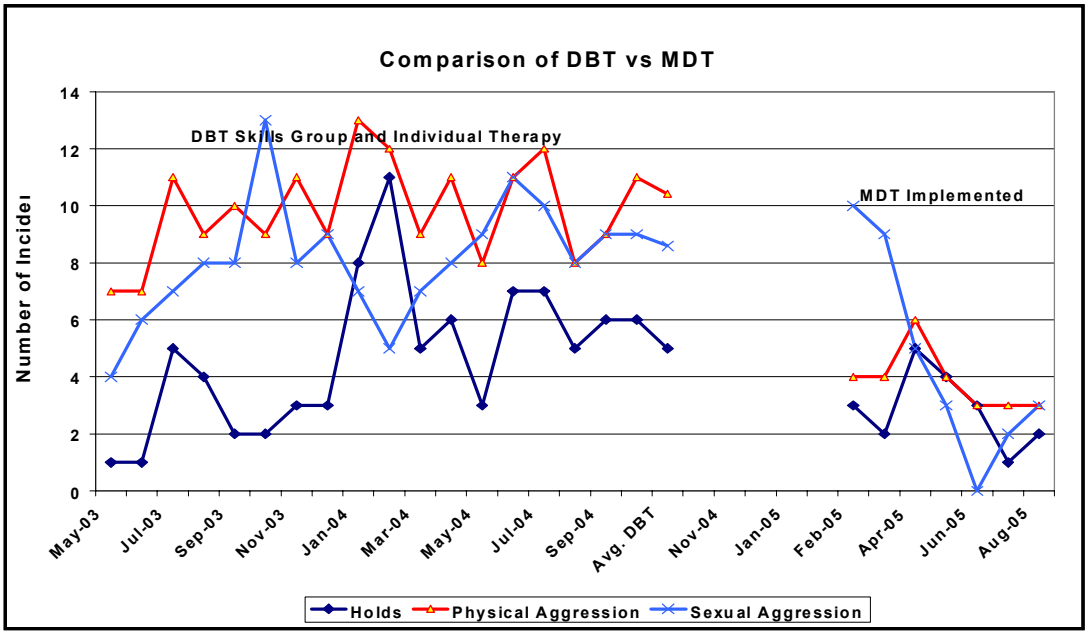

Figure 1: Comparison of DBT and MDT

Table 2: Post-Treatment Avg. Scores and Baseline Avg. Scores Across Treatments

	DBT		MDT	
	Post-Treatment Avg.	Baseline Avg.	Post-Treatment Avg.	Baseline Avg.
Holds	5	2.33	2.85	5
Physical Aggression	10.41	8.33	3.86	10.41
Sexual Aggression	8.58	2.33	4.57	8.58

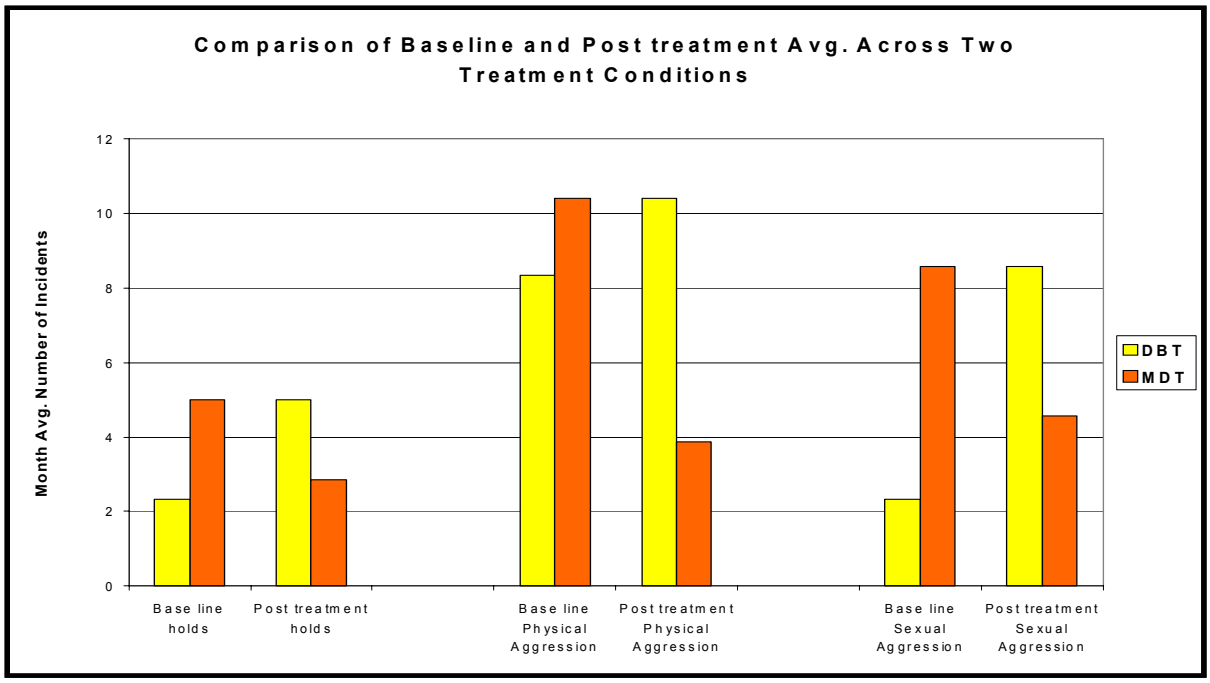

Figure 2: Comparison of Baseline and Post-Treatment across two treatment condition DBT and MDT.

After 15 months with limited progress in reducing his number of holds and aggressive behaviors, Peter was transferred into MDT. Shortly after starting MDT Peter's holds reduced by an average of 57.1 %, per month, along with his physical aggression and sexual aggression behavior which were reduced by 37.1 % and 53.3 % 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 type of youngster and there is data suggesting that it is a promising psychotherapy for adolescents. Treating adolescents with conduct and personality disorders is a difficult task. Many studies reporting success in treatment of specific personality and/or conduct disorders seem ineffective in cases of both conduct and mixed personality disorders. It is hoped that MDT will continue to develop as an effective psychotherapy for this specific population.

The authors hope to continue to develop MDT and conduct randomized studies to test it's effectiveness with DBT and other interventions.

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