

## Mode Deactivation Therapy (MDT) Family Therapy: A Theoretical Case Analysis

*Apsche, J.A. & Ward Bailey, S.R.*

This case study presents a theoretical analysis of implementing mode deactivation therapy (MDT) (Apsche & Ward Bailey, 2003) family therapy with a 13 year old Caucasian male. 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 effectiveness of MDT as applied in family therapy. The individual in this case, David, was a troubled youngster. Although he denied ever experiencing physical and/or emotional abuse, his family of origin demonstrated extremely poor physical and emotional boundaries. David did report that he had been sexually victimized by a boy. He did not disclose the name of the boy because his parents were friends with the boy's family and the lack of appropriate boundaries in his family created an unstable atmosphere, causing David to feel compelled to follow his parent's wishes to refrain from disclosing the name. David was learning disabled. In order to make sense of and compensate for his unstable home life, David developed a complex system of personality disorder beliefs. Along with providing David with a way to cope with his unpredictable world, they also led him to commit numerous sexual offenses. David had previous unsuccessful treatment and basic cognitive therapy techniques were ineffective. Mode deactivation therapy was found to be more effective, due to its ability to address the personality disorder beliefs without challenging David to engage in dialectical debates. It was essential to incorporate David's family in his therapy since they were so involved in his life and treatment. Unexpectedly, his family made progress along with him, gaining insight into his beliefs as well as their own beliefs. David and his family learned how to balance their beliefs and modify their behavior. The family's progress inspired the application of MDT in family therapy. This theoretical case study represents mode deactivation therapy, applying theory to clinical practice within family therapy.

Keywords: Mode Deactivation Therapy; Family therapy; Dialectical Behavior Therapy; Functional Analytic Psychotherapy; sexual, physical, emotional abuse.

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### 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 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 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, & Associates, 1991), which is not true with the adolescent typology as represented by David.

Often CBT, as viewed by “arguing” the concepts of cognitive distortions, fails with these youngsters. They do not respond well to being in a one-down position, no matter how aligned they are with their therapist. Cognitive therapy as normally practiced will eventually trigger a negative reaction by these youngsters. They perceive the therapist as another person attempting to change them from a system of defenses that has been developed to protect them. CBT as normally practiced will often fail with this typology of youngster. 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 & Ward, 2002). MDT has also been demonstrated as effective in a series of case studies (Apsche, Ward, Evile, 2002 a & b; Apsche & Ward Bailey, 2003).

Although MDT was developed to treat adolescents individually, it can also be applied in systems therapies such as family, couples, and group therapy. MDT focuses on addressing the underlying compound core beliefs that drive an individual’s behavior. Many of these beliefs are created by an individual in response or as a result of the environment fostered by their family of origin. In fact, many families recognize familiarity in the identified patient’s beliefs, as they reflect the family’s beliefs. These beliefs are not created consciously, rather they are created unconsciously to protect and facilitate survival. Addressing the individual’s beliefs within the system allows a more comprehensive effective approach. Without incorporating the system, the individual may make significant progress in treatment, but then return to old patterns of negative behavior upon termination of treatment. Incorporating the system allows the individual and system to sustain progress that has been made.

#### Mode Deactivation Therapy (MDT)

Mode deactivation therapy (MDT) (Apsche & 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 & Tsai, 1993) and dialectical behavior therapy (DBT) (Linehan, 1993). Additionally, there are areas of MDT which reflect concepts of schema therapy (Young, Klosko, & 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 Psychopathology* (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 & 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 contingencies, 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 & 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 change 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.

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 is a more cognitive approach suggesting 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 unhelped 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, 2003) In FAP theory, contingencies of reinforcement, such as families of origin, create the perception of reality and resulting beliefs, which drives behaviors. (Kohlenberg & 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) sees 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.

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 disorders 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 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 this typology of 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. The 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. MDT can be applied to couples and family therapy to provide a systems oriented approach.

Apsche, Ward, & Evile (2002) have suggested that the systematic approach of MDT has had positive results in reducing aberrant behaviors and beliefs of adolescents. Apsche & Ward Bailey (2003) have also reported positive descriptive results of MDT as compared to cognitive therapy in a descriptive, empirical but not comparison study. The study compared two groups of adolescent sex offenders who received different types of therapy. One group received treatment as usual (TAU), a cognitive behavior therapy approach, while the other group participated in MDT. These adolescents had prior unsuccessful treatment outcomes. The two groups were followed through their mean 16.36 months lengths of stay in residential treatment. At their twelfth month of treatment, both groups were tested, revealing that the group participating in MDT had lower scores on all measures than the TAU group. Groups were measured on the Child Behavior Checklist (CBCL), Devereaux Scales of Mental Disorders (DSMD), Juvenile Sex Offender Adolescent Protocol (J-SOAP), and Fear Assessment. Groups were also measured on behavior points earned, and need for restraints/ seclusions. MDT participants' scores on the CBCL were at least one standard deviation below the TAU group on all scales and scores on the DSMD were at or near one standard deviation below the TAU group, indicating a decrease in symptoms. The MDT group scores on the J-SOAP indicate a significantly lower level of risk to the community than the TAU group. The MDT group resulted in fewer restrictions and precautions for at-risk behavior than the TAU group. Additionally, results indicate that the MDT group had significantly less aggressive and destructive behaviors than the TAU group.

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.

### 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 David. It is hoped that MDT will be studied in rigorous empirically based studies.

Consider a case of a youngster (please see his MDT Case Conceptualization following this article). David is a 13-year-old adolescent who has been identified as emotionally delayed, functioning as an 8-year-old. Prior to his placement, he lived with both parents (who are still married), a 14-year-old sister, and a 7-year-old sister. The family lived in a lower income suburban neighborhood that is racially mixed with a moderate crime rate.

This was David's first admission to a sex offender residential treatment program. He had a two year history of progressively increasing initial and midstate insomnia, mood variation, dysphoria, and difficulty concentrating. David is taking Adderall and Zoloft.

At age 11, David offended against a 5-year-old neighborhood girl. He stated that the victim suggested that they participate in sexual play after seeing her sister and a boyfriend do it. He fondled her vagina. Over the next year, there were several additional incidents, both to that victim and to other children in the neighborhood, ranging in ages from 5-11 years of age. David also forced his primary victim to perform oral sodomy on him. David has 4 charges of Felony Sexual Assault, which he pled guilty to. Two additional charges of Sexual Assault and one charge of Sodomy were continued. According to the victims, all offenses included threats, force, and coercion, although David denied any form of aggression.

Although David denied any physical abuse, he did experience emotional abuse as the result of extremely poor boundaries within his family. He slept in the same bed as his mother downstairs while his father slept in a room that directly faced his 2 sisters' room upstairs. The family displayed a lack of boundaries during visits, as evidenced by the children groping at their mother's breasts, sitting on their parents' laps, and nuzzling in their mother's breasts. David did report being sexually abused by a boy in the neighborhood, but refused to disclose his name. David stated that he would never disclose the name because his parents told him not to since they were friends with the boy's family.

David experienced difficulty at school, requiring increased structure and individualized attention. He repeated the third grade and has been identified as a special education student. David has a history of repeated violations of school rules and suspension for disruption for class outing.



Prior to his admission, David did receive outpatient treatment with a certified sex offender treatment provider. He was resistant to treatment, refusing to complete psychological testing and shutting down in reaction to stress and anger. David did not show empathy for his victims. David denied any drug and/or alcohol use and has no additional legal charges. He has demonstrated difficulty relating to same age peers, resulting in David choosing younger children for friends. He has been described as avoidant and extremely reticent with poor eye contact during his outpatient therapy sessions.

David was determined to be a high risk to the community and was recommended for placement in a sex offense specific residential treatment program by his probation officer and outpatient therapist. He was placed in detention for 6 months while waiting for placement in a residential program.

#### Diagnosis

- Axis I: Major Depression, Recurrent and Specified  
Attention Deficit Hyperactivity Disorder  
Sexual Abuse of a Child (victim and offender issues)  
Functional Enuresis  
Learning Disorder, NOS
- Axis II: Personality Disorder, NOS - Mixed Features of borderline, antisocial, histrionic, and avoidant, and narcissistic
- Axis III: Seclor and Codeine Allergies
- Axis IV: Problems with primary support system, the social environment, educational problems, problems related to interaction with the legal system/ crime.
- Axis V: Highest GAF past year: 41  
Current GAF: 41  
Admission GAF: 41

#### 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, 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 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 has an assessment for the underlying compound core beliefs that are generated by the developing personality disorders. 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, is the 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. 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 as treatment interfering behaviors. The conglomerate of beliefs and behaviors is consistent with schema therapy's categories of maladaptive modes (Young et al, 2003), although 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 an 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 & Ward Bailey's (2003) interpretation of the applied methodology of Linehan's (1993) DBT, and Kohlenburg & 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 address the reactive adolescent 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.

Results from the Fear Assessment suggest that David 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 David's 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 trusting anyone outside of the family, being in a closed room/going to bed/being alone, being alone with kids that look like his abuser, his feelings, and hurting someone. These fears are matched with corresponding beliefs to complete the Trigger, Fear, Avoids, Beliefs (TFAB) worksheet.

The Compound Core Beliefs Questionnaire (CCBQ) suggests that David has a personality disorder NOS – 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 David'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: "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 feel better," "I deserve admiration and respect, whether I work for them or not, others don't deserve recognition," "I try to control 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 need," "only I count, others are there to fill my needs," "if it makes me feel good, I do what I want," "if you annoy me, I'll go off and let you know it."

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 adolescents often reacts aggressively and destructively 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 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 develop collaboratively the Conglomerate of Beliefs and Behaviors (COBB).

The collaborative nature of this process allowed David an opportunity to gain trust in his therapist as well as 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. David 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 thereby 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. David 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, David’s experience became clearer. By providing a visual representation, the worksheet clearly demonstrates the overwhelming nature of David’s cognitive system (preconscious processing, perceptions, beliefs, motivational schema), physiological system, affective schema, and behavioral schema all activating simultaneously. The deactivation of David’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, David could prevent his negative behavior from happening.

If David perceived that he could be in a situation where he may be confronted or reprimanded, his anxiety would increase and he would shut down. Anticipating the confrontation set in motion the cognitive, affective, behavioral, and physiological processes.

Although David 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 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 David 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 & 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 David, 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, David becomes tense, grinds his teeth, has involuntary muscle movements, increasingly intense head aches, tightened facial muscles, his hands and legs shake, move around, anxiety increases, and his fists may tighten.

The actual progression of the mode activates as David 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, heart races, etc.

David 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 to be able to mediate the conflict. Once he is able to mediate the fears and avoidance, he would be able to participate in a supportive meeting and the anxiety would begin to de-escalate.

David'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.

The final step in the MDT Case Conceptualization is completing the Functionally Based Treatment Development Form. This form literally walks through how to balance

beliefs and can be incorporated right into a treatment plan. The form is written from left to right. First identifying 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.

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 clarify the beliefs that are activated. It is important to understand and agree in the "grain of truth" in the clarification.

Redirect responses to others to other views or possibilities on his or her continuum of truths. 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 client 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 (all or nothing), is extremely validating and it is the basis for a positive redirection to other possibilities for the client.

In David's case, he was able to develop healthier beliefs by his therapist and all staff 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 David's 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 measure his level of trust for others allowed David to open his mind to possibilities, thereby balancing his beliefs about trust. The process also taught David how to balance his beliefs for himself. As a result, he developed a new belief, to trust some people some of the time.

#### Applications to family therapy

Following completion of David's COBB, he was excited to share his discoveries of himself and the family structure with his family. He reviewed each belief and explained the corresponding behaviors. His family remarked about the succinct capturing of David. Additionally, they remarked about how familiar his thinking was. The family recognized that they shared many of the same beliefs and were able to appreciate and understand the beliefs they did not share with David. They too remarked about how overwhelmed David must be feeling with so many conflicting beliefs.

While teaching David how to balance his beliefs with V-C-R, David shared his newly found knowledge with his family. He shared with them that he was using trust scales to measure his trust for people so that he had a concrete measure of how much he trusted someone today versus yesterday. He also shared insight he gained into the criteria he used to trust others, encouraging his family to use the scales as well. They began thinking about trust in measurable terms, identifying that a person demonstrated negative behavior they could decrease their level of trust, rather than immediately dismissing any possibility of trust based on one small indiscretion. This not only increased trust within the family, but also helped the family to see that authority figures were not all seeking to break the family apart. This revelation was truly validating for David, allowing him to communicate more openly in therapy sessions.

Beliefs are referenced and balanced with any issue presented in therapy sessions, whether individual or family therapy sessions. For example if David presented in a session upset about receiving a consequence from staff, he and his therapist would identify his behavior and the corresponding beliefs on his COBB. Once identified, he and his therapist could balance his belief and allow him an opportunity to recognize that he was reacting to the fear of being vulnerable, due to getting caught and given a consequence for negative behavior. This would work similarly in a family therapy session. If David presented in a family therapy session upset about this issue, he, his therapist and his family could collaboratively work, using his COBB to identify and balance his beliefs.

### Summary

Mode deactivation therapy is designed to assess and treat a conglomerate of personality disorders, as well as remediate aggression and other problematic behaviors. It is important to note that mode deactivation therapy is an empirically based and driven treatment methodology.

For example, David had not been receptive to traditional cognitive behavioral therapy techniques. He had exhibited a compendium of problem behaviors, which others labeled as antisocial aggression. David also demonstrated extremely poor boundaries with others and struggled with limits. He had been unable to deal with the concept of cognitive distortions or irrational beliefs. David's beliefs protected him, to change or strip his beliefs away activated his vulnerability. He would then become reactive and engage in dichotomous and defensive thinking, beliefs, and behavior. Therapy would be sabotaged at the very beginning.

Completing David's MDT Case Conceptualization revealed a conglomerate of beliefs, rather than discrete categorized beliefs. Understanding his conglomerate of beliefs allowed a better understanding of David and his behaviors. Reviewing his identified conglomerate of beliefs offered David insight, allowing him to feel hopeful. Recognizing the amount of beliefs and how they activated due to his identified underlying fears, validated how overwhelmed he felt and why he often overreacted.

The theoretical constructs of mode deactivation therapy are based on the mode model. Specifically, suggesting that people learn from unconscious experiential components and cognitive structural processing components. 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 developing personality disorders. This conglomerate is comprised of multiple clustered compound core beliefs. These conglomerates of personality disorders are the most pronounced impediment to treatment, and are systematically treated throughout mode deactivation therapy, beginning with the MDT Case Conceptualization.

Mode deactivation therapy is built on a mastery system. Adolescents move through a specifically designed MDT Workbook at the rate of learning that accommodates their individual learning style. The system is designed to allow the youngster to experience success, prior to undertaking more difficult materials. Through the MDT Case Conceptualization and MDT Workbook, the system allows the youngster to systematically address the underlying conglomerate of personality disorders as well as, the specific didactics necessary, the problem behaviors and/or anger/aggression. Mode deactivation therapy is designed to assess and treat this conglomerate of personality disorders, as well as remediate aberrant behaviors. It is important to note that mode deactivation therapy is an empirically based and driven treatment methodology. Carefully following the MDT Case Conceptualization and methodology ensures empirically based and driven treatment (Apsche & Ward Bailey, 2003, in press).

The MDT Case Conceptualization methodology provides the framework to assess and treat these complicated typologies of adolescents and integrates them into a functionally based treatment. The goal is to deactivate the Trigger → Fear → Avoids → Compound Core Beliefs mode and teach emotional regulation through the balancing of beliefs.

David initially perceived all authority figures as threats since his parents had convinced him that all authority figures had intentions to break the family apart. This obviously had an effect on David's ability to trust his therapist and therapeutic rapport was a primary focus in treatment.

David stopped intimidation and would verbalize his feelings, rather than shut down and withdraw from the situation. He attributed this to understanding his preconscious trigger of perceiving that he was vulnerable. This perceived vulnerability set off the entire mode system. He was able to identify situations that produced the vulnerability and to examine his cue beliefs that were part of the activation process. He began verbalizing when he felt or thought he was uncomfortable. He also knew his physiological responses to the danger signal, vulnerability and they disabled David to work on balancing his belief exercises. David was originally perceived as sexually



aggressive and proactive, which would have suggested that he was aggressive due to a perceived positive outcome from the aggression. Careful analysis of his MDT Case Conceptualization revealed that David is actually reactive, indicating an entirely different purpose for his aggression, and a need for a different focus in treatment.

David had previous unsuccessful treatment and basic cognitive therapy techniques were ineffective. Mode deactivation therapy was found to be much more effective due to its ability to address the personality disorder beliefs without challenging David to engage in dialectical debates. It was essential to incorporate David's family in his therapy since they were so involved in his life and treatment. His family made progress along with him, gaining insight into his beliefs as well as their own.

The theoretical case analysis presented provides the framework for future investigations for alternative treatment methodologies for reactive adolescents with personality disorders/ traits. MDT can be applied to treat existing problem behaviors as well as preventing future problem behaviors by addressing the underlying compound core beliefs, which drive behavior. MDT offers new methodology specifically designed for difficult adolescents, a treatment need as was indicated by Weissberg et al. (2003). MDT has been shown to be effective as compared to manualized CBT in a descriptive study (Apsche & Ward 2002). The authors are planning a randomized study testing MDT in an empirically based study.

### *Mode Deactivation Therapy Case Conceptualization*

#### RELEVANT CHILDHOOD DATA (ABUSE HISTORY)

**Date of Birth:** 7/4/88

**Date of Admission:** 3/27/01

**Physical/Emotional Abuse:**

David's family of origin demonstrates extremely poor boundaries. Family refuses to disclose the name of the boy who victimized David due to the family being close friends with the perpetrator's parents. Although sexual abuse was denied, his mother shared a bed with him downstairs and his father slept in a room upstairs, directly opposite David's older and younger sisters.

**Sexual Abuse:**

While in treatment at a residential sex offender treatment center, David disclosed an incident of sexual abuse. The alleged abuse was perpetrated by the son of a family who is friends with David's family.

**Developmental History** (include age, behavioral, environmental, social, biological):

David is a 13 year old male who at six months, David received bilateral myringotomies; at age 5 or 6 years, David broke his leg; at age 11 broke his wrist. David has been raised by an intact biological family in the local area. David has been labeled as learning disabled with an emotional level of an 8 year old. He reports having an active social life with many friends.

**Substance Abuse History** (include drug of choice, frequency of use, familial substance abuse history, etc.):

None noted

**Current Medication:**

Zoloft 50 mg qhs; Adderall 20 mg qid and 10 mg q 12 noon; DDAVP 0.2 mg tablet qhs

**PROBLEM BEHAVIOR DATA**

David has had four offenses that included the same three victims. He told his victims that they would not get in trouble to get them to participate in the sexual acts. David initiated sexual contact during his first offense which included three victims ranging in age from 5 to 11. After a 5 year old neighborhood girl told David about seeing her brother and brother's girlfriend having sexual contact, David asked his victims to act out the described acts. Initially the group refused, but David encouraged them to participate, telling them that they would not get in trouble. David, 1 other male, and 2 females took turns showing their "privates," performing oral sex, and touching each other with clothes on and off. David's second offense involved the same victims in a pool. David hit 1 female on her buttocks two times. After the first time she laughed, the second time she looked scared, so he stopped. The other female performed oral sex on David under water in the pool. David's third offense involved the same victims behind a shed in the backyard of one of the victims. David and his victims took turns exposing themselves and having dry sex with their clothes on. David's fourth offense included the same victims behind the same shed. David and his victims took turns exposing themselves and touching each other with their clothes on and "privates" exposed. Each took a turn lying on the floor with their privates exposed while the others performed oral sex. One of the females was caught exposing herself in front of her window by her mother and when asked what she was doing, told her mother about the offenses.

**DIAGNOSES**

- Axis I: 1. Major Depression, Recurrent, Unspecified  
 2. Attention Deficit Hyperactivity Disorder, Combined Type  
 3. Sex Abuse of a Child (Offender Issues)  
 4. Functional Enuresis

TRIGGER 1 Conscious Processing	TRIGGER 2 Unconscious Processing	FEAR	AVOIDS	COMPOUND CORE BELIEFS
Trusting others outside of the family  Bedtime routine (i.e., thought change)  Being alone  Treatment, therapy, 1:1 sessions with staff  Expressing feelings/ thoughts	Relationships  Bedtime, being alone  Free time  Boredom/ free time  Conflicts	Trusting anyone outside of the family  Going to bed/ being alone  Being alone with kids that look like my abuser/ Seeing someone the same size and race as my abuser  My feelings  Hurting someone	Relationships  Vulnerability  Being alone without staff/ adults directly next to him (potential for re-victimization)  Boredom (thinking about victimization)  Conflicts	If I am not on guard, others will take advantage of me.  If I act silly and entertain people, they won't notice my inadequacies. When I am in pain, I will do whatever I need to do to feel better.  If I am afraid something will be unpleasant, I will avoid it. Only I count, others are there to fill my needs.  When I am bored, I need to become the center of attention. I try to control and not show my grieving, loss, and sadness, but eventually it comes out in a rush of emotions. When I hurt emotionally, I do whatever it takes to feel better.  Weaker people are here for the strong to prey on, using any means I need.

5. Learning Disorder, NOS

Axis II: 1. Avoidant Features

Axis III: Ceclor and Codeine allergies

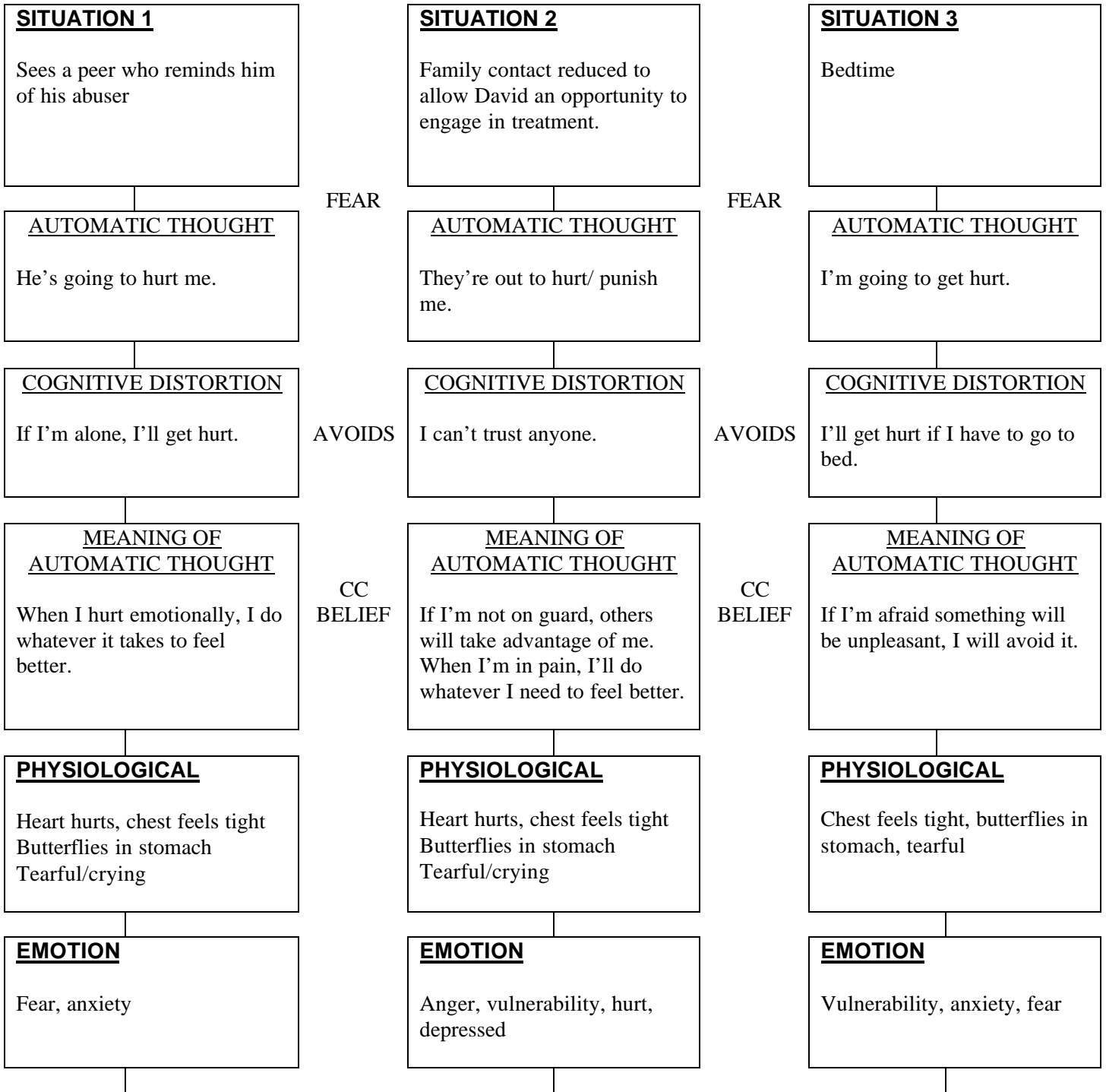
Axis IV: Problems with social environment, educational problems, problems related to interactions with the legal system/ crime.

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

**FEAR, AVOIDANT, - PERSONALITY DISORDER BELIEF CORRELATION (TFAB)**

CONGLOMERATE OF BELIEFS AND BEHAVIORS (COBB)

COMPOUND CORE BELIEF	CORRESPONDING BEHAVIOR(S)
If I let others know information about me, they'll use it against me.	Don't say anything Shut down Act up by throwing stuff
When I'm bored, I need to become the center of attention.	Act up by going in the hallway and being silly
If I act silly and entertain people, they won't notice my weaknesses.	Act silly; Go off task
When I hurt emotionally, I do whatever it takes to feel better.  When I'm in pain, I'll do whatever I need to feel better.	Don't talk; Talk to Mr. Monkey (stuffed animal) Fight, physically; Blame others; Become argumentative
I deserve admiration and respect, whether I work for them or not, others don't deserve recognition.	Provoking others Avoiding eye contact Ignoring others
I try to control and not show my grieving, loss, and sadness, but eventually it comes out in a rush of emotions.	Go off task; Provoke; Blame others
When I'm angry, my emotions are extreme and out of control.	Cursing; Throw stuff; Hit people/ wall; Break things; Put others down
If I'm afraid something will be unpleasant, I will avoid it.	Stay away from other people Seek negative attention from staff Become argumentative
If I'm not on guard, others will take advantage of me.	Stay on task; Hide anger with a smile
Weaker people are here for the strong to prey on, using any means I need.	Provoke; Hit; Prove strength
Only I count, others are there to fill my needs.	Manipulate others; Use others; Act like I want someone's help, while I'm using them; Get attention when I don't need anything
If it makes me feel good, I do what I want.	Interrupt people who are busy; Stay in the hallway at bedtime
If you annoy me, I'll "go off" and let you know it.	Curse; Yell; Argue; Tell you



BEHAVIOR(S)

Act out to get placed on close watch.

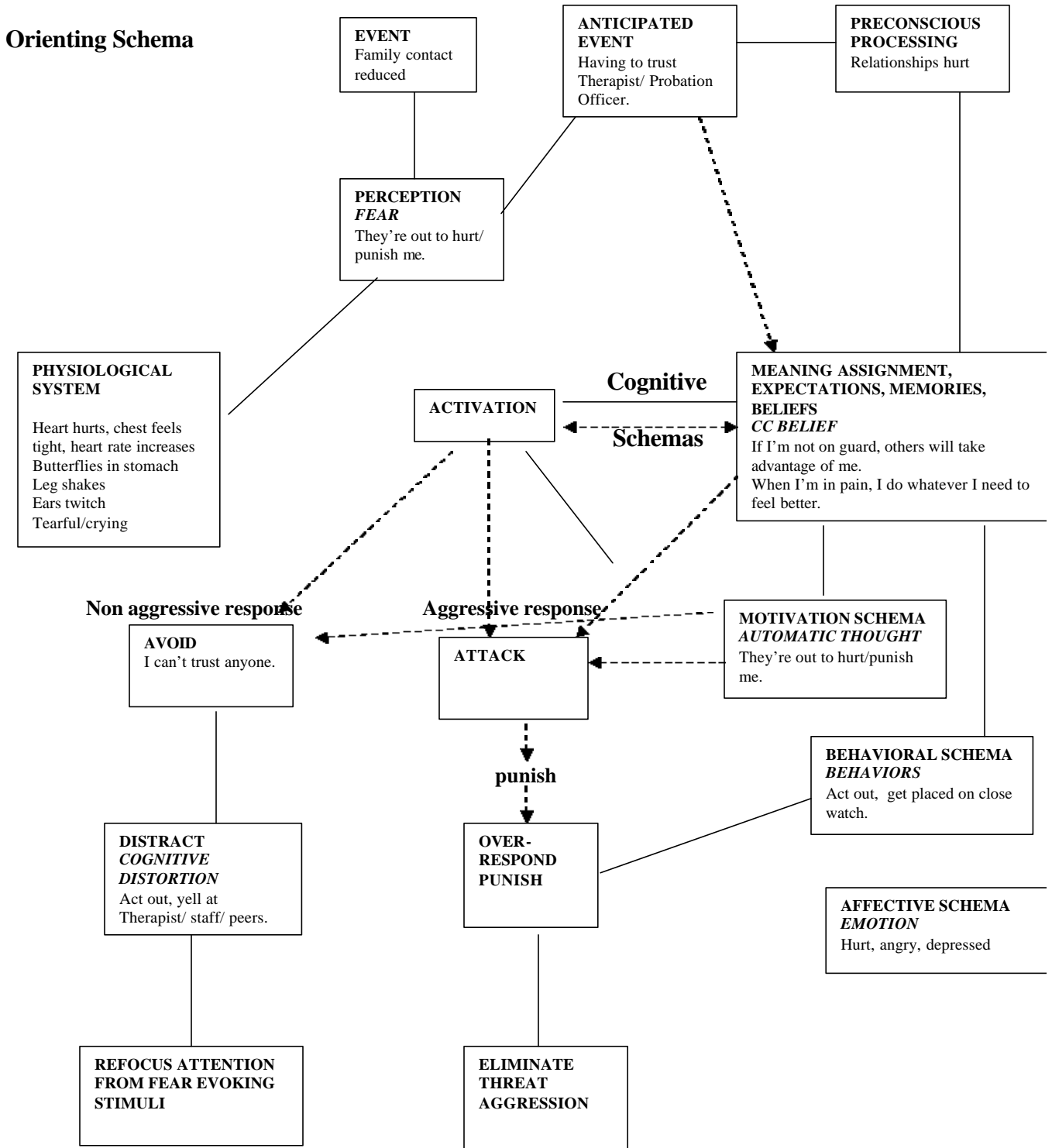
BEHAVIOR(S)

Act out, yell at therapist/  
staff/ peers.

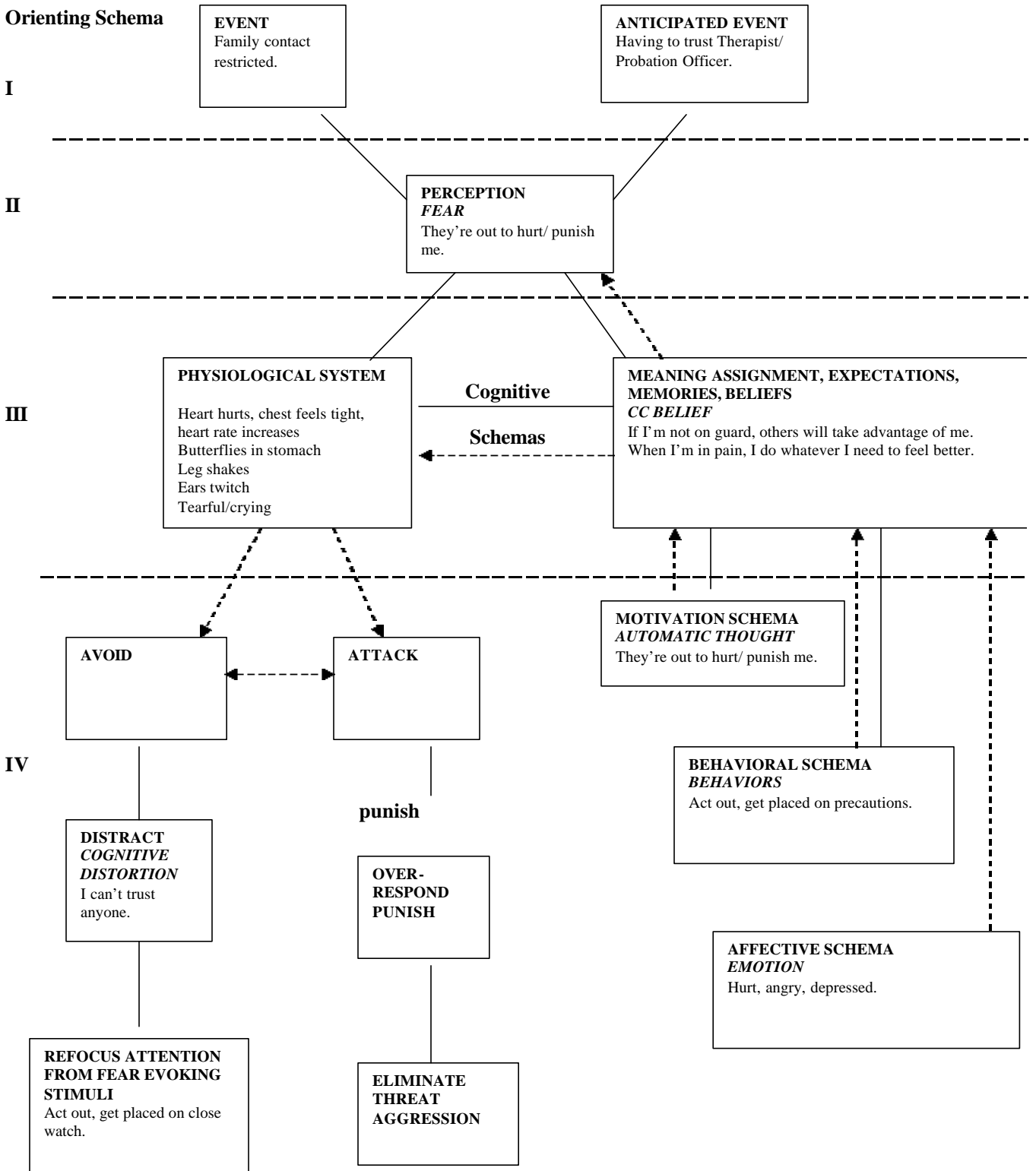
BEHAVIOR(S)

Act silly, become argumentative.

**REACTIVE PERSONALITY DISORDER MODE ACTIVATION  
(ADOLESCENT TYPOLOGY)**



**TREATMENT PARADIGM: PERSONALITY DISORDER  
MODE DE-ACTIVATION (ADOLESCENT – TYPOLOGY)**





**FUNCTIONALLY BASED TREATMENT DEVELOPMENT FORM**

IDENTIFY NEW BELIEF SYSTEM	IDENTIFY HEALTHY ALTERNATIVE THOUGHTS	FUNCTIONAL ALTERNATIVE COMPENSATORY STRATEGY	FUNCTIONAL REINFORCING BEHAVIOR(S)	SPECIFIC FUNCTIONAL TREATMENT THERAPY TO LIFE	VALIDATE/ CLARIFY/ REDIRECT (VCR) Validate the grain of truth in his responses/ clarify content of his responses/ Redirect his responses
<p>I can trust some people some times.</p> <p>I am adequate. I can balance myself.</p> <p>I can deal with unpleasant thoughts/ feelings.</p> <p>Everyone deserves the same respect, whether they are weak or strong.</p>	<p>Some people will not take advantage of me.</p> <p>I can take a risk to feel and/or be vulnerable.</p> <p>I can balance my feelings.</p> <p>I can deal with conflict.</p>	<p>I can trust others a little at a time.</p> <p>If I can accept others' faults, they can accept mine.</p> <p>Practice rational thought and balance.</p> <p>Identify physiological cues, rank. Identify beliefs and anticipated events.</p>	<p>Work on scales of trust with therapist to develop alliance.</p> <p>Work on balance of belief scales.</p> <p>Identify my balance thoughts.</p> <p>Practice through imagined exposure to all physiological and cognitive triggers.</p>	<p>Identify and build trust with one staff.</p> <p>Take a risk, deal with one issue at a time, with others.</p> <p>Identify issues that bring unpleasant thoughts/ feelings and practice balance.</p> <p>Identify when physiological triggers, identify when beliefs engage. Practice mode de-activation with others in vivo.</p>	<p>It's okay to not trust some people at times, identify one person he does trust some of the time and use scale of trust to measure trust daily</p> <p>It's okay to make mistakes, help him identify areas of adequacy and use belief scales to balance</p> <p>It's okay to feel overwhelmed by emotions, identify thoughts/ beliefs to balance emotions</p> <p>Conflict is okay, identify physiological system and beliefs to slow down, prevent, or reduce escalation Use belief scales to balance beliefs.</p>

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Author Information:

Jack A. Apsche, Ed.D., ABPP  
Liberty Healthcare, Bala Cynwyd, PA

Serene R. Ward Bailey, M.A., Private Practice