

## MODE DEACTIVATION THERAPY: A THEORETICAL CASE ANALYSIS (PART I)

Apsche, J.A. &amp; Ward Bailey, S.

This is the first part of a case study presenting a single case analysis of an 18 year-old African -American male. It also presents a theoretical analysis of the case implementing Mode Deactivation Therapy (MDT) (Apsche, Ward, & Evile, 2002). MDT is a form of CBT that combines the balance of DBT 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 MDT while reviewing this case presents an opportunity to understand the development of mdt, while reviewing it's effectiveness with this case. The individual in this case, John, was a troubled youngster. He had been the recipient of severe and pervasive physical abuse by his mother and father. He and his sister were neglected and abandoned as children at the age of 5 years old. John developed a complex system of personality disorder beliefs to cope with his world. These beliefs had led John to commit numerous violent acts as a sexual offense. This theoretical case study represents the beginning of mode deactivation therapy from theory to clinical practice. He was treatment savvy and was able to define basic cognitive therapy techniques but would engage in dialectical debates about distortions and would negatively engage his therapist who suggested that he distorted information.

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**INTRODUCTION**

The development of Mode Deactivation Therapy (MDT) as an applied CBT methodology has been a challenge. The difficulty begins in the attempt to treat adolescents with complicated history and multi-axial diagnoses. Many of the adolescents that we treat are victims of sexual, physical, and/ or emotional abuse. These individuals have developed survival coping strategies. Many of these survival mechanisms translate into personality traits and/or disorders. These personality traits and/or disorders are not cluster bound. Meaning that they are translated into beliefs and schemas that are inclusive of beliefs from all three clusters. Often it has been thought that individuals stay true to their cluster, this is not so, with the adolescent typology that we treat.

The concepts of mode deactivation therapy (MDT) are derived from many aspects of functional analytic behavioral therapy (FAP), dialectical behavior therapy (DBT), and cognitive behavior therapy (CBT). The focus of MDT is largely based on Beck's recent area of research and application, the system of modes (Beck, 1996, Alford and Beck, 1997).

Functional analytic psychotherapy (FAP) (Kohlenberg & Tsai, 1993) theory states people act based on reinforcement contingencies. Although FAP takes into consideration that cognitions are involved, the focus is on the deeper unconscious motivations that were formed as a result of past contingencies. 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.

By restructuring beliefs, MDT addresses underlying perceptions that may be applicable to setting in motion the mode related charge of aberrant schemes, that enable the behavior integration of DBT principles, (Linehan, 1993) of treating of sex offending or aggressive behaviors. 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.

Often CBT as viewed by "arguing" the concepts of cognitive distortions fails with these youngsters. They do not respond to being in a one-down position, no matter how aligned they are

with their therapist. Cognitive therapy as normally practiced will 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.

The early development of MDT was conceived from the need to apply the principles of CBT with complex adolescent aberrant typologies. These individuals have long histories of sexual, physical, and/or emotional abuse. Often they respond in ways that are translated into personality disorders and/or conduct disorders. These are youngsters that may respond by committing sexual offenses, aggressive acts, and/or other aberrant behaviors. Often these youngsters are viewed as “criminals” and are the underclass within our society and active within the criminal justice system. The term typology refers to this specific complex adolescent with these types of histories. CBT attempts to identify dysfunctional schemas and modify them. It is believed that aberrant behavior is related to dysfunctional schemas. MDT is a methodology that addresses dysfunctional schemas through systematically assessing and restructuring underlying dysfunctional compound core beliefs. MDT is applicable to adolescents who engage in aggressive and/or delinquent behaviors, as well as sexual offenders.

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 Beck’s notion of modes as integrated suborganizations of personality. 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.

Mode Deactivation Therapy 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 of the emotional dysregulation. The emotional dysregulation is the basis for the underlying typologies of these youngsters. Many of their underlying behaviors include aggression (physical and verbal) as well as addictive and self-harm.

Mode Deactivation Therapy is designed to assess and treat this conglomerate of personality disorders, as well as remediate aggression and sexual offending. 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, 2002, unpublished).

The theoretical underpinnings of Mode Deactivation Therapy are based on Beck’s (1996) 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 Case Conceptualization.

Mode Deactivation Therapy is built on the mastery system for youngsters. They 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 Case Conceptualization and workbook, the system allows the youngster to systematically address the underlying conglomerate of personality disorders as well as, the specific didactics necessary, the sexual offending and/or anger/aggression.

#### Mode Deactivation Therapy: Functionally Based Treatment

Beck (1996) describes the notion modes as a network of cognitive, affective, motivational, and behavioral components. He further described modes as consisting of integrated sections or suborganizations of personality, that are designed to deal with specific demands. 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. Beck also explains that the concept of charges (or cathexes) being related to the fluctuations in the intensity gradients of cognitive structures.

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 the mood, thought, and behavior.

Alford and 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.

Further study of cognitive therapy emphasizes the characteristic patterns of a person’s development, differentiation, and adaptation to social and biological environments (Alford & 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. Genetically and environmentally determined processes control these consistent coordinated acts 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.

Modes are important to understanding these typed 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 Beck (1997). Abused children develop systems to adapt to their hostile environment. These systems are often manifested by personality traits/ disorders (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 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 the typology of youngsters that we treat.

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 form perspectives. As 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 result in destruction.

### Mode Activation

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. Beck described modes as a network of cognitive, affective, motivational and behavioral components. He suggests that modes are consisting of integrated sectors of sub-organizations of personality that are designed to deal with specific demands to problems. They are the sub-organization that helps individuals adopt to solve problems such as, the adaptation of adolescents to strategies of protection and mistrust when they have been abused.

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

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 their own responses.

According to Dodge, Lochman, Harnish, Bates, and Petti (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 emotionally reactive or dysregulates. Forty percent of reactive adolescents have multiple personality disorder 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. John was originally perceived as proactive, until a careful analysis of his case conceptualization was considered. This reactive type of conduct disorder youth responds to their environment similarly to individuals with Borderline Personality Disorder. They are reactivities 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).

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. The 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 Fear→ Avoids→ Compound Core Beliefs mode and teach emotional regulations through the balancing or beliefs.

Apsche, Ward, & Evile (2002) have suggested that the systematic approach of MDT has had some positive results in reducing aberrant behaviors and beliefs of adolescents. Apsche & Ward (2002) have also reported positive descriptive results of MDT as compared to cognitive therapy in a descriptive, empirical but not comparison study. They found that MDT reduced personality disorder/trait beliefs significantly and fought the individual to self-monitor and balance their personality disorder beliefs.

This case analysis represents theory integrated into practice of a youngster who was in numerous (7) correctional and treatment facilities previous to this treatment. He has been removed from all facilities for aggression and he attacked staff and residents alike.

This case analysis is a step-by-step case study, with a corresponding theoretical analysis based in MDT. The methodology known as MDT suggests potential for effective treatment of youngsters with similar backgrounds as John. It is hoped that MDT will be studied in rigorous empirically based studies.

### Case Analysis

Consider a case of a youngster (please see the example of the mode activation from his Case Conceptualization following this case analysis). John is an adolescent who is reactive and has a conglomerate of personality disorders. He endorsed multiple Borderline Personality Disorder beliefs in various belief assessments. John was severely physically abused and perceives threats in many situations. He feels threatened by authority figures and perceives danger in many situations therefore reacts to prevent re-victimization.

If John perceives that he could be in a situation where he may be confronted or reprimanded, his anxiety would increase. For example, he can be involved in normal activities with a friend or peer, but if he notices the time getting closer to a group or meeting with

“authority figures” he feels his anxiety increasing. Even if he was not increasingly thinking about the meeting, group, etc., some kind of preconscious processing of the anticipated event is occurring and producing anxiety. The discernment that he will be involved in a situation that he perceives as confrontational has already set in motion the cognitive, affective, behavioral, and physiological processes.

Although John may not be consciously thinking about confrontation (and may be focused on the discussion or activity with a friend), 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 “slight” or correction and he would be able to discuss that he has a dichotomous belief in operation, such as “whenever I am angry my emotions are extreme and out of control.” 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 (feared group or meeting) 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 John 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 John, using 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, John 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 John 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 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.

John 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 deescalate.

Please note that John’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 and loss of control in the presence of other people.

### **Client Summary**

#### **Brief Treatment History Prior to Current Placement**

This is the first admission to this facility and second residential placement for this sixteen year old boy who sexually sodomized at least one younger male friend of the family and attempted to recruit two younger cousins to perform fellatio upon him. He was treated at a residential facility from May 1998 to May 1999, but was discharged because of chronic behavioral problems, including verbal and physical aggression and extreme oppositional and defiant behavior, in spite of numerous attempts to intervene. Since then, John was placed at a youth detention center until his current placement.

While at his previous residential placement, John was started on Prozac. He perceives no change in his mood on that medication. The discharge summary from his placement indicates that he was frequently non-compliant with treatment. At the youth detention center, he was also placed on Wellbutrin SR 150 mg, which he took every morning in combination with the Prozac. There was no bedtime dose of Wellbutrin given, according to John and available records. John reports that he perceives no effect from the Wellbutrin either. He chose to discontinue the medication.

John has a longstanding history of sleep disturbance with mid-state wakening as well as some diurnal mood variation. He reports that he frequently has excessive energy and periodic hypsomnia, but not excessively. Rather, it is difficult for him to assess this because he was frequently awakened while in the youth detention center. He does, however, report recurrent dreams in which he is killed either by drowning or by being shot. He associates the dreams to early physical trauma by his mother and father.

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John's behavioral problems were first noted in early childhood. He has historically been an extremely aggressive child who, from age four or five, was noted to be emotionally disturbed and a serious behavioral problem. Throughout his school career, he has repeatedly been suspended because of his poor anger control. He was in several foster homes and his father, on prior occasions, refused to continue to care for him and his siblings because of the resident's behavior.

John has no prior history of alcohol or other substance abuse, and does not smoke cigarettes.

#### **Family History**

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John's mother was a physically abusive woman who ultimately was incarcerated for child abuse. His family was reported to social services as early as when John was three years old. A year later, John reportedly grabbed a teacher's leg and attempted to fondle her genitalia, stating his mother did it to him. At that time, investigation determined an unknown perpetrator exploited John (at three and a half). A year later, after kicking his principal, he told his social worker that he was beaten with an electric cord and baseball bat. He and his sister were reported to be forced by his mother to sit in bleach because she perceived they were "too dark skinned." Five years after that, John and his siblings (sister and two brothers) were taken to live with their father when the mother was arrested. Subsequently, John and his sister and brothers were given over to their maternal aunt, where they lived with the aunt and her boyfriend, and her own children, a total of two adults and eight children, in a two bedroom apartment.

In January 1993, a Child Protective Services therapist insisted that John's aunt could not satisfactorily care for John and his father refused to take him back. At this time, he was placed in foster care because of his behavioral and emotional problems.

Subsequently, John went to live with his father and younger sister, Sadie, and his two brothers. In 1996, his father's longstanding girlfriend left the family because she could not tolerate John's behavior. The family moved because of financial constraints and ultimately John went back to live with his aunt.

In November 1997, John was accused of sexually assaulting three children in his aunt's home, as noted above. He pleaded guilty to one count of first-degree sexual assault and continued to deny the others, with the exception of the attempted grooming, as noted above. He was subsequently placed at a local locked residential program until his unsuccessful discharge because of his chronic behavioral problems.

There is no known or reported family history of substance abuse, serious psychiatric disturbance, or associated hospitalizations. However, John witnessed considerable physical abuse in his home, including on one occasion seeing his mother cut his father with a knife. It is known that she physically abused him with a two-by-four and extension cords, baseball bats, and belts.

Results from the Fear Assessment suggest that John 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. His mean score of 2.51 in external related fears suggest that the focus of his Post Traumatic Stress Disorder may be his fears of external stimuli activity upon him. This appears to validate his history of perverse and severe physical abuse.

Another score that suggests concern and requires treatment is his core of 2.25 on the Environmental Sub-score of the Fear Assessment. This score suggests that the resident has anxieties and fears of certain environmental stimuli, such as closed rooms, being locked in rooms, etc. This score is also congruent of an individual who has the resident's history of neglect and abuse.

John's initial score on the Beliefs of Aggression was 78, which suggests an individual who engages in aggression frequently to resolve problems. His score on the Beliefs about Victims suggests that he understands the impact of aggression and sexual offending on others. It also suggests that he may have the capacity for empathy for his victims.

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The Beliefs of Personality Disorders suggests that John has a Personality Disorder NOS – mixed features of Borderline, Dependent, Avoidant, Antisocial, and Histrionic.

John endorsed numerous beliefs of the Borderline Personality. Many of these beliefs appear to have gone untreated by the previous therapists. Previously, it was suggested that John used his aggression as an intimidation. Examining his beliefs indicates that it may be that his aggression is related to the emotional dysregulation and his dichotomous borderline beliefs.

#### Compound Core Beliefs

John endorsed the following compound core beliefs as occurring always:

- Everyone betrays my trust
- If I trust someone today, they will betray me later
- Whenever I hope, I will become disappointed
- When I am angry, my emotions are extreme and out of control
- When I hurt emotionally, I do whatever it takes to feel better
- Life at times feels like an endless series of disappointment followed by pain
- I try to control and not show my feelings of grieving, loss, and sadness, but eventually, it comes out in a rush of emotions
- In relationships, if the other person is not with me, they are against me

#### Diagnosis

- Axis I: Posttraumatic Stress Disorder  
Sexual Abuse of a Child (victim and offender issues)  
Physical Abuse of a Child (victim issues)  
Mood Disorder, NOS  
Obsessive Compulsive Disorder
- Axis II: Personality Disorder (NOS) Mixed Features of Borderline, Antisocial, Dependent, and Avoidant
- Axis III: Exercise Induced Asthma
- Axis IV: History of child abuse and child abandoned by mother age 5, legal and educational issues.
- Axis V: Current GAF: 35 Admission GAF: 43

#### Recommendations:

1. Cognitive Psychotherapy to address his underlying schema related to the borderline beliefs that he endorses (see Case Conceptualization).

2. Address the specific aggression that relates to his emotional dysregulation (see Case Conceptualization).
3. Continue Cognitive Group therapy, including conclusion of sexual offending specific therapy.
4. Address independent living skills to prepare resident for community placement.

#### John's Case Conceptualization

Underlying the MDT methodology is the Problem Solving Case Conceptualization. Problem solving case conceptualization is a combination of Judith Beck (1995) case conceptualization and Nezu, Nezu, Friedman, Haynes (1998) problem-solving model, with several new assessments and methodologies recently developed to address the specific issues of adolescents. The goal is to provide a blueprint to treatment within the case conceptualization.

The Case Conceptualization helps the clinician examine underlying fears of the resident. 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 posttraumatic stress disorder (PTSD) issues. The 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 our typology of youngsters have a conglomerate of personality disorder compound core beliefs. This conglomerate of beliefs, is the crux of why youngsters fail in treatment. One cannot treat specific disorders, such as sex offending and 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 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 abuse issues, which may present as treatment interfering behaviors. 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.

#### References

- Alford, B.A., & Beck, A.T. (1997). *The integrative power of cognitive therapy*. New York, NY: Guilford Press.
- Apsche, J.A. (1999). *Thought Change Workbook*. Portsmouth, VA: Alternative Behavioral Services.
- Apsche, J.A. & Ward, S. R. (2002). *Mode deactivation therapy (MDT): Case conceptualization*, unpublished.

Apsche, J.A. & Ward Bailey, S. R. (2003). Mode deactivation therapy (MDT): *A theoretical case analysis (part II)*, *Behavior Analyst Today*, in press.

Apsche, J.A. & Ward Bailey, S. R. (2003). Mode deactivation therapy (MDT): *A theoretical case analysis (part III)*, *Behavior Analyst Today*, in press.

Apsche, J.A., Ward, S. R., & Evile, M.M. (2002). Mode deactivation therapy (MDT): A functionally based treatment. *Behavior Analyst Today*, in press.

Beck, A.T. (1996). Beyond Belief: A Theory of Modes, Personality, and Psychopathology. In P.M. Salkovaskis (Ed.), *Frontiers of Cognitive Therapy (pp. 1-25)*. New York, NY: Guilford Press.

Beck, A.T., Freeman, A., & Associates. (1990). *Cognitive therapy of personality disorders*. New York: Guilford Press.

Beck, A.T., Wright, F.D., Newman, C.F., & Liese, B.S. (1993). *Cognitive therapy of substance abuse*. New York: Guilford Press.

Dodge, K.A., Lochman, J.E., Harnish, J.D., Bates, J.E., and Petti, G.S. (1997). *Reactive and proactive aggression in school children and psychiatrically impaired chronically assaultive youth*. *Journal of Abnormal Psychology*, 106 (1), 37-51.

Johnson, J.G., Cohen, P., Brown, J., Smailes, E.M., & Bernstein, D.P. (1999). *Childhood maltreatment increases the risk for personality disorders during early adulthood*. *Archives of General Psychiatry*, 56, 600-608.

Koenigsberg, H.W., Harvey, P.D., Mitropoulou, V., Antonia, N.S., Goodman, M., Silverman, J., Serby, M., Schopick, F., & Siever, L. (2001). *Are the interpersonal and identity disturbances in the borderline personality disorder criteria linked to the traits of affective instability and impulsivity?* *Journal of Personality*, 15 (4), 358-370.

Kohlenberg, R.J. & Tsai, M. (1993). *Functional Analytic Psychotherapy: A Behavioral Approach to Intensive Treatment*. In W. O'Donohue & L. Krasner (Ed.), *Theories of Behavior Therapy: Exploring Behavior Change (pp. 638-640)*. Washington, DC: American Psychological Association.

Linehan, M.M. (1993). *Treating borderline personality disorder: The dialectical approach*. New York: Guilford Press.

Nezu, A.M., Nezu, C.M., Friedman, S.H., & Haynes, S.N. (1998). Case Formulation in Behavior Therapy: Problem-Solving and Functional Analytic Strategies. In T.D. Eells (Ed.), *Handbook of Psychotherapy Case Formulation* (pp.368-401). *New York, NY: The Guilford Press.*

Woody, S., & Rachman, S. (1994). Generalized anxiety disorder (GAD) as an unsuccessful search for safety. *Clinical Psychology Review, 14*, 743-753.

**Jack A. Apsche, Ed.D., ABPP.**

**Contact: Regent University**

**1000 Regent University Drive**

**Virginia Beach, VA 23456.**

**e-mail: [Jackmdt@aol.com](mailto:Jackmdt@aol.com)**

**Serene R. Ward Bailey, M.A.,**

**The Pines Residential Treatment Center**