

## Family mode deactivation therapy (FMDT) as a contextual treatment

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### Abstract

Mode Deactivation Therapy (MDT) was developed as a third wave therapy approach to cater for the challenging population of adolescents with conduct and oppositional behavior problems, emotion dysregulation, physical and sexual aggression, and other complex comorbid psychopathologies. The theoretical construct of MDT is based on the Beck's Mode Model and the principles of Cognitive Behavioral Therapy with elements of Functional Analytic Psychotherapy (FAP), Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), and mindfulness. The methodology is based on the fundamental proposition that core beliefs based on an individual interpretation of past experiences regulate thoughts, emotions, and feelings when activated by a trigger event. This may lead to aberrant behaviors when cognitive processes are distorted. MDT has proven very successful in practice to balance the dichotomous thinking of the client by exploring positive alternatives on a continuum and realigning perceptions. Family MDT (FMDT) is especially valuable in a family therapy context as the family unit's experiences and interactions inarguably have an integral influence on the youth's beliefs and behavior. MDT is a structured and sequential process, although sufficiently flexibility to utilize continuous feedback loops to optimize the case conceptualization and treatment plan. Evidence is provided to support the claim that MDT is superior to Treatment as Usual (TAU) in treating the target population in an outpatient and residential setting with their families.

### Keywords

Mode Deactivation Therapy, MDT, mindfulness, ACT, DBT, CBT, adolescent, schema, family therapy, FMDT

Adolescent behavioral and conduct problems are widely associated with family-based issues such as marital problems, parental absence, domestic violence, substance abuse, child neglect and maltreatment, including physical and sexual abuse. Besides externalized problems such as aggression, violence, and criminal behavior, distress is also often internalized by the youth, causing anxiety, depression, substance abuse, social withdrawal, and suicide ideation. Furthermore, early onset of psychopathological symptoms is inarguably correlated with maturing persistent mental health problems in adulthood including depression, addiction, posttraumatic stress disorder (PTSD), personality disorders, as well as escalating criminality (Scott, Smith, & Ellis, 2010; Spataro, Mullen, Burgess, Wells, & Moss, 2004).

Earlier—pre-third wave—therapeutic approaches were either past- and disease-oriented (first wave therapies such as psychoanalysis and psychodynamic work), or exclusively present- and problem-oriented (second wave therapies such as behavioral, cognitive, and gestalt approaches). More recently there has been a move away from a focus on pathology and illness—problems instead of solution—and the clinician's role became more collaborative and expertly. In the late 1950s and early 1960s, Albert Ellis and Aaron Beck started to realize that traditional psychoanalytic therapies lacked a focus on conscious thought and belief processes, which they deemed central in guiding emotional experience and behavior. From there behavioral techniques were incorporated in the cognitive therapy methodology and became known as Cognitive Behavioral Therapy (CBT), the underlying basis of third wave derivative approaches.

In the early 2000s Dr. Jack Apsche recognized shortcomings in cognitive behavioral approaches, especially pertaining to persistent and complex psychopathology presentations among adolescent populations. The main areas of concern were the

focus on problems and dysfunction of the client seen as caused by faulty thinking, strong present orientation, and negation of unconscious thought processes and triggers. As a result Mode Deactivation Therapy (MDT) was developed by using CBT as a point of origin and incorporating elements and concepts from various other approaches and techniques, such as Functional Analytic Psychotherapy (FAP), Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), and mindfulness. MDT, as a “young” and developing therapy, has already demonstrated remarkable successes among troubled adolescent populations in individual and family settings, while much more potential scope exists to harness the methodology further—as I believe this work will clearly show.

### ■ Core concepts of family mode deactivation therapy (FMDT)

Mode Deactivation Therapy in family settings, or FMDT, utilizes several key concepts obtained from theorists and other therapeutic approaches that were adapted and incorporated into a treatment methodology to address the target population of adolescents with behavioral and conduct problems, which are often associated with comorbid child-onset mental health conditions and trauma-related distress. The three core concepts of experiential avoidance, defusion, and mindfulness are discussed below.

#### Experiential avoidance

Greco and Hayes (2008) viewed experiential avoidance as the opposite of acceptance, while it is also associated with behaviors that are inconsistent with personal values and goals (Bond, Hayes, Baer, Carpenter, Guenole, Orcutt, Waltz, & Zettle, 2011), persistent distress symptoms, and treatment interference (Hayes, Orsillo, & Roemer, 2010). O'Brien, Larson, and Murrell (2008) defined experiential

avoidance as the situation that occurs when an individual is either unwilling or too fearful to remain in contact with painful emotions, situations, thoughts, or memories. Hayes, Wilson, Gifford, Follette, and Strosahl (1996) explained this process as a lack of acceptance of private events—an individual's thoughts and perceptions of happenings—as they occur in an uncontrolled and an unregulated manner. A lack of acceptance precedes emotional dysregulation, which is the inability to respond appropriately in a socially acceptable and flexible way to the demand of experience (Cole, Michel, & O'Donnell Teti, 1994). A frequent failure to regulate emotions are typically associated with childhood traumatic experiences such as child abuse and maltreatment and results in a rise in psychosocial and behavioral dysfunctions (Bandura, Caprara, Barbaranelli, Gerbino, & Pastorelli, 2003). Experiential avoidance, a related coping mechanism, acts as a generalized psychological vulnerability by increasing PTSD and other symptoms and dysfunctional behavior in children as they attempt to avoid painful thoughts, emotions, memories, and physiology (Shenk, Putnam, & Noll, 2012; Kashdan, Barrios, Forsyth, & Steger, 2006).

A deeper understanding and appreciation of the effects of emotional regulation and experiential avoidance in children had a profound effect on the development of new treatment methodologies. Given the growing evidence of the importance of emotion regulation to counter experiential avoidance in positive interaction with the self and others, third wave therapy approaches were developed with the endeavor to facilitate a dynamic flexibility in emotional insight and experience, and the ability to pursue goals by selectively activating emotions and cognitions (Diamond & Aspinwall, 2003). Cognitive behavioral therapies (CBT) form the basis of these modern approaches, which include CBT derivatives such as Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), and Functional Analytic Psychotherapy (FAP). Third generation CBT therapists recognized that it is not only the content of thoughts that are important, but also underlying processes and context. Hayes (2004) explained:

*Grounded in an empirical, principle-focused approach, the third wave of behavioral and cognitive therapy is particularly sensitive to the context and functions of psychological phenomena, not just their form, and thus tends to emphasize contextual and experiential change strategies in addition to more direct and didactic ones. These treatments tend to seek the construction of broad, flexible and effective repertoires over an eliminative approach to narrowly defined problems, and to emphasize the relevance of the issues they examine for clinicians as well as clients. The third wave reformulates and synthesizes previous generations of behavioral and cognitive therapy and carries them forward into questions, issues, and domains previously addressed primarily by other traditions, in hopes of improving both understanding and outcomes. (p. 658).*

The most pressing issue was that cognitive therapies did not sufficiently appreciate the complexity of schemas and how they relate psychological responses to core beliefs formulated by past experiences. Mode

Deactivation Therapy (MDT) was developed from theory to practice to overcome the shortcomings that could be related to the top-down approach of cognitive therapies. MDT approaches adolescent behavioral problems from the view that the client experiences fear when an external demand is in conflict with a core belief. Therefore, MDT conceptualizes avoidance from a fear-avoids paradigm in which the adolescent avoids what he or she fears. Apsche & DiMeo (2012) explain experiential avoidance as a result of the adolescent responding to his or her fear(s). The fears and core beliefs of the client are identified and correlated in the context of his past experiences. These are organized in a beliefs-triggers-fears-avoids-behavior conglomerate, which are validated and explored with the client to produce positive alternatives.

### Defusion

Acceptance and Commitment Therapy (ACT) refers to defusion as a weakening of the literal, evaluative function of language; that is, separating the “words” from the emotions. According to the Relational Frame Theory, the social community establishes a context in which thoughts are equated to a literal meaning that results in focused emotional and behavioral regulations (Luoma & Hayes, in press).

Instead, MDT looks at defusion as two separate events: emotional defusion and cognitive defusion (Apsche & DiMeo, 2012). The approach targets emotions associated with avoidance-based cognitions through emotional defusion; the process that evolves from a sense where the emotional pain and feeling is located in the body. Cognitive defusion helps the adolescent de-escalate (defuse) the effect of his or her emotionally laden thoughts. This is based on the hypothesis that the power of the adolescent's avoidance is based both in language and in emotion (fear). Therefore, defusing the power of language cognitions and emotions is part of the MDT methodology and by extension the Family Mode Deactivation Therapy (FMDT) methodology also. The process of defusion allows the adolescent as well as his family members the opportunity to experience the thoughts and feelings that have created avoidance so that the youth can accept them as a valid part of himself or herself.

### Mindfulness

The practice of mindfulness permeates ACT treatment, from clinicians to clients. The concept of mindfulness originated from several key Early Buddhist psychological notions, including basic drives that motivate behavior, perception and cognition, consciousness, personal development and enlightenment, meditation, and behavior change. In the context of therapy, mindfulness is the focusing of attention and awareness on purpose in the present moment and in a nonjudgmental way in which each thought, feeling, or sensation that arises is acknowledged and accepted as a valid experience (Baer, 2003; Bishop et al., 2004). In their book, titled “Acceptance and Mindfulness Treatments for Children and Adolescents: A Practitioner's Guide”, Greco and Hayes (2008) highlighted the efficacy of using mindfulness in treating adolescents. The authors claimed that individuals who voluntarily begin a mindfulness

practice often have a “beginner's mind”—that is, they are open and ready to learn (receptive), enthusiastic, and not cynical. Furthermore, compared to adults, children are thought to have an advantage as they have had less opportunity to develop persistently resistant and interfering behaviors and related psychopathologies (Greco, Blackledge, Coyne, & Ehrenreich, 2005).

Unfortunately, adolescents who engage in MDT treatment are oftentimes oppositional and cynical. Nonetheless, MDT is grounded in a mindfulness-based methodology with a strong and open therapeutic alliance based on validation to manage resistance; mindfulness is to be fully present in the moment, without judgment. It is also highly recommended that the clinician has a personal mindfulness practice in order to be successful when treating youth with MDT. High-mindfulness clinicians tend to have a greater patient-centered pattern of communication, engage in more rapport building and mutual discussion, and display more emotional tone with patients (Beach et al., 2013). Woods (2013) agrees, stating that mindfulness training and practice will increase the practitioner's effectiveness in managing individual and group processes, “encourage and support interpersonal skills such as warmth, acceptance, compassion, and respect alongside appropriate professional and personal boundaries” (p. 470).

These are all vital skills in dealing persuasively with defiant and otherwise treatment resistant adolescents. In their mindfulness toolkit, Apsche and Jennings (2013) suggested a variety of mindful and meditation practices for adolescents and their families as an adjunct to treatment, to be crucial for individual and family participants. Practice has shown that mindfulness concepts practiced by the clinician openly and honestly according to the toolkit's guidelines will positively transfer to even the angriest adolescent or distant family because they become a collective of focus in the moment, not the past or the future.

### ■ FMDT treatment methodology

FMDT, as a contextual therapeutic methodology, is structured in a manner that provides an effective framework for adolescent and family treatment. Although it is a therapeutic framework, FMDT, much like MDT treatment, is never linear or “cookbook” in nature as will become more evident when other components of MDT presented throughout these guidelines are incorporated. There is a well-defined similarity in the use of mindfulness, acceptance, and defusion between ACT, MDT, and FMDT as well. Where ACT uses acceptance and mindfulness alongside commitment and behavior change strategies to help clients learn how to manage and diminish the effect of thoughts, feelings, memories and physical sensations that caused them fear or distress, MDT takes the cognitive defusion presented in ACT and adds emotional defusion to complete the process (Apsche, 2010; Apsche & DiMeo, 2012). MDT also continues to explore the use of mindfulness, breathing, and imagery as time in treatment progresses. It uses these mindfulness practices to develop trust and a collaborative alliance between clinician and

the family unit, which is imperative and arguably the most important factor in achieving treatment effectiveness and success.

The FMDT treatment approach is logically arranged in structured and sequential steps to improve the therapeutic alliance, treatment target selection and plan. The steps are, in order:

1. Informed Consent
2. Mindfulness
3. FMDT Assessments (Family Typology Survey, Family Behavior Scale, Fear Assessment, Compound Core Beliefs Questionnaire, Family Conglomerate of Beliefs and Behaviors, Family Fears, Triggers, Avoids, and Beliefs)
4. Case Conceptualization
5. Validation, Clarification, and Redirection

The individual steps of the FMDT process are now described in more detail.

### Informed consent

The process of informed consent is a vital component in modern mental health practices and is mandated by the professional and ethical guidelines of most psychological associations such as the American Psychological Association (APA). Although legally and professionally required, the informed consent process can be very valuable in establishing a professional relationship with the client and his family or guardian and an early start of a strong therapeutic alliance built on trust and openness. Before commencing with further steps, discuss the process, objectives, limitations, and privacy issues with the client and his family. Ask questions and ensure that all participants have a good understanding of expectations. Obtain written consent from the adolescent, parent or guardian, and other family members who will be participating.

### Mindfulness

The real practice of mindfulness by the FMDT clinician becomes a great bridge to building an effective, collaborative relationship with the adolescent and the family. One easy way to begin is by engaging the family in simple breathing exercises. The family is then joined in each breathing and mindfulness exercise by the clinician. These are simple exercises designed to build upon each other (Apsche & Jennings, 2013) to create an intense awareness of the present moment and encouraging acceptance of the self and others without judgment.

The following descriptions will aim to recreate—and guide the reader in—the experience of family mindfulness and awareness. The first exercise is intended for both the clinician and the entire family. It is suggested that the clinician practice it individually prior to implementing it with the family as a way to increase his or her understanding of and comfort with mindfulness to ensure that it is more effective for the family in practice. This basic exercise helps the individual and collective family member become more aware of their thoughts, feelings, and even physical sensations, acknowledge, and to let go of them as they don't define who you are. Developing self-awareness is the first step in becoming more

aware and empathetic to others' feelings and emotions. It is important not to fight any thought, feeling, or sensation, not to judge it as "good" or "bad", but just let it pass without lingering. The following exercise consists of three parts: awareness, description, and redirection. Let all participants sit in a comfortable position to begin.

- 1. Awareness.** Ask the family to observe and notice their surroundings. Ask them to pay attention to each of their surroundings, different body sensations, what they are thinking and feeling. Are they worrying about tension in the family, anger, sadness or the dysfunction of the family in general? Just ask them to notice what they feel as their body or notice about what they are feeling, their breath or breathing patterns.
- 2. Describe.** Put your observations into words and say how each of them feels. Ask them to start by asking them what they see: describe the "scene" that you are seeing in each of their minds. What or whom are each of them thinking about? Does this "scene" make them feel positive or negative, anxious or excited? If you don't want to say it out loud, write it down quietly!
- 3. Redirect yourself.** Slowly ask each family member to redirect their attention to your breath. Follow your breath—see your breath as a circle...in...and...out...  
Breathe in...count and visualize one...  
Expand yourself...  
Repeat five times...  
Then slowly ask them to...  
Expand their attention to their whole body...  
Try to sense any discomfort, tension, or resistance...  
Just ask them to feel whatever they feel...breathe in...breathe out...in...out...  
Allow them to feel whatever they feel without restraint or judgment...  
Ask them to each become aware of their feelings...  
Stay with it with the family as a group until everyone is still then...  
You have experienced a piece of mindfulness and awareness.

After completing this exercise and re-alerting yourself, notice your feelings and emotions. Do you feel more relaxed, calmer, and more alert? Sometimes, taking a moment to yourself, like in the previous exercise, can renew your energy and enthusiasm for life. Developing balance in your own life can assist you when working therapeutically with angry, aggressive, and oppositional adolescents.

#### **FMDT assessment process: sequence, scoring and Interpretation**

To reiterate: FMDT does not apply a "cookbook" formula as every client and his family is unique. Therefore it follows that treatment is individually developed for each family through the Family MDT assessments, of which all are either hand scored or scored by computer at The Apsche Institute. Because the scoring and interpretation complexity increases with more participants, the computerized scoring method is preferred for family assessments, as well as for ease of information sharing in the

group. The computerized scoring is color-coded and it gives the family members the opportunity to view their scores individually and as a group by using the color-coded distinctions. As such it is possible for each family member to view exactly how and where they differ on all assessment domains, as well as how each member differs from the family mean scores as a group or individually on all FMDT assessments.

- 1. Family Typology Survey:** A full diagnostic, behavior, medical, and health history.
- 2. Family Behavior Scale:** A review of the youth's and family's behavior.
- 3. The Family Fear Assessment:** An assessment of 60 items that identifies basic difficulties, anxieties, or fears of the family. Each family member participates in completing the assessment, the scores are totaled, and a mean score is determined for each item.
- 4. The Family Compound Core Belief Questionnaire:** An inventory of 209 (standard version) or 96 questions (short version) related to the family's belief systems. The Family Compound Core Belief Questionnaire (CCBQ) is scored in the same manner as the Family Fear Assessment.
- 5. The Functionally Based Treatment Development Form:** This form addresses the collective family beliefs and supplies the family a specific methodology to develop and maintain more functional family beliefs. It consists of the Family Conglomerate of Beliefs and Behaviors form, and the Family Triggers, Fears, Avoids, and Behaviors diagram.

**Family typology survey.** As highlighted in a previous paragraph, the case conceptualization process follows from the analysis of the FMDT assessment battery. The MDT treatment process is implemented according to the framework of a comprehensive case conceptualization that is obtained through the assessments, of which a structured diagnostic interview called the Family Typology Survey is the first step. This survey allows the clinician to develop an understanding of the client's behavioral and family history, and incorporates a detailed inventory of traumatic events. The Family Typology Survey is conducted with the child, guardian, and referral source, with each individual providing a response to every question. The survey consists of sections that explore family relationships, substance abuse, medical, and educational history, emotional, physiological, interpersonal, and social responses and habits, sexual offending, physical and sexual abuse, neglect, trauma, and expectations of the treatment—especially pertaining to the client, but also those of family members that may ultimately have an effect on the client's behavior. Responses from each participant is compared to corroborate, elaborate, and complete missing information.

**Family behavior scale.** Further individual assessments are determined by responses to the Typology Survey and the acuity of the adolescent's behavior problems. MDT uses a continuum to measure reactive to proactive responses on a successive scale of 1 to 10. The family behavior scale is not a set question set,

but rather emanates from issues that are highlighted by the Family Typology Survey. As an example: for a family where substance abuse issues are evident from their survey, sample questions may be the following:

*On a scale from 1 to 10, how much does your family believe substances are a problem for each of you?*

1	2	3	4	5	6	7	8	9	10
NONE									MUCH

How much does your family believe that substance abuse was involved in all of your problem behaviors?

1	2	3	4	5	6	7	8	9	10
NONE									MUCH

The family behavior scale offers a quick interpretation of the family's behavior patterns, indicating if they are impulsive or planned, and what each participant's perception is of the extent of the problem and the influence on behavioral and other problems. This offers valuable information for the clinician prior to the administration of the Family Fear Assessment and Family Compound Core Belief Questionnaire (CCBQ).

**Family fear assessment scale.** The Fear Assessment is the basic instrument that addresses the individual family member's problems with anxiety, fear, and PTSD. There are five different assessments to choose from based upon the perceived openness of the adolescent and the family. If it is clear that there is no amenability to treatment and there is evidence of multiple antisocial beliefs, the 'Others' series of assessments are appropriate. For more anxious and traumatic stressed families, the Fear-R assessment, The Fear-Pro, Fear-Difficulty, and Pro-R instruments are designed to engage the particular adolescent and family in the process of assessment. Each version of the Fear Assessment has 60 questions that are rated on a 4-point Likert scale, ranging from 1 (never) to 4 (always).

When administering the Fear Assessment, a couple of pointers are worth noting, which are useful to improve the assessment value. The purpose and types of questions should be explained to the question taker, and his/her understanding of terms such as "trust" and "retaliation" should be ascertained. Similarly, take care not to read the questions verbatim, rush through the assessment, or lead the individual's response. The clinician should be patient and provide narrated scenarios where appropriate. The Fear Assessment is scored by identifying the fears endorsed as occurring always or almost always (Apsche, Ward, & Evile, 2003). The hierarchy of target treatment behavior is then determined by prioritizing the fears as proposed by Miller, Rathus, and Linehan (1995), namely "(1) reducing life-threatening behaviors, (2) reducing therapy-interfering behaviors, (3) reducing quality-of-life interfering behaviors, and (4) increasing behavioral skills." (p. 124).

Following the Fear Assessment process, the therapist completes the Family Compound Core Beliefs Questionnaire (FCCBQ), which will further assist in identifying priorities for treatment.

**Family compound core beliefs questionnaire.** The short version of the Family Compound Core Beliefs Questionnaire (FCCBQ-SV) is a 96-item assessment of the adolescent's beliefs as they relate to personality traits, and is based on the work of Beck, Freeman, and Davis (2006). The Fear Assessment and FCCBQ are scored and used in the development of a thorough Case Conceptualization that also includes a functional behavioral analysis, which is updated throughout the treatment program. This approach is based on the Functional Analytic Psychotherapy (FAP) methodology (Kohlenberg & Tsai, 1993). FAP focuses on the in-session observation of clinically relevant behavior (CRB) through client-therapist interaction. However, the MDT behavioral analysis is more comprehensive as it considers and explores the entire beliefs → fears → avoids framework as triggered by a preceding event instead of focusing only on observable behavior.

**Family conglomerate of beliefs and behaviors.** The Family Conglomerate of Beliefs and Behaviors (FCOBB) forms the framework of the family treatment plan and it helps identify each family member's role in the treatment process. Each individual in the family, as well as the family collectively complete the Family Conglomerate of Beliefs and Behaviors (FCOBB). The FCOBB examines each individual's belief(s) as well as the corresponding behavior(s). In order to determine the priorities of treatment and enable progress, it is important to consider that beliefs affect emotions and feelings, which lead to behaviors that are often destructive to the individual and family unit. Beliefs are often activated by preceding events and unbalance family members' emotions. Therefore it is useful to explore each member's beliefs, feelings, emotions, thoughts, and resulting behavior processes to understand the dynamics and anticipate potential triggers. An example of an FCOBB table is included above (Table 1).

From the example above, it becomes apparent that the beliefs of this family, individually and collectively, are reinforced by the feelings and behaviors, which seem to form a chain reaction of increasingly persistent and potentially escalating negative outcomes for the group and individual members. Therefore, once the family's beliefs and behaviors are determined separately they are compared to each individual's beliefs and behavior, through which the effect on the whole is examined. Family progress is further assessed through the use of behavior report sheets that measure verbal and physical aggression, arguments, and "non-attending behavior". Home non-attending behaviors are defined as any behaviors by the parent or adolescent that can prohibit verbal engagement, resulting in non-compliance, walking away, or not responding to requests. To reiterate: The beliefs of the family, including individual and family beliefs, are reinforced by the feelings and behaviors of the individuals and the family collectively. A family can be so emotionally fragile that one negative belief, feeling, or behavior can cause a downward spiral for the individuals and the family as a group. Family MDT incorporates a family workbook (Apsche & Apsche, 2009) that are designed to structure the family therapy following the MDT methodology process.

**Table 1.** Family conglomerate of beliefs and behaviors (FCOBB)

FCOBB	Adolescent	Mother	Brother
Beliefs	Life at times feels like an endless series of disappointments followed by pain.	Whenever am shunned, I feel like a failure and I get angry.	Whenever there is confrontation, I want to forget everything.
Feelings, emotions, thoughts	Pain and worthlessness.	Hurt, failure, and rejection.	Small and alone, vulnerable.
Behavior	Isolation, withdraws from contact with family.	Screams that he is not appreciative and ruins the family and his life.	I drink at home or with friends.

The exercises help to reintegrate the troubled youth with the family and creates a collaborative effect for all family members.

**Family triggers, fears, avoids, and beliefs (FTFAB) analysis.** Following the FCOBB analysis, a table is completed by the adolescent and family members together with the clinician by associating the beliefs and corresponding behaviors with the fears that underlie the resulting coping or compensatory behavior, and the preceding events, or triggers that activate these fears. The Family Triggers, Fears, Avoids, and Beliefs (FTFAB) analysis is part of the treatment process to learn to anticipate triggers and realign thoughts to consider alternative positive beliefs and behavioral responses. Two main types of triggers are considered, namely Trigger 1 (T1)—things commonly known within the family unit to cause anxiety or fear and associated with conscious processing—and Trigger 2 (T2)—things the individual don't know, but others identify, that makes the group anxious or scared and associated with unconscious processing (Apsche & Apsche, 2009). T2s are often the most potent avoidance activators. An example of an FTFAB analysis is included in Table 2 below.

The FTFAB analysis is particularly useful to establish continuums of expectations instead of absolutes where an individual is easily disappointed and loses hope, whereby resultant behavior prompts negative reactions from family members, which often exacerbates the situation.

**Case conceptualization**

The assessments described above culminates in the Family Triggers, Fears, Avoids, and Behaviors (FTFAB) diagram, which provides a prioritization of problematic modes to be targeted for deactivation and realignment. Together with all other supporting information, it forms the basis of the case conceptualization from which the adolescent's treatment plan is developed with consideration of the roles and influences of participating family members.

The problem solving case conceptualization underlies the MDT methodology. Problem solving case conceptualization is a combination of the Beck (2011) case conceptualization model, and the problem-solving model of Nezu, Nezu, Friedman,

and Haynes (2007). These models were refined by developing and adding several new assessments and methodologies to address the specific issues of the target adolescent population. The goal of the case conceptualization process is to provide a blueprint to treatment by addressing the specific typology and continuously updating feedback obtained from the treatment as it progresses. The underlying fears that originate from the belief system of the client are identified and examined, which serve the function of placing them in the context of core beliefs with links to relevant modes and schemas. Associated triggers are noted and the client assisted to anticipate them in order to develop avoidance behaviors (Apsche & Ward Bailey, 2003). The client's fears commonly serve the purpose of developing avoidance behaviors, which are often problematic in their daily environment. Based on the case conceptualization process, the client is confronted with his reality by a problem orientation process whereby beliefs and assumptions are explored with the objective to understand and respond to how those relate to behavior (Nezu et al., 2007). A rational problem solving process is then applied through a set of specific cognitive and behavioral operations that help to realign the client's belief-schema-thought-behavior links and avail positive alternatives.

The majority of adolescents with aberrant behaviors—the target treatment population of MDT—experienced significant physical, emotional, or sexual abuse and neglect, which is often the cause of a "conglomerate of personality disorder compound beliefs" (Apsche, Ward, & Evile, 2002, p. 47). These core beliefs tend to be highly integrative as they serve the function of protecting the client from their environment. Their complexity and persistence are reasons why treatment often fail for this typology of client. Therefore, a systematic but flexible methodology is required to assess and manage compound beliefs. Realizing the need for an effective treatment approach for adolescents with dysfunctional behaviors, MDT was developed to provide a functional solution to this challenge, which is driven and individualized by the case conceptualization process based on an empirically supported assessment approach.

**Table 2.** Family triggers, fears, avoids, and beliefs (FTFAB) analysis

Trigger 1 (T1)	Trigger 2 (T2)	Fears	Avoids (behavior)	Beliefs
Experiencing disappointment.	Not meeting expectations.	Fear of failure, inadequacy, and worthlessness.	Family members isolate themselves which cause aggression from others.	When there is a disappointment or confrontation, I am not good enough and will never be.

As aggressive or destructive behaviors of clients typically correlate with their core beliefs through emotional dysregulation, all which need to be realigned and balanced with positive alternate reactions, the central feature of case conceptualization is building the Conglomerate of Beliefs. The structure of the Conglomerate of Beliefs relates behaviors with beliefs, which enables the therapist to balance beliefs and replace activation of emotional and behavioral dysregulation with positive alternatives. There are two main subtypes of adolescents with aggressive conduct issues, namely Proactive and Reactive, each of which activates in a different way and therefore requires an individual treatment approach (Dodge, Lochman, Hamish, Bates, & Petti, 1997). The proactive subtype is opportunistic and achieves benefits and rewards from premeditated aggression, while the reactive subtype activates aggression through a core belief system and emotional dysregulation.

It is therefore important to understand the association of social-cognitive and emotion-regulation processes to aggressive behavior in order to treat client effectively (Sukhodolsky & Ruchkin, 2004). In their study Fite, Wimsatt, Elkins, and Grasseti (2011) found that negative life events were linked with both reactive and proactive aggression, but much more strongly associated with reactive aggression, while best friend delinquency was positively associated with proactive aggression. An earlier study by Fite, Raine, Stouthamer-Loeber, Loeber, and Pardini (2009) came to the same conclusions and also associated the proactive subtype with psychopathic features and antisocial behavior. Proactive aggression predicts later externalizing problems much better than reactive aggression. However, Vitaro, Brendgen, and Barker (2006) found some indications that, developmentally, reactive aggression may precede proactive aggression. Furthermore, reactive aggression is protective, linked to high levels of anxiety, and Oppositional Defiance Disorder (ODD) symptoms, while proactive aggression is closer associated with Conduct Disorder (CD) behaviors (Vitaro, Gendreau, Tremblay, & Oligny, 1998). In fact, where proactively aggressive children are more at risk for concurrent and later delinquent behaviors, substance abuse, and conduct disorders, reactively aggressive children are more at risk for depression and suicidality, but also for violence in close dyadic contexts such as dating and romantic relationships (Brendgen, Vitaro, Tremblay, & Lavoie, 2001).

These findings have important implications for the case conceptualization and application of MDT within the adolescent population with dysfunctional behavior problems. According to Vitaro, Brendgen, and Barker (2006):

*“...interventions aimed at highly reactively aggressive children should focus on anger management and social cognitive reconstruction, especially with respect to cue selection and attributional biases...[ ]... On the other hand, proactively aggressive children may benefit from exposure to non-aggressive peers and to reinforcement contingencies that support non-aggressive behaviors. These children might also benefit from social cognitive restructuring about the negative consequences of their aggressive acts for themselves. (p. 17).*

The MDT case conceptualization methodology provides the framework to assess and plan treatment for these subtypes of aggression among adolescents by identifying and exploring the beliefs-fears-behaviors dynamics. According to Apsche, Ward, and Evile (2003), the goal is to deactivate the Fear → Avoidance → Compound Core Beliefs mode and encourage emotional regulations by anticipating triggers and considering positive alternate beliefs. The fruit of the case conceptualization process is the Conglomerate of Beliefs and Behaviors (COBB) cluster, which incorporates compound core beliefs and the corresponding behaviors. The COBB is developed collaboratively between the therapist and client, thereby validating the client's behavioral responses in congruence with his core beliefs. The COBB product forms the basis for all subsequent work in the MDT manual. As such, the case conceptualization is “a systematic carefully designed sequential methodology intended to provide functionally based treatment to complex emotional, thought, and behavioral disorders.” (p. 49).

### Validation, clarification, and redirection

MDT, in both individual and family work, offers the therapist and client the ability to objectively structure, measure, and track the therapeutic progress together in a treatment manual. It incorporates treatment strategies and elements from behavioral, cognitive, dialectical, and other supportive psychotherapeutic approaches. It is administered systematically via a method that is clearly delineated. Therapy is comprised of weekly individual and family therapy sessions, provided for an average of 8 to 12 months, depending upon the level of cooperation and amenability to treatment by the individual and family (Apsche, Bass, Zeiter, & Houston, 2009). The process of validation, clarification, and redirection is the crux of FMDT to strengthen the therapeutic alliance and ensure treatment progress.

**VCR method.** MDT teaches families how to balance beliefs in their family with the Validation, Clarification, and Redirection (VCR) method (Apsche & DiMeo, 2012). While there may be some identification of opposing beliefs by the family members, this method attempts to expose the irrational and illogical belief(s) deeply held by families in crisis. The individual components of the VCR method include:

- 1. Validation.** Each family member's thoughts and beliefs are identified and explored initially through the assessment process described above, and then validated. Therapists search for the “grain of truth” in each family member's responses. It is important to assure each member that his or her responses are accurate as far as he or she interprets perceptions born from past experiences. Each member is given appropriate therapist reinforcement to indicate that he or she is understood and believed.
- 2. Clarification.** The therapist clarifies the content of responses. Therapists also clarify the beliefs that are activated in response or anticipation of trigger events. It is important that the clinician, client, and family members understand and agree with the content of the clarification. The clarification step is crucial in understanding the long held thinking schemas—it reveals the family member's perspective of reality and beliefs.

- 3. Redirection.** To reiterate: Redirection is the crux of the MDT process to affect lasting positive change. The therapist redirects responses to help the family members consider other possibilities on the continuum of held beliefs. The goal of redirection is to help find the exception in the belief system. It involves examining the opposite side of the dichotomous or dialectical thinking. It is crucial to partner with the member to see the “grain of truth” in each of the dichotomous situations presented. The redirection is an attempt to aid the youth and family member(s) to see both sides of the dichotomous belief(s) and understand that neither is absolutely correct or false. It is also important to look for the kernel of truth in each belief and offer a compromise in understanding the truth in both beliefs. The use of a continuum of belief is implemented to examine the individual's belief of truth in both of the dichotomous beliefs and situations. The client is guided to discover positive alternative beliefs and apply a continuum method to move from the original (dysfunctional) belief towards the new possibility. Therefore, “through questioning the evidence, the therapist could try to shift the client's self-evaluation to a mid-point in this continuum to reduce absolutistic thinking” (Padesky, 1994, p. 270). Wenzel (2013) explains further:

*For example, a patient with a core belief of “I'm a failure” might write the word “Failure” under the anchor for 0% and the word “Successful” under the anchor for 100%. The patient is asked to provide an initial rating of where on the continuum he or she falls, as well as the point on the continuum in which the negative core belief begins (e.g., failure begins at 20%). As the exercise progresses, the patient considers the full spectrum of people who would lie on the continuum and lists some of these people as anchors (e.g., people who would be considered at 10%, 20%, et cetera, through 80% and 90%). Concurrently, the patient continually revises where he or she stands on the basis of these anchors. (pp. 28-29).*

The effectiveness of the VCR process depends strongly on the identification and assessment of the client's fears and core beliefs, which are correlated to form a beliefs → fears → avoids paradigm and the trigger(s) associated therewith. This is the basis of the case conceptualization, a continuous monitoring, planning, and readjustment process to track the client's progress with regards to the realignment of his beliefs to foster positive behavior.

According to Apsche and DiMeo (2012), the validation, clarification, and redirection (VCR) process is unique to mode deactivation therapy (MDT) and family mode deactivation therapy (FMDT). FMDT integrates mindfulness, acceptance, and defusion with validation, clarification, and redirection (VCR) of the functional alternative belief (FAB), or balanced beliefs. A functional alternative belief becomes a balanced belief the moment it is accepted by the adolescent to some degree, on a scale of 1 to 10. The purpose of the validation, clarification, and redirection process of the functional alternative belief is to reinforce and realign the adolescent's experience both emotionally

and cognitively. That is, it allows the youth to experience positive validation for his or her balanced belief. This is achieved by providing the adolescent feedback that his world views are reasonable in the context of his past experiences, but that they may have been skewed in attempting to cope in response (Bass & Apsche, 2013). However, the same experiences might also support more positive and realistic alternative world views and beliefs that may cause less distress and dysfunctional behavior.

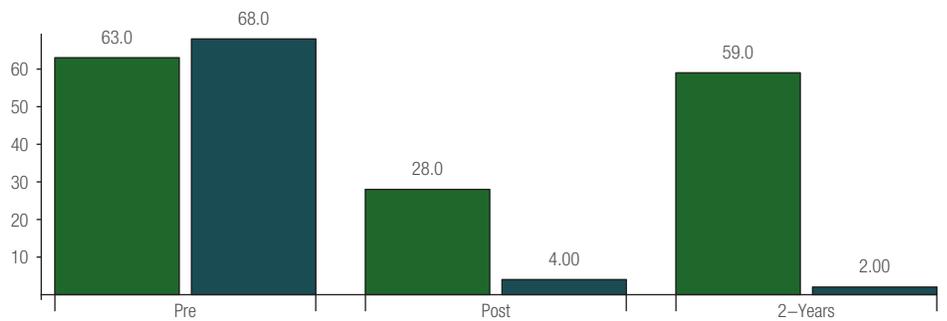
**Continuum technique and balanced beliefs.** The continuum technique is applied during the redirection phase of the VCR process. Core beliefs influence an individual's self-concept and world view and plays a crucial role in their development of emotional response and behavior. When core belief constructs are "faulty", dysfunctional behavioral responses are a way to cope with those wrong perceptions in order to alleviate distress. Instead of viewing the core beliefs in absolutes, such as "I am always failing" versus "I always have to be successful", the client (and his family) is guided to explore alternatives along a continuum. According to James and Barton (2004), the continuum technique is effective to achieve a lasting change in cognitive processes in order to realign belief systems and improve responding feelings and behavior. The balancing of beliefs alongside a continuum is the crux of the FMDT methodology. As explained previously, this feat is achieved through the validation, clarification, and redirection (VCR) process after identification of the major beliefs → fears → behaviors targets. The associated triggers are applied to anticipate and preempt potential problems by consciously selecting alternative beliefs on the continuum. Using the same previous example, the individual is prompted to consider that he may sometimes succeed, maybe 20% of the time, or 40%, but he is not always failing and it is certainly not expected of him to always be successful. By diluting the expectation to a more realistic level, the outcome is no longer only dichotomous, which should relieve the feelings of distress and constant failure. The secondary effect is that the family behavior and dynamics will also change in a positive way as the chain of negative events and responses are disrupted.

#### ■ Other pertinent issues and considerations in FMDT

In all therapeutic endeavors it is important for the clinician to be candid and attentive with regards to the limitations and risk aspects of any given approach at any time. Whether it is an innate trait of a participant, unexpected changes in environment or situation, or transference issues, if the necessary steps are not taken to anticipate or prepare for challenges, a treatment effort can easily be derailed. One such as example in family therapy is experiencing resistance or non-compliance from the adolescent client and/or his family member(s).

#### The resistant adolescent and family

Adolescents, especially oppositional adolescents, often do not want to attend therapy, and the same might be true for their families. Although other third parties, such as a criminal justice or juvenile justice



**Figure 1.** Pre- and post-physical aggression: MDT versus TAU  
Source: Apsche, Bass, Zeiter, & Houston, 2009, p. 336.

system agency, may have mandated treatment, the adolescent and/or family typically thinks that they are fine and that any intervention is not required. Furthermore, familial problems such as parental psychopathology or poor maternal parenting are likely to be the catalyst of a child's externalizing behaviors (Frick, Lahey, Loeber, Stouthamer-Loeber, Christ, & Hanson, 1992). These problems often include any or a multiple of maltreatment, physical and sexual abuse, family violence, substance abuse, divorce, and mental health issues. As a result, the therapeutic task in a family structure can be more complex and challenging. However, for a clinician practicing FMDT or MDT, the treatment process might prove less difficult as the approach is validating and nonjudgmental rather than focused on problems. In this case, MDT treatment is started with mindfulness as a first step. You need not discuss "issues" or problems; instead you work with the youth and family to be present in the moment. This requires the FMDT clinician to be there, joined with the client and family in awareness. Experience has shown that if the clinician does not practice mindfulness, the experience of the adolescent and his family will greatly diminish and lose effectiveness. FMDT mindfulness requires honest effort and, again, being real, and in the moment.

FMDT also involves the completion of a series of specific assessments in order to provide a basis and framework for the development of the case conceptualization. The concepts of validation and collaboration are intrinsically embedded throughout the assessment and case conceptualization process, which greatly strengthens the therapeutic alliance. The FMDT assessments are effective with a variety of adolescents presenting behaviors ranging from cooperative to oppositional and negative. Although the treatment may be mandated, in reality little prevents an adolescent from refusing to cooperate in the therapeutic environment. However, experience with the MDT approach has demonstrated that it rarely happens when implementing MDT treatment and even less so later on in the process. Interestingly, even the most defiant and oppositional adolescents appear responsive to the specific MDT assessments designated for him or her. This may be in part because the mindfulness and collaborative case conceptualization process systematically address resistance and opposition by validating and shaping responses with the clinician as guide rather than instructor. In addition, mindfulness exercises as a

validating experience in the present moment serve to create a feeling of self-efficacy and control over the process, improve cohesion between the adolescent, his family, and the clinician, and reduce resistance and non-compliance.

#### ■ FMDT outcomes

Family Mode Deactivation Therapy (FMDT) has been shown to be an effective treatment for a variety of adolescent disorders (Apsche, Bass, & Siv, 2006a), including emotional dysregulation (Apsche & Ward Bailey, 2003) behavioral dysregulation (Apsche, Bass, & Murphy, 2004), physical aggression (Apsche, Bass, & Houston, 2008), sexual aggression (Apsche, Bass, Jennings, Murphy, Hunter, & Siv, 2005), and many harmful symptoms of anxiety and traumatic stress (Apsche & Bass, 2006). Furthermore, MDT family therapy has been effective in reducing family disharmony in case studies (Apsche & Ward Bailey, 2004), and has been shown to be more efficacious as compared to treatment as usual (TAU) in treating families with a variety of problem behaviors (Apsche & Bass, 2006), as well as in reducing and maintaining treatment effects through two years of tracking recidivism rates (Apsche, Bass, & Houston, 2008; Apsche, Bass, Zeiter, & Houston, 2009; Murphy & Siv, 2011; Thoder & Cautilli, 2011; Apsche, Bass, Backland, 2012; Bass & Apsche 2013).

Results of a Family MDT clinical study of 14 adolescents presenting sexual and physical aggression, as well as oppositional behaviors including verbal aggression, indicated that MDT out-performed TAU (Apsche, Bass, & Siv, 2006b). At 18 months of observation, the MDT group had zero incidents of sexual recidivism, while the TAU group had 10 reported incidents. The MDT group reported three incidents of physical aggression while the TAU group reported 12 incidents. The results were promising for MDT as a family therapy, but the authors indicated that further studies with a larger group should be pursued to improve statistical significance (Apsche, Bass, & Siv, 2006b).

A study of outpatient Family MDT (Apsche, Bass, & Houston, 2008) was also completed comparing an MDT group and a separate TAU group. This study examined physically aggressive youth with conduct problems and characteristics of personality disorders. A total of 15 families participated; eight in the MDT group, and seven in the TAU group. MDT surpassed TAU at the 20-week interval of treatment.

The most compelling point of data was that the MDT group had no referrals for out-of-home placement, while the TAU group had seven. The results showed potential efficacy for Family MDT with this population, although the small number of participants was also a limitation of this study (Apsche, Bass, & Houston, 2008).

Apsche, Bass, Zeiter, and Houston (2009) completed a separate treatment study of 40 adolescents and their families; divided into a 20-member TAU control group and a 20-member MDT experimental group. The results of this study enhance the overall treatment data for MDT. MDT outperformed TAU in every area, including anger and aggression as measured by the STAXI-II. The Anger Control-Out component of the STAXI-II—client's ability to the expression of anger toward others or the environment—declined by 40% in the MDT group compared to 4% in the TAU group. The Anger Control-In component of the STAXI-II—client's ability to control inward directed anger—declined by 35% in the MDT group compared to 10% in the TAU group. The internalizing and externalizing disorders of the adolescents as assessed by the Child Behavior Checklist (CBCL) were reduced significantly by Family MDT as well. The study concluded that Family MDT is an effective treatment for families with adolescents with behavioral and conduct issues. In addition, FMDT performed well by reducing the recidivism measure of physical aggression over the course of two year follow up period to two incidents for all participants in the FMDT group as compared to the TAU group with 59 incidents reported (see Figure 1).

What may even be more significant is the fact that although TAU achieved a 44% decline in incidents of physical aggression during the treatment period, the number returned to almost pre-treatment levels after two years. Although larger studies are required to confirm this phenomenon, it may indicate that the FMDT approach enables the adolescent and his family to continue to practice the MDT concepts after treatment, which will sustain the benefits received well after the program is completed.

### ■ Conclusions and recommendations for further study and practice

Several studies have found that a lack of cohesion and harmony of the family unit is correlated with juvenile behavioral dysfunction, conduct problems and delinquency (Cottle, Lee, & Heilbrun, 2001; Demuth & Brown, 2004; Juby & Farrington, 2001; McCord, 1991). This breakdown in relationships and responsibilities is also likely to be directly associated with parental absence, marital problems, domestic violence, substance abuse, mental health disorders, child physical and sexual abuse, and neglect. Children who are subjected to these circumstances are also significantly more likely to develop child and adolescent onset disorders, which typically persist and develop further into adulthood. According to Kierkus and Baer (2002), the strength of parental attachments even overshadow structural and other problems, which implies that any early intervention has to address interpersonal relationships in the family as well as the particular presenting problems of the adolescent. According to Huey, Henggeler,

Brondino, and Pickrel (2000), positive changes in family interpersonal relationships tend to reduce delinquent peer affiliation and delinquent behavior in general.

Family Mode Deactivation Therapy (FMDT) has proven to be an effective integrated approach in decreasing aberrant behavior of the adolescent by addressing his and his family's dysfunctional and unsuitable core beliefs. Positive alternative beliefs are explored on a continuum, which, when activation of a negative belief is anticipated, enable the adolescent to consciously select appropriate behavior. Despite the range of evidence presented here to support the efficacy of FMDT for an adolescent population with persistent and severe conduct and behavioral problems, the depth of evidence-based research and practice can still be considered as novel and limited. In terms of empirical support, the key term "Cognitive Behavioral Therapy" lists 137,000 research links on Google Scholar compared to the 130 for "Mode Deactivation Therapy". Therefore, MDT in the various settings, including FMDT, requires a larger pool of independent research to establish the content, construct, and predictive validity, internal consistency, and inter-rater reliability of the MDT treatment outcomes and methodology. Nevertheless, the positive results achieved to this time with an arguably challenging population show great promise in continuing to test and improve MDT practices, including psychopathologies and settings yet partially or unexplored such as families affected by the trauma of armed conflict and incarcerated juveniles.

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