

A brief review and update of mode deactivation therapy

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Abstract

Mode Deactivation Therapy (MDT) is the most recent type of therapy among the new third wave therapies for the treatment of aggression, aggressive sexual disorders, conduct disorders, and oppositional conduct disorders among juvenile adolescent males. The goal of MDT is to alter specific behaviors that fall outside socially acceptable norms. The purpose of this article is to examine the effectiveness of third wave treatments across various adolescent populations. Multiple research studies have validated the overall reduction in recidivism and other criminal offenses as a result of receiving Mode Deactivation Therapy. Through the use of Mindfulness, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Functional Analytic Psychotherapy, Mode Deactivation Therapy has proven to be an effective treatment for multiple disorders in the adolescent male population.

Keywords

Mode deactivation therapy (MDT), third wave treatments, mindfulness, cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), functional analytic psychotherapy

Adolescence is a difficult period for any individual. Hormones, peer relations and emotional development rarely mix smoothly. According to domestic violence statistics over 10 million children are witness or victims of abuse (Linehan, 1993) as cited by the website domesticviolencestatistics.org (2014). These individuals find adolescence explosive and volatile. As men, the boys are twice as likely to become the abuser. Anxiety, Posttraumatic Stress Disorder (PTSD), physical aggression and inappropriate sexual behavior would become the behavioral expression of their misaligned emotional states (Bass & Apsche, 2013). These adolescents enter the system with a diagnosis of Conduct Disorder or Oppositional Disorder (Hollman, 2010). Rarely has a youth entered the juvenile justice system or therapy voluntarily; it is usually court ordered. For many therapists the goal is to simply manage their anger and re-direct the behavior; the first of these treatments is behavioral based.

In 1996, Aaron Beck developed the concept of Modes or core beliefs that impacted psychological functioning (Hollman, 2010). Beck posited that people learned from unconscious experiential components and cognitive structural processing components. Unconsciously a belief would be held internally and could activate anger and aggression, especially during interpersonal situations. In a study of over 500 males diagnosed with Conduct Disorder or Oppositional Conduct Disorder, 90% had personal history of sexual, physical and emotional abuse. This victimization altered their "real world" response to interpersonal situations (Hollman, 2010). A touch can be interpreted as an attack sparking inappropriate responses. Deviant and sexual behaviors are dysfunctional due to dysfunctional modes or schemas and in order to change a person's behavior, the experiential components have to be restructured (Apsche & DiMeo, 2010). By ending the dysfunctional behaviors and habitual responses and replacing them with self-awareness, acceptance and regulatory skills, this violent adolescent male population can recover (Hollman, 2010). This article will examine the third wave treatments and their effectiveness across various populations. The third wave therapies are defined by their nonjudgmental approach to the thoughts, feelings and behaviors found in vulnerable population.

■ Third wave therapies

Treatments like Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), Functional Analytic Psychotherapy (FAP), and Acceptance and Commitment Therapy (ACT) were the beginning of what is now termed the third generation of treatment (Hollman, 2010). Founded by Robert Kohlenberg and Mavis Tsai, Functional Analytic Psychotherapy (FAP) is a behavioral approach to therapy (Kohlenberg, 2012) and was based on B.F. Skinner's theories on human development (Bowen, Haworth, Grow, Tsai, & Kohlenberg, 2012). Its focus is on implementing a close and intense relationship between the therapist and the client. Its purpose is to treat the functional, contextual, analytical modes of human development while producing an intense personal therapeutic relationship (Bowen, et al, 2012). The core condition that FAP clients present are within the presence or lack of human relationships. In FAP, the therapeutic relationship is the healing vehicle for the patient. The therapeutic relationship consists of a sacred space, awareness, courage and love. The overall intent is to increase personal closeness with others through experiential skills teaching (Bowen, et al, 2012).

Since avoidance of openness and honesty in interactions with others is a major problem associated with interpersonal relationships, the client is encouraged to overcome the avoidance by taking a risk and being open and honest with others. Overcoming avoidance is accomplished through mindfulness training (Bowen, et al., 2012). By teaching the client to be aware of their thoughts and that they are only thoughts, the automatic maladaptive pattern can be shifted to a new perception and the client's behavior is decentered (Bowen, et al., 2012). This is also known as re-perceiving. A new behavior occurs in previous situations that elicits stimulus control (Bowen et al, 2012). Both FAP and Mode Deactivation Therapy (MDT) use meditation to produce this therapeutic safe zone. All of the therapies are unique in that they incorporate awareness, trust and acceptance. In terms of effectiveness, MDT has been empirically evidenced as a valuable treatment for adolescents diagnosed with Conduct Disorders, Oppositional Disorders, Proactive and

Reactive Aggressive Disorders, PTSD, and more recently Sexual Behaviors (Apsche & DiMeo, 2010; Jennings, Apsche, Blossom, & Bayles, 2013).

Mode Deactivation Therapy (MDT), introduced by Dr. Jack Apsche, incorporated a nonjudgmental concept and mindfulness to the programs previously used to treat adolescent males with Conduct Disorders and Oppositional Disorders compounded with Post Traumatic Stress Disorder, ages 14-17 (Bass & Apsche, 2013). Unlike Functional Analytic Psychotherapy (FAP), MDT uses the therapeutic relationship as a basic foundation while encompassing the family support system. The client is encouraged to continue their practicing of new skills outside the therapeutic office. For FAP clients, the client/therapist relationship is the central component of the treatment. The ancient practice of meditation usually consists of sitting or walking quietly while paying attention to one's interpersonal experience (Bowen, et al. 2012). This century old practice, mindfulness has become mainstream methodology in mental health treatment; it is a new development in the treatment of adolescents, especially adolescents displaying sexual behaviors related to their exposure to violent family life (Jennings, et al., 2013). When used in Mode Deactivation Therapy, the meditation is simply calming moment that allows the client to experience the moment, the thought and the stimuli without judgment. Meditation in Mode Deactivation Therapy consists of three deep breaths, body relaxation and then a moment to feel and experience. With MDT, the client is encouraged to use the new skill set in everyday situations. The skill of active mediation allows the client to feel in control of daily activities. This can be done during ordinary moments in life like walking in a park or riding on a bus (Jennings, et al. 2013). Meditation in Mode Deactivation Therapy is not clinical silence but awareness in ordinary moments and sensations. The process of meditation enhances the youth's level of awareness.

■ Why mindfulness?

Psychologist, Fritz Perls (1969), realized the core value of the client gaining immediate awareness of sensation, perception, emotion, thought, behavior, and bodily feelings. He understood the therapeutic effects of staying in the "here and now" (Jennings, et al, 2013). Mindfulness is achieved through a series of awareness and observation exercises, specifically designed for adolescents. This technique helps the youth develop trust, reduces anxiety, and increases commitment to treatment. Mindfulness allows the youth to know and accept exactly where and how he should be as a person given his history of abuse (Apsche & DiMeo, 2010).

Perls' first clinical trial using mindfulness was in 1969 as a stand-alone therapy. He attempted to unify the mind, body, and spirit of an individual in Gestalt Therapy. Defined as the "intentional process of observing, describing, and participating in reality, nonjudgmentally, in the moment", Greco and Hays (2008, p. 4), as cited by Jennings et al (2013), mindfulness has become a key factor in overcoming the traditional limitations of traditional CBT which challenged the youth's beliefs as dysfunctional. MDT uses direct training in mindfulness skills with

adolescents as a major intervention in the process of deactivating the youth's maladaptive mode responses (i.e. emotional dysregulation). Because of their emotional dysregulation, these adolescents were naturally resistant and reacted as severely dysfunctional. To relieve the appearance of the treatment being threatening, Drs. Jennings and Apsche (2013) developed a diverse toolkit of non-threatening ways of teaching mindfulness skills. Their methods toolkit included breathing exercises, guided imagery meditation, visual concentration tasks, nature walks, sensory explorations, and intentional, fun-packed activities such as sports and adventures that adolescents were willing to engage (Jennings, et al, 2013).

Mode Deactivation Therapy borrowed acceptance treatment from Marsha Linehan, who developed Dialectical Behavioral Therapy (DBT), when it was discovered that Cognitive Behavioral Therapy (CBT) was not able to help women with Borderline Personality Disorder (Linehan, 1993). Linehan's practice focused on women who self-harmed due to emotional dysregulation, dual diagnosis, mood disorder and eating disorder. Their lack of behavioral coping skills resulted in self-harm or self-mutilation such as cutting, eating disorders and suicide ideation. Linehan saw no progress in her clients until acceptance and change strategies were introduced. The main goal for Linehan was to keep the client alive, keep them in therapy and give them a quality of life (skills). By doing that, Linehan had to develop acceptance strategies that validated the client's feelings as perfectly normal while other behaviors could be produced without shame dominating the client (Linehan, 1993). The main goal of Mode Deactivation Therapy is to alter specific behaviors that fall outside socially acceptable norms. Through the use of Validation—Clarification—Redirection the therapist is able to transform detrimental, learned beliefs about the adolescent's environment into functional beliefs that are more balanced and lead to more compliant behaviors (Apsche, Bass & Backlund, 2012).

Mode Deactivation Therapy (MDT) incorporated the best of all these other treatments and rose above those beginnings with the addition of Validation, Clarification and Redirection (VCR). VCR is the core of the MDT effectiveness. While speaking through the mediation, thoughts and emotions are validated or considered to be the truth (Apsche & DiMeo, 2010). Unlike Cognitive Behavioral Therapy, the core beliefs (schemas) are not challenged by the therapist as dysfunctional but considered to hold a grain of truth (Apsche & DiMeo, 2010). Their sub-organization of personal modes was designed to combat specific demands of the problem. The modes, the focus of MDT, are labeled cognitive, affective, motivational and behavioral (Apsche, Bass & Backlund, 2012). Because MDT consistently validates the youth's life experiences as legitimate, the therapist clarifies the content of the beliefs and the re-directs the beliefs in order to create a balance in the youth's beliefs. This helps the youth identify the illogical and irrational beliefs that activated his emotional response that he unconsciously held. The clarification step of the MDT process is crucial to the therapist and the youth's understanding the belief system (Apsche, Bass, & Houston, 2008). The final step of the VCR

process is the intervention or redirection phase. The therapist redirects the youth's views to alternative possibilities to the beliefs that he currently holds. The validation, clarification, and redirection technique uses unconditional acceptance and validation of the youth's unconscious learning experience according to Apsche and DiMeo (2010) as it measures his acceptance of a slightly difference belief (Houston, Apsche, & Bass, 2007).

In most recent developments with MDT, as a specialized form of treatment for adolescents, the therapy has advanced to an even more aggressive form of treatment for adolescents with oppositional dynamics. Drs. Jennings and Apsche adopted the principles of validation, radical acceptance, balancing, and mindfulness (Jennings, et al, 2013). These principles, borrowed from DBT, joined the youth in collaboratively discovering how the youth's belief system is a reflection of his own life experiences, relationships, sense of self, and world view. Just as with ACT, the youth learns how to accept without judgment; MDT helps the youth to radically accept his or her beliefs as truths no matter how irrational; there is always a grain of truth in their story. MDT continually validates perceptions of reality, accepting the youth for who he or she is based on his or her belief systems which builds trust and collaboration with the therapist. Through MDT the youth and the therapist, together, apply cognitive balancing to introduce increasingly flexibility into the rigid and maladaptive dichotomous beliefs of the adolescent by opening the youth to the possibilities of an alternate continuum of truths and/or possibilities (Jennings, et al. 2013).

As a treatment for sexually abusive male adolescents, Apsche and colleagues (2005) compared the effectiveness of MDT to CBT and Social Skills Training (SST) with adolescents in an average residential treatment program of 11 months with 60 adolescents with serious sexual and aggressive problems (Jennings, et al, 2013). All three therapies were successful in reducing rates of physical aggression, but only MDT, with its focus on mindfulness, demonstrated a significant reduction of reduction in sexual aggression (Jennings, et al.). In a two year follow up study, only those who received treatment with MDT could boast a 7% drop in recidivism with no serious sexual or physical offenses (Bass & Apsche, 2013; Hollman, 2010). Twenty percent of the CBT group resulted in chargeable offenses of sexual and aggressive offences, auto theft, and drug sales. Forty-nine and one half percent of the social skills training (SST) group committed offenses that included attempted murder, rape, aggravated assault, and other serious offenses (Jennings, et al., 2013).

In 2010, Apsche and DiMeo conducted a meta-analysis of the effectiveness of MDT over a ten year period. This analysis consisted of published and unpublished (at that time) data. A review of 458 cases of adolescent males revealed more than half (55.5% had sexual offenses. Fifty-two percent were diagnosed with Conduct Disorder, 45% with oppositional defiant disorder, and 51% were diagnosed with PTSD (Jennings, et al, 2013). Overall, 92% of the adolescents had experienced four types of abuse, 54% witnessed violence, and 28% of the

adolescents presented with parasuicidal behaviors. Large effect sizes reported in the meta-analysis included Sex Offender/Physical Aggression (1.78), Conduct Disorder/Physical Aggression (1.85), Total Physical Aggression (1.82), and Sexual Aggression (1.80). Taking into consideration that effect size of 0.5 is medium and values of 0.8 are considered to be large effect sizes. This demonstration of such large effect sizes and reduced rates of recidivism strongly suggests that MDT (a mindfulness-based therapy) is an effective treatment in complex disorders and conditions, including sexually deviant behaviors (Jennings, et al, 2013).

As stated by Hollman (2010), MDT is one of the "Third Wave" treatments available today for vulnerable populations that display corruptive behaviors within personal interactions for multiple reasons. This type of treatment was founded out of necessity and has earned empirical evidence that it has been beneficial for adolescent males engaged in aggressive sexual deviance, conduct disorder, and oppositional conduct disorder (Bass & Apsche, 2013; Hollman, 2012; & Jennings, et al., 2013). Acceptance treatments are essential in healing those who have been victim or witness to abuse and neglect. MDT stands alone in its ability to treat all PTSD populations, regardless of sex or race or diagnosis. The use of active mediation allows the participants to feel centered in everyday activities not just in the therapeutic office. MDT gives the client power to choose adaptive behaviors and lose the knee jerk responses they previously used.

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