**Evidence Based Treatments**

You would think clinicians would be experiencing incredible success with the swarm of so-called evidence-based treatments now out there… they aren't. Why?

- Made for single-problem/dx; won't fit complex cases
- Tested in university labs, with analog cases; not relevant to real-world practice
- Make therapists technicians, not caring, empathic human beings
- Manuals use rigid steps; can't adjust to fit change, new information
- Manuals produce "scripted", non-authentic interactions with clients.
- Manuals undermine therapeutic relationship.
- Manuals rule out clinician judgment, innovation.
- Learning and using manuals is time-consuming and expensive.
- May not apply equally to all, but and element of truth here…

**Research Therapy Recruited Case – Clinic Therapy Clinic Referred**

Multi-problem clients often confound our ability to "stay true" to a single evidence-based treatment, clinicians often get lost in the complexity they are confronted by…

**MDT Will show us the way!**

- Gives Both the Client and Therapist a "Road Map" for treatment.
- It was designed and shown to be effective in treatment of the Most Difficult Adolescents.
- It allows for the Client and Therapist to work as a team in collaboration.
- MDT was developed to treat the aberrant typologies of reactive conduct disorder and personality disorders more effectively than traditional CBT strategies.
    - progress being measurable
    - client's sense of trust is higher due to working on a new script of himself
    - client has more control due to understanding and accepting himself

**Where has MDT been shown to be effective?**

Over the past ten years, MDT has been shown effective in multiple applications within Residential Treatment Settings, and has consistently been shown to be more effective than many current treatment models.

Recent studies in an Out-Patient Community are also positive

**Theoretical Constructs of MDT**

Beck (1997) introduced the concept of modes to respond to shortcomings in his concept of schematic processing. He suggests that a number of psychological problems are not adequately addressed by his model of individual schemas (linear schematic processing), listed next…

**Theory of Modes (1)**

The shortcomings of Beck's schematic processing theory are as follows:

**Theory of Modes (3)**

The "primal modes" of most interest for the study of psychopathology include the derivatives of ancient organizations that evolved in prehistoric circumstances and are manifested in survival reactions, but also, in an exaggerated way, in psychiatric disorders.

**Theory of Modes- Activation**

- I propose the use of the concept of charges (or cathexes) to explain the fluctuations in the intensity gradients of cognitive structures. This concept can be applied to the phenomena of sensitization, extinction, and remission. Modes are charged by fears and dangers that set off the system to protect against the fear.
    - For example, it helps to account for the clinical observation that at the onset of a particular clinical disorder (e.g. anxiety, panic, or depression), various systems (cognitive, affective, motivational, and behavioral) shift from a relative quiescent state to a highly activated state.
- The concept of modes encompasses clinical conditions characterized by the pre-potence (or hypercathexis) of a conglomerate of related or contiguous dys-functional beliefs, meanings, and memories that influence, if not control, the processing of information.
- The model also accounts for the observation that when the clinical syndrome remits, the characteristic dysfunctional interpretations and beliefs become les salient- or even disappear.

- Modes are activated by charges that are related to the danger in the fear ↔ avoids paradigm. The orienting schema signals danger, activates or charges all systems of the mode. The affective system signals the onset and increasing level(s) of anxiety. The beliefs are activated simultaneously reacting to the danger, fear ∧ avoids and physiological system. The motivational system signals the impulse to the attack and avoids (flight, fight) system. The physiological system produces the heart rate or increases or lowers the blood pressure, the tightening of muscles, etc.

**Why this is so crucial for our kids**

- Modes are important to the typology we serve in that they are particularly sensitive to danger and fear, serving to charge the modes. The understanding of conscious and unconscious fears being charged and activating the mode system explains the level of emotional dysregulation and impulse control of the typology of youngsters that we treat.

- 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 the Mode Deactivation methodology.

**Mode De-Activation**

The orienting schemas consists of the anticipation of an event. The orienting schemas in the typology of a youngster that we treat, usually involves a danger or threat. Adolescents who have been abused or deprived have developed reactions to

direction or instructions that may activate the orienting schemas because of the threat or perceived threats. For example, if an authority figure gives a directive in a firm and singular fashion (non-choia) it may activate the orienting schemas of danger. This danger activation or change will activate the modes.

The perception is the interpretation of the fear to danger activation, into an anxiety reaction. The perception activates the fear, anxiety that reacts to the danger activation from the orienting schema. The perception is effected by the fear and its relationship with the activated compound core belief. Thus a direction may activate the oriented schema and activate the fear ↔ belief paradigm.

The physiological system is a system that is generally involved when a fear related threat has been activated. These systems accompany states of fear and anxiety. The physiological system charges the individual for action.

Avoids is the last chance to deactivate the aggressive, self-destructive part of this mode. The avoids/attack modes are activated by the beliefs and physiological systems. To deactivate the attack mode it is necessary to teach the youngster to identify the physiological system firing, by rank order. This is simply the order in which the various physiological system fires (i.e. clutches fist, clinches teeth, etc.).

**Look for the Elevator**

BECKS CLINICAL EXAMPLE:

  - A young man, Bob, suffers from an elevator phobia. As he approaches a tall office building containing an elevator he will be using, he starts to feel anxious even though he is involved at the time in discussing routine business affairs with a colleague.

- As they come closer to the building, his anxiety increases. Although he has not been thinking about taking the elevator, obviously some kind of preconscious processing of the anticipated event is occurring and producing anxiety. The implicit knowledge that he will be taking an elevator to reach a top floor has already set in motion cognitive, affective, behavioral, and physiological processes.

- Although Bob may not be consciously thinking about the elevator (and may be absorbed in his business discussion), a "cognitive probe" at this point would elicit the same information as if he were actively ruminating about the elevator ride:
  - If asked to introspect- to explore all of his thoughts about his anticipation- he would acknowledge that he was fearful about taking the elevator.

- As he enters the lobby, however, the specific fear of catastrophe becomes salient. He becomes conscious of the fear that the elevator will crash or get stuck:
  - He will get killed, suffocate, or faint.
  - He is also fearful that his distress will accelerate to the point that he will start to yell uncontrollably and will be humiliated.

- Later when Bob is no longer confronted with the threat of taking an elevator, he is no longer fearful of these erstwhile "dangers."

- The distance from the source of danger represents a safety zone or a "safety signal" (Woody & Rachman, 1994). But when the same situation arises again, the same pattern of fears is repeated.

- The *activating circumstances* revolve around the anticipated event of riding in the elevator. These circumstances are processed through the orienting component of the primal mode relevant to danger, an anticipation of the event.

- As this specific fear is activated, the various component systems of the mode are energized. We then see the manifestation of the activation of the mode:
  - Bob becomes pale, sweaty, and shaky; his heart races, he feels faint; and he has a "squishy feeling" in his abdomen.

- The progression of events may be analyzed as follows. Initially, as Bob approaches the building, his *orienting* schema signals that there is danger ahead.

This signal is sufficient to activate all the systems of the *mode* : the affective system generates rapidly increasing levels of anxiety; the *motivational system* expresses an increasing intensity of the impulse to escape; the *physiological system* produces an increased heart rate, a lowered blood pressure resulting in a faint feeling, a tightening of the chest muscles and a cramping of the abdomen. At this point, Bob becomes fully aware of his unpleasant feelings and wishes to escape, but he is able to activate his voluntary controls to override this "primal" reaction and to force himself into the elevator. He manages to stay in the elevator, albeit with considerable anxiety, until it reaches the desired floor. As he steps out, his anxiety recedes.

We should note the importance of Bob's interpretation of his physical or psychological disaster.

Once the physiological system is identified, the therapist needs to help the youngster identify the 1st and 2nd physiological reaction and teach avoidance to the youngster.

It is imperative that the physiological be related to the compound core beliefs that are activated as they activate the physiological system.

**<u>Adolescent-Onset Personality Disorder</u>**

- Adolescents with complicated histories of abuse and neglect may develop personality disorders as survival coping strategies.
  - Cluster A and Cluster B personality disorder's may increase the risk for violent behavior that persists into early adulthood.

- Childhood physical abuse, sexual abuse and neglect may also be associated with elevations in different types of P.D. P.D. symptoms, sexual abuse is associated with elevated Physical abuse was associated with elevated antisocial and depressive borderline symptoms, neglect was associated with elevated symptoms of antisocial, avoidant, borderline, narcissistic, and passive aggressive P.D.

- Witnessing or being exposed to violence increases the likelihood of antisocial responses in adolescence. Schwab-Stone, Chen, Greenberger, Silver, Lichtman and Voyce. *American Journal of Adolescent Psychiatry*, 38:4, April 1999.

**Conduct Disorder**

Treatments have largely ignored two important characteristics of conduct disorder.

- Research suggests that conduct disorders are multi-determined. Children with conduct disorders represent a very heterogeneous group with respect to the causes of their behavior problems. Paul J. Frick, University of New Orleans. *Cognitive and Behavioral Practice*, 7, 30-33, 2000. Lochman and Dodge (1994) reported that different types of social cognition discriminate between severely violent and moderately aggressive boys, exhibited difficulties in information processing variables such as cue recall, hostile attributions and fewer protagonistic solutions.

Frick (1998A) proposed that the childhood-onset group can be further subdivided into
(A) a callous, unemotional subtype often characterized by temperamental vulnerabilities that negatively influence the development of the affective components of conscience (e.g., guilt and empathy) and,
(B) an impulsive type characterized by poor impulse control resulting from the interactions of a heterogeneous set of casual factors (e.g., loss intelligence, poor socialization in the home). Paul J. Frick, University of New Orleans.*Cognitive and Behavioral Practice*, 7, 30-37, 2000.

**Why not use CBT?**

- Distortions suggest that the adolescent's perception is faulty.
- A therapist's attempts to dispute cognitive distortions are seen as an opportunity for adolescents to argue in their own defense.
- This repeats past patterns of abuse and perceived need to defend and plays out the same old script.

- the underlying issues are often not represented in diagnoses because they may not reach diagnostic criteria, but they are still present and interfere with treatment

example: conduct disorder

**The MDT Method**

Therapeutic Alliance - The therapeutic alliance is key. Agreement on 15 questions that measure treatment and alliance with therapist. Therapist and client complete quarterly-totally independent. Measure agreement.

**Typology Survey**

Informed Consent:

The youth should be given an opportunity to consent to the assessment. It is important to explain the nature of the assessment and its purpose. Enlist the youth's cooperation by letting him know that he can help you help him more effectively by providing this information, as he is an expert on himself.

**Fear Assessment**

The Fear Assessment-Revised, administered after the Typology Survey is a 60-question assessment exploring fears of the youth. It provides insight into the youth's underlying traumas. The Fear Assessment-Revised is important and will be necessary to complete the Fear, Avoids, Compound Core Belief – Correlation component of the Case Conceptualization. Attempt to help the youth feel comfortable to allow for the youth to disclose as much information about their trauma as they are comfortable sharing. Explain the response scale to the youth.

Explain that fears can be present at various times, it is helpful to explore scenarios to help the youth identify if the fear is present during specific time.

Some youth feel that they are better since they have been in treatment and will therefore, under endorse. It is recommended to instruct the youth to answer as he felt prior to treatment. You may phrase the fears in the past tense.

Explain the questions you will ask i.e. "I am going to ask you some questions about how you feel about certain situations" and explain the scale of responses, i.e. 'tell me if you fear this sometimes, almost always, always, or never." Be sure to use words that are comfortable for the youth. If the you will react to the word "fear" use words like anxious, nervous, uncomfortable, hard time, difficulty, etc.

**Conglomerate of Beliefs and Behaviors (COBB)**

- The Conglomerate of Beliefs and Behaviors incorporates compound core beliefs and the corresponding behaviors. It developed as a defense to underlying trauma. It is the pathway to the complex series of moods, schemas, and behaviors.
- The beliefs are something the youth can endorse sometimes, almost always, or always. Or, the youth may not endorse the fear by responding "never."
- It is important to be aware that the youth may process on a concrete level and fail to endorse a belief if they are not believing it at that time.
- It is important to explain that beliefs can be present at various times. It is helpful to explore scenarios to help the youth identify if the fear is present during specific times.
- Some youths feel that they are better since they have been in treatment and will therefore, under-endorse.
- It is recommended to instruct the youth to answer as he felt prior to treatment. You may phrase the beliefs in the past tense.

**The Case Conceptualization (1)**
***Use the Case Example from the Clinician's Manual***

Suicidal Behaviors

1. Suicide crisis behaviors
2. Para-suicidal acts
3. Intrusive suicidal urges, images, and communications
4. Suicidal ideation, expectations, emotional responses

Therapy-interfering behaviors

1. Patient or therapist interfering behaviors likely to destroy therapy
2. Immediately interfering behaviors of patient or therapist
3. Patient or therapist interfering behaviors functionally related to suicidal behaviors

Quality of life interfering behaviors

1. Behaviors causing immediate crises
2. Easy-to-change (over difficult-to-change) behaviors
3. Behaviors functionally related to higher-order targets and to patient's life goals

Increasing Behavioral Skills

1. Skills currently being taught in skills training
2. Skills functionally related to higher-order targets
3. Skills not learned yet

**The Case Conceptualization (2)**

- Personal Reactive External is a subscale of the Fear Assessment. This category represents the predominant category of fears that is the basis of treatment. Personal Reactive External is a category of fears that is internally reactive to external events. These fears are based on negative experiences that simulate the cognitive conscious and subconscious. For example, to not trust anyone there has to be a person or external stimuli to the internal fear.

Personal Reactive-External Fears should be identified first in the treatment hierarchy.

- Avoids are the functional alternatives to the fears. Vulnerability is at the core of what the person avoids. For example, if you fear elevators you avoid elevators. And, if you fear trusting people, you avoid disclosing relationships and/or intimacy. Think in terms of non-functional alternatives. Sort of opposites. If your youth is afraid of being alone in dark rooms and dusk to dark, what do you think he may avoid? Dark rooms, dusk = bedtime, seclusion rooms; dusk to dark = bedtime, evening and night shift.

Ask yourself what might your youth's life look like in the youth's milieu/ ask yourself, when would expect your youth to have "behavioral" problems? Why

**Fears and Avoids**

This information should flow from the Fear Assessment. The fears produce an avoidance. It is important to understand the functional relationship between fears and

avoidance. This should be your step wise program to implement exposure training, as well as the basis for your case conceptualization.

Understanding the fear ◊⇓ avoidance relationship, will explain many of the problem behaviors in which the youngster engages. The youngster avoids these fears by escaping or avoiding.

**The Case Conceptualization**

OK, we have the first two, now we move to triggers

Triggers are anything that activates the fear, avoidance, compound core belief. They can be people, places, objects, noises, smells, sights, experiences, etc.

1. Trigger 1 (conscious trigger):
2. Trigger 2 (unconscious trigger):

**Triggers**

The same trigger may be both conscious (trigger 1) and unconscious (trigger 2).

When you have completed this section you should understand the youngster's behaviors. Be prepared to explain it to him, when he reaches the appropriate section in his Mode Deactivation Therapy Workbook.

Practice this section in the MDT Workbook. This should produce a cognitive pathway to the youngster's problematic behavior(s).

**Situational Analysis**

This section requires an analysis of actual situations in which the youngster has been involved. Completing the situational analysis provides an opportunity to test the hypotheses you formulated in the Fear, Avoids, Compound Core Belief – Correlation section.

**Functionally Based Treatment (1)**

This is the blueprint or "Road Map" to treatment. It takes time and thought. The Functionally Based Treatment Development Form is the culmination of all previous components of the case conceptualization. This form is intended to give direction to treatment based on what has been learned about the youth through doing the case. This form is completed left to right, although it is implemented from right to left due to each column building on the column to its right.

You will notice the basis of this form is the development of a new, healthier belief system as indicated in the first column, labeled "Identify New Belief System." These beliefs are healthy alternatives to the compound core beliefs identified in the *Fear, Avoid, Compound core belief Correlation*.

When you finish you should have measurable goals for you treatment plan. You also should be able to set up your program. A rule of thumb, is to set up trial groups of 10, which is congruent with a percentage score. An example of this is the scale of trust. A score of 1 indicates no trust, a score of 10 indicates total trust. You can use the scale of trust to objectively measure the level of trust your youth has for you (the therapist) and anyone else significant in his life (advocate, parent/ guardian, etc.) by asking for a score of trust each week.

**Functionally Based Treatment (1)**

- Begin with beliefs identified in the treatment hierarchy, or the beliefs that correspond to fears which are treatment interfering. Identify new belief system, the functional alternative to the dysfunctional belief. This functional alternative should be incompatible with the dysfunctional belief.
- Identify the healthy alternative thoughts in the next column, labeled "Identify Healthy Alternative Thoughts." These are thoughts that will help to build the new healthier belief system. Identify Healthy Alternative Thoughts, what thoughts would reinforce a functional belief? How would these healthy thoughts look? How would they fit into the new belief system?
- Identify strategies that will help the youth to compensate and adjust to their new belief system. Functional Alternative Compensatory Strategies, what would he the healthy functionally alternative compensatory strategy? What compensatory strategies would reinforce the new healthy thoughts?
- Identify behaviors which others will do to reinforce the new belief system in the column labeled, "functional reinforcing behavior(s)." What is the general class or general behavior do you want to be the functional alternative to the aberrant behavior? These behaviors should be the replacement behaviors that actually reinforce the future compensatory strategies.
- Identify specific ways that validation, clarification, and redirection will be generalized from the individual therapy setting to the milieu in the column labeled, "specific functional implementation of V-C-R: individual therapy to milieu." (Please view the training videotape of Dr. Apsche and John to review this process in vivo.) These are the actual behaviors and paradigms of behaviors that will be implemented in therapy. These are the step-by-step implementation actions that will begin to build the positive behavior chain. These behaviors are to be trials. It is important to continuously validate-clarify-redirect during individual therapy, which is indicated in the next column, labeled "Validate Clarify Redirect." Validate the grain of truth in his responses.
- VCR is a specific technique I should review separately

**Therapeutic Mindfulness**

Important with these "over-charged kids", but not to be confused with…

**Mindlessness**

- Operation on “autopilot”
- Being lost in fantasies of the past and future
- Breaking or spilling things because we’re not paying attention
- Rushing through activities with out attending to them