

Family Mode Deactivation Therapy in a Residential Setting: Treating Adolescents with Conduct Disorder and Multi-Axial Diagnosis.

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Mode Deactivation Therapy (MDT) has been shown to be an effective treatment for a variety of adolescent disorders (Apsche, Bass & Siv, 2006) including emotional dysregulation (Apsche & Ward-Bailey, 2004) behavioral dysregulation (Apsche, Bass & Murphy, 2006), physical aggression (Apsche, Bass & Houston,2007), sexual aggression (Apsche, Bass, Jennings, Murphy, Hunter & Siv, 2005), and many harmful symptoms of anxiety and traumatic stress, (Apsche & Bass, 2006). MDT Family Therapy has been effective in reducing family disharmony in case studies (Apsche & Ward, 2004), and has been shown to be efficacious as compared to treatment as usual (TAU) in treating families with a variety of problem behaviors (Apsche & Bass,2006) and in reducing and maintaining treatment effects through two years of tracking recidivism rates (Apsche, Bass & Houston,2007).

The nature of the pediatric behavioral health industry poses a challenge for treatment research – adequate sample sizes are not always available, and the organizations themselves are generally hostile to active research. The requirement for a control group is often viewed as a human rights concern in this population (often mandated to participate in treatment), and the resistance of the clients and families, although normative, demands that the clinician researcher find a strategy to motivate them to work hard to address their problems. These concerns have prompted us to use “treatment as usual” as the control group, with all of the problems inherent in this practice.

We completed a Family MDT clinical study of fourteen adolescents who evidenced problems such as sexual and physical aggression as well as oppositional behaviors including verbal aggression (Apsche & Bass,2006). The results indicated that MDT out performed treatment-as-usual. At the

eighteenth month of observation the MDT group has zero incidents of sexual recidivism, while the TAU group had ten reported incidents. The MDT group reported three incidents of physical aggression while the TAU group reported twelve incidents. The results were promising for MDT as a family therapy, and indicate that further study with a larger group should be pursued (Apsche, Bass & Siv,2006).

A study of outpatient Family MDT (Apsche, Bass, & Houston,2007) 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 disorder. A total of fifteen families were studied – eight in the MDT group, and seven in the TAU group. MDT surpassed TAU at the twenty 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 show potential for this population, although the small number of participants limits the claims of efficacy for Family MDT (Apsche, Bass, & Houston,2007).

Treatment Paradigm

Many Cognitive Behavioral therapists have attempted to identify and address both distorted schemas and maladaptive behavior patterns in family interactions (Dattilio, Epstein, & Baucom, 1998). According to Dattilio, et. al.(1998), Cognitive Behavioral therapists interview the family to determine perceptions of the family and how things operate in the home environment. In addition, the Cognitive Behavioral family therapists view the entire family as a case, avoiding the stigma of one identifying one patient or client. Epstein (1996) found that negative exchanges by family members increase the overall family distress. Dattilio, et al. suggested that the Cognitive Behavioral family therapist pays attention to the antagonistic exchanges between individual family members. Dattilio, et. al. (1998), further suggested that the Cognitive Behavioral family Therapists are attentive to the frequencies and patterns of antagonistic/discordant behavior exchanges; expressive and listening skills for communicating thoughts and feelings; and

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problems solving skills. Indeed, Dattilio et. al. (1998), posit that their theory is similar and amiable to System Theorists in that Cognitive Behavioral family therapists “carefully focus on the process of family interactions”(pp. 8-9) – his group has published numerous studies to support this contention.

Baucom & Epstein (1990) developed a typology of cognitions that are involved with relationship conflict and distress. The cognitions are enumerated as follows:

1. **Selective Attention:** This is defined as each member of a relationship tends to notice some aspects of events occurring in their interactions, but not others.
2. **Attributions:** This implies inferences that family members make about the cause of events in their relationships.
3. **Expectancies:** Predictions about the probabilities of particular events that occur in the future.
4. **Assumptions:** Beliefs about the characteristics of relationships and how relationships work.
5. **Standards:** Beliefs about how relationships should be.

Dattilio, et.al. (1998) affirms that Cognitive Behavioral therapists propose that these five types of cognitions have the potential to erode satisfaction in family relationships, and they elicit dysfunctional family interactions.

It is important to not that Doherty (1981) found that family members who believe that there is a high probability of unity will behave together as a group, if family members believe there is a low probability unity will act as if they are helpless rather than making active attempts to resolve family conflicts.

Distressed families tend to view each other's negative behaviors as due to unchangeable patterns, and positive behaviors as atypical (Dattilio, et.al. 1998). Dattilio, et al.(1998) further suggest that a basic tenant of the Cognitive-Behavioral model of family therapy is that the basic dysfunction and distress in the family is caused by

the interplay of the cognitive-behavioral and affective functioning. Epstein (1998) and Dattilio, et al.(1998), detail considerable evidence that various negative exchanges among family members adversely affect family relationships. Biglan, Lewin & Hops (1990) also address the problem of negative behavioral interactions directly contributing to dysfunctional outcomes for children in school, home and within interpersonal interactions. Dattilio, et al., delineate how traditional behavioral family therapy methods of assessment and modification remain the central component to a Cognitive-Behavioral approach.

MDT Family Therapy also examines the process of family interactions (Apsche & Ward, 2003; Apsche & Bass, 2006). MDT attempts to move the family to a new script or mode of interaction, based on the collective case conceptualization process (Apsche & Ward,2004; Apsche & Bass,2006). Unlike multi-systematic therapy, as delineated by Henggeler, et al., (1998) which would focus on the youth as embedded in multiple systems that have basic direct and indirect influences on his behavior, MDT focuses on the system of family beliefs and modes based on the collective and individual modes of the family. MDT therefore tends to be a psychotherapeutic intervention rather than a system of treatments. One therapist is central to the individual, group, and family process. The therapist is the team captain and coordinates individual, family, and group psychotherapy. Most Cognitive Behavioral treatments focus on an individual client (Henggeler, et al.,1998) MDT is a process that focuses first on the adolescent following the completion of the family core conceptualization, then the family. MDT includes a family workbook, (Apsche & Apsche, 2007), and exercises which help to reintegrate the troubled youth and his or her family.

MDT, in individual and family work, offers the therapist and client the ability to objectively structure, measure and track progress in treatment in the treatment manual (Apsche & Apsche,2007). MDT incorporates treatment strategies from behavioral, cognitive, dialectical and other supportive psychotherapeutic approaches. It is administered systematically via a method that is clearly delineated in the MDT Clinicians Manual. MDT is comprised of weekly individual and group therapy sessions, provided for an average of eight to 12 months, depending upon the level of

cooperation and amenability to treatment of the individual and family.

The MDT treatment process starts with a comprehensive Case Conceptualization obtained through the use of a structured diagnostic interview called the Typology Survey. 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 Typology Survey is conducted with the child, guardian, and referral source, with each providing a response to every question. Further individual assessments are determined by responses to the Typology Survey, and the acuity of conduct problems of the adolescent. MDT uses a continuum from reactive to proactive on a successive scale of one to 10. According to Dodge, Lochman, Harnish, Bates, and Petti (1997), there are two sub-groups of aggressive conduct type youngsters; proactive, the sub type that receives benefit and rewards from aggression and reactive, the sub type that is aggressive due to being emotionally reactive or dysregulates. Frequently, reactive adolescents have multiple personality disorder according to Dodge, et al.(1997). It appears that reactive conduct disorder adolescents emotionally dysregulate and many of their aberrant responses are results of their emotional dysregulation. Reactive conduct disorder youth tend to have a history of early life trauma, such as parental rejection, exposure to family violence, and family instability. In addition, these youth show a pattern of emotional dysregulation that includes somatization, depressive symptoms, sleep disorder symptoms, and personality disorders (Dodge et al., 1997). Reactive conduct disorder youth demonstrate a greater tendency to interpret peers' intents as hostile, responding to their environment similarly to individuals with borderline personality disorder. They are reactive and engage in dialectical thinking that seems contradictory and often attention seeking. In reality, these youngsters often endorse dichotomous beliefs and engage in dichotomous behaviors. Often what appears to be impulsive behavior may be their acting upon these dialectical beliefs or being reactive (Dodge, et. al., 1997). Reactive conduct disorder youth have difficulty regulating their emotions with incoming stimuli. (Dodge et al., 1997) Apsche (2008) further defined proactive and reactive aggression to include an ongoing continuum that scales the progression of reactive

to proactive aggression as an ongoing developmental scale that the adolescent moves fluidity on as they experience continued aberrant experiences thru their lives. The adolescent and/or family that score a three or higher, on a Likert scale of one to four, are considered to be proactive and needs the specific assessments that apply.

The Fear Assessment is the basic instrument that addresses the individual's problems with anxiety, fear, and Post Traumatic Stress. There are five different assessments to choose from based upon the perceived openness of the adolescent and the family. If it is evidenced that there is no amenability to treatment and evidence of multiple anti-social 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 his family in the process of assessment.

Following the Fear Assessment process, the therapist completes the Compound Core Beliefs Questionnaire (CCBQ). The CCBQ is a 109 item assessment of the adolescent's beliefs as they relate to personality traits, and is based upon the work of Beck, Freeman, Davis & Associates (2004). The Fears Assessment and CCBQ are scored and used in the development of a thorough Case Conceptualization that includes a Functional Behavioral Analysis. This methodology is based on the Functional Analytic Psychotherapy methodology (Kohlenberg & Tsai, 1993). From this Case Conceptualization, the adolescent's treatment plan is developed. Similarly, the family case conceptualization is developed through assessments given to the family treatment participants to determine the family's Conglomerate of Fears and Beliefs.

Most Cognitive Behavioral Therapy approaches have a focus on the individual client, who, with MDT Family therapy, is the adolescent (Apsche & Jennings, 2007). The MDT process focuses first on assessment and Case Conceptualization of the adolescent, always followed by the completion of a Case Conceptualization of the family. It is observed that the family is as equally important in the treatment effort. To avoid the tendency to stigmatize the child as the individual that is the object of dysfunction, the MDT Family Fear and

Belief assessments were created (Apsche & Ward, 2003); Apsche & Bass, 2006). This approach is not designed for implementation as a separate methodology, but is to be implemented as part of MDT treatment for adolescents. The assessments include:

1. The Fear-Family Assessment: An assessment of sixty 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.

2. The Family Core Belief Assessment: An inventory of ninety-six questions related to the family's belief systems. The Family Core Belief Assessment is scored in the same manner as the Family Fear Assessment.

3. 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.

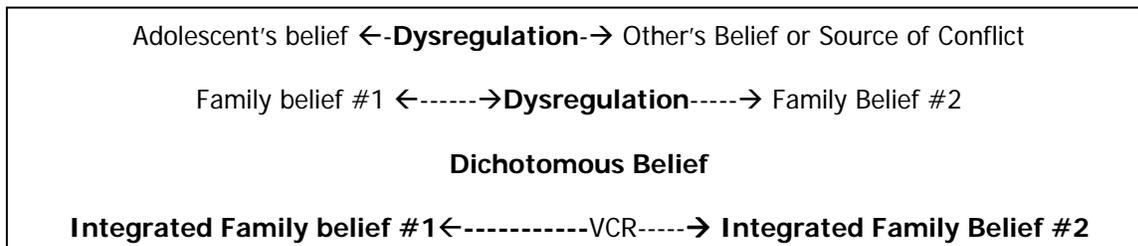
attempts to expose the irrational, illogical belief deeply held by families in crisis. The individual components of the V-C-R method include:

Validation:

Each family member's thoughts and beliefs are validated initially. 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. Each member is given appropriate therapist reinforcement to indicate that he or she is understood and believed.

Clarification:

The therapist clarifies the content of responses. Therapists also clarify the beliefs that are activated. It is important that the clinician understands and agrees 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.



A Family MDT Workbook accompanies this process, and is designed to structure the family therapy following the MDT methodology process. The workbook creates a collaborative effect for all family members by addressing the following topics.

1. Commitment to Treatment
2. Responsibility for the Family
3. Family Belief Analysis (Compound Core Beliefs)
4. Modes of the Family
5. Your Family's Beliefs and Problem Behaviors
6. Problem Behaviors and MDT
7. Substance Abuse in Your Family
8. Empathy for the Family
9. Becoming Survivors

The families are taught how to balance their beliefs with the V-C-R method. While there may be some identification of opposing beliefs, this method

Redirection:

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 above chart highlights the direction of the deregulated belief system. The redirection was an attempt to aid the youth and family member(s) to see both sides of the dichotomous belief(s). It is also important was to look for the kernel truth in each and offer a compromise in understanding the truth in both beliefs. The use of a continuum of belief was implemented to examine the individual's

belief of truth in both of the dichotomous beliefs and situation.

Each individual in the family, as well as the family collectively completed the Conglomerate of Beliefs and Behaviors, (COBB). The COBB examined each individual's belief as well as their corresponding

(the adolescent) said when you paint you are ok at that moment, on a scale of 1-10 how much could that be possible, since that you are in therapy and able to express that 'at times' you feel like you are ok, and actually might for a moment love your family. The adolescent responded that when he paints he is ok at that moment. On a scale of one

Pre-Treatment Beliefs

Adolescent's Belief	Behavior	Feeling	Parent's Belief	Emotion	Behavior	Sibling's Belief	Behavior	Pre-Treatment
Life at times feels like an endless series of disappointments followed by pain.	Isolation (physically & verbally withdraws)	Pain	Whenever I get angry my emotions go from annoyed to furious because the my child doesn't let me in.	Feels hurt, failure, and rejection	Parent screams that the child is a freak and ruining his or her life.	Whenever I hope I will be disappointed because nothing ever works out in this family	I don't even try to make myself a better person or follow mom or dad's rules or to get along with my	Whenever we allow ourselves to 'feel' in this family it is a problem because it is pointless. Nothing is possible or ever changes. Family is splintered.

behaviors. Once the families Beliefs and Behaviors were determined they were compared to each individual's beliefs and behavior. Family progress was further assessed through the use of behavior report sheets that measured verbal and physical aggression arguments, and 'non-attending behavior'. These home non-attending behaviors were defined as any behaviors by the parent or adolescent that would prohibit verbal engagement, such as non-compliance, walking away, or not responding to requests.

The beliefs of this family, including individual and Family beliefs are reinforced by the feelings and behaviors of the individuals and the family. The family is so emotionally fragile that one negative, belief, feelings, or behaviors sets a chain of negativity for the individuals and the family as a group.

The MDT therapist validates beliefs as the individuals and family's reality. This is the radical acceptance of the beliefs as real as they exist in their world(s).

The search for clarification of the alternative belief that might be possible in this situation might look as follows: "It could be possible in a situation, even for a moment, that life may not be a filled with disappointments, followed by pain." Given that you

to 10, he is at a 7 when he paints. The MDT therapists then suggests, "If you are at a 7, then you might not experience that you 'always', believe that life is a series of disappointments followed by pain at a four, or always every moment." He agreed that is true when he is practicing his art.

One of the adolescent responds a two (2) or better you have "redirected and reinforced" a possible alternative beliefs. In the family a question his prevalent was repeated for each family member. The collective family beliefs addressed their Conglomerate of Beliefs and Behaviors, (COBB). The family process is examining the family belief, "When we feel, it will be unpleasant."

The Family V-C-R process examines the family belief, "When we feel, it will be unpleasant." on a scale of one to 10 that there, could be a time, or a moment, that the family might experience a 'positive feeling'. They talk about how during a recent birthday celebration of the sibling, they went to a theme park and all "had a ball" together. The collective scale of one to 10, was a four – "at times the family can feel and it is positive", being a good feeling collectively. The MDT therapists helped the family address a belief and synthesize agreement that "at times we can 'feel' as a family, and it can b pleasant." The V-C-R allowed the family to accept their beliefs as their reality, clarify

how the belief translates to them individually and as a family, and redirected then to an alternative belief that might be real four out of 10 times, in this session. The collective experience of the family can slowly begin to move to healthier collective beliefs, balancing the family's belief systems.

which members of the therapy context are drawn into coalitions against other members. It has been the experience of the writers that MDT has a somewhat different response to these concerns than most therapies. The careful assessment of each individual member's Beliefs and Modes, and the sharing of these beliefs equally amongst all

Balanced Family Beliefs

Family Belief	V-C- R	Balancing Beliefs	Balanced Beliefs
Life at time is an endless series of disappointments followed by pain.	When we are able to talk about our feelings in therapy, we can hope at a five on a scale of one to 10.	At that moment we can believe that life at times can have some hope and some slight optimism. The belief is at a five on a scale of one to 10.	At times life can be ok.
Whenever I hurt emotionally I will do whatever it takes to feel better.	Sometimes, it is okay to hurt emotionally, and allow myself to feel bad.	At this moment I can believe that 20 percent of the time I can handle my bad feelings. The belief is at a two on a scale of one to 10.	Sometimes I can feel bad and deal with it.
Whenever I feel, it will be unpleasant.	There can be a time when I feel, and it is okay.	I was happy at the specific moment that listened to the new Kanye West CD. The belief is at a five on a scale of one to 10.	It is possible to feel ok at times.

Balanced Beliefs – Adolescent Focus

Adolescent's Belief	Behavior	Feeling	Mother's Belief	Behavior	Father's Belief	Behavior	Family Belief
Whenever I feel, it will be unpleasant	Isolates & withdraws)	Sadness, pain, being isolated	I try to control my grieving, loss, pain, or sadness, but they come out in a rush of emotions.	Isolated and withdrawn, drinks alcohol	If I don't think or deal with a problem, it is not real.	Focuses on distracting activities, sports, work, etc.	Whenever I feel it will be unpleasant.

It is customary in systemic or strategic family therapy paradigms to pay close attention to the proximity of each family member and the clinician at any given moment. Clinicians are trained to assess this sense of connectedness through the perception of a variety of non-verbal cues, affective states, etc. The allegiances between the family member, identified patient and the therapist are often shifting and mercurial and can even give rise to phenomena such as Minuchin's Triangles, in

members of the family results in a truly collaborative atmosphere. The family is the working unit here – the therapist focuses them on the work of understanding and assessing the beliefs of the each family member, and their combined perspective as a whole. The therapist models appropriate inquiry through the consistent validation, clarification, and redirection (V-C-R technique) of beliefs. This in itself defuses the tendency of family sessions focusing on attempts

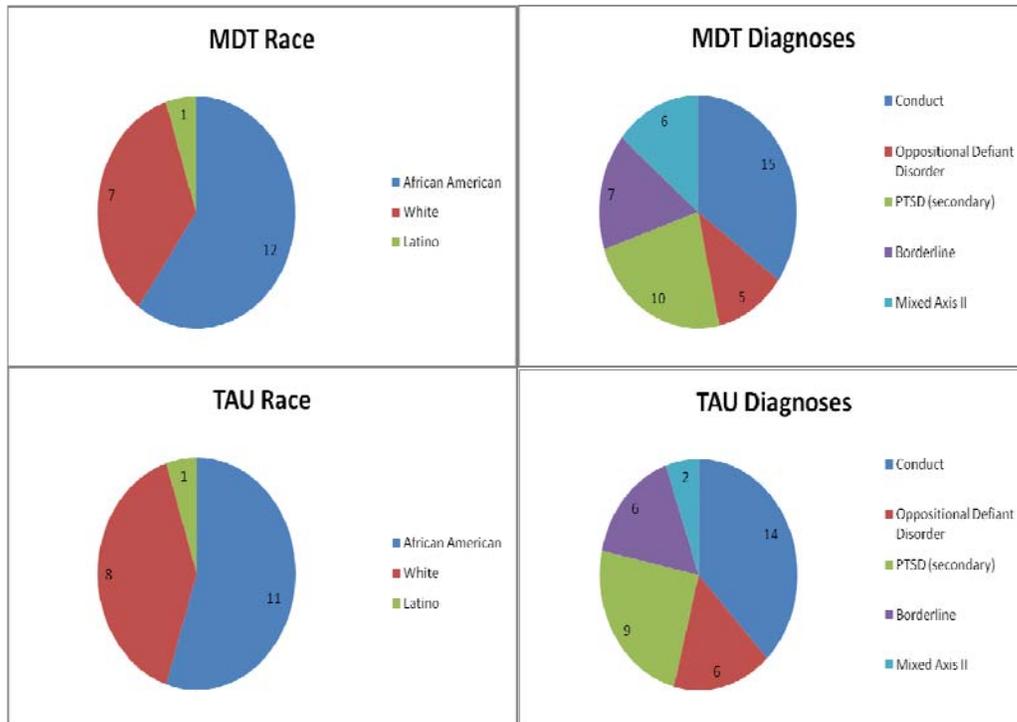
to form allegiances of one against another. Each understands that he or she will have a turn at looking closely at beliefs systems, with the support of family members.

Method

The study group was composed of forty residents in residential care and their families, divided into a twenty member control group and a twenty member experimental group. Admission to this study was done on a rolling basis based upon admissions to the facility – assignment to either

center, they could not be blinded for the post-test as these staff persons were involved in the therapeutic effort. The STAXI was completed by the assigned therapist with the child also within 30 days of admission. The post-test was also administered by the same therapist who provided the treatment, thus similarly not being blinded. These weaknesses must be overcome in future research on the efficacy of paradigm.

Please refer to the charts below for demographic



group was determined by a staff member not in any way related to this study. Families were defined as caregivers and their household members who occupied the residence where the patient was intended to be discharged. As this study was conducted in a functioning treatment center, with its own procedures for admission and discharge, it was impossible to establish a definitive length of stay for both groups – the members of each group had extreme variability in their length of stay ranging from approximately six to nine months. A full CBCL was completed by the direct care and educational staff within 30 days of admission. Both experimental groups were blinded at the outset as to which therapeutic paradigm would be used. Unfortunately due to the collaborative nature of a residential treatment

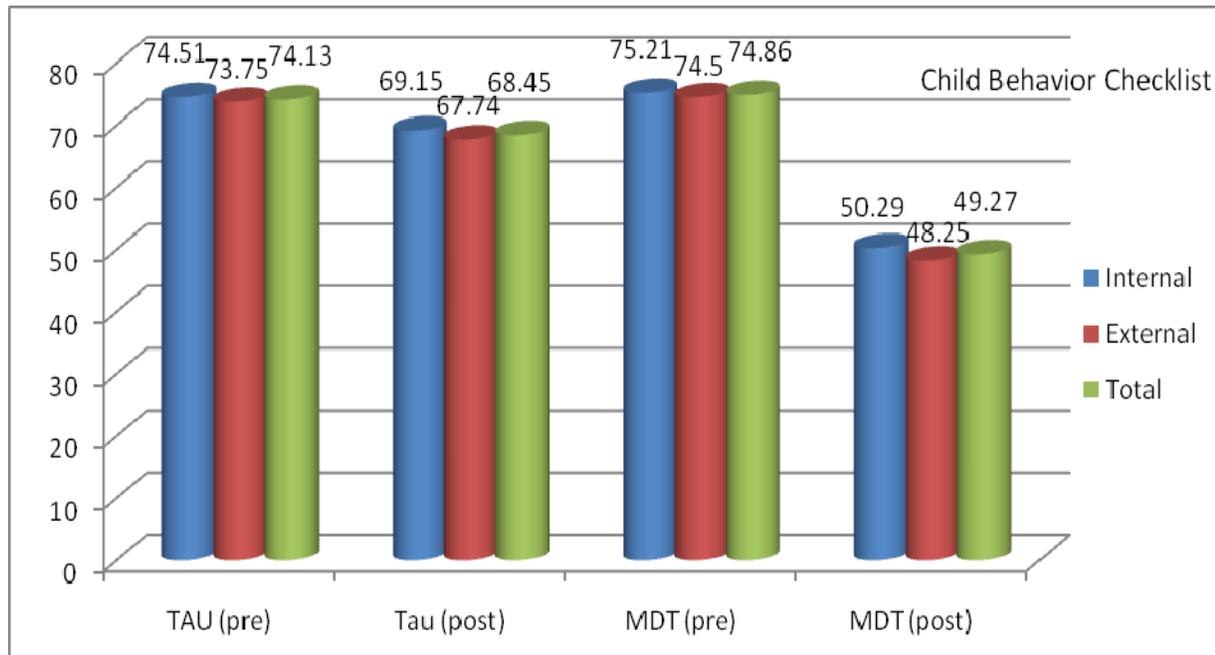
information, limited to race and diagnosis.

The methodology used for the TAU group was standard Cognitive Behavior Therapy, in both individual and family therapy, based on Dattilio, et. al.(1998) style. The providers were supervised in this methodology on a weekly basis throughout their treatment efforts by a doctoral level clinician with extensive training in this area. Similarly, the MDT group was supervised by a doctoral level clinician on a weekly basis.

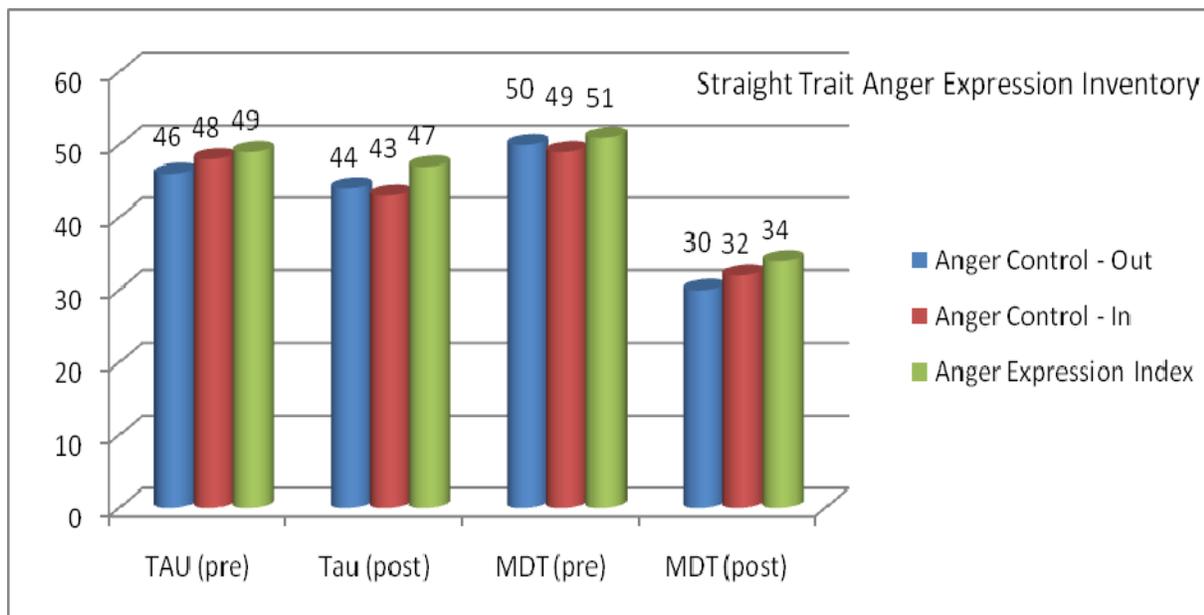
Both the TAU and MDT group participants were randomly assigned to the study groups from the resident population in the same facility. The participants shared a range of between 15 and 17 years of age. Participants were informed of all

possibilities of collected data being used in a study. Family member were also informed of used of collected data, as well as the Department of Youth and Family Services. Informed consent was

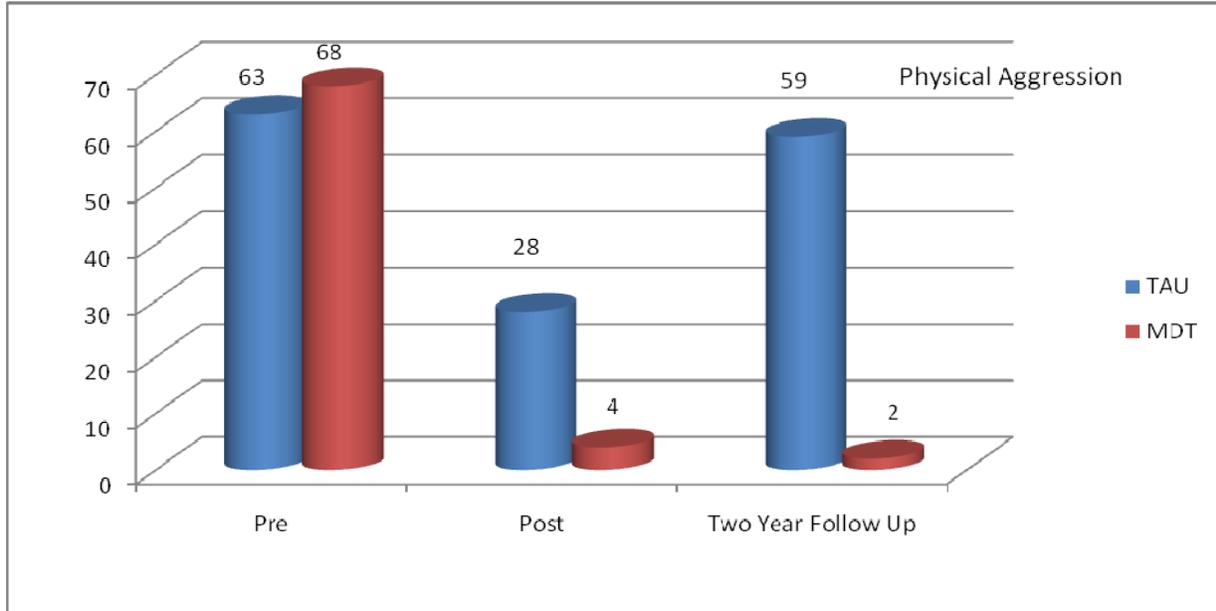
established in writing with all participants. All efforts were made to disguise the name of the



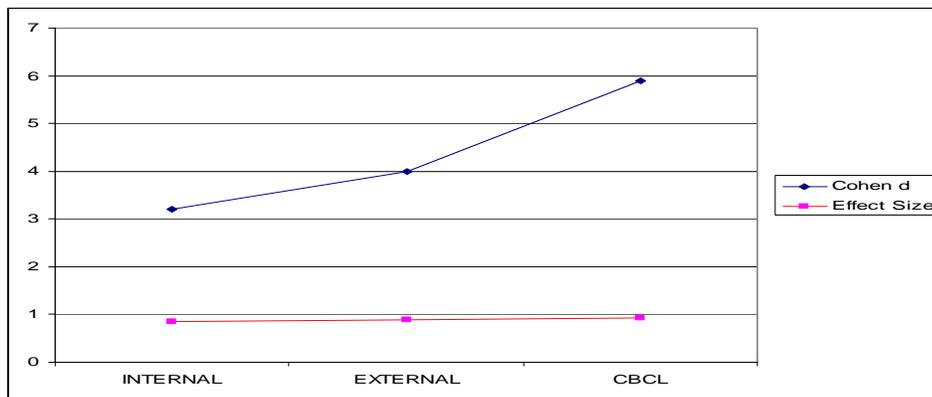
	TAU (pre)	Tau (post)	MDT (pre)	MDT (post)
Internal	74.51	69.15	75.21	50.29
External	73.75	67.74	74.5	48.25
Total	74.13	68.45	74.86	49.27



	TAU (pre)	Tau (post)	MDT (pre)	MDT (post)
Anger Control - Out	46	44	50	30
Anger Control - In	48	43	49	32
Anger Expression Index	49	47	51	34



	Pre	Post	Two Year Follow Up
TAU	63	28	59
MDT	68	4	2



Category	Cohen d	Effect Size
INTERNAL	3.209	.848
EXTERNAL	3.985	.893
CBCL	5.89	.9355

facility, as well as participants' identifying information

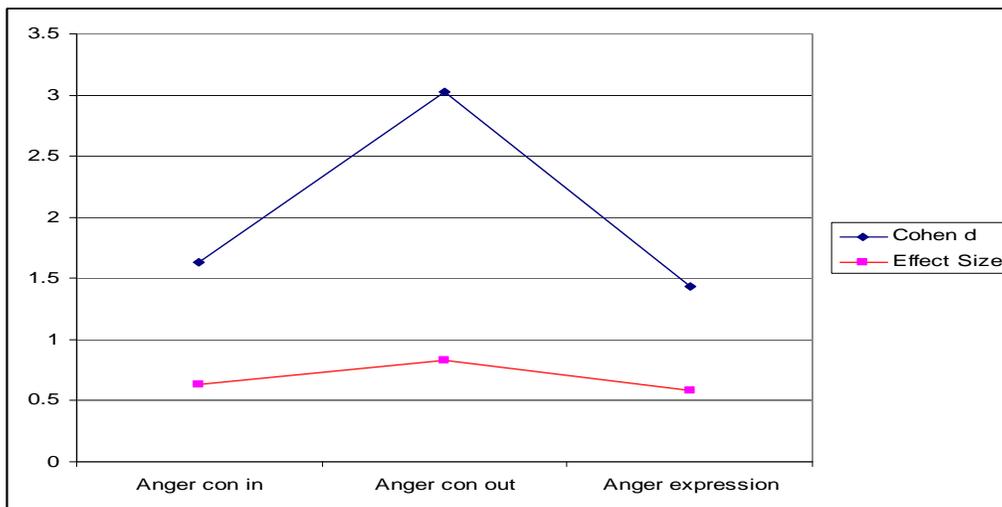
Results

Physical Aggression by the residents was selected as the third dependant variable as it represents one of the highest risk behaviors manifested by the residents.

The CBCL is a multi-axial assessment designed to obtain information regarding behaviors and symptoms of 11 to 18 year old children. For the purposes of this study we focused upon the results categorized into internalizing (somatic, withdrawn, anxious or depressive behaviors) and externalizing (aggressive or delinquent) behaviors. These two factors moved together when treated with TAU as well as MDT. Overall impact of the clinical interventions differed markedly, however – the TAU total score declined by 5.68 points (~8%) from pre treatment to post treatment with

others or the environment (Anger Control-Out) such as refraining from an aggressive outburst, and towards anger directed inward (Anger Control-In) such as self-soothing. Using TAU, the pre and post test data related to control of outward anger expression declined two points (~4%), and the inward expressions declined five points (~10%). The MDT group was generally assessed to be more impacted by anger issues than the control group. The Anger Control-Out score declined by 20 points (~40%), while the Anger Control-In score declined by 17 points (~35%). The categorizing of the patient anger expression showed similar impact, declining by 2 points (~4%) in the TAU group, and 17 points in the MDT group (~33%).

A more subjective but equally important measure



STAXI	Cohen d	Effect Size
Anger con in	1.636	.6331
Anger con out	3.028	.8344
Anger expression	1.434	.5828

Cognitive Behavioral techniques. The group treated with MDT techniques, however declined 25.59 points (~34%).

Similarly, the STAXI revealed a greater positive impact from treatment using MDT. This instrument was designed to assess the “components of anger” as manifested in the residents both in terms of the expression of anger, and the ability to control or contain it. Primary attention was given to components of instrument that assess the client’s ability to control the expression of anger towards

was assessed – physical aggression. Although both intervention techniques impacted the client’s tendency to manifest anger as physical violence, it is important to note that the two-year follow-up showed not only maintenance of an ability to bind anger, but also a further lessening of its frequency. These data were derived from report by staff during the first month of the child’s treatment, then again during the last month. Inter-rater reliability was enforced by the supervision of the unit supervisors. The two year follow up data was reported by the child’s family and was to reflect the

entire timeframe since discharge, for example the TAU group reported 59 incidents of physical aggression since discharge. These data are suspect due to the difficulty to insure inter-rater reliability, but were included for the interpretation of the reader.

As a final measure to assess meaningful outcomes, we decided to measure the magnitude of the result, rather than the probability that the result was due to chance. We employed the Cohen d statistic to measure the strength of the found outcomes as produced by effect size. The CBCL means indicated significantly large effect sizes for internal (.848) and external (.893) states. These effects sizes suggest that results analyzed were not due to chance.

The results of the STAXI were also analyzed utilizing the Cohen d method to assure valid results. The results show that the conclusions were not due to chance. The statistic reveals a medium effect size for general anger expressed (.582), while the control of anger outward had a large effect size (.834). Controlling inward anger showed a medium effect size (.663).

After ruling out chance, we can assume that the results of the study are valid and not due to chance.

Discussion

The difficulties inherent in conducting research within an active behavioral healthcare treatment facility are legion. It has been demonstrated elsewhere, however, that results of empirical work done in highly controlled academic institutions do not reliably generalize to "real-world" applications (Weisz, Sandler, Durlak, & Anton, 2006). The author's development of this paradigm springs directly from active work with a population that defies controlled empirical inquiry due to their age, the mandated nature of their participation in care, and the volatility of their behavior. It is this population; however, that most frequently stymies the clinicians who try to help them. We feel strongly that empirical work must be conducted here, in "the real world" where effective treatment strategies are so desperately needed.

This is another MDT preliminary study that indicates continued promise for Mode Deactivation Therapy, but it is clear that further work must be done. The sample size is small, yet the data from the effect size suggest a powerful effect, the researchers are not adequately blinded when

conducting the pre and post evaluations, and the two paradigms are applied for disparate periods of time, based upon the requirements of each individual case. There are many opportunities for improvement in design, none of which are insurmountable.

MDT is trauma-sensitive, and attempts to grapple with content areas that generally pose a problem for more typical cognitive intervention strategies, namely unconscious patterns of cognition that stem from early and or traumatic life-experiences. These core beliefs are carefully assessed and interweaved with more typical interventions in a way that we feel avoids the inherent sense of judgment and appraisal that activate the highly sensitive defensive patterns in this type of youth and family.

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