Is Mode Deactivation Therapy Effective for Adolescent Females?

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**Literature Review**

 The history of cognitive psychology has, in essence, evolved with the primary goal of understanding the mind. For a long time, studying behavior was the only way one could study the mind. It’s interesting that Cognitive Psychology has thus come full circle. Many cognitive psychologists today work to study the mind in order to better understand and treat various disorders. This has evolved from early psychology where “ideas about the mind were dominated by the belief that it is not possible to study the mind....because the mind cannot study itself” (Goldstein, 2021). Albeit, studying one’s own mind seems quite a feat to attempt. However, studying the minds of others, not so much. With this in mind, Cognitive Behavior Therapy was developed by Aaron Beck in the 1960s, “since then, it has been extensively researched and found to be effective in a large number of outcome studies for psychiatric disorders including depression, anxiety disorders, eating disorders, substance abuse, and personality disorders” (Chand et al., 2022). From the basis of CBT, various other psychology therapies have emerged. The most promising of them being Mode Deactivation Therapy (MDT).

According to Bayles et al. (2014), “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.” Created by Jack A. Apsche, it has been shown in multiple clinical studies to be an effective form of therapy in treating and redirecting negative behaviors. “Originating from CBT, ACT, and DBT, MDT also incorporates principles from FAP…in examining how change is made in a therapy session, specifically the notion that behavior is shaped and often maintained by contingencies of reinforcement” (Apsche, 2010). This is what sets MDT away from other therapies. Apsche based his Mode Deactivation Therapy upon Aaron Beck’s Theory of Modes (1996). To help better address psychopathological problems that weren’t fully addressed by the then-current model of schematic processing. In “Beyond Belief: A Theory of Modes, Personality, and Psycholpathology”, Beck stated that “First, I invoke the notion of modes, a network of cognitive, affective, motivational, and behavioral components. The modes, consisting of integrated sectors or suborganizations of personality, are designed to deal with specific demands or problems” (1996). Beck also stated that “The *cognitive system* accounts for the functions involved in information processing and assignment of meanings: selection of data, attention, interpretation (meaning assignment), memory, and recall. This system is composed of a variety of cognitive structures relevant to persons’ constructions of themselves and other people…Memories have an important place in the cognitive system. Even though memories of past events may not be conscious, they can help to mold reactions of present events” (1996). This aligns the core components of MDT. Most notably, that of the concept of Validate, Clarify, and Redirect (VCR). In “A Literature Review and Analysis of Mode Deactivation Therapy” Apsche states that “Validation was defined by Linehan as the therapist’s ability to uncover the validity within the client’s belief…VCR employs unconditional acceptance and validation of the youth’s cognitive unconscious or out-of-awareness learning experiences” (2010). Mode Deactivation Therapy utilizes the cognitive processes of perception, attention, memory, conceptual knowledge, judgement & reasoning, and problem solving. Apsche stated “the theoretical constructs of MDT are based on Beck’s Mode Model, which suggests that people learn from unconscious experiential components and cognitive structural processing components. Therefore, to change the behavior of individuals there must be a restructuring of the experiential components and a corresponding cognitive reformation of the structural components” (2010). This is where VCR comes in, which seems to me to be an extension of B.F. Skinner’s idea of operant conditioning. “which focused on how behavior is strengthened by the presentation of positive reinforcers” (Goldstein, 2021). The most promising findings in favor of the efficacy of MDT were a series of studies conducted by Jack Apsche. Most notable of these were a study he conducted in 2006 where he and Christopher K. Bass compared three different treatment methods: Mode Deactivation Therapy, Cognitive Behavior Therapy, and Social Skills Training. In this study, they state that “one crucial difference between Mode Deactivation Therapy and Cognitive Behavior Therapy is that the core beliefs (or schemas) of the individual are *not* seen and challenged as dysfunctional because this action necessarily invalidates the person’s life experience” (Apsche & Bass, 2006). This aligns with the idea of positive reinforcement in a sense, because, as they state “in MDT, core beliefs are consistently validated as legitimate creations from the person’s life experience” (2006). The act of validation is in a way a positive reinforcer. They then use this to retrain the subject’s cognitive processes to thus alter their behavior in a positive way. MDT seems to be one of if not the most effective therapy methodologies in existence in terms of treating adolescent males with conduct and personality disorders. The findings of this, and other studies suggest that “Mode Deactivation Therapy may achieve superior results to traditional Cognitive Behavior Therapy (CBT) and Social Skills Training (SST) in reducing both physical aggression and sexual aggression in conduct-disordered and personality-disordered youth in a long-term residential treatment setting” (Apsche & Bass, 2006). To remain ethical, however, they did note that “several factors may limit the strength of the conclusions drawn from the outcomes” (Apsche & Bass, 2006), and went on to explain the restrictions of their study and how further research is still needed. Additionally, Corliss Bayles and Jolene Van Nevel, in “Mode Deactivation Therapy: A Short Review” (2015) note that “Mode Deactivation Therapy does not work with adolescents alone. Family therapy is also a big part of MDT. Family Mode Deactivation Therapy (FMDT) works in conjunction with MDT and is concerned with the family structure as a whole.”

Where these studies lack, however, is in research about the efficacy of MDT for conduct-disordered female adolescents. In all of the studies I’ve found and read, not a single one mentions the efficacy or possibility in treating adolescent females with MDT. Males are not the only adolescents affected with conduct disorders or sexual aggressive disorders. Admittedly, they are much more prevalent. This is simply because, as noted in a study about female psychopathy, females in general tend to exhibit the symptoms of their mental disorders much differently than males. Namely, they tend to be less overtly violent when they act out (Ramsland, 2019). A comprehensive meta-analysis further found that “MDT is an effective-evidenced based methodology with the specific target population of male adolescents” (Apsche, Bass, & DiMeo, 2010). It is with this in mind that I pose the question of whether or not Mode Deactivation Therapy is an effective methodology to treat conduct-disordered adolescent females, or is it restricted to only males?

One obvious way to design a research study to answer this question would be to replicate Apsche & Bass’s 2006 study with female patients instead of males. This study was ethically sound and while it had some shortcomings as mentioned by the authors, it remains the most comprehensive study of MDT versus other therapies to date. The authors did a fantastic job of creating a study that was unbiased and thorough in its application. By ensuring that the “three treatment conditions showed similarity in terms of the frequency of Axis I and Axis II diagnoses, age, and racial background” (Apsche & Bass, 2006). they ensured the internal validity of the study. Nothing whatsoever in the methodology would need to be changed, except to switch out the male patients for female patients. One could accomplish this by utilizing a female inpatient treatment facility. Just as they did in the original study, one could work to ensure that the various diagnoses are equally spread within the three treatment conditions, thus ensuring continued internal validity. The primary issue I see with this, however, is the issue of sexual aggression. Which, according to Apsche and Bass (2006) was where “the most dramatic difference between treatment groups was found.” This can be problematic because females generally aren’t sexually aggressive. They may be violent in other areas, but sexual aggression seems to be a rarity in the female population as a whole. One way to avoid this problem, however, would be to instead perhaps focus on sexual promiscuity, which is a prominent symptom of many female behavioral and mental disorders. While sexual promiscuity itself is not necessarily a negative behavior, unsafe sexual promiscuity and needless risks are. If this can be treated with MDT, then shouldn’t it be researched just as heavily for females as it has been for males?

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