IASA RATIONALE & GOALS

Patricia Crittenden & Andrea Landini
with contributions from the IASA Board and Organizing Committee

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The Problem

Mental health problems are now the leading source of disability among the world's youth, surpassing all other medical conditions (Gore, et al., 2011). Lack of effective mental health treatment is expensive to society and perpetuates the suffering of individuals and families (cf. Kazdin, & Blasé, 2011).

Who is affected: Mental health issues affect almost everyone's life; 20-30% of the population has a diagnosable disorder at any given time (Diekstra, 1993; Dilling, Weyerer, & Castell, 1984; Hagnell, Öjesjö, Otterbeck, & Rorsman, 1994; Kessler, 1994; Roberts, Attkisson, & Rosenblatt, 1998; Rutter & Rutter, 1993; Schepank, 1987) and some groups are particularly vulnerable. Vulnerable groups include:

1. Low income families: Depression and anxiety, plus child maltreatment and criminal behavior have higher frequency than in those who can buy relative freedom from the demands of everyday living;
2. Immigrants: Clashes between disparate cultural patterns of protecting the self are often misunderstood in their new culture and place them in vulnerable positions (e.g., Sachs, 1983). When combined with a more frequent history of traumatic experiences, especially from childhood, this places them at special risk (e.g., Rutter et al, 1998);
3. New mothers and their babies: Rates of post-natal depression are rising, especially among well educated women and our awareness of the consequences of this for child development is becoming of major concern (CDC, 2004; Gaynes, Gavin, Meltzer-Brody, et al, 2005; Halbreich,& Karkun,2006; McGrath, Keita, Strickland, & Russo, 1990; Murray & Cooper, 1997);
4. Preschool and school-aged children: Rates of autistic spectrum disorder and ADHD are still rising (autism: Baird, Simonoff, Pickles, 2006; ADHD: ??);
5. 15-25 year olds in the 'transition to adulthood': Eating disorders, personality disorders, psychoses, drug and alcohol dependency, criminality, and suicide increase dramatically in frequency from adolescence onwards (Martin & Volkmar, 2007; Maugham, Iervolino,& Collishaw, 2005);
6. Mothers (with children at home): Career expectations and social acceptance of divorce have dramatically increased the burden on women raising children;
7. Males of all ages: Males have higher mortality compared to females over all age ranges from birth onwards, and their life expectancy is also more susceptible to geographical 'divides', such as North-South differences (Wilkinson, 2003). Society currently fails to address males as the vulnerable sex and the issues involved in the current American social construction of masculinity and how these impinge on men's health (Courtenay, 2000a & b). From high mortality in infancy to very high mortality in late adolescence to early mortality in later life, males are not only more vulnerable, but when

things go wrong in families, adult males are the first to be ejected, with adolescent males next.

Cost: The cost of these problems is overwhelming in (a) money (health care costs and child maltreatment investigation and service, cf., Felitti, et al., 1998; depression cost 83.1 billion US dollars in 2000, Greenberg, Kessler, Birnbaum, et al., 2003), (b) professionals (rates of 'burn-out' are high, reaching 59% in a community psychiatric nurse population**,** Imai**,** Nakao**,** Tsuchiya**,** Kuroda**,** Katoh, 2004), and (c) lost performance (under-education, under-employment, time lost from work). The cost in human suffering is immeasurable.

Treatment efficacy: We do not know how to effectively treat these problems. Treatment techniques can account for maximally 15% of a treatment program (Lambert, 1992). Hope and beneficial expectations of the treatment account for about 15% of the outcome, a good relationship between the therapist and patient accounts for about 30% of the outcome and 40% is accounted for by individual factors in the patient present before treatment started (Hubble, Duncan, Miller, 1999). One third of cases do not respond to any known treatment and, in almost half of successfully treated cases, symptoms reappear within one year (Young, Klosko, Weishar, 2003). On the other hand, 50% of cases spontaneously improve, leaving approximately 15% that respond well to treatment in the short-term. Moreover, studies indicate that no treatment or theory of treatment is more effective than any other (Crighton & Towl, 2007). Finally, recently emerging findings suggest that treatment can be detrimental (Lohr, Devilly, Lilienfeld, Olatunji, 2006; Stroebe., Schut, & Stroebe, 2005), with rates usually ranging from 10%-20% worsening of condition after treatment (Davidson, 2004; Lilienfeld, 2007), but occasionally reaching as high as 40% negative consequences compared to untreated individuals (e.g., grief counseling, 2000). Recently the Cochrane review concluded that there was no evidence for the effectiveness of debriefing after traumatic events (Rose, Bisson, Churchill, & Wessely 2000).

Were ancillary effects, such as divorce, considered, the rate of harmful outcomes might be higher. Rates of treatment success have not improved in 30 years of assessing treatment efficacy, in spite of there being more than 400 published treatments.

Conclusion: Successful treatment of psychological distress requires an understanding of the causes of disorder and unfortunately mental health treatment is almost where medicine was at the end of the 19th century, i.e., we lack an equivalent to the medical theory of infectious disease. The work on genetic contributions is exciting (cf. Tsankova, Renthal, Kumar, & Nestler, 2007), but understanding the complex interactions of genes and developmental experience that influence psychological dysfunction is still in the future but getting closer (Rutter, et al. 1997, Rutter, 2006). Knowing how to apply this information to distressed individuals is more distant yet. Similarly, pharmacological treatments have reduced the distress and suffering associated with mental illness, but they rarely cure the dysfunction and do not prevent its reoccurrence if the medication is discontinued.

More alarming is the state of psychotherapy. There are three major problems. First, although we have many treatments available, most have no proven effect. This does

not mean, however, that they have no effects. To the contrary, many probably have positive, null, and even negative effects, depending upon which patient receives the treatment, by whom and for which sort of problem. Lack of investigation of negative outcomes is not tolerated in medicine and should not be in psychology and psychiatry. Until we look systematically at the range and specificity of outcomes, we will not be able to apply treatments effectively and safely.

Second, psychotherapists are trained in particular disciplines and 'brands' of therapy and apply their brand to all their patients. Instead, we need to understand how each treatment affects a range of patients and to have either therapists with broad training or precise assessments that can match patients to specialized therapists.

Third, mental health treatment changes in a fad-like manner as old ideas fail and new ones are generated, usually by charismatic figures. Moreover, thinking in mental health treatment is often strongly influenced by advocacy groups, such that a political agenda regarding 'victims' of disorder often influences what hypotheses can be studied (that is, political correctness is often dominant over scientific accuracy.). In some cultures it has become *de riguer* to give debriefing although there is evidence it does harm. The media reports do not accept anything else.

The most immediately useful growing edge of treatment-applicable knowledge is the cognitive neurosciences. We are beginning to understand how brain functioning is tied to behavior. To the extent that emerging theory, assessment, and practice build on the cognitive neurosciences, there is both a theoretical basis for treatment and a basis for scientific tests of treatment efficacy for particular subgroups of people.

We are doing something fundamentally wrong. The mental heath treatment system does not need tweaking or greasing; it needs fundamental changes in how its role is conceptualized, how professionals are trained and work, and who should receive which sorts of services and at which time during the life span. The changes needed cannot be limited solely to the mental health treatment system, but must reflect a wide range of systemic influences on personal adjustment and family functioning from the cultural and political levels to (1) neighborhoods and schools, (2) services to families and (3) service providers themselves. Only a broad array of changes can promote improved understanding and treatment of depression, violence, substance abuse, etc. It appears we can no longer use the current diagnostic systems to identify the categories of distress which require help in particular ways. Although unlikely to be available for DSM V, moves are afoot to look at what dimensions of functioning characterize different disorders and a whole issue of the *Journal of Abnormal Psychopathology* was devoted to exploring this possibility in 2006.

What we need

In order to address the social and personal problems resulting from mental health issues, we need:

1. *An integrated theory of psychological dysfunction* that can provide:
    a. A *functional formulation of problems* (to augment ineffective symptom-based disgnoses) as the basis for selecting treatment approaches;
    b. *Age-appropiate assessments* tied to both the causes of dysfunction and approaches to treatment (to augment diagnosis-based, non-developmental assessments);

c. An associated *database regarding the effects of various treatments on information processing and behavior* and that specifically includes negative effects and contra-indicated populations.

2. *Interpersonal definition of dysfunction and its consequences* (rather than intra-personal);
3. *Mental health professionals with extensive and empirically sound developmental training* across the life-span;
4. *Mental health professionals who are competent across both treatment modalities and systemic influences on dysfunction*, from biological to psychological, familial, and cultural/political; artificial divisions fragment treatment of individuals who suffer from dissociation/fragmentation;
5. *Integrated child and adult services* are needed because no child grows up without adults and no adult develops problems unrelated to his or her childhood, and because the greatest mental health casualites fall in the gap between childhhood and adulthood;
6. *Treatment directed toward changing the information processing* that underlies the generation of behavior rather than symptoms;
7. *Service structuring that gives the fewest, most efficient, and best integrated services* to the least reflective and inter-personally skilled people (i.e., the families with multiple, chronic problems) rather than the opposite as we currently do;

What we have accomplished already

As of now, we have (1) an integrated developmental theory and (2) most of the needed assessments as well as an interpersonal definition of dysfunction; they are not in wide use, but they are ready for dissemination and application.

The theory is the Dynamic-Maturational Model (DMM) of attachment (Crittenden, 1995, 2006). The DMM is a meta-theory that combines the crucial components of earlier theories to create a viable, integrative theory of psychological function and dysfunction and of treatment. The crucial components were derived from Bowlby and Ainsworth's work by Crittenden who was a student of Ainsworth. Following Bowlby's lead, she integrated other elements to generate the DMM meta-theory. The crucial components are:

a. On-going integration of theory, clinical experience, and empirical data (Bowlby, 1969/82, 1973, 1980; Crittenden, 2006; Crittenden & Claussen, 2000; Ringer & Crittenden, 2007);
b. Recognition of the evolutionary role of danger in eliciting criminal and psychological disorder (Bowlby, 1969/1982, 1973, 1980);
c. Systemic understanding of multiple layers of transactional influence on behavior (Bowlby, 1969/1983);
d. Recognition of the importance of intrapsychic functioning (from psychoanalytic theory, Bowlby 1969/82, 1973, 1980);
e. Information processing (Bowlby, 1980, chapter 3);
f. Individual differences in behavioral organization (Ainsworth, Blehar, Waters, & Wall, 1978):
g. Longitudinal and empirically replicable data regarding the interpersonal context that underlies such organization (Ainsworth, 1979);
h. Empirical testing of theory by providing sound empirical data around central hypotheses (Ainsworth et al., 1978);

i. Description of a categorical framework (i.e., Ainsworth's A, B, C patterns of attachment) that can be:
   (1) Converted into self-protective strategies,
   (2) Organized into dimension-based model of the information processing underpinning strategies,
   (3) Extended developmentally across the life-span,
   (4) Is consistent with most other theories of dysfunction (Crittenden, 2000);
j. Integration of learning theory principles (Crittenden, 1997);
k. Generation of a comprehensive model (the DMM) that accomplishes 1-4 (above) in a systemic manner, i.e., combining the contributions of Bowlby and Ainsworth and extending them across the life-span (Crittenden, 1991, 2006, 2007).

DMM theory differs from many psychological theories in being derived from extensive data from many different cultures and a wide range of disorders. It can enable professionals to move beyond superficial symptoms to understanding adaptive meanings for behavior that appears inappropriate and inexplicable. This is not only important in and of itself, but also it demonstrates a way of looking at development that is focused on what is discrepant and not currently understood. This fosters a non-prejudicial, problem-solving approach to understanding troubled individuals. In addition, it implies a single, integrated understanding of normal and abnormal psychology, and maintaining a balanced focus on both what is universal among us and the varied meanings that humans give to similar behavior.

The goal is to allow professionals to understand why people do what they do, especially when their behavior seems maladaptive, reprehensible or dangerous. On the basis of the observation of the specific behaviors and the functional meaning that is made of them, the DMM guides professionals to formulate hypotheses of intervention that are specific and testable. This has implications for the precision and efficiency with which child protection, mental health interventions, and social policy can be implemented.

Practical solutions

Child protection: a focus on how the maladaptive behaviors of abusive or neglecting parents can reflect their own version of an attempt, however twisted, to protect their progeny. This implies that even parents that threaten their children can have a positive potential that should be known and assessed accurately, either to maximize its use for the children, or to decide that in the here and now of the child to be nurtured, the best interest of all is removal. The DMM provides ideas and procedures that can inform these decisions and the ways to reach them, and the subsequent interventions.

Mental health: a way to go beyond the current descriptive fashion of defining psychopathology, and the related treatments, that are usually symptomatic at best. If psychopathology is defined as the application of protective strategies out of their appropriate context, and the maladaptive consequences of this mismatch, the understanding of these processes allows professionals to plan treatments that address the causes of disorders, and not only their effects. This conceptual framework could allow professionals to study when and how psychotherapeutic and drug treatments have positive or negative effects.

Education: Schools both see every child and help to prepare him or her for adaptive adult life, but they also experience directly the problems of children whose lives have not been safe prior to or during their school years. Teachers need help recognizing the meaning of children's disruptive behavior and also need to identify non-disruptive children who are nevertheless at risk and in need of intervention before their problems produce dysfunction. A crucial issue is that the very serious pathologies (psychoses, eating disorders, personality disorders and criminality) all coalesce at the end of the school years. Alert teachers and school psychologists should be able to identify and assist these children before their problems exceed our ability to treat them successfully. The DMM provides both information about how to identify developmental risk for these disorders and also suggests avenues for treatment.

Justice: Custody and Criminal Applications: Family Court issues which the DMM addresses include both child protection issues regarding custody and placement of children and also custody disputes tied to divorce. In addition, the DMM is relevant to foster care and adoption. Studies are being carried out in all these areas.

In addition, the DMM is relevant to criminal issues, both management of prisoners and their rehabilitation. We are currently working with the Ministry of Justice in the UK to improve treatment of violent offenders, reduce recidivism, and initiate prevention with children and youth.

Politics and business: When the DMM self-protective strategies and the conditions calling for their use are described, it becomes clear that leaders who are expected to protect people, materials, or ideas must use these strategies. Indeed, the greater the threat and especially threat combined with treachery, the greater will be the need for leaders who themselves use highly persuasive and even deceptive strategies. Understanding this and being able to discern these strategies in leaders could be helpful not only in selecting leaders, whether in corporate, totalitarian, or democratic contexts, but also in working with leaders using various strategies.

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