The DMM as a diagnostic system for treatment planning

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Problems with symptom-based diagnoses: DSM, ICD

- Lack of specificity
- High co-morbidity & within diagnosis variability
- Lack of agreement among assessors
- Not address the midrange (poor functioning, no psychiatric diagnosis)
- *Lack of causal explanation
- *Lack of treatment implications

What is needed

A coherent conceptual model that describes

- the full range from adaptive to maladaptive behavior
- in ways that clarify causation and
- suggest differential treatment approaches.

The DMM as a diagnostic alternative

- Focus on danger: protection & comfort
- Addresses
  - Maturation
  - Experience
  - Context
  - Information processing
- Has life-span suite of assessments
- Flexible clustering
  - Categories (2, 3, 10, etc.)
  - Dimensions (source of information, extent of integration)
  - Unique personalized classifications for treatment planning
- Interpretation through adaptation (not mental health or security)

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DMM Formulations

CHILD DISORDERS

- Maltreatment (Crittenden; Ciotti; Grey; Kolb, et al.; Seefeldt; Strathearn)
- Post-natal depression (Crittenden)
- Bullying (Smith & Myron-Wilson)
- Foster care & adoption (Carr-Hopkins, et al.; Gogarty; Farnfield)
- Autism (Brewerton, Robson, et al.; Crittenden; Crittenden, Dallos, et al.; Keller)
- ADHD (Crittenden & Kulbotten; Crittenden, Dallos, Landini, & Kozlowska)
- Psychosomatic, conversion, & pain disorders (Crittenden; Kozlowska et al.; Letourneau, et al.)
- Pervasive developmental disorder (Crittenden)
- Child sexual abuse (Kwako, et al.)
- Factitious illness by proxy (Kozlowska, Foley, & CrittendenCrittenden;)

ADULT DISORDERS

- Post-natal depression (Crittenden)
- Psychosis (Crittenden & Landini)
- Domestic violence (Vetere; Worley, Walsh & Lewis)
- Eating disorders (Dallos; Ringer & Crittenden; Zachrisson)
- Personality Disorders (Crittenden & Newman; Kulbotten)
- PTSD (Crittenden & Heller; Kuo, Kaloupek,& Woodward)
- Sexual offending (Baim; Crittenden; O'Reilly; Purnell)
- ADHD (Syrjänen, Hautamäki, Pleshkova, & Maliniemi)

Commonalities

- Each addresses an intractable problem
- Each involved exposure to unprotected & uncomforted *childhood danger*
- Each was *inter*personal in an *attachment relationship* (parent-child or spousal partnership), i.e., *familial*
- Each involved *transformations of information* that brought past experience forward to affect the present
- Each had *symptom signals*, but many of the signals were ignored, unclear, or even framed positively in the relational context
- The most severe involved *sexuality serving attachment* functions
- Children's problems were based in *parents' problems*.
- There were *individual differences* within each psychiatric diagnosis or legal category
- Each could be described by a *critical causal process* (Crittenden & Ainsworth)

Implications for Treatment

- Explore the *functional meaning* of the presenting symptoms/problem (before changing them)
- Look for past *exposure to danger* and its tie to the present
- Look for past and current *experience with comfort*
- Look in past and current *relationships*
- Look for *misapplied transformations of information*
- Look for the *self-protective function* of the behavior and transformations of information
- **Look** before acting on a diagnosis, complaint, or legal condition
- **Select** therapeutic approaches with the patient, giving patients efficacy in their ZPD (without augmenting distorted protective strategies)

DMM Family Functional Formulations

- Address the full range of human adaptability, including dangerous outcomes without diagnosable psychiatric disorder.
- Often provide counter-intuitive explanations for clinical problems
- These explanations lead to new goals and means for treatment, often suggesting harm if common approaches are used.
- The treatments are drawn from the existing repertoire of therapeutic tools.
- The explanations are usually developmental and often suggest new approaches to prevention.

A case in point:

Suicide

The ultimate absence of adaptation

Recent suicides

Parts Unknown

What we know about suicide

- 10th most frequent cause of death (Heron, 2015) (2nd for adolescents) (Stone, et al. 2015)
- Rates increasing (25% in 2 decades) (Curtin, et al. 2016)
- More suicides than homicides or war deaths
- Highest in China (Sha, et al., 2018), then Russia, with both dropping over 2 decades
- China & Soviet Europe have a history of forcibly broken families
- 50% saw a doctor recently (Posner)
- 54% are not diagnosable with DSM/ICD
- Risk groups: autism (Vasa, et al., 2017), sexual minorities (Stone, et al, 2015), veterans, physicians (Boxer, Burnett, & Swanson, 1995)
- Can be 'contagious' (10% rise after Robin Williams' suicide) (Jack, 2014; Mueller, et al., 2015)
- Affects about 6 other people

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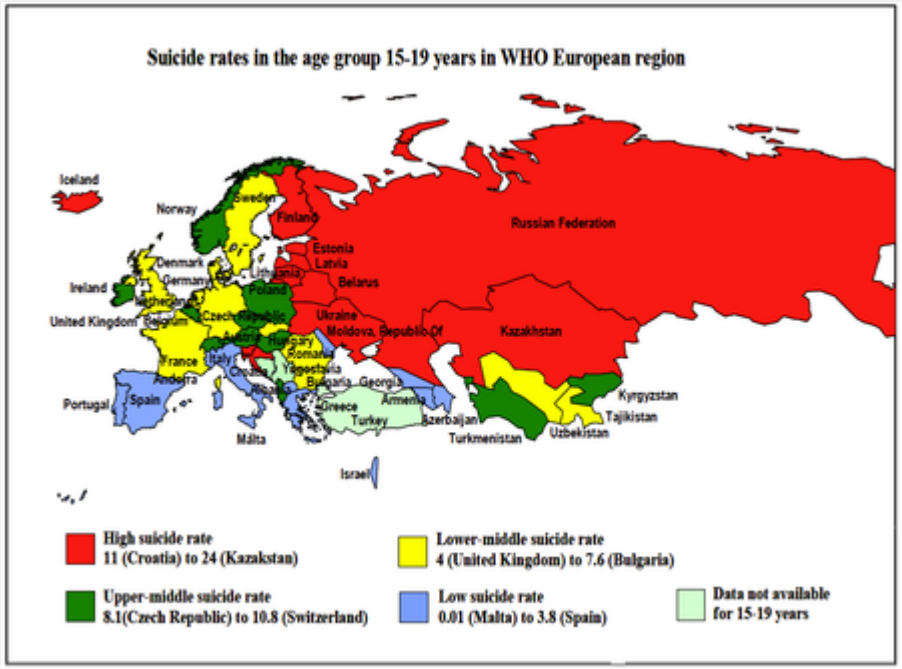
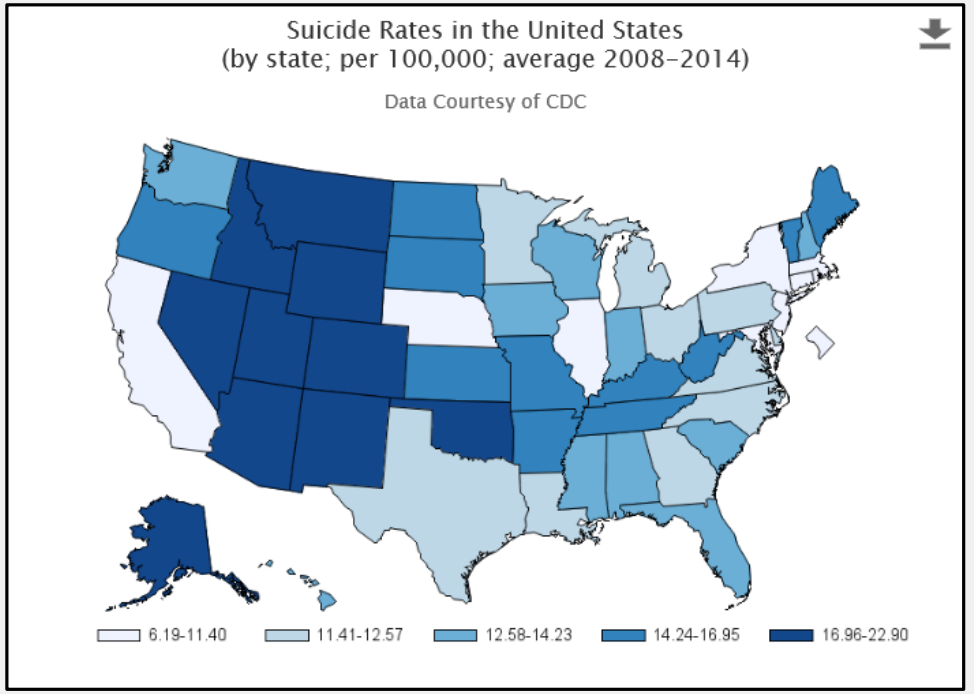
Suicide rates are rising (25% in 20 years)

Europe (16/100,000)



North America (13/100,000)



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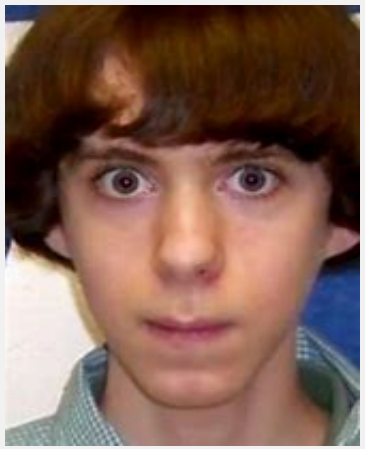
Mental health system response

- 5 (or 8 or 10) warning signs (Borowsky, et al. 2001 Gould, et al., 2003)
  demographic & risk conditions that are insufficiently precise and sometimes misleading
- Very poor prediction
- Help-lines can risk reinforcing sense of isolation and impermanence
- Fit existing tick-boxes
- Very poor prevention
- Lack an over-arching understanding of causation

Myths & truths about suicide

- Depression predicts suicide.
  Most depressed people are not at risk for suicide.
- No one is safe.
  Early unilateral rejection by parents predicts later suicide.
  Continued rejection by peers augments the risk to self - and others.
- Exceptionality protects.
  Exceptional performance, e.g., compulsive performance, is a major risk factor.
- Public intimacy is real.
  Public 'intimacy', without enduring family relationships, is a risk indicator.
  Both failure in family relationships and reliance on pseudo-intimacy augment risk.

Celebrate or castigate: miss the point



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Commonalities in suicide & homicide/suicide

People who commit suicide experience

- Caregivers early in life who do not connect (somatically, cognitively, or affectively) with their infant, thus disrupting the interpersonal process of adaptation
- Glorification by others of performance *or* predictably rejecting response to disruption
- Personal feeling of emptiness/failure
- Unacknowledged distress from professionals who find patients' suffering too hard to bear

Mental Health System

- Inability to recognize inner emptiness in the presence of performance or rebellion
- Failure to recognize high performance as a risk
- Unwillingness to protect before suicide is attempted
- Reliance on defined interventions - that lack input from (connection with) the individual

Protective ways to respond to suicidality

1. Be mentally balanced yourself (50-70% of mental health professionals are not)
2. Take all threats seriously, understanding their varied communicative functions
3. Consider all the risks in the home (e.g., medications prescribed to other family members, guns)
4. Consider family members' needs together (including other services), prioritizing parents
5. Work with family relationships (in person or in mind) & address all family members' safety
6. For children, don't compete with parents or unleash attacks that parents cannot (yet) withstand
7. Don't be fooled by exceptional performance & 'all fine' façades
8. Listen to the individual, setting your preconceptions aside & tolerating despair & grief (Goulston, 2015)
9. Structure a long-term plan, in family members' changing ZPDs (expecting meanings to change)
10. Don't open topics you can't close (with your skills & in the time available)
11. Expect silence (to avoid arguments with professionals & to prevent destabilizing the family)
12. Dare to care, without a 'therapeutic mask' (e.g., show what you feel, call after missed appointments)
    See #1: do not treat suicidality if expression of your feelings could harm the individual.
13. Know that successful patients often must trick you into meeting their needs
14. Accept that you're 'family' (a voice in the mind long after you've gone)

In sum, treatment of potential suicide

- **Is good treatment at its best** – because anything less might augment the risk.

- **It requires**:
  - exceptional self-awareness from professionals
  - exceptional tolerance of suffering and silence
  - exceptionally candid responses that demonstrate that no transformations are needed for the individual to be accepted (see Atwood & Stolorow, 2016 for an example).

A functional formulation of suicide

- **Critical causal process tied to connectedness** (Barber & Schluterman, 2008; CDC, 2009):
  - Caregivers' failure to connect in early childhood, creating an empty self that lacks interpersonal skills
  - Discovery of predictable caregiver responses to performance or rebellion, creating a false, efficacious self
  - 'Triggering' event in adolescence or adulthood (often an irresolvable conflict between empty & false selves)

- **Response of the rejected individual to unconnected caregiver**:
  - Temporary relief through creating a false, approved self *or* false angry self, being the 'baddest' of the bad
  - Hiding 'forbidden' aspects of self
  - Feeling of isolation – even when popular & successful – created by lack of connected self
  - Ultimate failure of strategies to enable enduring connections, thus leaving the individual isolated

- **Conditions that increase isolation**: unavailable parents, family silence, popularity, superficial relationships, rejection

- **Conditions that increase the probability of suicidal action:**
  - Professional support for false performing self (see Matakas & Rohrbach, 2007 for treatment that avoids performance).
  - Professionals who cannot connect or do so in harmful ways
  - Pre-defined treatment of 'illness' that does not involve family relationships (in person or content)
  - Rejection by community or accolades for false performing self
  - Access to easy means: meds, drugs, guns...

In conclusion

- **Consider a DMM paradigm shift**
  from individual psychiatric diagnoses & defined treatment to customized, developmental family treatment
- **Address danger – past, present, & imminent**
- **Think about protective strategies**
  Reasons for them & risks tied to them
- **Become a transitional attachment figure to patients & their families**
- **For suicide**
  - Attune yourself to new risk signs (e.g., compulsive performance, depressed coercion)
  - Dare to care: listen to and talk about the worst
  - Connect to the answers whether in words or behavior
- **Use the principles of DMM Integrative Treatment to guide treatment**

Citations

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https://www.iasa-dmm.org/iasa-conference/


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