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Aversive childhood experiences, without appropriate interventions, lead to life course violent and criminal behavior

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Editorial

There is a continuum of severity, chronicity, and complexity of presentation and histories of those with mental health problems. These range from people with very mild mental health conditions and no confounding factors, needing only self-help, increased family support, and/or education to improve their condition to those with severe and complex histories of multiple problems in multiple domains, needing a very integrated treatment plan among multiple providers for there to be significant improvement. Determining the most effective level of care and integration needed is essential to provide the most effective care at each level of complexity.[1]

For example, those with a mild Axis I diagnosis of mood disturbance, ADHD, or anxiety, with no history of violence, social maladaptation, or psychosis and very good coping skills may find that reading self-help books will give them the information they need to create more satisfying lives.[2]

Those with moderate depression, ADHD phobia's, or anxiety probably, few complicating factors, and good coping skills will do well with the traditional individual talk therapy such as CBT[3] National Association of psychotherapy, supportive relationship therapy or psycho-education once a week for 6months or less. Consultation with a psychiatrist for medication may also be needed. Individual weekly therapy for the mild to moderate group has a recovery rate around 90%.

Persons suffering from 2 diagnosable conditions such as mood or anxiety disorders and substance abuse issues, will likely need specialized group and individual and sometimes family therapy as much as twice a week for as much as 2years. Skill building and medication may also be needed. Recovery rates for those with dual diagnoses and complicating factors using traditional talk therapy methods is typically 50%.

Those with severe Axis I diagnoses (Mood and Anxiety disorders and Schizophrenia) and Axis II or personality disorders (DSM IV) and histories of trauma, and have been or are at risk for becoming criminal or violent need intensive and complex interventions involving multiple agencies, multiple times per week, including families in the therapy, case management, specialized services, skill building, and trauma work. Developmental skill building[4] and medication will almost certainly be needed. Recovery rates for this group using traditional talk type therapies are typically 30%. Most with highly complex cases end up being incarcerated, in rehab, hospitalized or dead. That is why prisons and jails have now become our de facto mental health inpatient facilities[5] However, well supported intensive community services, if readily available 24/7 with crisis management, would be far less expensive and more effective than hospitalization or incarceration and cost effective for tax payers.

If one uses individual, short term talk therapy for those with more severe conditions and more complex histories, it is applying the incorrect techniques and dosage for the clinical needs of the client. It is like using an aspirin for Cancer. The therapy is likely to be less effective and the recovery rate is often much lower than when the treatment is matched with client needs.

This is very elementary to most therapists who increase or decrease services depending on client need. Given recent shootings by those that were clearly mentally ill or autistic, there is pressure for better treatment for the mentally ill so they do not become violent. Those that are violent and also severely mentally ill often have 2 or more diagnosable conditions and are not in treatment. They may have trauma histories and immature coping skills. The violent and murderous men (usually 15-40years old) are often psychotic or autistic, paranoid, delusional, and narcissistic and without empathy for others.

Better mental health treatment, more readily available can reduce the likelihood of incarceration and violence among this population. However, we will only reduce these problems among the small group of those that are mentally ill and violent when we realize that those at risk for incarceration and violence have many seemingly unsurmountable problems and few coping skills and supports. When we help them change the balance in their lives to more coping skills and supports and fewer problems, they can begin to see a more positive path for themselves. This means that these folks need very practical help with safe homes, good jobs and job skills, good health, adequate income, a reason for living, natural supports and community involvement[6] through emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual wellness.

Interventions for people that are severely and chronically mentally ill and dangerous are not traditional talk therapy as most therapists think of it. It is more like what departments of social services and vocational rehabilitation might provide. To help those that are at high risk for violence they need to learn coping skills that we all take for granted (patience, waiting your turn, delaying gratification, speaking in a calm tone or soothing oneself when angry, seeing things from another person's point of view, learning how to make a budget and open a checking account). They need evaluations for the level of developmental skills that they have achieved and what skills may be

missing due to trauma or family chaos. Skills need to be built in a developmentally appropriate way despite the client's age.

For the clients at high risk for violence there needs to be inter-agency treatment teams that work together on developmental skill assessment and skill teaching, family and trauma therapy, housing, job skills, and the basic necessities of life. If we were able to apply the most helpful level of services to all clients, the system would be more efficient and cost effective. Outcomes would be better, and the overall cost to society would be less, as well. Clinicians would be able to help young people before a situation got out of control. This means early detection and interventions (preferably before the age of 12) of those at risk for violence is necessary.

Additionally, studies deriving out of the CDC Aversive Childhood Experiences study are showing that aversive life experiences in childhood are associated with poorer social and physical outcomes for adults, including depression, substance abuse, tobacco use, and heart disease.[7] Additionally, the research of Moffit[8] indicates that the source of life course anti-social behaviors is neuro developmental, starting before the age of 12, worsening over time, and life-long.

Braaten[4] using the Behavioral Objective Sequence determined that many youth with histories of acting out behaviors had basic skills (communication, self-management, task, interpersonal, adjustment, and personal) that were in the kindergarten levels of development although they were of average IQ and 1st grade or older. Tremblay et al.,[9] reported that children, developmentally, should not be using aggression to get their needs met beyond the age of 6. He further stated that those that are aggressive after entering school have not been taught alternative ways to get their needs met through verbal communication. Therefore, children that are aggressive in school need to be assessed for developmental level of basic skills and then taught these skills in appropriate developmental sequences.[4] Youth with acting out behaviors must learn elementary skills such as taking turns before they can effectively learn higher level skills such as controlling one's behavior when upset by not hitting others. This may be part of the key in helping youth behave I more pro-social ways. This becomes part of the intensive treatment plan for youth with highly complex histories that are at risk for violence.

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Conflicts of interest

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References

1. Seifert K. Youth Violence: Theory, Prevention and Intervention. Springer Publishing Company, New York, USA. 2012.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (4th edn), American Psychiatric Association, Arlington, USA. 2000.
3. http://www.nacbt.org/whatiscbt.htm
4. Braaten S. Behavioral objective sequence. Research Press, Champaigne, USA. 1998.
5. Daniel AE. Care of the mentally ill in prisons: challenges and solutions. *J Am Acad Psychiatry Law*. 2007;35(4):406–410.
6. http://www.promoteacceptance.samhsa.gov/10by10/default.aspx
7. http://cdc.com
8. Moffitt T. Adolescent Limited and Life Course Persistent anti-social Behavior: A developmental taxonomy. In: Piquero A, Mazerolle P (Eds.), Life-course criminology: contemporary and classic readings. *Wadsworth*, Belmont, USA. 2001.
9. Tremblay RE, Willard WH, John A. Developmental origins of aggression. Guilford Press, New York, USA. 2005.