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Making Mental Health Beliefs and Values Explicit for Clients, Clinicians, Scholars, and Trainers

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Value-Based Concerns of Relevance to Mental Health Clients, Clinicians, Scholars, and Trainers

I. Lack of Definitional Consensus

The DSM-IV-TR (APA, 2000) identifies mental illness as meeting criteria for one of 400 discrete behavioral and cognitive syndromes. Other perspectives contend that an "internal dysfunction" may be associated with specific forms of "mental illness,' but that much of what we label mental illness is economically and sociocultural determined (e.g., Hurwitz, 2002). Some argue that the construct of mental illness exists mainly for social control of those deemed dangerous or unacceptable (Spas (1961, 2011). Recently, NIMH's shift away from the DSM-5 has been seen as "a clash of mental health titans" (Waterman, 2013, p. 10).

II. Lack of Etiological Consensus

At one end of the continuum, the medical model contends that mental illness is biologically based, and tends to minimize environmental factors of etiological relevance; at the other end, humanistic ally oriented models tend to emphasize the importance of subjective experience and the problems of reductionism, thus underemphasizing the possible role of neurobiology in mental illness. Because clinicians, scholars, and trainers do not agree on such fundamental matters, it is not surprising that clients also experience confusion and conflict regarding what is and is not "real" or "true" regarding the origins and nature of their "mental illness" much less their own role in "treatment" (e.g., Hunt, 2007; Rockwell, 2012; Tanenbaum, 2009).

III. Lack of Treatment Consensus

Given the lack of consensus vis-à-vis matters of definition and etiology, there could be little expectation that clinicians or those who train them in the first place would have consensus on matters of treatment. Even so, considerable evidence suggests that 1) there are "common" factors to all therapeutic interventions and relationships that are experienced as effective regardless of one's definitional and etiological commitments (Ahn & Wampold, 2001; Blatt, 2001; Norcross, 2011); 2) regardless of orientation, best practice requires an integration between clinical research and experience in the context of patient characteristics, culture, and preferences (e.g., APA Task Force, 2006); and 3) clinicians may be shifting from a rigid applications of *just* biological or *just* psychological treatments to a continuum-based, integrative, and individualized approach (Ahn et al., 2010; Shealy, in press).

Implications for Clients, Clinicians, Scholars, and Trainers

This lack of consensus regarding definitional, etiological, and treatment levels of analysis has three implications for trainers, scholars, clinicians, and clients:

1. training programs, faculty, and staff should be explicit about the nature, basis, and understanding of their epistemological commitments (e.g., their beliefs and values regarding what "good" treatment is and why such conclusions have been reached and are defensible);
2. clinicians and mental health scholars should acknowledge their own beliefs and values about such matters (e.g., understanding why they are drawn toward particular ways of practicing or researching); and
3. clients should be aware that there are multiple ways of defining, explaining, and treating mental, emotional, and behavioral "conditions" (e.g., which has implications for the type and nature of "care" that they experience and their role in the treatment process).

Project Method

To help facilitate the process of making beliefs and values regarding mental health explicit for clients, clinicians, scholars, and trainers, representatives from the following three entities came together try and find consensus:

1. VOCAL, a Virginia network of people in mental health recovery (www.vocalvirginia.org/);
2. IBAVI, a non-profit organization that examines beliefs and values and how they influence actions, policies, and practices around the world (www.ibavi.org); and,
3. Combined-Integrated (C-I) Doctoral Program, an APA Accredited program in Clinical and School Psychology (www.psyc.jmu.edu/cipsyd/index.html).

Specifically, over the course of a semester-long doctoral seminar on professional psychology, students, staff, and faculty representatives from these three organizations developed ten draft "principles of consensus" on the basis of course readings, class discussions, guest presentations, further research, and subsequent deliberations. Such principles offer an opportunity for greater rapprochement and reflection while promoting common purpose and mutual understanding among mental health clients, clinicians, scholars, and trainers.

Mental Health Beliefs and Values: Ten Principles of Consensus for Clients, Clinicians, Scholars, and Trainers

1. Recognize that Etiology is Convergently Determined Human functioning is determined in no small part by an interaction among core needs (e.g., attachment, affiliation), formative variables (e.g., life history), adaptive potential (e.g., genetic predispositions), and extant contingencies (e.g., factors in one's current environment that influence thoughts, feelings, and behaviors). Such complex interactions all should be considered when attempting to explain why human beings function as they do, particularly in the realm of mental health research, training, and practice.

2. Understand that Treatment Models are Values-Based Many factors and forces affect the type of treatment models that trainers, scholars, clinicians, and clients prefer (e.g., their own life histories, training experiences, economic contingencies, educational level, Zeitgest, etc.). The potential impact of these factors and forces on matters of research and practice should be acknowledged by clinicians, scholars, and trainers, and discussed, in an open and accessible manner, with clients.

3. Eschew Dichotomies In many cases, it is neither helpful nor advised to conceptualize human beings as being either "mentally ill" or "mentally healthy." Psychological functioning typically manifests simultaneously across multiple domains and continua that have to be apprehended as an interactive gestalt throughout all phases of development and life.

4. Model Transparent Engagement It is the clinician's duty to ensure that terminology and practices (e.g., regarding matters of diagnosis, treatment approach) are communicated in a manner that fosters the greatest possible degree of shared ownership of the treatment process.

5. Appraise Referral Questions Clients come to clinicians with an understanding of their own experience. They have the right to do so, and clinicians have the duty to respect such perspectives. However, on the basis of their knowledge, experience, and judgment, clinicians also have the professional obligation to evaluate the meaning and intent of a referral question in light of a client's presentation (e.g., their history; motives) as well as larger clinical goals and processes.

6. Collaborate Interprofessionally Clinicians, scholars, and trainers should attempt to collaborate in a respectful and open manner, recognizing that no one mental health field or specialty areas asks "all the right questions" or has "all the right answers."

7. Appreciate Culture and Context Mental health clinicians, scholars, and trainers should appreciate that prevalent approaches to diagnosis, assessment, treatment, and research may differ substantially across contexts and cultures as well as locally and globally, while also striving to learn from and contribute to each other's approaches and worldviews.

8. Acknowledge Power Dynamics By dint of their training, credentials, and roles, clinicians, scholars, and trainers have great power vis-à-vis the human beings whom they assess , study, and treat. In full recognition of such power, the first commitment is to do no harm, while embracing a life-long commitment to learning and growth. Such humility and openness should be inculcated in students via the philosophy and curricula of training programs.

9. Strive for Self Awareness Clinicians, scholars, and researchers should strive to understand how their own life histories, training processes, and contexts have influenced what they believe and value vis-à-vis the mental health realm. (e.g., why they are drawn to particular diagnostic, etiological, or treatment frameworks). In all cases, clinicians, scholars, and trainers commit to an honest and ongoing process of acknowledging and exploring these value-based issues in their research, teaching, and practice.

10. Cultivate the Capacity to Care Human beings enter the world with a core set of needs (e.g., for attachment, affiliation). The degree to which these are met in a "good enough way" influences not only one's own psychological functioning, but the relative inclination and capacity to experience and express care for such needs in self, others, and larger world. As mental health clinicians, scholars, and trainers, it may be helpful to contemplate the implications of such a perspective on human nature for one's life and work.