Foreword

"I wish I had thought of that!" That was my first thought as I read *Transforming Teen Behavior*, by Mary Nord Cook, MD. My second thought was, "I am learning things here." That's a nice experience for someone who will begin his eighth decade before *Transforming* is published. Dr. Cook is a physician specializing in child and adolescent psychiatry with special expertise in treating families. To my mind, her work is not in family therapy, but in *family psychiatry.* She brings to her work and to this book the medical background of a physician, beginning with dissecting a human cadaver as a first year medical student, later seeing patients in the emergency room, the operating room, and the delivery room. In the latter, she goes into the procedure with one patient and emerges with two, the mother and infant, and ideally the father and perhaps older siblings. This represents the essence of child psychiatry, the true patient being the relationship between the parent(s) and child, the life-giving, nurturing, and loving relationship that results ultimately in a healthy independent adult.

As a child and adolescent psychiatrist, Dr. Cook brings to this project her knowledge of child and adolescent development, including physiological, psychological, and relational development; her knowledge and experience with child and adolescent psychiatric disorders, including the developmental processes that underlie these disorders; and her knowledge of child and adolescent counseling, individual psychotherapy, group psychotherapy, family psychotherapy, and pharmacotherapy. Bringing all of these areas of expertise and experience together creates a family psychiatrist. Notice that the last area of expertise listed is pharmacotherapy, because with most disorders affecting adolescents this is the least important and ideally the last utilized modality.

Child and adolescent psychiatry began in Chicago in 1909 in what is known today as the Institute for Juvenile Research (Levy, 1968; Richmond, 1960; Truitt, 1926). It was the first of hundreds of child guidance clinics. From the first day in this first clinic, the child guidance model involved both the child or adolescent and his or her parents. Typically, the child or adolescent would be interviewed and counseled by a child psychiatrist or child psychologist, and the parents would be interviewed and counseled by a psychiatric social worker. This model persisted into the 1940s, increasingly informed by the prevalent theory of the time—psychoanalytic theory—with an associated decrease in parent involvement. The child's intrapsychic conflicts became the target of treatment efforts.

In the early 1950s, a group of child psychiatrists, along with clinicians and theorists from other disciplines, began exploring the idea of treating whole families. The initial advocates were Nathan Ackerman, MD (Ackerman, 1972; Ackerman & Sobel, 1950), Gregory Bateson, MA (Bateson, 1972, 1978, 1979; Lipset, 1980; Ruesch & Bateson, 1951), and Carl Whitaker, MD (Whitaker, 1946, 1966, 1975, 1976, 1989; Whitaker & Malone 1953), the two physicians having trained in child psychiatry, and Mr. Bateson in anthropology (Bateson, 1958). In the meantime, child and adolescent psychiatry continued with a psychoanalytic and psychodynamic approach until the mid-1970s (McDermott & Char, 1974), when an initially gradual, but rapidly accelerating, emphasis on medication treatment emerged. The child's synapses and neurotransmitters were the new target of treatment efforts.

Thus, child psychiatry began in the child guidance clinics with parent and child treatment, moved into university centers and private practice settings with a primary focus on the individual child, and finally to an even more reductionistic worldview when the medication era became paramount. The treatment of families, with a number of theoretical orientations, remained multidisciplinary as the field matured over the second half of the twentieth century. In addition to Drs. Ackerman and Whitaker, two other child psychiatrists were instrumental in the foundation of family psychiatry, John Bowlby, MD (Bowlby, 1969, 1988; Bowlby & Robertson, 1953), and Salvador Minuchin, MD (Minuchin, 1965; Minuchin, Auerswald, King, & Rabinowitz, 1964).

Of all of the early advocates of treating whole families from all of the various disciplines, including general psychiatry, the contributions of the four founding child psychiatrists have been the most lasting (Kramer, in press). Three subsequent generations of child psychiatrists have contributed to both keeping family psychiatry a

healthy presence within general and child psychiatry, but have made and continue to make additional contributions and refinements in theory and technique. Dr. Cook is an important member of this fourth generation of child psychiatrists who practice family psychiatry. She and her colleagues at Children's Hospital Colorado have brought children, parents, and families back into treatment, drawing on the lessons of the founders of both child psychiatry and family psychiatry, in a context that emphasizes developmental, psychodynamic, and family systems principles, and based on the emerging sciences of interaction (Josephson & Kramer, 2014; Kramer, 2012, 2014). Hence, my initial thought, "I wish I had thought of that!" But that's how it should work in healthy systems. It's exciting to observe.

Based on the scientific advances of the past 30 years, I have often wondered—in terms of what is known as a *thought experiment*—what psychiatry would look like if we were tasked to invent it today—if somehow all of the rest of medicine had evolved as it has but without the invention of psychiatry? The last 15 years of the twentieth century and the first 15 of the twenty-first have seen the conception, intrauterine development, and birth of the sciences of interaction. At a minimum, these include gene × environment interaction (G × E) (Caspi et al., 2002; Caspi et al., 2003; Suomi, 2004), epigenetics (Champagne & Meaney, 2001; Kramer, 2005a; Weaver, Cervoni, Champagne, D'Alessio, Meaney 2004), and nonlinear brain dynamics (Asano & Freeman, 2012; Freeman, 1991, 1995, 2003; Pincus, Freeman, & Modell, 2007), the latter possibly being thought of as brain × environment interaction (B × E) (Kramer, 2005b).

The most important result of sequencing the human genome has been the discovery that variation among humans is more a function of G × E at the organismic level, and epigenetics at the chromosomal level, than strictly a gene driven result. Psychiatry's love affair with pharmacological treatments, although certainly helpful (and harmful) to many patients, rested on the belief that allelic differences contribute to synaptic and receptor variations and lead to psychiatric disorders.

Interestingly, my answer to our proposed thought experiment is that psychiatry, and more importantly child psychiatry, would look more like it did at the origin than it has during the psychoanalytic and psychopharmacologic eras. The one difference from those early years is that it would be understood, based on the sciences of interaction, that the patient would not be the child or adolescent (or the adult), nor would the patient be the parents. The patient would be the whole family—however constituted. For both trait and state differences, this is the unit where G × E and B × E interactions occur. These processes influence normal developmental, as well as facilitate possible corrections with respect to developing traits that may lead to or already constitute a psychiatric disorder (Kramer, in press).

In the introductory section of the adolescent portion of *Transforming Teen Behavior*, Dr. Cook describes her overall perspective: "An interactive, experiential, and psycho-educational style workshop is facilitated, each session covering specific topics of skill sets, as outlined by the syllabus. The clinicians use a method of psycho-educational and Socratic teaching in conjunction with empathic and reflective listening, to inspire adolescents to ponder and brainstorm, about themselves, their families, and peers." A similar parent-oriented statement occurs in their section.

In what context is this "interactive, experiential, and psycho-educational style" implemented? Although a number of reasonable modifications to the standard treatment format are suggested, especially as a function of staffing differences, the default condition is three Intensive Outpatient Program (IOP) sessions per week for 6 weeks. The first of the three IOPs involves two, concurrently run, parent and teen workshops of 90 minutes duration each. The second IOP might occur the following afternoon, and includes concurrent parent and teen workshops for 60 min, and either a 60-min multi-family group therapy session including all families in the current track, or individual family psychotherapy sessions for the (no more than) six current families. The last of the IOP sessions would logically occur on Thursday afternoon. This IOP uses a creative arts therapy approach—either art or music—to utilize a nonverbal modality to practice psychosocial skills learned in the first two sessions of the week. This IOP is multi-family, but also includes siblings 6 years and older, and might include grandparents as well (Kramer, 1988). There is continuity of therapists over the course of each 6-week treatment group. Intakes, orientation, urgent, and medication appointments are provided outside the IOP format.

Although an adolescent typically catalyzes a family to enter this treatment experience, the patients are the families (in multi-family groups), the parents (in parent groups), and adolescents (in teen groups). Neuroscientist Walter J. Freeman states, "... the most important function of brains is to interact with each other to form families and societies (Freeman, 1995)." How better to facilitate the learning (not the teaching) of psychosocial skills than through *experience* in a natural *interactional* setting, i.e., peer groups (either adolescent or adult/parent), multi-family groups (society), or single families, the primary source of G × E and B × E for developing children and adolescents?

This particular IOP approach is probably not for every struggling adolescent, but it offers wider applicability than one might anticipate at first glance. It is designed to be either a *step-down* option from a more acute setting, e.g., inpatient hospital or partial hospitalization; or a *step-up* option from traditional outpatient treatment. Because a rolling admission process is recommended, it might be used as an option for adolescents seen in crisis in the emergency room, or other crisis entry points, e.g., school guidance counselor, or community crisis intervention programs. In an integrated healthcare delivery system, it would be ideal for most adolescents admitted in crisis to inpatient units, to transfer to IOP after 1–2 days of initial evaluation and ascertainment of safety.

In situations where a family is able to self-pay, it might be used for prevention or early intervention, perhaps with a health plan supplement following completion of the program; and similarly as an option for families considering outdoor therapeutic programs, therapeutic boarding schools, or military schools. Why not use it in residential treatment programs where the families are from the local area? Although not mentioned directly by the author, I believe it would also be ideal for families struggling with substance abuse, which for adolescents is often a coping mechanism absent the kinds of psychosocial skills learned in this program, but with the added benefit of concurrent parent and family complementary change.

Transforming Teen Behavior: Parent–Teen Protocols for Psychosocial Skills Training, by Mary Nord Cook, MD, is so ingenious it feels magical. We have all heard the statement, "It isn't rocket science." Well, this is rocket science. Why is it rocket science? Rocket science is simply the ability to both understand 100,000 moving parts and simultaneously the entity or context in which these parts are operating. That is what Dr. Cook has accomplished. It isn't simply teaching empathy. It's learning empathy in a family context, empathy for the adolescent by the parent, empathy for the parents by the adolescent, empathy for each other in peer groups, all in a family and multi-family context. This goes directly to the purpose of the human (and primate) brain (Kramer, in press) which is "to form families and societies" (Freeman, 1995) through G × E and B × E interaction over the individual and family developmental stages.

Transforming Teen Behavior is perfectly integrated, yet easily modifiable. The rolling admissions concept eliminates the waiting list problem, and keeps the treatment group alive through having new members learning from members with longer tenure. The 15–18 sessions in 6 weeks is intense, but a reasonably short duration for most families as documented by an 85% completion rate. It is certainly cost-effective as typically measured, but parents, siblings, and even grandparents, as well as non-custodial parents potentially, are receiving "free" treatment (prevention)—thus possibly eliminating or reducing future insurance plan costs. In short, "I wish I had thought of that!"

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