CHAPTER 1

Introduction and Background

Unmet Child Mental Health Needs

Mary Nord Cook

Although most American youth experience normal, healthy development, research has demonstrated that as many as 1 in 10 youngsters, aged 9–17 years old, will suffer symptoms of mental illness significant enough to cause some level of impairment, in any given year (Department of Health and Human Services [DHHS], 1999). However, fewer than 20 percent of those youth who need mental health services will receive them (Kataoka, Zhang, & Wells, 2002). US annual expenditure estimates for behavioral health services for youth range from $11.7 to $14.07 billion (Ringel & Sturm, 1998). Left untreated, mental health disorders in youth are associated with higher rates of suicide, violence, school dropout, family dysfunction, juvenile incarcerations, substance abuse, and accidents.

CHILD MENTAL HEALTH PROVIDER SHORTAGE

The Council on Graduate Medical Education (COGME, 1990) reported that the nation would need more than 30,000 child and adolescent psychiatrists by 2000. In 2009, only 7418 child and adolescent psychiatrists were practicing in the United States—more than 22,000 short of the stated need (American Medical Association, 2009). The demand for child and adolescent psychiatrists is expected to increase by 100 percent between 1995 and 2020 (DHHS, 2008). Ideally, the nation would have 14.38 child and adolescent psychiatrists per 100,000 youth, or approximately one provider per 1700 youth.

CHILD MENTAL HEALTH PROVIDER MISDISTRIBUTION

As of 2006, ratios of child and adolescent psychiatrists per 100,000 youth ranged from 3.1 in Alaska to 21.3 in Massachusetts, with a national average of 8.7 (Thomas & Holzer, 2006). The problem, however, is not just a simple numbers issue. There is a severe misdistribution of child and adolescent psychiatrists in the United States, with children and adolescents in rural and low-socioeconomic areas facing significantly reduced access to psychiatric care. Child and adolescent psychiatrists tend to cluster around training institutions and in urban areas large enough to support a Children’s Hospital, and child psychiatrists in private practice often do not take Medicaid or low-reimbursing insurances. The result of these patterns is that the majority of counties in the United States have no local child psychiatry services. Pediatric mental health care is provided primarily by primary care providers, including family practitioners, pediatricians, general internists, physician assistants, and nurse practitioners. Care is also often delivered by general psychiatrists, who may have limited training in treating the pediatric population. The US Surgeon General declared the following in his report:

There is a dearth of child psychiatrists. … Furthermore, many barriers remain that prevent children, teenagers, and their parents from seeking help from the small number of specially trained professionals. … This places a burden on pediatricians, family physicians, and other gatekeepers to identify children and adolescents for referral and treatment decisions. (DHHS, 1999, p. 7)

*Following sections up to Challenges Translating Research to “Real World” adapted with permission from Cook (2012).
MANAGED CARE AND FISCAL CHALLENGES

State-of-the-art specialized psychiatric treatments for children and adolescents are difficult to sustain in a managed care environment; and grant funding sources, especially government-derived, are increasingly scarce. Academic programs, in particular, are generally embedded within tertiary care centers or large hospitals, and reimbursements for behavioral health services generally fall short of covering the costs of providing treatment in those settings. Most insurance carriers “carve out” behavioral health benefits to behavioral health insurance vendors that either cannot afford or are unwilling to negotiate payment rates that can support the maintenance of high-level, specialized mental health services for families. Many employers are unwilling or unable to afford to provide behavioral health benefits to their employees, instead offering insurance plans that contain provisions only for medical care physical ailments minus coverage for psychiatric treatments for mental illness.

Children and adolescents with serious emotional and behavior disturbances and their families warrant and deserve intensive mental health and educational services; unfortunately, few have access to appropriate and sufficient services. As the gap between the demand and availability of pediatric behavioral health specialty services widens, the burden for service delivery is shifting more and more toward educational and primary care settings (O'Donohue, Byrd, Cummings, & Henderson, 2005). Child psychiatrists and psychologists are functioning more and more in consultant roles—serving to educate, train, or consult around behavioral health program development—whereas direct treatment is being shifted to nonmental health professionals serving in nonbehavioral health settings such as primary care settings and schools. The field of pediatric mental health is faced with the challenge of evolving creative, cost-effective, and replicable systems of service delivery that hold the most promise for the greatest impact across the broadest and most treatable patient populations.

CHALLENGES TRANSLATING RESEARCH TO “REAL WORLD”

It is widely appreciated that translation of research-based protocols, to real-world, clinical environments, can be challenging, and limited, for a host of reasons. The Director of the National Institute of Mental Health (NIMH), Thomas Insel, alluded to some of the impediments associated with translating research findings, to clinical settings:

It is important to note that the changing landscape is found outside scientific laboratories as well. Demographically, America is a different nation than it was 10 years ago: we are more diverse, we are aging, and we are increasingly challenged by the costs and complexities of health care. A major goal of this Strategic Plan is to enhance the impact of research on the enormous public health burden that mental illnesses have across the lifespan. (DHHS, 2008, p. iii)

The current NIMH Strategic Plan, finalized in 2008, tactically focused many of its objectives around designing and supporting research with the greatest potential for impacting public health. The plan outlined the following goals:

Strengthen the application of mental health interventions in diverse care settings...and expand research efforts to identify factors that will improve access to service as well as better the quality and lower the costs of services.

To pave the way toward prevention, recovery, and cure, we must find ways to ensure that the interventions and information we generate can be used by patients, families, health care providers, and the wider community involved in mental health care. (DHHS, 2008, p. 38)

Additionally, the plan highlighted a need for “innovative approaches to help providers of mental health interventions ensure that every person who may fall along the trajectory of mental disorder can be helped to preempt or recover from illness” (DHHS, 2008, p. 18).

ROLE OF PARENTS IN CHILD MENTAL HEALTH TREATMENT

Regardless of theoretical orientation, intervention format, provider type, or target population, the potential for effecting change in the physical or emotional health of a youngster rests largely on that youth’s caregivers. Hostility, criticism, communication, attachment, autonomy, attributional sets, and behavior management are
among the important processes of family life and constitute a few examples of the factors that impact the development, health, and functioning of youth (Hoagwood, 2005). A strong correlation has been demonstrated between “harsh parental verbal discipline” and the development of depression in young adolescents (Wang & Kenny, 2013). The same study demonstrated a significantly increased risk of conduct problems in teens correlated with increased levels of harsh parental verbal discipline. The authors defined this parental behavior construct as “the use of psychological force with the intention of causing emotional pain or discomfort for the purposes of correction or control of misbehavior.” Additionally, it has been repeatedly shown that risk of substance abuse among adolescents increases with rising levels of parent–teen conflict, whereas higher levels of family cohesion confer a protective effect (Goldstein et al., 2013; Hawkins, Catalano, & Miller, 1992).

Access to care, symptomatic improvement, and the durability and generalizability of treatment effects are among the outcome variables that are highly mediated by parents. The underlying mechanisms whereby parental behavior and functioning mediate pediatric outcomes are multifold and intersecting, and can be understood from a wide array of theoretical paradigms.

FAMILY-BASED APPROACHES

It is well established that effective treatments for youth with eating, substance abuse, mood, anxiety, and disruptive behavior disorders indicate a family-based approach (Cohen, Mannarino, Berliner, & Deblinger, 2000; Diamond & Josephson, 2005; Fristad, Goldberg-Arnold, & Gavazzi, 2003; Greene & Ablon, 2006; Hoagwood, 2005; Kazdin, 2005; Kolko, Brent, Baugher, Bridge, & Birmaher, 2000). Clinical programs that attempt to treat these populations without using a family-based intervention, as at least a significant component of a treatment package, are ignoring the findings of contemporary literature. Some examples of empirically validated treatment models necessitating high levels of parent involvement are described below.

FAMILY-FOCUSED THERAPY

Family-Focused Therapy (FFT), developed by David Miklowitz et al. (Miklowitz et al., 2004, 2014), has been shown useful in managing bipolar disorder in youth and specifically effective in delaying and preventing relapse. This intervention focuses on coaching parents to model, teach, and positively reinforce optimal communication patterns and health-promoting behaviors, as well as providing psychoeducation to families, regarding its expected course, and effective strategies for predicting and preventing relapse. Recent finds from studies of FFT delivered to families with adolescents at heightened risk for developing bipolar disorder revealed that effect size or the degree to which the improvement could be tied to the therapy was positively correlated with the degree to which the therapist was active, “hands on,” and directive in their approach (Miklowitz et al., 2013). In other words, the treatment worked better, when administered in a highly explicit, concrete, and structured manner.

MULTIFAMILY PSYCHOEDUCATIONAL GROUPS

Multifamily Psychoeducational Groups (MFPG) have similarly been deployed to treat families with youth diagnosed with bipolar disorder (Fristad et al., 2003). Similar to FFT, these groups provide extensive psychoeducation, along with training on skills to promote overall health, adaptive behavior, and effective communication and enhanced family relationships. MFPG, in comparison to treatment as usual, led to improved knowledge about children’s mental health problems, improved family interactions, and increased use of appropriate services. In addition, child perceptions of parent support were higher in MFPG than in the comparison group.

COGNITIVE BEHAVIORAL THERAPY

Cognitive Behavioral Therapy (CBT) is well established as an empirically validated, psychosocial intervention for anxiety and depression. Studies of CBT for adolescent depression by Brent and colleagues (Kolko et al., 2000) have demonstrated that the addition of a family component decreased the risk of relapse and that enduring family conflict
predicted relapse. Parental involvement and cooperation, in the application of CBT approaches for Obsessive-Compulsive Disorder (OCD) and other anxiety disorders, is essential for promoting significant and lasting effects on symptoms and behaviors in affected families (Freeman et al., 2003). Parents of youth with OCD, for instance, often become entangled in their child’s OCD rituals and obsessions, in an effort to reduce their child’s and their own discomfort—reassurance from parents reinforces reassurance-seeking behavior, which perpetuates dysfunction. Patterns of parental accommodations associated with child anxiety, often drastic, impair family functioning.

Studies of trauma-focused CBT (TF-CBT) performed by Cohen et al. (2000) have documented poorer outcomes in children who experience distressed and/or unsupportive parental responses, along with associated dysfunctional abuse attributions, and higher levels of shame. Family involvement in TF-CBT has been associated with greater improvements in parental depression and distress. Inclusion of family members has additionally correlated to improved parenting practices, along with decreased anxiety among traumatized youth, at 3-month follow-up.

PARENT MANAGEMENT TRAINING PROGRAMS

Parent management training (PMT) represents the most empirically validated and widely deployed psychosocial intervention for youth with disruptive behavior disorders (Kazdin, 2005). PMT is conceptually based on the principles of operant conditioning and focuses largely on understanding and modifying antecedents, behaviors, and consequences. PMT is an intervention directed primarily toward parents, in which parents are taught and actively rehearse interactional patterns and coached to implement behavioral paradigms for positively reinforcing prosocial behavior, while avoiding the inadvertent negative reinforcement of maladaptive behavior. This can have a significant treatment effect regardless of whether or not the children directly participate in sessions.

COLLABORATIVE PROBLEM SOLVING

Developmental psychology research has demonstrated that emotion regulation, frustration tolerance, and problem-solving skills are not primarily wired in youth, but instead are cultivated via the relationships with primary caregivers and other key adults. Greene and Ablon (2006) have developed a program, aimed primarily at caregivers but also targeting other key adults, such as school, juvenile justice, and nursing staff. This program provides a framework for enhancing frustration tolerance, affect regulation, and problem solving in youngsters. Through active training and rehearsal, caregivers and other key adults are taught an empathic and collaborative style of responding to youth with patterns of disruptive, defiant, and explosive behavior. Primary effects are the reduction in aggression and dysregulation and secondary effects are improved behavioral, academic, and social functioning, along with improved self-efficacy and mood.

PSYCHODYNAMIC APPROACHES

Intrapsychic conflict can only be understood in the context of interpersonal relationships—it arises from relationships and complicates relationships. The most critical relationships affecting the inner world of youngsters are those between children and caregivers. Children “see themselves through their parents’ eyes” and the behaviors, attitudes, emotions, and messages, both implicit and explicit, of parents, shape a child’s development, functioning, and sense of self. For instance, a youngster who is starving or cutting herself is clearly experiencing intrapsychic pain, but at the same time, is implicitly begging for others to respond. An adolescent, enmeshed with a parent, wants age-appropriate independence, yet concurrently desires to remain connected to parents. Problems and arrests in psychosocial development can only be understood in the context of the family and, as such, require active participation and support of parents.

LIMITATIONS OF AVAILABLE TREATMENTS

A variety of standardized protocols have been published, describing psychosocial interventions for youth with mental illness. However, the published programs currently available have limitations and often fail to meet the
needs of “real-world” settings, which must tackle “real-world” challenges. One limitation of extant protocols for youth manifesting emotional and behavioral disturbances is that they were generally designed for delivery in routine, outpatient behavioral health or school settings, to treat patients who can be aptly served at low intensity levels in their communities. However, many youth and their families exhibit high acuity levels and complex problems that merit more intensive, multidisciplinary treatments, often only available in hospital-based and/or academic settings. It is well established, via comparisons of the clinical characteristics of patients derived from clinical and epidemiologic samples, that patients referred to specialty mental health clinics are often more severely symptomatic and likely to meet full-threshold criteria for one or more major psychiatric disorders (AACAP, 2007; Connor, 2002).

Patients who are ultimately served in specialty programs are generally considered “treatment refractory,” with histories of failure to respond adequately to routine outpatient, community-based treatments (Frampton, McCarthur, Crowe, Linn, & Lovering, 2008). Likewise, patients stepping down from higher levels of care, such as inpatient, residential or day treatment are often too acute to be adequately managed in routine outpatient settings. Many patients who fall into such categories would be most appropriately served in an intensive outpatient program or IOP level of care. A standardized approach for such patients is lacking in the field, especially in regards to treating a pediatric population with widely varied clinical presentations, potentially meeting full or subthreshold criteria, for a broad array of psychiatric diagnoses.

Community-based settings offer the advantage of greater convenience and cost effectiveness, while hospital-based and/or academic settings offer the promise of increased use of evidence-based, cutting edge, multidisciplinary team-delivered treatments, often not tenable in other settings. Hospital-based and/or academic sites are typically committed to ensuring that care is standardized, and that outcomes are systematically assessed. Research has demonstrated superior clinical outcomes, for mental health services delivered in academic centers, compared to treatment as usual, in community settings (Curry et al., 2006; MTA, 1999; Schinnar, Kamis-Gould, Enama-Markson, Rothbard, & Ramachandran, 1993).

As noted above, state-of-the-art, specialized, multidisciplinary treatment programs typically are developed in academic and/or hospital-based settings. Funding for the development of novel, empirically validated programs generally derives from finite grants, government or private, which are not intended to support the maintenance of such clinical programs, over the long term. In hospital-based and/or academic settings, it is challenging to fiscally sustain outpatient mental health programs, based on collections from insurance, secondary to the high “overhead” or indirect costs associated with delivering psychiatric specialty services at such sites. Reimbursements for mental health treatment are often poor and unreliable, typically failing to cover the costs of service delivery, especially in academic or hospital-based settings (Leslie & Rosenheck, 1999; Schinnar et al., 1993).

An additional challenge is that the majority of standardized, psychosocial programs for youth with mental illness were designed for delivery of sessions in a certain sequence, thus requiring groups to enroll in a “close-ended” fashion. Patients who present after the “close-ended,” sequential, group treatment protocol has begun, often must be “waitlisted” for several weeks, before they can access the next cycle of the sequential treatment. In clinical settings, it is difficult to set up and maintain close-ended groups, of several weeks’ duration, as patients present with acuities that make it difficult for them to wait for the next group to begin. Prolonged delays in access to care are known to be associated with relapse, emergency room visits, hospital admissions, and suicide attempts that could potentially be prevented, by timely access to treatment in a lower level of care (Sturn & Sherbourne, 2000).

Another limitation relates to the fact that the majority of extant, pediatric, mental health programs were designed to serve patients who meet specific, threshold criteria for a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-V; American Psychiatric Association, 2013) diagnosis. Inclusion of youth in outcome or efficacy trials for such programs is likewise usually dependent upon meeting stringent diagnostic criteria, with trials often excluding patients who fail to meet full symptom count or severity, and/or who have comorbid psychiatric disorders. This tendency presents practical challenges and limits the generalizability of treatment effects, when one considers that the majority of youth presenting with mental health concerns in clinical and even school-based settings are highly comorbid and diagnostically complex (AACAP, 2007; Connor, 2002). Patients do not typically present with “pure” disorders, and more often than not, children referred to specialty psychiatric clinics have multiple, comorbid disorders. Patients with acute needs may actually be “subthreshold” for any one disorder, but still in need of clinical attention.

Nearly all available, manualized, evidence-based protocols that target youngsters with mental illness intervene either predominately with parents, or with youth, but not both. For those programs which do target both children and parents, typically the parent component of interventions which are predominately child-directed
is marginal, and vice versa (Greene & Ablon, 2006; Kazdin, 2005, Kazdin, Esvedt-Dawson, French, & Unis, 1987; Kendall et al., 1997; Lochman, Barry, & Pardini, 2003). Clearly, there is merit to involving both children, and their parents and families, in behavioral health interventions, and doing so would inevitably bolster treatment effects.

In an era of ever-decreasing inpatient and partial hospitalization stays, coupled with shrinking community resources, increasing numbers of patients need intensive outpatient services that are readily accessible, convenient, and efficacious, as well as covered by insurance. There is a significant need for clinic-ready, manualized treatments for diagnostically complex, treatment-refractory youngsters, who present with a range of emotional and behavioral disturbances. Programs which intervene with youth, and their parents, to an equivalent degree, while ensuring clinical efficacy, as well as fiscal sustainability, would fill a significant, real-world need.

IOP AS A SOLUTION

A manualized IOP was developed at Children’s Hospital Colorado (CHCO) in January 2006 to serve a broad and diffuse patient population, aged 7–18 years old, referred on the basis of clinical acuity rather than primary diagnosis. The IOP program was initially developed in response to a clinical need for a program for youth “stepping down” from higher levels of care (e.g., psychiatric inpatient or partial hospitalization programs), who remained too acute to be effectively managed with routine outpatient services. Likewise, patients who had failed to respond adequately to routine outpatient services were also “stepped up” into IOP. To ensure standardization of service delivery and enable program dissemination, the written materials were deliberately evolved to be explicit and readily followed, by numerous provider types, with variable levels of training, experience, and psychological mindedness.

“2’ × 4’” METHODOLOGY OF IOP PROGRAM

In evolving the program which follows, based on findings from the literature, along with vast input from multiple, seasoned clinicians from varied disciplines, along with clinical experience in the early implementation stages that informed its development following an iterative process, plus substantial doses of intuition and common sense, the following conclusions were drawn:

- Effective intervention requires participation of the patient AND their parents AND their siblings
- Effective intervention requires input and ongoing involvement of a multidisciplinary team
- Effective intervention requires teaching via psychoeducation AND skills demonstration AND practice, practice, practice...

The psychosocial and parenting skills that were lacking in teens and families who initially presented for care could not be effectively imparted without attending to all aspects of the family system, as well as all of the essential steps required for acquiring new skills. Learning to regulate emotions, listen empathically, communicate assertively, solve problems, and resolve conflicts collaboratively can be compared to learning to crochet, golf, or dance. No one can expect to achieve mastery at any new procedural skill without first learning about the underlying theoretical paradigms and strategic philosophies, especially in tackling complex and sophisticated proficiencies. Without the knowledge base and familiarity with the theoretical paradigm, one will not have the background rationale and reasoning that facilitates “buy in” to the strategies being recommended. Nor would an apprentice be able to appreciate nuances or possess the informational foundation to craft one’s own style of implementation when facing novel situations.

So, too, skills that require thinking and doing are conferred, in part, by repeated observation of those who’ve achieved mastery. Observation of the demonstration of a procedural skill is a powerful and often essential method for vividly and pragmatically illustrating the mechanisms that constitute a competency. Such demonstrations often convey information more effectively and efficiently than book knowledge or verbal explanations. However, neither of the aforementioned steps is sufficient to reliably impart the ability to duplicate a new skill. Everyone knows that knowing what to do, that is, intellectually understanding those concepts which underlie a competency, in no way ensures that the learner will have the capacity to duplicate that skill. There are clear distinctions between declarative (intellectual) and procedural (performance) knowledge (Goleman, 2005).
Acquisition of one does not guarantee the other. Knowing does not equate to doing. Nor does watching a master perform or even the capacity to explicitly describe the performance of a task or activity necessarily bestow expertise in said task performance.

When it comes to truly and completely mastering a new complex skill and modifying one’s behavioral repertoire, nothing can replace guided practice and experience. The repeated rehearsal, armed with information and mental models of implementation, is the ultimate reinforcer and clincher of expertise in psychosocial competencies. Imagine learning to golf or crochet or dance without any of the aforementioned training components.

Any coach can attest to the fact that bad or ineffectual habits and techniques are often very refractory to change and challenging to unlearn. It is almost always preferable to start with a student who is fresh and new to a sport or musical instrument versus contending with one who has forged long-standing, deeply ingrained, poor, ineffectual habits. Families who present for treatment have typically become deeply and chronically ensconced in dysfunctional and destructive patterns of communicating and relating. Hence, they are often presenting as particularly challenging and change-resistant students. At the same time, though, neither parents nor their children will be willing and able to give up old habits or relinquish well-rehearsed methods of relating, until they have sufficient grasp and traction on new methods of interacting. In other words, they would rather cling fiercely to what they know, rather than gamble on novel, unchartered territory. So, in essence, the new territory must become sufficiently familiar and trusted, before families will allow, much less support, the supplementation of old stomping grounds with new turf. Finally, no new ability is likely to be acquired without practice, practice, practice...both guided and independent.

It can be argued that acquiring interpersonal or psychosocial skills, especially within the context of a family is perhaps even more challenging than other endeavors, related to the high stakes at play and emotionally charged nature of family interactions. In the case of medical training, clinical educators and medical students nationwide are well indoctrinated to the mantra referencing the classic physician teaching method sequence that follows: “See one, do one, teach one.” What should be added and precede that mantra is “Read one,” as all new clinical procedures and competencies are first broached in medical school and residency via prerequisite reading and acquisition of background information and theory.

A vast array of literature has demonstrated the feasibility and efficacy of a method broadly termed “skillstreaming” (Goldstein, 1999). Skillstreaming refers to a widely deployed psychoeducational approach to teaching an array of psychosocial skills, first popularized in the 1980s by Arnold Goldstein et al., following his aggression replacement training protocols. The components include psychoeducation, followed by demonstration, followed by guided practice, followed by independent practice with feedback sessions.

Literature findings, program development experience, and common sense coalesced to establish the first of two, 4-step processes incorporated to achieve optimal psychosocial and interpersonal skill training protocols:

**Step 1**: Provide background information regarding theoretical underpinnings and strategic models that underlie the approaches to be recommended.

**Step 2**: Demonstrate optimal performance of skill/s under consideration.

**Step 3**: Facilitate practice of new skill/s, while providing real-time observation from masters, with immediate feedback and coaching.

**Step 4**: Promote practice of new skill independently, but then review progress and provide corrective feedback to continually enhance and fine tune implementation of new skill/s.

In reflecting upon extant available empirically validated psychotherapy protocols, many of which are referenced above, it is striking that nearly all target either parents or youngsters, but almost never both (at least to a comparable degree). This comes as a surprise and is at odds with common sense and what we have concluded is a self-evident reality, that is, that parent–child interaction patterns are dyadic and reciprocal. In shaping interpersonal communication patterns, it stands to reason that any intervention should target both ends of the system, perhaps even to a comparable degree and at least in part, concurrently, with real-time practice involving all parties. To work exclusively with parents fails to acknowledge that youngsters have their own agendas and come armed with their own unique temperaments and collection of strengths and weaknesses. Likewise, to target only youth, without involving parents and siblings, fails to recognize the undisputable and powerful influence parents innately have on their children. At the same time, the orientation and nature of skills training must account for the developmental level and role of the individual. Hence, the verbiage, perspective taken, and background information imparted in approaching parents will differ significantly than those approaches designed for application directly with youngsters, even when covering the same topics or skill sets, such as assertive communication or empathic listening. Therefore, the same protocols would not apply in parent- versus child-targeted strategies.
Furthermore, what we have repeatedly and strikingly found is that the comparable and concurrent targeting of parents by this program has resulted in marked reduction of defensiveness and resistance about pediatric patients, especially teens. In so many cases, youth who presented with treatment refractoriness and/or long-term and multiple domain deficits and impairments had long experienced a multitude of services that clearly and often almost exclusively were aimed specifically at them. They have often been made to feel as though they, and they alone, were the problem and in need of “fixing.” In this context, teens in particular frequently evolve increasing levels of psychological defensiveness and initially present with high levels of resistance and rigidity in accepting treatment. However, the skills training bent of the IOP that is clearly aimed at whole families depathologizes the youngster and indeed their whole family. At the point of intake, the teens often lament, “Hey, my parents are the problem! There’s nothing wrong with me!” and so clearly acknowledging the essential and pivotal nature of the parents’ role, by concurrently involving them in all aspects of treatment, has often led to marked “buy in” and a significant lowering of defensiveness among teens, therefore enhancing treatability. So, too, the group nature of much of the program likewise has had a cathartic and depathologizing effect, often putting parents and teens at ease and increasing their level of openness, flexibility, and ripeness for change.

When working with parents, we often reiterate, “Remember...children don’t do as we (parents) say...they do as we do!” The skills training programs that are integrated in schools and other community and clinical sites have notoriously failed to achieve enduring effects and generalizability, most certainly, at least in part, because they lack a parent and/or family component (Chronis-Tuscano, Chacko, & Barkley, 2013). The reverse is also true, that is, that parent training programs that effect positive behavioral changes inside the home have demonstrated poor generalizability to other settings (e.g., schools). Working with one side of a dyadic pair is like teaching one member of a couple to do a couples’ dance or performing marital therapy or divorce mediation without both spouses present. It would be like attempting to drive a car, while keeping the parking brake engaged. Sure, it would still be possible to move the vehicle through the force of the accelerator (parents), but only through great resistance (kids or teens), while jeopardizing the health and longevity of the engine (family). It is so much more judicious and effective to simultaneously apply the force of the gas, with the parking brake disengaged—the energy applied will be used much more efficiently and without posing a risk of damage to the system. So, too, those attitudes and behaviors which parents routinely model, teach, and reinforce at home are those most likely to be adopted and mimicked by youngsters, regardless of influences outside the home. Hence these insights and conclusions led to the evolution of the second set of 4 steps involved in the design of skills-training protocols for families:

*Step 1:* Direct one arm of treatment protocol directly to parents.
*Step 2:* Direct one arm of treatment protocol directly to youngsters.
*Step 3:* Imbed recurring forums for parents and teens (or children) to practice with coaching.
*Step 4:* Imbed recurring forums for whole families to come together to reinforce new skills.

To the best of our knowledge, at the time of publication of this book, no other published, manualized programs are available that target a broad and diverse patient population referred to an IOP program based on acuity, symptoms, and skill impairments rather than diagnosis. Likewise, to our knowledge, no other manualized program exists that simultaneously targets both youth and their parents or caregivers to an equivalent degree. The book that follows will describe the adolescent or teen treatment protocols of the CHCO IOP program that served patients aged 12–18 years old and their families. A separate book was previously published, and made available to the public, describing the child or school-aged component of the CHCO IOP, which served patients aged 7–12 years old.